UPDATED MARCH 2015

INSURANCE SERVICES PROGRAM
NEW CLIENT ENROLLMENT APPLICATION

Date of Enrollment Request: _____

My client _____ is requesting enrollment in the *Insurance Services Program*.

☐ I have attached the following documentation on behalf of my client (*Note:* Applications without the required documentation will not be accepted. (SEE RELATED ATTESTATIONS SUBJECT TO CASE MANAGER SIGNATURE):

- ☐ Initiation of Services
- ☐ Copy of client's Benefits & Pharmacy Services Summary

My client is (check one): ☐ on HIV drug therapy ☐ not on HIV drug therapy

My client earns <400%FPL (check one): ☐ YES ☐ NO

My client needs (check one or both): ☐ Premium Assistance* ☐ Co-Payment Assistance

*NEW CLIENTS MUST ALSO COMPLETE A **STATEMENT OF DIAGNOSIS FORM.**

CLIENT DEMOGRAPHICS *(please insert numerical codes as specified in County MAR memorandum)*					
Social Security Number	**Gender**	**Ethnicity**	**Race**	**Income**	**Housing/Living Arrangements**
Medical Insurance	**HIV/AIDS Status**	**Enrollment Status**	**DOB**		**Exposure**

CLIENT INFORMATION

A. AICP PROGRAM STATUS *(check one):*
NOTE: *Applicants requesting ISP premium assistance must apply for AICP enrollment if eligible.*

	Enrolled or wait-listed for AIDS Insurance Continuation Program.
	Ineligible for AIDS Insurance Continuation Program.

B. COUNTY OF RESIDENCE *(check one):*

	Hardee		Highlands		Manatee		Pinellas
	Hernando		Hillsborough		Pasco		Polk

ESTIMATED ANNUAL SERVICE NEEDS

HEALTH INSURANCE		**PRESCRIPTION DRUG C0-PAYMENTS**	
Premium Payment Per Month	**$**	Drug Co-Payments Per Month	**$**
x 12 months	12	x 12 months	12
Estimated Total Premiums	**$**	**Estimated Total Co-Payments**	**$**

Signature below attests that I have had documented contact with my client within the last 60 days, and that I intend to continue to have contact with him/her at least every 60 days to keep him/her eligible for Insurance Services Program services. *My signature also attests that I have: 1. attached a copy of my client's Initiation of Services AND Benefits & Pharmacy Services Summary; AND 2. confirmed that the policy/group number listed on my client's health insurance card 'matches' the policy/group number listed on my client's Summary of Insurance Benefits in cases where the Summary of Insurance Benefits doesn't include the client's name in the documentation.* My client's premium notice and/or co-payment invoice is attached to this initial request for service.

CASE MANAGER'S SIGNATURE **AGENCY** **PHONE #** **FAX #**

PLEASE RETURN BY MAIL OR FAX TO:

Suncoast Health Council, Inc. Attn: Barbara Hay 9600 Koger Blvd - #221 St. Petersburg, FL 33702 FAX (727)570-3033