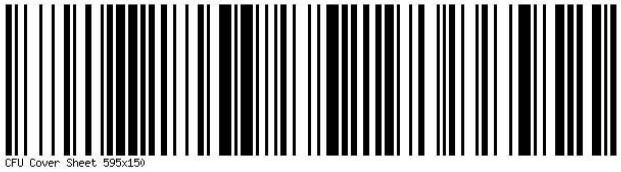

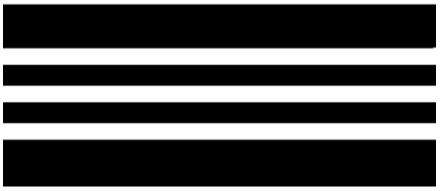

Project Citizenship PSI Fax Cover Sheet to MassHealth

Use this cover sheet when faxing a completed Permission to Share Information (PSI) form to MassHealth.

Please complete all relevant sections of the PSI form, check the "Other" box under Section 2, and write in, "I give permission for Project Citizenship to receive confirmation of my MassHealth eligibility in the form of a confirmation letter that includes my name and date of birth. Please fax to Project Citizenship at (617) 859-9993 a letter that states that my MassHealth eligibility status as of the date of the letter."

Important Message:

Do NOT photocopy the cover sheet containing the barcode. For barcodes to work, the sheet with the barcode must be an original, not a copy. Use a separate cover sheet for each member. Do NOT use the same cover sheet to send items for more than one household member.

Complete this cover sheet and fax it with the PSI form to 617-887-8748.

Please print clearly.

Member Information

Name: _____

Social Security number (if applicable):

_____

Date of birth (DD/MM/YYYY): _____

MassHealth ID number (if applicable):

_____

Number of pages (including cover sheet): _____

Date: _____

Sender—Project Citizenship

Name: B. Feldmann

Phone number: 617-694-5949

Name of facility (if applicable):

_____

_____

This facsimile transmittal may contain information that is privileged, confidential, or exempt from disclosure under applicable law. It is intended for the use of only the individual or department to which it is addressed. If you are not the recipient or the employee or the agent responsible for the delivery of this transmittal to the intended recipient, please notify the sender by telephone at the above number and destroy the attached documents. Anyone other than the intended recipient is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited.

SECTION 1 Name of MassHealth applicant or member

Permission is given for MassHealth and its representatives to share information listed in **Section 2** about

(name of applicant or member whose information is to be shared)

Street

City/State/Zip

Date of birth **Telephone number**

MassHealth ID number

Please Note: If you do not have a MassHealth ID number, please use your social security number, if one has been issued, unless you are applying for or getting only MassHealth Limited, Children's Medical Security Plan (CMSP), or Healthy Start benefits.

SECTION 2 What information do you want shared?

Check the box or boxes that apply.

☐ I am giving MassHealth permission to share eligibility notices and information about eligibility for, and access to, MassHealth benefits, with the person or organization listed in **Section 3**. Please note such notices may contain financial information. Check this box only if you want the person or organization in **Section 3** to be able to contact MassHealth to get eligibility information and copies of your eligibility notices.

Please Note: Eligibility notices include information about all members of a household. If you check this box, a separate PSI form must be submitted and signed by each member of your household who is 18 years or older. If we do not get forms signed by each member of your household who is 18 years or older, we will not be able to honor your request.

☐ a summary of my MassHealth claims from _____ (month/year) to _____ (month/year)

☐ MassHealth's file containing my applications and related information

☒ other (please be specific):

I give permission for Project Citizenship to receive confirmation of my MassHealth eligibility in the form of a confirmation letter that includes my name and date of birth. Please fax to Project Citizenship at 617-859-9993 a letter that states that my MassHealth eligibility status as of the date of the letter.

By giving MassHealth this permission to share information, are you also giving MassHealth permission to share drug and alcohol treatment information?

☐ Yes. Share drug and alcohol treatment information.

☐ No. Do not share drug and alcohol treatment information.

SECTION 3 Whom do you want us to share information with?

List the name of ONLY ONE person or organization in this section. You must fill out another PSI form if you want to name more than one person or organization.

MassHealth may share the information listed in **Section 2** with

Project Citizenship

Name of person or organization

In care of (name of person in organization to whom mail should be sent)

4 Faneuil South Market Building 3rd Floor

Street

Boston, MA 02109

City/State/Zip

617-694-5949

Telephone number

SECTION 4 Why do you want us to share your information?

Tell us why you want to share the information listed in **Section 2**. If you leave this section blank, we will assume you mean "at my request."

SECTION 5 End of permission

This PSI will end in 18 months unless you specify an end date here. _____

SECTION 6 Your signature

I understand the following.

- When the person or organization named in **Section 3** gets this information from MassHealth, that person or organization may be able to share it with others without my permission. If they do so, federal and state privacy laws may not protect the information.
- I need to send this PSI to the appropriate address on the back page of this brochure.
- I may cancel this permission at any time by sending a letter to Privacy Office, 600 Washington Street, Boston, MA 02111.
- If I cancel this permission, MassHealth cannot take back any information that it shared when it had my permission to do so.
- If I do not give MassHealth permission to share information, or if I cancel my permission to share information with the person or organization named in **Section 3**, my MassHealth benefits will not be affected in any way.
- In certain circumstances, MassHealth may not honor my request to share information.

Name of applicant or member

Signature of applicant or member **Date**

(*See other side.*)

SECTION 7 Signature/Legal guardian

Fill out the following section if this form is being filled out by someone who has the legal authority to act on behalf of the applicant or member (such as the parent of a minor child, an eligibility representative, or a legal guardian).

Printed name of person filling out this form

Signature of person filling out this form

Date

Address

Telephone number

Authority of person filling out this form to act on behalf of the applicant or member:*

** If this form is being filled out by someone who has been appointed by a court as a legal guardian or conservator, or who has power of attorney or health-care proxy, a copy of the applicable legal document must be attached.*

Where to send this form

Please follow the instructions below.

- If you are **applying for health benefits** and wish to submit a PSI, send it to

  MassHealth Enrollment Center
  Central Processing Unit
  P.O. Box 290794
  Charlestown, MA 02129-0214

- If you are **already getting health benefits** and wish to submit a PSI, send it to

  MassHealth Enrollment Center
  P.O. Box 1231
  Taunton, MA 02780

- If you are **authorizing only specific information to be shared (such as your claims information or application file)**, and have checked off the second, third, or fourth box in Section 2, send the PSI to

  Privacy Office
  600 Washington Street
  Boston, MA 02111

PSI (Rev. 02/13)

MASSHEALTH

Permission to Share Information (PSI) Form

- **Use this form** if you want MassHealth to share the information we have about you with another person or organization, such as
  - a family member, friend, or other relative;
  - someone who helps take care of you;
  - someone who helps you fill out MassHealth forms; or
  - a social worker, lawyer, or health-care advocacy group.

- **Do not** use this form if you want
  - information about yourself;
  - information about your children under age 18 (You can usually get this without filling out any forms.); or
  - your eligibility and payment information to be shared with your health-care provider. (Your health-care provider can get information about your MassHealth eligibility and payment for services provided to you without you filling out any forms.)

- **Important:** If you decide that you do need to fill out this form, you must fill out all sections completely. Please print clearly.

Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth