



Massachusetts HIV Drug Assistance Program (HDAP)

Agreement Regarding Reconciliation of Premium Tax Credits – Tax Year 2021

Please sign, date, and return this form immediately.

FAX this form to (617) 502-1703, **MAIL** it to: AccessHealth MA, ATTN: BRIDGE Team, Schrafft's City Center, 529 Main Street, Suite 301, Boston, MA 02129, or **EMAIL** it securely to: BRIDGEteam@accesshealthMA.org.

REQUIRED

I, (Name) _____, agree to make payment to AccessHealth MA for any federal tax refund I receive from the Internal Revenue Service (IRS) for Net Premium Tax Credits (PTCs), or a portion of it, resulting from health insurance premium payments made on my behalf by the Massachusetts HDAP/CHII program during tax year 2021.

I understand that this portion of my tax refund due to Net PTCs is the sole property of the HDAP/CHII program, which expects to receive payment within 10 days of my having received the refund from the IRS.

I also authorize HDAP/CHII to make a payment to the IRS on my behalf if I owe money to the IRS due to Excess Advance PTCs, as a result of overpayment of Advance PTCs due to underestimating my 2021 income, and I have provided them with the required documentation.

By signing below, I agree to these terms and conditions.

Signature: _____ **Date:** _____

Please contact the BRIDGE Team with questions: BRIDGEteam@accesshealthMA.org, or (617) 502-1700, press "1", then press "5".

This program is supported by funds from the U.S. Health Resources and Services Administration and the Massachusetts Department of Public Health, and is administered by AccessHealth MA.