Idaho Dept. of Health and Welfare
HIV/AIDS Drug Assistance
IDAGAP Application

ALL APPLICATION INFORMATION MUST BE PROVIDED. IF A QUESTION DOES NOT APPLY, PLEASE WRITE "NA" IN THE SPACE PROVIDED. INCOMPLETE APPLICATIONS CANNOT BE PROCESSED.

Client Identification Information: **ADAP ID:_____**

First Name:_____ Last Name:_____

DOB:_____/____/_____ SS#_____-_____-_____

Mailing Address:_____
Number and Street

_____
City, County, Zip Code

Contact Phone:_____ Case Manager Name_____

Programmatic Requirements:

- Applicant income is between 151% - 200% of FPL.
- The applicant does not qualify for Medicaid.
- Applicant has Medicare Part "A", or "A and B", and "D" Coverage.
- Applicant does not qualify for Low Income Subsidies.

Medicare Part D Insurance Plan Information: **A current photocopy of both sides of your Medicare Part D card MUST be submitted with this application.**

Insurance Documentation -- Annual Policy Deductible Amount: $_____

Insurance Documentation – Monthly Premium Amount: $_____

Pharmacy Information:

Pharmacy Name:_____ PH#_____

Address: _____ FAX#_____
Number and Street

_____ Contact:_____
City, County, Zip

Client Sig._____ C.M._____