

## ADAP Jail Assistance Application Instructions

The accompanying application should be used to request medications through the Jail Assistance Program administered by the AIDS Drug Assistance Program (ADAP) at the Iowa Department of Public Health (IDPH). Applicants must have a documented HIV diagnosis to qualify. All medications dispensed through the ADAP Jail Assistance Program are considered property of the applicant and must be sent home with the applicant upon their release from the jail.

The applicant is only required to sign the first application of their incarceration period to consent to have their information submitted to the ADAP Jail Assistance Program. Any remaining applications until the applicant is discharged will only require the jail staff's signature. If an applicant is discharged from jail and returns at a later date they will need to sign the first application of the new incarceration period.

Each approved application will authorize one 30-day supply of the medication(s) requested on the application. The jail should submit one application for each 30-day supply as needed. The ADAP formulary listing all excluded medications can be found on the Ryan White section of IDPH's website at <http://idph.iowa.gov/hivstdhep/hiv/support>.

All medications administered through the Jail Assistance Program will be dispensed and mailed to the jail by the ADAP contract pharmacy, NuCara Specialty Pharmacy. If an applicant leaves the jail before the requested medications arrive in the mail, the jail should contact the ADAP office via the ADAP administrative email: [adap.administrator@idph.iowa.gov](mailto:adap.administrator@idph.iowa.gov). Emails including applicant names or other identifying information must be sent securely.

The ADAP must verify an applicant's HIV diagnosis before an application can be approved. The ADAP office will reach out to the jail if the ADAP is unable to obtain a verification of diagnosis from the IDPH HIV Surveillance office. In rare cases, the jail may need to coordinate with the ADAP for diagnostic testing to be completed.

If the applicant has an active prescription, NuCara Specialty Pharmacy will request the prescription from the pharmacy listed on the application. If the applicant does not have an active prescription, it is the jail's responsibility to coordinate new prescriptions. New prescriptions should be sent to:

NuCara Specialty Pharmacy  
5042 Maple Dr.  
Pleasant Hill, IA 50327

**Phone:** 515-266-4167 **Fax:** 515-265-5431 **Email:** [nsp@nucara.com](mailto:nsp@nucara.com)

**Completed applications should be faxed to the ADAP office at (515) 281-0466.** Once received, a confirmation email or fax will be sent via the preferred method indicated on the application. Jail Assistance applications will be prioritized to reduce gaps in medication. Once approved, the ADAP will send notification to the contact person listed on the application. NuCara Specialty Pharmacy will call the contact person for required medication consultation and confirm the mailing address for the meds.

Questions can be directed to [adap.administrator@idph.iowa.gov](mailto:adap.administrator@idph.iowa.gov), or to the ADAP Coordinator, Meredith Heckmann, at 515-725-2011.

**Applicant Information**

|   |  |   |  |  |   |   |   |
|---|--|---|--|--|---|---|---|
| <b>Name</b>                                   |  |   |  |  |   |   |   |
| <b>Date of Birth</b>                          |  | <b>SSN</b>  |  | <b>Sex At Birth</b>                                    |   | <input type="checkbox"/> Male   | <input type="checkbox"/> Female               |
| <b>Gender</b>                                 |  | <input type="checkbox"/> Male   | <input type="checkbox"/> Female                    | <input type="checkbox"/> Transgender M to F            | <input type="checkbox"/> Transgender F to M         |   |   |
| <b>Estimated Release</b>                      |  | <input type="checkbox"/> 1-7 days   | <input type="checkbox"/> 8-30 days                 | <input type="checkbox"/> 30+ days                      | <input type="checkbox"/> Unknown                    |   |   |
| <b>State Applicant Received HIV Diagnosis</b> |  |   |  |  |   |   |   |
| <b>Ethnicity</b>                              |  | <input type="checkbox"/> Hispanic<br><b>Subgroup</b> (if Hispanic):<br><input type="checkbox"/> Mexican, Mexican American, Chicano/a<br><input type="checkbox"/> Cuban<br><input type="checkbox"/> Puerto Rican<br><input type="checkbox"/> Another Hispanic, Latino/a, or Spanish Origin                                     |  |  | <input type="checkbox"/> Non-Hispanic               |   | <input type="checkbox"/> Prefer not to answer |
| <b>Race</b>                                   |  | <input type="checkbox"/> White  | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Multi-racial                  | <input type="checkbox"/> Other/Prefer not to answer |   |   |
|   |  | <input type="checkbox"/> Asian<br><b>Subgroup</b> (if Asian):<br><input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese<br><input type="checkbox"/> Filipino <input type="checkbox"/> Japanese<br><input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese<br><input type="checkbox"/> Other Asian |  | <input type="checkbox"/> American Indian/Alaska Native |   | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander<br><b>Subgroup</b> (if Native Hawaiian/Other P.I.):<br><input type="checkbox"/> Native Hawaiian<br><input type="checkbox"/> Samoan<br><input type="checkbox"/> Guamanian or Chamorro<br><input type="checkbox"/> Other Pacific Islander |   |

**Medication Request**

|  |   |  |  |                              |  |                                       |  |
|--|---|--|--|------------------------------|--|---------------------------------------|--|
| <b>Name of Medication(s)</b>                           |   |  |  |                              |  |                                       |  |
| <b>Days of Meds Left as of</b> __/__/____              |   |  |  |                              |  |                                       |  |
| <b>Does the applicant have a current prescription?</b> |   |  |  | <input type="checkbox"/> Yes |  | <input type="checkbox"/> No           |  |
| <b>If Yes:</b>   | Pharmacy Name   |  |  | Phone                        |  |                                       |  |
| <b>If No:</b>  | A new prescription must be sent to NuCara Pharmacy, see Instructions for contact information. |  |  |                              |  |                                       |  |
| <b>Does the applicant have insurance?</b>              |   |  |  | <input type="checkbox"/> Yes |  | <input type="checkbox"/> No Insurance |  |
| <b>If Yes:</b>   | Does the applicant consent to ADAP using the insurance?                                       |  |  | <input type="checkbox"/> Yes |  | <input type="checkbox"/> No           |  |

**Jail Information**

|  |  |  |  |
|--|--|--|--|
| <b>Facility Name</b>                       |  | <b>Contact Phone</b>                     |  |
| <b>Contact Name</b>                        |  | <b>Contact Email</b>                     |  |
| <b>Mailing Address for Prescription(s)</b> |  | <input type="checkbox"/> Email Preferred |  |
|  |  | <b>Contact Fax</b>                       |  |
|  |  | <input type="checkbox"/> Fax Preferred   |  |

By signing this form, the jail staff signifies that the cost of HIV-related medications presents a significant hardship for the county or that the costs of medications will be passed on to the applicant. Additionally, jail staff agree that the medications provided by the ADAP are property of the applicant and will be sent with the applicant upon release or transfer.

**Signature of Jail Staff** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Applicant to authorize HIV related information to be released to IDPH** (only required for first application):

\_\_\_\_\_ **Date** \_\_\_\_\_