HIV Certification Form
West Virginia ADAP & Part B Programs

1 (a) Applicant's name_____

(b) Applicant's SSN _____

(c) Applicant's Date of Birth _____

2. Most recent CD4 count (T cells) _____

3. Date of most recent CD count _____

4. Has applicant been diagnosed with AIDS? ____yes _____no

5. Date of most recent Viral Load _____

6. Result of most recent Viral Load Test _____

7. Lowest CD4 count recorded for applicant _____

8. Physician's name _____

9. Office Address _____

_____

_____

10. Office Phone _____

11. I certify that the above named individual is HIV infected.

_____ _____

Physician's signature Date

Please return both pages in an envelope marked CONFIDENTIAL/ TO BE OPENED BY ADDRESSEE ONLY.

MMIS OPERATIONS & IT Support
Room 251
350 Capitol Street
Charleston, WV 25301-3709

APPLICATION FOR WV SPECIAL PHARMACY

Directions: Complete every line and sign on line 17

1. NAME _____

2. ADDRESS _____

_____ 3. COUNTY _____

4.PHONE # _____-_____ 5. DATE OF BIRTH _____

6. SOCIAL SECURITY NUMBER _____ - _____ - _____

7. SEX: MALE _____ FEMALE: _____ 8. RACE: _____

9. How did you hear about the program? _____

10. Do you have health insurance? Yes _____ NO _____

11. If yes, do you have prescription coverage? YES _____ NO _____

12. Year you tested positive for HIV: _____

13. State where you were tested: _____

14. Emergency contact: NAME _____

PHONE # (area code) _____ - _____ - _____

15. Current annual income from all sources: $_____

16. Give name and address of pharmacy you wish to use:

Name: _____ Address: _____
Phone # _____ _____

17. By my signature, I affirm that to the best of my knowledge and belief the answers and information furnished are complete and correct.

_____ _____
(signature) (date of signature)