The New HIV Drug Assistance Program Self-Attestation Form

The SHORT Form!

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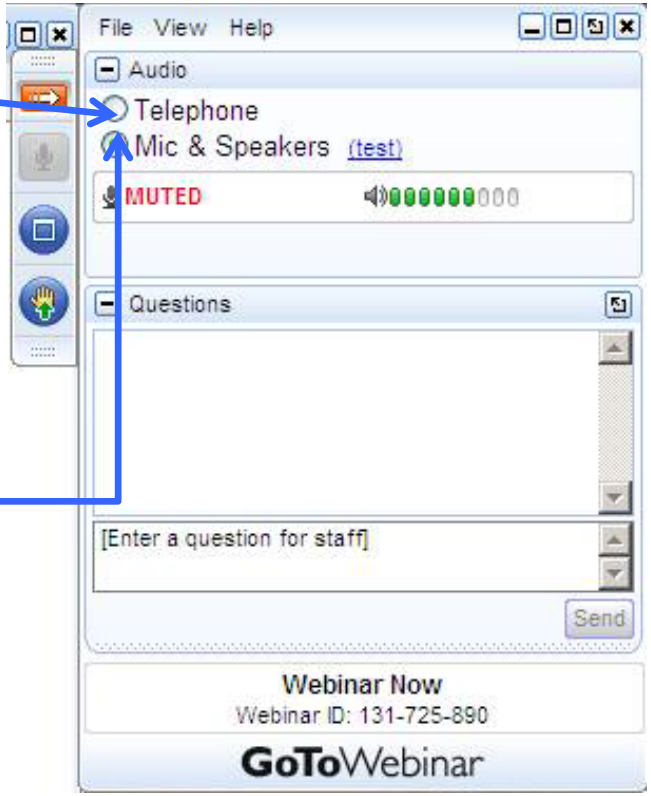
Webinar Tips

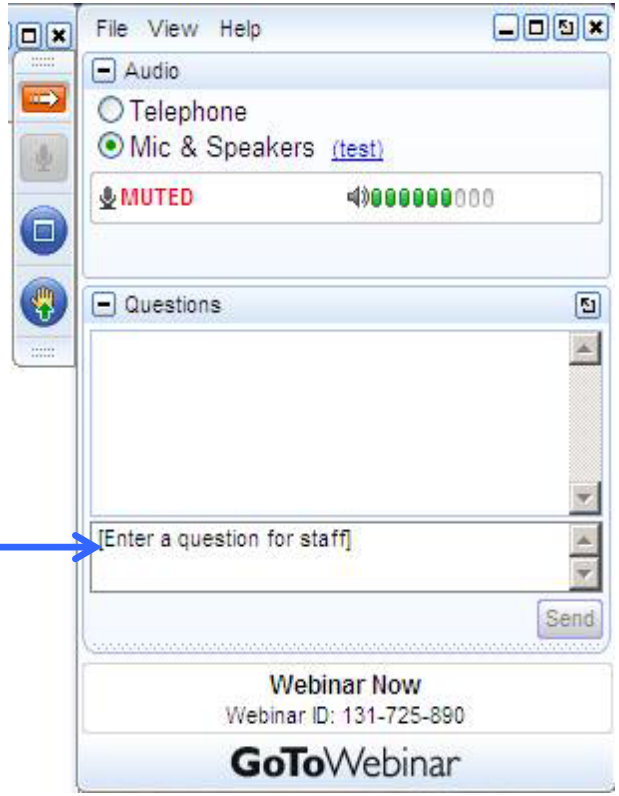
- **Audio Options**
  - Participate using a telephone: select the “Telephone” option
    - Call in using the phone number & access code provided in the registration email
  - Participate on a computer: select the “Mic & Speakers” option



For Tech Support, call 1-800-263-6317

Webinar Tips

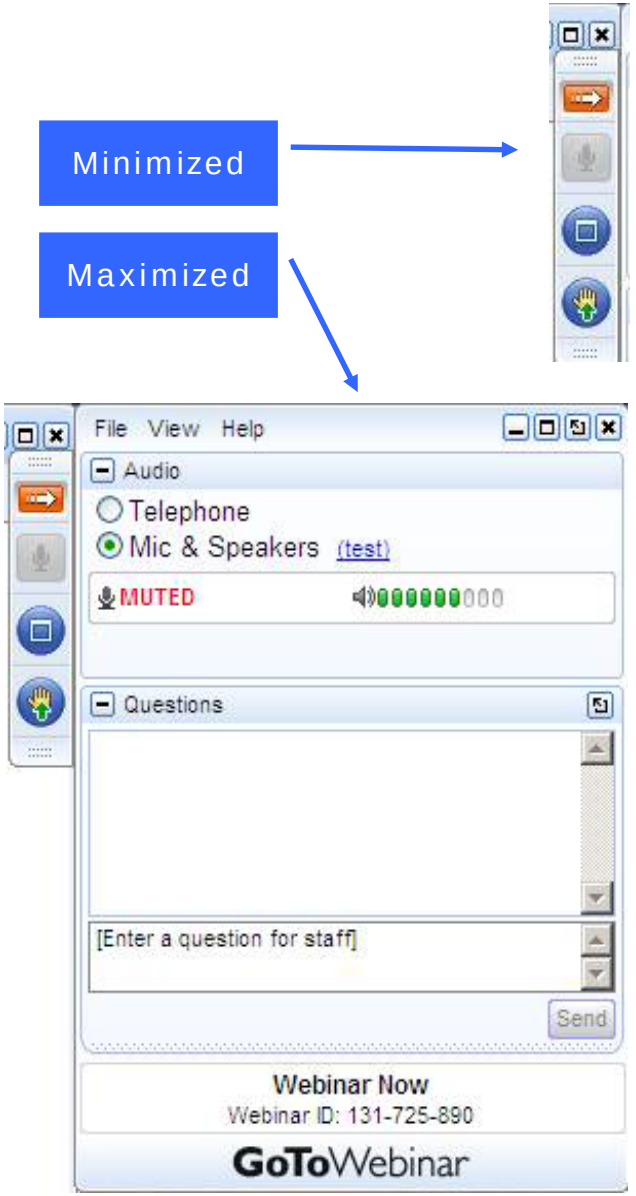
- **Muting**
  - All participants will be muted for the entirety of this webinar
- **Questions**
  - Type a question at any time



For Tech Support, call 1-800-263-6317

Webinar Tips

- **Viewing**
  - Minimize the webinar control panel after you are set up except when you need to type a question
  - Have the short form and instructions in front of you
- **Help**
  - Call GoTo Webinar Support at **1-800-263-6317**
    - Press 1 for GoTo Webinar
    - Press 1 for Tech Support
    - Press 1 for In Session



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Webinar Tips

Have the following documents available for review:

- Self-Attestation (Short) Form
- Short Form Instructions and Requirements Quick Reference Guide

**Documents were emailed to all webinar registrants this morning!*

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Webinar Tips

Process for Answering Questions

- We are monitoring questions throughout the webinar
  - We may pause to answer clarifying questions throughout the webinar
- We will have a Q&A at the end of the webinar
  - Any questions that we cannot get to or answer will be responded to later in an FAQ after the webinar

What we'll cover….

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

Why the Short Form?

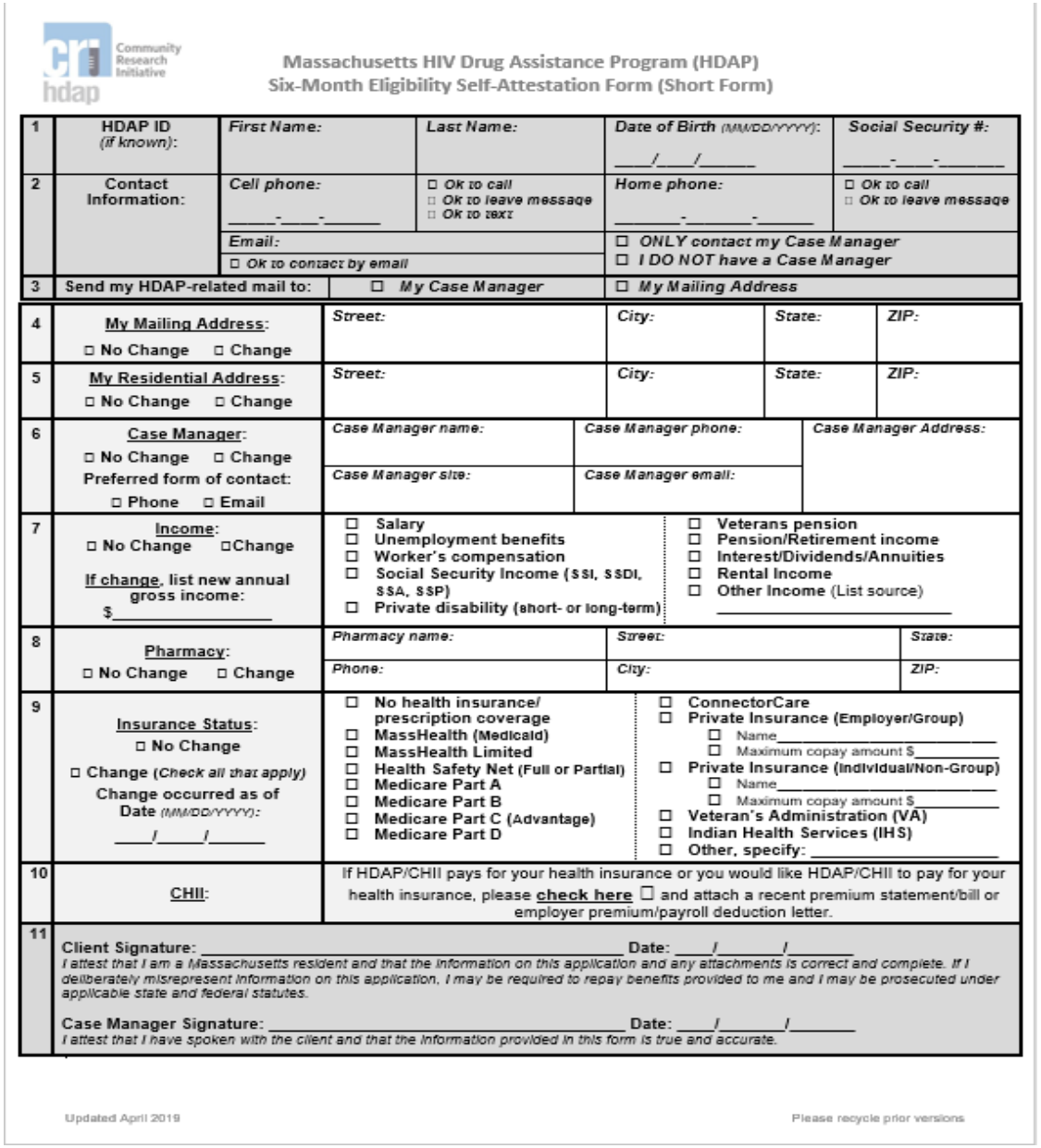
- Accelerates HDAP application processing time
- Reduces the burden of paperwork and application submission requirements
- Reduces barriers to timely recertification and improves continuity of HDAP/CHII coverage
- Allows clients to “attest” or formally certify/confirm that there have been no changes

Who Can Use the Form?

- 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
- Short forms received **after** the client's termination date will not be accepted, AND they will have to submit the full application to recertify
- A client can submit the short form once in a twelve-month cycle starting in May 2019 (*clients with May 31st HDAP termination dates*)

Short Form Overview

Self-Attestation (Short) Form



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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.			
11	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.*				

Updated April 2019

Please recycle prior versions

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Client Information

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:		☐ *ONLY contact my Case Manager*	
		☐ *Ok to contact by email*		☐ *I DO NOT have a Case Manager*	
3	Send my HDAP-related mail to:	☐ *My Case Manager*		☐ *My Mailing Address*	

All of the information in this section is REQUIRED: Failure to complete this section in its entirety will result in application REJECTION

- 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

	Self-Attestation Requirements Quick Reference Guide			
No.	**Category of Requested Information**	**Required if there is No Change**	**Required if there IS a Change**	**Required supporting documentation if there IS a Change**
1	Applicant Information	▪ Full name ▪ Date of birth ▪ Social Security Number (*If you don't have a social security number, use 999-99-9999*)	New full name	Proof of name change documentation
2	Contact Information	▪ Cell phone **AND/OR** ▪ Home phone **AND/OR** ▪ Email address	▪ Cell phone **AND/OR** ▪ Home phone **AND/OR** ▪ Email address	▪ Indicate whether you would like us to leave a message on your home, cell voicemail and/or email. ▪ Indicate if you would like us to send all communication to your Case Manager
3	Send my HDAP- related mail to	Mark either "My Case Manager" **OR** "My Mailing Address" checkbox - **NOT** both	Mark either "My Case Manager" **OR** "My Mailing Address" checkbox - **NOT** both	None

Mailing Address

Form

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

- 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
- If you have marked "My Case Manager" checkbox in section 3, then you should leave this section blank.

Reference

No.	Category of Requested Information	Required if there is No Change	Required if there IS a Change	Required supporting documentation if there IS a Change
4	My Mailing Address	Nothing	New mailing address	None

Residential Address

Form

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

- 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 new proof of residency documentation

Reference

No.	Category of Requested Information	Required if there is No Change	Required if there IS a Change	Required supporting documentation if there IS a Change
5	**My Residential Address**	Nothing	New residential address	New proof of residency documentation

Case Manager

Form

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:*	

- 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 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 your email address**

Reference

No.	Category of Requested Information	Required if there is No Change	Required if there IS a Change	Required supporting documentation if there IS a Change
6	Case Manager	Nothing	New Case Manager's contact information	None

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Income

Form

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) _____

- If there is no change, mark the "no change" checkbox and **STOP**
- If there is a change, mark the "change" box, calculate and list the new annual gross income amount, and check all boxes for sources of income

Reference

No.	Category of Requested Information	Required if there is No Change	Required if there IS a Change	Required supporting documentation if there IS a Change
7	Income	Nothing	New annual gross income amount	None

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*For tips on how to calculate annual gross income, please refer to slides in the 'Important HDAP Reminders" section of the presentation

Pharmacy

Form

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

- 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

No.	Category of Requested Information	Required if there is No Change	Required if there IS a Change	Required supporting documentation if there IS a Change
8	Pharmacy	Nothing	New pharmacy information	None

Insurance Status

Form

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: _____

Reference

No.	Category of Requested Information	Required if there is No Change	Required if there IS a Change	Required supporting documentation if there IS a Change
9	Insurance Status	Nothing	▪ New insurance name(s) ▪ Maximum copay amount(s) ▪ New insurance type(s) (*check all that applies*) ▪ Change occurred as of date(s)	Front and back copies of new insurance card(s)

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*If there is a change and the client now has Private Insurance – insurance name, maximum copay amount **AND** MassHealth determination letter 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 (*provided it is creditable coverage with a deductible of $500 or less*)
- MIC (Massachusetts Insurance Connection)
- VA (Veterans Administration) Insurance

Payer-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

- Please submit a copy of eligibility-based MassHealth determination letter dated within the past 12 months (include all pages of this letter)

OR

- 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

Requesting CHII Coverage

Form

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.

- **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

No.	Category of Requested Information	Required if there is No Change	Required if there IS a Change	Required supporting documentation if there IS a Change
10	CHII	▪ Mark "check here" checkbox ONLY IF new or current CHII client ▪ Current insurance premium statement	▪ Mark "check here" checkbox ONLY IF new or current CHII client ▪ Current insurance premium statement	Current insurance premium statement ONLY IF new or current CHII client

Signature and Date (REQUIRED)

Form

11	**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

Submission & Tracking

- All forms are processed in the order they are received
- It is required that you submit short and long forms **at least 15 days in advance of your termination date** to avoid gaps in HDAP/CHII coverage
- Leading up to and during Open Enrollment, it is important to make sure CHII clients are enrolled into the appropriate insurance
- **Be sure your agency is keeping records of applications and important dates for clients' HDAP information, including:**
  - ❑ HDAP ID
  - ❑ HDAP termination date
  - ❑ HDAP application submission type (short or long form)
  - ❑ MassHealth application submission date
  - ❑ MassHealth determination date

Important HDAP Reminders

HDAP Notice of Recertification

- Updated notices will include whether a client is required to use the short form or the long form
- **Please pay careful attention to this**–clients who submit short forms when long forms are required will have their applications rejected
- Updated notices will include whether or not a client is required to submit documentation of MassHealth (MH) eligibility (e.g. copy of MH application or MH determination letter)

Key reminders when working with 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?

Why are long forms being rejected?

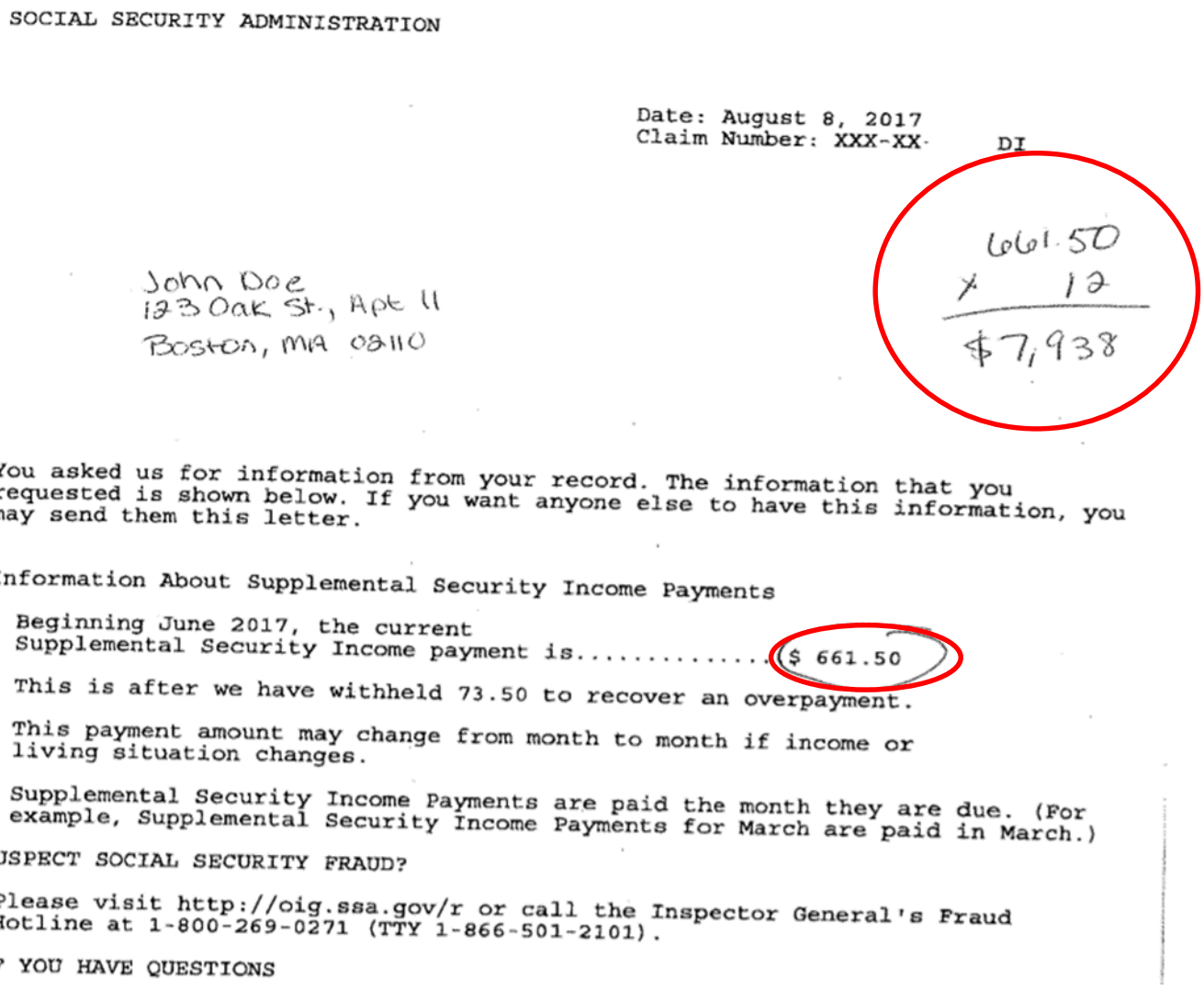
Applications that are received will be automatically rejected if they are:

- Missing any application pages
- Missing sections of personal information
- Missing provider signature/clinical information
- Missing the client's signature
- Illegible

*Applications will also be automatically rejected **if a client submits a short form when they <u>are not eligible</u> 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.

How to Calculate Income



SOCIAL SECURITY ADMINISTRATION

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

661.50
x 12
$7,938

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

How to Calculate Income (cont.)- **YTD**

Earnings Statement

Pay Period:	12/10/2017 - 12/16/2017
Advice Date:	12/21/2017
Advice Number:	875325
Advice Reason:	Normal Check
Personnel Type:	Hourly/Non-Exempt

Earnings

Current	Hours/Units	Rate	Amount	Dept/CC	Job
Absent	10.50	0.0000	0.00	79290	NEX506
Absent without Permission	2.10	0.0000	0.00	79290	NEX506
Earned Time Days	3.50	19.5119	68.29	79290	NEX506
Regular-Days	18.90	19.5119	368.77	79290	NEX506

Summary	Hours/Units	Amount	YTD Hours/Units	YTD Amount
Absent	10.50	0.00	17.05	0.00
Absent without Permission	2.10	0.00	34.80	0.00
Education / Seminar - Days	0.00	0.00	25.60	499.50
Earned Time Days	3.50	68.29	112.55	2,192.05
Earned Time Evenings	0.00	0.00	5.00	103.81
Unplanned Earned Time Days	0.00	0.00	81.85	1,596.76
Long Term Illness Bank - Days	0.00	0.00	120.00	2,341.44
Overtime - Days	0.00	0.00	2.00	58.53
Paid No Work-D	0.00	0.00	1.20	23.41
Regular-Days	18.90	368.77	1,394.20	27,187.81
Regular-Evenings	0.00	0.00	2.10	43.60
Gross Wages		**$437.06**	**1,796.35**	**$34,046.91**

Direct Deposit	This Period	Year to Dat
Checking (******5504)	312.79	24,036.7

Retirement Funds	Current Employer Cost	Year to Dat Employer Co
Transamerica	19.67	1,532.0

Accrual Balance	Current Taken	Current Accrued	Availabl Balanc
Earned Time	3.50	2.76	2.7
Long Term Illness Bank	0.00	0.00	0.0

Other Benefits and Information	Year to Dat Employer Co
403B	681.0
403B Core	851.0
Basic Life	15.8
Dental	243.7
LTD Basic	104.4
Network Blue	9,658.3

Taxable Wages	This Period	Year to Dat

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 dollar amount (**$681**). This will give you the client's average weekly pay. Multiply the quotient by 52:

$681 x 52= $35,412

How to Calculate Income (cont.)- **Weekly Paystubs**

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

09/01/2017	08/27/2017	20.75 HRS X 12 TRASH/LANDSCAPING	$249.00
09/01/2017	09/03/2017	15 HRS X 12 TRASH/LANDSCAPING	$180.00

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

09/13/2017	09/10/2017	18 HRS X 12 TRASH/LANDSCAPING	$216.00

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How to Calculate Income (cont.) - **Weekly Paystubs**

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

($249+$180)+$216=$645
$645/2= $322.5

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

$322.5 x 52= $16,770

***If the client is paid biweekly, multiply the average by 26**

2019 MassHealth Income Standards and Federal Poverty Guidelines

MassHealth & Other Health Programs: Upper Income Levels, March 1, 2019 to Feb 29, 2020										
Population/ Program	Seniors (MassHealth Standard)		Adults under 65 (MassHealth Standard or MassHealth CarePlus)		Children & Young Adults under Age 21 (MassHealth Standard) Full Health Safety Net		Pregnant women & infants (MH Standard); HIV+ individuals (MassHealth Family Assistance)		MassHealth Family Assistance (Children under 19); Small Business Premium Assistance, Partial Health Safety Net with a deductible	
	Not MAGI		MAGI		MAGI		MAGI		MAGI	
Percent of federal poverty	100% (plus $20 mo. disregard)		133%+ 5%		150%+5%		200%+5%		300%+5%	
	Monthly	Weekly	Monthly	Weekly	Monthly	Weekly	Monthly	Weekly	Monthly	Weekly
Family Size										
1	$1,061	$244.86	$1,438	$331.87	$1,615	$372.72	$2,135	$492.73	$3,176	$732.98
2	$1,430	$330.03	$1,946	$449.11	$2,185	$504.27	$2,890	$666.97	$4,299	$992.15
3	$1,798	$414.95	$2,454	$566.35	$2,756	$636.05	$3,644	$840.99	$5,422	$1,251.33
4	$2,166	$499.88	$2,962	$683.59	$3,327	$767.83	$4,400	$1,015.46	$6,546	$1,510.73
5	$2,535	$585.05	$3,470	$800.83	$3,898	$899.61	$5,155	$1,189.71	$7,669	$1,769.91
6	$2,903	$669.97	$3,979	$918.30	$4,469	$1,031.39	$5,910	$1,363.95	$8,793	$2,029.31
7	$3,271	$754.90	$4,487	$1,035.54	$5,040	$1,163.17	$6,665	$1,538.20	$9,916	$2,288.48
8	$3,640	$840.06	$4,995	$1,152.78	$5,610	$1,294.71	$7,420	$1,712.44	$11,039	$2,547.66
Each addtl.	$389	$89.78	$509	$117.47	$572	$132.01	$756	$174.47	$1,124	$259.40

This webinar has been recorded and will be available as a webcast along with the slide deck on CRI's website:

www.crine.org

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How to Contact Us

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617.502.1746

Brittany Morgan
BRIDGE Health Insurance Enrollment Specialist
bmorgan@crine.org
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)

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