Illinois Department of Public Health
Application for the AIDS Drug Assistance Program (ADAP)

The Illinois Department of Public Health, HIV/AIDS Section, administers the AIDS Drug Assistance Program (ADAP) with federal Ryan White CARE Act and state general revenue funding. ADAP provides any of 94 prescription drugs to eligible individuals up to a maximum benefits cap of $2,000 per month, excluding some select high cost drugs. ADAP provides up to a limit of five (5) antiretroviral, plus a reduced dose of ritonavir. Only drugs on the ADAP formulary are provided. All drugs are dispensed and shipped via mail order from the Department's contractor, PharmaCare Specialty pharmacy, Pittsburgh, PA.

Last Name (Print**)**	**First Name**		**M.I.**	**Telephone #** **(Home)** **(Cell)**
Social Security #	**Race**	**Date of Birth**	**Gender**	**Marital Status**
Street Address	**Apt. #**	**City**	**Zip Code**	**County**

To be eligible for the ADAP, an individual must –

- be diagnosed as having HIV or AIDS;
- be a resident of and domiciled in Illinois;
- not be Medicaid eligible through the Department of Healthcare and Family Services on the date drugs are dispensed (Individuals with a Medicaid spend-down unmet status may participate);
- not be eligible for the full "Extra Help" for assistance with a Medicare Part-D prescription drug plan;
- qualify financially (**gross** income must be at or below 400 percent of the current federal poverty level for the size of the household: For 2008, **$41,600** for a household of one or **$56,000** for a household of two).

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1. A copy of your laboratory report for CD4 or viral load is required for proof of HIV/AIDS status. Therefore, the lab reports MUST accompany this application before it can be processed.

   Request your doctor's office to fax labs to ADAP at 217-785-8013.

   My diagnosis is [ ] AIDS or [ ] HIV. Most current CD4 count: _____ ; viral load : _____.

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2. The financial eligibility is based on the **gross** income (before taxes are withheld) for your household. All sources of income must be reported. These sources may include wages (cash or check), SSDI, SSI, unemployment, and pensions. If you are married, your spouse's income must be included. If applicant is a minor, include income(s) for parents(s) living in the home.

   The number of persons in you household for which you are **legally** responsible is _____.

(Continued)

Person with Income	**Gross** Monthly Income	Income source as defined on last page
_____	_____	_____
_____	_____	_____
_____	_____	_____

NOTE**: If you have no income and someone is helping to provide for your needs, they must complete the attached "Confirmation of Support" letter.**

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3. If you claim any dependents, indicate below each individual and his/her relationship to you:

Name	Age	Relationship (child, sibling, or parent)
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Attach a separate sheet with information on any additional dependent household members)

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4. Do you have health insurance coverage that covers all or part of the cost of drugs? Yes [ ] No [ ]
If **yes**, you must submit a copy of your insurance card.

Name of insurance company _____ Insurance ID# _____

Insurance phone # _____ BIN# _____

NOTE: If you have health insurance coverage, our contracted dispensing pharmacy must be able to participate with your insurance plan for billing purposes for you to qualify for ADAP services. Only drugs on the ADAP formulary will be included in this coverage.

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5. Are you currently Medicare eligible? Yes [ ] No [ ]

If **no**, do you expect to become eligible within the next 12 months? When? _____

If **yes**, have you enrolled in a Part-D prescription drug plan? Name of plan: _____.
AND have you applied for the Low Income Subsidy through Social Security, known as "Extra Help"?

Yes [ ] No [ ] If **yes,** were you approved? Yes [ ] No [ ]

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6. Have you had military experience with a general of honorable discharge? Yes [ ] No [ ]

Have you applied for the Veterans Healthcare benefit through the Illinois Department of Veterans Affairs?

Yes [ ] No [ ] If **yes,** you must access your drugs through that benefit.

(Continued)

7. Please provide your doctor and, if applicable, your case manager information below.

Physician's name: _____ Case manager's name: _____

Hospital/clinic: _____ Clinic/agency: _____

Phone #: _____ Phone #: _____

You will be sent a decision regarding this application within 15 business days from the date your fully completed application is received. If approved, all covered prescriptions must be dispensed through the Department's contractor, PharmaCare Pharmacy in Pittsburgh, PA. Upon approval contact them at 800-238-7828 (phone); 800-682-7436 (fax). PharmaCare provides statewide mail delivery.

Clients approved for ADAP must re-apply on an annual basis in order to continue to receive services. Applications will be mailed to your address on file. Be sure to notify both ADAP and PharmaCare if you change your address within the 12-month period.

The following documentation **must** be received along with a completed, signed application in order to be approved. **Failure to provide all of the following documents will result in a delay in processing.**

1. **Proof of income (**copies of pay stubs (2) or SS award letter or bank statement)
2. **Most recent CD4 or viral load lab results**
3. **Proof of residency** (copy of utility/phone bill or valid driver's license or state ID)

Mail or fax **(217-785-8013)** signed and completed applications with accompanying documents to –

Illinois Department of Public Health
Attn: ADAP
525 West Jefferson Street, First Floor
Springfield, IL 62761

I understand that, if approved, a copy of my approval letter will be sent to the pharmacy, which includes information I have provided on this application. I understand that my Social Security number (if disclosed) will be used only for the sole purpose of serving as a unique identifier for your eligibility with the Department's contracted pharmacy. You are not required to disclose your Social Security number and no rights, benefits or privileges will be denied if you choose not to disclose it.

I understand that my doctor may be contacted to complete an HIV or AIDS case report. I understand that Department of Healthcare and Family Services, Department of Veterans Affairs, or Department on Aging may be contacted to verify eligibility for other benefits.

I have read and understand the above information. I verify that all information provided is accurate.
Providing inaccurate information could result in removal from the program.

_____ _____

Signature **(Required)** Date

Refer questions to 800-825-3518 or 217-524-5983, TTY 800-547-0466 (for hearing impaired only).