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State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: 13-0027-MM2

This file contains the following documents in the order listed:

1) Approval Letter
2) Additional Companion letter
3) CMS 179 Form/Summary Form (with 179-like data)
4) Superseding Pages Notice
5) Approved SPA Pages
6) Additional Attachments that are part of the state plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

November 9, 2015

Marylou Sudders, Secretary
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

RE: S-94 – Eligibility Process State Plan Amendment (SPA) MA 13-0027-MM2 – REVISED

Dear Secretary Sudders:

On March 26, 2014, the Centers for Medicare & Medicaid Services (CMS) approved Massachusetts' State Plan Amendment (SPA) No. 13-0027-MM2 with an effective date of October 1, 2013. This SPA included approval for the State to use an interim alternative single streamlined online application.

The CMS has reviewed the changes submitted with respect to Massachusetts' alternative single streamlined online application. The revised application addresses the concerns outlined in the companion letter that was issued with the original SPA approval. This letter serves as official approval of Massachusetts' alternative single streamlined online application.

Enclosed is a copy of the approved alternative single streamlined online application, labeled as Attachment 3. Please incorporate these pages into the State plan following Attachment 2 to S94 entitled "Use of the Alternative Single Streamlined Application."

CMS appreciates the significant amount of work your staff dedicated to preparing this application. If you have any questions concerning this letter, please contact Julie McCarthy at Julie.McCarthy@cms.hhs.gov or (617) 565-1244.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure/s

cc: Daniel Tsai, Assistant Secretary for MassHealth, Medicaid Director
Daniel Cohen, Interim State Plan Coordinator

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

March 26, 2014

John Polanowicz, Secretary
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

RE: S-94 – Eligibility Process State Plan Amendment (SPA) MA 13-0027-MM2

Dear Mr. Polanowicz:

Enclosed is an approved copy of Massachusetts' state plan amendment (SPA) MA-13-0027-MM2, which was submitted to CMS on December 30, 2013. SPA MA-13-0027-MM2 incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Massachusetts' Medicaid state plan in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of SPA MA-13-0027-MM2 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 S94 state plan pages and attachments to be incorporated within a separate section at the end of Massachusetts' approved state plan:

- S94, pages S94-1 and S94-2
- Attachment 1 – State of Massachusetts' alternative single streamlined paper application
- Attachment 2 – Statement of use with respect to the alternative single streamlined online application

In addition, enclosed is a summary of state plan pages which are superseded by SPA MA-13-0027-MM2, which should also be incorporated into a separate section in the front of the state plan.

- Superseding Pages of State Plan Material, MA-13-0027-MM2

CMS appreciates the significant amount of work your staff dedicated to preparing this state plan amendment. If you have any questions concerning this SPA, please contact Julie McCarthy at Julie.McCarthy@cms.hhs.gov or (617) 565-1244.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure/s

cc: Kristin Thorn, Medicaid Director
Michael Coleman, State Plan Coordinator

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

March 26, 2014

John Polanowicz, Secretary
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

RE: S-94 – Eligibility Process State Plan Amendment (SPA) MA 13-0027-MM2

Dear Mr. Polanowicz:

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) transmittal MA 13-0027-MM2. CMS is granting approval for Form S94 – Eligibility Process MA 13-0027-MM2, which was submitted to CMS on December 30, 2013. Our review of this submission included a review of the online alternative single streamlined 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 streamlined 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 Dena Greenblum at Dena.Greenblum@cms.hhs.gov or (410) 786-8684. If you have any additional questions or require any further assistance, please contact Julie McCarthy at Julie.McCarthy@cms.hhs.gov or (617) 565-1244.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure/s

cc: Kristin Thorn, Medicaid Director
Michael Coleman, State Plan Coordinator

Medicaid State Plan Eligibility: Summary Page (CMS 179)

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.

Proposed Effective Date

(mm/dd/yyyy)

Federal Statute/Regulation Citation

Federal Budget Impact

Federal Fiscal Year	Amount
First Year	$
Second Year	$

Subject of Amendment

Governor's Office Review

Governor's office reported no comment

Comments of Governor's office received

Describe:

No reply received within 45 days of submittal

Other, as specified

Describe:

Signature of State Agency Official

Submitted By:
Alison Kirchgasser
Last Revision Date:
Mar 24, 2014
Submit Date:
Dec 30, 2013

PLAN APPROVED – ONE COPY ATTACHED

DATE RECEIVED: 12/30/2013

DATE APPROVED: 03/26/2014

EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/2013

SIGNATURE OF REGIONAL OFFICIAL:

/s/

TYPED NAME: Richard R. McGreal

TITLE: Associate Regional Administrator, Division of Medicaid & Children's Health Operations Boston Regional Office

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: MA-13-0027-MM2	**STATE:** Massachusetts
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S94 – Eligibility Process	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Section 2.1(a), page 10, TN 91-21 Effective 10/01/1991, Approved 06/22/1992 Section 2.1(d), page 11a, TN 91-17 Effective 07/01/1991, Approved 12/02/1991

Medicaid Eligibility

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

General Eligibility Requirements
Eligibility Process — S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

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 for all insurance affordability programs, 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 in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

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.

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

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

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 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Medicaid Eligibility

Indicate the other electronic means below:

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

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

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 435.916:

■ 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.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

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 40 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.

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).

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) ______________

OFFICIAL

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

OFFICIAL

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

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

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

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

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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

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)

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)

OFFICIAL

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? ________	☐ 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 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)

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.

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): ______

Go back to the application. ▶

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) ____________________

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)

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

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.

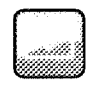
In addition, an authorized representative's designation for a minor child ends on the child's 18th birthday.

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:

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:

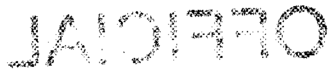
Authorized Representative's Address:
(mailing address, city, state, zip)

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:

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION ☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: MA-13-0027-MM2	**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.	



1.1 My Appeals

Customer: Egas Wahs

- My Profile
- My Eligibility
- My Appeals
- My Enrollments

My Appeals

IMPORTANT: This Form Cannot Be Used to Appeal Your MassHealth Decision

You cannot use this online form to appeal your MassHealth decision. If you would like to appeal your MassHealth decision, you must use the form that came in the mail with your MassHealth letter. For more information about appealing your MassHealth decision, please call the MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-888-665-9997).

If you are trying to update your account, correct a mistake you made in your application, have a problem with enrollment, or have a problem with billing, you should contact the Health Connector's Customer Service at 1-877-MA-ENROLL (1-877-623-6765). Customer Service can help you with the following:

- Update your household size (adding or removing people)
- Update your household income
- Update your citizenship/immigration status
- Update whether you have access to other insurance
- Update your residency status
- Update your incarceration status
- Update your American Indian status
- Update your other account information
- Help with enrollment in a health plan
- Problems with your premium bill payment

If you disagree with the action taken by the Massachusetts Health Connector, you have the right to appeal and ask for a hearing before an impartial hearing officer. Issues that may be addressed through an appeal include:

- Whether you qualify to shop for health insurance through the Health Connector, based on
  - Your residency
  - Your incarceration status
  - Your citizenship/immigration status
- Whether you qualify for subsidies to help you pay for insurance or the amount of subsidies you qualify for, based on
  - Income
  - Family size
  - Access to other insurance
- Whether you qualify for other benefits because of your American Indian status
- Failure of the Health Connector to give you timely notice of its action or its failure to take action on you request
- Denial of a Financial Hardship Waiver or Reduction of Premium Application

In most cases, if you would like to appeal an action by the Health Connector, you must submit your appeal request within 30 days from the day you receive notice of the action.

Need more information about submitting an appeal online to the Health Connector. You may also send in the paper appeal request form that you received with the notice you are appealing.

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	<u>**IMPORTANT: This Form Cannot Be Used to Appeal Your MassHealth Decision**</u> You cannot use this online form to appeal your MassHealth decision. If you would like to appeal your MassHealth decision, you must use the form that came in the			

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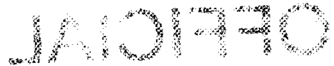
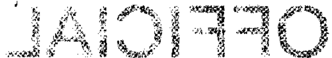
Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	mail with your MassHealth letter. For more information about appealing your MassHealth decision, please call the MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-888-665-9997).			
Static	If you are trying to update your account, correct a mistake you made in your application, have a problem with enrollment, or have a problem with billing, you should contact the Health Connector's Customer Service at 1-877-MA-ENROLL (1-877-623-6765). Customer Service can help you with the following: • Update your household size (adding or removing people) • Update your household income • Update your citizenship/immigration status • Update whether you have access to other insurance • Update your residency status • Update your incarceration status • Update your American Indian status • Update your other account information • Help with enrollment in a health plan • Problems with your premium bill payment			
Static	If you disagree with the action taken by the Massachusetts Health Connector, you have the right to appeal and ask for a hearing before an impartial hearing officer.			



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	Issues that may be addressed through an appeal include: • Whether you qualify to shop for health insurance through the Health Connector, based on o Your residency o Your incarceration status o Your citizenship/immigration status • Whether you qualify for subsidies to help you pay for insurance or the amount of subsidies you qualify for, based on o Income o Family size o Access to other insurance • Whether you qualify for other benefits because of your American Indian status • Failure of the Health Connector to give you timely notice of its action or its failure to take action on you request • Denial of a Financial Hardship Waiver or Reduction of Premium Application In most cases, if you would like to appeal an action by the Health Connector, you must submit your appeal request within 30 days from the day you receive notice of the action.			
URL	Please click <here> for more information about submitting an appeal online to the Health Connector. You may also send in the paper appeal request form that you	URL takes the user to the Appeal Form		



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	received with the notice you are appealing.			

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My Enrollments

MASSACHUSETTS HEALTH CONNECTOR the right place for the right plan

Manage Customer | Create Customer Profile | My Account | Learn More | Get Assistance

Sign Out

Customer: Egas Wahs

My Profile

My Eligibility

My Appeals

My Enrollments

You or your family members have selected a health plan through the Health Connector and are able to pay and enroll at this time.
Please note: You or your family members will still need to send the Health Connector or MassHealth verification documents within a 90 day time period to continue to be eligible for coverage in the plan you chose. Please make sure to send us the documents that we need to ensure that your enrollment is not interrupted. Go to My Eligibility > Actions - Detail > Documents Required for more details.

Application Year:

2015

Future Enrollment(s)

You are currently enrolled in the following plans: Change Amount of Tax Credit you take now

Edit Enrollment | Cancel Enrollment

Health Insurance Plan

View / Edit Details

ENROLLMENT ID:	HEAD OF HOUSEHOLD NAME:	SUBMITTED ON:	EFFECTIVE DATE:
RefID_1444944189443	Egas Wahs	10/16/2015	11/01/2015

Plan selected for Egas Wahs Costs include Advance Premium Tax Credit of $22 . 00
Tax credit claimed : $22 . 00

MONTHLY PREMIUM	INSURANCE CARRIER	HEALTH PLAN NAME	POLICY ID	ANNUAL DEDUCTIBLES	EST. OUT-OF-POCKET COSTS
$78 . 00 ConnectorCare	Tufts Health Plan	Tufts Health Direct Silver HMO/ Silver		$0 . 00 / Person $0 . 00 / Family	$1,500 . 00 / Person $3,000 . 00 / Family

Dental Insurance Plan

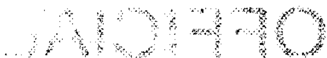
View / Edit Details

ENROLLMENT ID:	HEAD OF HOUSEHOLD NAME:	SUBMITTED ON:	EFFECTIVE DATE:
RefID_1444944189443	Egas Wahs	10/16/2015	11/01/2015

Plan selected for Egas Wahs

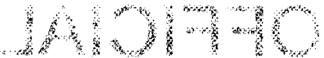
MONTHLY PREMIUM	INSURANCE CARRIER	DENTAL PLAN NAME	POLICY ID	ANNUAL DEDUCTIBLES
$26 . 19	altus dental	Altus Dental Low Plan PPO/ Low		Not Applicable / Person Not Applicable / Family

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	My Enrollments	NA		
Static	**You or your family members have selected a health plan through the Health**	NA		



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	Connector and are able to pay and enroll at this time. **Please note:** You or your family members will still need to send the Health Connector or MassHealth verification documents within a 90 day time period to continue to be eligible for coverage in the plan you chose. Please make sure to send us the documents that we need to ensure that your enrollment is not interrupted. Go to My Eligibility > Actions – Detail > Documents Required for more details.			
Dropdown	Application Year	2015 2016		
Dynamic	Current Enrollment(s) Future Enrollment(s) Cancelled Enrollment(s)			
Static	You are currently enrolled in the following plans	Shown for Current and Future Enrollments		
Link	Change Amount of Tax Credit you take now	Allows the user to adjust the tax credit amount that they are taking		
Button	Edit Enrollment	Allows the user to edit their enrollment. During closed enrollment, this button will take the user to a Qualifying Life Events		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		Questionnaire before allowing the user to change their enrollment		
Button	Cancel Enrollment	Allows the user to cancel their enrollment		
Static	Health Insurance Plan			
Static	Enrollment ID Head of Household Name Submitted On Effective Date	Field values will vary depending on the applicant		
Tooltip	Effective Date: This is when the health insurance plan begins providing coverage. Coverage in a plan will begin on the first day of the calendar month selected for coverage if all documentation and payments are received by the required due date.	NA		
Button	View Detail	View enrollment details		
Static	Plan selected for xxx <plan information entered here>	NA		
Static	Dential Insurance Plan	Shown if the user has a dental enrollment		
Static	Enrollment ID	Field values will vary		



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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	Head of Household Name Submitted On Effective Date	depending on the applicant		
Button	View Detail	View enrollment details		
Static	Plan selected for xxx <plan information entered here>	NA		

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HEALTH CONNECTOR

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Sign Out

Customer: Egas Wahs

- My Eligibility
- My Appeals
- My Enrollments

My Profile

Below you can view and edit your personal profile information.

View/Unlock Eligibility

Reasonable Accommodations

Basic Information
** Mandatory Field*

* First Name: Egas
Middle Name:
* Last Name: Wahs
Suffix: Suffix

Account Number: RefID_1444684104673

Email Address: E-mail Address

Date of Birth (MM/DD/YYYY): 10/12/1981

Social Security Number:

* Home Address
☐ No Home Address
* Address 1: 1 Main Street
Address 2: Apt 6
* City: Boston
* Zip: 02108
* County: SUFFOLK
* State: MA

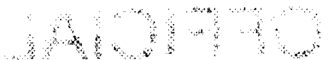
Mailing Address
☑ Select if it is the same as Contact Home Address
* Address 1: 1 Main Street
Address 2: Apt 6
* City: Boston
* Zip: 02108
* County: SUFFOLK
* State: MA

Contact Phone
* Phone Number: (888) 888-8888
Phone Type: Cell
Second Phone Number:
Secondary Phone Type: Home

Contact Preferences
Preferred Spoken Language: English
Preferred Written Language: English

Save

Privacy Policy | Terms of Use | Disclaimer
Contact | Accessibility Statement



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	My Profile			
Static	Below you can view and edit your personal profile information.			
Button	View/Unlock Eligibility	Edit the application		
Link	Reasonable Accommodations	Only visible after the application has been submitted		
Static	Basic Information			
Static	* Mandatory Field			
Textbox	First Name	Alphabetic Entry; hyphens and apostrophes also accepted	Yes	
Textbox	Middle Name	Alphabetic Entry; hyphens and apostrophes also accepted		
Textbox	Last Name	Alphabetic Entry; hyphens and apostrophes also accepted	Yes	
Dropdown	Suffix	Choose one from Jr. Sr. III & IV		
Textbox	Account Number	Auto populated	Yes	Cannot be edited
Textbox	Email Address	Alphanumeric Entry with special characters such as @, . , -	As of 10/7/14 – not a required field	
Textbox	Date of Birth	Date format (mm/dd/yyyy)	Yes	
Static	Home Address	N/A		
Checkbox	No Home Address	Checkbox selection		If this is clicked, all home address fields will be grayed out and user will be unable to add text; user will also be unable to click the "select

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
				if it's the same as Home Address" checkbox in the Mailing Address section
Textbox	Address 1	Alphanumeric Entry	Yes, if "No Home Address" is not checked	
Textbox	Address 2	Alphanumeric Entry		
Textbox	City	Alphabetic		
Textbox	Zip	Numeric		
Dropdown	County	Auto populated from the zip code entry Choose from dropdown list of counties that match the zip code entered		
Textbox	State	Alphabetic		Automatically filled in after a zip code and county is selected
Checkbox	I intend to reside in Massachusetts, even if I do not have a fixed address.	If selected along with "no home address" no IDP will be performed and this person will be identified as homeless If yes and eligible for MassHealth, no documentation will need to be provided If yes or no and eligible for QHP/APTC/WRAP, MA mailing address will be used for making all determinations and documentation will be asked accordingly		Only be shown if person does not provide a MA home address
Static	Mailing Address	N/A		
Checkbox	Select if the Mailing Address is the same as the Home Address	Checkbox selection		If checked, all Mailing Address fields will be filled

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
				with Home Address information; no edits allowed to the Mailing Address fields
Textbox	Address 1	Alphanumeric Entry	Yes	Should be mandatory if "Select if it's the same as Contact Home Address" is not checked.
Textbox	Address 2	Alphanumeric Entry		
Textbox	City	Alphabetic	Yes	
Textbox	Zip	Numeric	Yes	
Dropdown	County	Auto-populated from the entry Zip code entry Choose from dropdown list	Yes	
Textbox	State	Alphabetic Auto populated with the zip code and county entry	Yes	Automatically filled in after a zip code and county is selected
Static	Contact Phone	N/A		
Textbox	Phone Number	Numeric Dashes are prefilled	Yes	
Textbox	Ext	Numeric	No	
Dropdown (Default to "Cell")	Phone Type	Alphabetic Choose from the dropdown list Home, Work ,Cell	Yes	Default to Cell
Textbox	Second Phone Number (Optional)	Numeric Dashes are pre-filled	No	
Textbox	Ext	Numeric	No	
Dropdown – Second phone number	Phone Type	Alphabetic Choose from the	No	Default Home

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
default to "Home"		dropdown list Home, Work ,Cell		
Static	Contact Preferences	N/A		
Dropdown – Default display is English	Preferred Spoken Language	Alphabetic Choose from the dropdown list English Arabic Cambodian/Khmer Cape Verdean Creole Chinese - Cantonese Chinese - Mandarin French Greek Haitian Creole Hindi Italian Korean Laotian Nepalese Other Portuguese Russian Somali Spanish Vietnamese		If a language other than English or Spanish is chosen, all written communications will be sent in English Default to English
Dropdown Default language set to English	Preferred Written Language	Alphabetic Choose from the dropdown list English Arabic Cambodian/Khmer Cape Verdean Creole Chinese (Cantonese or Mandarin) French Haitian Creole Hindi Laotian Nepalese Other Portuguese Russian		Default to English

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		Somali Spanish Vietnamese Greek Italian		

Start your Application: Begin Process

HEALTH CONNECTOR

Manage Customer | Create Customer Profile | My Account | Learn More | Get Assistance

Sign Out

Application Year 2015

- Start Your Application
- Family & Household
- Income
- Additional Questions
- Review & Sign

Start Your Application: Begin Process

You will be asked in this application if you are interested in getting help paying for health coverage. If you are not interested in getting help paying for coverage, you will not need to answer any questions about your income.

However, if you would like to see if you can qualify for help, we will ask you a number of questions about your household, your income, and other things that will help us find the best programs and plans for you.

If you are already enrolled in MassHealth, and you still qualify, you may not qualify for additional benefits through the Massachusetts Health Connector.

If you currently are receiving Medicare or are 65 or older and low-income, you may also apply for additional benefits through www.mass.gov/MassHealth.

Notice of Consent and Authorization

You want to use the Massachusetts Health Insurance Exchange (HIX) application service to apply for health benefits and/or health plans such as Advance Premium Tax Credits, Health Connector plans, ConnectorCare, MassHealth, Health Safety Net, Children's Medical Security Plan, and premium subsidies from the Massachusetts Health Connector for yourself and/or members of your household.

To complete this application and obtain initial determinations of eligibility, you must provide personal information about everyone in your household who is applying. If you are applying for subsidized health benefits you will also have to provide health, health-coverage, and income information about you and everyone in your household who is applying. You may have to provide information about others if their information will affect the eligibility of the applicants. We may verify the accuracy of such information using various government and private sources including our electronic databases as well as the databases of the Department of Homeland

View Privacy Act Statement

☐ ***I hereby certify under the pains and penalties that I have the authority and consent described above and will, if necessary, perform the actions described above.**

Save and Continue

Privacy Policy | Terms of Use | Disclaimer   Contact | Accessibility Statement

Confidential and proprietary | Use pursuant to company instructions | Optum

OFFICIAL

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Start Your Application: Begin Process	Shown when a user lands on this page for the first time		
Static	Start Your Application	Shown any other time a user lands on this page		
Static	You will be asked in this application if you are interested in getting help paying for health coverage. If you are not interested in getting help paying for coverage, you will not need to answer any questions about your income.	N/A		
Static	However, if you would like to see if you can qualify for help, we will ask you a number of questions about your household, your income, and other things that will help us find the best programs and plans for you.			
Static	If you are already enrolled in MassHealth, and you still qualify, you may not qualify for additional benefits through the Massachusetts Health Connector.	N/A Active link to MassHealth: www.mass.gov/ MassHealth		
Static	If you currently are receiving Medicare or are 65 or older and low-income, you may also apply for additional benefits through www.mass.gov/MassHealth			
Static	Notice of Consent and Authorization	Shown the first time the user sees this page		

Notice of Consent and Authorization

You want to use the Massachusetts Health Insurance Exchange (HIX) application service to apply for health benefits and/or health plans such as Advance Premium Tax Credits, Health Connector plans, ConnectorCare and premium subsidies from the Massachusetts Health Connector for yourself and/or members of your household.

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation

To complete this application and obtain initial determinations of eligibility, you must provide personal information about everyone in your household who is applying. If you are applying for subsidized health benefits you will also have to provide health, health-coverage, and income information about you and everyone in your household who is applying. You may have to provide information about others if their information will affect the eligibility of the applicants. We may verify the accuracy of such information using various government and private sources including our electronic databases as well as the databases of the Department of Homeland Security and the Social Security Administration. Household members who do not want coverage will not be asked questions about citizenship or immigration status.

If you are applying for subsidized health benefits we may also verify the accuracy of such information by using the databases of the Internal Revenue Service and the Massachusetts Department of Revenue. If the information does not match, we may ask you to send us proof of your circumstances. We also will be automatically redetermining eligibility and may check your information at a later time to make sure your information is up to date. We will notify you if something has changed.

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

To proceed, you must give us certifications about your authority to complete the application and eligibility process on behalf of those individuals applying for benefits, and if applicable, your authority to provide and see information about others.

If applying for benefits for 1) yourself, 2) your own minor child or children, and/or 3) any minor or incapacitated person for whom you are either the legal guardian or for whom you have sufficient information to act responsibly on their behalf, then by electronically signing below, you will be certifying under penalty of perjury that you consent to the use of government and private sources to verify information about you and any such minor child and incapacitated person.

If applying for benefits on behalf of anyone else other than those described above, then by electronically signing below, you also will be certifying under penalty of perjury that you have consent and authorization from such individuals or, if applicable, their parent, guardian, or other legally authorized representative, to act on their behalf to complete this application and any ongoing or subsequent eligibility process and activity, including as examples:

- providing personal information about them, and seeing such information as may be provided by us;
- making choices about coverage options and methods of communication with us
- making changes to the application or related eligibility documents;
- completing and making changes to renewal forms and related documents
- providing information about any change in their circumstances;
- providing consent on their behalf to use government and private sources to verify information provided in this application and related documents and as may be necessary for continued eligibility; and
- if applying for subsidized health benefits, providing health, health-coverage, and income information about them, and seeing such information as may be provided by us.

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
By signing electronically below, you also certify under penalty of perjury that • you have the authorization of all individuals (or their authorized representatives) not seeking coverage but whose information is necessary for eligibility determinations for others on this application to see and provide their personal information to us and consent to the use of private and government sources to verify such information; • if applying for subsidized health benefits you also have the authorization of all individuals (or their authorized representatives) not seeking coverage but whose income information is necessary for eligibility determinations for others on this application to see and provide their income information to us and consent to the use of private and government sources to verify such information; • you have obtained sufficient information from all individuals for whom you are submitting this application or if applicable, from their parent or legally authorized representative, to act responsibly and provide accurate information in completing the application and other related eligibility documents and forms; • you have informed, or will inform as soon as possible, all adults in your household and the parent or legal guardian of any minor who is not your child about their rights and responsibilities as set forth in this application; and • you are either: • over eighteen years of age; or • younger than eighteen years of age and applying on behalf of yourself and/or your minor child.				
Link	View Privacy Act Statement	Active link to Health Connector Privacy Statement – link out to mahealthconnector.org MassHealth Privacy Statement: http://www.mass.gov/eohhs/gov/laws-regs/privacy-security/masshealth/member-information/notice-of-privacy-		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		practices.html		
Checkbox	I hereby certify under the pains and penalties that I have the authority and consent described above and will, if necessary, perform the actions described above.	Checkbox Selection	Yes	
Button	Save and Continue	Allows the user to move to the next page of the application		

1.1 Head of Household Information

Head of Household Contact Information

** Mandatory Field*

☑ Check here if you are the account holder.

Contact Information

* First Name	Middle Name	* Last Name	Suffix
Egas		Wahs	Suffix

* Date of Birth (MM/DD/YYYY)	Email Address
10/12/1981	

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Head of Household Contact Information	N/A		
Checkbox	Check here if you are the account holder	Checkbox Selection		
Textbox	First Name	Alphabetic Entry; hyphens and apostrophes also accepted	Yes	
Textbox	Middle Name	Alphabetic Entry; hyphens and apostrophes also accepted		
Textbox	Last Name	Alphabetic Entry; hyphens and	Yes	

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		apostrophes also accepted		
Dropdown	Suffix	Choose one from Jr. Sr. III & IV		
Textbox	Date of Birth	Date format (mm/dd/yyyy)	Yes	
Textbox	Email Address	Alphanumeric Entry with special characters such as @, . , -	As of 10/7 – not a required field	

1.2 Contact Home Address

Contact Home Address

☐ No Home Address

*** Address 1**

1 Main Street

Address 2

Apt 6

*** City**	*** Zip**	*** County**	*** State**
Boston	02108	SUFFOLK	MA

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Contact Home Address	N/A		
Checkbox	No Home Address	Checkbox selection		If this is clicked, all home address

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
				fields will be grayed out and user will be unable to add text; user will also be unable to click the "select if it's the same as Home Address" checkbox in the Mailing Address section
Textbox	Address 1	Alphanumeric Entry	Yes, if "No Home Address" is not checked	
Textbox	Address 2	Alphanumeric Entry		
Textbox	City	Alphabetic		
Textbox	Zip	Numeric		
Dropdown	County	Auto populated from the zip code entry Choose from dropdown list of counties that match the zip code entered		
Textbox	State	Alphabetic		Must be MA
Checkbox	I intend to reside in Massachusetts, even if I do not have a fixed address.	If selected along with "no home address" no IDP will be performed and this person will be identified as homeless If yes and eligible for MassHealth, no documentation will need		Only be shown if person does not provide a MA home address

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		to be provided If yes or no and eligible for QHP/APTC/WRAP, MA mailing address will be used for making all determinations and documentation will be asked accordingly		

1.3 Contact Mailing Address

Contact Mailing Address

☑ Select if it's the same as Contact Home Address

*** Address 1**

1 Main Street

Address 2

Apt 6

*** City**	*** Zip**	*** County**	*** State**
Boston	02108	SUFFOLK	MA

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Contact Mailing Address	N/A		
Checkbox	Select if it's the same as Contact Home Address	Checkbox selection		If checked, all Mailing Address fields will be filled with Home Address information; no edits allowed to the

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
				Mailing Address fields
Textbox	Address 1	Alphanumeric Entry	Yes	Should be mandatory if "Select if it's the same as Contact Home Address" is not checked.
Textbox	Address 2	Alphanumeric Entry		
Textbox	City	Alphabetic	Yes	
Textbox	Zip	Numeric	Yes	
Dropdown	County	Auto-populated from the entry Zip code entry Choose from dropdown list	Yes	
Textbox	State	Alphabetic Auto populated with the zip code and county entry	Yes	Automatically filled in after a zip code and county is selected

1.4 Contact Phone/Communication Preferences

Contact Phone

* Phone Number	Ext	Phone Type
(888) 888-8888		Cell
Second Phone Number	**Ext**	**Secondary Phone Type**
		Home

Contact Preferences

Preferred Spoken Language	Preferred Written Language
English	English

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Contact Phone	N/A		
Textbox	Phone Number	Numeric Dashes are prefilled	Y	
Textbox	Ext	Numeric		
Dropdown (Default to "Cell")	Phone Type	Alphabetic Choose from the dropdown list Home, Work ,Cell		
Textbox	Second Phone Number (Optional)	Numeric Dashes are pre-filled	N	
Textbox	Ext	Numeric		
Dropdown – Second phone number default to "Home"	Phone Type	Alphabetic Choose from the dropdown list		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		Home, Work ,Cell		
Static	Contact Preferences	N/A		
Dropdown – Default display is English	Preferred Spoken Language	Alphabetic Choose from the dropdown list English Arabic Cambodian/Khmer Cape Verdean Creole Chinese - Cantonese Chinese - Mandarin French Greek Haitian Creole Hindi Italian Korean Laotian Nepalese Other Portuguese Russian Somali Spanish Vietnamese		If a language other than English or Spanish is chosen, all written communications will be sent in English Default to English
Dropdown Default language set to English	Preferred Written Language	Alphabetic Choose from the dropdown list English Arabic Cambodian/Khmer Cape Verdean Creole Chinese (Cantonese or Mandarin) French Haitian Creole Hindi Laotian Nepalese		Default to English

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		Other Portuguese Russian Somali Spanish Vietnamese Greek Italian		
Submit Button	Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		
Submit Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		

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1.1 Is someone helping you?

Is someone helping you?

** Mandatory Field*

Enrollment Assister

If a Health Connector Navigator, Certified Application Counselor, Issuer Enrollment Assister or Broker Enrollment Assister is helping you with your application, please provide their organization's information below.

Enrollment Assister Organization Name

Full Name

Enrollment Assister ID

ID

For help finding an Enrollment Assister Find an Enrollment Assister near me to search for one near you.

Enrollment Assister

Enrollment Assisters can help you understand new coverage options available as a result of national health care reform and find the most affordable coverage that meets your needs.

***Is someone helping you with your application?**

Yes No

Back Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Enrollment Assister	N/A		
Static	If a Health Connector Navigator, Certified Application Counselor, or Issuer Enrollment Assister is helping you with your application,	N/A		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	please provide their organization's information below.			
Textbox	Enrollment Assister Organization Name	Alphabetic Entry		
Textbox	Enrollment Assister ID	Alphanumeric Entry		
Static	For help finding an Enrollment Assister click here to search for one near you.	Open URL in a new page https://www.mahealthconnector.org/help-center/		

1.2 Enrollment Assister

Enrollment Assister

Enrollment Assisters can help you understand new coverage options available as a result of national health care reform and find the most affordable coverage that meets your needs.

***Is someone helping you with your application?**

◉ Yes ○ No

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Enrollment Assister Enrollment Assisters are people who help you with your application and enrollment in coverage. They can help you understand new coverage options available as a result of national health care reform and find the most affordable coverage that meets your			

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	needs. Enrollment Assisters can be Navigators, Certified Application Counselors, Issuer Enrollment Assisters, or Authorized Representatives.			
Radio Button	Is someone helping you with your application?	Button Selection Yes, No	Yes	
Submit Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		Shown if person selects "no"
Submit Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		Shown if person selects "no"

1.3 Enrollment Assister Contact Information

Enrollment Assister Contact Information

*** First Name** **Middle Name** *** Last Name** **Suffix**

Suffix

Email Address

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Enrollment Assister Contact Information	N/A		

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Textbox	First Name	Alphabetic Entry	Yes	If the "YES" radio button is selected to the question "Do you want to name someone as your authorized representative?" then First Name field should be mandatory
Textbox	Middle Name	Alphabetic Entry	No	
Textbox	Last Name	Alphabetic Entry	Yes	If the "YES" radio button is selected to the question "Do you want to name someone as your authorized representative?" then First Name field should be mandatory
Dropdown	Suffix	Choose one from the dropdown list of Jr. Sr. III, IV	No	
Textbox	Email Address	Alphanumeric Entry including special characters such as @, . , -	~~Yes~~Optional	If First Name & Last Name fields contact information, then Email address field should be mandatory

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1.4 Enrollment Assister Mailing Address

Enrollment Assister Organization Mailing Address

***Address 1**

[ ]

Address 2

[ ]

***City** [ ] ***Zip** [ ] ***County** [County ▼] ***State** [ ]

***Is the person helping you apply for health insurance part of an organization?**

◉ Yes ○ No

***Organization Name** [ ] **Organization ID(if applicable):** [ ]

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Enrollment Assister Organization Mailing Address			
Textbox	Address 1	Alphanumeric Entry	Yes	If the "YES" radio button is selected to the question "Do you want to name someone as your authorized representative?" " then First Name field should be mandatory
Textbox	Address 2	Alphanumeric Entry	No	
Textbox	City	Alphabetic	Yes	If the "YES" radio

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
				button is selected to the question "Do you want to name someone as your authorized representative?" "then First Name field should be mandatory
Textbox	Zip	Numeric	Yes	If the "YES" radio button is selected to the question "Do you want to name someone as your authorized representative?" "then First Name field should be mandatory
Dropdown	County	Alphabetic Entry Choose from the auto populated dropdown list	Yes	
Textbox	State	Alphabetic Automatically pre-fills upon entering the zip code and county		Should only accept MA
Radio button	Is the person helping you apply for health insurance part of an organization?	Button Selection Yes, No	Yes	
Textbox	Organization Name	Alphanumeric Entry	Yes	If the "YES" radio button is selected to the question "Is this person part of an organization helping you apply for health

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
				insurance?" then Organization Name should be mandatory
Textbox	Organization ID (if applicable):	Alphanumeric Entry	No	

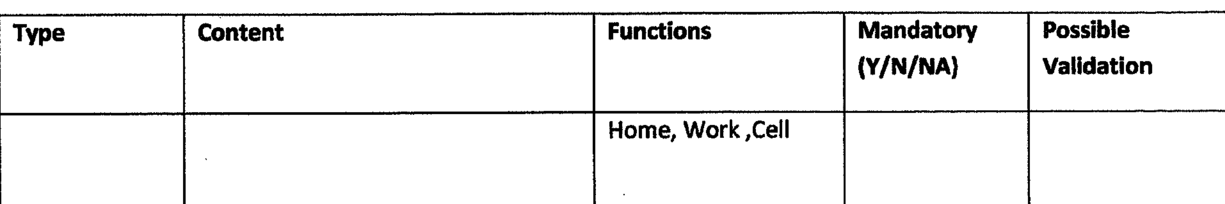
1.5 Enrollment Assister Phone Number

Enrollment Assister Organization Phone Number

***Phone Number** | **Phone Type**

Work

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Enrollment Assister Organization Phone Number	N/A		
Textbox	Phone Number	Numeric		If the "YES" radio button is selected to the question "Do you want to name someone as your authorized representative?" then First Name field should be mandatory
Textbox	Ext	Numeric		
Dropdown	Phone Type	Alphabetic Choose from the dropdown list		



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		Home, Work ,Cell		

1.6 Enrollment Assister Approval

Signature

In order to authorize your Enrollment Assister to help you complete your application, both of you will need to complete the authorization form and submit it to the address or fax number listed on the form.

*** Type Applicant Signature(Name must be typed as it appears on the application)**

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	In order to authorize your Enrollment Assister to help you complete your application, both of you will need to complete the appropriate form and submit it to the address or fax number listed on the form.	Live link to CCA microsite containing detailed information on the following forms: • the Authorized Representative form (PDF) • the Navigator Designation Form (PDF) • the Certified Application Counselor Form (PDF) the Permission to Share Information form (PDF) the Issuer Enrollment Assister form (PDF)		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		Link: https://www.mahealthconnector.org/forms/enrollment-assister-forms		
RadioButton	Signature	Button selection		
Textbox	Type Applicant Signature (Name must be typed as it appears on the application)	Alphabetic Entry	Y	
Submit Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		
Submit Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		

Do you want help paying for health coverage costs?

**Mandatory Fields*

*** Who needs health insurance?**

- Egas Wahs only
- Egas Wahs and other family members
- Other family members, not Egas Wahs

***Do you want to find out if you or your family can get help paying for some or all of your health insurance?**

- Yes
- No
- I'm not sure

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Do you want help paying for health coverage costs?			
Static	Who needs health insurance?	Title of the page		
Static	* Required Information	N/A		
RadioButton	Who needs health insurance?	Button selection • FirstName LastName only • FirstName LastName and other family members • Other family members. Not FirstName LastName	Y	Radio button must be selected
Submit Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		
Submit Button	Back	Action: Mouse Click Keyboard: Enter		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		Alt text: Back		

Do you want to find out if you can get help paying for health coverage? (YES)

Do you want help paying for health coverage costs?

*Mandatory Fields

*** Who needs health insurance?**

- Egas Wahs only
- Egas Wahs and other family members
- Other family members, not Egas Wahs

***Do you want to find out if you or your family can get help paying for some or all of your health insurance?**

Yes No I'm not sure

Back Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Do you want to find out if you can get help paying for health coverage?	Title of the page	n/a	
RadioButton	Do you want to find out if you/your family can get help paying for health coverage?	Button Selection Yes No I'm not sure	Y	If you click "yes" you can then click "save and continue" to move forward with the application through the financial assistance flow

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Tooltip	If you choose 'Yes,' you'll answer questions about your income to see what help you qualify for. If you choose 'No,' you'll answer fewer questions, but you won't be able to get help paying for coverage. If you're not sure whether you want to apply for help, answer the questions in the tool below to see if you might be able to qualify.	Action: Show on Mouseover; Hide on Mouse Off Keyboard: Tab		
Button	Save & Continue	Move to the next section of the application using the FINANCIAL ASSISTANCE flow		
Button	Back	Takes the user to the previous page		

Do you want to find out if you/your family can get help paying for health coverage? (NO)

Do you want help paying for health coverage costs?

**Mandatory Fields*

*** Who needs health insurance?**

- Egas Wahs only
- Egas Wahs and other family members
- Other family members, not Egas Wahs

***Do you want to find out if you or your family can get help paying for some or all of your health insurance?**

Yes No I'm not sure

You may be eligible for help with costs. Find out here! (optional)

Even working families can pay less for health coverage.You can be eligible for a free or low-cost ConnectorCare plan,MassHealth, or a tax credit that can be used to lower your monthly premiums right away.You can answer two questions to find out if you may be eligible for free or low-cost health insurance through the Massachusetts Health Connector or MassHealth:

How many people will be on your federal income tax return for the year you want insurance? (If you aren't sure, tell us how many people live with you, including yourself.)

#

Based on your best guess, do you expect your total household income to be less than $_ in the year you want health insurance?

Yes No I don't know

Back Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Do you want to find out if you/your family can get help	Yes	Y	If you click "no" you will see static

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	paying for health coverage?	No I'm not sure		text on the screen and then you can click "save and continue" to move forward with the application through the NON-FA flow
Toolitp	If you choose 'Yes,' you'll answer questions about your income to see what help you qualify for. If you choose 'No,' you'll answer fewer questions, but you won't be able to get help paying for coverage. If you're not sure whether you want to apply for help, answer the questions in the tool below to see if you might be able to qualify.			
Static	You will answer fewer questions, but you will not get help paying for health coverage.			
Button	Back	Action: Mouse Click Takes the user back to the previous page		
Button	Save and Continue	Action: Mouse Click User will move to the next section of the application using the NON-FINANCIAL ASSISTANCE flow		

OFFICIAL

Do you want to find out if you/your family can get help paying for health coverage? (I'M NOT SURE)

Do you want help paying for health coverage costs?

**Mandatory Fields*

*** Who needs health insurance?**

- Egas Wahs only
- Egas Wahs and other family members
- Other family members, not Egas Wahs

***Do you want to find out if you or your family can get help paying for some or all of your health insurance?**

Yes No I'm not sure (selected)

Even working families can pay less for health coverage. You can be eligible for a free or low-cost ConnectorCare plan, MassHealth, or a tax credit that can be used to lower your monthly premiums right away.
You can answer two questions to find out if you may be eligible for free or low-cost health insurance through the Massachusetts Health Connector or MassHealth.

You may be eligible for help with costs. Find out here! (optional)

Even working families can pay less for health coverage.You can be eligible for a free or low-cost ConnectorCare plan,MassHealth, or a tax credit that can be used to lower your monthly premiums right away.You can answer two questions to find out if you may be eligible for free or low-cost health insurance through the Massachusetts Health Connector or MassHealth:

How many people will be on your federal income tax return for the year you want insurance? (If you aren't sure, tell us how many people live with you, including yourself.)

#

Based on your best guess, do you expect your total household income to be less than $_ in the year you want health insurance?

Yes No I don't know

Back Save and Continue

Based on your best guess, do you expect your total household income to be less than $_ in the year you want health insurance?

◉ Yes ◎ No ◎ I don't know

We encourage you to apply to see what help you can get paying for health insurance. Based on what you told us about your family size and income, you may qualify for low- or no-cost coverage, or help paying for an insurance plan through the Massachusetts Health Connector. To begin the application, change your selection to "Yes" on the question above this tool.

Based on your best guess, do you expect your total household income to be less than $_ in the year you want health insurance?

◎ Yes ◉ No ◎ I don't know

Based on what you told us, your income may be too high to get help paying for health insurance. You may still want to answer 'Yes' to the question above this tool if you want to find out for sure whether you can get help with costs. If you answer 'No' you will have fewer questions to answer but you definitely won't be able to get help paying for coverage.

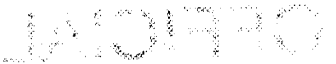
Based on your best guess, do you expect your total household income to be less than $_ in the year you want health insurance?

◎ Yes ◎ No ◉ I don't know

Based on the information you entered here, it looks like you may be able to qualify for help paying for health coverage. To begin the application and see which programs you can qualify for, choose "Yes" on the question above this tool.

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Do you want to find out if you/your family can get help paying for health coverage?	Yes No I'm not sure	Y	If you click "I'm not sure" we will ask you two questions to see whether

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
				you may be eligible for free or low-cost health insurance
Tooltip	If you choose 'Yes,' you'll answer questions about your income to see what help you qualify for. If you choose 'No,' you'll answer fewer questions, but you won't be able to get help paying for coverage. If you're not sure whether you want to apply for help, answer the questions in the tool below to see if you might be able to qualify.			
Static	Even working families can pay less for health coverage. You can be eligible for a free or low-cost ConnectorCare plan, MassHealth, or a tax credit that can be used to lower your monthly premiums right away. You can answer two questions to find out if you may be eligible for free or low-cost health insurance through the Massachusetts Health Connector or MassHealth.			
Static	How many people will be on -your federal income tax return for the year you want insurance? (If you are not sure, tell us how many people live with you, including yourself.)	N/A		
Textbox	#	Numeric values only	N	
Static	Based on your best guess, do you expect your total household income to be less than $ _ in the year you want health insurance?	Yes No I do not know	N	
Tooltip	Please include income from all family members. If you are not sure what your household income is, make your best guess. Remember to consider any additional income like Social			



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	Security benefits, rental income, income from a job, income from a pension, and unemployment benefits. You don't need to include child support or Supplemental Security Income (SSI).			
Dynamic	Based on the information you entered here, it looks like you may be able to qualify for help paying for health coverage. **To begin the application and see which programs you qualify for, change your selection to 'Yes' on the question above this tool.**	Response to question "Based on your best guess, do you expect your total household income to be less than $_ in the year you want health insurance?" Only shown if radio button is "Yes"		
	Based on what you told us, your income may be too high to get help paying for health insurance. You may still want to answer 'Yes' to the question above this tool if you want to find out for sure whether you can get help with costs. If you answer 'No' you will have fewer questions to answer but you definitely won't be able to get help paying for coverage.	Response to question "Based on your best guess, do you expect your total household income to be less than $_ in the year you want health insurance?" Only shown if radio button is "No"		
	Based on the information you entered here, it looks like you may be able to qualify for help paying for health coverage. **To begin the application and see which programs you can qualify for, choose 'Yes' on the question above this tool.**	Response to question "Based on your best guess, do you expect your total household income to be less than $_ in the year you want health insurance?" Only shown if radio button is "I do not know"		
Button	Save and Continue	Only shown if Yes or No are selected to the question "Do you want to find out if you can		

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		get help paying for health coverage?" The user needs to select yes or no in order to continue with the application through the financial assistance or non-financial assistance flow		
Button	Back	Takes the user to the previous page		

1.1 How Many Are Applying for Health Insurance?

How Many are Applying for Health Insurance?

How many people in your family and household want health insurance? Include yourself.

Include your spouse or domestic partner, anyone you claim as dependents on your tax return, anyone under age 19 who you take care of and lives with you, and any unborn children you are expecting.

If you are married, you must file taxes jointly to qualify for an Advance Premium Tax Credit, unless you are a victim of domestic abuse or an abandoned spouse.

Click here for more information on who to include on your application.

2

Back   Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	How Many are Applying for Health Insurance?	N/A		
+ Button	How many people in your family and household want health insurance? Include yourself.	Increase the numeric value		
- Button	How many people in your family and household want health insurance? Include yourself.	Decrease the numeric value		
On-screen text – SUBSIDIZED APPLICATION	Include your spouse or domestic partner, anyone you claim as dependents on your tax return, anyone under age 19 who you take care of and lives with you, and any unborn children you are expecting. If you are married, you must file taxes jointly to qualify for an Advance Premium Tax Credit, unless you are a victim of domestic abuse or an abandoned spouse.	Link to CCA page https://www.mahealthconnector.org/start		

	Click here for more information on who to include on your application.			
On-screen text – UNSUBSIDIZED APPLICATION [redacted]	Use this application for yourself and anyone in your household who needs health or dental insurance coverage. People in your household could include a spouse or domestic partner, a child under the age of 26, or a child over the age of 25 if they have a disability. **Click here for more information on who to include on your application.**	Link to CCA page https://www.mahealthconnector.org/start		
Submit Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		
Submit Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		

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1.2 Who is Applying for Health Insurance?

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Who is Applying for Health Insurance	N/A		
Static	Applicant 1 (Head of Household)	N/A	Y	
Textbox	First Name	Alphabetic Entry	Y	Pulls contact details from Head of Household Information

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
				page
Textbox	Middle Name	Alphabetic Entry	N	Pulls contact details from Head of Household Information page
Textbox	Last Name	Alphabetic Entry	Y	Pulls contact details from Head of Household Information page
Dropdown	Suffix : Jr. Sr. III, IV	Choose from dropdown list of Jr. Sr. III, IV	N	Pulls contact details from Head of Household Information page
Textbox	Date of Birth	Date Format Numeric Entry	Y	Pulls contact details from Head of Household Information page
Static	Applicant 2	N/A		This should only appear if the response to the previous question, "How many people in your family and household want health insurance? Include yourself" is

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
				greater than 1
Textbox	First Name	Alphabetic Entry	Y	
Textbox	Middle Name	Alphabetic Entry		
Textbox	Last Name	Alphabetic Entry	Y	
Dropdown	Suffix	Choose from the dropdown list of Jr. Sr. III, IV		
Textbox	Date of Birth	Date Format Numeric Entry	Y	

1.3 Who is Applying for Health Insurance Summary

Who is Applying for Health Insurance Summary

You are applying for health insurance for these people:

Egas Wahs (Head of Household)
Date of Birth 10/12/1981

Child Wahs
Date of Birth 10/15/2012

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Who is Applying for Health Insurance Summary	N/A		
Static	You are applying for health insurance for these people:	N/A		
Static	FirstName LastName (Head of Household)	Alphabetic Entry (is this auto-populated from		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		previous page)		
Display	Date of Birth	Date Format Auto-populated from previous screen		
Static	FirstName LastName	Alphabetic Entry (is this auto-populated from previous page)		
Display	Date of Birth	Date Format Auto-populated from previous screen		
Submit Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		
Submit Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		

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1 Family and Household

Family & Household

In this section, we will ask questions about everyone included on your federal income tax return (if you file taxes) and all family members who live with you, even if they are not applying for health insurance. These questions will help us match you with the right financial assistance programs. If you need help filling out this section, please call Customer Service at 1-877-MA-ENROLL (1-877-623-6765), TTY 1-877-623-7773. You can also get help from a local Navigator or Certified Application Counselor (CAC) through the "Get Assistance" page.

All fields on the Family & Household section are required unless otherwise indicated.

Call Customer Service at 1-877-MA-ENROLL (1-877-623-6765), TTY 1-877-623-7773 for assistance. Support is available in all languages.

You may need:

- Social Security numbers
- Document numbers for any people with eligible immigration status who need insurance
- Birth dates

Estimated time for this section: 10 Minutes - 15 Minutes

Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	In this section, we will ask questions about everyone included on your federal income tax return (if you file taxes) **and** all family members who live with you, even if they are not applying for health insurance. These questions will help us match you with the right financial assistance programs. If you need help filling out this section, please call Customer Service at 1-877-MA-ENROLL (1-877-623-6765), TTY 1-877-623-7773. You can also get help from a local Navigator or Certified Application Counselor (CAC) through the "Get Assistance" page.	https://www.mahealthconnector.org/enrollment-assisters		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	All fields on the Family & Household section are required unless otherwise indicated			
Static	You may Need: Social Security numbers Documents ~~numbers~~ for any people with an eligible immigration status who need insurance Birth dates	N/A		
Static	Estimated time for this section: 10 Minutes – 15 Minutes	N/A		
Submit Button	Continue	Action: Mouse Click Keyboard: Enter Alt text: Continue		

1.1 Tell Us About Your Household

Tell Us About Your Household

***If Egas Wahs gets an Advance Premium Tax Credit to help pay for health insurance in 2015, do they agree to file a federal income tax return for tax year 2015?**
Egas Wahs may not have needed or chosen to a file federal income tax return in the past, but they will have to file a federal income tax return for any year that they get an Advance Premium Tax Credit. Egas Wahs must check 'Yes' to get ConnectorCare or Advance Premium Tax Credit to help pay for their health insurance

◎ Yes ◎ No

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Tell Us About Your Household	N/A		
RadioButton	If **FULL_LEGAL_NAME** gets an Advance Premium Tax Credit to	Button selection		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	help pay for health insurance in 2015, do they agree to file a federal income tax return for tax year 2015? **FULL_LEGAL_NAME** may not have needed or chosen to a file federal income tax return in the past, but they will have to file a federal income tax return for any year that they get an Advance Premium Tax Credit. **FULL_LEGAL_NAME** must check 'yes' to get ConnectorCare or Advance Premium Tax Credit to help pay for their health insurance.	Yes, No		

Tell Us About Your Household

***If Egas Wahs gets an Advance Premium Tax Credit to help pay for health insurance in 2015, do they agree to file a federal income tax return for tax year 2015?**
Egas Wahs may not have needed or chosen to a file federal income tax return in the past, but they will have to file a federal income tax return for any year that they get an Advance Premium Tax Credit. Egas Wahs must check 'Yes' to get ConnectorCare or Advance Premium Tax Credit to help pay for their health insurance

◉ Yes ◯ No

***Is Egas Wahs considered married for tax filing purposes?**

◯ Yes ◯ No

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Is [First name] [Last name] considered married for tax filing purposes?	Button selection Yes, No		
Tooltip	Answer 'No' if you: Will be divorced or legally			

	separated as of December 31 Are married, but will file taxes next year as Head of Household. People who are married can qualify to file as Head of Household if they live apart from their spouse for the last 6 months of the tax year and claim at least one other person as a dependent on their taxes. See IRS Publication 501 for more information about filing as Head of Household. If you are unsure whether you will qualify to file as Head of Household, you should consult a tax professional.			

Tell Us About Your Household

***If Egas Wahs gets an Advance Premium Tax Credit to help pay for health insurance in 2015, do they agree to file a federal income tax return for tax year 2015?**
Egas Wahs may not have needed or chosen to a file federal income tax return in the past, but they will have to file a federal income tax return for any year that they get an Advance Premium Tax Credit. Egas Wahs must check 'Yes' to get ConnectorCare or Advance Premium Tax Credit to help pay for their health insurance

◉ Yes ○ No

***Is Egas Wahs considered married for tax filing purposes?**

◉ Yes ○ No

***Important: Egas Wahs must file a joint income tax return with his or her spouse for 2015 to qualify for certain programs, unless they are a victim of domestic abuse or abandonment. Does Egas Wahs plan to file a joint federal income tax return with his or her spouse for 2015?**

○ Yes ○ No

Back Save and Continue

Type	**Content**	**Functions**	**Mandatory (Y/N/NA)**	**Possible Validation**
RadioButton	Important: FirstName LastName must file a joint income tax return with his or her spouse for 2015 to qualify for certain programs, unless they are a victim of domestic abuse or abandonment. **Does FirstName**	Button selection Yes, No	Yes	

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	LastName plan to file a joint federal income tax return with his or her spouse for 2015?			
Tooltip	Usually, you can only get a tax credit to lower your monthly premiums if you file a joint tax return with your spouse. However, if you are filing taxes separately because you are a victim of domestic abuse or an abandoned spouse, you may still be able to qualify for a tax credit. Answer 'No' to the question about filing taxes jointly. We'll ask you a few more questions about your situation later on in the application. Remember, we won't share your answers to these questions, or any others in your application.	Added to above question: FirstName LastName must file a joint income tax with his or her spouse for 2015 to get an Advance Premium Tax Credit or ConnectorCare plan. **Does FirstName LastName plan to file a joint federal income tax return with his or her spouse for 2015?**	n/a	n/a

***Important: Egas Wahs must file a joint income tax return with his or her spouse for 2015 to qualify for certain programs, unless they are a victim of domestic abuse or abandonment. Does Egas Wahs plan to file a joint federal income tax return with his or her spouse for 2015?**

◉ Yes ○ No

***Who is Egas Wahs's spouse?**

○ Child Wahs

◉ Someone else not seeking health insurance

Spouse Name

***First Name** **Middle Name** ***Last Name** **Suffix**

Suffix

***Date of Birth (MM/DD/YYYY)**

Back Save and Continue

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RadioButton	Who is FirstName LastName's spouse?	Button selection • FirstName LastName • Someone else not seeking health insurance		
Textbox	Spouse Name	First Name Middle Name Last Name Suffix		If "someone else not seeking health insurance" is checked
Date	Date of Birth	MM/DD/YYYY	Y	If "someone else not seeking health insurance" is checked

***Will Egas Wahs claim any dependents on their federal income tax return for 2015? Egas Wahs will claim a personal exemption deduction on their 2015 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments**

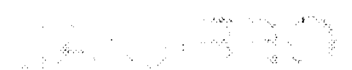
◉ Yes ○ No

☐ Child Wahs

☐ Someone else not seeking health insurance

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
RadioButton	Will FirstName LastName and FirstName LastName claim any dependents on their federal income tax for 2015? FirstName LastName will claim a personal exemption deduction on their 2015	Button selection Yes, No	Yes	



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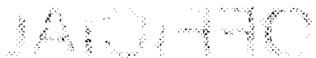
	federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments.			
Checkbox	FirstName LastName Someone else not seeking health insurance	If FirstName LastName select "yes" to claim dependents, then other household members will be shown in this area If "someone else not seeking health insurance" is selected the following fields will appear: Dependent Name* First Name Middle Name Last Name Suffix Date of Birth* MM/DD/YYYY		
Button	+ Add Dependent			Shown if "Someone else not seeking health insurance" is selected



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***Who is the tax filer that will claim Egas Wahs on their income tax return?**
If Egas Wahs is claimed by a married couple filing a joint tax return, select either spouse below

- ◯ Child Wahs
- ◯ Spouse Wahs
- ◉ Someone else not seeking health insurance

Tax filer Name

***First Name**	**Middle Name**	***Last Name**	**Suffix**
			Suffix

***Date of Birth (MM/DD/YYYY)**

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radiobutton	Will FirstName LastName be claimed as a dependent on someone else's federal income tax return for 2015? If you are claimed by someone else as a dependent on their 2015 federal income tax return, this may affect your ability to receive a premium tax credit.* Do not answer yes to this question if this is a child under the age of 21 being claimed by a non-custodial parent.			
Information box	Do not answer yes to this question if this is a child under the age of 21 being claimed by a non-custodial parent.	Once this is added as an information box, remove it from the question above		

***Will Egas Wahs claim any dependents on their federal income tax return for 2015? Egas Wahs will claim a personal exemption deduction on their 2015 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments**

◉ Yes ○ No

☑ Child Wahs

☐ Someone else not seeking health insurance

***How is Child Wahs related to Egas Wahs?**

Child

***How is Child Wahs related to Spouse Wahs?**

Child

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Dropdown	How is FirstName LastName related to FirstName LastName?	Full list of choices: Child Child-in-law Child of parent's domestic partner Cousin Domestic partner Former spouse Foster child Foster parent Grandchild Grandparent Guardian Nephew/Niece		

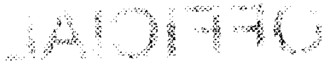
		Other relative Parent Parent-in-law Parent's domestic partner Sibling/Stepsibling Sibling-in-law Spouse Stepchild Stepparent Uncle/Aunt Unrelated Ward		

***Does Child Wahs live with Egas Wahs and/or Spouse Wahs?**

◉ Yes ◎ No

Back Save and Continue

RadioButton	Does FirstName LastName live with FirstName LastName and/or FirstName LastName	Button selection Yes, No		
Submit Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		
Submit Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		



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1.1 Personal Information

Egas Wahs - Personal Information

** Mandatory Field*

***Sex**

◉ Male ○ Female

***Does Egas Wahs have a Social Security Number?**

◉ Yes ○ No

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 on the Social Security Administration website or the MassHealth Member Booklet for more information.

***Social Security Number**

***Is Egas Wahs the same name that appears on his/her Social Security card?**

○ Yes ◉ No

Enter the same name as shown on Egas Wahs's Social Security Card

* First Name	Middle Name	* Last Name	Suffix
			Suffix

Back | Save and Continue

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Egas Wahs - Personal Information

* Mandatory Field

***Sex**

◉ Male ○ Female

***Does Egas Wahs have a Social Security Number?**

○ Yes ◉ No

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 on the Social Security Administration website or the MassHealth Member Booklet for more information.

***If no Social Security Number is available please select from the following explanations**

Select explanation

Select explanation
Illness Exception
Just Applied
Non-Citizen Exception
Religious Exception

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	FirstName LastName – Personal Information	N/A		
Radio Button	Sex*	Male, Female	Yes	
Radio Button	Does First Name Last Name have a Social Security Number?	Yes, No	Yes	
Static	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	On mouse click, open in new window/tab: http://www.mass.gov/eohhs/gov/departments/masshealth/applications-and-member-forms.html		

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	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 on the Social Security Administration website or the MassHealth Member Booklet for more information.			
Textbox	Social Security Number Text box 1: 3 numeric digits Text box 2: 2 numeric digits Text box 3: 4 numeric digits	Numeric Value		Only a total of 9 characters should be accepted, hyphens automatically insert or layout should contain 3 boxes. This information is mandatory only if the previous question of "Do you have a Social Security Number?" has been answered as "YES"
Dropdown	If no Social Security Number is available please select from the following explanations Illness Exception Just Applied Non-Citizen Exception Religious Exception	If the answer is "no" to "Does First Name Last Name have a Social Security Number?"		
Radio Button	Is FirstName LastName the same name that appears on his/her Social Security card?	Yes, No		
Static	Enter the same name as shown on FirstName LastName's Social Security card	Only if the name above is different from the Social Security card (if radio button selection in row above is "No")		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Textbox	FirstName MiddleName LastName Suffix	Three separate alphabetic value fields (First, Middle, Last Names) Dropdown field for Suffix		Only if the name above is different from the Social Security card
Submit Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		

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1.1 Citizenship/Immigration Status

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	FirstName LastName – Citizenship/Immigration Status	N/A		
URL	More information on Immigration Document Types	Link to Immigration guide https://www.mahealthconnector.org/immig		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		ration-document-types		
RadioButton	Is FirstName LastName a U.S. citizen or U.S. National?	Button selection Yes, No <this scenario the button selected is "Yes">		
Tooltip	A U.S. citizen is someone who was born in the United States or has been naturalized as a U.S. citizen (became a U.S. citizen after birth). A U.S. national is someone who is a U.S. citizen or a person who is not a U.S. citizen, but owes permanent allegiance to the U.S. (like people born in American Samoa or Swains Island)	Action: Show on Mouseover; Hide on Mouse Off Keyboard: Tab		
RadioButton	Is FirstName LastName a naturalized citizen?	Button selection Yes, No		
Tooltip	A naturalized citizen is a person who was not born as a U.S. citizen but became one later on. A naturalized citizen can have either a 'Certificate of Naturalization' (Form N-500) or a 'Certificate of Citizenship' (Form N-560 or N-561).	Action: Show on Mouseover; Hide on Mouse Off Keyboard: Tab		
RadioButton	Is FirstName LastName an honorably discharged veteran or active duty member of the military, or the spouse or child of an honorably discharged veteran or active duty member of the military?	Conditional Only shown if "No" to "Is FirstName LastName a US citizen or US national?"		

Egas Wahs - Citizenship/Immigration Status

More information on Immigration Document Types

** Mandatory Field*

***Is Egas Wahs a U.S. Citizen or U.S. National?**
Yes No

Check this box if Egas Wahs has an eligible immigration status:

Federal Services will try to verify your immigration status. See the member booklet for more information about immigration statuses. Check the box above to view the list of eligible immigration statuses and select an option, if applicable.

Is Egas Wahs an honorably discharged veteran or active duty member of the military, or the spouse or child of an honorably discharged veteran or active duty member of the military?
Yes No

Back Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Is FirstName LastName a U.S. Citizen or U.S. National?	Button selection Yes, No <this scenario the button selected is "no">		
Checkbox	Check this box if FirstName LastName has an eligible immigration status:	Checkbox selection Button Selection Document Type (Select one)		
Static (before below checkbox is checked)	Federal Services will try to verify your immigration status. See the **member booklet** for more information about immigration statuses. Check the box above to view the list of eligible immigration statuses and select an option, if applicable.	http://www.mass.gov/eohhs/gov/departments/masshealth/applications-and-member-forms.html		
RadioButton	Is FirstName LastName an honorably discharged veteran or active duty member of the	Conditional Only shown if "No" to		

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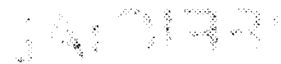
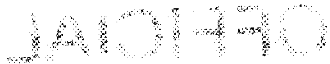
	military, or the spouse or child of an honorably discharged veteran or active duty member of the military?	"Is FirstName LastName a US citizen or US national?"		

Data Element	Description	Min Length	Max Length	Type	Required Y or N
AlienNumber	A Number of applicant	8	9	String	N
I94Number	Applicant I-94 Number (admission number)	11	11	String	N
SevisId	SEVIS ID of applicant Note to End User: SEVIS IDs start with the letter N followed by 10 digits. In this interface, remove the leading letter N and pass only the 10 digits.	10	10	String	N
PassportNumber	Foreign Passport Number of applicant applying for benefit(s)	6	12	String	N
CountryOfIssuance	COI code for passport presented to SAVE Note: This field is required if a Passport Number exists in the PassportNumber field. See Table 105 - COI Codes for a list of valid country codes.	1	5	String	Y - If Passport Number is present
VisaNumber	Visa Number of applicant	8	8	String	N
ReceiptNumber	Receipt or card number of applicant Note: The Receipt Number is 13 characters long, with the first 3 characters alpha and the remaining 10 characters numeric.	13	13	String	N
NaturalizationNumber	Naturalization Certificate number of applicant for benefit(s)	7	12	String	N

	Note: The Naturalization Certificate number is between 7 and 12 characters long and in alphanumeric characters. Pre-1956 certificates do not contain an alien number. In this case, enter 999999999 in this field for the alien number.				
CitizenshipNumber	Citizenship Certificate number of applicant for benefit(s). Note: The Citizenship Certification Number is between 6 and 12 characters long and in alphanumeric characters.	7	12	String	N
LastName	Applicant last name from any document in verification process	1	50	String	Y
FirstName	Applicant first name from any document in verification process	1	50	String	Y
MiddleName	Applicant middle name from any document in verification process	1	50	String	N
DateOfBirth	Applicant birth date from any document in the verification process	10	10	Date	Y
DocOtherDesc	Brief description of document	1	35	String	N
DocExpDate	Expiration date of alien document Note: Certain documents require presentation of the document expiration date.	10	10	Date	N
Comments	Comment field used to send short comment to MPA	1	400	String	N
AKA	Applicant alias name (also known as (AKA))	1	40	String	N
RequestedCoverageStartDate	Date when applicant desires coverage to begin	10	10	Date	Y



FiveYearBarApplicabilityIndicator	Identifies if the Hub needs to check Five Year Bar Apply criteria for applicant (true-Yes, false-No) based on August 22, 1996 entry Note: The administering entity (Requester) sends this indicator to the Hub.	N/A	N/A	Boolean	Y
RequestSponsorDataIndicator	true indicates an agency is requesting that an affidavit of support data be returned; otherwise, this field is false. An agency must be configured to receive this data. Note: The Requester populates this field.	1	1	Boolean	Y
RequestGrantDateIndicator	true indicates an agency is requesting that a grant date be returned; otherwise, this field contains false. An agency must be configured to receive this data. Note: The Requester populates this field.	1	1	Boolean	Y
RequesterCommentsForHub	Information attested to by applicant on application - This information cannot be used to start a SAVE inquiry, but the Requester collects this information and passes it to the Hub.	1	100	String	N
CategoryCode	Employment authorization code based on 8 CFR 274a.12 eligibility categories - The applicant attests to this information on the application.	1	3	String	N



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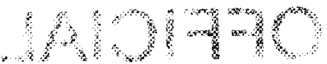
Doc Type	Doc ID	Alien Nbr	I 94 Nbr	Visa Nbr	Pssprt Nbr	SEVIS ID	NatzCertNbr	Cert of Cit Nbr	Card Nbr	Doc/Pssprt Exp Date	Doc Desc	Grant Date	Sponsorship Data
I-327 (Reentry Permit)	3	R	E	E	E	E	E	E	E	O	E	X	X
I-551 (Permanent Resident Card)	4	R	E	E	E	E	E	E	R	O	E	X	X
I-571 (Refugee Travel Document)	5	R	E	E	E	E	E	E	E	O	E	X	E
I-766 (Employment Authorization Card)	9	R	E	E	E	E	E	E	R	R	E	X	E
Certificate of Citizenship	23	R	E	E	E	E	E	R	E	E	E	E	E
Naturalization Certificate	20	R	E	E	E	E	R	E	E	E	E	E	E
Machine Readable Immigrant Visa (with Temporary I-551 Language)	22	R	E	O	R	E	E	E	E	O	E	X	X
Temporary I-551 Stamp (on passport or I-94)	21	R	E	E	O	E	E	E	E	O	E	X	X

I-94 (Arrival/Departure Record)	2	E	R	E	E	O	E	E	E	O	E	X	E
I-94 (Arrival/Departure Record) in Unexpired Foreign Passport	10	E	R	O	R	O	E	E	E	R	E	X	E
Unexpired Foreign Passport	30	E	O	E	R	O	E	E	E	R	E	X	E
I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status)	26	E	O	E	O	R	E	E	E	O	E	E	E
DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)	27	E	O	E	O	R	E	E	E	O	E	E	E
Other	1	R	E	E	O	O	E	E	E	O	R	E	E
		E	R	E	O	O	E	E	E	O	R	E	E

E - No value is provided for the input field
R - A value must be provided for the input field
O - A value may be provided for the input field
X - A request can be made for this type of document



☑ **Check this box if Egas Wahs has an eligible immigration status:**

***Document Type (select one)**

◉ Reentry Permit (I-327)

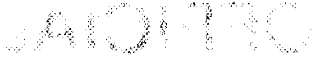
* Alien Number

A#

Document Expiration Date (MM/DD/YYYY)

◎ Permanent Resident Card ("Green Card," I-551)
◎ Refugee Travel Document (I-571)
◎ Employment Authorization Card (I-766)
◎ Machine Readable Immigrant Visa (with temporary I-551 language)
◎ Temporary I-551 Stamp (on passport or I-94, I-94A)
◎ Arrival Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
◎ Arrival Departure Record in unexpired foreign passport (I-94)
◎ Unexpired foreign passport
◎ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
◎ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
◎ Notice of Action(I-797)/Other - With Alien Number
◎ Notice of Action(I-797)/Other - With I-94 Number

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Document Type (select one) Reentry Permit (I-327) Permanent Resident Card ("Green Card," I-551) Refugee Travel Document (I-571) Employment Authorization Card (I-766) Machine Readable Immigrant Visa (with temporary I-551 language) Temporary I-551 Stamp (on passport or I-94, I-94A) Arrival Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services Arrival Departure Record in unexpired foreign passport (I-94)	If checkbox for eligible immigration status is checked) Passport number is alphanumeric Each radio button has different required fields	Y	



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	Document Expiration Date			

☑ **Check this box if Egas Wahs has an eligible immigration status:**

***Document Type (select one)**

- ○ Reentry Permit (I-327)
- ○ Permanent Resident Card ("Green Card," I-551)
- ○ Refugee Travel Document (I-571)
- ● Employment Authorization Card (I-766)

* Alien Number

A#

* Receipt/Card Number

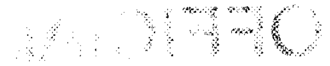
* Document Expiration Date (MM/DD/YYYY)

Other Documentation (select one)

Select any option

- ○ Machine Readable Immigrant Visa (with temporary I-551 language)
- ○ Temporary I-551 Stamp (on passport or I-94, I-94A)
- ○ Arrival Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
- ○ Arrival Departure Record in unexpired foreign passport (I-94)
- ○ Unexpired foreign passport
- ○ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- ○ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- ○ Notice of Action(I-797)/Other - With Alien Number
- ○ Notice of Action(I-797)/Other - With I-94 Number

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Employment Authorization Card (I-766) Alien Number Receipt/Card Number Document Expiration Date		Y – Alien Number Y - Receipt/Card Number Y – Document Expiration Date	



Radio Button	Other Documentation (select one) Document indicating American Indian born in Canada (LPR I-551) Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) Office of Refugee Resettlement (ORR) eligibility letter (if under 18) Cuban Haitian Entrant Document indicating withholding of removal Resident of American Samoa Other documents or status types		N	

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☑ **Check this box if Egas Wahs has an eligible immigration status:**

***Document Type (select one)**

- ○ Reentry Permit (I-327)
- ○ Permanent Resident Card ("Green Card," I-551)
- ○ Refugee Travel Document (I-571)
- ○ Employment Authorization Card (I-766)
- ● Machine Readable Immigrant Visa (with temporary I-551 language)

* Alien/Registration Number

A#

* Passport Number

Document Expiration Date (MM/DD/YYYY)

* Country Of Issuance

Country

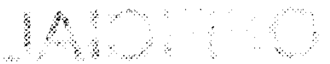
Visa Number

Other Documentation (select one)

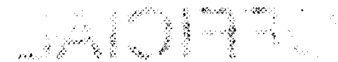
Select any option

- ○ Temporary I-551 Stamp (on passport or I-94, I-94A)
- ○ Arrival Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
- ○ Arrival Departure Record in unexpired foreign passport (I-94)
- ○ Unexpired foreign passport
- ○ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- ○ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- ○ Notice of Action(I-797)/Other - With Alien Number
- ○ Notice of Action(I-797)/Other - With I-94 Number

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Machine Readable Immigrant Visa (with temporary I-551 language) Alien/Registration Number Passport Number Document Expiration Date Document Country of Issuance		Y – Alien/Registration Number Y - Passport Number Y –Country of Issuance	



	Visa Number			
Radio Button	Other Documentation (select one) Document indicating American Indian born in Canada (LPR I-551) Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) Office of Refugee Resettlement (ORR) eligibility letter (if under 18) Cuban Haitian Entrant Document indicating withholding of removal Resident of American Samoa Other documents or status types		N	



OFFICIAL

☑ **Check this box if Egas Wahs has an eligible immigration status:**

***Document Type (select one)**

- ◎ Reentry Permit (I-327)
- ◎ Permanent Resident Card ("Green Card," I-551)
- ◎ Refugee Travel Document (I-571)
- ◎ Employment Authorization Card (I-766)
- ◎ Machine Readable Immigrant Visa (with temporary I-551 language)
- ◉ Temporary I-551 Stamp (on passport or I-94, I-94A)

* Alien Number

A#

Document Expiration Date (MM/DD/YYYY)

Passport Number

Country Of Issuance

Country

Other Documentation (select one)

Select any option

- ◎ Arrival Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
- ◎ Arrival Departure Record in unexpired foreign passport (I-94)
- ◎ Unexpired foreign passport
- ◎ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- ◎ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- ◎ Notice of Action(I-797)/Other - With Alien Number
- ◎ Notice of Action(I-797)/Other - With I-94 Number

Type	**Content**	**Functions**	**Mandatory (Y/N/NA)**	**Possible Validation**
Radio Button	Temporary I-551 Stamp (on passport or I-94, I-94A) Alien Number Passport Number Document Expiration Date Country of Issuance		Y – Alien Number	
Radio Button	Other Documentation (select one) Document indicating American Indian born in Canada (LPR I-551) Certification from U.S.		N	

	Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) Office of Refugee Resettlement (ORR) eligibility letter (if under 18) Cuban Haitian Entrant Document indicating withholding of removal Resident of American Samoa Other documents or status types			

☑ **Check this box if Egas Wahs has an eligible immigration status:**

***Document Type (select one)**

- ○ Reentry Permit (I-327)
- ○ Permanent Resident Card ("Green Card," I-551)
- ○ Refugee Travel Document (I-571)
- ○ Employment Authorization Card (I-766)
- ○ Machine Readable Immigrant Visa (with temporary I-551 language)
- ○ Temporary I-551 Stamp (on passport or I-94, I-94A)
- ◉ Arrival Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services

* I-94 Number [ ]

SEVIS ID Number N# [ ]

Document Expiration Date (MM/DD/YYYY) [ ]

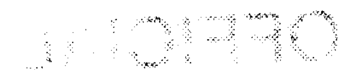
Other Documentation (select one)

Select any option

- ○ Arrival Departure Record in unexpired foreign passport (I-94)
- ○ Unexpired foreign passport
- ○ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- ○ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- ○ Notice of Action(I-797)/Other - With Alien Number
- ○ Notice of Action(I-797)/Other - With I-94 Number

Type	Content	Functions	Mandatory	Possible

			(Y/N/NA)	Validation
Radio Button	Arrival Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services I-94 Number SEVIS ID Number Document Expiration Date		Y – I-94 Number	
Radio Button	Other Documentation (select one) Document indicating American Indian born in Canada (LPR I-551) Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) Office of Refugee Resettlement (ORR) eligibility letter (if under 18) Cuban Haitian Entrant Document indicating withholding of removal Resident of American Samoa Other documents or status types		N	



☑ **Check this box if Egas Wahs has an eligible immigration status:**

***Document Type (select one)**

- Reentry Permit (I-327)
- Permanent Resident Card ("Green Card," I-551)
- Refugee Travel Document (I-571)
- Employment Authorization Card (I-766)
- Machine Readable Immigrant Visa (with temporary I-551 language)
- Temporary I-551 Stamp (on passport or I-94, I-94A)
- Arrival Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
- ● Arrival Departure Record in unexpired foreign passport (I-94)

* I-94 Number

* Passport Number

SEVIS ID Number

N#

* Document Expiration Date (MM/DD/YYYY)

* Country Of Issuance

Country

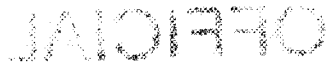
Visa Number

Other Documentation (select one)

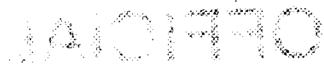
Select any option

- Unexpired foreign passport
- Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- Notice of Action(I-797)/Other - With Alien Number
- Notice of Action(I-797)/Other - With I-94 Number

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Arrival Departure Record in unexpired foreign passport (I-94) I-94 Number Passport Number SEVIS ID Number Document Expiration Date Country of Issuance		Y - Passport Number Y – Document Expiration Date Y – I-94 Number Y –Country of	



	Visa Number		Issuance	
Radio Button	Other Documentation (select one) Document indicating American Indian born in Canada (LPR I-551) Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) Office of Refugee Resettlement (ORR) eligibility letter (if under 18) Cuban Haitian Entrant Document indicating withholding of removal Resident of American Samoa Other documents or status types		N	



☑ **Check this box if Egas Wahs has an eligible immigration status:**

***Document Type (select one)**

- ○ Reentry Permit (I-327)
- ○ Permanent Resident Card ("Green Card," I-551)
- ○ Refugee Travel Document (I-571)
- ○ Employment Authorization Card (I-766)
- ○ Machine Readable Immigrant Visa (with temporary I-551 language)
- ○ Temporary I-551 Stamp (on passport or I-94, I-94A)
- ○ Arrival Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
- ○ Arrival Departure Record in unexpired foreign passport (I-94)
- ● Unexpired foreign passport

I-94 Number

* Passport Number

SEVIS ID Number

N#

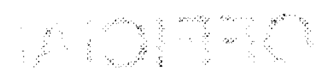
* Document Expiration Date (MM/DD/YYYY)

* Country Of Issuance

Country

- ○ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- ○ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- ○ Notice of Action(I-797)/Other - With Alien Number
- ○ Notice of Action(I-797)/Other - With I-94 Number

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Unexpired foreign passport I-94 Number Passport Number SEVIS ID Number Document Expiration Date Country of Issuance		Y - Passport Number Y – Document Expiration Date Y –Country of Issuance	



☑ **Check this box if Egas Wahs has an eligible immigration status:**

***Document Type (select one)**

- ◯ Reentry Permit (I-327)
- ◯ Permanent Resident Card ("Green Card," I-551)
- ◯ Refugee Travel Document (I-571)
- ◯ Employment Authorization Card (I-766)
- ◯ Machine Readable Immigrant Visa (with temporary I-551 language)
- ◯ Temporary I-551 Stamp (on passport or I-94, I-94A)
- ◯ Arrival Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
- ◯ Arrival Departure Record in unexpired foreign passport (I-94)
- ◯ Unexpired foreign passport
- ◉ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)

I-94 Number

* SEVIS ID Number

N#

Document Expiration Date (MM/DD/YYYY)

Passport Number

Country Of Issuance

Country

- ◯ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- ◯ Notice of Action(I-797)/Other - With Alien Number
- ◯ Notice of Action(I-797)/Other - With I-94 Number

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20) I-94 Number SEVIS ID Number Passport Number Document Expiration Date Country of Issuance		Y – SEVIS ID Number	

☑ **Check this box if Egas Wahs has an eligible immigration status:**

***Document Type (select one)**

- ○ Reentry Permit (I-327)
- ○ Permanent Resident Card ("Green Card," I-551)
- ○ Refugee Travel Document (I-571)
- ○ Employment Authorization Card (I-766)
- ○ Machine Readable Immigrant Visa (with temporary I-551 language)
- ○ Temporary I-551 Stamp (on passport or I-94, I-94A)
- ○ Arrival Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
- ○ Arrival Departure Record in unexpired foreign passport (I-94)
- ○ Unexpired foreign passport
- ○ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- ● Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)

I-94 Number

* SEVIS ID Number

N#

Document Expiration Date (MM/DD/YYYY)

Passport Number

Country Of Issuance

Country

- ○ Notice of Action(I-797)/Other - With Alien Number
- ○ Notice of Action(I-797)/Other - With I-94 Number

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019) I-94 Number SEVIS ID Number Passport Number Document Expiration Date Country of Issuance		Y – SEVIS ID Number	

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☑ **Check this box if Egas Wahs has an eligible immigration status:**

***Document Type (select one)**

- ◎ Reentry Permit (I-327)
- ◎ Permanent Resident Card ("Green Card," I-551)
- ◎ Refugee Travel Document (I-571)
- ◎ Employment Authorization Card (I-766)
- ◎ Machine Readable Immigrant Visa (with temporary I-551 language)
- ◎ Temporary I-551 Stamp (on passport or I-94, I-94A)
- ◎ Arrival Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
- ◎ Arrival Departure Record in unexpired foreign passport (I-94)
- ◎ Unexpired foreign passport
- ◎ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- ◎ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- ◉ Notice of Action(I-797)/Other - With Alien Number

* Alien Number: A#

SEVIS ID Number: N#

Document Expiration Date (MM/DD/YYYY)

Passport Number

Country Of Issuance: Country

Other Documentation (select one)

Select any option

◎ Notice of Action(I-797)/Other - With I-94 Number

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Notice of Action (I-797)/Other – With Alien Number Alien Number SEVIS ID Number Document Expiration Date Passport Number Country of Issuance		Y – Alien Number	

Radio Button	Other Documentation (select one) Document indicating American Indian born in Canada (LPR I-551) Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) Office of Refugee Resettlement (ORR) eligibility letter (if under 18) Cuban Haitian Entrant Document indicating withholding of removal Resident of American Samoa Other documents or status types		N	

☑ **Check this box if Egas Wahs has an eligible immigration status:**

***Document Type (select one)**

- ○ Reentry Permit (I-327)
- ○ Permanent Resident Card ("Green Card," I-551)
- ○ Refugee Travel Document (I-571)
- ○ Employment Authorization Card (I-766)
- ○ Machine Readable Immigrant Visa (with temporary I-551 language)
- ○ Temporary I-551 Stamp (on passport or I-94, I-94A)
- ○ Arrival Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
- ○ Arrival Departure Record in unexpired foreign passport (I-94)
- ○ Unexpired foreign passport
- ○ Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- ○ Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- ○ Notice of Action(I-797)/Other - With Alien Number
- ● Notice of Action(I-797)/Other - With I-94 Number

* I-94 Number

SEVIS ID Number

N#

Document Expiration Date (MM/DD/YYYY)

Passport Number

Country Of Issuance

Country

Other Documentation (select one)

Select any option

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Notice of Action (I-797)/Other – With I-94 Number Alien Number SEVIS ID Number Document Expiration Date Passport Number Country of Issuance		Y – I-94 Number	

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
RadioButton	Other Documentation (Select One) Document indicating American Indian born in Canada (LPR I-551) Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR) Office of Refugee Resettlement (ORR) eligibility letter (if under 18) Cuban Haitian Entrant Document indicating withholding of removal Resident of American Samoa Other documents or status types		N	

***Is Egas Wahs the same name that appears on his/her document?**

Yes No

*** First Name** **Middle Name** *** Last Name** **Suffix**

Suffix

***Did Egas Wahs arrive in the U.S. after August 22, 1996?**

Yes No

Is Egas Wahs an honorably discharged veteran or active duty member of the military, or the spouse or child of an honorably discharged veteran or active duty member of the military?

Yes No

Back Save and Continue

Radio Button	Is FirstName LastName the same name that appears on		Y	

	his/her document?			
Free Text	Name: First Name Middle Name Last Name Suffix		Y – First Name Y- Last Name N – Middle Name N - Suffix	
Radio Button	Did xxx arrive in the US after August 22, 1996?	Values: Yes No	Y	
Submit Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		
Submit Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		

Egas Wahs - Citizenship/Immigration Status

More information on Immigration Document Types

** Mandatory Field*

***Is Egas Wahs a U.S. Citizen or U.S. National?**

(•) Yes ( ) No

***Is Egas Wahs a naturalized citizen?**

(•) Yes ( ) No

Document Type (select one)

(•) **Naturalization certificate**

*** Alien Number:** A#

*** Naturalization Certificate Number:**

☐ I don't have one.

( ) **Certificate of citizenship**

*** Alien Number:** A#

*** Citizenship Number:**

☐ I don't have one.

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	FirstName LastName – Citizenship/Immigration Status			
RadioButton	Is FirstName LastName a U.S. citizen or U.S. National?	Button selection Yes, No <this scenario the button selected is "Yes">		
Tooltip	A U.S. citizen is someone who was born in the United States or has	Action: Show on Mouseover; Hide on		

	been naturalized as a U.S. citizen (became a U.S. citizen after birth). A U.S. national is someone who is a U.S. citizen or a person who is not a U.S. citizen, but owes permanent allegiance to the U.S. (like people born in American Samoa or Swains Island)	Mouse Off Keyboard: Tab		
RadioButton	Is FirstName LastName a naturalized citizen?	Button selection Yes, No <yes, in this scenario>		
Tooltip	A naturalized citizen is a person who became a U.S. citizen after birth and can have either a 'Certificate of Naturalization' (Form N-500) or a 'Certificate of Citizenship' (Form N-560 or N-561).	Action: Show on Mouseover; Hide on Mouse Off Keyboard: Tab		
Radio Button	Document Type (select one): Naturalization certificate Certificate of citizenship		Y – if a US citizen or US national AND a naturalized citizen	
Textbox	Naturalization certificate: Alien Number Naturalization Certificate Number I do not have one	Numeric entry Checkbox for "I do not have one"	Y - Alien Number N - Naturalization Certificate Number Checkbox for "I do not have one"	
Textbox	Certificate of citizenship: Alien Number Citizenship Number I do not have one	Numeric entry Checkbox for "I do not have one"	Y - Alien Number Y - Citizenship Number Checkbox for "I do not have one"	
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and		

		Continue		
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		

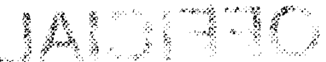
Egas Wahs - Citizenship/Immigration Status

More information on Immigration Document Types

Federal services are unable to verify your citizenship/immigration status at this time. Please choose an immigration status from the list below that best represents you so that we can provide you with benefits. You may also be asked to provide supporting documentation.
If you do not have one of the eligible immigration statuses listed below, use the Back button to go back to the last page to review and correct your answers. *

- Amerasian
- Granted asylum
- Cuban Haitian entrant
- Deportation Withheld
- Native Americans born in Canada or non U.S. territories
- Refugee
- Victim of severe trafficking or his or her spouse, child, sibling or parent.
- Iraqi Special Immigrant
- Afghan Special Immigrant
- Conditional entrant granted before 1980
- Veteran or active duty member of military or his/her spouse or dependent
- Lawful permanent resident
- Granted parole for at least one year
- Battered spouse or child (or his or her parent or child)
- Non-immigrant status (visa)
- Granted parole for less than one year
- Granted temporary resident status
- Granted Temporary Protected Status (TPS) or applicant for TPS with employment authorization
- Granted employment authorization under 8 CRF 274a(12)(c)
- Family Unity beneficiaries
- Deferred Enforced Departure
- Deferred Action Status except for Deferred Action for Childhood Arrivals Process (DACA)
- Granted an administrative stay of removal under 8 CFR 241
- Approved visa petition with a pending application for adjustment of status
- Applicant for asylum or for withholding of removal with employment authorization
- Applicant (for at least 180 days) under age 14 for asylum or withholding of removal
- Granted Withholding of Removal under the Convention Against Torture
- Applicant for Special Immigrant Juvenile status
- Applicant or granted status under Deferred Action for Childhood Arrivals (DACA)
- I have a document but do not have any of the statuses listed above (Person Residing Under Color of Law, PRUCOL)

Back | Save and Continue



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	FirstName LastName – Citizenship/Immigration Status			
Static	Federal services are unable to verify your citizenship/immigration status at this time. Please choose an immigration status from the list below that best represents you so that we can provide you with benefits. You may also be asked to provide supporting documentation. If you do not have one of the eligible immigration statuses listed below, use the Back button to go back to the last page to review and correct your answers.			
Radio Button	FULL LIST OF CITIZENSHIP STATUSES		Y	
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		

OFFICIAL

Review Application

You can review your application information below.

Contact Information [Edit]

Erin J Rashid Jr.

Address: 302 E Adams St, Pittsburg, KS, 66762

Email: boston4@yopmail.com

Phone: (617) 933-3058 - CELL

Family & Household [Edit]

Erin J Rashid Jr.

Social Security Number: •••-••-7509

Applying for coverage: Yes

Address: 302 E Adams St, Pittsburg, KS, 66762

Date of birth: 12/08/1981

Citizenship No

Satisfactory immigration status: Yes

Brian x Rashid

Social Security Number: •••-••-7509

Applying for coverage: Yes

Relationship to Erin J Rashid Jr.: Spouse

Address: Same as primary applicant

Date of birth: 12/08/1980

Citizenship Yes

Helen Q Rashid

Social Security Number: •••-••-7509

Applying for coverage: Yes

Relationship to Erin J Rashid Jr.: Son/Daughter

Address: Same as primary applicant

Date of birth: 12/08/2012

Citizenship Yes

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Citizenship	Display Yes or No for each household member		
Static	Immigration Status	This should display the immigration status used for PD (eg, Permanent Resident Card ("Green Card," I-551)		

OFFICIAL

1.1 Parent/Caretaker Relatives

Parent/Caretaker Relatives

***Does Egas Wahs live with at least one child under age 19 and is he/she the main person taking care of that child?**

◉ Yes ○ No

***Who does Egas Wahs live with and take care of?**

☑ Child Wahs

☐ Another Child

***Does Child Wahs live with two birth or adoptive parents?**

◉ Yes ○ No

***Does Spouse Wahs live with at least one child under age 19 and is he/she the main person taking care of that child?**

◉ Yes ○ No

***Who does Spouse Wahs live with and take care of?**

☑ Child Wahs

☐ Another Child

Back | Save and Continue

***Who does Spouse Wahs live with and take care of?**

☑ Child Wahs

☑ Another Child

***What's the name and date of birth of one child that Spouse Wahs lives with and takes care of?**

Dependent Name

***First Name**	**Middle Name**	***Last Name**	**Suffix**
Child Two		Wahs	Suffix

***Date of Birth (MM/DD/YYYY)**

10/16/2005

+ Add Dependent

How is Spouse Wahs related to Child Two Wahs?

Spouse Wahs is the Cousin of Child Two Wahs.

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Parent/Caretaker Relatives	N/A		
RadioButton	Does FirstName LastName live with at least one child under age 19 and is he/she the main person taking care of that child?	Button Selection Yes, No		
Checkbox	Who does FirstName LastName live with and take care of?	Checkbox Selection • FirstName LastName • Another Child		Only mandatory when "YES" radio button is selected for the question "Does FirstName LastName live with at least one child under age 19

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
				and is he/she the main person taking care of that child?"
Static	What's the name and date of birth of one child that FirstName LastName lives with and takes care of?			
Textbox	Dependent First Name	Alphabetic Entry	Yes	
Textbox	Dependent Middle Name	Alphabetic Entry		
Textbox	Dependent Last Name	Alphabetic Entry	Yes	
Dropdown	Suffix	Alphanumeric Entry Dropdown list – provide all available choices		
Textbox	Dependent Date of Birth	Date Format Numeric value	Yes	
Button	Add Dependent	Mouse click		
Button	Does FirstName LastName live with two birth or adoptive parents?	Yes, No	Yes	
Checkbox	Who does FirstName LastName live with and take care of?	Checkbox Selection • FirstName LastName Another Child		Only mandatory when "YES" radio button is selected for the question "Does FirstName LastName live with at least one child under age 19 and is he/she the main person taking

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
				care of that child?”
Dropdown	How is FirstName LastName related to FirstName LastName? FirstName LastName is the <dropdown value> of FirstName LastName	Dropdown values – provide all available choices		
Submit Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		
Submit Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		

1.1 Ethnicity & Race (optional)

Egas Wahs - Ethnicity & Race (optional)

Optional information: This information will be used to help the U.S. Department of Health and Human Services (HHS) better understand and improve the health of and health care for all Americans. Providing this information won't impact your eligibility for health coverage, your health plan options, or your costs in any way.

Is Egas Wahs of Hispanic, Latino, or Spanish origin?

◉ Yes ○ No

Ethnicity: (check all that apply.)

- ☐ Cuban
- ☐ Mexican, Mexican American, or Chicano(a)
- ☐ Puerto Rican
- ☐ Other:

Enter Other Ethnicity

Race: (check all that apply.)

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White or Caucasian
- ☐ Other:

Enter other race

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	FirstName LastName – Ethnicity & Race (Optional)	N/A		
Static	Optional information: This information will be used to help the U.S. Depart of Health and Human Services (HHS) better understand and improve the health of and health care for all Americans. Providing this information won't impact your eligibility for health coverage, your health plan options, or your costs in any way.	N/A		
RadioButton	Is FirstName LastName of Hispanic, Latino, or Spanish origin?	Button selection Yes, No		
Checkbox	Ethnicity: (check all that apply)	If "Yes" is selected above Cuban Mexican, Mexican American, or Chicano(a) Puerto Rican Other		
Textbox	Enter other ethnicity	If "Other" is selected above Alphabetic value		
Checkbox	Race: (check all that apply)	Checkbox Selection Mouse Click • American Indian or Alaskan Native • Asian Indian • Black or African American		

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		• Chinese • Filipino • Guamanian or Chamorro • Japanese • Korean • Native Hawaiian • Other Asian • Other Pacific Islander • Samoan • Vietnamese • White or Caucasian • Other		
Textbox	Enter other race	If "Other" is selected above Alphabetic value		

1.1 Other Addresses

Other Addresses

Mandatory Field

*** Do any of the people below live at an address different from Egas Wahs? (check all that apply.)**

- [x] Child Wahs
- [ ] Spouse Wahs
- [ ] None of these people

*** Where does Child Wahs live?**

(•) Home Address

*** Address 1**

1 Main Street

Address 2

*** City**	*** Zip**	*** County**	*** State**
Frisco	80443	SUMMIT	CO

Is Child Wahs living outside of Massachusetts temporarily?

(•) Yes ( ) No

Where will Child Wahs be living in Massachusetts?

*** City**	*** Zip**	*** County**	*** State**
Boston	02108	SUFFOLK	MA

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Other Addresses	N/A		
Checkbox	Do any of the people below live at an address different from <HoH>? [list every person in the household – INCLUDE the head of household as an option]	Checkbox Selection FirstName LastName FirstName LastName None of these people <HoH> should contain the full legal name		
Radio Button	Where does xxx live? Home Address	Home Address	Y	
Textbox	Address 1	Address fields are shown if one of the above people are selected as living at a different address Alphanumeric Entry		
Textbox	Address 2	Alphanumeric Entry		
Textbox	City	Alphabetic		
Textbox	Zip	Numeric		
Dropdown	County	Alphabetic Entry Choose from dropdown list		Make sure the user selects a county BEFORE asking the next question
Textbox	State	Alphabetic		Automatically pre-fills upon entering zip code and county

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Is xxx living outside of Massachusetts temporarily? Yes No	This question only appears if the mailing address is outside of Massachusetts		
Static	Where will xxx be living in Massachusetts?	Will only appear if "yes" is selected in the question above: Is xxx living outside of Massachusetts temporarily?	N (this is optional in the FFM – make sure this is optional in hCentive)	
Text box	City	Alphabetic	Yes	
Text box	Zip code	Numeric	Yes	Defaulted to accept ONLY an MA zip code
Text box	County	Dropdown – users chooses from list	Yes	
Text box	State	Auto-Populated -will only accept MA	Yes	
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		

OFFICIAL

1.1 More about this household

Sign Out

Application Year 2015

✔ Start Your Application

Family & Household

Income

Additional Questions

Review & Sign

More about this household

Answer the questions below to see if you can get additional financial assistance.

** Mandatory Field*

***Does anyone in the household who is applying 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.**

- [ ] Egas Wahs
- [ ] Child Wahs
- [x] None of these people

***Are any of the people below American Indian/Alaska Native?**

- [x] Egas Wahs

*** American Indians and Alaska Natives, including American Indians born in Canada, may qualify for additional benefits.**

***State:**

State

***Tribe name:**

Tribe

- [ ] Child Wahs
- [ ] None of these people

***Are any of the people below pregnant?**

- [ ] Spouse Wahs
- [x] None of these people

Do any of the people below have breast or cervical cancer? MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.

- [ ] Egas Wahs
- [ ] Child Wahs
- [x] None of these people

Are any of the people below HIV positive? MassHealth has special coverage rules for people who are HIV positive.

- [ ] Egas Wahs
- [ ] Child Wahs
- [x] None of these people

Back | Save and Continue

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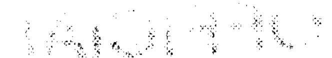
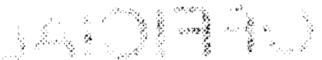
Contact | Accessibility Statement

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	More about this household	N/A		
Static	Answer the questions below to see if you can get additional financial assistance	N/A		
Checkbox	Does anyone in the household who is applying 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.	Checkbox Selection • FirstName LastName • FirstName LastName • FirstName LastName • None of these people		
Checkbox	Are any of the people below American Indian/Alaska Native?	List all household members None of these people	Yes	
Tooltip	American Indians and Alaska Natives who enroll in health coverage 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 Indian or Alaska Native, you may not have to pay premiums or co-payments, and may get special monthly enrollment periods.			
Text	American Indians and Alaska Natives, including American Indians born in Canada, may qualify for additional benefits.	Shown if someone in the household is AIAN		
Tooltip	Federally recognized tribes may get extra help – they may not have to pay cost sharing and may get monthly Special Enrollment Periods through the Health Connector. American Indians and Alaska Natives do not have			



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	copays or premiums for MassHealth.			
Dropdown	State	Shown if someone in the household is AIAN List all states with federal and/or state recognized		
Dropdown	Tribe name:	Shown if someone in the household is AIAN List all federally recognized tribes for the state selected above Also include "State tribe" as part of every dropdown		Federally recognized tribe selected – no logic change – will work same as today "State tribe" is selected – no logic added – just needs to be captured for MH benefits
Warning Message	You have selected a state tribe. If you are part of a federally-recognized tribe, you may want to go back to change your selection. American Indians and Alaska Natives who are part of federal-recognized tribes may get extra help paying for out-of-pocket costs and have extra enrollment opportunities. Press OK to continue with your current selection.	Shown if someone in the household is AIAN Shown if "state tribe" is selected		



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Are any of the people below pregnant? *

☑ Erin J Rashid Jr.

☐ None of these people

How many babies is Erin J Rashid Jr. expecting during this pregnancy? *

1

What is the due date for Erin J Rashid Jr. ? *

04/30/2015

Type	**Content**	**Functions**	**Mandatory (Y/N/NA)**	**Possible Validation**
Checkbox	Are any of the people below pregnant? FirstName LastName FirstName LastName None of these people		Y	Names displayed should be females who are between 8 and 65 years old
Dropdown	How many babies is FirstName LastName expecting during this pregnancy?	If checkbox above is checked for a pregnancy, this question will collect further information. Dropdown value – can select 1-9		
Date	What is the due date for <full legal name>?	Calendar date Numeric values		Due date cannot be more than 11 months in the future
Checkbox	Do any of the people below have breast or cervical cancer? MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.		No	

OFFICIAL

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Checkbox	Are any of the people below HIV positive? MassHealth has special coverage rules for people who are HIV positive.		No	
Checkbox	Are any people below filing taxes separately because they are a victim of domestic abuse or an abandoned spouse? <FULL LEGAL NAME> <FULL LEGAL NAME> None of these people	Only displays if applicant answers "NO" to married filing jointly and is NOT living with the spouse The name that appears here should ONLY appear if the applicant is NOT married filing jointly and is NOT living with the spouse. The name here should be based on the name entered on the question "Does FULL LEGAL NAME plan to file a joint federal income tax return with his or her spouse for 2015?....."	Yes If a name is selected, the system should NOT show the "Tax Filer & Other Additional Questions" question If "None of these people" are selected, the system SHOULD show the "Tax Filer & Other Additional Questions" question	
Tooltip	Usually, you can only get a tax credit to lower your monthly premiums if you file a joint tax return with your spouse. However, if you plan to file separately because you are a victim of domestic abuse or an abandoned spouse, you may still qualify for a tax credit if you also: • Are living apart from your spouse at the time you filed the current year tax return. • Certify on the tax return that you are a victim of domestic abuse or spousal			

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	abandonment. • Do not qualify to use Head of Household filing status. Remember, we won't share your answers to these questions. This information and all your application information are confidential.			
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		

Were any of the people below ever in foster care?

☐ WHAT DOPER QUICKS

☑ None of these people

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Checkbox	Were any of the people below ever in foster care?	Yes No	Yes	
Radio Button	Was FN LN getting health care through a state Medicaid program?	Yes No	Yes	

1.2 Enter Household Member Relationships

Enter Household Members Relationships

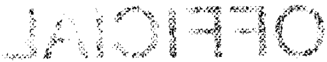
Please tell us how you and your other household members are related to each other so that we can determine the best benefits available for your household.

* Explain how the household members below relate to Egas Wahs (Born: 10/12/1981):

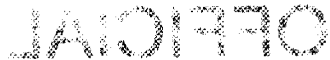
Name	Born	Relationship		with Member
Child Wahs	10/15/2012	is the	Child	of Egas Wahs
Spouse Wahs	10/12/1981	is the	Spouse	of Egas Wahs

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Enter Household Member Relationships	n/a		
Static	Please tell us how you and your other household members are related to each other so that we can determine the best benefits available for your household. Explain how the household members below relate to **Full Legal Name (Date of Birth: MM/DD/YYYY)**	n/a		
Text	Name	Auto-populated based on applicants entered into the application		
Date	Date of birth	Auto-populated based on applicant date of birth entered into the application		
Static	is the	Allows the user to better		



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		understand the relationship		
Dropdown	Relationship	User selects relationship: This list needs to be consistent with all other relationship lists in hCentive Should auto-populate if the user has entered this information already	Y	
Static	of	Allows the user to better understand the relationship		
Text	Name	The name of the person that each member of the household is related to Field is auto-populated with the same name as on the top of the screen		



1.3 Reasonable Accommodations

Reasonable Accommodations

Does anyone in the household need reasonable accommodation because of a disability or an injury? (Optional)

◉ Yes ○ No

Because you answered yes to the question above about yourself or any household member needing reasonable accommodation because of a disability or injury, please check all that apply below for each household member.

☑ Egas Wahs

Condition:

☐ Blind
☐ Deaf
☐ Developmentally Disabled
☐ Hard of Hearing
☐ Intellectually Disabled
☐ Low Vision
☐ Physically Disabled
☐ Other (please explain)

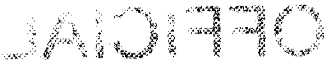
Accommodation:

☐ American Sign Language (ASL) Interpreter
☐ Assistive Listening Device
☐ Communication Access Real-time Translations (CART)
☐ Large Print Publication
☐ Publications in electronic format
☐ Publications in Braille
☐ Text Telephone (TTY)
☐ Video Relay Service (VRS)
☐ Other (please explain)

☐ Child Wahs

Back | Save and Continue

Type	Content	Functions	Mandatory (Y, N, N/A)	Possible Validation
Static Text	Reasonable Accommodation			Section heading



Radio Button	Does anyone in the household need reasonable accommodation because of a disability or an injury? *(Optional)*	Yes, No	No	If this is marked as "yes" then at least one checkbox for condition or accommodation needs to be checked
Dynamic Text	Because you answered yes to the question above about yourself or any household member needing reasonable accommodation because of a disability or injury, please check all that apply below for each household member.	Shown if the question above is marked as "yes"	n/a	
Dynamic Checkbox	[Household Member #1 full legal name]	Checkbox will get displayed next to each member of the household	No	
Checkbox/ Textbox	Condition: ▪ Low Vision ▪ Blind ▪ Deaf ▪ Hard of Hearing ▪ Developmentally Disabled ▪ Intellectually Disabled ▪ Physically Disabled ▪ Other (please explain) <ADD TEXT BOX>	Shown if the user selects the checkbox next to the household member's name If the user selects "other" allow for textbox field to be filled in (alphanumeric/special characters)	No	List should display for each household member
Checkbox/ Textbox	Accommodation: ▪ Text Telephone (TTY) ▪ Large Print Publications ▪ American Sign Language (ASL) Interpreter ▪ Video Relay Service (VRS) ▪ Communication Access Real-time Translations (CART) ▪ Publications in Braille ▪ Assistive Listening Device ▪ Publications in Electronic Format	Shown if the user selects the checkbox next to the household member's name If the user selects "other" allow for textbox field to be filled in (alphanumeric/special characters)	No	Should display for each household member

	▪ Other (please explain) <ADD TEXT BOX>			

1.4 Family & Household Summary

Family & Household Summary

Egas Wahs (Head of Household)

Social Security Number: Does not have SSN

Applying for coverage: Yes

Child Wahs

Social Security Number: Does not have SSN

Applying for coverage: Yes

Relationship to Egas Wahs: Child

Spouse Wahs

Social Security Number: Does not have SSN

Applying for coverage: No

Relationship to Egas Wahs: Spouse

Edit Household

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	Family & Household Summary	NA		
Display	List of all applicants: FirstName LastName (Head of Household) Social Security Number: xxx-xx-1234			

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	Applying for coverage: Yes/No FirstName LastName (Applicant #2) Social Security Number: xxx-xx-1234 Applying for Coverage: Yes/No Relationship to Head of Household			
Button	Edit Household	Takes you back to the beginning of the Family & Household section		
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

OFFICIAL

1 Income

Income

More information on Income Sources

We ask for current income information for everyone in your family and household to make sure you get the most financial assistance possible. **If spouses have joint income, only list it once.** If a dependent has to file taxes, his or her income will be considered when calculating Advance Premium Tax Credits and Reduced Co-Pays and Deductibles. Click here to see if your dependent will need to file taxes.

All fields on this Income section are required unless otherwise indicated.

You may need:

- Pay stubs
- W-2 Forms
- Information about any other income you get

Estimated time for this section: 10 Minutes - 15 Minutes

Back Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	**Income** We ask for current income information for everyone in your family and household to make sure you get the most financial assistance possible. **If spouses have joint income, only list it once.** If a dependent has to file taxes, his or her income will be considered when calculating Advance Premium Tax Credits and Reduced Co-pays and Deductibles. Click here to see if your dependent will need to file taxes	Link to http://www.irs.gov/publications/p501/ar02.html#en_US_2012_publink1000220702		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	All fields on this Income section are required unless otherwise indicated.	NA		
Static	You may need: Pay stubs W-2 Forms Information about any other income you get	NA		
Static	Estimated time for this section: 10 Minutes – 15 Minutes	NA		
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

1.1 Current Income

Egas Wahs's Current Income

More Information on Income Sources

** Mandatory Field*

Select Income Sources

***Does Egas Wahs have any income?**

Yes No

Back Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	FirstName LastName's Current Income	**NA**		
Static	Select Income Sources			
Radio Button	Does FirstName LastName have any income?	Button Selection: Yes, No	**Yes**	Per hCentive, only current income is being checked against IRS data
Tooltip	You do not need to tell us about child support, non-taxable veteran's payments, Supplemental Security Income (SSI), and most worker's compensation income.			

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1.2 Current Income – Check all that apply

Egas Wahs's Current Income

More information on Income Sources

* *Mandatory Field*

Select Income Sources

***Does Egas Wahs have any income?**

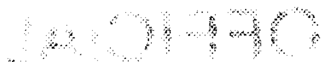
Yes No

Check all that apply.

- Job
- Self-Employment
- Social Security Benefits
- Unemployment
- Retirement
- Capital Gains
- Interest, Dividends, or Other Investment Income
- Rental or Royalty Income
- Farming or Fishing Income
- Alimony Received
- Other Income

Back Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	FirstName LastName's Current Income	NA		
Static	Select Income Sources	NA		
Radio Button	Does FirstName LastName have any income?	Button Selection: Yes, No		This asks whether the applicant has any income for the current month the person is applying for health



				coverage
Checkbox	Check all that apply: • Job • Self-Employment • Social Security Benefits • Unemployment • Retirement • Capital Gains • Interest, Dividends, or Other Investment Income • Rental or Royalty Income • Farming or Fishing Income • Alimony Received • Other Income	<only shown if user selects "yes" in question above> User can select more than one checkbox		
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		

1.3 Current Income Details

Egas Wahs's Current Income

More information on Income Sources

**All fields are required*

Job Income

*** Name of Employer:**

Employer Address

*** Address 1**

Address 2

*** City** *** Zip** **County** *** State**

How much does Egas Wahs get paid (before taxes are taken out)? You should also tell us here about a one-time amount you got from a current or former employer this month. If you have seasonal income please enter the monthly amount received in the Amount field below and select the frequency as Seasonal Income.

*** Amount:**

$ 0

*** How often does Egas Wahs get this amount?**

Select One

*** How many hours does Egas Wahs work per week?**

Is this job a sheltered workshop?

○ Yes ◉ No

Add Another

How much does Egas Wahs get paid (before taxes are taken out)? You should also tell us here about a one-time amount you got from a current or former employer this month. If you have seasonal income please enter the monthly amount received in the Amount field below and select the frequency as Seasonal Income.

*** Amount:**

$ 27000

*** How often does Egas Wahs get this amount?**

Seasonal Income

*** If Egas Wahs has seasonal income (i.e. income received only in certain months of the year), please choose each month of the calendar year that $27000 is earned.**

☐ January	☐ February	☐ March	☐ April
☐ May	☐ June	☐ July	☐ August
☐ September	☐ October	☐ November	☐ December

*** How many hours does Egas Wahs work per week?**

40

Is this job a sheltered workshop?

○ Yes ◉ No

Add Another

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	FirstName LastName's Current Income	NA		
Static	Job Income	NA <will appear if the applicant selected this box on the previous screen>		
Textbox	Name of Employer:	Alphanumeric Entry value	Yes	
Textbox	Employer Address Address 1 Address 2	Alphanumeric Entry	Yes Name of employer,	

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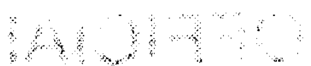
	City Zip County State		Employer Address 1, City, Zip, County, State	
Static	How much does FirstName LastName get paid (before taxes are taken out)? You should also tell us here about a one-time amount you got from a current or former employer this month.	NA Refers to Gross Income		
Textbox	Amount: Dollar Amount	Numeric value		
Dropdown	How often does FirstName LastName get this amount?	Please list all possible values • One time only • Weekly • Every two weeks • Twice a month • Monthly • Quarterly • Twice a Year • Yearly • Every other month • Seasonal Income		Default to "Select One" and make the user select from the list of values provided
Dropdown	Which month did FullLegalName earn this income?	List all calendar months	Yes	Only shows if "one time only" is selected above
Checkbox	If FN LN has seasonal income (i.e. income received only in certain months of the year), please choose each month of the calendar	Shown for seasonal income only	Yes	



	year that $xxxxx.xx is earned.			
Checkbox	[all months listed]	Take the dollar amount and multiply it by the # of months selected, then divide by 12	Yes (if seasonal income is selected)	
Textbox	How many hours does FullLegalName work per week?	Asked for all jobs	Yes	
Button	Is this job a sheltered workshop?	Yes or No	Y	Default to "No"
Tooltip	A sheltered workshop is an organization or work environment that employs people with disabilities.			
Button	Add Another			Will add another entry of the same type (eg, if you chose job income and clicked "add another," it will add another entry for additional job income)
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		

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Self-employment Income

*** Type of work**

On average, how much net income (profits once business expenses are paid) will you get from this self-employment each month?

To calculate your average monthly income, divide your annual self-employment income after business expenses are paid by 12.

*** Amount:**

$ 0

*** How many hours does Egas Wahs work per week?**

Add Another

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Self-employment Income	NA		
Text Box	Type of Work	Alphanumeric		
Static	On average, how much net income (profits once business expenses are paid) will you get from this self-employment each month? To calculate your average monthly income, divide your annual self-employment income after business expenses are paid by 12.	NA Need to enter this amount MONTHLY	Yes	
Text Box	Amount:	Numeric		
Button	Add Another			Will add another

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
				entry of the same type (eg, if you chose job income and clicked "add another," it will add another entry for additional job income)

Social Security Benefits Income

How much does Egas Wahs get from Social Security retirement, disability, or survivors benefits?

Enter your gross social security amount (amount before Medicare premiums or other deductions).

*** Amount:**

$ 0

You don't need to tell us about Supplemental Security Income (SSI).

*** How often does Egas Wahs get this amount?**

Select One

Add Another

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Social Security Benefits Income	NA		
Static	How much does [FN][LN] get from Social Security retirement, disability, or	NA		

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	survivors benefits? Enter your gross social security amount (amount before Medicare premiums or other deductions).			
Text Box	Amount	Numeric		Need to count gross income
Static	You don't need to tell us about Supplemental Security Income (SSI).	NA		
Drop Down	How often does [FN][LN] get this amount?	User need to choose one value • One time only • Monthly • Yearly	Yes	Default to "Select One" and make the user select from the list of values provided
Dropdown	Which month did FullLegalName earn this income?	Select a calendar month	Yes	Shown only if "one time only" is selected
Button	Add Another			Will add another entry of the same type (eg, if you chose job income and clicked "add another," it will add another entry for additional job income)

Unemployment Income

How much does Egas Wahs get?
*** Amount:**

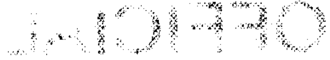
$ 0

*** How often does Egas Wahs get this amount?**

Select One

Add Another

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Unemployment Income	NA		
Static	How much does [FN][LN] get?	NA		
Text Box	Amount:	Numeric		
Drop Down	How often does [FN][LN] get this amount?	User need to choose one value • One time only • Weekly • Every two weeks • Monthly • Yearly	Yes	Default to "Select One" and make the user select from the list of values provided
Dropdown	Which month did FullLegalName earn this income?	Select calendar month	Yes	Only shown if "one time only" is selected
Button	Add Another			Will add another entry of the same type (eg, if you chose job income and clicked "add another," it will add another entry for additional job



				income)

Retirement/Pension Income

Source

How much does Egas Wahs get from this retirement account or pension? Include amounts received as a distribution from a retirement investment even if Egas Wahs is not retired.

*** Amount:**

$ 0

*** How often does Egas Wahs get this amount?**

Select One

Add Another

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Retirement/Pension Income	NA		
Textbox	Source		No	
Static	How much does [FN][LN] get from this retirement account or pension? Include amounts received as a distribution from a retirement investment even if [FN][LN] is not retired.	NA		
Text Box	Amount:	Numeric	Yes	
Drop Down	How often does [FN][LN] get this amount?	User need to choose one value • One time Only		Default to "Select One" and make the user select from the

		• Weekly • Every two weeks • Twice a month • Monthly • Yearly		list of values provided
Dropdown	Which month did FullLegalName earn this income?	Select calendar month	Yes	Only shown if "one time only" is selected
Button	Add Another			Will add another entry of the same type (eg, if you chose job income and clicked "add another," it will add another entry for additional job income)

Capital Gains Income

How much does Egas Wahs expect to get from net capital gains (the profit after subtracting capital losses) this month?

*** Amount:**

$ 0

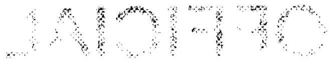
How much does Egas Wahs expect to get from net capital gains (the profit after subtracting capital losses) this year?

*** Amount:**

$

Add Another

Static	Capital Gains Income	NA		
Static	How much does [FN][LN] get from net capital gains(the profit after subtracting capital losses) this month?	NA		



Text Box	Amount	Numeric	Yes	
Static	How much does [FN][LN] expect to get from net capital gains (the profit after subtracting capital losses) this year?	NA		
Text Box	Amount	Numeric	Yes	
Button	Add Another			Will add another entry of the same type (eg, if you chose job income and clicked "add another," it will add another entry for additional job income)

Interest, Dividends, or Other Investment Income

How much does Egas Wahs get from investment income, like interest and dividends?
*** Amount:**

$ 0

*** How often does Egas Wahs get this amount?**

Select One

Add Another

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Interest/Dividends/Other Investment Income	NA		

Static	How much does [FN][LN] get from investment income, like interest and dividends?	NA		
Text Box	Amount:	Numeric	Yes	
Drop Down	How often does [FN][LN] get this amount?	User need to choose one value • One time Only • Weekly • Quarterly • Monthly • Yearly		Default to "Select One" and make the user select from the list of values provided
Dropdown	Which month did FullLegalName earn this income?	Select calendar month	Yes	Only shown if "one time only" is selected
Button	Add Another			Will add another entry of the same type (eg, if you chose job income and clicked "add another," it will add another entry for additional job income)

Rental or Royalty Income

How much does Egas Wahs get from net rental income (the profit after subtracting costs)?

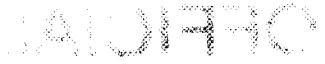
*** Amount:**

$ 0

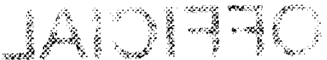
*** How often does Egas Wahs get this amount?**

Select One

Add Another



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Rental or Royalty Income	NA		
Static	How much does [FN][LN] get from net rental income(the profit after subtracting costs)? You can find this on line 17 of Form 1040.	NA		
Text Box	Amount:	Numeric		
Drop Down	How often does [FN][LN] get this amount?	User need to choose one value • One time Only • Weekly • Every two weeks • Twice a month • Monthly • Yearly		Default to "Select One" and make the user select from the list of values provided
Dropdown	Which month did FullLegalName earn this income?	Select calendar month	Yes	Only shown if "one time only" is selected
Button	Add Another			Will add another entry of the same type (eg, if you chose job income and clicked "add another," it will add another entry for additional job income)



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Farming or Fishing Income

How much does Egas Wahs get from net farming or fishing income (the profit after subtracting costs)?

*** Amount:**

$ 0

*** How often does Egas Wahs get this amount?**

Select One

Add Another

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Farming or Fishing Income	NA		
Static	How much does [FN][LN] get from net farming or fishing income (the profit after subtracting costs)?	NA		
Text Box	Amount:	Numeric		
Drop Down	How often does [FN][LN] get this amount?	User need to choose one value • One time Only • Weekly • Every two weeks • Twice a month • Monthly • Yearly		Default to "Select One" and make the user select from the list of values provided
Dropdown	Which month did FullLegalName earn this income?	Select calendar month	Yes	Only shown if "one time only" is selected
Button	Add Another			Will add another entry of the same type (eg, if you chose job income and clicked "add another," it will

				add another entry for additional job income)

Alimony Received

How much does Egas Wahs get from Alimony?

*** Amount:**

$ 0

*** How often does Egas Wahs get this amount?**

Select One

Add Another

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Alimony Received	NA		
Static	How much does [FN][LN] get from Alimony? You can find this on line 11 of Form 1040.	Na		
Text Box	Amount:	Numeric		
Drop Down	How often does [FN][LN] get this amount?	User need to choose one value • One time Only • Weekly • Every two weeks • Twice a month • Monthly • Yearly		Default to "Select One" and make the user select from the list of values provided
Dropdown	Which month did FullLegalName earn this	Select calendar month	Yes	Only shown if "one time only"

	income?			is selected
Button	Add Another			Will add another entry of the same type (eg, if you chose job income and clicked "add another," it will add another entry for additional job income)

Other Income

*** Which other type of income does Egas Wahs get?**

- [x] Canceled Debts
- [x] Court Awards
- [x] Jury Duty Pay
- [x] Other

You do not need to tell us about child support, Veteran's payments, Supplemental Security Income (SSI).

What other type of income does Egas Wahs have?

[ ]

How much does Egas Wahs get?

*** Amount:**

$ 0

*** How often does Egas Wahs get this amount?**

One time only

*** Which month did Egas Wahs earn this income?**

January

[Add Another]

[Back] [Save and Continue]

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Other Income	NA		
Static	Which other type of income does [FN][LN] get?	User can check boxes based on the option applicable. Check Boxes ☐ Canceled Debts ☐ Court Awards ☐ Jury Duty Pay ☐ Other		
Static	You do not need to tell us about child support, Veteran's payments, Supplemental Security Income (SSI).	NA		
Check Box	What other type of other income does [FN][LN] have?	User can input income type as applicable.		Only shown if "other" is selected above
Static	How much does [FN][LN] get?	NA		Only shown if "other" is selected above
Text Box	Amount:	User need to Input Amount. Numeric		
Drop Down	How often does [FN][LN] get this amount?	User need to choose one value • One time Only • Weekly • Every two weeks • Twice a month • Monthly • Yearly		Default to "Select One" and make the user select from the list of values provided
Dropdown	Which month did FullLegalName earn this	Select calendar month	Yes	Only shown if "one time only" is selected

	income?			
Button	Add Another			Will add another entry of the same type (eg, if you chose job income and clicked "add another," it will add another entry for additional job income)
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

Current Income Summary

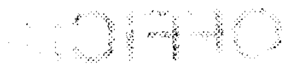
Egas Wahs's Current Income Details

More information on Income Sources

Total Income	$2250 /Monthly
Job: ABC	$2250 /Monthly

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	FirstName LastName's Current Income	NA		



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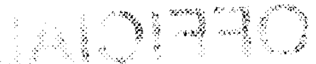
	Details			
Static	Total Income	It will show Total Income/Month.		Should display what was entered on previous screen
Static	Job: FirstName LastName	It will show income/month from the Job		Should display what was entered on previous screen
Static	Self-Employment	It will show income/month from Self Employment		Should display what was entered on previous screen
Static	Social Security Benefits	It will show income/month from Social Security Benefits		Should display what was entered on previous screen
Static	Unemployment	It will show income/month from Unemployment		Should display what was entered on previous screen
Static	Retirement	It will show income/month from Retirement		Should display what was entered on previous screen
Static	Capital Gains	It will show income/month from Capital Gains		Should display what was entered on previous screen
Static	Interest/Dividends/Other Investment Income	It will show income/month from the Investments		Should display what was entered on previous screen
Static	Rental or Royalty Income	It will show income/month from the Rental or Royalty.		Should display what was entered on previous screen
Static	Farming or Fishing Income	It will show income/month from Farming and Fishing		Should display what was entered on previous screen
Static	Alimony Received	It will show income/month from Alimony		Should display what was entered on previous



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				screen
Static	Other Income	It will show income/month from the other sources		Should display what was entered on previous screen

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1.4 Income Deductions

Egas Wahs's Current Income Details

More information on Income Sources

Mandatory Field

Income Deductions

*** If Egas Wahs pays for certain things that can be deducted on an income tax return, telling us about them could make the cost of health insurance a little lower. What does Egas Wahs pay for? (Check all that apply.)**

☐ **None** ☑ **Alimony Paid** ☑ **Student loan interest paid** ☑ **Other deductions**

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. You shouldn't include a cost that you already considered in your answer to net self-employment, net rental or royalty income, and net farming or fishing income.

Other tax deductions may include 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.

***What other deductions do you have?**

***Amount :**

$ 0

***How often:**

Select One

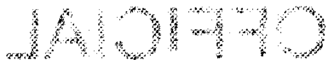
*** Is Egas Wahs's income steady from month to month?**

○ Yes ◉ No

***Enter the expected average monthly income for Egas Wahs.**

$

Back | Save and Continue



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Income Deductions	NA		Needs to be shown to all people on the application (applying and non-applying)
Static	If [FN][LN] pays for certain things that can be deducted on an income tax return, telling us about them could make the cost of health insurance a little lower. What does FullLegalName pay for? (Check all that apply.) *	User needs to select from following check boxes ☐ None ☐ Alimony paid ☐ Student loan interest paid ☐ Other deductions	Y	

Static	If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. You shouldn't include a cost that you already considered in your answer to net self-employment, net rental or royalty income, and net farming or fishing income. Other tax deductions may include 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.	This text appears when user check Other deductions box		
Text Box	What other deductions do you have?	This text appears when user check Other deductions box User can input any other deduction if she wants to		

Text Box	Amount:	User will input amount in this text box		
Drop Down	How Often:	User need to choose one value • One time Only • Weekly • Every two weeks • Twice a month • Monthly • Yearly • Quarterly • Twice a Year • Every other month		Default to "Select One" and make the user select from the list of values provided
Dropdown	Which month did FullLegalName pay this amount?	Select calendar month	Yes	Only shown if "one time only" is selected
Radio Button	Is [FN][LN]'S income steady from month to month?	User have to select either Yes No	Yes	
Textbox	Enter the expected average monthly income for FullLegalName		Yes	
Text	Dollar Amount	Numerical	Yes	
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

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1.5 Income Discrepancies – Additional Income Questions

! Your information contains 1 errors

Federal services are unable to verify your income at this time. You can continue with your enrollment through a manual verification process. You may be asked to provide supporting documentation. If you have questions, please contact Customer Service at 1-877-MA-ENROLL (1-877-623-6765), TTY: 1-877-623-7773 during business hours.

Income Discrepancies - Additional Income Questions

More information on Income Sources

During the last 12 months, which of these reasons apply for why the amount reported for Egas Wahs's job income is lower than what our electronic records show? (Select all that apply.)

- [ ] Stopped working at a job
- [ ] Hours changed at a job
- [ ] Wage or salary changed at a job
- [ ] Change in employment
- [ ] Marriage, legal separation, or divorce
- [ ] Death in family

Is there another explanation for why the amount reported for Egas Wahs's job income is lower than what our electronic records show?

Back | Continue with manual Verification

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Income Discrepancies – Additional Income Questions	NA	No	

Static	During the last 12 months, which of these reasons apply for why the amount reported for [FN] [LN]'s job income is lower than what our electronic records show? (Select all that apply.)	Check the boxes that apply. ☐ Stopped working at a job ☐ Hours changed at a job ☐ Wage or salary changed at a job ☐ Change in employment ☐ Marriage, legal separation, or divorce ☐ Death in family		
Text Box	Is there another explanation for why the amount reported for [FN][LN]'S job income is lower than what our electronic records show?	User can input explanation for income difference	N	
Button	Back	User can click on this button to go to previous screen		
Button	Save and Continue	User can click on this button to go to next screen		

1.1 Annual Income

Annual Income

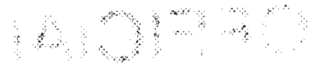
More information on Income Sources

* Mandatory Field

***Based on what you told us, if the income of Egas Wahs is steady month to month, then it is about $27000 per year. Is this how much you think Egas Wahs will get in 2015?**

◯ Yes ◯ No

Back | Save and Continue



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Annual Income

More information on Income Sources

** Mandatory Field*

***Based on what you told us, if the income of Egas Wahs is steady month to month, then it is about $27000 per year. Is this how much you think Egas Wahs will get in 2015?**

Yes **No**

Based on what you know today, how much do you think Egas Wahs will make in 2015?

List income below according to who receives it (e.g. job income). If there is any income you receive together (e.g. sale of shared property), only list it once.

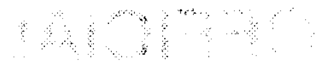
*** Total Yearly Amount**

$

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	**Annual Income**	NA		
	Based on what you told us, if the income for {Full Legal Name} is steady month-to-month, then it is about $ {x} per year. Is this how much you think {Full Legal Name} will get in 2015?			The year will need to be updated to 2016 for OE 2016.
Button	Yes No	If "yes" - need to calculate the annual income for the following year based on what was entered in the current year If "no" – need to answer next question		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Dynamic	Based on what you know today, how much do you think {Full Legal Name} will make in 2015?	Only shown if "no" is selected to the question above This is asked separately of each person on the application IRS Verifies the individual income		Needs to be updated to 2016 for OE2016
Static	**List income below according to who receives it (e.g., job income). If there is any income you receive together (e.g., sale of shared property), only list it once.**	NA		
Textbox or Checkbox	Total Yearly Amount $ {xxxxxxxxx.xx} OR I don't know	Dollar amount Numerical values OR Checkbox		
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		



1.2 Income Summary

Income Summary

More information on Income Sources

Egas Wahs

Income Type: Job: $27000/ Yearly

Projected Yearly Income: $29000.00

Self Attested Total amount received monthly: $2250.00

Child Wahs

Current Yearly Income $0.00

Current Monthly Income $0.00

Projected Yearly Income: $0.00

Self Attested Total amount received monthly: $0.00

Spouse Wahs

Income Type: Self-Employment: $1000/ Monthly

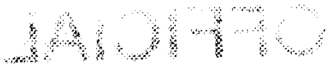
Projected Yearly Income: $12000.00

Self Attested Total amount received monthly: $1000.00

Edit Income

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Income Summary	NA		
Static	FirstName LastName Income Type: Projected Yearly Income: Self Attested Total Amount Received Monthly:	NA		Should display information previously entered



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Button	Edit Income			Takes the user back to the beginning of the Income section
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

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1 Additional Questions

Additional Questions

In this section, we will ask a few more questions about you and your family to make sure we are matching you accurately with the best available financial assistance programs.

All fields on this Additional Questions section are required unless otherwise indicated.

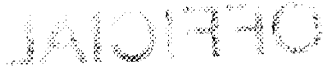
You may need:

- Information about your current health insurance (if you have it)
- Information about any job-related insurance you or your family may be able to get, even if you are not enrolled in it

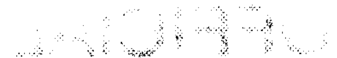
Estimated time for this section:5 Minutes - 10 Minutes

Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Additional Questions	NA		
Static	In this section, we will ask a few more questions about you and your family to make sure we are matching you accurately with the best available financial assistance programs.			
Static	*All fields on the Additional Questions section are required unless otherwise indicated.*			
Static	You may need: • Information about your current health insurance (if you have it) • Information about any job-related insurance you or your family may be able to get, even if you are not enrolled in it			



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Estimated time for this section: 5 Minutes – 10 Minutes			
Submit Button	Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		



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3 Employer Health Coverage Information for FN LN (offered – yes; enrolled – yes; any changes – no)

Employer Health Coverage Information for Egas Wahs

*** Will Egas Wahs be enrolled in a health plan offered by ABC during the time period he/she is applying for coverage?**

◉Yes ○No

*** Date Egas Wahs will be covered by ABC's plan (MM/DD/YYYY):**

☑I don't know

*** Does Egas Wahs expect any changes to ABC's health coverage in 2015?**

○Yes ◉No

What is the name of the lowest-cost individual health plan offered to Egas Wahs? (Note: Only include the individual plan, not the family plan, offered by the employer. Also only list a plan if it meets the "minimum value standard ". If no plans meet the minimum value standard, leave this field blank. However, most plans do meet minimum value.)

Is the lowest-cost individual plan from this employer considered affordable? Note: You only need to answer this question if the employer plans available to you meet the minimum value standard. Do not include family plans offered by the employer when answering this question—only the individual plans. (Click here to learn more about whether a plan meets minimum value OR if the plan is considered affordable, as defined by the Affordable Care Act.)

○ Yes, the lowest cost individual plan is affordable

○ No, the lowest-cost individual plan is not affordable. Or, the employer does not offer any plans that meet the minimum value standard

How much would Egas Wahs pay in premiums to enroll in this plan?
*** Amount:**

$

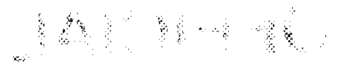
☐I don't know

*** How often would Egas Wahs pay this amount?**
How often:

How often ▾

☐I don't know

Back | Save and Continue



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Employer Health Coverage Information for FN LN	NA		
Radio button	Will <FN LN> be enrolled in a health plan offered by <company name> during the time period he/she is applying for coverage?	Button Selection Yes, No	Yes	
Textbox	Date FN LN will be covered by <company name>'s plan:	Date Selection MM/DD/YYYY Or I don't know	Yes	
Radio button	Does FN LN expect any changes to <company name>'s health coverage in 2015?	Button selection Yes, No	Yes	
Static Text	What is the name of the lowest-cost individual health plan offered to <FN LN>? Note: Only include the individual plan, not the family plan, offered by the employer. Also only list a plan if it meets the "minimum value standard". If no plans meet the minimum value standard, leave this field blank. However, most plans do meet minimum value.	N/A		
Textbox	Health Plan Name	Alphanumeric	No	If health plan name is put in, treat as if the plan meets minimum value
Static Text	Is the lowest-cost individual plan from this employer considered affordable? Note: You only need to answer this	https://www.mahealthconnector.org/start		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	question if the employer plans available to you meet the minimum value standard. Do not include family plans offered by the employer when answering this question—only the individual plans. (**Click here** to learn more about whether a plan meets minimum value OR if the plan is considered affordable, as defined by the Affordable Care Act.			
Checkbox	Yes, the lowest cost individual plan is affordable OR No, the lowest-cost individual plan is not affordable. Or, the employer does not offer any plans that meet the minimum value standard	Yes No	Yes	If health plan name is put in, treat as if the plan meets minimum value If 'yes' is selected: health plan name is left blank, the person should not be eligible for tax credits but may be eligible for MassHealth or unsubsidized Health Connector plans (if meets other criteria) If 'no' is selected: applicant is NOT barred to tax credits (applicant may still be eligible for tax credits if other criteria on the application are met) Further, if someone enters a

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
				plan name, then yes, treat as the plan meeting minimum value. But if they enter nothing, we still need to have an answer to the YES/NO, and those are the questions that really control whether or not there will be a bar to APTC.
Static Text	How much would FN LN pay in premiums to enroll in this plan?	N/A		
Textbox Or Checkbox	Amount Dollar Amount	Numeric OR I don't know		
Static Text	How often would FN LN pay this amount?	N/A		
Dropdown Or Checkbox	How often:	Weekly Every two weeks Twice per month Monthly Yearly Other OR I don't know		If "other" is selected an alphabetical textbox appears for the user to enter more information
Button	Back	Action: Mouse Click		User moves back one page in the

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		Keyboard: Enter Alt text: Back		application
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		User moves forward to the next page in the application

3.1 Employer Health Coverage Information for FN LN (offered – yes; enrolled – yes; any changes – yes)

Employer Health Coverage Information for Egas Wahs

*** Will Egas Wahs be enrolled in a health plan offered by ABC during the time period he/she is applying for coverage?**

◉Yes ○No

*** Date Egas Wahs will be covered by ABC's plan (MM/DD/YYYY):**

☑I don't know

*** Does Egas Wahs expect any changes to ABC's health coverage in 2015?**

◉Yes ○No

*** What does Egas Wahs expect to change in 2015?**

○ ABC will no longer offer health coverage

○ Egas Wahs plans to drop ABC's health coverage

Back Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Employer Health Coverage Information for FN LN	NA		
Radio button	Will FN LN be enrolled in a health plan offered by <company name> in 2015	Button Selection	Yes	

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		Yes, No		
Textbox	Date FN LN will be covered by <company name>'s plan:	Date Selection MM/DD/YYYY Or I don't know	Yes	
Radio button	Does FN LN expect any changes to <company name>'s health coverage in 2015?	Button selection Yes, No	Yes	
Checkbox	What does FN LN expect to change in 2015?	Checkbox – must select one <Company Name> will no longer offer health coverage FN LN plans to drop <company name>'s health coverage	Yes	<Company Name> will no longer offer health coverage: should act the same way as if the person did not have ESI

*** What does Egas Wahs expect to change in 2015?**

ABC will no longer offer health coverage

What's the last day ABC's coverage will be available to Egas Wahs? (MM/DD/YYYY)

I don't know

Egas Wahs plans to drop ABC's health coverage

Back | Save and Continue

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Checkbox	What does FN LN expect to change in 2015?	Checkbox – <Company Name> will no longer offer health coverage FN LN plans to drop <company name>'s health coverage	Yes	<Company Name> will no longer offer health coverage: should act the same way as if the person did not have ESI
Date Or Checkbox	What is the last day <company name>'s coverage will be available to FN LN?	MM/DD/YYYY Or I don't know		
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		User moves back one page in the application
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		User moves forward to the next page in the application

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*** What does Egas Wahs expect to change in 2015?**

◯ **ABC will no longer offer health coverage**

◉ **Egas Wahs plans to drop ABC's health coverage**

What will be Egas Wahs 's last day of coverage through ABC's health plan? (MM/DD/YYYY)

☐ **I don't know**

What is the name of the lowest-cost individual health plan offered to Egas Wahs? (Note: Only include the individual plan, not the family plan, offered by the employer. Also only list a plan if it meets the "minimum value standard ". If no plans meet the minimum value standard, leave this field blank. However, most plans do meet minimum value.)

Is the lowest-cost individual plan from this employer considered affordable? Note: You only need to answer this question if the employer plans available to you meet the minimum value standard. Do not include family plans offered by the employer when answering this question—only the individual plans. (Click here to learn more about whether a plan meets minimum value OR if the plan is considered affordable, as defined by the Affordable Care Act.)

◯ **Yes, the lowest cost individual plan is affordable**

◯ **No, the lowest-cost individual plan is not affordable. Or, the employer does not offer any plans that meet the minimum value standard**

How much would Egas Wahs pay in premiums to enroll in this plan?
*** Amount:**

$

☐ **I don't know**

*** How often would Egas Wahs pay this amount?**
How often:

How often ▾

☐ **I don't know**

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Checkbox	What does FN LN expect to change in 2015?	Checkbox – <Company Name> will no longer offer	Yes	

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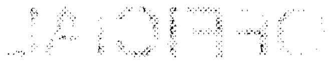
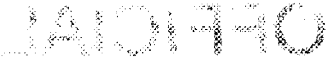
Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		health coverage **FN LN plans to drop <company name>'s health coverage**		
Date Or Checkbox	What will be FN LN's last day of coverage through <company name>'s health plan?	MM/DD/YYYY Or I don't know		
Static Text	What is the name of the lowest-cost individual health plan offered to <FN LN>? Note: Only include the individual plan, not the family plan, offered by the employer. Also only list a plan if it meets the "minimum value standard". If no plans meet the minimum value standard, leave this field blank. However, most plans do meet minimum value.			
Textbox	Health Plan Name	Alphanumeric	No	If health plan name is put in, treat as if the plan meets minimum value
Static Text	Is the lowest-cost individual plan from this employer considered affordable? Note: You only need to answer this question if the employer plans available to you meet the minimum value standard. Do not include family plans offered by the employer when answering this question—only the individual plans. (**Click here** to learn more about whether a plan meets minimum value OR if the plan is considered affordable, as defined by the Affordable Care Act.	https://www.mahealthconnector.org/start		
Checkbox	Yes, the lowest cost individual	Yes	Yes	If health plan name is put in, treat as if the

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	plan is affordable OR No, the lowest-cost individual plan is not affordable. Or, the employer does not offer any plans that meet the minimum value standard	No		plan meets minimum value If 'yes' is selected: health plan name is left blank, the person should not be eligible for tax credits but may be eligible for MassHealth or unsubsidized Health Connector plans (if meets other criteria) If 'no' is selected: applicant is NOT barred to tax credits (applicant may still be eligible for tax credits if other criteria on the application are met) Further, if someone enters a plan name, then yes, treat as the plan meeting minimum value. But if they enter nothing, we still need to have an answer to the YES/NO, and those are the questions that really control whether or not there will be a bar to APTC.
Static Text	How much would FN LN pay in premiums to enroll in this plan?	N/A		
Textbox	Amount:	Numeric OR I don't know	Yes	



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static Text	How often would FN LN pay this amount?	N/A		
Dropdown Or Checkbox	How often:	Weekly Every two weeks Twice per month Monthly Yearly Other OR I don't know		If "other" is selected an alphabetical textbox appears for the user to enter more information
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		User moves back one page in the application
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		User moves forward to the next page in the application



Health Insurance Information (Offered -Yes)

HEALTH CONNECTOR

Manage Customer | Create Customer Profile | My Account | Learn More | Get Assistance

Sign Out

Application Year 2015

- ✔ Start Your Application
- ✔ Family & Household
- ✔ Income
- Review & Sign

Health Insurance Information for Egas Wahs

More information on Employer Sponsored Insurance

*All fields are required

*Is Egas Wahs offered health insurance coverage through a job (even if it's from another person's job, like a spouse)?

◉ Yes ○ No

* Date Egas Wahs could start coverage (MM/DD/YYYY):

☑ I don't know

Tell us which employers offer health coverage:

*Employer Name: ABC

Federal Tax ID:

Employer Address

*Address 1: 1 main street

Address 2:

*City: boston | *Zip: 02108 | County: SUFFOLK | *State: MA

*Employer Phone Number: (888) 888-8888 | Ext: | Phone Type: Work

Who can we contact at this employer? If you are not sure, ask your employer (optional).

Phone Number: | Ext: | Phone Type: Home

Email Address:

+ Add Another

Back

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Is FirstName LastName offered health insurance coverage through a job (even if it's from another person's job, like a spouse)?	Button Selection Yes, No		
Date	Date FirstName LastName could start coverage (MM/DD/YYYY):	MM/DD/YYYY I don't know	Yes	If "I don't know" is selected, the user does not have to enter a date
Static	Tell us which employers offer health coverage:			
Textbox	Employer Name	Alphanumeric Entry	Yes	
Textbox	Federal Tax ID	Numeric Entry	No	9-digit number
Static	Employer Address:			
Textbox	Address 1	Alphanumeric Entry	Yes	
Textbox	Address 2	Alphanumeric Entry	No	
Textbox	City	Alphabetic	Yes	
Textbox	Zip	Numeric	Yes	
Dropdown	County	Alphabetic Entry Choose from dropdown list	Yes	
Textbox	State	Alphabetic	Yes	
Textbox	Employer Phone Number	Numeric Entry	Yes	
Dropdown	Phone Type	Selection Choose from	Yes	

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		dropdown list: Home, Work , Cell		
Static	Who can we contact at this employer? If you are not sure, ask your employer (optional).	N/A		
Textbox	Employer Contact Name	Alphabetic Entry	No	
Textbox	Phone Number; Extension	Numeric Entry	Yes	
Dropdown	Phone Type	Selection Choose from dropdown list: Home, Work , Cell	Yes	
Static	Email	Label		
Textbox	Email Address	Alphanumeric Entry	N	
Button	Add Another			Add another
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

1.1 Health Insurance Information (Offered - No)

Health Insurance Information for Egas Wahs

More information on Employer Sponsored Insurance

*All fields are required

***Is Egas Wahs offered health insurance coverage through a job (even if it's from another person's job, like a spouse)?**

○ Yes ◉ No

***Will Egas Wahs be enrolled in health coverage from any of the following in 2015?**

○ COBRA
○ Retiree Health Plan
○ Veterans Health Program
○ None of the above

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Health Insurance for FirstName LastName	NA		
Radio button	Is FirstName LastName offered health insurance coverage through a job (even if it's from another person's job, like a spouse)?	Button Selection Yes, No		
Radio button	Will FirstName LastName be enrolled in health coverage from any of the following in 2015?	Button Selection Provide choices COBRA, Retiree Health Plan, Veterans Health Insurance Plan, None of the above	Yes	Do not modify this question at all

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

2 Health Insurance Information (Offered through employer – NO; If user selects COBRA or Retiree Health Plan)

***Will Egas Wahs be enrolled in health coverage from any of the following in 2015?**

- ◯ COBRA
- ◉ Retiree Health Plan
- ◯ Veterans Health Program
- ◯ None of the above

Tell us which employers offer health coverage:

***Employer Name** [ ] **Federal Tax ID** [ ]

Employer Address

***Address 1** [ ]

Address 2 [ ]

***City** [ ] ***Zip** [ ] **County** [▼] ***State** [ ]

***Employer Phone Number** [ ] **Ext** [ ] **Phone Type** [Work ▼]

Who can we contact at this employer? If you are not sure, ask your employer (optional). [ ]

Phone Number [ ] **Ext** [ ] **Phone Type** [Home ▼]

Email Address: [ ]

+ Add Another

Back | Save and Continue

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio button	Will FirstName LastName be enrolled in health coverage from any of the following in 2015?	Button Selection Provide choices COBRA or Retiree Health Plan is selected	Yes	Do not modify this question at all
Static Text	Tell us which employers offer health coverage	N/A		
Textbox	Employer Name	Alphabetic Entry	Yes	
Textbox	Federal Tax ID	Alphanumeric entry	Yes	
Textbox	Employer Address: Address 1	Alphanumeric entry	Yes	
Textbox	Employer Address: Address 2	Alphanumeric entry	No	
Textbox	City	Alphabetical entry	Yes	
Textbox	Zip	Numeric	Yes	
Dropdown	County (Auto populated)	Choose one	Yes	
Textbox	State	Alphabetical entry	Yes	
Textbox	Employer phone number; Extension	Numeric entry	Yes	
Dropdown	Employer Phone Type	Select an option Default to	Yes	

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		work		
Static Text	Who can we contact at this employer? If you are not sure, ask your employer (optional)	N/A		
Textbox	Employer Contact Name	Alphabetical entry	No	
Textbox	Phone Number; Extension	Numeric entry	Yes	
Dropdown	Phone Type	Select an option Default to Work	Yes	
Textbox	Email address	Alphanumeric entry	No	
Button	+ Add Another	Click		Adds another employer who offers health coverage
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		Moves one page back in the application
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		Moves one page forward in the application

1 Health Insurance Information for an Individual

Health Insurance Information for Egas Wahs

More information on Employer Sponsored Insurance

*All fields are required

***Is Egas Wahs offered health insurance coverage through a job (even if it's from another person's job, like a spouse)?**

◯ Yes ◯ No

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Health Insurance Information for FirstName LastName	NA		
Radio Button	Is FirstName LastName offered health insurance coverage through a job (even if it's from another person's job, like a spouse)?	Button Selection Yes, No	Y	
Submit Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		
Submit Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

1.1 Other Insurance Information

Other Insurance for Egas Wahs

***Is Egas Wahs eligible for health coverage from any of the following? Select even if Egas Wahs is not currently enrolled.**

☑ Medicare
*Coverage Start Date (MM/DD/YYYY): ____________
Coverage End Date (MM/DD/YYYY): ____________

☑ TRICARE Federal Employees Health Benefit Program
*Coverage Start Date (MM/DD/YYYY): ____________
Coverage End Date (MM/DD/YYYY): ____________

☑ Peace Corps
*Coverage Start Date (MM/DD/YYYY): ____________
Coverage End Date (MM/DD/YYYY): ____________

☑ VA Healthcare Program
*Coverage Start Date (MM/DD/YYYY): ____________
Coverage End Date (MM/DD/YYYY): ____________

☐ None of the above

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Other Insurance for FirstName LastName	NA		
Static	Is FirstName LastName eligible for health coverage from any of the following? Select even if FirstName LastName is not currently enrolled.			
Checkbox	Medicare	Checkbox Selection		
Textbox	Coverage Start Date:	Date Format	Yes	

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		Numeric		
Textbox	Coverage End Date:	Date Format Numeric		
Checkbox	TRICARE Federal Employees Health Benefit Program	Checkbox Selection		
Textbox	Coverage Start Date:	Date Format Numeric	Yes	
Textbox	Coverage End Date:	Date Format Numeric		
Checkbox	Peace Corps	Checkbox Selection		
Textbox	Coverage Start Date:	Date Format Numeric	Yes	
Textbox	Coverage End Date	Date Format Numeric		
Checkbox	VA Healthcare Program	Checkbox Selection		
Textbox	Coverage Start Date:	Date Format Numeric	Yes	
Textbox	Coverage End Date:	Date Format Numeric		
Checkbox	None of the above	Checkbox Selection		
Button	Back	Action: Mouse Click Keyboard: Enter		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		Alt text: Back		
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

1 Tax Filer & Other Additional Questions

Tax Filer & Other Additional Questions for Egas Wahs

***Egas Wahs indicated that he is the claiming tax filer for Child Wahs; however a Social Security number (SSN) hasn't been entered for Egas Wahs. Providing a SSN may help get a better idea of how much help you can get in paying for health insurance coverage. The SSN you provide won't be used to verify citizenship or immigration status. Does Egas Wahs want to provide one now?**

◉ **Yes** ○ **No**

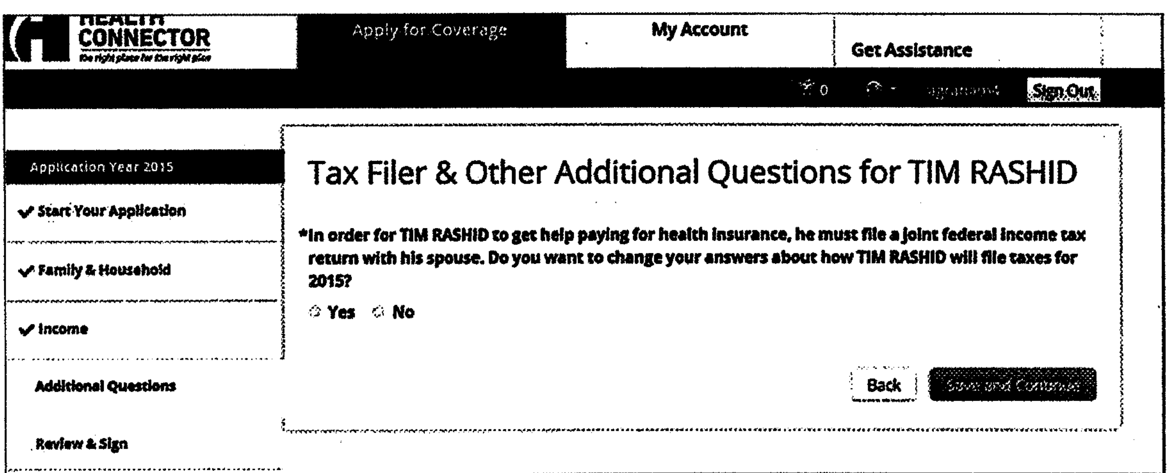
Social Security Number

[ ]

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Tax Filer & Other Additional Questions for FirstName LastName	NA		
Radio Button	FirstName LastName indicated that <she/he> is the claiming tax filer for DependentFirstName DependentLastName; however, a Social Security number (SSN) hasn't been entered for FirstName LastName. Providing a SSN may help get a better idea of how much help you can get in paying for health insurance coverage. The SSN you provide won't be used to verify citizenship or immigration status. Does FirstName LastName want to provide one now?	Button Selection Yes, No		
Text Field	Social Security Number	Numeric		Only if person selects "yes"

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	Text box 1: 3 numbers Text box 2: 2 numbers Text box 3: 4 numbers			above
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		
Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Dynamic	In order for <FULL LEGAL NAME> to get help paying for health insurance, <he/she> must file a joint federal income tax return with <his/her> spouse. Do you want to change your	Only show this question if the applicant is married filing separately and NOT a victim of domestic violence or an abandoned spouse	Yes	If the applicant selects "yes" (and presses "Save and Continue") then take the user to the "Tell us about your

	answers about how <FULL LEGAL NAME> will file taxes for 2015?			household" page If the applicant selects "no" (and presses "Save and Continue") then let the applicant move forward in the application
Button	Back	Takes the user to the previous page		
Button	*Save & Continue*	See validation of the dynamic text above.		

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1 MassHealth Specific Questions

MassHealth Specific Questions for Egas Wahs

**Mandatory Field*

***Does Egas Wahs have health insurance now?**

◉ Yes ○ No

***Which health insurance program does Egas Wahs have now?**

○ MassHealth
○ Medicare
○ Insurance through an employer
○ Veterans or TRICARE
◉ Other

***What is the health plan called?**

[ ]

***What is the policy number or member ID?**

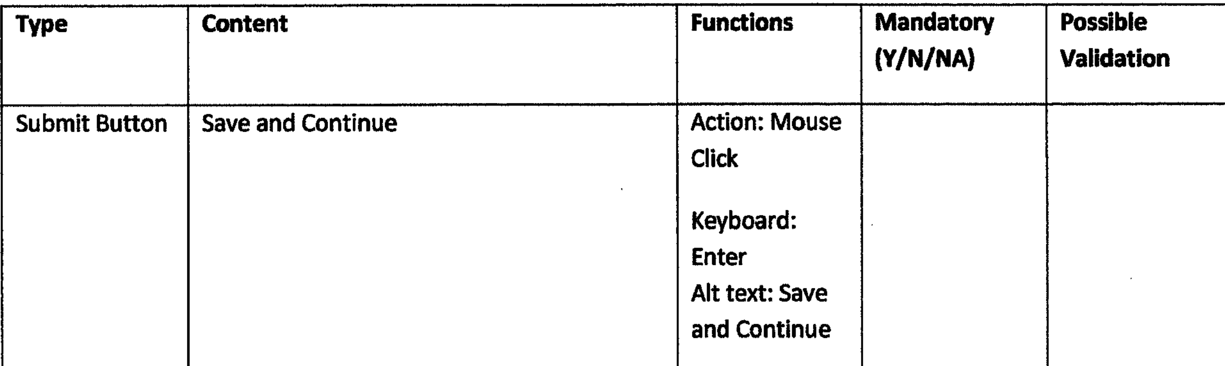
[ ]

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	MassHealth Specific Questions for FirstName LastName	NA		
Radio Button	Does FirstName LastName have health insurance now?	Button Selection Yes, No		
Radio Button	What health insurance program does FirstName LastName have now?	Button Selection Provide choices: MassHealth, Medicare, Insurance through an employer,		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		Veterans or TRICARE, Other		
Radio Button	Medicare: What is the policy number or member ID?	Numerical		
Radio Button	Insurance through an employer: What is the health plan called? What is the policy number or member ID?	Text Numerical		
Radio Button	Veterans or TRICARE: What is the policy number or member ID?	Numerical		
Radio Button	Other: What is the health plan called? What is the policy number or member ID?	Text Numerical		

*** Is Egas Wahs offered the Massachusetts state employee health benefit plan through a job, or a family member's job?**
◉ Yes ○ No

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Radio Button	Is FirstName LastName offered the Massachusetts state employee health benefit plan through a job, or a family member's job?	Button Selection Yes, No		
Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Submit Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

2 MassHealth Specific Questions (for American Indian/Alaska Native)

MassHealth Specific Questions for Child Wahs

Mandatory Field

***Does Child Wahs have health insurance now?**

◯ Yes ◯ No

***Has Child Wahs ever gotten a health 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

Is Child Wahs eligible to get health services from Indian Health Services or a Tribal Health Organization?

◯ Yes ◉ No

*** Is Child Wahs offered the Massachusetts state employee health benefit plan through a job, or a family member's job?**

◯ Yes ◯ No

Back | Save and Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	MassHealth Specific Questions for FirstName LastName	NA		
Radio Button	Does FirstName LastName have health insurance now?	Yes No	Yes	
Radio Button	Has FirstName LastName ever gotten a health 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	Yes	
Radio Button	Is FirstName LastName eligible to get health services from Indian Health Services or a Tribal Health Organization?	Yes No	Yes	Shown if answered "no" to the above question
Radio Button	Is FirstName LastName offered the Massachusetts state employee health benefit plan through a job, or a family member's job?	Button Selection Yes, No	Yes	
Submit Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

1 Additional Questions Summary

Additional Questions Summary

Egas Wahs (Head of Household)

Has MEC: No
Has option to enroll in employer health coverage: No

Child Wahs

Has MEC: No
Has option to enroll in employer health coverage: No

Back Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Additional Questions Summary	NA		
Dynamic Text	FirstName LastName (Head of Household)	Name of Head of Household		
Dynamic Text	Has MEC:	Dynamic text Display: Yes, **No**		
Dynamic Text	Has option to enroll in employer health coverage:	Dynamic text Display: Yes, No		
Dynamic Text	FirstName LastName	Name of Spouse or Dependent		
Dynamic Text	Has MEC:	Dynamic text Display: Yes, No		

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Dynamic Text	Has option to enroll in employer health coverage:	Dynamic text Display: Yes, No		
Dynamic Text	FirstName LastName	Name of Dependent 1		
Dynamic Text	Has MEC:	Dynamic text Display: Yes, No		
Dynamic Text	Has option to enroll in employer health coverage:	Dynamic text Display: Yes, No		
Submit Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		
Submit Button	Save and Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

1 Review & Sign

Review & Sign

Take a few minutes to review the information you gave us. This is your chance to go back and make changes before you submit your final application.

All fields on this Review & Sign section are required unless otherwise indicated.

Estimated time for this section: 5 Minutes - 10 Minutes

Call Customer Service at 1-877-MA-ENROLL (1-877-623-6765), TTY 1-877-623-7773 for assistance. Support is available in all languages.

Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Review & Sign	NA		
Static	Take a few minutes to review the information you gave us. This is your chance to go back and make changes before you submit your final application.	NA		
Static	*All fields on this Review & Sign section are required unless otherwise indicated.*	NA		
Static	Estimated time for this section: 5 Minutes – 10 Minutes	NA		
Submit Button	Continue	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

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2 Review Application

Review Application

Application Summary

You can review your application information below. If you have any changes in your household, such as in your income, tax filing status, pregnancy status, or disability status, please make those changes in your application.

Contact Information

Egas Wahs

Address: 1 Main Street, Apt 6, Boston, MA, 02108
Email:
Phone: (888) 888-8888 - CELL

Family & Household

Tax Filing Status

Family Income

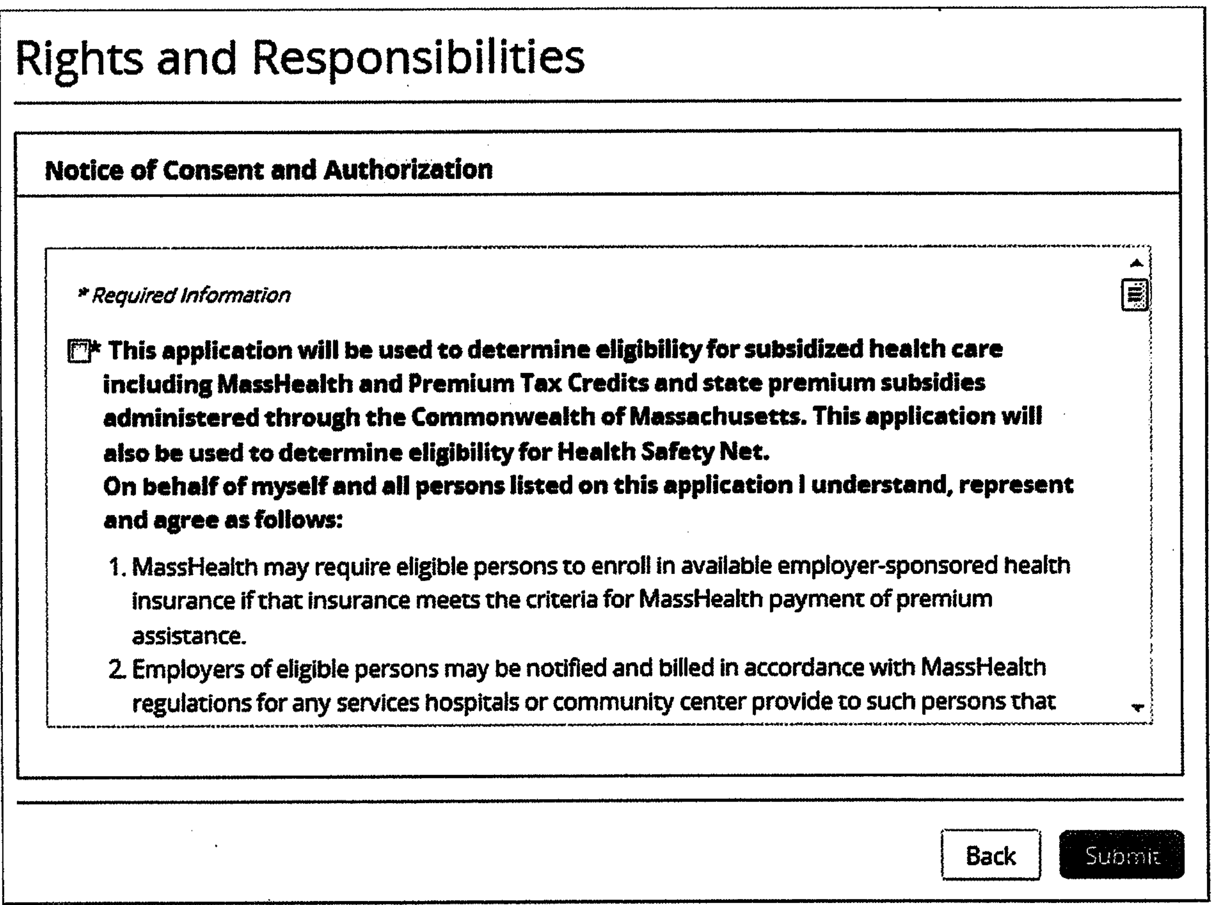
Additional Information

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Review Application		n/a	
Static	Application Summary		n/a	
Static	You can review your application information below. If you have any changes in your household, such as in your income, tax filing status, pregnancy status, or disability status, please make		NA	

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	those changes in your application.			
Static Category	Contact Information Family & Household Tax Filing Status Family Income Additional Information		NA	
Button	+/-	Expand or Minimize the Specified Category	NA	
Button	EDIT	Dynamically appears once a category has been expanded. Clicking the EDIT button will take the user to the corresponding RAC page on the 2015 application	No	
Static	Application Source *	This section is for BO and CSR users only Only visible to back office and CSR user roles	Yes	
Checkbox	This is a paper application	This section is for BO and CSR users only Only visible to back office and CSR user roles	No	
Date	Received Date	This section is for BO and CSR users only Only visible to back office and CSR user roles Appears if 'This is a paper application' is checked by BO or CSR user	Yes	
Checkbox	This is a phone application	This section is for BO and CSR users only Only visible to back office	No	

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		and CSR user roles		
Button	Back	Returns the user to the previous screen	Yes	
Button	Continue	Brings the user to the 'Review and Sign' screen	Yes	

3 Rights and Responsibilities (for applicants applying for subsidies)



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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Rights and Responsibilities	NA		
Static	Read and check the box next to each statement if you agree.	NA		
Checkbox	This application will be used to determine eligibility for subsidized health care including MassHealth and Premium Tax Credits and state premium subsidies administered through the Commonwealth of Massachusetts. This application will also be used to determine eligibility for Health Safety Net. On behalf of myself and all persons listed on this application I understand, represent and agree as follows:	Checkbox Selection		

1. MassHealth may require eligible persons to enroll in available employer-sponsored health insurance if that insurance meets the criteria for MassHealth payment of premium assistance.

2. Employers of eligible persons may be notified and billed in accordance with MassHealth regulations for any services hospitals or community center provide to such persons that are paid for by the Health Safety Net.

3. I may have to pay a premium for health coverage for myself and others on this application. Failure to pay any premium due may result in the State deducting the amount owed from the tax refunds of responsible persons. If I am a certain American Indian or Alaskan Native, I may not have to pay premiums for MassHealth.

4. MassHealth has the right to pursue and get money from third parties who may be obligated to pay for health services provided to eligible persons enrolled in MassHealth programs. Such third parties may include other health insurers, spouses 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 an absent parent unless they believe and tell MassHealth that cooperation will harm the children or the parent or guardian.

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation

6. Eligible persons who are injured in an accident, or 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 lawsuit filed because of an accident or injury.

8. The status of this application may be shared with a hospital, community health center, other medical provider or federal or state agencies when necessary for treatment, payment, operations or the administration of the programs listed above.

9. To the extent permitted by law, MassHealth may place a lien against any real estate owned by eligible persons or in which eligible persons have a legal interest. If MassHealth puts a lien against such property and it is sold, money from the sale of that property may be used to repay MassHealth for medical services provided.

10. To the extent permitted by law, for any eligible person age 55 or older, or 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.

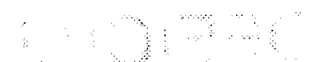
11. Eligible persons must tell the health care program(s) in which they enroll about any changes in their or their family's income or employment, family size, health-insurance coverage, health-insurance premiums, and immigration status, or about changes in any other information on this application and any supplements to it within 10 calendar days of learning of the change. Eligible persons who enroll through mahealthconnector.org 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 such 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 such persons. This includes, but is not limited to, information about policies, premiums, co-insurance, deductibles, and covered benefits that are, may be, or should have been available to such persons or members of their household.

13. MassHealth, the Massachusetts Health Connector and the Health Safety Net may get records or data about persons listed on this application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Revenue, and the Registry of Motor Vehicles, as well as private data sources, 1) to prove any information given on this application and any supplements, or other information given once a person becomes a member, 2) to document medical services claimed or provided to such persons, and 3) to support continued eligibility.

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
14. In connection with the eligibility and enrollment process, MassHealth, the Massachusetts Health Connector, and the Health Safety Net may send notices that contain personal information about persons listed on this application to other persons on this application, or otherwise communicate such information to such persons. 15. Under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by going to **www.hhs.gov/ocr/office/file**.				
Checkbox	To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Massachusetts Health Connector to use income data, including information from tax returns for the next three coverage years. The Massachusetts Health Connector will send me a notice and let me make changes. I understand that if I am eligible for an Advance Premium Tax Credit (APTC) and/or Reduced Co-pays and Deductibles these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or Reduced Co-pays and Deductibles may impact my tax liability for this year. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.	Checkbox Selection		
Checkbox	No one applying for health insurance on this application is in prison or in jail.	Checkbox (if checked, "Who is in prison…?" will be hidden)		
Tooltip	In prison or in jail applies to an individual under the supervision of the criminal justice system, who has been convicted of a crime, and is housed in a jail, prison or other penal institution. The individual is generally known as an inmate or offender. Specific examples include: an individual who is serving time in a jail or prison and an individual who is housed in a community corrections center or "half-way house."	Action: Show on Mouseover; Hide on Mouse Off Keyboard: Tab		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Checkbox	Who is in prison or in jail? [List FirstName LastName for each household member]	Checkbox Selection Names of applicants associated with household		Ensure Names are correct
Radio Button	Is this person awaiting trial?	If someone in the question above is selected. Yes No		
Checkbox	You agree to the following statements: 1. You have read or have had read to me the information on this application, including any supplements and instruction pages, and understand that the MassHealth Member Booklet contains important information and is available to you at http://www.mass.gov/eohhs/docs/masshealth/appforms/member-booklet.pdf; 2. You have permission to submit this application for all adults and all minor children listed on this application, according to the statements on the Notice of Consent and Authorization page at the beginning of this application, and as allowed by any legal documents you have submitted with this application; 3. You understand your rights and responsibilities and the rights and	Checkbox Selection Link: http://www.mass.gov/eohhs/docs/masshealth/appforms/member-booklet.pdf Link: Terms of Use https://www.mahealthconnector.org/site-polices/terms-of-use/		



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	responsibilities of all persons for whom you are submitting this application, as explained on the Rights and Responsibilities page; 4. You have or will tell such persons about such rights and responsibilities and the other individuals for whom you are signing also understand their rights and responsibilities; 5. You understand and agree that the Health Connector, MassHealth, and the Health Safety Net will treat electronic signatures and faxed signature(s) or copies of signatures with the same force and effect as an original signature(s); 6. The information you have supplied is correct and complete to the best of your knowledge about yourself and other members of your household; and 7. You may be subject to penalties under federal law if you intentionally provide false or untrue information.			
Static	By signing in this box, I hereby certify under the pains and penalties of perjury that the submissions I have made in this Application are true and complete to the best of my knowledge and I agree to accept and comply with the above Rights and Responsibilities.			
Textbox	Electronic Signature	Alphabetic		
Static	Voter Registration			
Static	If you are not registered to vote where you live now and you are eligible to register to vote would you like to apply to	Yes	Required if requesting financial	

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	register to vote today?	No	assistance and 1) Submitting a new application 2) Renewing coverage 3) Reporting a change in address	
Static	Please check "No" if you do not want to register to vote today for any reason, including that you are already registered to vote at your current address.			
Static	Your decision whether or not to register to vote has no effect on your getting health coverage.	NA		
Static	The forms to register to vote are found here:	NA		
Static	Massachusetts Mail-in Voter Registration form (PDF) – English	Open URL in a new page: http://www.sec.state.ma.us/ele/elepdf/2013-Voter-reg-mail-in.pdf Target _blank		
Static	Formulario de inscripción de votante por correo oficial de Massachusetts (PDF) – Spanish	Open URL in a new page: http://www.sec.state.ma.us/ele/elepdf/2013-Mail-in-ES.pdf Target _blank		
Static	The Massachusetts Secretary of State's Elections Division has more information on how to register to vote. If you have any	Open URL in a new page: http://www.se		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	questions about the voter registration process, or if you need help filling out the form, 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).	c.state.ma.us/ele/eleifv/howreg.htm Target _blank		
Submit Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		
Submit Button	Submit	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

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4 Rights and Responsibilities (for applicants not applying for subsidies)

✔Start Your Application

✔Family & Household

✔Additional Questions

4 Review & Sign

Rights and Responsibilities

Read and check the box next to each statement if you agree.

☐ This application will be used to determine eligibility for unsubsidized health care administered through the Commonwealth of Massachusetts. *

☐ No one applying for health insurance on this application is in prison or in jail. * ℹ

Who is in prison or in jail?

☐ Erin Rashid

☐

1. The Massachusetts Health Connector may get any records or data to prove any information given on this application and any supplements, or other information I give once I am a member and to support continued eligibility.
2. You have permission to submit this application for health insurance benefits for all adults and all minor children listed on this application, according to the statements on the Consent & Authorization page at the beginning of this application, and as allowed by any legal documents you have submitted with this application;
3. You understand your rights and responsibilities and the rights and responsibilities of all persons for whom you are submitting this application, as explained on this signature page;
4. You have or will tell such persons about such rights and responsibilities and the other individuals for whom you are signing also understand their rights and responsibilities;
5. You understand and agree that the Health Connector will treat electronic signatures and faxed signature(s) or copies of signatures with the same force and effect as an original signature(s);
6. The information you have supplied is correct and complete to the best of your knowledge about yourself and other members of your household; and
7. You may be subject to penalties under federal law if you intentionally provide false or untrue information.

By signing in this box, I hereby certify under the pains and penalties of perjury that the submissions I have made in this Application are true and complete to the best of my knowledge and I agree to accept and comply with the above Rights and Responsibilities.

Electronic Signature

Voter Registration

Do you or anyone else in your application want to register to vote?

○ Yes ○ No

Your decision whether or not to register to vote has no effect on your getting health coverage.

The forms to register to vote are found here:

Massachusetts Mail-in Voter Registration form (PDF) - English

Formulario de inscripción de votante por correo oficial de Massachusetts (PDF) – Spanish

The Massachusetts Secretary of State's Elections Division has more information on how to register to vote. If you have any questions about the voter registration process, or if you need help filling out the form, 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).

Back | Submit

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Rights and Responsibilities	NA		
Static	Read and check the box next to each statement if you agree.	NA		
Checkbox	This application will be used to determine eligibility for unsubsidized health care administered through the Commonwealth of Massachusetts.	Checkbox Selection		
Checkbox	No one applying for health insurance on this application is in prison or in jail.	Checkbox (if checked, "Who is in prison...?" will be hidden)		
Tooltip	In prison or in jail applies to an individual under the supervision of the criminal justice system, who has been convicted of a crime, and is housed in a jail, prison or other penal institution. The individual is generally known as an inmate or offender. Specific examples include: an individual who is serving time in a jail or prison and an individual who is housed in a community corrections center or "half-way house."	Action: Show on Mouseover; Hide on Mouse Off Keyboard: Tab		
Checkbox	Who is in prison or in jail? [List FirstName LastName for each household member]	Checkbox Selection Names of applicants associated with household		Ensure Names are correct
Radio Button	Is this person awaiting trial?	If someone in the question above is selected. Yes No		
Checkbox	1. The Massachusetts Health Connector may get any records or data to prove any information given on this application and any supplements, or other information I give once I am a member and to support continued eligibility.	Checkbox Selection		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	2. You have permission to submit this application for health insurance benefits for all adults and all minor children listed on this application, according to the statements on the Consent & Authorization page at the beginning of this application, and as allowed by any legal documents you have submitted with this application; 3. You understand your rights and responsibilities and the rights and responsibilities of all persons for whom you are submitting this application, as explained on this signature page; 4. You have or will tell such persons about such rights and responsibilities and the other individuals for whom you are signing also understand their rights and responsibilities; 5. You understand and agree that the Health Connector will treat electronic signatures and faxed signature(s) or copies of signatures with the same force and effect as an original signature(s); 6. The information you have supplied is correct and complete to the best of your knowledge about yourself and other members of your household; and 7. You may be subject to penalties under federal law if you intentionally provide false or untrue information.			
Static	By signing in this box, I hereby certify under the pains and penalties of perjury that the submissions I have made in this Application are true and complete to the best of my knowledge and I agree to accept and comply with the above Rights and Responsibilities.	NA		

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Textbox	Electronic Signature	Alphabetic Please note that this field is case-sensitive"—first, check and make sure that the name you typed into the e-Signature box is exactly how you typed it when you created an account.		
Static	Voter Registration			
Static	If you are not registered to vote where you live now and you are eligible to register to vote would you like to apply to register to vote today?	Yes No	No	
Static	Please check "No" if you do not want to register to vote today for any reason, including that you are already registered to vote at your current address.			
Static	Your decision whether or not to register to vote has no effect on your getting health coverage.	NA		
Static	The forms to register to vote are found here:	NA		
Static	Massachusetts Mail-in Voter Registration form (PDF) – English	Open URL in a new page: http://www.sec.state.ma.us/ele/elepdf/2013-Voter-reg-mail-in.pdf Target _blank		
Static	1 Formulario de inscripción de votante por correo oficial de Massachusetts (PDF) – Spanish	Open URL in a new page: http://www.sec.state.ma.us/ele/elepdf/2013-Mail-in-ES.pdf Target _blank		
Static	The Massachusetts Secretary of State's Elections Division has more information on how to register to vote. If you have any questions about the	Open URL in a new page:		

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	voter registration process, or if you need help filling out the form, 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).	http://www.sec.state.ma.us/ele/eleifv/howreg.htm Target _blank		
Submit Button	Back	Action: Mouse Click Keyboard: Enter Alt text: Back		
Submit Button	Submit	Action: Mouse Click Keyboard: Enter Alt text: Save and Continue		

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2015 Eligibility Results

We automatically made the changes that you reported for 2015 to your 2016 application. Your 2016 application is used to determine which Health Connector plans and programs you qualify for in 2016. If you want to change your application information for 2016, click here.

To begin shopping for Health Connector plans, click the "Find a Plan for 2015" button below.

Please note: Make sure you understand who can qualify as an eligible dependent in your tax household before you enroll in a health or dental family plan. A list of eligible dependents can be found in the Health Connector policy on Dependent Eligibility(NG-3A). If you buy a plan as a family and include people who do not qualify as a dependent, your insurance carrier could reject your enrollment and retroactively cancel your coverage.

Household[1] - Application Result FPL : 207.18

This household also qualifies for a tax credit (Advance Premium Tax Credit) to help lower monthly health coverage costs. Maximum monthly tax credit amount: $ 22 . 00

NAME	PROGRAMS ELIGIBLE FOR	DOCUMENTS REQUIRED
EGAS WAHS	ConnectorCare Plans Type 3A(Advance Premium Tax Credit plus Massachusetts state subsidy) ●	Proof of Residency Proof of Immigration Status Proof of Income
CHILD WAHS	MassHealth Children's Health Insurance Program (CHIP) (MassHealth Family Assistance) ●	Proof of U.S. Citizenship Status Proof of American Indian/Alaska Native Status
SPOUSE WAHS	Not Eligible ●	

Congratulations. Based on your MassHealth Income (FPL), you or some of your household members have been approved for coverage through MassHealth. Your MassHealth FPL maybe different than the Household FPL displayed on this page. You will get a letter from MassHealth in the next 3-5 days with more information about your coverage, including the coverage start date. You may also go to the MassHealth website for more information.

It is not an open enrollment period right now. But, you may still be able to shop if you experienced certain qualifying life events. If you experienced a qualifying event, you can have a special enrollment period to pick a plan. If the system was unable to verify your qualifying event, you may need to send us proof. Please see below to find out if you are able to shop and if you need to send us anything.

Your household is eligible for Special Enrollment Period:

You qualify to enroll in a new or different health insurance plan until 12/15/2015 .If you would like to enroll in new or different coverage, you must choose a plan and pay the first monthly premium before coverage can start.

Date Submitted = 10/16/2015

Required Documents

If the system was not able to verify your information during your application, you may be required to submit documentation to confirm your eligibility results. In the table above, the type of documentation that is required is shown next to each household member's eligibility results under "Documents Required".Based on the type of document(s) required for each member, you will need to mail or fax in documentation of each type shown.

The following table lists the documents that may be submitted in order to verify a member's eligibility.

Carefully review the list of accepted types of documentation below. In most cases, only one document from each category is needed, but there are some that may require more than one document. If you have questions about the requested documents, please contact us at **1-877-MA-ENROLL (1-877-623-6765), TTY: 1-877-623-7773** or **1-800-841-2900, TTY: 1-800-497-4648** for people who are deaf, hard of hearing, or speech disabled.

Document Category	Document Type
Proof of Residency	■ Copy of deed and record of most recent mortgage payment (if mortgage is paid in full, provide a copy of property tax bill from the most recent year) ■ Copy of lease and record of most recent rent payment ■ Mortgage deed showing primary residence ■ Nursery school or daycare records (if school is private, additional documentation may be requested) ■ Current utility bill or work order dated within the past 60 days ■ Statement from a homeless shelter ■ School records (if school is private, additional documentation may be requested) ■ Section 8 agreement ■ Homeowner's insurance agreement ■ Proof of enrollment of custodial dependent in public school ■ Notarized affidavit supporting residency
Proof of U.S.	■ U.S. passport, including a U.S. Passport Card issued by the Department of State,

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Results	NA		
Button	<Printer Image>	Print results page		
Static	**To begin shopping for Health Connector plans, click the "Find a Plan" button below.** Please note: Make sure you understand who can qualify as an eligible dependent in your tax household before you enroll in a health or dental family plan. A list of eligible dependents can be found in the Health Connector policy on Dependent Eligibility (NG-3A). If you buy a plan as a family and include people	Link to policy: https://www.mahealthconnector.org/wp-content/uploads/policies2014/Policy_NG_3A.pdf		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	who do not qualify as a dependent, your insurance carrier could reject your enrollment and retroactively cancel your coverage.			
Static	Household [1] – Application Result	Displays for each household		
Dynamic	FPL:			
Static	This household also qualifies for a tax credit (Advance Premium Tax Credit) to help lower monthly health coverage costs. Maximum monthly tax credit amount: $<APTC Amount>	Display if household qualifies for APTC		
Static	NAME; PROGRAMS ELIGIBLE FOR; DOCUMENTS REQUIRED; First Name Last Name	Household member name is dynamic text Programs Eligible For is dynamic text Documents Required is dynamic text		
Static Text	Congratulations. Based on your MassHealth Income (FPL), you or some of your household members have been approved for coverage through MassHealth. Your MassHealth FPL maybe different than the Household FPL displayed on this page. You will get a letter from MassHealth in the next 3-5 days with more information about your coverage. You may also go to the MassHealth website for more information. If you or some of your household members are disabled (and have not been determined eligible for MassHealth Standard or CommonHealth), you (or they) may be eligible for MassHealth but your application requires additional processing. While MassHealth is processing your application, you have been determined eligible for the following coverage. You will be receiving a letter from MassHealth explaining any additional next steps you need to take. Click here to find	Displayed ONLY if a member of the household is eligible for MassHealth Link to MassHealth member booklet: http://www.mass.gov/eohhs/gov/departments/masshealth/applications-and-member-forms.html Text at the end, starting with "if you or some of your household members..." was added through CR-988 (R6.0)		

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	out more about MassHealth coverage for disabled individuals.			
Button	Find a Plan	If applicable, will take the use to the shopping screens		
Static Text	Required Documents If the system was not able to verify your information during your application, you may be required to submit documentation to confirm your eligibility results. In the table above, the type of documentation that is required is shown next to each household member's eligibility results under "Documents Required." Based on the type of document(s) required for each member, you will need to **mail or fax** in documentation of each type shown. The following table lists the documents that may be submitted in order to verify a member's eligibility.	Document Category, Document Type Mail or fax will be a link to a page on MAhealthconnector.org https://www.mahealthconnector.org/verification-documents		
Dynamic	Carefully review the list of accepted types of documentation below. In most cases, only one document from each category is needed, but there are some that may require more than one document. If you have questions about the requested documents, please contact us at <insert applicable phone number(s)>.	**If CCA-only eligible:** 1-877-MA-ENROLL (1-877-623-6765), TTY: 1-877-623-7773. **If MH-only eligible:** 1-800-841-2900, TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled. **If a complex household, display both numbers:** 1-877-MA-ENROLL (1-877-623-6765), TTY: 1-877-623-7773 or 1-800-841-2900, TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech		

OFFICIAL

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
		disabled.		
Static (Programs Eligible For)	Health Connector Plans with Advance Premium Tax Credits			
Tooltip (Health Connector Plans with Advance Premium Tax Credits)	An Advance Premium Tax Credit (APTC) is applied to your monthly premium to help make it more affordable. The maximum (most) that you can qualify for is shown here. If you want to have less money applied to your monthly premium, you can change it at any time. We calculate how much of a tax credit you'll need to make your premiums more affordable by using the information you gave us about your household income and size. If your credit is $0, it's because the health plans available to you are considered affordable enough already.			
Static (Programs Eligible For)	Not Eligible			
Tooltip (Not Eligible)	Based on the information provided, you may not be eligible for health insurance in Massachusetts. You will receive a notice in the mail with details about this determination. For more information, call Health Connector Customer Service at 1-877-623-6765 (TTY 1-877-623-7773).			
Static (programs eligible for)	• MassHealth Standard • MassHealth CarePlus • MassHealth Family Assistance • MassHealth Limited • Children's Medical Security Plan • Health Safety Net	If eligible for MassHealth, show the exact program type that the applicant is eligible to receive		
Tooltip – MH Standard	MassHealth Standard pays for doctor and clinic visits, hospital stays, prescription medicines, some dental services, personal care attendant services, and transportation to medical appointments, even if it is not an emergency. Please refer to the notice you receive in mail for more information about your coverage.	Associated Aid Cats - A1, M1, L1, H1, J1, 48, 40, AD, T1, B1		

OFFICIAL

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	If you are an adult, you may have a copay for prescriptions and doctor or hospital visits. If you have breast or cervical cancer and have a higher income, you may also be charged a monthly premium. If you have to pay a monthly premium, MassHealth will send you a bill. Refer to the Member Booklet to find out more about MassHealth Standard coverage, copays and premiums.			
Tooltip – MH CarePlus	MassHealth CarePlus pays for doctor and clinic visits, hospital stays, prescription medicines, some dental services, and transportation to medical appointments, even if it is not an emergency. Please refer to the notice you receive in the mail for more information about your coverage. You may have a copay for prescriptions and doctor or hospital visits. There is no monthly premium (fee). Refer to the Member Booklet to find out more about MassHealth CarePlus coverage and copays.	Associated aid cat - D1		
Tooltip – MH Family Assistance	MassHealth Family Assistance pays for doctor and clinic visits, hospital stays, prescription medicines, and some dental services. Please refer to the notice you receive in the mail for more information about your coverage. If you are an adult, you may have a copay for prescriptions and doctor or hospital visits. If you have a higher income, you may also be charged a monthly premium. If you have to pay a monthly premium, MassHealth will send you a bill. Refer to the Member Booklet to find out more about MassHealth Family Assistance coverage, copays and premiums.	Associated aid cats - 93, 84, N1, 95, U3, 90, Q1		
Tooltip – MH Limited	MassHealth Limited covers emergency services such as ambulance transportation, pharmacy services, visits to emergency rooms, emergency	Associated aid cat - AX, 37		

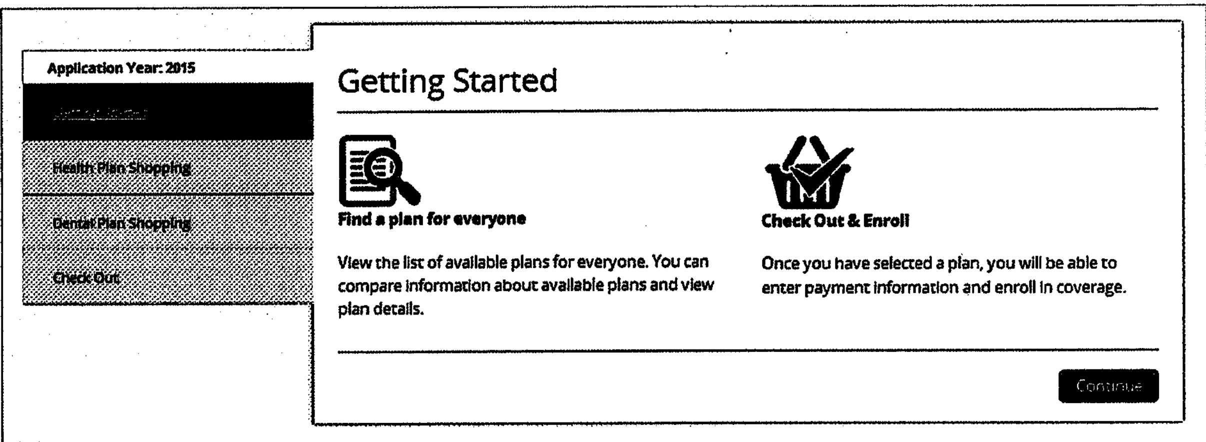
OFFICIAL

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	treatment of cancer, outpatient and inpatient hospital services, and labor and delivery. Nonemergency medical services, including organ transplants are not covered. The Health Safety Net may be able to help you pay for some services at Massachusetts acute hospitals or community health centers. If this is a child under the age of 19, they are also eligible for assistance through the Children Medical Security Plan. Please refer to the notice you receive in mail for more information about your coverage. With Limited, there is no monthly premium (fee). Refer to the Member Booklet to find out more about MassHealth Limited coverage, the Children's Medical Security Plan and Health Safety Net.			
Tooltip – MH CMSP	The Children's Medical Security Plan pays for outpatient services including preventive and sick visits, eye exams and hearing tests, dental services and prescription medicines. Please refer to the notice you receive in mail for more information about your coverage. You may have some copays and yearly ($) limits on certain types of covered services. If you have to pay a monthly premium, MassHealth will send you a bill. Refer to the Member Booklet to find out more about Children's Medical Security Plan coverage, copays, and yearly limits.	Associated aid cat – BA		
Tooltip – MH HSN	The Health Safety Net is not insurance. It pays for certain care at Massachusetts community health centers and acute hospitals. If this is a child under the age of 19, they are also eligible for assistance through the Children Medical Security Plan. Please refer to the notice you receive in mail for more information about your coverage.	Associated aid cat - AY, AQ, AP		

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	If you have a higher income, you may have to pay a deductible. If you have to pay a deductible, MassHealth will inform you of the amount. If you have other health insurance, you must use that first, before the Health Safety Net can pay for services. There may be copays and deductibles with that insurance. Pay those directly to the health care provider and keep a copy of all medical bills and payments. Refer to the Member Booklet to find out more about the Health Safety Net and Children's Medical Security Plan.			
Static (programs eligible for)	ConnectorCare Plan Type 1 (Advance Premium Tax Credit plus Massachusetts state subsidy) ConnectorCare Plan Type 2A (Advance Premium Tax Credit plus Massachusetts state subsidy) ConnectorCare Plan Type 2B (Advance Premium Tax Credit plus Massachusetts state subsidy) ConnectorCare Plan Type 3A (Advance Premium Tax Credit plus Massachusetts state subsidy) ConnectorCare Plan Type 3B (Advance Premium Tax Credit plus Massachusetts state subsidy)	If eligible for ConnectorCare, show the exact plan type that the applicant is eligible to receive		
Tooltip (ConnectorCare Plans)	All ConnectorCare plans cover the same services and the same co-pay and co-insurance costs, with no deductibles. The premium cost for each plan is different, based on which insurance carrier is offering it. Before you enroll, make sure providers you want to see are in that ConnectorCare plan's network. ConnectorCare plans have lower monthly premiums and lower out-of-pocket costs, because they are partially paid for by the Commonwealth of Massachusetts, in addition to federal tax credits.			

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static (programs eligible for)	American Indian/Alaska Native Benefits Eligible			
Tooltip (AI/NA)	American Indians and Alaska Natives may get extra help-they may not have to pay cost sharing and may get monthly Special Enrollment Periods.			
Static (programs eligible for)	Health Connector Plans			
Tooltip (Health Connector Plans)	You can shop for coverage from leading insurance companies in Massachusetts based on you and your family's health care needs. Before you enroll in a plan, check to make sure the providers you want are in the plan's network. Premiums and costs will depend on the plan's Metallic tier coverage level. Platinum plans offer the highest premiums and lowest out-of-pocket costs while Bronze plans offer the lowest premiums and highest out-of-pocket costs.			

1 Shopping



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Getting Started			
Static	Find a plan for everyone			
Static	View the list of available plans for everyone. You can compare information about available plans and view plan details			
Static	Check Out & Enroll			
Static Text	Once you have selected a plan, you will be able to enter payment information and enroll in coverage			
Button	Continue	Click and continue		

2 Health Plan Shopping

Health Plan Shopping

Find a Provider

Enrollment for Coverage Year 2015

The system created the following group(s) based on one or more of the following factors: Eligibility Determination, American Indian/Alaska Native status, Income, Age and/or tax relationships [a list of eligible dependents can be found in the Health Connector policy on Dependent Eligibility (NG-3A)]. Please proceed with plan shopping using these group(s).

> ***Note:*** Shopping is not complete. Click on the "Continue" button below and follow the instructions to submit your plan selection.

Shopping Group 1:
Egas Wahs *(Subscriber)*

The monthly premium shown below has been reduced by an Advance Premium Tax Credit of $22 . 00
You qualify for tax credit of up to $22 . 00
Change Tax Credit

Selected Plan for 2015

MONTHLY PREMIUM	CARRIER DETAILS	PLAN DETAILS	ANNUAL DEDUCTIBLES	EST. OUT-OF-POCKET COSTS	
$78 . 00 ConnectorCare	Tufts Health Plan Network Health	**Tufts Health Direct Silver Preferred Drug List** HMO/Silver	$0 . 00 / Person $0 . 00 / Family	$1,500 . 00 / Person $3,000 . 00 / Family	Remove

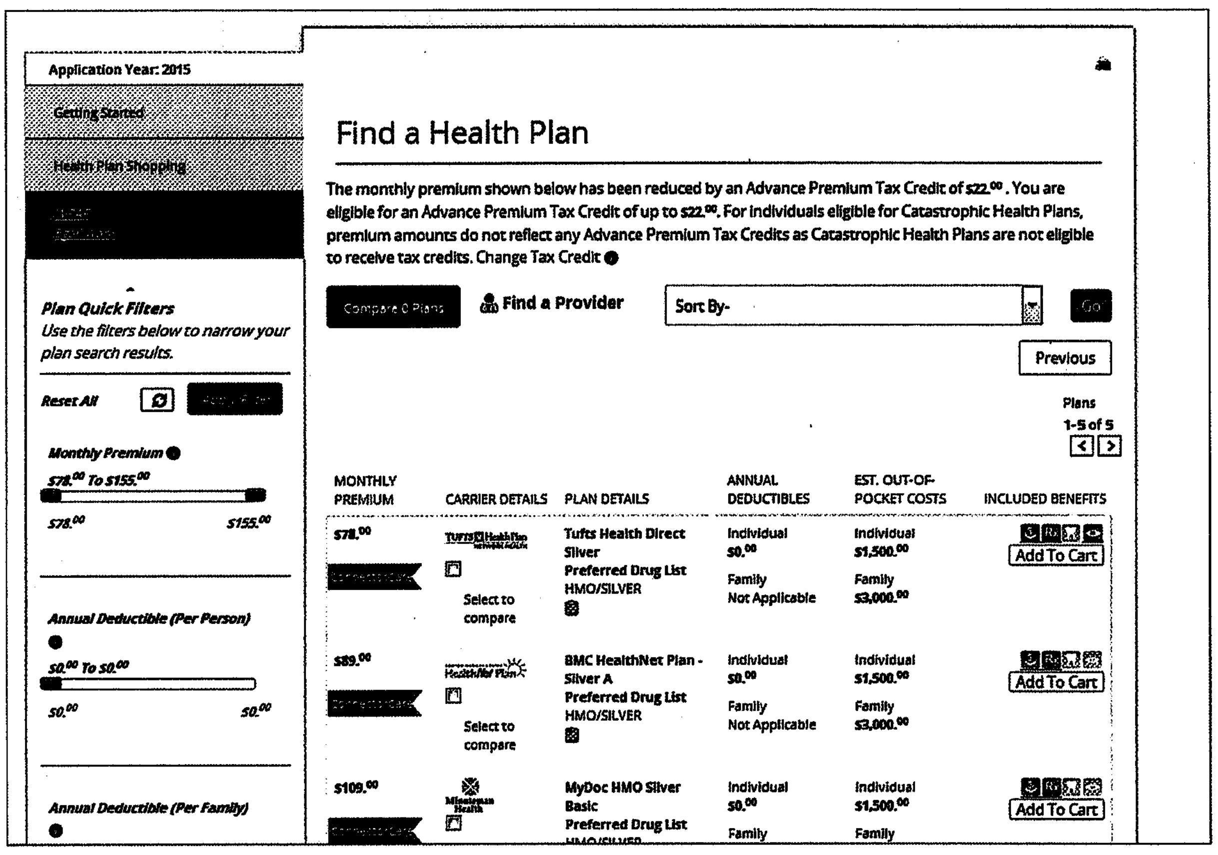
Find a Plan for 2015

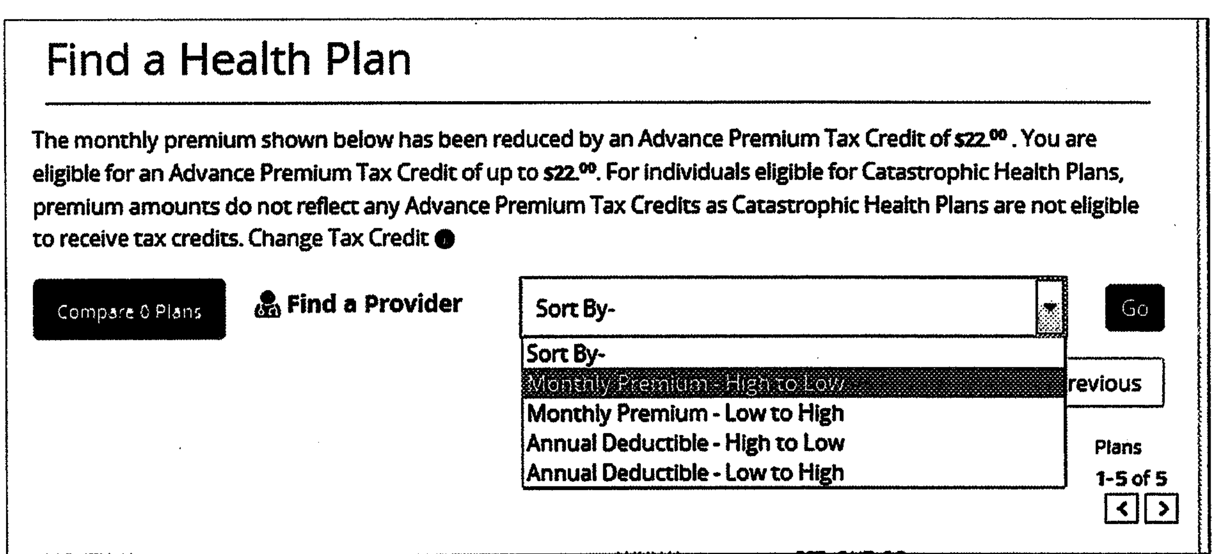
Back Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Health Plan Shopping		NA	

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	Enrollment for Coverage Year 201X			
Static	The system created the following group(s) based on one or more of the following factors: Eligibility Determination, American Indian/Alaska Native status, Income, Age and/or tax relationships [a list of eligible dependents can be found in the Health Connector policy on **Dependent Eligibility (NG-3A)]**. Please proceed with plan shopping using these group(s).	https://www.mahealthconnector.org/wp-content/uploads/policies2014/Policy_NG_3A.pdf		
Dynamic	**Note:** Shopping is not complete. Click on the "Continue" button below and follow the instructions to submit your plan selection.	Shown if the selected plan was changed by the user	n/a	
Dynamic	Shopping Group <#> : <FN LN> (Subscriber)	List all members of the shopping group	NA	
Dynamic	Shopping Group <#> : <FN LN> (Subscriber)	List all members of the shopping group	NA	
Buttons	Back; Continue	Click and Continue		

3 Find a Health Plan





Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Find a Health Plan			
Dropdown	Monthly Premium – High to low Monthly Premium – Lo to High Annual Deductible High to Low Annual Deductible Low to High	Check one		
Button	Compare "number of plans"	Able to compare up to three plans		
Buttons	Back; Save and Continue to Check out			
Column Heading	MONTHLY PREMIUM, CARRIER DETAILS, PLAN DETAILS, ANNUAL DEDUCTIBLES, EST OUT-OF-POCKET COSTS, PLANS			
Icon alt text	Click on the clip board icon to see detailed information about the selected plan			View plan details
Logo	Plan 1 Logo (Rating in Progress)			
Check box	Select to compare			
Static Text	Plan 1 Plan Details: Preferred Drug List Coverage Level (eg, HMO/Bronze) Annual Deductibles Dollar amount/Person Dollar amount/Family Est. Out-of-Pocket Costs Annual Max. Costs Dollar amount/person Dollar amount/Family			

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Icons	Icons for Wrap, Rx, Dental, Vision			
Button	Add to cart			
Logo	Plan 2 Logo (Rating in Progress)			
Check box	Select to compare			

Find a Health Plan

The monthly premium shown below has been reduced by an Advance Premium Tax Credit of $22.00 . You are eligible for an Advance Premium Tax Credit of up to $22.00. For individuals eligible for Catastrophic Health Plans, premium amounts do not reflect any Advance Premium Tax Credits as Catastrophic Health Plans are not eligible to receive tax credits. Change Tax Credit

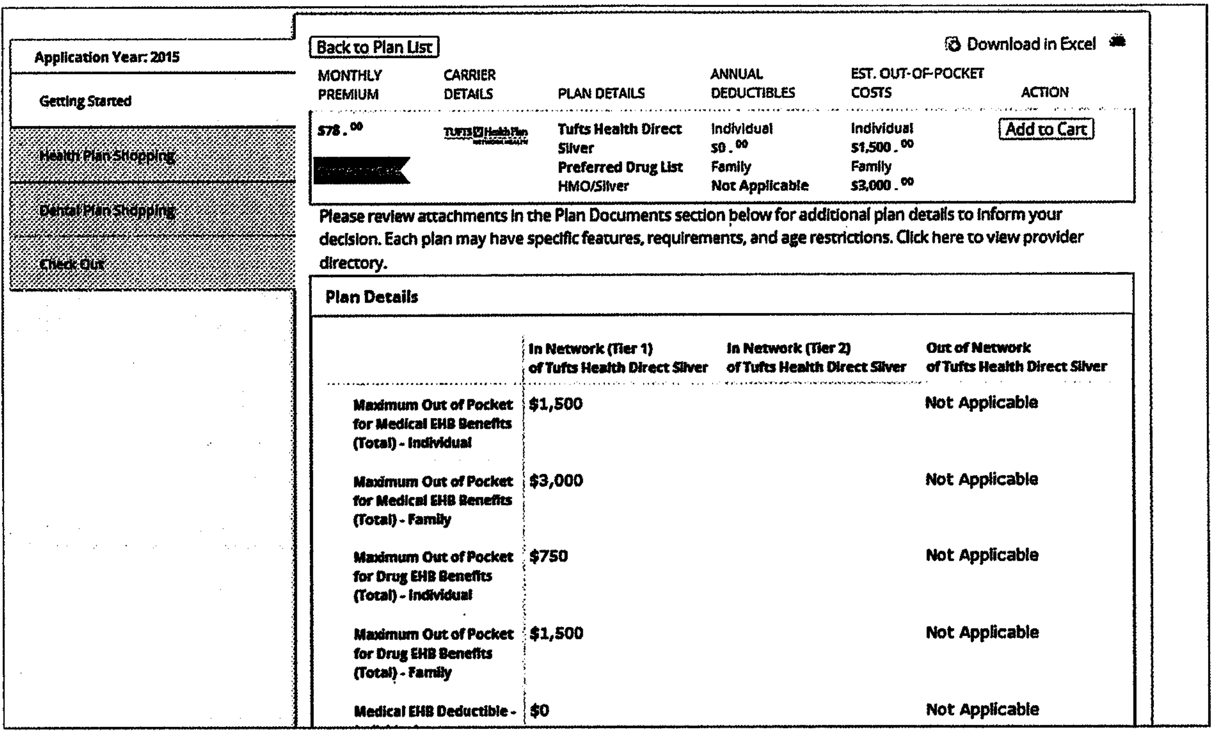
Compare 0 Plans | Find a Provider | Sort By- | Go

Previous

Plans

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Find a health plan			
Hybrid	The monthly premium shown below has been reduced by an Advanced Premium Tax Credit of XXX. You are eligible for an Advance Premium Tax Credit up to XXX. For individuals eligible for Catastrophic Health Plans, premium amounts do not reflect any Advance Premium Tax Credits as Catastrophic Health Plans are not eligible to receive tax credits. <Change Tax Credit>	<change tax credit> needs to open up to the sliding scale users can use to adjust their APTC amount		

If a plan is selected to view more details:



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Columns	MONTHLY PREMIUM, CARRIER DETAILS, PLAN DETAILS, ANNUAL DEDUCTIBLES, ANNUAL MAX. COSTS			
Button	Back to Plan List			
Link	Download in Excel with Icon			
Button	Add to Cart			
Static	Please review attachments in the Plan Documents section below for additional plan details to inform your decision. Each plan may have specific features, requirements and age restrictions. Click **here** to view provider directory	"click here" goes to the carrier's provider directory		
Expandable Rows	Please see ShareFile document: UIUX → 4-UI Supporting Documents → 2014.08.20 – Benefit Ordering on UI			
Columns	In Network (Tier 1)			

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	In Network (Tier 2) Out of Network			

4 Find a Dental Plan

Dental Plan Shopping

Enrollment for Coverage Year 2015

The system created the following group(s) based on one or more of the following factors: Eligibility Determination, American Indian/Alaska Native status, Income, Age and/or tax relationships [a list of eligible dependents can be found in the Health Connector policy on Dependent Eligibility (NG-3A)]. Please proceed with plan shopping using these group(s).

Note: Shopping is not complete. Click on the "Continue" button below and follow the instructions to submit your plan selection.

Shopping Group 1:
Egas Wahs *(Subscriber)*

Selected Plan for 2015

Your current renewal date is 11/01/2015. If you change plans for 2015, and your new start date is before your renewal date, you may need to wait six months before getting certain major services covered, such as crowns or dentures.

MONTHLY PREMIUM	CARRIER DETAILS	PLAN DETAILS	ANNUAL DEDUCTIBLES	
$26 . 19	altus dental	**Altus Dental Low Plan** PPO/Low	Not Applicable / Person Not Applicable / Family	Remove Remove

Find a Plan for 2015

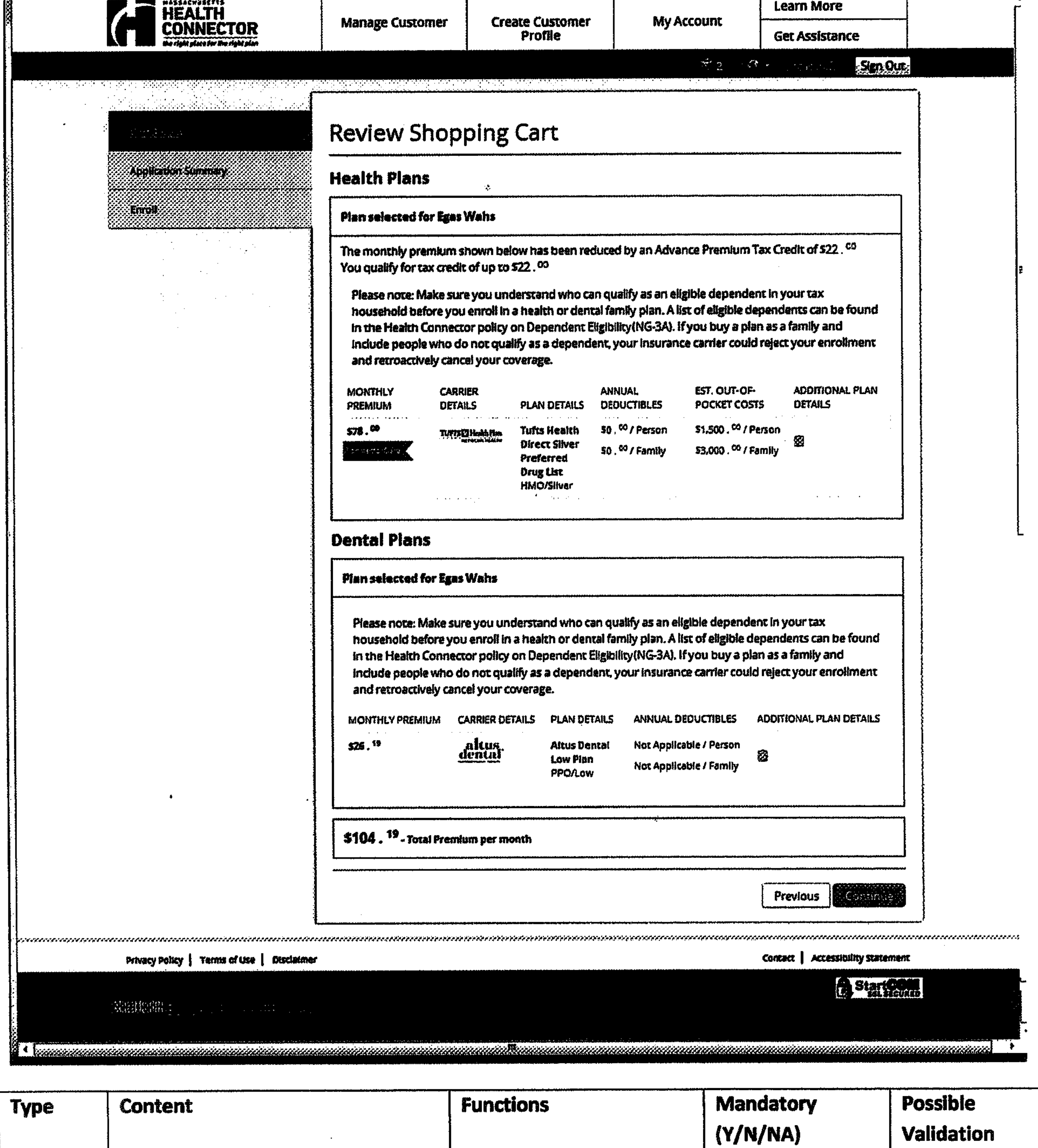
Back Continue

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Dental Plan Shopping Enrollment for Coverage Year 201X		NA	
Static	The system created the following group(s) based on one or more of the following factors: Eligibility Determination, American Indian/Alaska Native status, Income, Age and/or tax relationships [a list of eligible dependents can be found in the Health Connector policy on Dependent Eligibility (NG-3A)]. Please proceed with plan shopping using these group(s).	(current text on our shopping screens)		
Dynamic	Only the member(s) of your household who are turning 26 and no longer qualify for their family plan can shop at this time. Other enrolled household members will stay in their current coverage. However, your household's monthly premium may have changed. Please make sure to check your monthly premium amount below for any updates.	Only shown if a dependent in a family QHP is aging out Only shown during closed enrollment Shown on health plan shopping page and dental plan shopping page Shown in a yellow box	n/a	
Dynamic	**Note:** Shopping is not complete. Click on the "Continue" button below and follow the instructions to submit your plan selection.	Shown if the selected plan was changed by the user		
Dynamic	Shopping Group <#> : <FN LN> (Subscriber)	Show all members of the shopping group	NA	
Dynamic	201X Plan Your current renewal date is mm/dd/yyyy. If you change plans for 201X, and your new start date	Click "here" takes the user to the modal where the user can change the renewal date of the dental	NA	

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	is before your renewal date, you may need to wait six months before getting certain major services covered, such as crowns or dentures.	plan Shown if the user has a mapped/current dental plan		
Grid	201X Plan Details	Columns- • MONTHLY PREMIUM • CARRIER DETAILS • PLAN DETAILS • ANNUAL DEDUCTIBLES • EST. OUT-OF-POCKET COSTS • [ACTIONS] – Icons and Remove button	NA	
Button	Remove	Remove the plan from the user's cart and current selection	NA	
Button	Find a new Plan for 201X	When user clicks this button, system will display the 'Find a Dental Plan' page for 2016 plans	NA	
Button	Back	Takes the user back one page	NA	
Button	Continue	Takes the user forward to plan shopping		

5 Review Shopping Cart



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Review Shopping Cart			
Static	Health Plans Plan selected for First Name Last Name The monthly premium shown below has been reduced by an Advance Premium Tax Credit of $<dollar amount>. You are eligible for an Advance Premium Tax Credit of up to $<dollar amount>. **Change Tax Credit.** Please note: Make sure you understand who can qualify as an eligible dependent in your tax household before you enroll in a health or dental family plan. A list of eligible dependents can be found in the Health Connector policy on Dependent Eligibility(NG-3A). If you buy a plan as a family and include people who do not qualify as a dependent, your insurance carrier could reject your enrollment and retroactively cancel your coverage.	Paragraph only shown if applicant is eligible for APTC: The monthly premium shown below has been reduced by an Advance Premium Tax Credit of $<dollar amount>. You are eligible for an Advance Premium Tax Credit of up to $<dollar amount>. **Change Tax Credit.** Dollar amount is dynamic Link: https://www.mahealthconnector.org/wp-content/uploads/policies 2014/Policy_NG_3A.pdf		
Column Heading	MONTHLY PREMIUM, INSURANCE CARRIER, PLAN DETAILS, ANNUAL DEDUCTIBLES, ANNUAL MAX COSTS			
Dynamic text	Plan Monthly Premium Dollar Amount Plan Icon Plan Name Preferred Drug List Plan Category Annual Deductible			

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	Dollar Amount/Person Dollar Amount/Family Annual Max. Costs Dollar amount per person Dollar amount per family			
Buttons	Plan Details			
Dynamic	Dollar amount value for the selected plan – Total Premium per month			
Static	Dental Plans Plan selected for First Name Last Name Please note: Make sure you understand who can qualify as an eligible dependent in your tax household before you enroll in a health or dental family plan. A list of eligible dependents can be found in the Health Connector policy on Dependent Eligibility(NG-3A). If you buy a plan as a family and include people who do not qualify as a dependent, your insurance carrier could reject your enrollment and retroactively cancel your coverage.	Paragraph only shown if applicant is eligible for APTC: The monthly premium shown below has been reduced by an Advance Premium Tax Credit of $<dollar amount>. You are eligible for an Advance Premium Tax Credit of up to $<dollar amount>. **Change Tax Credit.** Dollar amount is dynamic Link: https://www.mahealthconnector.org/wp-content/uploads/policies2014/Policy_NG_3A.pdf		
Column Heading	MONTHLY PREMIUM, INSURANCE CARRIER, PLAN DETAILS, ANNUAL DEDUCTIBLES			
Dynamic text	Plan Monthly Premium Dollar Amount			

OFFICIAL

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	Plan Icon Plan Name Plan Category Annual Deductible Dollar Amount/Person Dollar Amount/Family			
Buttons	Plan Details			
Dynamic	Dollar amount value for the selected plan – Total Premium per month	Health + Dental		
Buttons	Continue			

6 Review Application

HEALTH CONNECTOR | Manage Customer | Create Customer Profile | My Account | Learn More | Get Assistance

Sign Out

✔ Cart Review

Enroll

Review Application

Application Summary

Contact Information

Egas Wahs

Address: 1 Main Street, Apt 6, Boston, MA, 02108
Email:
Phone: (888) 888-8888 - CELL

Family & Household

Tax Filing Status

Additional Information

Health Plans

Plan selected for Egas Wahs

The monthly premium shown below has been reduced by an Advance Premium Tax Credit of $22.00
You qualify for tax credit of up to $22.00

Please note: Make sure you understand who can qualify as an eligible dependent in your tax household before you enroll in a health or dental family plan. A list of eligible dependents can be found in the Health Connector policy on Dependent Eligibility(NG-3A). If you buy a plan as a family and include people who do not qualify as a dependent, your insurance carrier could reject your enrollment and retroactively cancel your coverage.

MONTHLY PREMIUM	CARRIER DETAILS	PLAN DETAILS	ANNUAL DEDUCTIBLES	EST. OUT-OF-POCKET COSTS
$78.00	Tufts Health Plan	Tufts Health Direct Silver Preferred Drug List HMO/Silver	$0.00 / Person $0.00 / Family	$1,500.00 / Person $3,000.00 / Family

Dental Plans

Plan selected for Egas Wahs

Please note: Make sure you understand who can qualify as an eligible dependent in your tax household before you enroll in a health or dental family plan. A list of eligible dependents can be found in the Health Connector policy on Dependent Eligibility(NG-3A). If you buy a plan as a family and include people who do not qualify as a dependent, your insurance carrier could reject your enrollment and retroactively cancel your coverage.

MONTHLY PREMIUM	CARRIER DETAILS	PLAN DETAILS	ANNUAL DEDUCTIBLES
$26.19	altus dental	Altus Dental Low Plan PPO/Low	Not Applicable / Person Not Applicable / Family

$104.19 - Total Premium per month

Back | Save and Continue

OFFICIAL

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Application Summary			
Dynamic	Contact Information Full Legal Name Address Email Phone			
Dynamic	Family and Household Full Legal Name Social Security Number Applying for Coverage Address Date of Birth Citizenship Immigration Status Reasonable Accommodations: Condition(s) Accommodation(s)			
Dynamic	Tax Filing Status Full Legal Name Status: Tax filer/ Non- Tax filer			
Dynamic	Additional Information Full Legal Name Has MEC: Yes/ No Has option to enroll in employer health coverage: Yes/No			

OFFICIAL

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Health Plans Plans selected for Full Legal Name			
	The monthly premium shown below has been reduced by an Advance Premium Tax Credit of $<dollar amount>. You are eligible for an Advance Premium Tax Credit of up to $<dollar amount>. Please note: Make sure you understand who can qualify as an eligible dependent in your tax household before you enroll in a health or dental family plan. A list of eligible dependents can be found in the Health Connector policy on Dependent Eligibility (NG-3A). If you buy a plan as a family and include people who do not qualify as a dependent, your insurance carrier could reject your enrollment and retroactively cancel your coverage.	Paragraph only shown if applicant is eligible for APTC: The monthly premium shown below has been reduced by an Advance Premium Tax Credit of $<dollar amount>. You are eligible for an Advance Premium Tax Credit of up to $<dollar amount Dollar amount is dynamic Link: https://www.mahealthconnector.org/wp-content/uploads/policies 2014/Policy_NG_3A.pdf		
Column Heading	Monthly Premium, Insurance Carrier, Plan Details, Annual Deductibles, Annual Max Costs			
Dynamic text	Plan Monthly Premium Dollar Amount Plan Icon Plan Name Preferred Drug List Plan Category Annual Deductible			

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	Dollar Amount/Person Dollar Amount/Family Annual Max. Costs Dollar amount per person Dollar amount per family			
Static	Dental Plans Plans selected for Full Legal Name			
	Please note: Make sure you understand who can qualify as an eligible dependent in your tax household before you enroll in a health or dental family plan. A list of eligible dependents can be found in the Health Connector policy on Dependent Eligibility (NG-3A). If you buy a plan as a family and include people who do not qualify as a dependent, your insurance carrier could reject your enrollment and retroactively cancel your coverage.	Paragraph only shown if applicant is eligible for APTC: The monthly premium shown below has been reduced by an Advance Premium Tax Credit of $<dollar amount>. You are eligible for an Advance Premium Tax Credit of up to $<dollar amount Dollar amount is dynamic Link: https://www.mahealthconnector.org/wp-content/uploads/policies2014/Policy_NG_3A.pdf		
Column Heading	Monthly Premium, Insurance Carrier, Plan Details, Annual Deductibles			
Dynamic text	Plan Monthly Premium Dollar Amount			

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	Plan Icon Plan Name Plan Category Annual Deductible Dollar Amount/Person Dollar Amount/Family			
Dynamic	Monthly premium dollar amount – (Total Premium per month)	Health + Dental		
Button	Back			
Button	Save and Continue			

OFFICIAL

7 Enroll

Enroll

Read the User Agreement and add your signature to submit your application.

TERMS AND CONDITIONS OF ENROLLMENT AGREEMENT

You have applied for a medical or dental insurance plan ("Plan") offered through the Commonwealth Health Insurance Connector Authority ("Connector"). The Connector is responsible for enrolling you, billing and collecting premiums from you, sending your premiums to the Plan in which you enroll, and, when appropriate, terminating your coverage. When we use the word "Connector" in this Agreement, it means the Connector or its Agents, Designees or subcontractors.

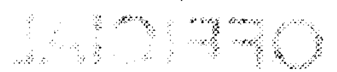
BY APPLYING FOR AND ENROLLING IN A PLAN THROUGH THE CONNECTOR, I UNDERSTAND AND AGREE TO, ON BEHALF OF MYSELF AND MY ENROLLED DEPENDENTS, THE FOLLOWING TERMS AND CONDITIONS:

1. **Eligibility.**

   My dependents and I are eligible to purchase insurance under state and federal law and Connector policies.
2. **Termination of Current Health Plan.**

   If I am currently enrolled in a Health Connector Plan, my enrollment in this new Plan indicates my request for the termination of my previous health plan. I will not have an overlap of health plan coverage through the Connector.
3. **Enrollment Requirements.**

   a. My enrollment in a Plan is subject to acceptance by the Issuer.
   b. My coverage in a Plan will begin on the first day of the calendar month selected for coverage if all documentation and payments are received by the required due date. This is called my "Effective Date".
   c. If requested, I will give the Connector complete information and documentation to establish my dependents' and my own eligibility, including, but not limited to, proof of residency, citizenship, or incarceration status. If I fail to comply with the request(s), the Connector may not be required to issue a Plan to me. I will promptly notify the Connector of any changes to my address or citizenship or residency status, and, if I am receiving any federal or state subsidies, any changes in income or access to other health insurance. I attest that I will enroll in a plan only with my eligible dependents, in accordance with Connector policy and state law. My dependents eligible to enroll with me may or may not be part of my tax household.



4. **Plan Selection.**

   a. I am free to select among any of the Plans offered by the Connector as long as I meet the eligibility requirements for enrolling in that Plan.
   b. Each Plan has its own written description of the benefits, terms and conditions that will apply to people enrolled in that Plan. This description is in a booklet usually called an "Evidence of Coverage". When I am accepted for enrollment in a Plan, my coverage will be provided according to all the terms and conditions of that Plan's Evidence of Coverage. The Issuer and not the Connector will:
      i. provide me with an Evidence of Coverage; and
      ii. provide me coverage for medical or dental benefits according to that Evidence of Coverage.

5. **Coverage Period.**

   a. For Platinum/Gold/Silver/Bronze Health Plans and ConnectorCare Plans.
      i. My coverage will end on December 31, 2015.
      ii. Once my coverage is effective, I cannot change to a different Plan outside of the open enrollment periods, as defined by state or federal law, unless an exception applies or I experience a triggering event in accordance with state and federal law.
      iii. If I become eligible for employer-sponsored coverage through the Connector, I may switch to that Plan regardless of the date.
   b. For Catastrophic Plans.
      i. My coverage will end December 31, 2015.
      ii. If my 30th birthday occurs prior to the coverage end date and I do not have a Certificate of Exemption granted on the basis of financial hardship or a lack of affordable coverage available to me, I may remain in the Catastrophic Plan until my renewal date, be disenrolled at the end of my plan year, or be offered an Individual/family non group plan prior to my termination date.
      iii. Once I am enrolled, I cannot change to a different Catastrophic Plan, except as permitted by state or federal law and Connector policies.
      iv. If I become eligible for employer-sponsored coverage through the Connector, I may switch to that plan regardless of the coverage end date.
   c. For Dental Plans
      i. My coverage will last twelve (12) months from the date of enrollment.
      ii. If I become eligible for employer-sponsored coverage through the Connector, I may switch to that Plan regardless of the date.
      iii. I understand that if I cancel coverage, I may not be able to repurchase a dental plan through the Health Connector for a period of time, depending on my Plan Issuer's policies.

6. **Annual Deductibles and Out-of-Pocket Maximums.**

   If I change health or dental plans, I will be subject to the new deductible and out of pocket maximum of that plan.

7. **Payment and Related Terms.**

   a. I agree to pay the monthly premium for the Plan that I select. I also agree to pay any applicable Connector-imposed fees related to my monthly premium payments, such as fees for non-sufficient funds, wire transfer fees, or reinstatement fees, if applicable.
   b. The Connector will bill me once a month. This bill will be sent to me approximately thirty (30) calendar days before the applicable coverage month. (For example, on July 1st the Connector will send me a bill for my August coverage.) The bill will state the premium as well as any fees I have incurred for the applicable coverage month.
   c. I agree to pay the Connector so that the premium is received five (5) full business days prior to the coverage month ("Due Date"). (For example, the Due Date for a bill sent on March 1st is March 24th.)
   d. The amount of my monthly premium will not change during my coverage period, unless I add or remove dependents. However, if I am receiving tax credits or other subsidies, the amount of the premium that I pay may change if I adjust my federal tax credit amount or if my eligibility changes. Changes in my premium payment will never be based on my dependents' or my health status or our use of medical services.
   (Please note, premium rates charged by health and dental insurance Issuers are subject to review by the Massachusetts Division of Insurance (DOI) and could change per DOI order.)
   e. I understand that if I was incorrectly enrolled in a ConnectorCare plan, for example, because I provided inaccurate information, the Health Connector may recover any state subsidies paid on my behalf.

8. **Cancellation and Termination.**

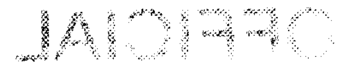
a. I may cancel my coverage at any time by notifying the Connector at least two business days in advance by phone, fax, email, or regular mail. My coverage will end on the last day of the calendar month in which I notify the Connector. I am not permitted to cancel my coverage retroactively (back in time). If I cancel my coverage, I am responsible for paying the premiums up until the effective date of my cancellation.

b. For persons receiving non-subsidized coverage, if the Connector does not receive my full premium by the due date indicated in the Notice of Delinquency, then the coverage is terminated on the day following that date when my account is two months past due. The coverage end date is retroactive to the last day of the coverage month for which my monthly premium was paid in full in accordance with Connector policies.
For subsidized coverage (receiving any state or federal subsidies), if the Connector does not receive my full premium by the due date indicated in the Notice of Delinquency, then the coverage is terminated on the day following that date. The coverage end date is retroactive to the last day of the first coverage month in which I was delinquent (i.e. one month grace period) in accordance with Connector policies.
If my coverage is terminated, I may be entitled to have my coverage reinstated with the same Plan and Issuer if my coverage has not lapsed for more than thirty (30) days from the termination date. To do so, I must pay all overdue premiums, the current month's premium, and any fees, if applicable, including charges due to insufficient funds, wire transfer fees, and reinstatement fees.

c. The Connector may cancel my Plan if:

i. I fail to pay my premiums;
ii. I commit fraud;
iii. I misrepresent my dependents' or my eligibility for the Plan or specific benefits of the Plan;
iv. I misrepresent any information relevant to my enrollment in the Plan;
v. I fail to comply in a material manner with the Plan requirements, including, but not limited to, by moving outside of the Carrier's service area; or
vi. My mail is returned as undeliverable and I do not confirm my correct address with the Health Connector.

The Connector will provide written notice of the effective date of the Plan's cancellation and I will be responsible for the cost of any medical care services that I or my dependents receive after that date.



9. **Connector Policies and Procedures.**

I may request from the Connector a copy of any detailed enrollment, billing or payment policies and procedures. These policies and procedures are considered a part of this Terms and Conditions Agreement.

10. **Amendments**

The Connector may amend these Terms and Conditions from time to time. The Connector shall provide me with notice of such amendment and its effective date.

11. **Limitation on Liability.**

Neither the Connector nor its Agent, Designee, or subcontractor shall have any liability or responsibility whatsoever to me, my enrolled dependents, or any third party:

a. If I do not pay my premium to the Connector in accordance with this Agreement; or
b. Based on the acts or omissions of:
   i. the Issuer with respect to its provision of coverage for medical benefits due, or alleged to be due, to me or my enrolled dependents under that Plan; or
   ii. any health care provider who provides health care services to me or my enrolled dependents under the Plan.

12. **Waiver.**

The Connector's exercise or non-exercise of any of its rights under this contract on any occasion shall not be construed as a waiver of any of my obligations nor shall it obligate the Connector to act in a similar fashion on any later occasion.

13. **Governing Law.**

This Agreement and the rights and obligations of you and the Connector will be governed by and interpreted in accordance with the laws of the Commonwealth of Massachusetts, without giving effect to its choice of law rules.

14. **ACCEPTANCE OF THIS AGREEMENT.**

EITHER (1) MY VERBAL CONSENT GIVEN TO THE CONNECTOR OR (2) PAYMENT OF MY FIRST MONTH'S PREMIUM AFTER A COMPLETED APPLICATION IS ACCEPTED BY THE CONNECTOR IS DEEMED TO BE ACCEPTANCE OF THIS AGREEMENT ON BEHALF OF ANY DEPENDENTS AND MYSELF.

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By signing this agreement, you are also agreeing to the following statements:

You understand that because advance payments of the premium tax credit will be paid on your behalf to reduce the cost of health coverage for yourself and/or your dependents:

- You must file a federal income tax return in 2016 for the tax year 2015.
- If you are married at the end of 2015, you must file a joint income tax return with your spouse.

You also expect that:

- No one else will be able to claim you as a dependent on their 2015 federal income tax return.
- You will claim a personal exemption deduction on your 2015 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments.

If any of your information changes, you understand that it may impact your ability to get an Advance Premium Tax Credit. You also understand that when you file your 2015 federal income tax return, you must reconcile the amount of advance payments actually made with the amount of any premium tax credit you are entitled to receive. You understand that if the amount of the advance payments made on your behalf is less than the amount of any premium tax credit you are entitled to receive, you may be entitled to an additional credit amount. Alternatively, if the amount of advance payments made on your behalf exceeds the amount of any credit you are entitled to receive, you may owe additional federal income tax.

You understand that failure to make the first premium payment towards your policy to the Massachusetts Health Connector could result in a delay in the start of your plan or cancellation of your enrollment.

You understand that providing this payment information does not guarantee approval or coverage. The Health Connector must process your enrollment request. Please contact the Massachusetts Health Connector if you have any questions or concerns.

☐ ***I have read and agreed to terms and services.**

*** Head of Household E-Signature**

Date Submitted : 10/16/2015

Previous | Finish

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Enroll			

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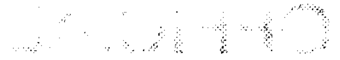
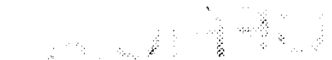
Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Static	Read the User Agreement and add your signature to submit your application			
Static	TERMS AND CONDITIONS OF ENROLLMENT AGREEMENT You have applied for a medical or dental insurance plan ("Plan") offered through the Commonwealth Health Insurance Connector Authority ("Connector"). The Connector is responsible for enrolling you, billing and collecting premiums from you, sending your premiums to the Plan in which you enroll, and, when appropriate, terminating your coverage. When we use the word "Connector" in this Agreement, it means the Connector or its Agents, Designees or subcontractors. **BY APPLYING FOR AND ENROLLING IN A PLAN THROUGH THE CONNECTOR, I UNDERSTAND AND AGREE TO, ON BEHALF OF MYSELF AND MY ENROLLED DEPENDENTS, THE FOLLOWING TERMS AND CONDITIONS:** **1. Eligibility.** My dependents and I are eligible to purchase insurance under state and federal law and Connector policies. **2. Termination of Current Health Plan.** If I am currently enrolled in a Health Connector Plan, my enrollment in this new Plan indicates my request for the termination of my previous health plan. I will not have an overlap of health plan coverage through the Connector.			



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	3. Enrollment Requirements. (a) My enrollment in a Plan is subject to acceptance by the Issuer. (b) My coverage in a Plan will begin on the first day of the calendar month selected for coverage if all documentation and payments are received by the required due date. This is called my "Effective Date." (c) If requested, I will give the Connector complete information and documentation to establish my dependents' and my own eligibility, including, but not limited to, proof of residency, citizenship, or incarceration status. If I fail to comply with the request(s), the Connector may not be required to issue a Plan to me. I will promptly notify the Connector of any changes to my address or citizenship or residency status, and, if I am receiving any federal or state subsidies, any changes in income or access to other health insurance. I attest that I will enroll in a plan only with my eligible dependents, in accordance with Connector policy and state law. My dependents eligible to enroll with me may or may not be part of my tax household. **4. Plan Selection.** (a) I am free to select among any of the Plans offered by the Connector as long as I meet the eligibility requirements for enrolling in that Plan. (b) Each Plan has its own written			



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	description of the benefits, terms and conditions that will apply to people enrolled in that Plan. This description is in a booklet usually called an "Evidence of Coverage." When I am accepted for enrollment in a Plan, my coverage will be provided according to all the terms and conditions of that Plan's Evidence of Coverage. The Issuer and not the Connector will: (i) provide me with an Evidence of Coverage; and (ii) provide me coverage for medical or dental benefits according to that Evidence of Coverage. **5. Coverage Period.** (a) For Platinum/Gold/Silver/Bronze Health Plans and ConnectorCare Plans. (i) My coverage will end on December 31, 2015. (ii) Once my coverage is effective, I cannot change to a different Plan outside of the open enrollment periods, as defined by state or federal law, unless an exception applies or I experience a triggering event in accordance with state and federal law. (iii) If I become eligible for employer-sponsored coverage through the Connector, I may switch to that Plan regardless of the date.			

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Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	(b) For Catastrophic Plans. (i) My coverage will end December 31, 2015. (ii) If my 30th birthday occurs prior to the coverage end date and I do not have a Certificate of Exemption granted on the basis of financial hardship or a lack of affordable coverage available to me, I may remain in the Catastrophic Plan until my renewal date, be disenrolled at the end of my plan year, or be offered an Individual/family non group plan prior to my termination date. (iii) Once I am enrolled, I cannot change to a different Catastrophic Plan, except as permitted by state or federal law and Connector policies. (iv) If I become eligible for employer-sponsored coverage through the Connector, I may switch to that plan regardless of the coverage end date. (c) For Dental Plans (i) My coverage will last twelve (12) months from the date of enrollment.			

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	(ii) If I become eligible for employer-sponsored coverage through the Connector, I may switch to that Plan regardless of the date. (iii) I understand that if I cancel coverage, I may not be able to repurchase a dental plan through the Health Connector for a period of time, depending on my Plan Issuer's policies. **6. Annual Deductibles and Out-of-Pocket Maximums.** If I change health or dental plans, I will be subject to the new deductible and out of pocket maximum of that plan. **7. Payment and Related Terms.** (a) I agree to pay the monthly premium for the Plan that I select. I also agree to pay any applicable Connector-imposed fees related to my monthly premium payments, such as fees for non-sufficient funds, wire transfer fees, or reinstatement fees, if applicable. (b) The Connector will bill me once a month. This bill will be sent to me approximately thirty (30) calendar days before the applicable coverage month. (For example, on July 1st the Connector will send me a bill for my August coverage.) The bill will state the premium as well as any fees I have incurred for the applicable coverage			

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	month. (c) I agree to pay the Connector so that the premium is received five (5) full business days prior to the coverage month ("Due Date"). (For example, the Due Date for a bill sent on March 1st is March 24th.) (d) The amount of my monthly premium will not change during my coverage period, unless I add or remove dependents. However, if I am receiving tax credits or other subsidies, the amount of the premium that I pay may change if I adjust my federal tax credit amount or if my eligibility changes. Changes in my premium payment will never be based on my dependents' or my health status or our use of medical services. (Please note, premium rates charged by health and dental insurance Issuers are subject to review by the Massachusetts Division of Insurance (DOI) and could change per DOI order.) (e) I understand that if I was incorrectly enrolled in a ConnectorCare plan, for example, because I provided inaccurate information, the Health Connector may recover any state subsidies paid on my behalf. **8. Cancellation and Termination.** (a) I may cancel my coverage at any time by notifying the Connector at least two business days in advance by phone, fax, email, or regular mail. My coverage will end on the last day of the calendar month in which I notify the			

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	Connector. I am not permitted to cancel my coverage retroactively (back in time). If I cancel my coverage, I am responsible for paying the premiums up until the effective date of my cancellation. (b) For persons receiving non-subsidized coverage, if the Connector does not receive my full premium by the due date indicated in the Notice of Delinquency, then the coverage is terminated on the day following that date when my account is two months past due. The coverage end date is retroactive to the last day of the coverage month for which my monthly premium was paid in full in accordance with Connector policies. For subsidized coverage (receiving any state or federal subsidies), if the Connector does not receive my full premium by the due date indicated in the Notice of Delinquency, then the coverage is terminated on the day following that date. The coverage end date is retroactive to the last day of the first coverage month in which I was delinquent (i.e. one month grace period) in accordance with Connector policies. If my coverage is terminated, I may be entitled to have my coverage reinstated with the same Plan and Issuer if my coverage has not lapsed for more than thirty (30) days from the termination date. To do so, I must pay all overdue premiums, the current month's premium, and any fees, if applicable, including charges due to			

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	insufficient funds, wire transfer fees, and reinstatement fees. (c) The Connector may cancel my Plan if: (i) I fail to pay my premiums; (ii) I commit fraud; (iii) I misrepresent my dependents' or my eligibility for the Plan or specific benefits of the Plan; (iv) I misrepresent any information relevant to my enrollment in the Plan; (v) I fail to comply in a material manner with the Plan requirements, including, but not limited to, by moving outside of the Carrier's service area; or (vi) My mail is returned as undeliverable and I do not confirm my correct address with the Health Connector. The Connector will provide written notice of the effective date of the Plan's cancellation and I will be responsible for the cost of any medical care services that I or my dependents receive after that date. **9. Connector Policies and Procedures.**			

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	I may request from the Connector a copy of any detailed enrollment, billing or payment policies and procedures. These policies and procedures are considered a part of this Terms and Conditions Agreement. **10. Amendments.** The Connector may amend these Terms and Conditions from time to time. The Connector shall provide me with notice of such amendment and its effective date. **11. Limitation on Liability.** Neither the Connector nor its Agent, Designee, or subcontractor shall have any liability or responsibility whatsoever to me, my enrolled dependents, or any third party: 1. If I do not pay my premium to the Connector in accordance with this Agreement; or 2. Based on the acts or omissions of: (i) the Issuer with respect to its provision of coverage for medical benefits due, or alleged to be due, to me or my enrolled dependents under that Plan; or (ii) any health care provider who provides health care services to me or my enrolled dependents under the Plan.			

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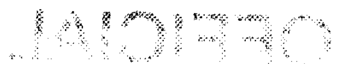
Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	12. Waiver. The Connector's exercise or non-exercise of any of its rights under this contract on any occasion shall not be construed as a waiver of any of my obligations nor shall it obligate the Connector to act in a similar fashion on any later occasion. **13. Governing Law.** This Agreement and the rights and obligations of you and the Connector will be governed by and interpreted in accordance with the laws of the Commonwealth of Massachusetts, without giving effect to its choice of law rules. **14. ACCEPTANCE OF THIS AGREEMENT.** **EITHER (1) MY VERBAL CONSENT GIVEN TO THE CONNECTOR OR (2) PAYMENT OF MY FIRST MONTH'S PREMIUM AFTER A COMPLETED APPLICATION IS ACCEPTED BY THE CONNECTOR IS DEEMED TO BE ACCEPTANCE OF THIS AGREEMENT ON BEHALF OF ANY DEPENDENTS AND MYSELF.** By signing this agreement, you are also agreeing to the following statements: You understand that because advance payments of the premium tax credit will be paid on your behalf to reduce the cost of health coverage for yourself and/or your dependents: • You must file a federal income tax return in 2016 for the tax year			

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	2015. • If you are married at the end of 2015, you must file a joint income tax return with your spouse. You also expect that: • No one else will be able to claim you as a dependent on their 2015 federal income tax return. • You will claim a personal exemption deduction on your 2015 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments. If any of your information changes, you understand that it may impact your ability to get an Advance Premium Tax Credit. You also understand that when you file your 2015 federal income tax return, you must reconcile the amount of advance payments actually made with the amount of any premium tax credit you are entitled to receive. You understand that if the amount of the advance payments made on your behalf is less than the amount of any premium tax credit you are entitled to receive, you may be entitled to an additional credit amount. Alternatively, if the amount of advance payments made on your behalf exceeds the amount of any credit you are entitled to receive, you may owe additional federal income tax. You understand that failure to make the first premium payment towards your policy to the Massachusetts Health Connector could result in a delay in the start of your plan or cancellation of your enrollment. You understand that providing this			



Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
	payment information does not guarantee approval or coverage. The Health Connector must process your enrollment request. Please contact the Massachusetts Health Connector if you have any questions or concerns.			
Check box	I have read and agreed to terms and services.		Yes	
Textbox	Head of Household E-Signature		Yes	
Dynamic Text	Submission date: mm/dd/yyyy			
Button	Back			
Button	Finish			

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8 Thank you for completing your application

Request submitted successfully

✓You have submitted your eligibility application and selected a plan.

What's next?

If your plan does not require you to pay a monthly premium, you will receive a letter confirming your coverage.

If your plan requires you to pay a monthly premium, you must make your first payment to complete your enrollment and begin your insurance coverage. Click here to make an online payment now. Or review all available payment options on the Connector website.

We will send you a bill in the mail. Payment is due on the 23rd day of the month before your coverage effective date.

If you have any questions, please contact the Health Connector Customer Service at 1-877-MA-ENROLL (1-877-623-6765), TTY 1-877-623-7773.

Close

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Modal	You have submitted your eligibility application and selected a plan.			
Modal	What's next?			Same size/font as above
Modal	If your plan does not require you to pay a monthly premium, you will receive a letter confirming your coverage.	EFT (make an online payment now): https://payment.MAHealthConnector.org		

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Close

Type	Content	Functions	Mandatory (Y/N/NA)	Possible Validation
Modal	You have submitted your eligibility application and selected a plan.			
Modal	What's next?			Same size/font as above
Modal	If your plan does not require you to pay a monthly premium, you will receive a letter confirming your coverage.	EFT (make an online payment now): https://payment.MAHealthConnector.org		