Alabama Ryan White HIV/AIDS ADAP Program

City/County Jail Incarceration form

For ADPH ADAP ServicePoint (SP) application for individuals, this form is an extension of the SP application. All information provided is expected to be accurate and true.

If a city or county jail does not contract with a healthcare provider to provide medication services to incarcerated ADAP clients, then **the incarcerated individual remains eligible** for ADAP medication services.

- To ensure the Ryan White HIV/AIDS Program remains the *payor of last resort* for medication services, the city/county jail must provide written documentation to the ADPH ADAP Central Office for each incarcerated ADAP enrollee, indicating no healthcare provider services are available to pay for medication services for individuals with HIV.
- ADAP medication will be shipped by the Pharmacy Benefit Manager, to the incarcerated ADAP enrollee's clinic, for the clinic to provide to the ADAP enrollee while incarcerated.
- This policy applies to persons who are in county or city "work release programs" as the individual remains in care and custody of the city of county jail.

Case Manager Instructions:

1. Ensure this form is provided to the city or county jail where the ADAP enrollee is incarcerated, for the jail officials to complete on behalf of the ADAP enrollee
2. Upon receipt of this completed from the city/county jail, upload this to the client's SP profile.

Incarcerated individuals information	
Legal First Name:	**Legal Last Name:**
Date of Birth: (MM/DD/YYYY)	**Incarceration Date: (MM/DD/YYYY)**
ServicePoint ID Number:	

Attestation *(City/County Jail Representative must complete all of the below)*	
I hereby certify that the information on this form is *accurate to the best of my knowledge*, I *reviewed this with the client, and it is complete and correct.* I advised the ADAP client that intentionally withholding and/or providing false or misleading information here will result in immediate denial or termination of all RWHAP Part B funded services, including ADAP services.	
Name and full address of the city/county jail	
City/County Jail representative *printed name*	
City/County Jail representative *signature*	
Date form signed	
My name, signature and date above confirm that this county/city jail that I represent, does not contract with a healthcare provider to pay for medication services for individuals with HIV.	