Massachusetts HIV Drug Assistance Program (HDAP)[i] Rapid Eligibility Determination (RED) Application Form

****To qualify for HDAP rapid eligibility, individuals must be HIV-positive and new to HDAP (applying for the first time).****

Applicant Information

Full First Name:	Full Last Name:
Preferred Name:	Pronoun(s):
Date of Birth:	Social Security Number: ☐ None

Contact Information

Client Residential Street Address _____ City/State/Zip _____

☐ Client currently lacks stable housing but most frequently resides in (City/State/ZIP) _____

Communication Preferences:

☐ Communicate with me ☐ Communicate with Case Manager ONLY ☐ Communicate with me and my case manager

Client Mailing Street Address/PO Box _____ City/State/ZIP _____

☐ Send mail to client ☐ Send mail to case manager (do NOT send mail to client)

Client Cell Phone:_____ ☐ OK to leave confidential cell message ☐ OK to send text message

Client Home Phone:_____ ☐ OK to leave confidential home message

Client Email Address:_____ ☐ OK to send confidential email

Case Manager

Case Manager Name: ☐ Client does not have a case manager	Agency/Site/Institute:_____ Address:_____ Phone:_____ Email:_____

Income Eligibility Information

Estimated annual gross income:_____	Income source(s):_____

Insurance and Prescription Coverage

☐ No health insurance or prescription coverage	Client has the following insurance (please enter all types of prescription insurance coverage):

Pharmacy Information

Pharmacy name: _____ Phone: _____

Street Address/City/State/ZIP:_____

Medical/Clinical Status

Patient's most recent lab results: Please provide the most recent viral load test result. For CD4, please provide 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:_____.___Nadir CD4:_____ Date:_____

Date of HIV diagnosis (if known):_____ Date of last negative HIV test (if available):_____

Client Consent and Certification

I certify that I am giving my permission for HDAP/CHII to contact all of the following: my pharmacist, my case manager/client advocate, my employer (for employee contribution or COBRA), and my current or past health care provider(s), insurance companies (third party payers/administrators), and any other person that I have specifically given you permission to contact)). I understand that HDAP/CHII staff may

i A program of the Massachusetts Department of Public Health

also contact any of the people in the above list when I leave the HDAP/CHII program if necessary, for the purpose of obtaining information about my participation in the HDAP/CHII program. I 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 or disenrolled from the HDAP/CHII program and I may be subject to penalties under state and federal laws. I ***understand that this is temporary approval for HDAP coverage and that I am to submit a full HDAP application (long-form) within 30 days from initial approval date.***

Client Signature:_____ Date:_____

Clinician Attestation (This section must be completed by a licensed health care provider)

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.

Provider Signature:_____ Date:_____ Medical License No.___

Provider Name (print):_____ Provider Site:_____

*The RED application is temporary approval for HDAP coverage and a full HDAP application (long-form) should be submitted within 30 days from the initial approval date.

Instructions to Complete the HDAP Rapid Eligibility Determination (RED)

The HDAP RED form can be used when there is a need for rapid enrollment in HDAP for clients who are:

- Individuals that have been newly diagnosed, especially with “acute” HIV infection
- Individuals experiencing homelessness
- Individuals with substance use disorder, especially those using needles to inject drugs
- Individuals at a high risk of loss to care

Eligible clients will be granted temporary HDAP coverage for **one month** pending receipt of a full long form application, including documentation. Case managers can individually reach out to HDAP if there are any significant barriers to submitting the long form application within this timeframe.

This form must be completed by the client’s healthcare provider and/or case manager. Please complete all sections clearly and as completely as possible. It is very important that both the client and health care provider signatures are completed in order for HDAP to process this form. Please contact HDAP at 617-502-1700 with any questions and to alert HDAP staff to any urgent client cases.

To submit your completed and signed RED HDAP application:

- **Fax** to 617-502-1703
- **Email** to the HDAP team through our secure email system
- **Mail** to:
  ATTN: HIV Drug Assistance Program
  The Schrafft’s City Center
  529 Main Street, Suite 301
  Boston, MA 02129