Massachusetts
HIV Drug Assistance Program (HDAP)

HDAP Application Training

July 28, 2021

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BRIDGE = Benefits, Resources, & Infectious Disease Guidance and Engagement

Topics for the Day

- HDAP Long Form Review
- HDAP Short Form Review
- HDAP Rapid Eligibility Form Review

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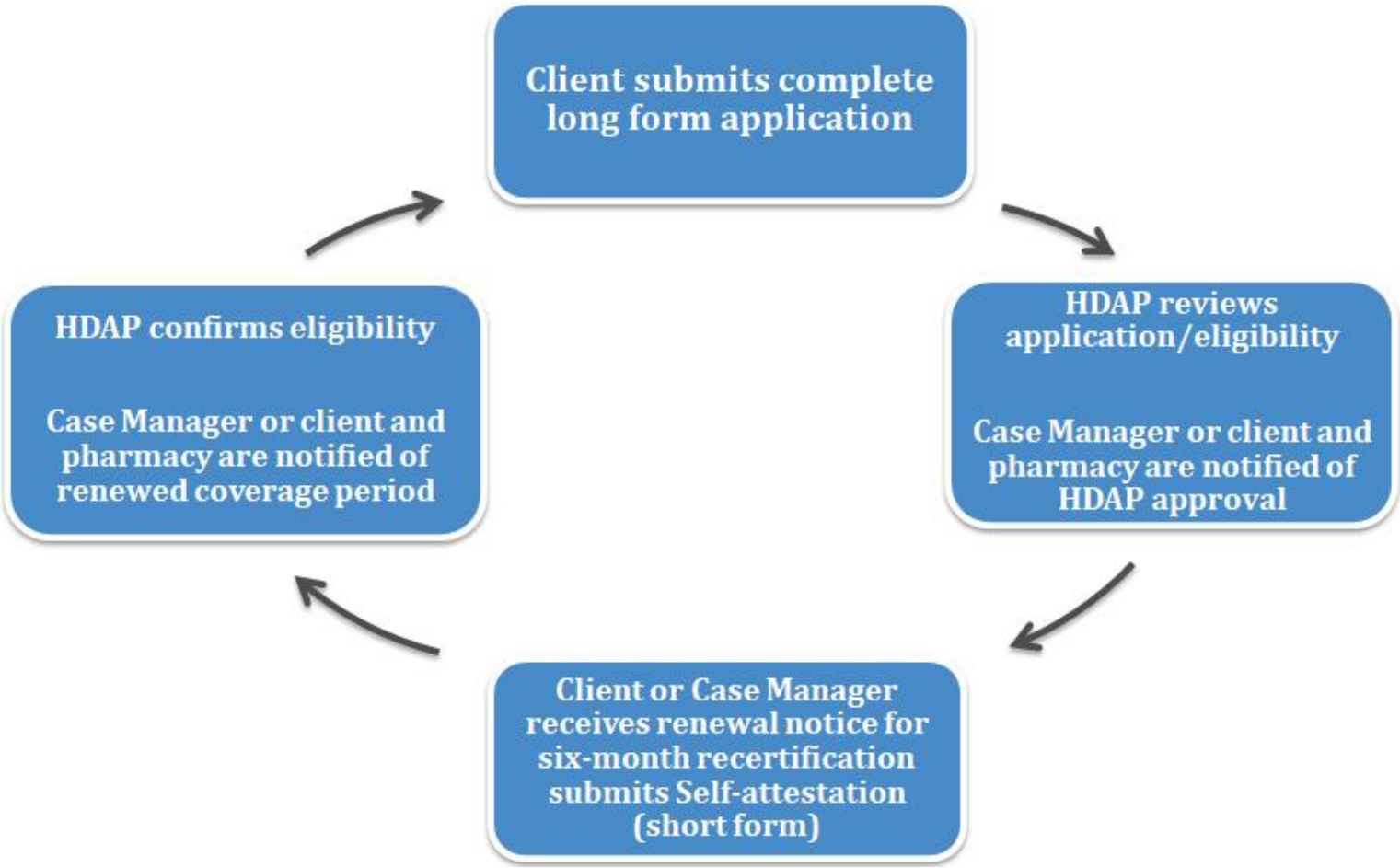

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Long Form Overview

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Section 1- Applicant Information

Massachusetts HDAP/CHII Application Form Name: Cure H. Ivy HDAP ID # 12345 (if known) Pg 1

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

Mailing Address: Community Research Initiative of New England/HDAP
The Schrafft's City Center, 529 Main Street, Suite 301, Boston, MA 02129
Phone : 800.228.2714 | Fax : 617.502.1703

SECTION 1 – APPLICANT INFORMATION
1. First name: Cure MI: H Last name: Ivy
2. Name of legal guardian (if applicant is a minor):
3. Mother's first name (required for coding purposes only): Martha
4. HDAP ID # (if known): 12345
5. Date of birth (MM/DD/YYYY): 01 / 01 / 1970
6. Social Security #: 999 - 99 - 9999
7. Residential street address (no PO boxes): 678 Mulberry Lane
Apt/Unit no: 9 City: Worcester
County: Worcester State: MA ZIP: 01601

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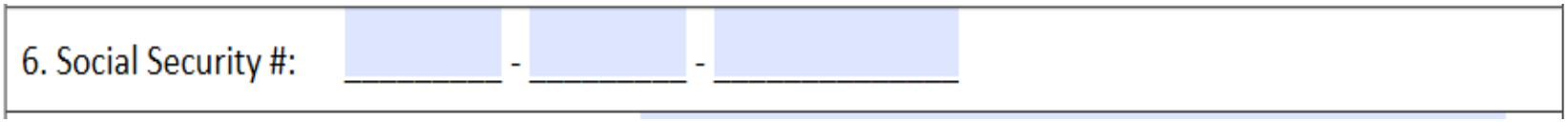
Applicant Information

All the information in section 1 of the application is REQUIRED: Failure to complete this section in will delay application processing and may result in the application being rejected

- Social Security number
  - ❑ 123-45-6789 – Accepted
  - ❑ XXX-XX-6789- Rejected
  - ❑ Clients that do not have a valid SSN should input **999-99-9999**. Do not indicate an SSN that is not valid



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8. Mailing address:

☒ Same as residential address

Other address: _____

Apt/Unit no: _____ City: _____ County: _____

State: _____ ZIP: _____

8A. ☒ I would like all my HDAP/CHII mail sent to my case manager (see Section 4).

9. Gender: ☐ Male ☒ Female ☐ Transgender ☐ Unknown

10. Sex at birth: ☐ Male ☒ Female ☐ Unknown

11. *If Transgender:* ☐ Male-to-Female (MTF) ☐ Female-to-Male (FTM) ☐ Unknown

12. Number of legal dependents: **2**

- Clients that **do not** check 8A on their application will have all HDAP notifications sent to their listed mailing address.
- If 8A is checked all notices will be sent to their Case Manager of record. Please discuss this option thoroughly with your clients.
- 8A will determine where HDAP will send future notices

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SECTION 1 – APPLICANT INFORMATION (continued)

13. Marital status: ☐ Single ☒ Married ☐ Separated ☐ Divorced ☐ Widowed

14. Country where you were born: Gambia

Preferred spoken language: English

15. Race (select all that apply):

- ☐ American Indian or Alaskan Native
- ☐ Asian. *If Asian:*
  - 15A. ☐ Asian Indian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Japanese
  - ☐ Korean
  - ☐ Vietnamese
  - ☐ Other Asian
- ☒ Black/African American
- ☐ Native Hawaiian or Pacific Islander.
  If Native Hawaiian or Pacific Islander:
  - 15B. ☐ Native Hawaiian
  - ☐ Guamanian or Chamorro
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ White

16. Ethnicity (select one):

- ☐ Hispanic/Latino. *If Hispanic/Latino:*
  - 16A. ☐ Mexican, Mexican American, or Chicano(a)
  - ☐ Puerto Rican
  - ☐ Cuban
  - ☐ Other Hispanic, Latino(a), or Spanish origin
- ☒ Non-Hispanic/Latino

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CONSENT TO CONTACT

17. Phone numbers:

Home phone number: (774) 123-4567

May we leave a confidential message on your voicemail or answering machine? ☒ Yes ☐ No

If yes, initial here: C.H

Cell phone number: (617) 502-1700

May we leave a confidential message on your voicemail or answering machine? ☒ Yes ☐ No

If yes, initial here: C.H

☐ Please do not contact me by phone. **Contact my case manager only** (see Section 4).

18. May we contact you by email? ☒ Yes ☐ No Email address: Curehivy23@gmail.com

If yes, initial here: C.H

19. May we contact you by text message? ☒ Yes ☐ No

If yes, initial here: C.H

Clients who initial and check the consent to contact boxes for phone and/or email are giving permission for representatives from HDAP/BRIDGE/CHII to contact them directly as needed and leave a voicemail if we are unable to reach them. Clients who list a phone number but do not check the box indicating that that a voicemail is ok and initial below, may get a call from us, but we will not be able to leave a voicemail if they do not answer.

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CONSENT TO CONTACT

17. Phone numbers:

Home phone number: (_____) _____
May we leave a confidential message on your voicemail or answering machine? ☐ Yes ☐ No
If yes, initial here: _____

Cell phone number: (_____) _____
May we leave a confidential message on your voicemail or answering machine? ☐ Yes ☐ No
If yes, initial here: _____

☒ Please do not contact me by phone. **Contact my case manager only** (see Section 4).

18. May we contact you by email? ☐ Yes ☐ No Email address: _____
If yes, initial here: _____

19. May we contact you by text message? ☐ Yes ☐ No
If yes, initial here: _____

Clients that do not want representatives from HDAP/ BRIDGE/CHII to contact them can check **"Please do not contact me by phone..."**. We will contact their Case Managers directly as needed.

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Section 2- Income Information

SECTION 2 - INCOME INFORMATION

20. Current annual income (gross): $ **$35,500**

21. Do you receive income from any of these sources?
(select all that apply):

- [x] Salary
- [ ] Unemployment benefits
- [ ] Social Security (SSI, SSDI, SSA)
- [ ] Worker's compensation
- [ ] Private disability (short- or long-term)
- [ ] Retirement/pension
- [ ] Veteran's pension
- [ ] Interest/dividends
- [ ] Rental income
- [ ] Other income, specify: _____

22. Did you file a federal or state income tax return for last year? [x] Yes [ ] No

If YES, was it: [ ] Single [x] Married filing jointly [ ] Married filing separately [ ] Other: _____

23. Are you currently working?

[x] Full-time (35 or more hours/week) [ ] Part-time (less than 35 hours/week) [ ] Not working

For question #21 please check all appropriate income sources and provide all relevant proof of income documents with the application.

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Section 3- Optional Alternate Contact and Signature

SECTION 3 – OPTIONAL ALTERNATE CONTACT AND SIGNATURE

☑ **PLEASE COMPLETE SECTION 3 ONLY IF YOU WANT TO DESIGNATE AN ALTERNATE CONTACT.**

24. You have the option to have another individual (i.e. a **family member** or **friend**) speak to HDAP staff about your HDAP/CHII enrollment or insurance status at any time you are not available. If you would like to designate someone other than yourself to communicate with HDAP staff, please sign the following statement.

I authorize HDAP staff to speak with the following individual on my behalf about coordination of my HDAP enrollment and coverage:

Name of alternate contact: **Mister Ivy**

Relationship to client: **Husband**

Client signature: *Cure H. Ivy* Date: **06** / **01** / **2021**

- Clients can choose to elect another individual (friend, family, etc.) to speak to HDAP staff of their behalf by completing Section 3- Alternate Contact, on their application. If they do not complete this section, we will only speak to the client or their Case Manager/Provider regarding their care.
- Case Managers do not need to list themselves as an alternative contact in this section.

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Section 4- Provider Information

SECTION 4 - PROVIDER INFORMATION

This section should be filled out by your health care provider(s).

25. Case manager information:

Name: John Doe Institution: John Doe HIV Institute

Street address: 742 Evergreen Terrace

City: Worcester State: MA ZIP: 01601

Phone: (774) 111-1111 Ext. 1 Fax: (774) 222-2222

Email address: JohnMDoe@JDInstitute.org Preferred form of contact: ☒ Phone ☐ Email

26. Clinician information:

Name: Marge Simpson, RN

Facility: John Doe HIV Institute Department: Infectious Disease

Street address: 742 Evergreen Terrace, Building 2

City: Worcester State: MA ZIP: 01601

Phone: (774) 333-3333 Ext. 3 Email address: MargeJSimpson@JDInstitute.org

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27. Is the patient ***currently*** taking any antiretroviral drugs for HIV/AIDS? ☒ Yes ☐ No

28. If not, has the patient ***ever*** taken any antiretroviral drugs for HIV/AIDS? ☐ Yes ☐ No

☑ **REQUIRED FIELD—PLEASE DO NOT LEAVE BLANK**

29. Patient's clinical status: ☐ HIV+, not AIDS ☒ HIV+, AIDS status unknown ☐ CDC-defined AIDS

30. Patient's mode of exposure:

- ☐ Men who have sex with men (MSM)
- ☐ Injection drug users (IDU)
- ☒ Heterosexual contact
- ☐ Perinatal transmission
- ☐ Hemophilia/Coagulation disorder
- ☐ Other blood, blood products, tissue
- ☐ Other risk
- ☐ Undetermined/Unknown

31. Patient's most recent lab results:

CD4 534 Date of last test: 04 / 20 / 2021

Viral load 20 Date of last test: 04 / 20 / 2021

32. Has the patient ever had a CD4 count equal to or below 200? ☐ Yes ☒ No ☐ Don't know

33. Does the patient currently have hepatitis C infection? ☐ Yes ☒ No ☐ Don't know

34. Clinician signature: Marge Simpson **(MD, DO, PA, NP, RN)**

Medical license # RN1234567 **Date:** 06 / 01 / 2021

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Provider Information

- Provide your contact information as a case manager
- Questions #26-34 should be completed by a healthcare provider with a medical license # (RN, NP, DO, MD, PA)
- The clinician signature must provide a signature dated within 6 months.
  - Applications that are received without a clinician's signature or a signature that is out of date will be considered incomplete.
- Lab results must be included and should be from within the past **12 months**
  - Recertifying clients do not need to submit new CD4 labs
  - New clients and clients that have been inactive for two or more years must submit CD4 labs
  - All clients must submit Viral Load lab results dated within 12 months

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Section 5- Pharmacy Information

SECTION 5 – PHARMACY INFORMATION

Please be sure to provide full address and contact information.

35. Pharmacy information:

Pharmacy name: Gower's Drug Store Pharmacy store #: 1010

Street address: 320 Sycamore Street Suite #:

City: Worcester State: MA ZIP: 01601

Phone: (774) 444-4444 Fax: (774) 555-5555

- Clients need to designate a primary pharmacy
- If a second pharmacy is needed, please provide the secondary pharmacy's information to HDAP staff
- Inform HDAP immediately of pharmacy changes to ensure co-pay coverage

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Section 6: Insurance Coverage/Co-Pay Information

SECTION 6 – INSURANCE COVERAGE/CO-PAY COVERAGE

36. What type(s) of health insurance/prescription coverage do you have? (select **all** that apply):

- [ ] No health insurance/prescription coverage
- [x] MassHealth (Medicaid)
- [ ] MassHealth Limited
- [ ] Health Safety Net (HSN) – If known: [ ] Full [ ] Partial
- [ ] ConnectorCare – Name of plan: _____
- [ ] Mass Insurance Connection (MIC)
- [ ] One Care
- [ ] Medicare Part A (hospital insurance)
- [ ] Medicare Part B (medical insurance)
- [ ] Medicare Part C (Medicare Advantage)
- [ ] Medicare Part D (prescription insurance) – Name of plan: _____
- [ ] Veterans Administration (VA) coverage
- [ ] Indian Health Services (IHS)
- [x] Private Insurance – Employer/Group – Name of plan: First Life Health Premier PPO
- [ ] Private Insurance – Individual/Non-group – Name of plan: _____

You must include a copy of a completed MassHealth application (or a MassHealth determination letter from within the past 12 months) with your HDAP application.

Please include a copy of your insurance card(s)/prescription card(s), front and back, with your application.

37. Type of prescription co-pay/co-insurance (choose one and indicate amount/percentage):

- [x] Maximum dollar amount per prescription (co-pay) $ 9.00

OR

- [x] Percentage per prescription (co-insurance) 20 %

- Check **all** active insurance types
- Make sure that the maximum co-pay or co-insurance amount on the application is accurate. **Discrepancies may result in clients having difficulty at the pharmacy getting their covered meds**

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Section 7: CHII Information

SECTION 7 – CHII INFORMATION

PLEASE COMPLETE SECTION 7 ONLY IF YOU WOULD LIKE HDAP/CHII TO PAY YOUR MONTHLY HEALTH INSURANCE. ATTACH A RECENT PREMIUM/BILL OR EMPLOYER PREMIUM/PAYROLL DEDUCTION LETTER.

38. Have you had health insurance coverage within the last 60 days? ☒ Yes ☐ No

39A. I would like the CHII program to cover the cost of my monthly premium/bill for:

- ☐ Private (non-group) insurance
- ☐ Small group or self-employed health insurance
- ☐ MassHealth
- ☐ ConnectorCare
- ☐ Medicare Part D
- ☐ COBRA
- ☒ Employee premium deduction
- ☐ Other, specify: _____

39B. If you are currently working, does your employer offer health insurance? ☒ Yes ☐ No

If YES, and you are currently not enrolled in your employer plan, please submit a copy of the summary of insurance benefits provided by your employer/human resources department.

- Clients that check #39A. Are indicating that they would like CHII to establish or continue payments for an insurance premium on their behalf. Please provide a recent premium statement with the application in order to establish or continue CHII payments
- Clients who are offered employer sponsored insurance and would like CHII to establish payments, should provide a copy of an employer insurance benefits summary and an employee premium deduction letter provided by employer/human resources department

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Section 8: Certification Statement (All Applicants Must Sign)

SECTION 8 – CERTIFICATION STATEMENT (ALL APPLICANTS MUST SIGN)

40. I certify that I have read (or have had read to me) the information on this application, the Grievance Procedure, the Client Agreement Statement, and the Consent to Contact section, and that I understand my rights and responsibilities. I also certify 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.

Signature (REQUIRED): Cure H. Ivy **Date:** 06 / 01 / 2021
(Applicant or Parent/Guardian)

- Long form applications must be signed by new clients. Applications for new clients received without the client's signature will not be approved

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Short Form Overview

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Who Can Use the Form?

- Clients who are active in HDAP after submitting a Long Form are eligible to recertify using a Short Form or Self-Attestation Form
- Short forms must be received **before** the client's current termination date.
- Short forms received **after** the client's termination date will not be accepted, and clients will need to recertify using the Long Form

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- Name
- Date of birth
- SS#
- Phone number
- Residential address
- Mailing address
- Demographic info
- Consent to contact
- Proof of Income
- Proof of residency
- Case manager info
- Clinician info
- Clinical status
- Mode of exposure
- Lab results
- Clinician signature
- Pharmacy
- Insurance Status
- Max co-pay
- CHII info (if rel.)
- Client or CM signature and date

Initial

6 month recert

- Name
- Date of birth
- SS#
- Contact information
- Mark where to send mail
- Client or CM signature and date

- Name
- Date of birth
- SS#
- Phone number
- Residential address
- Mailing address
- Demographic info
- Consent to contact
- Proof of Income
- Proof of residency
- Case manager info
- Clinician info
- Clinical status
- Mode of exposure
- Lab results
- Clinician signature
- Pharmacy
- Insurance Status
- Max co-pay
- CHII info (if rel.)
- Client or CM signature and date

Annual recert

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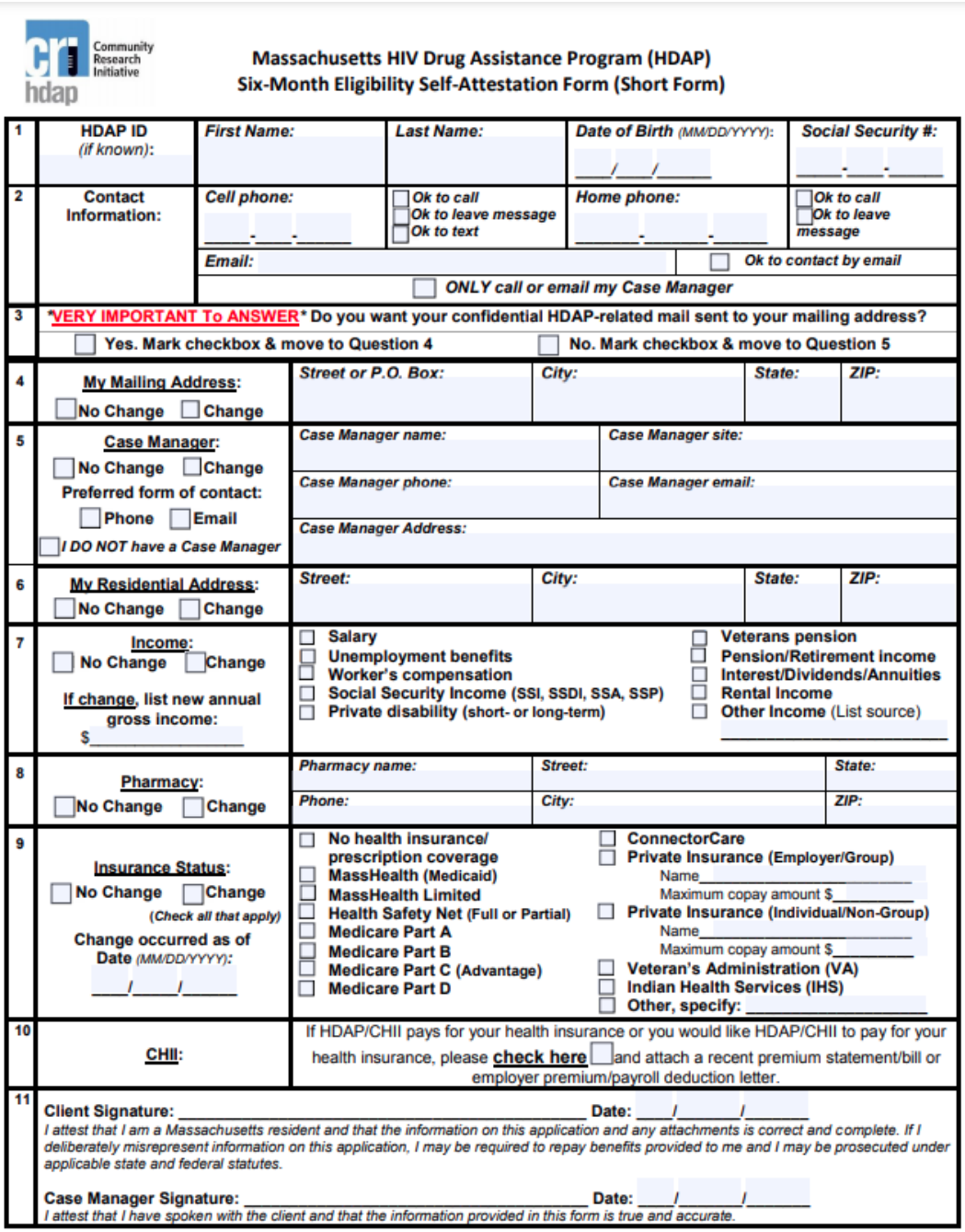
Self-Attestation (Short) Form



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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.*				

Updated July 2019

Please recycle prior versions

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Sections 1-3. Client Information

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**		

All the information in sections #1-3 are REQUIRED: Failure to complete these sections in their entirety will hold up the application processing and may lead to rejection

- Social Security number
  - ❑ 123-45-6789 – Accepted
  - ❑ XXX-XX-6789- Rejected
- Mark **either** 'My Case Manager' or 'My Mailing Address' checkbox
  - ❑ If left blank or if both are chosen, the application could be rejected
  - ❑ Information provided will determine where HDAP will send notifications to

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4. Mailing Address and 5. Case Manager Information

Form

4	My Mailing Address: ☐ No Change ☐ Change	*Street or P.O. Box:*	*City:*	*State:*	*ZIP:*

- If there is no change, mark the "no change" checkbox and STOP
- If there is a change, mark the "change" checkbox and write the new mailing address

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:	

- If there is no change, mark the "no change" checkbox and STOP
- If there is a change, mark the "change" checkbox and write the new case manager contact information
- Mark preferred form of contact. If left blank, we will default to "Phone"
- If you want to periodically receive important information from HDAP/CHII/BRIDGE like this webinar, provide your email address

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6. Residential Address and 7. Income

Form

6	My Residential Address: ☐ No Change ☐ Change	*Street:*	*City:*	*State:*	*ZIP:*

- If there is no change, mark the "no change" checkbox and STOP
- If there is a change, mark the "change" checkbox, write the new residential address, AND provide a new proof of residency documentation

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) _____

- If there is no change, mark the "no change" checkbox and STOP
- If there is a change, mark the "change" box, calculate and list the new annual gross income amount, and check all boxes for sources of income

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8. Pharmacy and 9. Insurance Status

Form

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

- If there is no change, mark the "no change" checkbox and STOP
- If there is a change, mark the "change" checkbox and write the new pharmacy information

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:** _____

- If there is no change, mark the "no change" checkbox and STOP
- If there is a change then please indicate the date that their new insurance became effective, and what their new insurance is
- For clients that have new Private Insurance – insurance name and maximum copay amount ARE REQUIRED

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10. Requesting CHII Coverage and 11. Signature

Form

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.

- Clients who would like CHII to pay a health insurance premium should mark section 10
- Submit a copy of a recent insurance premium statement (dated within 3 months) or employee deduction letter (dated within 1 year).

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.

- If client and Case Manager complete form together (in-person)
  - ❑ Client signs and dates
- If Case Manager completes form on behalf of client (by phone)
  - ❑ Case Manager (only) signs and dates

If client completes form by themselves

- ❑ Client signs and dates

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Self-Attestation Requirements Quick Reference Guide

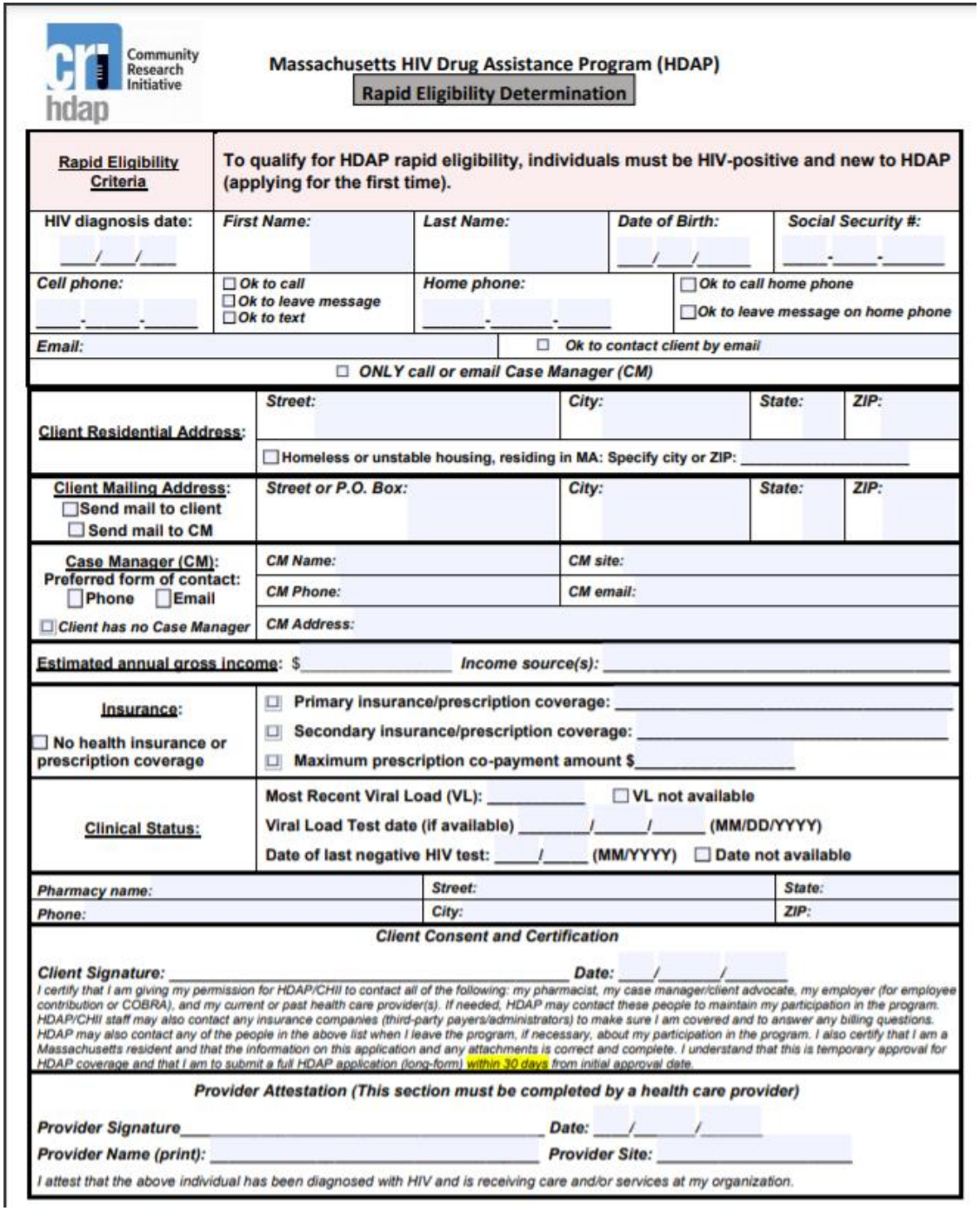
	Self-Attestation Requirements Quick Reference Guide			
No.	**Category of Requested Information**	**Required if there is <u>No Change</u>**	**Required if there <u>IS a Change</u>**	**Required supporting documentation if there <u>IS a Change</u>**
1	**Applicant Information**	▪ Full name ▪ Date of birth ▪ Social Security Number (*If you don't have a social security number, use 999-99-9999*)	New full name	Proof of name change documentation
2	**Contact Information**	▪ Cell phone **AND/OR** ▪ Home phone **AND/OR** ▪ Email address	▪ Cell phone **AND/OR** ▪ Home phone **AND/OR** ▪ Email address	None
		▪ Indicate whether you would like us to leave a message on your home, cell phone voicemail and/or email. ▪ Indicate if you would like us to call or email ONLY your Case Manager		
3	**HDAP-related mail sent to your mailing address**	▪ **You must mark either "Yes" <u>or</u> "No"** ▪ If marked, "Yes", move on to question 4 ▪ If marked, "No", move on to question 5		None
4	**My Mailing Address**	Nothing	New mailing address	None
5	**Case Manager**	Nothing	New Case Manager's contact information	None
		If you don't have a Case Manager, mark the checkbox		
6	**My Residential Address**	Nothing	New residential address	New proof of residency documentation
7	**Income**	Nothing	New annual gross income amount	None
8	**Pharmacy**	Nothing	New pharmacy information	None
9	**Insurance Status**	Nothing	▪ New insurance name(s) ▪ Maximum copay amount(s) ▪ New insurance type(s) (*check all that applies*) ▪ Change occurred as of date(s)	Front and back copies of new insurance card(s)
10	**CHII**	▪ Mark "check here" checkbox **<u>ONLY IF</u>** new or current CHII client ▪ Current insurance premium statement	▪ Mark "check here" checkbox **<u>ONLY IF</u>** new or current CHII client ▪ Current insurance premium statement	Current insurance premium statement **<u>ONLY IF</u>** new or current CHII client
11	**Signature and date**	▪ If client and Case Manager complete form together (*in-person*) – client signs and dates ▪ If Case Manager completes form on behalf of client (*by phone*) – Case Manager (***only***) signs and dates ▪ If client completes form by themselves – client signs and dates		

Community Research Initiative

Rapid Eligibility Determination (RED) Form

Community Research Initiative

Rapid Eligibility Determination form



Community Research Initiative hdap

Massachusetts HIV Drug Assistance Program (HDAP)

Rapid Eligibility Determination

Rapid Eligibility Criteria	To qualify for HDAP rapid eligibility, individuals must be HIV-positive and new to HDAP (applying for the first time).			
HIV diagnosis date: ___/___/___	First Name:	Last Name:	Date of Birth: ___/___/____	Social Security #: ___-___-____
Cell phone: ___-___-____	☐ Ok to call ☐ Ok to leave message ☐ Ok to text	Home phone: ___-___-____	☐ Ok to call home phone ☐ Ok to leave message on home phone	
Email:		☐ Ok to contact client by email		
☐ ONLY call or email Case Manager (CM)				

Client Residential Address:	Street:	City:	State:	ZIP:
	☐ Homeless or unstable housing, residing in MA: Specify city or ZIP: _____			
Client Mailing Address: ☐ Send mail to client ☐ Send mail to CM	Street or P.O. Box:	City:	State:	ZIP:
Case Manager (CM): Preferred form of contact: ☐ Phone ☐ Email ☐ Client has no Case Manager	CM Name:	CM site:		
	CM Phone:	CM email:		
	CM Address:			

Estimated annual gross income: $_____ **Income source(s):** _____

Insurance: ☐ No health insurance or prescription coverage	☐ Primary insurance/prescription coverage: _____ ☐ Secondary insurance/prescription coverage: _____ ☐ Maximum prescription co-payment amount $_____
Clinical Status:	Most Recent Viral Load (VL): _____ ☐ VL not available Viral Load Test date (if available) ___/___/___ (MM/DD/YYYY) Date of last negative HIV test: ___/___ (MM/YYYY) ☐ Date not available

Pharmacy name:	Street:	State:
Phone:	City:	ZIP:

Client Consent and Certification

Client Signature: _____ **Date:** ___/___/___

I certify that I am giving my permission for HDAP/CHII to contact all of the following: my pharmacist, my case manager/client advocate, my employer (for employee contribution or COBRA), and my current or past health care provider(s). If needed, HDAP may contact these people to maintain my participation in the program. HDAP/CHII staff may also contact any insurance companies (third-party payers/administrators) to make sure I am covered and to answer any billing questions. HDAP may also contact any of the people in the above list when I leave the program, if necessary, about my participation in the program. I also certify that I am a Massachusetts resident and that the information on this application and any attachments is correct and complete. I understand that this is temporary approval for HDAP coverage and that I am to submit a full HDAP application (long-form) within 30 days from initial approval date.

Provider Attestation (This section must be completed by a health care provider)

Provider Signature_____ **Date:** ___/___/___

Provider Name (print): _____ **Provider Site:** _____

I attest that the above individual has been diagnosed with HIV and is receiving care and/or services at my organization.

Community Research Initiative

Rapid Eligibility Determination (RED)

- The one-page Rapid Eligibility Determination form (RED) was created to provide quick access to lifesaving HIV medications for newly diagnosed clients.
- Currently, RED form can be used by anyone who is applying to HDAP for the first time
- RED **must** be completed in full and signed by both the client and a clinician.
- No supporting documentation is required.
- RED is processed urgently by HDAP.
- Client receives 3 months of temporary HDAP coverage but, must submit a full HDAP application, with supporting documents, to receive full coverage.
- Case managers should **always contact HDAP when submitting a RED**. Secure emails should be clearly titled as Urgent/RED. Call our main number regarding any RED sent by fax.

Community Research Initiative

Important Application Reminders

Community Research Initiative

Requesting Urgent Processing

If in need of urgent processing:

1) **Call HDAP staff directly to discuss urgent need** (i.e. insurance is being cancelled, 100% request, etc.)
2) Fax **completed** application and/or premium statement to HDAP
   - Call HDAP staff to inform us of the **time**, **date**, and **number of pages** of the fax that was sent so we can identify it in our system quicker

*Please allow 24-48 hours for processing time

Community Research Initiative

Requesting 100% Coverage

To be considered for 100% coverage:

1) Must be active in HDAP or have an application in-house
    - If a client is without insurance and inactive, they will need to submit a new Long Form application and supporting documents before they can be approved
2) Must be uninsured **and** lack access to Health Safety Net
3) Case managers must submit a 100% request letter explaining how the client lost insurance and what they are doing to get enrolled in coverage
4) Contact HDAP for individual case review

Community Research Initiative

How to Submit HDAP Applications

- Fax @ 617-502-1703
  - *Send with fax cover page
- Mail
- In-person delivery
- Email
  - https://web1.zixmail.net/s/login?b=crine

Community Research Initiative

Application Rejections

Applications may be rejected if they:

- Are missing any pages;
- Missing sections of personal information;
- Missing provider/clinical information;
- Missing the client signature;
- Missing a proof of residency document;
- Missing a proof of income document;
- The application is illegible.

Community Research Initiative

Note: When applications are rejected, we highly recommend that you cross-reference the list of potential rejection reasons with your previously submitted application.

Community Research Initiative
hdap

Schrafft's City Center
529 Main Street, Suite 301
Boston, MA 02129

T 617. 502. 1700
F 617. 502. 1703
www.crine.org

Date: _____/_____/_____

Dear: _____ HDAP ID# _____

Your Massachusetts HIV Drug Assistance Program (HDAP) application has been rejected by our system and cannot be processed because it is missing one or more of the following required elements:

- Signed Certification Statement
- Personal Information
- Proof of Massachusetts Residence
- Proof of Income
- Provider Information
- Clinical Status (***required for new HDAP clients only***)
- Mode of exposure (***required for new HDAP clients only***)
- Labs (***Viral load results are required for new HDAP clients, then once a year***; *CD4 results are only required for new clients or those inactive in HDAP more than two years*)
- Clinician Signature
- Pharmacy Information (*if the pharmacy is not changing at re-certification, HDAP may use historical information*)
- Ineligible for self-attestation (6-month short form)

- Copy of a complete, signed, and dated MassHealth /MA Health Connector application: A MassHealth (MH) application must be submitted to MassHealth ONCE each year (even if you expect to be denied).

- MassHealth/Health Connector Determination Letter: **HDAP requires a copy of your MassHealth determination letter.** Please check that the MH denial date is within the last 12 months. If a MassHealth application was submitted over TWO (2) months ago, you should have received a MassHealth determination letter. If you cannot find the original MH determination letter to submit to HDAP, you must contact the MassHealth Eligibility Center (800.841.2900) to request a copy of the letter. HDAP will accept a copy of the MH application and will approve temporary two-months coverage.

Please refer to the Application Instructions when revising the application and RE-SUBMIT the ENTIRE complete application along with the required documentation.

NOTE: All supporting documentation and signatures must be dated within the previous SIX (6) MONTHS ***(please replace all outdated portions of the application)*** *unless otherwise noted.*

If you have any questions, please contact HDAP staff at 617.502.1700 or toll free at 800.228.2714. Thank you for your prompt attention to this matter.

Sincerely,

HDAP Staff

Community Research Initiative

Proof of Residency Reminders

- Proof of residency is documents are required for the Long Form. Applications that are missing a residency document will not be approved.
  - Proof of residency documents are required for the Short Form **only** if a client's residential address has changed since they submitted their last application
- Documents must be dated within 6 months
- If a client is homeless and does not have formal proof of residential address HDAP will accept a letter from their Case Manager stating where they reside
  - All case manager letters must be written on agency letterhead, signed and dated
- Acceptable documents include
  - Case Manager letter, Utility bill, Current Driver's License/MA ID card, current lease, patient demographic sheet, Award letters from SSA or DTA, MassHealth/Health Connector, documents, etc.

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For more information, please refer to the HDAP 101 training.

Proof of Income Reminders

- Proof of income documents are only required for Long Form applications
  - HDAP may ask for income documents for Short Form applications if the client's apparent income would disqualify them for HDAP services
- Clients must submit documents for all sources of income
- Acceptable documents include:
  - Two recent paystubs from different pay periods showing gross income for each job
  - Document showing unemployment compensation
  - Awards letters or bank statements
  - If no formal documentation of wages; a case manager letter stating client's weekly, monthly, or yearly gross income and its source
  - If client has NO income; submit a case manager letter stating client has $0 income and **identify source of support** (i.e., family, friends, church, community resources, savings, etc.)

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For more information, please refer to the HDAP 101 training.

MassHealth Determination

Community Research Initiative

MassHealth Determination Reminders

- A MassHealth or Health Connector determination document must be submitted to HDAP every 12 months; even if clients do not anticipate being eligible
- HDAP may request MassHealth determinations if a client's income or insurance status has changed
- Clients do not have to submit MassHealth determinations if they are active in:
  - MassHealth (Standard, Family Assistance, CommonHealth, etc.)
  - Clients (age 65+) who previously submitted the MassHealth SACA-2 application and were denied due to income and/or assets.
  - MIC (MA Insurance Connection)
  - ConnectorCare 1, 2 or 3 plan through the Health Connector

Community Research Initiative

Commonwealth of Massachusetts
Executive Office of Health and Human Services

Health Insurance Processing Center
P.O. Box 4405
Taunton, MA 02780-0419

You can get this information in large print and braille. Call **1-800-841-2900** from Monday to Friday, 8:00 A.M. to 5:00 P.M. **TTY:** 1-800-497-4648

T013 P016 002078 20210520 1 **********ALL FOR AADC 015

[redacted]

Date: May 19, 2021
Notice ID: 0005035097 / APPR-HSN
Member ID: [redacted]
SSN: XXX-XX-[redacted]

Dear [redacted],

The person listed below does not qualify for MassHealth benefits. However, the Health Safety Net may be able to help pay for certain health care services at Massachusetts acute hospitals or community health centers.

- **Name:** [redacted], **Member ID:** 100049070186, **Date of Birth:** September 05, 1977 starting on May 07, 2021

Members of your family who applied for health benefits but are not listed above may get another letter about their eligibility.

If the person listed above is younger than the age of 19 and she or he is not approved for the Children's Medical Security Plan (CMSP) they do not qualify because they have access to other health insurance.

Questions? Visit MAhealthconnector.org or call **1-800-841-2900 TTY**: 1-800-497-4648

Community Research Initiative

Commonwealth of Massachusetts
Executive Office of Health and Human Services

The person listed above may be eligible for more benefits from MassHealth because they told us on their MassHealth application that they have a disability. We have sent you a form called the **MassHealth Disability Supplement** along with instructions for next steps. Please fill out the supplement and send it to us to find out whether they qualify for more benefits based on disability. Once we receive the completed supplement, MassHealth will process it and send another letter about any additional benefits based on disability when the process is complete.

Why doesn't the person on this letter qualify for MassHealth benefits?

The listed person does not qualify for MassHealth benefits because of one or more of the following reasons:

- The income for this person is too high. 130 CMR 506.007 (B) and 130 CMR 502.003
- The person does not have a special circumstance such as pregnancy, breast or cervical cancer or HIV or disability. 130 CMR 505.002(A) and (E) and 130 CMR 505.004
- The person does not meet citizenship and immigration requirements. 130 CMR 504.000
- The person is 65 years old or older. If they haven't already, they must complete the ***Application for Health Coverage for Seniors and People Needing Long-Term-Care Services***. 130 CMR 501.002(B)

To find out which of these reasons apply or if you think they may qualify for more benefits based on pregnancy, disability or other special circumstances, a decrease in income or a change in immigration status, call MassHealth Customer Service at 1-800-841-2900 (TTY:1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

How did we make our decision?
MassHealth uses the rules for household size and income to make a decision. We also consider pregnancy, disability, immigration status, and breast or cervical cancer or HIV.

Household size is based on how you and your dependents are claimed on your tax return and who you are related to and live with. If you do not file taxes, household size is based on who you are related to and live with.

We used this information to make our decision.

- Household size: **3**
- Monthly household income: **266.01%** of the federal poverty level (FPL)

My Cart: 0 [redacted] Out

My Account | My Profile | My Eligibility | My Appeals | My Enrollments | My Assisters | My Documents

2021 Eligibility Results

IMPORTANT MESSAGES

This screen may not reflect the coverage protections in effect for all individuals who have **MassHealth, Health Safety Net and Children's Medical Security Plan coverage** as of March 18, 2020 and for all individuals approved for coverage during the COVID-19 outbreak national emergency and for one month after the emergency period ends. Coverage will only end if an individual requests termination of eligibility or if they are no longer resident of the state.

If you have 2021 unemployment income

If you have unemployment income for 2021 and qualify for Health Connector coverage, you may be eligible for extra financial help in 2021. Your account may be updated with a new eligibility result soon. Please return to your account tomorrow to see if you have new lower-cost health plan choices.

Back to Eligibility Applications

When you see an ⓘ, roll over it with mouse or select it by pressing tab with keyboard to get definitions and learn more.

Read through your results below, learn about the programs you qualify for, and look at the proofs we may need you to send us.

To begin shopping for Health Connector plans, please click the "Find a Plan for 2021" button below.

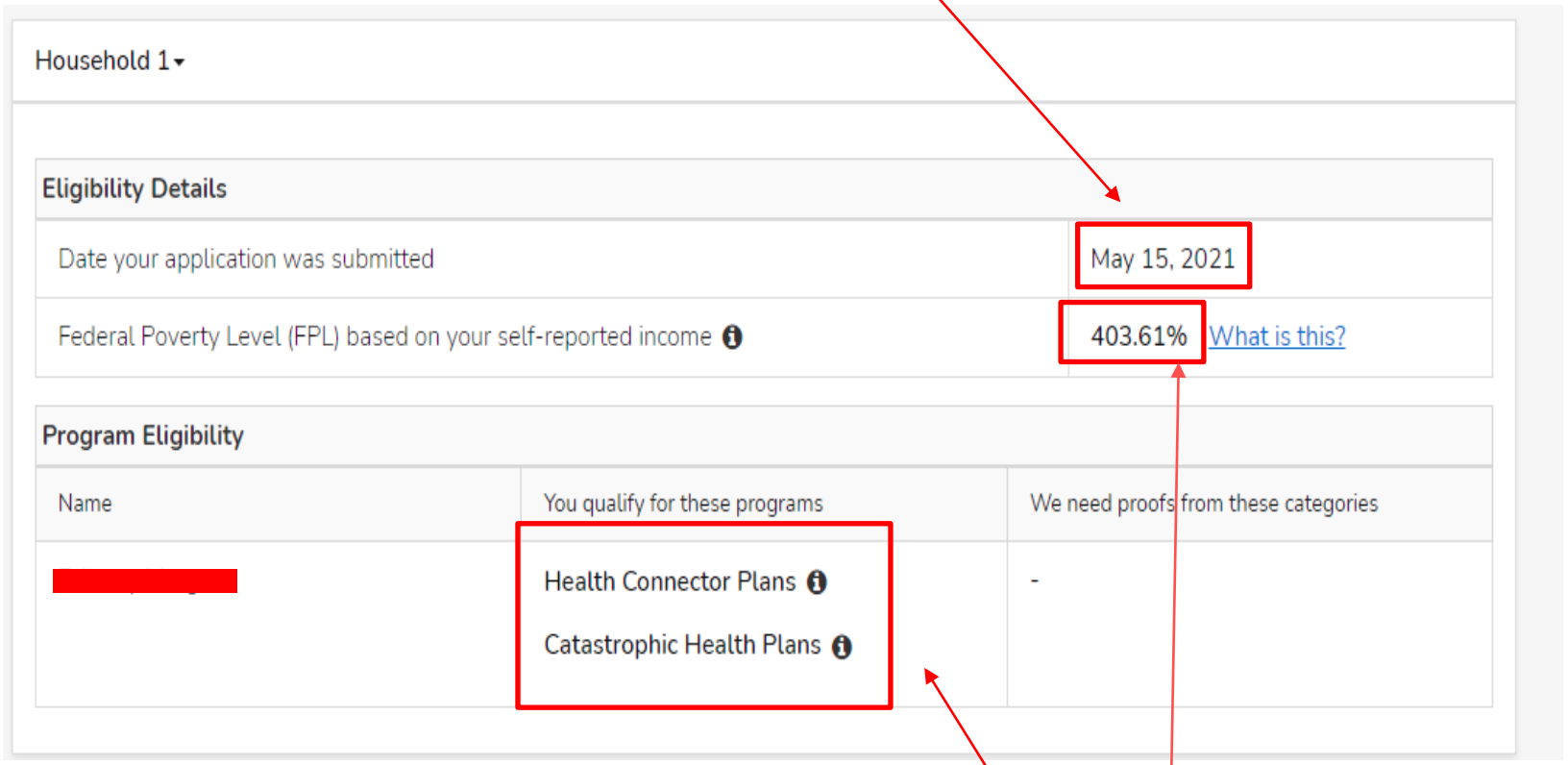
Find a Plan for 2021

Household 1

Eligibility Details	
Date your application was submitted	May 15, 2021
Federal Poverty Level (FPL) based on your self-reported income ⓘ	403.61% What is this?

Program Eligibility		
Name	You qualify for these programs	We need proofs from these categories
[redacted]	Health Connector Plans ⓘ Catastrophic Health Plans ⓘ	-

The application submitted date must be within 12 months



The reported FPL and the program eligibility must "make sense" in order to be accepted as a MassHealth determination

Community Research Initiative

Questions?

Community Research Initiative

How to Contact Us

HDAP
617-502-1700

BRIDGE Team
617-502-1700, press "1", then press "5"
BRIDGEteam@Crine.org

Massachusetts HIV Drug Assistance Program
c/o CRI of New England
The Schrafft City Center
529 Main Street, Suite 301
Boston, MA 02129

www.crine.org
800.228.2714 (toll-free)
617.502.1703 (fax)

Community Research Initiative