

**2016 MIDAP
Premium Assistance
Application**

V.16.0 All Previous Versions are Obsolete

**Michigan Department of Health and Human Services (MDHHS)
Premium Assistance Application**

**Mail or fax completed application and all supporting documentation to:
109 W. Michigan Ave., 9th Floor, Lansing, MI 48913
Phone: 888.826.6565 Fax: 517.335.7723**

Demographic Information: Please Print. All applicant information will be sent to the address entered below. Proof of residency must be attached.

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

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

Legal Middle Name: _____ Maiden Name: _____

3. Address: _____ APT #: _____

City: _____ State: MI Zip Code: _____ County: _____

4. Phone Number: (____) _____ May we leave a voicemail? Yes No

5. Social Security Number: _____ - _____ - _____ 6. Date of Birth: ____/____/____

7. Sex at Birth: Male Female

8. Current Gender: Male Female Transgender

9. Transgender Status: Male to Female

Female to Male

Unknown

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

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10. Household Size and Income:

Household Size: _____ MIDAP uses the number of people living in your house to determine eligibility. Household size includes you, your spouse and any dependents under the age of 19 who live with you.

Did you receive income from any of the following sources? If yes, check all that apply and indicate the amount on the line to the right in **MONTHLY** totals. **Proof of income must be attached to the application.**

Gross income is the income you receive before any taxes are taken out.

Employment Income (Gross): _____

Self-Employment: _____

Unemployment: _____

Social Security Income: _____

Supplemental Security Income: _____

Public Assistance: _____

Pension: _____

Retirement: _____

Other: _____

Gross **Annual** Income: _____

No Income

Date of DHHS application: ____/____/____

Must also apply for DHHS benefits prior to applying for MIDAP Full Prescription Coverage.

Insurance Plan Information: (Your most current billing statement must be included with this application)

11. Insurance Plan Name: _____ Insurance Plan Phone Number: (____) _____

12. Insurance Plan Address: _____

P.O. Box (if applicable): _____ City: _____ State: _____ Zip Code: _____

13. Account Number: _____ 14. Policy Number: _____

Premium Assistance Coverage: Please indicate the type of Premium Assistance Coverage you are requesting.
Check only ONE

15. **COBRA** Plan Start Date: ____/____/____ Plan End Date: ____/____/____

- Attach all COBRA notification paperwork and send COBRA election form

16. **Qualified Health Plan (QHP)** Plan Start Date: ____/____/____ Plan End Date: ____/____/____

- Attach a copy of the Marketplace assessment letter for tax credits and cost sharing reductions eligibility
 Gold Plan Silver Plan
- Attach QHP billing statement/invoice

17. **Medicare Part D** Plan Start Date: ____/____/____

- Attach a copy of your Extra Help/Low Income Subsidy application and/or letter of decision through Social Security Administration and attach Extra Help/Low Income Subsidy application and/or letter of decision through Social Security (SSA.gov)
- Attach a copy of your most recent Medicare part D or Advantage plan monthly premium billing statement.

Monthly Premium Payment

18. Monthly Premium Amount \$ _____ 19. Initial Payment Amount \$ _____

20. Premium Due Date ____/____/____

21. Have you personally contributed any amount towards initial payment?

Yes No If yes, how much? \$ _____

Include a copy of the invoice showing payment.

**Incomplete applications and/or missing information will not be accepted and will delay processing.
Incomplete applications will only be held for 45 days.**

**Michigan Department of Health and Human Services
Premium Assistance Program
Consent Form/Authorization for Release of Information**

By signing this consent, I authorize the Michigan Department of Health and Human Services (MDHHS)– Michigan Drug Assistance Program (MIDAP) to share, receive, disclose, and discuss medical information related to the care and treatment of my HIV infection with any health insurance plans, government health insurance program, case manager, physician, infectious disease doctor, or other individuals required.

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 in MIDAP and/or other programs for which I may be eligible.

I authorize payment of refunds to MDHHS –MIDAP for premiums paid by the program.

I understand that if I become enrolled in a health insurance program, prescription coverage program or if I qualify for medical assistance through other federal, state or county medical benefit programs, I must immediately notify MIDAP in addition to my case manager, 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 program. I understand that changes in my situation will be evaluated to determine my continued eligibility for MIDAP. I understand that if any of the information provided on this application changes, that I must notify 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 agree to re-enroll annually and recertify as required by the MIDAP Premium Assistance Program. I understand it is my responsibility to provide a medical update and proof of income every six months to 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, I will not be eligible for assistance until all of the requirements are met.

I understand that by utilizing MIDAP for medication assistance and by filling prescriptions, using my SGRX/MIDAP card that I have read all of the MIDAP Policies and Procedures and I am agreeing to abide by them. I understand that MIDAP is not insurance and is not valid outside the State of Michigan.

I acknowledge that the information I have provided on this application is true and complete to the best of my knowledge. I certify that I meet the eligibility requirements as specified in the MIDAP Instructions and have followed the necessary steps that are required for me to be eligible for MIDAP.

This application, when completed, contains confidential information that must be protected under applicable federal and state confidentiality laws.

Print Full Legal Name (First, Middle, Last)

_____/_____/_____
Date

Signature of Applicant

Case Manager, if applicable (Print Name)

Agency

(_____)_____
Phone Number

Email

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**Michigan Department of Health and Human Services
Michigan Drug Assistance Program (MIDAP)
2016 MIDAP Annual Recertification Application Instructions**

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1. **MIDAP ID:** Enter your MIDAP ID found on your SGRX/MIDAP card.
2. **Legal Full Name:** Enter your LEGAL LAST NAME, LEGAL FIRST NAME, LEGAL MIDDLE NAME, and MAIDEN NAME (if applicable).
3. **Address:** Enter your ADDRESS (including any Post Office box, Apartment number, or lot number) as well as the CITY, STATE, ZIP CODE and COUNTY OF RESIDENCE.

NOTE: MIDAP will use the address listed on your application as the address to contact you via the United States Postal Service.
4. **Phone Number:** Enter the phone number that you would like MIDAP to use to contact you. Check the box to tell us if we may leave you a voicemail. If we call you, we will give only our name and phone number. We will keep your HIV status confidential.
5. **Social Security Number:** Enter your number as it is listed on your Social Security card (###-##-####). Failure to provide our social security number may delay the processing of your application.
6. **Date of Birth:** Enter the month, date and year of your birth (MM/DD/YYYY).
7. **Sex at Birth:** Indicate your BIOLOGICAL SEX at BIRTH: Male or Female.
8. **Current Gender:** Indicate your CURRENT GENDER by filling in or putting a √ next to the appropriate gender identity. **NOTE:** Pharmacies require gender information (Male, Female or Transgender) to allow you to fill your prescriptions. If you select transgender, please answer transgender status.
9. **Transgender Status** Check √ the gender identification that you have communicated to the pharmacy to ensure you are able to pick up your medications upon program approval.

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10. Household Size and Income

- **Indicate your Household Size:** MIDAP uses the number of people living in your house to help determine if you are eligible. Your household size includes you, your spouse and any dependents under the age of 19 who live with you.
- **Income:** Indicate any income you receive by placing a √ next to each of the appropriate source(s) and then write in the gross (pre-tax) total monthly amount that you receive from the indicated source(s). You must also include the gross annual income (pre-tax amount) that you receive.

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- **If you are Self Employed:** Submit a copy of your 2015 – 1040 Federal tax forms, signed and dated by a licensed preparer, or a signed and dated 2015 – 1040 Federal tax form, signed by you, along with a copy of your Schedule E form, as proof of income.
- **No income:** If you do not receive any income, you must apply for Medicaid/Healthy Michigan Plan and/or the Adult Medical Program at your local county Department of Health and Human Services (DHHS) office prior to submitting your application to the MIDAP. Include the date your application was submitted to DHHS. If you have any questions please call the MIDAP office at 1.888.826.6565, or call DHHS, 1.877.342.2437.

To apply for the Healthy Michigan Plan, you can visit your local Department of Human Services Department, call 1.855.789.5610 or apply online at www.healthymichiganplan.org.

- **Submit Proof of Income:** The previous year's W-2 form must be submitted with your application along with one or more of the following options (unless you are self-employed, see below):
 - The most recent month's pay stubs (a 4 week, 30 day period)
 - Notice of award for SSI or SSDI
 - Notice of award for DHHS/SSA
 - Notarized statement from an employer showing gross pay for the last 30 days
 - Unemployment benefits award
 - Corrections release papers within 30 days of release
 - Declaration of no income
 - Declaration of support

11. Insurance Plan Name: Print the name of where payment is to be sent. This may be your insurance company or COBRA Administrator. Please refer to your billing statement or COBRA notification paperwork to locate this information.

12. Address: Print the NUMBER, STREET or PO BOX, CITY, STATE and ZIP CODE where the premium payment is to be sent. If the initial payment is to be sent to a separate address please attach a copy of this address to your application.

13. Account Number: Enter the account number for your plan. This information will be located on your premium billing statement or COBRA notification paperwork. **IMPORTANT:** If you are applying for COBRA premium assistance and cannot locate an account number on your paperwork, please contact your COBRA administrator to receive this information. If you do not have an account number there may be issues with your premium payment being credited to your account. It is important to follow up with your COBRA Administrator monthly to verify receipt of premium payment.

14. Policy Number: Enter your member ID or Policy Number. This is the number on your insurance card used for medical and /or prescription billing.

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15. COBRA: Select this option only if you are applying for premium assistance with a COBRA continuation insurance plan through your previous employer.

- **Include** the MONTH, DAY and YEAR of the start date indicated in the COBRA notification paperwork. Also, include the MONTH, DAY and YEAR of the end date (MM/DD/YYYY). Please note COBRA plans last for a maximum of 18 months. If another qualifying event is to occur during this time you may be eligible for a total of 36 months of coverage, please visit the United States Department of Labor's Employee Benefits Security Administration website at <http://www.dol.gov/ebsa/>.
- **Complete** the COBRA election form sent to you by your previous employer or COBRA Administrator. Mail this form back to the appropriate address provided in the election paperwork. **PLEASE NOTE:** premium payment is due 45 days after the COBRA election form is signed. It is important to send in the attached premium assistance form and all supporting documentation to MIDAP promptly after submitting election form to your COBRA Administrator.
- **Attach** all COBRA notification paperwork along with any billing statement that you have received.

16. Qualified Health Plan-Select this option only if you are applying for premium assistance with a Qualified Health Plan through the ACA Marketplace.

- **Include** the MONTH, DAY and YEAR your plan became effective or will become effective (MM/DD/YYYY).
- **Attach** a copy of the Marketplace generated assessment letter stating your plan eligibility and eligibility for tax credits and cost sharing. **PLEASE NOTE:** if you are eligible for a tax credit you must elect the full tax credit subsidy amount to be deducted from your monthly premium amount. It is important to provide the marketplace with the most accurate income information, lack to do so may result in you owing money when you file your taxes.
- **Attach** a copy of your most recent Qualified Health Plan premium billing statement.

17. Medicare Part D- Select this option only if you are applying for premium assistance with a Medicare Part D plan or Medicare Advantage plan.

- **Include** the MONTH, DAY and YEAR your plan became effective or will become effective (MM/DD/YYYY).
- **Attach** a copy of your Extra Help/Low Income Subsidy Application and/or letter of decision from the Social Security Administrations. To apply for extra help go to www.ssa.gov.
- **Attach** a copy of your most recent Medicare part D or Advantage plan monthly premium billing statement.

18. Monthly Premium Amount: Enter the amount to be paid to your plan on a monthly basis.

19. Initial Payment Amount: Enter the amount of the initial premium payment. For example if you have an overdue balance or your insurance will be retroactive, the initial premium payment amount will be the amount that covers those additional months. If the initial payment amount is the same as the monthly premium amount please enter that information in this section as well.

20. Premium Due Date: Enter the date that your initial premium amount is due to the insurance company or COBRA Administrator.

21. Have you personally contributed any amount towards initial payment? Please indicate if you have contributed any amount toward your insurance premiums that would impact the initial payment made by the premium assistance program.

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Consent Page: If you have a Case Manager, please provide their name or have them sign the consent page and provide their agency's information. This information will be used to communicate with them about your eligibility and status. If you do not have a case manager, leave this section blank.

NOTE: Failure to sign and date the consent page 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 1.888.826.6565. 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.