

VIRGINIA MEDICATION ASSISTANCE PROGRAM (VA MAP) APPLICATION

If you need assistance completing this application, please contact the Virginia Department of Health at 1-855-362-0658. The application may be mailed to Virginia Department of Health, HCS Unit, 1st Floor, James Madison Building, 109 Governor Street, Richmond, VA 23219 or faxed to 804-864-8050.

Did you:

1. Yes No Answer all of the questions on the application?
2. Yes No Include proof of residency with current Virginia address?
3. Yes No Include proof of current income?
4. Yes I have health insurance Include a front & back copy of your health insurance card (if applicable)? No, I don't have health insurance.
5. Yes No Sign and date application?
6. Yes No Medical Certification Form: HIV Diagnosis Status complete with HIV Medication List?

- ❖ If you checked "yes" to all questions above, your application will be processed within 72 hours.
- ❖ If you checked "I don't have health insurance" to question 4 above but checked "yes" to all other questions, your application will be processed within 72 hrs.
- ❖ If you answered "No" to any questions above, not including question 4, your application cannot be processed. Please send only completed application.

Please use the checklist above to confirm that the application is complete. Who is submitting this application (Client, Case Manager, Other)?:

Name: _____ Contact Phone Number: _____

Relationship to Client: _____ Date: _____

Signature: _____

?

APPLICANT AND CONTACT INFORMATION			
Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City	State	ZIP	
Social Security No.		Date of Birth	
Language Preference			
Primary Phone		Secondary Phone	
May VDH leave a detailed voice mail on your (Check all that apply)?	<input type="checkbox"/> Primary Phone	<input type="checkbox"/> Secondary Phone	
<input type="checkbox"/> I don't have a phone, the best way to reach me is:			
May Virginia VA MAP share your information with an alternate contact that you provide?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
If YES, name of alternate contact		Relationship of contact	
Phone number of contact			
DEMOGRAPHICS			
Current Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> Unknown			
Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female			
Race and Ethnicity (Please answer for RACE and ETHNICITY, as well as IF questions if applicable)			
Race (Check all that apply)	<input type="checkbox"/> White	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian (Please answer follow-up) <input type="checkbox"/> Native Hawaiian/Pacific Islander (Please answer follow-up) <input type="checkbox"/> American Indian or Alaska Native
IF Asian (Check all that apply)	<input type="checkbox"/> Asian-Indian	<input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese	<input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Origin: _____
IF Native Hawaiian, Pacific Islander (Check all that apply)	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander: _____
Ethnicity (Check one)	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Hispanic/Latino(a) (Please answer follow-up)	IF Hispanic/Latino(a) (Check all that apply) <input type="checkbox"/> Mexican, Mexican-American, Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other Hispanic Origin: _____

HEALTH DEPARTMENT

Please list the Local Health Department or Site you will/would use for medicine pick up:

INCOMECurrent Household Income: \$ _____ Annual Monthly Other, specify _____

Number of persons in your family unit (include yourself): _____

Are you currently employed? Yes No

Please check any other types of income you currently receive

 Alimony Child Support Unemployment Retirement/Pension Social Security Income/Social Security Disability Income Other, specify _____**MEDICAL PROVIDER INFORMATION**

Name of prescribing physician:

Name of physician's medical practice:

Physician Street Address

Physician City

Physician State

Physician ZIP

Physician Phone

Physician Fax

INSURANCE INFORMATION

Do you currently have any type of insurance?

 Yes No Don't Know

If Yes, check all types that you currently have:

 Private Insurance, Employer Private Insurance, Individual Medicare A/B Medicare D Indian Health Services (IHS) Medicaid/CHIP/Other Public Plan VA/TRICARE /Other Military Plan Other, specify _____

If you have insurance, does it provide prescription drug coverage?

 Yes No Don't Know

Are you applying or have you applied for Medicaid?

 Yes No Don't Know

Are you applying or have you applied for Medicare?

 Yes No Don't Know

If Yes, Have you applied for Medicare Part D (medication coverage)?

 Yes No Don't Know

If Yes to Medicare Part D, have you applied for the Low Income Subsidy (LIS)?

 Yes No Don't Know

Are you applying or have you applied for Social Security Income (SSI) or Social Security Disability Income (SSDI)?

 Yes, for SSI Yes, for SSDI No Don't Know

CONSENT AND SIGNATURE

I understand it is my responsibility to provide medical status and proof of income every six 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.

I understand my information is being entered into a database by the Virginia Department of Health. I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and/or other health care benefits. I request a third party payer to pay any authorized benefits to VDH on my behalf. 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 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 VA MAP 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

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.

MEDICAL CERTIFICATION FORM

Please complete and return to: Virginia Department of Health, HCS Unit, 1st Floor, James Madison Building, 109 Governor Street, Richmond, VA 23219 or fax to 804-864-8050. Call 855-362-0658 with any questions.

MEDICAL PROVIDER CONTACT INFORMATION		
Date Form Completed:		
Client First Name:	Client Last Name:	Client Date of Birth:
Person Completing Form		
Phone Number for Person Completing Form		
Medical Provider Name		
Medical Practice Name		
Provider Phone Number	Provider Fax Number	

CLIENT MEDICAL INFORMATION			
Current Disease Status	<input type="checkbox"/> HIV Positive, not AIDS	<input type="checkbox"/> HIV Positive, AIDS status unknown	<input type="checkbox"/> CDC-defined AIDS
Current CD4 Count	_____	Date of Current CD4 Count	___/___/_____
Current Viral Load	_____	Date of Current Viral Load	___/___/_____
Date of Last HIV Medical Care Visit	___/___/_____		
<u>List Medications Prescribed for this Client (or attach a medication list). Required if applying for ICAP.</u>			
MEDICATION NAME		DOSAGE	

I certify that I am treating the above named client for HIV and that all information provided in this form is accurate and complete to the best of my knowledge.

Signature of Authorized Personnel (Physician, Case Manager, etc.)

Date Signed

HEALTH COVERAGE INFORMATION (OPTIONAL)	
Have you used tobacco products in any form within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If, Yes please provide the type, amount of tobacco used and frequency?	