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

Applicant Information

Full First Name:	Full Last Name:
Date of Birth:	Social Security Number: [ ] None

Contact Information

Has your Residential Address changed? [ ] No [ ] Yes	If Yes, complete below and attach proof of MA residency.

Communication Preferences

[ ] Communicate with me [ ] Communicate with Case Manager ONLY [ ] Communicate with me and my case manager

Do you consent to receiving HDAP-related mail? [ ] No [ ] Yes	If Yes, please complete the following: Street Address/PO Box ____________________ City/State/ZIP ____________________

Cell Phone Number:____________________ [ ] OK to leave confidential cell message [ ] OK to send text message

Home Phone Number:____________________ [ ] OK to leave confidential home message

Email Address:____________________ [ ] OK to send confidential email

Case Manager

Has your Case Manager changed? [ ] No [ ] Yes [ ] 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? [ ] No [ ] Yes	If Yes, enter new annual gross income:____________________ Income source(s):____________________

Insurance and Prescription Coverage

Has your Insurance coverage changed? [ ] No [ ] 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):

[ ] No [ ] Yes

Pharmacy Information

Has your Pharmacy changed? [ ] No [ ] 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 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.

Client Signature:____________________ **Date:**____________________

I attest that I have spoken with the client and that the information provided in this form is true and accurate.

Case Manager Signature:____________________ **Date:**____________________

i A program of the Massachusetts Department of Public Health

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 Schrafft’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.