**SELF-ATTESTATION – INCOME TO BE ADDED**

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

[ ]  I am applying for Prescription Advantage and have income to be **added** to the amount on my federal tax return (e.g., Social Security not earned last year or Veteran’s Benefits)

[ ]  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 Changes

# Income to be Added The income reported below is for calendar year: \_\_\_\_\_\_\_\_\_\_\_

If you are currently receiving Social Security wages, Veteran’s Benefit (if applicable) or other incomethat are not listed on your federal tax returns, you must indicate the gross amount of that income. If your income changes, you may request a recalculation and you may be required to provide the income documentation.

# **Use this section to declare social security wages / income NOT listed on your federal tax return**

|  |  |  |
| --- | --- | --- |
| **Type (all applicable)** | **Gross Amount Applicant** | **Gross Amount Spouse** |
| Social Security Wages | $ | $ |
| Veteran’s Benefits | $ | $ |
| Other (**specify)**, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ | $ |
| **Total gross income (total of income above) = $\_\_\_\_\_\_\_\_\_\_\_** |

# 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 .....................

o Check here if you are an Authorized Representative