Washington State Department of Health

DOH 150-053 - May 2022

WASHINGTON STATE PRE-EXPOSURE PROPHYLAXIS DRUG ASSISTANCE PROGRAM (PREP DAP)

PrEP DAP Client ID:

Mailing Address: PrEP DAP PO Box 47840, Olympia, WA 98504
Phone: 360.236.3412 | Fax: 360.664.2216 | Email: PrEPDAP@doh.wa.gov

APPLICANT INFORMATION

Legal First & Last Name	M.I.	Social Security Number

Date of Birth (mm/dd/yyyy)	Current Gender Identity
	☐ Male ☐ Female ☐ Transgender – Male to Female ☐ Transgender – Female to Male ☐ Non-binary/Genderqueer ☐ Other _____

Preferred Name	Sex Assigned at Birth	Preferred Written Communications
	☐ Male ☐ Female	☐ English ☐ Spanish

Ethnicity

- ☐ Non-Hispanic
- ☐ Hispanic/Latino:
  - ☐ Mexican, Mexican American, Chicano
  - ☐ Puerto Rican
  - ☐ Cuban
  - ☐ Other Hispanic/Latino or Spanish origin

Race (Select all that apply)

- ☐ White
- ☐ Black or African American
- ☐ American Indian/Alaska Native
- ☐ Asian
  - ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean
- ☐ Vietnamese ☐ Other
- ☐ Native Hawaiian/Pacific Islander
  - ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

RESIDENTIAL ADDRESS (Provide a physical address - Not a PO Box)

Street Address	Apt / Lot / Floor

City	State	ZIP Code	County

MAILING ADDRESS

Is your mailing address the same as your residence? ☐ Yes ☐ No

Is it okay to send mail? ☐ Yes ☐ No
If **no**, provide an email address below.

Street Address (Only required if different from your residential address)	Apt / Lot / Floor

City	State	Zip Code	County

CONTACT INFORMATION

Okay to send email	Okay to leave voice mail	Okay to send text message
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Email Address	Phone Number

Washington State Department of Health

DOH 150-053 - May 2022

WASHINGTON STATE PRE-EXPOSURE PROPHYLAXIS DRUG ASSISTANCE PROGRAM (PREP DAP)

APPLICATION ASSISTANT (This is not your Prevention Navigator – see Prevention Navigator section below)

If someone helped you apply for PrEP DAP, do you want us to notify them of the application status? ☐ Yes ☐ No

First & Last Name	Email Address

PrEP PRESCRIBER (Please tell us who your healthcare provider is that prescribes you PrEP)

First & Last Name	Clinic Name
Have you seen your provider or had labs done in the last 90 days? ☐ Yes ☐ No	If **yes**, please provide the month and year for us to adjust your eligibility begin date to cover costs ____ /_____

PREVENTION NAVIGATOR

(This person can assist you with access to HIV prevention programs and other resources in your area)

Do you have a Prevention Navigator you are working with? ☐ Yes ☐ No If Yes, enter their information below:

First & Last Name	Agency	Email Address

HEALTH INSURANCE INFORMATION

Do you have health insurance? ☐ Yes ☐ No If **yes**, select plan type and enter the information below:

Type of Coverage

Insurance: ☐ Employer ☐ Qualified Health Plan ☐ Individual

Medicare: ☐ Medicare Part A only ☐ Medicare Part A & B ☐ Medicare Part C (MAPD) ☐ Medicare Part D (PDP)

Insurance Company Name	Policy / Plan Name	Effective Date

INCOME (Please tell us your current income below)

Income: $

Is the amount you entered Monthly or Annual Income?
☐ Monthly ☐ Annual

AUTHORIZED REPRESENTATIVE

(Please provide the following information for any person you would like us to talk to about your PrEP DAP coverage)

First & Last Name		
Date of Birth (mm/dd/yyyy)	**Phone Number**	**Email Address**

Washington State Department of Health

DOH 150-053 - May 2022

WASHINGTON STATE PRE-EXPOSURE PROPHYLAXIS DRUG ASSISTANCE PROGRAM (PREP DAP)

RISK FACTORS	
Please be sure to answer each question completely	
Have you ever had sex with a man?	☐ Yes ☐ No
In the last 12 months has a doctor, nurse or other health care provider told you that you had chlamydia, gonorrhea or syphilis?	☐ Yes ☐ No
If **yes**, tell us which one(s): ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis	
In the last 12 months have you used methamphetamines (crystal, tina, crank, ice)?	☐ Yes ☐ No
In the last 12 months have you used poppers (alkyl or amyl nitrates)?	☐ Yes ☐ No
In the last 12 months, did you have sex without using a condom with anyone you did not consider to be a main/primarypartner?	☐ Yes ☐ No
Are you in an ongoing sexual relationship with a partner who you know to be living with HIV?	☐ Yes ☐ No
If **yes**, is your partner on HIV medications?	☐ Yes ☐ No
If **yes**, are you or your partner trying to get pregnant?	☐ Yes ☐ No
In the last 12 months, have you injected or shot up any drugs not prescribed for you by a health careprovider?	☐ Yes ☐ No

Washington State Department of Health

DOH 150-053 - May 2022

WASHINGTON STATE PRE-EXPOSURE PROPHYLAXIS DRUG ASSISTANCE PROGRAM (PREP DAP)

AGREEMENT & RELEASE OF INFORMATION

Department of Health coordinates with the following agencies to verify eligibility for all applicable services, as well as treatment and care coordination with other programs related to PrEP DAP. They all adhere to the same confidentiality requirements:

- Contracted Pharmacy Benefits Manager/Ramsell Corporation
- WA State Department of Social and Health Services (Medicaid Verification)
- WA State Health Care Authority (Apple Health)
- All PrEP DAP contracted Providers
- System Software Vendor

I have the right to: Be treated with respect, consideration, and honesty. Receive PrEP DAP services without discrimination based on race, color, sex/gender, ethnicity, national origin, religion, age, class, or sexual orientation, as well as physical or mental ability. Have my records be treated as confidential. File an appeal about eligibility and coverage decisions.

I have the responsibility to: Treat the Department of Health staff and contracted service partners with respect, consideration, and honesty. Give correct, current, and complete information. Respond to the Programs request(s) for information. Adhere to medically recommended testing and treatment, including all activities recommended in current PrEP standards of practice. Notify the Program, or have my Prevention Navigator notify the Program, of any changes that affect my eligibility within 20 days. These changes include but are not limited to address or health insurance coverage.

I understand that: The information requested on this application is for the purpose of determining my eligibility for state funded services. The funding is limited and may expire at any time without extended or alternate funds being available. The Program will use other state and federal data systems as well as other information to verify the information I give them. Upon approval, my eligibility will expire after one year. Before the conclusion of that one year, I will be required to reapply and provide updated eligibility information to continue receiving services. If I am considered eligible for services, my information may be utilized by our contractual partners to provide Program services.

By signing this document, I agree that I have read this application, certify that the information in this application is true and accurate to the best of my knowledge, and understand the following:

Release of Information: I give my permission for the program to share information from this application and from subsequent documentation obtained by the Program with contracted partners, Prevention Navigators, and the family/friends I listed in the Authorized Representative section of this application. I give this permission for one year and 60 days from the date I sign this authorization.

_____ _____ /_____ /_____

Applicant or Legal Guardian Signature **Today's Date (mm/dd/yyyy)**