Maryland AIDS Drug Assistance Program
500 N. Calvert St., 5th Fl., Baltimore, MD 21202
Phone: (410) 767-6535 or Toll Free: 1-800-205-6308
or TTY- Maryland Relay Service 1-800-735-2258
Fax Numbers: (410) 333-2608; (410) 244-8696; (410) 244-8617
Website:http://phpa.health.maryland.gov/OIDPCS/CHCS/pages/madap.aspx

MADAP and MADAP Plus Enrollment Application

MADAP ID (if applicable): 94-________________________________

Are you a new applicant to MADAP and MADAP Plus? ☐ Yes ☐ No

Applying for (check one):

☐ MADAP (Drug Assistance)

☐ MADAP and MADAP Plus (Drug and Insurance Premium Payment Assistance)

If you have prescription coverage through Maryland Medicaid, you are NOT eligible for MADAP.

Section 1: Applicant Information

First Name: ______________________ **Middle Initial:** __________ **Last Name:** ______________________ **Suffix:** __________

Date of Birth (MM/DD/YYYY): ________/_____/_______

Social Security Number: _____ - _____ - _________
☐ Check if you do not have a social security number.
ITIN (if applicable): _________________________

Residential Address (proof of residency is required, see Section 2):

Street: ____ **Apt#**: ____________

City: ______________________________ **State:** __________ **Zip Code**: ______________

☐ I am homeless and live in Maryland. (check if applicable, complete and submit Form A-2)

Mailing Address (if different from residential address):

Street: ____ **Apt#**: ____________

City: ______________________________ **State:** __________ **Zip Code**: ______________

Telephone numbers where MADAP staff can reach you:

Home: (_______) -________ - ___________ May we leave a detailed message? ☐ Yes ☐ No

Work: (_______) -________ - ___________ May we leave a detailed message? ☐ Yes ☐ No

Cell: (_______) -________ - ___________ May we leave a detailed message? ☐ Yes ☐ No

Gender at Birth: ☐ Male ☐ Female

Gender: ☐ Male ☐ Female ☐ Transgender (☐ Male to Female ☐ Female to Male)

Legal Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Sexual Orientation: ☐ Straight or Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual ☐ Don't know
☐ Choose not to disclose ☐ Something else (please specify): ________________

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Race *(Check all that apply):*

☐ **Black or African American**
☐ **White**
☐ **American Indian/Alaskan Native**
☐ **Native Hawaiian/Pacific Islander**
(Check all that apply):
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander

☐ **Asian** (Check all that apply):
- ☐ Asian Indian
- ☐ Vietnamese
- ☐ Korean
- ☐ Japanese
- ☐ Chinese
- ☐ Filipino
- ☐ Other Asian

Ethnicity:

☐ Non-Hispanic
☐ Hispanic/Latino(a) *(Check all that apply):*
- ☐ Mexican, Mexican American, or Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Another Hispanic, Latino(a), or Spanish origin

United States Citizenship Status:

☐ U.S. Citizen
☐ Asylee (attach proof)
☐ U.S. Lawful permanent resident (attach copy of card)
☐ Not a citizen or permanent resident of the U.S.

Preferred Language for:

Reading: ☐ English ☐ Spanish ☐ Other: _______

Speaking: ☐ English ☐ Spanish ☐ Other: _______

Section 2: Maryland Residency: *Documentation must include your name and residential address as displayed in Section 1. Check the type of legible documentation being attached to verify your Maryland residency (choose one):*

Documents that must be dated within the past 60 days of submitting this application:

☐ Bills - (examples: utility, health insurance premium, cell phone, cable service, car or hospital)
☐ Employment:
- Paystubs (one month)
- Unemployment: Determination letter
- Other: A-2: Verification of No Income/Homeless Verification Form
- A-3: Cash Only Verification Form

☐ Change of address card from a U.S. Post Office or MVA (Maryland Vehicle Admin.)
☐ Bank statement
☐ Windowless envelope with dated postmark addressed to you, received at your residential address previously identified

Documents that must be dated within the past year of submitting this application:

☐ Social Security Award Letter
☐ Lease or Mortgage
☐ Driver's License

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Section 3: Medical Eligibility Criteria:

Are you a new applicant to MADAP and MADAP Plus?

☐ Yes, I have never been enrolled with the programs.

☐ No, I am currently enrolled or have been enrolled with MADAP in the past. **This section is not applicable for you.**

Only applicants who have never been a MADAP client must submit A-1: Medical Eligibility Form with your Enrollment Application. The form must be completed, dated, and signed by your licensed medical practitioner providing your HIV-related care. The practitioner must answer all questions to support your eligibility for MADAP. This Form can either be included in your enrollment application or sent directly to MADAP from your practitioner's office.

Section 4: Household/Projected Gross Income: *Household includes the applicant, spouse, and all dependents on your federal tax return. If you do not file taxes, list the people in your household whom you support financially.*

Are you under the age of 19? ☐ Yes ☐ No (If yes, please complete **A**, if no, proceed to **B**)

A. Parental Information

Parent/Guardian 1:

First Name: ________________ Middle Initial: ________ Last Name: _______________ Suffix: ____________

Date of Birth (mm/dd/yyyy): _____/_____/______ Social Security Number: _____ - _____ - __________

☐ Check if you do not have a social security number.
ITIN (if applicable): ____________________________

Parent/Guardian 2:

First Name: ________________ Middle Initial: ________ Last Name: _______________ Suffix: ____________

Date of Birth (mm/dd/yyyy): _____/_____/______ Social Security Number: _____ - _____ - __________

☐ Check if you do not have a social security number.
ITIN (if applicable): ____________________________

B. Marital Information (if applicable):

Spouse:

First Name: ________________ Middle Initial: ________ Last Name: _______________ Suffix: ____________

Date of Birth (mm/dd/yyyy): _____/_____/______ Social Security Number: _____ - _____ - __________

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C. Natural, Adopted, Stepchildren/Siblings *(attach additional sheets if necessary):*

Do you have any children/siblings who live within the household who are under the age of 19? ☐ **Yes** ☐ **No**.

(If yes, please list each child's name, age and date of birth.)

	Name	Date of Birth	Age
Child 1:			
Child 2:			
Child 3:			
Child 4:			

Additional Members of your household (*not listed above*):

Name	Relationship

D. Household Income:

You are required to report all your household's gross income, including your income, your legal spouse's income, and income of any dependents. Provide the requested information:

1. **Recipient**	**Income Source(s)**	**How Often**	**Gross Amount** (before deductions)
☐ Self ☐ Spouse ☐ Household member		☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually ☐ Semi-Monthly ☐ Seasonal: # of Months paid: _______	$ ___________
2. **Recipient**	**Income Source(s)**	**How Often**	**Gross Amount** (before deductions)
☐ Self ☐ Spouse ☐ Household member		☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually ☐ Semi-Monthly ☐ Seasonal: # of Months paid: _______	$ ___________
3. **Recipient**	**Income Source(s)**	**How Often**	**Gross Amount** (before deductions)
☐ Self ☐ Spouse ☐ Household member		☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually ☐ Semi-Monthly ☐ Seasonal: # of Months paid: _______	$ ___________
4. **Recipient**	**Income Source(s)**	**How Often**	**Gross Amount** (before deductions)
☐ Self ☐ Spouse ☐ Household member		☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually ☐ Semi-Monthly ☐ Seasonal: # of Months paid: _______	$ ___________

Total number of household members: _______________

Total household annual gross income: $ _______________

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Check all that applies and submit a legible copy of the required supporting documentation as described in the following chart.

	Income Source	**Supporting Documentation**
	Wages and Salaries (including tips)	One month's gross paystubs (including tips), dated within the last 60 days
	Net Income from Self-Employment	Most recent submitted quarterly tax statements, or Receipts, Journal, Manifests for most recent 30 days or Business Checking and/or Savings Bank Statements for the most recent 60 days)
	Alimony, Retirement, Pension, Annuity, Investment Dividends or Interest	Statement of monthly payments.
	Current Unemployment Benefits	Current Unemployment letter/printout with balance
	Social Security	Current award letter from Social Security Administration, inclusive of disability, if applicable.
	Rental Property	Statement of net income.
	Other Taxable Income (prizes, awards, gambling winnings)	Statement and evidence of other taxable income.
	No Income, supported by others	A-2: No Income and/or Homeless Verification Form - completed by the person who supports you.
	Cash only Income	A-3: Cash Only Verification Form

Do not report the following types of income: child support; gifts; Supplemental Social Security Income; Veterans' disability payments; workers' compensation; or proceeds from loans, such as student loans, home equity loans, or bank loans.

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Section 5: Health Insurance & Prescription Plan Coverage Information: *You must submit a copy of the front and back of all your insurance card(s) with this application, so we can verify your benefits. Also, submit a copy of any enrollment letter(s) you have received for LIS/Extra Help, SPDAP, or QMB/SLMB, if applicable.*

Complete the following for Health and Prescription Insurance Plans:

Primary Health Coverage (Choose plan type):
☐ Individual ☐ Individual/Spouse
☐ Family ☐ Individual/Child

Insurance company name: ____________________
Policy holder name: ____________________
Phone number: __________ Plan number: ________
Member ID: ____________ Group ID: __________
Effective date: ____________________

Secondary Health Coverage (Choose plan type):
☐ Individual ☐ Individual/Spouse
☐ Family ☐ Individual/Child

Insurance company name: ____________________
Policy holder name: ____________________
Phone number: __________ Plan number: ________
Member ID: ____________ Group ID: __________
Effective date: ____________________

Complete the following for all Other Plans:

Type of Coverage: ____________________
Company Name: ____________________
Policy Holder Name: ____________________
Plan ID#: ____________________
Effective Date: ____________________
Phone Number: ____________________

Type of Coverage: ____________________
Company Name: ____________________
Policy Holder Name: ____________________
Plan ID#: ____________________
Effective Date: ____________________
Phone Number: ____________________

If you do NOT have health insurance check all reasons that apply:

☐ Cost of premiums ☐ Cost of co-pays ☐ Not interested ☐ Other (describe): ____________

☐Check here if you need help obtaining insurance

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Section 6: MADAP Plus: *Premium payment assistance*

If you are interested in premium payment assistance, submit your health/prescription payment documentation (see chart below) with this application. You will be contacted about MADAP Plus enrollment determination after your MADAP eligibility has been approved and your insurance coverage has been verified.

Check the type of plan for which you are requesting assistance and include the required documentation indicated with this Enrollment Application.

	Type of Plans Covered by MADAP Plus	Payment Documentation Needed
	QHP from the Maryland Health Benefits Exchange (on-exchange)	Monthly Premium Invoice/Bill
	QHP directly from the insurance carrier or through an insurance broker (off-exchange)	Monthly Premium Invoice/Bill
	Medicare Part C Plan	Invoice or Coupon Booklet
	Medicare Part D - Prescription Drug/Advantage Plan	Invoice/Bill or Coupon Booklet
	Medicare Supplemental Plans (Medigap), if client has active Part D plan or credible coverage	Invoice/Bill or Coupon Booklet
	Dental and Vision Policies, if MADAP Plus is paying client's health and prescription coverage.	Invoice/Bill or Coupon Booklet
	Private Employer based plans (applicant's or spouse's employer, union or retirement plan), if client pays 50% or more of the premium, the plan covers HIV drugs, and the employer will accept payment from State of Maryland insurance program. **MADAP staff maintains client confidentiality of HIV status during all contact with employers and insurance companies.**	Provide a letter from your employer that includes the cost of your monthly premium, percentage employer pays, percentage you pay, where to send payment with who to address the check to, and whether your employer will accept a payment from a State of Maryland insurance program. MADAP Plus staff must be able to arrange payment of the applicant's portion of the premium. Staff will need to communicate with the employer to make arrangements for a payment plan approved by the employer.
	Plans not covered by MADAP Plus:	
	Medicare Part A – Hospital Coverage	
	Medicare Part B – Medical Coverage or Creditable Coverage (a plan usually obtained through an employer)	
	VA/Tricare; I.H.S. (Indian Health Services); Maryland Medicaid (Medical Assistance); or Maryland Children's Health Program	
	Private medical or prescription plans that do not cover HIV drugs or provide HIV care and employer plans where the employer does not accept payment from the program.	

It is your responsibility to provide monthly premium statements to MADAP Plus for timely payments.

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Section 7: Release & Exchange of Information:

I certify that the information provided in this application is complete and accurate, to the best of my knowledge.

- I understand that, for the purposes of determining my eligibility for Maryland AIDS Drug Assistance Program (MADAP), the Maryland Department of Health (MDH) may request further documentation to verify my HIV positive serostatus, Maryland residency, income, employment, and/or insurance information.
- I authorize my physician, case manager/social worker, and health care providers to exchange information with the Department that documents my diagnosis of HIV/AIDS and my need for services from the Department.
- I authorize the Department to exchange information with my physician, case manager/social worker, health care providers, insurance carrier(s) and/or pharmacy provider(s) to facilitate provision of MADAP services as needed.
- I understand that I am required to verify my eligibility for continued service every six months in accordance with the Department's Continued Eligibility Verification process. I understand that any change in my residency and/or income will be evaluated and that I will be notified of either continued eligibility or denial of services.
- I understand that my non-compliance to verify my continued eligibility every six months will result in termination of my MADAP enrollment.
- I agree to notify the Department of any circumstances affecting my participation in, or eligibility for, MADAP. I agree to notify MADAP within 10 days if my address, income or other information changes (COMAR 10.18.05.04A)

HIPAA Privacy Rule/Confidentiality/Acknowledgement of MDH Privacy Policy

- MADAP complies with the Health Insurance Portability and Accountability Act (HIPAA) privacy rule [45 CFR § 160.102]. Client-level data related to my enrollment will be reported only as required by law.
- I have the right to confidentiality of all information and records compiled, obtained and maintained in the course of applying for and/or receiving services.
- My signature on this document acknowledges receipt of MDH's PrivacyPractices.

Consumer's rights:

- If my application is denied, I have the right to request a reconsideration (COMAR 10.18.05.05A), and if I am dissatisfied with the reconsideration (COMAR 10.18.05.05C), I may request an appeal hearing.
- I understand that I may revoke this authorization at any time in writing. However, this release shall remain valid until I inform MADAP, in writing, of my wish to terminate services or until such time as I no longer qualify for these services, whichever occurs first, except to the extent that action has been taken in reliance on this authorization.

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Provide the following:

Case Manager:

Name: ______________________ Provider Site: ______________________ Phone number: ______________

Primary HIV Physician:

Name: ______________________ Provider Site: ______________________ Phone number: ______________

Alternate Contacts:

I authorize the MADAP program to speak with the following person(s) about my application and/or services (e.g.: family member):

Name	Organization	Relationship	Phone number

I certify that the information I have given on this application is true, correct, and complete. I agree to cooperate in documenting the information I have given or providing additional information to support my application as required by the department.

Applicant Name: ____
(please print)

Signature of Applicant: ____ Date: _____/______/______
(or legal guardian if applicant is a minor)

Spouse Signature: ____ Date: _____/______/______
(if applicable)

Mail or fax completed application and supporting documentation to:

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Please retain a copy of this application for your records.