Washington State Department of HEALTH

WASHINGTON STATE PRE-EXPOSURE PROPHYLAXIS DRUG ASSISTANCE PROGRAM (PrEP DAP)

PrEP DAP Client ID:

Mailing Address: PrEP DAP - PO Box 47840, Olympia, WA 98504
Phone: 1-877-376-9316| Fax: 360.359.7952 | Email: PrEPDAP@doh.wa.gov

PLEASE READ:

- **PrEP DAP Income Requirement:** PrEP DAP is for people who need help paying bills for PrEP medication, PrEP doctor visits, and PrEP tests and have gross monthly income at or below 500% of the Federal Poverty Level (FPL).
- **PrEP & Health Insurance**: PrEP medication, PrEP doctor visits and PrEP tests should be provided at $0 cost.
- **Please complete all sections of this application.** Print clearly or type your responses. Incomplete applications may delay processing.
- **Instructions**: Follow this link: How Do I Apply for PrEP DAP? or scan this QR code for instructions and information for completing the application.

1. APPLICANT INFORMATION

Legal First & Last Name	M.I.	Preferred Name

Date of Birth (mm/dd/yyyy)	Social Security Number	Preferred Written Communications
		☐ English ☐ Spanish

2. RESIDENTIAL ADDRESS

Provide a physical address - Not a PO Box – Mail will **only** be sent if this is also a mailing address

Street Address	Apt / Lot / Floor

City	State	ZIP Code	County

3. MAILING ADDRESS – Only required if different from your residential address

Is your mailing address the same as your residence? ☐ Yes ☐ No

Opt out of receiving mail? ☐ Yes ☐ No
If **Yes**, provide an email address below.

Street Address	Apt / Lot / Floor

City	State	Zip Code	County

4. CONTACT INFORMATION

Okay to send email	Okay to leave voice mail	Okay to send text message
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Email Address	Phone Number

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

5. Please tell us more about yourself

Sex Assigned at Birth	Current Gender Identity
☐ Male ☐ Female	☐ Male ☐ Female ☐ Transgender – Male to Female ☐ Transgender – Female to Male ☐ Non-binary/Genderqueer ☐ Other _____
Ethnicity	**Race** Select all that apply
☐ Non-Hispanic ☐ Hispanic/Latino: ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic/Latino or Spanish origin	☐ White ☐ Black or African American ☐ American Indian/Alaska Native ☐ Asian ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other ☐ Native Hawaiian/Pacific Islander ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

6. APPLICATION ASSISTANT OR AUTHORIZED REPRESENTATIVE

Please provide the following information for any person you would like us to talk to about your PrEP DAP coverage. Details provided will be used to verify their identity when contacting PrEP DAP.

Last Name	First Name	
Phone Number	**Email Address**	**Relationship to You**

7. PrEP PRESCIBER

Please tell us who your healthcare provider is that prescribes you PrEP.

Last Name	First Name	Clinic Name

Have you seen your provider, or had labs done in the last 90 days? ☐ **Yes** ☐ **No** If yes, please provide the **Month** and **Year** _____

8. HEALTH INSURANCE INFORMATION

Medicare Part B and most health insurance companies must provide PrEP, PrEP doctor visits and PrEP tests (HIV, STI, other labs) for FREE as long as the health care provider is in-network.

Do you have health insurance? ☐ Yes ☐ No If **yes**, select plan type and enter the information below:

Type of Coverage

Insurance: ☐ Employer ☐ Qualified Health Plan ☐ Individual

Insurance Carrier Name	Policy / Plan Name	Effective Date

9. INCOME

Gross Monthly Income

Please send proof of all income sources. If you are unsure what to send, or if your income is irregular, contact PrEP DAP and we can help. Missing or incomplete information may delay your eligibility. We may also verify income using state records when needed.

Enter your Gross Monthly Income: This is how much you make each month **before taxes or deductions:**

$_____

Please provide **copies** (do not send originals) of the following, if they apply to you:

- **If you are employed**
  - **By an employer**: Pay stubs from your **two (2) most recent months**
  - **Self-employed:** A **profit and loss statement** for your **two (2) most recent months** (Only include deductions the IRS allows, even if you do not file taxes)
- **If you receive income from other sources**
  - Current year **award letters** for Social Security, Unemployment, or Pension Benefits, etc.
- **If you receive cash income**
  - A **profit and loss statement** for your **two (2) most recent months**

If you do not have any income, check the box below.

☐ **By checking this box, I state that I do not have any income.**

I understand that PrEP DAP may ask for proof at any time, such as a letter from a former employer or a benefits end notice.

I agree to tell PrEP DAP within 20 days if my income changes.

I understand that giving false or incomplete information may result in a denial of eligibility, and I may be responsible for the cost of services if I was not eligible.

If you checked the box above, please explain how you meet your basic needs, such as food and housing:

_____

_____

10. RISK FACTORS

Pre-Exposure Prophylaxis (PrEP) is a medication that helps prevent HIV. PrEP DAP uses guidelines to help connect people to the program.

Please tell us which risk factors you identify with.

Be sure to answer each question completely.

Have you ever had sex with a man?	☐ Yes ☐ No
In the last 12 months has a doctor, nurse or other health care provider told you that you had chlamydia, gonorrhea or syphilis?	☐ Yes ☐ No
If yes, tell us which one(s): ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis	
In the last 12 months have you used methamphetamines? (crystal, tina, crank, ice)	☐ Yes ☐ No
In the last 12 months have you used poppers? (alkyl or amyl nitrates)	☐ Yes ☐ No
In the last 12 months, did you have sex without using a condom with anyone you did not consider to be a main/primarypartner?	☐ Yes ☐ No
Are you in an ongoing sexual relationship with a partner who you know to be HIV-positive?	☐ Yes ☐ No
If yes,	
Is your partner on HIV medications?	☐ Yes ☐ No
Is your partner trying to get pregnant	☐ Yes ☐ No
In the last 12 months, have you exchanged sex for things like money, shelter, or drugs?	☐ Yes ☐ No
In the last 12 months, have you injected or shot up any drugs not prescribed for you by a health care provider?	☐ Yes ☐ No

11. AGREEMENT & RELEASE OF INFORMATION

Department of Health coordinates with the following entities to verify eligibility for all applicable services and to support treatment and care coordination with contracted partners. All entities adhere to the same confidentiality requirements:

- Pharmacy Benefits Manager
- WA State Department of Social and Health Services (Medicaid Verification)
- WA State Health Care Authority (Apple Health)
- PrEP DAP contracted Providers
- Data System Software Vendor

I have the right to: Be treated with respect, consideration, and honesty. Receive PrEP DAP services without discrimination based on race, color, sex or gender, ethnicity, national origin, religion, age, class, sexual orientation, or physical or mental ability. Have my records be treated as confidential. File an appeal about eligibility or coverage decisions.

I have the responsibility to: Treat the Department of Health staff and contracted partners with respect, consideration, and honesty. Provide correct, current, and complete information. Respond to the Program's requests for information. Adhere to medically recommended testing and treatment, including activities recommended in current PrEP clinical guidelines. Notify the Program within **20 days** of any changes that affect eligibility, including, but not limited to, income, address, or health insurance coverage.

I understand that: The information requested on this application is for the purpose of determining eligibility for state-funded services. Funding is limited and may expire at any time without extended or alternate funds being available. The Program may use other data systems or records to verify the information I provide, when needed. Upon approval, my eligibility will expire after one year. Prior to the end of the eligibility period, I must reapply and provide updated information to continue receiving services. If I am eligible, my information may be shared with contracted partners to coordinate program services.

Release of Information: I give my permission for the program to share information from this application and from subsequent documentation obtained by the Program with contracted partners and anyone I listed in the Application Assistant or Authorized Representative section of this application This permission is valid for **one year and 60 days** from the date I sign this authorization.

By signing this form, I confirm I have read it and certify that the information provided is true and accurate to the best of my knowledge.

_____ _____

Applicant or Legal Guardian Signature | Today's Date (mm/dd/yyyy)

Pre-Exposure Prophylaxis Drug Assistance Program (PrEP DAP)

Verbal or Electronic Signature Attestation - If signed on behalf of a client

Date:

Client First and Last Name:
Date of Birth:

I am agreeing to virtually sign the PrEP DAP application by giving my verbal or written permission to:

Agency:
Staff Name:

By agreeing to this signature, I understand that I am virtually signing and submitting information and documents that commits me in the same manner as if I had signed in person. I also confirm that the information on this document is true and accurate to the best of my knowledge. By giving permission to virtually sign this document, I agree to the terms and conditions above.