APPLICATION FOR THE MADAP TRANSITIONAL ASSISTANCE PROGRAM (TAP)

Instructions:

- **TAP eligibility requirements are:** HIV+ status, eligibility for Maryland Medicaid (MA) and MADAP formulary medications being currently prescribed. ***Any applicant who is recertifying for MA will be ineligible for TAP, until a period of 30 days or more has elapsed from the MA expiration date.***
- A copy of a Medicaid application or the Short Form application from the Maryland Health Connection website may be used for single clients without children under the age of 18.
- A copy of a Medicaid application or the Standard Application from the Maryland Health Connection website may be used for married clients or clients with children under the age of 18.
- **Before** applying for TAP, a **complete** application **must** be submitted to Medical Assistance or to the Maryland Health Connection. A copy of the Maryland Health Connection or MA application **must** be attached with the TAP application.
- Applications for TAP must be completed and submitted **by an HIV Case Manager**.
- Applications for TAP should be faxed to: **410-333-2608, 410-244-8696 or 410-244-8617**. For phone inquiries call MADAP at **410-767-6535**.

Required Information (all questions must be answered)			
1.	First Name M. I. Last Name **Client:**		**Social Security Number:**
2.	**Client is HIV Positive**: ☐ Yes ☐ No (if no, client is ineligible. Stop here)		
3.	**List of MADAP formulary medications being currently prescribed to client:**		
	1.	2.	3.
	4.	5.	6.
4.	**Prescribing Clinician's Name:**		**Phone #:**
5.	**Lab Results, (not more than 12 months old):**		
	☐ Results of Last CD4 Test:	Date of Test:	
	☐ Results of Last Viral Load:	Date of Test:	
	☐ Results are **pending** and not available at this time (date of most recent test):		
6.	Does client have an *urgent* need for medication due to CD4 count below 200 and/or current opportunistic infection and/or less than 2 week's supply of medication (listed above)? *If yes,* ***30 days of TAP benefits*** *may be approved pending support documentation.* ***All*** *requirements must be met to allow up to 90 days.*		☐ Yes ☐ No
7.	**HIV Exposure Category (check one):**		
	☐ MSM	☐ Hemophilia/coagulation disorder	☐ Transfusion Recipient
	☐ IDU	☐ Heterosexual contact	☐ Mother HIV + (for child <12 years old)
	☐ IDU & MSM	☐ Born in Pattern II Country	☐ Other (describe):

Declaration of HIV/AIDS Case Manager, Licensed Social Worker, RN, or DOC representative assisting client with the Maryland Medicaid and TAP applications:

☐ ***Based on the information provided to me, the client appears to be eligible for Maryland Medicaid.***

☐ ***I have mailed the original MA application and all the supporting documentation required by MA. I am enclosing a copy of the completed application that was submitted to MA or to Maryland Health Connection.***

Case Manager's Signature & Date	**Case Manager's Printed Name**	**Phone Number**
Organization	**Street Address**	**City, State, ZIP**