Access Health CT
PO Box 670
Manchester, CT 06045-0670

Attestation of Non-Income

Application ID: _____

I, [First Name, Last Name],_____attest that I will have no household income for the benefit year in which I will receive financial assistance for my health plan.

I acknowledge that Access Health CT will only use the information provided on this form for healthcare eligibility determination for financial assistance.

I understand that I must report changes to my income to Access Health CT within 30 days of the change because it may affect the amount of Advanced Premium Tax Credits (APTCs) I will receive or the level of cost-sharing reduction for which I may qualify.

If I fail to timely report changes to my income to Access Health CT and I receive too much premium assistance (APTCs), I understand I will have to pay some or all of the premium assistance (APTCs) I received back to the Internal Revenue Services (IRS) when I file my federal income tax return for the benefit year.

I declare under penalty of perjury under the law of the State of Connecticut that the forgoing is true and correct.

Applicant's Signature: _____

Date: ____ / ____ / _____

If you are unable to upload your verification documents to us, you can mail them to:

Access Health CT | P.O. Box 670 | Manchester, CT 06045-0670

Be sure to include the cover sheet with the unique barcode that we sent to you. This cover sheet accompanied the letter asking for documentation.