



FOR AICP OFFICE USE ONLY:	
DATE APPROVED: _____	NUMBER: _____

**AIDS INSURANCE CONTINUATION PROGRAM (AICP)**

**SPECIAL SERVICES APPLICATION FORM**

COMPLETION OF THIS APPLICATION DOES NOT GUARANTEE SPECIAL SERVICES AUTHORIZATION

ONLY CLIENTS ENROLLED IN AICP ARE PERMITTED TO SUBMIT THIS APPLICATION. AICP APPLICANTS ON THE STATEWIDE DELAY-IN-SERVICE WAIT LIST ARE NOT PERMITTED TO SUBMIT THIS APPLICATION.

All applicants acknowledge by signing this application that approval for AICP Special Services is based on program qualification as determined by the Health Council of South Florida, Inc.

A CURRENT NOTICE OF ELIGIBILITY MUST BE PROVIDED. INCOMPLETE APPLICATIONS WILL BE RETURNED.

ASSURANCE OF CONFIDENTIALITY:

All information that you have provided on this application will be kept strictly confidential to the fullest extent as defined by state and federal law.

IDENTIFICATION INFORMATION:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Social Security Number (SSN): \_\_\_\_\_ AICP #: \_\_\_\_\_

FINANCIAL INFORMATION: Client income cannot exceed 400% of Federal Poverty Level. Please attach current Notice of Eligibility.

- 0 - 100% FPL  
  150% FPL  
  200% FPL  
  250% FPL  
  300% FPL  
  350% FPL  
  400% FPL

HEALTH INSURANCE INFORMATION: Please note: If you have an HMO as your health provider, point-of-service co-payments and annual policy deductibles may not apply.

Medication Co-Payment Amount: \$ \_\_\_\_\_

Provider Visit Co-Payment Amount: \$ \_\_\_\_\_

Annual Policy Deductible Amount: \$ \_\_\_\_\_

I declare that all statements made in this AICP SPECIAL SERVICES APPLICATION FORM are true and complete to the best of my knowledge and I realize that willful falsification of this information may result in immediate disqualification from participation in the AICP. I also understand that it may be necessary for the AICP to share relevant information with my case manager in order to facilitate this application process. I therefore release this form to the Health Council of South Florida, Inc. for Special Services program qualification evaluation, and that the submission of this application DOES NOT guarantee approval.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
AICP Case Manager's Printed name

\_\_\_\_\_  
AICP Case Manager's Signature

\_\_\_\_\_  
Date