Table of Contents

State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: MA-13-0026

This file contains the following documents in the order listed:

1) Approval Letter
2) SPA Summary Form
3) Approved SPA Pages
4) Additional Attachments that are part of the state plan

The complete title XXI state plan for Massachusetts consists of the most recent state plan posted on Medicaid.gov under CHIP and State Plan Amendments. The link is provided below. The following approved templates are in addition to, or replace sections of the state's posted current state plan. The attached approval letter(s) explain how these templates fit into that state plan.

Link to state title XXI state plans and amendments: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-State-Program-Information.html

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

MAY 05 2014

Robin Callahan
Deputy Medicaid Director
Massachusetts Executive Office of Health and Human Services
Office of Medicaid
1 Ashburton Place, 11th floor
Boston, MA 02108

Dear Ms. Callahan:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved Massachusetts Children's Health Insurance Program (CHIP) State Plan Amendment (SPA), MA-13-0026 submitted on December 30, 2013. This SPA incorporates the MAGI-based eligibility process requirements in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of SPA MA-13-0026 includes full approval of your state's alternative single streamlined paper application. The state is using an interim alternative single streamlined online application and by December 31, 2014, will implement a revised alternative single streamlined online application that addresses CMS concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the following CS24 state plan pages and attachments to be incorporated within a separate section at the end of Massachusetts approved state plan:

- CS24
- Attachment 1 – Statement of use with respect to the alternative single streamlined online application
- Attachment 2 – State of Massachusetts alternative single streamlined paper application

This approval and the attachments supercede the following sections of the current CHIP State Plan:

- Section 4.3: Single Streamlined Application Screen and Enroll Process
- Section 4.4: Renewals, Screening by Other Insurance Affordability Programs

The CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. Your title XXI project officer is Mr. Martin Burian. He is available to answer questions concerning this amendment and other CHIP-related issues. Mr. Burian's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Blvd.
Baltimore, MD 21244-1850
Telephone: (410) 786-3246
Facsimile: (410) 786-5882
E-mail: Martin.Burian@cms.hhs.gov

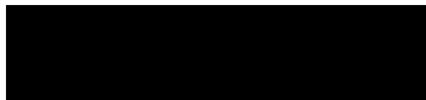
Official communications regarding program matters should be sent simultaneously to Mr. Burian and to Mr. Richard McGreal, Associate Regional Administrator (ARA) in our Boston Regional Office. Mr. McGreal's address is:

Mr. Richard McGreal
Office of the Regional Administrator
JFK Federal Building, Suite 2325
Boston, MA 02203-0003

If you have additional questions, please contact Barbara K. Richards, Acting Director, Division of State Coverage Programs at 410-786-5920.

We look forward to continuing to work with you and your staff.

Sincerely,



Eliot Fishman
Director

Enclosure

cc:
Richard McGreal, Associate Regional Administrator, CMS Boston Region I

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

MAY 05 2014

Robin Callahan
Deputy Medicaid Director
Massachusetts Executive Office of Health and Human Services
Office of Medicaid
1 Ashburton Place, 11th floor
Boston, MA 02108

RE: CS24 – Eligibility Process State Plan Amendment (SPA), MA-13-0026

Dear Ms. Callahan:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) MA-13-0026, which was submitted to CMS on December 30, 2013. Our review of this submission included a review of the alternative single streamlined online application developed by the state.

Until December 31, 2014, the state is using an interim alternative single streamlined online application. This interim application needs to be revised to reflect the following changes.

Necessary changes	**Date by which changes will be completed**
Questions regarding residency and health conditions will only be asked of applicants.	December 31, 2014
Questions on access to employer-sponsored coverage, when needed for APTC eligibility, will ask about the premium amount of the lowest-cost option offered by the employer.	December 31, 2014

Please submit the revised alternative single streamline online application to CMS for review no later than December 1, 2014, to ensure approval by December 31, 2014.

We continue to be available to provide technical assistance. If you have any questions about your application, please contact Victoria Collins at Victoria.Collins@cms.hhs.gov or (410) 786-2167. We look forward to continuing to work with you and your staff.

Sincerely,

Barbara K. Richards
Acting Director
Division of State Coverage Programs

cc:
Richard McGreal, Associate Regional Administrator, CMS Boston Region I

logged in as TONIABROWN(CMS CO Staff) read only mode application rev p01

Children's Health Insurance Program Eligibility

MA.0696.R00.00 - Oct 01, 2013

Home | Logout | Finder | Save | Validate | Print | Help

Control Panel

General Information

File Management

Tribal Input

Summary

Children's Health Insurance Program Eligibility: Summary Page

State/Territory name: Massachusetts

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

MA-13-0026

Type of SPA:

- ☐ MAGI Eligibility & Methods
- ☐ XXI Medicaid Expansion
- ☐ Establish 2101(f) Group
- ☑ Eligibility Processing
- ☐ Non-Financial Eligibility

Proposed Effective Date

10/01/2013 (mm/dd/yyyy)

Federal Statute/Regulation Citation

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

Federal Budget Impact

☐ This SPA has a budget impact.

Total budget impact:

State Funds: $

Federal Funds: $

Subject of Amendment

Please provide a brief summary of SPA changes.

Character Count:1959 out of 2000

MA, through this amendment, seeks approval for its alternative single streamlined app. for all insurance affordability programs. This application was developed in accordance with section 1413(b)(1)(A) of the ACA. MA continues to make changes to the online app. based on field testing and federal guidance.

Signature of State Agency Official

Submitted By: Alison Kirchgasser

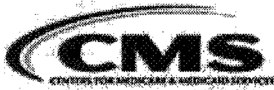
Last Revision Date: Oct 2, 2014

Submit Date: Dec 30, 2013

BACK CONTINUE

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: MA-13-0026	**STATE:** Massachusetts

Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.



CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Eligibility Processing — **CS24**

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

☑ The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.

☒ An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

☑ The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means.

☒ Other electronic means:

	Name of method	Description	
+	Fax	Applicants are able to fill out a paper application and fax it to the agency.	X

Screen and Enroll Process

☑ The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:

CHIP Eligibility

- [■] Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and
- [■] Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and
- [■] Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA. | Yes |

Redetermination Processing

- [✓] Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:
  - [■] Once every 12 months.
  - [■] Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.
  - [■] If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Screening by Other Insurance Affordability Programs

- [✓] The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.
- [X] The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.

  Check all types of agencies that apply:

  - [X] The Exchange
  - [X] Medicaid
  - [ ] Other agency administering insurance affordability programs

- [✓] The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.

CHIP Eligibility

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130709

OFFICIAL

Application for Health Coverage and Help Paying Costs Instructions

Commonwealth of Massachusetts | EOHHS

Please read these instructions before you fill out the application.

Apply faster online! Go to: **MAhealthconnector.org.** You will get results quickly. You can create a secure online account where you can see copies of notices and get important news fast.

Please read the attached Member Booklet carefully before you fill out the application. Keep the booklet. It may answer questions you have later.

Use this application to apply for subsidized health coverage

This is your application for MassHealth, the Children's Medical Security Plan (CMSP), the Massachusetts Health Connector (Health Connector) plans, and the Health Safety Net (HSN). MassHealth gives health care coverage and helps pay for health insurance premiums for families, children, and individuals.

The Massachusetts Health Connector is the state's marketplace for health and dental insurance. The Health Connector can help you shop for and enroll in insurance plans from leading health insurers in the state. You can also find out through the Health Connector if you are eligible for any programs that help you pay for health insurance premiums and lower your out-of-pocket health care costs. For more information about programs that are available through the Health Connector, see pages 3 and 19-20 in the Member Booklet.

For information about the CMSP or the HSN, see page 18 for CMSP and pages 21-22 for HSN in the Member Booklet.

The kind of health coverage you get depends on your household size, income, and other circumstances. This information helps us make sure everyone gets the best coverage. Fill out all information for each person in your household. After you fill out your application and submit it, we will review it. If you are eligible, you will get the most complete coverage available.

Who can use this application

This application is for people who need health insurance and/or help paying for it, and who:

- live in Massachusetts,
- are not living in or about to go into a nursing home, and
- are under age 65.

This application may also be used by people of any age who are:

- parents of children under age 19,
- adult relatives living with and taking care of children under age 19 when neither parent is living in the home, or
- disabled and either:
  - work 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, or
  - not working (only if under age 65).

If this application is not for you, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

Tell us about your household

Tell us about all household members who live with you and are applying for health coverage. You must answer all questions and fill out all supplements (if applicable) for each household member who is applying.

Do include

- Yourself
- Your spouse
- Your natural, adoptive, or step children under age 19
- Your unmarried partner if you have children together who are under age 19
- Your unmarried partner's children who live with you and who are under age 19, if you also include your unmarried partner
- Anyone you include on your tax return (even if they do not live with you)
- Anyone your unmarried partner included on his or her tax return (even if they do not live with you), if you also include your unmarried partner
- Anyone else under age 19 who you live with and take care of

You do not have to include

- Your unmarried partner, unless you have children together
- Your unmarried partner's children, unless they live with you
- Your parents who you live with and who file their own taxes if they do not claim you as a tax dependent (if you are aged 19 or older)
- Other adult relatives who you do not claim as a tax dependent

Filling out the application

Start with yourself, and then add other adults and children. If you have more than four people in your household including yourself, you will need to make copies of the pages for Person 4 before you fill them out, and attach them to the application.

Generally, you do not need to give us the citizenship or immigration statuses, or the social security numbers (SSNs) of household members who are not applying. However, 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 1-800-772-1213 (TTY: 1-800-325-0778 for people who are deaf, hard of hearing, or speech disabled), or go to socialsecurity.gov. Please see the Member Booklet for more information.

We keep the information provided to us private, and only use and disclose it in accordance with applicable law.

We will try to prove your information and determine eligibility with matches through federal data sources, such as the Social Security Administration (SSA), the Internal Revenue Service (IRS), the Department of Homeland Security (DHS), and state data sources, such as the Department of Revenue (DOR), the Registry of Motor Vehicles (RMV), and other state-run public programs. If we are not able to prove your information or need more information, we will contact you. We may give you provisional coverage for up to 90 days during the time period that we are waiting for proof of information (other than a determination of disability). See the Member Booklet for more information about disability.

To help us see if you are eligible:

- fill out the application completely,
- be sure to tell us in Part 3 about health insurance you may be able to get through your job,
- fill out the parts of Supplement A that apply, if you answer yes to any questions about injury, illness, disability, accommodation, or applying due to an accident or injury caused by someone else; do not leave any answer blank,
- answer all questions in Part 4 and in Supplement C about any health insurance that you may have now, and
- fill out Supplement B, if you or any household member is an American Indian or Alaska Native.

Remember, you must read, sign, and date the Rights and Responsibilities and Signature pages (Part 6, pages 16-18) after you have filled out the application.

When we get the signed and dated application, we will review it. If we need more information after we complete the data matches, we will contact 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 need medical care and you pay for it before you get an approval notice from us, you may be able to get a refund from your health care provider for what you paid.

To start filling out this application, go to page 1.

You can submit your application in any of the following ways.

- Sign on to your account at www.MAhealthconnector.org. You can create an online account if you do not already have one.
- Send your filled-out, signed application to:
  Health Insurance Processing Center
  P.O. Box 4405
  Taunton, MA 02780.
- Fax your filled-out, signed application to: 617-887-8770.
- Call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

If you have any questions about this application or the information you need to send, please call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

OFFICIAL

Application for Health Coverage and Help Paying Costs

Commonwealth of Massachusetts | EOHHS

Please print clearly. **Be sure to answer all questions. Fill out all parts of the application and 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.**

We need one adult in your household to be the contact person for your application (Person 1).

PART 1 Tell us about you (Person 1)—Fill out this part for yourself.

1. First name Middle initial Last name	Suffix (ex., Jr.)	Relationship to you SELF
2. Home street address	Apt. #	
City	State	Zip code

3. Are you homeless? ☐ Yes ☐ No	4. Mailing address (if different from home address)	
City	State	Zip code

5. Telephone number	Other telephone number	6. Email address

7. Date of birth (mm/dd/yyyy)	8. Gender ☐ M ☐ F	9. Written language choice	10. Spoken language choice

We need a social security number for every person applying for health coverage who has one. 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 needs help getting an SSN, call the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778 for people who are deaf, hard of hearing, or speech disabled), or go to socialsecurity.gov. Please see the application instructions or the Member Booklet for more information.

11. Do you have a social security number (SSN)? ☐ Yes ☐ No
    If **yes**, give us the number. ________ – ________ – __________ (Optional, if **not** applying)
    If **no**, check one of the reasons below.
    ☐ Applied, but have not received SSN ☐ Religious exemption ☐ Only eligible for nonwork SSN
    ☐ Not eligible to get SSN ☐ Eligible for SSN, but have not applied

12. Will you file a federal income tax return next year? ☐ Yes ☐ No
    (To get a tax credit, you must file taxes for the year you are requesting benefits. You can still apply for health coverage even if you do not file a federal income tax return.) If **yes**, answer 12.a., 12.b., and 12.c. If **no**, answer 12.c.
    12.a. Will you file jointly with a spouse? ☐ Yes ☐ No If **yes**, name of spouse: ______________________
    (If married, you must file federal taxes jointly for the year you are requesting benefits.)
    12.b. Will you claim any dependents on your income tax return? ☐ Yes ☐ No
    If **yes**, list name(s) of dependents: ______________________
    12.c. Will someone else claim you as a dependent on his or her tax return? ☐ Yes ☐ No
    If **yes**, name of tax filer: ______________________ How are you related to the tax filer? ______________

13. Are you pregnant? ☐ Yes ☐ No
    13.a. If **yes**, how many children are you expecting? ______ 13.b. What is the due date? (mm/dd/yyyy) ______________

14. Are you applying for health coverage for yourself? ☐ Yes ☐ No

If **no**, go to **Part 2: Tell us about other people in this household** on page 3. If **yes**, answer all questions below for Person 1 (yourself).

15. Are you living in Massachusetts and planning to stay? ☐ Yes ☐ No

16. Do you live with at least one child under age 19? ☐ Yes ☐ No

16.a. If **yes**, are you the main person taking care of this child? ☐ Yes ☐ No

17. Are you in jail or prison? ☐ Yes ☐ No

If **no**, go to the next question.

17.a. If **yes**, are you (Check one.):

☐ Convicted? What is your expected release date? (mm/dd/yyyy) ______________ ☐ Not convicted? (For example: confined only)

18. Did you age out of foster care at the age of 18 or older? ☐ Yes ☐ No

If **yes**, were you enrolled in Medicaid when you aged out of foster care? ☐ Yes ☐ No

"Aging out" means the individual was in the custody of a state child welfare agency in any state or of a tribe in any state when he or she turned 18 years of age, or older if the individual decided to stay in placement after age 18.

19. Are you a U.S. citizen, national, or naturalized U.S. citizen? ☐ Yes ☐ No

If **yes**, go to Question 20.

19.a. If **no**, do you have an eligible immigration status? (See the Member Booklet for more information.) ☐ Yes ☐ No ☐ No response

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 20.

19.b. If **yes**, do you have an immigration document? ☐ Yes ☐ No

We will try to prove your immigration status. Please list all the immigration statuses and/or conditions that have applied to you since you entered the U.S. (See the Member Booklet for more information about immigration statuses and documents.)

Immigration status		
Status award date* (mm/dd/yyyy)	Immigration document type	Document ID number

* For battered persons, status award date is date petition was approved as properly filed.

19.c. Did you come to live in the U.S. before August 22, 1996? ☐ Yes ☐ No

19.d. Did you use a different name to get your immigration status? ☐ Yes ☐ No **If yes, what is it?**

First name	Middle name	Last name	Suffix (ex., Jr.)

19.e. Are you an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

19.f. Are you a spouse or unremarried surviving spouse of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

19.g. Are you an unmarried dependent child of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

20. Do you have an injury, illness, or 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

If **no**, go to the next question. **If yes**, fill out **Part A** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

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

If **no**, go to the next question. **If yes**, fill out **Part B** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

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

If **no**, go to the next question. **If yes**, fill out **Part C** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

23. Do you have breast or cervical cancer? ☐ Yes ☐ No (Optional)
MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.
If **no**, go to the next question. 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.

24. Are you HIV positive? ☐ Yes ☐ No (Optional) If you are HIV positive, you may be eligible for additional coverage or benefits.
If **no**, go to the next question. If **yes**, you will need to give us proof of your HIV-positive status. Then MassHealth can see if your MassHealth benefits give you the most coverage possible.

25. Did you ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No
If **no**, go to the next question. If **yes**, answer questions 25.a. and 25.b.
25.a. When did you last get SSI? (mm/yyyy) ____________
25.b. Do you (Please check one.): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home?
☐ live and share expenses with another or others (not a spouse)? ☐ live in an assisted living facility? ☐ live in someone else's home?

26. Check the box below that best describes you. (Optional)
☐ American Indian/Alaska Native (Mashpee Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))
☐ American Indian/Alaska Native (Other Tribal Nation) ☐ Asian ☐ Black or African American ☐ Hispanic/Latino/Black
☐ Hispanic/Latino/White ☐ Hispanic/Latino/Other ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other ____________

27. If you are an American Indian or Alaska Native, fill out **Supplement B: American Indian (AI)/Alaska Native (AN)** on page 20. American Indians and Alaska Natives may not have to pay premiums or copayments, and may get special monthly enrollment periods.

Go to **Part 2** to add other household members, if needed, or go to **Part 3: Current Job and Income Information** on page 10.

PART 2 Tell us about other people in this household

Fill out this part for your spouse or partner and children who live with you and/or anyone included on your federal income tax return, if you file one. See the application instructions for more information about who to include. If you do not file an income tax return, remember to add other persons who live with you.

Person 2

1. First name   Middle initial   Last name | Suffix (ex., Jr.) | Relationship to Person 1

2. Home street address | Apt. #

City | State | Zip code

3. Is Person 2 homeless? ☐ Yes ☐ No | 4. Mailing address (if different from home address)

City | State | Zip code | 5. Telephone number

6. Email address | 7. Date of birth (mm/dd/yyyy) | 8. Gender ☐ M ☐ F | 9. Written language choice | 10. Spoken language choice

We need a social security number for every person applying for health coverage who has one. Please see the application instructions or the Member Booklet for more information.

11. Does Person 2 have a social security number (SSN)? ☐ Yes ☐ No
If **yes**, give us the number. ________ – _______ – _________ (Optional, if **not** applying)
If **no**, check one of the reasons below.
☐ Applied, but have not received SSN ☐ Religious exemption ☐ Only eligible for nonwork SSN
☐ Not eligible to get SSN ☐ Eligible for SSN, but have not applied

12. Will Person 2 file a federal income tax return next year? ☐ Yes ☐ No
(To get a tax credit, Person 2 must file taxes for the year he or she is requesting benefits. Person 2 can still apply for health coverage even if he or she does not file a federal income tax return.) **If yes**, answer 12.a., 12.b., and 12.c. If **no**, answer 12.c.

12.a. Will Person 2 file jointly with a spouse? ☐ Yes ☐ No **If yes**, name of spouse: ______
(If married, Person 2 must file federal taxes jointly for the year he or she is requesting benefits.)

12.b. Will Person 2 claim any dependents on his or her income tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: ______

12.c. Will someone else claim Person 2 as a dependent on his or her tax return? ☐ Yes ☐ No
If yes, name of tax filer: ______ How is Person 2 related to the tax filer? ______

13. Is Person 2 pregnant? ☐ Yes ☐ No
13.a. If **yes**, how many children is she expecting? ______ 13.b. What is the due date? (mm/dd/yyyy) ______

14. Is Person 2 applying for health coverage? ☐ Yes ☐ No
If **no**, go to **Person 3** or **Part 3: Current Job and Income Information** on page 10. If **yes**, answer all questions below for Person 2.

15. Is Person 2 living in Massachusetts and planning to stay? ☐ Yes ☐ No

16. Does Person 2 live with at least one child under age 19? ☐ Yes ☐ No
16.a. If **yes**, is Person 2 the main person taking care of this child? ☐ Yes ☐ No

17. Is Person 2 in jail or prison? ☐ Yes ☐ No
If **no**, go to the next question.
17.a. If **yes**, is Person 2 (Check one.):
☐ Convicted? What is his or her expected release date? (mm/dd/yyyy) ______ ☐ Not convicted? (For example: confined only)

18. Did Person 2 age out of foster care at the age of 18 or older? ☐ Yes ☐ No
If yes, was this person enrolled in Medicaid when he or she aged out of foster care? ☐ Yes ☐ No

"Aging out" means the individual was in the custody of a state child welfare agency in any state or of a tribe in any state when he or she turned 18 years of age, or older if the individual decided to stay in placement after age 18.

19. Is Person 2 a U.S. citizen, national, or naturalized U.S. citizen? ☐ Yes ☐ No
If yes, go to Question 20.

19.a. If **no**, does Person 2 have an eligible immigration status? (See the Member Booklet for more information.) ☐ Yes ☐ No ☐ No response
If **no** or **no response**, Person 2 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 20.

19.b. If **yes**, does Person 2 have an immigration document? ☐ Yes ☐ No

We will try to prove Person's 2 immigration status. Please list all the immigration statuses and/or conditions that have applied to Person 2 since he or she entered the U.S. (See the Member Booklet for more information about immigration statuses and documents.)

Immigration status

Status award date* (mm/dd/yyyy)	Immigration document type	Document ID number

* For battered persons, status award date is date petition was approved as properly filed.

19.c. Did Person 2 come to live in the U.S. before August 22, 1996? ☐ Yes ☐ No

19.d. Did Person 2 use a different name to get his or her immigration status? ☐ Yes ☐ No **If yes, what is it?**

First name	Middle name	Last name	Suffix (ex., Jr.)

19.e. Is Person 2 an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

19.f. Is Person 2 a spouse or unremarried surviving spouse of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

Please go to the next page. ▶

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19.g. Is Person 2 an unmarried dependent child of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

20. Does Person 2 have an injury, illness, or 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
If **no**, go to the next question. If **yes**, fill out **Part A** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

21. Does Person 2 need reasonable accommodation(s) because of a disability or injury? ☐ Yes ☐ No
If **no**, go to the next question.
If **yes**, fill out **Part B** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

22. Is Person 2 applying because of an accident or injury that someone else might be responsible for? ☐ Yes ☐ No
If **no**, go to the next question. If **yes**, fill out **Part C** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

23. Does Person 2 have breast or cervical cancer? ☐ Yes ☐ No (Optional)
MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.
If **no**, go to the next question. If **yes**, we will send a certificate to be filled out by Person 2's doctor to prove his or her breast cancer or her cervical cancer diagnosis. Then MassHealth can see if Person 2's MassHealth benefits give him or her the most coverage possible.

24. Is Person 2 HIV positive? ☐ Yes ☐ No (Optional)
If Person 2 is HIV positive, he or she may be eligible for additional coverage or benefits.
If **no**, go to the next question. If **yes**, Person 2 will need to give us proof of his or her HIV-positive status. Then MassHealth can see if Person 2's MassHealth benefits give him or her the most coverage possible.

25. Did Person 2 ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No
If **no**, go to the next question. If **yes**, answer questions 25.a. and 25.b.
25.a. When did Person 2 last get SSI? (mm/yyyy) ____________
25.b. Does Person 2 (Please check one.): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home?
☐ live and share expenses with another or others (not a spouse)? ☐ live in an assisted living facility? ☐ live in someone else's home?

26. Check the box below that best describes Person 2. (Optional)
☐ American Indian/Alaska Native (Mashpee Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))
☐ American Indian/Alaska Native (Other Tribal Nation) ☐ Asian ☐ Black or African American ☐ Hispanic/Latino/Black
☐ Hispanic/Latino/White ☐ Hispanic/Latino/Other ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other ____________

27. If Person 2 is an American Indian or Alaska Native, fill out **Supplement B: American Indian (AI)/Alaska Native (AN)** on page 20. American Indians or Alaska Natives may not have to pay premiums or copayments, and may get special monthly enrollment periods. Continue adding other household members, if needed, or go to **Part 3: Current Job and Income Information** on page 10.

Person 3

1. First name Middle initial Last name				Suffix (ex., Jr.)	Relationship to Person 1
2. Home street address				Apt. #	Relationship to Person 2
City				State	Zip code
3. Is Person 3 homeless? ☐ Yes ☐ No	4. Mailing address (if different from home address)				
City		State	Zip code	5. Telephone number	
6. Email address	7. Date of birth (mm/dd/yyyy)	8. Gender ☐ M ☐ F	9. Written language choice	10. Spoken language choice	

We need a social security number for every person applying for health coverage who has one. Please see the application instructions or the Member Booklet for more information.

11. Does Person 3 have a social security number (SSN)? ☐ Yes ☐ No

If **yes**, give us the number. ________ – ________ – __________ (Optional, if **not** applying)

If **no**, check one of the reasons below.

☐ Applied, but have not received SSN ☐ Religious exemption ☐ Only eligible for nonwork SSN
☐ Not eligible to get SSN ☐ Eligible for SSN, but have not applied

12. Will Person 3 file a federal income tax return next year? ☐ Yes ☐ No

(To get a tax credit, Person 3 must file taxes for the year he or she is requesting benefits. Person 3 can still apply for health coverage even if he or she does not file a federal income tax return.) If **yes**, answer 12.a., 12.b., and 12.c. If **no**, answer 12.c.

12.a. Will Person 3 file jointly with a spouse? ☐ Yes ☐ No **If yes**, name of spouse: ____________________
(If married, Person 3 must file federal taxes jointly for the year he or she is requesting benefits.)

12.b. Will Person 3 claim any dependents on his or her income tax return? ☐ Yes ☐ No
If **yes**, list name(s) of dependents: ____________________

12.c. Will someone else claim Person 3 as a dependent on his or her tax return? ☐ Yes ☐ No
If **yes**, name of tax filer: ____________________ How is Person 3 related to the tax filer? __________

13. Is Person 3 pregnant? ☐ Yes ☐ No

13.a. If **yes**, how many children is she expecting? ________ 13.b. What is the due date? (mm/dd/yyyy) __________

14. Is Person 3 applying for health coverage? ☐ Yes ☐ No

If **no**, go to **Person 4** or **Part 3: Current Job and Income Information** on page 10. If **yes**, answer all questions below for Person 3.

15. Is Person 3 living in Massachusetts and planning to stay? ☐ Yes ☐ No

16. Does Person 3 live with at least one child under age 19? ☐ Yes ☐ No

16.a. **If yes**, is Person 3 the main person taking care of this child? ☐ Yes ☐ No

17. Is Person 3 in jail or prison? ☐ Yes ☐ No

If **no**, go to the next question.

17.a. If **yes**, is Person 3 (Check one.):
☐ Convicted? What is his or her expected release date? (mm/dd/yyyy) __________ ☐ Not convicted? (For example: confined only)

18. Did Person 3 age out of foster care at the age of 18 or older? ☐ Yes ☐ No

If **yes**, was this person enrolled in Medicaid when he or she aged out of foster care? ☐ Yes ☐ No

"Aging out" means the individual was in the custody of a state child welfare agency in any state or of a tribe in any state when he or she turned 18 years of age, or older if the individual decided to stay in placement after age 18.

19. Is Person 3 a U.S. citizen, national, or naturalized U.S. citizen? ☐ Yes ☐ No

If **yes**, go to Question 20.

19.a. If **no**, does Person 3 have an eligible immigration status? (See the Member Booklet for more information.) ☐ Yes ☐ No ☐ No response

If no or **no response**, Person 3 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 20.

19.b. If **yes**, does Person 3 have an immigration document? ☐ Yes ☐ No

We will try to prove Person's 3 immigration status. Please list all the immigration statuses and/or conditions that have applied to Person 3 since he or she entered the U.S. (See the Member Booklet for more information about immigration statuses and documents.)

Immigration status		
Status award date* (mm/dd/yyyy)	**Immigration document type**	**Document ID number**

* For battered persons, status award date is date petition was approved as properly filed.

19.c. Did Person 3 come to live in the U.S. before August 22, 1996? ☐ Yes ☐ No

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19.d. Did Person 3 use a different name to get his or her immigration status? ☐ Yes ☐ No **If yes, what is it?**

First name	Middle name	Last name	Suffix (ex., Jr.)

19.e. Is Person 3 an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

19.f. Is Person 3 a spouse or unremarried surviving spouse of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

19.g. Is Person 3 an unmarried dependent child of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

20. Does Person 3 have an injury, illness, or 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
If **no**, go to the next question. If **yes**, fill out **Part A** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

21. Does Person 3 need reasonable accommodation(s) because of a disability or injury? ☐ Yes ☐ No
If **no**, go to the next question. If **yes**, fill out **Part B** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

22. Is Person 3 applying because of an accident or injury that someone else might be responsible for? ☐ Yes ☐ No
If **no**, go to the next question. If **yes**, fill out **Part C** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

23. Does Person 3 have breast or cervical cancer? ☐ Yes ☐ No (Optional)
MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.
If **no**, go to the next question. If **yes**, we will send a certificate to be filled out by Person 3's doctor to prove his or her breast cancer or her cervical cancer diagnosis. Then MassHealth can see if Person 3's MassHealth benefits give him or her the most coverage possible.

24. Is Person 3 HIV positive? ☐ Yes ☐ No (Optional)
If Person 3 is HIV positive, he or she may be eligible for additional coverage or benefits.
If **no**, go to the next question. If **yes**, Person 3 will need to give us proof of his or her HIV-positive status. Then MassHealth can see if Person 3's MassHealth benefits give him or her the most coverage possible.

25. Did Person 3 ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No
If **no**, go to the next question. If **yes**, answer questions 25.a. and 25.b.
25.a. When did Person 3 last get SSI? (mm/yyyy) ________
25.b. Does Person 3 (Please check one.): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home?
☐ live and share expenses with another or others (not a spouse)? ☐ live in an assisted living facility? ☐ live in someone else's home?

26. Check the box below that best describes Person 3. (Optional)
☐ American Indian/Alaska Native (Mashpee Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))
☐ American Indian/Alaska Native (Other Tribal Nation) ☐ Asian ☐ Black or African American ☐ Hispanic/Latino/Black
☐ Hispanic/Latino/White ☐ Hispanic/Latino/Other ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other ________

27. If Person 3 is an American Indian or Alaska Native, fill out **Supplement B: American Indian (AI)/Alaska Native (AN)** on page 20. American Indians or Alaska Natives may not have to pay premiums or copayments, and may get special monthly enrollment periods. Continue adding other household members, if needed, or go to **Part 3: Current Job and Income Information** on page 10.

If you have more than three people to add, make a copy of Person 4's blank information pages (pages 7-9) before you fill them out.

Person 4

1. First name Middle initial Last name		Suffix (ex., Jr.)	Relationship to Person 1
2. Home street address		Apt. #	Relationship to Person 2
City	State	Zip code	Relationship to Person 3
3. Is Person 4 homeless? ☐ Yes ☐ No	4. Mailing address (if different from home address)		

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City	State	Zip code	5. Telephone number

6. Email address	7. Date of birth (mm/dd/yyyy)	8. Gender ☐ M ☐ F	9. Written language choice	10. Spoken language choice

We need a social security number for every person applying for health coverage who has one. Please see the application instructions or the Member Booklet for more information.

11. Does Person 4 have a social security number (SSN)? ☐ Yes ☐ No

If **yes**, give us the number. ________ – _______ – __________ (Optional, if **not** applying)

If **no**, check one of the reasons below.

☐ Applied, but have not received SSN ☐ Religious exemption ☐ Only eligible for nonwork SSN

☐ Not eligible to get SSN ☐ Eligible for SSN, but have not applied

12. Will Person 4 file a federal income tax return next year? ☐ Yes ☐ No

(To get a tax credit, Person 4 must file taxes for the year he or she is requesting benefits. Person 4 can still apply for health coverage even if he or she does not file a federal income tax return.) **If yes**, answer 12.a., 12.b., and 12.c. **If no**, answer 12.c.

12.a. Will Person 4 file jointly with a spouse? ☐ Yes ☐ No **If yes**, name of spouse: ______________________________

(If married, Person 4 must file federal taxes jointly for the year he or she is requesting benefits.)

12.b. Will Person 4 claim any dependents on his or her income tax return? ☐ Yes ☐ No

If **yes**, list name(s) of dependents: ______________________________

12.c. Will someone else claim Person 4 as a dependent on his or her tax return? ☐ Yes ☐ No

If **yes**, name of tax filer: ______________________________ How is Person 4 related to the tax filer? ____________

13. Is Person 4 pregnant? ☐ Yes ☐ No

13.a. If **yes**, how many children is she expecting? _______ 13.b. What is the due date? (mm/dd/yyyy) ______________

14. Is Person 4 applying for health coverage? ☐ Yes ☐ No

If **no**, go to **Part 3: Current Job and Income Information** on page 10. If **yes**, answer all questions below for Person 4.

15. Is Person 4 living in Massachusetts and planning to stay? ☐ Yes ☐ No

16. Does Person 4 live with at least one child under age 19? ☐ Yes ☐ No

16.a. If **yes**, is Person 4 the main person taking care of this child? ☐ Yes ☐ No

17. Is Person 4 in jail or prison? ☐ Yes ☐ No

If **no**, go to the next question.

17.a. If **yes**, is Person 4 (Check one.):

☐ Convicted? What is his or her expected release date? (mm/dd/yyyy) ______________ ☐ Not convicted? (For example: confined only)

18. Did Person 4 age out of foster care at the age of 18 or older? ☐ Yes ☐ No

If **yes**, was this person enrolled in Medicaid when he or she aged out of foster care? ☐ Yes ☐ No

"Aging out" means the individual was in the custody of a state child welfare agency in any state or of a tribe in any state when he or she turned 18 years of age, or older if the individual decided to stay in placement after age 18.

19. Is Person 4 a U.S. citizen, national, or naturalized U.S. citizen? ☐ Yes ☐ No

If **yes**, go to Question 20.

19.a. If **no**, does Person 4 have an eligible immigration status? (See the Member Booklet for more information.) ☐ Yes ☐ No ☐ No response

If **no** or **no response**, Person 4 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 20.

19.b. If **yes**, does Person 4 have an immigration document? ☐ Yes ☐ No

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We will try to prove Person's 4 immigration status. Please list all the immigration statuses and/or conditions that have applied to Person 4 since he or she entered the U.S. (See the Member Booklet for more information about immigration statuses and documents.)

Immigration status

Status award date* (mm/dd/yyyy)	Immigration document type	Document ID number

* For battered persons, status award date is date petition was approved as properly filed.

19.c. Did Person 4 come to live in the U.S. before August 22, 1996? ☐ Yes ☐ No

19.d. Did Person 4 use a different name to get his or her immigration status? ☐ Yes ☐ No **If yes, what is it?**

First name	Middle name	Last name	Suffix (ex., Jr.)

19.e. Is Person 4 an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

19.f. Is Person 4 a spouse or unremarried surviving spouse of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

19.g. Is Person 4 an unmarried dependent child of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

20. Does Person 4 have an injury, illness, or 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

If **no**, go to the next question. If **yes**, fill out **Part A** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

21. Does Person 4 need reasonable accommodation(s) because of a disability or injury? ☐ Yes ☐ No

If **no**, go to the next question. If **yes**, fill out **Part B** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

22. Is Person 4 applying because of an accident or injury that someone else might be responsible for? ☐ Yes ☐ No

If **no**, go to the next question. If **yes**, fill out **Part C** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

23. Does Person 4 have breast or cervical cancer? ☐ Yes ☐ No (Optional)

MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.

If **no**, go to the next question. If **yes**, Person 4 will send a certificate to be filled out by Person 4's doctor to prove his or her breast cancer or her cervical cancer diagnosis. Then MassHealth can see if Person 4's MassHealth benefits give him or her the most coverage possible.

24. Is Person 4 HIV positive? ☐ Yes ☐ No (Optional)

If Person 4 is HIV positive, he or she may be eligible for additional coverage or benefits.

If **no**, go to the next question. If **yes**, Person 4 will need to give us proof of his or her HIV-positive status. Then MassHealth can see if Person 4's MassHealth benefits give him or her the most coverage possible.

25. Did Person 4 ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No

If **no**, go to the next question. If yes, answer questions 25.a. and 25.b.

25.a. When did Person 4 last get SSI? (mm/yyyy) ____________

25.b. Does Person 4 (Please check one.): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home? ☐ live and share expenses with another or others (not a spouse)? ☐ live in an assisted living facility? ☐ live in someone else's home?

26. Check the box below that best describes Person 4. (Optional)

☐ American Indian/Alaska Native (Mashpee Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah)) ☐ American Indian/Alaska Native (Other Tribal Nation) ☐ Asian ☐ Black or African American ☐ Hispanic/Latino/Black ☐ Hispanic/Latino/White ☐ Hispanic/Latino/Other ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other ____________

27. If Person 4 is an American Indian or Alaska Native, fill out **Supplement B: American Indian (AI)/Alaska Native (AN)** on page 20. American Indians or Alaska Natives may not have to pay premiums or copayments, and may get special monthly enrollment periods. Continue adding other household members, if needed, or go to **Part 3: Current Job and Income Information** on page 10.

PART 3 Current Job and Income Information

We use your income to see if you are eligible for health coverage. See the Member Booklet. If you are self-employed, and pay yourself wages, fill out both the Current Job and Self-employed income sections.

About You (Person 1)

1. (Check all that apply.)

☐ Employed (Go to **Current Job 1.**) ☐ Self-employed (Go to **Self-employed income.**) ☐ Not employed (Go to **Money from other sources** section.)

Current Job 1

2. Employer name

Employer address	City	State	Zip code
Employer telephone	Employer Identification Number (EIN—if you know)		

3. Does this job offer health insurance? ☐ Yes ☐ No

If **yes**, check one.

☐ This job offers health insurance now.

☐ This job will offer health insurance, starting ______________ (mm/dd/yyyy).

3.a. If this job offers health insurance now or will at a later date, can the health plan cover an employee's spouse or dependent(s)?

☐ Yes List the name(s): ____ ☐ No

- How much will the employee pay for the lowest-cost individual health plan? $ ________
  How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
- If an employee joins a program to stop smoking or using tobacco, how much money could he or she save on the monthly premium? $ ________
- Does the health insurance plan(s) offered by the employer meet the "minimum value" standard? ☐ Yes ☐ No

Minimum value means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

3.b. What health insurance changes will this job make for the next year? (if you know)

☐ This job will stop offering health insurance.

☐ This job will start offering health insurance to employees or change the premium for the lowest-cost available plan.

- How much will the employee's premiums be (for an individual plan)? $ ________
  How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
- Date of change: ______________ (mm/dd/yyyy)

3.c. ☐ No health insurance plans offered by the employer will meet the "minimum value" standard.

Minimum value means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

4. Does this employer have 50 or fewer full-time employees? ☐ Yes ☐ No (If you do not know, answer **no** to this question.)

If **yes**, we may be able to help you pay for your coverage. For more information, see the Member Booklet for description of coverage.

5. Is this job a sheltered workshop? ☐ Yes ☐ No

6. How much do you currently earn in gross wages, less pre-tax deductions? $ ______________

6.a. How often are you paid? (Check one.) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6.b. About how many hours do you work each WEEK? ______________

6.c. When did you begin getting this income? ______________ (mm/dd/yyyy)

7. If your income from this job changes during the year (such as seasonal or contract employment), check the months you have worked or expect to work. ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

Self-employed Income

8. a. (Check one.) ☐ Partnership ☐ S-Corporation ☐ Self-employed

8.b. Business name: ______

8.c. What is your expected yearly income from this source, less any business expenses? (Do not include your wages and tips.) $ ______

8.d. Date you began getting this income ______ (mm/dd/yyyy)

Current Job 2 (If none, go to **Money from other sources** section.)

9. Employer name

Employer address	City	State	Zip code
Employer telephone	Employer Identification Number (EIN—if you know)		

10. Does this job offer health insurance? ☐ Yes ☐ No

If **yes**, check one.

☐ This job offers health insurance now.

☐ This job will offer health insurance, starting ______ (mm/dd/yyyy).

10.a. If this job offers health insurance now or will at a later date, can the health plan cover an employee's spouse or dependent(s)?

☐ Yes List the name(s): ______ ☐ No

- How much will the employee pay for the lowest-cost individual health plan? $ ______
  How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
- If an employee joins a program to stop smoking or using tobacco, how much money could he or she save on the monthly premium? $ ______
- Does the health insurance plan(s) offered by the employer meet the "minimum value" standard? ☐ Yes ☐ No

Minimum value means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

10.b. What health insurance changes will this job make for the next year? (if you know)

☐ This job will stop offering health insurance.

☐ This job will start offering health insurance to employees or change the premium for the lowest-cost available plan.

- How much will the employee's premiums be (for an individual plan)? $ ______
  How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
- Date of change: ______ (mm/dd/yyyy)

10.c. ☐ No health insurance plans offered by the employer will meet the "minimum value" standard.

Minimum value means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

11. Does this employer have 50 or fewer full-time employees? ☐ Yes ☐ No (If you do not know, answer **no** to this question.)

If **yes**, we may be able to help you pay for your coverage. For more information, see the Member Booklet for description of coverage.

12. Is this job a sheltered workshop? ☐ Yes ☐ No

13. How much do you currently earn in gross wages, less pre-tax deductions? $ ______

13.a. How often are you paid? (Check one.) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

13.b. About how many hours do you work each WEEK? ______

13.c. When did you begin getting this income? ______ (mm/dd/yyyy)

14. If your income from this job changes during the year (such as seasonal or contract employment), check the months you have worked or expect to work. ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

OFFICIAL

Self-employed Income

15. a. (Check one.) ☐ Partnership ☐ S-Corporation ☐ Self-employed

15.b. Business name: ______

15.c. What is your expected yearly income from this source, less any business expenses? (Do not include your wages and tips.) $ ______

15.d. Date you began getting this income ______ (mm/dd/yyyy)

Money from other sources

16. Do you get money from other sources? ☐ Yes ☐ No

Check all of the sources, give the amount, and how often you get it.
(You do not need to tell us about child support, nontaxable veterans' payments, or Supplemental Security Income (SSI).)

☐ Unemployment	$ ______	How often? ______	☐ Ordinary or qualified dividend	$ ______	How often? ______
☐ Pension	$ ______	How often? ______	☐ Trusts	$ ______	How often? ______
☐ Annuity	$ ______	How often? ______	☐ Interest	$ ______	How often? ______
☐ Social Security	$ ______	How often? ______	☐ Net farming/fishing	$ ______	How often? ______
☐ Net rental income	$ ______	How often? ______	☐ Royalty	$ ______	How often? ______
☐ Capital gains	$ ______	How often? ______	☐ Alimony received	$ ______	How often? ______
☐ Gambling proceeds	$ ______	How often? ______	☐ Tax-excluded foreign income	$ ______	How often? ______

☐ Taxable military retirement pay (not paid through the Veterans' Administration) $ ______ How often? ______

☐ Tax refund, credit, or offset of state or local income taxes $ ______ How often? ______

☐ Other income (Specify:) ______ $ ______ How often? ______

Deductions allowed on federal tax return All or part of certain expenses can be deducted from income so that you do not pay taxes on them. These amounts are not counted in your income, and may lower the cost of your health coverage.

17. Do you have any of the deductible expenses below? ☐ Yes ☐ No

If **yes**, please check all of the types you have, fill in the deductible amount, and how often you have this expense.
Do not include an expense that you already claimed under self-employment income above.

☐ Alimony paid $ ______ How often? ______ ☐ Student loan interest $ ______ How often? ______

☐ Other tax deductions (such as business expenses, IRA contributions, contributions to taxable retirement income, deductible part of self-employment tax, educator expenses, health savings account contributions (deduction), moving expenses, penalty on early withdrawal of savings, self-employment health insurance, self-employment retirement plan, and tuition and other school-related costs)

Type: ______ $ ______ How often? ______

Type: ______ $ ______ How often? ______

Type: ______ $ ______ How often? ______

Total Income (Person 1)

18. Do you expect your total income (including earned income and money from other sources) to be the same next year? ☐ Yes ☐ No
(If you are not sure, answer **no** to this question.)

If **no**, what do you expect your total income to be next year? $ ______ (Estimate)

Person 2 (Second adult) (If you have income to report for more than two persons, make a copy of pages 12-15 before you fill them out.)

Name:

1. (Check all that apply.)

☐ Employed (Go to **Current Job 1**.) ☐ Self-employed (Go to **Self-employed income**.) ☐ Not employed (Go to **Money from other sources** section.)

OFFICIAL

Current Job 1

2. Employer name

Employer address	City	State	Zip code
Employer telephone	Employer Identification Number (EIN—if you know)		

3. Does this job offer health insurance? ☐ Yes ☐ No

   If **yes**, check one.

   ☐ This job offers health insurance now.

   ☐ This job will offer health insurance, starting ______________ (mm/dd/yyyy).

   3.a. If this job offers health insurance now or will at a later date, can the health plan cover an employee's spouse or dependent(s)?

   ☐ Yes List the name(s): ______________________________ ☐ No

   - How much will the employee pay for the lowest-cost individual health plan? $ __________
     How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
   - If an employee joins a program to stop smoking or using tobacco, how much money could he or she save on the monthly premium? $ __________
   - Does the health insurance plan(s) offered by the employer meet the "minimum value" standard? ☐ Yes ☐ No

   Minimum value means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

   3.b. What health insurance changes will this job make for the next year? (if you know)

   ☐ This job will stop offering health insurance.

   ☐ This job will start offering health insurance to employees or change the premium for the lowest-cost available plan.

   - How much will the employee's premiums be (for an individual plan)? $ __________
     How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
   - Date of change: ______________ (mm/dd/yyyy)

   3.c. ☐ No health insurance plans offered by the employer will meet the "minimum value" standard.

   Minimum value means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

4. Does this employer have 50 or fewer full-time employees? ☐ Yes ☐ No (If you do not know, answer **no** to this question.)

   If **yes**, we may be able to help pay for this coverage. For more information, see the Member Booklet for description of coverage.

5. Is this job a sheltered workshop? ☐ Yes ☐ No

6. How much does this person currently earn in gross wages, less pre-tax deductions? $ ______________

   6.a. How often is this person paid? (Check one.) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

   6.b. About how many hours does this person work each WEEK? ______________

   6.c. When did this person begin getting this income? ______________ (mm/dd/yyyy)

7. If this person's income from this job changes during the year (such as seasonal or contract employment), check the months this person has worked or expects to work. ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

Self-employed Income

8. a. (Check one.) ☐ Partnership ☐ S-Corporation ☐ Self-employed

   8.b. Business name: ______________________________

   8.c. What is this person's expected yearly income from this source, less any business expenses? (Do not include his or her wages and tips.) $ ______________

   8.d. Date this person began getting this income ______________ (mm/dd/yyyy)

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Current Job 2 (If none, go to **Money from other sources** section.)

9. Employer name

Employer address	City	State	Zip code
Employer telephone	Employer Identification Number (EIN—if you know)		

10. Does this job offer health insurance? ☐ Yes ☐ No

If **yes**, check one.

☐ This job offers health insurance now.

☐ This job will offer health insurance, starting _______________ (mm/dd/yyyy).

10.a. If this job offers health insurance now or will at a later date, can the health plan cover an employee's spouse or dependent(s)?

☐ Yes List the name(s): ____ ☐ No

- How much will the employee pay for the lowest-cost individual health plan? $ __________
  How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
- If an employee joins a program to stop smoking or using tobacco, how much money could he or she save on the monthly premium? $ __________
- Does the health insurance plan(s) offered by the employer meet the "minimum value" standard? ☐ Yes ☐ No

Minimum value means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

10.b. What health insurance changes will this job make for the next year? (if you know)

☐ This job will stop offering health insurance.

☐ This job will start offering health insurance to employees or change the premium for the lowest-cost available plan.

- How much will the employee's premiums be (for an individual plan)? $ __________
  How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
- Date of change: _______________ (mm/dd/yyyy)

10.c. ☐ No health insurance plans offered by the employer will meet the "minimum value" standard.

Minimum value means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

11. Does this employer have 50 or fewer full-time employees? ☐ Yes ☐ No (If you do not know, answer **no** to this question.)

If **yes**, we may be able to help pay for this coverage. For more information, see the Member Booklet for description of coverage.

12. Is this job a sheltered workshop? ☐ Yes ☐ No

13. How much does this person currently earn in gross wages, less pre-tax deductions? $ _______________

13.a. How often is this person paid? (Check one.) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

13.b. About how many hours does this person work each WEEK? _______________

13.c. When did this person begin getting this income? _______________ (mm/dd/yyyy)

14. If this person's income from this job changes during the year (such as seasonal or contract employment), check the months this person has worked or expects to work. ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

Self-employed Income

15. a. (Check one.) ☐ Partnership ☐ S-Corporation ☐ Self-employed

15.b. Business name: ____

15.c. What is this person's expected yearly income from this source, less any business expenses?
(Do not include his or her wages and tips.) $ _______________

15.d. Date this person began getting this income _______________ (mm/dd/yyyy)

Money from other sources

16. Does this person get money from other sources? ☐ Yes ☐ No

Check all of the sources, give the amount, and how often this person gets it.
(You do not need to tell us about child support, nontaxable veterans' payments, or Supplemental Security Income (SSI).)

☐ Unemployment $ ________ How often? ________
☐ Pension $ ________ How often? ________
☐ Annuity $ ________ How often? ________
☐ Social Security $ ________ How often? ________
☐ Net rental income $ ________ How often? ________
☐ Capital gains $ ________ How often? ________
☐ Gambling proceeds $ ________ How often? ________
☐ Ordinary or qualified dividend $ ________ How often? ________
☐ Trusts $ ________ How often? ________
☐ Interest $ ________ How often? ________
☐ Net farming/fishing $ ________ How often? ________
☐ Royalty $ ________ How often? ________
☐ Alimony received $ ________ How often? ________
☐ Tax-excluded foreign income $ ________ How often? ________
☐ Taxable military retirement pay (not paid through the Veterans' Administration) $ ________ How often? ________
☐ Tax refund, credit, or offset of state or local income taxes $ ________ How often? ________
☐ Other income (Specify:) ________________ $ ________ How often? ________

Deductions allowed on federal tax return

All or part of certain expenses can be deducted from income so that this person does not pay taxes on them. These amounts are not counted in this person's income, and may lower the cost of his or her health coverage.

17. Does this person have any of the deductible expenses below? ☐ Yes ☐ No

If **yes**, please check all of the types he or she has, fill in the deductible amount, and how often this person has this expense.
Do not include an expense that he or she already claimed under self-employment income above.

☐ Alimony paid $ ________ How often? ________ ☐ Student loan interest $ ________ How often? ________

☐ Other tax deductions (such as business expenses, IRA contributions, contributions to taxable retirement income, deductible part of self-employment tax, educator expenses, health savings account contributions (deduction), moving expenses, penalty on early withdrawal of savings, self-employment health insurance, self-employment retirement plan, and tuition and other school-related costs)

Type: ________________ $ ________ How often? ________
Type: ________________ $ ________ How often? ________
Type: ________________ $ ________ How often? ________

Total Income (Person 2)

18. Do you expect Person 2's total income (including earned income and money from other sources) to be the same next year? ☐ Yes ☐ No
(If you are not sure, answer **no** to this question.)
If **no**, what do you expect Person 2's total income to be next year? $ ________ (Estimate)

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PART 4 Health Insurance You Have Now

Please answer the questions below about **health insurance**, and follow the instructions. If you or any household member has enrolled in one of the health insurance plans below, but the benefits have not yet started, check **yes** to the question. MassHealth may be able to help pay premiums.

1. Do you or any household member have Medicare? ☐ Yes ☐ No
   If yes, fill out **Part A** of **Supplement C: Health Insurance** on page 21.
2. Do you or any household member have federal health insurance provided by the U.S. military (Veterans' Affairs or TRICARE) or other federal coverage? ☐ Yes ☐ No
   If yes, fill out **Part B** of **Supplement C: Health Insurance** on page 21.
3. Do you or any household member currently have any other type of health insurance? (This includes insurance through an employer, union, college or university, former employer (COBRA), and coverage bought by you or any household member, or a parent who is not living in the household.)
   ☐ Yes ☐ No
   If yes, fill out **Part C** of **Supplement C: Health Insurance** on page 21.

If you answered **no** to all three questions above, go to **Part 5: Parental Information.**

PART 5 Parental Information

For all children in the household, please answer the following three questions.

1. Was any child in the household adopted by a single parent? ☐ Yes ☐ No
   If yes, list child's(rens') name(s):
2. Does any child in the household have a parent who has died? ☐ Yes ☐ No
   If yes, list child's(ren's) name(s):
3. Does any child in the household have a parent who is unknown? ☐ Yes ☐ No
   If yes, list child's(ren's) name(s):

If there are any children in the household who have a noncustodial parent (a parent who does not live with the child) **but are not listed above**, give us the following information.

Child's(ren's) name(s): ______________________________

We will send a form to the child's(ren's) custodial parent to fill out and return to us. This form asks questions about any parents who do not live with the child. Go to **Part 6: Rights and Responsibilities and Signature Page.**

PART 6 Rights and Responsibilities and Signature Page

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 state regulations for any services that hospitals or community health centers provide to these persons that are paid for by the Health Safety Net.
3. Health coverage premiums must be paid for all persons listed on this application who are applying. Failure to pay any premium due may result in the State deducting the amount owed from the tax refunds of responsible persons. If any person applying is a certain American Indian or Alaska Native, MassHealth premiums may not have to be paid.
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. These third parties may include other health insurers, spouses, or 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 a noncustodial 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 property is sold, money from the sale of that property may be required to be used to repay MassHealth for medical services provided.
10. To the extent permitted by law, for any eligible person aged 55 or older, or for any eligible person for whom MassHealth helps pay for care in a nursing home, MassHealth may 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 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled). A change in information could affect eligibility for these persons or for persons in their household.*
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 these 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 these persons or members of their household.
13. MassHealth, the Massachusetts Health Connector, and the Health Safety Net may get any records or data about persons listed on this application to document medical services claimed or provided to them. We will keep such information private, and only use and disclose it in accordance with applicable law.
14. MassHealth, the Massachusetts Health Connector, and the Health Safety Net may get records or data 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, to prove any information given on this application and any supplements, or other information once an individual becomes a member, and to support continued eligibility. We will keep all records and data provided to us private, and only use and disclose it in accordance with applicable law.

(For renewal of coverage in future years)

15. MassHealth, the Massachusetts Health Connector, and the Health Safety Net will use income data, including information from federal tax returns, to determine eligibility. To make it easier to check income at renewal time, I may authorize MassHealth, the Massachusetts Health Connector, and the Health Safety Net to use data from federal tax returns to redetermine eligibility in future years. MassHealth, the Massachusetts Health Connector, and the Health Safety Net will use this data to the extent I authorize, and will send me a notice, let me make any changes, and allow me to opt out at any time.

    On behalf of all persons applying for health coverage, I: (Check one.)

    ☐ permit use of the data for the next five years; or

    ☐ permit use of the data for: (Check one.)
    ☐ one year, ☐ two years, ☐ three years, ☐ four years
    ☐ do not permit the use of federal tax data to renew eligibility for help paying for health coverage.

16. MassHealth, the Health Connector, and the Health Safety Net may send notices and share information pertaining to the eligibility, renewal of eligibility or enrollment of persons listed on this application to me and to the other persons listed on this application.
17. If I am acting on behalf of someone in filling out this application and any supplements, I have filled out and sent the enclosed Authorized Representative Designation Form with this application or have such form on record. I understand that my signature on this application and any supplements as an authorized representative certifies that the information on this application and any supplements, including those submitted with this application as well as any other forms or documents that may be submitted to or required by MassHealth, the Health Connector, the Children's Medical Security Plan, or the Health Safety Net, is correct and complete to the best of my knowledge.

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18. If I think that MassHealth or the Health Connector has made a mistake in eligibility for me and/or other applicants, I have the right to appeal or file a grievance. If I disagree with the action taken by MassHealth or the Health Connector, I have the right to appeal and ask for a hearing before an impartial hearing officer. I can also ask for a hearing if I did not receive a notice telling me about the action that was taken. To find out how to appeal, please call 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled). I understand that I may be eligible to continue getting benefits while my appeal is being decided. I may have a lawyer or other person represent me, but I may also represent myself. MassHealth or the Health Connector will not pay for anyone to represent me. Additional information about appeals will be provided with any notices I receive, as well as during the appeal process.
19. 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.

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

- Sign on to your account at www.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: 617-887-8770.

I certify under the penalties of perjury that:

- I have read or have had read to me the information on this application, including any supplements and instruction pages, and understand that the Member Booklet contains important information;
- I have permission to submit this application for and receive eligibility enrollment information about all persons listed on this application and as may be allowed by any legal documents I have submitted with this application;
- I understand my rights and responsibilities and the rights and responsibilities of all persons for whom I am submitting this application, as explained in the rights and responsibilities before this signature page;
- I have told or will tell all persons for whom I am submitting this application about these rights and responsibilities so they also understand their rights and responsibilities;
- I understand and agree that MassHealth and the Health Connector will treat electronic, faxed, telephonic, 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 for whom I am submitting this application; and
- I may be subject to penalties under federal law if I intentionally provide false or untrue information.

X ____________________________ ____________________________ ____________

Signature of Person 1 or authorized representative | Print name | Date

Important: If you are submitting this application as an authorized representative, you must submit an **Authorized Representative Designation Form** to us for us to process this application.

For certified application counselors, navigators, agents, and brokers only.

Fill out this section if you are a certified application counselor, navigator, agent, or broker filling out this application for someone else.

____

First name, middle initial, last name, suffix

____

Organization name

Send the filled-out application to:

Health Insurance Processing Center
P.O. Box 4405
Taunton, MA 02780 or fax to 617-887-8770.

SUPPLEMENT A
Illness, Disability, or Accommodation

Part A

If you answered **yes** to Question 20 in **Parts 1 and/or 2** about you or any household member having an injury, illness, or disability that has lasted or may last for at least 12 months, answer the next three questions.

1. Does this person get money from Social Security for a disability? ☐ Yes ☐ No
   If **yes**, name(s): __________
2. Did this person ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No
   If **yes**, name(s): __________
3. Is this person legally blind? ☐ Yes ☐ No
   If **yes**, name(s): __________

Part B

If you answered **yes** to Question 21 in **Parts 1 and/or 2** about you or any household member needing reasonable accommodation because of a disability or injury, check all that apply below, and list name(s).

1. **Condition**

☐ Low vision—Name(s): __________
☐ Blind—Name(s): __________
☐ Deaf—Name(s): __________
☐ Hard of hearing—Name(s): __________
☐ Developmentally disabled—Name(s): __________
☐ Intellectually disabled—Name(s): __________
☐ Physically disabled—Name(s): __________
☐ Other (Please explain.)—Name(s): __________

2. **Accommodation**

☐ Text telephone (TTY)—Name(s): __________
☐ Large print publications—Name(s): __________
☐ American Sign Language interpreter—Name(s): __________
☐ Video Relay Service (VRS)—Name(s): __________
☐ Communication Access Real-time Translations (CART)—Name(s): __________
☐ Publications in Braille—Name(s): __________
☐ Assistive listening device—Name(s): __________
☐ Publications in electronic format—Name(s): __________
☐ Other (Please explain.)—Name(s): __________

Part C

If you answered **yes** to Question 22 in **Parts 1 and/or 2** about you or any household member applying because of an accident or injury that someone else may be responsible for, answer the next two questions.

1. 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
   If **yes**, name the injured person(s): __________
2. Has this person filed a lawsuit, a workers' compensation claim, or an insurance claim for this accident or injury? ☐ Yes ☐ No
   If **yes**, name the injured person(s): __________

SUPPLEMENT B
American Indian (AI)/Alaska Native (AN)

Fill out this supplement if you or any household member is an American Indian or Alaska Native.

American Indians and Alaska Natives who enroll in MassHealth can also get services from the Indian Health Services, 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. To make sure you and your household members get the most help possible, please fill out this supplement.

AI/AN Person 1

Name: First Middle initial Last Suffix

1. Is this person a member of a federally recognized tribe? ☐ Yes ☐ No
   If **yes**, check the box that applies.
   ☐ American Indian/Alaska Native (Mashpee Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))
   ☐ American Indian/Alaska Native (Other Tribal Nation)
2. Did this person ever get 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
   2. a. If **no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
3. Certain money received may not be counted for MassHealth. List the combined income from the following sources, if applicable.
   - 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 Interior (including reservations and former reservations)
   - Money from selling things that have cultural significance

   $ ________ How often? ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other (Explain) ________

AI/AN Person 2

Name: First Middle initial Last Suffix

1. Is this person a member of a federally recognized tribe? ☐ Yes ☐ No
   If **yes**, check the box that applies.
   ☐ American Indian/Alaska Native (Mashpee Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))
   ☐ American Indian/Alaska Native (Other Tribal Nation)
2. Did this person ever get 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
   2. a. If **no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
3. Certain money received may not be counted for MassHealth. List the combined income from the following sources, if applicable.
   - 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 Interior (including reservations and former reservations)
   - Money from selling things that have cultural significance

   $ ________ How often? ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other (Explain) ________

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SUPPLEMENT C
Health Insurance

Part A: Medicare

Fill out this part if any household member answered **yes** to having Medicare in the health insurance part (Part 4).

1. Name:	Medicare claim number:	When did coverage start? (mm/dd/yyyy)

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

1.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) ____________

2. Name:	Medicare claim number:	When did coverage start? (mm/dd/yyyy)

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

2.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) ____________

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

____

____

Part B: Federal health insurance benefits

Fill out this part if any household member answered **yes** in the health insurance part (Part 4) to having federal health insurance provided by the U.S. military (Veterans' Affairs or TRICARE) or other federal coverage.

Name of insurance plan or policy:	Policyholder name:

Names of covered household members:

____

____

Claim/policy number:	When did coverage start? (mm/dd/yyyy)

Part C: Other health insurance

Fill out this part if any household member answered **yes** in the health insurance part (Part 4) to having any other type of health insurance.
This includes insurance through an employer, union, college or university, former employer (COBRA), and coverage bought by a household member or parent who is not living in the household.

1. Name of insurance plan or policy:	Policyholder name:	Date of birth: (mm/dd/yyyy)	SSN (if you know):

Names of covered household members:

____

____

Policy number:	Group number (if you know):	When did coverage start? (mm/dd/yyyy)

Please go to the next page. ▶

OFFICIAL

Source: (Check one.)
☐ Employer-sponsored (give employer name): ____________ ☐ Union-sponsored (give union name): ____________
☐ College/university ☐ COBRA ☐ Retiree ☐ Coverage provided by someone outside household
☐ Other (Please explain.): ____________

Type of coverage this plan provides: (Check all that apply.)
☐ Doctor's visits and hospitalizations ☐ Vision coverage ☐ Dental coverage ☐ Pharmacy coverage ☐ Catastrophic only

Premium cost: $	Premium frequency: (Check one.) ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

2. Name of insurance plan or policy:	Policyholder name:	Date of birth: (mm/dd/yyyy)	SSN (if you know):

Names of covered household members:
____
____

Policy number:	Group number (if you know):	When did coverage start? (mm/dd/yyyy)

Source: (Check one.)
☐ Employer-sponsored (give employer name): ____________ ☐ Union-sponsored (give union name): ____________
☐ College/university ☐ COBRA ☐ Retiree ☐ Coverage provided by someone outside household
☐ Other (Please explain.): ____________

Type of coverage this plan provides: (Check all that apply.)
☐ Doctor's visits and hospitalizations ☐ Vision coverage ☐ Dental coverage ☐ Pharmacy coverage ☐ Catastrophic only

Premium cost: $	Premium frequency: (Check one.) ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Go back to the application. ▶

Authorized Representative Designation Form

Commonwealth of Massachusetts | EOHHS

Note that you don't 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.

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 Massachusetts Health Connector. You can do this by filling out this form (the Authorized Representative Designation Form) or a sufficiently similar designation document. You 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 Massachusetts Health Connector will choose an authorized representative for you. You must designate in writing using this form (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.
2. If, because of a mental or physical condition, you cannot designate an authorized representative in writing, a person (not an organization) who is acting responsibly on your behalf can be your authorized representative if that person certifies, by filling out Section II, that you are not able to provide a written designation, and that he or she is acting responsibly on your behalf.
3. An authorized representative can also be someone who has been appointed by law to act on your behalf. 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 is lawfully representing you.
4. A person appointed by law to act on behalf of the estate of an applicant or member who has died can also serve as an authorized representative by following the instructions above. An authorized representative under Section III may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the estate's administrator or executor. What this person is authorized to do for you or for the applicant or member's estate will depend on the wording of the legal appointment.

You must provide the authorized representative's date of birth and an e-mail address, if he or she has one, so that we can prove his or her identity and protect your privacy.

What can an authorized representative do?

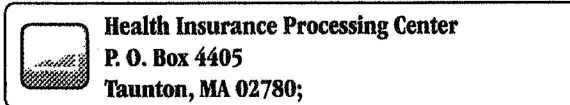
An authorized representative may:

- fill out your application or eligibility review forms;
- fill out other MassHealth or Massachusetts 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 Massachusetts Health Connector eligibility and enrollment notices; and
- act on your behalf in all other matters with MassHealth and the Massachusetts Health Connector.

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:

- Signing on to your account at www.MAhealthconnector.org to remove your representative from your case (you can create an account if you don't already have one) (effective 1/1/14);
- Mailing a letter notifying us that the designation has ended to:



Health Insurance Processing Center
P. O. Box 4405
Taunton, MA 02780;

- Faxing a letter notifying us that the designation has ended to (617) 887-8770; or
- Calling us at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

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.

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

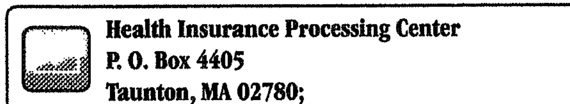
In addition, an authorized representative's designation for a minor child ends on the child's 18th birthday.

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 by:

- Signing on to your account at www.MAhealthconnector.org (you can create an account if you don't already have one) (effective 1/1/14);
- Mailing your form to:



Health Insurance Processing Center
P. O. Box 4405
Taunton, MA 02780;

- Faxing your form to (617) 887-8770; or
- Calling us at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

SECTION I: 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): xxx/xx/xxxx	Date of birth: (mm/dd/yyyy)

Applicant's/Member's e-mail 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 Massachusetts 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 date of birth: (mm/dd/yyyy)

Authorized Representative's e-mail 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 Massachusetts 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).

Authorized Representative's printed name (organization):

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

Signature of provider, staff member, or volunteer completing form:	Date:

Please go to the next page. ►

SECTION II: 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 I know enough about the applicant or member set forth below to take responsibility for the correctness of the statements made on his or her behalf during the eligibility process and in other communications with MassHealth or the Massachusetts Health Connector, that I understand my duties and responsibilities as this person's authorized representative (as explained earlier in this form), and that this person cannot provide written designation. If this person can understand, I have told the person that MassHealth and the Massachusetts 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 Massachusetts 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 SSN: xxx/xx/xxxx	Applicant's/Member's date of birth: (mm/dd/yyyy)

Authorized Representative's Name:

Authorized Representative's Address:
(mailing address, city, state, zip)

Authorized Representative's phone number:	Authorized Representative's date of birth: (mm/dd/yyyy)

Authorized Representative's e-mail address:

Authorized Representative's signature:	Date:

SECTION III: Authorized Representative Designation (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 Massachusetts 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 SSN: xxx/xx/xxxx	Applicant's/Member's date of birth: (mm/dd/yyyy)

Authorized Representative's Name:

Authorized Representative's Address:
(mailing address, city, state, zip)

Authorized Representative's phone number:	Authorized Representative's date of birth: (mm/dd/yyyy)

Authorized Representative's e-mail address:

Authorized Representative's signature:	Date: