Massachusetts HIV Drug Assistance Program House of Correction Application

If you have any questions about this application, please contact the House of Correction Manager at jails@crine.org or 617-502-1723

1 Applicant Information:

First Name:	***Last Name:***	***Date of Birth*** *(MM/DD/YYYY)*: ____/____/______

Social Security #: _____-____-______	☐ ***999-99-9999*** (for clients without Social Security Number)	***Date of Incarceration:*** ____/____/______	**HDAP ID** *(if known)*:

2 Gender Identity:

- ☐ Male
- ☐ Female
- ☐ Non-binary (neither exclusively female or male)/gender non-conforming (GNC)
- ☐ Transgender Male/Trans Man/FTM
- ☐ Transgender Female/Trans Woman/MTF
- ☐ Not Reported

3 Race:
(Select all that apply)

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian Or Pacific Islander
- ☐ White

Ethnicity:

- ☐ Non-Hispanic/Latinx
- ☐ Hispanic/Latinx

4 Medical Information:

☐ Client is HIV positive

Clinician Signature:____ (MD, DO, PA, NP, RN)

License #:_________________________Date:____________

If lab results from within the last twelve months are accessible, please list them below. <u>If labs are unavailable, leave this section blank and submit the application to enroll the client for a standard six-month term.</u> Please provide lab results obtained while the client is incarcerated to the House of Correction Manager at CRI.

Results	Date *(MM/DD/YYYY)*
VL:	____/____/______
CD4:	____/____/______

5 I attest that:

- ☐ Client resides at (Name of Jail)__________________________________
- ☐ Client has $0 income
- ☐ Client has no health insurance

6

Name of Coordinator/HSA: ____

Coordinator/HSA Phone Number/Email: ____

Coordinator/HSA Signature: ____ **Date:** ____/_______/_______

Client Consent and Certification (*to be signed by the individual enrolling in HDAP*)

I certify that I am a Massachusetts resident and that the information on this application is correct and complete. I certify that I am giving my permission for HDAP to contact all of the following: pharmacist, case manager/HIV Coordinator, healthcare provider, and any other person that I have specifically given HDAP permission to contact. If needed, HDAP may contact these people to keep my participation in the program or about my participation in the program when I am no longer enrolled.

Applicant Signature: ____________________________________ **Date:** ____/_______/_______