THE HEALTH COUNCILS INC.
We Make Health Care Better

REVISED FORM – JAN07

INSURANCE SERVICES PROGRAM
NEW CLIENT ENROLLMENT APPLICATION

Date of Enrollment Request: _______________

My client ____________________________ URN # ____________________ is requesting to be enrolled in the *Insurance Services Program* administered by The Health Councils, Inc.

☐ A copy of my client's RWIS consent form is attached *(NOTE: Applications without RWIS forms will not be accepted).*

My client is (check one): ☐ on HIV drug therapy ☐ not on HIV drug therapy

My client needs (check one or both): ☐ Premium Assistance* ☐ Co-Payment Assistance

**NEW CLIENTS NEEDING PREMIUM ASSISTANCE MUST ALSO COMPLETE: 1) AICP APPLICATION; 2) STATEMENT OF DIAGNOSIS; 3) CLIENT CONSENT TO RELEASE INFORMATION/ASSIGNMENT OF PRO RATA REFUND; AND 4) ACKNOWLEDGEMENT OF CLAIM AGAINST ESTATE.*

CLIENT DEMOGRAPHICS
(please insert numerical codes as specified in County MAR memorandum)

Social Security Number	Sex	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 C0-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. Attention: Barbara Hay
9455 Koger Boulevard, Suite 104 St. Petersburg, Florida 33702 FAX (727)570-3033