MassHealth

Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Application for Waiver or Reduction of MassHealth Premium

For office use only

Customer account #: _____

Date received: _____

Return this form to:
MassHealth Customer Service, Attn: Premium Billing, P.O. Box 120049, Boston, MA 02112

To get a MassHealth Premium Hardship Waiver, you must meet one of the hardships described below. You must give MassHealth proof of your financial hardship. Hardship waivers are good for six months. You will not get billed for premiums during the approved hardship period.

The start date cannot be more than three months before the date that MassHealth gets your waiver application.

If you have any questions about this form or a premium billing payment plan or if you need a new hardship waiver application, please call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss).

Applicant information

Last name	First name	Middle initial

MassHealth ID no.	Daytime phone no.

Street address		

City	State	Zip

Details of hardship

Please check all of the boxes below that relate to your or your family's extreme financial hardship.

☐ I am more than 30 days late paying my rent or mortgage, have an eviction notice, or am homeless. Please send in a copy of any notices from your landlord, bank or mortgage company, or court as proof.

☐ I have a shut-off notice from a utility company (gas, electric, oil, water, or telephone), one or more of my utilities has been shut off, or one or more of my utility companies will not deliver services because I cannot pay. (If you have a large or long-overdue utility bill, but you cannot be shutoff because you are disabled or it is winter, check this section.) Please send in a copy of your shut-off notice or overdue bill as proof.

☐ I have high medical and/or dental bills. These bills are more than 7.5% of my gross annual income. The bills may be for me or for someone else in my immediate family (such as a child or a spouse). They cannot be paid for by Health Safety Net or any other health insurance, including MassHealth. Please send in copies of these medical bills as proof.

☐ In the past six months, I have had a large, unexpected increase in basic expenses. Please tell us about the expenses in the Comments section and send proof of the amount.

over ▶

If your hardship waiver is approved and your account has a past-due balance, MassHealth will start a payment plan for you for the past-due amount. You will get a separate premium billing statement. If you do not make payments according to the payment plan, you will lose your hardship waiver.

At the end of the six months of the hardship waiver, you can ask for another hardship waiver if you think you are still eligible.

Comments

If you need more space, please attach a separate sheet.

I certify that I have read or had read to me the information on this application. I understand my rights and responsibilities. I certify under the penalty of perjury that the information on this application and any papers added to it is correct and complete to the best of my knowledge.

If you are acting for someone in filling out this form, you must be active on our computer system as a MassHealth Eligibility Representative (ERD). If you are not, you must fill out an ERD form and send it back with this application.

Your signature or the signature of your eligibility representative on this application certifies that the information on this form is correct and complete to the best of your knowledge.

X _____ _____

Signature of member | Date

X _____ _____

Signature of eligibility representative | Date