Participant Enrollment and Consent Form

Instructions

Please review all program goals and requirements with client FIRST.

When reviewing program goals and requirements with client, please ensure all questions are answered before client signs.

Please call Member Services for additional questions at (800) 556-0689.

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What is the goal of the program?

Amida Care is beginning a viral load suppression incentive program to help Amida Care's adult members living with HIV achieve and maintain viral suppression.

For most people living with HIV, taking antiretroviral (ARV) medications exactly as prescribed by your primary care doctor will reduce the level of HIV virus in the blood to a very low level (sometimes described as an "undetectable" viral load or "viral load suppression").

Research shows that people living with HIV who have a viral load that is suppressed by ARVs to an undetectable level live longer, are healthier, and are un-able to transmit the HIV virus to other people. Viral load suppression is defined as a viral load laboratory result of less than 200 copies/ml.

To help you take your ARV medications regularly in order to achieve viral suppression, Amida Care can provide supportive services and tools decided by you and your primary care provider. If you decide to enroll in the program and your viral load becomes undetectable (viral load of less than 200 copies/ml), you will receive a financial incentive of $100 for each three-month period that you stay undetectable.

In order to enroll in the Live Your Life Undetectable program, you must meet the following requirements:

- Must be HIV Positive
- Must be 18 years or older or an emancipated minor.
- Must be actively enrolled with Amida Care
- Agree to attend a medical visit with your HIV primary care provider and have viral load blood work done every three months.
- Complete and sign a Regional Health Information Organization (RHIO) consent form (consenting yes) giving Amida Care approval to access your medical records through the systems of the Bronx RHIO and Healthix.
- Agree to use HIV primary care provider-recommended ARV adherence tools including participation in supportive services at least one time per month.
- Complete a health assessment at enrollment and agree to complete a re-assessment every six months.

Agree to join in a case conference with your primary care provider and supportive service provider as needed.

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To collect the financial incentive of $100 per quarter (three-month period), all of the following requirements must be met:

- You cannot be enrolled in another Viral Load Suppression Incentive program at the same time.
- Evidence of viral suppression (VL less than 200 copies/ml) in your most recent viral load test during the quarter must be sent to Amida Care by your doctor's office.
- Evidence of supportive service activity, such as medication adherence counseling, case management, or behavioral health treatment, for the quarter must be sent to Amida Care by your doctor's office.
- You must be an active Amida Care member to receive the incentive payment. Your incentive payment of $100 will be added to your Amida Care "Healthy Rewards" VISA card.

For members who are virally suppressed (VL less than 200 copies/ml) for at least 12 months in a row:

- Talk to your doctor about reviewing your medical records to find out if you qualify to schedule viral load testing less often.

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Participant Name and Contact Information:

Participant's First Name: | Initial: | Participant's Last Name:

Date of Birth: | CIN#

Address #1: | Address #2:

City | State | Zip Code

Telephone: | Cell Phone (if different than Telephone):

Participant's Email:

HIV Primary Care Provider:

HIV PCP First Name: | Initial: | HIV PCP Last Name:

Clinic Name: | Clinic Address:

Clinic's City | State | Zip Code

Clinic's Telephone: | Clinic's Email

If the Primary Care Provider (PCP) listed above is different from what Amida Care has on file, Amida Care will update your records to show the new Primary Care Provider and will send you a new Amida Care I.D card with the corrected information.

HIV Supportive Services Provider Name and Contact Information:

HIV Supportive Services Provider First Name: | Initial: | HIV Supportive Services Provider Last Name:

Supportive Service Program: | Supportive Service Program Address:

Supportive Service Program City | State | Zip Code

Supportive Service Program Telephone: | Supportive Service Program Email

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Participant Emergency Contact:

Emergency Contact First Name: _____ Initial: _____ Emergency Contact Last Name: _____

Relationship to Participant: _____ Is Contact Aware of HIV Status? ☐ YES ☐ NO

Emergency Contact Address #1: _____ Emergency Contact Address #2: _____

Emergency Contact City _____ State _____ Zip Code _____

Emergency Contact Telephone: _____ Emergency Contact Cell Phone (if different than Telephone): _____

Emergency Contact Email: _____

Participant Signature:

When you sign this document, you are agreeing to enroll and take part in the Live Your Life Undetectable viral load suppression incentive program. If you have any questions or there is something you do not understand, please ask.

Signature of Participant: _____

Print Name of Participant: _____

Date of Signature: _____