Massachusetts HIV Drug Assistance Program (HDAP)
Application (HOC Form)

Applicant Information		
Legal First Name		
Legal Last Name		
Date of Birth		
Social Security Number		☐ None
Applicant Contact Phone		
Applicant Contact Email		
Client Resides at	Jail Name: _____ ☐ Client has no income ☐ Client has no health insurance	
Current Gender Identity	*Please check the one that best describes your gender identity* ☐ Female ☐ Male ☐ Transgender Female/Trans Woman/MTF ☐ Transgender Male/Trans Man/FTM ☐ Non-binary ☐ Not Reported	
Race	*Select all that apply* ☐ American Indian or Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Prefer not to answer	
If Asian	*Please specify* ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other	

If Native Hawaiian or Pacific Islander	*Please specify* ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander
Ethnicity	*Select One* ☐ Non-Hispanic/Latino/Latina ☐ Hispanic/Latino/Latina ☐ Prefer not to answer *If Hispanic/Latino/Latina, please specify:* ☐ Puerto Rican ☐ Cubano ☐ Other Hispanic, Latino, Latina, or Spanish Origin

Applicant's Most Recent Test Results:
If lab results from within the last twelve months are accessible, please list them. If labs are unavailable, leave blank. Please upload any new lab results obtained while the client is incarcerated.

VL:_____ Date:_____

CD4:_____Date:_____

Jail Information		
House of Corrections		
Incarceration Date		
HIV Coordinator Name		
Address		
Direct Phone		☐ Preferred
Fax		☐ Preferred
Email		☐ Preferred
Clinician: Same as HIV Coordinator?	☐ Yes ☐ No	
If No, Clinician Name		
Title		
License		

Client Consent and Certification

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.

Signature (REQUIRED):_____Date:_____

Coordinator/HSA Signature

Name of Coordinator/HSA:

Coordinator/HSA Phone Number:_____Email:_____

Coordinator/HSA Signature: _____Date:_____

CRI HIV Drug Assistance Program (HDAP)
Houses of Correction (HOC) Program Application
Instructions

Please submit this application via fax (617-502-1703) or secure e-mail through Community Resource Initiative's Zixcorp portal. Instructions for the Zixcorp portal can be found here: www.crihealth.org/Contact.
Additional documents are no longer required to enroll clients in this program. If you have any questions about this application, please contact HDAP's Houses of Correction Manager at Jails@crihealth.org or 617-502-1723. The numbers below correspond to the numbered sections of the application.

1. Application Information
    a. Please provide the client's first name, last name, and date of birth. If the client has a valid Social Security number, please provide all nine digits of the number. If the client does not have a valid Social Security number, check the box next to None.
    b. Please provide the date the client entered the HOC.
2. Gender Identity: Please do not leave this section blank. If the client declines to disclose his/her/their gender identity, please check the box next to Not Reported.
3. Race and Ethnicity: Please fill out the client's self-reported race and ethnicity. If this information is not available or the client wishes not to report this, leave the section blank. The Houses of Correction Manager may follow up with staff to collect race and ethnicity data if this is left blank.
4. Client contact information: This section has been included to enhance Community Resource Initiative's outreach efforts to released clients. Providing this information is optional. Please encourage clients to provide this contact information so that Community Resource Initiative can better assist them with their post-release medication and health insurance needs. Applications without client contact information will not impact eligibility and will be processed.
5. Medical Information: Please have a clinician (MD, DO, PA, NP, RN) check the box next to Client is HIV Positive to verify the client's HIV status (only clients diagnosed with HIV are eligible for HDAP). The clinician also needs to sign, date, and provide a license number. If lab results from the last twelve months are accessible, please list the results and provide the dates the labs were drawn. If labs are unavailable, please leave this section blank and submit the application (this will not impact the client's HDAP eligibility). Please provide lab results obtained while the client is incarcerated to the Houses of Correction Manager. The Houses of Correction Manager will also follow up with staff to obtain this information if it is not submitted on the application.
6. Attestation: Please check all the boxes in question 5. Please also write or type in the name of the HOC.
7. Please write or type the contact information and name of the HOC staff person assisting with the application. The person assisting with the application also needs to sign and date the application. A client signature is required. If a client is refusing to sign the application, please contact the Houses of Correction Manager.