[X] State

Required Form

Exhibit A - Redacted Client File
Notice of Eligibility

Date **Client's Name**

[redacted]

Client's Address

[redacted]

It has been determined that you comply with the required eligibility requirements to receive allowable services from the Department of Health, Ryan White Program. Allowable services are based on availability, accessibility, funding and program qualifications for the AIDS Drug Assistance Program (ADAP), the ADAP Premium Plus (Insurance), and the state Housing Opportunities for Persons with AIDS (HOPWA) specialty programs.

Your eligibility status for receiving allowable services from the HIV/AIDS Patient Care Programs is valid for 6 months from the date of this correspondence. You must have a new determination for eligibility no later than the expiration date provided below in order to continues services. You must advise the originating eligibility staff when there are changes which affect your eligibility status.

Re-Determination Date Due No Later Than:

05/31/2017

Household Size: [redacted]

Other Programs (list all that apply)

Additional Comments

Your signature below acknowledges your understanding of the following:

- I have received a copy and verbal explanation of this notice.
- I understand the requirements for receiving HIV/AIDS services.
- I verify that I have complied with all of the Rights and Responsibilities in the application verified by my signature on the application.

Client's Signature

Date

Eligibility Staff Signature

Date

Eligibility Staff Name

Phone:

[redacted]

Eligibility Staff Address

[redacted]

Keep this notice of eligibility in a safe place. Bring this notice along with photo identification when meeting with an ADAP, ADAP Premium Plus, HOPWA or case management representative about services.

Florida AIDS Drug Assistance Program
Notice of Program Enrollment

Client Name: [redacted]

You are qualified for and have been enrolled in the AIDS Drug Assistance Program **Your enrollment is valid for six (6) months and will expire on 05/31/2017**. You must schedule an appointment to re-enroll on or before this day to avoid an interruption in service.

As an ADAP Client, you are expected to:

- Appear for scheduled appointments
- Pick up medications within five days of the scheduled pick-up date.
- Provide requested information within specified time frames
- Report changes to your status
- Treat staff with courtesy and respect.

Please be sure to bring copies of the following to your re-enrollment appointment on

_____:

___ Patient Care Core Eligibility Letter
___ Current CD4+ (less 1 year old) and Viral Load lab results(less than 6 months old)
___ Proof of Insurance or Insurance Documentation
___ Current Prescription(s)
___ Other (Specify below)

_____

_____

By signing below, I verify that:

- I have given complete, accurate, and truthful information for the purposes of qualification and participation in the program.
- I do not have access to private insurance, Medicaid, or other source of payment for medications.
- I have reported any upcoming open enrollment periods or will notify the program if I become eligible for private insurance through my employer.
- I understand that if any of the information I have provided is false, incomplete, or inaccurate, I may forfeit the right to receive ADAP services and may be responsible for repaying the costs of the medications I was provided.

Client Name: [redacted]

Client Signature: _____ **ADAP Staff:** _____

Original to file copy to client

☑ State

Notice of Eligibility

Required Form

Date [redacted]

Client's Name [redacted]

Client's Address [redacted]

It has been determined that you comply with the required eligibility requirements to receive allowable services from the Department of Health, Ryan White Program. Allowable services are based on availability, accessibility, funding and program qualifications for the AIDS Drug Assistance Program (ADAP), the ADAP Premium Plus (insurance), and the state Housing Opportunities for Persons with AIDS (HOPWA) specialty programs.

Your eligibility status for receiving allowable services from the HIV/AIDS Patient Care Programs is valid for 6 months from the date of this correspondence. You must have a new determination for eligibility no later than the expiration date provided below in order to continue services. You must advise the originating eligibility staff when there are changes which affect your eligibility status.

Household Size [redacted]

Other Programs (list all that apply)

Additional Comments

Re-determination Date Due No Later Than

5/10/2017

Your signature below acknowledges your understanding of the following:

- I have received a copy and verbal explanation of this notice.
- I understand the requirements for receiving HIV/AIDS services.
- I verify that I have complied with all of the Rights and Responsibilities in the Application as verified by my signature on the application.

[redacted]

Keep this notice of eligibility in a safe place. Bring this notice along with photo identification when meeting with an ADAP, ADAP Premium Plus, HOPWA, or case management representative about services.

DH8000-PHSPM-08/2014, Rule 64D-4.007(1)(a), F.A.C.

Prescription Authorization Form

Pt. # 15

[redacted]

[redacted]

[redacted]

9051
64963

Rick Scott
Governor

FLORIDA DEPARTMENT OF HEALTH

John H. Armstrong, M.D.
State Surgeon General

AIDS Drug Assistance Program Pharmacy: **MDCHD**

Notice of Program Enrollment

Client [redacted]

You have are qualified for and have been enrolled in the AIDS Drug Assistance Program.
Your enrollment is valid for 6 months and will expire on: **5/9/2017** You must schedule an appointment to re-enroll on or before this day to avoid an interruption in service.

As an ADAP Client, you are expected to:

* Appear for scheduled appointments
* Pick up medications within five days of the scheduled pick-up date.
* Provide requested information within specified time frames
* Report changes to your status
* Treat staff with courtesy and respect

Please be sure to bring copies of the following to your re-enrollment appointment

____ Patient Care Core Eligibility Letter
____ Current CD4+ and Viral Load lab results (less than 6 month old)
____ Proof of Insurance or Insurance Documentation.
____ Current Prescription(s)
____ Other (Specify below)

_____

By signing below, I verify that:

* I verify that I have given complete, accurate, and truthful information for the purposes of qualification and participation in the program.
* I do not have access to private insurance, Medicaid, or other source of payment for medications.
* I have reported any upcoming open enrollment periods, or will notify the program if I become eligible for private insurance through my employer
* I understand that if any of the information I have provided is false, incomplete, or inaccurate, I may forfeit the right to receive ADAP services and may be responsible for repaying the costs of the medications I was provided.

[redacted]

Miami-Dade County Health Department
8600 NW 17th St., Ste. 200, Miami, FL 33126
Tel: (305)470-6999 Fax: (305)470-5752
Website: www.dadehealth.org

Public Health
Prevent. Promote. Protect.
Miami-Dade County Health Department

☑ State

Six Month Recertification Review Form

Required Form

To be completed by Eligibility staff to document applicant's re-determination

[redacted]

Please indicate any changes that have occurred and attach appropriate documentation:

	Change	No Change
Living in Florida	☐	☑
Participating in Other Social Service Programs	☐	☑
Income	☐	☑

The client has provided updated documentation for any items marked "change" and/or updated income information where necessary. ** All employment income must be verified every six months.

Fill in the following information based on the re-determination.

[redacted]

[redacted] all that apply)

Florida HEALTH

INITIATION OF SERVICES

PART 1 CONSENT FOR CARE, TREATMENT AND INFORMATION DISCLOSURE (TREATMENT, PAYMENT OR OPERATIONS)

[redacted]

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representative to render routine health care.

I understand routine health care is confidential and voluntary and may involve medical office visitsincluding obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue the relationship at any time.

PART II DISCLOSURE OF INFORMATION CONSE (treatment, payment, or healthcare operations purposes only)

I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations.

PART II MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELAEASE, AND PAYMENT REQUE (Only applies to Medicare Clients)

As Client /Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefitsbe made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART I ASSIGNMENT OF BENEFI (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART V MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

[redacted]

Florida HEALTH

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATON

[redacted]

EXPIRATION DATE: This authorization will expire (insert date or event) _____ I understand that if I fail to specify an expiration date or event, this authoriztion will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization; I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

[redacted]

Rick Scott
Governor

FLORIDA DEPARTMENT OF HEALTH

John H. Armstrong, M.D.
State Surgeon General

HIV/AIDS DRUG ASSISTANCE PROGRAM

There are limited funds to purchase medication for the AIDS Drug Assistance Program. Enrollment in the program and acceptance of medication through this program or its offer from the Department of Health, does not obligate the Department of Health to continue to supply medication indefinitely.

There is a possibility that the current funds to purchase medications for distribution will be exhausted, and that you may have to pursue other methods of supply at that time. Medication(s) through this program are supplied as a benefit, and not as a right or entitlement.

Medication through this program is provided for personal use, and it is illegal to sell, trade, barter or in any other way exchange this prescription medication with any other person. Such activity is grounds for criminal prosecution.

The information supplied by you to apply for this program must be truthful, to the best of your knowledge. The information supplied may be verified, and any untruthful or knowingly misleading statements may be cause for disqualification from the program.

Medication provided through the AIDS Drug Assistance Program may have dangerous side effects, and your physician should explain to you all possible side effects.

Should you become eligible for treatment under a different program, you will notify the local AIDS Drug Assistance Program manager or pharmacist so that you may continue to receive treatment under a different source of payment and allow another person access to AIDS Drug Assistance Program funding.

[redacted]

DH 2058 4/97 (Obsoletes previous editions which may not be used)
Stock Number 5744-000-2058-0

Original-Client Record
Copy-Client

FLORIDA DEPARTMENT OF HEALTH

CLIENT CONSENT TO FAX CONFIDENTIAL INFORMATION

Rick Scott
Governor

John H. Armstrong, M.D.
State Surgeon General

Florida law requires that information contained in medical records be held in strict confidence and not be released without your written authorization. You must give specific written authorization to release certain types of sensitive medical information. The Florida Department of Health may fax confidentital medical information to a provider or receive faxed information that was requested from a provider with your permission. Faxing such information is voluntary. You will not be denied services based on a refusal to allow your confidential information to be faxed.

Steps will be taken to make sure your information arrives safely, but faxes can be misdirected.

[redacted]

Rick Scott
Governor

FLORIDA DEPARTMENT OF HEALTH

John H. Armstrong, M.D.
State Surgeon General

HIV/AIDS DRUG ASSISTANCE PROGRAM

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[redacted]

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FLORIDA DEPARTMENT OF HEALTH

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Steps will be taken to make sure your information arrives safely, but faxes can be misdirected.

[redacted]

FLORIDA DEPARTMENT OF HEALTH

Patient Statement of Understanding
Medication Regimen

_____ I must take my medicine every day as my doctor has told me to take it. If I don't, my medicines may not work to keep me healthy.

_____ If I am taking Abacavir, or Epzicom, or Trizivir, I may not stop taking it without my doctor's apporval. If I stop taking it, even for one day, and then start again, I risk having a very bad allergic reaction that can cause serious injury or even death.

_____ I must pick up my medicine every month from the Health Department before I run out of medicine. Every time I miss a dose, it increases the risk my treatment will stop working.

_____ I understand the importance of not stopping my medication. If I am late picking up my medication, the AIDS Drug Assistance Program may contact my health care provider.

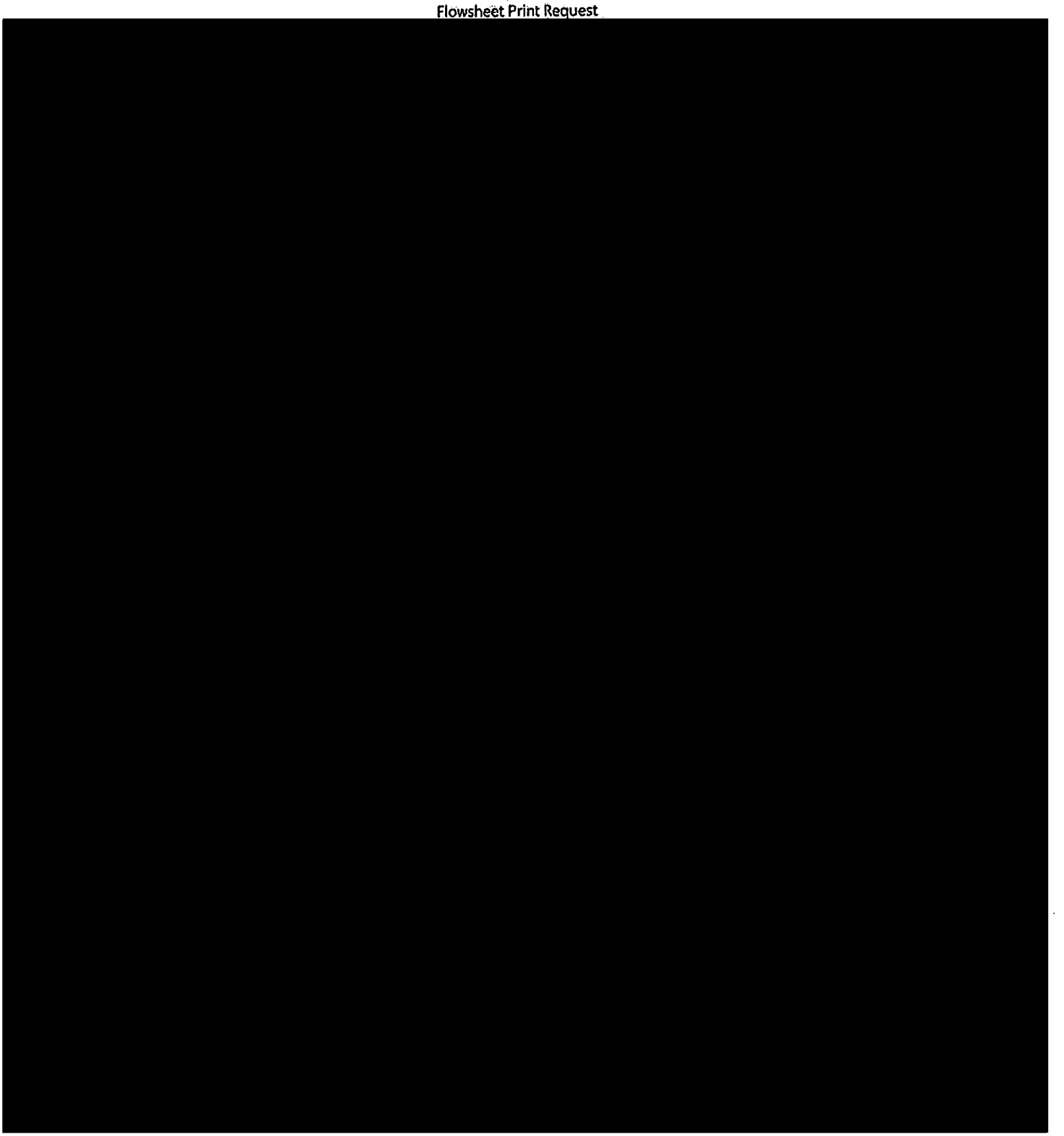
_____ If I do not pick up my medication for a month or longer, I will need to see my health care provider before I can get any new medication.

_____ If I do not pick up my medications for two or more months, the AIDS Drug Assistance Program will stop providing services to me. I will need to provide new labs, prescriptions, and/or my health care provider's written approval to begin receiving medications again.

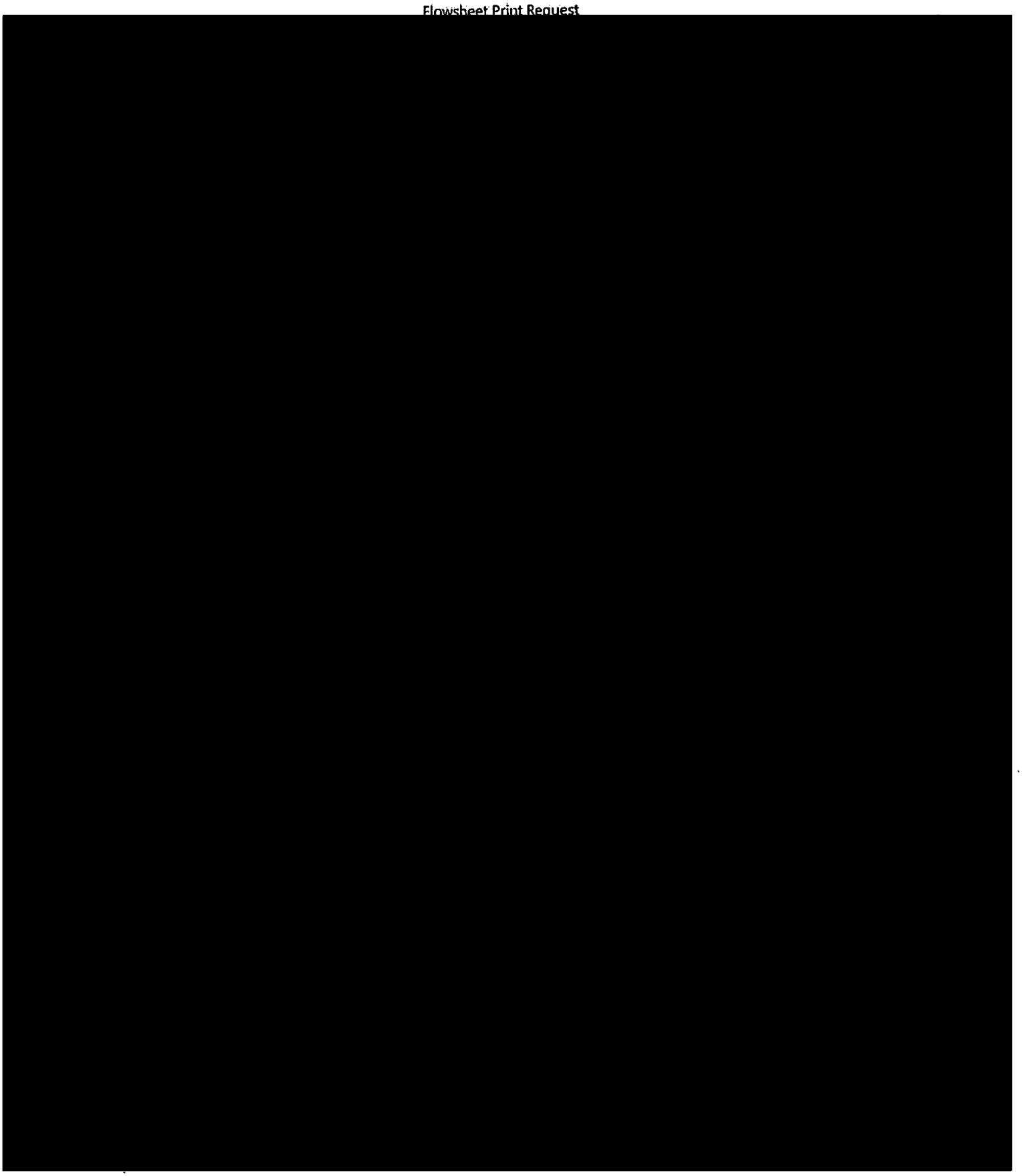
_____ If I regularly have problems picking up my medications on time or taking them as I have been told, I may have to meet with my health care provider and the health department about my treatment.

_____ If I am confused or need help with my medications, I should contact my health care provider. If I am confused about when I need to pick up my medications, I should contact the Health Department.

[redacted]



Flowsheet Print Request



Florida ADAP
AIDS Drug Assistance Program

Prescription Dispensing Authorization

[redacted]

Pharmacy Comments:

ADAP Authorization: _____ **Date:** _____

Pharmacist: _____ **Date:** _____

Client: _____ **Date:** _____

By signing above, I agree that I have picked up all the drugs listed above unless otherwise noted.

Please do not dispense medications after the PDA expiration date.

BO1604230569916 0511 JMH JACKSON MEMORIAL
Prevention, Education and Treatmen
615 Collins Avenue
Miami Beach, FL 33139

[redacted]