State of California—
Health and Human Services Agency

California Department of Public Health

CONFIDENTIAL AES SUBMISSION

(844) 421-8008 ADAP Fax (844) 421-7050 ADAP Phone

Submission Details

Date: _____ Number of pages (Including this form): _____

Enrollment Worker Information:

Full Name: _____

Site Name: _____

Site ID Number: _____ Email: _____

Phone Number: _____ Extension: _____

Secure Fax Number: _____

Client Information:

First Name: _____ Last Name: _____

ADAP ID: _____ Date of Birth: _____

Type of Submission (Select all that apply):

ADAP Related:

- ☐ New ADAP Application
- ☐ Re-enrollment ADAP Application
- ☐ Health Coverage Change
- ☐ Supporting Documentation (Misc.)
- ☐ Mailing Address Change
- ☐ MEER/EER
- ☐ Other (please explain below)

Insurance Assistance Related:

- ☐ New HIPP Application
- ☐ Re-enrollment HIPP Application
- ☐ HIPP Binder Payment Request
- ☐ HIPP Premium/Plan Change
- ☐ HIPP Dental/Vision Included
- ☐ New Medicare D Application
- ☐ Re-enrollment Medicare D Application

For Client with Expired Eligibility:

Client is or will be out of medicine in ___days

Explanation/Comments (optional):