Massachusetts HIV Drug Assistance Program (HDAP) Jail Application Form

Eligibility:
- HIV positive
- Referred by a physician
- **All** applications must include a Statement from the HIV/AIDS Coordinator, indicating that the applicant has no source of income or health insurance due to incarceration
- HDAP will only accept applications signed by the applicant and have **the physician's original signature**.
- **HDAP will only accept applications that include the inmate's most recent CD4 and viral load lab results** (*Lab results should be no more than six months old).* **If no results are available, please attach a cover letter explaining the reason why they are not available and forward these lab results to us as soon as possible.**)
- **All** applicants **must recertify** with HDAP Program **every six (6) months**
- HDAP must be notified of your release from prison with your current address and pharmacy information.
- If you wish to continue in HDAP past your original six (6) months of coverage, you must fill out a new non-jail HDAP application

PART 1

A. Demographic Information

Last name First name MI		Date of Birth (MM/DD/YYYY)
Social Security # (if issued) *Please enter all 9's if no SS#* Length of Incarceration ☐ Less than 180 days ☐ More than 180 days	Sex ☐ M ☐ F ☐ Transgender	Have you ever been enrolled in HDAP? ☐ Yes HDAP # (if known) __________ ☐ No
Race/Ethnicity ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black, not Hispanic ☐ Hispanic ☐ White, not Hispanic ☐ Other ________________________	If Hispanic checked, please specify: ☐ White ☐ Black ☐ More than one race ☐ American Indian ☐ Unknown	Preferred spoken language: Country of Birth

B. HIV Coordinator Information and Applicant Address

HIV/AIDS Coordinator Name	Institution
Street Address	City State Zip
Phone & Extension ( )	Fax Email ( )

C. Clinician Information

Name of Clinician	Hospital or Clinic
Street Address	City State Zip
Phone & Extension ( )	Fax ( )

Patient's current clinical status?	*Patient's Mode of Transmission (Check all that apply)*	*Patient's Current:*
☐ HIV + and Asymptomatic ☐ HIV + and Symptomatic ☐ CDC-defined AIDS	☐ MSM ☐ Heterosexual Sex ☐ IDU ☐ Pediatric ☐ Blood/products ☐ Other: _________________	♦ CD4 ________________ Date Last Test: ___/___/___ ♦ Viral Load____________ Date Last Test: ___/___/___

CLINICIAN SIGNATURE: ________________________________ ____________________

MA Medical License #

DATE: _______________

D. Pharmacy or Third Party Billing Source

Payment and approval letter will be sent to this address

Pharmacy Name/Third Party Billing Source	Street Address
City	State Zip
Phone & Extension ( )	Fax ( )

Please mail completed application to:

HDAP/Community Research Initiative
The Schrafft's City Center
529 Main Street, Suite 301
Boston, MA 02129

Phone: 617-502-1700 **TTY 617-502-1704**

From the time of receipt, please allow at least two weeks for a complete application to be processed. You will be notified by mail of our decision.

Thank you.

Client Agreement Statement/Contract for Coverage

HDAP/CHII Program

The following rules need to be followed for you to receive drug and medical coverage through HDAP and CHII. HDAP/CHII shall keep all your information strictly confidential. No individual information shall be reported to the Massachusetts Department of Public Health (DPH). **However, if any of these rules are broken or we are given false information, HDAP may give information to legal agencies to make sure money is used correctly.**

By signing this agreement/contract:

1. **You give your permission for HDAP/CHII to contact:**
   a) The pharmacist
   b) Case manager
   c) Employer *(if applicable)*
   d) Healthcare provider
   e) Any other person that you have specifically given us permission to contact

   These are the people that you approved HDAP to contact in the application. If needed, HDAP may contact these people to keep your participation in the program. HDAP/CHII staff may also contact any insurance companies (third party payors/administrators) to make sure you are covered and to answer any billing questions.

2. You agree to notify HDAP/CHII as soon as possible if any of this information changes. You need to report any other information that might change your eligibility for these programs. This includes, but is not limited to:
   a) Release from jail ****Please notify HDAP of new address upon release****
   b) Employment status
   c) Income
   d) Residence
   e) Access to insurance coverage
   f) Insurance premiums

3. HDAP may also contact any of the people in the list above when you leave the program. This is done to get information about your participation in the program.

4. Your application may be rejected if you have knowingly provided false information.

5. HDAP/CHII may make you pay back any payments made if you were not eligible at the time. You may also be required to pay back HDAP/ if you were misusing services.

6. HDAP/CHII is not required to make retroactive payments for coverage before you were a part of the program.

7. You certify that the information on this application is correct and complete to the best of your knowledge.

8. It is your responsibility to recertify with HDAP/CHII every six (6) months. **If not, your HDAP/CHII services may be stopped.**

Grievance Procedure

At any stage in this procedure, a client may be accompanied or represented by anyone s/he feels is an appropriate advocate:

a) Case Manager
b) Attorney
c) Paralegal
d) Translator
e) Friend
f) Relative

The client must provide written authorization (permission) for HDAP staff to share information with this person, if s/he is not a contact listed in the HDAP/CHII application. Written permission is also needed to share information if you are not to be part of the conversation or interaction.

If you have a concern or grievance (complaint) with the program, you can tell **the staff member** you have dealt with. You need to report this complaint within 10 business days of its happening.

You can make your complaint either in person, by writing a letter, or by telephone.

Address: 529 Main Street, Suite 301
Boston, MA 02129

Telephone: 617-502-1700
Fax: 617-502-1703

A staff member will get back to you within 10 business days (not counting weekends and holidays).

You may not be happy with the answer you get. You may then ask for a meeting with that **staff member's supervisor**. You can do this in a letter or by phone. This has to be done within 10 business days after you get a response. The supervisor will get back to you within 10 business days.

If you are still not happy with the answers you have received, you may take the complaint to **the HDAP Director**. This must be in writing. It can be mailed, e-mailed, faxed or hand delivered. It has to be done within 10 business days after you get an answer from the supervisor. You can request a face-to-face meeting, write a letter, or telephone your complaint. The HDAP Director will issue a written decision within 10 business days of the receipt of the concern/grievance.

Address: HDAP Director
HDAP/CRI
529 Main Street, Suite 301
Boston, MA 02129

Telephone: 617-502-1700

By signing below you agree to all of the above terms and conditions.

________________________________ ____________________

Signature (Applicant or Parent/Guardian) Date