MassHealth Buy-In
for people who are eligible for Medicare

What is MassHealth Buy-In?
MassHealth Buy-In is a program authorized by Congress for persons who are eligible for Medicare. MassHealth Buy-In allows MassHealth to pay all of the Medicare Part B premium for Massachusetts residents who are not getting other MassHealth benefits. It can also help get Medicare Part B for persons who only have Medicare Part A.

How much can I have in income and assets?
For MassHealth Buy-In, your income and assets (including bank accounts, stocks, bonds, or a second car) must be under certain limits. The chart (at the top right of this page) shows how much you can have and what you will get if your income and assets are within these limits.

If I am eligible for MassHealth Buy-In, how do I get paid?
If MassHealth Buy-In finds that you are eligible for payment of all of your Medicare Part B premium, we will tell Medicare. If your Medicare Part B premium is deducted from your social security check, your check will be adjusted so that your Medicare premium is no longer deducted. This means that the amount of your social security check will increase based on the amount that had been deducted to pay for your Medicare Part B premium.

When does coverage begin?
If you are eligible for, but not yet getting Medicare Part B, or if you are paying your Medicare Part B premium in some other way, like getting a quarterly bill from Medicare, MassHealth Buy-In will start paying this bill for you.

It will take several months to adjust your social security benefit or to pay your bill. However, you will get a refund for the amount you paid for your Medicare Part B premium back to the month you became eligible for MassHealth Buy-In. You will get this refund in the same way as you now get your social security: either through a check or direct deposit to your bank account.

Medicare and Medicaid Services, Registry of Motor Vehicles, Department of Revenue, Department of Transitional Assistance, Department of Industrial Accidents, Division of Unemployment Assistance, Department of Veterans’ Services, Human Resource Division, Bureau of Special Investigations, and the Department of Public Health’s Bureau of Vital Statistics. Files may also be matched with social service agencies in this state and other states, and computer files of banks and other financial institutions, insurance companies, employers, and managed care organizations.

Medicare has the right to get back money from the estates of certain MassHealth members after they die. In general, the money that must be repaid would include Medicare premiums paid by MassHealth for a member after the member turned age 55, and at any age while the member was permanently in a long-term-care facility. Effective with Medicare premiums paid on or after January 1, 2010, MassHealth will not recover premium payments made for members who were aged 55 or older at the time the premiums were paid.

There are also some additional protections and exceptions to this estate recovery rule. If a deceased member leaves behind a spouse, or a child who is blind, permanently and totally disabled, or younger than 21, MassHealth will not require repayment while any of these persons are still living. If real property, like a home, must be sold to get money to repay MassHealth, MassHealth, in limited circumstances, may decide that the estate does not need to repay MassHealth. Also, certain income, resources, and property of American Indians and Alaska Natives may be exempt from recovery.

For more information about estate recovery, see the MassHealth regulations at 130 CMR 515.000, and Chapter 118E of the Massachusetts General Laws.

Confidentiality and Fair Treatment
MassHealth cannot discriminate against you because of race, color, sex, age, handicap, country of origin, sexual orientation, religion, or creed. MassHealth is committed to keeping confidential the personal information we have about you. All personal information that MassHealth has about any applicant or member, including medical data, health status, and the personal information you give us during your application

<table>
<thead>
<tr>
<th>IF your monthly income before taxes and deductions is below…</th>
<th>AND your assets are at or below…</th>
<th>THEN MassHealth Buy-In will pay…</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><em>$1,345</em> for individuals</em>*</td>
<td>$7,280**</td>
<td>all of your Medicare Part B premium.</td>
</tr>
<tr>
<td><strong>$1,813</strong> (combined) for married couples who live together</td>
<td>$10,930**</td>
<td>all of the Medicare Part B premiums for both you and your spouse.</td>
</tr>
</tbody>
</table>

*These amounts are effective on March 1, 2015.
**These amounts are effective on January 1, 2015.
for and receipt of benefits is confidential. This information may not be used or released for purposes other than the administration of MassHealth without your permission, unless required by law or a court order. You can give us your written permission to use your personal health information for a specific purpose or to share it with a specific person or organization.

**Authorized Representative**

An authorized representative is someone you choose to help you get health care coverage through programs offered by MassHealth and the Massachusetts Health Connector. You can do this by filling out the Authorized Representative Designation Form (ARD) or a similar designation form. An authorized representative may fill out your application or eligibility review forms, give proof of information given on these eligibility forms, report changes in your income, address, or other circumstances, get copies of all MassHealth or Health Connector eligibility or enrollment notices sent to you, and act on your behalf in all other matters with MassHealth or the Health Connector.

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. MassHealth or the Health Connector will not choose an authorized representative for you.

You must designate in writing on the Authorized Representative Designation Form or a similar designation document or authorization document the person or organization you want to be your authorized representative. In most cases, your authorized representative must also fill out this form or a similar designation document or authorization document. This form is included in the application packet, or you can call us or visit www.mass.gov/masshealth to get one. Please see the instructions on the form for more details.

An authorized representative can also be someone who is acting responsibly on your behalf if you cannot designate an authorized representative in writing because of a mental or physical condition, or has been appointed by law to act on your behalf or on behalf of your estate. This person must fill out the applicable parts of the Authorized Representative Designation Form or provide a similar designation document. If this person has been appointed by law to represent you, either you or this person must also submit to MassHealth or the Health Connector a copy of the applicable legal document stating that this person is lawfully representing you or your estate. This person may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or if the applicant or member has died, the estate's administrator or executor.

**Permission to Share Information**

If you want us to share your personal health information, including sending copies of your eligibility notices, with someone who is not your authorized representative, you can do this by giving us written permission. We have forms you can use to do this. You can call us or visit www.mass.gov/masshealth to get a copy of the appropriate form.

**Reporting Changes**

If there are any changes in your income, assets, address, health insurance, immigration status, or disability status, you must tell us within 10 calendar days of the changes or as soon as possible. If you do not tell us about these changes, you may lose your benefits. You can call us about any changes by calling 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled).

**Other MassHealth benefits**

MassHealth offers other health care benefits that either pay for medical services directly, or pay your Medicare copayments and deductibles. You may be eligible for these benefits if your income and assets are under certain amounts, or if you are disabled and younger than 65. 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) to learn about these benefits. You should also call this number if you have any questions about MassHealth Buy-In.

**Other benefits**

Medicare recipients can get help with prescription drug costs through Medicare. To get more information, call Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048 for people who are deaf, hard of hearing, or speech disabled), or visit www.medicare.gov.

The Executive Office of Elder Affairs also offers help with prescription drug costs through Prescription Advantage. Call Elder Affairs toll free at 1-800-AGE-INFO (1-800-243-4636) (TTY: 1-877-610-0241 for people who are deaf, hard of hearing, or speech disabled) to learn more about these benefits.

**How do I apply for MassHealth Buy-In?**

1. To apply for MassHealth Buy-In, fill out the attached application. Include information about your spouse too, if he or she lives with you.

2. Sign the filled-out application, include proof of your income (except for social security income), and send it to:  MassHealth Enrollment Center
   Central Processing Unit
   P.O. Box 290794
   Charlestown, MA 02129-0214

   or fax it to:  1-857-323-8300

3. When we get the application, we will review it for completeness. If we need more information, we will write to you or call. Once we get all information, we will decide if you are eligible. We will also decide if your spouse is eligible.

4. A voter registration form is included with your application. (You do not need to register to vote to get MassHealth Buy-In.)

5. If you want someone to act on your behalf as your authorized representative, use the enclosed Authorized Representative Designation Form to tell us.
MassHealth Buy-In Application
for people who are eligible for Medicare

This is an application for payment of your Medicare Part B premium. It can also help you get Medicare Part B if you are only getting Medicare Part A. If you want to apply for other MassHealth benefits, 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) for a different application. Please print clearly and fill out all sections.

General Information

Who is applying? [ ] you [ ] you and your spouse

If you and your spouse live together, you must also give us information about your spouse even if he or she is not applying for benefits.

You

Last name ___________________________ First name ___________________________ MI

Street address ___________________________ City ___________________________ State ___________________________ Zip ___________________________

Mailing address (if different from above) [ ] homeless

City ___________________________ State ___________________________ Zip ___________________________

Date of birth / / Gender [ ] M [ ] F Preferred written language

Social security number ___________________________ For office use only Medicare claim number ___________________________ For office use only

Your Spouse

Last name ___________________________ First name ___________________________ MI

Date of birth / / Gender [ ] M [ ] F Preferred written language

Social security number ___________________________ For office use only Medicare claim number ___________________________ For office use only

Income

Fill out this section for you and your spouse. List the gross monthly income (before taxes and other deductions, such as the Medicare Part B premium).

Send proof of your income, like a copy of a recent paystub or pension check stub. (You do not have to send proof of social security income.)

<table>
<thead>
<tr>
<th>Source of income</th>
<th>Your gross monthly income before taxes and deductions</th>
<th>For office use only</th>
<th>Your spouse’s gross monthly income before taxes and deductions</th>
<th>For office use only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social security</td>
<td>$</td>
<td>For office use only</td>
<td>$</td>
<td>For office use only</td>
</tr>
<tr>
<td>Pensions</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Veterans’ benefits</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Annuities or trusts</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Dividends and/or interest</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Income from a job (before deductions)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Rental income (after expenses)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>$</td>
<td></td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>
## Assets

<table>
<thead>
<tr>
<th>Source</th>
<th>You</th>
<th>Your spouse</th>
<th>You and your spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings accounts</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Checking accounts</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Second car</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Certificates of deposit</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Stocks</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Bonds</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Mutual funds</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>$</td>
<td><strong>For office use only</strong></td>
<td>$</td>
</tr>
</tbody>
</table>

## Signature

Please read the following carefully. Then sign and date the bottom of this page. Both you and your spouse must sign if your spouse lives with you.

I give permission to MassHealth to get any records or data to prove any information given on this application. I understand that I must tell MassHealth of any changes in information I gave on this application. I further certify under the penalty of perjury that the information on this application is correct and complete to the best of my knowledge.

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

If you think MassHealth’s decision about whether you are eligible is wrong, you have the right to appeal. If you are denied benefits, you will get information on how to appeal.

X __________________________        Print name __________________________        Date ____________
Signature of applicant or authorized representative

X __________________________        Print name __________________________        Date ____________
Signature of applicant’s spouse or authorized representative

Once you have filled out and signed this form,

send it to:

MassHealth Enrollment Center
Central Processing Unit
P.O. Box 290794
Charlestown, MA 02129-0214

OR

fax it to:

1-857-323-8300.
Massachusetts Official
Mail-In Agency Voter Registration Form

How to use this form

1. Check all the boxes that apply to you.
2. Print your name: last name, first name, middle name or initial.
3. Print your former name, if applicable.
4. Print the address where you live now: number and street name or rural route number and box number (do not provide a post office box number), apartment number, city or town and full zip code. Use the map at right if you cannot otherwise identify your address.
5. Print the address where you receive all your mail, if it is different from the address entered on #4.
6. Print your date of birth: month, day and year.
7. Federal law requires that you provide your driver’s license number to register to vote. If you do not have a current and valid Massachusetts driver’s license, you must provide the last four digits of your social security number. If you have neither, you must write “none” in the box.
8. It is optional to provide your telephone number. If you include your telephone number and do not check “unlisted” it will be a public record.
9. Check a party, 'no party' or print a political designation (not a party).
10. Print the address where you were last registered to vote.
11. If a person is helping you because you are physically unable to sign this form, that assisting person must print his or her name and address and has the option to print his or her telephone number.
12. Read the oath.
13. Print today's date.
14. Sign your name.

This form may be mailed or hand-delivered to your city or town hall. If mailed, fold the form, tape it closed, place a first class stamp on it, print your city or town name and zip code for that city or town ball and drop into any mailbox.

Print all information in black ink. Follow above instructions for proper delivery.

Check all that apply:
Are you a Citizen of the United States of America? ☐ Yes ☐ No
Will you be 18 years of age or older on or before Election Day? ☐ Yes ☐ No

NOTE: If you checked “no” to either of these questions, do not complete this form.

Full name:
last name first name middle name or initial.

Former name:
last name first name middle name or initial.

Address where you live now (street number, street name, rural route number and box number):
street number / street name / rural route number and box number, apartment number, city or town, zip code + 4-digit

Address where you receive all your mail (if different from #4): street number / street name / rural route number and box number, apartment number, city or town, zip code + 4-digit

Date of birth:
month day year

Identification #:
license # or last four digits of your Social Security # (circle one if appropriate)

Telephone (optional): ☐ Check if unlisted
☐ 

Party enrollment or designation (check one): ☐ Democratic ☐ Republican ☐ Green-Rainbow ☐ United Independence Party ☐ No Party (unenrolled) ☐ Political Designation (not a political party):

Address at which you were last registered to vote:
street number / street name / rural route number and box number, post office box, apartment number, city or town, state, zip code + 4-digit

If the applicant is unable to sign this form, give the name, address and telephone number (optional) of the person helping the applicant:
name address telephone number (optional)

I hereby swear (affirm) that I am the person named above, that the above information is true, that I AM A CITIZEN OF THE UNITED STATES, that I am not a person under a guardianship which prohibits my registering to vote, that I am not temporarily or permanently disqualified by law from voting because of corrupt practices in respect to elections, that I am not currently incarcerated for a felony conviction, and that I consider this residence to be my home. Signed under the penalty of perjury.

Today’s date: month day year
Signed: Sign your name here.
Agency Designation: BBA
This form must be received by the local Board of Registrars or Election Commission or postmarked on or before the deadline for voter registration (listed below) for that election, primary, preliminary or town meeting.

DEADLINES FOR VOTER REGISTRATION

To participate in... You must register...

state primaries
state elections
city and town preliminaries
city and town elections
regularly scheduled town meetings

at least 20 days before

special town meetings

at least 10 days before

If you do not hear from your local election officials in 2 or 3 weeks, please call them!

Check to make sure that you have completed all the information on the voter registration affidavit on the opposite side!

If you do not hear from your local election officials in 2 or 3 weeks, please call them!