New Jersey Department of Health
AIDS Drug Distribution Program (ADDP) /
Health Insurance Continuation Program (HICP)

CERTIFICATION BY PHYSICIAN

If you need assistance completing this form, call toll free 1-800-353-3232.

SECTION I - TO BE COMPLETED BY APPLICANT

Please complete the requested information in Section I. Forward to your physician for completion of Section II. Ask your physician to return the completed form to you.

Name	Social Security Number
Street Address	Date of Birth
City, State, Zip Code	

PERMISSION FOR RELEASE OF INFORMATION

I hereby give permission to my physician to release the requested information to the New Jersey Department of Health for the purpose of determining my eligibility to participate in the AIDS Drug Distribution Program (ADDP) or Health Insurance Continuation Program (HICP).

Signature of Applicant	Date

SECTION II - TO BE COMPLETED BY PHYSICIAN

The individual named above has applied to the New Jersey Department of Health for participation in the AIDS Drug Distribution Program or Health Insurance Continuation Program. Please provide the following information regarding the above applicant. Return this completed Certification form to the applicant to submit along with the completed Application.

1. Is the applicant HIV+ (lab confirmed)? ☐Yes ☐No
2. Does the applicant meet CDC criteria for AIDS? ☐Yes ☐No
3. Date of the most recent T Helper (CD4+) lymphocyte count test (if test not done use "00/00"; if unknown use "99/99"): ____ ____ / ____ ____ *Month* *Year*
   a. Absolute CD4+ lymphocyte count for the above test: _____ cells/mm3
4. Date of the most recent viral load test (if test not done use "00/00"' if unknown use "99/99"): ____ ____ / ____ ____ *Month* *Year*
   a. Viral load: _____ Results
5. HIV Risk Factor(s) – please check appropriate category(ies):
   - ☐ Male who has sex with male(s)
   - ☐ Injecting drug user
   - ☐ Hemophilia/coagulation disorders
   - ☐ Heterosexual contact
   - ☐ Perinatal transmission
   - ☐ Undetermined/unknown, risk not reported or identified
   - ☐ Receipt of transfusion of blood, blood components or tissue
   - ☐ Other, specify: _____

CERTIFICATION

I hereby certify that the above-named applicant has a medical necessity to obtain FDA-approved AIDS/HIV-related drugs.

Name of Physician (Print)	License Number and State
Street Address	Telephone Number
City, State, Zip Code	
Signature	Date

Applicant: Forward this completed Certification to ADDP/HICP along with your completed Application.