AccessHealth MA

Massachusetts
Pre-Exposure Prophylaxis
Drug Assistance Program (PrEPDAP)

Application Form

- Please print clearly and answer all questions. Review the attached instructions before you begin.
- Mail the completed application and supporting documentation to:

  AccessHealth MA
  Attn: PrEPDAP
  The Schrafft's City Center 529
  Main Street, Suite 301
  Boston, MA 02129

- Or you may **fax** the application and supporting materials to **617.502.1701**.
- For help with this application, please call the PrEP Drug Assistance Program at **800.228.2714, ext. 3737**

REMEMBER TO:

- ☐ Attach proof of Massachusetts residence
- ☐ Attach proof of your current income from all sources
- ☐ Include a copy of your health insurance card(s)
- ☐ Completely fill out Sections 1, 2, 3, 5, 6, and 7 of your PrEPDAP application
- ☐ Have your provider fill out Section 4 of your PrEPDAP application

AccessHealth MA

Massachusetts Pre-Exposure Prophylaxis Drug Assistance Program (PrEPDAP) Application Form

Mailing Address: AccessHealth/PrEP DAP
The Schrafft's City Center | 529 Main Street, Suite 301 | Boston, MA 02129
Phone : 800.228.2714 | Fax : 617.502.1701

SECTION 1 – APPLICANT INFORMATION

1. First name: MI: Last name:

2. Name of legal guardian (if applicable):

3. Mother's first name (required for coding purposes only):

4a. PrEPDAP ID #: _____ 4b. MDPH PrEP ID #:_____
(PrEP demonstration sites only)

5. Date of birth (MM/DD/YYYY): _____/_____/_____

6. Social Security #: _____ - _____ - _____

7. Residential street address (no PO boxes):_____
Apt/Unit #: _____ City:_____ County: _____
State: _____ ZIP: _____

8. Mailing address:
☐ Same as residential address
Other address: _____
Apt/Unit #: _____ City:_____ County: _____
State: _____ ZIP: _____
8A. ☐ **I would like all my MA PrEPDAP mail sent to my PrEP Navigator** (see Section 4).

9. What is your current gender identity? ☐ Male ☐ Female ☐ Other _____

10. What was your assigned sex at birth? ☐ Male ☐ Female ☐ Other _____
(i.e. what does it say on your birth certificate?)

11. Do you identify as transgender? ☐ Yes ☐ No

11A. *If yes:* ☐ Male-to-Female (MTF) ☐ Female-to-Male (FTM) ☐ Other _____

12. Number of legal dependents:

SECTION 1 – APPLICANT INFORMATION (continued)

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

14. Race (select all that apply):

☐ American Indian or Alaskan Native
☐ Asian. *If Asian:*
  14A. ☐ Asian Indian
  ☐ Chinese
  ☐ Filipino
  ☐ Japanese
  ☐ Korean
  ☐ Vietnamese
  ☐ Other Asian
☐ Black/African American
☐ Native Hawaiian or Pacific Islander.
If Native Hawaiian or Pacific Islander:
  14B. ☐ Native Hawaiian
  ☐ Guamanian or Chamorro
  ☐ Samoan
  ☐ Other Pacific Islander
☐ White

15. Ethnicity (select one):

☐ Hispanic/Latino. *If Hispanic/Latino:*
  15A. ☐ Mexican, Mexican American, or Chicano(a)
  ☐ Puerto Rican
  ☐ Cuban
  ☐ Other Hispanic, Latino(a), or Spanish origin
☐ Non-Hispanic/Latino

CONSENT TO CONTACT

☐ **Please do not contact me by phone. Contact my PrEP Navigator <u>only</u>** (see Section 4).
If checked, please proceed to Question 17.

16. 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: _____

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

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

SECTION 2 - INCOME INFORMATION

19. Current annual income (gross): $_____

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

- ☐ 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:_____

21. Are you currently working?

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

SECTION 3 – OPTIONAL ALTERNATE CONTACT AND SIGNATURE

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

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

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

Name of alternate contact: _____

Relationship to client: _____

Client signature: _____ Date: ____/ ____/_____

SECTION 4 - PROVIDER INFORMATION

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

23. PrEP Navigator information:

Name: _____ Institution: _____

Street address: _____

City:_____ State: _____ ZIP: _____

Phone: (_____) _____ Ext._____ Fax: (_____) _____

Email address: _____ Preferred form of contact: ☐ Phone ☐ Email

24. Prescriber information:

Name: _____

Facility: _____ Department: _____

Street address: _____

City:_____ State: _____ ZIP: _____

Phone: (_____) _____ Ext._____ Email address: _____

Preferred form of contact: ☐ Phone ☐ Email

Standing order: ☐ Yes ☐ No

25. Patient's potential category of risk (select all that apply):

- ☐ Men who have sex with men (MSM) (including transgender men) who have had recent repeated unprotected anal sex
- ☐ Transgender females who currently have repeated unprotected anal and/or vaginal sex with men
- ☐ Members of a heterosexual, serodiscordant couple wishing to conceive who have been educated about the potential risks/benefits
- ☐ Other individuals in a sexual relationship with a known HIV+ partner
- ☐ Injecting drug users at risk for HIV acquisition through blood exposure secondary to sharing injection equipment for whom other prevention strategies have proven ineffective
- ☐ Individuals with recent and/or repeated diagnoses of syphilis, rectal gonorrhea or rectal chlamydia infection
- ☐ Individuals otherwise deemed appropriate by the prescribing clinician

26. Clinical testing:

- ☐ Date of most recent 4th generation NEGATIVE HIV test (must be within the past 30 days) DATE: _____
- ☐ Date of most recent HBV test DATE: _____
- ☐ Date of most recent creatinine test DATE: _____

27. Is the patient currently on PrEP? ☐ Yes ☐ No

If yes, what was the patient's most recent PrEP initiation date? _____

SECTION 5 – PHARMACY INFORMATION

Please be sure to provide full address and contact information.

28. Pharmacy information:

Pharmacy name: _____ Pharmacy store #: _____

Street address:_____ Suite #: _____

City:_____ State: _____ ZIP: _____

Phone: (_____) _____ Fax: (_____) _____

If your health insurance plan requires you to use a mail order pharmacy or specialty pharmacy for some or all of your medications, please contact PrEPDAP staff at 800.228.2714.

SECTION 6 – INSURANCE COVERAGE/CO-PAY COVERAGE

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

☐ No health insurance/prescription coverage
☐ 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)
☐ Private Insurance – Employer/Group – Name of plan: _____
☐ Private Insurance – Individual/Non-group – Name of plan: _____

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

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

☐ Maximum dollar amount per prescription (co-pay) $ _____ **OR**

☐ Percentage per prescription (co-insurance) _____ %

31. Do you have an insurance deductible? ☐ Yes ☐ No

If yes, amount of deductible:_____

32. Have you applied to Gilead's Patient Assistance Program for help with the cost of Truvada (PrEP medication)? ☐ Yes ☐ No

SECTION 7 – CERTIFICATION STATEMENT (ALL APPLICANTS MUST SIGN)

33. I certify that I have read (or have had read to me) the information on this application, the Grievance Procedure, and the Client Agreement Statement, 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): _____ **Date**:___/___/_____
(Applicant or Legal Guardian)