Renewal Application

FY2014
MIDAP Renewal Application
Michigan Department of Community Health
HIV/AIDS Drug Assistance Program

v.14.0 All Previous Versions Obsolete

MIDAP ID (found on SGRX/MIDAP Card, if applicable)

Last Name | First Name | Middle Name

Address

Please Note: All MIDAP related information will be sent to this address

City | State Michigan | Zip Code | County

Social Security Number | Phone Number | Birthdate

Gender: ◯ Female ◯ Male

Are You Pregnant?: ◯ No ◯ Yes

If yes, What is your due date?

Transgender: ◯ Female to Male ◯ Male to Female

HIV Positive Date:

Ethnicity: ☐ Hispanic/Latino ☐ Other

Race (Check all that apply):

☐ Black or African American ☐ White
☐ American Indian or Alaska Native ☐ Asian
☐ Pacific Islander/Native Hawaiian ☐ Other

Please Answer the Following Questions:

Are you a Resident of the State Of Michigan? ◯ Yes ◯ No
Are You Homeless? ◯ Yes ◯ No
Do You Have Private Dental Insurance? ◯ Yes ◯ No
Do you have or are you eligible for Medicare? ◯ Yes ◯ No

Household Size and Income - For each income box checked enter the total gross received in the box to the right

Household Size: (Include yourself, and those supported by you, including spouse, partner and or other dependants living with you.)

Do you receive income from any of the following sources? If, yes check all that apply and indicate the amount in the box to the right.

☐ Employment - Monthly Total
☐ Self Employment - Monthly Total
☐ Unemployment - Monthly Total
☐ Social Security Disability Income - Monthly Total
☐ Supplemental Security Income - Monthly Total
☐ Public Assistance - Monthly Total
☐ Pension - Monthly Total
☐ Retirement - Monthly Total
☐ Other - Monthly Total
☐ **None - If checked, DHS application must have been filled out and submitted to DHS prior to applying for MIDAP**

For complete instructions, please visit http://www.michigan.gov/dap or contact MIDAP at 1-888-826-6565 to request an instruction booklet.

MIDAP OFFICE USE ONLY

Total Annual Income $_____

F(3000) _____ PI(4000) _____ MD(6000) _____ QHP(8000)_____ VA(1000) _____ HIVC(2000) _____

Denied:_____ Reason:_____

Reviewed By: _____ Date: _____ Member ID: __ __ - __ __ __ - __ __ __

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Prescription Coverage

Do you have prescription coverage/ insurance through any of the following that require you to pay a copay and/or deductible at the pharmacy? ◯ No ◯ Yes (check all that apply below and provide additional information)

☐ Employer Sponsored Insurance Including COBRA — Name of Carrier

☐ Individual Policy (paid for by you or other entity) — ID Number — RxBin No.

☐ Qualified Health Plan (Marketplace) — RxGrp No. — RxPCN No.

☐ Medicare Part D or Advantage Plan — Name of Part D Plan - — ID Number — RxBin No. — RxPCN No. — RxGrp No. — Part A Start Date

☐ Veteran's Administration Benefits - VA Location/City Where You Receive Care

Please indicate what type of MIDAP assistance you are requesting **(Check One Only):**
Incomplete applications and/or missing information will not be accepted and/or will delay processing.
All incomplete applications will only be held for 45 days.

◯ Full Drug Assistance- If you have no additional insurance (uninsured)

◯ Copay Assistance- ☐ Private ☐ Qualified Health Plan ☐ Employer Sponsored ☐ COBRA ☐ Veteran's Assistance

◯ Copay Assistance- ☐ Medicare D ☐ Advantage Plan (Part C)

Please see checklist provided for all required supporting documentation.
Please attach a copy of your insurance card for accuracy.

Proof Of HIV Status/Lab Update
Must fill in section with most recent lab values.

Date of Test Result: Absolute CD4 Number/mm3:

Date of Test Result: HIV RNA/Viral Load:

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Consent Form/Authorization for Release of Information

I authorize MIDAP 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, or other individuals as required and necessary.

I understand that the information I have provided on this application will be shared with other government agencies,health insurance companies and/or the contracted pharmacy benefits manager for the purpose of verifying the accuracy of the information provided and in determining my eligibility for MIDAP and/or other programs that I may be eligible for.

I understand that if I become enrolled in a health insurance program prescription coverage 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 (MIDAP) and Michigan Dental Program (MDP) in addition to my pharmacist, and physician.

I understand and agree to submit periodic information regarding my continued eligibility for MIDAP, including proof of income, proof of residency, health insurance coverage, and general updates on forms provided by the MIDAP. I understand that changes in my situation will be evaluated to determine my continued eligibility for MIDAP. I will be notified in writing if I am to be discontinued from MIDAP.

I understand that I must annually, or as required to fulfill funding requirements, recertify as eligible for MIDAP to receive assistance with my medications. I understand that if I submit an application that is determined to be incomplete in fulfilling the requirements for approval that I will not be eligible for assistance until all the requirements are met.

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

I understand that by utilizing MIDAP for medication assistance and by filling prescriptions using my SGRX/MIDAP card that I am agreeing to abide by all MIDAP policies and procedures.

I understand that MIDAP is not insurance and is not valid outside of the state of Michigan.

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 eligible for the Michigan Drug Assistance Program.

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 Signed: [ ]

PLEASE MAIL OR FAX APPLICATION AND ANY SUPPORTING DOCUMENTATION TO:
MIDAP
109 Michigan Avenue, 9th Floor
Lansing, Michigan 48913
Phone: (888) 826-6565
Fax: (517) 335-7723

CASE MANAGER (IF APPLICABLE)

Print Name: [ ]

Phone Number: [ ]

Agency: [ ]