



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

**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: <input type="checkbox"/> Same as residential address Other address: _____ Apt/Unit #: _____ City: _____ County: _____ State: _____ ZIP: _____		
8A. <input type="checkbox"/> I would like all my MA PrEPDAP mail sent to my PrEP Navigator (see Section 4).		
9. What is your current gender identity? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____		
10. What was your assigned sex at birth? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____ (i.e. what does it say on your birth certificate?)		
11. Do you identify as transgender? <input type="checkbox"/> Yes <input type="checkbox"/> No		
11A. <i>If yes:</i> <input type="checkbox"/> Male-to-Female (MTF) <input type="checkbox"/> Female-to-Male (FTM) <input type="checkbox"/> 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 only (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):

- | | |
|---|---|
| <input type="checkbox"/> Salary | <input type="checkbox"/> Retirement/pension |
| <input type="checkbox"/> Unemployment benefits | <input type="checkbox"/> Veteran's pension |
| <input type="checkbox"/> Social Security (SSI, SSDI, SSA) | <input type="checkbox"/> Interest/dividends |
| <input type="checkbox"/> Worker's compensation | <input type="checkbox"/> Rental income |
| <input type="checkbox"/> Private disability (short- or long-term) | <input type="checkbox"/> 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)