Before applying for the Georgia AIDS Drug Assistance Program (ADAP), the following Medicaid Screening Worksheet must be completed and attached to the application.

Please answer the following questions to assist in determining if the client is eligible for Medicaid before applying for the ADAP. Answering ***Yes*** to any of the questions may indicate that the client is eligible for Medicaid assistance. **The contact number for the Georgia Department of Community Health (DCH) is 404-656-3200.**

1. Does the client have a Social Security Number?
   - ☐ Yes Please indicate number:_______________
   - ☐ No

2. What is the current (gross) annual income for client? ____________

3. Is the client a female with a minor child(ren) in the home?
   - ☐ Yes
   - ☐ No

4. Is the client 65 years of age or older?
   - ☐ Yes
   - ☐ No

5. Is the client disabled?
   - ☐ Yes
   - ☐ No

6. Has client previously applied for Medicaid, and been denied?
   - ☐ Yes
   - ☐ No

   When? ______________

   Is denial being appealed? ☐ Yes ☐ No (Refer to DCH to appeal)

7. Has client's physical condition gotten worse since last applied for Medicaid?
   - ☐ Yes (Refer to back to DCH)
   - ☐ No

8. Has the client applied for Medicaid and been approved for full benefits.
   - ☐ Yes If yes please stop here, client is not eligible for ADAP.
   - ☐ No If no and only eligible for QMB or SLMB, continue completing the application.

9. Has the client applied for a Medicare Part D plan and LIS?
   - ☐ Yes
   - ☐ No

10. Has the client been approved for Full LIS?
    - ☐ Yes If yes, not eligible for ADAP
    - ☐ No If no, continue completing the application

GEORGIA AIDS DRUG ASSISTANCE PROGRAM (ADAP) APPLICATION

I. PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	MAIDEN

ADDRESS	CITY AND STATE	ZIP CODE	County

MAILING ADDRESS	CITY AND STATE	ZIP CODE	County

MARITAL STATUS
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

DATE OF BIRTH

____/____/______

SOCIAL SECURITY #

-- --

(IF APPLICABLE)

ETHNICITY
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown

GENDER
- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Unknown

RACE
- ☐ White/Caucasian
- ☐ Asian
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ Other
- ☐ Unknown

TELEPHONE NUMBER(s)

#1 (   )   -

#2 (   )   -

ADAP STATUS

☐ **Newly Enrolled in ADAP in Georgia** **Slot #:__________**

☐ **Transfer From: __________________**

II. CLINICAL INFORMATION

DIAGNOSIS	CD4 COUNT	HIV VIRAL LOAD
☐ AIDS DATE: _____/_____/_______	**CURRENT: _______ DATE: _____/_____/_______** **LOWEST: _______ DATE: _____/_____/_______**	CURRENT: ________ DATE: _____/_____/_______ HIGHEST: ________ DATE: _____/_____/_______
☐ HIV POSITIVE DATE: _____/_____/_______	**CASE REPORT FORM ATTACHED:** YES ☐ NO ☐	

HIGHLY ACTIVE ANTIRETROVIRAL THERAPY (HAART) HISTORY

☐ **HAART EXPERIENCED** (Indicate Previous Payor Source of Rx)
- ☐ Other State ADAP ______________________
- ☐ Patient Assistance Program
- ☐ Medicaid
- ☐ Third Party Insurance
- ☐ Department of Corrections
- ☐ Previously Enrolled in Georgia ADAP
- ☐ Other ____________________

(Please provide proof of previous HAART therapy).

☐ **HAART NAÏVE**

☐ **INDICATIONS for** initiating **HAART** (Check all that apply)
- ☐ History of Opportunistic Infections
- ☐ HIV-related Malignancy
- ☐ CD4 count less than 350
- ☐ Pregnant (any CD4 count)
- ☐ HIV-Associated Nephropathy (any CD4 count)
- ☐ Hepatitis B Treatment Indicated (any CD4 count)
- ☐ CD4 count greater than 350 (physician must provide justification in space below)
- ☐ Continuation of Therapy

PHYSICIAN'S COMMENTS (Provide details to warrant initiation of HAART)**:**

____

III. PHYSICIAN INFORMATION

PRINT NAME	CLINIC NAME		
ADDRESS	CITY	STATE	ZIP
PHYSICIAN'S SIGNATURE	PHONE ( ) -		

IV. FINANCIAL/INCOME INFORMATION

FAMILY SIZE

NAME	RELATIONSHIP TO CLIENT	AGE	GROSS MONTHLY INCOME	SOURCE OF INCOME
APPLICANT	**SELF**			
		TOTAL	$	
		TOTAL X 12 MONTHS =		$ / YEAR

ASSETS

TYPE	AMOUNT
CASH ON HAND	$
CHECKING ACCOUNT	$
SAVINGS ACCOUNT	$
STOCKS	$
BONDS	$
SEVERENCE PAY	$
OTHER	$
TOTAL	**$**

NOTE: Total assets cannot exceed $10,000.

DOCUMENTATION OF INCOME

Type of Income (indicate all that are applicable):	**Documentation Attached:**
☐ Employment	☐ Paycheck Stub for last month ☐ Signed Employer Statement with Dates ☐ Tax Return ☐ Other (Specify):
☐ Child Support Payments	☐ Court Order/Copy of Check
☐ Social Security Disability Income (SSDI)	☐ Social Security Award Letter
☐ Supplemental Security Income (SSI)	☐ SSI Award Letter
☐ Veterans Benefits	☐ VA Award Letter
☐ Interest/Investment Income	☐ Bank Statements
☐ Other	☐ Other (Specify):
☐ No Income Please complete the Support and Residency Verification Letter	☐ 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?	☐ Yes ☐ No
Client provided the following to document Georgia residency:	**Documentation Attached:**
Copy of Client's Utility Bill	☐ Yes ☐ No
Copy of Client's Lease/Mortgage Agreement	☐ Yes ☐ No
Client is homeless (in Georgia) Shelter Name/Location:	☐ Yes ☐ No
Georgia Driver's License or Georgia State ID **NOTE**: A Georgia Driver's license alone, is not adequate proof of residency	☐ Yes ☐ No
Other (Please Specify):	☐ Yes ☐ 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 a Support and Residency Verification Letter signed by the applicant.

VI. THIRD PARTY PAYER/INSURANCE INFORMATION	
☐ MEDICAID ☐ MEDICAID SPENDDOWN (QMB)	MEDICAID #: N/A ☐
☐ MEDICARE ☐ PART A ☐ PART B ☐ PART D	MEDICARE #: N/A ☐ Applied for Low Income Subsidy (LIS) “extra help”: yes ☐ no ☐ Approved for Full Low Income Subsidy (LIS) “extra help” yes ☐ no ☐ Approved for Partial Low Income Subsidy (LIS) “extra help” yes ☐ no ☐ MEDICARE Part D Plan Company Name: ______________________________ Deductible $_____ Co-pays $______ Premiums $________
☐ VETERANS BENEFITS	Did the client ever serve in the Armed Forces, Reserves, or National Guard? yes ☐ no ☐
☐ PRIVATE HEALTH INSURANCE ☐ INDIVIDUAL ☐ GROUP ☐ COBRA INCLUDES DRUG COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY:
	POLICY #:
	PHONE NUMBER OF INSURANCE COMPANY: ( ) -
☐ 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 Unit, 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 DECLARE OR DOCUMENT
CITIZENSHIP OR IMMIGRATION STATUS TO BE ELIGIBLE FOR SERVICES.

______________________________ _____/_____/_______
Print Client Name Date

____
Client Signature

THIS APPLICATION FORM MUST NOT BE ALTERED

VIII. CASE MANAGER AGREEMENT

I attest that all of the information contained in this application is complete and accurate to the best of my knowledge.

Date:

____
Print Case Manager Name

____
Case Manager Signature

(_____)_______-_________________________
Case Manager Phone Number

(_____)_______-_________________________
Case Manager Fax Number

CASEMANAGER'S COMMENTS:

____
____
____
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____

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

X. WAITING LIST CRITERION

In the event of a waiting list, the HIV Unit will assign a priority level for each new ADAP application based on the criterion listed below. Clients with the highest priority will be enrolled in the program, followed by those clients assigned to a lower priority.

Priority Level (1=highest)	Criterion	Check the one that applies √
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	

FOR DHR USE ONLY

DISPOSITION OF APPLICATION

☐ NO PROOF OF HIV+ STATUS
☐ INCOME EXCEEDS CURRENT CRITERION
☐ NO PROOF OF GEORGIA RESIDENCY
☐ CLIENT HAS INSURANCE (WITH RX COVERAGE)
☐ CLIENT HAS VA BENEFITS
☐ CLIENT HAS OTHER PAYOR SOURCE ________________________
☐ CLIENT EXCEEDS MEDICAL ELIGIBILITY CRITERION
☐ INCOMPLETE APPLICATION*
☐ WAITING LIST
PRIORITY LEVEL: ______________________________

☐ APPROVED
☐ NOT APPROVED

____
REVIEWED BY

______/______/________
*DATE RETURNED TO ENROLLING AGENCY