Washington State Department of Health

# Pre-Exposure Prophylaxis Drug Assistance Program (PrEP DAP)

## HIV & Health Status Information Form

### HIV & HEALTH STATUS INFORMATION (HHSI)

HIV and health status must be confirmed in order to process your application. This section must be completed by you **AND** your health care provider who is prescribing PrEP to you. Please submit this form to us with this application or ask your health care provider to send it directly to us by mail or fax.
Call (800) 272-2437 if you have questions about this form.

### Client Section – To be Completed by the Client – *Signature and Date REQUIRED*

| Last Name | First Name | |
|---|---|---|
| | | |
| Applicant or Legal Guardian Signature **(do not leave blank)** | Date of Birth | Today's Date **(do not leave blank)** |
| | ____ / ____ / ____ | ____ / ____ / ____ |

**I authorize my health care provider to release the information on this form to the Washington State Department of Health.**

### Required Health Care Provider Section – To be Completed by the Health Care Provider

**Please answer the following questions about the patient:**

(For HIV – test date, new applicants date must be within 14 days, for renewing participants date must be within 90 days)

**Is your patient HIV-negative?** ❑Yes ❑ No **Date of the last HIV-negative test:** ____ / ____ / ____

**Please tell us which of the following eligibility risk factors apply to your patient:**

**Does your patient have sex with men?** ❑ Yes ❑ No

In the last 12 months has your patient tested positive for chlamydia, gonorrhea or syphilis? ❑ Yes ❑ No

If Yes, tell us which one(s): ❑ Chlamydia ❑ Gonorrhea ❑ Syphilis

In the last 12 months has your patient used methamphetamines (crystal, tina, crank, ice)? ❑ Yes ❑ No

In the last 12 months has your patient used poppers (alkyl or amyl nitrates)? ❑ Yes ❑ No

In the last 12 months, did your patient have sex without using a condom with anyone they did not consider to be a main/primary partner? ❑ Yes ❑ No

**Is your patient in an ongoing sexual relationship with a partner who you know to be HIV-positive?** ❑ Yes ❑ No

Is the patient's partner on HIV medications? ❑ Yes ❑ No

Is the patient's partner trying to get pregnant? ❑ Yes ❑ No

**In the last 12 months, has your patient exchanged sex for things like money or drugs?** ❑ Yes ❑ No

**In the last 12 months, has your patient injected or shot up any drugs not prescribed by a health care provider?** ❑ Yes ❑ No

**Briefly share any information you would like PrEP DAP to consider when making the patients eligibility determination**

By signing below, you:

- Declare that you are the health care provider for the patient named above
- Confirm that you have evidence of the patient's HIV status and risk
- Understand and will follow current standards of care for PrEP
- Prescribed TRUVADA® to this patient
- Certify the information on this form is accurate and complete to the best of your knowledge.

Provider Signature: _____ **(Do Not Leave Blank)**

Today's Date: ____ / ____ / ____ **(Do Not Leave Blank)**

**Please provide us with information about your practice:**

| Provider Name: | Facility Name: |
|---|---|
| Facility Phone: | Provider/Facility Email: |
| Facility Full Address: | |

Mail or Fax this form to: **PrEP DAP, PO BOX 47840, Olympia WA 98504 – FAX: 360-664-2216**