AccessHealth MA

Self-Attestation Requirements and Specific Instructions

Before you begin completing this self-attestation form, carefully review these instructions.
If you need assistance, contact your Case Manager or call HDAP at (800) 228-2714 or (617) 502-1700. You can fax the completed form to 617-502-1703 or by mail it to AccessHealth MA/HDAP, Schrafft's City Center, 529 Main St., Suite 301, Boston, MA 02129.

Eligibility: To be eligible for submitting an HDAP/CHII application in self-attestation form, you must be continuously enrolled in HDAP for 6 consecutive months without a lapse in coverage. Individuals applying to HDAP for the first time must complete a full annual application. Application forms can be found at **www.AccessHealthMA.org/HDAP**.

Preliminary instructions: Please complete all required sections clearly and completely. Incomplete self-attestation forms and forms without supporting documentation (*where required*) will delay your enrollment and may result in your application being rejected. Please refer to your copy of the last annual certification submitted to HDAP to ensure that you provide the requested information accurately and completely.

- If there is no change to the information requested since your last annual certification, please **mark the 'No Change' checkbox** for each section and **STOP**. Don't enter any other information in that field.
- If there has been a change in your information, please **mark the 'Change' checkbox** AND provide the new/changed information in the specified sections.
- If you have additional changes not shown on this form, you are required to fill out a full standard application (long form).

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.

- If it has been more than a year since your last MassHealth application, please submit documentation of a current MassHealth application with this form.
- If you have been determined to be ineligible for MassHealth within the past 12 months, please submit a copy of your MassHealth determination letter (include all pages).
- If you are already enrolled in MassHealth, ConnectorCare, or the Massachusetts Insurance Connection (MIC), you are not required to reapply to these programs at this time.

1	**Applicant Information:**	▪ **You are required** to provide your full name, date of birth, social security number and your HDAP ID number (if known). If you don't have a social security number, use 999-99-9999. ▪ If your name has changed since your last annual certification, please provide supporting documentation, e.g. a marriage certificate, divorce decree, driver's license, passport, or ID card.
2	**Contact Information:**	▪ **You are also required** to list your phone and email address, if available. Be sure to indicate whether you would like us to leave a message on your home and/or cell voicemail. If yes, mark the appropriate checkbox. ▪ If you would like us to **ONLY** call or email your Case Manager, make sure to mark the appropriate checkbox.
3	**HDAP-related mail sent to your mailing address**	*VERY IMPORTANT TO ANSWER*. If you want to receive your confidential HDAP-related mail, mark the "Yes" checkbox and move to question 4. **BUT** if you prefer your confidential HDAP-related mail to be sent to your Case Manager, make sure to mark the "No" checkbox and move to question 5.
4	**My Mailing Address:**	▪ If there is no change in the mailing address to be used by HDAP, mark the "No Change" checkbox and **STOP**. ▪ If the **mailing address** that you would like to receive mail from HDAP/CHII **has changed**, mark the "Change" checkbox and provide your new mailing address.
5	**Case Manager:**	▪ If there is no change, mark the "No Change" checkbox. **If your Case Manager has changed**, mark the "Change" checkbox and provide current contact information for your Case Manager or client advocate. If you DO NOT have a Case Manager, mark the appropriate checkbox and **STOP**.
6	**My Residential Address:**	▪ If there is no change in your residential address, mark the "No Change" checkbox and **STOP**. **NOTE:** You are not required to submit proof of residence if there is no change. ▪ **If you have moved** since your last annual certification, please mark the "Change" checkbox and provide your new residential address, and include documentation of your new address. Please refer to the HDAP application instructions for examples of acceptable documents. Documents must be dated within the past 6 months.
7	**Income:**	▪ If there is no change, mark the "No Change" checkbox and **STOP**. **NOTE:** You are not required to submit proof or income. ▪ **If your income has changed** since your annual certification, mark the "Change" checkbox and provide an estimate of your annual gross income before any deductions. Please indicate all sources of income.
8	**Pharmacy:**	▪ If there is no change, mark the "No Change" checkbox and **STOP. If the pharmacy** that you use to access prescriptions covered by HDAP **has changed**, mark the "Change" checkbox and provide the new pharmacy information in the section indicated.
9	**Insurance Status:**	▪ If there is no change, mark the "No Change" checkbox and **STOP**. **If your insurance status has changed** since your annual certification, mark the "Change" checkbox and indicate what type of health insurance you currently have by checking off all the boxes that apply. If your new insurance plan is a private/commercial insurance plan, please provide the name and the maximum copay amount in the sections indicated. ▪ Please also send copies of the front and back of all your insurance cards.
11	**Signature:**	▪ Applications that are missing a signature and date in this section cannot be processed and will be rejected. ▪ If a client has a Case Manager, it is recommended that the client fills out this form with their Case Manager and signs the form themselves. **However**, the Case Manager may sign after reviewing the form with the client by phone, if the client is not present or available to sign the form.

Please turn over for quick reference guide

AccessHealth MA

	Self-Attestation Requirements Quick Reference Guide			
No.	**Category of Requested Information**	**Required if there is <u>No Change</u>**	**Required if there <u>IS a Change</u>**	**Required supporting documentation if there <u>IS a Change</u>**
1	**Applicant Information**	▪ Full name ▪ Date of birth ▪ Social Security Number (*If you don't have a social security number, use 999-99-9999*)	New full name	Proof of name change documentation
2	**Contact Information**	▪ Cell phone **AND/OR** ▪ Home phone **AND/OR** ▪ Email address	▪ Cell phone **AND/OR** ▪ Home phone **AND/OR** ▪ Email address	None
		▪ Indicate whether you would like us to leave a message on your home, cell phone voicemail and/or email. ▪ Indicate if you would like us to call or email ONLY your Case Manager		
3	**HDAP-related mail sent to your mailing address**	▪ **You must mark either "Yes" <u>or</u> "No"** ▪ If marked, "Yes", move on to question 4 ▪ If marked, "No", move on to question 5		None
4	**My Mailing Address**	Nothing	New mailing address	None
5	**Case Manager**	Nothing	New Case Manager's contact information	None
		If you don't have a Case Manager, mark the checkbox		
6	**My Residential Address**	Nothing	New residential address	New proof of residency documentation
7	**Income**	Nothing	New annual gross income amount	None
8	**Pharmacy**	Nothing	New pharmacy information	None
9	**Insurance Status**	Nothing	▪ New insurance name(s) ▪ Maximum copay amount(s) ▪ New insurance type(s) (*check all that applies*) ▪ Change occurred as of date(s)	Front and back copies of new insurance card(s)
10	**CHII**	▪ Mark "check here" checkbox **<u>ONLY IF</u>** new or current CHII client ▪ Current insurance premium statement	▪ Mark "check here" checkbox **<u>ONLY IF</u>** new or current CHII client ▪ Current insurance premium statement	Current insurance premium statement **<u>ONLY IF</u>** new or current CHII client
11	**Signature and date**	▪ 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		