



Massachusetts HIV Drug Assistance Program (HDAP)
Six-Month Eligibility Self-Attestation Form (Short Form)

Applicant Information	
Full First Name:	Full Last Name:
Date of Birth:	Social Security Number: <input type="checkbox"/> None
Contact Information	
Has your Residential Address changed? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, complete below and attach proof of MA residency.
Communication Preferences <input type="checkbox"/> Communicate with me <input type="checkbox"/> Communicate with Case Manager ONLY <input type="checkbox"/> Communicate with me and my case manager	
Do you consent to receiving HDAP-related mail? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, please complete the following: Street Address/PO Box _____ City/State/ZIP _____
Cell Phone Number: _____ <input type="checkbox"/> OK to leave confidential cell message <input type="checkbox"/> OK to send text message	
Home Phone Number: _____ <input type="checkbox"/> OK to leave confidential home message	
Email Address: _____ <input type="checkbox"/> OK to send confidential email	
Case Manager	
Has your Case Manager changed? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> I don't have a case manager	If Yes, new case manager name: _____ Agency/Site/Institute: _____ Phone: _____ Email: _____
Income Eligibility Information	
Has your Income changed? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, enter new annual gross income: _____ Income source(s): _____
Insurance and Prescription Coverage	
Has your Insurance coverage changed? <input type="checkbox"/> No <input type="checkbox"/> Yes, date effective: _____	If Yes, enter insurance information (please enter all prescription drug coverage plans): _____
I would like CHII to pay my health insurance premiums (if yes, please include a copy of a recent premium bill): <input type="checkbox"/> No <input type="checkbox"/> Yes	
Pharmacy Information	
Has your Pharmacy changed? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, please complete the following: Pharmacy name _____ Phone _____ Street Address/City/State/ZIP: _____
Attestation (must be signed by Client or Case Manager)	
<i>I certify 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 or disenrolled from the HDAP/CHII program and I may be subject to penalties under state and federal laws.</i>	
Client Signature: _____	Date: _____
<i>I attest that I have spoken with the client and that the information provided in this form is true and accurate.</i>	
Case Manager Signature: _____	Date: _____

Instructions:

- Complete all sections of the HDAP application.
- Application must be signed and dated by either Client OR Case Manager.
- If you select “Yes” for Change of residential address, attach proof of Massachusetts residence.
 - Document must include your name, match the residential street address provided in the application, and be dated within the past six (6) months.
 - Examples of acceptable documents include:
 - Utility bill
 - Pay Stub/earnings statement
 - Lease
 - Current driver’s license/Massachusetts identification card
 - Government assistance mailing
 - Case manager letter attesting to your current residential address.
 - If you currently lack housing or do not have documentation of residential address available, please submit a letter from your case manager verifying your current residential address.
 - All case manager letters must be on agency letterhead and must be signed by the case manager.
 - If you have no change to your residential address, you do not have to submit a proof.
- If you have a change of Income, please select “Yes” and provide the new annual gross income and new source(s) of income. You are not required to provide a proof.
 - If you have no change in income, you do not have to submit a proof.
- Attach a copy of your completed MassHealth paper application, the Results page of your Massachusetts Health Connector online application, or a MassHealth/Health Connector determination letter from within the past 12 months.
- If you have a change of insurance, attach a copy of your health insurance card (front and back).
- If you have lost insurance since your last application and are currently without prescription coverage, please include a signed letter from your Case Manager requesting Full HDAP coverage.
- If applying for CHII to cover the cost of your premium, please attach a copy of your most recent health insurance (bill), or a letter from Employer or HR to allow CHII to pay employee contributions (if applicable).
- If applicable, attach a Summary of Benefits from your Employer/HR.
- Mail the completed application and supporting documents to:
 - ATTN: HDAP
 - The Schraff’s City Center
 - 529 Main Street, Suite 301
 - Boston, MA 02129
- Or you may fax the application and supporting materials to 617.502.1703.
- For help with this application, please call HDAP at 800.228.2714.