MARYLAND
Department of Health

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) 244-8617
Website:http://phpa.health.maryland.gov/OIDPCS/CHCS/pages/madap.aspx

MADAP Temporary Assistance Program (TAP) Application

Instructions:

- Select the reason for applying for temporary assistance.
- TAP eligibility requirements are: HIV+ status, eligible for Maryland Medicaid (MA) or Low-Income Subsidy/Extra Help (LIS).
- Before applying for TAP, a complete application must be submitted to the applicable program either for MA or LIS.
- A copy of the electronic confirmation may be used if the applicant applied for MA or LIS on line. If applicant is applying for MA and does not have the online confirmation, the applicant must attach a copy of a complete and signed MA application.
- TAP applications must be completed and submitted by a Case Manager or Healthcare Professional **ONLY**.

MADAP ID: 94-_____

New client: ☐ **Yes** ☐ **No** **Is applicant HIV positive?** ☐ Yes ☐ No *(if no, applicant is ineligible.* **Stop here**.)

Applied for (check box): ☐ **LIS** ☐ **MA** **If applicant has prescription coverage through MA, he/she is NOT eligible for TAP.**

Required Information *(All questions must be answered)*

First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: _____

Date of Birth (mm/dd/yyyy): ____/___/_____ Social Security Number: ___ - ____ -_____

Spouse: (*if applicable*)

First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: _____

Date of Birth (mm/dd/yyyy): ____/___/_____ Social Security Number: ___ - ____ -_____

Residential Address:

Street: _____ Apt#: _____

City: _____ State: ____ Zip Code: _____

☐ Applicant is homeless but lives in Maryland. (check if applicable)

Mailing Address (if different from residential address):

Street: _____ Apt#: _____

City: _____ State: ___ Zip Code: _____

Telephone numbers where MADAP staff can reach the applicant:

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): _____

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: _____

Race (Check all that apply):

☐ White ☐ Black or African American ☐ Asian
☐ American Indian/Alaskan Native (Check all that apply):
☐ Native Hawaiian/Pacific Islander ☐ Asian Indian
(Check all that apply) ☐ Vietnamese
☐ Native Hawaiian ☐ Korean
☐ Guamanian or Chamorro ☐ Japanese
☐ Samoan ☐ Chinese
☐ Other Pacific Islander ☐ Filipino
☐ Other Asian

Ethnicity:

☐ Non-Hispanic

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

Lab Results (New applicants to MADAP only):
Results of Last Viral Load: _____ Date of Test: _____
(not more than 12 months old)

Results are **pending** and not available at this time. *(date of most recent test):* _____

Is applicant being prescribed HIV Medication**:** ☐**Yes** ☐**No**

Does the applicant have an *urgent* need for medication due to:

☐ The CD4 count is below 200 and/or current opportunistic infection?

☐ The applicant has less than 2 week's supply of medication?

HIV Exposure Category (check one):

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

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

Number of children natural or legally adopted in the home under 19 years of age: _____

Does the applicant have insurance that covers prescriptions? ☐Yes ☐ No
If yes, provide the name of the insurance company, policy number and group number. _____
LIS/Extra Help/MA confirmation: _____

Declaration of Case Manager, Healthcare Professional assisting applicant with the MA or LIS/Extra Help and TAP applications:

☐ **Based on the information provided to me, the applicant appears to be eligible for MA. I have submitted the original MA application and all the supporting documentation. I have attached a copy of the completed MA application or online confirmation page.**

☐ **I have assisted the applicant with applying for LIS/Extra Help online. I have attached a copy of the completed LIS/Extra Help online confirmation page.**

Signature: _____ Date: _____

Printed Name: _____ Phone number: _____

Organization: _____

Street Address: _____City: _____ State: _____ Zip Code: _____