



**Nevada Office of HIV/AIDS  
Ryan White Part B Program  
Nevada Medication Assistance Program (NMAP)  
Client Acknowledgement Form**

**Client Information**

Legal First Name: \_\_\_\_\_

Legal Last Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

*Please initial that you understand the following program requirements:*

\_\_\_\_\_ I understand that as a client of the Nevada Medication Assistance Program (NMAP), I will complete my annual certification and re-certification in the time frame established by the Ryan White Program in order to remain eligible for NMAP.

\_\_\_\_\_ I understand that failure to complete my annual certification and re-certification in the time frame established by the Ryan White Program may lead to dis-enrollment from NMAP.

\_\_\_\_\_ I understand that I must use the Ramsell Insurance Card provided by the program to fill any and all medications that are currently on the NMAP Formulary.

\_\_\_\_\_ I understand that by enrolling in NMAP (for assistance with health insurance premiums) I must use a contracted NMAP's pharmacy network to access my medications. If after two (2) months of not using NMAPs contracted Walgreens Pharmacy network to fill my prescription(s) I will be contacted to ensure that I am still in care.

\_\_\_\_\_ I understand that after three (3) months of not using NMAPs contracted pharmacy network to fill my prescription(s) I will be choosing to opt-out of my enrollment and services in NMAP. Opting-out of NMAP means the program will no longer be able to pay for my insurance premiums and/or the costs of my medications and I will be responsible for the full cost of my medications and/or insurance premiums.

I fully understand that by completing this form, I am divulging personal information that will be used to assist me with benefits associated with NMAP. I understand this information will be kept confidential but will be used by staff to review my eligibility for this program.

Client Signature:

Date:

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