AIDS Drug Assistance Program (ADAP)
Consent Form

Consent to Participate and Consent to Release Personal and Medical Information

The AIDS Drug Assistance Program (ADAP) is a subsidy program administered by the California Department of Public Health (CDPH) to provide prescription drug treatments and other health services to persons infected with human immunodeficiency virus (HIV). ADAP includes prescription drug assistance and insurance assistance programs. Individuals applying for ADAP services must meet eligibility standards. Services are only available to persons who reside in California, are uninsured or underinsured, are not fully covered by Medi-Cal and have a modified adjusted gross income up to 500 percent of federal poverty level, based on family size and household income. To verify eligibility for this program, CDPH or its agents may be required to obtain personal information from other agencies or health care providers. If you decide to enroll in ADAP, the enrolling agency will collect personal information including your name, date of birth, address, social security number, medical history (including viral load and CD4 count records), and financial eligibility for the program. The information will be considered confidential, but may be exchanged with health care providers, CDPH staff, ADAP enrollment workers, the Department of Health Care Services (DHCS), Franchise Tax Board (FTB), Covered California, CDPH contractors associated with the administration of the program, Ryan White-funded programs for coordinating client eligibility, the ADAP and Care Evaluation and Informatics Branch of CDPH, and other governmental or public agencies as necessary for the limited purposes of administering the program and determining program eligibility. Information that you provide for your ADAP application may also be made available to your local health department for statistical and research purposes. This information includes, but is not limited to, gender, ethnicity, zip code, diagnosis status, and date of birth. This information may also be used for research and professional writings under strict assurances that all identifying information including, name and social security number, is deleted. Any professional or research reports that may be published will not use your name nor any personal identifying information. Confidentiality agreements are in place which keep client information confidential except with specific client consent or as otherwise allowed by law.

For those specifically enrolled in, or applying for, the insurance assistance programs within ADAP, which provides health insurance premium payment and medical out-of-pocket cost payment assistance to eligible ADAP clients, CDPH or its agents may also be required to obtain and exchange personal and medical information, as described in the above paragraph, with health insurance plans, Consolidated Omnibus Budget Reconciliation Act (COBRA) administrators, employers and employer administered health insurance plans as necessary to determine your eligibility and for the purpose of administering the program.

I understand and agree that ADAP is the payer of last resort. If it is determined that services or items I obtained from ADAP should have been paid by other Federal, State, or private entities, I understand and agree that ADAP and its agents may disclose protected health information to these other entities for the purpose of obtaining reimbursement. This process may create an explanation of benefits that could be sent to a primary policyholder who may not be the ADAP client.

I, _____, consent to release of personal and medical information to the applicable entities and for the purposes described above, as necessary for all of the ADAP program(s) for which I am enrolled in, or applying for services. I also consent for ADAP to obtain my viral load and CD4 count records from the ADAP and Care Evaluation and Informatics Branch of CDPH to determine and maintain my eligibility and facilitate access to ADAP services.

This consent shall remain in effect for two (2) years from the date of my signature below. A photocopy of this consent shall be considered as valid as the original.

Applicant's Name (print)	Applicant's Signature	Date