

Georgia AIDS Drug Assistance Program (ADAP) Application

<b>I. PATIENT INFORMATION</b>				
<u>LAST NAME</u>	<u>FIRST NAME</u>	<u>MIDDLE INITIAL</u>	<u>MAIDEN</u>	
<u>ADDRESS</u>	<u>CITY AND STATE</u>	<u>ZIP CODE</u>	<u>COUNTY</u>	<u>MARITAL STATUS</u> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated
<u>MAILING ADDRESS</u>	<u>CITY AND STATE</u>	<u>ZIP CODE</u>	<u>COUNTY</u>	
<u>DATE OF BIRTH</u> ____/____/____	<u>SOCIAL SECURITY #</u> -- -- (IF APPLICABLE)	<u>ETHNICITY</u> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		
<u>GENDER</u> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown	<u>RACE</u> <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ Other Pacific Islander		<input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
<u>ADAP STATUS</u> <input type="checkbox"/> Newly Enrolled in ADAP in Georgia <input type="checkbox"/> Transfer From: _____				<input type="checkbox"/> Previously Enrolled in ADAP in Georgia    Slot #: _____
<b>II. CLINICAL INFORMATION</b>				
<u>DIAGNOSIS</u> <input type="checkbox"/> AIDS DATE: ____/____/____ <input type="checkbox"/> HIV POSITIVE DATE: ____/____/____	<u>CD4 COUNT</u> CURRENT: _____ DATE: ____/____/____ LOWEST: _____ DATE: ____/____/____		<u>HIV VIRAL LOAD</u> CURRENT: _____ DATE: ____/____/____ HIGHEST: _____ DATE: ____/____/____	
<u>CASE REPORT FORM ATTACHED:</u> YES <input type="checkbox"/> NO <input type="checkbox"/>				
<b>HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART) HISTORY</b>				
<input type="checkbox"/> <b>HAART EXPERIENCED</b> (Indicate Previous Payor Source of Rx) <input type="checkbox"/> Other State ADAP _____ <input type="checkbox"/> Patient Assistance Program <input type="checkbox"/> Medicaid <input type="checkbox"/> Third Party Insurance <input type="checkbox"/> Department of Corrections <input type="checkbox"/> Other _____ (Please provide proof of previous HAART therapy)		<input type="checkbox"/> <b>INDICATIONS for INITATING HAART</b> (Check all that apply) <input type="checkbox"/> History of Opportunistic Infections <input type="checkbox"/> HIV-related Malignancy <input type="checkbox"/> CD4 count less than 350 <input type="checkbox"/> Pregnant (any CD4 count) <input type="checkbox"/> HIV-Associated Nephropathy (any CD4 count) <input type="checkbox"/> Hepatitis B Treatment Indicated (any CD4 count) <input type="checkbox"/> CD4 count greater than 350 (physician must provide justification in space below) <input type="checkbox"/> Continuation of Therapy		
<input type="checkbox"/> <b>HAART NAÏVE</b>				
<u>PHYSICIAN'S COMMENTS</u> (Provide details to warrant initiation of HAART): _____ _____ _____				
<b>III. PHYSICIAN INFORMATION</b>				
<u>PRINT NAME</u>		<u>CLINIC NAME</u>		
<u>ADDRESS</u>	<u>CITY</u>	<u>STATE</u>	<u>ZIP</u>	

Georgia AIDS Drug Assistance Program (ADAP) Application

_____ PHYSICIAN'S SIGNATURE	(    ) _____ PHONE
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**IV. FINANCIAL/INCOME INFORMATION**

FAMILY SIZE				
NAME	RELATIONSHIP TO CLIENT	AGE	GROSS MONTHLY INCOME	SOURCE OF INCOME
APPLICANT	SELF			
<b>TOTAL</b>			\$	
<b>TOTAL X 12 MONTHS =</b>				\$ / YEAR

ASSETS	
TYPE	AMOUNT
CASH ON HAND	\$
CHECKING ACCOUNT	\$
SAVINGS ACCOUNT	\$
STOCKS	\$
BONDS	\$
SEVERENCE PAY	\$
OTHER	\$
<b>TOTAL</b>	<b>\$</b>

**NOTE:** Total assets cannot exceed \$10,000.

**DOCUMENTATION OF INCOME**

Type of Income (indicate all that are applicable):	Documentation Attached:
<input type="checkbox"/> Employment	<input type="checkbox"/> Paycheck Stub for last month <input type="checkbox"/> Signed Employer Statement with Dates <input type="checkbox"/> Tax Return <input type="checkbox"/> Other (Specify):
<input type="checkbox"/> Child Support Payments	<input type="checkbox"/> Court Order/Copy of Check
<input type="checkbox"/> Social Security Disability Income (SSDI)	<input type="checkbox"/> Social Security Award Letter
<input type="checkbox"/> Supplemental Security Income (SSI)	<input type="checkbox"/> SSI Award Letter
<input type="checkbox"/> Veterans Benefits	<input type="checkbox"/> VA Award Letter
<input type="checkbox"/> Interest/Investment Income	<input type="checkbox"/> Bank Statements
<input type="checkbox"/> Other	<input type="checkbox"/> Other (Specify):
<input type="checkbox"/> No Income	<input type="checkbox"/> Signed Statement of Source of Living Expenses (i.e., Family/Friends, with Witness Signature)

**V. GEORGIA RESIDENCY**

The client is currently living in the State of Georgia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Client provided the following to document Georgia residency:</b>	<b>Documentation Attached:</b>

## Georgia AIDS Drug Assistance Program (ADAP) Application

Copy of Client's Utility Bill	<input type="checkbox"/> Yes <input type="checkbox"/> No
Copy of Client's Lease/Mortgage Agreement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Client is homeless (in Georgia) Shelter Name/Location:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Georgia Driver's License or Georgia State ID <b>NOTE:</b> A Georgia Driver's license alone, is not adequate proof of residency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (Please Specify):	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Applicants who have no proof of residency in their names can submit a statement from persons with whom they live that is attached to an affidavit signed by the applicant.**

### VI. THIRD PARTY PAYER/INSURANCE INFORMATION

<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICAID SPENDDOWN (QMB)	MEDICAID #:
<input type="checkbox"/> MEDICARE <input type="checkbox"/> PART A <input type="checkbox"/> PART B <input type="checkbox"/> PART D	MEDICARE #: Applied for Low Income Subsidy (LIS) "extra help": yes <input type="checkbox"/> no <input type="checkbox"/> Approved for Full Low Income Subsidy (LIS) "extra help" yes <input type="checkbox"/> no <input type="checkbox"/> Approved for Partial Low Income Subsidy (LIS) "extra help" yes <input type="checkbox"/> no <input type="checkbox"/> MEDICARE Part D Plan Company Name: _____ Deductible \$ _____ Co-pays \$ _____ Premiums \$ _____
<input type="checkbox"/> VETERANS BENEFITS	Did the client ever serve in the Armed Forces, Reserves, or National Guard? yes <input type="checkbox"/> no <input type="checkbox"/>
<input type="checkbox"/> PRIVATE HEALTH INSURANCE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> GROUP <input type="checkbox"/> COBRA INCLUDES DRUG COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	INSURANCE COMPANY: <hr/> POLICY #: <hr/> PHONE NUMBER OF INSURANCE COMPANY: (    )    -    _____
<input type="checkbox"/> NO INSURANCE	CONTACT PERSON:

### VII. APPLICANT AGREEMENT

I fully understand that the AIDS Drug Assistance Program (ADAP) is intended for clients with HIV infection who are unable to pay for their medications. I hereby certify that the information supplied in this application, and accompanying attachments, is complete and accurate. I fully understand that I am responsible for completing the recertification process, every 6 months, in order to continue to receive ADAP services. If I fail to comply with this policy, I fully understand that I can be removed from ADAP.

Furthermore, I hereby authorize the release of medical information, including information about my HIV status, to the Department of Human Resources, Division of Public Health, HIV Section, all other entities involved in the processing of ADAP documentation and dispensing HIV/AIDS medication, and the Pharmacy Benefit Manager (PBM). In the event of a program audit, I understand that ADAP applications, recertifications and other supporting documentation may be subject to review by State of Georgia Auditors and I therefore authorize access to my records

**APPLICANTS DO NOT HAVE TO DOCUMENT  
CITIZENSHIP OR IMMIGRATION STATUS TO BE ELIGIBLE FOR SERVICES.**

\_\_\_\_\_  
Print Client Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature



## Georgia AIDS Drug Assistance Program (ADAP) Application

		<b>applies</b> <input checked="" type="checkbox"/>
1	CD4 < 50 with an AIDS defining illness	
2	CD4 50-199 with an AIDS defining illness	
3	CD4 ≤ 200 with an AIDS defining illness	
4	CD4 < 50 without an AIDS defining illness	
5	CD4 50-99 without an AIDS defining illness	
6	CD4 100-199 without an AIDS defining illness	
7	CD4 200-350 without an AIDS defining illness or a 50% decline in CD4 over the past 6 months	
8	CD4 < 350 with viral loads >100,000	
9	Patients who are on therapy, but lose their payer source (i.e. Medicaid, third-party insurance, Dept. of Corrections, other State ADAP, etc.) and did not fit any of the above categories at initiation of treatment	

**X. ADAP DISTRICT OR AGENCY STAFF MUST USE THE FOLLOWING CHECKLIST TO ENSURE THAT ALL DOCUMENTATION IS ATTACHED AND THE APPLICATION IS COMPLETE. PLEASE CHECK ALL THAT APPLY.**

**All applications must include the following information or documentation.**

<input type="checkbox"/> Section I: Patient Information is Complete	<input type="checkbox"/> Medicaid Screening Worksheet is Complete
<input type="checkbox"/> Section II: Clinical Information is Complete	<input type="checkbox"/> Copy of Medicaid/Medicare Card, if applicable
<input type="checkbox"/> Copies of Lab Results (CD4 and/or Viral Load) (Tests must not be more than 6 months old)	<input type="checkbox"/> Copy of Medicare Part D Plan enrollment card (if applicable)
<input type="checkbox"/> Section IX: Waiting List Criteria, if applicable	<input type="checkbox"/> Copy of denial or approval letter for Low Income Subsidy (LIS)
<input type="checkbox"/> Section IV: Financial Information is Complete	<input type="checkbox"/> Application Has Been Signed And Dated By: <input type="checkbox"/> Client <input type="checkbox"/> Physician <input type="checkbox"/> Case Manager
<input type="checkbox"/> Proof of Income is Attached	
<input type="checkbox"/> Proof of Georgia Residency is Attached	<input type="checkbox"/> Prescriptions & Prescription Memorandum are Attached Note: Pilot sites are <b>not</b> required to attach Prescriptions & Prescription Memorandum
<input type="checkbox"/> Case Report is Attached	<input type="checkbox"/> Application is Complete with all required attachments
Date: _____	Signature of person completing the checklist _____

FOR DHR USE ONLY	
	DISPOSITION OF APPLICATION
	<input type="checkbox"/> NO PROOF OF HIV+ STATUS <input type="checkbox"/> INCOME EXCEEDS CURRENT CRITERION / ____ / ____ <input type="checkbox"/> NO PROOF OF GEORGIA RESIDENCY <input type="checkbox"/> CLIENT HAS INSURANCE (WITH RX COVERAGE) <input type="checkbox"/> CLIENT HAS VA BENEFITS <input type="checkbox"/> CLIENT HAS OTHER PAYOR SOURCE _____ <input type="checkbox"/> CLIENT EXCEEDS MEDICAL ELIGIBILITY CRITERION <input type="checkbox"/> INCOMPLETE APPLICATION* <input type="checkbox"/> WAITING LIST PRIORITY LEVEL: _____
DATE RECEIVED	<input type="checkbox"/> APPROVED <input type="checkbox"/> NOT APPROVED

## Instructions for Completing the Georgia ADAP Application

### **Section I. Patient Information**

- Last Name:** Enter the client's last name.
- First Name:** Enter the client's first name.
- Middle Initial:** Enter the client's middle initial.
- Maiden Name:** Enter the client's maiden name, if applicable.
- Address:** Enter the client's home address, city, state and zip code
- Mailing Address:** Enter the client's mailing address, city, state and zip code if different from home address. If the mailing and home addresses are the same, enter same as above.
- Date of Birth:** Enter the client's date of birth using the **MM/DD/YYYY** format. Example: 01/01/1965
- Social Security Number:** Enter the client's 9-digit social security number, if applicable.
- Gender:** Check the box identifying the client's gender.
- Telephone Number #1:** Enter the primary phone number for the client, including area code.
- Telephone Number #2:** Enter the emergency phone number for the client, including area code.
- Ethnicity:** Indicate whether the client is Hispanic, Non-Hispanic or Unknown.
- Race:** Indicate the client's race. Note: If a client does not identify with any of the races indicated on the form, check "unknown."
- Marital Status:** Check the box indicating the client's current legal marital status.
- Client Status:** Check the box indicating if this is a new client application or a client transferring from another enrollment site; if the client is being transferred, please include slot if known.

### **Section II. Clinical Information**

- Diagnosis:** Indicate the client's current diagnosis, and include the date the diagnosis was *initially* made.
- CD4:** Indicate the client's current CD4, and include the date of the test. Also indicate the lowest CD4 count, if known, and include the date.
- Viral Load:** Indicate the client's current HIV Viral Load, and include the date of the test. Also include the highest viral load, if known, and include the date.
- Pregnant:** Indicate whether or not the client is pregnant. If pregnancy status does not apply, check N/A.

## Georgia AIDS Drug Assistance Program (ADAP) Application

**HAART History:** *HAART (Highly Active Antiretroviral Therapy): An aggressive anti-HIV treatment usually including a combination of two or more drugs with activity against HIV whose purpose is to reduce the viral load to undetectable levels.*

Indicate whether the client is *HAART experienced* and check the box(es) to identify the client's previous means of accessing HAART. If the client is new to HAART, or *HAART naïve*, check the box(es) that support the decision to initiate HAART.

Example #1: If the client's CD4 count is 300 and he/she has never been on HAART, the prescribing clinician will check the boxes marked  HAART Naïve and  Initiating HAART in accordance with PHS Guidelines.

Example #2: If the client's CD4 count is 600 and he/she has never been on HAART but has a history of Opportunistic Infections, the prescribing clinician will check the boxes marked  HAART Naïve and  History of Opportunistic Infections.

Example #3: If the client's CD4 count is 800 and the client was on HAART while in the Department of Corrections, the prescribing clinician will check the boxes marked  HAART Experienced and  Department of Corrections.

For patients with CD4 's > 350, the appropriate criteria box should be checked. If the physician feels that therapy is warranted, the PHYSICIAN'S COMMENTS section should contain detail regarding this recommendation.

Case Reports must be attached to all new ADAP applications. The yes box should be checked of the Case Report is attached. If the no box is checked or no Case Report is attached, the applications will not be approved

### **Section III. Physician Information**

**Physician Information:** Complete the name of the physician, clinic name, address, city, state, and zip code and phone number. The prescribing clinician must sign the form.

### **Section IV. Financial/Income Information**

Indicate the current age of the client, his/her **gross monthly income**, and the source of income.

**Assets:** Complete this section by entering the amount of client assets for each of the types listed in the section.

**\*\* Cash Assets COUNTED towards ADAP eligibility are defined as any easily accessible or liquid cash such as assets in:**

- *Checking account, savings account, short term CD (3 months or less)*
- *Non retirement stock portfolios/mutual funds*
- *Equity in rental/vacation property*

**Assets NOT COUNTED towards ADAP include:**

- *Life insurance policies, and retirement/pension accounts*
- *Personal residence*
- *Personal transportation*

## Georgia AIDS Drug Assistance Program (ADAP) Application

**Documentation of Income:** Complete the documentation of income section and attach appropriate documents verifying the source of the client's income.

### **Section V. Georgia Residency**

Indicate whether or not the client is currently living in Georgia.

Indicate the type of documentation the client provided to document GA residency and attach copies.

**Applicants who have no proof of residency in their names can submit a statement from persons with whom they live that is attached to an affidavit signed by the applicant**

### **Section VI. Third Party Payer/Insurance Information**

**Insurance Information:** Complete this section by indicating if the client has any of the listed sources of insurance coverage. Include policy numbers, insurance company names, phone numbers, and contacts as applicable. Please include all requested Medicare, Low Income Subsidy (LIS) and/or Medicaid information. Attach information/documentation regarding Medicare Part D plan status and coverage details and the Medicaid Screening Worksheet.

### **Section VII. Applicant Agreement**

Print the client's name. This section must be signed and dated by the client, indicating that he/she understands the intent of the AIDS Drug Assistance Program and authorizes his/her HIV information to be released to the Department of Human Resources, Division of Public Health, HIV Section. **Also, inform the client that applicants do not have to document citizenship or immigration status to be eligible for services.**

### **Section VIII. Case Manager Agreement**

Case manager must print his/her name and contact information and sign the application.

### **Section IX. Waiting List Criterion**

Indicate the medical criteria that reflects the client's current status (if applicable).

### **Section X. Checklist**

The checklist is to be completed by the case manager. Each of the items on the checklist is required, if applicable, in order to enroll a client into the AIDS Drug Assistance Program. Incomplete application packets **can not** be processed and will be returned to the enrolling agency. Please attach all supporting documents to the application **prior** to submission.

The Medicaid Screening Worksheet and income, residency, and other supporting documents must be included with the ADAP Application. Applications and supporting documents are to be marked **CONFIDENTIAL** and sent to:

Georgia Division of Public Health  
Prevention Services Branch  
2 Peachtree Street NW 12<sup>th</sup> Floor  
Atlanta, Georgia 30303  
ATTN: ADAP Associate