AccessHealth MA

The Massachusetts HIV Drug Assistance Program (HDAP) and Comprehensive Health Insurance Initiative (CHII)

Application Instructions

General Information

The **Massachusetts HIV Drug Assistance Program (HDAP)** is a program to help HIV-positive Massachusetts residents pay for drugs for the treatment of HIV and HIV-related conditions. The program assists clients by either paying for the full cost of drugs or, through the **Comprehensive Health Insurance Initiative (CHII),** paying for health insurance premiums. HDAP can also assist insured clients with co-pays for prescriptions.

Eligibility

To be eligible for HDAP/CHII, you must be a Massachusetts resident, be HIV-positive, and have a gross annual income from all sources of no more than 500% of the Federal Poverty Level (FPL), or **$67,950** as of January 12, 2022. For each legal dependent living with you, $4,720 is added to the limit. You do not have to be a U.S. citizen to be eligible.

Instructions for Completing this Application

Before you begin completing this application, carefully review these instructions. If you need assistance, contact your case manager or call HDAP at (800) 228-2714.

Please complete all sections clearly and completely. Incomplete applications and applications without supporting documentation will delay your enrollment and may result in your application being returned to you to complete. Complete applications submitted with all required documentation will typically be processed within two weeks. We suggest you make a copy of your completed application for your records.

You are required to submit a copy of a completed MassHealth application in order for your HDAP application to be considered complete. If you have been determined to be ineligible for MassHealth within the past 12 months, please submit a copy of your MassHealth determination letter (include all pages). If you are already enrolled in MassHealth, ConnectorCare, or the Massachusetts Insurance Connection (MIC), you are not required to reapply.

All information provided by you will be kept completely **confidential.**

Once your application has been approved, HDAP/CHII will send you an approval letter showing the end date of your current eligibility and providing any further instructions for your continued enrollment. You must recertify to HDAP/CHII every six months in order to remain active in the program.

An application form in Spanish is available upon request.

Schrafft's City Center • 529 Main Street, Suite 301 • Boston, MA 02129
T 617. 502. 1700 • F 617. 502. 1701 • www.accesshealthma.org

Application Requirements and Specific Instructions

Section 1: Applicant Information

1. List your full name. If you have changed your name since your last application, you must submit legal documentation or a letter from your case manager stating the change.

3. Please provide your mother's first name for coding purposes.

6. If you don't have a social security number, do not make one up; use "999-99-9999" instead.

7. You are required to submit proof of Massachusetts residency with this application. Submitted documents must match the residential street address provided in this section, must include your name, and must be dated within the past six (6) months. Examples of acceptable documents include:

- Utility bill
- Paystub/earnings statement
- Lease
- Current driver's license/Massachusetts identification card
- Government assistance mailing (see exceptions below)

- If you are homeless or do not have documentation of residential address available, please submit a letter from your case manager verifying your current residential address. All case manager letters must be on agency letterhead and must be signed by the case manager.

- The following forms of documentation **cannot** serve as proof of residence:

  - Envelopes
  - Tax returns
  - MassHealth applications or notices from MassHealth/the Connector
  - Notices from the Massachusetts Dept. of Transitional Assistance (DTA)
  - Documents showing only PO boxes
  - Letters from landlords, roommates, family members, or caretakers
  - Client affidavits without the case manager's signature

8. Fill out this field if your mailing address differs from your residential address. **If you do not want to receive mail from HDAP at your mailing address, please be sure to check box 8A.**

12. If you have any legal dependents, indicate how many. Do not include yourself.

15. Please be sure to indicate your race, as this information is required by program funders. Select all that apply.

16. Indicate whether or not you are Hispanic/Latino.

17. Be sure to indicate whether you would like us to leave a message on your home and/or work/cell voicemail. If yes, initial your response.

18. Please provide your e-mail address only if HDAP/CHII can communicate with you via email about your application and enrollment status.

Section 2: Income Information

20. Provide an estimate of your annual gross income, before any deductions.

21. Indicate all sources of income.

You are required to submit proof of all income. Please provide documentation for each source of income checked. Acceptable proof of income may include:

- At least two paystubs from your job, from within the past 3 months, showing gross income for those pay periods
- A copy of your unemployment statement, from within the past 3 months
- Award letters for the current year from SSI/SSDI, TAFDC/EAEDC, long-/short-term disability, and/or Worker's Compensation. (If you do not have copies of recent award letters, recently dated bank statements showing corresponding direct deposit amounts for monthly benefits received are acceptable)
- Monthly pension statements for the current year

If you are working but have no documentation (i.e. paystubs) of your income:

- A letter from your case manager stating your weekly, monthly, or yearly gross income and its source

If you have no income:

- A letter from your case manager or provider verifying that you have no income and identifying your source of support: i.e. partner, parents, other family members, community resources, etc. All case manager letters must be on agency letterhead and must be signed by the case manager

22. **Please note that you may be required to submit a copy of your most recent federal tax return with all accompanying schedules/forms to HDAP with your application, if requested.**

23. If your employer offers health insurance, even if you are not currently enrolled in that insurance, you are required to submit a summary of benefits for all available plans, as well as the date of your employer's next open enrollment period. If you are employed full-time but are not offered health insurance, please provide a letter from your employer stating this.

Section 3: Alternate Contact and Signature

24. Complete this section if you would like to authorize someone other than yourself (and your case manager, client advocate, and/or clinician) to communicate with HDAP staff on your behalf in helping you with your enrollment in HDAP. HDAP staff will not discuss your enrollment with a spouse, friend, or other family member unless this section is completed and signed.

Section 4: Provider Information

25. Provide current contact information for your case manager or client advocate. If you checked off box 8A, HDAP will send your mail to this case manager or client advocate.

26 - 33. These fields should be completed by your clinician (health care provider). All sections are required to be filled out. Lab results should be from within the past year.

34. Be sure that your clinician signs and dates this section, and provides his/her medical license number.

Section 5: Pharmacy Information

35. HDAP clients may only use one pharmacy for their prescriptions covered by the program. Once your application has been approved, HDAP will send an approval letter directly to the pharmacy you have chosen.

- You must inform HDAP immediately if you decide to go to a different pharmacy.
- If it is necessary that you use a second pharmacy to fill certain medications, please have your case manager or provider submit a request in writing to HDAP.
- HDAP only covers 30-day prescriptions, unless your health insurance requires 90-day prescription fills. In that case, please notify HDAP staff so that we may adjust our payment procedure.

Section 6: Insurance Coverage / Co-Pay Assistance

36. Indicate what type of health insurance you currently have. If you do not have any insurance coverage, check the first box.

Attach a copy of all health insurance/prescription cards (front and back) to your HDAP application.

37. **Your insurance coverage has either a maximum dollar co-pay or a percentage co-pay per 30-day prescription. Please indicate which co-pay type and amount you have under your current insurance. This information can be obtained by calling your insurance company.**

If you do not currently have active health insurance, please skip question 37.

Section 7: CHII Information

38 - 39. The CHII program can assist with paying the cost of your health insurance premium. If you are applying to CHII to cover the cost of your premium, please complete this section and **include a copy of your most recent health insurance premium (bill) with your HDAP/CHII application.**

If you do not have a health insurance premium or do not want CHII to pay your premium, skip this section. If you are applying for assistance for your employee premium deductions (current employer-based insurance), include a letter from your employer (i.e. benefits administrator, human resources staff), on company letterhead, which confirms:

1) Your employment
2) Your employer-based insurance policy
3) The amount that you contribute to that insurance (this will be the amount that CHII will cover)
4) When CHII payments are to be applied
5) That your employer agrees to accept payment for this amount
6) Where to send payment (name of person, department, and mailing address)

Section 8: Certification Statement

40. It is important that you read carefully the attached Client Agreement Statement and Grievance Procedure before submitting your HDAP application. These documents describe both your rights and your responsibilities in enrolling in HDAP/CHII.

After reviewing the Grievance Procedure and Client Agreement statements, sign and date the Certification Statement in Section 8. Applications that are missing a current signature and date in this section cannot be processed by HDAP, and will be returned.

AccessHealth MA

The Massachusetts HIV Drug Assistance Program (HDAP) and Comprehensive Health Insurance Initiative (CHII)

Client Agreement Statement

In order for you to receive drug and/or insurance coverage through HDAP and CHII, you need to agree to the following rules. HDAP/CHII shall keep all your information strictly confidential to the extent permitted by law. However, if you do not follow these rules, if you give us false information, or if we suspect you are using funds from the HDAP/CHII program to which you are not entitled, HDAP staff may provide information to government agencies and you may be disenrolled from HDAP/CHII.

By signing the Certification Statement on the HDAP application:

1. **You give your permission for HDAP/CHII to contact <u>all</u> of the following**:

    - Your pharmacist
    - Your case manager/client advocate
    - Your employer (for employee contribution or COBRA)
    - Your current or past health care provider(s)
    - Any other person that you have specifically given us permission to contact.

If needed, HDAP may contact these people to maintain your participation in the program. HDAP/CHII staff may also contact any insurance companies (third party payers/administrators) to make sure you are covered and to answer any billing questions.

HDAP may also contact any of the people in the above list when you leave the program, if necessary. This is done to get information about your participation in the program.

2. **You give your permission for your HDAP enrollment application files to be reviewed by all of the following:**

    - HDAP/CHII staff
    - Your case manager and/or health care provider
    - Auditors or other individuals reviewing application files as required for program or fiscal monitoring.

Information in your HDAP/CHII enrollment application files will be kept strictly confidential. Under no circumstances will any personal identifying information in your HDAP/CHII file be shared with any unauthorized individual.

3. **You give your permission for HDAP/CHII to share some of your personal information with state and/or federal agencies that are responsible for monitoring program utilization and expenditures.** This includes, but is not limited to, the U.S. Health Resources Services Administration (HRSA) and the federal Centers for Medicare and Medicaid Services (CMS), which tracks money spent by HDAP to cover prescription costs for Medicare beneficiaries in the coverage gap (or “donut hole”). Information about you that may be shared includes, but is not limited to your:

Schrafft’s City Center • 529 Main Street, Suite 301 • Boston, MA 02129
T 617. 502. 1700 • F 617. 502. 1701 • www.accesshealthma.org

- Name
- Social Security Number (if available)
- Date of birth
- Health insurance information
- Prescription information

Any information about you that is shared with a government agency will be protected by the strict terms of a data-sharing agreement and will not be disclosed to any unauthorized individuals. All information will be used solely for program monitoring and will be kept strictly confidential by the agency receiving it.

4. **You agree to notify HDAP/CHII as soon as possible if any of this information changes. You need to report any other information that might change your eligibility for these programs. This includes, but is not limited to, changes in your:**

    - Employment status
    - Income
    - Address
    - Access to insurance coverage/MassHealth status
    - Insurance premium
    - Citizenship status
    - Pharmacy
    - Employer-sponsored insurance

5. Your application may be rejected if you have provided false information.

6. **HDAP/CHII is unable to provide payments or reimbursement directly to clients for any reason**.

7. As long as you remain eligible and actively enrolled in the CHII program and follow the HDAP/CHII rules, HDAP/CHII will continue to pay for your health insurance premiums. However, ***you*** **must agree to contact your health insurance carrier about your policy and its coverage. It is your sole responsibility to do so, not the responsibility of HDAP/CHII staff.** HDAP/CHII staff will not contact your insurance company, nor will HDAP/CHII staff be notified by your insurance company of any policy changes. HDAP/CHII only pays for the cost of your insurance premium; the CHII program is not authorized to do anything but pay for your health insurance.

8. If you are working, you may be required by HDAP/CHII to enroll in health insurance provided by your employer, if such insurance is available and provides comprehensive prescription coverage. You may choose to have the CHII program cover the employee contribution of the monthly premium.

9. HDAP/CHII may require you to re-pay any payments made if you were not eligible for them. You may also be required to pay back HDAP/CHII if you were misusing services. This includes, but is not limited to, health insurance premiums refunded directly to you in certain circumstances. Failure to comply with this rule may result in disenrollment from the program.

10. HDAP/CHII is not required to make retroactive payments for coverage before you were enrolled in the program or if your HDAP enrollment lapses.

11. It is your responsibility to re-apply ("recertify") with HDAP/CHII every 6 months, regardless of whether or not you have received recertification reminders from HDAP or your case manager. **If you do not recertify, your HDAP/CHII benefits will be terminated, including insurance coverage if you are enrolled in the CHII program.**

AccessHealth MA

The Massachusetts HIV Drug Assistance Program (HDAP) and Comprehensive Health Insurance Initiative (CHII)

Grievance Procedure

If you have a concern or grievance (complaint) with HDAP, you can tell the HDAP staff member you have dealt with. You need to report this complaint within ten business days of its happening.
You can make your complaint either in person, by writing a letter, or by telephone:

Address: AccessHealth MA
HDAP Staff Contact
The Schrafft's City Center, 529 Main Street, Suite 301
Boston, MA 02129
Telephone: 1-800-228-2714 **Fax:** (617) 502-1703

A staff member will get back to you within ten business days.

If you are not happy with the answer you receive, you may ask for a meeting with that **staff member's supervisor**. You can do this in a letter or by phone. This has to be done within ten business days after you get a response. The supervisor will get back to you within ten business days.

If you are still not happy with the answers you have received, you may then take the complaint to the **HDAP Program Director**. This must be in writing. It can be mailed, e-mailed, faxed or hand delivered, and must be done within ten business days after you get an answer from the supervisor. You can request a face-to-face meeting, write a letter, or telephone your complaint. The HDAP Program Director will issue a written decision within ten business days of the receipt of the concern/grievance.
At any stage in this procedure, you may be accompanied or represented by anyone you feel is an appropriate advocate, including:

- a case manager
- an attorney
- a paralegal
- a translator
- a friend
- a relative

You must provide written authorization (permission) for HDAP staff to share information with this person, if s/he is not a contact listed in the HDAP/CHII application. Written permission is also needed to share information if you are not to be part of the conversation or interaction.

For more information contact:

Address: AccessHealth MA
HDAP Program Director
The Schrafft's City Center, 529 Main Street, Suite 301
Boston, MA 02129
Telephone: (617) 502-1700

Schrafft's City Center • 529 Main Street, Suite 301 • Boston, MA 02129
T 617. 502. 1700 • F 617. 502. 1701 • www.accesshealthma.org