



## **FINANCIAL ASSISTANCE**

BrightView Health is dedicated to servicing the health care needs of its patients. To assist in meeting those needs, we have established this "Financial Assistance Policy" to provide financial relief to those patients who first meet the requirements as described in this policy.

BrightView Health is committed to providing medically necessary healthcare services to patients regardless of their insurance status or ability to pay. This financial assistance policy is intended to be in compliance with applicable federal and state laws for our service area. Patients qualifying for assistance under this policy will receive a discount for services rendered.

BrightView Health offers financial assistance to patients seeking treatment whose income is at or under a percentage of the publicly available Federal Poverty Guidelines. To qualify for financial assistance from BrightView Health, the patient must:

- Cooperate with Case Manager and Financial Counselor efforts to apply and qualify for Medicaid
- Be deemed ineligible for Medicaid or other governmental programs
- Submit application for financial assistance and all accompanying documentation



**Proof of income**

As part of the application, at least one of the items in the following list of documentation is required for proof of income. If more than one is applicable, all should be submitted.

- a. If you claim that you have no income, a sworn statement from the individual providing you basic support is required.
- b. Three consecutive months of pay stubs, or all pay stubs within past three months if not employed for three months.
- c. Copy of previous year’s federal tax return.
- d. Social Security, Unemployment, or retirement income documentation in the form of a written statement, or verification of benefits from the applicable agency.

Some individuals may not have income able to be documented as indicated above but have significant assets available to pay for healthcare services. In these situations, BrightView Health may require documented proof of assets for evaluation and approval of the application.

**Application Processing**

Upon receipt of the required documentation, the application will be processed by the Revenue Cycle team and resulting discounts will be applied to outstanding patient balances. The patient or guarantor is responsible for the remaining balance after discounts. The Revenue Cycle team will attempt to notify the patient of discounts, but no guarantees are made of notification, outside of the reflection of discounts on future statements or requests for payment.

**Eligibility Criteria**

Eligibility for discount will be based upon income for the family, as a percentage of Federal Poverty Guidelines. The qualification for discounts is listed in the table below and may be updated in accordance with updates to the Federal Poverty Guidelines.

<b>For families/households with more than 8 persons, add \$4,480 for each additional person.</b>				
	<b>100% discount</b>	<b>100% discount</b>	<b>85% discount</b>	<b>50% discount</b>
Family Size	Under FPL	100% - 200% FPL	200% - 300% FPL	300% - 400% FPL
1	\$12,760	\$25,520	\$38,280	\$51,040
2	\$17,240	\$34,480	\$51,720	\$68,960
3	\$21,720	\$43,440	\$65,160	\$86,880
4	\$26,200	\$52,400	\$78,600	\$104,800
5	\$30,680	\$61,360	\$92,040	\$122,720
6	\$35,160	\$70,320	\$105,480	\$140,640
7	\$39,640	\$79,280	\$118,920	\$158,560
8	\$44,120	\$88,240	\$132,360	\$176,480

**Approval Duration**

Approval for Financial Assistance will be for six-month time periods. After six months, an updated application will be required.

## RESOURCES

- **Massachusetts Health Connector:** (800) 841-2900,  
<https://www.mahealthconnector.org/>
- **Massachusetts Department of Unemployment Assistance:**  
<https://www.mass.gov/orgs/departement-of-unemployment-assistance>
- **Massachusetts Department of Children and Families:**  
<https://www.mass.gov/orgs/massachusetts-department-of-children-families>



Date Received by Site:	_____
Primary Site:	_____
MRN:	_____
Date Received by FCT:	_____

## FINANCIAL ASSISTANCE APPLICATION

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

1. This application must be completed in its entirety to be considered for financial assistance.
2. Please list all family members (including yourself). Family members include the applicant, spouse, children (natural or adoptive) under the age of 18 in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, Social Security/Pension benefits, alimony, public assistance, self-employment, etc. Income also includes rent or living expenses that are being provided for you.

Family Member	Age	Relationship to Patient	Income Source	Income for 3 months prior to date of service	Income for 12 months prior to date of service
1.		Self			
2.					
3.					
4.					
5.					
6.					

Send proof of three months of gross income with this application:

Gross income is total income before taxes are taken out, and includes but is not limited to:

- Three consecutive months of pay stubs or all pay stubs within the last three months if not employed for three months.
- Copy of previous year's federal tax return.
- Social security, unemployment, alimony, child support, workers compensation award letter, or retirement income documentation in the form of a written statement, or verification of benefits from the applicable agency.
- Any other income statements.

3. If you reported zero total income, how are you being supported?

\_\_\_\_\_

\_\_\_\_\_

**Please have the following support statement completed by the person(s) helping to support you and/or your family.**



# FINANCIAL ASSISTANCE APPLICATION

## Support Statement

For applicants who stated zero income, the person(s) providing you with basic financial support must provide a brief explanation as to how you are being supported financially. List services, if any, that you are receiving for providing this support.

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I certify that all of the above information provided is true and correct to the best of my knowledge. My signature does not obligate me to provide financial support related to the medical service of the applicant.

\_\_\_\_\_  
Signature of person providing financial support to applicant

\_\_\_\_\_  
Address of responsible party

\_\_\_\_\_  
City, State

\_\_\_\_\_  
Zip Code

4. Have you applied for Medicaid or any other county assistance?

\_\_\_\_\_ No      \_\_\_\_\_ Yes (Date/State \_\_\_\_\_ )

5. Did you have health insurance on the date of service?

\_\_\_\_\_ No      \_\_\_\_\_ Yes (Provide a copy of your card)

By signing this document, I affirm the answers on this application are true. Should further review of an individual's financial assistance application reveal that information provided was either incorrect or fraudulent, the decision to provide assistance may be reversed and the responsible party will be billed.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Applicant or Representative Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**Mail completed application and documentation to:**

**Column Health, LLC DBA BrightView Health**

**P.O. Box 639886**

**Cincinnati, Ohio 45263-9886**

# Massachusetts Application for Health and Dental Coverage and Help Paying Costs



## HOW TO APPLY



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

- **Sign on to your account at [www.MAhealthconnector.org](http://www.MAhealthconnector.org).**  
You can create an online account if you do not already have one.  
**Applying online may be a faster way for you to get coverage than mailing a paper application.**
- **Mail** your filled-out, signed application to  
Health Insurance Processing Center  
PO Box 4405  
Taunton, MA 02780.
- **Fax** your filled-out, signed application to (857) 323-8300.
- **Call** us at **(800) 841-2900** (TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled) or **(877) MA ENROLL ((877) 623-6765)**.
- **Visit** a MassHealth Enrollment Center (MEC). To apply in person or to schedule an appointment with a MassHealth representative, go to [www.mass.gov/masshealth/appointment](http://www.mass.gov/masshealth/appointment). See the **Member Booklet for Help with Health and Dental Coverage and Help Paying Costs** for a list of MEC addresses.
- You can use this application to apply for the Supplemental Nutrition Assistance Program (SNAP). SNAP is a federal program that helps you buy food each month. If you are interested, check the box on page 1, then read and sign the SNAP rights and responsibilities on pages 20-25. Your application will then be sent automatically to the Department of Transitional Assistance. You do not have to apply for the SNAP Program to be considered for MassHealth.



## USE THIS APPLICATION TO SEE WHAT COVERAGE CHOICES YOU MAY QUALIFY FOR.

- Affordable coverage from MassHealth, the Health Safety Net (HSN), the Children's Medical Security Plan (CMSP), or the Health Connector. You may qualify for one of these programs no matter what your income.
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A tax credit that can help pay your premiums for health coverage right away



## WHO CAN USE THIS APPLICATION?

This application is for people who need health or dental coverage and help paying for it, and who

- live in Massachusetts;
- are not living in or not about to go into a nursing facility; and
- are younger than age 65.

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

- parents of children younger than age 19, or
- adult relatives living with and taking care of children younger than age 19 when neither parent is living in the home.

If this application is not for you, call us at (800) 841-2900, TTY: (800) 497-4648.

This application is available in Spanish. Please call the number above to request one.

Apply even if you or your child already has health coverage including coverage from MassHealth and the Health Connector. You could qualify for coverage. We need to know about all members of your household to make a decision on your eligibility.

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



## WHAT YOU MAY NEED TO APPLY

- Social security numbers. You must give us an SSN or proof that anyone on this application has also applied for an SSN. There are exceptions for anyone who
  - has a religious exemption as described in federal law
  - is eligible only for a nonwork SSN, or
  - is not eligible for an SSN.
- Federal tax returns, if you file
- Information about citizenship/national status or immigration status
- Employer and income information for everyone in your household (for example, from paystubs or wage statements)
- Information about any job-related or other health insurance that you are currently enrolled in or have access to



## WHY DO WE ASK FOR THIS INFORMATION?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We will keep all the information you provide private and secure, as required by law.** To view the Health Connector's Privacy Policy, go to [www.MAhealthconnector.org](http://www.MAhealthconnector.org). To view the MassHealth Privacy Policy see the Member Booklet or go to [www.mass.gov/service-details/masshealth-member-privacy-information](http://www.mass.gov/service-details/masshealth-member-privacy-information).



## WHAT HAPPENS NEXT?

You will get instructions on the next steps to complete your eligibility process. If you're eligible for MassHealth and have to enroll in a health plan, we will notify you. Then, you can choose a plan by going to [www.mass.gov/how-to/enroll-in-a-masshealth-health-plan-individuals-and-families-younger-than-65](http://www.mass.gov/how-to/enroll-in-a-masshealth-health-plan-individuals-and-families-younger-than-65). Filling out this application does not mean you have to buy health coverage. If you need help choosing a health plan, you can learn much more by going to [MassHealthChoices.com](http://MassHealthChoices.com).



## GET HELP WITH THIS APPLICATION

**Phone:** please call us for help with this application or if you need interpreter services. **(800) 841-2900**, TTY: (800) 497-4648.



## GENERAL INSTRUCTIONS

- Please **print clearly and answer all questions completely**. There are a few sections where you may be instructed to skip some questions. Other than those exceptions, blank or incomplete answers will slow down the processing of your application.
- You can download pages for additional persons at [www.mass.gov/masshealth](http://www.mass.gov/masshealth). Be sure to tell us how each person is related to each other person. We need this information to determine eligibility.
- It is not necessary to send blank pages for Step 2 if you do not have that many people in your household. Please make sure that you indicate in Section 1 the number of people applying, and send all other sections even if they are blank or partially blank.
  - MassHealth or the Massachusetts Health Connector will send a Request for Information notice if we need any additional information or proof to make an eligibility decision. If we send a Request for Information notice, the individual has 90 days to send the requested proof. MassHealth may provide provisional benefits during this 90-day period to eligible applicants under age 21 and to those individuals who self-attest to pregnancy, HIV positive status, or breast or cervical cancer. **MassHealth benefits may not be provided to an individual age 21 or older until all income in the MAGI household is verified, unless that person is pregnant, has HIV, or is in active treatment for breast or cervical cancer.**
  - In order to get any benefits you are entitled to as quickly as possible, you may include any documentation you have that verifies all household income.

To find resources and information related to the coronavirus for MassHealth applicant and members, go to [www.mass.gov/coronavirus-disease-covid-19-and-masshealth](http://www.mass.gov/coronavirus-disease-covid-19-and-masshealth).

# Massachusetts Application for Health and Dental Coverage and Help Paying Costs



## Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP) is a federal program that helps you buy healthy food each month.

- Check this box if you want this application to be sent to the Department of Transitional Assistance to serve as an application for SNAP benefits. You must read the rights and responsibilities on pages 20-25 and sign on page 26 to proceed with the application.

### STEP 1 Person 1. Tell us about yourself. Please print clearly.

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

1. First name, middle name, last name, and suffix			2. Date of birth	
3. What is your email address?				
<input type="checkbox"/> No home address. Note: if you check this box, you must provide a mailing address.				
4. Street address			5. Apartment or unit number	
6. City		7. State	8. ZIP code	9. County
10. Mailing address <input type="checkbox"/> Check if same as home address.			11. Apartment or unit number	
12. City		13. State	14. ZIP code	15. County
16. Phone number		17. Other phone number		18. # of people listed on the application
19. What is your preferred language, if not English? Spoken _____ Written _____				
20. Is anyone on this application in prison or jail? <input type="checkbox"/> Yes <input type="checkbox"/> No Please select <b>No</b> if this person will be released in the next 60 days. If <b>Yes</b> , who? Enter the name here: _____ If <b>Yes</b> , is this person awaiting trial? <input type="checkbox"/> Yes <input type="checkbox"/> No				

### FOR ENROLLMENT ASSISTERS ONLY

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

Check one  Navigator  Certified Application Counselor

First name, middle name, last name, and suffix		Email address		
Organization name		Organization identification number		Organization phone number



## STEP 2 Tell us about your household.

### Who do you need to include on this application?

Tell us about all the household members who live with you. If you file taxes, we need to know about everyone on your tax return. You do not need to file taxes to get MassHealth, the Health Safety Net, or the Children's Medical Security Plan, if you qualify.

#### DO Include

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

#### DO NOT include

- Your unmarried partner, unless you have children together
- Your unmarried partner's children, unless they live with you or your unmarried partner included them on their tax return
- Your parents whom you live with if your parents file their own taxes and do not claim you as tax dependent (if you are age 19 or older)
- Other adult relatives whom you do not claim as tax dependents

The amount of help or type of program you may qualify for depends on the number of people in your household and their incomes. This information helps us make sure everyone gets the coverage they may be eligible for.

**COMPLETE STEP 2 FOR YOURSELF** and **ALL ADDITIONAL HOUSEHOLD MEMBERS** who live with you, or anyone on your same federal income tax return if you file one. If you do not file a tax return, remember to still add household members who live with you.

## STEP 2 Person 1. This section is to gather more information about the contact person named on page 1.

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

2. Relationship to you **SELF**

3. Date of birth (mm/dd/yyyy)

4. Gender  Male  Female

5. **Optional** What is your race or ethnicity? \_\_\_\_\_ Please see page 27.

MassHealth is committed to providing equitable care for all members regardless of race, ethnicity, or language spoken. Please complete this question to help us meet your language and cultural needs. Know that your response is voluntary, confidential, and will not impact your eligibility or be used for any discriminatory purpose.

6. Do you have a social security number (SSN)?  Yes  No. (optional if **not** applying)

We need a social security number (SSN) for every person applying for health coverage who has one. There are exceptions for anyone who has a religious exemption as described in federal law, who is eligible only for a nonwork SSN, or who is not eligible for an SSN. 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 (800) 772-1213 (TTY: (800) 325-0778), or go to [socialsecurity.gov](https://www.socialsecurity.gov). For more details on how we use your social security number, please see the Member Booklet for Health and Dental Coverage and Help Paying Costs.

If **Yes**, give us the number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If **No**, check one of the following reasons.  Just applied  Noncitizen exception  Religious exception

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

If **No**, what name is on your social security card? \_\_\_\_\_

\_\_\_\_\_  
First name, middle name, last name, and suffix

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

Individuals may not have needed or chosen to file a tax return in the past, but they will have to file a federal income tax return for any year that they get an APTC. They must check "Yes" to question 7 to be eligible for ConnectorCare or APTCs to help pay for your health insurance. **You do NOT need to file a tax return to apply for or to get MassHealth, CMSP, or HSN, if you qualify**

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

Individuals must file a joint federal tax return with their spouse for the year for which they are applying to get certain programs (ConnectorCare or APTCs) unless they are a victim of domestic abuse or abandonment or they will file taxes as Head of Household. If an individual will file taxes as Head of Household, they should answer No to question 7a ("Are you legally married?"). One way an individual may qualify as Head of Household is to live apart from their spouse and claim another person as a dependent. See IRS Publication 501 or consult a tax professional for tax filing information. They will only need to include themselves and any dependents on this application.

- a. Are you legally married?  Yes  No  
If **No**, skip to question 7c.  
If **Yes**, list name of spouse and date of birth. \_\_\_\_\_
- b. Do you plan to file a joint federal tax return with your spouse for the tax year for which you are applying?  Yes  No
- c. Will you claim any dependents on your federal income tax return for the year for which you are applying?  Yes  No  
You will claim a personal exemption deduction on your federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments. List the name(s) and date(s) of birth of dependents.  
\_\_\_\_\_
- d. Will you be claimed as a dependent on someone else's federal income tax return for the year for which you are applying?  
 Yes  No  
If you are claimed by someone else as a dependent on their federal income tax return, this may affect your ability to receive a premium tax credit. Do not answer **Yes** to this question if you are a child under the age of 21 being claimed by a noncustodial parent. If **Yes**, please list the name of the tax filer. \_\_\_\_\_  
Tax filer date of birth \_\_\_\_\_ How are you related to the tax filer? \_\_\_\_\_  
Is the tax filer married, filing a joint return?  Yes  No  
If **Yes**, list name of spouse and date of birth. \_\_\_\_\_  
Who else does the tax filer claim as dependents? \_\_\_\_\_
- e. Are you filing taxes separately because you are a victim of domestic abuse or abandonment?  Yes  No

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

Answer **Yes** if: 1. You have received an APTC or ConnectorCare in the past, and  
2. The statement is true for all people listed in the household.

8. Are you applying for health or dental coverage for **YOURSELF**?  Yes  No  
If **Yes**, answer all the questions below. If **No**, answer Questions 14 and 15, then go to **Income Information** on page 4.
9. Are you a U.S. citizen or U.S. national?  Yes  No  
If **Yes**, are you a naturalized citizen (not born in the U.S.)?  Yes  No  
Alien number \_\_\_\_\_ Naturalization or citizenship certificate number \_\_\_\_\_
10. If you are a noncitizen, do you have an eligible immigration status?  Yes  No. If **No**, go to Question 11.
- See page 27, "Immigration Statuses and Document Types" for help. If no or no response, applicants 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).
- a. If **Yes**, do you have an immigration document?  Yes  No
- It may help us to process this application faster if you include a copy of immigration documents for all the individuals who are applying. We will try to verify immigration status through an electronic data match. Please list all the immigration

statuses or conditions that have applied to all the individuals on this application since they entered the U.S. If you need more space, attach another sheet of paper.

Status award date (mm/dd/yyyy) \_\_\_\_\_ (For battered persons, enter the date the petition was approved as properly filed.)

Immigration status \_\_\_\_\_ Immigration document type \_\_\_\_\_  
Choose one or more document status and types from the list on page 27.

Document ID number \_\_\_\_\_ Alien number \_\_\_\_\_

Passport or document expiration date (mm/dd/yyyy) \_\_\_\_\_ Country \_\_\_\_\_

- b. Did you use the same name on this application that you did to get your immigration status?  Yes  No  
If **No**, what name did you use? First, middle, last, and suffix \_\_\_\_\_
- c. Did you arrive in the U.S. after August 22, 1996?  Yes  No
- d. Are you an honorably discharged veteran or active-duty member of the U.S. military, or the spouse or child of an honorably discharged veteran or an active-duty member of the U.S. military?  Yes  No
- e. **Optional** Are you a:  victim of severe trafficking,  a spouse, child, sibling, or parent of a trafficking victim  
 a battered spouse,  a child or the parent of battered spouse?

11. Do you live with at least one child younger than age 19, and are you the main person taking care of this child(ren)?  
 Yes  No  
Name(s) and date(s) of birth of child(ren) \_\_\_\_\_

12. Are you living in Massachusetts, and do you either intend to reside here, even if you do not have a fixed address, or have you entered Massachusetts with a job commitment or seeking employment?  Yes  No  
If you are visiting in Massachusetts for personal pleasure or for the purposes of receiving medical care in a setting other than a nursing facility, you must answer **No** to this question.

13. 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

14. Do you need reasonable accommodation because of a disability or an injury?  Yes  No  
If **Yes**, complete the rest of this application, including Supplement C: Accommodation.

15. Are you pregnant?  Yes  No  
If **Yes**, how many babies are you expecting? \_\_\_\_\_ What is your expected due date? \_\_\_\_\_

16. **Optional** Do you have breast or cervical cancer?  Yes  No (Special coverage rules may apply.)

17. **Optional** Are you HIV positive?  Yes  No (MassHealth has special coverage rules for people with HIV.)

- 18. Were you ever in foster care?  Yes  No
  - a. If **Yes**, in what state were you in foster care? \_\_\_\_\_
  - b. Were you getting health care through a state Medicaid program?  Yes  No

**INCOME INFORMATION (You may send proof of all household income with this application.)**

19. Do you have any income?  Yes  No  
If you don't have any income, skip to question 33.

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

20. **CURRENT JOB 1:** Employer name and address \_\_\_\_\_ Federal Tax ID# \_\_\_\_\_

21. a. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  
 Yearly (Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)  
b. Income effective date \_\_\_\_\_

22. Average number of hours worked each WEEK \_\_\_\_\_

**STEP 2** Person 1 (continued)

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

24. **CURRENT JOB 2:** Employer name and address

Federal Tax ID#

25. a. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  
 Yearly (Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)  
b. Income effective date \_\_\_\_\_

26. Average number of hours worked each WEEK \_\_\_\_\_

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

28. **SELF-EMPLOYMENT:** Are you self-employed?  Yes  No

- a. If **Yes**, what type of work do you do? \_\_\_\_\_
- b. On average, how much net income (profits or losses after business expenses are paid) will you get from this self-employment each month? \$ \_\_\_\_\_/month **profit** or \$ \_\_\_\_\_/month **loss**?
- c. How many hours do you work per week? \_\_\_\_\_

**OTHER INCOME**

29. Check all that apply, and give the amount and how often you get it. **NOTE: You do not need to tell us about child support, nontaxable veteran's payments, Supplemental Security Income (SSI), or most workers' compensation income.**

- Social security benefits \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Unemployment \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Retirement or pension \$ \_\_\_\_\_ How often received? \_\_\_\_\_ Source \_\_\_\_\_
- Interest, dividends, and other investment income \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Royalty income \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Taxable veteran's benefits \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Taxable military retirement pay \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Alimony received \$ \_\_\_\_\_ How often received? \_\_\_\_\_  
If you are receiving alimony payments from a divorce, separation agreement, or court order that was finalized before January 1, 2019, enter the amount of those payments here. \$ \_\_\_\_\_
- Other taxable income \$ \_\_\_\_\_ How often received? \_\_\_\_\_ Type \_\_\_\_\_
- Net rental income: On average, how much net income (profits after rental expenses are paid) will you get from this rental each month, or how much will you lose from this rental each month? \$ \_\_\_\_\_ month **profit** or \$ \_\_\_\_\_ month **loss**
- Capital gains: On average, how much net income or loss will you get from this capital gain each month? \$ \_\_\_\_\_/profit or \$ \_\_\_\_\_/loss
- Net farming or fishing income: On average, how much net income (profits after business expenses are paid) or loss will you get from this business each month? \$ \_\_\_\_\_/profit or \$ \_\_\_\_\_/loss
- Lottery and gambling winnings: \$ \_\_\_\_\_ Effective Date \_\_\_\_\_  
How often?  One time only  Weekly  Every two weeks  Twice a month  Monthly  Yearly  
Non-cash prizes are not counted as qualified lottery and gambling winnings. Do not include any losses in the amount.

**ONE-TIME ONLY INCOME**

30. Have you or will you receive income during this calendar year as a one-time only payment?  Yes  No  
Examples might be a lump-sum pension payment or a one-time capital gain.  
If **Yes**: Type \_\_\_\_\_ Amount \$ \_\_\_\_\_ Month Received \_\_\_\_\_ Year received \_\_\_\_\_
31. Will you receive income during the next calendar year as a one-time only payment?  Yes  No  
If **Yes**: Type: \_\_\_\_\_ Amount \$ \_\_\_\_\_ Month Received \_\_\_\_\_ Year received \_\_\_\_\_

**DEDUCTIONS**

32. What deductions do you report on your income tax return?

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. Check all that apply. Your deductions should be what you report on your federal income tax return in the section "Adjusted Gross Income." For each deduction you select, give the yearly amount. You can enter up to the maximum deduction amount allowed by the IRS.

- Educator expense: Yearly amount \$ \_\_\_\_\_
- Certain business expenses of reservists, performing artists, or fee-based government officials: Yearly amount \$ \_\_\_\_\_
- Health Savings Account deduction: Yearly amount \$ \_\_\_\_\_
- Moving expenses for members of the Armed Forces: Yearly amount \$ \_\_\_\_\_
- Deductible part of self-employment tax: Yearly amount \$ \_\_\_\_\_
- Contribution to self-employed SEP, SIMPLE, and qualified plans: Yearly amount \$ \_\_\_\_\_
- Self-employed health insurance deduction: Yearly amount \$ \_\_\_\_\_
- Penalty on early withdrawal of savings: Yearly amount \$ \_\_\_\_\_
- Alimony paid for a divorce, separation agreement, or court order that was finalized before January 1, 2019:  
Yearly amount \$ \_\_\_\_\_
- Individual Retirement Account (IRA) deduction: Yearly amount \$ \_\_\_\_\_
- Student loan deduction (interest only, not total payment): Yearly amount \$ \_\_\_\_\_
- None

**YEARLY INCOME**33. Did you receive any unemployment benefits this calendar year?  Yes  No

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

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

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

**STEP 2 Person 2**

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

2. Relationship to Person 1

Does this person live with Person 1?  Yes  NoIf **No**, list address.

3. Date of birth (mm/dd/yyyy)

4. Gender  Male  Female5. **Optional** What is this person's race or ethnicity? \_\_\_\_\_ Please see page 27.6. Does this person have a social security number (SSN)?  Yes  No (optional if **not** applying)  
We need a social security number (SSN) for every person applying for health coverage who has one.

For important SSN information and how to apply for SSN, please see instructions for Question 6 under Person 1.

If **Yes**, give us the number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_If **No**, check one of the following reasons.  Just applied  Noncitizen exception  Religious exceptionIs the name on this application the same as the name on this person's social security card?  Yes  NoIf **No**, what name is on this person's social security card?\_\_\_\_\_  
First name, middle name, last name, and suffix7. If this person gets an Advance Premium Tax Credit (APTC), does this person agree to file a federal tax return for the tax year that the credits are received?  Yes  No

See instructions for Question 7 under Person 1.

**STEP 2** | Person 2 (continued)

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

a. Is this person legally married?  Yes  No

If **No**, skip to question 7c.

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

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

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

This person will claim a personal exemption deduction on their federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments. List the name(s) and date(s) of birth of dependents.

\_\_\_\_\_

d. Will this person be claimed as a dependent on someone else's federal income tax return for the year for which this person is applying?  Yes  No

If this person is claimed by someone else as a dependent on their federal income tax return, this may affect this person's ability to receive a premium tax credit. Do not answer **Yes** to this question if this person is a child under the age of 21 being claimed by a noncustodial parent. If **Yes**, please list the name of the tax filer. \_\_\_\_\_

Tax filer date of birth \_\_\_\_\_ How is this person related to the tax filer? \_\_\_\_\_

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

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

Who else does the tax filer claim as dependents? \_\_\_\_\_

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

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

If **Yes**, answer all the questions below. If **No**, answer Questions 14 and 15, then go to **Income Information** on page 8.

9. Is this person a U.S. citizen or U.S. national?  Yes  No

If **Yes**, is this person a naturalized citizen (not born in the U.S.)?  Yes  No

Alien number \_\_\_\_\_ Naturalization or citizenship certificate number \_\_\_\_\_

10. If this person is a noncitizen, does he or she have an eligible immigration status?  Yes  No

See instructions for Question 10 under Person 1.

a. If **Yes**, does this person have an immigration document?  Yes  No

Status award date (mm/dd/yyyy) \_\_\_\_\_ (For battered persons, enter the date the petition was approved as properly filed.)

Immigration status \_\_\_\_\_ Immigration document type \_\_\_\_\_

Choose one or more document status and types from the list on page 27.

Document ID number \_\_\_\_\_ Alien number \_\_\_\_\_

Passport or document expiration date (mm/dd/yyyy) \_\_\_\_\_ Country \_\_\_\_\_

b. Did this person use the same name on this application that he or she did to get this person's immigration status?  
 Yes  No

If **No**, what name did this person use? First, middle, last, and suffix \_\_\_\_\_

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

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

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

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

Name(s) and date(s) of birth of child(ren) \_\_\_\_\_

12. Is this person living in Massachusetts, and does this person either intend to reside here, even if he or she does not have a fixed address, or has this person entered Massachusetts with a job commitment or seeking employment?  Yes  No  
If this person is visiting in Massachusetts for personal pleasure or for the purposes of receiving medical care in a setting other than a nursing facility, you must answer **No** to this question.
13. Does this person 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
14. Does this person need reasonable accommodation because of a disability or an injury?  Yes  No  
If **Yes**, complete the rest of this application, including Supplement C: Accommodation.
15. Is this person pregnant?  Yes  No  
If **Yes**, how many babies is she expecting? \_\_\_\_\_ What is the expected due date? \_\_\_\_\_
16. **Optional** Does this person have breast or cervical cancer?  Yes  No (Special coverage rules may apply.)
17. **Optional** Is this person HIV positive?  Yes  No (MassHealth has special coverage rules for people with HIV.)
18. Was this person ever in foster care?  Yes  No  
a. If **Yes**, in what state was this person in foster care? \_\_\_\_\_  
b. Was this person getting health care through a state Medicaid program?  Yes  No

**INCOME INFORMATION (You may send proof of all household income with this application.)**

19. Does this person have any income?  Yes  No  
If this person doesn't have any income, skip to question 33.

**EMPLOYMENT | If this person needs more space, attach another sheet of paper.**

20. **CURRENT JOB 1:** Employer name and address \_\_\_\_\_ Federal Tax ID# \_\_\_\_\_
21. a. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  
 Yearly (Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)  
b. Income effective date \_\_\_\_\_
22. Average number of hours worked each WEEK \_\_\_\_\_
23. Is this person seasonally employed?  Yes  No. If **Yes**, which months does this person work in a calendar year?  
 Jan.  Feb.  March  April  May  June  July  August  Sept.  Oct.  Nov.  Dec.
24. **CURRENT JOB 2:** Employer name and address \_\_\_\_\_ Federal Tax ID# \_\_\_\_\_
25. a. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  
 Yearly (Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)  
b. Income effective date \_\_\_\_\_
26. Average number of hours worked each WEEK \_\_\_\_\_
27. Is this person seasonally employed?  Yes  No. If **Yes**, which months does this person work in a calendar year?  
 Jan.  Feb.  March  April  May  June  July  August  Sept.  Oct.  Nov.  Dec.
28. **SELF-EMPLOYMENT:** Is this person self-employed?  Yes  No  
a. If **Yes**, what type of work does this person do? \_\_\_\_\_  
b. On average, how much net income (profits or losses after business expenses are paid) will this person get from this self-employment each month? \$ \_\_\_\_\_/month **profit** or \$ \_\_\_\_\_/month **loss**?  
c. How many hours does this person work per week? \_\_\_\_\_



**OTHER INCOME**

29. Check all that apply, and give the amount and how often this person gets it. **NOTE: You do not need to tell us about child support, nontaxable veteran's payments, Supplemental Security Income (SSI), or most workers' compensation income.**

- Social security benefits \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Unemployment \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Retirement or pension \$ \_\_\_\_\_ How often received? \_\_\_\_\_ Source \_\_\_\_\_
- Interest, dividends, and other investment income \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Royalty income \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Taxable veteran's benefits \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Taxable military retirement pay \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Alimony received \$ \_\_\_\_\_ How often received? \_\_\_\_\_  
If this person is receiving alimony payments from a divorce, separation agreement, or court order that was finalized before January 1, 2019, enter the amount of those payments here. \$ \_\_\_\_\_
- Other taxable income \$ \_\_\_\_\_ How often received? \_\_\_\_\_ Type \_\_\_\_\_
- Net rental income: On average, how much net income (profits after rental expenses are paid) will you get from this rental each month, or how much will you lose from this rental each month? \$ \_\_\_\_\_ month **profit** or \$ \_\_\_\_\_ month **loss**
- Capital gains: On average, how much net income or loss will this person get from this capital gain each **month**? \$ \_\_\_\_\_ /**profit** or \$ \_\_\_\_\_ /**loss**
- Net farming or fishing income: On average, how much net income (profits after business expenses are paid) or loss will this person get from this business each month? \$ \_\_\_\_\_ /**profit** or \$ \_\_\_\_\_ /**loss**
- Lottery and gambling winnings: \$ \_\_\_\_\_ Effective Date \_\_\_\_\_  
How often?  One time only  Weekly  Every two weeks  Twice a month  Monthly  Yearly  
Non-cash prizes are not counted as qualified lottery and gambling winnings. Do not include any losses in the amount.

**ONE-TIME ONLY INCOME**

30. Has or will this person receive income during this calendar year as a one-time only payment?  Yes  No  
Examples might be a lump-sum pension payment or a one-time capital gain.  
If **Yes**: Type: \_\_\_\_\_ Amount \$ \_\_\_\_\_ Month Received \_\_\_\_\_ Year received \_\_\_\_\_
31. Will this person receive income during the next calendar year as a one-time only payment?  Yes  No  
If **Yes**: Type: \_\_\_\_\_ Amount \$ \_\_\_\_\_ Month Received \_\_\_\_\_ Year received \_\_\_\_\_

**DEDUCTIONS**

32. What deductions does he or she report on their income tax return?

See instructions for Question 33 under Person 1.

- Educator expense: Yearly amount \$ \_\_\_\_\_
- Certain business expenses of reservists, performing artists, or fee-based government officials: Yearly amount \$ \_\_\_\_\_
- Health Savings Account deduction: Yearly amount \$ \_\_\_\_\_
- Moving expenses for members of the Armed Forces: Yearly amount \$ \_\_\_\_\_
- Deductible part of self-employment tax: Yearly amount \$ \_\_\_\_\_
- Contribution to self-employed SEP, SIMPLE, and qualified plans: Yearly amount \$ \_\_\_\_\_
- Self-employed health insurance deduction: Yearly amount \$ \_\_\_\_\_
- Penalty on early withdrawal of savings: Yearly amount \$ \_\_\_\_\_
- Alimony paid for a divorce, separation agreement, or court order that was finalized before January 1, 2019:  
Yearly amount \$ \_\_\_\_\_
- Individual Retirement Account (IRA) deduction: Yearly amount \$ \_\_\_\_\_
- Student loan deduction (interest only, not total payment): Yearly amount \$ \_\_\_\_\_
- None



## YEARLY INCOME

33. Did this person receive any unemployment benefits this calendar year?  Yes  No

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

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

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

## STEP 2 Person 3

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

2. Relationship to Person 1 Relationship to Person 2 Does this person live with Person 1?  Yes  No

If **No**, list address.

3. Date of birth (mm/dd/yyyy)

4. Gender  Male  Female

5. **Optional** What is this person's race or ethnicity? \_\_\_\_\_ Please see page 27.

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

For important SSN information and how to apply for SSN, please see instructions for Question 6 under Person 1.

If **Yes**, give us the number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If **No**, check one of the following reasons.  Just applied  Noncitizen exception  Religious exception

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

If **No**, what name is on this person's social security card?

\_\_\_\_\_  
First name, middle name, last name, and suffix

7. If this person gets an Advance Premium Tax Credit (APTC), does this person agree to file a federal tax return for the tax year that the credits are received?  Yes  No

See instructions for Question 7 under Person 1.

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

a. Is this person legally married?  Yes  No

If **No**, skip to question 7c.

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

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

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

This person will claim a personal exemption deduction on their federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments. List the name(s) and date(s) of birth of dependents.

d. Will this person be claimed as a dependent on someone else's federal income tax return for the year for which this person is applying?  Yes  No

If this person is claimed by someone else as a dependent on their federal income tax return, this may affect this person's ability to receive a premium tax credit. Do not answer **Yes** to this question if this person is a child under the age of 21 being claimed by a noncustodial parent. If **Yes**, please list the name of the tax filer. \_\_\_\_\_

Tax filer date of birth \_\_\_\_\_ How is this person related to the tax filer? \_\_\_\_\_

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

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

Who else does the tax filer claim as dependents? \_\_\_\_\_

- e. Is this person filing taxes separately because they are a victim of domestic abuse or abandonment?  Yes  No
- 
8. Is this person applying for health or dental coverage?  Yes  No  
If **Yes**, answer all the questions below. If **No**, answer Questions 14 and 15, then go to **Income Information** on page 12.
- 
9. Is this person a U.S. citizen or U.S. national?  Yes  No  
If **Yes**, is this person a naturalized citizen (not born in the U.S.)?  Yes  No  
Alien number \_\_\_\_\_ Naturalization or citizenship certificate number \_\_\_\_\_
- 
10. If this person is a noncitizen, does he or she have an eligible immigration status?  Yes  No  
**See instructions for Question 10 under Person 1.**
- a. If **Yes**, does this person have an immigration document?  Yes  No  
Status award date (mm/dd/yyyy) \_\_\_\_\_ (For battered persons, enter the date the petition was approved as properly filed.)  
Immigration status \_\_\_\_\_ Immigration document type \_\_\_\_\_  
Choose one or more document status and types from the list on on page 27.  
Document ID number \_\_\_\_\_ Alien number \_\_\_\_\_  
Passport or document expiration date (mm/dd/yyyy) \_\_\_\_\_ Country \_\_\_\_\_
- b. Did this person use the same name on this application that he or she did to get this person's immigration status?  
 Yes  No  
If **No**, what name did this person use? First, middle, last, and suffix \_\_\_\_\_
- c. Did this person arrive in the U.S. after August 22, 1996?  Yes  No
- d. Is this person an honorably discharged veteran or active-duty member of the U.S. military, or the spouse or child of an honorably discharged veteran or an active-duty member of the U.S. military?  Yes  No
- e. **Optional** Is this person a:  victim of severe trafficking,  a spouse, child, sibling, or parent of a trafficking victim  
 a battered spouse,  a child or the parent of battered spouse?
- 
11. Does this person live with at least one child younger than age 19, and is this person the main person taking care of this child(ren)?  Yes  No  
Name(s) and date(s) of birth of child(ren) \_\_\_\_\_
- 
12. Is this person living in Massachusetts, and does this person either intend to reside here, even if he or she does not have a fixed address, or has this person entered Massachusetts with a job commitment or seeking employment?  Yes  No  
If this person is visiting in Massachusetts for personal pleasure or for the purposes of receiving medical care in a setting other than a nursing facility, you must answer **No** to this question.
- 
13. Does this person 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
- 
14. Does this person need reasonable accommodation because of a disability or an injury?  Yes  No  
If **Yes**, complete the rest of this application, including Supplement C: Accommodation.
- 
15. Is this person pregnant?  Yes  No  
If **Yes**, how many babies is she expecting? \_\_\_\_\_ What is the expected due date? \_\_\_\_\_
- 
16. **Optional** Does this person have breast or cervical cancer?  Yes  No (Special coverage rules may apply.)
- 
17. **Optional** Is this person HIV positive?  Yes  No (MassHealth has special coverage rules for people with HIV.)
- 
18. Was this person ever in foster care?  Yes  No
- a. If **Yes**, in what state was this person in foster care? \_\_\_\_\_
- b. Was this person getting health care through a state Medicaid program?  Yes  No
-

**INCOME INFORMATION (You may send proof of all household income with this application.)**

19. Does this person have any income?  Yes  No  
If this person doesn't have any income, skip to question 34.

**EMPLOYMENT | If this person needs more space, attach another sheet of paper.**

20. **CURRENT JOB 1:** Employer name and address \_\_\_\_\_ Federal Tax ID# \_\_\_\_\_
21. a. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  
 Yearly (Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)  
b. Income effective date \_\_\_\_\_
22. Average number of hours worked each WEEK \_\_\_\_\_
23. Is this person seasonally employed?  Yes  No. If **Yes**, which months does this person work in a calendar year?  
 Jan.  Feb.  March  April  May  June  July  August  Sept.  Oct.  Nov.  Dec.
24. **CURRENT JOB 2:** Employer name and address \_\_\_\_\_ Federal Tax ID# \_\_\_\_\_
25. a. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  
 Yearly (Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)  
b. Income effective date \_\_\_\_\_
26. Average number of hours worked each WEEK \_\_\_\_\_
27. Is this person seasonally employed?  Yes  No. If **Yes**, which months does this person work in a calendar year?  
 Jan.  Feb.  March  April  May  June  July  August  Sept.  Oct.  Nov.  Dec.
28. **SELF-EMPLOYMENT:** Is this person self-employed?  Yes  No
- a. If **Yes**, what type of work does this person do? \_\_\_\_\_
- b. On average, how much net income (profits or losses after business expenses are paid) will this person get from this self-employment each month? \$ \_\_\_\_\_/month **profit** or \$ \_\_\_\_\_/month **loss**?
- c. How many hours does this person work per week? \_\_\_\_\_

**OTHER INCOME**

29. Check all that apply, and give the amount and how often this person gets it. **NOTE: You do not need to tell us about child support, nontaxable veteran's payments, Supplemental Security Income (SSI), or most workers' compensation income.**
- Social security benefits \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Unemployment \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Retirement or pension \$ \_\_\_\_\_ How often received? \_\_\_\_\_ Source \_\_\_\_\_
- Interest, dividends, and other investment income \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Royalty income \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Taxable veteran's benefits \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Taxable military retirement pay \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Alimony received \$ \_\_\_\_\_ How often received? \_\_\_\_\_  
If this person is receiving alimony payments from a divorce, separation agreement, or court order that was finalized before January 1, 2019, enter the amount of those payments here. \$ \_\_\_\_\_
- Other taxable income \$ \_\_\_\_\_ How often received? \_\_\_\_\_ Type \_\_\_\_\_
- Net rental income: On average, how much net income (profits after rental expenses are paid) will you get from this rental each month, or how much will you lose from this rental each month? \$ \_\_\_\_\_ month **profit** or \$ \_\_\_\_\_ month **loss**
- Capital gains: On average, how much net income or loss will this person get from this capital gain each **month**?  
\$ \_\_\_\_\_/profit or \$ \_\_\_\_\_/loss
- Net farming or fishing income: On average, how much net income (profits after business expenses are paid) or loss will this person get from this business each **month**? \$ \_\_\_\_\_/profit or \$ \_\_\_\_\_/loss

**STEP 2** Person 3 (continued)

- Lottery and gambling winnings: \$ \_\_\_\_\_ Effective Date \_\_\_\_\_  
How often?  One time only  Weekly  Every two weeks  Twice a month  Monthly  Yearly  
Non-cash prizes are not counted as qualified lottery and gambling winnings. Do not include any losses in the amount.

**ONE-TIME ONLY INCOME**

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30. Has or will this person receive income during this calendar year as a one-time only payment?  Yes  No  
Examples might be a lump-sum pension payment or a one-time capital gain.  
If **Yes**: Type: \_\_\_\_\_ Amount \$ \_\_\_\_\_ Month Received \_\_\_\_\_ Year received \_\_\_\_\_
31. Will this person receive income during the next calendar year as a one-time only payment?  Yes  No  
If **Yes**: Type: \_\_\_\_\_ Amount \$ \_\_\_\_\_ Month Received \_\_\_\_\_ Year received \_\_\_\_\_

**DEDUCTIONS**

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32. What deductions does he or she report on their income tax return?
- See instructions for Question 33 under Person 1.
  - Educator expense: Yearly amount \$ \_\_\_\_\_
  - Certain business expenses of reservists, performing artists, or fee-based government officials: Yearly amount \$ \_\_\_\_\_
  - Health Savings Account deduction: Yearly amount \$ \_\_\_\_\_
  - Moving expenses for members of the Armed Forces: Yearly amount \$ \_\_\_\_\_
  - Deductible part of self-employment tax: Yearly amount \$ \_\_\_\_\_
  - Contribution to self-employed SEP, SIMPLE, and qualified plans: Yearly amount \$ \_\_\_\_\_
  - Self-employed health insurance deduction: Yearly amount \$ \_\_\_\_\_
  - Penalty on early withdrawal of savings: Yearly amount \$ \_\_\_\_\_
  - Alimony paid for a divorce, separation agreement, or court order that was finalized before January 1, 2019:  
Yearly amount \$ \_\_\_\_\_
  - Individual Retirement Account (IRA) deduction: Yearly amount \$ \_\_\_\_\_
  - Student loan deduction (interest only, not total payment): Yearly amount \$ \_\_\_\_\_
  - None

**YEARLY INCOME**

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33. Did this person receive any unemployment benefits this calendar year?  Yes  No
34. What is your total expected income for the current calendar year?
35. What is your total expected income for next calendar year, if different?

**THANKS! This is all we need to know about this person. Go to Step 2 Person 4 to add another household member, if needed. Otherwise, go to Step 3 American Indian or Alaska Native (AI/AN) Household Member(s).**

**STEP 2** Person 4 (If more than 4 people, this is Person \_\_\_\_ )

If you have to include more than four people on this application, make a copy of blank information pages for Step 2 Person 4 BEFORE you fill them out. When filling out the additional pages please be sure to tell us how each person is related to each other person on the application.

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

2. Relationship to Person 1 \_\_\_\_\_

Relationship to Person 2 \_\_\_\_\_

Relationship to Person 3 \_\_\_\_\_

Does this person live with Person 1?  Yes  No

If **No**, list address. \_\_\_\_\_

3. Date of birth (mm/dd/yyyy) \_\_\_\_\_

4. Gender  Male  Female

5. **Optional** What is this person's race or ethnicity? \_\_\_\_\_ Please see page 27.

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

**|** For important SSN information and how to apply for SSN, please see instructions for Question 6 under Person 1.

If **Yes**, give us the number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If **No**, check one of the following reasons.  Just applied  Noncitizen exception  Religious exception

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

If **No**, what name is on this person's social security card? \_\_\_\_\_

\_\_\_\_\_  
First name, middle name, last name, and suffix

7. If this person gets an Advance Premium Tax Credit (APTC), does this person agree to file a federal tax return for the tax year that the credits are received?  Yes  No

**|** See instructions for Question 7 under Person 1.

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

a. Is this person legally married?  Yes  No

If **No**, skip to question 7c.

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

b. Does this person plan to file a joint federal tax return with a spouse for the tax year for which this person is applying?

Yes  No

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

This person will claim a personal exemption deduction on their federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments. List the name(s) and date(s) of birth of dependents.  
\_\_\_\_\_  
\_\_\_\_\_

d. Will this person be claimed as a dependent on someone else's federal income tax return for the year for which this person is applying?  Yes  No

If this person is claimed by someone else as a dependent on their federal income tax return, this may affect this person's ability to receive a premium tax credit. Do not answer **Yes** to this question if this person is a child under the age of 21 being claimed by a noncustodial parent. If **Yes**, please list the name of the tax filer. \_\_\_\_\_

Tax filer date of birth \_\_\_\_\_ How is this person related to the tax filer? \_\_\_\_\_

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

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

Who else does the tax filer claim as dependents? \_\_\_\_\_

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

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

If **Yes**, answer all the questions below. If **No**, answer Questions 14 and 15, then go to **Income Information** on page 16.

9. Is this person a U.S. citizen or U.S. national?  Yes  No

If **Yes**, is this person a naturalized citizen (not born in the U.S.)?  Yes  No

Alien number \_\_\_\_\_ Naturalization or citizenship certificate number \_\_\_\_\_

10. If this person is a noncitizen, does he or she have an eligible immigration status?  Yes  No

See instructions for Question 10 under Person 1.

a. If **Yes**, does this person have an immigration document?  Yes  No

Status award date (mm/dd/yyyy) \_\_\_\_\_ (For battered persons, enter the date the petition was approved as properly filed.)

Immigration status \_\_\_\_\_ Immigration document type \_\_\_\_\_

Choose one or more document status and types from the list on page 27.

Document ID number \_\_\_\_\_ Alien number \_\_\_\_\_

Passport or document expiration date (mm/dd/yyyy) \_\_\_\_\_ Country \_\_\_\_\_

b. Did this person use the same name on this application that he or she did to get this person's immigration status?

Yes  No

If **No**, what name did this person use? First, middle, last, and suffix \_\_\_\_\_

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

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

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

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

Name(s) and date(s) of birth of child(ren) \_\_\_\_\_

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

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

13. Does this person 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

14. Does this person need reasonable accommodation because of a disability or an injury?  Yes  No

If **Yes**, complete the rest of this application, including Supplement C: Accommodation.

15. Is this person pregnant?  Yes  No

If **Yes**, how many babies is she expecting? \_\_\_\_\_ What is the expected due date? \_\_\_\_\_

16. **Optional** Does this person have breast or cervical cancer?  Yes  No (Special coverage rules may apply.)

17. **Optional** Is this person HIV positive?  Yes  No (MassHealth has special coverage rules for people with HIV.)

18. Was this person ever in foster care?  Yes  No

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

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

**INCOME INFORMATION (You may send proof of all household income with this application.)**

19. Does this person have any income?  Yes  No  
If this person doesn't have any income, skip to question 34.

**EMPLOYMENT | If this person needs more space, attach another sheet of paper.**

20. **CURRENT JOB 1:** Employer name and address \_\_\_\_\_ Federal Tax ID# \_\_\_\_\_
21. a. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  
 Yearly (Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)  
b. Income effective date \_\_\_\_\_
22. Average number of hours worked each WEEK \_\_\_\_\_
23. Is this person seasonally employed?  Yes  No. If **Yes**, which months does this person work in a calendar year?  
 Jan.  Feb.  March  April  May  June  July  August  Sept.  Oct.  Nov.  Dec.
24. **CURRENT JOB 2:** Employer name and address \_\_\_\_\_ Federal Tax ID# \_\_\_\_\_
25. a. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  
 Yearly (Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)  
b. Income effective date \_\_\_\_\_
26. Average number of hours worked each WEEK \_\_\_\_\_
27. Is this person seasonally employed?  Yes  No. If **Yes**, which months does this person work in a calendar year?  
 Jan.  Feb.  March  April  May  June  July  August  Sept.  Oct.  Nov.  Dec.
28. **SELF-EMPLOYMENT:** Is this person self-employed?  Yes  No
- a. If **Yes**, what type of work does this person do? \_\_\_\_\_
- b. On average, how much net income (profits or losses after business expenses are paid) will this person get from this self-employment each month? \$ \_\_\_\_\_/month **profit** or \$ \_\_\_\_\_/month **loss**?
- c. How many hours does this person work per week? \_\_\_\_\_

**OTHER INCOME**

29. Check all that apply, and give the amount and how often this person gets it. **NOTE: You do not need to tell us about child support, nontaxable veteran's payments, Supplemental Security Income (SSI), or most workers' compensation income.**
- Social security benefits \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Unemployment \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Retirement or pension \$ \_\_\_\_\_ How often received? \_\_\_\_\_ Source \_\_\_\_\_
- Interest, dividends, and other investment income \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Royalty income \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Taxable veteran's benefits \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Taxable military retirement pay \$ \_\_\_\_\_ How often received? \_\_\_\_\_
- Alimony received \$ \_\_\_\_\_ How often received? \_\_\_\_\_  
If this person is receiving alimony payments from a divorce, separation agreement, or court order that was finalized before January 1, 2019, enter the amount of those payments here. \$ \_\_\_\_\_
- Other taxable income \$ \_\_\_\_\_ How often received? \_\_\_\_\_ Type \_\_\_\_\_
- Net rental income: On average, how much net income (profits after rental expenses are paid) will you get from this rental each month, or how much will you lose from this rental each month? \$ \_\_\_\_\_ month **profit** or \$ \_\_\_\_\_ month **loss**
- Capital gains: On average, how much net income or loss will this person get from this capital gain each **month**?  
\$ \_\_\_\_\_/**profit** or \$ \_\_\_\_\_/**loss**
- Net farming or fishing income: On average, how much net income (profits after business expenses are paid) or loss will this person get from this business each **month**? \$ \_\_\_\_\_/**profit** or \$ \_\_\_\_\_/**loss**

**STEP 2** Person 4 (continued)

- Lottery and gambling winnings: \$ \_\_\_\_\_ Effective Date \_\_\_\_\_  
How often?  One time only  Weekly  Every two weeks  Twice a month  Monthly  Yearly  
Non-cash prizes are not counted as qualified lottery and gambling winnings. Do not include any losses in the amount.

**ONE-TIME ONLY INCOME**

30. Has or will this person receive income during this calendar year as a one-time only payment?  Yes  No  
Examples might be a lump-sum pension payment or a one-time capital gain.  
If **Yes**: Type: \_\_\_\_\_ Amount \$ \_\_\_\_\_ Month Received \_\_\_\_\_ Year received \_\_\_\_\_
31. Will this person receive income during the next calendar year as a one-time only payment?  Yes  No  
If **Yes**: Type: \_\_\_\_\_ Amount \$ \_\_\_\_\_ Month Received \_\_\_\_\_ Year received \_\_\_\_\_

**DEDUCTIONS**

32. What deductions does he or she report on their income tax return?  
**See instructions for Question 33 under Person 1.**
- Educator expense: Yearly amount \$ \_\_\_\_\_
- Certain business expenses of reservists, performing artists, or fee-based government officials: Yearly amount \$ \_\_\_\_\_
- Health Savings Account deduction: Yearly amount \$ \_\_\_\_\_
- Moving expenses for members of the Armed Forces: Yearly amount \$ \_\_\_\_\_
- Deductible part of self-employment tax: Yearly amount \$ \_\_\_\_\_
- Contribution to self-employed SEP, SIMPLE, and qualified plans: Yearly amount \$ \_\_\_\_\_
- Self-employed health insurance deduction: Yearly amount \$ \_\_\_\_\_
- Penalty on early withdrawal of savings: Yearly amount \$ \_\_\_\_\_
- Alimony paid for a divorce, separation agreement, or court order that was finalized before January 1, 2019:  
Yearly amount \$ \_\_\_\_\_
- Individual Retirement Account (IRA) deduction: Yearly amount \$ \_\_\_\_\_
- Student loan deduction (interest only, not total payment): Yearly amount \$ \_\_\_\_\_
- None

**YEARLY INCOME**

33. Did this person receive any unemployment benefits this calendar year?  Yes  No
34. What is your total expected income for the current calendar year?
35. What is your total expected income for next calendar year, if different?

**THANKS! This is all we need to know about this person. Please go to Step 3 American Indian or Alaska Native (AI/AN) Household Member(s).**



### STEP 3 American Indian or Alaska Native (AI/AN) Household Member(s)

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

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

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

Names(s) of person(s) \_\_\_\_\_

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

### STEP 4 Your Household's Health Coverage

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

1. Is anyone listed on this application **offered** health coverage from a job but **NOT ENROLLED** in it?  Yes  No  
Answer **Yes**, even if this insurance is from another person's job, like a spouse, even if the person does not live in the household.

If **Yes**, you will need to complete and include **Supplement A: Health Coverage from Jobs**, and the rest of this application.

Name(s) of person(s) covered \_\_\_\_\_

Is this a state employee benefit plan?  Yes  No

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

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

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

- Enrolled in **Medicare** or qualifies for a Medicare Part A plan with no premium.

Name(s) of person(s) covered \_\_\_\_\_

Start date \_\_\_\_\_ End date \_\_\_\_\_ Medicare ID # \_\_\_\_\_

- Qualifies for **Peace Corps** health benefits . . . . . Start date \_\_\_\_\_ End date \_\_\_\_\_

Name(s) of person(s) covered \_\_\_\_\_

- Qualifies for **TRICARE** or a Federal Employees' health benefit program. Start date \_\_\_\_\_ End date \_\_\_\_\_

Name(s) of person(s) covered \_\_\_\_\_

- Enrolled in a **Veterans Affairs (VA) health program** . . . . . Start date \_\_\_\_\_ End date \_\_\_\_\_

Name(s) of person(s) covered \_\_\_\_\_

- MassHealth**

Name(s) of person(s) covered \_\_\_\_\_

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

Name of employer \_\_\_\_\_ Plan name \_\_\_\_\_

Names of covered household members \_\_\_\_\_

Policy # or Member ID \_\_\_\_\_ . . . . . Start date \_\_\_\_\_ End date \_\_\_\_\_

- Other coverage** (including COBRA or Retiree health plans) . . . . . Start date \_\_\_\_\_ End date \_\_\_\_\_

Name(s) of person(s) covered \_\_\_\_\_

Policy # or Member ID \_\_\_\_\_

## STEP 5 Health Reimbursement Arrangements

Is anyone in the household offered Health Reimbursement Arrangements (HRAs) from their employer?  Yes  No

Name(s) of individual

Date of Birth

Employer Name

Federal Tax ID

Type of HRA offered by employer  Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)  
 Individual Coverage Health Reimbursement Arrangement (ICHRA)

Start date

End date

Enter the maximum yearly self-only coverage benefit amount:

If you have a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) do you intend to use QSEHRA family coverage benefits from your employer?  Yes  No

If you have QSEHRA, enter the maximum yearly family coverage benefit amount through the QSEHRA:

Does anyone in the household intend to accept an Individual Coverage Health Reimbursement Arrangement (ICHRA) benefit from their employer?  Yes  No

Name(s) of individual

Date of Birth

Employer Name

Federal Tax ID

Type of HRA offered by employer  Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)  
 Individual Coverage Health Reimbursement Arrangement (ICHRA)

Start date

End date

Enter the maximum yearly self-only coverage benefit amount:

If you have a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) do you intend to use QSEHRA family coverage benefits from your employer?  Yes  No

If you have QSEHRA, enter the maximum yearly family coverage benefit amount through the QSEHRA:

Does anyone in the household intend to accept an Individual Coverage Health Reimbursement Arrangement (ICHRA) benefit from their employer?  Yes  No

## STEP 6 Parental Information

Please answer these questions for any child younger than the age of 18, who is listed on this application but who does not have two custodial parents also listed on this application.

1. Was any child adopted by a single parent?  Yes  No

If **Yes**, name(s) of child(ren) \_\_\_\_\_

2. Does any child have a parent who has died?  Yes  No

If **Yes**, name(s) of child(ren) \_\_\_\_\_

3. Does any child have a parent whose identity is unknown?  Yes  No

If **Yes**, name(s) of child(ren) \_\_\_\_\_

4. Does any child have a parent who does not live with the child and who is not included in the previous questions?  Yes  No

If **Yes**, name(s) of child(ren) \_\_\_\_\_

## STEP 7 Read and sign this application.

### FOR MASSHEALTH AND HEALTH CONNECTOR APPLICANTS

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

1. MassHealth may require eligible persons to enroll in available employer-sponsored health insurance if that insurance meets the criteria for MassHealth payment of premium assistance.
2. Employers of eligible persons may be notified and billed in accordance with MassHealth regulations for any services that hospitals or community health centers provide to such persons that are paid for by the Health Safety Net.
3. I may have to pay a premium for health coverage for myself and others listed on this application. Failure to pay any premium due may result in the state deducting the amount owed from the tax refunds of responsible persons. If I am a certain American Indian or Alaska Native, I may not have to pay premiums for MassHealth.
4. MassHealth has the right to pursue and get money from third parties who may be obligated to pay for health services provided to eligible persons enrolled in MassHealth programs. Such third parties may include other health insurers, spouses, parents obligated to pay for medical support, or individuals obligated to pay under accident settlements. Eligible persons must cooperate with MassHealth in establishing third-party support and obtaining third-party payments for themselves and anyone whose rights they can legally assign. Eligible persons may be exempted from this obligation if they believe and tell MassHealth that cooperation could result in harm to them or anyone whose rights they can legally assign.
5. A parent and/or guardian of minor children must agree to cooperate with state efforts to collect medical support from an absent parent unless they believe and tell MassHealth that cooperation will harm the children or the parent or guardian.
6. Eligible persons who are injured in an accident, or in some other way, and get money from a third party because of that accident or injury must use that money to repay MassHealth or the Health Safety Net for certain services provided.
7. Eligible persons must tell MassHealth or the Health Safety Net, in writing, within 10 calendar days, or as soon as possible, about any insurance claims or lawsuits filed because of an accident or injury.
8. The status of this application may be shared with a hospital, community health center, other medical provider, or federal or state agencies when necessary for treatment, payment, operations, or the administration of the programs listed above.
9. To the extent permitted by law, after notice and an opportunity to appeal, MassHealth may place a lien against any real estate owned by an eligible MassHealth member or in which the eligible member has a legal interest, if the member is receiving long-term care in a nursing facility or other medical institution and MassHealth determines that the member is not reasonably expected to return home. If MassHealth puts a lien against such property and the property is later sold, money from the sale of that property may be used to repay MassHealth for medical services provided.
10. To the extent permitted by law, and unless exceptions apply, for any eligible person age 55 or older, or any eligible person regardless of age for whom MassHealth helps pay for long-term care in a nursing home or other medical institution, MassHealth will seek money from the eligible person's estate after death for the total cost of care. For more information on estate recovery, visit [mass.gov/EstateRecovery](http://mass.gov/EstateRecovery).
11. Eligible persons must tell the health care program(s) in which they enroll about any changes in their or their household's income or employment, household size, health insurance coverage, health insurance premiums, and immigration status, or about changes in any other information on this application and any supplements to it within 10 calendar days of learning of the change. Eligible persons can make changes by calling **(800) 841-2900**, TTY: (800) 497-4648 for people who are deaf, hard of hearing or speech disabled. A change in information could affect eligibility for such persons or for persons in their household.  
**You can also report changes in any of the following ways.**
  - Sign on to your account at [www.MAhealthconnector.org](http://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  
PO Box 4405  
Taunton, MA 02780.**
  - Fax the change information to **(857) 323-8300.**
12. MassHealth, the Massachusetts Health Connector, and the Health Safety Net will obtain from eligible persons' current and former employers and health insurers all information about health insurance coverage for such persons. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to such persons or members of their household.

13. MassHealth, the Massachusetts Health Connector, and the Health Safety Net may get records or data about persons listed on this application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Revenue, and the Registry of Motor Vehicles, as well as private data sources including financial institutions, 1) to prove any information given on this application and any supplements, or other information given once a person becomes a member, 2) to document medical services claimed or provided to such persons, and 3) to support continued eligibility.
14. In connection with the eligibility and enrollment process, MassHealth, the Massachusetts Health Connector, and the Health Safety Net may send notices that contain personal information about persons listed on this application to other persons on this application, or otherwise communicate such information to such persons.
15. Under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by going to [www.hhs.gov/ocr/complaints/index.html](http://www.hhs.gov/ocr/complaints/index.html).
16. I agree to allow the Massachusetts Health Connector to use income data, including information from tax returns to determine my eligibility in future years. Review the Health Connector Privacy Policy for more information about how the Health Connector uses your tax information. The Massachusetts Health Connector will send me a notice and let me make changes to my eligibility application. I understand that if I am eligible for an Advance Premium Tax Credit (APTC) and/or ConnectorCare, these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or ConnectorCare may impact my annual tax liability. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.

## FOR MASSHEALTH AND HEALTH CONNECTOR APPLICANTS

### I AGREE TO THE FOLLOWING STATEMENTS.

- I have read or have had read to me the information on this application, including any supplements and instructions. I understand that the Member Booklet contains important information about this application.
- I have permission from all persons listed on this application (or their parent or other legally authorized representative) to submit this application. I also have permission to act on their behalf to complete this application and any related eligibility process. This may include, for example:
  - providing personal information about them, including health, health coverage, and income information, seeing such information as may be provided by the Massachusetts Health Connector, MassHealth, and the Health Safety Net, and providing consent on their behalf to use their information as described in this application;
  - making choices about coverage options and how to communicate with the Massachusetts Health Connector, MassHealth, or the Health Safety Net;
  - making changes to the application or related eligibility documents and providing information about any change in their circumstances; and
  - providing consent on their behalf to use government and private sources to verify the information described in this application.
- I understand my rights and responsibilities and the rights and responsibilities of all persons listed on this application as explained in this Step 7.
- I have told or will tell anyone listed on this application (or their parent or legally authorized representative, if applicable) about these rights and responsibilities so they understand them.
- I understand and agree that MassHealth, the Health Safety Net, and the Massachusetts Health Connector will treat any electronic or faxed signature, or copy of a signature with the same effect as an original signature.
- I understand that MassHealth
  - is allowed to ask for SSNs under federal and state law;
  - uses SSNs to check income and other information to see who is eligible for help with health coverage costs;
  - uses SSNs to detect fraud, to see if anyone is getting duplicate benefits, or to see if others should be paying for services;
  - matches the SSN of anyone in the household who is applying and anyone who has or who can get health insurance for anyone in the household with the files of agencies and financial institutions.
- I understand that if MassHealth pays part of anyone's health insurance premiums, MassHealth will add the SSN or the SSN of that policyholder to the State Comptroller's vendor file.
- I understand that the policyholder in my household must have a valid SSN before getting a payment from MassHealth.
- The information I have supplied is correct and complete to the best of my knowledge about myself and other persons listed on this application.
- I may be subject to penalties under federal law if I intentionally provide false information.

If someone does not have an SSN or needs help getting one, call the Social Security Administration at (800) 772-1213, TTY: (800) 325-0778, or go to [www.socialsecurity.gov](http://www.socialsecurity.gov). For a full explanation on how we use your social security number, please refer to the Member Booklet for Health and Dental Coverage and Help Paying Costs.

## FOR SUPPLEMENTAL NUTRITIONAL ASSISTANCE PROGRAM (SNAP) APPLICANTS

### SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS

If you checked the box on page 1, MassHealth will send this application to the Department of Transitional Assistance (DTA). This will serve as your application for SNAP! If you are eligible, your SNAP will start from the date DTA receives this MassHealth application. By signing below, you agree that you have read and agree to your SNAP Rights, Responsibilities, and Penalties under the program.

You may be eligible for SNAP benefits within 7 days of when DTA gets this application if:

- Your income and money in the bank add up to less than your monthly housing expenses, or
- Your monthly income is less than \$150, and your money in the bank is \$100 or less, or
- You are a migrant worker and your money in the bank is \$100 or less.

For more information about SNAP in Massachusetts, go to [mass.gov/SNAP](http://mass.gov/SNAP).

#### Department of Transitional Assistance (DTA) Notice of Rights, Responsibilities and Penalties

This notice lists rights and responsibilities for all DTA programs. You must follow the rules for programs you apply for.

Please read these pages and keep them for your records.

Let DTA know if you have any questions.

I swear under penalty of perjury that:

- I have read the information in this form, or someone read it to me.
- My answers in this form are true and complete to the best of my knowledge.
- I will give DTA information that is true and complete to the best of my knowledge during my interview and in the future.

I understand that:

- giving false or misleading information is fraud,
- misrepresenting or withholding facts to get DTA benefits is fraud,
- fraud is considered an Intentional Program Violation (IPV), and
- if DTA thinks I committed fraud, DTA can pursue civil and criminal penalties against me.

I also understand that:

- DTA will verify the information I give with my application. If any information is false, DTA may deny my benefits.
- I may also be subject to criminal prosecution for providing false information.
- If DTA gets information from a reliable source about a change in my household, my benefit amount may change.
- By signing this form, I give DTA permission to verify my eligibility for benefits, including:
  - Get information from other state or federal agencies, local housing authorities, out-of-state welfare departments, financial institutions, and Equifax Workforce Solutions (the Work Number). I also give these agencies permission to share information about my household's eligibility for benefits with DTA.

- If DTA uses information from Equifax about my household earned income, I have the right to a free copy of my Equifax report if I request it within 60 days of DTA's decision. I have the right to question the information in the re-port. I may contact Equifax at: Equifax Workforce Solutions, 11432 Lackland Road, St. Louis, MO 63146, 1-800-996-7566 (toll free).
- I have a right to a copy of my application, including the information that DTA uses to decide about my household's eligibility and benefit amount. I can ask DTA for an electronic copy of the completed application.

#### How will DTA use my information'?

By signing below, I give DTA permission to get information from and share information about me and members of my household with:

- Banks, schools, government, employers, landlords, utility companies and other agencies to check if I am eligible for benefits.
- Electric, gas and telephone companies so I can get utility discounts. The companies cannot share my information or use it for any other purpose.
- The Department of Housing and Community Development to enroll me in the Heat & Eat Program. This program helps people get the most SNAP benefits possible.
- The Department of Early and Secondary Education so my children can get free school meals.
- The Woman, Infants and Children (WIC) Program so that any children under age 5 or a pregnant woman in my household can get WIC.
- The United States Citizenship and Immigration Services (USCIS), to verify my immigration status. Information from USCIS may affect my household's eligibility and amount of DTA benefits.

Note: Even if you are not eligible for benefits due to immigration status, DTA will not report you to immigration authorities unless you show DTA a final order of deportation.

- The Department of Revenue (DOR) to verify my eligibility for income-based tax credits, such as Earned Income and Limited Income, and to see if I am eligible for "No Tax Status" or hardship status.
- The Department of Children and Families (DCF) to coordinate services offered jointly by DTA and DCF.

#### How does DTA use Social Security Numbers (SSNs)?

DTA is allowed to ask for SSNs under The Food and Nutrition Act of 2008 (7 U.S.C. 2011-2036) for SNAP and under M.G.L. c. 18 Section 33 for TAFDC and EAEDC. DTA uses SSNs to:

- Check the identity and eligibility of each household member I apply for through data matching programs.

- Monitor compliance with program rules.
- Collect money if DTA claims I got benefits that I was not eligible for.
- Help law enforcement agencies catch people hiding from the law.

I understand that I do not have to give DTA the SSN of any non-citizen in my household, including myself, who does not want benefits. The income of a non-citizen may count even if the non-citizen does not get benefits.

### Right to an Interpreter

I understand that:

- I have a right to a free professional interpreter provided by DTA if I prefer to communicate in a language other than English.
- If I have a DTA hearing, I can ask DTA to give me a free professional interpreter, or if I prefer, I can bring someone to interpret for me. If I need DTA to give me an interpreter for a hearing, I must call the Division of Hearings at least one week before the hearing date.

### Right to Register to Vote

I understand that:

- I have the right to register to vote through DTA.
- DTA will help me fill out the voter registration application form if I want help.
- I can fill out the voter registration application form in private.
- Applying to register or declining to register to vote will not affect my DTA benefits.

### Employment Opportunities

I agree that DTA may share my name and contact information with employment and training providers, including:

- SNAP Path Work providers or DTA specialists for SNAP clients; and
- Contracted Employment and Training providers or Full Engagement Workers for TAFDC clients.

SNAP clients may voluntarily participate in education and employment training services through the SNAP Path to Work program.

### Citizenship Status

I swear that all members of my household applying for DTA benefits are either U.S. citizens, or lawfully residing noncitizens.

### Supplemental Nutrition Assistance Program

I understand that:

- DTA manages the SNAP program in Massachusetts.
- When I file an application with DTA (by phone, online, in person, or by mail or fax), DTA has 30 days from the date it got my application to decide if I am eligible.
  - If I am eligible for expedited (emergency) SNAP, DTA has to give me SNAP and make sure I have an Electronic Benefit Transfer (EBT) card within 7 days from the date they got my application.

- I have a right to speak to a DTA supervisor if:
  - DTA says I am not eligible for emergency SNAP benefits, and I disagree.
  - I am eligible for emergency SNAP benefits, but do not get my benefits by the 7th day after I applied for SNAP.
  - I am eligible for emergency SNAP benefits but do not get my EBT card by the 7th day after I applied for SNAP.

- When I get SNAP, I have to meet certain rules. When I am approved for SNAP, DTA will give me a copy of the “Your Right to Know” brochure and the SNAP Program brochure. I will read the brochures or have someone read them to me. If I have any questions or need help reading or understanding this information, I can call DTA at 1-877-382-2363.
- Telling DTA about changes in my household:
  - If I am a SNAP Simplified Reporting household, I do not have to report most changes to DTA until the Interim Report or Recertification is due. The only things I have to report sooner are:
    - If my household’s income goes over the gross income threshold (listed on my approval notice).
  - I have to report this by the 10th day of the month after the month my income went over the threshold.
    - If I have to meet the Able-Bodied Adults Without Dependents (ABAWD) Work Rules and my work hours drop below 20 hours per week.
    - If everyone in my household is 60 or older, disabled, or under 18 years old, and no one has earnings from work, the only things I have to report are:
      - If someone starts working, or
      - Someone joins or leaves my household.
  - I have to report these changes by the 10th day of the month after the month of the change.
    - If I get SNAP through Transitional Benefits Alternative (TBA) because my TAFDC stopped, I do not have to report any changes to DTA for the 5 months that I get TBA.
    - If I get SNAP through Bay State CAP, I do not have to report any changes to DTA.

If I and everyone in my household gets cash assistance (TAFDC or EAEDC), I must report certain changes to DTA within 10 days of the change. See When do I need to tell DTA about changes in my household? under Transitional Aid to Families with Dependent Children (TAFDC) and Emergency Aid to the Elderly, Disabled, and Children (EAEDC) below.

I may get more SNAP benefits if I report and give DTA proofs for the following, at any time:

- Child or other dependent care costs, shelter costs, and/or utility costs;
- Child support that I (or someone in my household) is legally required to pay to a non-household member; and
- Medical costs for members of my household, including myself, who are 60 or older or disabled.



Work rules for SNAP clients: If you get SNAP benefits and are between the ages of 16 and 59 you may need to meet general SNAP work rules or the ABAWD work rules unless you are exempt. DTA will tell me and members of my household if we need to meet any Work Rules, what the exemptions are, and what will happen if we do not meet the rules.

If you are under the SNAP Work Rules, you must:

- Register for work at application and when you recertify for SNAP. You register when you sign the SNAP application or recertification form.
- Give DTA information about your employment status when DTA asks.
- Report to an employer if referred by DTA.
- Accept a job offer (unless you have a good reason not to).
- Not quit a job of more than 30 hours a week without a good reason.
- Cut your work hours to less than 30 hours a week without a good reason.

### **SNAP Rules**

- Do not give false information or hide information to get SNAP benefits.
- Do not trade or sell SNAP benefits.
- Do not alter EBT cards to get SNAP benefits you are not eligible for.
- Do not use SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco.
- Do not use someone else's SNAP benefits or EBT card unless you are an authorized representative, or the recipient has given you permission to use their card on their behalf.

### **SNAP Penalty Warnings**

I understand that if I or any member of my SNAP household intentionally breaks any of the rules listed above, that person will not be eligible for SNAP for one year after the first violation, two years after the second violation and forever after the third violation. That person may also be fined up to \$250,000, imprisoned up to 20 years, or both. They may also be subject to prosecution under Federal and State laws.

I also understand the following penalties. If I or a member of my SNAP household:

- Commit a cash program Intentional Program Violation (IPV) they will be ineligible for SNAP for the same period they are ineligible for cash assistance.
- Make a fraudulent statement about their identity or residency to get multiple SNAP benefits at the same time they will be ineligible for SNAP for ten years.
- Trade (buy or sell) SNAP benefits for a controlled substance/illegal drug(s), they will be ineligible for SNAP for two years for the first finding, and forever for the second finding.
- Trade (buy or sell) SNAP benefits for firearms, ammunition or explosives, they will be ineligible for SNAP forever.
- Make an offer to sell SNAP benefits or an EBT card online or in person the State may pursue an IPV against them.
- Pay for food purchased on credit they will be ineligible for SNAP.

- Buy products with SNAP benefits with the intent to discard the contents and return containers for cash they will be ineligible for SNAP.
- Flee to avoid prosecution, custody or confinement after conviction for a felony they will be ineligible for SNAP.
- Violate probation or parole, where law enforcement is actively seeking to arrest them they will be ineligible for SNAP.

Anyone who became a convicted felon after February 7, 2014 is ineligible for SNAP benefits if they are a fleeing felon or are violating probation or parole - in accordance with 7 CFR §273.11(n) - and were convicted as an adult of:

1. Aggravated sexual abuse under section 2241 of title 18, U.S.C.;
2. Murder under section 1111 of title 18, U.S.C.;
3. Any offense under chapter 110 of title 18, U.S.C.;
4. A Federal or State offense involving sexual assault, as defined in section 4002(a) of the 1994 VAWA (42 U.S.C. 13925a); or
5. An offense under State law determined by the Attorney General to be substantially similar to an offense described in this list.

### **Nondiscrimination Statement**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 1-800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination:

- Complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [ascr.usda.gov/complaint\\_filing\\_cust.html](https://ascr.usda.gov/complaint_filing_cust.html), and at any USDA office. You can ask for a copy of the complaint form by calling 1-866-632-9992; or
- Write a letter addressed to USDA and put in the letter all of the information requested in the form.

Submit your completed form or letter to USDA by:

- mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue SW Washington, D.C.20250-9410; or
- fax: 1-202-690-7442; or
- email: [program.intake@usda.gov](mailto:program.intake@usda.gov)

### **This institution is an equal opportunity provider.**

Transitional Aid to Families with Dependent Children (TAFDC) and Emergency Aid to the Elderly, Disabled, and Children (EAEDC)

TAFDC and EAEDC are cash assistance programs. To learn more and to apply, visit DTACconnect.com or call your local DTA office. This information only applies to households who are applying for or get TAFDC or EAEDC.

### **When do I need to tell DTA about changes in my household?**

I must tell DTA about changes that could affect my TAFDC or EAEDC (cash benefits) within 10 days, except that I do not have to tell DTA about a change in my earnings of less than \$100 per month. This includes changes in my income, assets, address, who I live with, family size, work, and health insurance.

### **How do I get health insurance?**

- If I get TAFDC or EAEDC, I will get MassHealth too.
- If I am denied TAFDC or EAEDC, MassHealth will use my information to see if I am eligible for health insurance.
- If my EAEDC stops, I need to apply for MassHealth separately. To ask for an application call 1-800-841-2900.

If I get MassHealth, I agree that MassHealth may collect:

- money owed to me from another source for my medical care, and
- medical support from the absent parent of any child under age 19 who gets MassHealth benefits.

### **Are there special rules if I am eligible only because of an accident or injury?**

If my family gets benefits from MassHealth or DTA because of an accident or injury, I must use any money I get for the accident or injury to pay them back. The money could be from an insurance policy, a settlement, or any other source. This applies even if I do not know what the possible sources of money are yet.

I agree to cooperate with MassHealth and DTA by:

- Filing claims for money from other sources.
- Telling MassHealth and DTA right away about any insurance claim, lawsuit, or other process to get money.
- Giving MassHealth and DTA new information when I get it.

If I don't cooperate, MassHealth and DTA may stop or deny my benefits. --I agree that MassHealth and DTA may:

- Share information about my benefits in order to collect money to repay those benefits.
- See all records about money I might get due to the accident or injury, such as records at the Department of Industrial Accidents.

If I am getting EAEDC because I have a disability or I am over 65 years old, I have to apply for federal Supplemental Security Income (SSI) benefits. If I am approved for SSI benefits that cover the same time that I got EAEDC, the Social Security Administration will send some of my retroactive SSI to DTA to repay the EAEDC.

### **Important Notice About the Law and Your Benefits**

An Intentional Program Violation (IPV) is intentionally giving a false or misleading statement or misrepresenting, hiding, or withholding facts, either orally or in writing, in order to establish or maintain eligibility for TAFDC or EAEDC benefits, or to gain benefits to which I am not entitled.

If I am found guilty of an IPV by a court of law, an administrative disqualification hearing, or by signing a waiver, I will be disqualified from receiving TAFDC or EAEDC benefits for a period of:

- 6 months for the first violation
- 12 months for the second violation
- forever for the third violation

In addition, other laws may apply.

### **Prohibitions on EBT Card Purchases**

I understand it is illegal to use TAFDC or EAEDC funds held on an electronic benefit transfer (EBT) card to pay for the following: alcoholic beverages; tobacco products; lottery tickets; adult oriented material or performances; gambling; firearms and ammunition; vacation services; tattoos; body piercings; jewelry; televisions; stereos; video games or consoles at rent-to-own stores; recreational marijuana; court-ordered fees; fines; bail or bail bonds.

### **Prohibitions on Where I may Use My EBT Card**

I understand it is illegal to use my electronic benefit transfer (EBT) card at the following locations: adult bookstores; adult paraphernalia stores or adult oriented performance establishments; ammunitions dealers; casinos; gambling casinos or gaming establishments; cruise ships; firearms dealers; jewelry stores; liquor stores; manicure shops or aesthetic shops; cash transmittal agencies to foreign countries; recreational marijuana stores or tattoo parlors.

### **Penalties for prohibited EBT card cash purchases**

- First Offense: I must pay back DTA the amount spent.
- Second Offense: I must pay back DTA the amount spent and will lose cash benefits for two months.
- Third Offense: must pay back DTA the amount spent and will lose cash benefits permanently.



## SIGN THIS APPLICATION — REQUIRED.

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

If I have indicated that I am applying for the Supplemental Nutritional Assistance Program (SNAP) on page 1 of this application, I certify that I understand and agree to the rights, rules, and penalties of the SNAP program, as outlined above. I ask that MassHealth send my information, including Protected Health Information subject to the Health Insurance Portability and Accountability Act (HIPAA), to the Department of Transitional Assistance (DTA) for the purpose of applying for SNAP benefits.

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

Signature of Person 1 or authorized representative or responsible party .....	Print name
	Date

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

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

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

## STEP 8 Send us your completed application.

Mail your signed application to: **Health Insurance Processing Center;** or Fax to: **(857) 323-8300**  
**PO Box 4405**  
**Taunton, MA 02780**



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

## EMPLOYEE INFORMATION

1. Employee name (first, middle, last)	2. Employee social security number _____ - _____ - _____
3. a. Is at least one person on this application currently eligible for or enrolled in coverage offered by this employer, or will at least one person on this application become eligible within the next 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If the answer to 3a is <b>Yes</b> , continue. If the answer to 3a is <b>No</b> , stop here and skip the rest of <b>Supplement A</b> .	
b. If any person is in a waiting or probationary period, when can this person enroll in coverage? (mm/dd/yyyy) _____	

## EMPLOYER INFORMATION

4. Employer name	5. Federal Tax ID	
6. Employer address	7. Employer phone number	
8. City	9. State	10. ZIP code
11. Who can we contact about employee health coverage at this job?		
12. Phone number (if different from above)	13. Email address	

## TELL US ABOUT THE HEALTH PLAN OFFERED BY THIS EMPLOYER.

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

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

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

c. How much did this employee pay in premiums to enroll in this plan, or how much does this employee pay for this plan?  
\$ \_\_\_\_\_

d. How often would or does this employee pay this amount? \_\_\_\_\_

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

a. Employer will not offer health coverage  
Coverage end date (mm/dd/yyyy): \_\_\_\_\_

b. The person plans to drop the employer's health coverage  
Coverage end date (mm/dd/yyyy): \_\_\_\_\_

c. Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.\* (Premium should reflect the discount for wellness programs.)  
How much does the employee have to pay in premiums for the lowest cost-plan that meets the minimum value standard?  
Only tell us about the cost of the individual (self only) health plans, not the cost of a family health plan. \$ \_\_\_\_\_  
How often?  Weekly  Every 2 weeks  Twice a month  Once a month  Quarterly  Yearly  
Date of change (mm/dd/yyyy) \_\_\_\_\_

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



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

**TELL US ABOUT YOUR AMERICAN INDIAN OR ALASKA NATIVE HOUSEHOLD MEMBER(S).**

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

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

**AI/AN PERSON 1**

1. Name (first, middle, last) \_\_\_\_\_
  
2. Member of a federally recognized tribe?  
 Yes  No  
 If **Yes**, tribe name \_\_\_\_\_
  
3. Member of a Massachusetts-recognized tribe?  
 Yes  No  
 If **Yes**, tribe name \_\_\_\_\_
  
4. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs?  
 Yes  No  
 If **No**, is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Program, or through a referral from one of these programs?  
 Yes  No
  
5. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from
  - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;
  - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations); or
  - Money from selling things that have cultural significance.
 \$ \_\_\_\_\_ How often? \_\_\_\_\_

**AI/AN PERSON 2**

1. Name (first, middle, last) \_\_\_\_\_
  
2. Member of a federally recognized tribe?  
 Yes  No  
 If **Yes**, tribe name \_\_\_\_\_
  
3. Member of a Massachusetts-recognized tribe?  
 Yes  No  
 If **Yes**, tribe name \_\_\_\_\_
  
4. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs?  
 Yes  No  
 If **No**, is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Program, or through a referral from one of these programs?  
 Yes  No
  
5. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from
  - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;
  - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations); or
  - Money from selling things that have cultural significance.
 \$ \_\_\_\_\_ How often? \_\_\_\_\_

If you answered **Yes** to Question 14 in Step 2 about yourself or any household member needing reasonable accommodation because of a disability or injury, check all that apply below, and list name(s).

1. Condition

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

2. Accommodation

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

# Authorized Representative Designation Form



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

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

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

## You can choose someone to help you.

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

## Who can help me?

1. An authorized representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose an authorized representative if you want one. Neither MassHealth nor the Health Connector will choose an authorized representative for you. You must designate in writing (fill out Section I, Part A) the person or organization who you want to be your authorized representative. Your authorized representative must also fill out Section I, Part B. We sometimes refer to this person or organization as a "Section I authorized representative."
2. If you cannot designate an authorized representative in writing and you do not have an existing authorized representative or other person who is authorized by law to act on your behalf, a person (not an organization) who certifies that he or she will act responsibly on your behalf can be your authorized representative if that person fills out Section II of this form. We sometimes refer to this person as a "Section II authorized representative."
3. An authorized representative can also be someone who has been appointed by law to act on your behalf, or on behalf of the estate of an applicant or member who has died. This person must fill out Section III and either you or this person must submit to us, together with this form, a copy of the applicable legal document stating that this person has authority to represent you, or the estate of a deceased applicant or member. We sometimes refer to this person as a "Section III authorized representative."
4. A **Section III** authorized representative may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the personal representative of the estate.

## What can an authorized representative do?

A **Section I** or **II** authorized representative may

- fill out your application or renewal forms;
- fill out other MassHealth or Health Connector eligibility or enrollment forms;
- give proof of information reported on these forms;
- report changes in income, address, or other circumstances;
- get copies of all of your MassHealth and Health Connector eligibility and enrollment notices; and
- act on your behalf in all other matters with MassHealth and the Health Connector.

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

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

# SECTION 1 Authorized Representative Designation (if applicant or member is able to sign)

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

Applicant's/Member's Name		Applicant's/Member's date of birth (mm/dd/yyyy)	
MassHealth ID number _____		OR last four digits of the Applicant's/Member's SSN _____	
Applicant's/Member's email address			
I certify that I have chosen the following person or organization to be the authorized representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form).			
Applicant's/Member's signature		Date	
Authorized representative's name		Authorized representative's phone number	
Authorized representative's address (mailing address, city, state, zip)			

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

### B1. COMPLETE IF AUTHORIZED REPRESENTATIVE IS A PERSON.

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

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

Authorized representative's signature		Date	
Authorized representative's printed name		Authorized representative's email address	

### B2. COMPLETE IF AUTHORIZED REPRESENTATIVE IS AN ORGANIZATION.

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

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

Signature of provider, staff member, or volunteer completing form		Date	
Printed name of provider, staff member, or volunteer completing form			
Email of provider, staff member, or volunteer completing form		Authorized representative organization name	

## SECTION 2 Authorized Representative Designation (if applicant or member cannot provide written designation)

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

### AN ORGANIZATION IS NOT ELIGIBLE TO BE AN AUTHORIZED REPRESENTATIVE UNDER THIS SECTION.

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

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

If I am also a provider, staff member, or volunteer affiliated with an organization, and I am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I further 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 CFR part 431 subpart F, 42 CFR §477.10, and 45 CFR §155.260(f).

Applicant's/Member's Name	Applicant's/Member's date of birth (mm/dd/yyyy)
MassHealth ID number _____	OR last four digits of the Applicant's/Member's SSN _____
Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	Authorized representative's email address

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

Officer's Name	Officer's Title
Officer's Signature	Date (mm/dd/yyyy)

## SECTION 3 Authorized Representative Designation (if appointed by law)

To be filled out by an authorized representative appointed by law (with authority to act on behalf of the applicant or member in making decisions related to health care including, but not limited to, a guardian, conservator, personal representative of the estate of an applicant or member, holder of power of attorney, or an invoked health care proxy.) Please print, except for signature.

**Please submit a copy of the applicable legal document with this form.**

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

Applicant's/Member's Name	Applicant's/Member's date of birth (mm/dd/yyyy)
MassHealth ID number _____	OR last four digits of the Applicant's/Member's SSN _____
Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	Authorized representative's email address

### How does an authorized representative designation end?

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

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

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

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

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

### How do I submit this form?

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

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

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