GENERAL REVENUE (GR) CONTRACEPTIVE AND
SHORT-TERM ANTIRETROVIRAL (ARV) OR OPPORTUNISTIC INFECTION (OI) ASSISTANCE
for the Florida Department of Health and Ryan White Part A/MAI Programs in Miami-Dade County

Referral Start Date:_____ **Referral Stop Date*:_____**
***Maximum referral length is one (1) month for ARV or OI medications.**

REFERRAL FROM:

Part A/MAI Medical Case Manager Name: _____
Agency Name: _____
Phone: _____ **Fax: _____**

MEDICATIONS NEEDED:

List prescribed antiretroviral (ARV), opportunistic infection (OI), or contraceptive medication needed per this referral:

_____
_____

Prescribing Practitioner Name: _____
Prescribing Practitioner Phone Number: _____

Special Instructions: _____

CLIENT INFORMATION: **CIS#: _____**

Name: _____ **DOB: ____/____/____**
Current SFAN# or Jackson "I01" Card #: _____
Social Security #: _____
Street Address: _____
City: _____ **Zip: _____** **Phone Number: _____**

REASON FOR ASSISTANCE: *(Check one)*

- ☐ **ADAP application or re-certification process pending current labs**
- ☐ **ADAP application or re-certification process pending original prescription**
- ☐ **ADAP medical exception/exemption request pending**
- ☐ **ADAP re-enrollment is past due and requires emergency supply of medications to ensure adherence to treatment regimen**
- ☐ **ADAP application/enrollment pending (specify reason: _____)**
- ☐ **Contraceptive prescribed, no other funding source available**
- ☐ **Affordable Care Act (ACA) binder payment for premium delayed *(not applicable for premiums that would be paid by ADAP)***

I attest that all documentation provided with this referral is complete, accurate and true. I hereby authorize my medical case manager to provide this information to the Public Health Trust of Miami-Dade County / Jackson Health System for the purpose of obtaining short-term access to ARV or OI medications while my enrollment into the ADAP program or ACA premium payment is pending; or for access to contraceptives, if checked above.

Client's Signature: _____ **Date: ___/___/___**

Required Documentation: This referral must be accompanied by proof of HIV positive status, financial eligibility, and permanent Miami-Dade County residency. Please see the accompanying Client Eligibility Documentation Checklist for a list of acceptable eligibility documents and check the type of proof provided with this referral.

Medical Case Management Supervisor's Signature: _____ **Date: ___/___/___**