ADAP-Miami

REQUIRED forms / Consent forms

INSTRUCTIONS:

1. OPEN the BLANK forms > SAVE AS > "ADAP ID - mmddyy" > then complete ALL FIELDS in this page ONLY.
2. ENSURE all information is valid and correct. SIGN FORMS WHERE REQUIRED. PRINT a copy for your records.
3. ATTACH proof of: (1) FL residency; (2) Household Income (all); (3) recent Labs (tracking); (4) other if needed.
4. SEND file & documents to only one: e-FAX: 786-420-3082 OR e-mail: ADAP.FLDOHMDC@flhealth.gov

NOTE: Program Staff will contact you from 305-643-7400.

TODAY's DATE

11/21/2024

TO LOCK ALL FIELDS, PRINT AS PDF

ADAP ID

*Patient Name | * Pt Initials | *SSN

*DOB | *Case Manager | *CM Agency

Select Case Management AGENCY

*ADDRESS | *CITY | *ZIP CODE

*PHONE NUMBER

OK to e-Mail ?

e-MAIL ADDRESS

I consent to share my information via email

*** TYPE YOUR INITIALS TO CONSENT

Household Members & Names**

Select status

Select status

Select status

Select Status

Select Status

Select Status

Select Status

** HOUSEHOLD SIZE & HOUSEHOLD INCOME > Must submit recent pay checks (last 2 months) & SSN's for ALL adult dependents in the household.

Authorizes a Third Party/Designee?

*** Name of Authorized Third Party/Designee

NOTES TO CM: ALL forms MUST be signed where required.

Required FORMS. Please sign & date where highlighted.

* DH2116 - Consent to Fax
* DH 3203 - Authorization to Disclose
* DH150-741 - Privacy Practices
* DH8001 - Initiation of Services
* Statement of Agreement & Acknowledgement
* Patient Right & Responsibilities

FOR PROGRAM USE ONLY

CLIENT CONSENT TO FAX CONFIDENTIAL INFORMATION

Florida law requires that information contained in medical records be held in strict confidence and not be released without your written authorization. You must give specific written authorization to release certain types of sensitive medical information. The Florida Department of Health may fax confidential medical information to a provider or receive faxed information that was requested from a provider with your permission. Faxing such information is voluntary. You will not be denied services based on a refusal to allow your confidential information to be faxed.

Steps will be taken to make sure your information arrives safely, but faxes can be misdirected.

I, _____ **, do hereby authorize:** FDOHMDC - ADAP Program & CHD Pharmacy
(name of client/legal representative) (Agency or Individual in possession of the record)

2515 W Flagler Street, Suite 102-A. Miami FL 33135 // 18255 Homestead Avenue, Miami FL 33157
Address (street, city, state) of agency/individual with record

to fax the following information: (initial by any or all that apply)

_____	a.	STD records	_____	b.	TB records
XXXX	c.	HIV/AIDS records	_____	d.	Drug/alcohol treatment records
_____	e.	Psychiatric/psychological information/records	_____	f.	Adult and child abuse information
XXXX	g.	Other (specify) Eligibility/Enrollments/Insurance/Pharmacy records			

This information will be faxed to:

Provider Name (fax recipient)	Select Case Management AGENCY
Contact Person	
Provider Phone Number	
Provider Fax Number	

_____ 11/21/2024 _____
Signature of Client or Legal Representative **Date** **Witness**

_____
Legal Representative's Relationship to the Client

USE THIS SPACE ONLY IF CLIENT WITHDRAWS CONSENT

_____ _____
Date Consent Revoked **Signature of Client or Legal Representative**

_____ _____
Witness **Legal Representative's Relationship to Client**

Client Name	
ID Number	
Date of Birth	

DH 2116, 2/01
Stock Number: 5744-000-2116-1

Attachment E

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: FDOHMDC - ADAP Program & CHD Pharmacy **Phone #:** 305-643-7400//305-278-3021

Address: 2515 W Flagler Street, Ste 102A. Miami FL 33135 // 18255 Homestead Avenue, Miami FL 33157 **Fax #:** _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: Select Case Management AGENCY _____ **Phone #:** _____

Address: _____ **Fax #:** _____

Other method of communication: _____

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ General Medical Record(s), including STD and TB _____ Progress Notes _____ History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

_____ Diagnostic Test Reports (Specify Type of test(s)) _____

XX Other: (specify) Core Eligibility, Program Enrollment, Premium Plus, Pharmacy Records

I specifically authorize release of information relating to: (initial selection)

XX HIV test results for non-treatment purposes _____Substance Abuse Service Provider Client Records

_____Psychiatric, Psychological or Psychotherapeutic notes _____Early Intervention _____WIC

PURPOSE OF DISCLOSURE:

XX Continuity of Care _____ Personal Use _____ Other (specify)_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

X _____ X 11/21/2024

Client/Representative Signature Date

_____ _____

Printed Name Representative's Relationship to Client

_____ _____

Witness (optional) Date

Client Name:

ID#:

DOB:

DH 3203, 11/08 **Original:** To File **Copy:** To Client **Copy:** To Accompany Disclosure

Attachment D2
Required Form

State of Florida
Department of Health

Notice of Privacy Practices Acknowledgment Form

Name: _____ **Client ID#** _____

Facility/Site/Program: 2515 W Flagler Street, Suite 102-A. Miami FL 33135 // 18255 Homestead Avenue, Miami FL 33157

I have received a copy of the DOH Notice of Privacy Practices Form DH 150-741, 09/13.

***Signature:** _____ **Date:** 11/21/2024
Individual or Representative with legal authority to make health care decisions

If signed by a Representative:

Print Name: _____ Role: _____
(Parent, guardian, etc.)

Witness: _____ Date: _____

If the individual has a representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the representative. ***If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.***

Notice of Privacy Practices given to the individual on 11/21/2024
date

- [x] Face to face meeting
- [ ] Mailing
- [x] Email
- [x] Other Fax communication

Reason Individual or Representative did not sign this form:

- [ ] Individual or Representative chose not to sign
- [ ] Individual or Representative did not respond after more than **one** attempt
- [ ] Email receipt verification
- [ ] Other _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual's or Representative signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.

- [x] Face to face presentation(s) 11/21/2024
- [x] Telephone contact(s) _____
- [ ] Mailing(s) _____
- [x] Email _____
- [ ] Other _____

Staff Signature: _____

Print Name: _____

Date: _____

DH 150-741 Notice of Privacy Practices

This form must be retained for a period of at least six years in the appropriate record.
DOH Notice of Privacy Practices Acknowledgement Form, DH 150-741, 09/13

INITIATION OF SERVICES

PART I. **CLIENT-PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: FDOHMDC - ADAP Program & CHD Pharmacy

Agency Address: 2515 W Flagler Street, Suite 102-A. Miami FL 33135 // 18255 Homestead Avenue, Miami FL 33157

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representatives to render routine health care. I understand routine health care is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory tests and/or minor procedures. I may discontinue this relationship at any time.

PART II. **DISCLOSURE OF INFORMATION CONSENT** (treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and health care operations

PART III. **COMMUNICATIONS**

I understand the Florida Department of Health (DOH) uses a patient portal to communicate with me about my health care. In order to receive electronic communications about my health care, I need to provide my email address to the department and then I will be contacted by email to create a portal account.

I understand that I must agree to the terms and conditions of use associated with the portal when I create my account. I understand that the portal is password protected and that I am responsible for maintaining the confidentiality of my username and password and for all activities that are conducted through my portal account. I understand that I will receive emails letting me know that DOH has sent information to the portal.

*** _____ Initial here to authorize and give my express consent to the DOH to make your health care information available to you through the portal.

*** Email Address: _____

I understand that I have a right to stop participation in the portal at any time by either removing my email address or closing my portal account.

_____ Initial here to remove your email address from the DOH system and stop receiving information through the portal.

PART IV. **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST** (Only applies to Medicare Clients)

As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART V. **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

As Client /Representative signed below, I assign to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART VI. **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER**

(This notice is provided pursuant to Section 119.071(5)(a), Florida Statutes.)

For health care programs, the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071(5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VII. MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS

11/21/2024

***Client/Representative Signature | Self or Representative's Relationship to Client | Date

Witness (optional) | Date

PART VIII. WITHDRAWAL OF CONSENT

I, _____ WITHDRAW THIS CONSENT, effective _____
Client/Representative Signature | Date

Witness (optional) | Date

Client Name:
ID#:
DOB:

Original to file; Copy to client

Florida Department of Health, AIDS Drug Assistance Program (ADAP)

Statement of Agreement and Acknowledgement

By signing this Statement of Agreement and Acknowledgement you certify that you fully understand and agree to abide by the policies stated herein. All references to "program" or "programs" refers to the Florida Department of Health, AIDS Drug Assistance Program (ADAP) and/or successor programs in which you participate or to which you apply for services.

Please read the following:

1. I certify that the information and documentation I submit for access to ADAP services is true and accurate to the best of my knowledge. I understand that I may be disqualified from this program(s) and/or prosecuted for willfully providing false information.

2. I understand that the information requested is for the purpose of determining my eligibility for a state and federally funded program. The funding is limited and may expire at any time without extended or alternate funds being available and does not obligate the Department of Health to continue to supply services (medications, insurance premiums, copays or deductibles or other related) indefinitely. Service (s) through this program are supplied as a benefit and not as a right or entitlement.

3. If I am considered eligible for services, my information will be provided to contractual partners for the reasons explained in this document. Eligibility approval does not mean I will receive or be enrolled in all services. I understand each service may require additional information, and that I must provide this information for verification before enrollment into said services.

4. Upon approval, my eligibility will expire after six months. I will be required to reapply and provide updated eligibility information to continue accessing services within 30 days of the eligibility expiration date. I agree to submit periodic information regarding my continued eligibility for participation in the program(s), including proof of income, proof of residency, availability of health insurance coverage, and an updated and signed version of this form with my Recertification Application every 6 months as per federal guidelines.

5. I agree to notify, or to have my Medical Case Manager notify the program(s) of any circumstances affecting my participation in, or eligibility for, the program(s). I agree to notify the program(s) within ten (10) days of a change in address and understand that all program correspondence will be sent to the address I have on file with the program(s). I understand changes in my situation will be periodically evaluated to determine continued eligibility for the program(s).

6. I authorize the program to release my enrollment, eligibility and service records and other information necessary to facilitate the provision of program services to my physicians, other providers, treatment centers, pharmacy benefit managers, third party administrators, health insurers, pharmacies, insurance carriers and insurance benefits coordinators, or any entity under contract with the program.

7. If I request enrollment into Medical Case Management or request any service that requires coordination with a Medical Case Manager, my information will be shared with the Medical Case Management agency.

8. I acknowledge that my health insurance premiums (if applicable) are being paid by the program via a contractual third party payer source. In consideration of same, I hereby authorize and direct my health insurer to directly reimburse the Florida Department of Health contractor, Broward Regional Health Planning Council for any unused premium payments should my insurance policy terminate or be cancelled for any reason, including but not limited to future ineligibility, death, voluntary termination, involuntary cancellation, or termination by operation of law.

9. I agree to indemnify and hold the Florida Department of Health harmless from any and all claims for making premium reimbursement payments directly to Florida Department of Health's contracted Insurance Benefit Manager (IBM) entity, Broward Regional Health Planning Council or any entity under contract with the Florida Department of Health in connection with Program Services. I agree to indemnify and hold Florida Department of Health, or any entity under contract with Florida Department of Health in connection with Program Services, harmless from any and all claims for receiving premium reimbursement payments directly from Florida Department of Health or my health insurer. This agreement shall be binding on my administrators, executors, heirs, successors and assigns and shall remain in full force and effect during the time period in which I am enrolled in the Program(s).

10. I agree to reimburse Florida Department of Health for any and all premium reimbursement payments that are paid to me in error at any time.

11. I understand that my records are protected under the Health Insurance Portability and Accountability Act, Pub. L 104-491, 110 Stat. 1936, enacted August 21, 1996, relating to confidentiality of medical information, and cannot be disclosed to any other entity except those referenced herein without my written consent. I do not have to consent to the release of this information. However, if I refuse to sign this authorization, I will be ineligible to receive services through this program.

12. I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid for a period of 6 months from the date of acceptance, or until such time as I inform the Program in writing, of my wish to terminate services in the Program(s), except to the extent that action has been taken in reliance on this authorization.

13. I understand that the medication(s) through this program is provided for personal use, and it is illegal to sell, trade, barter or in any other way exchange this prescription medication with any other person. Such activity is grounds for criminal prosecution.

14. I understand that taking my HIV medicine as directed by my health care provider is the best chance for the medicine to keep me healthy for the rest of my life. Research confirms that when a person living with HIV is on effective treatment, it will reduce the level of HIV to "undetectable" levels which protects their health and makes them incapable of transmitting HIV to their sexual partners, or what is called "Undetectable = Untransmittable: U=U". As a prevention strategy, this is often referred to as Treatment as Prevention.

15. I understand that if I am taking Abacavir, Epzicom, Trizivir, Ziagen, or Triumeq, I may not stop taking it without my doctor's approval. If I stop taking it, even for one day, and then start again, I risk having a very bad allergic reaction that can cause serious injury or even death.

16. I understand that it is important to pick up my HIV medication(s) every month (or every 90 days) from the county health department, a retail pharmacy, or my medical provider before I run out of medicine. Failing to pick up my medication(s) on time may affect my ability to remain in the ADAP program.

17. I understand the importance of not stopping my medication(s). If I am late picking up my medication(s), the ADAP staff may contact my health care provider to get approval to begin receiving medication(s) again.

18. I understand that missing scheduled medication(s) doses could result in my virus becoming resistant to one or more of my HIV medication(s). Resistance means that HIV medication will no longer work in keeping my virus controlled.

19. I understand that if I regularly have problems picking up my medication(s) on time or taking them as I have been told, I may have to meet with my health care provider and the ADAP county staff about my treatment.

20. I agree that it is important for my health care provider and pharmacist to know all my medications that I take including over-the-counter medicines, vitamins, and herbal and dietary supplement since there can be interactions with my HIV medication(s). Before starting a new medication, I should talk to my health care provider or pharmacist to make sure it is safe to take the new medication with my HIV medicine.

21. I understand that if I am confused or need help with my medication(s), I should contact my health care provider. If I am confused about when I need to pick up my medication(s), I should contact the ADAP staff at the Florida Department of Health in the county I receive services or if I receive my medications from the CVS Specialty pharmacy, I should call CVS Specialty Pharmacy at 1-800-498-2037.

22. I understand that medication(s) provided through the AIDS Drug Assistance Program may have dangerous side effects, and my physician should explain to me all possible side effects.

23. I agree that should I become eligible for treatment under a different program, I will notify the local AIDS Drug Assistance Program manager or pharmacist so that I may continue to receive treatment under a different source of payment.

24. I understand that if I travel, it is important to take my HIV medication(s) with me. Should the medications get lost while I am out of town, ADAP may not be able to assist.

25. I understand that monitoring of my HIV lab (CD4 T-Cell count and HIV viral load) are required by ADAP every 6 months. I understand ADAP staff will request my lab information from my provider or the states Electronic Lab Reporting (ELR) system.

26. I agree to treat ADAP staff with courtesy and consideration.

The agencies listed below and their subcontractors, are used to coordinate and verify eligibility for all services following the same confidentiality requirements identified above in statements 1-26:

- System Software Vendor, Groupware Technologies, Inc.
- Insurance Benefits Manager Entity, Broward Regional Health Planning Council
- Pharmacy Benefits Manager Vendor, CVS Caremark
- Centers for Medicare & Medicaid Services
- FL Department of Children and Family Services - (Medicaid verification)

If you are an ADAP client receiving services within the state's Emerging Metropolitan Area (EMA) or Transitional Grant Area (TGA), your records will be accessible by the Ryan White Part A designated agency.

If you are an ADAP client receiving services from a Ryan White Part B provider, your ADAP information will be accessible by the Ryan White Part B provider through state's CAREWare system.

11/21/2024

*** Client Signature Date

ADAP Staff Signature Date

Application to Receive Allowable Services for HIV/AIDS Patient Care Programs

- AIDS Drug Assistance Program (ADAP)
- ADAP Premium Plus (Insurance Services)
- State Housing Opportunities for Persons with AIDS (HOPWA)
- Ryan White Part B Consortia and other HIV/AIDS Programs

Part 5 Rights & Responsibilities *(initial each item shown)*

_____ I understand that I am responsible for giving truthful and correct information on this application to the best of my knowledge. Failure to be truthful may prevent or delay a determination of eligibility to receive services.

_____ I understand if I knowingly give information that is not true or withhold information and receive services that I am not eligible to receive, I may be lawfully punished and have to reimburse the Department of Health for services.

_____ I understand the information I provide may be verified that may include computer matching, and the information I give about my income may be checked.

_____ I understand that the information will be kept confidential in accordance with Florida and Federal law.

_____ I understand not all services I am eligible to receive may be available, accessible, or funded; and I may not meet specific program qualifications for some programs.

_____ I understand that at any time during the application process, I can be denied eligibility if my actions are uncooperative, disruptive of office procedures, threatening, or hostile toward staff.

_____	_____	11/21/2024
Client Name	Client Signature	Date

_____ I understand that the Department of Health eligibility staff cannot discriminate because of race, color, sex, age, disability, religion, nationality, or political beliefs.

_____ I understand I have the right to ask for a fair hearing if I think the decision of my case was unfair or incorrect.

Client Signature

_____	11/21/2024
Client Signature	Date