

**Virginia Pre-Exposure Prophylaxis Drug Assistance Program
(VA PrEP DAP) C O N F I D E N T I A L A P P L I C A T I O N**

APPROVED

SECTION 1: APPLICANT INFORMATION

Must Provide Proof of Legal Name

Legal Last Name: _____ **Legal First Name:** _____ **MI:** _____

Preferred name (if different than legal name): _____

Date of Birth: ____/____/____ **Email:** _____
MM DD YYYY

Assigned Sex at Birth: male female

Current Gender Identity: male female transgender(male to female) transgender (female to male)
 transgender-unspecified: _____

Pronoun (optional): he/him she/her they/they

Home Address If you have a home address, complete the address field below. **Must Provide Proof of Virginia Residency**
If you do not have a home address, complete the **No Home Address Declaration.** **PO Boxes cannot be accepted**

Address: _____ **Apartment/Unit #:** _____

City: _____ **State:** ____ **ZIP:** _____

No Home Address Declaration If you do not have a home address complete the following statement:

I do not have a home address. Last night I stayed (circle):

at a park in a car at a shelter on the street with family/friends somewhere else

In the city of: _____

Mailing Address Same as my home address above: Yes No **If no**, please provide a physical address below.
PO Boxes cannot be accepted

Address: _____ **Apartment/Unit #:** _____

City: _____ **State:** VA **ZIP:** _____

Primary Phone: (____) _____ - _____ **May we leave a voicemail?** Yes No

¿Quisiera usted recibir documentos de nosotros en español? Sí No
Would you like to receive documents from us in Spanish?

Race (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Asian | <input type="checkbox"/> Alaska Native/American Indian |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Native Hawaiian/Pacific Islander |
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Other, specify: _____ |

Ethnicity (Check One):

- Hispanic/Latino(a)
 Non-Hispanic/Latino(a)

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Health Insurance and Medical History

Do you currently have any type of health insurance? Yes No
If yes, does your insurance provide prescription drug coverage? Yes No

Prior to today, have you ever been diagnosed with (check all that apply):

- Syphilis Gonorrhea Chlamydia

If you checked any of the boxes above, were you diagnosed with these in the last year? Yes No

Have you ever used any of the following substances (check all that apply):

- Alcohol (ex. beer, wine, liquor)
- Amphetamines (ex. meth, speed, non-prescription use of Adderall)
- Cocaine or crack-cocaine
- MDMA (ex. molly, ecstasy)
- Hallucinogens (ex. LSD, acid, mushrooms)
- GHB
- Marijuana (ex. joints, blunts, edibles)
- Opiates (ex. heroin, Fentanyl, OxyContin or Morphine)
- None of the above
- Refused

Have you ever injected any of the following substances (check all that apply):

- Amphetamines (ex. meth, speed, non-prescription use of Adderall)
- Cocaine or crack-cocaine
- Opiates (ex. heroin, Fentanyl, OxyContin or Morphine)
- Injected other substance, specify:

- None of the above
- Refused

Please check ALL risk categories that apply to you: in the last year

- Man who has sex with men and engages in unprotected anal intercourse
- Diagnosed with a Sexually Transmitted Infection (example, syphilis, gonorrhea, chlamydia)
- Exposure to an STI through a sexual network
- Ten or more sexual partners
- Injection drug user who has shared injection drug equipment and/ or injected one or more times a day and/or injected methamphetamines and/or engaged in high risk sexual behavior
- Have had unprotected anal intercourse with a partner of unknown HIV-1 status with any of the factors listed above
- Engaged in transactional sex (sex for money, drugs, gifts, etc)
- Engage in high risk sexual behaviors with known HIV-infected partner

What is your annual income from all sources? \$ _____

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Authorized Representative

Please provide the following information for any family/friends you would like us to be able to talk to about your PrEP DAP

First and Last Name: _____

Primary Phone Number: _____ Email: _____

Date of Birth: ____/____/____
MM DD YYYY

Eligibility, Agreement, Release of Information, & Assignment of Benefits

CONSENT and Signature

I understand that this is a pilot program and funding may not be available after 1 year. The continuation of this program depends on the availability of funds. I understand it is my responsibility to provide medical status and proof of income every 12 months. I further understand it is my responsibility to notify VDH of any changes in my contact information, income or insurance status (if applicable). Failure to provide the necessary documentation could jeopardize my approved assistance through the Virginia Department of Health.

My information is being entered into a statewide database by the Virginia Department of Health. VDH agrees to treat all information as confidential. I hereby give my consent to VDH to obtain, verify, and/or release my demographic, medical, prescription, and/or insurance coverage information, with other entities as necessary to effectively determine financial eligibility and manage my medication access. Information may be shared with but is not limited to the following: physician, health department personnel, other Division of Disease Prevention programs (including Surveillance, Care and Prevention), treatment center personnel, pharmacy services provider, referral source, clinic, insurance broker and/or insurance carrier. VDH agrees to treat any and all such information as confidential.

I understand that this consent will remain in effect as long as my dependent or I remain on PrEP DAP or until I withdraw it.

I have read, understand and agree to the above Client Responsibilities and Release of Consent. I verify that the information provided in this application is complete and accurate to the best of my knowledge.

Signature of Client, Parent/Legal Guardian or Person acting in Loco Parentis

Date Signed

Relationship (If signature is not of Client)

Signature of Person Obtaining Consent

Date Signed

Please provide the information below if a friend, family member or advocate helped to complete this application:

First Name MI Last Name

Address

City State Zip

Phone Number

In order to process your application in a timely manner it is important that the application is complete. If your application is not complete, we will not be able to process your application and there may be a delay in obtaining your medication.

For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-864-VDH (TDD/TTY call 711).

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Checklist for Submitting a Complete PrEP DAP Application:

☐ Proof of Legal Name (New PrEP DAP Applicants Only)

Please provide us a copy of one of the following to verify your full legal name:

- Any state driver's license or identification card
- Passport

☐ Proof of VA Residency

Please provide us a copy of one of the following to verify your VA residency:

- Current Virginia State driver's license or identification card
- Virginia voter registration card
- Utility bill (cell phone bills are not accepted)
- Lease/rental/mortgage agreement

☐ Proof of Income

Please provide us a copy of one of the following to verify your proof of income:

- Copies of three most recent, consecutive pay stubs that show gross income and payroll deductions
complete copy of most recent Federal Income tax return
- Veteran's or other retirement benefits (a copy of award letter or any other official documentation
showing the amount received on a regular basis)
- Government benefits and/or award (such as Social Security and unemployment benefits)

☐ Proof of No Income

Please provide us a copy of one of the following to verify no income proof:

- Termination or layoff notice from most recent employer on company letterhead
- A "proof of no income" letter that identifies the source of the applicant's food and shelter (letter
signed by agency, shelter, relative, friend, or some other non-agency source of support)

☐ Insurance Card

If you have insurance, please provide us a copy of your insurance card.

☐ Application completed in pen

**☐ Application filled out completely (both Section 1 & Section 2) with all required
documentation, dates and signatures**

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