NEW YORK STATE DEPARTMENT OF HEALTH
AIDS Institute
Uninsured Care Programs
Empire Station, P.O. Box 2052
Albany, NY 12220-0052

Uninsured Care Programs – Medical Eligibility Form

SU MEDICO NECESITA ESTA FORMA

INSTRUCTIONS: This form must be completed by the attending clinician. The information will be used to determine the patient's eligibility to receive assistance through the Uninsured Care Programs. Questions related to medical eligibility should be directed to the New York State Department of Health's Uninsured Care Programs toll-free hotline at **1-800-542-2437 or 1-844-682-4058.** When completed, mail the form to: **Empire Station, P.O. Box 2052, Albany, New York 12220-0052.**

Uninsured Care Programs

- ☐ AIDS Drug Assistance Program (ADAP-Medications)
- ☐ ADAP Plus (Primary Care)
- ☐ ADAP Plus Insurance Continuation (APIC)
- ☐ HIV Home Care Program
- ☐ Pre-exposure Prophylaxis Assistance Program (PrEP-AP)

Patient Information

Last Name _____ First Name _____ M.I._____

Street Address_____ Apt. No. _____

City_____ State_____ ZIP _____

Date of Birth (Month/Day/Year) _____ Social Security Number _____

Home Phone (_____) _____ Alternate Phone (_____) _____

Practitioner Information and Verification

Last Name _____ First Name _____ M.I._____

NPI Number_____ NYS License Number _____

Hospital or Facility _____ Medicaid Number _____

Address_____

City_____ State_____ ZIP _____

Office Phone (_____) _____

Name of Alternate Contact for Medical Follow-up_____

Alternate Contact Phone (_____) _____ E-mail Address _____

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 or 1-844-682-4058. When completed please return to:

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

Medical Information *Please Answer All Questions*

Patient's Name _____ Date of Birth _____

1. Is the applicant HIV infected? ☐ Yes ☐ No Date of First Positive Test _____

   To be eligible for assistance under PrEP-AP, the patient must have a documented negative HIV test result and be at risk of acquiring HIV infection.

2. Does the applicant now have or ever had: ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

3. Risk(s):

   ☐ IVDU
   ☐ Transfusion/Blood Product
   ☐ Other
   ☐ Unknown

   ☐ Sexual Abuse/Assault
   ☐ Health Care Setting
   ☐ Mother to Child

   ☐ Sexual Contact with:
   - ◯ Male
   - ◯ Female
   - ◯ Person with HIV/AIDS
   - ◯ IVDU Partner

Complete PrEP, ARV and Hepatitis C, prescribing and monitoring guidelines are available at **www.hivguidelines.org**

Practitioner Verification

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

Practitioner's Signature *(Must be actual signature)* _____ Date _____