Virginia (VA) Medication Assistance Program (MAP) and Ryan White Emergency Enrollment Form

Client fill out this section:

Client Name: _____ **Date of Birth:** _____

Temporary Virginia Address: _____

Local Phone #: _____ **OK to leave message** (please circle one)**? YES NO**

Alt. Phone #: _____

Site fill out this section:

Local Health Department or other Agency Name: _____

Contact Name and Phone Number for local agency/person assisting you in accessing services (name & phone #)**:**

_____

Your address in home state: _____

Do you have current prescriptions available? (If so, leave at site--please circle one) **YES NO**

Prescribing physician information (name, address, phone number, name of clinic – any info the client can recall):

_____

Pharmacy where last ADAP medications were dispensed (please provide as much information as possible, i.e. pharmacy name, street address, city, phone number, pharmacist's name**):**

_____

Do you have any allergies to medications (please circle one)? **YES NO**

If YES, please list: _____

List current medications: _____

_____

_____

Do you currently have any type of health insurance (please circle one response)**? YES NO** (If yes, please provide a copy of insurance card if client has it)

Do you need other services (please circle one response)**? YES NO**

If YES, provide list of services needed: _____

Service provider information (other than medical provider) in your state (name, address, phone number)

_____

By signing this form, the applicant attests to the following facts:

a. I meet the eligibility criteria for the State ADAP and/or other Ryan White (RW) services that I was originally approved in.
b. I understand that deliberately omitting or giving false information could cause my removal from VA MAP and RW.
c. I understand that to receive emergency assistance from VA MAP, I give permission for the release of my medical information to VA MAP. I also give permission to VA MAP to share confidential information to provide any RW or other services while in Virginia, which may include communication with my originating State ADAP, RW or other service providers in Virginia and my state¸ and any 3rd party entity that provides or supports these services.
d. I understand that this approval is for temporary assistance, with a time limit of 30 days from the date of approval. I will need to complete a VA MAP Application and other intake information if I need continued assistance after that time.
e. I understand that this application is a legal document. My signature attests that all the information I have provided is true and correct.

_____

Signature of Applicant (required) **Date**

Please fax this completed form to 1-804-864-8050. You may fax the completed form without a prescription. If no prescription available, please obtain copies/pictures of the medication bottles' full label or pharmacy receipts. For questions/issues, call the Medication Eligibility Hotline at 1-855-362-0658.