

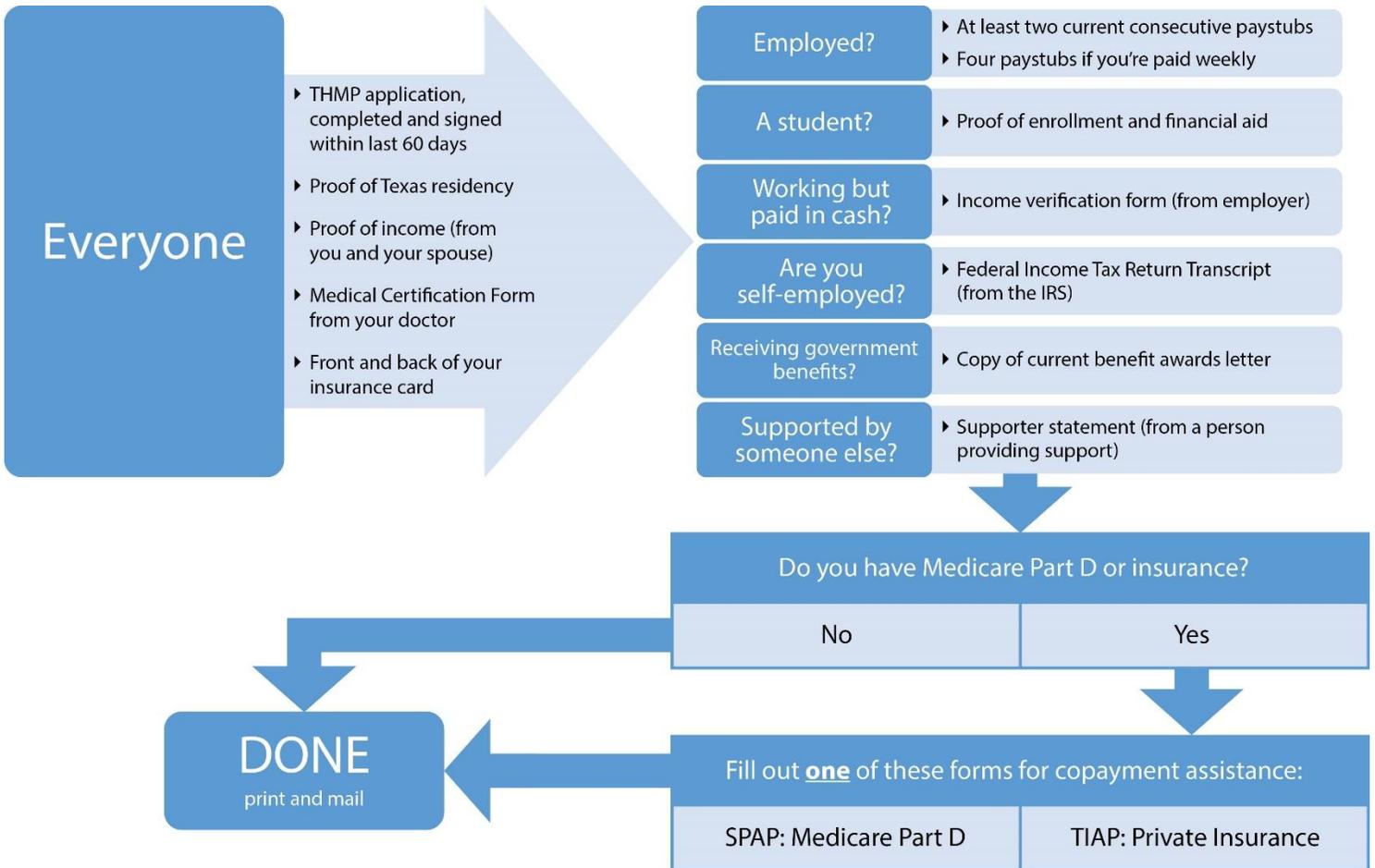


APPLICATION FOR MEDICATION ASSISTANCE

Texas Department of State Health Services
 ATTN: MSJA - MC 1873
 PO Box 149347, Austin, TX 78714-9347
 1-800-255-1090

- Mail the completed application and copies of supporting documentation to the address listed above
- Do not send original documents, they will not be returned
- For help with this application call **1-800-255-1090** or visit www.dshs.texas.gov/hivstd/meds

Is your application complete?



PRIVACY NOTIFICATION

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See www.dshs.texas.gov for more information on privacy notification. (Reference: Texas Government Code, Sections 522.021, 522.023, 559.003 and 559.004)

For additional information, including a review of Frequently Asked Questions and downloadable copies of program documents, please visit the THMP web site at www.dshs.texas.gov/hivstd/meds.

For additional information on AIDS service organizations, case management services and community resources in your local area, please call 2-1-1. If you have any questions, comments or concerns regarding the Texas HIV Medication Program and this application for assistance, please call the program directly at 1-800-255-1090.

PERSONAL INFORMATION

1. Last Name	First Name	Middle Name	Suffix (Jr., Sr., III)
2. Previous names (including maiden name, aliases, and name changes)			
3. Do you have a SSN? <input type="checkbox"/> No <input type="checkbox"/> Yes	Social Security Number:	Tax ID (only if you do not have a SSN):	
4. Date of Birth:	5. Client's Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish Other:		
6a. Current Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender: Male to Female <input type="checkbox"/> Transgender: Female to Male	6b. Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	7b. Race (check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian (if Asian, please select subgroup) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander (please select subgroup) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Charmorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other/Unknown <input type="checkbox"/> American Indian/Alaska Native	
6c. If applicable, are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date:			
7a. Ethnicity (check the one that best describes you) <input type="checkbox"/> Hispanic (if Hispanic, please select subgroup) <input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic, Latino/a or Spanish origin <input type="checkbox"/> Non-Hispanic			
8. Residential Street Address – (No P.O. Boxes or Rural Routes)		Apartment Number	
City	State	Zip Code	
<i>If you wish to have mail sent somewhere other than your residential address please provide an alternate mailing address:</i>			
9. Mailing Address - (P.O. Boxes and Rural Routes accepted here)		Apartment Number	
City	State	Zip Code	
10. Home Phone Number (area code + number)		Work/Alternate Phone (area code + number)	
May we leave a voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No		May we leave a voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you are unavailable, are there any special instructions as to how we should leave a message for you?			
AUTHORIZATION OF RELEASE			
11. Agency Worker (if applicable):	Agency Worker Phone & Fax #: Direct Line: Fax:	Agency:	
11b. Alternate contact: The following individual(s) may speak on my behalf regarding my application and program status. These individuals may be family members or friends.			
Name of Person	Relation to You	Phone Number	
12. Have you recently been released or are you currently incarcerated in a jail or prison? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Facility Name	Correctional ID #	Release Date	
Approximate Length of Incarceration:			

IF UNDER 18 : GUARDIAN INFORMATION

If you are under the age of 18 list parent or guardian information. Your parents must complete the Income Section on the next page.

A. Name of Parent or Guardian		B. Name of Other Parent or Guardian (if applicable)	
Social Security Number	Date of Birth	Social Security Number	Date of Birth

MARITAL STATUS

13. What is your current Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced, Date: <input type="checkbox"/> Separated, Date: (explanation required) <input type="checkbox"/> Married/Common Law (provide spouse information below)	If you are separated, please explain your current legal situation.
14. Spouse Name:	Spouse SSN:
Spouse Date of Birth:	Is spouse also on program? <input type="checkbox"/> Yes <input type="checkbox"/> No

HOUSEHOLD INFORMATION

15. Including yourself, how many people live in your home?

Complete the following table for your family. This only includes your legal or common law spouse and children under 18 (including biological, adopted and step-children).

Name	Age and Date of Birth (Birth Date Required for under 18)	Relationship

16. Do you receive HOPWA/Section 8 housing assistance/subsidized housing? Yes No
(If yes, include agency verification)

17. Is there anything else you would like to tell us about your living situation that could help clarify your application? For example, if you live with someone who supports you please explain your situation.

INCOME, EMPLOYMENT and BENEFITS

18. How do you support yourself? Please check ALL that apply below:

Required Documentation

<input type="checkbox"/> I am employed <ul style="list-style-type: none"> • Include 2 current, consecutive pay stubs. If paid weekly, submit 4 consecutive pay stubs. (For you AND your spouse.) <p>Do you work but you're paid in cash?</p> <ul style="list-style-type: none"> • Have your employer complete the Income Verification Form (Page 8). You may be required to submit a Tax Return Transcript or Proof of Non-filing and/or bank statements. . (For you AND your spouse.) <p>Do you have more than one job?</p> <ul style="list-style-type: none"> • Include 2 current, consecutive pay stubs for each job. If paid weekly, submit 4 consecutive pay stubs for each job. You may be required to submit a Tax Return Transcript or Proof of Non-filing. (For you AND your spouse.) <input type="checkbox"/> I am self-employed <ul style="list-style-type: none"> • Include complete copy of your most recent Federal Income Tax Return Transcript (obtained directly from the IRS). . (For you AND your spouse.) <input type="checkbox"/> I receive disability benefits, unemployment benefits, retirement/pension, VA benefits, or other awarded benefits <ul style="list-style-type: none"> • A copy of your benefit award letter or other official documentation showing the amount received on a regular basis. (For you AND your spouse.) 	<input type="checkbox"/> I'm a student <ul style="list-style-type: none"> • Submit proof of enrollment and financial aid from your school's financial aid office. <input type="checkbox"/> I don't work. A relative, friend, or agency provides support in the form of room and board, cash assistance, or payment of bills. <ul style="list-style-type: none"> • The person who supports you must complete the Supporter Statement (Page 7). • Provide proof of agency assistance you receive (if applicable). <input type="checkbox"/> I am under 18 (parent must fill out this page)
<input type="checkbox"/> I am homeless <ul style="list-style-type: none"> • Provide proof of agency/shelter assistance you receive (if applicable). 	
<input type="checkbox"/> Other (please explain here) <hr/> <hr/> <hr/>	

19. Employment: We may verify your income with other sources such as the Texas Workforce Commission. Spouse information is required (common law or legally married). Parents of applicants under 18 must be complete this.

	Applicant or Parent A (if minor)	Spouse or Parent B (if minor)
Employment Status	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Temp/seasonal	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Temp/seasonal
Job 1: Employer (current or last)		
Job Title (current or last)		
End date (if unemployed)		
Job 2: Employer (current or last)		
Job Title (current or last)		
End date (if unemployed)		

20. Income and Benefits: Report MONTHLY gross income (the amount received before taxes/deductions). Submit proof of income!

Wages, salary, commissions, tips, unemployment benefits	\$	\$
Social Security Income (SSI or SSDI)	\$	\$
Retirement / Pension	\$	\$
Other Income (includes financial aid, alimony, investment income)	\$	\$

HEALTH INSURANCE or MEDICATION ASSISTANCE

21. If you currently have health care coverage or health insurance, why are you applying for this program? *(Please check ALL that apply. Submit documentation from the insurance plan verifying your situation.)*

- I do not have health care coverage or health insurance (proceed to question 22).
- I need help paying my medication deductibles, medication copayments, or coinsurance expenses.
- Private insurance (complete Copayment Assistance: Insurance on page 6)
- Medicare (complete Copayment Assistance: Medicare on page 6)
- My insurance does not cover prescription drugs or it doesn't cover one or more HIV meds I need.
- Coverage will end soon *(specify ending date):* _____
- Expenses have or are about to exceed the plan's annual prescription cap.
Amount of annual prescription cap: \$ _____
- Other limitations on coverage or payment *(specify):* _____

22. How are you currently getting medications for HIV (antiretroviral therapy)? *(check ALL that apply)*

- I am not currently taking medications for HIV (antiretroviral therapy).
- Private Health Insurance, Employer *(if a card is issued, submit a copy the front and back of the card.)*
- Private Health Insurance, Individual *(if a card is issued, submit a copy the front and back of the card.)*
- Patient Assistance Program (PAP)
- Medicare (Part A, Part B, Part C or Part D)
- Indigent Care (City/County plans such as MAP, Gold Card, Carelink or local agency assistance)
- Veteran's Affairs (VA)
- Medicaid (including Star and Star +)
- ACA, "ObamaCare" or Marketplace Plans
- Other: _____

23. Have you previously had any health insurance: Yes No If yes, please list name and date coverage ended. **If your insurance terminated in the last 90 days, submit proof of termination.**

Insurance Name:	End Date:
Insurance Name:	End Date:

ADDITIONAL INFORMATION

24. Is there anything you would like to clarify on this application? Please use this space to provide any additional information that may help THMP process your application. Attach additional pages if needed.

IMPORTANT – THE FOLLOWING CERTIFICATION AND AUTHORIZATION MUST BE SIGNED BY THE APPLICANT:

- a. I understand that this application is a legal document. My signature (1) attests that all the information given is true and correct, (2) authorizes the release of my medical information to the Texas HIV Medication Program (THMP) and (3) attests that I do reside in the State of Texas.
- b. I understand that it is my responsibility to notify the THMP immediately if my/our income increases; if I/we move from Texas; if my/our residential or mailing address changes; or if my/our marital, household or insurance status changes.
- c. I understand that the THMP may request verification of the information I have provided in order to process my application, and also at any time thereafter. I also understand that the processing of my application may be delayed until such requested verification is received.
- d. I understand that the THMP may verify information provided on this application with data resources made available to the program for the purpose of eligibility determination.
- e. I understand that deliberately omitting or giving false information could cause me to be removed from the THMP, or criminally prosecuted, or both.
- f. I understand that the THMP reserves the right to limit enrollment based upon availability of funds.
- g. I understand that the THMP is required to recertify my eligibility status per the program rules in order to continue receiving services.
- h. I understand that I must order HIV medications from this program on a monthly basis and that I will be dropped from the program if I don't order medications for six consecutive months.
- i. **I understand that my information will be shared with my HIV service providers and Agency Workers. I will contact THMP if I want an exception to be made.**

Signature of Applicant <i>(please print and sign)</i>	Date
Signature of Parent (if applicant is under 18 years of age) <i>(please print and sign)</i>	Date

**COPAYMENT ASSISTANCE – Complete only if you do not have:
Medicare part D (State Pharmaceutical Assistance Program)
Or Private Insurance (Texas Insurance Assistance Program)**

Applicants with MEDICARE or PRIVATE INSURANCE should fill out this form in addition to the main THMP form. The SPAP provides help with co-pays, coinsurance and gap coverage associated with a Medicare Part D prescription drug plan. The TIAP provides help with co-pays, coinsurance and premiums associated with COBRA plans and private insurance.

First and Last Name	Social Security Number	Date of Birth
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DO YOU HAVE MEDICARE? FILL THIS SECTION

Your Medicare Number	Effective Date of Medicare Part A (listed on your Red White & Blue Medicare Card)
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Are you enrolled in a Medicare Prescription Drug Plan (Part D)? No Yes (if yes, please provide plan information below)

Rx Plan Name:	Effective Date:
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Have you applied for the Low Income Subsidy or Extra Help through the Social Security Administration? No Yes (please indicate application status below)

Low Income Subsidy/Extra Help Application Status

Approved, 100% Assistance Denied Assistance (attach a copy of pre-decisional or denial letter)

Approved, partial assistance (attach copy of approval letter) Awaiting determination, application date:

DO YOU HAVE INSURANCE? FILL THIS SECTION INSTEAD

Are you enrolled in a private insurance plan? No Yes (if yes, please provide plan information below)

Plan Name:	Effective Date:	Member ID
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Do you have an Affordable Care Act (ACA) Marketplace Plan? Yes No

PROVIDE COPY OF FRONT & BACK OF INSURANCE CARD

Is this an Individual, Non-ACA, Off Marketplace Plan? Yes No

Is this plan offered through an employer? Yes No

If you have COBRA or may be eligible for COBRA, please submit copies of your COBRA paperwork:

Have you already submitted your COBRA paperwork? <input type="checkbox"/> No <input type="checkbox"/> Yes date submitted:	COBRA Election/Enrollment Due Date: COBRA Initial Payment Due Date: COBRA Account #:
COBRA Administrator's Phone Number:	

COPAYMENT ASSISTANCE AGREEMENT

- 1) I understand that it is my responsibility to:
 - a) enroll in a Medicare Prescription Drug Plan and apply for the Low Income Subsidy if I have Medicare,
 - b) maintain my enrollment in an insurance plan or a Medicare Prescription Drug Plan, and
 - c) pay the monthly prescription drug plan premium directly to the prescription drug plan.
- 2) If I have private insurance, it is my responsibility to inform the program of any changes in my private insurance benefits or COBRA.
- 3) I understand that it is my responsibility to notify the THMP immediately if any of the following happen:
 - a) my household income changes, b) my address changes or I move out of the State of Texas, c) my marital status changes, or d) my Medicare benefits are terminated, I lose my insurance coverage or my eligibility for Medicaid or Medicare changes
- 4) I understand that the THMP reserves the right to limit enrollment based upon availability of funds.
- 5) I understand that the THMP is required to recertify my eligibility status per program rules in order to continue receiving services.
- 6) I understand that information may be shared with THMP staff and my insurance plan. I hereby give consent to the THMP to obtain or release my demographic, medical and /or insurance coverage information with other entities as necessary.
- 7) I agree to participate in a periodic follow up by the THMP Insurance Assistance Program staff to determine the effectiveness of the program.
- 8) I understand that I must order HIV medications from this program on a monthly basis and that I will be dropped from the program if I don't order medications for six consecutive months.
- 9) I understand that this is a legal document. My signature (1) attests that all the information given is true and correct, (2) authorizes the release of my medical information to the THMP, and (3) attests that I do reside in the State of Texas.

Signature of Applicant (please print and sign)	Date
Signature of Parent (if applicant is under 18) (please print and sign)	Date

FORM A: SUPPORTER STATEMENT

If an applicant has no income or is unable to provide any documentation showing how they manage, this form can be used as documentation. This form must be completed and signed by the person providing support; it **should not** be filled out by the person applying for the program.

I, _____, certify that I currently support
(printed name of supporter)

_____, who resides at the following
(printed name of person you support)

address: _____
(person you support's street address, city, state, & zip code)

I have supported him/her since _____ . My relationship to the applicant
(Date)

is _____ .
(examples: parent, spouse, roommate, friend, sister, etc.)

The type of support I provide is (check all that apply):

Room Food/Clothing Rent/Mortgage Utility Bills

Cash Assistance in the amount of \$ _____ per month

Other: _____

Additional explanation (if necessary):

I can be reached at the following phone number(s) to verify this information: _____

By signing this form, I affirm that the above information is an accurate statement of assistance being provided to the applicant. I understand that if I deliberately omit or give false information the applicant may be removed from the program and/or criminally prosecuted.

Signature of Supporter *(please print and sign)*

Date

Please note: If there are special circumstances surrounding your household situation that would need to be explained or verified by a social worker, Agency Worker, or public health nurse, please have them provide a detailed support statement on your behalf and attach it to your application when applying for assistance.

FORM B: INCOME VERIFICATION

This form should be used **only when no supporting income documentation is available**. If paystubs are available to the employee **copies must** be submitted. This should be signed by the employer only.

I. Employee Information

Employee Name:

Employee Address:

II. Employer Contact Information

Business Name:

Business Address:

Business Phone Number:

Contact Name:

Contact Phone Number:

III. Employee Income

Type of work performed by the employee:

First Day of Employment:

Last Day of Employment (if applicable):

Average number of hours worked per week:

Method of payment (*check one*):

Cash Personal check Payroll check Other (please specify)

Frequency of payment (*check one*):

Weekly Biweekly Semi-monthly Monthly Daily Other (please specify)

Gross earnings \$ per pay period

Estimated amount of **weekly** tips or commissions: \$ *per week*

IV. Employee Health Coverage

Is employer-sponsored health coverage offered? Yes No

If yes, is/was this employee enrolled in health coverage? Yes No

V. Additional Information

Will there be any changes to this person's employment in the next few months?

VI. Certification

I verify that the above information is true and correct to the best of my knowledge.

Signature of **Employer** (*please print and sign*)

Date

**TEXAS HIV MEDICATION PROGRAM
MEDICAL CERTIFICATION FORM**

TO BE COMPLETED BY PHYSICIAN

Texas HIV Medication Code (if known)

The information requested is necessary to determine the patient's eligibility for program-supplied, HIV-related therapy as prescribed by you. All information requested will be kept strictly confidential by the Texas Department of State Health Services; personal identifying info is never released.

PATIENT INFORMATION

Full Name: _____
 Mailing Address: _____ Apt #: _____
 City, State, Zip: _____ Phone #: _____
 Date of Birth: _____ Social Security Number: _____
 Requested Pharmacy _____

*****NOTICE*** Changes in therapy after initial approval and/or recertification may be faxed to (512) 533-3178.**

I hereby certify that this patient has been diagnosed with HIV infection, and I am reporting the following viral load and CD4 count:

Plasma RNA Viral Load: copies/ml	Test Date:	Current CD4 Count:	Test Date:
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PRESCRIBED MEDICATIONS FOR OPPORTUNISTIC INFECTIONS:

Please check here if patient is pregnant:

- acyclovir**, for acute or chronic herpetic infection (*NOTE: not all strengths available due to manufacturer shortages*), **OR**
- valacyclovir**, for acute or chronic herpetic infection
- itraconazole**, for diagnosed histoplasmosis or blastomycosis (either caps or OS), **OR** for esophageal candidiasis (OS only)
- clarithromycin**, for a current or previous mycobacterium avium complex (MAC) diagnosis, **OR**
- azithromycin**, if client failed therapy on (or is intolerant of) clarithromycin
- ethambutol**, for a current or previous mycobacterium avium complex (MAC) diagnosis
- fluconazole**, for diagnosed cryptococcal meningitis or esophageal candidiasis
- valganciclovir** (Valcyte), for diagnosed CMV disease with infection(s) of major organ(s) or organ system(s)
- megestrol acetate**, for diagnosed cachexia or anorexia with profound, involuntary, acute weight loss $\geq 10\%$ of baseline body weight or chronic weight loss $\geq 20\%$ of baseline body weight
- rifabutin** (Mycobutin), for a CD4 cell count ≤ 100
- pyrimethamine** (Daraprim), for the treatment and suppression of toxoplasmosis
- leucovorin** calcium tablets, used w/Daraprim for treatment/suppression of toxoplasmosis (**please provide RX dosage details**)
- pentamidine** or **SMZ/TMP** or **Dapsone** or **atovaquone** (Mepron) (choose one, if applicable), for CD4 ≤ 200 or thrush or previous PCP diagnosis or unexplained fever $>100^{\circ}$ for >2 weeks, or if atovaquone is being prescribed to treat toxoplasmosis

*****REQUIRED***** Is this patient naïve to antiretroviral therapy? (check one) Yes No

PRESCRIBED ANTIRETROVIRAL MEDICATIONS: MONTHLY CLIENT LIMIT OF FOUR ANTIRETROVIRALS (ARVs)

- | | | |
|---|---|--|
| <input type="checkbox"/> Atripla (Sustiva/Truvada)* | <input type="checkbox"/> atazanavir (Reyataz) | <input type="checkbox"/> abacavir sulfate (Ziagen) |
| <input type="checkbox"/> Combivir (AZT/3TC)* | <input type="checkbox"/> darunavir (Prezista) | <input type="checkbox"/> didanosine (DDI EC) |
| <input type="checkbox"/> Complera (Edurant/Truvada)* | <input type="checkbox"/> indinavir (Crixivan) | <input type="checkbox"/> emtricitabine (Emtriva) |
| <input type="checkbox"/> Epzicom (Ziagen/3TC)* | <input type="checkbox"/> invirase (Saquinavir) | <input type="checkbox"/> lamivudine (3TC) |
| <input type="checkbox"/> Trizivir (AZT/Ziagen/3TC)* | <input type="checkbox"/> lopinavir/ritonavir (Kaletra) | <input type="checkbox"/> stavudine (D4T) |
| <input type="checkbox"/> Truvada (Emtriva/Viread)* | <input type="checkbox"/> nelfinavir (Viracept) | <input type="checkbox"/> zidovudine (AZT) |
| <input type="checkbox"/> efavirenz (Sustiva) | <input type="checkbox"/> ritonavir (Norvir) | <input type="checkbox"/> delavirdine (Rescriptor) |
| <input type="checkbox"/> nevirapine (Viramune XR) | <input type="checkbox"/> tipranavir (Aptivus) | <input type="checkbox"/> enfuvirtide (Fuzeon) |
| <input type="checkbox"/> raltegravir (Isentress) | <input type="checkbox"/> fosamprenavir (Lexiva) – if unboosted dosage, written justification from physician required | <input type="checkbox"/> Triumeq (Tivicay/abacavir/3TC)* |
| <input type="checkbox"/> dolutegravir (Tivicay) | <input type="checkbox"/> cobicistat (Tybost) | <input type="checkbox"/> elvitegravir (Vitekta) |
| <input type="checkbox"/> rilpivirine (Edurant) | <input type="checkbox"/> Prezcobix (Prezista/Tybost)* | <input type="checkbox"/> Descovy (Emtriva/Viread TAF)* |
| <input type="checkbox"/> tenofovir (Viread) | <input type="checkbox"/> Evotaz (Reyataz/Tybost)* | |
| <input type="checkbox"/> etravirine (Intelence) – For treatment experienced w/viral resistance/toxicity to ARV agents. | | |
| <input type="checkbox"/> maraviroc (Selzentry) – CCR5 monotropism proof via assay must be attached. | | <input type="checkbox"/> Odefsey (Edurant/Emtriva/Viread TAF)* |
| <input type="checkbox"/> Stribild (elvitegravir/cobicistat/Emtriva/Viread)* | | <input type="checkbox"/> Genvoya (Vitekta/Tybost/Emtriva/Viread TAF)* |

*Please note: Combivir, Descovy, Evotaz, Epzicom, Prezcobix & Truvada each count as 2 ARVs; Atripla, Complera, Odefsey, Trizivir & Triumeq each count as 3 ARVs; Stribild and Genvoya each count as 4 ARVs.

PHYSICIAN SIGNATURE: _____ TX MD/DO LICENSE #: _____

PRINTED NAME OF PHYSICIAN: _____

OFFICE ADDRESS: _____

TELEPHONE: _____ FAX: _____ DATE: _____

THMP, ATTN: MSJA - MC1873, PO Box 149347, Austin, TX 78714-9347

(5/2016)