

Application for Temporary Hardship Waiver of MassHealth Income Deductible



If you have been assessed an income deductible in order to qualify for MassHealth benefits and you would like to request a hardship waiver of this deductible during the COVID-19 national emergency:

- Call MassHealth Customer Service at (800) 841-2900
TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled, OR
- Return this completed form to:

Mail: Commonwealth of Massachusetts
Health Insurance Processing Center
P.O. Box 4405
Taunton, MA 02780

Fax: (857) 323-8300

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

If your deductible hardship waiver is approved, MassHealth will temporarily approve your benefits for the duration of your six-month deductible period, or for the duration of the COVID-19 outbreak national emergency and through the end of the month in which the national emergency period ends, whichever is later. Upon the end of the national emergency, you will receive a new notice with information about your continued eligibility for MassHealth.

If you have questions about your MassHealth eligibility, or need to report changes to your case, call MassHealth Customer Service at (800) 841-2900, TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled.

APPLICANT INFORMATION

Last name..... First name Middle initial.....
MassHealth ID..... Daytime phone.....
Street address.....
City..... State..... Zip.....

COMMENTS (If you need more space, please attach a separate sheet.)

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SIGNATURE

I certify that I have read or had read to me the information on this application. I understand my rights and responsibilities. I certify under penalty of perjury that the information on this application and in any included documents is correct and complete to the best of my knowledge. If you are acting for someone in filling out this form, you must be designated in MassHealth's computer system as an authorized representative. If you are not, you must fill out an Authorized Representative Designation (ARD) form and send it in with this application. Your signature or the signature of your authorized representative on this application certifies that the information on this form is correct and complete to the best of your knowledge. I attest that due to COVID-19 emergency, meeting my deductibles would present an undue financial hardship to me.

Signature of member Date.....

Signature of authorized representative Date.....
(if applicable)