Maryland
DEPARTMENT OF HEALTH

Client Services
1223 W. Pratt Street, Baltimore, MD 21223
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
Email: Client.services@maryland.gov

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).
- Applicants that are currently enrolled in MA with prescription benefits are not eligible for TAP.
- 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 online. If the applicant is applying for MA and does not have the online confirmation, the applicant must attach a copy of a completed and signed MA application.
- TAP applications must be completed and submitted by a Case Manager or Healthcare Professional **ONLY**.

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** Once the applicant has prescription coverage through MA, the applicant will no longer be eligible for TAP.

Section I: Applicant Information

Required Information *(All questions must be answered)*

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

*Date of Birth (MM/DD/YYYY): _____

*Social Security Number:_____
☐ Check if applicant does not have a social security number.
ITIN (if applicable): _____

Spouse *(if applicable)*

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

*Date of Birth (MM/DD/YYYY): _____

*Social Security Number:_____
☐ Check if spouse does not have a social security number.
ITIN (if applicable): _____

***Residential Address** (proof of residency is required):

*Street: _____ Apt#: _____

*City: _____ *State: _____ *Zip Code: _____

Mailing Address (if different from residential address):

Street: _____Unit/Apt#: _____

City: _____ State: _____ Zip Code: _____

***Telephone numbers where 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

***Sex at Birth:** ☐ Male ☐ Female

***Gender:** ☐ Male ☐ Female ☐ Transgender Man ☐ Transgender Woman

***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): _____

***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

***Citizenship/ Immigration Status:**

U.S. Citizen: ☐ Yes ☐ No
Green Card: ☐ Yes (attach copy of card) ☐ No
Asylee: ☐ Yes (attach documentation) ☐ No

Section II: Medical Eligibility

New Applicants Only

*****Medical Eligibility Criteria can be met by providing documentation using one of the options below:

- Lab reports that show diagnosis or viral load
- The A-1 Medical Form: The Medical Eligibility Form must be completed, dated, and signed by the licensed medical practitioner who provides the client's medical care. The practitioner must answer all questions to support eligibility. Medical eligibility is required once; if you are unsure whether we have a medical form on file, please contact Client Services.

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	☐ Hemophilia/coagulation disorder
☐ Mother with or at risk for HIV infection (perinatal transmission)	☐ Other: _____	

Section III: Household/Projected Gross Income:

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

*****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: _____