Facility Information	Head of Household (HOH) Information
Facility Name: _____	Name: _____
Sender's Phone No: _____	DOB: _____
Sender's Name: _____	Soc. Sec. No: _____

Please include this cover sheet when faxing or mailing any documents to the MassHealth UCP Review Team.

FAX NUMBER

617-241-6005

Place a checkmark (✓) in the appropriate space below identifying the attached verification(s).

____ **UCP Eligibility Review Form**

____ **Income**

____ **Other** _____

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