Massachusetts HIV Drug Assistance Program (HDAP)[1]
HDAP Alternate Contact Form

Please complete this form if you would like to authorize HDAP to contact an Alternate Contact, e.g. family member, friend, etc., on your behalf. **Alternate contacts do NOT include case managers**. Please do not enter case manager information here. (You do not need this form if you have already provided Alternate Contact information on an HDAP application.)

First Name: Last Name

HDAP ID (if known) Date of Birth (MM/DD/YYYY):

SSN:

I would like to authorize HDAP/CHIII to speak with another individual about my enrollment and insurance at this time.

Contact Name:

Relationship to Client: Phone Number:

HDAP may send mail to my Alternate Contact:

Addressee (Care Of Line):

Street Address/P.O. Box: Apartment/Unit #:

City: State: Zip:

Client Signature: Date:

Submit this form via:

- HDAP Client Portal (https://mahdap.providecm.net/)
- Fax: 617-502-1703
- Secure email (go to https://crihealth.org/contact/#Secure for instructions) or
- Mail to Attn: HDAP, Community Resource Initiative, 529 Main Street, Suite 301 Boston MA 02129

If you have questions, please reach out to HDAP at 617 502 1700 or by email at: HDAP@crihealth.org.

[1] A program of the Massachusetts Department of Public Health