DC | HEALTH

District of Columbia Department of Health
HIV/AIDS, Hepatitis, STD, and TB Administration
PrEP Drug Assistance Program
899 North Capitol Street N.E. 4th Floor, Washington, D.C. 20002

For office use only:
Eligibility Determination
Date___/__/___

SECTION I: APPLICANT INFORMATION

Last Name		**First**		**M.I.**	**Other Name(s):**	**Date of Birth** *MM/DD/YYYY*	/ /
Street Address (*Proof of Residency Required*)				**Apartment/Unit #**			
City		**State**		**ZIP**			
Social Security No.		**Can program information be sent to the address listed? YES ☐ NO ☐**		**Mailing Address:**			
Phone		**E-mail Address**					

Sex/ Gender ☐ Male ☐ Female ☐ Transgender Woman (Male to Female) ☐ Transgender Man (Female to Male)

Race ☐ White ☐ Black/African American ☐ Asian ☐ Hawaiian/ Pacific Islander ☐ Native American/Alaskan ☐ More than one race

☐ Other_____

If Asian, ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian

Ethnicity ☐ Hispanic ☐ Non-Hispanic

If Hispanic/Latino ☐ Mexican, Mexican-American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic Origin

Language ☐ English ☐ Spanish ☐ Other_____

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

Are you a veteran (Optional)? ☐ Yes ☐ No

Are you a registered voter in the District of Columbia? ☐ Yes ☐ No

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

SECTION II: INCOME INFORMATION (*Proof of income required for applicant and household)*

Income Source (check all that apply)

☐ Employed: Salary/Wages: ☐ FT ☐ PT ☐ Public Assistance ☐ Veteran's Benefits ☐ No Income, Supported by others

☐ Self Employed ☐ Unemployment ☐ Social Security ☐ No Income, Living off Savings

☐ Worker's Compensation ☐ Rental Property ☐ Pension ☐ No Income

☐ Interest/CD's/ Stocks/ bonds ☐ Dividends/Royalties ☐ Other ☐ Alimony/ Child Support

For all checked please indicate:

Income Source	Gross Amount	How Often		Recipient	Start Date
1._____	$_____	☐ Weekly ☐ Monthly	☐ Bi-Weekly ☐ Annually	☐ Applicant ☐ Spouse ☐ Household Member	___/___/___
2._____	$_____	☐ Weekly ☐ Monthly	☐ Bi-Weekly ☐ Annually	☐ Applicant ☐ Spouse ☐ Household Member	___/___/___
3._____	$_____	☐ Weekly ☐ Monthly	☐ Bi-Weekly ☐ Annually	☐ Applicant ☐ Spouse ☐ Household Member	___/___/___

SECTION III: HEALTHCARE COVERAGE

Do you have healthcare coverage? ☐ **Yes** ☐ **No**

Specify Type of Insurance here _____

If No, proceed to Alternate Contact and Signature on Page 2.

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Please complete below and attach a copy of the front and back of your cards and complete below:

Health Insurance Company Name: _____ Effective Date on Policy: ____/____/____

Policy Number: _____ Group Number: _____

Have you utilized any patient assistance programs this year to pay for Truvada? ☐ **Yes** ☐ **No**

If yes, select which program below, and do you have any benefits left? ☐ **Yes** ☐ **No**

☐ Gilead Advancing Access Co-pay Assistance Program ☐ Gilead Advancing Access Patient Assistance Program

☐ Unknown ☐ Patient Access Network

If no, have you applied for a patient assistance program but was denied? (Please select which program you applied for)

☐ Gilead Advancing Access Co-pay Assistance Program ☐ Gilead Advancing Access Patient Assistance Program ☐ Unknown

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MEDICAID

Have you applied? ☐ Yes ☐ No

If yes, what was the outcome? ☐ Pending

☐ Approved- Medicaid/Alliance No. _____

☐ Denied– Reason: _____

MEDICARE

Do you have Medicare? ☐ Yes ☐ No

If yes, what type(s)? ☐ A - Hospitalization ☐ B - Primary Care ☐ C - Medicare Advantage Plan ☐ D - Prescription Drug

Patients must take their prescription for Truvada to a PrEP DAP contracted pharmacy. To locate a contracted pharmacy, please see our Pharmacy Benefit Manager website: www.ramsellcorp.com/individuals/dc.aspx, and search in Pharmacy locator.

Alternate Contact(s) and Signature

By signing this application, I authorize the DC ADAP to speak with the following person(s) about my application (i.e., social worker, case manager, family member):

Name/Organization	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____

Certification Statement

I certify that all the information in this application is true and correct and that I am a District of Columbia Resident. I understand the following: This information is being given in connection with the receipt of federal funds by the District of Columbia. Program officials will verify the information on this form. If I deliberately misrepresent information on this application, I may be required to repay benefits provided to me and I may be prosecuted under applicable State & Federal Statutes. I hereby apply for benefits under DC PrEP DAP and consent for my information to be used and disclosed as necessary for the purposes of my treatment, for payment of healthcare services, payment of healthcare premiums and for the healthcare operations of the Program.

Sign and Date this Form:

_____

Signature of Applicant (or legal guardian if applicant is a minor) **Date**

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SECTION IV: HEALTH STATUS INFORMATION (To Be Completed by a Medical Professional)

APPLICANT NAME: **DATE OF BIRTH:**

PHYSICIAN INFORMATION and VERIFICATION (Please print or type) DEA #_____

Name_____ DC License # _____

Hospital or Facility _____ Medicaid # _____

Address _____ NPI # _____

City _____ State_____ Zip Code_____

Office Telephone Number (___) _____ Ext. _____

HIV STATUS

1.) Is the applicant HIV negative? [ ] Yes [ ] No Date of last negative test _____

HIV and health status must be confirmed in order to process this application. Please submit this form with the application or ask your healthcare provider to send it directly by mail or fax.

Telephone: 202-671-4815 Fax: 202-673-4365

HEALTH HISTORY

1.) Sexually Transmitted Diseases, if known:

- ☐ Rectal or Urethral gonorrhea in the prior 12 months
- ☐ Rectal Chlamydia in the prior 12 months
- ☐ Syphilis in the prior 12 months

2.) Other Conditions, if known:

- ☐ History of providing sex for money, drugs, food, shelter, or transportation in the prior 12 months
- ☐ Unprotected anal sex outside of a mutually monogamous relationship
- ☐ A sexual relationship with a person living with HIV who:
  - ☐ Is not on Anti-Retroviral Therapy
  - ☐ Is on Anti-Retroviral Therapy but is not virally suppressed
  - ☐ Is within 6 months of initiating Anti-Retroviral Therapy
  - ☐ Is on Anti-Retroviral Therapy and is virologically suppressed
  - ☐ Has an ongoing sexual relationship in which the female partner is trying to get pregnant
  - ☐ Is injecting drugs that are not prescribed by a medical provider

PHYSICIAN VERIFICATION:

I verify that the information on this application is true to the best of my knowledge. Confirm that you have evidence of the patient's HIV status and risk. Understand and will follow current standards of care for PrEP. Prescribed Truvada to this patient.

Physician Signature _____

(MUST BE ACTUAL SIGNATURE) **(DATE)**

Please keep copies of all documents. Complete the application in its entirety. Incomplete applications will not be processed for eligibility.