NEW YORK STATE DEPARTMENT OF HEALTH
UNINSURED CARE PROGRAMS
Empire Station, PO BOX 2052
Albany, NY 12220

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

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+ (T_4) count? _____/mm^3 Date of Test ___/___/_____

3.) What is lowest CD4+ (T_4) count? _____/mm^3 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**:	**or**	Evidence of TB **but**:
[ ] Active, receiving treatment		[ ] 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