

# Rhode Island AIDS Drug Assistance Program Client Agreement Statement

The following are guidelines that must be followed for you to receive drug coverage through the Rhode Island AIDS Drug Assistance Program (ADAP). The RI ADAP will keep your information strictly confidential (§23-6-17 Confidentiality, §23-6-18 Protection of Records). If you do not follow these guidelines, if you provide false information, or if we suspect you are using funds for ADAP to which you are not entitled, you may be terminated from RI ADAP.

**By participating in ADAP, I agree to the following:**

**1. I give permission to the RI ADAP staff (coordinator, program manager, eligibility technician, administrator) to contact:**

- a. My pharmacist
- b. My case manager
- c. My employer (for employee contributions to COBRA)
- d. My current or past health care provider(s)
- e. Any other person that I have specifically given permission to contact.

If needed, RI ADAP may contact these people to maintain my participation in the program. RI ADAP staff may also contact any insurance companies (third party payers/administrators) to make sure I am covered and to answer any billing questions. RI ADAP may also contact any of the people in the above list when I leave the program, if necessary. This may be done to get information about my participation in the program.

**2. I give permission for my ADAP enrollment application files to be reviewed by the following:**

- a. HEALTH staff
- b. My case manager and/or health care provider
- c. Auditors or other individuals reviewing application files as required for program fiscal monitoring.

Information in your ADAP enrollment application files will be kept strictly confidential. Under no circumstances will any personal identifying information in my ADAP file be shared with any unauthorized individual.

**3. I agree to notify HEALTH as soon as possible if any of this information changes. I need to report any other information that might change my eligibility for programs, including but not limited to:**

- a. Employment status
- b. Income
- c. Residence and Mailing address if separate
- d. Access to insurance coverage/Medicaid status
- e. Citizenship status

**4. My application may be rejected if I have provided false information.**

**5. ADAP cannot provide payments or reimbursements directly to me for any reason.**

**6. I may be required to pay back any ADAP benefits received if I was not eligible for them.**

**7. ADAP is not required to make retroactive payments for coverage before I was enrolled in the program or if my enrollment lapses.**

**8. It is my responsibility to re-apply (recertify) with ADAP every 6 months on or before my birth month and 6 months following. If I do not recertify, my ADAP benefits will be terminated.**

**9. It is my responsibility to pick up medications prescribed to me. I understand if I do not adhere to medication(s) prescribed, my ADAP benefits will be terminated.**

Revised 10/15/2010

This form must be provided to ADAP clients as part of the annual application/recertification.