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

Maryland AIDS Drug Assistance Program

Client Services Enrollment Application

GENERAL INFORMATION

MADAP ensures that people living with HIV/AIDS in Maryland have access to the medication they need to stay healthy. MADAP is a statewide program and is funded primarily through the Ryan White CARE Act. MADAP pays for medications for eligible clients with no insurance and helps clients with insurance by paying for eligible insurance premiums, copay and deductible costs so that clients can get their medication. The list of medicines covered by MADAP (the MADAP formulary) includes all FDA approved HIV treatment medications, a wide range of medications used to treat opportunistic infections, and complications of HIV infection or related conditions.
Clients approved for MADAP must re-apply for the program annually. Clients enrolled in MADAP can use MADAP to receive their medications at any of the approximately 1,636 pharmacies that accept Maryland Medical Assistance (Medicaid). When you are approved, you will receive a welcome letter and MADAP ID card. You must present your MADAP ID card with your prescription(s) at a participating pharmacy to receive covered medications at no charge.

CLIENT SERVICES CONFIDENTIALITY STATEMENT

HIPAA Privacy Rule/Confidentiality/ Acknowledgement of MDH Privacy Policy MDH complies with the Health Insurance Portability and Accountability Act (HIPAA) privacy rule [45 CFR § 160.102]. Client-level data related to enrollment will be reported only as required by law.
Clients have the right to confidentiality of all information and records compiled, obtained and maintained in the course of applying for and/or receiving services.
Email addresses will not be sold to any third-party vendors or used to communicate one's specific case. Email addresses will only be used to quickly relay any updates and important information pertaining to the program.

APPLICATION INSTRUCTIONS

New Clients

This enrollment application must be completed, signed and submitted for eligibility determination and include required documentation applicable to your circumstances. Once your eligibility is approved, this will be your official enrollment application on file with Client Services.
Only complete applications will be considered for eligibility, so please provide all information requested. If a question or request is not applicable to you, answer "n/a". Include all required documents with your enrollment application. Please have your clinician complete, sign, and submit Form A-1: Medical Eligibility Form.

Active Clients

Client Services requires you to recertify your eligibility annually. The annual eligibility recertification occurs by the end of the 12th month of your enrollment period. The annual eligibility recertification form is due by the end of the 11th month of your eligibility period and will be sent to you prior to the end of the 11th month of your eligibility period.

- You must renew eligibility by submitting a completed and signed annual recertification form along with required supporting documentation for residency and income.

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Inactive Clients/Re-Enrolling

- If you previously were assigned a client ID, but your services are not currently active, you can re-enroll by following the guidance below:
    - If it has been 2 or more years since you were active, please complete and submit the Client Services Enrollment Application.
    - If it has been less than 2 years since you were active, please complete and submit the Annual Recertification Form.

I: APPLICANT INFORMATION & II: MARYLAND RESIDENCY

Name
List your full name, social security number and date of birth.

Address
Residency documentation must include the client's name and current address. Documentation must be current (e.g. current lease, recent utility bill, etc.). Acceptable proof of residency may include, but is not limited to, the following:

- Current notice of decision from Medicaid
- Valid Maryland driver's license or Maryland Identification card dated within the last 12 months
- Voter registration card dated within the last 12 months
- Current signed and dated lease (within the last 12 months) or current mortgage agreement
- Rent receipt, dated within the last 60 days
- Current utility bill, dated within the last 60 days
- Letter from a government agency, signed and dated within the last 60 days and mailed to the client's home, a letter from a case manager on agency letterhead, signed and dated within the last 60 days and mailed to the client's home

Homeless clients may provide a letter stating that they are homeless. The letter must be written on agency letterhead and be signed and dated within the last 60 days. MADAP's A-2 Verification of No Income Form may be submitted in place of a letter.
The following individuals may verify that the client is homeless:

- Case manager
- Housing manager
- Any staff member employed by an agency who receives Ryan White support

Sex/Race/Ethnicity/Language
Please check your sex, race, ethnicity and language preference.

III: MEDICAL ELIGIBILITY CRITERIA

The A-1: Medical Eligibility Form must be completed, dated, and signed by your licensed medical practitioner who provides your medical care. The practitioner must answer all questions to support your eligibility. This form can either be included in your enrollment application or sent directly to client services from your practitioner's office. This form is only required once, if you are not sure that we have a medical form on file, please contact Client Services.

IV: HOUSEHOLD/PROJECTED GROSS INCOME

Household includes the applicant, spouse, and all dependents on your federal tax return. If you do not file taxes, list the people in your household whom you support financially.

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V: HEALTH & PRESCRIPTION PLAN COVERAGE INFORMATION

You must submit a copy of the front and back of all your insurance card(s) with this application, so that we can verify your benefits. Also, submit a copy of any enrollment letter(s) you have received for LIS/Extra Help, SPDAP, or QMB/SLMB, if applicable.

VI: CLIENT SERVICES PLUS *(Insurance Premium Payment Assistance)*

Client services can assist with insurance premiums during approved eligibility periods. If you would like to request insurance premium payment assistance upon client services eligibility determination, please submit your health/prescription payment documentation (see chart on page 10) with this application. You will be contacted about Client Services Plus enrollment determination after your eligibility has been approved and your insurance coverage has been verified.

Covered plan types:

- QHP from the Maryland Health Benefits Exchange (on-exchange)
- QHP directly from the insurance carrier or through an insurance broker (off-exchange)
- Medicare Part C Plan
- Medicare Part D - Prescription Drug/Advantage Plan
- Medicare Supplemental Plans (Medigap), only if client has an active Part D plan or creditable coverage
- Dental and Vision Policies, only if client services is paying for the client's health and/or prescription coverage.
- Private Employer based plans (applicant's or spouse's employer, union or retirement plan), if client pays 50% or more of the premium, the plan covers your medication, and the employer will accept payment from the State of Maryland insurance program.

Plans not covered:

- Medicare Part A – Hospital Coverage
- Medicare Part B – Medical Coverage or Creditable Coverage (a plan usually obtained through an employer)
- VA/Tricare; I.H.S. (Indian Health Services);
- Maryland Medicaid (Medical Assistance); or Maryland Children's Health Program
- Private medical or prescription plans that do not cover HIV drugs or provide HIV care and employer plans where the employer does not accept payment from the program.

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Client Services Enrollment Application

Client Services ID (if applicable): _____
Are you a new applicant to Client Services? ☐ Yes ☐ No

Applying for (check one):
☐ Drug Assistance
☐ Drug and Insurance Premium Payment Assistance

If you have prescription coverage through Maryland Medicaid, you are NOT eligible.

Section I: Applicant Information

Items with an asterisk mark (*) must be filled in for this form to be considered completed. Incomplete forms will delay the processing of your application.

***First Name:** _____ **Middle Initial:** _____ ***Last Name:** _____ **Suffix:** _____

***Date of Birth (MM/DD/YYYY):** _____

***Social Security Number**: _____
☐ Check if you do not have a social security number.
ITIN (if applicable): _____

***Residential Address** (proof of residency is required, see Section 2):

***Street:** _____ **Apt#**: _____

***City:** _____ ***State:** _____ ***Zip Code**: _____
☐ I am homeless and live in Maryland. (check if applicable, complete and submit Form A-2)

Mailing Address (if different from residential address):

Street: _____ **Unit/Apt#**: _____

City: _____ **State:** _____ **Zip Code**: _____

***Telephone numbers where Client Services staff can reach you:**
Home: (_____) -_____ - _____ May we leave a detailed message? ☐ Yes ☐ No
Work: (_____) -_____ - _____ May we leave a detailed message? ☐ Yes ☐ No
Cell: (_____) -_____ - _____ May we leave a detailed message? ☐ Yes ☐ No

Email address where Client Services staff can reach you: _____
(see page 1, Client Services Confidentiality Statement for more information.)

Gender at Birth: ☐ Male ☐ Female

***Gender:** ☐ Male ☐ Female ☐ Transgender (☐ Male to Female ☐ Female to Male)

***Legal Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Sexual Orientation: ☐ Straight or Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual
☐ Don't know ☐ Choose not to disclose
☐ Something else (please specify): _____

***Race** *(Check all that apply):*

- ☐ **Black or African American**
- ☐ **White**
- ☐ **American Indian/Alaskan Native**
- ☐ **Native Hawaiian/Pacific Islander**

(Check all that apply):

  - ☐ Native Hawaiian
  - ☐ Guamanian or Chamorro
  - ☐ Samoan
  - ☐ Other Pacific Islander

- ☐ **Asian** (Check all that apply):
  - ☐ Asian Indian
  - ☐ Vietnamese
  - ☐ Korean
  - ☐ Japanese
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Other Asian

***Ethnicity:**

- ☐ Non-Hispanic
- ☐ Hispanic/Latino(a) *(Check all that apply):*
  - ☐ Mexican, Mexican American, or Chicano/a
  - ☐ Puerto Rican
  - ☐ Cuban
  - ☐ Another Hispanic, Latino(a), or Spanish origin

***Citizenship/ Immigration Status:**

- ☐ U.S. Citizen
- ☐ Not a citizen or permanent resident of the U.S.
- ☐ Green Card (attach copy of card)
- ☐ Asylee (attach documentation)

*Section II: Maryland Residency: Documentation must include your name and residential address as displayed in Section 1. Check the type of legible documentation being attached to verify your Maryland residency (choose one):

Documents that must be dated within the past 60 days of submitting this application:

- ☐ Bills - (examples: utility, health insurance premium, cell phone, cable service, car or hospital)
- ☐ Employment:
  - Paystubs (one month)
  - Unemployment: Determination letter
  - Other: A-2: Verification of No Income/Homeless Verification Form
  - A-3: Cash Only Verification Form
- ☐ Change of address card from a U.S. Post Office or MVA (Maryland Vehicle Admin.)
- ☐ Bank statement
- ☐ Windowless envelope with dated postmark addressed to you, received at your residential address previously identified

Documents that must be dated within the past year of submitting this application:

- ☐ Social Security Award Letter
- ☐ Lease or Mortgage
- ☐ Driver's License

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Section III: Medical Eligibility Criteria:

Are you a new applicant to Client Services?

☐ Yes, I have never been enrolled with the programs.
☐ No, I am currently enrolled or have been enrolled in the past. **This section is not applicable for you.**

The **A-1: Medical Eligibility Form** must be completed, dated, and signed by your licensed medical practitioner who provides your medical care. The practitioner must answer all questions to support your eligibility. This form can either be included in your enrollment application or sent directly to client services from your practitioner's office. This form is only required once, if you are not sure we have a medical form on file, please contact Client Services.

*Section IV: Household/Projected Gross Income: *Household includes the applicant, spouse, and all dependents on your federal tax return. If you do not file taxes, list the people in your household whom you support financially.*

Is the applicant under the age of 19 and financially supported by parent(s)/guardian(s)? ☐ **Yes** ☐ **No** (If yes, please complete **A**, if no, proceed to **B**)

A. Parental Information

Parent/Guardian 1:

First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: _____

Date of Birth (mm/dd/yyyy): _____/_____/_____ Social Security Number: _____ - _____ - _____
☐ Check if no social security number.
ITIN (if applicable): _____

Parent/Guardian 2:

First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: _____

Date of Birth (mm/dd/yyyy): _____/_____/_____ Social Security Number: _____ - _____ - _____
☐ Check if no social security number.
ITIN (if applicable): _____

B. Marital Information (if applicable):

Spouse:

First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: _____

Date of Birth (mm/dd/yyyy): _____/_____/_____ Social Security Number: _____ - _____ - _____
☐ Check if no social security number.
ITIN (if applicable): _____

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C. Natural, Adopted, Stepchildren/Siblings *(attach additional sheets if necessary):*

Do you have any children/siblings who live within the household who are under the age of 19? ☐ **Yes** ☐ **No**.
(If yes, please list each child's name, age and date of birth.)

Name **Date of Birth** **Age**

Child 1: _____

Child 2: _____

Child 3: _____

Child 4: _____

Additional Members of your household (*not listed above*):

Name	**Relationship**	**Do you plan to claim this person as a dependent on your taxes?**	**If yes, please provide their social security number**
		☐ **Yes** ☐ **No**	**SS#** _____
		☐ **Yes** ☐ **No**	**SS#** _____
		☐ **Yes** ☐ **No**	**SS#** _____

D. Household Income:

*You are required to report all your household's gross income, including your income, your legal spouse's income, and income of any dependents even if it is zero ($0). Provide the requested information:

1. Recipient ☐ Self ☐ Spouse ☐ Household member	**Income Source(s)**	**How Often** ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually ☐ Semi-Monthly ☐ Seasonal: # of Months paid: _____	**Gross Amount** (before deductions) $ _____
2. Recipient ☐ Self ☐ Spouse ☐ Household member	**Income Source(s)**	**How Often** ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually ☐ Semi-Monthly ☐ Seasonal: # of Months paid: _____	**Gross Amount** (before deductions) $ _____
3. Recipient ☐ Self ☐ Spouse ☐ Household member	**Income Source(s)**	**How Often** ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually ☐ Semi-Monthly ☐ Seasonal: # of Months paid: _____	**Gross Amount** (before deductions) $ _____
4. Recipient ☐ Self ☐ Spouse ☐ Household member	**Income Source(s)**	**How Often** ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually ☐ Semi-Monthly ☐ Seasonal: # of Months paid: _____	**Gross Amount** (before deductions) $ _____

***Total number of household members:** _____

***Total household annual gross income: $** _____

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Based on the reported household income in the previous section, please submit a copy of the required supporting documentation for each source of income as described in the following chart.

Income Source	Supporting Documentation
Wages and Salaries (including tips)	One month's gross pay stubs (including tips), dated within the last 60 days
Net Income from Self-Employment	Most recent submitted quarterly tax statements, or Receipts, Journal, Manifests for most recent 30 days or Business Checking and/or Savings Bank Statements for the most recent 60 days)
Alimony, Retirement, Pension, Annuity, Investment Dividends or Interest	Statement of monthly payments.
Current Unemployment Benefits	Current Unemployment letter/printout with balance
Social Security	Current award letter from Social Security Administration, inclusive of disability, if applicable.
Rental Property	Statement of net income.
Other Taxable Income (prizes, awards, gambling winnings)	Statement and evidence of other taxable income.
No Income, supported by others	A-2: No Income and/or Homeless Verification Form -completed by the person who supports you.
Cash only Income	A-3: Cash Only Verification Form

Do not report the following types of income: child support; gifts; Supplemental Social Security Income; Veterans' disability payments; workers' compensation; or proceeds from loans, such as student loans, home equity loans, or bank loans, school stipends such as scholarships or fellowship payments for tuition, fees, and course related expenses that are necessary for all students.

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Section V: Health & Prescription Plan Coverage Information:

You must submit a copy of the front and back of all your insurance card(s) with this application, so we can verify your benefits. Also, submit a copy of any enrollment letter(s) you have received for LIS/Extra Help, SPDAP, or QMB/SLMB, if applicable.

Complete the following for Health and Prescription Insurance plans:

Pharmacy Benefits:

Complete the section below if you have pharmacy benefits or submit a copy of the front and back of your pharmacy benefits card.

Company Name: _____ Rx BIN: _____
Policy Holder Name: _____ Rx PCN: _____
Effective Date: _____ Rx Group: _____
Phone Number: _____ Plan ID: _____

Health Insurance Plans:

Primary Health Coverage (Choose plan type):
☐ Individual ☐ Individual/Spouse
☐ Family ☐ Individual/Child

Insurance company name: _____
Policy holder name: _____
Phone number: _____ Plan number: _____
Member ID: _____ Group ID: _____
Effective date: _____

Secondary Health Coverage (Choose plan type):
☐ Individual ☐ Individual/Spouse
☐ Family ☐ Individual/Child

Insurance company name: _____
Policy holder name: _____
Phone number: _____ Plan number: _____
Member ID: _____ Group ID: _____
Effective date: _____

Complete the following for all Other Plans:

Type of Coverage: _____
Company Name: _____
Policy Holder Name: _____
Plan ID#: _____
Effective Date: _____
Phone Number: _____

Type of Coverage: _____
Company Name: _____
Policy Holder Name: _____
Plan ID#: _____
Effective Date: _____
Phone Number: _____

If you do NOT have health insurance check all reasons that apply:

☐ Cost of premiums ☐ Cost of co-pays ☐ Not interested ☐ Other (describe): _____
☐ Check here if you need help obtaining insurance

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Section VI: Client Services Plus: *Insurance Premium payment assistance*

Client Services will only provide premium assistance during approved eligibility dates.

Client services can assist with insurance premiums during approved eligibility periods. If you would like to request insurance premium payment assistance upon client services eligibility determination, please submit your health/prescription payment documentation (see chart below) with this application. You will be contacted about Client Services Plus enrollment determination after your eligibility has been approved and your insurance coverage has been verified.

Type of Plans Covered	Payment Documentation Needed
QHP from the Maryland Health Benefits Exchange (on-exchange)	Monthly Premium Invoice/Bill
QHP directly from the insurance carrier or through an insurance broker (off-exchange)	Monthly Premium Invoice/Bill
Medicare Part C Plan	Invoice or Coupon Booklet
Medicare Part D - Prescription Drug/Advantage Plan	Invoice/Bill or Coupon Booklet
Medicare Supplemental Plans (Medigap), if client has active Part D plan or creditable coverage	Invoice/Bill or Coupon Booklet
Dental and Vision Policies, if client services is paying client's health and prescription coverage.	Invoice/Bill or Coupon Booklet
Private Employer based plans (applicant's or spouse's employer, union or retirement plan), if client pays 50% or more of the premium, the plan covers your medication, and the employer will accept payment from the State of Maryland insurance program.	Provide a letter from your employer that includes the cost of your monthly premium, percentage employer pays, percentage you pay, where to send payment with who to address the check to, and whether your employer will accept a payment from a State of Maryland insurance program. Client services staff must be able to arrange payment of the applicant's portion of the premium. Staff will need to communicate with the employer to make arrangements for a payment plan approved by the employer.
Plans not covered:	
Medicare Part A – Hospital Coverage	
Medicare Part B – Medical Coverage or Creditable Coverage (a plan usually obtained through an employer)	
VA/Tricare; I.H.S. (Indian Health Services); Maryland Medicaid (Medical Assistance); or Maryland Children's Health Program	
Private medical or prescription plans that do not cover HIV drugs or provide HIV care and employer plans where the employer does not accept payment from the program.	

It is your responsibility to provide monthly premium statements to Client Services for timely payments.

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Section VII: Release & Exchange of Information:

I certify that the information provided in this application is complete and accurate, to the best of my knowledge.

- I understand that, for the purposes of determining my eligibility for services, the Maryland Department of Health (MDH) may request further documentation.
- I authorize my physician, case manager/social worker, and health care providers to exchange information with the MDH that documents my diagnosis and need for services from MDH.
- I authorize MDH to exchange information with my physician, case manager/social worker, health care providers, insurance carrier(s) and/or pharmacy provider(s) to facilitate provision of Client Services as needed.
- I understand that if MDH requests it, I am required to attest to continuing eligibility and provide supporting documentation within the specified timeframe given. I understand that my non-compliance to verify my continued eligibility will result in suspension or termination of my services.
- I agree to notify MDH *(at the address on this form)* of any circumstances affecting my eligibility for services. . I agree to notify MDH within 10 days if my address, income or other information changes. (COMAR 10.18.05.04A)
- I authorize MDH to contact me via phone, email, or mail to exchange information related to my case. If a phone call is made, I will let MDH know if they are approved to leave a voice message and/or speak with an alternate contact on my behalf.

Consumer's rights:

- If my application is denied, I have the right to request a reconsideration (COMAR 10.18.05.05A), and if I am dissatisfied with the reconsideration (COMAR 10.18.05.05C), I may request an appeal hearing.
- I understand that I may revoke this authorization at any time in writing. However, this release shall remain valid until I inform Client Services, in writing, of my wish to terminate services or until such time as I no longer qualify for these services, whichever occurs first, except to the extent that action has been taken in reliance on this authorization.

Provide the following:

Case Manager:

Name: _____

Provider Site: _____ Phone number: _____

Primary HIV Physician:

Name: _____

Provider Site: _____ Phone number: _____

*** Alternate Contacts:**

I authorize Client Services to speak with the following person(s) about my application and/or services (e.g.: family member):

Name	Organization	Relationship	Phone number
_____	_____	_____	_____
_____	_____	_____	_____

I certify that the information I have given on this application is true, correct, and complete. I agree to provide documentation upon request as required by MDH. I acknowledge receipt of MDH Privacy Practices, and Consumer Rights policies and agree to the Release and Exchange of Information.

*Applicant Name: _____
(please print)

*Signature of Applicant: _____ Date: _/_____/_____
(or legal guardian if applicant is a minor)

*Spouse Signature: _____ Date: _____/_____/_____
(if applicable)

Mail, fax, or email completed application and supporting documentation to:

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Baltimore, MD 21223
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Email: Client.Services@maryland.gov

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Appendix

Appendix A:

Acceptable Residency Documentation

- Please provide one form of acceptable proof of residency from the list below. Documentation must be current (e.g. current lease, recent utility bill, etc.). Acceptable proof of residency may include, but is not limited to, the following:
  - Current notice of decision from Medicaid
  - Valid Maryland driver's license or Maryland Identification Card dated within the last 12 months
  - Voter registration card dated within the last 12 months
  - Current signed and dated lease (within 12 months) or mortgage agreement
  - Rent receipt, dated within the last 60 days
  - Current utility bill, dated within the last 60 days
  - Letter from a government agency, signed and dated within the last 60 days and mailed to the client's home
  - Letter from a case manager on agency letterhead, signed and dated within the last 60 days and mailed to the client's home
- Homeless clients may provide a letter stating that they are homeless. The letter must be written on agency letterhead and be signed and dated within the last 60 days. A-2 Verification of No Income Form may be submitted. The following individuals may verify that the client is homeless:
  - Case manager
  - Housing manager
  - Any staff member employed by an agency who receives Ryan White support

Appendix B:

Acceptable Income Documentation

- Income includes any income earned through employment, disability, public benefits, etc. Forms of income include, but are not limited to, the following:
  - Employment income
  - Retirement income
  - Unemployment benefits
  - Supplemental Security Income (SSI)
  - Social Security Disability Insurance (SSDI)
  - Income for dependents
  - Alimony payments
  - Private disability
  - Rental property income
  - Interest income or other investment income
  - Cash support from family and friends
- Income information should be collected for the client and individuals over the age of 18 who share financial responsibility. All income must be current, signed, and dated (e.g. current year award letter, recent pay stubs, etc.). Acceptable proof of income may include, but is not limited to, the following:
  - One month of consecutive pay stubs
  - Tax forms (W-2 form or 1099)
  - Letter on letterhead from employer stating hourly wage and hours worked per week
  - Pension benefits letter
  - Retirement benefits check or letter
  - Unemployment income check or letter
  - Disability benefits check or letter
  - Social Security check or award letter
  - Bank direct deposit indicating payment from Social Security
  - Alimony Agreement Letter
  - If receiving support from family and friends, signed statement documenting who provides monetary support, and the frequency of the support
  - If no income, the A-2 Verification of no Income form may be submitted

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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 completed. 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 you do 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:**