MASSACHUSETTS APPLICATION FOR HEALTH AND DENTAL COVERAGE AND HELP PAYING COSTS— ADDITIONAL PERSONS

Commonwealth of Massachusetts | EOHHS

ACA-3-AP-LP-0325

Primary Contact from Step 1

_____

STEP 2 PERSON ___ .

Use this Additional Persons form if you have more than four people to include with this application. 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.

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 through 9 under Person 1.

5. Which best describes this person's current gender identity?

   ☐ 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–c.
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 the name(s) and date(s) of birth of dependents.
If **Yes**, list name(s) and date(s) of birth of dependents.

_____

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

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. If **Yes**, 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 as properly filed.)
   Immigration status _____
   Immigration document type _____
   Document ID number _____
   Alien number _____
   Passport or document expiration date (mm/dd/yyyy) ___/___/_____
   Country _____

b. 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

   _____

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

d. 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

e. **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. 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

    _____

16. 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.

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 healthcare 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 does not 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. 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.

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. 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.

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 you 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
P.O. Box 4405
Taunton, MA 02780;

or

Fax to (857) 323-8300.