APPLICATION FOR HEALTH COVERAGE FOR SENIORS AND PEOPLE NEEDING LONG-TERM-CARE SERVICES

Commonwealth of Massachusetts | EOHHS

SACA-2-LP-0719

APPLICATION INSTRUCTIONS

HOW TO APPLY

Please identify which program each household member is applying for on pages 1-3 of the application. You can submit your application in any of the following ways.

Mail or fax your filled-out, signed application to

MassHealth Enrollment Center
Central Processing Unit
P.O. Box 290794
Charlestown, MA 02129-0214
Fax: (617) 887-8799

Hand deliver your filled-out, signed application to

MassHealth Enrollment Center
Central Processing Unit
The Schrafft Center
529 Main Street, Suite 1M
Charlestown, MA 02129-0214

In order to get any benefits you are entitled to as quickly as possible, you may send us any documentation you have that verifies all household income and assets.

MASSHEALTH and the HEALTH SAFETY NET

Who Can Use This Application

This is your application for health coverage if you live in Massachusetts and are:

- an individual 65 years of age or older and living at home and
  - not the parent of a child under 19 years of age who lives with you; or
  - not an adult relative living with and taking care of a child younger than 19 years of age when neither parent is living in the home; or
  - disabled and are either working 40 or more hours a month or are currently working and have worked at least 240 hours in the six months immediately before the month of the application;
- an individual of any age and need long-term-care services in a medical institution or nursing facility; or
- an individual who is eligible under certain programs to get long-term-care services to live at home; or
- a member of a married couple living with your spouse, and
  - both you and your spouse are applying for health coverage;
  - there are no children under 19 years of age living with you; and

- one spouse is 65 years of age or older and the other spouse is under 65 years of age. (Please see Step 8 of the application.)

If you meet any of the following exceptions, you should complete the Application for Health and Dental Coverage and Help Paying Costs (ACA-3). To obtain a copy of this application, call us at **(800) 841-2900** (TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled).

- You are the parent of a child under 19 years of age who lives with you.
- You are an adult relative living with and taking care of a child younger than 19 years of age when neither parent is living in the home.

You will also need to fill out a Long-Term-Care Supplement if you are:

- in an institution, such as a nursing home, chronic hospital, or other medical institution (You may have to pay a monthly payment, called a patient-paid amount, to the long-term-care facility. For more information, see page 52 in the Large Print (LP) version of the Senior Guide.);
- in an acute hospital waiting for placement in a long-term-care facility; or
- living in your home and applying for or getting long-term-care services under a Home- and Community-Based Services Waiver.

If someone is helping you fill out this application, you may need to fill out a separate form that gives that person permission to act on your behalf. See Authorized Representative Designation Form at the end of this application.

MASSACHUSETTS HEALTH CONNECTOR

Who Can Use This Application

This is your application for health coverage if you live in Massachusetts, your income is at or below 400% of the federal poverty level, and you:

- are 65 years of age or older;
- are not otherwise eligible for MassHealth;
- are not getting Medicare; and
- do not have access to an affordable health plan that meets the minimum value requirement.*****

***** Minimum value requirement means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee.

The Health Connector uses Modified Adjusted Gross Income (MAGI) rules to determine eligibility. See the Senior Guide for more information.

WHAT YOU NEED WHEN YOU APPLY

The following MUST be sent with the application when applying for MassHealth, the Health Safety Net, and the Massachusetts Health Connector

Social Security Number (SSN)

You must give us an SSN or proof that one has been applied for for every household member who is applying, unless one of the following exceptions applies.

- You or any household member has a religious exemption as described in federal law.
- You or any household member is eligible only for a nonwork SSN.
- You or any household member is not eligible for an SSN.

Unless an exception applies, **we need SSNs for all persons applying** for health coverage. **An SSN is optional for persons not applying for health coverage, but giving us an SSN can speed up the application process.** We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone does not have an SSN or needs help getting one, call the Social Security Administration at (800) 772-1213, TTY: (800) 325-0778, or go to www.socialsecurity.gov. Please see the Senior Guide for more information.

Proof of income, assets, and insurance

We will attempt to verify some of this information through electronic data matches and will notify you if we need further proof. It may speed up the processing of your application if you send proof of these items with it.

- Proof of all current income before deductions, such as copies of pay stubs or pension check stubs (You do not have to send proof of social security or SSI income, but you must fill out the social security and SSI income information, if applicable.)
- Proof of all assets, such as bank accounts and life insurance policies
- Copies of your current health insurance premium bills (such as Medex) if you are applying for long-term-care services in a medical facility. (You do not have to send copies of your Medicare cards.)
- Policy numbers for any current health coverage
- Information about any other health insurance available to your household

Proof of citizenship/national status

We will try to verify this information through electronic data matches. We will notify you if we need further proof. It may speed up the processing of your application if you send proof of these items with it.

- Proof of U.S. citizenship/national status and proof of identity, such as U.S. passports or U.S. naturalization papers. You can also prove U.S. citizenship with a U.S. public birth certificate. You can also prove identity with a driver's license or some other form of government-issued card. We may be able to prove your identity through the Massachusetts Registry of Motor Vehicles records if you have a Massachusetts driver's license or a Massachusetts ID card. Once you give MassHealth proof of your U.S. citizenship/national status and identity, you will not have to give us this proof again. You must give us proof of identity for all household members who are applying. **Seniors and disabled persons who get or can get Medicare or Supplemental Security Income (SSI), or disabled persons who get Social Security Disability (SSDI), do not have to give proof of their U.S. citizenship/national status and identity.** (See Section 9 in the Senior Guide for complete information about acceptable forms of proof.)
- A copy of both sides of all immigration cards (or other documents that show immigration status) for you or your spouse if you or your spouse are not U.S. citizens/nationals and are applying for MassHealth (except for MassHealth Limited), the Health Safety Net, or the Health Connector plans.

For more information on immigration statuses and document types, please see page 73.

Why we ask for this information

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We will keep all the information you provide private and secure, as required by law.** To view the Health Connector's privacy policy, go to mahealthconnector.org. To view MassHealth's privacy policy, go to www.mass.gov/service-details/masshealth-member-privacy-information.

WHAT HAPPENS NEXT and WHERE TO GET HELP

When we get your filled-out, signed, and dated application, we will review it. If we need more information, we will write or call you. Once we get all needed information, we will make a decision about your eligibility. We will send you a written notice about this decision. If you are determined eligible for MassHealth, show this notice right away to any health care provider if you already paid for medical services that would be covered by MassHealth during your eligibility period. If the health care provider determines that MassHealth will pay for these services, the provider will refund what you paid.

If you need more information about how to apply, or if you need another copy of **Supplement C: Personal-Care Attendant** for your spouse who is also applying, call us

at (800) 841-2900, TTY: (800) 497-4648. This application is available in Spanish. Please call the number above to request one.

If you have any questions about any form or the information you need to send, please call us at (800) 841-2900, TTY: (800) 497-4648.

APPLICATION FOR HEALTH COVERAGE FOR SENIORS AND PEOPLE NEEDING LONG-TERM-CARE SERVICES

Commonwealth of Massachusetts | EOHHS

Please Print Clearly. Be sure to answer all questions. Fill out all parts of the application, along with all supplements that apply. If you need more space, attach a separate piece of paper to the application. Put Person 1's name and social security number at the top of any attached paper.

For each member in your household, please put the name(s) of the individual(s) under the program or programs he or she wants to apply for. Please see the Senior Guide to learn more about coverage under these programs.

Please list the names of everyone who is applying for health coverage on this application.

☐ **MassHealth or the Health Safety Net (HSN)**

(If living at home, or in a rest home, an assisted living facility, a continuing care retirement community, or life care community, fill out this application and any supplements that apply to you or any household member.) MassHealth will check if anyone applying for health coverage on this application is eligible for MassHealth or the HSN.

You: _____

Spouse: _____

☐ **Long-Term Care**

☐ **Home- and Community-Based Services Waiver**

(If applying for or getting long-term-care services at home under an HCBS Waiver, or in a nursing home or chronic hospital, fill out this application and any supplements that apply to you or any household member, including all or part of the Long-Term-Care Supplement.)

You: _____

Spouse: _____

☐ **Health Connector Programs**

Health coverage through the Massachusetts Health Connector is not MassHealth. If you have Medicare, you will not be eligible for any cost sharing or Advance Premium Tax Credits, and you cannot purchase a plan through the Health Connector, unless you were enrolled in a Health Connector plan when you became eligible for Medicare. The only time you should apply for Health Connector programs if you have Medicare is if you are not enrolled in Medicare yet but would have to pay for your Medicare Part A premium. In this case, you may be eligible for a Health Connector plan.

You: _____

Spouse: _____

Note:
PACE – Program of All-Inclusive Care for the Elderly

Some MassHealth members may be eligible to enroll in the Program of All-Inclusive Care for the Elderly (PACE), which provides members access to a wide range of medical, social, recreational, and wellness services through a center-based model. See page 34 of the Senior Guide for more information.

STEP 1 PERSON 1 (YOU)— TELL US ABOUT YOURSELF.

We need one adult in the household to be the contact person for your application. Please note that this should be someone who appears on the application, not a third party who wishes to serve as a contact for the applicant(s). Please see the Authorized Representative Designation (ARD) at the end of this application, to establish a third-party contact.

1. First name, middle name, last name, and suffix

   _____

2. Date of birth (mm/dd/yyyy) ___ /___ /_____

3. Street address ☐ Check this box if homeless.
   You must provide a mailing address.

   _____

4. Apartment or unit number _____

5. City _____

6. State _____ 7. Zip code _____

8. County _____

9. Is this a hospital, nursing facility,or other institution?
   ☐ Yes ☐ No
   If **Yes**, facility name

   _____

10. Mailing address ☐ Check if same as street address.

    _____

11. Apartment or unit number _____
12. City _____
13. State _____ 14. Zip code_____
15. County _____
16. Phone number _____
17. Other phone number _____
18. Email _____
19. # of people listed on the application _____
20. What is your preferred language, if not English?
    Spoken _____
    Written _____
21. Is anyone on this application in prison or jail?
    ☐ Yes ☐ No
    If **Yes**, who? Enter the name here:

    _____

For enrollment assisters only

Complete this section if you are an enrollment assister and are filling out this application for someone else. Navigators must fill out a Navigator Designation Form if they have not done so already. Certified Application Counselors must fill out a Certified Application Counselor Designation Form if they have not done so already.

Check one

☐ Navigator ☐ Certified Application Counselor

First name, middle name, last name, and suffix

_____

Email address _____

Organization name _____

Organization identification number _____

Organization phone number _____

STEP 2 PERSON 1

1. First name, middle name, last name, and suffix

   _____

2. Gender ☐ Male ☐ Female

3. Relationship to you **SELF**

4. Are you applying for health coverage for YOURSELF? ☐ Yes ☐ No

   If **Yes,** answer all the questions below in Step 2 for Person 1 (yourself).
   If **No**, answer Question 17 (accommodations), then go to the Income Information section on page 16.

5. Do you have a social security number (SSN)?
   ☐ Yes ☐ No (optional if **not** applying)
   We need a social security number (SSN) for every person applying for health coverage who has one. Giving us an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. A social security number is required if a person is applying for MassHealth Premium Assistance. If someone needs help getting an SSN, call the Social Security Administration at (800) 772-1213 (TTY: (800) 325-0778), or go to socialsecurity.gov.

   If **Yes**, give us the number __ __ __ - __ __ - __ __ __ __

If **No**, check one of the following reasons.

☐ Just applied
☐ Noncitizen exception
☐ Religious exception

Is your name on this application the same as your name on your social security card? ☐ Yes ☐ No

If **No**, what name is on your Social Security card?
First name, middle name, last name, and suffix

_____

6. If you get an Advance Premium Tax Credit (APTC), do you agree to file a federal tax return for the tax year that the credits are received? ☐ Yes ☐ No

   You may not have needed or chosen to file a tax return in the past, but you will have to file a federal income tax return for any year that you get an APTC. You must check **Yes** to question 6 to be eligible for ConnectorCare or APTCs to help pay for your health insurance.
   You do NOT need to file a tax return to apply for or to get MassHealth or HSN, if you qualify.

   If **Yes**, please answer questions a–d.
   If **No**, skip to question d.

   You must file a joint federal tax return with your spouse for the year for which you are applying to get certain programs (ConnectorCare or APTCs) unless you are a victim of domestic abuse or abandonment or you will file taxes as Head of Household. If you will

file taxes as Head of Household, you should answer **No** to question 6a ("Are you legally married?"). One way you may qualify as Head of Household is to live apart from your spouse and claim another person as a dependent. See IRS Publication 501 or consult a tax professional for tax filing information. You will only need to include yourself and any dependents on this application.

a. Are you legally married? ☐ Yes ☐ No
   If **No**, skip to question 6c.
   If **Yes**, list name of spouse and date of birth.

   _____

b. Do you plan to file a joint federal tax return with your spouse for the tax year for which you are applying? ☐ Yes ☐ No

c. Will you claim any dependents on your federal income tax return for the year which you are applying? ☐ Yes ☐ No
   You will claim a personal exemption deduction on your federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments.

   List name(s) and date(s) of birth of dependents.

   _____

d. Will you be claimed as a dependent on someone else's federal income tax return for the year for which you are applying? ☐ Yes ☐ No
If you are claimed by someone else as a dependent on their federal income tax return, this may affect your ability to receive a premium tax credit. Do not answer **Yes** to this question if you are a child under the age of 21 being claimed by a noncustodial parent.

If **Yes**, please list the name of the tax filer.

_____

Tax filer date of birth ___ /___ /_____

How are you related to the tax filer? _____

Is the tax filer married, filing a joint return?
☐ Yes ☐ No

If **Yes**, list name of spouse and date of birth.

_____

Who else does the tax filer claim as dependents?

_____

e. Are you filing taxes separately because you are a victim of domestic abuse or abandonment?
☐ Yes ☐ No

Optional: To complete this section, read the following statement. Then check yes below the statement if:

1. You have received an APTC or ConnectorCare in the past, and

2. The statement is true for all people listed in the household.

Statement

I filed a federal income tax return with the Internal Revenue Service (IRS) for every year that I received an Advance Premium Tax Credit (APTC). When I filed, I included IRS Form 8962, which had information about the tax credit I received, so the IRS could reconcile my APTC. ☐ Yes ☐ No

7. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

   If **Yes**, are you a naturalized citizen (not born in the US)? ☐ Yes ☐ No

   Alien number _____

   Naturalization or citizenship certificate number

   _____

8. If you are a noncitizen, do you have an eligible immigration status? ☐ Yes ☐ No
   See page 73, “Immigration Statuses and Document Types” for help. If **No** or **no response**, you may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children’s Medical Security Plan (CMSP), or the Health Safety Net (HSN). Go to Question 9.

   a. If **Yes**, do you have an immigration document? ☐ Yes ☐ No

It may help us to process this application faster if you include a copy of your immigration document with the application. We will try to verify your immigration status through an electronic data match. Please list all the immigrations statuses and/or conditions that have applied to you since you entered the U.S. If you need more space, attach another sheet of paper.

Status award date (mm/dd/yyyy) ___ /___ /_____
(For battered persons, enter the date the petition was approved.)

Immigration status _____

Immigration document type

_____

Choose one or more document status and type from the list on page 73.

Document ID number _____

Alien number _____

Passport or document expiration date
(mm/dd/yyyy) ___ /___ /_____

Country _____

b. Did you use the same name on this application that you did to get your immigration status?
☐ Yes ☐ No

If **No**, what name did you use?

_____
First, middle, last, and suffix

c. Did you arrive in the U.S. after August 22, 1996?
☐ Yes ☐ No

d. Are you an honorably discharged veteran or active-duty member of the U.S. military, or the spouse or child of an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

e. **Optional** Are you a
☐ victim of severe trafficking,
☐ a spouse, child, sibling,
or parent of a trafficking victim
☐ a battered spouse,
☐ a child or the parent of battered spouse?

9. What is your race or ethnicity? (Optional)

_____

Please see page 76.

10. Are you living in Massachusetts, and do you either intend to reside here, even if you do not have a fixed address or have you entered Massachusetts with a job commitment or seeking employment? ☐ Yes ☐ No

    If you are visiting in Massachusetts for personal pleasure or for the purposes of receiving medical care in a setting other than a nursing facility, you must answer **No** to this question.

11. Do you live with at least one child younger than age 19, and are you the main person taking care of this child or children? ☐ Yes ☐ No

Names(s) and date(s) of birth of child(ren)

_____

12. Are you pregnant? ☐ Yes ☐ No

    If **Yes**, how many babies are you expecting? __
    What is the expected due date? ___ /___ /____

13. Were you ever in foster care? ☐ Yes ☐ No

    a. If **Yes**, in what state were you in foster care? _____

    b. Were you getting health care through a state Medicaid program? ☐ Yes ☐ No

14. Are you in jail or prison? Please select **No** if you will be released in the next 60 days. ☐ Yes ☐ No
    If **Yes**, are you awaiting trial? ☐ Yes ☐ No

15. Do you rent or own your property? ☐ Rent ☐ Own

16. **DISABILITY** Answer this question if you are under age 65 or age 65 or older and working.
    Do you have a disability (including a disabling mental health condition) that has lasted or is expected to last for at least 12 months? (If legally blind, answer **Yes**.)
    ☐ Yes ☐ No
    Name: _____

17. Do you need reasonable accommodation(s) because of a disability or injury? ☐ Yes ☐ No

    If **No**, go to the next question.
    If **Yes**, answer questions a and b.

a. Condition:
   - ☐ Low vision ☐ Blind ☐ Deaf
   - ☐ Hard of hearing ☐ Developmentally disabled
   - ☐ Intellectually disabled ☐ Physically disabled
   - ☐ Other (Please explain.) _____

b. Accommodation:
   - ☐ Text telephone (TTY)
   - ☐ Large-print publications
   - ☐ American Sign Language interpreter
   - ☐ Video Relay Service
   - ☐ Communication Access Real-time Translations (CART)
   - ☐ Publications in braille
   - ☐ Assistive listening device
   - ☐ Publications in electronic format
   - ☐ Other (Please explain.) _____

18. Are you applying because of an accident or injury that someone else might be responsible for? ☐ Yes ☐ No

    a. Did someone else cause your injury, illness, or disability, or could someone else's insurance or your own insurance, other than health insurance (like homeowner's or auto insurance) cover it?
       ☐ Yes ☐ No

    b. Have you filed a lawsuit, a workers' compensation claim, or an insurance claim for this accident or injury? ☐ Yes ☐ No

19. Did you ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No

    If **No**, go to Income Information.
    If **Yes**, answer questions a and b.

    a. When did you last get SSI? (mm/yyyy) ___ /___ /_____

    b. Do you (check one.):
    ☐ live alone?
    ☐ live with a spouse?
    ☐ live in a rest home?
    ☐ live in someone else's home?

Income Information **(You may send proof of all household income with this application.)**

20. Do you have any income? ☐ Yes ☐ No
    If you don't have income, skip to question 30.

21. Is your income steady from month to month?
    ☐ Yes ☐ No

    If **No**, please provide the average income for the time period (per week, per month, etc.) for the questions below.

Current Job
If you have more jobs and need more space, attach another sheet of paper.

22. Employer name and address

    _____

    _____

Federal Tax ID# _____

23. a. Wages/tips (before taxes) $ _____
☐ Weekly ☐ Every 2 weeks
☐ Twice a month ☐ Monthly ☐ Yearly
(Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)

    b. Income effective date ___ /___ /_____

24. Average number of hours worked each WEEK ____

25. Are you seasonally employed? ☐ Yes ☐ No
If **Yes**, which months do you work in a calendar year?
☐ Jan. ☐ Feb. ☐ March ☐ April ☐ May
☐ June ☐ July ☐ August ☐ Sept. ☐ Oct.
☐ Nov. ☐ Dec.

Self-employment
If self-employed, answer the following questions.
If you need more space, attach another sheet of paper.

26. Are you self-employed? ☐ Yes ☐ No

    a. If **Yes**, what type of work do you do?

    _____

    b. On average, how much net income (profits after business expenses are paid) will you get from this self-employment each month, or, how much will you lose from this self-employment each month?
    $_____/month **profit** OR $_____/month **loss**?

    c. How many hours do you work per week? _____

Other income

27. Check all that apply, and give the amount and how often you get it. **NOTE: You do not need to tell us about child support or Supplemental Security Income (SSI).**

☐ Social Security benefits
$ _____ How often received? _____

☐ Retirement or Pension
$ _____ How often received? _____

☐ Annuities
$ _____ How often received? _____

☐ Trusts
$ _____ How often received? _____

☐ Unemployment
$ _____ How often received? _____

☐ Interest, dividends, and other investment income
$ _____ How often received? _____

☐ Royalty income
$ _____ How often received? _____

☐ Alimony received
$ _____ How often received? _____

☐ Federal veteran's benefits
Taxable? ☐ Yes ☐ No
$ _____ How often received? _____

☐ Taxable military retirement pay
$ _____ How often received? _____

☐ Other taxable income (include type)
$ _____ How often received? _____
Type _____

☐ Capital gains: On average, how much net income or loss will you get from this capital gain each **month**?
$ _____/ **profit** OR $ _____/ **loss**

☐ Net farming or fishing income: On average, how much net income (profits after business expenses are paid) or loss will you get from this business each **month**?
$ _____/ **profit** OR $ _____/ **loss**

Rental Income

28. Do you get rental income? **(You must answer this question.)** ☐ Yes ☐ No

    If **Yes**, **send proof** of current rental income, such as a written statement from each tenant, a copy of the lease, or a current federal tax return. Also **send proof** of all of the following expenses, if applicable, for the last 12 months: mortgage, taxes, utilities (gas/electric), heat, water/sewer, insurance, condo or co-op fee, repairs and maintenance.

    a. What type of real estate do you own?
    ☐ one-family ☐ two-family ☐ three-family
    ☐ other (describe): _____

b. How much **monthly** rental income or loss do you get from each rental unit from the real estate indicated above? (List each rental unit and address separately.)

Address _____ Unit #____
Amount of Income _____ Amount of Loss _____
Owner-occupied? ☐ Yes ☐ No

Address _____ Unit #____
Amount of Income _____ Amount of Loss _____
Owner-occupied? ☐ Yes ☐ No

c. Do you pay for heat or utilities for your tenant?
☐ Yes ☐ No

One-Time-Only Income

29. Have you or will you receive income during this calendar year as a one-time only payment? ☐ Yes ☐ No
Examples might be a lump-sum pension payment or a one-time capital gain.

If **Yes**: Type: _____ Amount $ _____
Month Received _____ Year received _____

30. Will you receive income during the next calendar year as a one-time only payment? ☐ Yes ☐ No

If **Yes**: Type: _____ Amount $ _____
Month Received _____ Year received _____

Deductions

31. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. What deductions do you report on your income tax return? Check all that apply. Your deductions should be what you report on your federal income tax return in the section “Adjusted Gross Income.” For each deduction you select, give the yearly amount. You can enter up to the maximum deduction amount allowed by the IRS.

- ☐ Educator expenses $ _____ Yearly amount
- ☐ Certain business expenses of reservists, performing artists, or fee-based government officials
  $ _____ Yearly amount
- ☐ Health Savings Account deduction
  $ _____ Yearly amount
- ☐ Moving expenses for members of the Armed Forces
  $ _____ Yearly amount
- ☐ Deductible part of self-employment tax
  $ _____ Yearly amount
- ☐ Contribution to self-employed SEP, SIMPLE, and qualified plans $ _____ Yearly amount
- ☐ Self-employed health insurance deduction
  $ _____ Yearly amount

☐ Penalty on early withdrawal of savings
$ _____ Yearly Amount

☐ Alimony paid $ _____ Yearly amount

☐ Individual Retirement Account (IRA) deduction
$ _____ Yearly amount

☐ Student loan deduction (interest only, not total payment) $ _____ Yearly amount

☐ Higher education tuition and fees
$ _____ Yearly amount

☐ None

Yearly income

32. What is your total expected income for the current calendar year? _____

33. What is your total expected income for next calendar year, if different? _____

THANKS! This is all we need to know about you. Go to Step 2 Person 2 to add another household member, if needed. Otherwise, go to Step 3 American Indian or Alaska Native (AI/AN) Household Member(s).

STEP 2 PERSON 2—SPOUSE OR OTHER PEOPLE IN THIS HOUSEHOLD

Fill out this part for your spouse who lives with you or anyone included on your federal income tax return, if you file one.

If you have to include more than two people on this application, make a copy of blank information pages for Step 2 Person 2 BEFORE you fill them out. When filling out the additional pages please be sure to tell us how each person is related to each other person on the application. We need this information to determine eligibility. You can also download pages for additional persons at mass.gov/masshealth. Under MassHealth Publications, click on MassHealth Member Library. Click on MassHealth Member Applications, then Massachusetts Application for Health and Dental Coverage and Help Paying Costs – Additional Persons.

1. First name, middle name, last name, and suffix

   _____

2. Date of birth ___ /___ /_____

3. Gender ☐ Male ☐ Female

4. Relationship to Person 1 _____

5. Does this person live with Person 1? ☐ Yes ☐ No

   If **No**, provide street address

   _____

☐ No street address. Note: if you check this box, you must provide a mailing address.

6. Is this a hospital, nursing facility, or other institution? ☐ Yes ☐ No
   If **Yes**, facility name _____

7. Mailing address
   ☐ Check if same as street address.

   _____

8. Apartment or unit number _____

9. City _____

10. State _____ 11. ZIP code _____

12. County _____

13. What is your preferred language, if not English?
    Spoken _____
    Written _____

14. Is this person applying for health or dental coverage?
    ☐ Yes ☐ No

    If **Yes**, answer all the questions below in Step 2 for Person 2

    If **No**, answer Question 27 (accommodations), then go to the Income Information section on page 34.

15. Does this person have a social security number (SSN)?
    ☐ Yes ☐ No (optional if **not** applying)
    We need a social security number (SSN) for every person applying for health coverage who has one.

Giving us an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. A social security number is required if a person is applying for MassHealth Premium Assistance. If someone needs help getting an SSN, call the Social Security Administration at (800) 772-1213 (TTY: (800) 325-0778), or go to socialsecurity.gov.

If **Yes**, give us the number __ __ __ - __ __ - __ __ __ __

If **No**, check one of the following reasons.

☐ Just applied
☐ Noncitizen exception
☐ Religious exception

Is the name on this application the same as the name on this person's social security card? ☐ Yes ☐ No

If **No**, what name is on this person's social security card? First name, middle name, last name, and suffix

_____

16. If this person gets an Advance Premium Tax Credit (APTC), does this person agree to file a federal tax return for the tax year that the credits are received?
☐ Yes ☐ No
He or she may not have needed or chosen to file a tax return in the past, but this person will have to file a federal income tax return for any year that he or she gets an APTC. You must check **Yes** to question 16 to be eligible for ConnectorCare or APTCs to help pay for this person's health insurance.

This person does NOT need to file a tax return to apply for or to get MassHealth or HSN, if he or she qualifies.

If **Yes**, please answer questions a–d.
If **No**, skip to question d.

This person must file a joint federal tax return with a spouse for the year for which this person is applying to get certain programs (ConnectorCare or APTCs) unless this person is a victim of domestic abuse or abandonment or they will file taxes as Head of Household. If this person will file taxes as Head of Household, he or she should answer **No** to question 6a ("Are you legally married?"). One way this person may qualify as Head of Household is to live apart from his or her spouse and claim another person as a dependent. See IRS Publication 501 or consult a tax professional for tax filing information. This person will only need to include him- or herself and any dependents on this application.

a. Is this person legally married? ☐ Yes ☐ No
   If **No**, skip to question 6c.
   If **Yes**, list name of spouse and date of birth.

   _____

b. Does this person plan to file a joint federal tax return with a spouse for the tax year for which this person is applying? ☐ Yes ☐ No

c. Will this person claim any dependents on this person's federal income tax return for the year for which this person is applying? ☐ Yes ☐ No

This person will claim a personal exemption deduction on his or her federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments.

List name(s) and date(s) of birth of dependents.

_____

d. Will this person be claimed as a dependent on someone else's federal income tax return for the year for which this person is applying?
☐ Yes ☐ No
If this person is claimed by someone else as a dependent on their federal income tax return, this may affect this person's ability to receive a premium tax credit. Do not answer **Yes** to this question if this person is a child under the age of 21 being claimed by a noncustodial parent.

If **yes**, please list the name of the tax filer.

_____

Tax filer date of birth ___ /___ /_____

How is this person related to the tax filer? _____

Is the tax filer married, filing a joint return?
☐ Yes ☐ No

If **Yes**, list name of spouse and date of birth.

_____

Who else does the tax filer claim as dependents?

_____

e. Is this person filing taxes separately because they are a victim of domestic abuse or abandonment?
☐ Yes ☐ No

17. Is this person a U.S. citizen or U.S. national?
☐ Yes ☐ No
If **yes**, is he or she a naturalized citizen (not born in the U.S.)? ☐ Yes ☐ No

Alien number _____

Naturalization or citizenship certificate number

_____

18. If this person is a noncitizen, does he or she have an eligible immigration status? ☐ Yes ☐ No
See page 73, “Immigration Statuses and Document Types” for help. If **No** or **no response**, you may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children’s Medical Security Plan (CMSP), or the Health Safety Net (HSN). Go to Question 19.

a. If **Yes**, does this person have an immigration document? ☐ Yes ☐ No
It may help us to process this application faster if you include a copy of his or her immigration document with the application. We will try to

verify this person's immigration status through an electronic data match. Please list all the immigrations statuses and/or conditions that have applied to this person since he or she entered the U.S. If you need more space, attach another sheet of paper. For immigration status, choose one or more statuses from the list on page 73.

Status award date (mm/dd/yyyy) ___ /___ /_____
(For battered persons, enter the date the petition was approved.)
Immigration status _____
Immigration document type

_____

Choose one or more document status and types from the list on page 73.
Document ID number _____
Alien number _____
Passport or document expiration date (mm/dd/yyyy) ___ /___ /_____
Country _____

b. Did this person use the same name on this application to get his or her immigration status?
☐ Yes ☐ No

If **No**, what name did you use?

_____

First, middle, last, and suffix

c. Did this person arrive in the U.S. after August 22, 1996? ☐ Yes ☐ No

d. Is this person an honorably discharged veteran or active-duty member of the U.S. military, or the spouse or child of an honorably discharged veteran or an active-duty member of the U.S. military?
☐ Yes ☐ No

e. **Optional:** Is this person a
☐ victim of severe trafficking,
☐ a spouse, child, sibling, or parent of a trafficking victim
☐ a battered spouse,
☐ a child or the parent of battered spouse?

19. What is this person's race or ethnicity? (Optional)

_____

Please see page 76.

20. Is this person living in Massachusetts, and does this person either intend to reside here, even if he or she does not have a fixed address, or has this person entered Massachusetts with a job commitment or seeking employment? ☐ Yes ☐ No

    If this person is visiting in Massachusetts for personal pleasure or for the purposes of receiving medical care in a setting other than a nursing facility, you must answer no to this question.

21. Does this person live with at least one child younger than age 19, and is this person the main person taking care of this child(ren)? ☐ Yes ☐ No

Name(s) and date(s) of birth of children

_____

_____

22. Is this person pregnant? ☐ Yes ☐ No

    If **Yes**, how many babies is she expecting? ___
    What is the expected due date? ___ /___ /_____

23. Was this person ever in foster care? ☐ Yes ☐ No

    a. If **Yes**, in what state was this person in foster care?

       _____

    b. Was this person getting health care through a state Medicaid program? ☐ Yes ☐ No

24. Is this person in jail or prison? Please select **No** if this person will be released in the next 60 days.
    ☐ Yes ☐ No
    If **Yes**, is this person awaiting trial? ☐ Yes ☐ No

25. Does this person rent or own his or her property?
    ☐ Rent ☐ Own

26. **DISABILITY** Answer this question if this person is under age 65 or age 65 or older and working.
    Does this person have a disability (including a disabling mental health condition) that has lasted or is expected to last for at least 12 months? (If legally blind, answer **Yes**.)
    ☐ Yes ☐ No

    Name: _____

27. Does this person need reasonable accommodation(s) because of a disability or injury? ☐ Yes ☐ No

If **No**, go to the next question.
If **Yes**, answer questions a and b.

a. Condition:
   - ☐ Low vision ☐ Blind ☐ Deaf
   - ☐ Hard of hearing ☐ Developmentally disabled
   - ☐ Intellectually disabled ☐ Physically disabled
   - ☐ Other (Please explain.) _____

b. Accommodation:
   - ☐ Text telephone (TTY)
   - ☐ Large-print publications
   - ☐ American Sign Language interpreter
   - ☐ Video Relay Service
   - ☐ Communication Access Real-time Translations (CART)
   - ☐ Publications in braille
   - ☐ Assistive listening device
   - ☐ Publications in electronic format
   - ☐ Other (Please explain.) _____

28. Is this person applying because of an accident or injury that someone else might be responsible for?
☐ Yes ☐ No

a. Did someone else cause this person's injury, illness, or disability, or could someone else's insurance or this person's own insurance, other than health insurance (like homeowner's or auto insurance) cover it? ☐ Yes ☐ No

b. Has this person filed a lawsuit, a workers' compensation claim, or an insurance claim for this accident or injury? ☐ Yes ☐ No

29. Did this person ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No

If **No**, go to Income Information.
If **Yes**, answer questions a and b.

a. When did this person last get SSI? (mm/yyyy)
___ /___ /_____

b. Does this person (check one.):
☐ live alone?
☐ live with a spouse?
☐ live in a rest home?
☐ live in someone else's home?

Income Information **(You may send proof of all household income with this application.)**

30. Does this person have any income? ☐ Yes ☐ No
If you don't have income, skip to question 40.

31. Is this person's income steady from month to month?
☐ Yes ☐ No

If **No**, please provide the average income for the time period (per week, per month, etc.) for the questions below.

Current Job

If this person has more jobs and needs more space, attach another sheet of paper.

32. Employer name and address

    _____

    _____

    Federal Tax ID# _____

33. a. Wages/tips (before taxes) $ _____

    ☐ Weekly ☐ Every 2 weeks

    ☐ Twice a month ☐ Monthly ☐ Yearly

    (Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)

    b. Income effective date ___ /___ /_____

34. Average number of hours worked each WEEK ____

35. Is this person seasonally employed? ☐ Yes ☐ No

    If **yes**, which months do you work in a calendar year?

    ☐ Jan. ☐ Feb. ☐ March ☐ April ☐ May

    ☐ June ☐ July ☐ August ☐ Sept. ☐ Oct.

    ☐ Nov. ☐ Dec.

Self-employment

If self-employed, answer the following questions.

If you need more space, attach another sheet of paper.

36. Is this person self-employed? ☐ Yes ☐ No

    a. If **Yes**, what type of work does he or she do?

    _____

b. On average, how much net income (profits after business expenses are paid) will this person get from this self-employment each month, or, how much will he or she lose from this self-employment each month? $_____/month profit OR $_____/month loss?

c. How many hours does this person work per week? ____

Other income

37. Check all that apply, and give the amount and how often this person gets it. **NOTE: You do not need to tell us about child support, or Supplemental Security Income (SSI).**

☐ Social Security benefits
$ _____ How often received? _____

☐ Retirement or Pension
$ _____ How often received? _____

☐ Annuities
$ _____ How often received? _____

☐ Trusts
$ _____ How often received? _____

☐ Unemployment
$ _____ How often received? _____

☐ Interest, dividends, and other investment income
$ _____ How often received? _____

☐ Royalty income
$ _____ How often received? _____

☐ Alimony received
$ _____ How often received? _____

☐ Federal veteran's benefits
Taxable? ☐ Yes ☐ No
$ _____ How often received? _____

☐ Taxable military retirement pay
$ _____ How often received? _____

☐ Other taxable income (include type)
$ _____ How often received? _____
Type _____

☐ Capital gains: On average, how much net income or loss will this person get from this capital gain each **month**?
$ _____/ **profit** OR $ _____/ **loss**

☐ Net farming or fishing income: On average, how much net income (profits after business expenses are paid) or loss will this person get from this business each **month**?
$ _____/ **profit** OR $ _____/ **loss**

Rental Income

38. Does this person get rental income? ☐ Yes ☐ No

If **Yes**, **send proof** of current rental income, such as a written statement from each tenant, a copy of the lease, or a current federal tax return. Also **send proof** of all of the following expenses, if applicable, for the last 12 months: mortgage, taxes, utilities (gas/electric), heat, water/sewer, insurance, condo or co-op fee, repairs and maintenance.

a. What type of real estate does this person own?
☐ one-family ☐ two-family ☐ three-family
☐ other (describe): _____

b. How much **monthly** rental income or loss does this person get from each rental unit from the real estate indicated above? (List each rental unit and address separately.)

Address _____ Unit #____
Amount of Income _____ Amount of Loss _____
Owner-occupied? ☐ Yes ☐ No

Address _____ Unit #____
Amount of Income _____ Amount of Loss _____
Owner-occupied? ☐ Yes ☐ No

c. Do you pay for heat or utilities for your tenant?
☐ Yes ☐ No

One-Time-Only Income

39. Has or will this person receive income during this calendar year as a one-time only payment?
☐ Yes ☐ No
Examples might be a lump-sum pension payment or a one-time capital gain.

    If **Yes**: Type: _____ Amount $ _____
    Month Received _____ Year received _____

40. Will this person receive income during the next calendar year as a one-time only payment? ☐ Yes ☐ No

    If **Yes**: Type: _____ Amount $ _____
    Month Received _____ Year received _____

Deductions

41. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. What deductions do you report on your income tax return? Check all that apply. Your deductions should be what you report on your federal income tax return in the section “Adjusted Gross Income.” For each deduction you select, give the yearly amount. You can enter up to the maximum deduction amount allowed by the IRS.

    ☐ Educator expenses $ _____ Yearly amount

☐ Certain business expenses of reservists, performing artists, or fee-based government officials
$ _____ Yearly amount

☐ Health Savings Account deduction
$ _____ Yearly amount

☐ Moving expenses for members of the Armed Forces
$ _____ Yearly amount

☐ Deductible part of self-employment tax
$ _____ Yearly amount

☐ Contribution to self-employed SEP, SIMPLE, and qualified plans $ _____ Yearly amount

☐ Self-employed health insurance deduction
$ _____ Yearly amount

☐ Penalty on early withdrawal of savings
$ _____ Yearly Amount

☐ Alimony paid $ _____ Yearly amount

☐ Individual Retirement Account (IRA) deduction
$ _____ Yearly amount

☐ Student loan deduction (interest only, not total payment) $ _____ Yearly amount

☐ Higher education tuition and fees
$ _____ Yearly amount

☐ None

Yearly income

42. What is this person's total expected income for the current calendar year? _____

43. What is this person's total expected income for next calendar year, if different? _____

THANKS!

This is all we need to know about this person.

STEP 3

AMERICAN INDIAN OR ALASKA NATIVE (AI/AN) HOUSEHOLD MEMBER(S)

Are you or is anyone in your household an American Indian or Alaska Native? ☐ Yes ☐ No

If **No**, skip to Step 4.

If **Yes**, complete the rest of this application, including **Supplement B: American Indian or Alaska Native Household Member**.

Names(s) of person(s)

_____

American Indians and Alaska Natives who enroll in health coverage can also get services from the Indian Health Service, tribal health programs, or Urban Indian Health Programs. If you or any household members are American Indians or Alaska Natives, you may not have to pay premiums or copayments, and may get special monthly enrollment periods.

STEP 4

PREVIOUS MEDICAL BILLS

Do you or your spouse have bills for medical services you got in the three months before the month we got your application? ☐ Yes ☐ No

If **No**, go to Step 5: Assets.

If **Yes**, fill out the rest of this section. We may be able to pay for these bills.

Do you or your spouse want to apply for MassHealth for that time period? ☐ Yes ☐ No

If **Yes**, what is the earliest date for which you need MassHealth? (mm/dd/yyyy) ___ /___ /_____
(You must give us proof of all income and assets owned during that time period.)

STEP 5

ASSETS

You must fill out all blocks for each asset you and/or your spouse own.

If you live in the community and you want help with medical bills up to three months before the month you apply, you must tell us about any open and closed accounts for that period. If you are applying for long-term care, you must also give us information about all assets you or your spouse owned in the past 60 months. If you need more space, attach another sheet of paper.

BANK ACCOUNTS

1. Do you or your spouse have any bank accounts or certificates of deposit, including checking, savings, credit union, NOW, money-market, and personal needs allowance (PNA) accounts? ☐ Yes ☐ No

   a. Do you or your spouse have any retirement accounts, including individual retirement accounts (IRAs), Keogh, or pension funds? ☐ Yes ☐ No

   b. Have you or your spouse or a joint owner closed any accounts in the past 60 months, including any accounts you had owned jointly with anyone else? ☐ Yes ☐ No

   If you answered **Yes** to **any** of these questions, fill out this section. If you answered no to all of these questions, go to the next section **(REAL ESTATE)**.

Send a copy of your passbooks updated within 45 days and/or **a copy** of your current account statements. Please see the Senior Guide for information about financial institutions charging for copies of statements. If applying for nursing facility coverage, please provide account statements for the past 60 months.

Name on account _____
Account type _____
Name of bank/institution _____
Account number _____
Current balance $ _____
Balance on admission date* $ _____
☐ Account open ☐ Account closed
Date account closed (mm/dd/yyyy) ___ /___ /_____
Amount on the date account closed $ _____

Name on account _____
Account type _____
Name of bank/institution _____
Account number _____
Current balance $ _____
Balance on admission date* $ _____
☐ Account open ☐ Account closed
Date account closed (mm/dd/yyyy) ___ /___ /_____
Amount on the date account closed $ _____

* Enter the account balance on the date of admission to medical institution, hospital, or nursing facility

REAL ESTATE

2. Do you or your spouse own or have a legal interest in your primary residence?
   You ☐ Yes ☐ No
   Your spouse ☐ Yes ☐ No

3. Do you or your spouse own or have a legal interest in any real estate **other than** your primary residence?
   You ☐ Yes ☐ No
   Your spouse ☐ Yes ☐ No

   If you answered **Yes** to any of these questions, fill out this section. If **No**, go to the next section **(LIFE INSURANCE).**

Send a copy of the deed(s), current tax bill(s), and proof of amount owed on all property owned.

Address _____
Type of property _____
Current value $ _____

Address _____
Type of property _____
Current value $ _____

LIFE INSURANCE

4. Do you or your spouse own any life insurance?
   ☐ Yes ☐ No

   If **Yes**, fill out this section. **If no**, go to the next section **(SECURITIES (STOCKS/BONDS/OTHER))**.

Send a copy of the first page of all life-insurance policies. If total face value of all policies exceeds $1,500 per person, also **send a letter** from the insurance company showing the current cash-surrender value (for all policies except term policies).

Name(s) of owner(s)

_____

Insurance company _____

Policy number _____

Face value $ _____

Insurance type _____

Name(s) of owner(s)

_____

Insurance company _____

Policy number _____

Face value $ _____

Insurance type _____

SECURITIES (STOCKS/BONDS/OTHER)

5. Do you or your spouse own any stocks, bonds, savings bonds, mutual funds, securities, assets held in safe-deposit boxes, cash not in the bank, options, or future contracts? ☐ Yes ☐ No

   If **Yes**, fill out this section.
   If **No**, go to the next section **(ANNUITIES)**.

Send proof of current value (except cash).

☐ Cash
Owner(s) name(s) _____
Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

☐ Stocks
Owner(s) name(s) _____
Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

☐ Bonds
Owner(s) name(s) _____
Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

☐ Savings bonds
Owner(s) name(s) _____

Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

☐ Mutual funds
Owner(s) name(s) _____
Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

☐ Options
Owner(s) name(s) _____
Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

☐ Future contracts
Owner(s) name(s) _____
Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

☐ Other _____
Owner(s) name(s) _____
Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

* Enter the account balance on the date of admission to medical institution.

ANNUITIES

6. Did you or your spouse or someone on your or your spouse's behalf purchase or in any way change an annuity? ☐ Yes ☐ No

   If **Yes**, fill out this section. To be eligible, you may be required to name the Commonwealth as a remainder beneficiary. (See the Senior Guide for more information.) If **No**, go to the next section **(ASSISTED LIVING/OTHER)**.

Send a copy of the contract. For each annuity owned, **give us proof** from the annuity company of the full value of the annuity less any penalties and fees if it can be cashed in.

Name(s) of owner(s) _____
Name of institution issuing the annuity

_____

Contract number _____
Date purchased (mm/dd/yyyy) ___ /___ /_____

Name(s) of owner(s) _____
Name of institution issuing the annuity

_____

Contract number _____
Date purchased (mm/dd/yyyy) ___ /___ /_____

ASSISTED LIVING/OTHER

7. Have you, your spouse, or someone acting on your behalf given a deposit to any health-care or residential facility, like an assisted-living facility, a continuing-care retirement community, or life-care community?
   ☐ Yes ☐ No

   If **Yes**, fill out this section. If **no**, go to the next section **(VEHICLES/MOBILE HOMES)**.

Send a copy of the contract you signed with the facility and any documents about this deposit.

Name of facility

_____

Address of facility

_____

Amount of deposit $ _____

Date deposit given to facility (mm/dd/yyyy) ___ /___ /_____

VEHICLES/MOBILE HOMES

8. Do you or your spouse own any vehicles, like cars, vans, trucks, recreational vehicles, mobile homes, or boats? ☐ Yes ☐ No

   If **Yes**, fill out this section.
   If **No**, go to the next section **(PREPAID BURIAL PLANS/TRUSTS)**.

Send a copy of the registration for each vehicle, and proof of the outstanding loan balance. For mobile homes, **send a copy** of the bill of sale. If you have a spouse at home, **send proof** of the fair-market value of each vehicle as of the date of admission to the medical institution.

(You) Type of vehicle _____
Year/make/model _____
Fair-market value $ _____
Amount owed $ _____
Mobile home address

_____

(Your spouse) Type of vehicle _____
Year/make/model _____
Fair-market value $ _____
Amount owed $ _____
Mobile home address

_____

PREPAID BURIAL PLANS/TRUSTS

9. Do you or your spouse have any prepaid burial contracts or trusts, life insurance set up for funeral and burial expenses, or bank accounts set aside for funeral expenses? ☐ Yes ☐ No

   If **Yes**, fill out this section.
   If **No**, go to the next section **(TRUSTS)**.

Send a copy of the trust contract, trust instrument, insurance policy, or burial-only account.

(You) Burial contract
☐ Yes (Amount $) ☐ No

Burial trust
☐ Yes (Amount $) ☐ No

Life insurance for burial
☐ Yes (total face value $) ☐ No

Burial-only account
☐ Yes (Amount $) ☐ No

Burial plot ☐ Yes ☐ No

Insurance company _____
Policy number _____
Bank name _____
Account number _____

(Your spouse) Burial contract

☐ Yes (Amount $) ☐ No

Burial trust

☐ Yes (Amount $) ☐ No

Life insurance for burial

☐ Yes (total face value $) ☐ No

Burial-only account

☐ Yes (Amount $) ☐ No

Burial plot ☐ Yes ☐ No

Insurance company _____

Policy number _____

Bank name _____

Account number _____

TRUSTS

10. Are you or your spouse the grantor/donor, trustee, or beneficiary of any trusts? ☐ Yes ☐ No

11. Have you, your spouse, or someone else on your behalf, including a court or administrative body, contributed income or assets owned by you or your spouse to a trust? ☐ Yes ☐ No

    If you answered **Yes** to any of these questions, fill out this section. If you answered **No** to these questions, go to **Step 6: Health Insurance Information**

Send a copy of the trust document(s), any amendments, documents showing financial activity, and the schedule of beneficiaries.

Trust name _____
Revocable? ☐ Yes ☐ No Current trust principal $ ____
Trust principal on admission date* $ _____
Trustee(s) _____
Grantor(s)/Donor(s) _____
Beneficiaries _____

Trust name _____
Revocable? ☐ Yes ☐ No Current trust principal $ ____
Trust principal on admission date* $ _____
Trustee(s) _____
Grantor(s)/Donor(s) _____
Beneficiaries _____

* Enter the trust principal on the date of admission to medical institution.

STEP 6

HEALTH INSURANCE INFORMATION

MassHealth regulations require members to obtain and maintain available health insurance, including health insurance available through an employer. In order to determine continued MassHealth eligibility for you and members of your household, we may request additional information from you and your employer about your access to employer sponsored health insurance coverage. You must cooperate in providing information necessary to maintain eligibility, including evidence of obtaining or maintaining available health insurance, or your MassHealth benefits may be terminated. See the Senior Guide for more information.

1. Is anyone listed on this application offered health coverage from a job but not enrolled in it?
   ☐ Yes ☐ No

   Answer **Yes** even if this insurance is from another person's job, like a spouse, even if this person does not live in the household.
   If **Yes**, you will need to complete and include **Supplement D: Health Coverage from Jobs**, and the rest of this application.

   Is this a state employee benefit plan? ☐ Yes ☐ No

2. Does anyone qualify for or is anyone enrolled in the following types of health coverage? ☐ Yes ☐ No

   If **Yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have.

   Answer **Yes** even if this insurance is from another person, like a spouse, even if the person does not live in the household.

☐ Enrolled in Medicare or qualifies for a Medicare Part A plan with no premium

Name: _____

Medicare claim number: _____

When did coverage start? (mm/dd/yyyy) ___ /___ /____

a. Does this person have a Medicare Part D plan?
   ☐ Yes ☐ No
   If **Yes**, when did coverage start? (mm/dd/yyyy)
   ___ /___ /_____

b. Does this person have a Medigap/Medicare supplemental policy? ☐ Yes ☐ No
   If **Yes**, name of coverage plan
   _____
   When did coverage start? (mm/dd/yyyy)
   ___ /___ /_____
   Name _____
   Medicare ID number _____
   When did coverage start? (mm/dd/yyyy)
   ___ /___ /_____

a. Does this person have a Medicare Part D plan?
☐ Yes ☐ No
If **Yes**, when did coverage start? (mm/dd/yyyy)
___ /___ /_____

b. Does this person have a Medigap/Medicare supplemental policy? ☐ Yes ☐ No
If **Yes**, name of coverage plan

_____

When did coverage start? (mm/dd/yyyy)
___ /___ /_____

Do any of the persons above want to apply for help paying for the Medicare Part B premiums?
☐ Yes ☐ No
If **Yes**, name(s)

_____

If you check any of the following programs provide details below.

☐ Qualifies for **Peace Corps**

☐ Qualifies for **TRICARE**
(Do not check if you have direct care or Line of Duty.)

☐ Enrolled in **Veterans Affairs (VA) health programs**

☐ **MassHealth**

☐ **Other coverage**
(including COBRA and retiree health plans)
Name(s) of covered household members

_____

Policy number or Member ID

_____

Start date and end date (mm/dd/yyyy)
___ /___ /_____ ___ /___ /_____

☐ Enrolled in employer coverage.
If anyone on this application is enrolled in employer coverage, you must complete and include Supplement D: Health Coverage from Jobs.

Name of employer

_____

Name(s) of covered household members

_____

Plan name

_____

Policy number or Member ID

_____

Start date and end date? (mm/dd/yyyy)
___ /___ /_____ ___ /___ /_____

STEP 7

PERSONAL-CARE-ATTENDANT SERVICES

For people 65 years of age or older who are not going to be in a long-term-care facility

To get more information about personal-care-attendant (PCA) services and how filling out this PCA section could affect the way we decide if you can get MassHealth if you do need PCA services, read the PCA section in the Senior Guide that is enclosed.

1. Do you or your spouse need the services of a personal-care attendant? ☐ Yes ☐ No

   If **Yes**, fill out this section and answer all questions.

   If **No**, go to **STEP 9: Read and sign this application**.

2. Have you or your spouse had the services of a personal-care attendant paid for by MassHealth within the last six months? ☐ Yes ☐ No

   If **Yes**, go to **STEP 9: Read and sign this application**.

   If **No**, answer the following questions in this section.

3. Do you or your spouse have a permanent or long-lasting disability?
   You ☐ Yes ☐ No
   Your spouse ☐ Yes ☐ No

a. If **Yes**, does your (or your spouse's) disability keep you (or your spouse) from being able to do your (or your spouse's) daily living activities, like bathing, eating, toileting, dressing, etc., unless someone physically helps you (or your spouse)?
   You ☐ Yes ☐ No
   Your spouse ☐ Yes ☐ No

b. If **Yes**, do you (or your spouse) plan to contact a MassHealth personal-care-management (PCM) agency to ask for personal-care-attendant services?
   You ☐ Yes ☐ No
   Your spouse ☐ Yes ☐ No

Note: You must contact the PCM agency within 90 days of the date that MassHealth decides you are eligible for MassHealth or you will not be able to benefit from the special PCA rules.

MassHealth may not pay certain members of your family to be your personal-care attendant.

Each spouse who answered "Yes" to all parts of Question 3 above must fill out his or her own Supplement C: Personal-Care Attendant. One copy is enclosed. If you need a second copy, call MassHealth Customer Service at (800) 841-2900, TTY: (800) 497-4648 to ask for one. If you (or your spouse) do not send us your filled-out PCA supplement(s), we will determine your MassHealth eligibility as if you do not need PCA services.

STEP 8

Additional (Optional) Coverage – For married persons under 65 years of age

Fill out this section ONLY if you are married and living with your spouse. One spouse applying must be under 65 years of age, with no children under 19 years of age in the household. Answer these questions for the spouse who is under 65 years of age.

If this section applies to you and you want more information about income standards and other information that may apply, call us at (800) 841-2900, TTY: (800) 497-4648 to get a Senior Guide. If this section does not apply, go to **Step 9: Read and sign this application**.

BREAST OR CERVICAL CANCER (OPTIONAL) (Only for persons under 65 years of age)

1. Do you have breast or cervical cancer?
   ☐ Yes ☐ No
   MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.

   If **Yes**, we will send you a certificate to be filled out by your doctor to prove your breast or cervical cancer diagnosis. Then MassHealth can see if your MassHealth benefits give you the most coverage possible.

   Name: _____

HIV INFORMATION (OPTIONAL)
(Only for persons under 65 years of age)

2. Are you HIV positive? ☐ Yes ☐ No
   If you are HIV positive, you may be eligible for additional coverage or benefits.

   Name: _____

STEP 9

READ AND SIGN THIS APPLICATION

On behalf of myself and all persons listed on this application, I understand, represent, and agree as follows.

1. MassHealth may require eligible persons to enroll in available employer-sponsored health insurance if that insurance meets the criteria for MassHealth payment of premium assistance.
2. Employers of eligible persons may be notified and billed in accordance with MassHealth regulations for any services that hospitals or community health centers provide to such persons that are paid for by the Health Safety Net.
3. I may have to pay a premium for health coverage for myself and others listed on this application. Failure to pay any premium due may result in the state deducting the amount owed from the tax refunds of responsible persons. If I am a certain American Indian or Alaska Native, I may not have to pay premiums for MassHealth.
4. MassHealth has the right to pursue and get money from third parties who may be obligated to pay for health services provided to eligible persons enrolled in MassHealth programs. Such third parties may include other health insurers, spouses, parents obligated to pay for medical support, or individuals obligated

to pay under accident settlements. Eligible persons must cooperate with MassHealth in establishing third-party support and obtaining third-party payments for themselves and anyone whose rights they can legally assign. Eligible persons may be exempted from this obligation if they believe and tell MassHealth that cooperation could result in harm to them or anyone whose rights they can legally assign.

5. A parent and/or guardian of minor children must agree to cooperate with state efforts to collect medical support from an absent parent unless they believe and tell MassHealth that cooperation will harm the children or the parent or guardian.
6. Eligible persons who are injured in an accident, or in some other way, and get money from a third party because of that accident or injury must use that money to repay MassHealth or the Health Safety Net for certain services provided.
7. Eligible persons must tell MassHealth or the Health Safety Net, in writing, within 10 calendar days, or as soon as possible, about any insurance claims or lawsuits filed because of an accident or injury.
8. The status of this application may be shared with a hospital, community health center, other medical provider, or federal or state agencies when necessary for treatment, payment, operations, or the administration of the programs listed above.

9. To the extent permitted by law, MassHealth may place a lien against any real estate owned by eligible persons or in which eligible persons have a legal interest. If MassHealth puts a lien against such property and it is sold, money from the sale of that property may be used to repay MassHealth for medical services provided.
10. To the extent permitted by law, and unless exceptions apply, for any eligible person age 55 or older, or any eligible person for whom MassHealth helps pay for care in a nursing home, MassHealth will seek money from the eligible person's estate after death.
11. Eligible persons must tell the health care program(s) in which they enroll about any changes in their or their household's income or employment, household size, health insurance coverage, health insurance premiums, and immigration status, or about changes in any other information on this application and any supplements to it within 10 calendar days of learning of the change. Eligible persons can make changes by calling (800) 841-2900, TTY: (800) 497-4648 for people who are deaf, hard of hearing or speech disabled. A change in information could affect eligibility for such persons or for persons in their household.

You can also report changes in any of the following ways.

- Sign on to your account at MAhealthconnector.org. You can create an online account if you do not already have one.

- Send the change information to
  Health Insurance Processing Center
  P.O. Box 4405
  Taunton, MA 02780.
- Fax the change information to (857) 323-8300.

12. MassHealth, the Massachusetts Health Connector, and the Health Safety Net will obtain from eligible persons' current and former employers and health insurers all information about health insurance coverage for such persons. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to such persons or members of their household.
13. MassHealth, the Massachusetts Health Connector, and the Health Safety Net may get records or data about persons listed on this application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Revenue, and the Registry of Motor Vehicles, as well as private data sources including financial institutions, 1) to prove any information given on this application and any supplements, or other information given once a person becomes a member, 2) to document medical services claimed or provided to such persons, and 3) to support continued eligibility.

14. In connection with the eligibility and enrollment process, MassHealth, the Massachusetts Health Connector, and the Health Safety Net may send notices that contain personal information about persons listed on this application to other persons on this application, or otherwise communicate such information to such persons.

15. Under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by going to www.hhs.gov/ocr/office/file.

16. I agree to allow the Massachusetts Health Connector to use income data, including information from tax returns to determine my eligibility in future years. Review the Health Connector Privacy Policy for more information about how the Health Connector uses your tax information. The Massachusetts Health Connector will send me a notice and let me make changes to my eligibility application. I understand that if I am eligible for an Advance Premium Tax Credit (APTC) and/or ConnectorCare, these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or ConnectorCare may impact my annual tax liability. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.

I AGREE TO THE FOLLOWING STATEMENTS.

- I have read or have had read to me the information on this application, including any supplements and instruction pages, and I understand that the Senior Guide contains important information.
- I have permission from all persons listed on this application (or their parent or other legally authorized representative) to submit this application and to act on their behalf to complete this application and any ongoing or subsequent eligibility process and activity, including, for example:
  - providing personal information about them, including health, health coverage, and income information, seeing such information as may be provided by the Massachusetts Health Connector, MassHealth, and the Health Safety Net, and providing consent on their behalf to the use and disclosure of their information as described in this application;
  - making choices about coverage options and methods of communication with the Massachusetts Health Connector, MassHealth, and the Health Safety Net;
  - making changes to the application or related eligibility documents and providing information about any change in their circumstances; and
  - providing consent on their behalf to use government and private sources to verify information as described in this application.

- I understand my rights and responsibilities and the rights and responsibilities of all persons listed on this application as explained in STEP 9.
- I have told or will tell all such persons (or their parent or legally authorized representative, if applicable) about these rights and responsibilities so they understand them.
- I understand and agree that MassHealth, the Massachusetts Health Safety Net, and the Health Connector will treat electronic, faxed, or copies of signatures with the same force and effect as an original signature(s).
- The information I have supplied is correct and complete to the best of my knowledge about myself and other persons listed on this application.
- I may be subject to penalties under federal law if I intentionally provide false or untrue information.

SIGN THIS APPLICATION.

By signing this application below, I hereby certify under the pains and penalties of perjury that the submissions and statements I have made in this application are true and complete to the best of my knowledge, and I agree to accept and comply with the above rights and responsibilities.

Important: If you are submitting this application as an authorized representative, you must submit an **Authorized Representative Designation Form (ARD)** to us or have a form on record for us to process this application. The ARD is at the end of this application.

Signature of Person 1 or authorized representative or responsible party

_____

Print name _____

Date ___/___/_____

If you are under 18 years of age, are you an emancipated minor? ☐ Yes ☐ No

If **No**, we need a responsible party who is at least 18 years old to sign this application on your behalf. Please provide that person's information below.

First name _____ Middle name _____
Last name _____ Suffix _____
Social Security Number __ __ __ - __ __ - __ __ __ __
Relationship to you _____
Date of birth ___/___/_____
Street address _____
Apartment/Unit # _____ City _____
Zip code _____ County _____
Phone _____ Ext. ____ Phone type _____
Second phone _____ Ext. _____
Phone type _____
Email address _____

Send us your completed application.

Mail your signed application to:

MassHealth Enrollment Center
Central Processing Unit
PO Box 290794
Charlestown, MA 02129-0214; or

Fax: (617) 887-8799

Hand deliver your signed application to:

MassHealth Enrollment Center
Central Processing Unit
The Shrafft Center
529 Main Street, Suite 1M
Charlestown, MA 02129

Voter Registration

The form to register to vote is included with this application or can be found at www.sec.state.ma.us. More information on how to register to vote can also be found at www.sec.state.ma.us. If you have any questions about the voter registration process, or if you need help filling out the form, please visit a local MassHealth Enrollment Center or call the MassHealth Customer Service Center at (800) 841-2900, TTY: (800) 497-4648.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, with your right to privacy in deciding to register or in applying to register to vote, or with your right to choose your own political party or other political preference, you may file a complaint with:

Secretary of the Commonwealth, Elections Division
One Ashburton Place
Room 1705
Boston, MA 02108

Tel: (617) 727-2828 or (800) 462-8683.

If you or anyone else in your application are not registered to vote where you live now, would you like to apply to register to vote today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Immigration Statuses and Document Types

Question 8a/18a on the application asks noncitizens about their immigration status and about the type or types of immigration documents they have to support their immigration status. Please refer to the following lists to fill out Question 8a/18a. If you need further help, details can be found online at www.mahealthconnector.org/immigration-document-types.

Eligible Immigration Statuses

In the "Immigration Status" section of Question 8a/18a, write in any status that applies to you or members of your household. You may write in more than one status.

- Amerasian
- Granted asylum
- Cuban Haitian entrant
- Deportation withheld
- Native American born in Canada or non-U.S. territories
- Refugee
- Victim of severe trafficking or his or her spouse, child, sibling, or parent
- Iraqi special immigrant
- Afghan special immigrant
- Conditional entrant granted before 1980
- Veteran or active duty member of military or his or her spouse or dependent

- Lawful permanent resident
- Granted parole for at least one year
- Battered spouse or child (or his or her parent or child)
- Non-immigrant status (visa)
- Granted parole for less than one year
- Granted temporary resident status
- Granted Temporary Protected Status (TPS) or applicant for TPS with employment authorization
- Granted employment authorization under 8 CFR 274a(12)(c)
- Family unity beneficiaries
- Deferred enforced departure
- Deferred Action Status except for Deferred Action for Childhood Arrivals Process (DACA)
- Granted an administrative stay of removal under 8 CFR 241
- Approved visa petition with a pending application for adjustment of status
- Applicant for asylum or for withholding of removal with employment authorization
- Applicant (for at least 180 days) under 14 years of age for asylum or for withholding of removal
- Granted withholding of removal under the Convention Against Torture
- Applicant for Special Immigrant Juvenile (SIJ) status
- Applicant or granted status under Deferred Action for Childhood Arrivals (DACA)
- I have a document but do not have any status listed above (Person Residing Under Color of Law, PRUCOL)

Immigration Document Types

In the “Immigration Document Type” section of Question 8a/18a, write in any document type you or members of your household have. You may list more than one immigration document type.

- Reentry Permit (I-327)
- Permanent Resident Card (“green card” I-551)
- Refugee Travel Document (I-571)
- Employment Authorization Card (I-766)
- Machine Readable Immigrant Visa (with temporary 1-551 language)
- Temporary I-551 stamp (on passport or I-94, I-94A
- Arrival Departure Record (I-94, I-94A) issued by US Citizenship and Immigration Services
- Arrival Departure Record in unexpired foreign passport (I-94)
- Unexpired foreign passport
- Certificate of Eligibility for Nonimmigrant (F1) Student Status (I-20)
- Certificate of Eligibility for Exchange Visitor (J1) Status (DS2019)
- Notice of Action (I-797)/Other-with Alien Number
- Notice of Action (I-797)/Other-with I-94 Numbe

Race or ethnicity (Optional)
Choose the option(s) that best describe you.
Write in all that apply.

Please specify in Question 9 on page 13 and Question 19 on page 30.

- American Indian or Alaska Native
  (Complete Step 3 and Supplement B)
- Black or African-American
- White or Caucasian
- Hispanic, Latino, or Spanish origin
  - Cuban
  - Mexican, Mexican-American, or Chicano
  - Puerto Rican
  - Other Hispanic/Latino/Spanish origin
- Asian
  - Asian Indian
  - Chinese
  - Japanese
  - Korean
  - Vietnamese
  - Other Asian
- Pacific Islander
  - Filipino
  - Guamanian or Chamorro
  - Native Hawaiian
  - Samoan
  - Other Pacific Islander
- For any race or ethnicity not listed here, please specify in Question 9.

SUPPLEMENT A

LONG-TERM CARE

- Do you need long-term-care services in a nursing home type facility? ☐ Yes ☐ No

  If **Yes,** you must answer all questions and fill out all sections of this supplement.

- Are you applying for or getting long-term-care services at home under a Home- and Community-Based Services Waiver? ☐ Yes ☐ No

  If **Yes**, you need to fill out the **"Resource Transfers"** section on page 80, and the "Long –Term Care Insurance" section 17 on page 86.

Please print clearly. Answer all questions and fill out all sections. If you need more space to finish any section, please use a separate sheet of paper (include your name and social security number), and attach it to this supplement.

Applicant/Member Information

Last name, first name, middle initial

_____

Social security number __ __ __ - __ __ - __ __ __ __

Name and address of hospital, nursing facility, or other institution _____

_____

Date of admission (mm/dd/yyyy) ___ /___ /_____

Were you placed here by another state? ☐ Yes ☐ No

If **Yes**, what state?_____

1. Do you have to pay guardianship expenses for a court-appointed guardian? ☐ Yes ☐ No

Living expenses of the spouse and family members living at home

Your spouse living at home may be able to keep some of your income. Fill out the following information about your spouse's current living expenses. **If you do not have a spouse**, go to the next section **(Resource Transfers).**

Send proof of your spouse's current living expenses.

Spouse's last name, first name, middle initial

_____

Social security number __ __ __ - __ __ - __ __ __ __

2. How much does your spouse pay each month for:

   Rent?_____
   Mortgage (principal and interest)? _____
   Homeowner's/tenant's insurance? _____
   Real estate taxes? _____
   Required maintenance charge for a condo or co-op? _____
   Room and board for assisted living? _____

3. Does your spouse pay for heat? ☐ Yes ☐ No
4. Does your spouse pay for utilities? ☐ Yes ☐ No
5. Is a child, parent, brother, and/or sister living with your spouse? ☐ Yes ☐ No

   If **Yes,** fill out this section. If **No**, go to the next section **(Resource Transfers)**.

Send proof of their monthly income before deductions.

A deduction may be allowed for their maintenance needs. These persons must be related to you or your spouse, and one of you must claim them as dependents on your federal income tax return.

Name

_____

Social security number __ __ __ - __ __ - __ __ __ __
Relationship _____
Date of birth (mm/dd/yyyy) ___ /___ /_____
Monthly income before deductions $ _____

Name

_____

Social security number __ __ __ - __ __ - __ __ __ __
Relationship _____
Date of birth (mm/dd/yyyy) ___ /___ /_____
Monthly income before deductions $ _____

Resource Transfers (resources include both income and assets)

6. In the past 60 months:
    a. Has any property that was available or belonged to you or your spouse been transferred into or out of a trust? ☐ Yes ☐ No
    b. Did you, your spouse, or someone on your behalf transfer income or the right to income? ☐ Yes ☐ No
    c. Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real estate? ☐ Yes ☐ No
    d. Did you, your spouse, or someone on your behalf change the deed or the ownership of any real estate, including creating a life estate, even if the life estate was purchased in another person's residence? ☐ Yes ☐ No
    e. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate? ☐ Yes ☐ No
    f. Did you, your spouse, or someone on your behalf add another name to the deed of any property you own? ☐ Yes ☐ No

g. Did you, your spouse, or someone on your behalf receive or give anyone a mortgage, loan, or promissory note on any property or other asset?
☐ Yes ☐ No

h. Did you, your spouse, or someone on your behalf purchase or in any way change an annuity?
☐ Yes ☐ No

If you answered yes to any of the questions above, you must fill out the following, and **send us proof** of this information.

Description of asset/income _____
Date of transfer (mm/dd/yyyy) ___ /___ /_____
Transferred to whom _____
Relationship to you or your spouse _____
Amount of transfer $ _____

Description of asset/income _____
Date of transfer (mm/dd/yyyy) ___ /___ /_____
Transferred to whom _____
Relationship to you or your spouse _____
Amount of transfer $ _____

Description of asset/income _____
Date of transfer (mm/dd/yyyy) ___ /___ /_____
Transferred to whom _____
Relationship to you or your spouse _____
Amount of transfer $ _____

7. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, like an assisted living facility, a continuing care retirement community, or life care community?
☐ Yes ☐ No

If **Yes**, give us the name and address of the facility, the amount of the deposit, answer the following questions, and **send us a copy** of the contract you signed with the facility and any documents about this deposit.

Name of facility

_____

Address of facility

_____

Amount $ _____

a. Does the facility still have the deposit?
☐ Yes ☐ No

b. Did the facility return the deposit?
☐ Yes ☐ No

If **Yes**, give us the name and address of the person who got the deposit from the facility.

Name of person

_____

Address

_____

Real Estate

The answers to the following questions will be used to decide if: (1) your real estate will be counted as an asset; or (2) a lien will be placed against your real estate.

Note: If the equity interest in your principal place of residence is over a certain limit, you may be ineligible for payment of long-term-care services, unless certain conditions are met.

8. Do you or your spouse own or have a legal interest in your home, including a life estate? ☐ Yes ☐ No

   If **Yes**, fill out the following information and answer questions 8 through 15.

   If **No**, answer question 15 only.

Name and address of person(s) on ownership papers

_____

_____

Description and address of property location

_____

Type of ownership (Check one.)

☐ Individual (Fair-market value) $ _____
☐ Tenancy in common (Fair-market value) $ _____
☐ Joint tenancy (Fair-market value) $ _____
☐ Life estate (Fair-market value) $_____

Name and address of person(s) on ownership papers

_____

_____

Description and address of property location

_____

Type of ownership (Check one.)

☐ Individual (Fair-market value) $ _____

☐ Tenancy in common (Fair-market value) $ _____

☐ Joint tenancy (Fair-market value) $ _____

☐ Life estate (Fair-market value) $ _____

9. Do you have a spouse? ☐ Yes ☐ No
   If **Yes**, fill out this section.
   Name _____

   Is this person living in your home? ☐ Yes ☐ No

10. Do you have a permanently and totally disabled or blind child? ☐ Yes ☐ No
    If **Yes**, fill out this section.
    Name _____

    Is this person living in your home? ☐ Yes ☐ No

11. Do you have a child under 21 years of age?
    ☐ Yes ☐ No
    If **Yes**, fill out this section.
    Name _____

    Is this person living in your home? ☐ Yes ☐ No

12. Do you have a brother or sister with a legal interest in the home who was living in the home for at least one year immediately before your admission to the medical institution? ☐ Yes ☐ No
    If **Yes**, fill out this section.
    Name _____

    Is this person living in your home? ☐ Yes ☐ No

13. Do you have a son or daughter who has lived in the home for at least the last two years before your admission to the medical institution and has provided care to you that allowed you to live in the home?
    ☐ Yes ☐ No
    If **Yes**, fill out this section.
    Name _____

    Is this person living in your home? ☐ Yes ☐ No

14. Do you have a dependent relative? ☐ Yes ☐ No
    If **Yes,** fill out this section.
    Name _____

    Is this person living in your home? ☐ Yes ☐ No

    Describe the relationship and the nature of the dependency: _____

    _____

15. Do you intend to return to your home? ☐ Yes ☐ No

16. Do you or your spouse own or have a legal interest in other real estate not listed in #7 above? ☐ Yes ☐ No
If **Yes**, please describe the property and list its address below.

_____

_____

If you need more space, please use a separate sheet of paper.

Long-Term-Care Insurance

17. Do you or your spouse have long-term-care insurance? ☐ Yes ☐ No

If **yes**, fill out this section. If **no**, go to the next section **(Tax Returns)**.

Send a copy of the policy.

Company name/Policy number

_____

Policyholder name _____

Effective date (mm/dd/yyyy) ___ /___ /_____

Premium amount $ _____

Company name/Policy number

_____

Policyholder name _____

Effective date (mm/dd/yyyy) ___ /___ /_____

Premium amount $ _____

Tax Returns

18. Did you or your spouse file U.S. income tax returns in the last two years? (Check one.)
    - ☐ Yes, both years
    - ☐ Yes, one of these years
    - ☐ No, neither year

If **Yes**, you must **send copies** of these returns. If you did not keep copies of one or more of these returns, **you must send in a filled-out and signed Form 4506**. Form 4506 is included as part of the Long-Term-Care Supplement if you need to use it.

Sign this supplement.

By signing this supplement below, I hereby certify under the pains and penalties of perjury that the submissions and statements I have made in this supplement are true and complete to the best of my knowledge, and I agree to accept and comply with the above rights and responsibilities.

Important: If you are submitting this supplement as an authorized representative, you must submit an Authorized Representative Designation Form (ARD) to us for us to process this application. It is important to complete this form as this is the only way we may speak to you about this application.

Signature of applicant/member or authorized representative

_____

Print name _____

Date ___ /___ /_____

SUPPLEMENT B

AMERICAN INDIAN OR ALASKA NATIVE HOUSEHOLD MEMBER (AI/AN)

Complete this supplement if you or a household member are an American Indian or Alaska Native.

Tell us about your American Indian or Alaska Native household member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or Urban Indian Health Programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your household gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach

AI/AN Person 1

1. Name (first, middle, last) _____
2. Member of a federally recognized tribe? ☐ Yes ☐ No
   If **Yes**, tribe name _____
3. Member of a Massachusetts-recognized tribe?
   ☐ Yes ☐ No
   If **Yes**, tribe name _____

4. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs? ☐ Yes ☐ No

   If **No**, is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Program, or through a referral from one of these programs? ☐ Yes ☐ No

5. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from:
   - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations); or
   - Money from selling things that have cultural significance.

   $ _____ How often? _____

AI/AN Person 2

1. Name (first, middle, last) _____
2. Member of a federally recognized tribe? ☐ Yes ☐ No
   If **Yes**, tribe name _____

3. Member of a Massachusetts-recognized tribe?
   ☐ Yes ☐ No
   If **Yes**, tribe name _____

4. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs? ☐ Yes ☐ No

   If **No**, is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Program, or through a referral from one of these programs? ☐ Yes ☐ No

5. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from:
   - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former rese rvations); or
   - Money from selling things that have cultural significance.

   $ _____ How often? _____

SUPPLEMENT C

PERSONAL-CARE-ATTENDANT

Please print clearly. Fill out all sections. If you need more space to finish any section on this form, please use a separate sheet of paper (include name and social security number), and attach it to this form.

Send to: MassHealth Enrollment Center
P.O. Box 4405
Taunton, MA 02780

Or Fax to: (857) 323-8300

Applicant/Member information

Last name _____

First name _____ MI _____

Telephone number (_____) _____

Social security number __ __ __ - __ __ - __ __ __ __

Date of birth (mm/dd/yyyy) ___ /___ /_____

Gender ☐ M ☐ F

Street address _____

City _____ State _____ ZIP _____

Information about your health problems

List and describe below all your medical and mental health problems. Include anything that makes it hard for you to do daily living activities, like bathing, eating, toileting, dressing, etc., even if you are not getting treatment for the problem.

1. _____

2. _____

3. _____

Information about your daily living activities that you need physical (hands-on) help with

Please tell us in the chart below if you need hands-on help from another person to do the following daily living activities. If you check **Yes** to any of the items below, tell us how often you need help.

Mobility (moving from bed to chair, walking, or using approved medical equipment)

Do you need hands-on help? ☐ Yes ☐ No
How many times a day do you need hands-on help? _____
How many days a week do you need hands-on help? _____

Taking medications

Do you need hands-on help? ☐ Yes ☐ No
How many times a day do you need hands-on help? _____
How many days a week do you need hands-on help? _____

Bathing (tub, bed bath, shower, or washing chair) or general grooming (like brushing teeth or combing hair)

Do you need hands-on help? ☐ Yes ☐ No
How many times a day do you need hands-on help? _____
How many days a week do you need hands-on help? _____

Dressing/Undressing

Do you need hands-on help? ☐ Yes ☐ No
How many times a day do you need hands-on help? _____
How many days a week do you need hands-on help? _____

Range-of-motion exercises (exercising joints by moving them)

Do you need hands-on help? ☐ Yes ☐ No
How many times a day do you need hands-on help? _____
How many days a week do you need hands-on help? _____

Eating

Do you need hands-on help? ☐ Yes ☐ No
How many times a day do you need hands-on help? _____
How many days a week do you need hands-on help? _____

Toileting (like getting on or off toilet, wiping yourself, getting clothes off and on, or changing diapers)

Do you need hands-on help? ☐ Yes ☐ No
How many times a day do you need hands-on help? _____
How many days a week do you need hands-on help? _____

Caregiver information

Please give us the name(s) and relationship to you of the person(s) who now helps you.

Caregiver name _____
Relationship to you (like relative, neighbor, personal-care attendant) _____

Caregiver name _____
Relationship to you (like relative, neighbor, personal-care attendant) _____

I certify, under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge.

If you are acting on behalf of someone in filling out this form, an Authorized Representative Designation Form must also be filled out and sent back with this form. Your signature on this form as an authorized representative certifies that the information on this form is correct and complete to the best of your knowledge.

X _____

Signature of applicant/member or authorized representative

Print name _____
Date ___ /___ /_____

SUPPLEMENT D

HEALTH COVERAGE FROM JOBS

Part A: Medicare

Answer these questions if someone in the household is eligible for health coverage from a job, whether or not they are enrolled in the coverage. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

EMPLOYEE Information

1. Employee name (first, middle, last)

   _____

2. Employee Social security number

   __ __ __ - __ __ - __ __ __ __

3. a. Is at least one person on this application currently eligible for or enrolled in coverage offered by this employer, or will at least one person on this application become eligible within the next 3 months? ☐ Yes ☐ No

   If the answer to 3a is **Yes**, continue. If the answer to 3a is no, stop here and skip the rest of Supplement D.

   b. If any person is in a waiting or probationary period, when can this person enroll in coverage? (mm/dd/yyyy) ___ /___ /_____

EMPLOYER Information

4. Employer name _____

5. Federal Tax ID (if known)

   _____

6. Employer address

   _____

7. Employer phone number ( ) _____

8. City _____

9. State _____ 10. ZIP code _____

11. Whom can we contact about employee heath coverage at this job? _____

12. Phone number (if different from above)
    ( ) _____

13. Email address _____

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. a. What is the name of the lowest cost self-only health plan offered to the employee?

    _____

    b. Does the health plan offered by the employer meet the minimum value standard for coverage?
    ☐ Yes ☐ No

c. How much does the employee have to pay in premiums for the lowest cost plan that meets the minimum value standard? Only tell us about the cost of the individual (self-only) health plans, not the cost of a family health plan. $ _____

d. How often would the employee pay this amount, or how often does the employee pay this amount?

_____

16. What change will the employer make for the new plan year (if known)?

☐ Employer will not offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs.)

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is at least 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often?

☐ Weekly ☐ Every 2 weeks ☐ Twice a month
☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy) ___ /___ /_____

AUTHORIZED REPRESENTATIVE DESIGNATION FORM

Commonwealth of Massachusetts | EOHHS

You can submit this form if you would like to designate an authorized representative to act on your behalf. If an authorized representative signed your application for you, or if you are an authorized representative applying on behalf of someone else, you must submit this form for the application to be processed.

You do not need to fill out this form if you live in an institution and want copies of eligibility notices sent to you and to your spouse who still lives at home. We will do that automatically.

Note: An authorized representative has the authority to act on an applicant's or member's behalf in all matters with MassHealth and the Health Connector, and will receive personal information about the applicant or member until we receive a cancellation notice terminating their authority, or upon the death of the applicant or member. Their authority will not automatically terminate once we process your application.

You can choose someone to help you.

You may choose an authorized representative to help you get health care coverage through programs offered by MassHealth and the Health Connector. You can do this by filling out this form (the Authorized Representative Designation Form). You or a representative can sign for yourself and for any of your dependent children under the age of 18 for whom you are the custodial parent. You are not required to have a representative in order to apply for or receive benefits.

Who can help me?

1. An authorized representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose an authorized representative if you want one. Neither MassHealth nor the Health Connector will choose an authorized representative for you. You must designate in writing (fill out Section I, Part A) the person or organization who you want to be your authorized representative. Your authorized representative must also fill out Section I, Part B. We sometimes refer to this person or organization as a "Section I authorized representative."
2. If you cannot designate an authorized representative in writing and you do not have an existing authorized representative or other person who is authorized by law

to act on your behalf, a person (not an organization) who certifies that he or she will act responsibly on your behalf can be your authorized representative if that person fills out Section II of this form. We sometimes refer to this person as a "Section II authorized representative."

3. An authorized representative can also be someone who has been appointed by law to act on your behalf, or on behalf of the estate of an applicant or member who has died. This person must fill out Section III and either you or this person must submit to us, together with this form, a copy of the applicable legal document stating that this person has authority to represent you, or the estate of a deceased applicant or member. We sometimes refer to this person as a "Section III authorized representative."

4. Section III authorized representative may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the personal representative of the estate.

What can an authorized representative do?

A Section I or II authorized representative may

- fill out your application or renewal forms;
- fill out other MassHealth or Health Connector eligibility or enrollment forms;
- give proof of information reported on these forms;

- report changes in income, address, or other circumstances;
- get copies of all of your MassHealth and Health Connector eligibility and enrollment notices; and
- act on your behalf in all other matters with MassHealth and the Health Connector.

What a section III authorized representative is authorized to do for you (or for the Estate of a deceased applicant or member) will depend on the wording of the legal appointment.

Please note: Eligibility notices may include information about other members of an applicant's or member's household. If there are multiple people in your household we may not be able to send copies of some of your notices to your authorized representative unless each household member has also designated the same authorized representative by completing a separate Authorized Representative Designation Form.

SECTION 1
AUTHORIZED REPRESENTATIVE DESIGNATION
(if applicant or member is able to sign)

Part A—to be filled out by applicant or member. Please print, except for signature.

Please note: Your social security number (SSN) is required if one has been issued.

Applicant's/Member's Name

_____

SSN (if you have one) ___ ___ ___ - ___ ___ -___ ___ ___ ___

Date of birth (mm/dd/yyyy) ___/___/_____

Applicant's/Member's email address

_____

I certify that I have chosen the following person or organization to be the authorized representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form).

Applicant's/Member's signature Date

_____ ___/___/_____

Authorized representative's name

_____

Authorized representative's phone number

_____

Authorized representative's address
(mailing address, city, state, zip)

_____

Part B—to be filled out by authorized representative. Please print, except for signature.

B1. Complete if authorized representative is a person.

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to me by MassHealth or the Health Connector.

If I am also a provider, staff member, or volunteer affiliated with an organization, and am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10 and 45 C.F.R. § 155.260(f).

Authorized representative's signature Date

_____ ___/___/_____

Authorized representative's printed name

_____

Authorized representative's email address

_____

B2. Complete if authorized representative is an organization.

I certify, on behalf of the organization set forth below, that such organization will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to the organization by MassHealth or the Health Connector.

I, the provider, staff member, or volunteer of the organization set forth below, completing this form, certify on behalf of myself and on behalf of the organization I represent, that any providers, staff members, or volunteers acting on behalf of the organization in connection with this authorized representative designation will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information, and conflicts of interest, including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10 and 45 C.F.R. § 155.260(f).

Signature of provider, staff member, or volunteer completing form

_____

Date ___/___/_____

Printed name of provider, staff member, or volunteer completing form

_____

Email of provider, staff member, or volunteer completing form

_____

Authorized representative organization name

_____

SECTION 2
AUTHORIZED REPRESENTATIVE DESIGNATION
(if applicant or member cannot provide written designation)

To be filled out by authorized representative. Please print, except for signature. Please provide a separate form for each applicant or member.

An organization is not eligible to be an authorized representative under this section.

I certify that the applicant or member set forth below cannot provide written designation and to the best of my knowledge does not otherwise have an individual who can act on his or her behalf such as an existing authorized representative, guardian, conservator, personal representative of the estate, holder of power of attorney, or an invoked health-care proxy. In addition, I certify that I am sufficiently aware of this applicant's or member's circumstances to assume responsibility for the accuracy of the statements made on his or her behalf during the eligibility process and in other communications with MassHealth or the Health Connector, that I understand my rights and responsibilities as this person's authorized representative (as explained earlier in this form). If this person can understand, I have told the person that

MassHealth and the Health Connector will send me a copy of all MassHealth and Health Connector eligibility and enrollment notices and this person agrees to this, and I have told this person that he or she may remove or replace me as his or her authorized representative at any time by the methods described earlier in this form.

I further certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth below that is provided to me by MassHealth or the Health Connector.

If I am also a provider, staff member, or volunteer affiliated with an organization, and I am acting in my capacity as a provider, staff member, or volunteer in connection with my designation an authorized representative, I further certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentially of information and conflicts of interest including those set forth at 42 CFR part 431 subpart F., 42 CFR §477.10, and 45 CFR §155.260(f).

Please note that the applicant's or member's social security number (SSN) is required if one has been issued.

Applicant's/Member's name

_____

Applicant's/Member's date of birth (mm/dd/yyyy)
___/___/_____

Applicant's/Member's SSN
___ ___ ___ - ___ ___ - ___ ___ ___ ___

Authorized representative's signature

_____

Date (mm/dd/yyyy) ___/___/_____

Authorized representative's name (first, middle, last)

_____

Authorized representative's phone number

_____

Authorized representative's address
(mailing address, city, state, zip)

_____

Authorized representative's email address

_____

If the Section II authorized representative is affiliated with an organization, and is acting in such capacity, an individual authorized to act on behalf of the organization, such as an officer, must sign below to indicate the organization's acknowledgment of and agreement with the representations and warranties made above.

Officer's Name _____

Officer's Title _____

Officer's Signature _____

Date (mm/dd/yyyy) ___/___/_____

SECTION 3
AUTHORIZED REPRESENTATIVE DESIGNATION
(if appointed by law)

To be filled out by an authorized representative appointed by law (as explained earlier on this form). Please print, except for signature. **Please submit a copy of the applicable legal document with this form.**

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member as set forth below, that is provided to me by MassHealth or the Health Connector.

Please note that the applicant's or member's social security number (SSN) is required if one has been issued.

Applicant's/Member's name

_____

Applicant's/Member's date of birth (mm/dd/yyyy)
___/___/_____

Applicant's/Member's SSN
___ ___ ___ - ___ ___ - ___ ___ ___ ___

Authorized representative's signature

_____

Date (mm/dd/yyyy) ___/___/_____

Authorized representative's name (first, middle, last)

_____

Authorized representative's phone number

_____

Authorized representative's address
(mailing address, city, state, zip)

_____

Authorized representative's email address

_____

How does an authorized representative designation end?

If you decide that you no longer want a **Section I** or **Section II** authorized representative, you must notify us at the time you want the designation to end by mail, fax, or phone. See our contact information below. If you mail or fax this notice to us, the notice must include your name, address, and date of birth, the name of your authorized representative, a statement that the designation has ended and your signature or, if you cannot provide written notice, the signature of someone acting on your behalf (in the case of a **Section II** authorized representative only).

In addition, if your authorized representative notifies us that such person or organization is no longer acting on your behalf, we will no longer recognize the person or organization as your authorized representative.

The authority of a **Section I** or **Section II** authorized representative will end upon the death of the applicant or member.

A **Section III** authorized representative's designation ends when his or her legal appointment ends. The authorized representative must notify us as instructed above.

In addition, an authorized representative's designation for a minor child ends on the child's 18th birthday.

How do I submit this form?

If you are applying for health benefits, send your filled-out Authorized Representative Designation Form to us with your application.

If you are already getting benefits, you must submit the form to us at the time you want to designate an authorized representative, or you want the declared designation to end, by

- Mailing your form to

  Health Insurance Processing Center
  P.O. Box 4405
  Taunton, MA 02780;
- Faxing your form to **1-857-323-8300**; or
- Calling us at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).