State of California—Health and Human Services Agency

California Department of Public Health

Request for Services – Confidentiality Concerns

Required Documents

- Proof of identification
- Proof of California residency or Residency Verification Affidavit
- Copy of lab results dated within six months from today

Rights and Responsibilities

1. I understand that every reasonable measure will be taken to protect my confidentiality.
2. I understand that I will receive an electronic ID card that is for identification purposes only and does not verify eligibility. I understand that I may need to present this card on my mobile device to some providers in order to obtain benefits. If I do not have a mobile device, my enrollment worker will print paper cards for me.
3. I understand that I will receive confidential notifications regarding updates or changes to my eligibility through an electronic client portal that can be accessed on any mobile device or computer. I understand that I am responsible for safeguarding my log in information so that no one else will be able to access information on my client portal. If I do not have a mobile device or computer, I understand that I am responsible for checking in with my enrollment worker before the re- enrollment due date listed below.
4. I understand that my eligibility is good for one year from the date my completed application is approved. If I would like to continue receiving the assistance requested after my eligibility expires, I must re-enroll.
5. I understand that if I am being enrolled for the first time without lab results, I will only be granted 30-days of temporary eligiblity and that I must provide my enrollment worker with the required lab results within 30days or my eligibility will end.
6. I understand that I will be required to provide updated lab results dated within six months of my application when I re-enroll into the program.
7. I understand that I must tell my enrollment worker if any of the following happens:
    a. I move or change my phone number
    b. I no longer have confidentiality concerns

Applicant Information

Date:_____ Re-Enrollment Due On:_____ Date of Birth:_____

Client ID Number:_____ Name:_____

Email Address:_____

_____ _____

Enrollment Site Number Enrollment Site Name

Applicant Consent

If you decide to enroll in the PrEP Assistance Program, the enrolling agency will collect personal information including your name, date of birth, email address, and medical history (including HIV labs).The information will be considered confidential, but may be exchanged with health care providers, CDPH staff, program enrollment workers, CDPH contractors associated with the administration of the program in order to administer the program, CDPH staff and contractors administering the AIDS Drug Assistance Program, and with the United States Health and Human Services Secretary or designee and the California State Auditor when overseeing an audit or investigation for purposes directly related to PrEP Assistance Program. Information that you provide for your PrEP Assistance Program application may also be made available to your local health department for statistical and research purposes. This information includes, but is not limited to, gender, ethnicity, diagnosis status, zip code, and date of birth. This information may also be used for research and professional writings under strict assurances that all identifying information, including name, is deleted. Any professional or research reports that may be published will not use your name nor any personal identifying information. Confidentiality agreements are in place which keep client information confidential except with specific client consent or as otherwise allowed by law. Health information disclosed through the authorization may be subject to re-disclosure and is no longer protected if it is disclosed to anyone other than a covered entity.

I,_____, consent to release of personal and medical information to the applicable entities and for the purposes described above, as necessary for the PrEP Assistance Program in which I am enrolled in, or applying for services. I understand that I may revoke this authorization in writing by submitting a revocation request by mailing a request to CDPH, PO Box 997426, Mail Stop 7708, Sacramento, CA 95899-9908 or you may email a request to PrEPSupport@cdph.ca.gov. I understand that I have the right to receive a copy of this authorization form. I understand that my treatment, payment, enrollment, or eligibility for benefits cannot be conditioned upon this patient authorization.
This consent shall remain in effect for two (2) years from the date of my signature below. A photocopy of this consent shall be considered as valid as the original.

Applicant Name (print): _____

Applicant Signature: _____ Date: _____