Maryland
DEPARTMENT OF HEALTH

Client Services
1223 W. Pratt Street, Baltimore, MD 21223
Phone: (410) 767-6535 or Toll Free: 1-800-205-6308
or TTY- Maryland Relay Service 1-800-735-2258
Fax Numbers: (410) 333-2608; (410) 244-8617

A1: Medical Eligibility Form

Instructions: This form must be completed by the licensed medical practitioner who provides the applicant's HIV-related care. Once all sections have been completed, signed, and dated, it may be submitted to Client Services with the rest of the application or faxed to Client Services by the provider. Items with an asterisk mark (*) must be filled in for this form to be considered complete. Incomplete forms will delay the processing of your application.

APPLICANT'S INFORMATION:			
First Name:	MI:	Last Name:	Suffix:
Date of Birth: _____/____/_____		Social Security Number: _____-___-_____	
☐ *Check here if this patient does not have a social security number.*			

***1. VIRAL STATUS:**	
Is this patient HIV infected?	☐ **Yes** ☐ **No** *(If **No**, stop here, this patient is ineligible for Client Services)*
Has this patient's case been reported by you to the local health department as required by state law?	☐ **Yes** ☐ **No**

***2. LABORATORY REPORTS:**			
Enter this patient's most recent CD4 Count and Viral Load test results.		**TEST DATE**	**TEST RESULT**
	CD4 COUNT	**MM DD YYYY / /**	**cells/µL**
	VIRAL LOAD	**MM DD YYYY / /**	**copies/µL**

***3. HIV EXPOSURE CATEGORY:** *Check one*		
☐ Male who has sex with males (MSM)	☐ Heterosexual contact	☐ Not Reported
☐ Injection drug use (IDU)	☐ Receipt of blood transfusion, blood components, or tissue	☐ Other:
☐ Hemophilia/coagulation disorder	☐ Mother with or at risk for HIV infection (perinatal transmission)	

***4. MEDICAL PRACTITIONER'S INFORMATION** (Physician, Nurse Practitioner or Physician Assistant):				
Name			Degree: / Phone#:	Fax #:
Street Address:			License Number & Issuing State:	NPI#:
City:	State:	Zip Code:	Signature:	Date:

A-1 Medical Form - rev. January 2025