Massachusetts Application for Health and Dental Coverage and Help Paying Costs—Additional Persons

Primary Contact from Step 1

STEP 2 Person __ .

If you have to include more than four people on this application, download or make a copy of blank information pages for Step 2 Person 4 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.

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

2. Relationship to Person 1	Relationship to Person 2	Relationship to Person 3
Relationship to Person 4	Relationship to Person 5	Relationship to Person 6

Does this person live with Person 1? ☐ Yes ☐ No

If **No**, list address.

3. Date of birth (mm/dd/yyyy)	4. What was this person's sex assigned at birth? ☐ Male ☐ Female. This is usually the sex that was originally listed on their birth certificate.

OPTIONAL: See instructions for Questions 5–9 under Person 1.

5. 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 is not listed. Please specify _____ ☐ Don't know ☐ Choose not to answer

6. 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

7. Is this person of Hispanic or Latino origin or descent?
   ☐ Yes, Hispanic or Latino ☐ No, not Hispanic or Latino ☐ Don't know ☐ Choose not to answer

8. Race	9. Ethnicity

10. 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 an SSN, please 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 this person's 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

11. 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

    See instructions for Question 11 under Person 1.

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

    a. Is this person legally married? ☐ Yes ☐ No
       If **No**, skip to question 11c.
       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 date(s) of birth.

_____

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 their 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

12. Is this person applying for health or dental coverage? ☐ Yes ☐ No
If **Yes**, answer all the questions below. If **No**, answer Questions 18 and 19, then go to **Income Information**.

13. Is this person a US citizen or US national? ☐ Yes ☐ No

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

Alien number _____ Naturalization or citizenship certificate number _____

14. If this person is a noncitizen, do they have an eligible immigration status? ☐ Yes ☐ No

See instructions for Question 14 under Person 1.

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

Status award date (mm/dd/yyyy) _____ (For battered persons, enter the date the petition was approved.)

Immigration status _____ Immigration document type _____

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 that they did 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 US military, or the spouse or child of an honorably discharged veteran or an active-duty member of the US military? ☐ Yes ☐ No

f. **Optional** Is this person a ☐ victim of severe trafficking; ☐ spouse, child, sibling, or parent of a trafficking victim; ☐ battered spouse; or ☐ child or parent of a battered spouse?

15. 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.

16. Does this person live with at least one child younger than 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 child or children _____

17. Does this person have an injury, illness, or 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

18. Does this person need reasonable accommodation because of a disability or an injury? ☐ Yes ☐ No
If **Yes**, complete the rest of this application, including Supplement C: Accommodation.

19. Is this person pregnant? ☐ Yes ☐ No
If **Yes**, how many babies are they expecting? _____ What is the expected due date? _____

20. **Optional** Does this person have breast or cervical cancer? ☐ Yes ☐ No (Special coverage rules may apply.)

21. **Optional** Is this person HIV positive? ☐ Yes ☐ No (MassHealth has special coverage rules for people with HIV.)

22. 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

INCOME INFORMATION (You may send proof of all household income with this application.)

23. Does this person have any income? ☐ Yes ☐ No
If this person doesn't have any income, skip to Question 37.

EMPLOYMENT | If this person needs more space, attach another sheet of paper.

24. **CURRENT JOB 1:** Employer name and address | Federal Tax ID#

25. a. Wages/tips (before taxes) **$** _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly (Subtract any pretax deductions, such as nontaxable health insurance premiums.)
    b. Income effective date _____

26. Average number of hours worked each WEEK _____

27. Is this person seasonally employed? ☐ Yes ☐ No. If **Yes**, which months does this person work in a calendar year?
☐ Jan. ☐ Feb. ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

28. **CURRENT JOB 2:** Employer name and address | Federal Tax ID#

29. a. Wages/tips (before taxes) **$** _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly (Subtract any pretax deductions, such as nontaxable health insurance premiums.)
    b. Income effective date _____

30. Average number of hours worked each WEEK _____

31. Is this person seasonally employed? ☐ Yes ☐ No. If **Yes**, which months does this person work in a calendar year?
☐ Jan. ☐ Feb. ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

32. **SELF-EMPLOYMENT:** Is this person self-employed? ☐ Yes ☐ No
    a. If **Yes**, what type of work does this person do? _____
    b. On average, how much net income (profits or losses after business expenses are paid) will this person get from this self-employment each month? $ _____/month **profit** or $ _____/month **loss**
    c. How many hours does this person work per week? _____

OTHER INCOME

33. 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, nontaxable veteran's payments, Supplemental Security Income (SSI), or most workers' compensation income.**

☐ Social Security benefits $ _____ How often? _____
☐ Unemployment $ _____ How often? _____
☐ Retirement or pension $ _____ How often? _____ Source _____
☐ Interest, dividends, and other investment income $ _____ How often? _____
☐ Taxable veteran's benefits $ _____ How often? _____

☐ Taxable military retirement pay $ _____ How often? _____

☐ Alimony received $ _____ How often? _____
If this person is 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. $ _____

☐ Other taxable income $ _____ How often? _____ Type _____

☐ Net rental or royalty income $ _____ **profit** or $ _____ **loss** How often? _____

☐ 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.

ONE-TIME-ONLY INCOME

34. 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 _____

35. 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

36. What deductions do they report on their income tax return?

See instructions for Question 36 under Person 1.

☐ 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

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

38. 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. For additional copies of this form, the ACA-3-AP, go to www.mass.gov/lists/applications-to-become-a-masshealth-member. Click on Massachusetts Application for Health and Dental Coverage and Help Paying Costs—Additional Persons.

Send your complete application to **Health Insurance Processing Center**
PO Box 4405
Taunton, MA 02780

or Fax to (857) 323-8300