Update to the HIV Drug Assistance Program (HDAP) Enrollment Process

Self-Attestation (Short) Form

April 16th, 2019

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Massachusetts Department of Public Health

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Community Research Initiative

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BRIDGE Team
Community Research Initiative
Webinar Objectives

• How the new self-attestation (short) form can streamline HDAP enrollment
• Self-attestation eligibility
• Requirements for supporting documentation
• Tips for submitting completing short and long forms in a timely manner
Background

• Commitment to improving the quality of services provided by our HIV Drug Assistance Program
• Reducing ongoing delays with processing HDAP/CHII applications
• Implementing best practices that improve client/case manager experience
• Planning for long-term system enhancements
### Self Attestation (Short) Form

<table>
<thead>
<tr>
<th>HDAP ID (if known):</th>
<th>First Name:</th>
<th>Last Name:</th>
<th>Date of Birth (MM/DD/YYYY):</th>
<th>Social Security #:</th>
</tr>
</thead>
</table>

**Contact Information:**
- Cell phone:
- Home phone:

**Email:**
- ONLY contact my Case Manager
- DO NOT have a Case Manager

**Send my HDAP-related mail to:**
- My Case Manager
- My Mailing Address

**My Mailing Address:**
- No Change
- Change

**My Residential Address:**
- No Change
- Change

**Case Manager:**
- No Change
- Change

**Preferred form of contact:**
- Phone
- Email

**Income:**
- No Change
- Change

If change, list new annual gross income: $ ___

**Pharmacy:**
- No Change
- Change

**Insurance Status:**
- No health insurance
- MassHealth (Medicaid)
- MassHealth Limited
- Health Safety Net (Full or Partial)
- Medicare Part A
- Medicare Part B
- Medicare Part C (Advantage)
- Medicare Part D

**CHII:**
- ConnectorCare
- Private Insurance (Employer/Group)
- Private Insurance (Individual/Non-Group)
- Veteran’s Administration (VA)
- Other, specify:

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.

**Client Signature:**
- 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.

**Date:** ___/___/___

**Case Manager Signature:**
- I attest that I have spoken with the client and that the information provided in this form is true and accurate.

**Date:** ___/___/___

Updated April 2019

Please recycle prior versions.
Current HDAP Application Process

**Initial Application**
- Name
- Date of birth
- SS#
- Phone number
- Residential address
- Mailing address
- Demographic info
- Consent to contact
- Proof of Income
- Proof of residency
- Case manager info
- Clinician info
- Clinical status
- Mode of exposure
- Lab results
- Clinician signature
- Pharmacy
- Insurance Status
- Max co-pay
- CHII info (if rel.)
- Client or CM signature and date

6 months later

**Annual Recertification**
- Name
- Date of birth
- SS#
- Phone number
- Residential address
- Mailing address
- Demographic info
- Consent to contact
- Proof of Income
- Proof of residency
- Case manager info
- Clinician info
- Clinical status
- Mode of exposure
- Lab results
- Clinician signature
- Pharmacy
- Insurance Status
- Max co-pay
- CHII info (if rel.)
- Client or CM signature and date

6 months later
What is Self-Attestation?

• A one-page short form where a client can “attest” or formally certify/confirm that there have been no changes
• A case manager can attest on behalf of the client if no changes have been made
• A client can submit the short form once in a twelve month cycle starting in May 2019 (clients with May 31st HDAP termination dates)
Why the Short Form?

- Accelerate HDAP application processing time
- Reduce the burden of paperwork and application submission requirements
- Reduce barriers to timely recertification and improve continuity of HDAP/CHII coverage
New HDAP Application Process

- Name
- Date of birth
- SS#
- Phone number
- Residential address
- Mailing address
- Demographic info
- Consent to contact
- Proof of Income
- Proof of residency
- Case manager info
- Clinician info
- Clinical status
- Mode of exposure
- Lab results
- Clinician signature
- Pharmacy
- Insurance Status
- Max co-pay
- CHII info (if rel.)
- Client or CM signature and date

6-month Recert

- Name
- Date of birth
- SS#
- Contact information
- Mark where to send mail
- Client or CM signature and date

Annual Recert

- Name
- Date of birth
- SS#
- Phone number
- Residential address
- Mailing address
- Demographic info
- Consent to contact
- Proof of Income
- Proof of residency
- Case manager info
- Clinician info
- Clinical status
- Mode of exposure
- Lab results
- Clinician signature
- Pharmacy
- Insurance Status
- Max co-pay
- CHII info (if rel.)
- Client or CM signature and date

Initial

Community Research Initiative
RESEARCH. PREVENTION. ACCESS. IMPACT.
Self-Attestation Eligibility

• Clients must be active in HDAP for 6 months with no gaps in coverage
• Short forms must be received before the end of the client's HDAP termination date
• Applications received after the client's previous termination date will not be accepted, AND they will have to submit the full application to recertify
Short Form Overview
# Client Information

## Form

<table>
<thead>
<tr>
<th>HDAP ID (if known):</th>
<th>First Name:</th>
<th>Last Name:</th>
<th>Date of Birth (MM/DD/YYYY):</th>
<th>Social Security #:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><em><strong>/</strong></em>/_______</td>
<td><em><strong>-</strong></em>-_______</td>
</tr>
</tbody>
</table>

**Contact Information:**

<table>
<thead>
<tr>
<th>Cell phone:</th>
<th>Home phone:</th>
<th>Social Security #:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><strong>-</strong></em>-_______</td>
<td><em><strong>-</strong></em>-_______</td>
<td><em><strong>-</strong></em>-_______</td>
</tr>
</tbody>
</table>

- OK to call
- OK to leave message
- OK to text

**Email:**

- OK to contact by email

**Send my HDAP-related mail to:**

- My Case Manager
- My Mailing Address

### Required Information
- if this is not provided in its entirety the application will be rejected
  - Social Security number
    - 123-45-6789 – Accepted
    - XXX-XX-6789- Rejected
  - Mark either ‘My Case Manager’ or ‘My Mailing Address’ checkbox
    - If left blank or if both are chosen the application will be rejected
## Client Information (cont.)

### Reference

<table>
<thead>
<tr>
<th>Category of Requested Information</th>
<th>Required if there is No Change</th>
<th>Required if there IS a Change</th>
<th>Required supporting documentation if there IS a Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant Information</td>
<td>• Full name</td>
<td>New full name</td>
<td>Proof of name change documentation</td>
</tr>
<tr>
<td></td>
<td>• Date of birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Social Security Number (If you don’t have a social security number, use 999-99-9999)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Information</td>
<td>• Cell phone AND/OR</td>
<td>• Cell phone AND/OR</td>
<td>• Indicate whether you would like us to leave a message on your home, cell voicemail and/or email.</td>
</tr>
<tr>
<td></td>
<td>• Home phone AND/OR</td>
<td>• Home phone AND/OR</td>
<td>• Indicate if you would like us to send all communication to your Case Manager</td>
</tr>
<tr>
<td></td>
<td>• Email address</td>
<td>• Email address</td>
<td></td>
</tr>
<tr>
<td>Send my HDAP-related mail to</td>
<td>Mark either “My Case Manager” OR “My Mailing Address” checkbox - NOT both</td>
<td>Mark either “My Case Manager” OR “My Mailing Address” checkbox - NOT both</td>
<td>None</td>
</tr>
</tbody>
</table>
# Mailing Address

## Form

<table>
<thead>
<tr>
<th>My Mailing Address:</th>
<th>Street:</th>
<th>City:</th>
<th>State:</th>
<th>ZIP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No Change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- If there is no change, mark the “no change” checkbox and **STOP**
- If there is a change, mark the “change” checkbox and write the new mailing address

## Reference

<table>
<thead>
<tr>
<th>Category of Requested Information</th>
<th>Required if there is No Change</th>
<th>Required if there IS a Change</th>
<th>Required supporting documentation if there IS a Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Mailing Address</td>
<td>Nothing</td>
<td>New mailing address</td>
<td>None</td>
</tr>
</tbody>
</table>
Residential Address

Form

<table>
<thead>
<tr>
<th>My Residential Address:</th>
<th>Street:</th>
<th>City:</th>
<th>State:</th>
<th>ZIP:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No Change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- If there is no change, mark the “no change” checkbox and STOP
- If there is a change, mark the “change” checkbox, write the new residential address, AND provide a proof of residency

Reference

<table>
<thead>
<tr>
<th>Category of Requested Information</th>
<th>Required if there is No Change</th>
<th>Required if there IS a Change</th>
<th>Required supporting documentation if there IS a Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Residential Address</td>
<td>Nothing</td>
<td>New residential address</td>
<td>Proof of residence documentation</td>
</tr>
</tbody>
</table>
Case Manager

Form

<table>
<thead>
<tr>
<th>Case Manager:</th>
<th>Case Manager name:</th>
<th>Case Manager phone:</th>
<th>Case Manager Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No Change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Change</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Preferred form of contact:**

- ☐ Phone
- ☐ Email

**Case Manager site:**

**Case Manager email:**

- If there is no change, mark the “no change” checkbox and **STOP**
- If there is a change, mark the “change” checkbox, write the new case manager contact information
- Mark preferred form of contact. **If left blank, we will default to “Phone”**
- If you want to periodically receive important information from HDAP/CHII/BRIDGE like this webinar, **provide email address**

Reference

<table>
<thead>
<tr>
<th>Category of Requested Information</th>
<th>Required if there is No Change</th>
<th>Required if there IS a Change</th>
<th>Required supporting documentation if there IS a Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Manager</td>
<td>Nothing</td>
<td>New Case Manager’s contact information</td>
<td>None</td>
</tr>
</tbody>
</table>
Income

Form

- If there is no change, mark the “no change” checkbox and stop.
- If there is a change in income, calculate and list new annual gross income amount, and check all sources of income.

Reference

<table>
<thead>
<tr>
<th>Category of Requested Information</th>
<th>Required if there is No Change</th>
<th>Required if there is a Change</th>
<th>Required supporting documentation if there is a Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>Nothing</td>
<td>New annual gross income amount</td>
<td>None</td>
</tr>
</tbody>
</table>

*For tips on how to calculate annual gross income, please refer to slides in the “Tips & Tricks” section of the presentation.*
Pharmacy

Form

<table>
<thead>
<tr>
<th>Pharmacy:</th>
<th>Pharmacy name:</th>
<th>Street:</th>
<th>State:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No Change □ Change</td>
<td>Phone:</td>
<td>City:</td>
<td>ZIP:</td>
</tr>
</tbody>
</table>

- If there is no change, mark the “no change” checkbox and **STOP**
- If there is a change, mark the “change” checkbox and write the new pharmacy information

Reference

<table>
<thead>
<tr>
<th>Category of Requested Information</th>
<th>Required if there is <strong>No Change</strong></th>
<th>Required if there <strong>IS a Change</strong></th>
<th>Required supporting documentation if there <strong>IS a Change</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>Nothing</td>
<td>New pharmacy information</td>
<td>None</td>
</tr>
</tbody>
</table>
**Insurance Status**

**Form**

<table>
<thead>
<tr>
<th>Insurance Status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No Change</td>
</tr>
<tr>
<td>□ Change (Check all that apply)</td>
</tr>
<tr>
<td>Change occurred as of Date (MM/DD/YYYY):</td>
</tr>
</tbody>
</table>

| □ 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 |

| □ 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: ______________ |

**Reference**

<table>
<thead>
<tr>
<th>Category of Requested Information</th>
<th>Required if there is No Change</th>
<th>Required if there IS a Change</th>
<th>Required supporting documentation if there IS a Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Status</td>
<td>Nothing</td>
<td>▪ New insurance name(s)</td>
<td>Front and back copies of new insurance card(s)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Maximum copay amount(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ New insurance type(s) (check all that applies)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Change occurred as of date(s)</td>
<td></td>
</tr>
</tbody>
</table>

*If there’s a change and client has Private Insurance – insurance name and maximum copay amount **ARE REQUIRED***
HDAP is always the Payer-of-Last Resort

If eligible, HDAP enrollees must access and enroll in:

- MassHealth
- ConnectorCare Plans
- Medicare Part D
- Employer-sponsored group insurance
- MIC (Massachusetts Insurance Connection)
- VA (Veterans Administration) Insurance
Payor-of-Last Resort Requirement

MassHealth application or determination requirement

• You are required to apply to MassHealth at least once a year in order to be considered for HDAP eligibility, except for those:
  ❑ Currently enrolled in MassHealth
  ❑ Previously denied MassHealth due to income and assets (65+)
  ❑ Enrolled in MIC (MA insurance Connection) or ConnectorCare

• If it has been more than a year since your last MassHealth application, please submit documentation of a current MassHealth application with this form for temporary coverage

• If you have been determined to be ineligible for MassHealth within the past 12 months, please submit a copy of your MassHealth determination letter (include all pages).
Requesting CHII Coverage

Form

| 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. |

• For premium assistance, check insurance type under “Insurance Status”
• Mark “check here” checkbox if new or current CHII client
• Submit a copy of a recent insurance premium statement (dated within 3 months) or employer deduction letter (dated within 1 year).

Reference

<table>
<thead>
<tr>
<th>Category of Requested Information</th>
<th>Required if there is No Change</th>
<th>Required if there IS a Change</th>
<th>Required supporting documentation if there IS a Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHII</td>
<td>• Mark “check here” checkbox ONLY IF new or current CHII client&lt;br&gt;• Current insurance premium statement</td>
<td>• Mark “check here” checkbox ONLY IF new or current CHII client&lt;br&gt;• Current insurance premium statement</td>
<td>Current insurance premium statement ONLY IF new or current CHII client</td>
</tr>
</tbody>
</table>
Signature and Date

Form

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.

- If client and Case Manager complete form together (in-person)
  - Client signs and dates
- If Case Manager completes form on behalf of client (by phone)
  - Case Manager (only) signs and dates
- If client completes form by themselves
  - Client signs and dates
How to Submit Short Form

• Fax @ 617-502-1703
  *Send with fax cover page
• Mail
• In-person delivery
Tips & Tricks
Messaging from Case Managers to Clients

• Importance of reading notices from HDAP
• Agreeing on where HDAP should send clients’ HDAP-related mail?
• What should clients do when they receive HDAP-related mail?
HDAP’s Notice of Recertification

• Based on our records, your HDAP/CHII coverage termination date is MM/DD/YYYY

• You are now eligible to complete and submit a simplified ‘Self-Attestation’ form for your semi-annual renewal of your HDAP enrollment

• You must complete the enclosed self-attestation form and return it to HDAP/CHII with all supporting documentation as specified in the instructions

• Please retain a copy of your submitted form for your records

We have also determined that you WILL NOT be required to complete a MassHealth application at this time. This determination is dependent on our receiving your HDAP/CHII self-attestation form before your HDAP termination date

OR

• According to our records, you are also due to complete a MassHealth application. Please provide a copy of a recent MassHealth determination letter or proof of a recent MassHealth application along with your completed self-attestation form
HDAP’s Notice of Recertification

- Completed self-attestation forms are processed in the order they are received.
- For us to be able to process your submitted form in a timely manner, it is required that you submit it **at least 15 days in advance of your termination date**. We recommend that you do not submit your completed form more than 6 weeks in advance of your termination date to maintain your full six months’ worth of current coverage.
- If you do not submit your completed self-attestation form and required supporting documents, HDAP/CHII will not be able to continue paying for your prescriptions, prescription co-payments, and/or health insurance premiums.
- **During your period of enrollment in HDAP/CHII**, it is your responsibility to notify us immediately if there is any change in your mailing and/or residential address, pharmacy, health insurance premium cost, or insurance status.
How to calculate income

SOCIAL SECURITY ADMINISTRATION

Date: August 8, 2017
Claim Number: XXX-XX

John Doe
123 Oak St., Apt 11
Boston, MA 02110

You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, you may send them this letter.

Information About Supplemental Security Income Payments

Beginning June 2017, the current Supplemental Security Income payment is..................($661.50)

This is after we have withheld 73.50 to recover an overpayment.

This payment amount may change from month to month if income or living situation changes.

Supplemental Security Income Payments are paid the month they are due. (For example, Supplemental Security Income Payments for March are paid in March.)

SUSPECT SOCIAL SECURITY FRAUD?

Please visit http://oig.ssa.gov/r or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

IF YOU HAVE QUESTIONS
### Earnings Statement

**Friday, January 12, 2018 14:23**

<table>
<thead>
<tr>
<th>Employee Information</th>
<th>14839</th>
<th>Home Department: 79290</th>
<th>HIV CASE MANAGEMENT</th>
<th>Base Rate: 19.5119</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay Period:</td>
<td></td>
<td></td>
<td>12/10/2017</td>
<td>12/16/2017</td>
</tr>
<tr>
<td>Advice Date:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice Number:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice Reason:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel Type:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Earnings

<table>
<thead>
<tr>
<th>Current</th>
<th>Hours/Units</th>
<th>Rate</th>
<th>Amount</th>
<th>Dept/CC</th>
<th>Job</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absent</td>
<td>10.50</td>
<td>0.000</td>
<td>0.00</td>
<td>79290</td>
<td>NEX506</td>
</tr>
<tr>
<td>Absent without</td>
<td>2.10</td>
<td>0.000</td>
<td>0.00</td>
<td>79290</td>
<td>NEX506</td>
</tr>
<tr>
<td>Permission</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Earnings Time Days</td>
<td>3.50</td>
<td>19.5119</td>
<td>68.29</td>
<td>79290</td>
<td>NEX506</td>
</tr>
<tr>
<td>Regular-Days</td>
<td>18.90</td>
<td>19.5119</td>
<td>368.77</td>
<td>79290</td>
<td>NEX506</td>
</tr>
</tbody>
</table>

#### Direct Deposit

<table>
<thead>
<tr>
<th>This Period</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checking (***)5504</td>
<td>312.79</td>
</tr>
</tbody>
</table>

#### Retirement Funds

<table>
<thead>
<tr>
<th>Transamerica</th>
<th>Current</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Cost</td>
<td>19.67</td>
<td>1,532.2</td>
</tr>
</tbody>
</table>

#### Summary

<table>
<thead>
<tr>
<th>Summary</th>
<th>Hours/Units</th>
<th>Amount</th>
<th>Hours/Units</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absent</td>
<td>10.50</td>
<td>0.00</td>
<td>17.05</td>
<td>0.00</td>
</tr>
<tr>
<td>Absent without</td>
<td>2.10</td>
<td>0.00</td>
<td>34.80</td>
<td>0.00</td>
</tr>
<tr>
<td>Permission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education / Seminar - Days</td>
<td>0.00</td>
<td>0.00</td>
<td>25.60</td>
<td>409.50</td>
</tr>
<tr>
<td>Earned Time Days</td>
<td>3.50</td>
<td>68.29</td>
<td>112.55</td>
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<td>2.10</td>
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</tbody>
</table>

#### Gross Wages

- 1/1/2018: $437.06
- 1/2/2018: 1,796.35
- **Year to Date:** $34,046.91

#### Taxable Wages

- This Period: **Year to Date:**
How to Calculate Income (Cont.)- YTD

• The week of the year is the week of the pay period end date. For this example, the pay period end date is 12/16/17. December 16th occurs during the 50th week of the year. Divide the gross YTD amount by the week of the year

$34,046.91/50= $680.9382

• Round to the nearest hundredth ($681). This will give you the client’s average weekly pay. Multiply the quotient by 52

$681 \times 52= $35,412
How to Calculate Income (Cont.) - Weekly paystubs

SOUTH HADLEY HOUSING AUTHORITY

Check Total: $429.00
Check Date: 9/7/2017
Vendor: 358
$249.00
$180.00

09/01/2017 08/27/2017
20.75 HRS X 12 TRASH/LANDSCAPING
09/01/2017 09/03/2017
15 HRS X 12 TRASH/LANDSCAPING

SOUTH HADLEY HOUSING AUTHORITY

Check Total: $216.00
Check Date: 9/13/2017
Vendor: 358
$216.00

09/13/2017 09/10/2017
18 HRS X 12 TRASH/LANDSCAPING
How to Calculate Income (Cont.)-
Weekly paystubs

• Add the weekly incomes and divide the total by the number of weekly incomes you have added

$$\frac{249 + 180 + 216}{3} = 215$$

• This will give you the client’s average weekly income. Multiply the quotient by 52* to find their annual salary

$$215 \times 52 = 11,180$$

*If the client is paid biweekly, multiply the average by 26
### 2019 MassHealth Income Standards and Federal Poverty Guidelines

<table>
<thead>
<tr>
<th>Population/Program</th>
<th>Seniors (MassHealth Standard)</th>
<th>Adults under 65 (MassHealth Standard or MassHealth CarePlus)</th>
<th>Children &amp; Young Adults under Age 21 (MassHealth Standard) Full Health Safety Net</th>
<th>Pregnant women &amp; infants (MH Standard); HIV+ individuals (MassHealth Family Assistance)</th>
<th>MassHealth Family Assistance (Children under 19); Small Business Premium Assistance, Partial Health Safety Net with a deductible</th>
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<tr>
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<tr>
<td>Percent of federal poverty</td>
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<td>MAGI</td>
<td>MAGI</td>
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<td>$1,438</td>
<td>$331.87</td>
<td>$1,615</td>
</tr>
<tr>
<td>133%+ 5%</td>
<td>$1,430</td>
<td>$330.03</td>
<td>$1,946</td>
<td>$449.11</td>
<td>$2,185</td>
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<tr>
<td>150%+5%</td>
<td>$1,798</td>
<td>$414.95</td>
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<td>$2,756</td>
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<tr>
<td>200%+5%</td>
<td>$2,166</td>
<td>$499.88</td>
<td>$2,962</td>
<td>$683.59</td>
<td>$3,327</td>
</tr>
<tr>
<td>300%+5%</td>
<td>$2,535</td>
<td>$585.05</td>
<td>$3,470</td>
<td>$800.83</td>
<td>$3,898</td>
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<tr>
<td>Each addtl.</td>
<td>$2,903</td>
<td>$669.97</td>
<td>$3,979</td>
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<td>8</td>
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<td>$840.06</td>
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<td>$89.78</td>
<td>$509</td>
<td>$117.47</td>
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</table>
Clinical Information Requirements

• **CD4 and Viral load count ARE NOT required** to be submitted with short form

• Currently, CD4 result is **optional** when submitting the annual certification (long form)
  - Even then, HDAP will only **require submission of CD4 results** when:
    - client’s initial application OR
    - client’s HDAP enrollment has lapsed for two years or more
Automatic Rejections of Long Forms

Applications that are received will be automatically rejected if they are:

• Missing any pages
• Missing sections of personal information
• Missing provider/clinical information
• Missing the client or case manager signature
• The application is illegible
• The client is not eligible for self-attestation

Note: When applications are rejected, we highly recommend that you cross-reference the list of potential rejection reasons with your previously submitted application.
Important Takeaways
Expectations Moving Forward

- Timely recertification (short form) submission
- Timely complete annual recertification (long form) submission
  - Heightened attention on annual recertification
- Leading up to and during Open Enrollment, you will need to be on top of properly enrolling CHII clients into the right insurance
Building Better Systems

Creating and using tracking processes is vital!

- Excel spreadsheets or other online systems can be used to keep track of important dates for clients
  - HDAP termination date
  - MassHealth application submission date
  - MassHealth determination date
- Keep records of applications
  - Fillable PDF can be saved in your shared files
This webinar has been recorded and will be available as a webcast along with the slide deck on CRI’s website: www.crine.org
How to Contact Us

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617.502.1758

Massachusetts HIV Drug Assistance Program (HDAP)
c/o CRI of New England
The Schrafft's City Center
529 Main Street, Suite 301
Boston, MA 02129

www.crine.org
800.228.2714 (toll-free number)
617.502.1703 (HDAP fax)