

KAPP'D

KAIROS Access Program for PrEP/DoxyPEP

MENTAL HEALTH + SEXUAL HEALTH · [MYPREPPROVIDER.COM](https://myprepprovider.com)

KAPP'D helps make your PrEP & DoxyPEP care more affordable — fill this out to see if you qualify.

Full name

Date of birth

Phone number

Email

Street address

City

State

Zip code

Insurance (check your plan):

☐

AETNA

☐

Ambetter

☐

BCBS

☐

CIGNA

☐

UHC

☐

Curative Health

☐

Other:

Member ID

Group number

Are you the policy holder?

☐

Yes

☐

No

If no, provide the policy holder's details:

Policy holder's name

Policy holder's date of birth

SECTION 1 — Program Acknowledgment

Please initial each statement:

I understand this program helps reduce out-of-pocket lab costs related to PrEP/DoxyPEP care.

I understand insurance will be billed first.

I understand financial assistance is limited and based on eligibility criteria.

I understand payments are made directly to the lab, not to me.

SECTION 2 — Household Income (self-attested)

Select ONE:

☐

Under \$30,000

☐

\$30,000 to \$49,999

☐

\$50,000 to \$74,999

☐

\$75,000 to \$99,999

☐

\$100,000 or more

SECTION 3 — Financial Hardship

Check all that apply:

- ☐ Lost job or reduced income in the past 6 months
- ☐ Housing instability — spending a disproportionate amount of income on housing (often 30%–50%+ of gross income), leading to difficulty paying rent/mortgage, frequent involuntary moves, and severe, compounding financial stress
- ☐ Supporting dependents
- ☐ Significant debt affecting ability to pay for care

SECTION 4 — Member Responsibilities

Please initial each statement:

- I agree to maintain active care with the clinic.
- I agree to attend scheduled appointments.
- I agree to complete required lab work as ordered.
- I understand I must maintain a balance under \$50 with the clinic.
- I understand failure to meet these requirements may result in removal from the program.

SECTION 5 — Attestation

I attest that the information provided is accurate to the best of my knowledge. I understand this information will be used to determine eligibility and my financial assistance for select HIV prevention services. By signing this document electronically, I acknowledge and agree that my electronic signature is legally binding and has the same force and effect as an original handwritten signature.

Signature

Date

**Finished? Email your completed application to:
info@myprepprovider.com**



VISIT US ONLINE

myprepprovider.com

Scan the code with your phone's camera,
or type the address into your browser.