FY2011

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

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

MIDAP Subscriber number (found on ScriptGuideRx 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 MIDAP are on the current MIDAP formulary.

_____
Case Manager Printed Name Agency 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.

I understand that the information I have provided on this application may be shared with other government agencies or health insurance companies for the purpose of determining my eligibility for MIDAP and/or other programs that I may be eligible for. 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 MIDAP AT 517-335-7723

MIDAP OFFICE USE ONLY

☐Not on MIDAP BRIDGES ☐None ☐Pending ☐Denied Beginning Date ____/_____/_____

Approved: _____Date:_____ ___ ___ ___ ___ ___ ___ ___ ___ Ending Date _____/_____/_____

******* Please note: A subscriber card WILL NOT be produced until an approval for continuous MIDAP coverage is issued.*******