CONFIDETNIAL AIDS DRUG ASSISTANCE PROGRAM (ADAP) APPLICATION
INSTRUCTIONS FOR COMPLETION
(This is just an example and not HRSA/HAB approved)

Please print clearly and answer all questions. If you need assistance completing this application, please contact the ADAP at INSERT STATE SPECIFIC INFORMATION. The application may be mailed to INSERT STATE SPECIFIC INFORMATION or faxed to INSERT STATE SPECIFIC INFORMATION HERE. Please include all required documents. Submission of an incomplete form will result in your application being delayed and could result in your application being denied.

APPLICATION AND CONTACT INFORMATION

Name	Give your legal name as shown on your state-issued ID or passport and send us a copy. Do not give your nickname or preferred name. If you do not have this kind of ID, talk to your HIV case manager or call ADAP. If we do not get a copy of your state-issued ID or passport, we will have to request it from you. This will delay your eligibility.
Street Address	Give the address where you live - where you sleep at night. If you are homeless, check the box "I do not have a home address." You must give us a residential address. Give the address you want us to use when we send you mail. You must give us a mailing address. If you are homeless, ask your case manager or health care provider if you can use their address to get your mail.
Social Security Number (SSN)	Give your SSN. It will help us make sure you are getting the right coverage.
Date of Birth	Give your full date of birth (month/day/year).
Language preference	Tell us what language you would prefer to receive information in.
Phone	Enter telephone number in the spaces provided. Check the appropriate box if we may contact you by phone. If we call you, we will give only our name and phone number. We will keep your HIV status confidential.
Alternate contact	Fill in this section if you have a friend or family member who you would like to be able to talk to us. Give the person's first and last name, relationship to you, and phone number.

DEMOGRAPHICS

Gender	Check the appropriate box of the gender you identify with.
Race	Check the appropriate box of the race you most identify with. Check all that apply.
Ethnicity	Check the box that most closely matches your ethnicity.
Pregnancy	Check the appropriate box if you are currently pregnant.
Relationship Status	Check the appropriate box that describes your relationship status.

INCOME

Family Income	Enter the dollar amount of your current total household income in the space provided and check the appropriate box that describes the income amount.
Household size	Enter the number of individuals, including you, related by blood or legal marriage that live in the same dwelling.
Employment Status	Check the appropriate box that describes your current employment status.
Types of Income	Check the appropriate box that describes the source of your current household income. If

the source is not listed, check the 'Other' box and enter the source in the space provided.

INSURANCE INFORMATION

Insurance Status	Check the appropriate box if you have health insurance coverage.
Type of Insurance	Check the appropriate box to tell us the type of insurance coverage you have.
Prescription Drug Coverage	Check the appropriate box if your insurance covers prescriptions.
Annual Amount for Medications	Check the appropriate box if your insurance has a prescription cap. If your insurance has a prescription coverage cap, please provide the dollar amount of the drug benefit cap limit and the time period it occurs (Examples: $200/month, $5000/year, etc.) and/or if a brand name specific cap (Example: $500 max for brand name drugs/month).
Date of Last Insurance Coverage	If you do not currently have insurance of any kind, tell us the last date you had insurance coverage.
Medicaid	Check the appropriate box if you have applied to Medicaid. If you have NOT applied, you should seek assistance from your case manager (if you have one) with completing a Medicaid application. If you HAVE applied, enter the date of application and the application status or outcome. *Enter approximate month/year if exact date is unknown.*
Medicare	Check the appropriate box if you have applied for Medicare coverage. If you have NOT applied, you should seek assistance from your case manager (if you have one) with completing a Medicare application. If you HAVE applied, enter the date of application and the application status or outcome. *Enter approximate month/year if exact date is unknown.*
Social Security Income or Social Security Disability Income	Check the appropriate box if you have applied for Social Security Income or Social Security Disability Income. If you HAVE applied, enter the date of application and the application status or outcome. *Enter approximate month/year if exact date is unknown.*

MEDICAL PROVIDER INFORMAITON

Prescribing Physician	Give your physician's full name.
Physician's Medical Practice	Give the full name of your physician's medical practice.
Physician's Street Address	Give the complete address your physician wants us to use when we send him/her mail. You must give us a mailing address.
Phone	Enter telephone number in the spaces provided.
Fax	Enter fax number in the spaces provided.

MEDICATION INFORMAITON

Currently on Medications	Check the appropriate box to tell us if you are currently on medications that you would get from the ADAP.
Who Pays for your Medications?	Check the appropriate box to tell us who is currently paying for your medications.
Last Date on Medication	If you are not currently receiving medications, tell us the last date when you did.

CONSENT AND SIGNATURE

Please take the time to read this section. It tells you what we expect you to do when you are a client in our program. You must sign and date this section.

APPLICATION CHECKLIST

Use the checklist to make sure that you have included everything we need to process your application. If you do not send something that is required or fill out the application incorrectly, we may have to send you a letter to ask for it again. This will delay your eligibility.

MEDICAL CERTIFICATION FORM

Please give this form to your physician for him/her to complete. If you do not send in this completed form, we may have to send you a letter to ask for it again. This will delay your eligibility.

ADAP FORMULARY

INCLUDE A LISTING OF OR LINK TO YOUR ADAP FORMULARY

For Central Office Use Only
Date of receipt of completed application: __/__/____
Date of approval: __/__/____
Initials of approver: _____
Comments: _____

CONFIDENTIAL AIDS DRUG ASSISTANCE PROGRAM (ADAP) APPLICATION

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APPLICANT AND CONTACT INFORMATION			
Last Name:	First:	M.I.:	Date:
Residential Address:		Apartment/Unit #:	
City:	State:	ZIP:	
☐ I do not have a home address			
Mailing Address:		Apartment/Unit #:	
City:	State:	ZIP:	
Social Security No.:	☐ Do not have Social Security Number	Date of Birth: ___/___/____	
Language Preference:			
Home Phone:	Cell Phone:	Work Phone:	
May ADAP leave a detailed voice mail on your (Check all that apply)?	☐ Home phone	☐ Cell phone	☐ Work phone
I don't have a phone, the best way to reach me is:			
Preferred time to contact: Between _____ am/pm (Circle one) and _____ am/pm (Circle one)			
May ADAP share your information with an alternate contact?		☐ YES	☐ NO
If YES, name of alternate contact:	Relationship of contact:		
Phone number of contact:			

DEMOGRAPHICS						
Gender	☐ Male	☐ Female	☐ Transgender (Male to Female)	☐ Transgender (Female to Male)	☐ Unknown	
Race	☐ American Indian or Alaskan Native	☐ Asian	☐ Black or African American	☐ Native Hawaiian or Pacific Islander	☐ White	☐ Unknown
Ethnicity	☐ Hispanic	☐ Non-Hispanic	☐ Unknown			

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Are you currently pregnant?	☐ Yes	☐ No	☐ Not Applicable	☐ Unknown	
Relationship Status	☐ Single	☐ Married	☐ Divorced	☐ Separated	☐ Partnered	☐ Widowed

INCOME AND EMPLOYMENT

Resource	Do you or your family have this resource?		Value
Cash, savings or checking account	☐ Yes	☐ No	
Real estate (not counting the home you live in)	☐ Yes	☐ No	
Trust funds, annuity, or certificate or deposit	☐ Yes	☐ No	
Stocks or bonds	☐ Yes	☐ No	
Vehicles and recreational vehicles (not counting one vehicle)	☐ Yes	☐ No	

Current Family Income:	$_____	☐ Annual	☐ Monthly	☐ Other, specify_____

What is your current living arrangement?

☐ Live alone	☐ Live with spouse or significant other	☐ Live with parent or guardian	☐ Live with nonrelatives who share expenses and/or care
☐ Live with other nonrelatives	☐ Live with children who receive assistance or support from client	☐ Live with relatives other than spouse, children or parents	☐ Homeless

Number of persons in your family unit (include yourself):	_____				
Are you currently employed?	☐ Yes	☐ No			
Wages/tips (before taxes)	☐ Hourly	☐ Weekly	☐ Twice a month	☐ Monthly	$_____
Yearly income (if your income changes from month to month)	$_____				
In the past year, did you:	☐ Change jobs	☐ Stop working	☐ Start working fewer hours	☐ None of these	

Please check all types of income you currently receive:

☐ Alimony	☐ Child Support	☐ Unemployment
☐ Retirement/Pension	☐ Social Security Income / Social Security Disability Income	☐ Other, specify _____

Notes on Income:

- If you are pregnant, you may claim your unborn child as a family member for this application.
- Definition of Family Income – For purposes of ADAP eligibility, "Family" includes applicant, legal spouse (husband or wife), and dependents. "Family" may also include unmarried adults who identify as a family unit and pool or co-mingle income. (For example, a client lives with a companion, shares a lease or mortgage, and both pay food utilities, etc., could be assessed a family unit of two.) Income from all defined "Family" members will be considered when determining Family Income. If the applicant is younger than 18 years old, income is considered for each parent living in the home unless there are extenuating circumstances that would result in undesired disclosure of the client's health status.
- A husband and wife who are separated and are not living together shall be considered separate Family units.

Proof of Income

The following documentation examples can be used as proof of income. Specific client circumstances may require additional considerations.

1. Employment income: Copies of the three most recent, consecutive pay stubs that show gross income and payroll deductions. If it is unclear how often a paycheck is issued (weekly, biweekly, monthly, etc.), a statement may be obtained from the employer on company letterhead. If the employer does not provide pay stubs, a letter from the employer on company letterhead with the following items is required: 1) gross monthly pay and how often client is paid, 2) a specific statement verifying that the employer does not provide actual pay stubs, 3) a statement that the applicant receives no health insurance through the employer, and 4) the name, signature, job title and phone number of

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the person writing the letter. A notarized complete copy of the most recent Federal Income Tax Return may also be considered as documentation.

2. Self-employment income: A notarized complete copy of the most recent Federal Income Tax Return is required, including all applicable attachments.
3. Veterans or other retirement benefits: A copy of the benefit award letter or any other official documentation showing the amount received on a regular basis. If the benefit is being directly deposited into a bank account, a bank statement can be used as proof of benefit if the statement lists where the deposited amount is coming from.
4. Net rental income (after expenses): A complete copy of the most recent Federal Income Tax Return.
5. Alimony/child support: A copy of the benefit letter or any other official documentation showing amount received on a regular basis.
6. Government benefits and/or award (such as Social Security and unemployment benefits): Copies the award letters showing current dollar amounts received. If the benefit is being directly deposited into a bank account, a bank statement can be used as proof of benefit if the statement lists where the deposited amount is coming from, such as with Social Security.

Proof of No Income

If you have no income, you can provide the following:

1. Termination or layoff notice from most recent employer on company letterhead.
2. A "proof of no income" letter that identifies the source of the applicant's food and shelter. This signed letter can be provided by an agency or shelter on appropriate letterhead, and should have a contact phone number if verification is needed.
3. If the applicant is dependent on a relative, friend, or some other non-agency source of support, the individual providing the source of support must provide the "proof of no income" letter. This letter must include a statement of the relationship to the applicant and a certification as to the truthfulness of the letter; along with a statement describing the extent of the support and that there is no knowledge of any income received by the applicant.

INSURANCE INFORMATION					
Do you currently have any type of insurance?	☐ Yes	☐ No	☐ Don't Know		
If Yes, check all types that you currently have:					
☐ Medicaid	☐ Medicare A/B	☐ Medicare D	☐ Private Insurance		
☐ PCIP	☐ Other Public Insurance (Veterans, Indian Health, TRICARE, etc)	☐ Other, specify _____			
If you have insurance, does it provide prescription drug coverage?	☐ Yes	☐ No	☐ Don't Know		
If Yes (you have prescription drug coverage through insurance), is there a cap on the annual amount your insurance will pay for medications?	☐ Yes	☐ No	☐ Don't Know		
	If Yes, what is the amount of the cap? $_____				
If you don't currently have insurance, what was the date of your last insurance coverage?	_____/_____ Month Year		☐ Don't Know		
Are you applying or have you applied for Medicaid?	☐ Yes	☐ No	☐ Don't Know		
If Yes, when did you apply for Medicaid?	_____/___/____	**Have you received a response?**	☐ Yes	☐ No	
If yes, what is your Medicaid number?		If yes, what is your Medicaid spenddown amount?			
Are you applying or have you applied for Medicare?	☐ Yes	☐ No	☐ Don't Know		
If Yes, when did you apply for Medicare?	_____/___/____	**Have you received a response?**	☐ Yes	☐ No	
If Yes, have you applied for Medicare Part D (medication coverage)?	☐ Yes	☐ No	☐ Don't Know		

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If Yes to Medicare Part D, have you applied for the Low Income Subsidy (LIS)?	☐ Yes	☐ No	☐ Don't Know		
Are you applying or have you applied for Social Security Income (SSI) or Social Security Disability Income (SSDI)?	☐ Yes, for SSI	☐ Yes, for SSDI	☐ No	☐ Don't Know	
If Yes, when did you apply for SSI/SSDI?	_____/___/____	**Have you received a response?**		☐ Yes	☐ No

MEDICAL PROVIDER INFORMATION		
Name of prescribing physician:		
Name of physician's medical practice:		
Physician Street Address:		
Physician City:	Physician State:	Physician ZIP:
Physician Phone:	Physician Fax:	

MEDICATION INFORMATION			
Are you currently receiving the medications that would be covered under ADAP?	☐ Yes	☐ No	☐ Don't Know
If Yes, what is the payer source for the medications?			
☐ Patient Assistance Program (includes Welvista)	☐ Private Insurance	☐ Medicaid	☐ Medicare Part D
☐ Out of Pocket	☐ VCC/Indigent Care	☐ Other, please specify _____	
If you are not receiving the medications, what is the last date you received these medications?	_____/_____ Month Year		

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CONSENT AND SIGNATURE

I understand it is my responsibility to provide medical status and proof of income every six months. I further understand it is my responsibility to notify ADAP of any changes in my contact information, income or insurance status (if applicable). Failure to provide the necessary documentation could jeopardize my approved assistance through the ADAP. My information is being entered into a statewide database by the ADAP. I authorize ADAP to release records necessary to support the application for payment by Medicare, Medicaid, and/or other health care benefits, including Welvista. I request a third party payer to pay any authorized benefits to ADAP on my behalf. ADAP agrees to treat all information as confidential. I hereby give my consent to ADAP to obtain, verify, and/or release my demographic, medical, prescription, and/or insurance coverage information, with other entities as necessary to effectively manage my medication access. Information may be shared with but is not limited to the following: physician, health department personnel, treatment center personnel, pharmacy services provider, referral source, clinic, insurance broker and/or insurance carrier. ADAP agrees to treat any and all such information as confidential. I understand that this consent will remain in effect as long as my dependent or I remain on the ADAP waiting list or on ADAP or until I withdraw it. **I have read, understand and agree to the above Client Responsibilities and Release of Consent. I verify that the information provided in this application is complete and accurate to the best of my knowledge.**

_____ Signature of Client, Parent/Legal Guardian or Person acting in Loco Parentis	_____ Date Signed
_____ Relationship (If signature is not of Client)	
_____ Signature of Person Obtaining Consent	_____ Date Signed

Please provide the information below if a friend, family member or advocate helped to complete this application:

First Name MI Last Name

Address

City State Zip

Phone Number

In order to process your application in a timely manner it is important that the application is complete. If your application is not complete, we will not be able to process your application and there may be a delay in obtaining your medication.

APPLICATION CHECKLIST

☐ Answer all of the questions on the application?	☐ Include a copy of your health insurance card (if applicable)?
☐ Include proof of residency?	☐ Sign application?
☐ Include proof of current income?	☐ Include the Medical Certification Form, completed and signed by your doctor?

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MEDICAL CERTIFICATION FORM: CONFIDENTIAL ADAP APPLICATION

MEDICAL PROVIDER CONTACT INFORMATION		
Date Form Completed:		
Client First Name:	Client Last Name:	Client Date of Birth: ____/____/_____
Person Completing Form:		
Phone Number for Person Completing Form:		
Medical Provider Name:	Medical Practice Name:	
Provider Phone Number:	Provider Fax Number:	

CLIENT MEDICAL INFORMATION			
Current Disease Status			
☐ HIV Positive, not AIDS	☐ HIV Positive, AIDS status unknown	☐ CDC-defined AIDS	☐ Unknown
Nadir CD4 Count (Lowest Ever CD4 count)	_____	**Date of Nadir CD4 Count**	____/____/_____
Current CD4 Count	_____	**Date of Current CD4 Count**	____/____/_____
Current Viral Load	_____	**Date of Current Viral Load**	____/____/_____
Date of Last HIV Medical Care Visit	___/____/_____		

List Medications Prescribed for this Client (or attach a medication list)

MEDICATION NAME	**DOSAGE**

Does the Client Currently have an Opportunistic Infection (OI)?	☐ Yes	☐ No	☐ Unknown
Has the Client ever had an Opportunistic Infection (OI)?	☐ Yes	☐ No	☐ Unknown
Has the Client ever received treatment for an Opportunistic Infection (OI) or for OI prevention?	☐ Yes	☐ No	☐ Unknown
Is the client currently pregnant?	☐ Yes	☐ No	☐ Unknown
If Yes, expected delivery date:	_____/_____/_____		

I certify that I am treating the above named client for HIV and that all information provided in this form is accurate and complete to the best of my knowledge.

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_____ Signature of Physician	_____ Date Signed

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