



ADAP Waiting List Medical Categorization Form

CLIENT NAME	DATE OF BIRTH	CLIENT ID	DATE

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.

Clinician/Designee Signature

Print Clinician/Designee Name

Date

CHD/Office Name

County

CHD/Office Address

Clinician Contact Number