MEDICAL INFORMATION

Please Answer All Questions

APPLICANTS NAME: _____

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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 _____ **Date of test:** ____/____/____

PLEASE ENCLOSE A COPY OF THE LAB (CD4+ 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

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SECTION II - DISEASE HISTORY

1.) Does the applicant now have or ever had:

[ ] Malignancies [ ] AIDS Dementia/PML [ ] Mycobacterium Avium Complex
[ ] Wasting Syndrome [ ] Syphilis [ ] PCP

2.) Tuberculosis - No Evidence of TB [ ]

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.) Risk Behavior (check all that apply):

Sex with:

[ ] IVDU
[ ] Transfusion/Blood Product [ ] IVDU [ ] Other
[ ] Sexual Abuse/Assault [ ] Male [ ] Unknown
[ ] Health Care Setting [ ] Female
[ ] Maternal [ ] Person with HIV/AIDS

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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 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

HIV UNINSURED CARE PROGRAMS

DATE RECEIVED BY PROGRAM: _____

AIDS DRUG ASSISTANCE PROGRAM (ADAP)
ADAP PLUS (PRIMARY CARE)
HIV HOME CARE PROGRAM

MEDICAL ELIGIBILITY FORM
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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+**

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

1.) PATIENT INFORMATION (Please print or type) Date ____/____/____

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)

Name _____ NYS License # _____

Hospital or Facility _____

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