

**Massachusetts HIV Drug Assistance Program (HDAP)  
& Comprehensive Health Insurance Initiative (CHII):  
Adult & Pediatric Application Form**

**Please read these instructions before you fill out the following application**

**To be eligible for HDAP/CHII, you must:**

- ◆ Be HIV-positive
- ◆ Be a Massachusetts resident (undocumented individuals who live in Massachusetts are eligible)
- ◆ Have a gross annual income not exceeding \$54,150; add \$3,740 per dependent

**Application Process:**

- ◆ All applicants must **re-apply** to the HDAP/CHII Program **every six (6) months**
- ◆ All applicants must complete Part 1 of the application and read and sign pages 6-8
- ◆ If you have health insurance or MassHealth and would like HDAP to pay for the cost of your prescription co-pays, please fill out Part 2
- ◆ If you are applying or recertifying for reimbursement for health insurance premium payments, please also complete Part 3
- ◆ Please be sure to fill out the application completely and clearly; we cannot process applications with incomplete or missing information

**Please mail completed application to:**

**Community Research Initiative of New England/HDAP  
23 Miner Street  
Boston, MA 02215-3319  
800.228.2714 ~ TTY 617.502.1704**

**From the time of receipt of completed application materials, please allow two weeks for your application to be processed. You will be notified by mail of our decision.  
We suggest you make a copy of this application for your records. Thank you.**

**DID YOU REMEMBER:**

- To attach proof of Massachusetts residence?
- To attach proof of income: at least two pay stubs or individual tax forms (1040, W-2, 1099)?
- To attach a *copy* of your completed and submitted MassHealth application (MBR form) or MassHealth denial letter from within the past 12 months? *Not applicable for those already enrolled in the Massachusetts Insurance Connection (MIC)*
- To attach a *copy* of your completed application submitted to private non-group health insurance?\* (if you are not already enrolled in private insurance or MassHealth)
- To include a *copy* of your health insurance or MassHealth card (if applicable)?
- To have a clinician involved in your care fill out and sign Section D, including your most recent CD4 and viral load test results? (*Note: lab results should be no more than six months old; see page 3*)
- To sign the Client Agreement Statement? (see page 8)
- To fill out Part 3 if applying/re-certifying for CHII?** (see pages 4-5)
- To include a copy of your private non-group or MassHealth premium bill?

*\*If you are applying to Tufts or Harvard Pilgrim for the first time, you must include the original completed application.*

**Aplicación disponible en español  
Spanish application available upon request**



**B. Income Information**Are you currently working?  Yes  No

Yearly Gross Income: \$ \_\_\_\_\_

***You must include proof of income, such as a copy of at least two of your most recent pay stubs showing the period covered by the check, or a tax return or W-2 form for the most recent tax year. If self-employed, please include a copy of your most recent federal tax return or 1099 form. All earnings, including SSDI, SSI, unemployment compensation, and any other benefits or entitlements must be reported. If you have no earnings, please include a letter, either from your case manager or health care provider, stating that you have no income and how you are being supported.***

**C. Provider Information**

*If you receive case management services, please fill out Section C. If not, please go on to Section D.*

Case Manager Name	Institution		
Street Address	City	State	Zip
Phone & Extension ( )	Fax ( )	Email address	

**D. Clinician Information**

*Have your clinician complete the information and sign on the line below.  
Lab results should be no more than six months old.*

Name of Clinician ( <i>please print</i> )	Credentials	Facility
Department/Street Address	City	State Zip
Phone & Extension ( )	Email Address	
<i>Patient's clinical status:</i> <input type="checkbox"/> HIV+ and asymptomatic <input type="checkbox"/> HIV+ and symptomatic <input type="checkbox"/> CDC-defined AIDS	<i>Patient's mode of exposure (check all that apply):</i> <input type="checkbox"/> Men who have sex with men <input type="checkbox"/> Heterosexual Sex <input type="checkbox"/> Injection Drug Use <input type="checkbox"/> Perinatal (Pediatric) <input type="checkbox"/> Blood/products <input type="checkbox"/> Other: _____	<i>Patient's current:</i> ♦ CD4 _____ Date Last Test: ___/___/___ ♦ Viral Load _____ Date Last Test: ___/___/___ Has patient ever had a CD4 count ≤200? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Clinician Signature \_\_\_\_\_ Medical License # \_\_\_\_\_

Date \_\_\_\_\_

**PART 2**

NAME \_\_\_\_\_

HDAP ID #  
(if known)

**Prescription Co-Payment Information**

Health Insurance Provider \_\_\_\_\_

Health Insurance Member Number \_\_\_\_\_

Health Insurance Group Number \_\_\_\_\_

**Do you have MassHealth?**    **YES**                    **NO**                    MassHealth Number \_\_\_\_\_

What type of prescription co-pay do you have? (please check and indicate amount or percentage):

Maximum dollar amount per prescription    \$ \_\_\_\_\_

**OR**

Percentage per prescription                    \_\_\_\_\_%

***If you are enrolled in MassHealth, be sure to include a copy of your MassHealth card or MassHealth authorization letter.***

***Pharmacy Information: PLEASE SPECIFY THE PHARMACY YOU WILL BE USING ON THE LINES PROVIDED BELOW. IF YOU LATER CHANGE TO A DIFFERENT PHARMACY FROM THE ONE INDICATED BELOW, YOU MUST SUBMIT A WRITTEN REQUEST WITH NEW PHARMACY INFORMATION TO HDAP STAFF.***

Pharmacy Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/Town \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

*If you are enrolling for the first time or re-certifying with HDAP, you are required to submit a copy of your completed application to a private non-group health insurance company (unless you are already **enrolled** in private health insurance or MassHealth). If you have applied to MassHealth and were denied coverage within the past 12 months, please include a copy of the denial letter you received from MassHealth. If you are categorically ineligible for MassHealth due to immigration status, you need to submit a letter written and signed by your case manager/health care provider stating this.*

**PART 3**

**Comprehensive Health Insurance Initiative (CHII) Information**

*Please complete the following section if you are interested in having the Comprehensive Health Insurance Initiative assist with the cost of your health insurance premium, COBRA payment, MassHealth premium, or employee contribution to health insurance offered through your job.*

**Have you had health insurance coverage within the last 60 days? (Circle one) YES NO**

I am applying for coverage of: *(check one only)*

- Non-Group health insurance
- Small Group health insurance
- Self-Employed health insurance
- MassHealth Premium
- COBRA
- Employee Premium Deduction



## Grievance Procedure Massachusetts HDAP/CHII

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

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

**Address:** HDAP Staff Contact  
CRI  
23 Miner Street  
Boston, MA 02215

**Telephone:** 800.228.2714  
**Fax:** 617.502.1703

A staff member will get back to you within ten business days.

*If you are not happy* with the answer you receive, you may 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 ten business days after you get a response. The supervisor will get back to you within ten business days.

*If you are still not happy* with the answers you have received, you may then take the complaint to the **HDAP Director**. This must be in writing. It can be mailed, e-mailed, faxed or hand delivered, and must be done within ten 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 ten business days of the receipt of the concern/grievance.

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

- a case manager
- an attorney
- a paralegal
- a translator
- a friend
- a 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.

For more information contact:

**Address:** HDAP Enrollment Coordinator  
HDAP/CRI  
23 Miner Street  
Boston, MA 02215

**Telephone:** 617.502.1700

## Client Agreement Statement Massachusetts HDAP/CHII

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 to the extent permitted by law. No individual identifying information shall be reported to the Massachusetts Department of Public Health or any other agency. **However, if you do not follow these rules, if you give us false information, or if we suspect you are using funds from the HDAP/CHII program to which you are not entitled, HDAP staff may provide information to government agencies and you may be disenrolled from HDAP/CHII.**

By signing this agreement/contract:

1. **You give your permission for HDAP/CHII to contact all of the following:**
  - Your pharmacist
  - Your case manager
  - Your employer (*for employee contribution or COBRA*)
  - Your current or past health care provider(s)
  - Any other person that you have specifically given us permission to contact.

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

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

2. **You give your permission for your HDAP enrollment application files to be reviewed by all of the following:**
  - HDAP/CHII staff
  - Your case manager and/or health care provider
  - Auditors or other individuals reviewing application files as required for program or fiscal monitoring.

Information in your HDAP/CHII enrollment application files will be kept strictly confidential. Under no circumstances will any personal identifying information in your HDAP/CHII file be shared with any unauthorized individual.

3. **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, your:**
  - Employment status
  - Income
  - Residence
  - Access to insurance coverage/MassHealth status
  - Insurance premium
  - Citizenship status

4. Your application may be rejected if you have provided false information.
5. **HDAP/CHII is unable to provide payments or reimbursement directly to clients for any reason.**
6. As long as you remain eligible and actively enrolled in the CHII program and follow the HDAP/CHII rules, HDAP/CHII will continue to pay for your health insurance premiums. However, **you must agree to contact your health insurance carrier about your policy and its coverage. It is your sole responsibility to do so, not the responsibility of HDAP/CHII staff.** HDAP/CHII staff will not contact your insurance company, nor will HDAP/CHII staff be notified by your insurance company of any policy changes. HDAP/CHII only pays for the cost of your insurance premium; the CHII program is not required to do anything but pay for your health insurance.
7. HDAP/CHII may require you to re-pay any payments made if you were not eligible for them. You may also be required to pay back HDAP/CHII if you were misusing services. This includes, but is not limited to, health insurance premiums refunded directly to you in certain circumstances. Failure to comply with this rule may result in disenrollment from the program.
8. HDAP/CHII is not required to make retroactive payments for coverage before you were enrolled in the program or if your HDAP enrollment lapses.
9. It is your responsibility to re-apply (“recertify”) with HDAP/CHII every six (6) months. **If you do not recertify, your HDAP/CHII benefits will be terminated.**
10. **You certify that you have read or had read to you the information on this application, the Grievance Procedure, and this Client Agreement Statement, and that you understand your rights and responsibilities. You further certify under the penalty of perjury that the information on this application and any attachments to it are correct and complete to the best of your knowledge.**

\_\_\_\_\_  
Signature (Applicant or Parent/Guardian)

\_\_\_\_\_  
Date