Updated COVID-19 Vaccine Attestation Form

Updated: March 18, 2022

Acquired Brain Injury (ABI) and Moving Forward Plan (MFP) Waiver Providers Participating in MassHealth: Non-Agency (Self-Employed) Providers

This updated form will help the ABI/MFP Waiver participant and/or their representative verify your vaccine status and make decisions about their safety and personal care, in accordance with 130 CMR 630.000. The updated form must be completed by each MassHealth enrolled non-agency (self-employed) provider, stored in their personal records, and provided to the ABI/MFP Waiver participant and/or their representative to confirm the non-agency (self-employed) provider'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 non-agency (self-employed) provider who refuses to complete this form and/or comply with regulations promulgated or orders issued by the Department of Public Health pertaining to COVID-19 vaccination requirements will be subject to financial penalty by the MassHealth agency.

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 non-agency (self-employed) providers working in the MassHealth ABI and MFP Waiver programs were required to complete the full required regimen of COVID-19 vaccine doses by October 31, 2021, and that all new non-agency (self-employed) providers providing services 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, non-agency (self-employed) providers 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 non-agency (self-employed) providers providing services 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 can produce proof of my vaccination or booster status or proof supporting my need for a valid 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 the ABI/MFP Waiver participant and/or their representative may choose not to have me provide ABI/MFP Waiver services based on this requirement.**

Non-Agency (Self-Employed) Provider 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 required regimen of the COVID-19 vaccine doses. 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 have requested 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 provided 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.

Provider Name	Provider Signature	Date Signed

Waiver Participant Name	Waiver Participant Signature	Date Signed

Print **Clear**