The New HIV Drug Assistance Program Self-Attestation Form

The SHORT Form!

April 16th, 2019

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BRIDGE Team
Community Research Initiative
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
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!*
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 31\textsuperscript{st} HDAP termination dates)
Short Form Overview
Self-Attestation (Short) Form

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 HDAP ID</strong> (if known)</td>
<td>First Name: Last Name: Date of Birth (MM/DD/YYYY): Social Security #:</td>
</tr>
<tr>
<td><strong>2 Contact information</strong></td>
<td>Cell phone: □ OK to call □ OK to leave message Home phone: □ OK to call</td>
</tr>
<tr>
<td></td>
<td>□ OK to contact by email □ ONLY contact my Case Manager □ DO NOT have</td>
</tr>
<tr>
<td></td>
<td>a Case Manager</td>
</tr>
<tr>
<td><strong>3 Send my HDAP-related</strong></td>
<td>mail to: □ My Case Manager □ My Mailing Address</td>
</tr>
<tr>
<td><strong>4 My Mailing Address</strong></td>
<td>Street: City: State: ZIP:</td>
</tr>
<tr>
<td><strong>5 My Residential Address</strong></td>
<td>Street: City: State: ZIP:</td>
</tr>
<tr>
<td><strong>6 Case Manager</strong></td>
<td>Case Manager name: Case Manager phone: Case Manager Address:</td>
</tr>
<tr>
<td></td>
<td>Case Manager site: Case Manager email:</td>
</tr>
<tr>
<td><strong>7 Income</strong></td>
<td>□ Salary □ Unemployment benefits □ Worker's compensation □ Social</td>
</tr>
<tr>
<td></td>
<td>Security Income ($S1, $S2L, $S5A, $S5P) □ Private disability</td>
</tr>
<tr>
<td></td>
<td>(short- or long-term)</td>
</tr>
<tr>
<td><strong>8 Pharmacy</strong></td>
<td>Pharmacy name: Street: City: State: ZIP:</td>
</tr>
<tr>
<td><strong>9 Insurance Status</strong></td>
<td>□ No Change □ Change (Check all that apply)</td>
</tr>
<tr>
<td></td>
<td>□ No health insurance/ prescription coverage □ MassHealth (Medicaid)</td>
</tr>
<tr>
<td></td>
<td>□ MassHealth Limited □ Health Safety Net (Full or Partial) □ Medicare</td>
</tr>
<tr>
<td></td>
<td>Part A □ Medicare Part B □ Medicare Part C (Advantage) □ Medicare</td>
</tr>
<tr>
<td></td>
<td>Part D □ ConnectorCare □ Private insurance (Employer/Group)</td>
</tr>
<tr>
<td></td>
<td>□ Name □ Maximum copay amount $ □ Maximum copay amount $</td>
</tr>
<tr>
<td></td>
<td>□ Private Insurance (Individual/Non-Group) □ Name □ Veteran's Administration (VA)</td>
</tr>
<tr>
<td></td>
<td>□ Other, specify:</td>
</tr>
<tr>
<td><strong>10 CHII</strong></td>
<td>If HDAP/CHII pays for your health insurance, please check here and</td>
</tr>
<tr>
<td></td>
<td>attach a recent premium statement/bill or employer premium/payroll</td>
</tr>
<tr>
<td></td>
<td>deduction letter.</td>
</tr>
<tr>
<td><strong>11 Client Signature</strong></td>
<td>Date: □ □ I attest that I am a Massachusetts resident and that the</td>
</tr>
<tr>
<td></td>
<td>information on this application and any attachments is correct and</td>
</tr>
<tr>
<td></td>
<td>complete. If I deliberately misrepresent information on this</td>
</tr>
<tr>
<td></td>
<td>application, I may be required to repay benefits provided to me and I</td>
</tr>
<tr>
<td></td>
<td>may be prosecuted under applicable state and federal statutes.</td>
</tr>
<tr>
<td><strong>Case Manager Signature</strong></td>
<td>Date: □ □ I attest that I have spoken with the client and that the</td>
</tr>
<tr>
<td></td>
<td>information provided in this form is true and accurate.</td>
</tr>
</tbody>
</table>

Updated April 2019  Please recycle prior versions
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

<table>
<thead>
<tr>
<th>No.</th>
<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>1</td>
<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></td>
<td>▪ Date of birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<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>2</td>
<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></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></td>
<td>▪ Email address</td>
<td>▪ Email address</td>
<td></td>
</tr>
<tr>
<td>3</td>
<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

- 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

<table>
<thead>
<tr>
<th>No.</th>
<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>4</td>
<td>My Mailing Address</td>
<td>Nothing</td>
<td>New mailing address</td>
<td>None</td>
</tr>
</tbody>
</table>
Residential Address

Form

- 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

<table>
<thead>
<tr>
<th>No.</th>
<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>5</td>
<td>My Residential Address</td>
<td>Nothing</td>
<td>New residential address</td>
<td>New proof of residency documentation</td>
</tr>
</tbody>
</table>

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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>□ Change</td>
<td>□ Phone</td>
<td>□ Email</td>
</tr>
</tbody>
</table>

Prefered form of contact:

- 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

<table>
<thead>
<tr>
<th>No.</th>
<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>6</td>
<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, mark the “change” box, calculate and list the new annual gross income amount, and check all boxes for sources of income

Reference

<table>
<thead>
<tr>
<th>No.</th>
<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>7</td>
<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 ‘Important HDAP Reminders” 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></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- □ No Change  □ Change

<table>
<thead>
<tr>
<th>Phone:</th>
<th>City:</th>
<th>ZIP:</th>
</tr>
</thead>
<tbody>
<tr>
<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 pharmacy information

Reference

<table>
<thead>
<tr>
<th>No.</th>
<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>8</td>
<td>Pharmacy</td>
<td>Nothing</td>
<td>New pharmacy information</td>
<td>None</td>
</tr>
</tbody>
</table>

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**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>

**Reference**

<table>
<thead>
<tr>
<th>No.</th>
<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>9</td>
<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></td>
<td>▪ Maximum copay amount(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ New insurance type(s) (check all that applies)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Change occurred as of date(s)</td>
<td></td>
</tr>
</tbody>
</table>

*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

- 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>No.</th>
<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>
</table>
| 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

<table>
<thead>
<tr>
<th>Client Signature: __________________________</th>
<th>Date: <strong>/</strong>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case Manager Signature: __________________</th>
<th>Date: <strong>/</strong>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>I attest that I have spoken with the client and that the information provided in this form is true and accurate.</td>
<td></td>
</tr>
</tbody>
</table>

- 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 are 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.
How to Calculate Income

SOCIAL SECURITY ADMINISTRATION

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

John Doe
133 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.)

SUPECT 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

[Image of earnings statement with highlighted values]
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 \times 52 = $35,412
How to Calculate Income (cont.) - Weekly Paystubs

Check Total: $429.00  Check Date: 9/7/2017
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: $218.00  Check Date: 9/13/2017
09/13/2017  09/10/2017  18 HRS X 12 TRASH/LANDSCAPING  $218.00
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:

\[\$322.5 \times 52 = \$16,770\]

*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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not MAGI</td>
<td>MAGI</td>
<td>MAGI</td>
<td>MAGI</td>
<td>MAGI</td>
</tr>
<tr>
<td>Percent of federal poverty (100% (plus $20 mo. disregard))</td>
<td>133% + 5%</td>
<td>150% + 5%</td>
<td>200% + 5%</td>
<td>300% + 5%</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>$1,061</td>
<td>$244.86</td>
<td>$1,438</td>
<td>$331.87</td>
<td>$1,615</td>
</tr>
<tr>
<td>2</td>
<td>$1,430</td>
<td>$330.03</td>
<td>$1,946</td>
<td>$449.11</td>
<td>$2,185</td>
</tr>
<tr>
<td>3</td>
<td>$1,798</td>
<td>$414.95</td>
<td>$2,454</td>
<td>$566.35</td>
<td>$2,756</td>
</tr>
<tr>
<td>4</td>
<td>$2,166</td>
<td>$499.88</td>
<td>$2,962</td>
<td>$683.59</td>
<td>$3,327</td>
</tr>
<tr>
<td>5</td>
<td>$2,535</td>
<td>$585.05</td>
<td>$3,470</td>
<td>$800.83</td>
<td>$3,898</td>
</tr>
<tr>
<td>6</td>
<td>$2,903</td>
<td>$669.97</td>
<td>$3,979</td>
<td>$918.30</td>
<td>$4,469</td>
</tr>
<tr>
<td>7</td>
<td>$3,271</td>
<td>$754.90</td>
<td>$4,487</td>
<td>$1,035.54</td>
<td>$5,040</td>
</tr>
<tr>
<td>8</td>
<td>$3,640</td>
<td>$840.06</td>
<td>$4,995</td>
<td>$1,152.78</td>
<td>$5,610</td>
</tr>
<tr>
<td>Each addtl.</td>
<td>$389</td>
<td>$89.78</td>
<td>$509</td>
<td>$117.47</td>
<td>$572</td>
</tr>
</tbody>
</table>
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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