SELF-ATTESTATION FORM

For those applying for MassHealth, the Children's Medical Security Plan, and the Health Safety Net

Complete this form if

- You are applying for MassHealth, the Children's Medical Security Plan (CMSP), and the Health Safety Net (HSN), and
- You are unable to provide verification due to the COVID-19 national emergency.

Important! We will try to verify citizenship or immigration status through data matching. We will only ask for verification if we cannot verify through data matching. We may still need proof of citizenship or immigration status. See the Member Booklet Section 11, Senior Guide Section 8 for information on how to verify.

Please print clearly and fill out all sections.

SECTION A: Head of Household/Member Information

....
Last name First name MI

....
SSN (if any) Date of Birth

.....
MassHealth Member ID number (if known)

Home Address (where you are living in Massachusetts)

....
Street City State ZIP

☐ No home address. Note: if you check this box, you must provide a mailing address.

Mailing Address (if different from home address)

....
Street City State ZIP

Important Information Regarding MassHealth, CMSP, or HSN Eligibility

When you completed a MassHealth application, you gave us information about income, assets, employment, health insurance, household composition, tax filing, residency, and incarceration status, among other things. By signing this form you are telling us that you are not able to provide verification documents (except with respect to citizenship and immigration status) due to the COVID-19 national emergency and that the information you provided on your MassHealth application is correct and complete.

If you need to report changes or update your application, you must contact us within 10 days of the change.

SECTION B: This affidavit applies to the following individual(s):

If you have more than six people in your household who require verification, except citizenship or immigration status, make a copy of blank information pages for Section B and fill in the required information.

..... Full Name of household member asked to submit verifications (please print)	..... Full Name of household member asked to submit verifications (please print)
..... Full Name of household member asked to submit verifications (please print)	..... Full Name of household member asked to submit verifications (please print)
..... Full Name of household member asked to submit verifications (please print)	..... Full Name of household member asked to submit verifications (please print)

SECTION C: Signature

I certify, under penalty of perjury, that the information on my application and on this form is correct and complete to the best of my knowledge.

.....
.....
.....
.....

Print name ..... Date .....

If you are filling out this form for someone else, you need to complete an Authorized Representative Designation (ARD) form and send it back with this form. If you need an ARD form, call MassHealth Customer Service or go to www.mass.gov/eohhs/consumer/insurance/masshealth-member-library/member-forms.html to download a form.

☐ Check here if you are an Authorized Representative

Send to: Health Insurance Processing Center
P.O. Box 4405
Taunton, MA 02780

Or

Fax to: (857) 323-8300

Or

If you are under the age of 65 and currently have an account on www.maheathconnector.org, you may upload the document to your account

Please contact MassHealth Customer Service at (800) 841-2900, TTY: (800) 497-4648 if you have any additional questions about this form or would like to verbally submit your self-attestation.

Print **Clear**