

# 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? <input type="checkbox"/> I live in permanent housing: <input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> I live in temporary housing (staying with a friend, hotel, college dorm) <input type="checkbox"/> I am homeless and/or live in a shelter <input type="checkbox"/> Other:				
Residential/Home Address (Proof of residency must be attached)				Apartment Number
City	State <b>MI</b>	Zip Code	County	
Can program information be sent to the address listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Mailing Address (if different than residential)				Apartment Number
City	State <b>MI</b>	Zip Code	County	
Can program information be sent to the address listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Primary Phone Number you can be reached during daytime hours _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work Can MIDAP contact you at this number about your application? <input type="checkbox"/> Yes <input type="checkbox"/> No Can MIDAP leave a voicemail at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No		Alternate Phone Number you can be reached during daytime hours _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work Can MIDAP contact you at this number about your application? <input type="checkbox"/> Yes <input type="checkbox"/> No Can MIDAP leave a voicemail at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Email Address		Social Security Number	Date of Birth	
Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female		Current Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other, please specify _____		
Transgender Status <input type="checkbox"/> Male to Female <input type="checkbox"/> Female to Male <input type="checkbox"/> 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) <input type="checkbox"/> HIV-positive, AIDS status unknown
Estimated AIDS Positive Date, if applicable <input type="checkbox"/> NA	<input type="checkbox"/> HIV-positive, not AIDS <input type="checkbox"/> 3 <sup>rd</sup> Stage HIV (CDC defined AIDS) <input type="checkbox"/> 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
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, check all of the income sources that you have. Put the total amount on the line to the right in <b>MONTHLY</b> totals in <b>GROSS</b> (before taxes) amount	
	<input type="checkbox"/> No Income	<input type="checkbox"/> Worker's compensation _____
	<input type="checkbox"/> Employment wages _____	<input type="checkbox"/> Social Security Disability Income _____
	<input type="checkbox"/> Unemployment _____	<input type="checkbox"/> Supplemental Security Income _____
	<input type="checkbox"/> Alimony/child support _____	<input type="checkbox"/> FIP/TANF _____
	<input type="checkbox"/> Pension/retirement Income _____	<input type="checkbox"/> State Disability Assistance _____
	<input type="checkbox"/> Social Security Income _____	<input type="checkbox"/> Veteran's Benefits _____
	<input type="checkbox"/> Self-Employment Income _____	<input type="checkbox"/> 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
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### 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.