

FY 2009

# DAP Renewal Application

Michigan Department of Community of Health  
HIV/AIDS Drug Assistance Program



**\* = Required field; please do not submit form without this information**

<input type="checkbox"/> New <input type="checkbox"/> Renewal – Subscriber ID/Member ID (found on RxAmerica card, if applicable): _____ (max 8)	
Last Name*: _____ First Name*: _____ Middle Initial*: _____ Preferred Mailing Address (All DAP related information will be sent to this address) *: _____	
City*: _____ State*: _____ Zip Code*: _____ County of Residence*: _____ Phone Number*: (____) _____ - _____	
Social Security Number*: _____ - _____ - _____ Date of Birth*: ____/____/____ <small>required or all zeros mm dd yyyy</small>	
Gender (check one) *: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	
Race/Ethnicity* (check all that apply): <input type="checkbox"/> African American <input type="checkbox"/> African National <input type="checkbox"/> Arab/Chaldean <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander/Native Hawaiian	Please Answer the Following Questions*: Are You a Michigan Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No Are You Homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No Do You have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Do You have Private Dental Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Family Size*: _____ (include yourself, and those supported by you, including spouse, partner and/or other dependants living with you)	My TOTAL Gross (pre-tax) Monthly Income is*: \$ _____ (Please see pages 5-10 of instructions on what to provide as proof of income based on level of coverage needed, if applicable)
<b>What Type of DAP Assistance Are You Requesting? (check one box only) * :</b>	
<input type="checkbox"/> Veteran's Administration Copay Assistance (see pg. 5 of instructions)	<input type="checkbox"/> County Health Plan Assistance <b>Are You On Plan B?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (see pg. 9 of instructions) (Please attach a copy of your health plan card)
<input type="checkbox"/> Private Insurance Copay Assistance (see pg.6 of instructions) (Please attach a copy of your insurance card)	<input type="checkbox"/> Full Drug Assistance (see pg.10 of instructions)
<input type="checkbox"/> Medicare Part D – Are You Enrolled in a Prescription Drug Plan (PDP)/Medicare Rx Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (see pg.7 of instructions) (Please attached a copy of your Medicare Part D Prescription Drug Card and your Medicare Card)	
<b>Proof of HIV Status/Lab Update*</b> (*If New to Program Must Have Physician Signature and/or Labs Showing detectable Viral Load and/or Positive Western Blot*)	
Absolute CD4 Number/mm3: _____ Test Date: ____/____/____ HIV RNA/Viral Load: _____ copies Test Date: ____/____/____ Physician Name: _____ Physician Signature: _____	



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## Consent Form/Authorization for Release of Information

I understand that if I become enrolled in a health insurance program that pays for any portion of my medications or if I qualify for medical assistance through other federal, state or county medical benefit programs, I must immediately notify the Michigan Department of Community Health, Drug Assistance Program (DAP) and Michigan Dental Program (MDP) in addition to my pharmacist, and physician, and that I may no longer be eligible to receive assistance from the DAP. I understand that if I am a Medicare recipient that I must enroll in a Medicare Rx plan or provide proof of creditable coverage to the DAP.

I authorize the DAP to receive, disclose, and discuss medical/dental information related to the care and treatment of my HIV infection with any health insurance or government health insurance program representative, or other individuals as required and necessary. In addition, specific agencies and phone numbers are listed below.

The information that I have provided on this application is complete and true to the best of my knowledge. I certify that I meet the eligibility requirements as specified in the instructions and have followed the necessary steps that are required for me to be on the Drug Assistance Program.

I understand that I must reapply annually, prior to March 31<sup>st</sup> every year to receive assistance with my medications from the DAP. I understand that if I submit an application that is determined to be incomplete in fulfilling the requirements for approval that my assistance will be inactive until all the requirements are met.

I understand that if any of the information provided on this application changes that I must notify the DAP immediately. In addition, I understand that failure to report changes and/or reporting of inaccurate information may affect DAP coverage and program eligibility.

This application, when completed, contains patient information that must be protected in accordance with the Health Insurance Portability and Accountability Act.

Case Manager: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Other: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Signature of Applicant\*: \_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_  
mm dd yyyy

Name of Applicant\*: \_\_\_\_\_

**PLEASE MAIL OR FAX APPLICATION AND ANY SUPPORTING DOCUMENTATION TO:**

**DAP**  
109 Michigan Avenue, 9<sup>th</sup> Floor  
Lansing, Michigan 48913  
Phone: (888) 826-6565  
Fax: (517)335-7723

**DAP OFFICE USE ONLY**

VA (10000)     Private Insurance(4000)     County Program, Plan B(2000)- Co# \_\_\_\_\_  
 Medicare D(7000)     Full Drug Assistance(3000)     Spenddown(6000)     Denied \_\_\_\_\_

Approved Date \_\_\_\_/\_\_\_\_/\_\_\_\_    Member ID \_\_\_\_ - \_\_\_\_ - \_\_\_\_    Approved by \_\_\_\_\_