



Application for Health Safety Net (HSN) Presumptive Determination

Application received date: _____

FOR MASSHEALTH USE ONLY

Instructions

Temporary Health Safety Net (HSN) through presumptive determination is time-limited and based on an applicant's responses to the questions below. If approved, the determination will last until the end of the month after it was approved or the date a determination is made based on a full application, whichever is earlier. Temporary HSN may also end if MassHealth, upon receiving this Application for Health Safety Net Presumptive Determination, determines that the individual does not qualify for temporary HSN.

An applicant must submit a full application (ACA-3 or SACA-2) in order to determine if the services provided to the applicant will continue to be eligible for payment by the Health Safety Net, or if he or she is eligible for benefits through MassHealth or the Massachusetts Health Connector.

Unless otherwise indicated, the representative from the hospital/community health center identified below ("Facility Representative") is required to complete all parts of this application in order to confirm the applicant's HSN presumptive determination. Please complete **one** application per applicant.

If the Facility Representative is providing assistance via telephone, the Facility Representative may sign this application with the applicant's verbal consent received via telephone. The Facility Representative should sign his or her name on the signature line below with a notation that documents the consent as follows: "Facility Representative name is signing for individual's name based on authorization provided by individual's name over the phone on (xx/xx/2021) at (timestamp)."

In order to qualify for temporary HSN, an individual must

- Be a Massachusetts resident
- Meet certain income criteria
- Not have current subsidized benefits through MassHealth, Children's Medical Security Plan, the Massachusetts Health Connector, or another Health Safety Net determination

During the COVID-19 public health crisis, HSN has waived the requirement that an individual must not have received an HSN presumptive determination within the last 12 months.

PART A: HOSPITAL/COMMUNITY HEALTH CENTER INFORMATION

Facility Name _____

Facility Site Name _____

Facility Representative Name _____

Facility Representative Phone No. _____

Health Safety Net Provider Organization ID (required) _____

Today's Date _____

By checking the box below, the Facility Representative filling out this application and whose name appears above attests that he or she is trained and qualified to grant temporary Health Safety Net status through a presumptive determination (HSN-PD); has the permission of the applicant to submit this application to MassHealth, receive limited information from MassHealth about this application, and contact the applicant on related matters; will read the Rights and Responsibilities in **Part E** to the applicant; and will not submit any information that the Facility Representative knows to be false.

I, the Facility Representative, have read the information above and agree to the terms and conditions set forth in this application.

PART B: APPLICANT INFORMATION

1. Basic Information

First Name _____ Last Name _____

Date of Birth _____ Gender _____ Social Security No. (if available) _____

Phone No. _____

2. Residential Address

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

3. Mailing Address – If the applicant’s mailing address is different from her/his residential address, please provide it below. If not, skip to question 4.

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

4. Are you homeless? (optional) ___ Yes ___ No

5. Residency: Are you living in Massachusetts and planning to stay? ___ Yes ___ No

If the answer to question 5 is no, then the patient does not qualify for HSN-PD.

6. Do you currently have subsidized benefits through MassHealth, the Children’s Medical Security Plan, or the Massachusetts Health Connector, or have another Health Safety Net Determination? ___ Yes ___ No

Please check EVS and ask the applicant about her/his health insurance coverage to make sure applicant does not currently qualify for any of the above programs. If the answer to question 6 is yes, then the patient does not qualify for HSN-PD.

7. Citizenship: Are you a U.S. Citizen or U.S. National? ___ Yes ___ No

8. Languages (optional) Preferred Written _____ Preferred Spoken _____

9. Parent/Guardian Information – If applicant is younger than age 19, please provide the custodial parent/guardian information below

First Name _____ Last Name _____

Date of Birth _____ Gender _____ Social Security No. (if available) _____

PART C: DETERMINE HOUSEHOLD SIZE AND INCOME

10. Household Size and Income

a) How many people are in your household (including yourself)? _____

This should include:

- Parents (natural, step, or adoptive) who live together with a child younger than age 19, including parents who are mutually responsible for one or more children who live with them.
- Caretaker Relatives: Any adult who is the primary caregiver for a child and is related to the child by blood, adoption, or marriage and lives in the same home as that child. Neither parent may be living in the home.
- Children younger than age 19, including those who are absent from home to attend school.
- Siblings younger than age 19, including any of their children who live together, even if no adult is present.
- Any unborn children of any countable family member.

b) What is your household's total gross monthly income? __\$_____

This should include:

- Earned Income: All income from employment for all family members.
- Non-Working Income: All income received from retirement, social security, or other income that is not from a job (**do not** count TAFDC, EAEDC, SSI income).
- Net Rental Income: Total amount of gross rental income received less any deductions.

PART D: HSN PRESUMPTIVE DETERMINATION

Use the applicant's household size and gross monthly income from questions 10a and 10b, and determine the applicant's FPL using the chart below.

2021 MassHealth Federal Poverty Levels		
Household Size	Household is less or equal to 150% Federal Poverty Level if monthly income is less than or equal to:	Household is less or equal to 300% Federal Poverty Level if monthly income is less than or equal to:
1	\$1,610	\$3,220
2	\$2,178	\$4,355
3	\$2,745	\$5,490
4	\$3,313	\$6,625
5	\$3,880	\$7,760
6	\$4,448	\$8,895
7	\$5,015	\$10,030
8	\$5,583	\$11,165
For each additional person add	\$568	\$1,135

Based on the information supplied by the applicant, the Facility Representative named on page 1 has determined that the applicant can receive Temporary Health Safety Net through a Presumptive Determination (HSN-PD) because (check the applicable FPL below)

Based on Applicant's Household Size, the Income is less than or equal to 150% of FPL

Based on Applicant's Household Size, the Income is more than 150% FPL but less than or equal to 300% of FPL

PART E: RIGHTS AND RESPONSIBILITIES

Facility Representative will read and explain the following to the applicant before submitting the application. For purposes of this application, references to “MassHealth” means the Office of Medicaid, in which the Health Safety Net Office is housed.

1. 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.
2. MassHealth has the right to pursue and get money from third parties who may be obligated to pay for health services provided to eligible persons enrolled in MassHealth programs. These third parties may include other health insurers, spouses, or parents obligated to pay for medical support, or individuals obligated to pay under accident settlements. Eligible persons must cooperate with MassHealth in establishing third party support and obtaining third-party payments for themselves and anyone whose rights they can legally assign. Eligible persons may be exempted from this obligation if they believe and tell MassHealth that cooperation could result in harm to them or anyone whose rights they can legally assign.
3. 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 for certain services provided.
4. Eligible persons must tell MassHealth, in writing, within 10 calendar days, or as soon as possible, about any insurance claims or lawsuits filed because of an accident or injury.
5. 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.
6. MassHealth may obtain from eligible person’s current and former health insurers all information about health insurance coverage for these persons. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to these persons or members of their household.
7. MassHealth may get any records or data about persons listed on this application to document medical services claimed or provided to them. MassHealth will keep such information private and only use and disclose it in accordance with applicable law.
8. Under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. The applicant can file a complaint of discrimination by going to www.hhs.gov/ocr/office/file.

signature of applicant or guardian

date

printed name