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

1	**HDAP ID** *(if known)*:	***First Name:***	***Last Name:***	***Date of Birth*** *(MM/DD/YYYY)*: ____/____/_____	***Social Security #:*** _____-____-_____
2	**Contact Information:**	***Cell phone:*** _____-____-_____ ☐ ***Ok to call*** ☐ ***Ok to leave message*** ☐ ***Ok to text***		***Home phone:*** _____-_____-_____ ☐ ***Ok to call*** ☐ ***Ok to leave message***	
		Email: ☐ ***Ok to contact by email***		☐ ***ONLY contact my Case Manager*** ☐ ***I DO NOT have a Case Manager***	
3	**Send my HDAP-related mail to:**	☐ ***My Case Manager***		☐ ***My Mailing Address***	

4	**My Mailing Address:** ☐ **No Change** ☐ **Change**	***Street:***	***City:***	***State:***	***ZIP:***
5	**My Residential Address:** ☐ **No Change** ☐ **Change**	***Street:***	***City:***	***State:***	***ZIP:***

6	**Case Manager:** ☐ **No Change** ☐ **Change** **Preferred form of contact:** ☐ **Phone** ☐ **Email**	***Case Manager name:***	***Case Manager phone:***	***Case Manager Address:***
		Case Manager site:	***Case Manager email:***	

7	**Income:** ☐ **No Change** ☐ **Change** **If change, list new annual gross income:** $_____	☐ **Salary** ☐ **Unemployment benefits** ☐ **Worker's compensation** ☐ **Social Security Income (SSI, SSDI, SSA, SSP)** ☐ **Private disability (short- or long-term)**	☐ **Veterans pension** ☐ **Pension/Retirement income** ☐ **Interest/Dividends/Annuities** ☐ **Rental Income** ☐ **Other Income** (List source) _____

8	**Pharmacy:** ☐ **No Change** ☐ **Change**	***Pharmacy name:***	***Street:***	***State:***
		Phone:	***City:***	***ZIP:***

9	**Insurance Status:** ☐ **No Change** ☐ **Change (*Check all that apply*)** **Change occurred as of Date** *(MM/DD/YYYY)*: ____/_____/_____	☐ **No health insurance/ prescription coverage** ☐ **MassHealth (Medicaid)** ☐ **MassHealth Limited** ☐ **Health Safety Net (Full or Partial)** ☐ **Medicare Part A** ☐ **Medicare Part B** ☐ **Medicare Part C (Advantage)** ☐ **Medicare Part D**	☐ **ConnectorCare** ☐ **Private Insurance (Employer/Group)** ☐ Name_____ ☐ Maximum copay amount $_____ ☐ **Private Insurance (Individual/Non-Group)** ☐ Name_____ ☐ Maximum copay amount $_____ ☐ **Veteran's Administration (VA)** ☐ **Indian Health Services (IHS)** ☐ **Other, specify:** _____

10	**CHII:**	If HDAP/CHII pays for your health insurance or you would like HDAP/CHII to pay for your health insurance, please **check here** ☐ and attach a recent premium statement/bill or employer premium/payroll deduction letter.

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Client Signature: _____ **Date:** ____/_____/_____

I attest 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 and I may be prosecuted under applicable state and federal statutes.

Case Manager Signature: _____ **Date:** ____/_____/_____

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