

**Rapid Eligibility Determination**

<b>Rapid Eligibility Criteria</b>	<b>To qualify for HDAP rapid eligibility, individuals must be HIV-positive and new to HDAP (applying for the first time).</b>			
HIV diagnosis date: ____/____/____	First Name:	Last Name:	Date of Birth: ____/____/____	Social Security #: ____-____-____
Cell phone: ____-____-____	<input type="checkbox"/> Ok to call <input type="checkbox"/> Ok to leave message <input type="checkbox"/> Ok to text	Home phone: ____-____-____	<input type="checkbox"/> Ok to call home phone <input type="checkbox"/> Ok to leave message on home phone	
Email:	<input type="checkbox"/> Ok to contact client by email <input type="checkbox"/> ONLY call or email Case Manager (CM)			
<b>Client Residential Address:</b>	Street:	City:	State:	ZIP:
	<input type="checkbox"/> Homeless or unstable housing, residing in MA: Specify city or ZIP: _____			
<b>Client Mailing Address:</b> <input type="checkbox"/> Send mail to client <input type="checkbox"/> Send mail to CM	Street or P.O. Box:	City:	State:	ZIP:
<b>Case Manager (CM):</b> Preferred form of contact: <input type="checkbox"/> Phone <input type="checkbox"/> Email  <input type="checkbox"/> Client has no Case Manager	CM Name:	CM site:		
	CM Phone:	CM email:		
	CM Address:			
Estimated annual gross income: \$ _____ Income source(s): _____				
<b>Insurance:</b> <input type="checkbox"/> No health insurance or prescription coverage	<input type="checkbox"/> Primary insurance/prescription coverage: _____			
	<input type="checkbox"/> Secondary insurance/prescription coverage: _____			
	<input type="checkbox"/> Maximum prescription co-payment amount \$ _____			
<b>Clinical Status:</b>	Most Recent Viral Load (VL): _____ <input type="checkbox"/> VL not available			
	Viral Load Test date (if available) ____/____/____ (MM/DD/YYYY)			
	Date of last negative HIV test: ____/____ (MM/YYYY) <input type="checkbox"/> Date not available			
Pharmacy name:	Street:	State:		
Phone:	City:	ZIP:		
<b>Client Consent and Certification</b>				
<b>Client Signature:</b> _____ <b>Date:</b> ____/____/____ 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) <b>within 30 days</b> from initial approval date.				
<b>Provider Attestation (This section must be completed by a health care provider)</b>				
<b>Provider Signature</b> _____ <b>Date:</b> ____/____/____ <b>Provider Name (print):</b> _____ <b>Provider Site:</b> _____ I attest that the above individual has been diagnosed with HIV and is receiving care and/or services at my organization.				