



CDPH PRE-EXISTING CONDITION INSURANCE PLAN PROGRAM APPLICATION



I. Eligibility Criteria

1. Have you had health insurance in the past six months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Are you currently enrolled in ADAP?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are you currently enrolled in Medicare or Medi-Cal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Are you currently enrolled in the Low-Income Health Program (LIHP)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Are you currently enrolled in the Major Risk Medical Insurance Program (MRMIP)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

II. Applicant Information

Applicant's Name (First, MI, Last)		Social Security Number*		Mother's Maiden Name	
Home Address (Number, Street, Apt #)		City	County	State	Zip Code
Mailing Address (if different than home)		City	County	State	Zip Code
Telephone Number		Email Address		Date of Birth (mm/dd/yyyy)	

III. Demographic Information

1. Hispanic: Yes No

2. Race (check all that apply): White Black Asian American Indian or Native Alaskan Pacific Islander Other

Male Transgender Male to Female Other _____

Female Transgender Female to Male

HIV Positive, Disease Stage Unknown HIV Positive, Asymptomatic CDC Defined AIDS

HIV Positive, Symptomatic, not AIDS HIV Positive, Disabling Disabling AIDS

IMPORTANT: Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH). The information may be used to contact insurance companies, employers, providers of health care services, and state and county agencies to determine the extent of available health insurance and eligibility for insurance assistance. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information, contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (800) 367-2437.

AUTHORIZATION: I authorize insurance companies, employers, providers of health care services, and state and county agencies to release of information to the CDPH with regard to health insurance premiums and benefits. I authorize payment of refunds to CDPH for premiums paid by the program.

DECLARATION: I agree to re-enroll annually and re-certify as required by the program. I agree to inform CDPH of any changes to my eligibility requirements for the program as soon as I am aware of these changes. I certify that the answers I have given in this application and the documents provided are true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance.

Signature of Applicant	Date	
Name of Policy Holder (if different)	Signature of Policy Holder	Date