

Uninsured Care Programs - Medical Eligibility Form

SU MEDICO NECESITA ESTA FORMA

Uninsured Care Programs:

- AIDS DRUG ASSISTANCE PROGRAM (ADAP)
- ADAP PLUS (PRIMARY CARE)
- HIV HOME CARE PROGRAM
- ADAP PLUS INSURANCE CONTINUATION (APIC)

The Medical Eligibility Form must be completed by a physician and should be submitted in conjunction with the Uninsured Care Programs Eligibility Application (DOH-2794). The information will be used to determine your patient's eligibility to receive assistance through the Programs.

MEDICAL ELIGIBILITY: Patients applying for the Uninsured Care Programs must be **HIV positive**.

1.) PATIENT INFORMATION (Please print or type)

Name _____
(Last) (First) (M.I.)

Address _____
(c/o) (Street) (Apt. #)

City _____ State New York Zip Code _____

Date of Birth ____/____/____ Social Security # _____

Telephone (____) _____ (____) _____ (Ext.) _____
(Home) (Work)

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

Name _____ NYS License # _____

Hospital or Facility _____ Medicaid # _____

Address _____ NPI # _____

City _____ State _____ Zip Code _____

Office Telephone Number (____) _____ Ext. _____

Alternate Contact for
Medical Follow Up _____
(Name) (Telephone #)

Physician Verification:

I verify that the information on this application is true to the best of my knowledge.

Physician Signature _____ (MUST BE ACTUAL SIGNATURE) _____ (DATE)

ON THE BACK OF THIS FORM, PLEASE PROVIDE THE INFORMATION REQUESTED. IF YOU HAVE ANY QUESTIONS ABOUT MEDICAL ELIGIBILITY PLEASE CONTACT OUR TOLL FREE HOTLINE **1-800-542-2437**. WHEN COMPLETED PLEASE RETURN TO:

**EMPIRE STATION
P.O. BOX 2052
ALBANY, NY 12220-0052**

MEDICAL INFORMATION

Please Answer All Questions

Patient's Name _____ DOB _____

SECTION I - DISEASE STAGING

- 1.) Is the applicant HIV infected? Yes No Year of First Positive Test _____
- 2.) What is this applicant's most recent CD4+ (T₄) count? _____/mm³ Date of Test ____/____/____
- 3.) What is lowest CD4+ (T₄) count? _____/mm³ Date of Test ____/____/____
- 4.) Lymphocyte % _____% Date of Test ____/____/____
- 5.) Viral Load (absolute value) _____ Date of Test ____/____/____

PLEASE ENCLOSE A COPY OF THE LAB (CD4+ and/or Viral Load) REPORT

- 6.) Does the applicant have CDC-defined AIDS? Yes No Date of Diagnosis ____/____/____
- Location at time of AIDS diagnosis (State and County) _____

SECTION II - DISEASE HISTORY

- 1.) Does the applicant now have or ever had:
- Malignancies AIDS Dementia/PML Mycobacterium Avium Complex
- Wasting Syndrome Syphilis PCP
- Hepatitis: A B C E
- 2.) Tuberculosis: No Evidence of TB Unknown
- Evidence of TB **and**: Active, receiving treatment **or** Evidence of TB **but**: Inactive, prophylaxis
- Active, no treatment Inactive, no prophylaxis
- Active, treatment unknown Inactive, treated
- 3.) Mode of HIV transmission (check all that apply):
- IVDU Sexual Abuse/Assault Sexual contact with:
- Transfusion/Blood Product Health Care Setting Male
- Other Maternal Female
- Unknown Person with HIV/AIDS
- IVDU

SECTION III - TREATMENT HISTORY

- 1.) Has a comprehensive HIV evaluation been conducted? Yes No
- 2.) Has anti-retroviral treatment been recommended? Yes No
- 3.) Has PCP prophylaxis been recommended? Yes No
- 4.) Has the applicant had these immunizations: Influenza Yes No
- Hepatitis B Vaccine Yes No
- Pneumovax Yes No
- 5.) Is the applicant participating in clinical trials for the treatment of HIV? Yes No