COMMUNITY RESOURCE INITIATIVE

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 or send via secure email the completed application and supporting documentation to:

  Community Resource Initiative
  Attn: PrEPDAP
  The Schrafft's City Center
  529 Main Street Suite 301
  Boston, MA 02129

- Or you may securely **fax** the application and supporting materials to **617.502.1701**.
- For help with this application, please call the PrEP Drug Assistance Program at **617-502-1700 and select Option 4**

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

COMMUNITY RESOURCE INITIATIVE

Massachusetts Pre-Exposure Prophylaxis Drug Assistance Program (PrEPDAP) Application Form

Mailing Address: CRI/PrEPDAP
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):

4. PrEPDAP ID # (if known):

5. Date of birth (MM/DD/YYYY): ___/___/_____

6. Social Security #: ___-___-____ *use 999-99-9999 if applicant does not have a social security number*

7. Residential street address (no PO boxes):

☐ No address provided. Please attach a letter from Navigator/Case Worker attesting to this

8. Mailing address:

☐ Same as residential address ☐ None

Other address:

Apt/Unit #: City: County: State: ZIP:

8A. ☐ Please contact my PrEP Navigator for my application, recertification and pharmacy approval needs.

9. What is your current gender identity? ☐ Male ☐ Female ☐ Other

9A. If you would prefer a particular pronoun be used, please indicate here

10. What was your assigned sex at birth? ☐ Male ☐ Female ☐ Other
(i.e. what does it say on your birth certificate?)

11. Do you identify as transgender? ☐ Yes ☐ No

11A. *If yes:* ☐ Male-to-Female (MTF) ☐ Female-to-Male (FTM) ☐ 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
☐ Other _____
☐ Prefer not to answer

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
☐ Other _____
☐ Prefer not to answer

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: _____

SECTION 2 - INCOME INFORMATION

18. Current annual income (gross): $_____

19. Do you receive income from any of these sources?
(select all that apply):

- ☐ Salary
- ☐ Unemployment benefits
- ☐ Social Security (SSI, SSDI, SSA)
- ☐ Worker's compensation
- ☐ Private disability (short- or long-term)
- ☐ No income (Please attach a letter from Navigator/Case Worker attesting to this.)
- ☐ Retirement/pension
- ☐ Veteran's pension
- ☐ Interest/dividends
- ☐ Rental income
- ☐ Other income, specify: _____

20. 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.**

21. 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 can be filled out by you or your PrEP provider(s)

22. Case Manager/ PrEP Navigator information:

Name: _____ Institution: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Phone: (_____) _____ Ext. _____ Fax: (_____) _____

Email address: _____ Preferred form of contact: ☐ Phone ☐ Email

23. Prescriber information:

Name: _____

Facility: _____ Department: _____

Street address: _____

City: _____ State: _____ ZIP: _____

Phone: (_____) _____ Ext. _____ Email address: _____

Preferred form of contact: ☐ Phone ☐ Email

24. Patient's potential category of risk (select all that apply):

- ☐ MSM
- ☐ MSM/IDU
- ☐ HET (Heterosexual)
- ☐ Presumed HET
- ☐ Other

24a. Additional Options

- ☐ Anal or vaginal sex in the past 6 months
- ☐ HIV-positive sexual partner (with unknown or detectable viral load)
- ☐ Bacterial STI in the past 6 months
- ☐ History of inconsistent or no condom use with sexual partners
- ☐ HIV-positive injecting partner or sharing of injection equipment Prefer not to answer

25. Clinical testing:

☐ Please check this box if appropriate clinical testing has been performed as outlined in the updated CDC PrEP Clinical Guidelines released in 2021.

26. Is the patient currently on PrEP? ☐ Yes ☐ No

- ☐ Emtricitabine/tenofovir disproxil fumarate (Truvada or generic)
- ☐ Emtricitabine/tenofovir alafenamide fumarate (Descovy)
- ☐ Long-acting cabotegravir (Apretude)

SECTION 5 – PHARMACY INFORMATION

Please be sure to provide full address and contact information.

27. 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

28. What type(s) of health insurance/prescription coverage do you have? (select **all** that apply):

- ☐ No health insurance/prescription coverage (Please attach a letter from Navigator/Case Worker attesting to this.)
- ☐ 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 check here if you have insurance confidentiality concerns.

*Please include a copy of your insurance d*ollar amount per prescription (co-pay) $_____

29. 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) _____%

30. Do you have an insurance deductible? ☐ Yes ☐ No

If yes, amount of deductible: _____

31. Have you applied to any manufacturer patient assistance programs for help paying for the cost of PrEP? ☐ Yes Which one? _____ ☐ No

SECTION 7 – CERTIFICATION STATEMENT (ALL APPLICANTS MUST SIGN)

32. 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)