13. SIGNATURE PAGE: AGREEMENT, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

The following agencies coordinate and verify eligibility for all applicable services, as well as treatment and care coordination with other programs related to PrEP DAP. They all adhere to the same confidentiality requirements listed below:

- Pharmacy Benefits Manager/Ramsell Corporation • Insurance Benefits Manager/Evergreen Health Insurance Program (EHIP)
- WA State Department of Social and Health Services (Medicaid Verification)
- WA State Health Care Authority (Apple Health) • All PrEP DAP contracted Providers • System Software Vendor

By signing this document, I agree that I have read this application, certify that the information in this application is true and accurate to the best of my knowledge, and understand the following:

I have the right to:

1. Be treated with respect, consideration and honesty.
2. Receive PrEP DAP services without discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, or sexual orientation, as well as physical or mental ability.
3. Have my records be treated as confidential.
4. File an appeal about eligibility and coverage decisions.

I have the responsibility to:

1. Treat Department of Health staff and contracted service partners with respect, consideration and honesty.
2. Give correct, current, and complete information.
3. Respond to the Programs request(s) for information.
4. Adhere to medically recommended testing and treatment, including all activities recommended in current PrEP standards of practice.
5. Reimburse the Program for any and all premium or benefit reimbursement payments that are paid to me in error during my enrollment.
6. Reimburse the Program if premiums are paid on my behalf for excess advance premium tax credit received as part of an Income Tax refund, if applicable.
7. File income tax forms, if applicable.
8. Update my income in the WA Healthplanfinder and with PrEP DAP if I have a Qualified Health Plan through WA Health Benefits Exchange.
9. Notify the Program, or have my Prevention Navigator notify the Program, of any changes that affect my eligibility within 20 days. These changes include, but are not limited to: address, health insurance coverage and risk conditions.
10. Apply for other services for which I may be eligible before I receive services from PrEP DAP.
11. Submit information regarding my continued eligibility for participation in the Program(s), including proof of proof of residency, availability of health insurance coverage, and an updated and signed version of this form with my recertification application every (1 year).

I understand that:

1. The information requested on this application is for the purpose of determining my eligibility for state funded services.
2. The funding is limited and may expire at any time without extended or alternate funds being available.
3. The Program will use other state and federal data systems as well as other information to verify the information I give them.
4. Upon approval, my eligibility will expire after one year. Before the conclusion of that one year, I will be required to reapply and provide updated eligibility information to continue receiving services.
5. If I am considered eligible for services, my information may be utilized by our contractual partners to provide Program services.
6. Eligibility approval does not mean I will receive or be enrolled in all available services. I understand each service may require additional information, and that I must provide this information for verification before enrollment into said services.
7. If I am approved for premium assistance:
   a. I will need to select EHIP as my Sponsorship Representative for a Qualified Health Plan in the WA Healthplanfinder, if applicable. By selecting EHIP as my sponsor, I authorize EHIP to communicate and share information with the WA Healthplanfinder.
   b. I must notify the Program & EHIP of any changes to my insurance coverage such as:
      i. Receiving insurance from my job, Medicaid, Medicare, partner, spouse or other source(s).
      ii. Receiving a premium statement, premium coupon or coupon book.
      iii. Receiving a late premium notice, letter or phone call.
      iv. Receiving a premium change notice or letter.
   c. I give the Program & EHIP authorization to communicate and share information about my Qualified Health Plan (QHP), Healthcare for Workers with Disabilities (HWD), Medicare Part D (PDP) or Employer Sponsored Insurance (ESI) through myself, my parent(s), my partner, my spouse's employer.
   d. I authorize and direct my health insurer to directly reimburse the Program for any unused premium payments should my insurance policy terminate or be cancelled for any reason, including but not limited to future ineligibility, voluntary termination, involuntary cancelation, termination by operation of law, or death.
   e. If I want to revoke this authorization and terminate the agreement, I must do so in writing to both insurance benefits manager and the health plan administrator.

Release of Information: I give my permission for the program to share information from this application and from subsequent documentation obtained by the program with contracted partners, prevention navigators, and the family/friends I listed in the Authorized Representative section of this application. I give this permission for one year and 60 days from the date I sign this authorization.

Assignment of Benefits: I hereby assign to the State of Washington Department of Health any right to drug or medical benefits to which I may be entitled under any other plan of assistance or insurance from any other liable third party. I consent to the assignment of these benefits to Washington State Department of Health and I understand that the Washington State Department of Health is entitled to repayment for incorrectly provided benefits or benefits to which a third party is liable.

Pre-Exposure Prophylaxis Drug Assistance Program (PrEP DAP)

Verbal or Electronic Signature Attestation - If signed on behalf of a client

Date:

Client First and Last Name:
Date of Birth:

I am agreeing to virtually sign the PrEP DAP application by giving my verbal or written permission to:

Agency:
Staff Name:

By agreeing to this signature, I understand that I am virtually signing and submitting information and documents that commits me in the same manner as if I had signed in person. I also confirm that the information on this document is true and accurate to the best of my knowledge. By giving permission to virtually sign this document, I agree to the terms and conditions above.

Comments/Statements Etc