Application Form 2019
Access to Treatment Program

Date of Application	Date of Receipt AFA LAC	Date of Receipt AFA int.
	(Office use Only)	(Office use Only)

A. I am Applying for the following ATAP Program:

❒ Latin American Program (LAP) ❒ Africa/Asia Program (AAP) ❒ Caribbean Program (CP)

B. If you are applying for Access to Treatment Program:

1. Please check the medicine you are requesting with the milligrams

Nucleoside/Nucleotide Reverse Transcriptase Reverse Inhibitors	Combination Drugs	Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI	Protease Inhibitors	Entry Inhibitors	Integrase Inhibitors
Combivir	**Atripla**	**Edurant**	**Evotaz**	**Fuzeon**	**Isentress**
Emtriva	**Complera**	**Intelence**	**Invirase**	**Selzentry**	**Tivicay**
Epivir	**Genvoya**	**Sustiva**	**Kaletra**		
Epzicom	**Odefsey**	**Viramune**	**Lexiva**		
Retrovir	**Stribild**		**Norvir**		
Trizivir	**Triumeq**		**Prezcobix**		
Truvada	**Biktarvy**		**Prezista**		
Viread			**Reyataz**		
Ziagen			**Viracept**		

2. Do you have access to any of these meds? ❒ Yes (Which ones):_____ ❒ No

C. **Personal Information**

First Name:		Last Name:	
Age:	Date of Birth:	Nationality:	Gender: ❒ F ❒ M ❒ Transgender
Sexual Orientation: ❒ Heterosexual ❒ Homosexual ❒ Bisexual		Marital Status:	Languages you speak:
Permanent Address:			No. Apt. / Home #:
City:	State:	Zip Code:	Country:
Phone. #:	Cell Phone #:	Fax #:	e-mail:
Profession:	Address where you want to be reached:		
Person that we can contact about this case:	Relationship:	Phone #.	e-mail:

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D. **Information about medical provider:**

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

E. **Medical History**

1. How many times have you been hospitalized because of HIV? ❒ Never ❒____Times

2. Have you suffered or are you suffering from any 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 ❒ __/__/__ Sarcoma de Kaposi ❒ __/__/__ Meningitis ❒ __/__/__
Tuberculosis ❒ __/__/__ Cytomegalovirus ❒ __/__/_ Other _____ ❒ __/__/__
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 treatment: ❒ Yes ❒ No
2. Are you currently receiving treatment? ❒ Yes ❒ No
3. Describe your treatment, starting with the most recent one (add new sheets if you have had more than 3).

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

Former treatment		Since / / till / /
	Name of the medicine	Reason of the change

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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 depression or any other mental illness? ❒ Yes ❒ No
2. Have you received any medication for this? (Including antidepressant meds) ❒ Yes ❒ No
3. Have you ever had any suicidal ideation? ❒ Yes ❒ No
4. Have you ever tried to commit suicide? ❒ Yes ❒ No
5. In the lasts three months, have you had trouble sleeping? ❒ Yes ❒ No
6. Do you easily cry? Do you have any particular reasons? ❒ Yes ❒ No
7. Do you get tired easily? ❒ Yes ❒ No
8. Do you enjoy daily activities? ❒ Yes ❒ No
9. Do you feel sad or bored? ❒ Yes ❒ No
10. Do you feel like you do not wish to go on living? ❒ Yes ❒ No

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

_____

_____

H. **Income**

1. Who do you live with? ❒Alone, ❒With relatives: ❒Parents, ❒Partner, ❒Spouse, ❒Friends, ❒Other Clarify)_____
2. Do you currently work? ❒ Yes ❒ No
3. What your profession or trade: _____
4. What is your monthly income in local currency? _____
6. What is your level of education? ❒ Elementary, ❒Secondary, ❒College, ❒Graduate
7. Do you have health coverage? (Health insurance, National program or private).
   ❒No ❒Yes If it does, it covers all treatment ❒Yes (specify below which does not cover you)

_____

_____

List all the reasons why you are requesting the help of AID FOR AIDS for treatment

Do you provide any kind of work or service to the community of people living with HIV?
❒Yes ❒No

If your answer was (Yes), describe their work and the Organization to which works or providing services.

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_____

_____

Important information:

- You are applying to a program where the confidentiality of his name will be highly respected.
- It is necessary that you provide correct and complete information how to contact you (address, phone no., e-mail address). We have to be able to contact you at all times to do a good follow-up of your case and to thus keep profits.
- Please fill out the application as well as any additional information in machine-readable form, preferably in print.
- Send a copy of the original of their CD4 and Viral Load results.
- This request does not guarantee your admission into the program. All requests will be processed depending on the order they are received, in that all documentation this full and availability we have with that medication.

Remember

- Include in your application the following documents. (These are mandatory) for the processing of your order.
- Medical history related to HIV, written this by your doctor (drugs, results of laboratories and related medical events).
- Copy of your Viral Load (dated no more than 3 months).
- Copy of your CD4 (dated no more than 3 months).
- Prescription of medications that you are requesting (dated no more than 3 months).

It will also be helpful if you can send the following results to thus better monitor your case:

Hematology and Biochemistry of blood

- Hepatic enzymes (AST-SGOT) (ALT-SGPT)
- Creatinine
- Amylase Pancreatic
- Bilirubin (Direct/Indirect)
- Total Cholesterol (HDL-LDL)
- Triglyceride

By signing this application you authorize personnel of AID FOR AIDS to maintain fluid communication with their / s provider (s) of medical services (either doctor, nurse or social worker) in place of residence.

Sign: _____

Please send the required information to Dr. Jaime Valencia: JValencia@aidforaids.org