Maryland AIDS Drug Assistance Program,
500 N. Calvert St., 5th Fl., Baltimore, MD 21202
Phone: 410-767-6535 or 1-800-205-6308 (Toll-Free);
Fax numbers: 410-333-2608 or 410-244-8696 or 410-244-8617

Notice Sent: _____ Due Back by: _____
Batch Month: _____

SEMIANNUAL VERIFICATION NOTICE FORM

This form must be completed and signed by the client to verify your continued eligibility for MADAP services. If nothing has changed, please sign, date and return this form to the address listed above. If your residence, income or insurance coverage has changed, please attach proof of the change when you return this form.

Client's First Name	**MI**	**Last Name**	**Last 4 digits of SS#**

MADAP No.: 94_____
MADAP Plus: Yes or No

MADAP Eligibility Period: _____

Information Generated from MADAP's Client Services System	**If your information has changed, please fill in the correct information below and attach current documented to support proof of change(s).**
1. Your Current Maryland Residence/Number: **Phone Number:**	
2. Your Gross Household Income: Client: $_____ Spouse: $_____ Minor Child: $_____ TOTAL: $_____ Household Size: ____ [# children under 18: ___]	
3. Insurance/Prescription Coverage: Company/Plan Name:_____ Policy No.: _____ Medicare coverage? ___ Yes ___ No	
4. **Citizenship:** __ US Citizen or ___ Legal Permanent Resident as of _____. **(Date)**	

I, _____ certify that the information which I have provided is true, complete and accurate to the best of my knowledge.

Client Signature:	**Date:**
Spouse/Legal Guardian Signature	**Date**