



Pat Quinn, Governor  
Damon T. Arnold, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • [www.idph.state.il.us](http://www.idph.state.il.us)

## MEMORANDUM

**TO:** Interested Parties  
**FROM:** Dr. Jeffrey P. Maras  
ADAP/CHIC Administrator  
**SUBJECT:** AIDS Drug Assistance Program

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. The Department provides any of 80 prescription drugs, with a maximum of five (5) antiretrovirals, plus ritonavir. ADAP provides a \$2,000 per month maximum benefit cap, with the exception of the high-cost drugs in Category V. Only drugs on the ADAP formulary are provided, and they are dispensed and shipped via mail-order by the Department's contractor, CVS CareMark Specialty Pharmacy.

**To be eligible** for the ADAP, an individual must meet the following criteria and demonstrate:

- Proof of HIV infection as demonstrated by a recent CD4 and Viral Load test results within the last 6 months;
- Proof of Illinois residency (be a resident of and domiciled in Illinois);
- Qualify for financial need (gross annual income must be at or below 500 percent of the current federal poverty level for the size of the household: For 2011, \$54,450 for a household of one; \$73,550 for a household of two);
- If applicant has no income or income \$500 or less, documentation of support (**letter of support**) must be provided;
- Not eligible for medical assistance through the Illinois Department of Healthcare & Family Services, Medical Assistance Program on the date drugs are obtained. [Individuals with a financial/medical assistance application pending or in a spend-down unmet status may participate];
- If eligible for health insurance coverage, the company must be willing to participate with the contracted dispensing pharmacy for dispensing and billing purposes and only drugs on the ADAP Formulary will be covered. In addition, applicant's insurance company cannot mandate greater than 30 day medication fills;
- If applicant is Medicare Part-D (prescription drug plan) eligible, then provide a clear copy of the front and back of the Medicare Part-D insurance card ; and
- If applicant is Federal Extra Help and Illinois Cares Rx eligible, applicant is required to apply to both programs and approval/denial letters are required to be forwarded to ADAP; as well as clear copy of front/back of ICRx card.

All applicants filing **COMPLETED** forms will be notified by mail regarding their approval status.

Those applications being filed **INCOMPLETE** (i.e., missing CD4 and Viral Load test results [needing to be collected within the past 6 months of application], or failure to verify income, residency, or provide insurance documentation) **will be shredded after 30 business days**. At that time all applicants will need to submit a new **COMPLETE** application.

**Clients approved for ADAP must re-apply biannually/every six (6) months in order to continue receiving services.**

Completed applications are to be **accompanied with proof of (1) most recent CD4 and Viral Load test results, (2) income, and (3) legal residency, and (4) insurance, if applicable and mailed to:**

Illinois Department of Public Health/ADAP  
525 W. Jefferson St.  
Springfield, IL 62761                      Or                      faxed to: **217-785-8013**.

Applications may be obtained online from the Department website: [idph.state.il.us](http://idph.state.il.us), (The A to Z listing).

For questions regarding this program, phone 800-825-3518 or 217-524-5983; TTY 800-547-0466 (hearing impaired only).



**(B). Mailing Address - (Where you want mailings sent to – if same as residency then insert “SAME AS” option) If you choose not to receive mail, you will not be notified of your upcoming reapplication deadline.**

Do you want to receive mail?  Yes  No

Mail Address 1 \_\_\_\_\_ Mail Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**(C). Prescription Address (Where you want your medications mailed from CVS Caremark – if same as residency then insert “SAME AS” option). Only complete this section if you are applying for ADAP.**

Address 1 \_\_\_\_\_ Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**II. HOUSEHOLD MEMBERS: defined as spouse, birth child (0-17 years of age), guardianship, or foster child (If more pages are needed, please use the additional sheets of paper.) This is required for all dependants (including spouse or civil union partner).**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth:   /   /     Relationship: \_\_\_\_\_

Gender (Select One):  Female  Male  Transgender Female to Male  Transgender Male to Female

Race (select all that apply):  Alaskan Native  Asian  Black or African American  Native American  
 Native Hawaiian  Pacific Islander  White  Other

Ethnicity (Select One):  Hispanic  Non-Hispanic

HIV Status:  HIV Negative  HIV+ AIDS Status Unknown  HIV+ Not AIDS  
 CDC Defined AIDS  Unknown

Dependant:  Yes  No Gross Month Income: \$   ,

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth:   /   /     Relationship: \_\_\_\_\_

Gender (Select One):  Female  Male  Transgender Female to Male  Transgender Male to Female

Race (select all that apply):  Alaskan Native  Asian  Black or African American  Native American  
 Native Hawaiian  Pacific Islander  White  Other

Ethnicity (Select One):  Hispanic  Non-Hispanic

HIV Status:  HIV Negative  HIV+ AIDS Status Unknown  HIV+ Not AIDS  
 CDC Defined AIDS  Unknown

Dependant:  Yes  No Gross Month Income: \$   ,

**III. APPLICANT'S INCOME INFORMATION** (below, please enter the GROSS amount received (before taxes and other deductions) each month. Round income to the nearest dollar. **If your total monthly income is less than \$500 you must attach a completed "Continuation of Support Letter".**

<u>Source of Income</u> <i>Complete all that apply</i>	<u>Applicant Monthly</u> <u>Income Amount</u>	<u>Source of Income</u> <i>Complete all that apply</i>	<u>Applicant Monthly</u> <u>Income Amount</u>
Salary/Wages; Self employed	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>	Worker's Compensation	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
Unemployment Compensation	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>	Temporary Assistance for Needy Families	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
Social Security (SSA)	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>	General Assistance	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
Social Security Disability (SSDI)	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>	Veteran's Pension	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
<b>Date Effective:</b> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Retirement	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
Supplemental Social Security (SSI)	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>	Child Support	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
Veteran's Disability	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>	Alimony or Other Spousal Support	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
Private Disability (Short / Long Term)	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>	Other Income	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>

**Documentation of Income (Check all that apply)**

- Paycheck Stubs (minimum of 2)     
  Benefit Statement     
  Award Letter     
  Court Order  
 Federal Tax Return     
  Other (specify): \_\_\_\_\_  
 \*(for self employed clients only does ADAP/CHIC accept federal tax return)

**IV. PHYSICIAN INFORMATION**

**(A). HIV Care Physician – the information of the physician providing your primary care.**

Primary Care Provider (Physician) \_\_\_\_\_  
 Hospital/Clinic \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_ Prescribes your HIV Medicine?  Yes  No

**(B). HIV Prescribing Physician – If your HIV care physician does not prescribe your HIV medicine, please provide the information of the physician prescribing your HIV medication.**

HIV Prescribing Provider \_\_\_\_\_  
 Hospital/Clinic \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**(C). ADAP/CHIC Liaison** – the information of the individual you want ADAP/CHIC to contact on your behalf regarding your ADAP/CHIC application (if applicable).

Liaison Name \_\_\_\_\_

Agency \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_\_\_ ) \_\_\_\_\_

E-mail \_\_\_\_\_

**V. INSURANCE/BENEFIT INFORMATION** - Provide clear copy of Prescription Insurance Card (both sides) (if applicable)

**(A). Prescription Insurance Information** – the information of your private prescription insurance coverage (if applicable).

Do you have private prescription insurance coverage for your drugs?  Yes  No (skip to next section)

Insurance Company Name \_\_\_\_\_

Member ID #: \_\_\_\_\_ Bin # \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**(B). Medicare Information** – the information of your Medicare coverage (if applicable). Check ALL that apply.

Do you have Medicare coverage?  Yes  No

If yes, what parts (select all that apply)?  Part A Only  Part B Only  Part A and B  Part C Only

Do you have Medicare Part D coverage?  Yes  No

**(C). Medicare Part D Information** – If you selected Part D (prescription Plan) in the Medicare section above, you must provide the information of your Medicare Part D plan card and provide clear front and back copy of your Medicare Part Prescription Card.

Insurance Company Name \_\_\_\_\_

Member ID \_\_\_\_\_ Bin # \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**(D). Medicare Supplement** – If you have a Medicare Supplement plan, you must provide the information of your supplemental plan card and a clear copy of the front and back of the insurance card.

Insurance Company Name \_\_\_\_\_

Member ID \_\_\_\_\_ Bin # \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**(G). Illinois Cares Rx – the information of your Illinois Cares Rx coverage (if applicable).**

Do you have prescription coverage through Illinois Cares RX?  Yes  No

Date coverage began:  /  /

**(H). Veteran’s Affairs (VA) – the information of your VA Medical coverage (if applicable).**

Do you have medical coverage through Veteran’s Affairs?  Yes  No

Date coverage began:  /  /

**VI. CLINICAL INFORMATION - Lab** results must not be more than **(6) months old**. Appropriate documentation will need to be provided and may either be mailed to address on 1<sup>st</sup> page/faxed to (217) 785-8013, if being filled out electronically the documentation may be scanned in or image files may be attached to the application.

Current Diagnosis:  HIV+ Not AIDS  CDC Defined AIDS

Initial HIV Diagnosis:  /  /

Initial AIDS Diagnosis:  /  /

Most Recent CD4 Count:

Date of Most Recent Test:  /  /

Most Recent Viral Load:

Date of Most Recent Test:  /  /

Lowest CD4 Count:

Date of Test:  /  /

Highest Viral Load:

Date of Test:  /  /

**Required Documentation List Proof of HIV Status:**

Recent CD4 Labs  Recent Viral Load Labs **OPTIONAL:**  Lowest CD4  Highest Viral Load

Please list all medications the client is currently prescribed that are on the IL AIDS Drug Assistance Formulary:

Medication	Dosage	Formulation (pill, liquid, etc.)

**How did patient contract HIV/AIDS? (check all that apply)**  Blood Transfusion  Hemophilia  Heterosexual Contact

Prenatal Transmission  Men Who Have Sex With Men (MSM)  IV Drug Use  Undetermined  Other

Has the client been diagnosed with Hepatitis B?  Yes  No If yes, when:  /  /

Has the client been diagnosed with Hepatitis C?  Yes  No If yes, when:  /  /

**VII. CLIENT VERIFICATION AND AUTHORIZATION – Your Signature is required below!**

ALL REQUIRED DOCUMENTATION WILL BE SENT VIA:

Fax

Mail

**Required Documentation**

Proof of Residence  Proof of Income  Proof of Assets (if applicable)  Proof of Insurance (if applicable)  Proof of Labs  Proof of Medicare Part D (if applicable)

*Authorization to Release Confidential Information*

As a client enrolled in the AIDS Drug Assistance Program (ADAP) or/and Continuation of Health Insurance Coverage (CHIC) Program, I hereby acknowledge that my information related to my client record is deemed confidential and may only be released upon my written consent.

By signing the paper application below will authorize your confidential information to be shared between the Illinois Department of Public Health – HIV/AIDS Section, Illinois Public Health Association (IPHA), Groupware Technology Inc. (GTI) and/or CVS CareMark Specialty Pharmacy, the department’s contracted representatives, for the purposes outlined below.

**Purposes of Release:**

- 1. To protect your individually identifiable health information transmitted or maintained in any form or medium... oral communications, paper records, and electronic records... (Protecting Health Information Privacy and Complying with Federal HIPAA Regulations, 2004).**
- 2. To verify the begin date and end date of service for your COBRA coverage.**
- 3. To ensure timely premium payments.**
- 4. To obtain information concerning changes with your COBRA and/or Insurance coverage.**
- 5. To determine eligibility to the AIDS Drug Assistance Program (ADAP) and/or Continuation of Health Insurance Coverage (CHIC) Program by obtaining appropriate documentation.**
- 6. To obtain your lab information from organizations housing lab tests and/or results.**
- 7. To ensure that all possible benefits are being maximized by the client.**
- 8. I have provided my e-mail address with the understanding that I may receive discreet correspondence from AIDS Drug Assistance Program (ADAP) and/or Continuation of Health Insurance Coverage (CHIC) Program.**

I recognize that this release is effective for 6 months from the date I sign below; moreover, the agreement of this authorization release of information will assist, more efficiently, in the coordination of ADAP/CHIC Services. 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 I do not have to consent to the release of this information. I also accept that my Social Security Number will be used only for the sole purpose of serving as a unique identifier for the eligibility with the Department’s contracted entities and for the purpose of checking benefit eligibility.

I understand that my doctor may be contacted to complete an HIV/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 understand that if I refuse to sign below to authorize this consent to release information that I could be denied services due to an above mentioned organization ability to provide service due to a lack of information. 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.

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**Applicant Signature (Required)**

**Date**