PrEP Assistance Program (PrEP-AP)
Request for Services – Minors

Required Documents

- Proof of identification or submission of a signed and completed CDPH 8745 – Request for Services – Minors Form
- Copy of lab results dated within six months from today

Rights and Responsibilities

1. I understand that every reasonable measure will be taken to protect my confidentiality.
2. I understand that I will receive an electronic ID card that is for identification purposes only and does not verify eligibility. I understand that I may need to present this card on my mobile device to some providers to obtain benefits. If I do not have a mobile device, my enrollment worker will print paper cards for me.
3. I understand that if I am 13 or older I will receive confidential notifications regarding updates or changes to my eligibility through an electronic client portal that can be accessed on any mobile device or computer. I understand that I am responsible for safeguarding my log in information so that no one else will be able to access information on my client portal. If I am 12 years old, or do not have a mobile device or computer, I understand that I am responsible for checking in with my enrollment worker before the re-enrollment due date listed below.
4. I understand that my eligibility is good for one year from the date my completed application is approved. If I would like to continue receiving the assistance requested after my eligibility expires, I must re-enroll.
5. I understand that if I am being enrolled for the first time without lab results, I will only be granted 30 days of temporary eligibility and that I must provide my enrollment worker with the required lab results within 30 days, or my eligibility will end.
6. I understand that I will be required to provide updated lab results dated within six months of my application when I re-enroll into the program.
7. I understand that, when I turn 18 years old, I must meet additional program requirements in order to re-enroll into the program.
8. I understand that I must be a California resident to remain eligible for the program.
9. I understand that I must tell my enrollment worker if I move or change my phone number.

Applicant Information

Date:_____ Re-Enrollment Due On: _____ Date of Birth: _____

Client ID Number (optional): _____ Name: _____

Email Address: _____

_____ _____

Enrollment Site Number Enrollment Site Name

Applicant Consent

Applicants complete this section:

CDPH contracts with enrollment agencies, clinical providers, and other entities (collectively, "agents") to help administer PrEP-AP. By signing this form, you are authorizing CDPH and its agents to obtain information about you from other state and federal agencies or your health care provider(s) in order to verify your eligibility for PrEP-AP. You are also authorizing the enrollment agencies to collect information from you in order to enroll you in PrEP-AP.

The information you are authorizing CDPH and its agents to obtain includes your name, date of birth, Social Security Number, income, demographic data, HIV test results, diagnosis and other medical information, and health benefits information.

Only authorized personnel at CDPH's agents will have access to your information, and only on a need-to-know basis, as required under California law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Confidentiality agreements are in place which keep client information confidential except with specific client authorization or as otherwise permitted by law. Information disclosed may be subject to re-disclosure and is no longer protected if it is disclosed to anyone other than a covered entity.

By signing this form, you are authorizing CDPH and its agents involved in administration of PrEP-AP to collect and use your information and you are consenting to their disclosure of information about you for the following purposes:

- To and from each other to verify program eligibility and for coordination of care and benefits, program monitoring and evaluation, and other purposes directly connected with administration of PrEP-AP.
- To and from each other to comply with state and federal reporting requirements.
- To and from the Department of Health Care Services, the Franchise Tax Board, Covered California, the Centers for Medicare and Medicaid Services, and other federal and state agencies as necessary to verify program eligibility and other purposes directly connected with administration of PrEP-AP.
- To and from your health care provider(s) to coordinate medication billing coverage and other purposes directly connected with administration of PrEP-AP.
- To and from your local health department for program monitoring and evaluation and to facilitate linkage to care.

- To and from the California State Auditor, the California Center for Data Insights and Innovations, the California Office of Information Security, or other state and federal agencies as required by law.

You agree that your consent and authorization in this form shall remain in effect for one year from the date of your signature below, and a digital or photocopy of this form shall be considered as valid as the original.

You have the right to modify or revoke this consent and authorization in writing by contacting cdphmedassistfax@cdph.ca.gov. You also have the right to receive a copy of this form.
I hereby consent to and authorize the collection, use and disclosure of my personal information as set forth above.

Client/Representative Name (print): _____

Client/Representative Signature: _____ Date: _____

*If you are signing as a legal representative on behalf of the client, please provide documentation evidencing your appointment as the client's legal representation.