6-Month Verification

Michigan Department of Community Health (MDCH)
Michigan Drug Assistance Program (MIDAP)

2015 MIDAP Six-Month Verification Form

v.15.0 All Previous Versions Obsolete

Demographic Information: Please Print.
NOTE: All applicant information will be sent to the address entered below.

1. **MIDAP ID (found on your SGRX/MIDAP card, if applicable):** _____

2. **Legal Last Name:** _____ **Legal First Name:**_____

Legal Middle Name:_____ **Maiden Name:**_____

Alias: _____ **3. Date of Birth:**_____/_____/_____

4. **Social Security Number:**_____-_____-_____

5. **Provide your current mailing address and phone number. If you have moved within the last six months, proof of residency must be attached.**

Address:_____ **APT #:**_____ **City:**_____

State: MI **Zip Code:** _____ **County:** _____ **Phone Number:** (_____)_____

6. **Are you currently pregnant?**

☐ Yes If yes, when is your due date: _____/_____/_____ ☐ No ☐ Not Applicable ☐ Unknown

7. Viral Load Update

This section **must be filled in** with the **most recent lab values.**

Viral Load: _____ Date of most recent test result: _____/_____/_____

8. Household Size

Current household size:_____

9. Income

Check one:

a. ☐ My income **has not** changed b. ☐ I have no income c. ☐ My income **has** changed

*If your income **has changed** since your last recertification six months ago, include all appropriate documentation. This may include: your most recent months' pay stubs (a 4 week, 30 day period), your unemployment determination, notice of award for SSI/SSDI OR copy of your most recent bank statement showing payroll deposits for the last 30 days **(bank deposit statements will only be accepted for SSI or SSDI). Eligibility is determined by the total gross (pre-tax) amount you receive.***

Completion Authority: PA 368 of 1978 Is voluntary, but is necessary to receive coverage under the Michigan Drug Assistance Program

Michigan Department of Community Health is an equal opportunity employer, services, and programs provider

10. Insurance Status

Has your insurance status changed in the last six months? ☐ Yes ☐ No If yes, check any that apply and **attach a copy of your insurance card for accuracy and include plan start date**: _____/_____/_____

☐ Employer Sponsored Insurance (Including COBRA)

☐ Private Policy (Paid for by you or other entity)

☐ Qualified Health Plan (Marketplace)

☐ Medicare Part A/B

☐ Medicare Part D or Advantage

☐ Medicaid**:** Date Applied _____/_____/_____

☐ Veteran's Administration Benefits (VA)

☐ No Insurance

☐ Other _____

I attest that my signature on this form indicates the information provided is accurate, true and complete to the best of my knowledge.

_____ _____

Print Full Legal Name (First, Middle, Last) Date

_____

Signature of Applicant

_____ _____ (____)_____

Print Name (Case Manager, if applicable) Agency Phone Number

Mail or fax completed application and all supporting documentation to:
MDCH-MIDAP
109 W. Michigan Ave. 9th Floor
Lansing, MI 48913
Phone: 1-888-826-6565 - Fax: (517) 373-1495

2015 MIDAP Six-Month Verification Form Instructions

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Demographic Information:

1. **MIDAP ID:** Enter your SGRX/MIDAP ID Number as printed on your card.

2. **Legal Full Name:** Enter your LEGAL LAST NAME, LEGAL FIRST NAME, LEGAL MIDDLE NAME, MAIDEN NAME (if applicable) and ALIAS (if applicable).

3. **Date of Birth:** Enter the month, date and year of your birth (MM/DD/YYYY).

4. **Social Security Number:** Enter your number as it is listed on your Social Security card (###-##-####). Failure to provide may delay the processing of your application.

5. **Address:** Enter your CURRENT ADDRESS (including any Post Office box, Apartment number, or lot number) as well as the CITY, STATE, ZIP CODE and COUNTY OF RESIDENCE.

   If you have moved in the last six months, you must provide your proof of residency. This can include any of the following:
   - Current State of Michigan identification card or Driver's License
   - Utility bill in individual's name showing address
   - Benefits award letter (Department of Human Services (DHS)/Social Security Administration(SSA)) with individual's name and address
   - Lease or mortgage in individual's name showing address
   - Voter registration card

   NOTE: MIDAP will use the address that you list on your application as the address to contact you via the United States Postal Service.

   Phone Number: Enter the phone number that you would like MIDAP to use to contact you.

6. **Are you currently pregnant?** Indicate whether you are pregnant at the time of applying for MIDAP. If yes, specify your approximate due date (MM/DD/YYYY).

7. **Viral Load Update:** Enter your most recent HIV viral load result and include the date of the most recent test result.

8. **Household Size:** Include yourself and any other joint income- including your legal spouse and dependents living

9. **Income:** Check the appropriate box on the application regarding your income status within the last six months.
   a. My income **has not** changed: Nothing needs to be submitted.
   b. I have no income: Submit your unemployment declaration
   c. My income **has** changed: Proof of new income needs to be submitted. Income can be submitted in one or more of the following ways

      - **Submit Proof of Income:** Eligibility is determined by the total gross (pre-tax) amount you receive. Proof of income can be submitted in one or more of the following ways (unless you are self-employed, see below):
        - The most recent month's pay stubs (a 4 week, 30 day period) **and** the previous year's W-2 form
        - Notice of award for SSI or SSDI

- Notice of award for DHS/SSA
- Notarized statement from an employer showing gross pay for that last 30 days
- Unemployment benefits award
- Corrections release papers within 30 days of release
- Declaration of no income
- Declaration of support

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10. **Insurance Status:** Has your insurance status changed in the last six months? If your insurance status has not changed, check no. If your insurance status has changed within the last six months, check all that apply and provide the additional required information. Attach a copy of your insurance card for accuracy.

    If you have prescription coverage/medical insurance through any of the following that require you to pay a copay and/or deductible at the pharmacy, check all that apply and provide the additional required information. Attach a copy of your insurance card for accuracy.
    - Employer Sponsored (including COBRA)
    - Private Policy (Paid for by you or other entity)
    - Qualified Health Plan (Marketplace)
    - Medicare Part A/B
    - Medicare Part D or Advantage
    - Medicaid
    - Veteran's Administration Benefits (VA)
    - No Insurance
    - Other

Signature: Print full Legal Name (First, Middle, Last), sign and date the verification form. By signing the verification form you are attesting that your signature indicates the information provided is accurate, true and complete to the best of your knowledge. If you have a case manager, please indicate your case manager's name, agency and phone number.

NOTE: Failure to sign and date the verification form will result in a delay of processing and access to medications.

For copies of any MIDAP forms please see the website at www.michigan.gov/dap

If you need assistance filling out the application, please contact your case manager or the MIDAP office at 1.888.825.6565

For a list of AIDS Service Organizations, case management, clinic and testing locations, please call 1.800.872.2437 or see website at www.michigan.gov/survivehiv