AIDS Drug Assistance Program (ADAP) Application
Arizona Department of Health Services

The ADAP program is obligated under Title 42 300 ff-27(b)(7)(F) of the United States Code to show that medications provided by ADAP reasonably cannot be expected to be provided through any other source. Applicants will be required to show that they have no available alternative other than the ADAP program that can provide the HIV treatment for which they are applying. In order to make this determination, the ADAP program may request additional information/documentation that establishes that there is no other provider source available to the applicant. For questions, contact your case manager or call the ADAP office at 602-364-3610 or 1-800 334-1540.

Instructions: **Please fill in all blanks. Submit documentation where requested.**

APPLICANT INFORMATION

Date _____

Name		
Last	**First**	**MI**
Birth date (month/day/year)	**AKA (also known by these other names)**	

Gender		
☐ **Male**	☐ **Female** **Are you currently pregnant?** _____ **Have you had a live birth in last 6 months?** _____	**Transgender** ☐ **Male to female** ☐ **Female to male**

Ethnicity		**Language Preference**
☐ **Hispanic**	☐ **Non-Hispanic**	☐ **English** ☐ **Spanish** ☐ **Other** _____

Race (choose all that apply)

☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaska Native

Contact Information: Please describe any concerns you may have with staff contacting or leaving messages at the below numbers and addresses. Only one contact number is required. Circle Contact Type.

Contact Phone # (home, cell, work)	Secondary Contact Phone # (home, cell, work)	List concerns / limitations
OK to leave messages ☐	OK to leave messages ☐	

Residential Address (where you live) **Are you Homeless? Y N**

Street Address	Apt/Suite #	City	State	Zip Code

May we contact you at this address? ☐ Yes ☐ No

Mailing Address (Check here if same as residential address ☐) If Homeless, address where can receive mail

Street Address	Apt/Suite #	City	State	Zip Code

May we contact you at this address? ☐ Yes ☐ No

Primary Representative Contact, if any (parent/guardian or power of attorney) **Aware of Status? Yes ☐ No ☐**

Name	Phone Number		
Street Address (check if same as residential address ☐)	City	State	Zip Code

Person(s) &/or case manager ADAP may speak to & share info regarding applicant's enrollment in ADAP

Name	Phone Number	Agency
Name	Phone Number	Agency

Proof of Arizona Residency - REQUIRED
Please attach proofs of residency per attachment B.

Employment Status for Applicant/Adult in the family unit – check all that apply
☐ Full time __ hours per week ☐ Part Time ____hours per week ☐ Seasonal/ temporary ☐Unemployed ☐ Self-employed ☐ Retired ☐ Other _____ (specify)
Are you or an adult in the family unit receiving public assistance? ☐ Yes ☐ No Are you or an adult in the family unit receiving regular monetary payments from a source other than employment or public assistance? ☐ Yes ☐ No If yes, list the source _____ Are you (the applicant) receiving other assistance in obtaining food, water, housing or clothing? ☐ Yes ☐ No If yes, list the source _____

Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI)	
I am currently receiving Supplemental Security Income (SSI) ☐ Yes (if you are receiving SSI you are automatically eligible for AHCCCS) ☐ No If No, have you applied for SSI? ☐ Yes ☐ No	I am currently receiving SSDI ☐ Yes ☐ No If Yes, date started ___/____/_____, If No, have you applied for SSDI ? ☐ Yes ☐ No

HOUSEHOLD INFORMATION TABLE

In the table below:

List every person **you** claim on your current Federal taxes (starting with yourself/applicant).
List the Modified Adjusted Gross Income (MAGI) that each adult claimed on your current Federal taxes (age 18 or older, married or emancipated) brings to the household. This amount is identified as the "adjusted gross income" on your Federal Tax returns.

ALL EARNED AND UNEARNED INCOME MUST BE REPORTED and DOCUMENTED (see Attachment C for details)
If the adult applicant income is shown as $0, you will need to complete and sign the Certification of Income &/or Support Form (Attachment D) and have it signed by your Case Manager or Health Care provider.

Applicant or Family Member Name	Relation	**Applicant's** Social Security Number*	Adult? Yes No	Modified Adjusted Gross Income (MAGI) (if under age 18, income is not required to be reported)
	SELF			

***** This information is not used for eligibility determination. ADHS uses your SSN for matching with Arizona Dept. of Economic Security to verify income and AHCCCS and Medicare or Social Security to verify Medicare/Medicaid coverage. **Enter your Alien ID if no SSN.**

Total Family Income and Size (enter totals from HOUSEHOLD INFORMATION TABLE)	
Total number of individuals claimed on your current Federal taxes _____	Total Combined Modified Adjusted Gross Income (MAGI) $_____ (Annual Income)

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Arizona Department of Health Services

HEALTH INSURANCE

Please tell us if you are eligible to be enrolled in any of the following programs. You may be required to provide proof of denial if it appears you may be eligible. If you have medical coverage, please attach a copy of your health insurance card and prescription drug card.

Arizona Medicaid – AHCCCS If you receive Supplemental Security Income you are automatically eligible for AHCCCS

I am approved or receiving AHCCCS: ☐ **Yes** (Attached copy of letter/card) ☐ **No** (If No you must apply and attach a copy of your full application or a "Turn Around Document" from your Case Manager.) ⇨	I have a pending application for AHCCCS: ☐ **Yes** ☐ **No** Case # _____ Date scheduled to discuss eligibility: _____/_____/_____	I have a denial letter from AHCCCS: ☐ **Yes** ☐ **No** (Attach copy of letter)

Federal Facilitated Marketplace (FFM) Insurance If your income is over 138% FPL you may be eligible.
If eligible, please complete the Private Health Insurance section below

I am approved or receiving FFM Insurance: ☐ **Yes** (Attached copy of letter/card) ☐ **No** (If No you must apply and attach a copy of your application.) ⇨	I have a pending application for FFM: ☐ **Yes** ☐ **No** Case # _____ Date scheduled to discuss eligibility: _____/_____/_____	I have a denial letter from FFM: ☐ **Yes** ☐ **No** (Attach copy of letter) I have a Certificate of Exemption from FFM/IRS: ☐ **Yes** ☐ **No** (Attach copy of letter)

Medicare - if eligible for Medicare, **you must apply** for Part D and Extra Help/LIS to be eligible for ADAP

I'm eligible for Medicare: ⇨ ☐ **Yes;** date started ___/___/_____ ☐ **No;** date eligible ___/___/_____ Have you applied? ☐ **Yes** ☐ **No**	If Yes, eligible for Medicare, are you Covered under Medicare Part D (Prescription plan)? ☐ **Yes** ☐ **No** If Yes, provide a copy of your card Are your Medicare premiums paid by Medicaid? ☐ **Yes** ☐ **No**	If eligible for Medicare, have you applied for Extra Help/LIS ☐ **Yes** ☐ **No** Eligible for Extra Help/LIS subsidy? ☐ **Yes;** attach award letter and indicate Subsidy _____% ☐ **No;** attach denial letter

Other Governmental Health Insurance Programs

I am eligible for health insurance under: Indian Health Service: ☐ **Yes** ☐ **No** If Yes, are you receiving health insurance or services from the Indian Health Services? ☐ **Yes** ☐ **No**	Did you ever serve on active duty in the Air Force, Army, Coast Guard, Marines, Navy, or as a National Guardsman? ☐ **Yes** ☐ **No** Are you eligible for health services from the VA**?** ☐ **Yes** ☐ **No** Are you receiving health services from the VA**?** ☐ **Yes** ☐ **No**

Private or Employer-Provided Health Insurance

I have private health insurance: ☐ **Yes** ☐ **No**
If Yes, provide a copy of your insurance card and the following:
Insurance Company Name:_____ Phone Number: _____
Policy Number:_____ Member Number: _____
Does your health insurance provide coverage for prescription drugs? ☐ **Yes** ☐ **No**
Which of your prescribed HIV medication(s) are NOT covered by the plan? Please list or attach _____

Copies of your health insurance formulary and the policy description are required.

I am eligible for health insurance but am not covered: ☐ **Yes** ☐ **No**
Explain_____
If Yes, I am eligible for: ☐ **Employer-provided** ☐ **COBRA** ☐ **Family/Other Person's Policy** ☐ **Other Policy**
Have you applied for coverage? ☐ **Yes** ☐ **No, If No,** when are you eligible to apply for coverage? ____/___/____
Does the health insurance provide coverage for prescription drugs? ☐ **Yes** ☐ **No**

Copies of the health insurance premiums, formulary and the policy description are required.

Arizona Department of Health Services – AIDS Drug Assistance Program (ADAP) Application
(Under Provision of A.A.C. R9-6-401, et seq)
Applicant Certification & Authorization of Release of Information

I agree that I or my designated representative must provide AZ ADAP with proof of ineligibility for enrollment for Arizona Health Care Cost Containment System (AHCCCS) and/or for Medicare Part D low-income subsidy, if not provided with this application. I also agree that I or my designated representative must provide AZ ADAP with proof of enrollment in a Medicare drug plan, if I am eligible for Medicare. Last, I agree that I or my designated representative must provide AZ ADAP with proof of or exception from enrollment the Federally Facilitated Marketplace, if applicable.

I grant permission to AZ ADAP to share the minimum necessary information contained in this application with AHCCCS, for the purpose of determining AHCCCS eligibility, with Medicare and the Social Security Administration for the purpose of determining eligibility for a low-income subsidy and enrollment in a Medicare drug plan, with my primary care provider or their designee to confirm clinical information and acquire test results related to the service I am requesting, with the vendor pharmacy to assist with drug distribution, with other Ryan White providers in Arizona with whom I am enrolled to maintain my enrollment in ADAP or ADAP-Assist, and with any other entity as necessary to establish eligibility for enrollment in AZ ADAP.

I or my designated representative agrees to notify the AZ ADAP of any changes that affect my eligibility within **30** calendar days. Such changes include: any change in MAGI-based income, household size, residential or mailing address, phone number, employment status, availability of insurance coverage, AHCCCS eligibility, or primary care provider.

I understand that my AZ ADAP eligibility will terminate if I do not refill my AZ ADAP-covered Anti-Retroviral (ARV) medications for greater than 90 days.

I certify that to the best of my knowledge and belief, I am eligible for AZ ADAP and all statements made herein regarding personal and other non-medical information are accurate and complete. I certify that I am not eligible for any health insurance plan that would provide the support for which I am applying, other than those which I have declared.

I understand that my failure to be accurate and complete may prevent or delay a determination of eligibility to receive assistance from AZ ADAP, or may result in termination of my enrollment.

I understand that if there is any discrepancy in the documents provided to AZ ADAP, I must present government issued documentation to confirm my identity.

I understand that AZ ADAP may terminate my enrollment in AZ ADAP if I exhibit violent or threatening behavior to a representative of the AZ ADAP or the AZ ADAP pharmacy.

I understand that AZ ADAP ceases to provide drugs when available funding is exhausted or terminated. AZ ADAP is not an entitlement program and does not create a right to assistance absent available funding (R9-6-402).

I, _____ (applicant's printed name) authorize Lisa Fuentes, Jimmy Borders, Claudia Cardiel, Jessica Alvidrez, Louisa Vela, LisaMarie Bates, Laura Kroger, Greg Romero, or Jennifer Warrington, in their capacity as staff members of the AIDS Drug Assistance Program (ADAP) of the Arizona Department of Health Services, to represent me for the following purposes:

1. During my ADAP enrollment, facilitating the payment of premiums for marketplace coverage by the ADAP, provided that the ADAP determines that the marketplace coverage remains the most cost effective means to provide me with HIV medications for which I am seeking assistance from the ADAP. Please note that the Advance Premium Tax Credit (APTC) must be applied to total premium cost prior to ADAP facilitating the payment of premiums for marketplace coverage.

2. I further authorize the staff members named above, in their capacity as staff members of the ADAP of the Arizona Department of Health Services, to disclose my confidential information to the extent necessary to carry out the three purposes listed above.

I understand and agree that this authorization will remain in effect for a period of one year from the date of signature.

Applicant Name (PRINT) Signature Date

Return this application to: ADAP, Arizona Dept. of Health Services
150 North 18th Avenue, Suite 110 Phoenix, AZ 85007-3233
Fax: (602) 364-3263

AIDS Drug Assistance Program (ADAP) Application
Arizona Department of Health Services (Under Provision of A.A.C. R9-6-401, et seq)
Primary Care Provider Information -- to be completed by Prescribing Medical Care Provider

Applicant's Name: _____ Date of Birth: _____
Primary Care Provider (PCP) Name: _____ License Number: _____
PCP Address: _____ City: _____ State: _____ Zip Code: _____
PCP's Phone: (_____) _____ PCP's Fax: (_____) _____

***Date Applicant was first diagnosed with HIV infection:** _____ [ ] check if date is estimated
***If the Applicant has an AIDS diagnosis, list the date of diagnosis:** _____ [ ] check if date is estimated

TESTS (Initial application only)
Tests to confirm the diagnosis of HIV disease include the tests in one of the following bullet points:

- Positive HIV immunoassay and positive HIV Western Blot
- Positive HIV immunoassay and detectable HIV RNA
- Two positive HIV immunoassays (should be different assays based on different antigens or different principles)

TESTS (All applications)	**RESULTS**	**DATE OF TEST**
CD4 CELL COUNT (required within the last 6 months)	_____	_____
VIRAL LOAD (within the last 6 months)	_____	_____

Medication(s) prescribed from the most current ADAP Formulary
[PLEASE list full prescription below or provide a copy of prescriptions-Include all prescribed drugs]:

Drug	Strength	Quantity	Instructions	# Refills

I certify that this applicant has been diagnosed as having HIV infection.

I understand that I am required to notify the vendor pharmacy within 7 calendar days of the following:
Prescribing a new medication
Discontinuing a medication

I agree to notify the Arizona ADAP program within 14 calendar days following my notification of:
Death of the patient/client
Change in the HIV PCP

I certify that to the best of my knowledge and belief all information, I have provided to AZ ADAP is accurate and complete.

_____ _____
Signature of Primary Care Provider Date

Return to: ADAP, Arizona Dept. of Health Services
150 North 18th Avenue, Suite 110 Phoenix, AZ 85007-3233
Fax: 1-(602) 364-3263
Toll-Free 1-(800) 334-1540

Attachment A. ADAP Eligibility Requirements Summary

Eligibility is defined as follows:

Eligibility Requirements

An individual is eligible to enroll in ADAP if the individual:

1. Has a diagnosis of HIV infection from a physician, registered nurse practitioner, or physician assistant;
2. Is a resident of Arizona, as established by documentation that complies with R9-6-404(A) (9);
3. Have a Modified Adjusted Gross Income (MAGI) that is less than or equal to 300% of the Federal poverty level;
4. Satisfies one of the following:
    a. Has no health insurance coverage;
    b. Has health insurance coverage that:
        i. Does not cover drugs, or
        ii. Does not include on its formulary at least one of the drugs prescribed for the individual that is on the ADAP formulary;
    c. Is an American Indian or Alaska Native who:
        i. Is eligible for, but chooses not to use, the Indian Health Service to receive drugs; and
        ii. Either has no other health insurance coverage or has health insurance coverage that:
        (1) Does not cover drugs, or
        (2) Does not include on its formulary at least one of the drugs prescribed for the individual that is on the ADAP formulary; or
    d. Is a veteran who:
        i. Is eligible for, but chooses not to use, Veterans Health Administration benefits to receive drugs; and
        ii. Either has no other health insurance coverage or has health insurance coverage that:
        (1) Does not cover drugs, or
        (2) Does not include on its formulary at least one of the drugs prescribed for the individual that is on the ADAP formulary;
5. Is ineligible for enrollment in AHCCCS, as established by documentation issued by AHCCCS; and
6. If eligible for Medicare:
    a. Is ineligible for a full low-income subsidy, as established by documentation issued by the Social Security Administration; and
    b. Has enrolled in a Medicare drug plan.

Attachment B. Proof of Residency

To be eligible for ADAP, an applicant must be a resident of Arizona (AAC R9-6-403.2). Arizona Administrative Code defines Arizona residency as follows (see http://www.azsos.gov/public_services/Title_09/9-06.htm#Article_4)

R9-6-401.53. "Resident" means an individual who has a place of habitation in Arizona and lives in Arizona as other than a tourist.

Per State Rules R9-6-404.A.9, the Arizona ADAP program requires proof of Arizona residency. Proof can be demonstrated by attaching documentation from the following STEP 1, 2 or 3.

STEP 1: requires 1 item from list, circle attached

Public assistance documents w/in last 60 days;
AHCCCS-current documents w/in 6 mo;
Social Security Administration or Dept of Veteran's Affairs eligibility documents;
DES-UI current documents;
Property tax statement-most recent;
Homeowner's assoc fee w/in 60 days;
Current lease agreement;
Mortgage statement-most recent year

IF NONE GO TO STEP 2: ⇨

STEP 2: requires 2 items, circle the items attached

Utility bill;
Tax bill;
W-2;
Pay check stub;
Bank statement;
Driver's license-AZ;
AZ vehicle registration;
AZ ID card;
Tribal enrollment;
US Immigration;
ID card;

IF LESS THAN 2 GO TO STEP 3: ⇨

STEP 3: requires 2 items, circle the items attached

Any step 2 item w/in 60 days;
Non-permanent housing letter;
Community service organization verifying homeless status & AZ resident;
Credit card or other bill;
Vehicle insurance card;
Voter registration or other official doc;
Case manager statement/home visit;
Primary care provider statement;

Attachment C. Definitions of Family and Income

To be eligible for ADAP, an applicant **MUST** have a Modified Adjusted Gross Income (MAGI) that is less than or equal to 300% of the Federal poverty level.

R9-6-401.65 Unearned Income: a. Unemployment Insurance, b. Worker's Comp, c. Disability Payments, d. SSI/SSDI, e. TANF/Public Assistance, f. Insurance or Annuity Payments, g. Retirement or Pension Payments, h. strike benefits, i. training stipends, j. Child Support, k. Alimony, l. Military family allotments, m. Regular support from those not living in household, n. investment income, o. royalty payments, p. periodic payments from trusts or estates, q. other monetary payments

REQUIRED DOCUMENTATION FOR INCOME (reference AAC R9-6-404 (A)(7)).

7. Proof of annual family income, including the following items as applicable to the applicant's family unit:

a. For each job held by an adult in the family unit:

i. An income tax return submitted for the previous tax year to the U.S. Internal Revenue Service or the Arizona Department of Revenue;

ii. Paycheck stubs from the 30 calendar days before the date of application, or

iii. A statement from the employer listing gross wages for the 30 calendar days before the date of application;

b. From each self-employed adult in the family unit, documentation of the current net income from self-employment, such as:

i. An income tax return submitted for the previous tax year to the U.S. Internal Revenue Service or the Arizona Department of Revenue;

ii. The Internal Revenue Service Forms 1099 prepared for the previous tax year for the self-employed adult in the family unit;

iii. A profit and loss statement for the self-employed adult's business; or

iv. Bank statements from the self-employed adult's checking and savings accounts;

c. A letter from each entity providing public assistance to an adult in the family unit, describing payments from public assistance;

d. A letter from an entity providing a monetary award to an adult in the family unit to cover educational expenses other than tuition, describing the monetary award; and

e. Documentation showing the amount and source of any regular monetary payments received by an adult in the family unit from sources other than those specified in subsection (A)(7)(a) through subsection (A)(7)(d);

8. If the applicant or the applicant's representative has stated on the HOUSEHOLD INFORMATION TABLE of the application that the applicant has no source of regular monetary payments and is unable to provide any of the documentation specified in subsection (A)(7), ATTACHMENT D must be completed and signed within 30 calendar days before the date of application, containing:

a. Information completed by the applicant or the applicant's representative stating whether:

i. An adult in the applicant's family unit receives money from intermittent work performed by the adult in the family unit for which no paycheck stub is received and, if so, the average monthly earnings, and the adult's occupation;

ii. The applicant is homeless or living in a shelter;

iii. The applicant is receiving assistance from another individual; and

iv. The applicant has another source of assistance for obtaining food, water, housing, and clothing, and, if so, an identification of the source;

R9-6-404.C. For purposes of enrollment in ADAP, an applicant or the applicant's representative may report annual family income using actual family income for the most recent 12 months or estimated annual family income determined by multiplying the most recent monthly family income by 12.

Attachment D. CERTIFICATION OF INCOME & OR SUPPORT

I, _____, confirm that I am supporting myself in the following manner (initial and complete all that apply):

_____ I or an adult in my family unit receives money from intermittent work performed for which no paycheck stub is received.
The average monthly earnings are: $_____
The occupation is for which these monies are earned is: _____;

_____ I am homeless or living in a shelter;

_____ I am receiving assistance from another individual. Describe:_____.

_____ I am receiving another source of assistance for obtaining food, water, housing, and clothing.
Please specify the source of the assistance_____.

I attest that to the best of my knowledge and belief that the information submitted is accurate and complete.

_____ _____
Applicant Signature Date

I certify that to the best of my knowledge and belief that the information submitted is accurate and complete.

_____ _____
Case Manager or Primary Care Provider Signature Date

Eligibility Criteria for Medicaid and Insurance Affordability Programs: Modified Adjusted Gross Income (MAGI)[4]

	Income	Assets	Household size	Residency	Immigration status	Redetermination
MAGI	*Criteria* Based on Internal Revenue Service definition of income[1] MINUS: • Educator expenses • Business expenses • Health savings account deduction • Moving expenses • Certain self-employment expenses • Penalty on early withdrawal of savings • Alimony Medicaid-specific exceptions to MAGI definition of income: • Amount received as lump sum is only counted as income in month received • Educational grants are excepted from income • Certain American Indian/Alaska Native income is excepted[2] • Across-the-board 5% disregard of income (all other income disregards eliminated) Budget periods: • MAGI income determinations are based on "point-in-time" income for Medicaid • Income determination for premium tax credits are based on projected annual income (credits are paid in advance and reconciled at end of year based on tax returns) • States have option of using point-in-time or projected annual income methods for *current* Medicaid beneficiaries and to take into account reasonably predictable income changes for new and current beneficiaries	*Criteria* No assets test	*Criteria* Tax filing unit (individual plus anyone for whom individual claims personal exemption) For individuals who do not file a tax return and are not claimed as tax dependent, household size is the individual and the following (if living with the individual): • Spouse • Natural, adopted, and step children (those under age 19, or, at state option those under age 21 and full-time student) • If applicant is a child, natural, adopted, and step parents and natural, adopted, and step siblings[3]	*Criteria* State of residence is the state where the individual is living and Intends to reside, including without a fixed address; or state in which person has entered with a job commitment or seeking employment (whether or not currently employed).	*Criteria* Undocumented immigrants are barred from coverage through exchanges or Medicaid Legal immigrants are barred from Medicaid coverage for 5 years, but are eligible for subsidized coverage through exchanges during this time.	*Criteria* Once every 12 months.
	Supporting documents The final regulation limits use of documentation and requires states to use electronic sources for verification wherever possible, including: • Internal Revenue Service (IRS) • State Wage Information Collection Agency • Social Security Administration (SSA); and • Other social services programs (e.g., SNAP) The regulation requires states to access information available through the federal "Data Services Hub" as well as the Public Assistance Reporting Information System (PARIS). If information obtained through electronic sources is not "reasonably compatible" with information provided by applicant, agency must request additional documentation.	*Supporting documents* N/A	*Supporting documents* Self-attestation accepted	*Supporting documents* Self-attestation accepted	*Supporting documents* Social Security Number or paper documentation (verification with federal data hub required)	*Supporting documents* States are required to use an administrative renewal process using electronic data sources. If eligibility cannot be verified with existing databases, beneficiaries must be sent a pre-populated renewal form and must supply missing information.

[1] IRS Form 1040 defines income as: wages, salaries, tips, interest, dividends, taxable refunds, credits or offsets of state and local income taxes, business income, capital gain, IRA distributions, pensions and annuities, rental real estate, royalties, partnerships, S corporations, trusts, unemployment compensation, and farm income.

[2] Exceptions include: distributions from Alaska Native corporations and settlement trusts, distributions from any property held in trust located within prior federal Indian reservation, distributions and payments from property rights associated with federal Indian reservation land, and student financial assistance under the BIA.

[3] Certain exceptions to MAGI household size rules apply, including the provision that married couples living together are each included in the other's household regardless of filing status. For a full list of exceptions (most of which involve treatment of children), see State Health Reform Assistance Network: Overview of Final Medicaid Eligibility Regulation (April 2012).

[4] MAGI applies to income determinations for newly-eligible Medicaid beneficiaries (the 2014 expansion population), some traditional Medicaid groups (children, parents, and caretakers), and subsidies to purchase insurance through exchanges. MAGI does NOT apply to certain traditional Medicaid groups (e.g., disabled populations and medically needy). Application of MAGI for new applicants will begin January 1, 2014. For current Medicaid beneficiaries, the MAGI formula will be effective on March 31, 2014 (or the next regularly scheduled renewal if later).

Mock MAGI Worksheet

Only for use with applicant's who have not filed a tax return for the most recent tax year

Income types listed in ALL CAPS are not calculated in MAGI, but are required fields

****For any income losses, enter negative $ amount****

Client Name **SS#** - - **DOB** / /

Income Sources Total Monthly $ Amount for all Legal Household Members				
Wages, Salaries, tips, etc.		Pensions & Annuities (Veteran/Employer Based Pensions, Retirements,or Disability)		
Taxable Interest				
Tax Exempt Interest		Rental real estate,partnerships, S Corporations, Trusts, ect.		
Ordinary Dividends		Farm income or loss		
Taxable refunds of State/Local Income Taxes		Unemployment Income		
Alimony or other Spousal Support Received		Retirement Income from Social Security (SSA)		
Business Income/Loss		Disability Income from Social Security (SSDI)		
Capital Gain/Loss		SUPPLEMENTAL INCOME FROM SOCIAL SECURITY (SSI)	Specialty Line A	
Other Gains/Losses		Other income (Jury Duty Pay, Gambling Winnings)		
IRA Distributions - Taxable amount		CHILD SUPPORT RECEIVED, WORKERS COMP, MONETARY GIFTS	Specialty Line B	
Total Column 1		**Total Column 2**		
Total Income (Total Column #1 plus Total Column #2)				

Non MAGI (Not calculated but, required) Total Monthly $ Amount for all Legal Household Members			
Educator Expenses		Penalty on Early Withrawal of Savings	
Business Expenses		Alimony Paid	
Health Savings Account		IRA deduction	
Moving Expenses		Student Loan Interest Deduction	
Deductible Part of Self Employment Tax		Tuition and Fees	
Self Employed SEP, SIMPLE plans		Domestic Production Activities	
Self Employed Health Insurance Deduction			
Total Column 1		**Total Column 2**	
Total Adjustments (Total Column #1 plus Total Column #2)			
Add Specialty Line A			
Add Specialty Line B			
(Total Adjustments+ Spec Line A+Spec Line B) **= NON MAGI SUBTOTAL**			
		Total Income minus Non MAGI Subtotal above	
Modified Adjusted Gross Income (MAGI)			

Notes

Client Signature Date

(Signature, Date and Supporting Documentation is also required)

Revised 7/15/13