

<b>1</b>	<b>Applicant Information:</b>	<b>First Name:</b> _____	<b>Last Name:</b> _____	<b>Date of Birth (MM/DD/YYYY):</b> _____						
		<b>Social Security #:</b> ____-____-____	999-99-9999 <small>(for clients without Social Security Number)</small>	<b>Date of Incarceration:</b> _____						
<b>2</b>	<b>Gender Identity:</b>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">                 Male Female Non-binary Genderfluid/Gender Non-Conforming/Genderqueer             </td> <td style="width: 50%; border: none;">                 Transgender Male/Trans Man/FTM Transgender Female/Trans Woman/MTF Prefer to self describe _____ Not Reported             </td> </tr> </table>			Male Female Non-binary Genderfluid/Gender Non-Conforming/Genderqueer	Transgender Male/Trans Man/FTM Transgender Female/Trans Woman/MTF Prefer to self describe _____ Not Reported				
Male Female Non-binary Genderfluid/Gender Non-Conforming/Genderqueer	Transgender Male/Trans Man/FTM Transgender Female/Trans Woman/MTF Prefer to self describe _____ Not Reported									
<b>3</b>	<b>Race:</b> <i>(Select all that apply)</i>	<b>Ethnicity:</b>	<b>4</b>	<b>Client contact information (Optional):</b>						
	American Indian or Alaskan Native Asian Black/African American Native Hawaiian or Pacific Islander White	Non-Hispanic/Latinx Hispanic/Latinx		Email: _____  Phone: _____						
<b>5</b>	<b>Medical Information:</b> Client is HIV Positive  Clinician Signature: _____ (MD, DO, PA, NP, RN)  License #: _____ Date: _____									
	<p><i><b>If lab results from within the last twelve months are accessible, please list them below. If labs are unavailable, leave this section blank and submit the application to enroll the client for a standard six-month term. Please provide lab results, obtained while the client is incarcerated, to the Houses of Correction Manager at AccessHealth MA.</b></i></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;">Results</th> <th style="width: 50%;">Date (MM/DD/YYYY)</th> </tr> </thead> <tbody> <tr> <td>VL: _____</td> <td>_____</td> </tr> <tr> <td>CD4: _____</td> <td>_____</td> </tr> </tbody> </table>				Results	Date (MM/DD/YYYY)	VL: _____	_____	CD4: _____	_____
Results	Date (MM/DD/YYYY)									
VL: _____	_____									
CD4: _____	_____									
<b>6</b>	<b>I attest that:</b> Client resides at (Name of Jail) _____ Client has \$0 income Client has no health insurance									
<b>7</b>	<b>Name of Coordinator/HSA:</b> _____  <b>Coordinator/HSA Phone Number:</b> _____ <b>Email:</b> _____  <b>Coordinator/HSA Signature:</b> _____ <b>Date:</b> _____  <b>Client Consent and Certification (to be signed by the individual enrolling in HDAP)</b> <i>I certify that I am a Massachusetts resident and that the information on this application is correct and complete. I certify that I am giving my permission for HDAP to contact any of the following: pharmacist, case manager/HIV Coordinator, healthcare provider, and any other person that I have specifically given HDAP permission to contact. If needed, HDAP may contact these people to keep my participation in the program or about my participation in the program when I am no longer enrolled.</i>  <b>Applicant Signature:</b> _____ <b>Date:</b> _____									