

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 dental care, 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, physician, and/or dental provider and that I may no longer be eligible to receive assistance from the DAP/MDP. 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/MDP 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 and/or the Michigan Dental Program.

I understand that I must reapply annually, prior to March 31st every year to receive assistance with my medications and/or dental coverage from the DAP/MDP. 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/MDP 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: _____

Printed Name of Applicant: _____ This consent expires 3/31/2009

PLEASE MAIL OR FAX APPLICATION AND ANY SUPPORTING DOCUMENTATION TO:

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

MDP OFFICE USE ONLY
<input type="checkbox"/> MDP Approved Date ___/___/___ Member ID ___ - _____
Approved by _____