

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

1	HDAP ID <i>(if known):</i>	First Name:	Last Name:	Date of Birth (MM/DD/YYYY): ____/____/____	Social Security #: ____-____-____
2	Contact Information:	Cell phone: ____-____-____	<input type="checkbox"/> <i>Ok to call</i> <input type="checkbox"/> <i>Ok to leave message</i> <input type="checkbox"/> <i>Ok to text</i>	Home phone: ____-____-____	<input type="checkbox"/> <i>Ok to call</i> <input type="checkbox"/> <i>Ok to leave message</i>
		Email: _____		<input type="checkbox"/> <i>Ok to contact by email</i>	
		<input type="checkbox"/> ONLY call or email my Case Manager			
3	*VERY IMPORTANT To ANSWER* Do you want your confidential HDAP-related mail sent to your mailing address? <input type="checkbox"/> Yes. Mark checkbox & move to Question 4 <input type="checkbox"/> No. Mark checkbox & move to Question 5				
4	My Mailing Address: <input type="checkbox"/> No Change <input type="checkbox"/> Change	Street or P.O. Box:	City:	State:	ZIP:
5	Case Manager: <input type="checkbox"/> No Change <input type="checkbox"/> Change Preferred form of contact: <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> I DO NOT have a Case Manager	Case Manager name:		Case Manager site:	
		Case Manager phone:		Case Manager email:	
		Case Manager Address:			
6	My Residential Address: <input type="checkbox"/> No Change <input type="checkbox"/> Change	Street:	City:	State:	ZIP:
7	Income: <input type="checkbox"/> No Change <input type="checkbox"/> Change If change, list new annual gross income: \$ _____	<input type="checkbox"/> Salary <input type="checkbox"/> Unemployment benefits <input type="checkbox"/> Worker's compensation <input type="checkbox"/> Social Security Income (SSI, SSDI, SSA, SSP) <input type="checkbox"/> Private disability (short- or long-term)		<input type="checkbox"/> Veterans pension <input type="checkbox"/> Pension/Retirement income <input type="checkbox"/> Interest/Dividends/Annuities <input type="checkbox"/> Rental Income <input type="checkbox"/> Other Income (List source) _____	
8	Pharmacy: <input type="checkbox"/> No Change <input type="checkbox"/> Change	Pharmacy name:	Street:	State:	
		Phone:	City:	ZIP:	
9	Insurance Status: <input type="checkbox"/> No Change <input type="checkbox"/> Change <i>(Check all that apply)</i> Change occurred as of Date (MM/DD/YYYY): ____/____/____	<input type="checkbox"/> No health insurance/prescription coverage <input type="checkbox"/> MassHealth (Medicaid) <input type="checkbox"/> MassHealth Limited <input type="checkbox"/> Health Safety Net (Full or Partial) <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part C (Advantage) <input type="checkbox"/> Medicare Part D		<input type="checkbox"/> ConnectorCare <input type="checkbox"/> Private Insurance (Employer/Group) Name _____ Maximum copay amount \$ _____ <input type="checkbox"/> Private Insurance (Individual/Non-Group) Name _____ Maximum copay amount \$ _____ <input type="checkbox"/> Veteran's Administration (VA) <input type="checkbox"/> Indian Health Services (IHS) <input type="checkbox"/> 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 <input type="checkbox"/> and attach a recent premium statement/bill or employer premium/payroll deduction letter.			
11	Client Signature: _____ Date: ____/____/____ <i>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.</i> Case Manager Signature: _____ Date: ____/____/____ <i>I attest that I have spoken with the client and that the information provided in this form is true and accurate.</i>				