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 and MADAP Plus Enrollment and Continued Eligibility Process

This enrollment application must be completed, signed, and submitted for eligibility determination with supporting documentation applicable to your circumstances. Once your eligibility is approved, this will be your official enrollment application on file with MADAP/MADAP Plus and will only need to be completed once.

General Instructions for Enrollment Application

Provide all information requested including required documents. If a question or request is not applicable to you, answer "n/a". If you have never been a MADAP client, your clinician must complete, sign, and submit **Form A-1: MADAP Medical Eligibility Form**.

- If you have been a MADAP client in the past, and MADAP **does not** have this enrollment application on-file, you will be required to complete and submit this MADAP enrollment application with supporting documentation.

- If you were enrolled in MADAP in the past, and MADAP **does** have the enrollment application on file with MADAP, you can re-enroll in MADAP by using the Annual CEV Form for eligibility determination.

Continuing Eligibility Verification Form (CEV Form)

Federal requirements mandate that MADAP verifies your continued eligibility every six-months. The mid-year verification occurs by the end of the 6th month of your initial MADAP enrollment with the annual verification occurring by the end of the 12th month of your initial MADAP enrollment.

- Mid-Year CEV Form - Replaces SVN Form

  By mid-year of your enrollment period you will need to verify continued eligibility for MADAP. A Mid-Year CEV Form will be sent to you. If there was a change in your residency and/or income you must submit the Mid-Year CEV Form with proof of change(s).***See Appendix A and B on page 9 for acceptable forms of documentation.*** If there has not been a change to your residency or income, you must indicate "no changes" on the form, sign it, and return it to MADAP

- Annual CEV Form

  Annually you will need to verify eligibility by submitting a completed and signed Annual CEV Form (to be sent to you) along with required documents.

You must inform MADAP of any changes to your health and prescription insurance coverage at the time of change.

Do not include this page with your Enrollment Application.

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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

Email address (for MADAP use only): _____

(see page 10 for more information)

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): _____

Race *(Check all that apply):*

☐ **Black or African American**

☐ **White**

☐ **American Indian/Alaskan Native**

☐ **Native Hawaiian/Pacific Islander**

(Check applicable ethnic group(s) below):

- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander

☐ **Asian** *(Check applicable ethnic group(s) below):*

- ☐ Asian Indian
- ☐ Vietnamese
- ☐ Korean
- ☐ Japanese
- ☐ Chinese
- ☐ Filipino
- ☐ Other Asian

Ethnicity:

☐ Non-Hispanic

☐ Hispanic/Latino(a) *(Check applicable ethnic group(s) below):*

- ☐ 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 written in Section 1. Check the type of legible documentation being attached to verify your Maryland residency (choose one):* *(See appendix for more information)*

Accepted forms of documentation dated within 60 days of submission of application:

☐ Current Utility Bill - dated within the past 60 days

☐ Rent Receipt - dated within the past 60 days

☐ Letter from a government agency, signed and dated within the past 60 days and mailed to client's home

☐ Letter from a case manager on agency letterhead signed and dated within the past 60 days and mailed to client's home

☐ Homeless clients can provide a letter written on agency letterhead that is signed and dated within the last 60 days. *(see appendix for more information)*

Other accepted forms of documentation dated within 12 months of submission of application:

☐ Current notice of decision from Medicaid

☐ Valid Maryland driver's license or Maryland Identification Card dated within the last 12 months of submitting application

☐ Voter registration card dated within the last 12 months of submitting application

☐ Signed and dated lease (within 12 months) or mortgage agreement

Section 3: Medical Eligibility Criteria:

Are you a new applicant to MADAP and MADAP Plus?

Only applicants who have never been a MADAP client must submit Form A-1: Medical Eligibility Form with your Enrollment Application. The form must be completed, signed, and dated 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 with 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: _____ - _____ - _____

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

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 claimed as dependents on your income taxes (*not listed above*):

Name	**Relationship**

D. Household Income:

You are required to report all of 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: $ _____

Check all that applies and submit a legible copy of the required supporting documentation as described in the following chart. *(See appendix for more acceptable forms of income)*

- ☐ **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, Receipts, Journal, or 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, workers compensation, or proceeds from loans, such as student loans, home equity loans, or bank loans.

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 that 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 Pharmacy Benefits:

Complete the section below if you have pharmacy benefits or submit a copy of the front and back of your pharmacy benefits card.

Company Name: _____

Policy Holder Name: _____

Effective Date: _____

Phone Number: _____

Rx BIN: _____

Rx PCN: _____

Rx Group: _____

Plan ID: _____

Complete the following for Dental Benefits:

Complete the section below if you have dental benefits or submit a copy of the front and back of your dental benefits card.

Company Name: _____

Member ID: _____

Group Number: _____

Complete the following for Vision Benefits:

Complete the section below if you have vision benefits or submit a copy of the front and back of your vision benefits card.

Company Name: _____

Member ID: _____

Group 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

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 receive a letter in the mail regarding your 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 do cumentation indicated below 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 an active Part D plan or credible coverage (employer insurance)	Invoice/Bill or Coupon Booklet
	Dental and Vision Policies, only 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 3rd party 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.

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, household 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.
- Email addresses will not be sold to any third-party vendors or used to communicate one's specific case. This is for MADAP to quickly relay any updates and important informaton pertaining to the program.
- 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 that 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:

Maryland AIDS Drug Assistance Program
500 N. Calvert St., 5th Fl.
Baltimore, MD 21202
Fax: (410) 333-2608; (410) 244-8617

Please retain a copy of this application for your records.

Appendix

Appendix A:

Acceptable Residency Documentation

- Residency documentation must include the client's name and current address. Documentation must be current (e.g. current lease, recent utility bill, etc.). Acceptable proof of residency may include, but is not limited to, the following:
    - Current notice of decision from Medicaid
    - Valid Maryland driver's license or Maryland Identification Card dated within the last 12 months
    - Voter registration card dated within the last 12 months
    - Current signed and dated lease (within 12 months) or mortgage agreement
    - Rent receipt, dated within the last 60 days
    - Current utility bill, dated within the last 60 days
    - Letter from a government agency, signed and dated within the last 60 days and mailed to the client's home
    - Letter from a case manager on agency letterhead, signed and dated within the last 60 days and mailed to the client's home
- Homeless clients may provide a letter stating that they are homeless. The letter must be written on agency letterhead and be signed and dated within the last 60 days. MADAP's A-2 Verification of No Income Form may be submitted. The following individuals may verify that the client is homeless:
    - Case manager
    - Housing manager
    - Any staff member employed by an agency who receives Ryan White support

Appendix B:

Acceptable Income Documentation

- Income includes any income earned through employment, disability, public benefits, etc. Forms of income include, but are not limited to, the following:
    - Employment income
    - Retirement income
    - Unemployment benefits
    - Supplemental Security Income (SSI)
    - Social Security Disability Insurance (SSDI)
    - Income for dependents
    - Alimony payments
    - Private disability
    - Rental property income
    - Interest income or other investment income
    - Cash support from family and friends
- Income information should be collected for the client and individuals over the age of 18 who share financial responsibility. All income must be current, signed and dated (e.g. current year award letter, recent pay stubs, etc.). Acceptable proof of income may include, but is not limited to, the following:
    - One month of consecutive pay stubs
    - Tax forms (W-2 form or 1099)
    - Letter on letterhead from employer stating hourly wage and hours worked per week
    - Pension benefits letter
    - Retirement benefits check or letter
    - Unemployment income check or letter
    - Disability benefits check or letter
    - Social Security check or award letter
    - Bank direct deposit indicating payment from Social Security
    - Alimony Agreement Letter
    - If receiving support from family and friends, signed statement documenting who provides monetary support, and the frequency of the support
    - If no income, the A-2 Verification of no Income form may be submitted

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A-2: No Income and/or Homeless Verification Form

Required Proof of no Income/Maryland Residency/Homelessness

ID: 94 _____

Instructions: *Complete section 1 or 2.*

First Name: _____ MI: ___ Last Name: _____ Suffix: ___ Date of Birth: __/__/__

Section 1. Supporting relative or friend (all information is required)

I, _____, certify that _____ is:
(applicant)

☐ **Currently without income.**
I am supporting him/her by providing the following:

- ☐ Payment for room and board outside of my home.
- ☐ Free room and board in my home.
- ☐ Other, please explain: _____

☐ **I certify that the information provided on this form and any attached documentation is true, correct and complete.**

First Name: _____ Last Name: _____ Relationship to Applicant: _____

Street Address: _____ City: _____ State: ____ Zip code: _____

Phone number: _____

Signature: _____ Date: _____

Section 2. Shelter or Agency *(if applicant is homeless)*

I, _____, certify that _____resides at _____, at
(Name of Shelter Representative) (Applicant) (Facility Name)

_____ for the period of: ☐ less than 6 months ☐ 6 to 12 months ☐ 12 months or more.
(Facility Location)

☐ **The applicant has no income.** ☐ **Client is homeless and is Not currently living in a shelter**
☐ **The applicant has income.**

☐ **I certify that this information is true, correct and complete.**

Organization Name: _____

First Name: _____ Last Name: _____

Street Address: _____ City: _____ State: ___ Zip code: _____

Phone number: _____

Signature: _____ Date: _____

☐ **Self reported**
☐ **Case manager reported**

MARYLAND DEPARTMENT OF HEALTH AND YOUR HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Introduction

The Maryland Department of Health (MDH) is committed to protecting your health information. MDH is required by law to maintain the privacy of Protected Health Information (PHI). PHI includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for health care. As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. In order to provide treatment or to pay for your healthcare, MDH will ask for certain health information and that health information will be put into your record. The record usually contains your symptoms, examination and test results, diagnoses, and treatment. That information, referred to as your health or medical record, and legally regulated as health information, may be used for a variety of purposes. MDH and its Business Associates are required to follow the privacy practices described in this Notice, although MDH reserves the right to change our privacy practices and the terms of this Notice at any time. You may request a copy of the new Notice from any MDH agency. It is also posted on our website at https://health.maryland.gov.

Permitted Uses & Disclosures

MDH employees will only use your health information when doing their jobs**.** For uses beyond what MDH normally does, MDH must have your written authorization unless the law permits or requires it, and you may revoke such authorization with limited exceptions**.** The following are some examples of our possible uses and disclosures of your health information:

Uses and Disclosures without Consent Relating to Treatment, Payment, or Health Care Operations:

- **For treatment:** MDH may use or share your health information to approve, deny treatment, and to determine if your medical treatment is appropriate. For example, MDH health care providers may need to review your treatment with your healthcare provider for medical necessity or for coordination of care.
- **To obtain payment:** MDH may use and share your health information in order to bill and collect payment for your health care services and to determine your eligibility to participate in our services. For example, your health care provider may send claims for payment of medical services provided to you.
- **For health care operations:** MDH may use and share your health information to evaluate the quality of services provided, or to our state or federal auditors.

Other Uses and Disclosures of Health Information Required or Permitted by Law:

- **Information purposes:** Unless you provide us with alternative instructions, MDH may send appointment reminders and other materials about the program to your home.
- **Required by law:** MDH may disclose health information when a law requires us to do so.
- **Public health activities:** MDH may disclose health information when MDH is required to collect or report information about diseases, injuries, or to report vital statistics to other divisions in the department and other public health authorities.
- **Health oversight activities:** MDH may disclose your health information to other divisions in the department and other agencies for oversight activities required by law. Examples of these oversight activities are audits, inspections, investigations, and licensure.
- **Coroners, Medical Examiners, Funeral Directors and Organ Donations:** MDH may disclose health information relating to a death to coroners, medical examiners or funeral directors, and to authorized organizations relating to organ, eye, or tissue donations or transplants.
- **Research purposes**: In certain circumstances, and under the supervision of our Institutional Review Board or other designated privacy board, MDH may disclose health information to assist medical research. MDH 4617 (07/17) Page **1** of **3**
- **Avert threat to the health or safety:** In order to avoid a serious and imminent threat to health or safety, MDH may disclose health information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **Abuse and neglect:** MDH will disclose your health information to appropriate authorities if we reasonably believe that you may be a possible victim of abuse, neglect, domestic violence, or some other crime. MDH may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- **Specific government functions:** MDH may disclose health information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.
- **Family, friends, or others involved in your care:** MDH may share your health information with people as it is directly related to their involvement in your care or payment for your care. MDH may also share your health information with people to notify them about your location, general condition, or death.
- **Worker's compensation:** MDH may disclose health information to worker's compensation programs that provide benefits for work-related injuries or illnesses without regard to fault.
- **Patient directories:** MDH entities generally do not maintain directories for disclosures to callers or visitors who ask for you by name. However, if a MDH entity does maintain a directory, you will not be identified to an unknown caller or visitor without

authorization, and the limited information we disclose may include your name, location in the entity, your general condition (e.g., fair, stable, etc.) and your religious affiliation.

- **Lawsuits, disputes and claims:** If you are involved in a lawsuit, a dispute, or a claim, MDH may disclose your health information in response to a court or administrative order, subpoena, discovery request, the investigation of a complaint filed on your behalf, or other lawful process.
- **Law enforcement:** MDH may disclose your health information to a law enforcement official for purposes that are required by law or in response to a subpoena.
- **Other parties for conducting permitted activities:** MDH may conduct the above-described activities ourselves, or we may use non-MDH entities (known as Business Associates) to perform those operations. In those instances where we disclose your PHI to a third party acting on our behalf, we will protect your PHI through an appropriate privacy agreement.
- **Fundraising Activities:** MDH may use information about you to contact you in an effort to raise money for MDH and its operations. The information we release about you will be limited to your contact information, such as your name, address and telephone number and the dates you received treatment or services at MDH.

Your Rights

You Have a Right to:

- **Request restrictions:** You have the right to request a restriction or limitation on the health information MDH uses or discloses about you. MDH will accommodate your request if possible, but is not legally required to agree to the requested restriction. Except as otherwise required by law, MDH must accommodate your request if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.
- **Request confidential communication:** You have the right to ask that MDH send you information at an alternative address or by alternative means. MDH must agree to your request as long as it is reasonably easy for us to do so.
- **Inspect and copy:** With certain exceptions (such as psychotherapy notes, information collected for certain legal proceedings, and health information restricted by law), you have a right to see your health information upon your written request. If you want copies of your health information, you may be charged a reasonable and cost-based fee for copying, postage, and preparing an explanation or summary of the protected health information. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying. If MDH maintains your health information using electronic health records, we will provide access in electronic format and transmit copies of the health information to an entity or person designated by you, provided that any such choice is clear, conspicuous, and specific**.**
- **Request amendment:** You may request in writing that MDH correct or add to your health record. MDH will respond to your request within 60 days, with up to a 30-day extension, if needed. MDH may deny the request if MDH determines that the health information is: (1) correct and complete; (2) not created by us and/or not part of our records; (3) not permitted to be disclosed. If MDH approves the request for amendment, MDH will change the health information and inform you, and MDH will tell others that need to know about the change in the health information.
- **Require authorization:** You have the right to require your authorization for most uses and disclosures of psychotherapy notes, for receiving marketing communication and for the sale of your PHI.
- **Receive accounting of disclosures:** You have a right to request a list of the disclosures made of your health information after April 14, 2003, and in the six years prior to the date on which the accounting is requested**.** Exceptions are health information that has been used for treatment, payment, and health care operations. In addition, MDH does not have to list disclosures made to you, based on your written authorization, provided for national security, to law enforcement officers, or correctional facilities. There will be no charge for up to one such list each year**.** Additionally, MDH will provide an accounting for disclosures made through an electronic health record for treatment, payment, and health care operations, but information is limited to three years prior to date of request.
- **Opt-Out:** You have the right to receive fundraising communication and the right to request to opt-out of fundraising communication. You also have a right to opt-out of a MDH facility's patient directory, and you have the right to opt-out of Maryland's Health Information Exchange (HIE), which is the Chesapeake Regional Information System for our Patients (CRISP).
- **Receive notice:** You have the right to receive a paper copy of this Notice and/or an electronic copy by mail upon request.
- **Receive breach notification:** You have the right to receive notification whenever a breach of your unsecured PHI occurs.
- **Receive protection of genetic information***:* If any of MDH's health care components is considered a health plan, the health plan is prohibited from using or disclosing your genetic information for certain underwriting purposes.
- **Receive protection of mental health records:** If a medical record that is developed in connection with you receiving mental health services is disclosed without your authorization, MDH will only release the information in your record that is relevant to the purpose for which the disclosure is sought. **For More information:** This document is available in other languages and alternative formats that meet the guidelines for the Americans with Disabilities Act. If you have questions and would like more information, you may contact: Client Services at 410-767-6535.
- **To Report a Problem about our Privacy Practices:** If you believe that your privacy rights have been violated, you may file a complaint.
- You can file a complaint with the Maryland Department of Health, Division of Corporate Compliance at 1-866-770-7175.

You can file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may call the Maryland Department of Health for the contact information.
MDH will take no retaliatory action against you if you make such complaints.
Effective Date: This notice is effective on August 19, 2013

NOTICE TO THE PUBLIC
NON-DISCRIMINATION STATEMENT AND ACCESSIBILITY REQUIREMENTS

MADAP, as a unit of the Department of Health and Mental Hygiene (the Department) complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

The Department, upon request:

- Provides free aids and services to people with disabilities to communicate effectively with Department staff, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need any of the services listed above, please contact MADAP directly at 410-767-6535 or fax MADAP at 410-333-2608.

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If you believe that the Department has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Delinda Johnson, Equal Access Compliance Unit
Office of Equal Opportunity Programs
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 514, Baltimore, Maryland 21201
410-767-6600 (voice),1-800-735-2258 (TTY)
410-333-5337 (Fax), or delinda.johnson@maryland.gov (email).

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Delinda Johnson is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Interpreter Services Are Available for Free

Help is available in your language:**1-800-205-6308** ***(TTY:1-800-735* -2258*).***
These services are available for free.

Español/Spanish
Hay ayuda disponible en su idioma: **1-800-205-6308** *(TTY: 1-800-735* -2258*)*. Estos servicios están disponibles gratis.

አማርኛ/Amharic
እገዛ በ ቋንቋዎ ማግኘት ይችላሉ፡-**1-800-205-6308** *(TTY: 1-800-735-2258)* ።
እነዚህ አገልግሎቶች ያለክፍያ የሚገኙ ነጻ ናቸው

العربية /Arabic
1-800-205-6308*ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم*
(رقم هاتف الصم والبكم: (1-800-.735-2258)

中文/Chinese
用您的语言为您提供帮助：**1-800-205-6308** *(TTY: 1-800-735-2258)*。 这些服务都是免费的

فارسی /Farsi
خط تلفن کمک به زبانی که شما صحبت می کنید : 1-800-735-2258 (خط تماس افراد ناشنوا 1-**800**-502-**8036**)
این خدمات به صورت رایگان در دسترس هستند

Français/French
Vous pouvez disposer d'une assistance dans votre langue :**1-800-205-6308** *(TTY: 1-800-735-2258)*. Ces services sont disponibles pour gratuitement.

ગુજરાતી/Gujarati
તમારી ભાષામાં મદદ ઉપલબ્ધ છે: **1-800-205-6308** (ટીટીવાય: *(TTY: 1-800-735-2258*). સેવાઓ મફત ઉપલબ્ધ છે

kreyòl ayisyen/Haitian Creole
Gen èd ki disponib nan lang ou: **1-800-205-6308** *(TTY: 1-800-735-2258)*. Sèvis sa yo disponib gratis.

Igbo
Enyemaka di na asusu gi: **1-800-205-6308**
(TTY: 1-800-735-2258). Ọrụ ndị a dị na enweghi ugwo i ga akwu maka ya.

한국어/Korean
사용하시는 언어로 지원해드립니다: **1-800-205-6308** *(TTY: 1-800-735-2258)*. 무료로 제공 됩니다

Português/Portuguese
A ajuda está disponível em seu idioma: **1-800-205-6308** *(TTY: 1-800-735-2258)*. Estes serviços são oferecidos de graça.

Русский/Russian
Помощь доступна на вашем языке: **1-800-205-6308** *(TTY*: *1-800-735-2258).* Эти услуги предоставляются бесплатно.

Tagalog
Makakakuha kayo ng tulong sa iyong wika: **1-800-205-6308** *(TTY: 1-800-735-2258).* Ang mga serbisyong ito ay libre.

اردو/Urdu).
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال
1-800-205-6308 *(TTY: 1-800-735-2258).* کر

Tiếng Việt/Vietnamese
Hỗ trợ là có sẵn trong ngôn ngữ của quí vị **1-800-205-6308** *(TTY: 1-800-735-2258).* Những dịch vụ này có sẵn miễn phí.

Yorùbá/Yoruba
Ìrànlọ́wọ́ wà ní àṣẹwọ́tó ní èdè rẹ: **1-800-205-6308** *(TTY: 1-800-735-2258).* Awon ise yi wa fun o free.