FY 2008

MDCH-DHWDC-HAPIS-DRUG ASSISTANCE PROGRAM (DAP) INTERIM MEDICATION FORM

This form must be received and processed by the DAP office in order for the applicant to be eligible to pick up medications.

DAP Subscriber number (found on RxAmercia card - if applicable):______________________________________

Name:____
Last First M.I.

Address:____

City:______________________ State:________Zip Code:____________County:___________________________

Phone Number:______________ Social Security Number: ___________________Date of Birth:_______________

Gender	Race/Ethnicity		Are you a Michigan Resident?
☐ Male	☐ African American	☐ Caucasian	☐ Yes ☐ No
☐ Female	☐ African National	☐ Hispanic/Latino	
☐ Transgender	☐ Arab/Chaldean	☐ Native American	Do you have Medicare?
	☐ Asian	☐ Pacific Islander/ Native Hawaiian	☐ Yes ☐ No

Please list all requested medications:____

____

List reason for request:____

____

I have referred to the Interim Medication Program Eligibility Criteria and have determined that this individual is eligible for service and that the financial and other information necessary to make this decision is available for review in agency files. I also verify by my signature below that the medications to be billed to DAP are on the current DAP formulary.

____
Case Manager Name, Agency and Phone Number

Case Manager Signature:____Date:____________________________

I authorize the Michigan Department of Community Health, Drug Assistance Program to receive, disclose and discuss medical 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.

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

____ _______________________________
Signature of Applicant Date

Fax to the DAP at 517-335-7723

DAP office use only

☐ Not on DAP CIMS ☐ None ☐ Pending ☐ Denied Beginning Date: ___/___/___

Approved:_____Date:________________ ___ ___ ___ ___ ___ ___ ___ ___ Ending Date: ___/___/___

Coverage Group 5000 Only

****Please note: A subscriber card will not be produced until an approval for continuous DAP coverage is issued.*