FY 2009

DAP Renewal Application

Michigan Department of Community of Health
HIV/AIDS Drug Assistance Program

☐ New
☐ Renewal – Subscriber ID/Member ID (found on RxAmerica card, if applicable) __ __ __ __ __ __ __ __ (max. 8)

Last Name:____________________________ First Name:_________________________ Middle Initial: _______

Preferred Mailing Address (All DAP related information will be sent to this address):

____

City: __________________________________ State: ______________________ Zip Code: _______________

County of Residence: _____________________________ Phone Number: ( )________________________

Social Security Number: __ __ __ - __ __ - __ __ __ __ Date of Birth: ___________________________________
Month/Day/Year(19XX)

Gender (check one): ☐ Male ☐ Female ☐ Transgender

Race/Ethnicity (check all that apply):
☐ African American ☐ African National
☐ Arab/Chaldean ☐ Asian
☐ Caucasian ☐ Hispanic/Latino
☐ Native American ☐ Pac. Islander/Native Hawaiian

Please Answer the Following Questions:
Are You a Michigan Resident? ☐ Yes ☐ No
Are You Homeless? ☐ Yes ☐ No
Do You have Medicare? ☐ Yes ☐ No
Do You have Private Dental Insurance? ☐ Yes ☐ No

Family Size: ________ (include yourself , and those supported by you, including spouse, partner and/or other dependants living with you)

My TOTAL Gross (pre-tax)Monthly Income is:

$ _____________________________

What Type of DAP Assistance Are You Requesting? (check one box only) :

☐ Veteran's Administration Copay Assistance (pg. 5)

☐ County Health Plan Assistance- Are You On Plan B? ☐ Yes ☐ No (pg. 9)
(Please attach a copy of you Health Plan card)

☐ Private Insurance Copay Assistance (pg.6)
(Please attach a copy of your insurance card)

☐ Full Drug Assistance (pg.10)

☐ Medicare Part D – Are You Enrolled in a Prescription Drug Plan (PDP)/Medicare Rx Plan? ☐ Yes ☐ No (pg.7)
(Please attach a copy of you Medicare Part D Prescription Drug Plan Card)

Proof of HIV Status/Lab Update*
(*If New to Program Must Have Physician Signature and/or Labs Showing detectable Viral Load and/or Positive Western Blot*)

Absolute CD4 Number/mm3: _____ Test Date:__ __/__ __/__ __ __ __

HIV RNA/Viral Load: _________copies Test Date: __ __/__ __/__ __ __ __

Physician Name: ____________________________ Physician Signature: _________________________

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Consent Form/Authorization for Release of Information

I understand that if I become enrolled in a health insurance program that pays for any portion of my medications, or if I qualify for medical assistance through other federal, state or county medical benefit programs, I must immediately notify the Michigan Department of Community Health, Drug Assistance Program (DAP) in addition to my pharmacist, physician, and/or dental provider and that I may no longer be eligible to receive assistance from the DAP/MDP. I understand that if I am a Medicare recipient that I must enroll in a Medicare Rx plan or provide proof of creditable coverage to the DAP.

I authorize the DAP/MDP to receive, disclose, and discuss medical/dental information related to the care and treatment of my HIV infection with any health insurance or government health insurance program representative, or other individuals as required and necessary. In addition, specific agencies and phone numbers are listed below.

The information that I have provided on this application is complete and true to the best of my knowledge. I certify that I meet the eligibility requirements as specified in the instructions and have followed the necessary steps that are required for me to be on the Drug Assistance Program.

I understand that I must reapply annually, prior to March 31st every year to receive assistance with my medications from the DAP. I understand that if I submit an application that is determined to be incomplete in fulfilling the requirements for approval that my assistance will be inactive until all the requirements are met.

I understand that if any of the information provided on this application changes that I must notify the DAP immediately. In addition, I understand that failure to report changes and/or reporting of inaccurate information may affect DAP/MDP coverage and program eligibility.

This application, when completed, contains patient information that must be protected in accordance with the Health Insurance Portability and Accountability Act.

Case Manager: ____ Phone Number: ______________________

Other: ____ Phone Number: ______________________

Signature of Applicant: __________________________________ **Date:** ____________________________

Printed Name of Applicant: ____

PLEASE MAIL OR FAX APPLICATION AND ANY SUPPORTING DOCUMENTATION TO:
DAP/MDP
109 Michigan Avenue, 9th Floor
Lansing, Michigan 48913
Phone: (888) 826-6565
Fax: (517)335-7723

DAP OFFICE USE ONLY

□VA (10000) **□Private Insurance(4000)** **□County Program, Plan B(2000)- Co#____**

□Medicare D(7000) **□Full Drug Assistance(3000)** **□Spendown(6000)** **□Denied_________________**

Approved Date __ __/__ __/__ __ __ __Member ID __ __ -__ __ __-__ __ __Approved by ______________