



OA-PCIP CHECKLIST

The Office of AIDS Pre-Existing Insurance Plan (OA-PCIP) will pay PCIP health insurance premiums for individuals that meet the following requirements:

- Must be a California resident;
- Must be a U.S. Citizen, U.S. National, or lawfully present individual;
- Must be without health insurance coverage for the past six months, including an individual or job based health plan, COBRA, Cal-COBRA, Medicare Part A, and/or Part B, Medi-Cal, CMSP, or LIHP;
- Must be at least 18 years old;
- Must have an HIV/AIDS diagnosis; and
- Must have an adjusted gross income not to exceed \$50,000

If you meet the program requirements and would like to enroll in OA-PCIP, please completely and accurately complete the following forms that apply. Applications will not be processed until all forms and documentation are provided. The OA-PCIP and PCIP forms are located at <http://www.cdph.ca.gov/programs/aids/Pages/OAPCIP.aspx>.

Determine ADAP co-enrollment status	With ADAP		Without ADAP	
	Enroll	Recert	Enroll	Recert
Determine if this is the OA-PCIP initial/annual enrollment or recertification				
1. OA-PCIP Application	x	x	x	x
ID Verification - Submit a copy of one of the following: Driver's License, State ID, School ID, Military ID, Passport, Permanent Residence Card, Work Permit, Photo identification document issued by a foreign government, or Immigration Card. If no other form of photo ID - Birth Certificate			x	
California Residency Verification - Submit a copy of one of the following in the client's name: Utility Bill (electricity, water, gas, cable), Lease Agreement, Rent Receipt, Mortgage Statement, Voter's Registration, Vehicle Registration, or Support Verification Affidavit			x	
HIV/AIDS Diagnosis Form (one-time)	x		x	
Income Verification - Submit the Financial Eligibility Form and the following income documentation that apply: California State tax Return, Federal Income Tax return, W-2 or 1099 tax form, Pay Stub*, Bank Statement* (must clearly state income source), Benefit Receipt* or Check Stub*, Disability Award letter, Support Verification Affidavit, or Self-Employment Affidavit *3 current consecutive months			x	
Public Assistance Screening Form and supporting documentation		x	x	x
2. OA-PCIP Consent Form	x		x	
3. Client Report Form	x		x	
4. PCIP Enrollment Application (one-time)	x		x	
Proof of citizenship or immigration status - Submit a copy of one of the following: U.S. Birth Certificate, U.S. Passport, Certificate of U.S. Citizenship or U.S. Naturalization, or green card. For other acceptable forms of proof of citizenship or immigration status go to www.pcip.ca.gov .	x		x	

Please mail the completed forms and supporting documentation to:

Insurance Assistance Section
 California Department of Public Health
 P.O. Box 997426, MS 7704
 Sacramento, 95899-7426

Or fax to (916) 449-5860