

**NEW YORK STATE DEPARTMENT OF HEALTH  
HIV UNINSURED CARE PROGRAMS**

DATE RECEIVED BY PROGRAM: \_\_\_\_\_

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

**MEDICAL ELIGIBILITY FORM  
SU MEDICO NECESITA ESTA FORMA**

This form must be completed by the attending physician. The information will be used to determine your patient's eligibility to receive assistance through the Programs, which are federally funded programs administered by the New York State Department of Health. Please note that the disclosure of HIV information should occur with the signed written consent of the patient.

**MEDICAL ELIGIBILITY:** AIDS Drug Assistance Program and/or ADAP Plus = **HIV**

Home Care = HIV Illness and Medically or Chronically Dependent due to HIV Illness  
**(PLEASE ATTACH TREATMENT PLAN FORMS: AI 485, AI 487, AI 3615 and Nursing Assessment)**

**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 (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
(Home) (Work) (ext.)

**2.) PHYSICIAN INFORMATION and VERIFICATION** (Please print or type)

DEA # \_\_\_\_\_

Name \_\_\_\_\_ NYS License # \_\_\_\_\_

Hospital or Facility \_\_\_\_\_ Medicaid # \_\_\_\_\_

Address \_\_\_\_\_

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, NEW YORK 12220-0052**

## MEDICAL INFORMATION

Please Answer All Questions

APPLICANTS NAME: \_\_\_\_\_

### 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+ (T<sub>4</sub>) count? \_\_\_\_\_/mm<sup>3</sup> Date of Test: \_\_\_/\_\_\_/\_\_\_
- 3.) What is lowest CD4+ (T<sub>4</sub>) count? \_\_\_\_\_/mm<sup>3</sup> 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): \_\_\_\_\_
- 7.) Does the applicant have Clinical/Symptomatic HIV Illness (includes CDC-Defined AIDS and HIV related disease)?  Yes  No

### SECTION II - DISEASE HISTORY

- 1.) Does the applicant now have or ever had:
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Malignancies     | <input type="checkbox"/> AIDS Dementia/PML | <input type="checkbox"/> Mycobacterium Avium Complex |
| <input type="checkbox"/> Wasting Syndrome | <input type="checkbox"/> Syphilis          | <input type="checkbox"/> PCP                         |
- 2.) Tuberculosis - No Evidence of TB
- Evidence of TB **and**: **or** Evidence of TB **but**:
- |  |   |
|--|---|
| <input type="checkbox"/> Active, receiving treatment | <input type="checkbox"/> Inactive, prophylaxis    |
| <input type="checkbox"/> Active, no treatment        | <input type="checkbox"/> Inactive, no prophylaxis |
| <input type="checkbox"/> Active, treatment unknown   | <input type="checkbox"/> Inactive, treated        |
- 3.) Risk Behavior (check all that apply):
- |  |   |                                  |
|--|---|----------------------------------|
| <input type="checkbox"/> IVDU                      | Sex with:                                     |                                  |
| <input type="checkbox"/> Transfusion/Blood Product | <input type="checkbox"/> IVDU                 | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Sexual Abuse/Assault      | <input type="checkbox"/> Male                 | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Health Care Setting       | <input type="checkbox"/> Female               |                                  |
| <input type="checkbox"/> Maternal                  | <input type="checkbox"/> Person with HIV/AIDS |                                  |

### 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           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis B Vaccine | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pneumovax           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- 5.) Is the applicant participating in clinical trials for anti-retroviral or secondary infections treatment?  Yes  No
- 6.) Does the applicant currently require Home Care?  Yes  No
- 7.) PPD Status:  Positive  Anergic  Negative  Unknown