MICHIGAN DRUG ASSISTANCE PROGRAM (MIDAP)

Michigan Department of Health and Human Services

☐ New (Never been on MIDAP) ☐ Existing MIDAP Member MIDAP ID: _____

Please check if any of the following criteria apply to you

☐ I am currently pregnant
☐ My CD4 count is less than 200 (CD4 <200; provide CD4 count _____).
☐ I am under the age of 18
☐ I have been released from prison within the last 30 days
☐ I have been released from the hospital in the last 14 days
☐ I recently moved to Michigan in the last 60 days
☐ I lost my insurance within the last 30 days. (Provide name of insurance carrier: _____ .)
☐ I was on another state's drug assistance program. (Provide the name of the state: _____ .)

ELIGIBILITY ASSESSMENT

A. Applicant Information and Demographics (please print)

Legal Last Name	Legal First Name	Legal Middle Name

Maiden Name	Preferred Name

What is your current housing status?

☐ I live in permanent housing: ☐ Rent ☐ Own
☐ I live in temporary housing (staying with a friend, hotel, college dorm)
☐ I am homeless and/or live in a shelter
☐ Other:

Residential/Home Address (Proof of residency must be attached)	Apartment Number

City	State	Zip Code	County
	MI		

Can program information be sent to the address listed above? ☐ Yes ☐ No

Mailing Address (if different than residential)	Apartment Number

City	State	Zip Code	County
	MI		

Can program information be sent to the address listed above? ☐ Yes ☐ No

Primary Phone Number you can be reached during daytime hours	Alternate Phone Number you can be reached during daytime hours
_____ ☐ Home ☐ Cell ☐ Work	_____ ☐ Home ☐ Cell ☐ Work
Can MIDAP contact you at this number about your application? ☐ Yes ☐ No	Can MIDAP contact you at this number about your application? ☐ Yes ☐ No
Can MIDAP leave a voicemail at this number? ☐ Yes ☐ No	Can MIDAP leave a voicemail at this number? ☐ Yes ☐ No

Email Address	Social Security Number	Date of Birth

Sex Assigned at Birth	Current Gender
☐ Male ☐ Female	☐ Male ☐ Female ☐ Transgender ☐ Other, please specify _____

Transgender Status

☐ Male to Female ☐ Female to Male ☐ Other, please specify _____

What is your preferred language?

☐ English ☐ Spanish ☐ Arabic ☐ Other _____

Are you currently pregnant? If yes, when is your due date?

☐ Yes ☐ No ☐ Not Applicable ☐ Unknown

Race (**One or more categories** may be selected)

☐ White ☐ Black or African American ☐ American Indian or Alaska Native

Native Hawaiian/Pacific Islander (Select one or more **subcategories** that apply below):

☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

Asian (Select one or more **subcategories** that apply below):

☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian

Ethnicity (**Select one** of the following)

☐ Hispanic/Latino ☐ Non-Hispanic ☐ Unknown

If you are of Hispanic, Latino/a or Spanish origin, select one or more subcategories that apply below

☐ Mexican, Mexican American, Chicano/a ☐ Cuban ☐ Puerto Rican

☐ Another Hispanic, Latino/a or Spanish Origin

B. Status and Date of Disease

Estimated HIV Positive Date/Diagnosis	HIV Stage of Disease (Check one)
	☐ HIV-positive, AIDS status unknown
Estimated AIDS Positive Date, if applicable ☐ NA	☐ HIV-positive, not AIDS
	☐ 3rd Stage HIV (CDC defined AIDS) ☐ Unknown

C. Proof of HIV Status (For New Applicants Only)

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

Absolute CD4 Count	Date of most recent test result	HIV RNA/Viral Load	Date of most recent test result

If laboratory results are not immediately available, please have your physician or his/her designee (as allowed under Michigan law) sign to receive 30 days of temporary coverage.

Physician/Designee Name (Print)	Date
Physician/Designee Signature	**Physician NPI Number**

If signing as Designee, please print the physicians name

D. Household Size and Income

Household Size

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

Do you have income? ☐ Yes ☐ No

If yes, check all of the income sources that you have. Put the total amount on the line to the right in **MONTHLY** totals in **GROSS** (before taxes) amount

☐ No Income

☐ Employment wages _____

☐ Unemployment _____

☐ Alimony/child support _____

☐ Pension/retirement Income _____

☐ Social Security Income _____

☐ Self-Employment Income _____

☐ Worker's compensation _____

☐ Social Security Disability Income _____

☐ Supplemental Security Income _____

☐ FIP/TANF _____

☐ State Disability Assistance _____

☐ Veteran's Benefits _____

☐ Other _____

If you have no income or low income (below 138% of the Federal Poverty Level), you must apply to Medicaid and provide the tracking number to MIDAP before any coverage can be provided. *For help in determining your income, please refer to page 3 of this application for the income chart.*

Date of MDHHS Application	MDHHS Tracking Number

E. Health Care and Drug Insurance

Check all boxes that describe your health insurance status and provide plan information below. At least one item must be checked.

☐ **Not eligible for Insurance of any kind.** If you are not eligible for Medicaid/Healthy Michigan Plan, the Declaration of Insurance Ineligibility is required.

☐ **Private – Employer** (Employer Sponsored Insurance)

☐ **Private – Individual** (Paid for by you or other entity)

☐ **Medicare**

☐ Part A (Hospital) ☐ Part B (Medical) ☐ Part C (Advantage) ☐ Part D (Prescription)

If you are enrolled in Medicare Part D, **you must enroll in the Extra Help/Low Income Subsidy (LIS) Program.** Once you receive notification whether you are **approved** (for either full or partial subsidy) or **denied** for Extra Help/LIS, **a copy of the letter must be sent to MIDAP**.

☐ Approved – 100% assistance ☐ Denied

☐ Approved – partial assistance ☐ Awaiting determination: application date: _____

If you have Medicare Part A or Medicare Part B, please provide the following information:

Medicare ID Number: _____ Part A Start Date: _____ Part B Start Date: _____

☐ **Medicaid**

☐ "Straight" Full ☐ HMO ☐ Healthy Michigan Plan ☐ CHIP ☐ Spenddown

☐ **Veteran's Administration** (VA), Tricare or other military health care

Location/City where you receive care: _____

☐ **Indian Health Services (IHS)**

☐ **Qualified Health Plan (Marketplace)**

☐ **COBRA**

☐ **Other Plan** _____

Insurance Card Information

Name of Carrier 1			Plan Start Date
ID Number	RxBin Number	RXPCN Number	RXGroup Number
Name of Carrier 2			Plan Start Date
ID Number	RxBin Number	RXPCN Number	RXGroup Number

Persons in Household	2017 Federal Poverty Level Guidelines 48 Contiguous States and D.C. Poverty Guidelines (ANNUAL)									
	100%	133%	138%	150%	200%	250%	300%	400%	450%	500%
1	$12,060	$15,804	$16,644	$18,090	$24,120	$30,150	$36,180	$48,240	$54,270	$60,300
2	$16,240	$21,600	$22,416	$24,360	$32,480	$40,600	$48,720	$64,960	$73,080	$81,200
3	$20,420	$27,156	$28,188	$30,630	$40,840	$51,050	$61,260	$81,680	$91,890	$102,100
4	$24,600	$32,724	$33,948	$36,900	$49,200	$61,500	$73,800	$98,400	$110,700	$123,000
5	$28,780	$38,280	$39,720	$43,170	$57,560	$71,950	$86,340	$115,120	$129,510	$143,900
6	$32,960	$43,836	$45,492	$49,440	$65,920	$82,400	$98,880	$131,840	$148,320	$164,800
7	$37,140	$49,404	$51,252	$55,710	$74,280	$92,850	$111,420	$148,560	$167,130	$185,700
8	$41,320	$54,960	$57,024	$61,980	$82,640	$103,300	$123,960	$165,280	$185,940	$206,600
Add $4,180 for each person in the household over 8.										

CONSENT/AUTHORIZATION FOR RELEASE OF INFORMATION

Michigan Department of Health and Human Services
Michigan Drug Assistance Program (MIDAP)

By signing this consent, I authorize the Michigan Department of Health and Human Services – Michigan Drug Assistance Program (MIDAP) to share, receive, disclose medical information related to the care and treatment of my HIV infection with any health insurance or 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 that I may be eligible for.

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 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 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 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 of the state of Michigan.

I acknowledge that the information that 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)	Signature of Applicant	Date
Parent/Legal Guardian Signature (if applicable)	Date	

Alternate Contact(s): I authorize the MIDAP and Premium Assistance Program to speak to the following person(s) about my application (i.e. case manager, social worker, family member and friend)

Name	Organization/Relationship	Email Address	Telephone Number

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.