



APPLICATION FOR MEDICATION ASSISTANCE

Texas HIV Medication Program
 ATTN: MSJA - MC 1873
 PO Box 149347, Austin, TX 78714-9347
 1-800-255-1090

Please print clearly and answer all questions. Review the attached instructions carefully before you begin. If you need assistance completing this application, please contact the THMP at the above phone number. Mail the completed application to the THMP at the address listed above. Unless otherwise requested, please send legible copies of any required documents; if you send original documents, they will not be returned to you.

SECTION I – PERSONAL INFORMATION

1. Last Name		First Name		Middle Name		2. Date of Birth	
3. Residential Street Address – (No P.O. Boxes or Rural Routes)				4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender		5. If female, are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If you wish to have mail sent somewhere other than your residential address please provide an alternate mailing address:</i>							
6. Mailing Address - (P.O. Boxes and Rural Routes accepted here)				City, State Zip			
7. Are you currently a resident of the State of Texas? <input type="checkbox"/> Yes <input type="checkbox"/> No				Proof of current TX residency is required. Examples: DPS issued driver's license or identification card; Social Security, Medicaid, Medicare benefit award letter; current rental agreement; electric, gas or phone bill in your name.			
8. Home Phone Number (area code + number) May we leave a message on your voice mail or answering machine? <input type="checkbox"/> Yes <input type="checkbox"/> No				9. Work/Alternate Phone (area code + number) May we leave a message on your voice mail or answering machine? <input type="checkbox"/> Yes <input type="checkbox"/> No			
10. In order to process your application faster, we may need to call you at home with additional questions. If you are unavailable, are there any special instructions as to how we should leave a message for you?							
11. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married/Common Law <input type="checkbox"/> Divorced <i>(see instructions)</i>				12. If your marital status has changed in the past year please explain briefly when and how it has changed.			
13. Your Social Security Number				14. Your Spouse's Social Security # (if applicable)			
15. Race/Ethnicity (please check the one that best describes you) <input type="checkbox"/> White (Non-Hispanic) <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black/African American (Non-Hispanic) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hispanic <input type="checkbox"/> Other/Unknown							
16. Do you currently reside in a residential or correctional facility? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Facility Name & Location:				Residential Facility Type <input type="checkbox"/> Halfway House <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Nursing Home <input type="checkbox"/> Rehabilitation Facility		Correctional Facility Type <input type="checkbox"/> City/County Jail <input type="checkbox"/> TDCJ Date you expect to be released from custody? _____	
17. Have you recently been released from a Texas Department of Criminal Justice (TDCJ) facility, County Jail, or Federal Penitentiary? <i>(please state when you were released and from what facility)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No							
Facility Name			TDCJ Number (if applicable)		Release Date (or expected release date)		

SECTION II – HOUSEHOLD AND MONTHLY INCOME INFORMATION

18. Including yourself, how many people live in your home? _____
 Complete the following for **all** persons living in your home other than yourself (*this includes children, spouse, relatives, friends and roommates*):

Name	Age (give date of birth if under 18)	Relationship

19a. Do you have income or receive benefits? Yes No (If Yes, answer 19c, if No answer 19d)

19b. If married/common law, does your spouse have income or receive benefits? Yes No (If Yes, answer 19c, if No answer 19d)

19c. If YES, complete this section
 List all sources of income below - documentation for all income is **required** and must be submitted with application:

Sources of Income/Benefits (Monthly – gross pretax totals)	Applicant	Spouse	Required documentation
Wages, salary, commissions, tips			At least Two (2) current, consecutive pay stubs or earnings statements. If paid weekly, four (4) consecutive pay stubs will be required. (<i>please see instructions for additional details</i>).
Self employment income			A copy of your benefit award letter or any other official documentation showing the amount received on a regular basis.
Interest, cash dividends or investment income			
Unemployment Benefits/Income			
Social Security Income (retirement or disability benefits)			
Retirement Pension Benefits			
Veteran’s Benefits			
Supplemental Security Income			
Other Disability Benefits/Income			
Food Stamps			
Temporary Assistance to Needy Families (TANF) Benefits			
Alimony/child support received:			
Other Income (specify source):			

Do you receive HOPWA/Section 8 housing assistance/subsidized housing? Yes No (*If yes, include agency verification*)

19d. If NO, complete this section - Please tell us how you (or your spouse) are supported: (i.e., housing, food, clothes, bills, etc.) **Please include a supporter statement completed and signed by the person(s) or agency that is providing this support.** If the applicant is married and is reporting income in section 19c and the spouse does not have income please state the applicant is the sole provider of the household in the space below. Please note that deliberately omitting or giving false information could cause you to be removed from the THMP, criminally prosecuted, or both. Attach an additional sheet if necessary.

SECTION III – EMPLOYMENT STATUS

20. What is your current employment status? <i>(you must check the ones that apply)</i>		Self	Spouse <i>(if applicable)</i>
Employed Full-Time (working usually 30-40+ hours a week)		<input type="checkbox"/>	<input type="checkbox"/>
Employed Part-Time (working usually less than 30 hours per week)		<input type="checkbox"/>	<input type="checkbox"/>
Employed by a Temporary Agency		<input type="checkbox"/>	<input type="checkbox"/>
Seasonally Employed		<input type="checkbox"/>	<input type="checkbox"/>
Not Employed/Unemployed If not employed where and when were you last employed?		<input type="checkbox"/>	<input type="checkbox"/>
21. Your Employer Name & Your Job Title		22. Spouse's Employer Name & Their Job Title	

SECTION IV – HEALTH INSURANCE STATUS

23. Do you have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, you will also need to fill out the Texas HIV State Pharmacy Assistance Program (SPAP) – Enrollment Form (page 8)	
	Applicant	Spouse <i>(if applicable)</i>	Required Documentation
24. Do you or your spouse have employer sponsored private health insurance benefits or COBRA (for insurance continuation)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide a copy of both sides of the insurance card and include documentation as to how your prescription coverage works.
24a. If yes, are prescription drugs covered?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
25. If you or your spouse were recently unemployed (within the last 60 days), did you have employer sponsored insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide proof insurance ended or terminated (certificate of prior coverage)
26. Other type(s) of Health Insurance Coverage	Applicant	Spouse <i>(if applicable)</i>	
Veterans Administration Health Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number (self): Number (Spouse):
City/County Medical Assistance Programs <i>(such as MAP Card, Gold Card, Carelink, etc.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any other health coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify:
27. If you have health insurance (other than Medicaid, Medicare or City/County Assistance) that covers prescription drugs, why are you applying for this program? <i>(Please check ALL that apply, and submit supplemental documentation from the insurance plan verifying your situation.)</i>			
<input type="checkbox"/>	One or more HIV/AIDS prescriptions I need are not covered by my plan.		
<input type="checkbox"/>	Insurance/COBRA Coverage will expire soon <i>(specify expiration date)</i> : _____		
<input type="checkbox"/>	Expenses have exceeded the insurance plan's lifetime cap.		
<input type="checkbox"/>	Expenses have or are about to exceed the plan's annual prescription cap. Amount of annual prescription cap: \$ _____		
<input type="checkbox"/>	HIV/AIDS is a pre-existing condition for my health insurance plan. If known, please specify the date that the pre-existing condition limit in your insurance plan will be met: _____		
<input type="checkbox"/>	Other limitations on coverage or payment <i>(specify)</i> : _____		

SECTION V – PARENT INFORMATION (if applicant is under the age of 18)

If the applicant is **under the age of 18** this section must be filled out for the parent(s) who live with the child. If there is additional information that would help clarify the child's situation, please submit the information on a separate sheet of paper. If the applicant is **over** the age of 18, please leave this page blank.

A. Name of Parent	B. Name of Parent (if applicable)
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C. Do the parent(s) listed above have income or benefits? Yes No
 If **Yes**, complete Section C1.
 If **No**, provide a statement of how the child is supported (i.e., housing, food, clothes, bills, etc.) and include a supporter statement completed and signed by the person(s) or agency that is providing this support.

C1. List all sources of income below - documentation for all income is required and must be submitted with the application

Sources of Income/Benefits <i>(Monthly – gross pretax totals)</i>	Parent (A)	Parent (B)	Required Documentation
Wages, salary, commissions, tips			Two (2) current, consecutive pay stubs or earnings statements <i>(see instructions for additional details)</i> .
Unemployment Benefits/Income			A copy of your benefit award letter or any other official documentation showing the amount received on a regular basis.
Social Security Income (retirement or disability benefits)			
Retirement Pension Benefits			
Veteran's Benefits			
Supplemental Security Income			
Other Disability Benefits/Income			
Interest, cash dividends or investment income			A completed copy of your most recent Federal Income Tax Return. Please note that per IRS regulations, anyone with net self-employment earnings of more than \$400 is required to file a Federal Tax Return for that calendar year.
Self employment income			
Food Stamps			A copy of your benefit award letter or any other official documentation showing the amount received on a regular basis.
Temporary Assistance to Needy Families (TANF) Benefits			
Alimony/child support received:			
Other Income (specify source):			

D. Do the parent(s) receive HOPWA/Section 8 housing assistance/subsidized housing? <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(If yes, include agency verification)</i>
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EMPLOYMENT STATUS

E. What is the current employment status of the parent(s)? <i>(you must check the ones that apply)</i>	Parent (A)	Parent (B)
Employed Full-Time (working usually 30-40+ hours a week)	<input type="checkbox"/>	<input type="checkbox"/>
Employed Part-Time (working usually less than 30 hours per week)	<input type="checkbox"/>	<input type="checkbox"/>
Employed by a Temporary Agency	<input type="checkbox"/>	<input type="checkbox"/>
Seasonally Employed	<input type="checkbox"/>	<input type="checkbox"/>
Not Employed/Unemployed If not employed where and when you were last employed?	<input type="checkbox"/>	<input type="checkbox"/>

F. Parent (A) - Employer Name & Job Title	G. Parent (B) - Employer Name & Job Title
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INSURANCE STATUS

H. Does the parent(s) receive employer sponsored or private health insurance benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide a copy of both sides of the insurance card and include documentation as to how your prescription coverage works.
If yes, does the policy cover the child for prescription drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION VI – VETERAN’S STATUS (see application instructions for further details)

28. Are you a United States Veteran? Yes No

If yes,

Do you currently receive Veteran's healthcare benefits? Yes No

Have you served on active duty service for more than 180 days (6 months) with the Army, Navy, Air Force, Marines, Coast Guard, or the Reserves? Yes No

Did you receive an honorable or General Discharge? Yes No

SECTION VII – APPLICANT CERTIFICATION AND AUTHORIZATION

29. Authorization to release confidential information: In order to process my application as quickly as possible, I am authorizing the following individual(s) to speak to the THMP on my behalf regarding my eligibility status and any questions that arise regarding my application. The individuals may be specific friends and family members, or they may be care coordinators, social workers or other case managers operating on my behalf. This authorization is in effect until I revoke it in writing, which I may do at any time.
(please see instructions for further details)

Name of Person	Relation to you <small>(or agency name, if applicable)</small>	Phone Number

30. Additional Information –
If someone is assisting you with applying for social service programs & other benefits, please list them below:

Care Coordinator/Social Worker/Case Manager Name:

Agency:

Phone Number:

SECTION VIII – APPLICANT CERTIFICATION AND AUTHORIZATION

IMPORTANT – THE FOLLOWING CERTIFICATION AND AUTHORIZATION MUST BE SIGNED BY THE APPLICANT:

- a. I understand that this application is a legal document. My signature (1) attests that all the information given is true and correct, and (2) authorizes the release of my medical information to the Texas HIV Medication Program (THMP).
- b. I understand that it is my responsibility to notify the THMP immediately if my/our income increases; if I/we move from Texas; or if my/our marital, household or insurance status changes.
- c. I understand that the THMP may request verification of the information I have provided in order to process my application, and also at any time thereafter. I also understand that the processing of my application may be delayed until such requested verification is received.
- d. I understand that deliberately omitting or giving false information could cause me to be removed from the THMP, or criminally prosecuted, or both.
- e. I understand that the THMP reserves the right to limit enrollment based upon availability of funds.
- f. I understand that the THMP is required to recertify my eligibility status per the program rules in order to continue receiving services.

Signature of Applicant	Date
Signature of Parent (if applicant is under 18 years of age)	Date

Is your application complete?

If your application is not complete when submitted, we won't be able to determine your eligibility. Did you:

- Answer all of the questions on the application?
- Include proof of Texas residency?
- Include proof of current income?
- Include a copy of your health insurance card (if applicable)?
- Sign the application?
- Include the Medical Certification Form, completed and signed by your doctor?
- If you have Medicare, have you also included the completed SPAP Enrollment form?

If you have any questions please call the THMP at 1-800-255-1090.

Mail all application materials to:
Texas Department of State Health Services
Attn: MSJA - MC 1873
PO BOX 149347
Austin, Texas 78714-9347

PRIVACY NOTIFICATION

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on privacy notification. (Reference: Texas Government Code, Sections 522.021, 522.023, 559.003 and 559.004)

For additional information, including a review of Frequently Asked Questions and downloadable copies of program documents, please visit the Texas HIV Medication Program web site at <http://www.dshs.state.tx.us/hivstd/meds>.

For additional information on AIDS service organizations, case management services and community resources in your local area, please call 2-1-1.

If you have any questions, comments or concerns regarding the Texas HIV Medication Program and this application for assistance, please call the program directly at 1-800-255-1090.

Once you have completed the application and gathered the necessary attachments, please mail the completed application to: Texas HIV Medication Program, ATTN: MSJA MC 1873, PO BOX 149347, Austin TX 78714-9347

(revised 12/2007)

SUPPORTER STATEMENT

If the applicant's total income and benefits equals zero, this form must be completed and signed by the person providing support.

I, _____, certify that I currently support
(Printed name of supporter)

_____, who resides at the following
(Printed name of client)

address: _____
(Client's street address, city, state, & zip code)

I have supported him/her since _____. My relationship to the applicant
(Date)

is _____. To the best of my knowledge, his/her

total monthly income is \$_____.

The type of support I provide is (check all that apply):

- Room Only Room and Board (food/clothing) Payment of utility bills and/or mortgage/rent
 Cash Assistance * Other _____

* If cash assistance, I am providing \$_____ per month to applicant.

Additional explanation (if necessary):

I can be reached at the following number(s) to verify this information: _____

By signing this form, I affirm that the above information is an accurate statement of assistance being provided to the applicant. I understand that if I deliberately omit or give false information the applicant may be removed from the program and/or criminally prosecuted.

Signature of Supporter

Date

Please note: If there are special circumstances surrounding your household situation that would need to be explained or verified by a social worker, case manager, or public health nurse, please have them provide a detailed support statement on your behalf and attach it to your application when applying for assistance.



Phone: 1-800-255-1090
Fax: 512-371-4670

Enrollment - Texas HIV State Pharmacy Assistance Program

Mailing Address: Texas Department of State Health Services
ATTN: MSJA - MC 1873
PO Box 149347
Austin, TX 78714-9347

Applicants with MEDICARE should fill out this form. Individuals with Medicare who are eligible for assistance from the Texas HIV Medication Program (THMP) will be enrolled in the HIV State Pharmacy Assistance Program (SPAP) to obtain their medications. The SPAP is designed to provide help with co-pays, coinsurance and gap coverage associated with a Medicare Part D prescription drug plan. If you have questions about the SPAP or this application please call 1-800-255-1090. **If you are not already enrolled in the THMP, you must also fill out the full THMP application.**

SECTION I – PERSONAL INFORMATION

Last Name	First Name	Middle Name
Mailing Address		Phone Number (area code + number)
May we leave a message on your voice mail or answering machine? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Your Social Security Number	Your Medicare Number	Effective Date of Medicare Part A (listed on your Red White & Blue Medicare Card)

SECTION II – MEDICARE PRESCRIPTION DRUG INFORMATION

Are you enrolled in a Medicare Prescription Drug Plan (Part D)? Yes if yes, please provide plan information below.
 No

Plan Name:	Effective Date:		
ID Number:	RxBin:	RxPCN:	RxGroup:

SECTION III – LOW INCOME SUBSIDY

Have you applied for the Low Income Subsidy or Extra Help through the Social Security Administration? Yes - please indicate application status below.
 No - you need to apply for this assistance, please call 1-800-255-1090 to have an application mailed to you.

Low Income Subsidy/Extra Help Application Status

Approved, 100% Assistance Denied Assistance (attach a copy of pre-decisional or denial letter)
 Approved, partial assistance (attach copy of approval letter) Awaiting determination, application date: _____

SECTION IV – SPAP AGREEMENT

- 1) I understand that it is my responsibility to:
 - a) enroll in a Medicare Prescription Drug Plan,
 - b) maintain my enrollment in a Medicare Prescription Drug Plan, and
 - c) pay the monthly prescription drug plan premium directly to the prescription drug plan.
- 2) I understand that it is my responsibility to notify the Texas HIV SPAP immediately if any of the following happen:
 - a) my household income increases,
 - b) my address changes or I move out of the State of Texas,
 - c) my marital, household or insurance status changes, or
 - d) my Medicare benefits are terminated.
- 3) I understand that the Texas HIV SPAP reserves the right to limit enrollment based upon availability of funds.
- 4) I understand that the Texas HIV SPAP is required to recertify my eligibility status every other year per program rules in order to continue receiving services.
- 5) I understand that this is a legal document. My signature (1) attests that all the information given is true and correct, (2) authorizes the release of my medical information to the Texas HIV Medication Program, including the Texas HIV SPAP, and (3) attests that I do reside in the State of Texas.

Signature of Applicant	Date
Signature of Parent (if applicant is under 18)	Date

**TEXAS HIV MEDICATION PROGRAM
MEDICAL CERTIFICATION FORM**

(TO BE COMPLETED BY PHYSICIAN)

Texas HIV Medication Code (if known) _____

The information requested is necessary to determine the patient's eligibility for program-supplied, HIV-related therapy as prescribed by you. All information requested will be kept strictly confidential by the Texas Department of State Health Services; personal identifying info is never released.

PATIENT INFORMATION

Full Name: _____

Mailing Address: _____ Apt. # _____

City, State, Zip: _____ Phone # () _____

Date of Birth: _____ / _____ / _____ Social Security Number: _____
Month Day Year

*****NOTICE*** Changes in therapy after initial approval and/or recertification may be faxed to (512) 371-4670.**

I hereby certify that this patient has been diagnosed with HIV infection, and I am reporting the following viral load and CD4 count:

Plasma RNA Viral Load: _____ copies/ml	Test Date: _____ / _____ / _____	Current CD4 Count: _____	Test Date: _____ / _____ / _____
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PRESCRIBED MEDICATIONS FOR OPPORTUNISTIC INFECTIONS:

Please check here if patient is pregnant: _____

- _____ **Acyclovir**, for acute or chronic herpetic infection
- _____ **Itraconazole capsules**, for diagnosed histoplasmosis or blastomycosis
- _____ **Clarithromycin**, for a current or previous mycobacterium avium complex (MAC) diagnosis, **OR**
- _____ **Azithromycin**, if client failed therapy on, or is intolerant of, clarithromycin
- _____ **Fluconazole**, for diagnosed cryptococcal meningitis or esophageal candidiasis, **OR**
- _____ **Itraconazole suspension**, for diagnosed esophageal candidiasis
- _____ **Valganciclovir** (Valcyte), for diagnosed CMV disease with infection(s) of major organ(s) or organ system(s)
- _____ **Megesterol Acetate**, for diagnosed cachexia or anorexia with profound, involuntary, acute weight loss $\geq 10\%$ of baseline body weight or chronic weight loss $\geq 20\%$ of baseline body weight
- _____ **Atovaquone** (Mepron), for diagnosed acute, mild to moderate PCP and intolerance to both SMZ-TMP and dapsone
- _____ **Rifabutin** (Mycobutin), for a CD4 cell count ≤ 100
- _____ **Ethambutol**, for a current or previous mycobacterium avium complex (MAC) diagnosis
- _____ **Pentamidine** or _____ **SMZ/TMP** or _____ **Dapsone** (choose one, if applicable), for CD4 ≤ 200 , or thrush, or previous PCP diagnosis, or unexplained fever $> 100^\circ$ for > 2 weeks

*****REQUIRED***** Is this patient naïve to antiretroviral therapy? (check one) _____ Yes _____ No

PRESCRIBED ANTIRETROVIRAL MEDICATIONS: LIMIT OF FOUR (4) ANTIRETROVIRALS MAX PER CLIENT

- | | | |
|---|---|---|
| _____ zidovudine (AZT) | _____ invirase (Saquinavir) | _____ nevirapine (Viramune) |
| _____ didanosine (DDI) | _____ ritonavir (Norvir) | _____ delavirdine (Rescriptor) |
| _____ stavudine (D4T) | _____ indinavir (Crixivan) | _____ efavirenz (Sustiva) |
| _____ lamivudine (3TC, Epivir) | _____ nelfinavir (Viracept) | _____ tenofovir (Viread) |
| _____ abacavir sulfate (Ziagen) | _____ lopinavir/ritonavir (Kaletra) | _____ raltegravir (Isentress) |
| _____ emtricitabine (Emtriva) | _____ atazanavir (Reyataz) | |
| _____ Combivir (AZT/3TC)* | _____ tipranavir (Aptivus) | _____ Atripla (Sustiva/Truvada)* |
| _____ Trizivir (AZT/3TC/Ziagen)* | _____ darunavir (Prezista) | _____ enfuvirtide (Fuzeon) |
| _____ Truvada (Emtriva/Viread)* | _____ fosamprenavir (Lexiva) – boosted dosage, 1 bottle/mo (recommended) | |
| _____ Epzicom (3TC/Ziagen)* | _____ fosamprenavir (Lexiva) – unboosted dosage (2 btl/mo <u>without</u> low-dose ritonavir); dosage requires consultation/written justification from physician. | |
- _____ **etravirine** (Intelence) – For treatment experienced patients with viral resistance or toxicity to antiretroviral agents.
- _____ **maraviroc** (Selzentry) – For treatment experienced, CCR5 mono-tropic HIV-1 detectible patients with viral resistance to multiple antiretroviral agents. (**Proof of CCR5 monotropism via CCR5 Trofile test must be included with this form for maraviroc approval.**)

Please note: *For the 4 antiretroviral limit, Combivir, Truvada & Epzicom each count as 2 antiretrovirals; Trizivir & Atripla count as 3 antiretrovirals.

PHYSICIAN SIGNATURE: _____ TX MD/DO LICENSE #: _____

PRINTED NAME OF PHYSICIAN: _____

OFFICE ADDRESS: _____

TELEPHONE: _____ FAX: _____ DATE: _____ / _____ / _____