AIDS Drug Assistance Program (ADAP)
Temporary Access Period (TAP) Request Form

INSTRUCTIONS

This form is used to request a Temporary Access Period (TAP) for new ADAP applicants or existing ADAP clients who are unable to provide documentation to substantiate ADAP eligibility**. An approved TAP grants the applicant 30-days of temporary ADAP eligibility to obtain and submit required documentation** to a certified ADAP enrollment worker. All sections of this form must be completed and the completed form must be attached to the applicant's electronic application within the ADAP Enrollment System (AES).

APPLICANT INFORMATION

Full Name: _____

Date of Birth: _____ Client ID Number: _____

MISSING INFORMATION

Select all that apply:

- ☐ Proof of Identification—I will provide my ADAP enrollment worker with photo identification.
- ☐ Proof of California Residency—I will provide my ADAP enrollment worker with proof that I am a California resident.
- ☐ Proof of Diagnosis—I provided a positive rapid HIV test result and will provide confirming HIV lab result.
- ☐ Proof of Income—I will provide my ADAP enrollment worker with proof of my household income.
- ☐ Proof applied for Medi-Cal and/or proof of Medi-Cal determination—I will apply for Medi-Cal, or I have applied for Medi-Cal but my determination is pending. I will provide my ADAP enrollment worker with proof that I applied to Medi-Cal and/or documentation showing my Medi-Cal eligibility determination.

CERTIFICATION

Applicant complete this section:

By signing below, I hereby certify that the above information is factual, accurate, and complete. I understand that I have a 30-day Temporary Access Period in which to obtain and submit the necessary documentation indicated above to substantiate that I qualify for ADAP, and that my ADAP eligibility will not extend beyond 30 days if I fail to obtain and submit the required eligibility documentation before the Temporary Access Period expires. I also understand that ADAP may request that I provide additional documentation if the documentation I submit appears to be inconsistent, inaccurate or insufficient. I agree to promptly notify ADAP of any changes to my eligibility information, including changes to my residency, income, and/or health coverage. I understand that failure to provide accurate information or deliberately omitting information may result in suspension or termination of ADAP services and I may be held financially liable for any services obtained.

Applicant's Signature: _____ Date: _____

ADAP-Approved Designated Agent (if applicable): _____ _____

(Print Full Name) (Signature)

CERTIFICATION CONTINUED

Enrollment Worker complete this section if enrolling a client over the phone:
By signing below, I hereby certify that I screened the client for eligibility over the phone and am placing the client on a TAP.

Enrollment Worker's Name:_____ Date: _____

Enrollment Worker's ID: _____ Enrollment Worker's Signature: _____