THE HEALTH COUNCILS INC.
We Make Health Care Better

REVISED FORM – June 11

INSURANCE SERVICES PROGRAM
NEW CLIENT ENROLLMENT APPLICATION

Date of Enrollment Request: _____

My client _____ RWIS # _____ ***residing in zip code*** _____ is requesting to be enrolled in the *Insurance Services Program* administered by The Health Councils, Inc.

☐ I have attached the following documentation on behalf of my client (*Note:* Applications without the required documentation will not be accepted):

- ☐ RWIS consent form
- ☐ Copy of client's health insurance policy benefit summary, including a description of pharmacy benefits

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 NEEDING PREMIUM ASSISTANCE MUST ALSO COMPLETE ALL MATERIALS INCLUDED IN THE AICP APPLICATION PACKET (refer to AICP case manager manual).*

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: ***All applicants for enrollment to ISP must apply for enrollment in the AICP 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 CO-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 attached a copy my client's RWIS consent form to this application for use by The Health Councils, Inc.*** 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:
The Health Councils, Inc. Attn: Barbara Hay 9600 Koger Blvd - #221 St. Petersburg, FL 33702 FAX (727)570-3033