May 2011

Montana AIDS DRUG ASSISTANCE PROGRAM (ADAP)

The Montana STD/HIV Section administers the AIDS Drug Assistance Program (also known as ADAP) with funding provided by the Ryan White Part B CARE Act which is administered through the federal Health Resources and Services Administration. This program provides HIV anti-retroviral drugs, medications to prevent opportunistic infection, and certain drugs to treat HIV-related disease for individuals who are uninsured or under-insured and who are unable to pay for such treatment. To be eligible for ADAP, an individual must meet the following criteria and furnish the following information to the Montana STD/HIV Section:

- **Have a permanent Montana address**

- **Have income less than 330% of the federal poverty level (adjusted gross taxable income)**

- **Be ineligible for any other assistance programs that would pay for such treatments. (Applicants may have to provide evidence of Medicaid denial.)**

Applicant must submit a completed ADAP application and a completed medical verification form which has been signed by a medical provider certifying that the patient is HIV positive and in care.

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The information above is intended to provide a brief description of the program and the eligibility criteria. It is not intended to answer all questions concerning the AIDS Drug Assistance Program. For specific questions, or an application please call the Montana AIDS Program at (406) 444-4744, or e-mail jnielsen@mt.gov

Mail completed applications to:

Judy Nielsen, DPHHS
P.O Box 202951
Cogswell Bldg C-211
Helena, MT 59620-9910
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AIDS DRUG ASSISTANCE PROGRAM APPLICATION

Montana Department of Public Health and Human Services

Send to: J. Nielsen, DPHHS P.O. Box 202951 COGSWELL BLG C211 HELENA, MT 59620-9910 Mark Envelope: CONFIDENTIAL	OFFICE USE ONLY Date Received: Date Approved: Conditional: Date Denied:

NAME of applicant	*Race/ethnicity*	*SEX*	*BIRTH DATE*

ADDRESS	*CITY*	*STATE*	*ZIP CODE*

SOCIAL SECURITY NUMBER	*PHONE NUMBER:* ***Optional*** ***E-Mail Address**:*

REPRESENTATIVE WHO MAY PICK UP PRESCRIPTION	*PHONE*

FAMILY INFORMATION--Provide information on your spouse and dependents.

Name	*Birth Date*	*Relationship*

HEALTH INSURANCE INFORMATION

MEDICAID ELIGIBLE?	*DATE LAST APPLIED FOR MEDICAID*	*Receiving SSD? If yes, Date:* *Receiving SSI? If yes, Date:*

ARE YOU ELIGIBLE FOR INDIAN HEALTH SERVICE?	*ARE YOU ELIGIBLE FOR VETERANS ASSISTANCE?*

***COMPLETE THE FOLLOWING IF YOU HAVE HEALTH INSURANCE**:*

Name of INSURANCE COMPANY	*Name of POLICY HOLDER*
ADDRESS	*GROUP NUMBER/POLICY NUMBER*
THIS POLICY PAYS FOR _____% OF PRESCRIPTIONS	*Deductible Amount:*

WHICH MEMBERS OF THE HOUSEHOLD DOES THIS POLICY COVER?

INCOME INFORMATION--Provide information on all net incomes in your household below		
List all sources of income for yourself and your spouse	*Person who receives income*	*Net Monthly amount*

INCOME TAX INFORMATION--Provide copy of your last state or federal tax return form

Excluding (not counting) the home you live in and one vehicle, do you own property, other vehicles or liquid assets (bank or credit union accounts, CDs, cash, stocks, etc.) with a combined equity value (the value of the asset minus any money you owe on the asset) of:

$2,000.00 for a single individual [ ] yes [ ] no
$3,000.00 for a married individual [ ] yes [ ] no

Have you been declared blind or disabled by the federal Social Security Administration? [ ] yes [ ] no

You may be required to provide the Montana ADAP program with written evidence of Medicaid denial.

CERTIFICATION

I am applying for services under the AIDS Drug Assistance Program (ADAP), Montana Department of Public Health and Human Services. I declare that I have examined the information given on this application and that it is true, correct and complete. I understand that if I have willfully misrepresented any information on this application, benefits from ADAP may be terminated.

Applicant signature ____ Date _____________

RELEASE OF INFORMATION

I, (print) ___ _____________________________________, authorize Montana ADAP staff to share information with public or private insurance programs for which I may be eligible, my health care providers and case managers, and pharmacies designated to fill my prescriptions. This authorization is valid while I am a recipient of ADAP benefits.

If I included an e-mail address, I authorize program staff to communicate with me using e-mail. I understand that e-mail systems are not confidential.

Applicant signature ____ Date ________________

Medical eligibility form must be completed by current health care provider and returned to address on front page

MEDICAL VERIFICATION for Montana HIV Treatment Programs

PATIENT INFORMATION	
Name:	Birth date:

MEDICAL INFORMATION		
Primary Diagnosis:	Year of 1st positive test:	
Secondary Diagnosis:		
Date of last CD4:	CD4 Count:	Cd4 %
Date of latest Viral Load:	Copies:	

Medical Provider INFORMATION		
PRINTED Name:	Phone:	
Address:	City:	Zip:

I certify that the above patient is:

___ HIV infected

___ currently in care

Medical Provider Signature ____Date:______________

NOTE: HIV/AIDS cases are reportable by Montana law. Please contact the local county health officer or the Montana STD/HIV Prevention Program at (406) 444-3049 for more information or a reporting form.

Please mail or fax this form to:

Judy Nielsen, DPHHS
P.O. Box 202951
Cogswell Bldg C-211
Helena, MT 59620-9910

Confidential Fax: 406-443-2527