**Maryland AIDS Drug Assistance Program (MADAP)**

**Reimbursement Agreement for Net Premium Tax Credit**

**(Please complete and return no later than Sept 30, 2021)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MADAP ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residential Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can leave message? Yes / No

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to reimburse MADAP for any insurance premium overpayments made on my behalf during tax year 2020 for my Qualified Health Plan obtained through the Maryland Health Exchange. I understand that this amount is equal to the **Net Premium Tax Credit** found on line 8 of Schedule 3 of the 2020 IRS Form 1040, and may be prorated based on the number of months I was MADAP Plus eligible and received premium payment assistance.

I agree to send copies of my completed and filed 2020 IRS tax forms 1095-A, 8962 & 1040 along with Schedules 2 & 3 to MADAP for review **no later than Sept 30, 2021**. Once MADAP notifies me of any final amount due, I agree to submit payment via personal check, certified check or money order to:

MDH Unit #54/PTC

500 N Calvert Street 5th Floor

Baltimore MD 21202

I understand that the Net Premium Tax Credit represents the amount MADAP Plus overpaid for my health insurance premiums for 2020, and that failure to repay this amount to MADAP may result in the loss of my MADAP/MADAP Plus benefits and that MADAP reserves the right to refer this debt to the State of Maryland Central Collection Unit. By signing below, I agree to these terms and conditions.

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse signature (if family plan): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_