

**IMPORTANT! You do NOT need to fill out this form. It is optional. Complete it only if you want assistance with health insurance.**

**Dear Parent,**

**Your child may be eligible for FREE OR LOW-COST HEALTH COVERAGE through MassHealth or the Children's Medical Security Plan (CMSP).**

**If you would like assistance with health coverage or have questions, please complete this form and return it to your school.**

**Please fill out only one form for all family members.**

**Thank you.**

*Check all the boxes that apply:*

I would like assistance in obtaining MassHealth or the Children's Medical Security Plan for my child.

My child has MassHealth or CMSP and I have questions about it (such as how to find a doctor, what medical services are covered, and how to keep the coverage)

*Complete the following information:*

I agree that school staff may give my name, address and phone number to the Vineyard Health Care Access Program to contact me to provide more information and/or assistance with a MassHealth/ Children's Medical Security Plan application.

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Name of parent/guardian \_\_\_\_\_

Street address \_\_\_\_\_ Apartment no. \_\_\_\_\_

City \_\_\_\_\_ Zip code \_\_\_\_\_ Phone no. \_\_\_\_/\_\_\_\_-\_\_\_\_

Name of child

Child's date of birth

Child's school

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

Best time of day to contact me (*circle one*): morning afternoon evening

***If you have questions, or would like assistance applying contact the Vineyard Health Care Access Program at (508) 696-0020.***