SC ADAP DIRECT DISPENSING RECERTIFICATION

D H E C
PROMOTE PROTECT PROSPER

Return to:
SC Drug Assistance Program/
Direct Dispensing
3rd Floor, Mills Jarrett
Box 101106, Columbia, SC 29211
PH: (803) 898-0367 or (800) 856-9954
FAX: (803) 898-0475

FOR ADAP USE ONLY - DO NOT WRITE IN THIS SPACE
Date Received: _____ Status/Date: _____
Final Status/Date: _____
Completed by: _____

Instructions: This form is to recertify for the Direct Dispensing Program.

I. PATIENT INFORMATION

Last Name: _____ First Name: _____ Full Middle Name: _____

Date of Birth: _____ /_____ /_____ Social Security #: _____ -_____ -_____ Gender: _____

Street Address 1:_____ Street Address 2: _____

City: _____ State: _____ Zip: _____ County: _____

Mailing Address:_____ City: _____ Zip: _____

Home Phone (_____) _____ Other Phone (_____) _____

Ethnicity (check one): ☐ Hispanic/Latino (a) ☐ Non-Hispanic/Latino (a)

Race (check all that apply): ☐ Asian ☐ American Indian or Alaskan Native ☐ Black ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Unknown ☐ Other_____

II. ELIGIBILITY INFORMATION *(Please attach a separate page for income if more pages are needed for additional household members)*

Applicant and Other Members in Household	Relationship to Applicant	Gender	Date of Birth	Place of Employment or Source of Other Income	Estimated **Yearly** Gross Income
Applicant					

Current Physician: _____ **Current Case Manager:** _____

III. BENEFITS INFORMATION *(To be completed by the Case Manager, Nurse, or Physician)*

Does the client have Medicaid coverage? ☐ Yes ☐ No Medicaid application pending? ☐ Yes ☐ No

Does the client have Medicare Part D coverage? ☐ Yes ☐ No Medicare Part D application pending? ☐ Yes ☐ No

Does client have Insurance Coverage for Prescriptions? ☐ Yes ☐ No

IV. CLINICAL INFORMATION *(To be completed by the Physician)*

The ***most recent*** CD4 (T4) lymphocyte count was _____ on _____/_____/_____ (date drawn)

The ***most recent*** viral load result was _____ on _____/_____/_____ (date drawn) ☐ Pretreatment? ☐ On therapy?

V. CERTIFICATION/CONSENT

I certify that the information provided in this application is true and correct to the best of my knowledge. I give permission to ADAP to verify this information, either through written documentation or electronic files. I agree to notify ADAP of any changes to my income or Medicaid/insurance status within 30 days. I will inform ADAP if my address changes or if I choose not to participate in the program. I understand that refusal to use third party resources and/or other requirements are reasons for closure to further program sponsorship. I also understand the importance of taking medications as prescribed and that failure to do so may result in my being automatically dropped from the program after 90 days. By my signature, I authorize the release of information pertaining to my participation in ADAP to other pharmaceutical companies or pharmacies, as needed. I further authorize the release of information pertaining to my participation in ADAP for the purpose of payment and to the organization(s) associated with the referring physician, referring case manager, and/or case manager if not the referring case manager. By my signature below as parent, guardian or client, I request that payment of Medicare/Medicaid or other third party insurance benefits be made on my behalf to the South Carolina Department of Health and Environmental Control for any services, including STD and/or HIV, provided to me. Permission is also granted to DHEC to exchange the medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents or other agents needed to determine these benefits for related services. If applicable, I certify that information provided regarding the number of household members, family income and insurance benefits is true and correct to the best of my knowledge.

_____ _____
Applicant's Signature Date

_____ _____ _____ _____
Referring Physician or Case Manager (Print Name) Signature Date Organization (Please Print)

_____ _____ _____ _____
Case Manager if NOT the Referring Case Manager (Print Name) Signature Date Organization (Please Print)

SC ADAP DIRECT DISPENSING PROGRAM (DDP) RECERTIFICATION
Instructions- DHEC 1541

Purpose: This form will be used to provide relevant information to recertify clients for the SC ADAP Direct Dispensing Program (DDP).

Important:
This form must be completed and signed by the applicant AND the applicant's case manager. All supporting documentation (including income documentation) must be submitted with the form.

Instructions:
I. Patient information
Name: Enter the client's last, first, and full middle name.
Date of Birth: Enter the month, day, and year of the client's birth.
Social Security Number: Enter the client's social security number. Contact the SC ADAP staff if the client does not have a social security number.
Gender: Enter the client's gender (Male, Female, or Transgender)
Home Address: Enter the street address where client lives. Do not enter a PO Box.
County: Enter the county name where the client lives.
Mailing Address: If different from the street address, enter the address (Street or PO Box #) where the client wants to receive medications and other correspondence. *NOTE:* You must notify SC ADAP immediately if there is a change in the mailing address.
Telephone: Enter the area code and telephone number where the applicant can be reached. Please list both home and work numbers, if possible.
NOTE: You must notify SC ADAP immediately if there is a change in the telephone number.

II. Eligibility Information
Financial Data: List the following in the table:
Place of employment, estimated yearly income of the applicant.
Other members of the household, relationship to the applicant, gender, date of birth, place of employment or source of income.
Write "unemployed" if not working - do not write N/A, do not leave blank and do not draw a line through the space.
Proof of income is required for the applicant and for each member of the household listed in the application.
NOTE: The Eligibility Information section is important and must be completed or the form will be returned. Please enter all of the information including a complete list of the household dependents and their individual income documentation (this may be useful in determining if the applicant still qualifies for the program).
Current Physician/Current Case Manager: Enter the name(s) of the client's physician or case manager

III. Benefits Information
Medicaid coverage: Check the appropriate box if the client has Medicaid coverage.
Medicaid application pending: Check the appropriate box if the client Medicaid application is pending.
Medicare Part D coverage: Check the appropriate box if the client has Medicare Part D coverage.
Medicare Part D application pending: Check the appropriate box if the client has an application pending for Medicare Part D coverage.
Insurance coverage: Check the appropriate box if the client has private or commercial insurance that covers prescription drugs

IV. Clinical Information *(This section should be completed by the physician)*
CD4 count: Enter the most recent CD4 count and the date the blood was drawn.
Viral load: Enter the most recent Viral Load information and the date the blood was drawn.

V. Certification and Consent
Consent: This section is mandatory. The applicant must read and understand the conditions for acceptance into the program and sign on the line *"Applicant's Signature"* and date the application.

Referring physician or case manager: The referring physician or case manager must sign and date this section. The organization name must be printed clearly. *The referring case manager is typically the applicant's nurse or social worker who actively monitors the patient's clinical progress and treatment adherence.*
Case manager if not the referring case manager: This section is to be completed if the applicant has a case manager who different from the referring case manager. The case manager should sign and date this section. The organization name must be printed clearly. *This case manager is usually a nurse or social worker who assists the patient with completing the application. In some instances, the application will be forwarded to another nurse or social worker who actively monitors the patient's clinical progress and treatment adherence.*

Completed recertification forms must be mailed / faxed to:
SC Drug Assistance Program
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