DOCUMENTS THMP WILL ACCEPT

This form has examples of documents THMP will take. This list does not contain all documents that THMP will take. Please see the application for more information. Call your local agency or THMP with questions about documents.

You must fill out the whole application. We need the most up-to-date information. Please sign and date Section 8 before you turn it in.
You can find the most current application at: dshs.texas.gov/hivstd/meds/document.shtm.

(1) THMP needs proof of where you live. This proof must have your full name and be current and valid. If you are a **student living outside of Texas** to attend school, you may apply for THMP if you have: **a) a denial letter from ADAP in your school's state, b) proof with the address where you live in Texas, and c) proof of school enrollment.**

(2) THMP needs proof of your current income. We need to know how much money you earn and how often you get paid. If you are married, we also need proof of income for your spouse. This includes if you are common law married. We also need to know how many children age of 17 and younger live with you. This includes your biological or adopted children and your stepchildren. We use this to figure out your family and household income.

If you do not earn income, we can accept other proof:

If you are a student:	We can take a letter that shows you are in school and your current financial aid award letter. This letter needs to be from your school, not from FAFSA.
If you pay your bills with savings:	We can take a copy of your most recent bank account statement. The bank statement should show deposits and withdrawals.
If you pay your bills with child support:	We need your child support letter from the Office of the Attorney General. If your child support is an informal agreement, we can take a letter from you and the other parent. Your child support document needs to say how much you get and how often.
If you are homeless:	Provide a letter from the shelter or agency worker about you and where you get mail.
If somebody else supports you:	We can take a copy of the THMP Supporter Statement. The person who supports you needs to fill out and sign the statement.

(3) If you are new to the program, ask your doctor to fill out a "Medical Certification Form" (MCF). This will tell us what medication you need.

THMP may ask for more information. This may include items such as a copy of your most recent IRS Tax Return Transcript or IRS Proof of non-filing.

Examples of Documents THMP will take:

Proof of Residency **Choose one**. Proof must be where you live and include your name.	**Proof of Income** **Choose one**. Proof must show one month's worth of income.	**Proof of Insurance**
Motor Vehicle Records: • Valid/unexpired vehicle registration • Valid/unexpired Texas Driver's license • Auto insurance **State Documents:** • Valid/Unexpired Texas Driver's License, Texas State ID card • Active Medicaid, SNAP, or TANF benefit award letters • Unemployment letter **Federal Documents**: • Current Social Security, Medicaid or Medicare benefit letters, USPS receipt showing you changed your address, IRS Tax Return Transcript, IRS Verification of Non-Filing, W2 • Current voter registration **Copies of Bills** (**within 30 days from your signature date on application**): • Mortgage or rental agreement with signature page • Property tax documents • electric/gas, land-line phone, cable bills) **Other Documents** (**within 30 days from the client signature date on application**): • Current employment • records (pay stubs), proof of school enrollment, financial aid approval letter • Mail addressed to you that has envelope date-stamped with post-mark or meter mark from USPS • A letter from shelter or agency worker (signed and dated) for verification of Homelessness	**Current Pay Stubs from Employment**: • Paystubs **(30 continuous days of payment within the last 60 days**) **Award Letters**: • Social Security Disability • Social Security Income • Veteran's benefits • Retirement benefits • Alimony benefits • Unemployment benefits **Wage Verification Form**: • Paid in cash or proof of a new job (for new job, include paystubs received, even if you only received one) **Copy of Tax Return**: • If self-employed, a copy of Your most recent Tax Return forms • Your tax return must be signed by you, or a tax preparer, or must include IRS Proof of E-filing • If you do not have a copy of your personal tax return, ask for a copy of your IRS Tax Return Transcript from the IRS. Ask for your Tax Return 30 days before your THMP application is due. **Self-Employment Log**: • DSHS self-employment log that shows earned income from the last 30 days. The log should include the type of work you do, how often you get paid, and the form of payment you receive (for example: cash, written check, barter). The log must be signed and dated.	**If you have health insurance**: • Include proof of coverage, completed Copayment Assistance Form (Section 7 of the THMP application) • Include a copy of your insurance card (front and back) • If your insurance policy ended less than 90 days ago, submit proof policy ended such as a Certificate of Creditable Coverage or Certificate of Prior Coverage. **If you want to apply for COBRA help, provide the following**: • Proof of health insurance policy termination and Section 7 of the THMP application • Copies of COBRA paperwork, and a copy of insurance card (front and back), including a copy of your prescription benefit card • If you are eligible, THMP will pay your COBRA premium, prescription deductibles, and medication copayments.

Texas Application for Medication Assistance

Please mail your completed application to: Texas Department of State Health Services, ATTN: MSJA - MC 1873, PO Box 149347, Austin, TX 78714-9347 **-OR- Fax to (512) 989-4011**.

If you need help with this form, call your local community agency. Call 2-1-1 for information on local agencies. **Call THMP at** 1-800-255-1090 **with questions about this application.**

Section 1: Personal Information

1. Last Name	**First Name**	**Middle Name**	**Suffix** (Jr., Sr., III)

2. Previous Names (including maiden name, aliases, and name changes)	**2a. Preferred Name or Pronouns**

3. Do you have a Social Security Number (SSN)? ☐ **No** ☐ **Yes**	**SSN or Tax ID** (if no SSN)**:**	**4. Date of Birth** *(mm/dd/yyyy)***:**

5. Preferred Language: ☐ English ☐ Spanish ☐ Other:

6a. Gender	**6b. Sex Assigned at Birth**	**6c.** Are you **pregnant?**
☐ Male ☐ Female ☐ Unknown ☐ Transgender M/F ☐ Transgender F/M	☐ Male ☐ Female ☐ Unknown	☐ **No** ☐ **Yes** Due Date:

7a. Ethnicity (check one)

- ☐ Hispanic (check origin below)
  - ☐ Mexican, Mexican American, Chicano/a
  - ☐ Puerto Rican
  - ☐ Cuban
  - ☐ Another Hispanic, Latino/a or Spanish origin
- ☐ Non-Hispanic

7b. Race (check all that apply)

- ☐ White ☐ Black/African American
- ☐ Asian (check origin below)
  - ☐ Asian Indian ☐ Korean ☐ Chinese
  - ☐ Vietnamese ☐ Filipino ☐ Japanese ☐ Other
- ☐ Native Hawaiian/Pacific Islander (check origin)
  - ☐ Native Hawaiian ☐ Guamanian or Chamorro
  - ☐ Samoan ☐ Other Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ Other/Unknown

8. Are you currently **married, including common-law**? ☐ **No**
☐ **Yes (*If yes, you must complete 8a-8b for your spouse.*)**

8a. Is your **Spouse** on THMP? ☐ **No** ☐ **Yes**

8b. Spouse Name	**Spouse SSN** (if applicable)	**Spouse Date of Birth**

9. Were you **recently released or are you currently incarcerated** in a jail or prison?
☐ **No** *(If no, please go to Section 2.*)
☐ **Yes** (*If yes, please complete 9a. through 9d. below.)*

9a. Facility Name	**9b. Correctional ID Number #**	**9c. Release Date**

9d. How long were you incarcerated?

Section 2: Proof of Residency (**must be within 30 days from date you signed application and/or not expired)**

Please **send copies of documents** that prove where you live (residency) with this application. **Refer to the form: Documents THMP Will Accept**.

10. Residency: List the address where you live below. Check the document you are providing to verify your address: ☐ Texas Driver's License or Texas ID ☐ electric, water, or other utility bill ☐ voter registration ☐ motor vehicle registration ☐ postmarked mail with date ☐ signed lease agreement ☐ letter from homeless shelter ☐ other:

10a. Are you currently experiencing homelessness? ☐ **No** ☐ **Yes** (***If yes, skip to Section 3. A letter from the shelter or agency worker is required.)***

10b. Current Street Address where you live now (**Do Not Use** P.O. Boxes or Rural Routes)		**Apartment Number:**
City:	State:	Zip Code:

Section 3: Contact Information (**How can THMP contact you?)**

11. Can THMP send mail to your residential address, where you live?
☐ If **No (go to 11a.)** ☐ **Yes**

11a. Please provide a mailing address below where THMP can mail updates to you.

Mailing Address (You can use P.O. Boxes or Rural Routes)		**Apartment Number:**
City:	**State:**	**Zip Code:**

11b. How can THMP contact you? ☐ **by mail** ☐ **by phone**

12. Provide phone numbers where THMP Staff can call you.
1st Phone Number: 2nd Phone Number:

12a. Can THMP leave you a **voice mail message**? ☐ **No** ☐ **Yes**

13. If an agency worker is helping you complete this application, provide their information below.

Agency Name:	**Agency Phone #:**
Agency Worker:	**Agency Fax #:**

Section 4: Household Information

14. How many of **your own biological or adopted children or stepchildren** age 17 years and younger live with you?

15. Are you **age of 17 years or younger**? ☐ **No** (skip to 16) ☐ **Yes** (If yes, you must complete **Household** and **Income** information for each parent or stepparent who lives with you.) If you are 17 years or younger and **do not** live with your parent(s), please contact THMP or your local agency for help.

15a. Full Name of Parent or Guardian		**15b. Full Name of Second Parent or Guardian** *(if applicable)*	
Social Security Number	**Date of Birth**	**Social Security Number**	**Date of Birth**

Section 5: Proof of Income

Income eligibility is based on household income for you and your spouse, if you are married or common-law. *Please send copies of documents that prove how you support yourself (your income).* ***If you have no income, Documentation of Support is required.***

16. How do you support yourself? *Please check **ALL** that apply below, **for you and your spouse**.*

16a. My Income (**attach all** that apply)	**16b.** My Spouse's Income (**attach all** that apply):
☐ I receive income from employment. ☐ paystubs from the last 30 days ☐ personal income tax return, **signed and dated** ☐ other:	☐ My spouse receives income from employment. ☐ paystubs from the last 30 days ☐ personal income tax return, **signed and dated** ☐ other:
Name of Employer:	**Name of Employer:**
Name of **Second Employer:**	Name of **Second Employer:**
☐ I receive income that is not from employment. ☐ Social Security award letter ☐ unemployment benefit award letter ☐ other:	☐ My spouse receives income not from employment. ☐ Social Security award letter ☐ unemployment benefit award letter ☐ other:
☐ I have no income and I have attached: ☐ **Form: THMP Supporter Statement** ☐ other:	☐ My spouse has no income (no document required)
☐ I am paid in cash and I have attached: ☐ **Form: Self-Employment Log** ☐ **Form: Income Verification Form** ☐ other:	☐ My spouse is paid in cash and I have attached: ☐ **Form: Self-Employment Log** ☐ **Form: Income Verification Form** ☐ other:

17. If you or your spouse **left a job** in the last 90 days, please complete this section.

Name of employer:	End date of job:
Name of employer:	End date of Job:

Section 6: Authorization of Release

18. **Personal Contacts:** If you would like THMP to speak to family or friends regarding your application or program status, please list them below. **Please note that this is not required.**

Name of Person	**Relation to You**	**Phone Number**

Section 7: Health Insurance Information (Provide a copy of the front and back of your insurance card.)

19. ☐ I **do not have** any type of health insurance. **Please skip to Section 8.**

19a. ☐ I **am currently enrolled** in one of the following: ☐ **Medicare (Part A, B, C or D)** ☐ **Medicaid** ☐ **Private Health Insurance** ☐ **Affordable Care Act-ACA/Marketplace Plan** ☐ **COBRA**

Section 7: Health Insurance Information (continued)

Please answer sections **20 and 21** about your insurance and COBRA.

20. I am **enrolled in a private insurance plan:** ☐ **NO (skip to Section 8)**
☐ **YES (provide plan information below):**

Insurance Name:

Individual Policy Number:	Insurance Phone Number:

My health insurance has ended. ☐ **No** ☐ **Yes**
If yes, provide **date health insurance ended:**

21. I have **COBRA**, or **I lost my Employer Health Insurance within the last 90 days and I am interested in COBRA**: ☐ **No (Skip to Section 8.)**
☐ **Yes** (**Complete 20a-20b** and submit copies of COBRA paperwork and payment coupon.)

21a. Have you already submitted your COBRA paperwork? ☐ **No** ☐ **Yes** Date submitted: COBRA Administrator's Phone Number: COBRA Election/Enrollment Due Date: COBRA First Payment Due Date: COBRA Account #:	**21b.** To apply for COBRA assistance, you must call your plan and authorize "The Texas Department of State Health Services Texas Insurance Assistance Program" to speak to your health insurance plan directly on your behalf. **Date Completed:**

Section 8: Certification (Applicant signature and date are required and must be within 30 days of application submission. Missing signature and date will result in denial of application.)

By signing below, I agree:

- To let DSHS and other state, federal, and local agencies check, share, and get facts about me or my spouse.
- To let other people, businesses, and organizations share facts they have about me or my spouse with DSHS
- To let THMP check and share facts, including any information that helps THMP decide if I am eligible for medication assistance through the THMP, including information on any insurance or Medicare plan in which I may be enrolled.
- To let THMP check these facts to process my application and at any time in the future while I am enrolled in THMP to see if I remain eligible for medication assistance through THMP.

I also understand that:

- THMP may change enrollment, eligibility criteria, or services covered based on funding in the future.
- If I do not order medications from THMP on a regular basis or maintain my eligibility by reapplying every six months, THMP will remove me from the program.
- THMP will share my information with my service providers and agency workers. I will contact THMP if I want them to make an exception.

My answers are true: I certify under penalty of perjury that the information I provided on this application is true and complete to the best of my knowledge. If it is not true, I may be subject to criminal prosecution. I signed below to show that I agree with these statements:

X.	**Date (required)** *(mm/dd/yyyy)*

Signature of Applicant (or signature of parent or guardian if applicant is age 17 years or younger) or Agency Worker if completed with client over the phone *(please print and sign)*

- Clients completing applications in person must sign the application.
- Applications completed over the phone must include the name of the agency worker completing the form on behalf of the client, worker signature, and agency name.
- Applications submitted electronically should include the agency worker's typed name in the "worker name" field below as the electronic signature.

Worker Name	**Agency/Program**	**Phone**	**Fax**

To be completed by secondary reviewer:	Primary Reviewer	Date
	Secondary Reviewer	Date

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: _____.
(street address, city, state and zip code of person you support)

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 number(s) to verify this information: _____.
(phone number)

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.

X.	
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, case manager, 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.

THMP Self-Employment Log

Self-employment income is any money you make working for yourself or as a subcontractor. *Do not complete this form if you have a job where you are paid and taxes are taken out. Instead, you should submit paystubs. If you work for someone else, the person that employs you must complete the Income Verification Form.*

You might be self-employed if you are a: babysitter, landscaper, day laborer, house cleaner, hair stylist, auto mechanic, or person who makes money from sales, crops, leases, commissions, fees, or **anything you do or sell.**

First and Last Name	Social Security Number	Date of Birth

If you use this form to show your self-employment income: Answer all questions below and sign and date at the bottom.

1. What type of work do you do to earn this money?

2. How many hours do you work each week?

3. How are you paid? *(check one)*
☐ Cash ☐ Personal check ☐ Payroll check ☐ Other (please specify):

4. How long have you been doing this type of work? *(check one)*
☐ less than 6 months ☐ 6 months to 1 year ☐ 1 year to 5 years ☐ 5 years or more

5. Fill out the table below to tell us about all money you have earned from self-employment from the last 30 days

Date	Who paid this money	Amount Paid
		$
		$
		$
		$
		$
		$
		$
		$
	Total self-employment income:	$ 0.00

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

X.	
Signature of person getting self-employment income	**Date**

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.

Section 1. Employee Information

Employee Name:

Employee Address:

Section 2. Employer Contact Information

Business Name:

Business Address:

Business Phone Number:

Contact Name:	Contact Phone Number:

Section 3. 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

Gross hourly wage: $ per hour

Estimated amount of weekly tips or commissions: $ per week

Section 4. Employee Health Coverage

Is employer-sponsored health coverage offered? ☐ Yes ☐ No

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

Section 5. Additional Information

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

Section 6. Certification

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

X.	**Date:**

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

TEXAS HIV MEDICATION PROGRAM
MEDICAL CERTIFICATION FORM
Fax to (512) 989-4003

(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.

***** Both pages are required. *****

PATIENT INFORMATION

Full Name: _____

Mailing Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ Phone: _____

Date of Birth (mm/dd/yyyy): _____ Social Security Number: _____

Requested Pharmacy: _____

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

Plasma RNA Viral Load: copies/ml	**Test Date** (mm/dd/yyyy)**:**	**Current CD4 Count:**	**Test Date** (mm/dd/yyyy)**:**

***REQUIRED* Is this patient new to any medications in this antiretroviral therapy regimen?**
(check one) **Yes** ☐ **No** ☐

On the following page, mark the appropriate box to specify supply quantity for each medication prescribed. Please refer to the THMP Medication Formulary and Maximum Quantities Table for available dosages and quantities of medications.

Note:** Combivir, Descovy, Dovato, Evotaz, Epzicom, Prezcobix, Truvada, and Juluca each count as 2 ARVs; Atripla, Complera, Odefsey, Trizivir, Triumeq, Biktarvy, and Delstrigo each count as 3 ARVs; Stribild, Symtuza, and Genvoya each count as 4 ARVs. ***HLA-B*5701 test result of negative is required for treatment-naïve patients starting medications that contain abacavir (Ziagen, Epzicom, Trizivir, or Triumeq).

I certify that this patient is being prescribed the medications selected on the attached page.

Physician Signature**:** _____ TX MD/DO License # _____

Printed Name of Physician: _____

Office Address: _____

Phone: _____ Fax: _____ Date: _____

*****NOTICE*** Changes in therapy after initial approval and/or recertification may be faxed to (512) 989-4003.**

If this form is completed as part of an initial program application, it should be mailed to:
Texas HIV Medication Program, ATTN: MSJA - MC1873, PO Box 149347, Austin, TX 78714-9347

Patient Name: _____

Date of Birth: _____ **Texas HIV Medication Code (if known):** _____

Qty Prescribed (days)			**Qty Prescribed** (days)			**Qty Prescribed** (days)	
30 day			**30 day**			**30 day**	
☐	**azithromycin**	**OR**	☐	**Clarithromycin**			*(choose one)*
☐	**Dapsone**	**OR**	☐	**pentamidine**	**OR**	☐	**SMZ/TMP** *(choose one)*
☐	**acyclovir**	**OR**	☐	**famciclovir**	**OR**	☐	**Valacyclovir** *(choose one)*
☐	**Gynazole** (butoconazole)	**OR**	☐	**Monistat** (tioconazole)	**OR**	☐	**terconazole** topical *(choose one)*
☐	**fluconazole**	**OR**	☐	**itraconazole**	**OR**	☐	**Voriconazole** *(choose one)*
☐	**atovaquone** (Mepron)					☐	**clindamycin**
☐	**clotrimazole troche**					☐	**Daraprim** (pyrimethamine)
☐	**ethambutol**					☐	**isoniazid**
☐	**leucovorin** calcium tablets					☐	**megesterol acetate** oral susp
☐	**nystatin** oral susp					☐	**Oravig** (miconazole)
☐	**prednisone**					☐	**primaquine phosphate**
☐	**rifampin**					☐	**rifabutin**
☐	**sulfadiazine**					☐	**Valcyte** (valganciclovir)

ANTIRETROVIRALS RX: MONTHLY CLIENT LIMIT OF FOUR ANTIRETROVIRALS (ARVs)

30 day		**30 day**		**30 day**	
☐	**Aptivus** (TPV)	☐	**Atripla** (ABC/FTC/TDF)	☐	**Biktarvy** (BIC/FTC/TAF)
☐	**Combivir** (AZT/3TC)	☐	**Complera** (FTC/RPV/TDF)	☐	**Delstrigo** (DOR/3TC/TDF)
☐	**Descovy** (FTC/TAF)	☐	**Dovato** (DTG/3TC)	☐	**Edurant** (RPV)
☐	**Emtriva** (FTC)	☐	**Epivir** (3TC)	☐	**Epzicom** (ABC/3TC)
☐	**Evotaz** (ATV/c)	☐	**Genvoya** (c/EVG/FTC/TAF)	☐	**Intelence** (ETR)
☐	**Invirase** (SQV)	☐	**Isentress** (RAL)	☐	**Isentress HD** (RAL)
☐	**Juluca** (DTG/RPV)	☐	**Kaletra** (LPV/r)	☐	**Lamivudine/Tenofovir** (3TC/TDF)
☐	**Lexiva** (FPV)	☐	**Norvir** (ritonavir)	☐	**Odefsey** (RPV/FTC/TAF)
☐	**Pifeltro** (DOR)	☐	**Prezcobix** (DRV/c)	☐	**Prezista** (DRV)
☐	**Reyataz** (ATV)	☐	**Rukobia ER** (fostemsavir)	☐	**Selzentry** (MVC)
☐	**Stribild** (c/EVG/FTC/TDF)	☐	**Sustiva** (EFV)	☐	**Symfi** (EFV/3TC/TDF)
☐	**Symtuza** (c/DRV/FTC/TAF)	☐	**Tivicay** (DTG)	☐	**Triumeq** (DTG/ABC3TC)
☐	**Trizivir** (AZT/ABC/3TC)	☐	**Truvada** (FTC/TDF)	☐	**Viracept** (NFV)
☐	**Viramune XR** (NVP)	☐	**Viread** (TDF)	☐	**Ziagen** (ABC)
☐	**Zidovudine** (AZT)				

ATTENTION: The medications below will be suspended November 1, 2021. Please ensure there is a transition plan to another program before adding these medications through THMP.

☐	**Amlodipine** (5mg/#90)	☐	**Atorvastatin** (20mg/#90)	☐	**Baraclude**
☐	**Duloxetine** (30mg/#90)	☐	**Egrifta** (tesamorelin acetate P/F)	☐	**Gabapentin** (300mg/#100)
☐	**Hydrocholorothiazide** (25mg/#100)	☐	**Lisinopril** (10mg/#100)	☐	**Livalo** (2mg/#90)
☐	**Metformin** (500mg/#100)	☐	**Metoprolol Tart** (50mg/#100)	☐	**Mytesi** (crofelemer)
☐	**Sertraline (**50mg/#30)	☐	**Trazodone** (100mg/#100)	☐	**Vemlidy**
☐	**Zypitamag** (2mg/#90)				