AccessHealth MA

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.