# MassHealth
## Child Disability Supplement

Commonwealth of Massachusetts | Executive Office of Health and Human Services

### Instructions for Completing the Supplement

You have indicated on your MassHealth application that your child has a disability. Disability standards require that the disability has lasted or is expected to last at least 12 months. UMass Disability Evaluation Services (DES) will review your child's disability application for MassHealth. It is very important that you complete this Disability Supplement.

For your child to get MassHealth based on his or her disability, you need to tell us about

- your child's medical and mental health providers. These providers may include doctors, psychologists, therapists, social workers, physical therapists, chiropractors, hospitals, health centers, and clinics from whom your child has gotten or is getting treatment; and
- your child's daily activities and his or her educational background.

**Completing the Disability Supplement will give us this information and will help us make a quick decision.**

Please read the following instructions before beginning.

- Print or write clearly and complete the supplement to the best of your ability.
- Sign and date a Medical Release Form for each medical and mental health provider you list on the supplement.
- After you have filled out the supplement, submit it to
  Disability Evaluation Services / UMASS Medical DES
  P.O. Box 2796
  Worcester, MA 01613-2796

DES will ask for your child's medical and treatment records from the providers you have listed. If you have any of the following, please send a copy with this form: your child's medical records, Individualized Family Services Plan (IFSP), Individualized Educational Plan (IEP), testing, or other records that describe your child's conditions. If more information or tests are needed, a member of DES will get in touch with you. Your child's eligibility will be decided more quickly if all items on the supplement are filled in.

This is not an application for medical benefits. If you have not already completed a MassHealth application for your child, you must fill one out in addition to this form. If you have any questions about how to apply, please call 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

**If you need help with this form, you can call the UMass Disability Evaluation Services (DES) Help Line at 1-888-497-9890. Fill in every section of this form. If you do not fill in every section, we may not be able to decide if your child is disabled.**

### Information about your child ☐ Male ☐ Female

| Last name First name Middle initial | | | Social security number |
|---|---|---|---|
| Street address | | | Apt. # |
| City | State | Zip code – | Date of birth (mm/dd/yyyy) |
| Home phone | Cell phone | | Work/other phone |

Does your child have a pending application with Social Security? ☐ yes ☐ no

Does your child get Social Security? ☐ yes ☐ no

Does your child get MassHealth? ☐ yes ☐ no

## Information about your family

| Mother: Last name First name Middle initial | Daytime phone |
|---|---|
| Father: Last name First name Middle initial | Daytime phone |
| Street address | Apt. # |
| City / State / Zip code | |

Does your family currently get MassHealth? ☐ yes ☐ no

If **yes**, under which program? ☐ MassHealth ☐ Supplemental Security Income (SSI)
☐ Transitional Aid to Families with Dependent Child (TAFDC) ☐ Other (please specify) _____

Does the child live with both parents? ☐ yes ☐ no

If **no**, which parent does not live with the child ☐ mother ☐ father
What is his or her address? _____

## PART 1 Your child's health issues and medical providers

Please describe your child's disabling condition and when it first became a problem.

Is your child's developmental (functional) level age-appropriate? ☐ yes ☐ no

If **no**, what is the developmental age? _____

Is your child's disability the result of an accident? ☐ yes ☐ no

If **yes**, please briefly explain.

Did your child get any health care in the past year? ☐ yes ☐ no

If **yes**, please include the child's primary care doctor and every medical and mental health provider that treated your child for any of his or her problems since the problems started. A medical or mental health provider may include a doctor, psychologist, therapist, social worker, physical therapist, chiropractor, hospital, health center, and clinic from which your child got treatment. You can write on a separate piece of paper if you run out of space. If your child is getting treatment from only one facility, list only that facility.

| Name of medical and mental health providers | Phone | Date of most recent visit |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Please fill out a **Medical Records Release Form** for each medical and mental health provider on this list. Be sure to sign and date each form. These release forms are at the end of this packet. If you need more copies of the Medical Release Form, call a MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled) or download the form at www.mass.gov/masshealth.

## Part 1. Your child's health issues and medical providers (continued)

Does your child have a scheduled hospital visit within the next 12 months? ☐ yes ☐ no

If **yes**, please complete the following.

| Where | When | Why |
|---|---|---|
| | | |
| | | |
| | | |

## PART 2 Your child's education and other service providers

Is your child currently enrolled in a Department of Public Health Early Intervention Program? ☐ yes ☐ no

If **yes**, name of program _____

Does your child attend school? ☐ yes ☐ no

If **yes**, name of school _____

If **no**, does your child get home services through the school system? ☐ yes ☐ no

If **yes**, please explain.

_____

_____

_____

Is there an Individualized Education Plan (IEP) for your child? ☐ yes ☐ no

If **yes**, we need a copy of the most recent IEP ☐ included with this supplement ☐ I will send a copy.
☐ I will complete a MassHealth Medical Records Release Form so that MassHealth can request a copy.

Please identify the agencies currently providing services for your child. Please provide the contact person and the agency address.

| Name of agency | Contact person & telephone number | Address |
|---|---|---|
| Department of Child and Family Services | Name<br>Phone | |
| Department of Developmental Services | Name<br>Phone | |
| Department of Education | Name<br>Phone | |
| Department of Mental Health | Name<br>Phone | |
| Department of Public Health | Name<br>Phone | |
| Massachusetts Commission for the Blind | Name<br>Phone | |
| Community Case Management | Name<br>Phone | |
| Other | Name<br>Phone | |

## PART 3 Your child's activities of daily living

**Movement and general hygiene:** Please indicate your child's function level by putting a checkmark in one of the columns for each activity.

| Activity | Independent | With assistance | Is not able |
|---|---|---|---|
| *Walk* | | | |
| *Crawl* | | | |
| *Sit up* | | | |
| *Turn* | | | |
| *Bathing* | | | |
| *Dressing* | | | |

**Sight, hearing, and speech:** Please indicate your child's function level.

| Activity | Good | Fair | Poor | None |
|---|---|---|---|---|
| *Sight* | | | | |
| *Hearing* | | | | |
| *Speech* | | | | |

**Toileting:** Please indicate your child's function level.

| Function | Yes | No | Other (such as catheter, colostomy) |
|---|---|---|---|
| *Bladder control* | | | |
| *Bowel control* | | | |

**Feeding:** Please indicate how your child is fed and note how often and for how long.

| Function | Feedings per day | Minutes per feeding |
|---|---|---|
| *Oral* | | |
| *Gastrostomy or jejunostomy tube (circle one)* | | |
| *Nasogastric tube* | | |

Does your child need any special diet or formula? ☐ yes ☐ no

If **yes**, please explain.

Does your child receive parenteral (intravenous) nutrition? ☐ yes ☐ no

If **yes**, please describe solutions and frequency _____

## PART 4 Your child's medical condition

**Respiratory:** Does your child require any of the following aids?

| Aid | Yes | No | | |
|---|---|---|---|---|
| *Suction - bulb* | | | Frequency | |
| *Suction - machine* | | | Frequency | |
| *Oxygen* | | | Number of hours per day | Liter flow |
| *Humidification* | | | Number of hours per day | Liter flow |
| *Chest physical therapy* | | | Times per day | |

## Part 4. Your child's medical condition (continued)

**Home nursing care:** Does your child get skilled nursing care at home? ☐ yes ☐ no

If **yes**, how many hours per week? _____

Please describe care: _____

How is your child's care provided? ☐ by a home health agency ☐ by an independent nurse provider

Please note the type of caregiver ☐ registered nurse (RN) ☐ licensed practical nurse (LPN) ☐ home health aide

Are there any additional nursing services you feel would benefit your child? ☐ yes ☐ no

If **yes**, please describe.

### Therapies

Does your child get skilled nursing care at home? ☐ yes ☐ no

If **yes**, please indicate the type, location, and agency providing services.

| Type of therapy | Number of visits per week at home | Number of visits per week at school | Provider agency |
|---|---|---|---|
| *Speech* | | | |
| *Physical* | | | |
| *Respiratory* | | | |
| *Occupational* | | | |
| *Other* _____ | | | |

**Medications:** Please provide the following information for all medications your child takes on a regular basis.

| Medication | Dosage | Frequency | Medication | Dosage | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
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**Equipment and supplies:** Please indicate whether your child needs any of the following items.

| | | | | |
|---|---|---|---|---|
| ☐ Ventilator | ☐ Apnea monitor | ☐ Prone stander | ☐ Orthopedic shoes | ☐ Nasogastric tubes |
| ☐ Generator | ☐ Cardiac monitor | ☐ Feeding pump/pole | ☐ Shoe lifts | ☐ Syringes |
| ☐ Ambu bag | ☐ Nebulizer | ☐ Walker | ☐ Tracheostomy tubes | ☐ Formula |
| ☐ Suction machine | ☐ I.V. pump | ☐ Body jacket | ☐ Gastrostomy tubes | ☐ Intravenous fluids |
| ☐ Oxygen compressor | ☐ Wheelchair | ☐ Braces | ☐ Feeding bags/tubing | ☐ Dialysis |
| ☐ Oxygen tanks | ☐ Hospital bed | ☐ Splints | ☐ I.V. tubing | |

☐ Other (please list) _____

## PART 5 Other information

Please include any other information about your child's care that would be helpful to know in considering your request for MassHealth for your child.

## PART 6 Signature and rights

**THIS SECTION MUST BE COMPLETED.**

Your child has the right to privacy. The information on this form is confidential. All possible precautions will be taken to ensure your child's privacy rights.

### Parent/Guardian Section

I understand the information contained in this supplement will be reviewed by MassHealth staff and its agents for the purpose of determining my child's eligibility for medical benefits.

Signature of parent/guardian _____ Date _____

### Authorized Representative Information Section

You may choose an authorized representative to help with some or all of the responsibilities of applying for or getting health benefits for your child.

You can do this by filling out a MassHealth Authorized Representative Designation Form (ARD). To request an ARD form, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

If this form is being filled out by someone other than the parent or guardian who has the legal authority to act on behalf of the child (such as an authorized representative), you must fill out and submit an ARD and give us the following information.

Signature of person filling out this form _____

Print name _____

Authority of person filling out this form on behalf of the child _____

DES may send copies of notices to the authorized representative. This area does not authorize release of medical records.

**REMINDER**

Did you remember to

- ☐ complete a medical release form for
  - each medical provider listed on page 2?
  - each mental health provider listed on page 2?
  - your child's Individualized Education Plan (if not provided with this supplement and you cannot send us a copy)?
- ☐ sign all medical release forms;
- ☐ sign this Disability Supplement above?
- ☐ include a completed and signed Authorized Representative Designation Form (ARD) if needed?

# MassHealth
## Medical Records Release Form

**Commonwealth of Massachusetts | Executive Office of Health and Human Services | www.mass.gov/masshealth**

### MassHealth Disability Evaluation Service

This MassHealth Medical Records Release Form helps us get medical information from your health-care provider so that the MassHealth Disability Evaluation Service (DES) can make a disability determination.

Please read the instructions carefully before you fill out this form. If you leave any sections of this form blank, this permission will not be valid, and the health-care provider will not be able to share your information with the MassHealth DES. If the health-care provider does not share medical information with the MassHealth DES, we will not be able to make a disability determination.

### General instructions for filling out the Medical Records Release Form

You must follow these instructions when filling out the Medical Records Release Forms. The health-care providers will not send medical records to the MassHealth DES if you do not fill out the forms the right way. We need copies of medical records to make a disability determination.

1. Sign and date a Medical Records Release Form for each doctor, hospital, health center, clinic, or other health-care provider you listed in the Disability Supplement.
2. All signatures must be in ink and must be originals. No copies or stamps of signatures are permitted.
3. Only one signature may appear on a line.
4. If this form is for a child younger than age 18, one parent or legal guardian must sign for the child.

### SECTION I

Permission is given for the health-care provider listed in Section II to share the medical information listed in Section III about

_____ with the MassHealth DES.
(Please print name of applicant or member.)

### SECTION II

Please print the name of the health-care provider that may share medical information with the MassHealth DES.

Name of doctor, health center, or other health-care provider

Street address

City, state, zip

Phone (  )

### SECTION III

The health-care provider listed in **Section II** above may share the following information with the MassHealth DES to determine eligibility for MassHealth benefits.

All medical records or other information about my treatment, hospitalization, or outpatient care for conditions including

- psychological/psychiatric impairments
- AIDS/HIV
- other (please describe) _____
- how impairments affect activities of daily living and ability to work
- drug and alcohol use

Check here **if you do not want** the health-care provider to share information about AIDS/HIV status. ☐

Check here **if you do not want** the health-care provider to share information about drug or alcohol use. ☐



(continued on back) ▶

## SECTION IV

**Any medical information that the health-care provider releases to the MassHealth Disability Evaluation Service (DES) will continue to be protected by federal privacy laws.**

**This permission to release medical information to the MassHealth DES ends six months from the date you sign this release form, unless you have cancelled permission in writing before then.**

I understand that I may cancel this permission at any time by sending a letter to the health-care provider I listed in Section II.

I understand that even if I cancel this permission, the health-care provider I listed in Section II cannot take back any information that it shared with the MassHealth DES when it had my permission to do so.

I also understand that my decision whether to give the health-care provider permission to share medical information with the MassHealth DES is voluntary. However, I also understand that if I do not give permission to the health-care provider to share medical information with the MassHealth DES, the MassHealth DES will not be able to make a disability determination, and the decision about eligibility for MassHealth benefits will be made without consideration of any disability claimed.

## SECTION V

Signature of applicant/member Date

Print name of applicant/member Phone ( )

Street address Date of birth

City/Town State Zip code —

If this form is being filled out by someone who has the legal authority to act on behalf of the applicant/member (such as the parent of a minor child, an eligibility representative, or a legal guardian), please give us the following information.

Signature of person filling out this form

Print name Date

Authority of person filling out this form to act on behalf of the applicant/member

Please give us a copy of the document that gives this person the authority to act on behalf of the applicant/member.

MassHealth will send you back a copy of this signed Medical Records Release Form for you to keep for your records. You can also ask for another copy of this signed Medical Records Release Form at any time by contacting MassHealth at the following address.

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- AIDS/HIV
- other (please describe) _____
- how impairments affect activities of daily living and ability to work
- drug and alcohol use

Check here **if you do not want** the health-care provider to share information about AIDS/HIV status. ☐

Check here **if you do not want** the health-care provider to share information about drug or alcohol use. ☐



(continued on back) ▶

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Permission is given for the health-care provider listed in Section II to share the medical information listed in Section III about

_____ with the MassHealth DES.
(Please print name of applicant or member.)

### SECTION II

Please print the name of the health-care provider that may share medical information with the MassHealth DES.

Name of doctor, health center, or other health-care provider

Street address

City, state, zip

Phone (  )

### SECTION III

The health-care provider listed in **Section II** above may share the following information with the MassHealth DES to determine eligibility for MassHealth benefits.

All medical records or other information about my treatment, hospitalization, or outpatient care for conditions including

- psychological/psychiatric impairments
- AIDS/HIV
- other (please describe) _____
- how impairments affect activities of daily living and ability to work
- drug and alcohol use

Check here **if you do not want** the health-care provider to share information about AIDS/HIV status. ☐

Check here **if you do not want** the health-care provider to share information about drug or alcohol use. ☐



(continued on back) ▶

## SECTION IV

**Any medical information that the health-care provider releases to the MassHealth Disability Evaluation Service (DES) will continue to be protected by federal privacy laws.**

**This permission to release medical information to the MassHealth DES ends six months from the date you sign this release form, unless you have cancelled permission in writing before then.**

I understand that I may cancel this permission at any time by sending a letter to the health-care provider I listed in Section II.

I understand that even if I cancel this permission, the health-care provider I listed in Section II cannot take back any information that it shared with the MassHealth DES when it had my permission to do so.

I also understand that my decision whether to give the health-care provider permission to share medical information with the MassHealth DES is voluntary. However, I also understand that if I do not give permission to the health-care provider to share medical information with the MassHealth DES, the MassHealth DES will not be able to make a disability determination, and the decision about eligibility for MassHealth benefits will be made without consideration of any disability claimed.

## SECTION V

Signature of applicant/member Date

Print name of applicant/member Phone ( )

Street address Date of birth

City/Town State Zip code —

If this form is being filled out by someone who has the legal authority to act on behalf of the applicant/member (such as the parent of a minor child, an eligibility representative, or a legal guardian), please give us the following information.

Signature of person filling out this form

Print name Date

Authority of person filling out this form to act on behalf of the applicant/member

Please give us a copy of the document that gives this person the authority to act on behalf of the applicant/member.

MassHealth will send you back a copy of this signed Medical Records Release Form for you to keep for your records. You can also ask for another copy of this signed Medical Records Release Form at any time by contacting MassHealth at the following address.

Disability Evaluation Services
UMASS Medical DES
P.O. Box 2796
Worcester, MA 01613-2796