MADAP - MADAP Plus Combined Application

Maryland AIDS Drug Assistance Program
Maryland AIDS Drug Assistance Program - Plus Insurance Assistance

Return Completed, Signed Applications to:

Prevention and Health Promotion Administration • 500 North Calvert Street, 5th Floor • Baltimore, Maryland 21202
(410) 767-6535 • Toll Free 1-800-205-6308 • Fax (410) 333-2608 •TTY - Maryland Relay Service 1-800-735-2258

MADAP, MADAP-Plus are administered by the Maryland Department of Health and Mental Hygiene, Prevention and Health Promotion Administration. Eligibility is based on income, Maryland residence and medical need.

Instructions for completing this application: If you wish to receive benefits through MADAP or MADAP-Plus you must complete the attached application and submit it with the appropriate documentation as requested on the form. All information provided is kept completely **confidential.** The application will be used to determine your eligibility for assistance in obtaining prescription medication and/or paying health insurance premiums. MADAP provides prescription drug coverage for medications used to treat HIV/AIDS. MADAP Plus provides assistance in paying certain health insurance premiums. You may be eligible for more than one program. You do not need to submit a separate application for each program.

Carefully read the following information to prevent delay in processing your application. If you have questions or need help completing the application, please call (410) 767-6535 or 1-800-205-6308 (toll-free). Our staff is available to assist you with this application or in finding other HIV/AIDS resources in your area.

It takes 5-10 business days to process a complete application. You will be notified by mail of your status. If any of the requested information is missing, you will be sent a letter requesting the needed information, or your application will be returned to you to complete.

If you have partial prescription insurance coverage for your HIV/AIDS drugs, MADAP may be able to help pay whatever your insurance does not cover. However, your pharmacy must bill your insurance company for the part of the drug cost for which the insurance is liable.

Eligibility for these programs continues for a twelve-month period. You must verify eligibility at your six month mark of your year and then you must reapply to the program. You will be sent your six month form and another application in time for your coverage to continue without interruption.

BEFORE YOU MAIL THIS APPLICATION, PLEASE CHECK THE FOLLOWING:

- ❑ Have you completely answered all questions and SIGNED the application (if you are married, your spouse must also sign)?
- ❑ Did you provide proof of current Maryland residence?
- ❑ Did you attach copies of proof of income (copies of 1 month's recent pay stubs, current Social Security award letter, unemployment letter, etc.)?
- ❑ Did you attach a copy of your health insurance card(s), if you have insurance?
- ❑ Is the medical section (A-1) completed and SIGNED by your health care provider?

If any of the items above are missing you will be notified by mail. Any missing information must be mailed to our office within 30 days or we will not be able to process your application.

Please note that all proof of documents must be within the past 60 days at time of the Application.

MADAP - MADAP Plus
500 North Calvert Street- Fifth Floor
Baltimore, Maryland 21202
Telephone: (410) 767-6535 Fax: (410) 333-2608
Toll-free 1-800-205-6308 TTY Maryland Relay 1-800-735-2258
Hours: Mon.-Fri. 8:30 a.m. - 4:30 p.m.
(Closed on State Holidays)

For Agency **Use Only**

New ____ MMIS-II _____ Initials: _____ Recert: _____

Eligibility Dates: _____

Client ID: _____

All information provided is kept completely CONFIDENTIAL

PART1. APPLICANT INFORMATION: Please enter ALL the information below and include proof of your current Maryland residency such as a copy of your Maryland driver's license, or a copy of a bill showing your name and current address, or a notarized statement that you live at the address on this application. If you want mail from us sent to an address different from the one below, please attach the mailing information to this form. Please be sure to include your apartment or suite number, if applicable.

Name: _____

Address: _____

City, State, and Zip: _____

Telephone:

May we leave a message at this number?

Daytime: _____ ❑ Yes ❑ No

Evening: _____ ❑ Yes ❑ No

Date of Birth: _____

Are you a Citizen or Lawful Permanent Resident of the United States? ❑ Yes ❑ No **(Your immigration status will NOT affect your eligibility** for MADAP or MADAP Plus.)

Sex:
01= Male _____
02=Female

Please give the number of natural or legally adopted children under 18 years of age living with you: _____

If application is filed on behalf of a child under 18 years of age, please print the parent's or guardian's name below: _____

Race: _____

01=White
02=Black or African American
03=Asian
04-'-Native Hawaiian or Other Pacific Islander
05=American Indian or Alaska Native 06=Other
06=Other

Ethnicity: _____

Are you Hispanic, Latino/a, or of Spanish heritage/ 01=yes 02=no

Marital Status: _____

01=Single
02=Married
03=Separated
04=Divorced
05=Widowed

Employment Status: _____

01=Full-Time
02=Part-Time
03=Permanent Disability
04=Not Currently Employed/Other
05=Not Applicable (child)

PART2. INCOME INFORMATION: For each source of income below, write how much each person in your household expects to receive in the next year (gross annual income). ENCLOSE COPIES OF PROOF OF ALL INCOME such as one month's pay stubs, entitlement (SSDI) award notice, most recently filed tax return or current W-2 form, or a letter from your employer stating your gross annual salary. Enclose copies of proof of income for spouse and/or dependent children if applicable.

Your Social Security Number: _____

Spouse's Social Security Number: _____

Spouse's Name: _____

Yearly Income:

Applicant: _____

Spouse: _____

Children: _____

Source(s) of income:

❑ Social Security (SSI, SSDI)
❑ Pension, Retirement, Private Disability
❑ Interest Income
❑ Employment Income
❑ Rental Income
❑ Unemployment Benefits
❑ Other Source of Income

PART 3. HEALTH INSURANCE INFORMATION: Please complete the following insurance information. If you have private health insurance you please provide a copy of both sides of your card(s). If you pay 50% or more of the monthly premium(s) for your health insurance, please provide us with payment information. If applicable, please provide copies of COBRA letters, monthly bills for health insurance premiums, etc. If you have Medicare, please provide a copy of your Medicare card.

Do you have Medicaid? ❑Yes ❑No Do you have Medicare? ❑Yes ❑No

Do you have health insurance? ❑Yes ❑No Do you pay 50% or more of the monthly premium? ❑ Yes ❑No

Insurance Company Name: _____ Plan Number: _____

Insurance Company Address: _____ Group Number: _____

City, State, and Zip Code: _____ Member Number: _____

Services Covered: ❑0ffice Visits ❑Hospital ❑ Emergency Room ❑ Dental ❑ Vision ❑ Prescriptions

Where do you make your monthly health insurance premium payments (attach premium bill or COBRA letter, if applicable)

Payable to: _____ Monthly Premium Amount: _____

Address: _____ Contact Person: _____

City, State, Zip: _____ Telephone Number: _____

Employer: _____ Telephone Number: _____

PART4. CASE MANAGER INFORMATION: Please complete the information below, if applicable. If you do not have a case manager, and would like information on case management resources in your area, please call MADAP for more information.

PART5. CERTIFICATION: Read the following information, and if you agree, please sign your name and write the date If you are married, your spouse must also sign and date this statement. If you have a legal guardian or someone acting as an attorney on your behalf, that person must also sign and write the date.

I certify that the information provided on this form is true, correct, and complete. I understand that if I give any false information, withhold information, or fail to promptly report changes in income or residency, I will be breaking the law and can be prosecuted and/or have services discontinued. I understand that I or my legal representative may be asked to provide proof of any information on this form or additional information as required by the Prevention and Health Promotion Administration, Maryland Department of Health and Mental Hygiene (DHMH).

I agree to the release of my medical, income, and insurance information to the Prevention and Health Promotion Administration-DHMH pertinent to determination of eligibility and my participation in MADAP, MADAP Plus.

I agree to the release of my insurance information as necessary to process MADAP claims and/or MADAP Plus payments of health insurance premiums on my behalf. I give permission to the Prevention and Health Promotion Administration-DHMH to contact my insurance company and/or my current or past employer to the extent necessary to verify insurance coverage and to make MADAP Plus payments of health insurance premiums on my behalf.

I agree to the release of information to the State of Maryland, Division of Reimbursements, for the purpose of their collecting any necessary fees necessary for my participation in MADAP, MADAP Plus, I request that payment of authorized benefits be made on my behalf.

If I am denied eligibility for services covered by this application, I understand I will be notified in writing of the decision and the reason(s) for denial and will be given instructions as to how I may appeal the decision. If you have questions, you may call the MADAP Administrator at 410-767-5678.

A photocopy of this authorization will be considered as effective and valid as the original.

Signature of Applicant	Spouse/Legal Guardian's Name (Printed)	Signature of Spouse/Legal Guardian
Date		Date

Maryland AIDS Drug Assistance Program
500 N. Calvert St., 5th Floor, 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

MEDICAL ELIGIBILITY FORM (A-1)

Note to Applicant: **Give this form to the licensed medical practitioner who provides your HIV-related care to complete and sign. Completion of this form is required to determine MADAP eligibility. The information in this form will be kept strictly confidential.**

Applicant's Name and Identifying Information:

First	Middle Initial	Last	Date of Birth (Month / Day / Year)
MADAP ID:		**SSN:**	

Note to Medical Practitioner: **All sections of this form must be completed to certify that the patient named above is medically eligible for MADAP. Once completed and signed, return this form to the patient to include with the full MADAP application.**

1 Confirmation of Viral Status:

Is this patient HIV infected? ☐ Yes ☐ No (***If No**, stop here, this patient is ineligible for MADAP*)

Has this patient's case been reported by you to the local health department as required by state law? ☐ Yes ☐ No

Does this patient have a history of Hepatitis C virus (HCV) infection?
☐ Yes, with detectable HCV VL
☐ Yes, with undetectable HCV VL from treatment
☐ No, HCV ab negative / undetectable HCV VL
☐ No HCV test on record

2 Laboratory Reports:

Enter this patient's most recent CD4 Count and Viral Load test results.
***If the patient's CD4 count is >500* cells/µL *and Viral Load is < 200* copies/mL, the CD4 test date may be older than 12 months.**
VIRAL LOAD test date must be within the last 12 months.

	Test Date	Test Result
CD4 Count	mm dd yyyy	cells/µL
Viral Load	mm dd yyyy	copies/mL

3 Certification of medical need for MADAP:

Are you prescribing at least one of the medications on the Maryland AIDS Drug Assistance Program (MADAP) formulary? ☐ Yes ☐ No

If No, are you planning to prescribe at least one of the medications on the MADAP formulary in the next 6 months? ☐ Yes ☐ No

Note: The MADAP formulary is available online at www.mdrxprograms.com

4 CDC Classification: *Check the appropriate stage and enter the corresponding date*

Stage / Date	Classifications of CDC HIV Infection Stages and/or associated CD4+ T-lymphocyte evidence*		Age on date of CD4+ T-lymphocyte test					
			<1 yr.		1-5 yrs.		≥ 6 yrs.	
			Cells/µL	%	Cells/µL	%	Cells/µL	%
☐ **Stage 0** ___/___/___	Based on testing history or algorithm for early HIV infection: The first confirmed positive HIV test result was done 0–180 days before or after a negative or indeterminate HIV test result.	***If Stage 0 is checked and early HIV infection was confirmed within 180 days of completing this form, skip to Section 5.***						
☐ **Stage 1** ___/___/___	Laboratory confirmation of HIV infection, no Stage-3-defining opportunistic illness, **and**		≥1,500	≥34	≥1,000	≥30	≥500	≥26
☐ **Stage 2** ___/___/___	Laboratory confirmation of HIV infection, no Stage-3-defining opportunistic illness, **and**		750-1,499	26-33	500-999	22-29	200-499	14-25
☐ **Stage 3** ___/___/___	Laboratory confirmation of HIV infection with Stage-3-defining opportunistic illness, **or**		<750	<26	<500	<22	<200	<14

Revised Surveillance Case Definition for HIV Infection – United States, 2014: MMWR 2014;63(No RR-03):1-10 **Website: www.cdc.gov/mmwr**

5 HIV exposure category (for statistical analysis only): *Check one*

☐ Male who has sex with males (MSM)
☐ Injection drug use (IDU)
☐ Heterosexual contact
☐ Receipt of blood transfusion, blood components, or tissue
☐ Mother with or at risk for HIV infection (prenatal transmission)
☐ Hemophilia/coagulation disorder
☐ Not Reported

6 Medical Practitioner's Information (Physician, Nurse Practitioner or Physician Assistant):

Printed Name:	Degree	Phone Number	Fax Number

Street Address	License Number and Issuing State	NPI #

City	State	Zip Code	Signature:	Date:

Informed Consent for the Release and/or Exchange of Information

It may be necessary for the Maryland Department of Health and Mental Hygiene to release or exchange certain information with your employer and/or insurance company in order to make health insurance premium payments on your behalf. If you wish to participate in the health insurance premium payment program offered by the Department, you must complete this form, sign it, and have it witnessed by an adult person who knows you.

_____, born _____

(Applicant's Name) (Applicant's Date of Birth)

and residing at: _____

(Applicants Address, City, State**,** and Zip)

Hereby give permission to the Maryland Department of Health and Mental Hygiene, 500 N. Calvert Street, 5Th Floor, Baltimore, Maryland 21202 to release and/or exchange information with my employer and/or insurance company named below for the express purpose of making health insurance premium payments on my behalf. Further, I give my permission to the employer and/or insurance company named below to release and/or exchange information with the Maryland Department of Health and Mental Hygiene for the express purpose of making health insurance premium payments on my behalf.

Employer: _____

Employer's Address: _____

Employer's Phone Number: _____

Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone Number. _____

I understand that I may revoke this authorization by notifying the Department of Health and Mental Hygiene in writing at any time, should I choose to do so.

Applicant Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Witness Name (Printed): _____ Relationship to Applicant: _____