Massachusetts HIV Drug Assistance Program (HDAP)[i] and Comprehensive Health Insurance Initiative (CHII) Application – Long Form

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.

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.

i A program of the Massachusetts Department of Public Health

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: ____/____/____

SECTION 1 – APPLICANT INFORMATION	
Full first name:	Full last name:
Preferred name:	Pronouns:
HDAP ID (if known):	Date of Birth (MM/DD/YYYY):
Social Security Number: - -	[ ] None
Name of parent/legal guardian (if applicant is under age 18):	[ ] None
Enrollment Status: [ ] New client [ ] Returning client [ ] Unknown Year last active (if known):	

SECTION 2 – DEMOGRAPHIC INFORMATION	
Sex assigned at birth: [ ] Female [ ] Male [ ] Other [ ] Prefer Not to Answer	
Current gender identity (please check **one** that best describes your gender identity): [ ] Female [ ] Male [ ] Transgender Female/Trans Woman/MTF [ ] Transgender Male/Trans Man/ FTM [ ] Non-binary [ ] Genderfluid/gender non-conforming/genderqueer [ ] Prefer to self-describe:	
Country of Birth:	I can communicate in English: [ ] Yes [ ] No
Languages (check all that apply): [ ] English [ ] Spanish [ ] Portuguese [ ] Creole-Haitian [ ] Creole-French [ ] Creole-Cape Verde [ ] French [ ] Other	
Race (check all that apply): [ ] American Indian/Alaskan Native [ ] Asian [ ] Black or African American [ ] Native Hawaiian/Other 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: [ ] Hispanic/Latino/Latina [ ] Non-Hispanic/Latino/Latina [ ] Prefer not to answer *If Hispanic/Latino/Latina, please specify:* [ ] Mexican, Mexican American, Chicano/a [ ] Puerto Rican [ ] Cubano [ ] Other Hispanic/Latino, Latina, or Spanish origin	

SECTION 3 – CONTACT INFORMATION & PREFERENCES

Residential Street Address: ______________________________ Apt/Lot/Floor:

City: ____________________________ State: ____________ ZIP Code:

[ ] I currently lack stable housing (please enter in above line the City/State/ZIP where you most frequently reside).

Communication Preferences:

☐ Communicate with me

☐ Communicate with my Case Manager ONLY

☐ Communicate with me and my Case Manager

OK to send confidential emails?

[ ] Yes [ ] No

If Yes, Email address:

[ ] Send mail to case manager ONLY.

[ ] My mailing address is the same as my residential address listed above.

[ ] My mailing address is not the same as my residential address and is entered here:

Care of: ____________________ Street Address/ Unit #:

PO Box (if applicable): _________________ City/State/ZIP Code:

Cell phone with area code: ( ) ________________ OK to leave confidential cell message? [ ] Yes [ ] No

OK to send text message? [ ] Yes [ ] No *If Yes, please enter name of cell phone carrier:*

Home phone with area code: ( ) ______________ OK to leave confidential home message? [ ] Yes [ ] No

[ ] I authorize HDAP/CHII to speak with another individual about my enrollment and insurance status at any time:

Contact Name: __________________________ Relationship to client:

Phone Number: ( )

SECTION 4 – PROVIDER INFORMATION

[ ] I do not have a case manager (skip to Clinician Name)

Case Manager Name: ______________________________ Title:

Case Manager Institute:

Street Address: ________________________________City: ___________State: _____ ZIP Code: _______

Direct Phone: ___________________ Fax: __________________ Email:

Clinician Name: ___________________________________ Title:

Clinician Institute: _________________________________ Department:

Street Address: ________________________________City: ___________State: _____ ZIP Code:________

Direct Phone: ___________________ Fax: __________________ Email:

SECTION 4 QUESTIONS BELOW MUST BE COMPLETED BY A CLINICIAN

You can have your clinician complete a Clinician Form (available at https://accesshealthma.org/printable-forms/) in lieu of completing below.

Patient's clinical status (must select one):

- ☐ HIV+, not AIDS
- ☐ HIV+, AIDS status unknown
- ☐ CDC-defined AIDS

Date of Diagnosis (if known):

Date of last negative HIV test (if known):

Has patient had a CD4 count less than or equal to 200?

[ ] Yes [ ] No

Patient's risk factors of exposure (check all that apply):

- ☐ Blood, blood products, tissue
- ☐ Hemophilia/coagulation disorder
- ☐ Heterosexual contact
- ☐ Man who has sex with men (MSM)
- ☐ Other risk (known but not listed)
- ☐ Perinatal transmission
- ☐ Person who injects drugs
- ☐ Undetermined/unknown

Patient's lab results (please provide **most recent Viral Load** results, and **nadir or lowest CD4** and date of test). (NOTE: federal funding requires that we collect this information. If this section is left blank, patient can still enroll, but provider will be contacted to complete):

Viral Load: ___________ Date of test:________________ *Viral load is required within past 12 months.*

CD4: ___________ Date of test:________________ *CD4 required for new clients or those inactive > 2 years.*

By signing this form, I attest that the above individual has been diagnosed with HIV and is receiving care and/or services at my organization.

Clinician signature: ______________________________ (MD, DO, PA, NP, RN) Date:

Clinician printed name: ____________________________ Medical license #

SECTION 5 – INCOME ELIGIBILITY INFORMATION

Do you have income? [ ] Yes, estimated annual gross income amount: ___________________ [ ] No

If No, please include a letter from your case manager attesting to no income and identifying your source of support.

If Yes, please select all sources of income that apply:

[ ] Salary [ ] Unemployment benefits [ ] Social Security (SSI, SSDI, SSA) [ ] Worker's compensation

[ ] Private disability [ ] Retirement/pension [ ] Veteran's pension [ ] Interest/dividends

[ ] Rental income [ ] Other income:

I file federal income tax: [ ] Yes [ ] No

If Yes, please select tax filing status: [ ] Single [ ] Married, filing jointly [ ] Married, filing separately

[ ] Head of household [ ] Qualifying widow(er)

If Yes, please enter number of dependents claimed:

SECTION 6 – INSURANCE & PRESCRIPTION COVERAGE

I have insurance with prescription (Rx) drug coverage: [ ] Yes [ ] No

If No, I need temporary full coverage of prescriptions pending activation of insurance coverage: [ ] Yes [ ] No

If you need temporary full coverage, you must include a letter from your case manager or provider requesting this

If you answered Yes that you have insurance with prescription drug coverage, please complete the following to the best of your ability using your insurance card or statement of benefits:

Member ID: ____ Rx Bin #:

Rx PCN #: ______________________ Rx Group Number (GRP):

My prescription coverage has a deductible: [ ] Yes [ ] No Deductible amount:

Types of Insurance Coverage (please select all types that apply and submit copies of insurance cards if available):

MassHealth (check one option only):

- ☐ MassHealth (Standard, CommonHealth, Family Assistance, or Careplus)
- ☐ MassHealth Limited
- ☐ MassHealth Integrated Care (One Care or Senior Care Options/SCO)

Health Safety Net (check one option only):

[ ] Full [ ] Partial [ ] Not sure if full or partial

Health Connector plan (check one option only):

☐ ConnectorCare Name of plan:
☐ Other Health Connector plan* Name of plan:

Medicare* (check **all** options that apply):

- ☐ Part A (hospital insurance)
- ☐ Part B (outpatient medical insurance)
- ☐ Part C (Medicare Advantage) Name of plan:
- ☐ Part D (prescription insurance) Name of plan:
- ☐ Supplemental (e.g. Medex, Medigap) Name of plan:
- ☐ Current or Former Employer plan Name of plan:
- ☐ Other plan Name of plan:

Private insurance* (e.g. Blue Cross Blue Shield, Harvard Pilgrim, Cigna, etc.) (check one option only):

- ☐ Employer insurance Name of plan:
- ☐ Individual (non-group) Name of plan:

Other

- ☐ Veterans Administration (VA) coverage*
- ☐ Indian Health Services (IHS)*

These insurance types require submission of a copy of an eligibility-based MassHealth determination letter dated within the past 12 months for the full HDAP coverage term OR a copy of a current MassHealth application for temporary HDAP coverage.

SECTION 7 – CHII INFORMATION

The Comprehensive Health Insurance Initiative (CHII) program can assist with payment of health insurance premiums.

I would like CHII to pay my monthly health insurance premiums: [ ] Yes [ ] No (you can skip to Section 8)

If Yes, please answer the following questions:

I have access to employer insurance: [ ] Yes [ ] No

I am enrolled in employer insurance: [ ] Yes [ ] No

SECTION 8 – PHARMACY INFORMATION

Pharmacy Name:______________________________

Pharmacy Street Address:

City: ______________________________State: ______________ ZIP Code:

Pharmacy phone: ______________________________ Pharmacy fax:

If your health insurance plan requires you to use a secondary pharmacy, such as a mail order pharmacy or specialty pharmacy for some or all of your medications, please submit that information with your application.

To submit your application you may:

- Mail to:
    - ATTN: HDAP
    - The Schrafft's City Center
    - 529 Main Street, Suite 301
    - Boston, MA 02129
- Fax to: 617.502.1703
- Email using our secure email system: https://web1.zixmail.net/s/welcome.jsp?b=crine