



ADAP Waiting List Medical Categorization Form

| CLIENT NAME | DATE OF BIRTH | SSN | DATE |
|-------------|---------------|-----|------|
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This form must be completed by a medical provider, clinician, or designated clinical staff member.

PART I – PRIORITIZATION CATEGORY

CATEGORY A

- Diagnosis of AIDS and/or CD4 < 200 cells/mm³ and/or CD4% < 14%
- Diagnosis of active opportunistic infection
- Diagnosis of HIV-associated nephropathy (HIVAN)

OR

CATEGORY B

- Persons who are currently on ARV therapy
- Persons who were previously on ARV therapy but therapy was interrupted
- Treatment naïve clients with CD4 cell count between 201-350 cells/ mm³

OR

CATEGORY C

- Treatment naïve clients with CD4 cell count > 350 cells/mm³

PART II – CLINICIAN SIGNATURE

By signing below, I agree that the information provided in this form is accurate to the best of my knowledge.

| | | |
|--------------------------------------|-------------------------------------|---------------------------------|
| PRINT Clinician/Designee Name | Clinician/Designee Signature | Date |
| CHD/Office Name | County | Clinician Contact Number |