Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) Confidentiality Concern Enrollment Worker Verification Affidavit

Instructions

This form must only be used by an enrollment worker (EW) enrolling a client with confidentiality concerns. This form must be completed if the applicant has confidentiality concerns and cannot use insurance they have through a primary policy holder like a parent, spouse, or registered domestic partner. Alternatively, this form must be completed if the applicant is seeking non-occupational post exposure prophylaxis (nPEP) for HIV and the applicant's in-network provider will not prescribe the necessary medications.

Section 1: Applicant Information (Required)

Applicant Name (First, M.I., Last): _____

Applicant Date of Birth: _____ Client ID Number (optional): _____

Section 2: Confidentiality Concern Attestation and Verification (Required)

◯ I am the applicant's PrEP-AP enrollment worker and I attest that, to the best of my knowledge and belief, the applicant has insurance through a primary policy holder, like a parent, spouse, or registered domestic partner. The client is not the primary policy holder for their insurance. The client is unable to use their insurance to access PrEP services and medications due to confidentiality concerns with the primary policy holder of their insurance plan.

◯ I am the applicant's PrEP-AP enrollment worker and I attest that, to the best of my knowledge and belief, the applicant sought nPEP through an in-network provider and the provider would not prescribe the necessary medications. Client will be enrolled in PrEP-AP with a Temporary Access Period (TAP).

Enrollment Workers Only: Please read the statement below and sign.

I understand that knowingly providing inaccurate information or deliberately omitting information on this form may result in the termination or suspension of my enrollment worker privileges.

I hereby certify that the information provided in the ADAP Enrollment System and within this Affidavit is factual, accurate, and complete. I also understand that ADAP/PrEP-AP is permitted to request additional verification documentation if this affidavit appears to be inconsistent or incorrect. I agree to promptly notify the program of any changes to the client's health coverage.

Enrollment Worker complete this section:

By signing this form, I _____, hereby certify that the above information is factual and accurate.

Enrollment Site: _____ Enrollment Site Number: _____

Signature (EW): _____ Date: _____