AIDS Drug Assistance Program (ADAP) and Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) CLIENT ATTESTATION

Instructions

This form must be completed by the applicant when submitting an ADAP/PrEP-AP application using the electronic ADAP Enrollment System (AES). ADAP/PrEP-AP clients who knowingly provide inaccurate or false documentation may be in violation of various Penal Code laws and the California False Claims Act.

Certification (Required)

By signing below, I hereby certify that the information provided in the ADAP Enrollment System and within this Attestation is factual, accurate, and complete. I also understand that ADAP/PrEP-AP is permitted to request additional verification documentation if the submitted documentation appears to be inconsistent or incorrect. I agree to promptly notify the program of any changes to my income, residency, or health coverage. I understand that failure to provide accurate information or deliberately omitting information may result in suspension or termination of services and I may be held financially responsible for any covered services obtained.

Select All That Apply (Required)

- ☐ **Applying for ADAP**
- ☐ **Applying for PrEP-AP**
- ☐ **Applying for MPPP** (Medicare Premium Payment program) Part C/D
- ☐ **Applying for OA-HIPP** (Office of AIDS Health Insurance Premium Payment program)
- ☐ **Applying for EB-HIPP** (Employer-Based Health Insurance Premium Payment program)
- ☐ **Applying for Medigap premium payments**

If applicable, by selecting to apply for OA-HIPP or MPPP, as indicated in the checkbox above, I also authorize, through my signature below, for CDPH to make a health insurance binder payment on my behalf to effectuate my health plan policy. A binder payment is the initial health insurance premium due to a health plan to begin coverage under the selected policy. I understand and hereby acknowledge that CDPH is not responsible or liable for late payments, late fees, and/or termination of my health policy for missing the binder payment due date. I understand that to have a binder payment made on my behalf, I must have active program eligibility and cannot be on a Temporary Access Period.

Applicant Information (All fields are required unless otherwise noted)

Client ID Number (optional): _____ Family Size*: _____ Date: _____

_____ _____

(Applicant's Printed Name) (Applicant's Signature)

* Health and Safety Code section 120960(e)(1) "Family size" has the meaning given to that term in Section 36B(d)(1) of the Internal Revenue Code of 1986, and shall include same or opposite sex married couples, registered domestic partners, and any tax dependents, as defined by Section 152 of the Internal Revenue Code of 1986, of either spouse or registered domestic partner.

ADAP-Approved Designated Agent Information (if applicable)

_____ _____

(Designated Agent's Printed Name) (Designated Agent's Signature)

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(Date Signed)