AccessHealth MA HDAP

Massachusetts HIV Drug Assistance Program (HDAP)
Six-Month Eligibility Self-Attestation Form (Short Form)

1	**HDAP ID** *(if known)*:	***First Name:***	***Last Name:***	***Date of Birth*** *(MM/DD/YYYY)*: ____/____/______	***Social Security #:*** _____-____-______
2	**Contact Information:**	***Cell phone:*** _____-____-______	☐ *Ok to call* ☐ *Ok to leave message* ☐ *Ok to text*	***Home phone:*** _______-_______-______	☐ *Ok to call* ☐ *Ok to leave message*
		Email:		☐ ***Ok to contact by email***	
		☐ ***ONLY call or email my Case Manager***			

3	***VERY IMPORTANT To ANSWER*** **Do you want your confidential HDAP-related mail sent to your mailing address?**
	☐ **Yes. Mark checkbox & move to Question 4** ☐ **No. Mark checkbox & move to Question 5**

4	**My Mailing Address:** ☐ No Change ☐ Change	***Street or P.O. Box:***	***City:***	***State:***	***ZIP:***
5	**Case Manager:** ☐ No Change ☐ Change **Preferred form of contact:** ☐ Phone ☐ Email ☐ ***I DO NOT have a Case Manager***	***Case Manager name:***	***Case Manager site:***		
		Case Manager phone:	***Case Manager email:***		
		Case Manager Address:			
6	**My Residential Address:** ☐ No Change ☐ Change	***Street:***	***City:***	***State:***	***ZIP:***

7	**Income:** ☐ No Change ☐Change **If change, list new annual gross income:** $________________	☐ **Salary** ☐ **Unemployment benefits** ☐ **Worker's compensation** ☐ **Social Security Income (SSI, SSDI, SSA, SSP)** ☐ **Private disability (short- or long-term)**	☐ **Veterans pension** ☐ **Pension/Retirement income** ☐ **Interest/Dividends/Annuities** ☐ **Rental Income** ☐ **Other Income** (List source) ________________________

8	**Pharmacy:** ☐ No Change ☐ Change	***Pharmacy name:***	***Street:***	***State:***
		Phone:	***City:***	***ZIP:***

9	**Insurance Status:** ☐ No Change ☐ Change ***(Check all that apply)*** **Change occurred as of Date** *(MM/DD/YYYY)*: ____/_____/______	☐ **No health insurance/ prescription coverage** ☐ **MassHealth (Medicaid)** ☐ **MassHealth Limited** ☐ **Health Safety Net (Full or Partial)** ☐ **Medicare Part A** ☐ **Medicare Part B** ☐ **Medicare Part C (Advantage)** ☐ **Medicare Part D**	☐ **ConnectorCare** ☐ **Private Insurance (Employer/Group)** Name________________________ Maximum copay amount $__________ ☐ **Private Insurance (Individual/Non-Group)** Name________________________ Maximum copay amount $__________ ☐ **Veteran's Administration (VA)** ☐ **Indian Health Services (IHS)** ☐ **Other, specify:** ___________________
10	**CHII:**	If HDAP/CHII pays for your health insurance or you would like HDAP/CHII to pay for your health insurance, please **check here** ☐ and attach a recent premium statement/bill or employer premium/payroll deduction letter.	

11	**Client Signature:** ____ **Date:** ____/_______/_______ *I attest that I am a Massachusetts resident and that the information on this application and any attachments is correct and complete. If I deliberately misrepresent information on this application, I may be required to repay benefits provided to me and I may be prosecuted under applicable state and federal statutes.* **Case Manager Signature:** _________________________________ **Date:** ____/_______/_______ *I attest that I have spoken with the client and that the information provided in this form is true and accurate.*