AccessHealth MA HDAP

Massachusetts HIV Drug Assistance Program Houses of Correction Application

If you have any questions about this application, please contact the Houses of Correction Manager at Jails@AccessHealthMA.org or 617-502-1723

1 Applicant Information:

First Name: | ***Last Name:*** | ***Date of Birth*** *(MM/DD/YYYY)*: _____

Social Security #: _____-____-_____

☐ ***999-99-9999*** (for clients without Social Security Number)

Date of Incarceration: _____

HDAP ID *(if known)*: _____

2 Gender Identity:

- ☐ 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

3 Race:
(Select all that apply)

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

Ethnicity:

- ☐ Non-Hispanic/Latinx
- ☐ Hispanic/Latinx

4 Client contact information
(*Optional*):

Email: _____

Phone: _____

5 Medical Information:

☐ **Client is HIV Positive**

Clinician Signature:_____ **(MD, DO, PA, NP, RN)**

License #:_____**Date:**_____

If lab results from within the last twelve months are accessible, please list them below. <u>If labs are unavailable, leave this section blank and submit the application to enroll the client for a standard six-month term.</u> Please provide lab results, obtained while the client is incarcerated, to the Houses of Correction Manager at AccessHealth MA.

Results	Date *(MM/DD/YYYY)*
VL: _____	_____
CD4: _____	_____

6 I attest that:

- ☐ **Client resides at (Name of MA Jail)** _____
- ☐ **Client has $0 income**
- ☐ **Client has no health insurance**

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Name of Coordinator/HSA: _____

Coordinator/HSA Phone Number: _____ **Email:** _____

Coordinator/HSA Signature: _____ **Date:** _____

Client Consent and Certification (*to be signed by the individual enrolling in HDAP*)

I certify 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.

Applicant Signature: _____ **Date:** _____