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

VIRGINIA ADAP APPLICATION

Please print clearly and answer all questions. If you need assistance completing this application, please contact the Virginia Department of Health at 1-855-362-0658. The application may be mailed to Virginia Department of Health, Attn: Eligibility, 1st Floor, P.O Box 2448, Room 326 Richmond, VA 23218 or faxed to 804-864-8050.

Please include all required documents.

APPLICANT AND CONTACT INFORMATION

Last Name	First	M.I.	Date
Street 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 VDH 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 Virginia 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

Are you currently pregnant? ☐ Yes ☐ No ☐ Not Applicable ☐ Unknown

Relationship Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Partnered ☐ Widowed

HEALTH DEPARTMENT

Please list the Local Health Department or Site you will/would use for medicine pick up. If there is also an alternate site you could use, list that as well:

1)_____

2)_____

Are you able to receive medications delivered to your home by USPS (United States Postal Service)? ☐ Yes ☐ No

INCOME

Current Family Income: $_____	☐ Annual	☐ Monthly	☐Other, specify_____			
Number of persons in your family unit (include yourself):_____	**Are you currently employed?**	☐ Yes	☐ No			
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 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. Veteran's 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.

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	

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, 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		
Have you applied for insurance in the last 12 months?	☐ Yes	☐ No	☐ Don't Know	
If Yes, were you denied for insurance coverage or approved with an exclusionary rider?	☐ Yes	☐ No	☐ Don't Know	
If **Yes**, please send copy of Denial or Approval Letter				
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
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	
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

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		

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 VDH 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 Virginia Department of Health.

My information is being entered into a statewide database by the Virginia Department of Health. I authorize VDH 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 VDH on my behalf. VDH agrees to treat all information as confidential. I hereby give my consent to VDH 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. VDH 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

Did you:

- ☐ Answer all of the questions on the application?
- ☐ Include proof of Virginia residency if your current address is not in Virginia?
- ☐ Include proof of current income? (see examples in income section)
- ☐ Include a copy of your health insurance card (if applicable)?
- ☐ Sign application?
- ☐ Include the Medical Certification Form, completed and signed by your doctor?

VIRGINIA ADAP APPLICATION

MEDICAL CERTIFICATION FORM

Please complete and return to: Virginia Dept. of Health, Attn: Eligibility, 1st floor, P.O Box 2448, Room 326 Richmond, VA 23218 or fax to 804-864-8050. Call 855-362-0658 with any questions.

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.

_____ Signature of Physician

_____ Date Signed