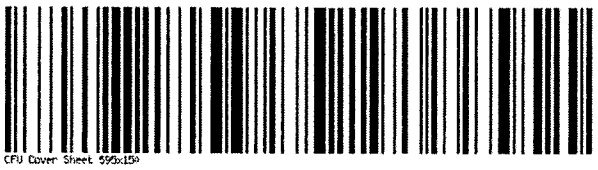

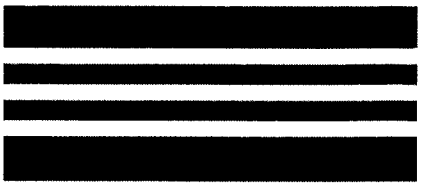

Project Citizenship PSI Fax Cover Sheet to MassHealth

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: E. Finn

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 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

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