New Jersey Department of Health
AIDS Drug Distribution Program (ADDP)

CERTIFICATION BY LICENSED HEALTH CARE PROVIDER

If you need assistance completing this form, call the ADDP toll-*free at 1-877-613-4533.*

SECTION I – TO BE COMPLETED BY APPLICANT

Instructions for Applicant:
Applicant: Please complete Section I, then give this form to your licensed Health Care Provider to complete Section II.
Ask your Health care Provider to return the completed form back to you. Then, attach the completed form to your completed ADDP Application and submit both forms to the ADDP.

Applicant's First Name:	Applicant's Last Name:	Middle Initial:	Social Security Number (*optional*):

Street Address:

City:	State:	Zip Code:	Date of Birth:

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give permission to my Licensed Health Care Provider to release the information requested below to the New Jersey Department of Health for the purpose of determining my eligibility to participate in the AIDS Drug Distribution Program.

Signature of Applicant:	Date:

SECTION II – TO BE COMPLETED BY LICENSED HEALTH CARE PROVIDER

Instructions for Health Care Provider:
The individual named above has applied to the New Jersey Department of Health to participate in the AIDS Drug Distribution Program.

Please provide the following information regarding the above applicant, sign this form, and **return the form to the applicant**.

1. Did a Health Care Provider Diagnose HIV?
   ☐ Yes ☐ No
2. Does the applicant meet CDC criteria for HIV Stage 3?
   ☐ Yes ☐ No
3. Provide the date of the most recent T Helper (CD4+) lymphocyte count test. (If test not done use “00/00”; if unknown use “99/99”):
   _____
   Month *Year*
4. Provide the absolutely CD4+ lymphocyte count for above test:
   _____Cells/mm
5. Provide the date of the most recent viral load test (if test not performed, use “00/00”; if unknown, use “99/99”).
   _____
   Month *Year*
6. Provide the Viral Load: _____

7. Specify the applicant’s HIV Risk Factors (Please check all that apply):
   - ☐ Male who has sex with male(s)
   - ☐ Injection drug use
   - ☐ Hemophilia/coagulation disorders
   - ☐ Heterosexual contact
   - ☐ Perinatal transmission
   - ☐ Undetermined or unknown; or risk not reported or identified
   - ☐ Receipt of transfusion of blood, blood components, or tissue
   - ☐ Other (Specify):_____

CERTIFICATION

I hereby certify that the above-named applicant has a medical necessity to obtain FDA-approved HIV-related drugs.

Name of Licensed Health care Provider (Print or Type)	License Number:

Street Address:

City:	State:	Zip Code	Telephone Number:

Signature	Date