

Application Form

AIDS Treatment Access Program – ATAP

Date of Application

Date of Reception AFA LAC

Date of Reception AFA Int.

A. I am applying for the following Program:

- Latin America AIDS Program (LAP)
 Africa/Asia AIDS Program (AAP)
 Caribbean AIDS Program (CAP)

B. If you are applying for ATAD Program:

Nucleoside/Nucleotide Reverse Transcriptase Inhibitors	Combination Drugs	Non-Nucleoside Reverse Transcriptase inhibitors (NNRTIs)	Protease Inhibitors	Entry Inhibitors	Integrase Inhibitors
<input type="checkbox"/> Emtriva mg <input type="checkbox"/> Epivir mg <input type="checkbox"/> Retrovir mg <input type="checkbox"/> Videx mg <input type="checkbox"/> Viread mg <input type="checkbox"/> Zerit mg <input type="checkbox"/> Ziagen mg	<input type="checkbox"/> Atripla mg <input type="checkbox"/> Combivir mg <input type="checkbox"/> Epzicom mg <input type="checkbox"/> Trizivir mg <input type="checkbox"/> Truvada mg	<input type="checkbox"/> Intelence mg <input type="checkbox"/> Sustiva mg <input type="checkbox"/> Viramune mg	<input type="checkbox"/> Aptivus mg <input type="checkbox"/> Crixivan mg <input type="checkbox"/> Invitase mg <input type="checkbox"/> Kaletra mg <input type="checkbox"/> Lexiva mg <input type="checkbox"/> Norvir mg <input type="checkbox"/> Prezista mg <input type="checkbox"/> Reyataz mg <input type="checkbox"/> Viracept mg	<input type="checkbox"/> Fuzeon mg <input type="checkbox"/> Selzentry mg	<input type="checkbox"/> Isentress mg

2. Are you able to buy any of this meds? Yes (Which ones): _____ No

C. Personal Information

First name:		Last name:			
Age:	Date of Birth:	Nationality:		Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Transgender	
Sexual Orientation: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual		Civil State:		Languages you speak:	
Permanent address:				Apt. / Home #:	
City:	Stated:	Zip Code:	Country:		
Phone Home#:	Cell phone #:	Fax #:	e-mail:		
Profession:		Address where you want to be reach:			
Person that we can contact on its case:		Relation ship:	Phone #:	e-mail:	

D. Current Doctor's History:

Name of the doctor in the original country:		
Institution where you are being treated:		
Phone #:	Fax #:	e-mail:

1. How many times have you been hospitalized because of HIV/AIDS? Never ____ times

2. Have you suffered or are you suffering from any of these symptoms?

- Diarrhea (chronic diarrhea) Adenopathy Severe Depression
 Mouth lesion Skin lesions Weight loss

3. Have you had or do you have any of the following opportunistic diseases? (Check the dates)

- Pneumonia PCP ___/___/___ Kaposi's sarcoma ___/___/___ Meningitis ___/___/___
 Tuberculosis ___/___/___ Cytomegalovirus ___/___/___ _____ ___/___/___
 Toxoplasmosis ___/___/___ M. Avium Complex ___/___/___ _____ ___/___/___

4. Lab results (send a copy of the results)

CD4	Quantity	Date
Last count		
Lowest count		

Viral Load	Quantity	Date
Last result		
Highest load		

Current Weight: _____ lbs.

5. Other relevant labs (name them and attach a copy of each one of them):

F. Treatment:

1. Have you had any previous HIV/AIDS treatment: Yes No

2. Are you currently receiving a treated? Yes No

3. Describe your treatments, starting with the most recent one (add new sheets if you had more than 3):

Most recent treatment:		Since	/	/	till	/	/
	Name of the medicine	Daily dosage					
1.							
2.							
3.							
4.							
5.							

Former treatment:		Since	/	/	till	/	/
	Name of the medicine	Reason of the change					
1.							
2.							
3.							
4.							
5.							

Former treatment		Since	/	/	till	/	/
	Name of the medicine	Reason of the change					
1.							
2.							
3.							
4.							
5.							

G. MOOD

- | | | |
|---|------------------------------|-----------------------------|
| 1. Have you been hospitalized for any mental or depression illness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you received any medication for this? (include antidepressant meds) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you ever had any suicidal ideation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have you ever try to commit suicide? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. In the lasts three months, have you had trouble sleeping? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Do you easily cry? Do you have any particular reasons? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Do you get tired easily? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Are you enjoying your daily activities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Do you feel sad or bored? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Do you not care to be alive? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Comments (State any additional comments on any topic you want us to know):

H. Income

Profession:	
Employed: YES <input type="checkbox"/> (If yes, please specify what you do) NO <input type="checkbox"/>	
Monthly Income \$:	<input type="checkbox"/> Less than \$200 <input type="checkbox"/> Between \$200 - \$500 <input type="checkbox"/> Between \$500 - \$1.000 <input type="checkbox"/> Between \$1.000 - \$5.000 <input type="checkbox"/> Between \$5.000 - \$10.000 <input type="checkbox"/> More than \$10.000
Education:	<input type="checkbox"/> Elementary <input type="checkbox"/> High School <input type="checkbox"/> University <input type="checkbox"/> Graduate
Do you have any kind of health coverage? (Private Insurance, National, public or private programs) YES <input type="checkbox"/> If yes, does it cover all your therapy Needs? YES <input type="checkbox"/> (Name what's not covered) NO <input type="checkbox"/> NO <input type="checkbox"/>	
List all the reasons why you are requesting AIDFOR AIDS to help you with your drug treatment.	

Important Information:

- You are applying to a program where the confidentiality of your name will be respected.
- It is necessary that you provide us with your complete contact information (address, phone #s, email address), we must be able to contact you at all times in order to keep your benefits and follow up on you.
- Please fill out the form and any additional information in a legible way, preferably in a typed format.
- Send a copy of the original lab results for CD4 count and viral Load
- This form does not guaranty your admission into the program. All forms will be processed depending on the date submitted, the completion of documents required and ultimately the availability of the medication requested.
- Do not forget to include with your application the following documents. They are mandatory for its processing
 - Medical History related to HIV/AIDS written by your treating doctor (Drug, lab results and events history).
 - Viral Load result.
 - CD4 count result
 - HIV Test Result
 - Prescription done by your treating doctor of the medications you are requesting
- It will be also very helpful if you can provide us with the following lab results to better monitor your case:
 - WBC, RBC, HGB, HCT, Lymphocyte
 - (AST-SGOT) (ALT-SGPT)
 - Creatinine
 - Amylase Serum
 - Bilirubine total & direct
 - Cholesterol (HDL-LDL)
 - Triglycerides.
 - Weight
 - VDRL Test
 - Tuberculin Skin Testing
 - Toxoplasma antibodies
 - PAP smear (including men)

Social Activities

- Are you doing community services for people who are living with VIH?
YES NO
- If your answer yes, witch organization and what kind of work you do?