Oklahoma HIV Drug Assistance Programs
2017 Certification of Understanding and Agreement for Services

Please read the statements below and sign in the space provided to certify that you have read and understand our agreement. A reference to "Program" or "Programs" refers to the HIV Drug Assistance Program (HDAP), HIV Insurance Assistance Program (HIAP), or successor programs in which you participate or to which you apply for services.

1. I certify that the information in this application is true and accurate to the best of my knowledge. I understand that I may be disqualified from this Program(s) and/or prosecuted for willfully providing false information.

2. I understand that the information requested on this application is for the purpose of determining my eligibility for a federally funded program. The funding is limited and may expire at any time without extended or alternate funds being available.

3. I understand and I agree to submit periodic information regarding my continued eligibility for participation in the Program(s), including proof of income, proof of residency, availability of health insurance coverage, and a Recertification Form provided by the Oklahoma State Department of Health (OSDH).

4. I agree to notify, or to have my Care Coordinator notify the OSDH of any circumstances affecting my participation in, or eligibility for, Program(s). I agree to notify the OSDH within thirty (30) days of a change in address and understand that all Program correspondence will be sent to the address I have on file with the OSDH.

5. I understand changes in my situation will be evaluated to determine continued eligibility for Program(s). I will be notified in writing if I am to be discontinued from any of the Program(s).

6. I authorize OSDH to contact the Alternate Contact Person listed below when unable to contact me.

7. I authorize my physician, other health care providers, treatment center, Care Coordinator, third party health insurance administrator, health insurer, employer, or entity under contract with OSDH to provide claims processing services to release information necessary to determine my eligibility for services or to facilitate Program services.

8. By signature below, I acknowledge that my health insurance premiums are being paid by Healthcare Strategic Initiatives (HSI) under contract with OSDH. In consideration of the same, I hereby authorize and direct my health insurer to directly reimburse HSI for any unused premium payments should by insurance policy terminate or be cancelled for any reason, including but not limited to future ineligibility, death, voluntary termination, involuntary cancellation, or termination by operation of law.

9. I agree to indemnify and hold Insure Oklahoma or my health insurer harmless from any and all claims for making premium reimbursement payments directly to the OSDH or any entity under contract with the OSDH in connection with Program Services. I agree to indemnify and hold the OSDH or any entity under contract with the OSDH in connection Program Services, harmless from any and all claims for receiving premium reimbursement payments directly from Insure Oklahoma or my health insurer. This agreement shall be binding on my administrators, executors, heirs, successors and assigns and shall remain in full force and effect during the time period in which I am enrolled in the Program(s). I agree to reimburse the OSDH for any and all premium reimbursement payments that are paid to me in error during my enrollment.

10. I authorize Insure Oklahoma or my health insurer and OSDH to release information to my physicians, other providers, treatment centers, pharmacy benefit managers, third party administrators or health insurers to facilitate provision of Program services. Further, I authorize, Insure Oklahoma or my health insurer and/or OSDH to release my enrollment, eligibility and service records and other information necessary to facilitate provision of Program Services to any entity under contract with OSDH to provide medical and/or health insurance services including by not limited to claims processing services.

11. I understand that my records are protected under state law (63-1-502.2) relating to confidentiality of medical or epidemiological information involving a communicable diseases and/or under the federal regulations governing confidentiality of alcohol or drug use (Patient Records 42 CFR Part 2), and cannot be disclosed to any other entity except those referenced herein without my written consent.

12. I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid until such time as I inform the administrator of the Program(s) in writing of my wish to terminate services in the federally funded program(s), or until such time as I no longer qualify for these services, whichever occurs first, except to the extent that the action has been taken in reliance with this authorization.

A copy of this authorization has the same effect as an original.

Applicant's Signature

Applicant's Name (Please print) Applicant's Social Security Number

Date

Alternate Contact Person's Name

Street Address

City State Zip Code

(_____)_____-_____
Phone

Is the Alternate Contact Person aware of your HIV+ status? ☐ Yes ☐ No