BREVARD COUNTY ADAP REFERRAL and ENROLLMENT VERIFICATION FORM

FAX TO: 321-690-3286

Please include this form with client referral/NOE to expedite ADAP enrollment.

REFERRAL TO ADAP DATE: ____/____/_____

HIV Case Manager: _____

FAX #: _____

Required for assisting ADAP, Brevard in pulling information and documentation from CAREWare.

Client Name: _____
(*exactly as entered in CAREWare*)

Birth Date: ____/____/_____ **Current Gender:** (*circle*) M F T **Birth Gender**: (*circle*) M F

Telephone Number(s): _____ _____

Preferred Language: (please check) __English __Spanish __Other _____

HIV Diagnosis Date: ____/____/_____

For ADAP Staff Completion

ADAP QUALIFIED
Individual Qualified for ADAP Program Enrollment Date: ____/_____/_____

ADAP NON-QUALIFIED
Individual is not qualified for ADAP Program Enrollment Date: ____/_____/_____

Based on the information provided, the above individual is not eligible for ADAP dispense enrollment. This individual is non-qualified because of the following.

___Individual has a private individual insurance policy that covers medications.
Individual insurance in non-Marketplace coverage that individuals purchase for themselves or Marketplace plan not ADAP supported. Individual plans are those plans that are NOT sponsored by an employer or the government.
___ Individual has a Medicare Prescription Plan and is below 150% of FPL. *Proof of denial for LIS or partial LIS needs to be presented to ADAP for further review of eligibility.*
___ Individual is not the sole beneficiary of currently held health insurance policy. *Other beneficiary is not ADAP enrolled/qualified*
___ Other reason: _____

Reapplication for ADAP is encouraged if there are any changes to this status.
Please be advised that all information provided will be verified for accuracy.