Prescription Advantage

SELF-ATTESTATION NEW APPLICANT - INCOME FORM

Select why you are completing this form (check all that apply)

☐ You are applying for Prescription Advantage AND you have not filed federal tax returns in the last (2) calendar years

☐ You are applying for Prescription Advantage and requesting to remove income no longer received from your reported income

☐ Other, (specify) ________________________________

Please print clearly and fill out all applicable income amounts.

SECTION A: Applicant Information

....	....	....
Last name (Applicant)	**First name (Applicant)**	**Date of Birth**
Last name (Applicant Spouse)	**First name (Applicant Spouse)**	**Date of Birth**

....

Street Address (where you are living in MA) **City** **State** **ZIP**

SECTION B: Income Calculation

The income reported below is for calendar year: __________

- If you have NOT filed federal income tax returns in the last (2) calendar years list all gross annual income received in the previous year. The ***gross amount is before deductions, such as Part B or Part D premiums, and taxes and must include applicant & spouse.***
- If you are requesting to have income removed from your previous year's earnings enter the gross amount in the appropriate type, i.e., employment wages. If your reported income impacts your eligibility in the Prescription Advantage program and / or your membership category, you may be asked to provide supporting documentation.

Type (all applicable)	Gross Amount (Applicant & Spouse)	Income No Longer Received	Type (all applicable)	Gross Amount (Applicant & Spouse)	Income No Longer Received
Social Security	$	$	Business/Self-Employment	$	$
Employment Wages	$	$	Alimony	$	$
1099 - Income Reported	$	$	Rental Income	$	$
Unemployment	$	$	Veterans Taxable Benefits	$	$
Disability Payments	$	$	Taxable Refunds	$	$
Retirement	$	$	3rd Party Sick Pay	$	$
Railroad Retirement	$	$	Trust Fund	$	$
Pension / Annuity	$	$	Other **(specify)**, __________	$	$
IRA	$	$	Other **(specify)**, __________	$	$
Gambling	$	$	Other **(specify)**, __________	$	$
Capital Gains	$	$	Other **(specify)**, __________	$	$
Dividends /Interest	$	$	Other **(specify)**, __________	$	$
Total annual gross income = $__________			**Total income to be removed = $__________**		
Total gross income (total annual – income removed) = $____________					

SECTION C: Signature (Required)

I hereby certify, under the pains and penalties of perjury, that I have examined all the information on this form and the accompanying documentation and that it is true, complete, and correct to the best of my knowledge and belief. I further certify that any information I submit in the future related to this form and the accompanying documentation submitted will also be true, complete, and correct to the best of my knowledge and belief.

If you are acting on behalf of someone who is unable to complete this form because of a physical or mental condition, by signing this form, you are declaring that the information submitted, and any accompanying or supplemental information is true, complete, and correct to the best of your knowledge and belief. ****Note* - If you are a Healthcare Proxy/Power of Attorney, you must complete an Authorized Representative Form specifically for Prescription Advantage.***

Sign name (Applicant).. Date ....

Sign name (Applicant Spouse, if applying) .... Date ....

☐ Check here if you are an Authorized Representative