Special Circumstances HSN Application

If you need help filling out this application, contact CHA Financial Assistance
350 Main Street, 4th Floor, Malden, MA 02145
617-665-1100

Please scan and email your completed application to certifiedca@challiance.org or fax to 781-338-0268

This form will be used to determine if you are eligible for Health Safety Net Confidential or health care coverage through other programs. If you are applying for someone else, please answer all questions using the applicant's information. If a section or question does not apply to you or any family member, write "N/A". If you need additional space, please use another sheet of paper.

APPLICANT INFORMATION

Last Name, First Name, Middle initial and Social Security (SSN) / Tax ID Number (TIN) (if issued)

_____

Telephone Numbers: (Home) _____ *(Work)* _____

Street Address _____

City, State, Zip and Mailing Address (if different from the street address)

_____

Date of Birth _____ *Gender: Male Female Nonbinary Are you pregnant? Yes No*

OPTIONAL QUESTION

This question is asked for data collection and analysis purposes only and in no way will be used to determine program eligibility.

Race: *American Indian or Alaskan Native __ Asian or Pacific Islander __ White, not Hispanic __*
Black, not Hispanic __ Hispanic __ Other _____

ASSIGNMENT OF RIGHTS

Please read this section carefully and sign at the bottom.

While I am eligible for Health Safety Net, I agree to tell this hospital or community health center of any changes in my family status including family size, income changes, and health insurance coverage which could change my eligibility for Health Safety Net.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request. I authorize this hospital or community health center to give to the Division of Health Care Finance and Policy or designee the information needed to confirm my eligibility for Health Safety Net and to administer the Health Safety Net.

I understand that this hospital or community health center cannot share confidential information, such as the information contained in this application, with any other state or federal agency, except as stated above, without my prior approval.

Signature of applicant _____ ***Date*** _____

Revised 11.4.2019

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Standard Affidavit for Residency Documentation

Date _____

I,_____ certify that:
(Applicant Name)

1) ___ I am a resident of Massachusetts
2) ___ I have lived in Massachusetts since I received health care services at this facility.
3) ___ I have no residency status in another state or country.
4) ___ I intend to remain in Massachusetts indefinitely.
5) ___ I have not moved to Massachusetts for the sole purpose of receiving health care benefits.

I am currently living at _____
(Address)

I do not have documentation that I am living at this address because:
_____

I verify that the above statement is true and correct:

_____
(Signature)

****If this affidavit was not provided by the applicant, please explain why:***

_____

_____

Affidavit provided by:

_____
(Name)

Relationship to applicant: _____

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Standard Affidavit Form for No Income

Date _____

I, _____,
(Applicant Name)
certify that I have no income earned or unearned, or from any source.

I currently support myself by:_____

I verify that the above statement is true and correct:

_____
(Signature)

****If this affidavit was not provided by the applicant, please explain why:***
_____

_____

Affidavit provided by:
_____
(Name)

Relationship to applicant: _____