APPLICATION FOR HEALTH COVERAGE FOR SENIORS AND PEOPLE NEEDING LONG-TERM-CARE SERVICES

Commonwealth of Massachusetts | EOHHS





SACA-2-LP_2026-08

APPLICATION INSTRUCTIONS

HOW TO APPLY

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

- Mail your filled-out, signed application to
  MassHealth Enrollment Center
  PO Box 290794
  Charlestown, MA 02129-0214
- Fax your filled-out, signed application to (617) 887-8799
- Call us at (800) 841-2900, TDD/TTY: 711, or (877) MA ENROLL ([877] 623-6765)
- Visit mass.gov/how-to/apply-for-masshealth-coverage-for-seniors-and-people-of-any-age-who-need-long-term-care-services

To schedule an appointment with a MassHealth representative or to apply in person, go to **mass.gov/masshealth/appointment**.

To get the benefits you need, you may send us documentation that verifies your household income and assets.

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 76-91. Your application will then be sent automatically to the Department of

Transitional Assistance. You do not have to apply for SNAP to be considered for MassHealth.

MASSHEALTH and the HEALTH SAFETY NET

Who Can Use This Application

This is your application for health coverage if you live in Massachusetts and are any of the following.

- A person 65 or older and living at home who is
  - not the parent of a child younger than 19 who lives with you,
  - not an adult relative living with and taking care of a child younger than 19 when neither parent is living in the home, or
  - disabled and either working 40 or more hours a month or is currently working and has worked at least 240 hours in the six months immediately before the month of the application.
- A person of any age that needs long-term-care services in a medical institution or nursing facility.
- A person who is eligible under certain programs to get long-term-care services to live at home.
- A member of a married couple living with their spouse when
  - both they and their spouse are applying for health coverage,

- there are no children younger than 19 living with them, and
- one spouse is 65 or older and the other spouse is under 65. (See Step 9 of the application.)

If you meet any of the following exceptions, you should complete the Application for Health and Dental Coverage and Help Paying Costs (ACA-3). To obtain a copy of this application, call us at (800) 841-2900, TDD/TTY: 711.

- You are the parent of a child younger than 19 who lives with you, or
- You are an adult relative living with and taking care of a child younger than 19 when neither parent is living in the home.

You will also need to fill out a Long-Term-Care Supplement if you are

- In an institution, such as a nursing home, chronic hospital, or other medical institution (You may have to pay a monthly payment, called a patient-paid amount, to the long-term-care facility. For more information, see the Senior Guide.)
- In an acute hospital waiting for placement in a long-term-care facility
- Living in your home and applying for or getting long-term-care services under a Home- and Community-Based Services Waiver

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 Authorized Representative Designation Form (ARD) at the end of this application.

MASSACHUSETTS HEALTH CONNECTOR

Who Can Use This Application

This is your application for health coverage if you live in Massachusetts, your income is at or below 400% of the federal poverty level, and you are the following.

- You are 65 or older;
- are not otherwise eligible for MassHealth;
- are not getting Medicare; and
- do not have access to an affordable health plan that meets the minimum value requirement.*****

***** Minimum value requirement means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee.

The Health Connector uses Modified Adjusted Gross Income (MAGI) rules to determine eligibility.

WHAT YOU NEED WHEN YOU APPLY

The following MUST be sent with the application when applying for MassHealth, the Health Safety Net (HSN), and the Massachusetts Health Connector.

Social Security Number (SSN)

You must give us an SSN or proof that anyone on this application has also applied for an SSN. There are exceptions for the following people.

- Anyone who has a religious exemption as described in federal law
- Anyone who is eligible only for a nonwork SSN
- Anyone who is not eligible for an SSN

Unless an exception applies, **we need SSNs for all people applying** for health coverage. **An SSN is optional for people not applying for health coverage, but giving us an SSN can speed up the application process.** We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone does not have an SSN or needs help getting one, call the Social Security Administration at (800) 772-1213, TTY: (800) 325-0778, or go to www.socialsecurity.gov. See the Senior Guide for more information.

Proof of income, assets, and insurance

We will attempt to verify some of this information through electronic data matches and will notify you if we need further proof. It may speed up processing if you send proof of these items when you apply.

- Proof of all current income before deductions, such as copies of pay stubs or pension check stubs (You do not have to send proof of social security or SSI income, but you must fill out the social security and SSI income information, if applicable).
- Proof of all assets, such as bank accounts and life insurance policies.
- Copies of your current health insurance premium bills (such as Medex) if you are applying for long-term-care services in a medical facility (You do not have to send copies of your Medicare cards.)
- Policy numbers for any current health coverage.
- Information about any other health insurance available to your household.

Proof of citizenship/national status

We will try to verify this information through electronic data matches. We will notify you if we need further proof. It may speed up the processing of your application if you send proof of these items with it.

- Proof of US citizenship/national status and proof of identity, such as US passports or US naturalization papers. You can also prove US citizenship with a US public birth certificate. You can also prove identity with a driver's license or some other form of government-issued card. We may be able to prove your identity through the Massachusetts Registry of Motor Vehicles if you have a Massachusetts driver's license or a Massachusetts ID card. Once you give MassHealth proof of your US citizenship/national status and identity, you will not have to give us this proof again. You must give us proof of identity for all household members who are applying. **Seniors and disabled persons who get or can get Medicare or Supplemental Security Income (SSI), or disabled persons who get Social Security Disability Insurance (SSDI), do not have to give proof of their US citizenship/national status and identity.** (See Section 9 in the Senior Guide for more information)
- A copy of both sides of all immigration cards (or other documents that show immigration status) for you or your spouse if you or your spouse are not US citizens/nationals and are applying for MassHealth (except for MassHealth Limited), the Health Safety Net, or the Health Connector plans.

For more information on immigration statuses and document types, see page 121.

Why 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 MAhealthconnector.org. To view MassHealth's privacy policy, go tomass.gov/service-details/masshealth-member-privacy-information.

WHAT HAPPENS NEXT and WHERE TO GET HELP

When we get your filled-out, signed, and dated application, we will review it. If we need more information, we will write or call you. Once we get what we need, we will make a decision about your eligibility and send you a written notice. If you are eligible for MassHealth, show this notice right away to any health care provider if you have paid for medical services that would be covered by MassHealth during your eligibility period. If the health care provider determines that MassHealth will pay for these services, the provider will refund what you paid.

If you need more information about how to apply, or if you need another copy of **Supplement C: Personal-Care Attendant** for your spouse who is also applying, call us at (800) 841-2900, TDD/TTY: 711.

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

If you have any questions about any form or the information you need to send, please call us at (800) 841-2900, TTY: 711.

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Please Print Clearly. Be sure to answer all questions. Fill out all parts of the application, along with all supplements that apply. If you need more space, attach a separate piece of paper to the application. Put Person 1's name and Social Security number at the top of any attached paper.

For each member in your household, put the name(s) of the individual(s) under the program or programs they want to apply for. See the Senior Guide to learn more about coverage under these programs.

Please list the names of everyone who is applying for health coverage on this application.

☐ **MassHealth or the Health Safety Net (HSN)**

(If living at home, or in a rest home, an assisted living facility, a continuing care retirement community, or life care community, fill out this application and any supplements that apply to you or any household member.) MassHealth will check if anyone applying for health coverage on this application is eligible for MassHealth or the HSN.

You: _____

Spouse: _____

☐ **Long-Term Care**

☐ **Home- and Community-Based Services Waiver**

(If applying for or getting long-term-care services at home under an HCBS Waiver, or in a nursing home or chronic hospital, fill out this application and any supplements that apply to you or any household member, including all or part of the Long-Term-Care Supplement.)

You: _____

Spouse: _____

☐ **Health Connector Programs**

Health coverage through the Massachusetts Health Connector is not MassHealth. If you have Medicare, you will not be eligible for any cost sharing reductions or Advance Premium Tax Credits through the Health Connector, and you cannot purchase a health plan through the Health Connector, unless you were already enrolled in a Health Connector plan when you became eligible for Medicare. The only time you should apply for Health Connector programs if you have Medicare is if you are not enrolled in Medicare yet but would have to pay for your Medicare Part A premium. In this case, you may be eligible for coverage through the Health Connector, which may include Advance Premium Tax Credits and ConnectorCare plans.

You: _____

Spouse: _____

Note:
Program of All-inclusive Care for the Elderly (PACE)

Some MassHealth members may be eligible to enroll in the PACE, which provides members access to a wide range of medical, social, recreational, and wellness services through a center-based model. See page 35 of the Senior Guide for more information.

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 as an application for SNAP benefits. You must read the rights and responsibilities on pages 73-86 and sign on page 89 to proceed with the application.

What happens after you apply for SNAP benefits?

- DTA will call you soon for a phone interview and to check if you can get emergency SNAP within 7 days.
- DTA will work with you to verify information about your case.
- You will get an Electronic Benefit Transfer (EBT) card to access benefits, if approved.
- You will receive a notice about your decision within 30 days.

STEP 1 PERSON 1 (YOU)— TELL US ABOUT YOURSELF.

We need one adult in the household to be the contact person for your application. This person should be someone who appears on the application, not a third party who wishes to serve as a contact for the applicant(s). See the Authorized Representative Designation (ARD) 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 (mm/dd/yyyy) ___ /___ /_____

3. Street address ☐ No home address.
   You must provide a mailing address.

   _____

4. Apartment or unit number _____

5. City _____

6. State _____ 7. Zip code _____

8. County _____

9. Is this a hospital, nursing facility,or other institution?
   ☐ Yes ☐ No
   If **Yes**, facility name

   _____

10. Mailing address ☐ Check if same as street address.

    _____

11. Apartment or unit number _____

12. City _____

13. State _____

14. Zip code_____

15. County _____

16. Mobile phone number _____

17. Other phone number _____

18. Email address _____

19. # of people listed on the application _____

20. What is your preferred language, if not English?
    Spoken _____
    Written _____

Your preferred written language may be used to communicate with you. If you do not answer, we will send your notices in English.

21. Is anyone on this application in prison or jail? Please select **No** if this person will be released in the next 60 days. ☐ Yes ☐ No

    If **Yes**, who? Enter the name here:

    _____

    If **Yes**, is this person awaiting trial? ☐ Yes ☐ 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. Certified Application Counselors must fill out a Certified Application Counselor Designation Form.

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 PERSON 1 — Tell us about your household.

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

   _____

2. Relationship to you **SELF**

3. What was your sex assigned at birth?
   ☐ Male ☐ Female

This is usually the sex that was originally listed on your birth certificate.

4. Are you applying for health coverage for YOURSELF? ☐ Yes ☐ No

   If **Yes,** answer all the questions below in Step 2 for Person 1 (yourself).
   If **No**, answer Question 20 (accommodations), then go to the Income Information section on page 19.

OPTIONAL: MassHealth is committed to providing equitable care for all members regardless of race, ethnicity gender, sexual orientation or language spoken. Please complete questions 5-9 to help us meet your language and cultural needs. Your response is voluntary and will not impact your eligibility or be used for any discriminatory purpose.

5. Which best describes your current gender identity? Select up to five options.

Gender identity is how a person defines and understands their gender as a man, a woman, non-binary, gender nonconforming, transgender, or something else.

☐ Male ☐ Female ☐ Transgender man/trans man
☐ Transgender woman/trans woman
☐ Genderqueer/gender nonconforming/nonbinary/ neither exclusively male nor female
☐ Gender Identity not listed here.
Please specify. _____
☐ Don't know ☐ Choose not to answer

6. Which of these describes your current sexual orientation? Select up to five options.

Sexual orientation describes how a person defines their physical and/or emotional attraction to others.

☐ Straight or heterosexual ☐ Lesbian or gay
☐ Bisexual ☐ Queer, pansexual, or questioning
☐ Sexual orientation is not listed.
Please specify. _____
☐ Don't know ☐ Choose not to answer

7. Are you of Hispanic or Latino origin or descent?

Hispanic or Latino refers to someone of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

☐ Yes, Hispanic or Latino
☐ No, Non-Hispanic or Latino
☐ Don't know ☐ Choose not to answer

8. Race (see page 118) _____

Race refers to a person's self-identification with one or more social groups. You may report multiple races.

9. Ethnicity (see page 118) _____

Ethnicity refers to your background, heritage, culture, ancestry, or the country where you or your family were born.

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10. 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 people 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 you need help getting an SSN, call the Social Security Administration at (800) 772-1213, TTY: (800) 325-0778, or go to **socialsecurity.gov**.

For more details on how we use your Social Security number, refer to the Senior Guide for Health Care Coverage.

If **Yes**, give us the number __ __ __ - __ __ - __ __ __ __

If **No**, check one of the following reasons.
☐ Illness exception ☐ 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

_____

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

    You may not have needed or chosen to file a tax return in the past, but you will have to file a federal income tax return for any year that you get an APTC. You must check **Yes** to question 11 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 or HSN, if you qualify.

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

    You must file a joint federal tax return with your spouse for the year for which you are applying to get certain programs (ConnectorCare or APTCs) unless you are a victim of domestic abuse or abandonment or you will file taxes as Head of Household. If you will file taxes as Head of Household, you should answer **No** to question 11a ("Are you legally married?"). One way you may qualify as Head of Household is to live apart from your spouse and claim another person as a dependent. See IRS Publication 501 or consult a tax professional for tax filing information. You will only need to include yourself and any dependents on this application.

a. Are you legally married? ☐ Yes ☐ No
If **No**, skip to question 11c.
If **Yes**, list your spouse's name 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 which you are applying? ☐ Yes ☐ No
You will claim a personal exemption deduction on your federal income tax return for any individual who is listed on this application as a dependent and 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 dependents' name(s) and birth date(s).

_____

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 whether you can receive a premium tax credit. Do not answer **Yes** to this question if you are a child younger than 21 being claimed by a non-custodial 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 the spouse's name 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 each year in the past two years that I received an Advance Premium Tax Credit (APTC) to lower my monthly premium payment, including if I was enrolled in ConnectorCare. I included the tax forms showing the tax credits I received when I filed my tax return so the IRS could calculate how much Advance Premium Tax Credit I was eligible to receive based on my final income for the year. ☐ 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.

12. Are you a US citizen or US national? ☐ Yes ☐ No

    If **Yes**, are you a naturalized, derived, or acquired citizen (not born in the US)? ☐ Yes ☐ No

    Alien number _____
    Naturalization or citizenship certificate number

    _____

13. If you are a noncitizen, do you have an eligible immigration status? ☐ Yes ☐ No
    See page 113, "Immigration Statuses and Document Types" for help. If **No** or **no response**, you may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN). Go to Question 14.

    a. Are you a Lawful Permanent Resident (LPR or green card holder), a Cuban-Haitian Entrant (CHE), or a Compact of Free Association (COFA) Migrant?
    ☐ Yes ☐ No, not sure, or prefer not to answer

    b. Do you have an immigration document?
    ☐ Yes ☐ No
    It may help us to process this application faster if you include a copy of your immigration document with the application. We will try to verify your immigration status through an electronic data match. Please list all the immigrations statuses and/or conditions that have applied to you since you entered the US. 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.)

Immigration status _____

Immigration document type _____
Choose one or more document status and type from the list on page 114.

Document ID number _____

Alien number _____

Passport or document expiration date
(mm/dd/yyyy) ___ /___ /_____

Country _____

c. 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 name, middle name, last name, and suffix

d. Did you arrive in the U.S. after August 22, 1996?
☐ Yes ☐ No

e. Are you an honorably discharged veteran or active-duty member of the US military, or the spouse or child of an honorably discharged veteran or an active-duty member of the US 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 parent of a battered spouse?

14. 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 Massachusetts for personal pleasure or to receive medical care in a setting other than a nursing facility, you must answer **No** to this question.

15. Do you live with at least one child younger than age 19, and are you the main person taking care of this child or children? ☐ Yes ☐ No

    Names(s) and date(s) of birth of child(ren)

    _____

16. Are you pregnant? ☐ Yes ☐ No

    If **Yes**, how many babies are you expecting? __
    What is the expected due date? ___ /___ /____

17. Were you ever in foster care? ☐ Yes ☐ No

    a. If **Yes**, in what state were you in foster care? _____

    b. Did you get health care through a state Medicaid program? ☐ Yes ☐ No

18. Do you rent or own your property? ☐ Rent ☐ Own

19. **DISABILITY** Answer this question if you are younger than 65 or age 65 or older and working.
Do you have a 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

Name: _____

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

If **No**, go to the next question.
If **Yes**, answer questions a and b.

a. Condition:
☐ Low vision ☐ Blind ☐ Deaf
☐ Hard of hearing ☐ Developmentally disabled
☐ Intellectually disabled ☐ Physically disabled
☐ Other (Please explain) _____

b. Accommodation:
☐ Text telephone (TTY)
☐ Large-print publications
☐ American Sign Language interpreter
☐ Video Relay Service
☐ Communication Access Real-time Translations (CART)
☐ Publications in braille
☐ Assistive listening device
☐ Publications in electronic format
☐ Other (Please explain) _____

21. Did you ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No

If **No**, go to Income Information.
If **Yes**, answer questions a and b.

a. When did you last get SSI? (mm/yyyy) ___ /___ /_____

b. Do you (check one.):
- ☐ live alone?
- ☐ live with a spouse?
- ☐ live in a rest home?
- ☐ live in someone else's home?

Income Information **(You may send proof of all household income with this application.)**

22. Do you have any income? ☐ Yes ☐ No
If **No**, skip to question 31.

Current Job
If you have more jobs and need more space, attach another sheet of paper.

23. Employer name and address

_____

_____

Federal Tax ID# _____

24. a. Wages/tips (before taxes) $ _____
☐ Weekly ☐ Every 2 weeks
☐ Twice a month ☐ Monthly ☐ Yearly

(Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)

b. Income effective date ___ /___ /_____

25. Average number of hours worked each WEEK ____

26. 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.

Self-employment
If self-employed, answer the following questions.
If you need more space, attach another sheet of paper.

27. Are you self-employed? ☐ Yes ☐ No

a. If **Yes**, what type of work do you do?

_____

b. On average, how much net income (profits after business expenses are paid) will you get from this self-employment each month, or, how much will you lose from this self-employment each month?
$_____/month **profit** OR $_____/month **loss**?

c. How many hours do you work per week? _____

Other income

28. Check all that apply. State the amount and how often you get it. **NOTE: You do not need to tell us about child support or Supplemental Security Income (SSI).**

☐ Social Security benefits
$ _____ How often? _____

☐ Retirement or pension
$ _____ How often? _____
Source _____

☐ Annuities
$ _____ How often? _____

☐ Trusts
$ _____ How often? _____

☐ Unemployment
$ _____ How often? _____

☐ Interest, dividends, and other investment income
$ _____ How often? _____

☐ Royalty income
$ _____ How often? _____

☐ Alimony received
$ _____ How often? _____

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. $ _____

☐ Federal veteran's benefits
$ _____ How often? _____

☐ Military retirement pay
$ _____ How often? _____

☐ Other taxable income (include type)
$ _____ How often? _____
Type _____

☐ 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
$ _____/ **profit** OR $ _____/ **loss**
How many hours each week? _____

☐ 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.

Rental Income

29. Do you get rental income? **(You must answer this question.)** ☐ Yes ☐ No

If **Yes**, **send proof** of current rental income, such as a written statement from each tenant, a copy of the lease, or a current federal tax return. Also **send proof** of all of the following expenses, if applicable, for the last 12 months: mortgage, taxes, utilities (gas/electric),

heat, water/sewer, insurance, condo or co-op fee, repairs and maintenance.

a. What type of real estate do you own?
☐ one-family ☐ two-family ☐ three-family
☐ other (describe): _____

b. How much **monthly** rental income or loss do you get from each rental unit from the real estate indicated above? (List each rental unit and address separately.)

Address _____ Unit #____
Amount of Income _____ Amount of Loss _____
Owner-occupied? ☐ Yes ☐ No

Address _____ Unit #____
Amount of Income _____ Amount of Loss _____
Owner-occupied? ☐ Yes ☐ No

c. Do you pay for heat or utilities for your tenant?
☐ Yes ☐ No

One-Time-Only Income

30. Have you or will you receive income during this calendar year as a one-time only payment? ☐ Yes ☐ No
An example might include a lump-sum pension payment.

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 expenses: 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 from 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 interest deduction (interest only, not total payment): Yearly amount $ _____

☐ None

Yearly income

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

34. 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—SPOUSE OR OTHER PEOPLE IN THIS HOUSEHOLD

Fill out this part for your spouse who lives with you, or anyone included on your federal income tax return, if you file one.

If you have to include more than two people on this application, make a copy of blank information pages for Step 2 Person 2 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. We need this information to determine eligibility. You can also download pages for additional people at mass.gov/lists/applications-to-become-a-masshealth-member.

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

_____

2. Date of birth ___ /___ /_____

3. What was this person's sex assigned at birth?
   ☐ Male ☐ Female
   This is usually the sex that was originally listed on their birth certificate.

4. Relationship to Person 1 _____

5. Does this person live with Person 1? ☐ Yes ☐ No
   If **No**, provide street address

   _____

☐ No street address. Note: if you check this box, you must provide a mailing address.

6. Is this a hospital, nursing facility, or other institution? ☐ Yes ☐ No
   If **Yes**, facility name _____

7. Mailing address
   ☐ Check if same as street address.
   _____

8. Apartment or unit number _____

9. City _____

10. State _____ 11. ZIP code _____

12. County _____

13. What is this person's preferred language, if not English?
    Spoken _____
    Written _____

Preferred written language may be used by MassHealth and the Health Connector to communicate with you. If you do not answer, we will send your notices in English.

14. Is this person applying for health or dental coverage?
    ☐ Yes ☐ No
    If **Yes**, answer all the questions below in Step 2 for Person 2
    If **No**, answer Question 30 (accommodations), then go to the Income Information section on page 37.

OPTIONAL: See instructions for questions 5-9 under Person 1.

15. Which best describes this person's current gender identity? Select up to five options.

    ☐ Male ☐ Female ☐ Transgender man/trans man
    ☐ Transgender woman/trans woman
    ☐ Genderqueer/gender nonconforming/nonbinary/ neither exclusively male nor female
    ☐ Gender Identity not listed.
    Please specify. _____
    ☐ Don't know ☐ Choose not to answer

16. Which of these describes this person's current sexual orientation? Select up to five options.

    ☐ Straight or heterosexual ☐ Lesbian or gay
    ☐ Bisexual ☐ Queer, pansexual, or questioning
    ☐ Sexual orientation is not listed.
    Please specify. _____
    ☐ Don't know ☐ Choose not to answer

17. Is this person of Hispanic or Latino origin or descent?

    ☐ Yes, Hispanic or Latino
    ☐ No, Non-Hispanic or Latino
    ☐ Don't know ☐ Choose not to answer

18. Race (see page 118) _____

19. Ethnicity (see page 118) _____

20. 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, see instructions for Question 10 under Person 1.

If **Yes**, give us the number __ __ __ - __ __ - __ __ __ __

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

Is the name on this application the same as the name on their 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

_____

21. 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
They may not have needed or chosen to file a tax return in the past, but this person will have to file a federal income tax return for any year that they get an APTC. You must check **Yes** to question 21 to be eligible for ConnectorCare or APTCs to help pay for this person's health insurance.
This person does NOT need to file a tax return to apply for or to get MassHealth or HSN, if they qualify.

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

This person must file a joint federal tax return with a spouse for the year for which this person is applying to get certain programs (ConnectorCare or APTCs) unless this person is a victim of domestic abuse or abandonment or they will file taxes as Head of Household. If this person will file taxes as Head of Household, he or she should answer **No** to question 21a ("Are you legally married?"). One way this person 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. This person will only need to include themself and any dependents on this application.

a. Is this person legally married? ☐ Yes ☐ No
   If **No**, skip to question 21c.
   If **Yes**, list the spouse's name 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 dependents' name(s) and birth date(s).

_____

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 the spouse's name 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

22. Is this person a US citizen or US national?
☐ Yes ☐ No
If **yes**, are they a naturalized, derived, or acquired citizen (not born in the US)? ☐ Yes ☐ No
Alien number _____
Naturalization or citizenship certificate number
_____

23. If this person is a noncitizen, do they have an eligible immigration status? ☐ Yes ☐ No
See page 113, "Immigration Statuses and Document Types" for help. If **No** or **no response**, you may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN). Go to Question 24.

    a. Is this person a Lawful Permanent Resident (LPR or green card holder), a Cuban-Haitian Entrant (CHE), or a Compact of Free Association (COFA) Migrant?
    ☐ Yes ☐ No, not sure, or prefer not to answer

    b. Does this person have an immigration document? ☐ Yes ☐ No
    It may help us to process this application faster if you include a copy of their immigration document with the application. We will try to verify this person's immigration status through an electronic data match. Please list all the immigration statuses and/or conditions that have applied to this person since they entered the US 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.)
Immigration status _____
Immigration document type

_____

Choose one or more document status and types from the list on page 114.
Document ID number _____
Alien number _____
Passport or document expiration date (mm/dd/yyyy) ___ /___ /_____
Country _____

c. Did this person use the same name on this application to get their immigration status?
☐ Yes ☐ No

If **No**, what name did this person use?

_____

First name, middle name, last name, and suffix

d. Did this person arrive in the US after August 22, 1996? ☐ Yes ☐ No

e. 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

f. **Optional:** Is this person a
- ☐ 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?

24. Is this person living in Massachusetts, and does this person either intend to reside here, even if they do 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 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.

25. 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 or children? ☐ Yes ☐ No

    Name(s) and date(s) of birth of children

    _____

    _____

26. Is this person pregnant? ☐ Yes ☐ No

    If **Yes**, how many babies are they expecting? ____
    What is the expected due date? ___ /___ /_____

27. 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

28. Does this person rent or own their property?
    ☐ Rent ☐ Own

29. **DISABILITY** Answer this question if this person is under age 65 or age 65 or older and working.
    Does this person have a 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

    Name: _____

30. Does this person need reasonable accommodation(s) because of a disability or injury? ☐ Yes ☐ No

    If **No**, go to the next question.
    If **Yes**, answer questions a and b.

    a. Condition:
    ☐ Low vision ☐ Blind ☐ Deaf
    ☐ Hard of hearing ☐ Developmentally disabled
    ☐ Intellectually disabled ☐ Physically disabled
    ☐ Other (Please explain)

    _____

b. Accommodation:

- ☐ Text telephone (TTY)
- ☐ Large-print publications
- ☐ American Sign Language interpreter
- ☐ Video Relay Service
- ☐ Communication Access Real-time Translations (CART)
- ☐ Publications in braille
- ☐ Assistive listening device
- ☐ Publications in electronic format
- ☐ Other (Please explain)

_____

31. Did this person ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No

If **No**, go to Income Information.
If **Yes**, answer questions a and b.

a. When did this person last get SSI? (mm/yyyy)
___ /___ /_____

b. Does this person (check one.):

- ☐ live alone?
- ☐ live with a spouse?
- ☐ live in a rest home?
- ☐ live in someone else's home?

Income Information **(You may send proof of all household income with this application.)**

32. Does this person have any income? ☐ Yes ☐ No
    If you don't have income, skip to question 44.

Current Job
If this person has more jobs and needs more space, attach another sheet of paper.

33. Employer name and address

    _____

    _____

    Federal Tax ID# _____

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

35. Average number of hours worked each WEEK ____

36. Is this person 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.

Self-employment

If self-employed, answer the following questions. If you need more space, attach another sheet of paper.

37. Is this person self-employed? ☐ Yes ☐ No

    a. If **Yes**, what type of work do they do?

    _____

    b. On average, how much net income (profits after business expenses are paid) will this person get from this self-employment each month, or, how much will they lose from this self-employment each month?
    $_____/month profit OR $_____/month loss?

    c. How many hours does this person work per week?

    ____

Other income

38. Check all that apply. State the amount and how often this person gets it. **NOTE: You do not need to tell us about child support, or Supplemental Security Income (SSI).**

    ☐ Social Security benefits
    $ _____ How often? _____
    Source _____

    ☐ Retirement or pension
    $ _____ How often? _____

    ☐ Annuities
    $ _____ How often? _____

☐ Trusts
$ _____ How often? _____

☐ Unemployment
$ _____ How often? _____

☐ Interest, dividends, and other investment income
$ _____ How often? _____

☐ Royalty income
$ _____ How often? _____

☐ Alimony received
$ _____ How often? _____

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. $ _____

☐ Federal veteran's benefits
$ _____ How often? _____

☐ Military retirement pay
$ _____ How often? _____

☐ Other taxable income (include type)
$ _____ How often? _____
Type _____

☐ 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
$ _____/ **profit** OR $ _____/ **loss**
How many hours each week? _____

☐ 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.

Rental Income

39. Does this person get rental income? ☐ Yes ☐ No

If **Yes**, **send proof** of current rental income, such as a written statement from each tenant, a copy of the lease, or a current federal tax return. Also **send proof** of all of the following expenses, if applicable, for the last 12 months: mortgage, taxes, utilities (gas/electric), heat, water/sewer, insurance, condo or co-op fee, repairs and maintenance.

a. What type of real estate does this person own?
☐ one-family ☐ two-family ☐ three-family
☐ other (describe): _____

b. How much **monthly** rental income or loss does this person get from each rental unit from the real estate indicated above? (List each rental unit and address separately.)

Address _____ Unit #____
Amount of Income _____ Amount of Loss _____
Owner-occupied? ☐ Yes ☐ No

Address _____ Unit #____
Amount of Income _____ Amount of Loss _____
Owner-occupied? ☐ Yes ☐ No

c. Do you pay for heat or utilities for your tenant?
☐ Yes ☐ No

One-Time-Only Income

40. Has or will this person receive income during this calendar year as a one-time only payment?
☐ Yes ☐ No
An example might be a lump-sum pension payment.

If **Yes**: Type: _____ Amount $ _____
Month received _____ Year received _____

41. 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

42. What deductions does this person report on their income tax return?
If this person pays 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. This person's deductions should be what they report on their federal income tax return in the section "Adjusted Gross Income." For each deduction selected, give the yearly amount. You can enter up to the maximum deduction amount allowed by the IRS.

- ☐ Educator expenses: 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: If this person paid alimony payments for a divorce, separation agreement, or court order that was finalized before January 1, 2019, enter the amount of those payments here.
Yearly Amount $ _____

☐ Individual Retirement Account (IRA) deduction:
Yearly amount $ _____

☐ Student loan interest deduction (interest only, not total payment): Yearly amount $ _____

☐ None

Yearly income

43. What is this person's total expected income for the current calendar year? _____

44. What is this person's total expected income for next calendar year, if different? _____

THANKS!

This is all we need to know about this person.

STEP 3

AMERICAN INDIAN OR ALASKA NATIVE (AI/AN) HOUSEHOLD MEMBER(S)

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**.

STEP 4

PREVIOUS MEDICAL BILLS

Do you or your spouse have bills for medical services you got in the three months before submitting this application? ☐ Yes ☐ No

If **Yes**, MassHealth may be able to pay for these bills. If **No**, go to Step 5: Assets.

Do you or your spouse want to apply for MassHealth for that time period? ☐ Yes ☐ No

If **Yes**, what is the earliest date for which you need MassHealth? (mm/dd/yyyy) ___ /___ /_____
(You must give us proof of all income and assets owned during that time period.)

Please list below any individuals requesting payment of previous medical bills. You must give us proof of all income and assets owned during that time period.

Name _____
Earliest date requested ___ /___ /_____
Any change in circumstances during this time?
☐ Yes ☐ No

Name _____
Earliest date requested ___ /___ /_____
Any change in circumstances during this time?
☐ Yes ☐ No

STEP 5

ASSETS

You must fill out all blocks for each asset you and/or your spouse own.

If you live in the community and you want help with medical bills up to three months before the month you apply, you must tell us about any open and closed accounts for that period. If you are applying for long-term care, you must also give us information about all assets you or your spouse owned in the past 60 months. If you need more space, attach another sheet of paper.

BANK ACCOUNTS

1. Do you or your spouse have any bank accounts or certificates of deposit, including checking, savings, credit union, NOW, money-market, and personal needs allowance (PNA) accounts? ☐ Yes ☐ No

   a. Do you or your spouse have any retirement accounts, including individual retirement accounts (IRAs), Keogh, or pension funds? ☐ Yes ☐ No

   b. Have you or your spouse or a joint owner closed any accounts in the past 60 months, including any accounts you had owned jointly with anyone else? ☐ Yes ☐ No

   If you answered **Yes** to **any** of these questions, fill out this section. If you answered no to all of these questions, go to the next section **(REAL ESTATE)**.

Send a copy of your passbooks updated within 45 days and/or **a copy** of your current account statements. See the Senior Guide for information about financial institutions charging for copies of statements. If applying for nursing facility coverage, please provide account statements for the past 60 months.

Name on account _____
Account type _____
Name of bank/institution _____
Account number _____
Current balance $ _____
Balance on admission date* $ _____
☐ Account open ☐ Account closed
Date account closed (mm/dd/yyyy) ___ /___ /_____
Amount on the date account closed $ _____

Name on account _____
Account type _____
Name of bank/institution _____
Account number _____
Current balance $ _____
Balance on admission date* $ _____
☐ Account open ☐ Account closed
Date account closed (mm/dd/yyyy) ___ /___ /_____
Amount on the date account closed $ _____

* Enter the account balance on the date of admission to medical institution, hospital, or nursing facility

REAL ESTATE

2. Do you or your spouse own or have a legal interest in your primary residence?
   You ☐ Yes ☐ No
   Your spouse ☐ Yes ☐ No

3. Do you or your spouse own or have a legal interest in any real estate **other than** your primary residence?
   You ☐ Yes ☐ No
   Your spouse ☐ Yes ☐ No

   If you answered **Yes** to any of these questions, fill out this section. If **No**, go to the next section **(LIFE INSURANCE).**

Send a copy of the deed(s), current tax bill(s), and proof of amount owed on all property owned.

Address _____
Type of property _____
Current value $ _____

Address _____
Type of property _____
Current value $ _____

LIFE INSURANCE

4. Do you or your spouse own any life insurance?
   ☐ Yes ☐ No

   If **Yes**, fill out this section. **If no**, go to the next section **(SECURITIES (STOCKS/BONDS/OTHER))**.

Send a copy of the first page of all life-insurance policies. If total face value of all policies exceeds $1,500 per person, also **send a letter** from the insurance company showing the current cash-surrender value (for all policies except term policies).

Name(s) of owner(s)

_____

Insurance company _____

Policy number _____

Face value $ _____

Insurance type _____

Name(s) of owner(s)

_____

Insurance company _____

Policy number _____

Face value $ _____

Insurance type _____

SECURITIES (STOCKS/BONDS/OTHER)

5. Do you or your spouse own any stocks, bonds, savings bonds, mutual funds, securities, assets held in safe-deposit boxes, cash not in the bank, options, or future contracts? ☐ Yes ☐ No

   If **Yes**, fill out this section.
   If **No**, go to the next section **(ANNUITIES)**.

Send proof of current value (except cash).

☐ Cash
Owner(s) name(s) _____
Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

☐ Stocks
Owner(s) name(s) _____
Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

☐ Bonds
Owner(s) name(s) _____
Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

☐ Savings bonds
Owner(s) name(s) _____
Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

☐ Mutual funds
Owner(s) name(s) _____
Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

☐ Options
Owner(s) name(s) _____
Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

☐ Future contracts
Owner(s) name(s) _____
Company name _____
Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

☐ Other _____
Owner(s) name(s) _____
Company name _____

Account number _____
Current value $ _____ Value on admission date* $ _____
Joint asset? ☐ Yes ☐ No

* Enter the account balance on the date of admission to medical institution.

ANNUITIES

6. Did you or your spouse or someone on your or your spouse's behalf purchase or in any way change an annuity? ☐ Yes ☐ No

   If **Yes**, fill out this section. To be eligible, you may be required to name the Commonwealth as a remainder beneficiary. (See the Senior Guide for more information.) If **No**, go to the next section **(ASSISTED LIVING/OTHER)**.

Send a copy of the contract. For each annuity owned, **give us proof** from the annuity company of the full value of the annuity less any penalties and fees if it can be cashed in.

Name(s) of owner(s) _____
Name of institution issuing the annuity

_____
Contract number _____
Date purchased (mm/dd/yyyy) ___ /___ /_____

Name(s) of owner(s) _____
Name of institution issuing the annuity

_____
Contract number _____
Date purchased (mm/dd/yyyy) ___ /___ /_____

ASSISTED LIVING/OTHER

7. Have you, your spouse, or someone acting on your behalf given a deposit to any health-care or residential facility, like an assisted-living facility, a continuing-care retirement community, or life-care community?
☐ Yes ☐ No

   If **Yes**, fill out this section. If **no**, go to the next section **(VEHICLES/MOBILE HOMES)**.

Send a copy of the contract you signed with the facility and any documents about this deposit.

Name of facility

_____

Address of facility

_____

Amount of deposit $ _____
Date deposit given to facility (mm/dd/yyyy) ___ /___ /_____

VEHICLES/MOBILE HOMES

8. Do you or your spouse own any vehicles, like cars, vans, trucks, recreational vehicles, mobile homes, or boats? ☐ Yes ☐ No

   If **Yes**, fill out this section.
   If **No**, go to the next section **(PREPAID BURIAL PLANS/TRUSTS)**.

Send a copy of the registration for each vehicle, and proof of the outstanding loan balance. For mobile homes, **send a**

copy of the bill of sale. If you have a spouse at home, **send proof** of the fair-market value of each vehicle as of the date of admission to the medical institution.

(You) Type of vehicle _____
Year/make/model _____
Fair-market value $ _____
Amount owed $ _____
Mobile home address _____

(Your spouse) Type of vehicle _____
Year/make/model _____
Fair-market value $ _____
Amount owed $ _____
Mobile home address _____

PREPAID BURIAL PLANS/TRUSTS

9. Do you or your spouse have any prepaid burial contracts or trusts, life insurance set up for funeral and burial expenses, or bank accounts set aside for funeral expenses? ☐ Yes ☐ No

   If **Yes**, fill out this section.
   If **No**, go to the next section **(TRUSTS)**.

Send a copy of the trust contract, trust instrument, insurance policy, or burial-only account.

(You) Burial contract
☐ Yes (Amount $) ☐ No

Burial trust
☐ Yes (Amount $) ☐ No

Life insurance for burial
☐ Yes (total face value $) ☐ No

Burial-only account
☐ Yes (Amount $) ☐ No

Burial plot ☐ Yes ☐ No

Insurance company _____
Policy number _____
Bank name _____
Account number _____

(Your spouse) Burial contract
☐ Yes (Amount $) ☐ No

Burial trust
☐ Yes (Amount $) ☐ No

Life insurance for burial
☐ Yes (total face value $) ☐ No

Burial-only account
☐ Yes (Amount $) ☐ No

Burial plot ☐ Yes ☐ No

Insurance company _____
Policy number _____
Bank name _____
Account number _____

TRUSTS

10. Are you or your spouse the grantor/donor, trustee, or beneficiary of any trusts? ☐ Yes ☐ No

11. Have you, your spouse, or someone else on your behalf, including a court or administrative body, contributed income or assets owned by you or your spouse to a trust? ☐ Yes ☐ No

    If you answered **Yes** to any of these questions, fill out this section. If you answered **No** to these questions, go to **Step 6: Health Insurance Information**

Send a copy of the trust document(s), any amendments, documents showing financial activity, and the schedule of beneficiaries.

Trust name _____
Revocable? ☐ Yes ☐ No Current trust principal $ ____
Trust principal on admission date* $ _____
Trustee(s) _____
Grantor(s)/Donor(s) _____
Beneficiaries _____

Trust name _____
Revocable? ☐ Yes ☐ No Current trust principal $ ____
Trust principal on admission date* $ _____
Trustee(s) _____
Grantor(s)/Donor(s) _____
Beneficiaries _____

* Enter the trust principal on the date of admission to medical institution.

STEP 6

HEALTH INSURANCE INFORMATION

MassHealth regulations require members to obtain and maintain available health insurance, including health insurance available through an employer. 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, and we may share information about you and members of your household with your employer(s) and /or health insurer(s) to confirm this information.

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 Senior Guide 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, like a spouse, even if this person does not live in the household.
   If **Yes**, you will need to complete and include **Supplement D: Health Coverage from Jobs**, and the rest of this application.

2. Does anyone qualify for or is anyone enrolled in 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 of person covered: _____

Medicare claim number: _____

When did coverage start? (mm/dd/yyyy) ___ /___ /____

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

b. Does this person have a Medigap/Medicare supplemental policy? ☐ Yes ☐ No
   If **Yes**, name of coverage plan
   _____
   When did coverage start? (mm/dd/yyyy)
   ___ /___ /_____

Name: _____

Medicare claim number: _____

When did coverage start? (mm/dd/yyyy) ___ /___ /____

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

b. Does this person have a Medigap/Medicare supplemental policy? ☐ Yes ☐ No
If **Yes**, name of coverage plan
_____
When did coverage start? (mm/dd/yyyy)
___ /___ /_____

Do any of the people above want to apply for help paying for the Medicare Part B premiums?
☐ Yes ☐ No
If **Yes**, name(s)
_____

If you check any of the following programs provide details below.

☐ Qualifies for **Peace Corps**

☐ Qualifies for **TRICARE**
(Do not check if you have direct care or Line of Duty.)

☐ Enrolled in **Veterans Affairs (VA) health programs**

☐ **MassHealth**

☐ **Other coverage**
(including COBRA and retiree health plans)

Name(s) of covered household members

_____

Policy number or Member ID

_____

Start date and end date (mm/dd/yyyy)
___ /___ /_____ ___ /___ /_____

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

Name of employer

_____

Name(s) of covered household members

_____

Plan name

_____

Policy number or Member ID

_____

Start date and end date? (mm/dd/yyyy)
___ /___ /_____ ___ /___ /_____

STEP 7

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

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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

STEP 8

PERSONAL-CARE-ATTENDANT SERVICES

For people 65 years or older who are not going to be in a long-term-care facility

To get more information about personal-care-attendant (PCA) services and how filling out this PCA section could affect the way we decide if you can get MassHealth if you do need PCA services, read the PCA section in the enclosed Senior Guide.

1. Do you or your spouse need the services of a personal-care attendant? ☐ Yes ☐ No

   If **Yes**, fill out this section and answer all questions.

   If **No**, go to **STEP 10: Read and sign this application**.

2. Have you or your spouse had the services of a personal-care attendant paid for by MassHealth within the last six months? ☐ Yes ☐ No

   If **Yes**, go to **STEP 10: Read and sign this application**.

   If **No**, answer the following questions in this section.

3. Do you or your spouse have a permanent or long-lasting disability?
   You ☐ Yes ☐ No
   Your spouse ☐ Yes ☐ No

a. If **Yes**, does your (or your spouse's) disability keep you (or your spouse) from being able to do your (or your spouse's) daily living activities, like bathing, eating, toileting, dressing, etc., unless someone physically helps you (or your spouse)?
   You ☐ Yes ☐ No
   Your spouse ☐ Yes ☐ No

b. If **Yes**, do you (or your spouse) plan to contact a MassHealth personal-care-management (PCM) agency to ask for personal-care-attendant services?
   You ☐ Yes ☐ No
   Your spouse ☐ Yes ☐ No

Note: You must contact the PCM agency within 90 days of the date that MassHealth decides you are eligible for MassHealth or you will not be able to benefit from the special PCA rules.

MassHealth may not pay certain members of your family to be your personal-care attendant.

Each spouse who answered "Yes" to all parts of Question 3 above must fill out their own Supplement C: Personal-Care Attendant. One copy is enclosed. If you need a second copy, call MassHealth Customer Service at (800) 841-2900, TDD/TTY: 711 to ask for one. If you (or your spouse) do not send us your filled-out PCA supplement(s), we will determine your MassHealth eligibility as if you do not need PCA services.

STEP 9

Additional (Optional) Coverage for married persons younger than 65

Fill out this section ONLY if you are married and living with your spouse. One spouse applying must be younger than 65, with no children younger than 19 in the household. Answer these questions for the spouse who is under 65.

If this section applies to you and you want more information about income standards and other information that may apply, call us to get a Senior Guide at (800) 841-2900. TDD/TTY: 711. If this section does not apply, go to **Step 10: Read and sign this application**.

BREAST OR CERVICAL CANCER (OPTIONAL) (Only for persons younger than 65.)

1. Do you have breast or cervical cancer?
   ☐ Yes ☐ No
   MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.
   Name: _____

HIV INFORMATION (OPTIONAL) (Only for persons younger than 65.)

2. Are you HIV positive? ☐ Yes ☐ No
   If you are HIV positive, you may be eligible for additional coverage or benefits.
   Name: _____

STEP 10

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, or parents obligated to pay

for medical support, or individuals obligated to pay under accident settlements. Eligible persons must cooperate with MassHealth in establishing third-party support and obtaining third-party payments for themselves and anyone whose rights they can legally assign. Eligible persons may be exempted from this obligation if they believe and tell MassHealth that cooperation could result in harm to them or anyone whose rights they can legally assign.

5. A parent and/or guardian of minor children must agree to cooperate with state efforts to collect medical support from an absent parent unless they believe and tell MassHealth that cooperation will harm the children or the parent or guardian.

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 55 or older receiving long-term services and supports (LTSS), 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 permitted by law. For more information on estate recov-ery, visit mass.gov/EstateRecovery.

11. To the extent permitted by law, MassHealth will seek money from a Special Needs Trust belonging to an eligible individual after death for the total cost of care. The total cost of care includes the cost MassHealth paid directly for care (Fee for Service) and the total amount it paid to a health plan (like an Accountable Care Organization or a One Care plan) for care, regardless of what services the member may have received.

12. 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/TTD: 711. 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 in to your account at 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.

13. 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. MassHealth may share information about me and members of my household with my employer(s) and/or health insurers to obtain this information. 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.

14. 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.

15. 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.

16. 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 hhs.gov/ocr/complaints/index.html.

17. 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) or ConnectorCare, these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC 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.

18. I agree that MassHealth or anyone acting on its behalf may contact me including by mail, email, call, or text for any communications about my relationship with MassHealth or my health care needs, benefits, eligibility, or coverage using the contact information I provide, now or in the future, or information obtained from a reliable data source. These calls and texts may be made using automated technology, such as an automatic dialing system or artificial or prerecorded voice messages. Standard message and data rates may apply. I also agree that MassHealth may get, use, or share my information for the purpose of coordinating other health related benefits that I may be eligible to receive.

19. 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.

20. 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, including the following.

    - 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 the use and disclosure of 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
    - Providing consent on their behalf to use government and private sources to verify the information described in this application

21. I understand my rights and responsibilities and the rights and responsibilities of all persons listed on this application as explained in this Step 8.
22. 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.
23. 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.
24. 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; and
    - 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.
25. 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.

26. I understand that the policyholder in my household must have a valid SSN before getting a payment from MassHealth.
27. The information I have supplied is correct and complete to the best of my knowledge about myself and other persons listed on this application.
28. I may be subject to penalties under federal law if I intentionally provide false or untrue 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 tosocialsecurity.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.

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

This notice lists rights and responsibilities for the SNAP program.

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 report. 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.

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.
- You must give DTA information about your employment status when DTA asks.
- You must report to an employer if referred by DTA.
- You must accept a job offer (unless you have a good reason not to).
- You must mot quit a job of more than 30 hours a week without a good reason.
- You must not 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 40002(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 US Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g. Braille, large print, audiotape, American Sign Language), 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 (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete Form AD-3027, the USDA Program Discrimination Complaint Form, which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. mail:
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314, or
2. fax:
   (833) 256 1665 or (202)-690-7442. or
3. email:
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

Voter Registration

The form to register to vote is included with this application or can be found at sec.state.ma.us. More information on how to register to vote can also be found at www.sec.state.ma.us. If you have any questions about the voter registration process, or if you need help filling out the form, visit a local MassHealth Enrollment Center or call the MassHealth Customer Service Center at (800) 841-2900, TDD/TTY: 711.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, with your right to privacy in deciding to register or in applying to register to vote, or with your right to choose your own political party or other political preference, you may file a complaint with:

Secretary of the Commonwealth, Elections Division
One Ashburton Place
Room 1705
Boston, MA 02108

Tel: (617) 727-2828 or (800) 462-8683.

If you or anyone else in your application are not registered to vote where you live now, would you like to apply to register to vote today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

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 applicants 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 younger than 18, 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 _____
Zip code _____ County _____
Phone _____ Ext. ____ Phone type _____
Second phone _____ Ext. _____
Phone type _____
Email address _____

Send us your completed application.

Mail or fax your filled-out, signed application to

MassHealth Enrollment Center
PO Box 290794
Charlestown, MA 02129-0214
Fax: (617) 887-8799

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**.

SUPPLEMENT A

LONG-TERM CARE SERVICES AND SUPPORTS

- Do you need long-term-care services and supports in a nursing home type facility? ☐ Yes ☐ No

  If **Yes,** you must answer all questions and fill out all sections of this supplement.

- Are you applying for or getting long-term-care services and supports at home under a Home- and Community-Based Services Waiver (HCBS)? ☐ Yes ☐ No

  If **Yes**, you need to fill out “Resource Transfers” and “Long –Term Care Insurance“.

- Are you applying for or getting long-term-care services and supports through Program of All-Inclusive Care for the Elderly (PACE)? ☐ Yes ☐ No

  If **Yes**, you need to fill out “Resource Transfers” and “Long –Term Care Insurance“.

Please print clearly. If you need more space to finish any section, use a separate sheet of paper (include your name and Social Security number), and attach it to this supplement.

Applicant/Member Information

Last name, first name, middle initial

_____

Social Security number __ __ __ - __ __ - __ __ __ __

Name and address of hospital, nursing facility, or other institution _____

_____

Date of admission (mm/dd/yyyy) ___ /___ /_____

Were you placed here by another state? ☐ Yes ☐ No

If **Yes**, what state?_____

1. Do you have to pay guardianship expenses for a court-appointed guardian? ☐ Yes ☐ No

Living expenses of the spouse and family members living at home

(Do not complete this section if you are applying for a Home- and Community-Based Services Waiver or PACE.)

Your spouse living at home may be able to keep some of your income. Fill out the following information about your spouse's current living expenses. **If you do not have a spouse**, go to the next section **(Resource Transfers).**

Send proof of your spouse's current living expenses.

Spouse's last name, first name, middle initial

_____

Social Security number __ __ __ - __ __ - __ __ __ __

2. How much does your spouse pay each month for:
   Rent?_____
   Mortgage (principal and interest)? _____
   Homeowner's/tenant's insurance? _____
   Real estate taxes? _____
   Required maintenance charge for a condo or co-op? _____
   Room and board for assisted living? _____
3. Does your spouse pay for heat? ☐ Yes ☐ No
4. Does your spouse pay for utilities? ☐ Yes ☐ No
5. Is a child, parent, and/or sibling living with your spouse? ☐ Yes ☐ No

   If **Yes,** fill out this section. If **No**, go to the next section **(Resource Transfers)**.

Send proof of their monthly income before deductions.

A deduction may be allowed for their maintenance needs. These persons must be related to you or your spouse, and one of you must claim them as dependents on your federal income tax return.

Name _____
Social Security number __ __ __ - __ __ - __ __ __ __
Relationship _____
Date of birth (mm/dd/yyyy) ___ /___ /_____
Monthly income before deductions $ _____

Name _____

Social Security number __ __ __ - __ __ - __ __ __ __

Relationship _____

Date of birth (mm/dd/yyyy) ___ /___ /_____

Monthly income before deductions $ _____

Resource Transfers (resources include both income and assets)

6. In the past 60 months:
   a. Has any property that was available or belonged to you or your spouse been transferred into or out of a trust? ☐ Yes ☐ No
   b. Did you, your spouse, or someone on your behalf transfer income or the right to income? ☐ Yes ☐ No
   c. Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real estate? ☐ Yes ☐ No
   d. Did you, your spouse, or someone on your behalf change the deed or the ownership of any real estate, including creating a life estate, even if the life estate was purchased in another person's residence? ☐ Yes ☐ No
   e. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate? ☐ Yes ☐ No

f. Did you, your spouse, or someone on your behalf add another name to the deed of any property you own? ☐ Yes ☐ No

g. Did you, your spouse, or someone on your behalf receive or give anyone a mortgage, loan, or promissory note on any property or other asset? ☐ Yes ☐ No

h. Did you, your spouse, or someone on your behalf purchase or in any way change an annuity? ☐ Yes ☐ No

If you answered yes to any of the questions above, you must fill out the following, and **send us proof** of this information.

Description of asset/income _____
Date of transfer (mm/dd/yyyy) ___ /___ /_____
Transferred to whom _____
Relationship to you or your spouse _____
Amount of transfer $ _____

Description of asset/income _____
Date of transfer (mm/dd/yyyy) ___ /___ /_____
Transferred to whom _____
Relationship to you or your spouse _____
Amount of transfer $ _____

Description of asset/income _____

Date of transfer (mm/dd/yyyy) ___ /___ /_____

Transferred to whom _____

Relationship to you or your spouse _____

Amount of transfer $ _____

7. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, like an assisted living facility, a continuing care retirement community, or life care community?
☐ Yes ☐ No

   If **Yes**, give us the name and address of the facility, the amount of the deposit, answer the following questions, and **send us a copy** of the contract you signed with the facility and any documents about this deposit.

   Name of facility _____

   Address of facility

   _____

   Amount $ _____

   a. Does the facility still have the deposit? ☐ Yes ☐ No

   b. Did the facility return the deposit? ☐ Yes ☐ No

      If **Yes**, give us the name and address of the person who got the deposit from the facility.

      Name of person _____

      Address

      _____

Real Estate

The answers to the following questions will be used to decide if: (1) your real estate will be counted as an asset; or (2) a lien will be placed against your real estate.

Note: If the equity interest in your principal place of residence is over a certain limit, you may be ineligible for payment of long-term-care services and supports, unless certain conditions are met.

8. Do you or your spouse own or have a legal interest in your home, including a life estate? ☐ Yes ☐ No

   If **Yes**, fill out the following information and answer questions 8 through 15.

   If **No**, answer question 15 only.

Name and address of person(s) on ownership papers

_____

_____

Description and address of property location

_____

Type of ownership (Check one.)

☐ Individual (Fair-market value) $ _____

☐ Tenancy in common (Fair-market value) $ _____

☐ Joint tenancy (Fair-market value) $ _____

☐ Life estate (Fair-market value) $_____

Name and address of person(s) on ownership papers

_____

_____

Description and address of property location

_____

Type of ownership (Check one.)

☐ Individual (Fair-market value) $ _____

☐ Tenancy in common (Fair-market value) $ _____

☐ Joint tenancy (Fair-market value) $ _____

☐ Life estate (Fair-market value) $ _____

9. Do you have a spouse? ☐ Yes ☐ No
   If **Yes**, fill out this section.
   Name _____
   Is this person living in your home? ☐ Yes ☐ No

10. Do you have a permanently and totally disabled or blind child? ☐ Yes ☐ No
    If **Yes**, fill out this section.
    Name _____
    Is this person living in your home? ☐ Yes ☐ No

11. Do you have a child under 21 years old?
    ☐ Yes ☐ No
    If **Yes**, fill out this section.
    Name _____
    Is this person living in your home? ☐ Yes ☐ No

12. Do you have a sibling with a legal interest in the home who was living in the home for at least one year immediately before your admission to the medical institution? ☐ Yes ☐ No
    If **Yes**, fill out this section.
    Name _____

    Is this person living in your home? ☐ Yes ☐ No

13. Do you have a child who has lived in the home for at least the last two years before your admission to the medical institution and has provided care to you that allowed you to live in the home?
    ☐ Yes ☐ No
    If **Yes**, fill out this section.
    Name _____
    Is this person living in your home? ☐ Yes ☐ No

14. Do you have a dependent relative? ☐ Yes ☐ No
    If **Yes,** fill out this section.
    Name _____

    Is this person living in your home? ☐ Yes ☐ No

    Describe the relationship and the nature of the dependency: _____

    _____

15. Do you intend to return to your home? ☐ Yes ☐ No
    (Do not complete this section if you are applying for a Home- and Community-Based Services Waiver.)

16. Do you or your spouse own or have a legal interest in other real estate not listed in #7 above? ☐ Yes ☐ No
If **Yes**, please describe the property and list its address below.

_____

_____

If you need more space, use a separate sheet of paper.

Long-Term-Care Insurance

17. Do you or your spouse have long-term-care insurance? ☐ Yes ☐ No
If **Yes**, fill out this section. If **no**, go to the next section **(Tax Returns)**.

Send a copy of the policy.

Company name/Policy number

_____

Policyholder name _____

Effective date (mm/dd/yyyy) ___ /___ /_____

Premium amount $ _____

Company name/Policy number

_____

Policyholder name _____

Effective date (mm/dd/yyyy) ___ /___ /_____

Premium amount $ _____

Tax Returns

18. Did you or your spouse file US income tax returns in the last two years? (Check one.)
    ☐ Yes, both years ☐ Yes, one of these years
    ☐ No, neither year

If **Yes**, you must **send copies** of these returns. If you did not keep copies of one or more of these returns, **you must send in a filled-out and signed Form 4506**. Form 4506 is included as part of the Long-Term-Care Supplement if you need to use it.

Sign this supplement.

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

Important: If you are submitting this supplement as an authorized representative, you must submit an Authorized Representative Designation Form (ARD) to us for us to process this application. It is important to complete this form as this is the only way we may speak to you about this application.

Signature of applicant/member or authorized representative

_____

Print name _____

Date ___ /___ /_____

SUPPLEMENT B

AMERICAN INDIAN OR ALASKA NATIVE HOUSEHOLD MEMBER (AI/AN)

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 Services, tribal health programs, or Urban Indian Health Programs. They also may not have to pay cost sharing 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 the following.
   - 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)
   - 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 the following.
   - 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 rese rvations)
   - Money from selling things that have cultural significance

   $ _____ How often? _____

SUPPLEMENT C

PERSONAL-CARE-ATTENDANT

Please print clearly. Fill out all sections. If you need more space to finish any section on this form, use a separate sheet of paper (include name and Social Security number), and attach it to this form.

Send to: Health Insurance Processing Center
PO Box 4405
Taunton, MA 02780

Or Fax to: (857) 323-8300

Applicant/Member information

Last name _____

First name _____ MI _____

Telephone number (_____) _____

Social Security number __ __ __ - __ __ - __ __ __ __

Date of birth (mm/dd/yyyy) ___ /___ /_____

Gender ☐ M ☐ F

Street address _____

City _____ State _____ ZIP _____

Information about your health problems

List and describe below all your medical and mental health problems. Include anything that makes it hard for you to do daily living activities, like bathing, eating, toileting, dressing, etc., even if you are not getting treatment for the problem.

1. _____

2. _____

3. _____

Information about your daily living activities that you need physical (hands-on) help with

Please tell us in the chart below if you need hands-on help from another person to do the following daily living activities. If you check **Yes** to any of the items below, tell us how often you need help.

Mobility (moving from bed to chair, walking, or using approved medical equipment)

Do you need hands-on help? ☐ Yes ☐ No
How many times a day do you need hands-on help? _____
How many days a week do you need hands-on help? _____

Taking medications

Do you need hands-on help? ☐ Yes ☐ No
How many times a day do you need hands-on help? _____
How many days a week do you need hands-on help? _____

Bathing (tub, bed bath, shower, or washing chair) or general grooming (like brushing teeth or combing hair)

Do you need hands-on help? ☐ Yes ☐ No
How many times a day do you need hands-on help? _____
How many days a week do you need hands-on help? _____

Dressing/Undressing

Do you need hands-on help? ☐ Yes ☐ No
How many times a day do you need hands-on help? _____
How many days a week do you need hands-on help? _____

Range-of-motion exercises (exercising joints by moving them)

Do you need hands-on help? ☐ Yes ☐ No
How many times a day do you need hands-on help? _____
How many days a week do you need hands-on help? _____

Eating

Do you need hands-on help? ☐ Yes ☐ No
How many times a day do you need hands-on help? _____
How many days a week do you need hands-on help? _____

Toileting (like getting on or off toilet, wiping yourself, getting clothes off and on, or changing diapers)

Do you need hands-on help? ☐ Yes ☐ No
How many times a day do you need hands-on help? _____
How many days a week do you need hands-on help? _____

Caregiver information

Please give us the name(s) and relationship to you of the person(s) who now helps you.

Caregiver name _____
Relationship to you (like relative, neighbor, personal-care attendant) _____

Caregiver name _____
Relationship to you (like relative, neighbor, personal-care attendant) _____

I certify, under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge.

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

X _____

Signature of applicant/member or authorized representative

Print name _____
Date ___ /___ /_____

SUPPLEMENT D

HEALTH COVERAGE FROM JOBS

Part A: Medicare

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.

Tell us about the 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? ☐ Yes ☐ No

   If the answer to 3a is **Yes**, continue. If the answer to 3a is no, stop here and skip the rest of Supplement D.

   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 (if known) _____
6. Employer address

   _____
7. Employer phone number ( ) _____
8. City _____
9. State _____ 10. ZIP code _____
11. Whom can we contact about employee heath coverage at this job? _____
12. Phone number (if different from above)
    ( ) _____
13. Email address _____

Tell us about health plans offered by this employer.

14. a. What is the name of the lowest cost individual 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 would this employee pay in premiums for this plan? $ _____

    d. How often would the employee pay this amount?

    _____

15. a. What is the name of the lowest cost health plan to cover the other household members who qualify through the employer?

    _____

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

    c. How much would this employee pay in premiums for this plan? $ _____

    d. How often would this employee pay this amount?

    _____

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 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 individual or family health plans that are available and meet the minimum value standard.* (Premium should reflect the discount for wellness programs.)

How much would this employee pay in premiums for this plan? $ _____ How often? _____

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).

IMIGRATION STATUSES AND DOCUMENT TYPES

Question 9a/19a on the application asks noncitizens about their immigration status and about the type or types of immigration documents they have to support their immigration status. Refer to the following lists to fill out Question 9a/19a. If you need further help, details can be found online at www.MAhealthconnector.org/immigration-document-types.

Eligible Immigration Statuses

As of October 1, 2026, people who are US citizens and nationals, Lawful Permanent Residents (LPR or green card holders), Cuban-Haitian Entrants (CHEs), and Compact of Free Association (COFA) migrants are eligible for full MassHealth coverage.

- Amerasian
- Granted asylum
- Cuban Haitian entrant
- Deportation withheld
- Native American born in Canada or non-US territories
- Refugee
- Victim of severe trafficking or their spouse, child, sibling or parent
- Iraqi special immigrant

- Afghan special immigrant or certain Afghan evacuees
- Conditional entrant granted before 1980
- Veteran or active-duty member of military or their spouse or dependent
- COFA migrant
- Lawful permanent resident
- Granted parole for at least one year
- Battered spouse or child (or their parent or child)
- Nonimmigrant status (visa)
- Granted parole for less than one year
- Granted temporary resident status
- Granted Temporary Protected Status (TPS) or applicant for TPS with employment authorization
- Granted employment authorization under 8 CFR 274a(12)(c)
- Family unity beneficiaries
- Deferred enforced departure
- Deferred Action Status except for Deferred Action for Childhood Arrivals Process (DACA)
- Granted an administrative stay of removal under 8 CFR 241
- Approved visa petition with a pending application for adjustment of status
- Applicant for asylum or for withholding of removal with employment authorization

- Applicant (for at least 180 days) under 14 years old for asylum or for withholding of removal
- Granted withholding of removal under the Convention Against Torture
- Applicant for Special Immigrant Juvenile (SIJ) status
- Applicant or granted status under Deferred Action for Childhood Arrivals (DACA)
- I have a document but do not have any status listed above (Person Residing Under Color of Law, PRUCOL)

Immigration Document Types

- Reentry Permit (I-327)
- Permanent Resident Card ("green card," I-551)
- Refugee Travel Document (I-571)
- Employment Authorization Card (I-766)
- Machine Readable Immigrant Visa (with temporary 1-551 language)
- Temporary I-551 stamp (on passport or I-94, I-94A)
- Arrival/Departure Record (I-94, I-94A)
- Arrival/Departure Record in unexpired foreign passport (I-94)
- Foreign passport
- Certificate of Eligibility for Nonimmigrant Student Status (I-20)
- Certificate of Eligibility for Exchange Visitor Status (DS-2019)

- Notice of Action (I-797)
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Document indicating withholding of removal (or withholding of deportation)
- Administrative order staying removal issued by the Department of Homeland Security
- Document indicating a member of a federally-recognized Indian tribe or American Indian born in Canada
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Resident of American Samoa Card
- USCIS Acknowledgement of Receipt (I-797C)
- S. Visas (such as B1/B2, R-Visa, Border Crossing Card, J/F/M)

RACE (Optional)

Choose the option(s) that best describe you. Write in all that apply. Please specify in Questions 8 and 9 for Person 1 and Question 18 and 19 for Person 2.

American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White , Race is not listed here, Don’t know, Choose not to answer.

ETHNICITY

African, African American, American, Asian Indian, Brazilian, Cambodian, Cape Verdean, Caribbean Islander, Central American, Chicano/a, Chinese, Colombian, Cuban, Dominican, Eastern European, European, Filipino, Guamanian or Chamorro, Guatemalan, Haitian, Honduran, Japanese, Korean, Laotian/Lao, Mexican, Mexican American, Middle Eastern or North African, Other Asian, Portuguese, Puerto Rican, Russian, Salvadoran, Samoan, South American, Vietnamese, Ethnicity is not listed (please specify), Don’t know, Choose not to answer.

AUTHORIZED REPRESENTATIVE DESIGNATION FORM

Commonwealth of Massachusetts | EOHHS





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. 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 an authorized representative, I further certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentially 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 (as explained earlier on this form). Please print, except for signature. **Please submit a copy of the applicable legal document with this form.**

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member as set forth below, that is provided to me by MassHealth or the 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 18th birthday.

How do I submit this form?

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

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

- Mailing your form to
  Health Insurance Processing Center
  PO 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.