PROOF OF POSITIVITY FORM: LOUISIANA HEALTH ACCESS PROGRAM

MUST be completed and signed by a clinician who has seen client in past.

MEDICAL CLINICIAN CONTACT INFORMATION	
Applicant First Name:	Applicant Last Name:
Applicant Date of Birth: ____/____/_____	Person Completing Form:
Medical Clinician Name:	Clinician Phone Number:
Medical Practice Name:	Clinician Fax Number:
Medical Clinician's License #:	Medical Clinician's State of Licensure:

MEDICAL INFORMATION

1. When was the applicant's last HIV medical care visit? _____/_____/________

2. What is the applicant's current HIV disease status?

☐ HIV Positive, not AIDS ☐ HIV Positive, AIDS status unknown ☐ CDC-defined AIDS: Both HIV and AIDS diagnosis date(s) are required (even if the same date)

3. HIV Diagnosis Date _____/_____/________ **AIDS Diagnosis Date** _____/_____/________ ☐ N/A

4. Provide most recent lab values AND regimen at time of labs in space provided.

Date drawn on lab values must be within the last 12 months.
Check the "results pending" space if most recent lab results are pending.

Date Drawn	Results Pending?	CD4	CD4%	Viral load	ARV regimen at time of labs
					☐ No ARVs
					☐ No ARVs

CLINICIAN SIGNATURE

I certify that all information provided above is accurate and complete to the best of my knowledge.

____ Signature of Clinician

_____________________________ Date Signed

Complete & return to LA HAP via fax (504) 568-3157 Questions? Please Call (504) 568-7474

Once completed, this form contains confidential information that is legally privileged and must be protected in compliance with HIPAA regulations.