APPLICATION FOR MEDICATION ASSISTANCE

Texas HIV Medication Program
ATTN: MSJA - MC 1873
PO Box 149347, Austin, TX 78714-9347
1-800-255-1090

- Please print clearly and answer all questions
- For help with this application call 1-800-255-1090
- Mail the completed application and copies of supporting documentation to the address listed above
- Do not send original documents, they will not be returned
- Detailed instructions are available at www.dshs.state.tx.us/hivstd/meds or by calling 1-800-255-1090

SECTION I – PERSONAL INFORMATION

1. Last Name	First Name	Middle Name	Suffix (Jr., Sr., III)

2. Social Security Number:	3. Sex	4. If female, are you currently pregnant?
5. Date of Birth:	☐ Male ☐ Female ☐ Transgender: Male to Female ☐ Transgender: Female to Male	☐ Yes ☐ No Due Date: / /

6. Race (check all that apply)	7. Ethnicity (check the one that best describes you)
☐ White ☐ Black/African American ☐ Asian/Pacific Islander ☐ American Indian/Alaska Native ☐ Other/Unknown	☐ Hispanic ☐ Non-Hispanic

8. Residential Street Address – (No P.O. Boxes or Rural Routes)	Apartment Number

City	State	Zip Code

*If you wish to have mail sent somewhere **other** than your residential address please provide an alternate mailing address:*

9. Mailing Address - (P.O. Boxes and Rural Routes accepted here)	Apartment Number

City	State	Zip Code

10. Home Phone Number (area code + number)	Work/Alternate Phone (area code + number)
May we leave a message on your voice mail or answering machine? ☐ Yes ☐ No	May we leave a message on your voice mail or answering machine? ☐ Yes ☐ No

11. In order to process your application faster, we may need to call you with additional questions. If you are unavailable, are there any special instructions as to how we should leave a message for you?

12. Have you recently been released or are you currently incarcerated in a jail or prison?
☐ Yes ☐ No If no, continue to next page

Facility Name	TDCJ or SPN Number	Release Date (or expected release date)

Approximate Length of Incarceration:

SECTION II –MARITAL STATUS

13. What is your current Marital Status: ☐ Single ☐ Widowed ☐ Divorced, Date: _____ ☐ Separated, Date: _____ (explanation required) ☐ Married/Common Law (provide spouse information below)	If you are separated, please explain your current legal situation.
14. Spouse Name:	Spouse SSN:
Spouse Date of Birth:	Is spouse also on program? ☐ Yes ☐ No

SECTION III-HOUSEHOLD INFORMATION

15. Including yourself, how many people live in your home? _____
If the applicant is under the age of 18 please fill out page 9 of the application.

Complete the following table for <u>all</u> **persons living in your home. This includes children, spouse, relatives, friends and roommates**

Name	Age and Date of Birth (Birth Date Required for under 18)	Relationship

16. Do you receive HOPWA/Section 8 housing assistance/subsidized housing? ☐ Yes ☐ No
(If yes, include agency verification)

17. Is there anything else you would like to tell us about your living situation that could help clarify your application?

SECTION IV – INCOME, EMPLOYMENT and BENEFITS

18. Please give a brief explanation of how you support yourself**:** For example: I work full time, I'm on disability, I don't work and live with a relative who provides room and board, or I'm a student.

19. Employment: Please complete the table for employment status. If you are not working, make sure you list where and when you were last employed. This program may verify your income with other sources such as the Texas Workforce Commission.

	Applicant	Spouse	Required Documentation
a. Employment Status	☐ Full time ☐ Part time ☐ Unemployed ☐ Temporary ☐ Seasonal ☐ Student ☐ Self Employed	☐ Full time ☐ Part time ☐ Unemployed ☐ Temporary ☐ Seasonal ☐ Student ☐ Self Employed	If you have never worked or are a full time student please explain this in the top section or in the space provided at the end of the application.
b. If employed Employer Name			- If you work more than one job list all employers in the section above. - If you have recently changed jobs please indicate this in the section above. - Provide pay stubs for all current employment. - If you are paid in cash have your employer complete the Income Verification form.
Job Title			
c. If unemployed Where were you last employed			
Date employment ended	/ /	/ /	

20. Income and Benefits: Please complete the table for all income received. Report monthly gross income. Gross income is the amount received before any taxes or deductions are taken. Submit documentation for all income.

Wages, salary, commissions, tips	$	$	At least Two (2) current, consecutive pay stubs or earnings statements. If paid weekly, four (4) consecutive pay stubs will be required.
Self employment income	$	$	A completed copy of your most recent Federal Income Tax Return. Please note that per IRS regulations, anyone with net self-employment earnings of more than $400 is required to file a Federal Tax Return for that calendar year.
Interest, cash dividends or investment income	$	$	
Unemployment Benefits/Income	$	$	A copy of your benefit award letter or any other official documentation showing the amount received on a regular basis.
Social Security Income (retirement or disability-SSDI)	$	$	
Supplemental Security Income (SSI)	$	$	
Retirement Pension or Annuities	$	$	
Veteran's Administration	$	$	
Other Disability Benefits/Income	$	$	
Food Stamps	$	$	
Temporary Assistance to Needy Families (TANF) Benefits	$	$	
Alimony/child support received	$	$	
Other Income (specify source)	$	$	Source:

If no income is reported, a supporter statement must be completed by the person who provides support. Please complete page 7 and submit with the application.

SECTION V – HEALTH INSURANCE

21. Are you currently taking medications for HIV (antiretroviral medications)? ☐ Yes ☐ No

If yes, please tell us how you are getting your medications.

22. What types of health care coverage or health insurance do you have?
Please check all that apply. If a card is issued provide a copy of the front and back of the card.

- ☐ Health Insurance offered by my employer (examples: Blue Cross Blue Shield, Aetna, Humana)
- ☐ Health Insurance offered by the employer of my spouse, parent or domestic partner
- ☐ Private Health Insurance that I purchased on my own or someone else helped me purchase
- ☐ Medicaid (including Star and Star +)
- ☐ Children's Health Insurance Program (CHIP)
- ☐ Medicare (Part A, Part B, Part C or Part D)
- ☐ COBRA - continued group health coverage offered to you after leaving an employer plan
- ☐ High Risk Pool (Texas or Federal)
- ☐ Veterans Administration Health Benefits
- ☐ City or County Indigent Program (examples: MAP, Gold Card, Parkland Plus, Wilco, Carelink)
- ☐ Other: _____
- ☐ I don't have any health coverage or health insurance

23. Have you previously had any health insurance: ☐ Yes ☐ No If yes, please list name and date coverage ended.

Insurance Name:	End Date:
Insurance Name:	End Date:
Insurance Name:	End Date:

24. If you currently have health care coverage or health insurance, why are you applying for this program?
(Please check ALL that apply, and submit supplemental documentation from the insurance plan verifying your situation.)

- ☐ My insurance does not cover prescription drugs.
- ☐ One or more HIV/AIDS medications I need are not covered by the plan.
- ☐ Coverage will end soon *(specify expiration date)*: _____
- ☐ I have Medicare and I need help paying the medication deductibles, copays or coinsurance (please complete the SPAP enrollment form)
- ☐ Expenses have or are about to exceed the plan's annual prescription cap.
  Amount of annual prescription cap: $_____
- ☐ HIV/AIDS is a pre-existing condition for my health insurance plan. If known, please specify the date that the pre-existing condition limit in your insurance plan will be met: _____
- ☐ Other limitations on coverage or payment *(specify)*:

SECTION VI: ADDITIONAL INFORMATION

25. Is there anything you would like to clarify on this application? Please use this space to provide any additional information that may help THMP process your application. Attach additional pages if needed.

SECTION VII: APPLICANT CERTIFICATION AND AUTHORIZATION

Authorization to release confidential information: I am authorizing the following individual(s) to speak to the THMP on my behalf regarding my application and eligibility status. The individuals may friends and family members, or they may be care coordinators, social workers or other case managers operating on my behalf. This authorization is in effect until I revoke it in writing, which I may do at any time.

Name of Person	Relation to You or Agency Name	Phone Number

IMPORTANT – THE FOLLOWING CERTIFICATION AND AUTHORIZATION MUST BE SIGNED BY THE APPLICANT:

a. I understand that this application is a legal document. My signature (1) attests that all the information given is true and correct, and (2) authorizes the release of my medical information to the Texas HIV Medication Program (THMP).

b. I understand that it is my responsibility to notify the THMP immediately if my/our income increases; if I/we move from Texas; or if my/our marital, household or insurance status changes.

c. I understand that the THMP may request verification of the information I have provided in order to process my application, and also at any time thereafter. I also understand that the processing of my application may be delayed until such requested verification is received.

d. I understand that the THMP may verify information provided on this application with data resources made available to the program for the purpose of eligibility determination.

e. I understand that deliberately omitting or giving false information could cause me to be removed from the THMP, or criminally prosecuted, or both.

f. I understand that the THMP reserves the right to limit enrollment based upon availability of funds.

g. I understand that the THMP is required to recertify my eligibility status per the program rules in order to continue receiving services.

Signature of Applicant	Date
Signature of Parent (if applicant is under 18 years of age)	Date

Is your application complete?

If your application is not complete when submitted, we won't be able to determine your eligibility. Did you:

- ☐ Answer all of the questions on the application?
- ☐ Include proof of Texas residency?
- ☐ Include proof of current income?
- ☐ Sign the application?
- ☐ Include the Medical Certification Form, completed and signed by your doctor?
- ☐ Include a copy of both sides of your health insurance card and information on how your prescription drug coverage works (if applicable)?

Do you need to include any additional forms?

- ☐ If you have zero income, include a supporter statement (page 7)
- ☐ If you have Medicare, include the SPAP Enrollment form (page 8)
- ☐ If you are under 18, include your parent's information (page 9)
- ☐ If you are paid in cash, include the income verification form signed by your employer (page 10)

If you have any questions please call the THMP at 1-800-255-1090.

Mail all application materials to:

Texas Department of State Health Services
Attn: MSJA - MC 1873
PO BOX 149347
Austin, Texas 78714-9347

PRIVACY NOTIFICATION

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on privacy notification. (Reference: Texas Government Code, Sections 522.021, 522.023, 559.003 and 559.004)

For additional information, including a review of Frequently Asked Questions and downloadable copies of program documents, please visit the Texas HIV Medication Program web site at http://www.dshs.state.tx.us/hivstd/meds .

For additional information on AIDS service organizations, case management services and community resources in your local area, please call 2-1-1.

If you have any questions, comments or concerns regarding the Texas HIV Medication Program and this application for assistance, please call the program directly at 1-800-255-1090.

Once you have completed the application and gathered the necessary attachments, please mail the completed application to: Texas HIV Medication Program, ATTN: MSJA MC 1873, PO BOX 149347, Austin TX 78714-9347

(revised 04/2012)

SUPPORTER STATEMENT

If an applicant has no income or is unable to provide any documentation showing how they manage, this form can be used as documentation. This form must be completed and signed by the person providing support; it should not be filled out by the applicant.

I, _____, certify that I currently support
(Printed name of supporter)

_____, who resides at the following
(Printed name of applicant)

address: _____.
(applicant's street address, city, state, & zip code)

I have supported him/her since _____. My relationship to the applicant
(Date)

is _____. To the best of my knowledge, the monthly

income of the person I am supporting is: _____.
(applicant's income)

The type of support I provide is (check all that apply):

☐ Room ☐ Food/Clothing ☐ Rent/Mortgage ☐ Utility Bills

☐ Cash Assistance in the amount of $_____ per month

☐ Other _____

Additional explanation (if necessary):

I can be reached at the following number(s) to verify this information: (____)_____

By signing this form, I affirm that the above information is an accurate statement of assistance being provided to the applicant. I understand that if I deliberately omit or give false information the applicant may be removed from the program and/or criminally prosecuted.

Signature of Supporter	Date

Please note: If there are special circumstances surrounding your household situation that would need to be explained or verified by a social worker, case manager, or public health nurse, please have them provide a detailed support statement on your behalf and attach it to your application when applying for assistance.

Enrollment -Texas HIV State Pharmacy Assistance Program

TEXAS Department of State Health Services
Phone: 1-800-255-1090
Fax: 512-371-4670

Mailing Address: Texas Department of State Health Services
ATTN: MSJA - MC 1873
PO Box 149347
Austin, TX 78714-9347

Applicants with MEDICARE should fill out this form. Individuals with Medicare who are eligible for assistance from the Texas HIV Medication Program (THMP) will be enrolled in the HIV State Pharmacy Assistance Program (SPAP) to obtain their medications. The SPAP helps with co-pays, coinsurance and gap coverage associated with a Medicare Part D prescription drug plan. **If you are not already enrolled in the THMP, you must also fill out the full THMP application.**

SECTION I – PERSONAL INFORMATION

Last Name	First Name	Middle Name	Date of Birth

Mailing Address			Phone Number (area code + number)
City	State	Zip	May we leave a message on your voice mail or answering machine? ☐ Yes ☐ No

Your Social Security Number	Your Medicare Number	Effective Date of Medicare Part A (listed on your Red White & Blue Medicare Card)

SECTION II – MEDICARE PRESCRIPTION DRUG INFORMATION

Are you enrolled in a Medicare Prescription Drug Plan (Part D)? ☐ Yes if yes, please provide plan information below. ☐ No

Plan Name:			Effective Date:
ID Number:	RxBin:	RxPCN:	RxGroup:

SECTION III – LOW INCOME SUBSIDY

Have you applied for the Low Income Subsidy or Extra Help through the Social Security Administration?

☐ Yes - please indicate application status below.
☐ No - you need to apply for this assistance, please call 1-800-255-1090 to have an application mailed to you.

Low Income Subsidy/Extra Help Application Status

☐ Approved, 100% Assistance
☐ Approved, partial assistance (attach copy of approval letter)
☐ Denied Assistance (attach a copy of pre-decisional or denial letter)
☐ Awaiting determination, application date:_____

SECTION IV – SPAP AGREEMENT

1) I understand that it is my responsibility to:
   a) enroll in a Medicare Prescription Drug Plan,
   b) maintain my enrollment in a Medicare Prescription Drug Plan, and
   c) pay the monthly prescription drug plan premium directly to the prescription drug plan.
2) I understand that it is my responsibility to notify the Texas HIV SPAP immediately if any of the following happen:
   a) my household income increases,
   b) my address changes or I move out of the State of Texas,
   c) my marital, household or insurance status changes, or
   d) my Medicare benefits are terminated.
3) I understand that the Texas HIV SPAP reserves the right to limit enrollment based upon availability of funds.
4) I understand that the Texas HIV SPAP is required to recertify my eligibility status every other year per program rules in order to continue receiving services.
5) I understand that this is a legal document. My signature (1) attests that all the information given is true and correct, (2) authorizes the release of my medical information to the Texas HIV Medication Program, including the Texas HIV SPAP, and (3) attests that I do reside in the State of Texas.

Signature of Applicant	Date
Signature of Parent (if applicant is under 18)	Date

PARENT INFORMATION

If an applicant is under the age of 18 this form must be filed out by the parent (s) who live with the applicant.

A. Name of Parent		B. Name of Parent (if applicable)	
Social Security Number	Date of Birth	Social Security Number	Date of Birth

Employment: Please complete the table for employment status of the applicant's parents. If you are not working make sure you list where and when you were last employed. Employment may be verified with other sources such as the Texas Workforce Commission.

	Parent (a)	Parent (b)	Required Documentation
a. Employment Status			Full time, part time, unemployed, seasonal etc.
b. If employed Employer Name			- If you work more than one job list all employers in the section above. - If you have recently changed jobs please indicate this in the section above. - Provide pay stubs for all current employment. - If you are paid in cash have your employer complete the Income Verification form.
Job Title			
c. If <u>un</u>employed Where were you last employed			
Date employment ended	/ /	/ /	

Income and Benefits: Please complete the table for all income received by the parent. Report monthly gross income. Gross income is the amount received before any taxes or deductions are taken. Submit documentation for all income. If the child receives income this should be reported on page 3 of the application.

Wages, salary, commissions, tips	$	$	At least Two (2) current, consecutive pay stubs or earnings statements. If paid weekly, four (4) consecutive pay stubs will be required.
Self-employment income	$	$	A completed copy of your most recent Federal Income Tax Return. Please note that per IRS regulations, anyone with net self-employment earnings of more than $400 is required to file a Federal Tax Return for that calendar year.
Interest, cash dividends or investment income	$	$	
Unemployment Benefits/Income	$	$	A copy of your benefit award letter or any other official documentation showing the amount received on a regular basis.
Social Security Income (retirement or disability benefits)	$	$	
Supplemental Security Income (SSI)	$	$	
Retirement Pension or Annuities	$	$	
Veteran's Administration	$	$	
Other Disability Benefits/Income	$	$	
Food Stamps	$	$	
Temporary Assistance to Needy Families (TANF) Benefits	$	$	
Alimony/child support received	$	$	
Other Income (specify source)	$	$	Source:

INSURANCE

Does the parent(s) have any type of health insurance or health coverage?	☐ Yes*	☐ No
If yes, is the applicant (child) covered under the policy?	☐ Yes*	☐ No
If no, is family coverage offered by the parent's health insurer or employer?	☐ Yes	☐ No

* If yes, provide a copy of <u>both</u> sides of the insurance card and include documentation as to how your prescription coverage works.

INCOME VERIFICATION

This form should be used only when no supporting income documentation is available. If paystubs are available to the employee copies must be submitted.

I. Employee Information

Employee Name:

Employee Address:

II. Employer Contact Information

Business Name:

Business Address:

Business Phone Number:

Contact Name:	Contact Phone Number:

III. Employee Income

Type of work performed by the employee:

First Day of Employment:

Average number of hours worked per week:

The employee is paid by *(check one):*
☐ Cash ☐ Personal check ☐ Payroll check ☐ Other (please specify) _____

The employee is paid *(check one):*
☐ Weekly ☐ Biweekly ☐ Semi-monthly ☐ Monthly ☐ Daily ☐ Other (please specify) _____

The employee receives a gross amount of $ _____ per pay period

The employee's gross **hourly** wage: $_____ *per hour*

The employee receives **weekly** tips or commissions in this estimated amount: $ _____ *per week*

IV. Employee Health Coverage

Is the employee offered health coverage? ☐ Yes ☐ No

If yes, is this employee enrolled in health coverage? ☐ Yes ☐ No

V. Additional Information

Will there be any changes to this person's employment in the next few months?

VI. Certification

I verify that the above information is true and correct to the best of my knowledge.

Signature of Employer	Date

TEXAS HIV MEDICATION PROGRAM
MEDICAL CERTIFICATION FORM

(TO BE COMPLETED BY PHYSICIAN) **Texas HIV Medication Code (if known)** _____

The information requested is necessary to determine the patient's eligibility for program-supplied, HIV-related therapy as prescribed by you. All information requested will be kept strictly confidential by the Texas Department of State Health Services; personal identifying info is never released.

PATIENT INFORMATION

Full Name: _____

Mailing Address: _____ Apt. # _____

City, State, Zip: _____ Phone # (____) _____

Date of Birth: ____/____/____ Social Security Number: _____
Month Day Year

*****NOTICE*** Changes in therapy after initial approval and/or recertification may be faxed to (512) 371-4670.**

I hereby certify that this patient has been diagnosed with HIV infection, and I am reporting the following viral load and CD4 count:

Plasma RNA Viral Load:	Test Date:	Current CD4 Count:	Test Date:
_____copies/ml	/ /		/ /

PRESCRIBED MEDICATIONS FOR OPPORTUNISTIC INFECTIONS:

Please check here if patient is pregnant: _____

_____ **acyclovir,** for acute or chronic herpetic infection ***(NOTE:** may not be available due to manufacturer shortages)*, **OR**
_____ **valacyclovir** (Valtrex), for acute or chronic herpetic infection
_____ **itraconazole** (either **capsules** or **suspension**), for diagnosed histoplasmosis or blastomycosis
_____ **clarithromycin**, for a current or previous mycobacterium avium complex (MAC) diagnosis, **OR**
_____ **azithromycin**, if client failed therapy on (or is intolerant of) clarithromycin
_____ **fluconazole**, for diagnosed cryptococcal meningitis or esophageal candidiasis, **OR**
_____ **itraconazole suspension**, for diagnosed esophageal candidiasis
_____ **valganciclovir** (Valcyte), for diagnosed CMV disease with infection(s) of major organ(s) or organ system(s)
_____ **megesterol acetate**, for diagnosed cachexia or anorexia with profound, involuntary, acute weight loss ≥10% of baseline body weight or chronic weight loss ≥20% of baseline body weight
_____ **atovaquone** (Mepron), for diagnosed acute, mild to moderate PCP and intolerance to both SMZ-TMP and dapsone
_____ **rifabutin** (Mycobutin), for a CD4 cell count ≤ 100
_____ **ethambutol**, for a current or previous mycobacterium avium complex (MAC) diagnosis
_____ **pentamidine** or _____ **SMZ/TMP** or _____ **Dapsone** (choose one, if applicable), for CD4 ≤ 200, or thrush, or previous PCP diagnosis, or unexplained fever>100º for >2 weeks

*****REQUIRED***** Is this patient naïve to antiretroviral therapy? (check one) _____ Yes _____ No

PRESCRIBED ANTIRETROVIRAL MEDICATIONS: LIMIT OF FOUR (4) ANTIRETROVIRALS MAX PER CLIENT

_____ **Atripla** (Sustiva/Truvada)*****
_____ **Combivir** (AZT/3TC)*****
_____ **Complera** (Edurant/Truvada)*****
_____ **Epzicom** (Ziagen/3TC)*****
_____ **Trizivir** (AZT/Ziagen/3TC)*****
_____ **Truvada** (Emtriva/Viread)*****
_____ **efavirenz** (Sustiva)
_____ **nevirapine** (Viramune XR)
_____ **raltegravir** (Isentress)
_____ **rilpivirine** (Edurant)
_____ **tenofovir** (Viread)
_____ **etravirine** (Intelence) – For treatment experienced patients with viral resistance or toxicity to antiretroviral agents.
_____ **maraviroc** (Selzentry) – Proof of CCR5 monotropism via CCR5 assay **must** be included with this form for approval.

_____ **atazanavir** (Reyataz)
_____ **darunavir** (Prezista)
_____ **indinavir** (Crixivan)
_____ **invirase** (Saquinavir)
_____ **lopinavir/ritonavir** (Kaletra)
_____ **nelfinavir** (Viracept)
_____ **ritonavir** (Norvir)
_____ **tipranavir** (Aptivus)
_____ **fosamprenavir** (Lexiva) – boosted dosage, 1bottle/mo (recommended)
_____ **fosamprenavir** (Lexiva) – unboosted dosage (2 btls/mo without low-dose ritonavir); dosage requires consultation/written justification from physician.

_____ **abacavir sulfate** (Ziagen)
_____ **didanosine** (DDI EC)
_____ **emtrictabine** (Emtriva)
_____ **lamivudine** (3TC)
_____ **stavudine** (D4T)
_____ **zidovudine** (AZT)
_____ **delavirdine** (Rescriptor)
_____ **enfuvirtide** (Fuzeon)

***Please note:** For the 4 antiretroviral (ARV) limit, Combivir, Epzicom & Truvada each count as 2 ARVs; Atripla, Complera & Trizivir count as 3 ARVs.

PHYSICIAN SIGNATURE**:** _____ TX MD/DO LICENSE #: _____

PRINTED NAME OF PHYSICIAN: _____

OFFICE ADDRESS: _____

TELEPHONE: _____ FAX: _____ DATE: ____/____/____

Texas HIV Medication Program, ATTN: MSJA - MC1873, PO Box 149347, Austin, TX 78714-9347 **(2/2012)**