Updated COVID-19 Vaccine Attestation Form

Updated: March 18, 2022

MassHealth Home and Community-based Services MFP Waivers Self-Directed Program

This updated form will help your Waiver Participant Consumer-employer verify your vaccine status and make decisions about their safety and personal care. The updated form must be completed by each direct care worker (DCW), stored in the DCW's personal records, and provided to the ABI/MFP Waiver participant and/or their representative to confirm the DCW's vaccine status and help the Waiver participant make decisions about their safety and personal care.

This form must be submitted to the MassHealth agency or its designee upon request.

Any direct care worker who refuses to complete this form and/or comply with regulations promulgated or orders issued by the Department of Public Health (DPH) pertaining to COVID-19 vaccination requirements may be subject to termination, as determined by their Waiver Participant Consumer-employer.

By signing below, I acknowledge the following:

- I understand, per the Massachusetts Department of Public Health regulation 105 CMR 159.000: *COVID-19 Vaccinations for Certain Staff Providing Home Care Services in Massachusetts*, that Direct Care Workers (DCWs) working in the MassHealth Home and Community-based Services MFP Waivers Self-Directed Program are required to complete the full required regimen of COVID-19 vaccine doses by October 31, 2021, and that all new DCWs hired after that date must have completed the full required regimen by the date of hire;
- I understand that pursuant to COVID-19 Public Health Emergency Order No. 2022-01 issued by the Commissioner of Public Health on January 6, 2022, that DCWs were required to receive a COVID-19 additional dose or booster vaccination by February 28, 2022, which has been extended to March 21, 2022, or within three weeks of becoming eligible for a COVID-19 additional dose or booster vaccination if eligible after that date, and that all new DCWs hired after that date must receive the COVID-19 additional dose or booster vaccination within three weeks of the date of hire, or within three weeks of becoming eligible for a COVID-19 additional dose or booster vaccination if not eligible by the date of hire;
- I have received information regarding the risks and benefits of receiving a COVID-19 vaccine, which includes information available at www.mass.gov/info-details/massachusetts-law-about-vaccination-immunization;
- I understand that under state and federal employment law, my Waiver Participant Consumer-employer has a legal right to require that I receive a COVID-19 vaccine as a condition of employment. **My Waiver Participant Consumer-employer can make hiring, termination, and scheduling decisions based on this requirement**;
- I can produce proof of my vaccination or booster status or proof supporting a qualified exemption;
- I understand that if I qualify for an exemption or if I otherwise do not get the vaccine or booster, I may be at greater risk of contracting COVID-19 and/or spreading it to others; and
- I understand that my Waiver Participant Consumer-employer may choose to terminate employment even if I qualify for an exemption if I cannot perform my essential job functions through a reasonable accommodation without creating an undue burden on my Waiver Participant Consumer-employer.

DCW Vaccine Status

By signing below, I attest to the following under the pains and penalties of perjury (please check one):

☐ I have completed the full regimen of the COVID-19 vaccine dose. Specifically, I have received two doses of the Pfizer-BioNTech vaccine, or two doses of the Moderna vaccine, or one dose of the Johnson & Johnson vaccine plus a COVID-19 additional dose or booster vaccination.

☐ I have received two doses of the Pfizer-BioNTech vaccine, or two doses of the Moderna vaccine, or one dose of the Johnson & Johnson vaccine, but I have not received a COVID-19 additional dose or booster vaccination as I am not eligible at this time. I will become eligible on _____(Insert Date).

☐ I am requesting a COVID-19 vaccine exemption based on one of the following (please check one):

☐ A licensed independent practitioner who has a practitioner/patient relationship with me has determined that administration of the COVID-19 vaccine is medically contraindicated, meaning the COVID-19 vaccine would likely be detrimental to my health, and I have documentation from said licensed independent practitioner demonstrating this determination;

or

☐ I object to receiving a COVID-19 vaccine based on a sincerely held religious belief, and I have documentation to support this sincerely held religious belief.

☐ I am not currently vaccinated against COVID-19 and am not requesting (or do not qualify for) an exemption

DCW Name	DCW Signature	Date Signed
Waiver Participant Consumer Name	Waiver Participant Consumer, Surrogate, or Legal Guardian Signature	Date Signed

Print **Clear**