MASSACHUSETTS HIV DRUG ASSISTANCE PROGRAM (HDAP)[i]

CLIENT CONSENT FOR THE RELEASE OF INFORMATION
AND
CLIENT CERTIFICATION STATEMENT

BACKGROUND

Community Research Initiative of New England Inc. d/b/a Community Resource Initiative (referred to as Community Resource Initiative) administers the Massachusetts HIV Drug Assistance Program (HDAP) for the Massachusetts Department of Public Health (MDPH). In order to administer the program effectively, Community Resource Initiative collects client information, which is held in a secure database to maintain confidentiality.

CLIENT CONSENT

In order to determine my eligibility for enrollment in HDAP, and manage my benefits under the HDAP program, I understand that Community Resource Initiative may need to collect and use certain information about me. In addition, Community Resource Initiative may need to discuss my care with other people as described in this form. By signing this form, I authorize Community Resource Initiative staff to collect, use, and share my information as necessary for the administration of the HDAP program.

Community Resource Initiative will share this information confidentially and will only disclose to third parties my information that is necessary for the administration of the program. The information about me may include my medical information, including HIV lab results, and HIV/AIDS diagnosis or HIV treatment, and other identifying information such as my name, social security number, and date of birth. I authorize Community Resource Initiative staff to share my information with the following parties:

- Authorized vendors or subcontractors as necessary to operate the program
- My pharmacist/pharmacy
- My health care provider/clinical site (current and/or past)
- My case manager or case manager provider organization (current and/or past)
- Any other person that I specifically give Community Resource Initiative permission to contact on the application
- Auditors reviewing application files as required for program or fiscal monitoring
- Federal and state government agencies as may be required by state and federal laws and regulations, including, but not limited to the Massachusetts Department of Public Health, the U.S. Health Resources Services Administration (HRSA), and the federal Centers for Medicare and Medicaid Services (CMS)
- Public or Private insurance companies (including third party payers/administrators)

If I request employer sponsored coverage through the Comprehensive Health Insurance Initiative (CHII) program, Community Resource Initiative staff will contact my employer to confirm they are willing to accept payment from the program and to obtain the details necessary to make payments.

Community Resource Initiative will only collect, use, and share my information as described in this form. For example, Community Resource Initiative will not share my information with immigration officials or any other unauthorized government agencies, or individuals such as my landlord, family, friends, neighbors, or anyone else without my consent, or as required by law.

i A program of the Massachusetts Department of Public Health

My permission to collect, use, and share my information as described in this form will expire at such time when I no longer participate in HDAP. I understand that authorizing the collection, use, and sharing of my information is voluntary, and I can refuse to sign this form. However, if I do not sign this form, I will not be eligible to receive HDAP assistance. If I sign this form, and later change my mind, I have the right to withdraw my consent or terminate my enrollment in HDAP at any time by sending a written notice to HDAP at 529 Main Street, Suite 301, Boston MA 02129. By withdrawing my permission to use and share my information as described in this form, I will also be terminating my enrollment in HDAP.

CLIENT STATEMENT

I understand that if I deliberately misrepresent information on this application, I may be required to repay benefits provided to me or be disenrolled from HDAP/CHII and I may be subject to penalties under state and federal laws. By signing this form, I specifically attest to the following:

- I understand it is my responsibility to re-apply ("recertify") with HDAP/CHII as required by HDAP/CHII and understand if I do not submit a complete recertification application, my HDAP/CHII benefits will be terminated, including CHII insurance payments if I am enrolled in CHII.
- I understand that HDAP/CHII may require me to re-pay any payments made on my behalf if I am deemed not eligible for them. This includes, but is not limited to, health insurance premiums refunded directly to me in certain circumstances. I understand that failure to comply with this rule may result in disenrollment from HDAP/CHII.
- I commit to notifying HDAP as soon as possible if any information provided in this application changes. This includes, but is not limited to, changes in my employment status, income, residential and/or mailing address, access to insurance coverage/MassHealth status, and/or pharmacy information.
- The information I am submitting on my application and any attachments is correct to the best of my knowledge.

If I have questions regarding this form, I may contact HDAP staff at 617-502-1700.

STATEMENT OF CONSENT

By signing this form, I state that I have read the information provided in this form and the HDAP application. I understand the conditions for participation in HDAP. I authorize the collection, use and sharing of my information as described in this form. I understand I can request a signed copy of this form for my records at any time.

Print Name: _____

Signature: _____

Date: ____/____/____