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

Commonwealth of Massachusetts | EOHHS


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 _____
   Person 2 _____ Person 3 _____
   Person 4 _____ Person 5 _____
   Does this person live with Person 1? ☐ Yes ☐ No
   If **No**, list address.

   _____

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

4. Gender ☐ Male ☐ Female

5. **Optional** What is this person's race or ethnicity?

   _____

6. 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, please see instructions for Question 6 under Person 1.

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

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

_____

7. 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 7 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 7c.
If **Yes**, list name of spouse 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 his or her 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 name of spouse 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

8. Is this person applying for health or dental coverage? ☐ Yes ☐ No
If **Yes**, answer all the questions below. If **No**, answer Questions 14 and 15, then go to Income Information on page 8.

9. Is this person a U.S. citizen or U.S. national?
☐ Yes ☐ No
If **Yes**, is this person a naturalized citizen (not born in the U.S.)? ☐ Yes ☐ No
Alien number _____
Naturalization or citizenship certificate number

_____

10. If this person is a noncitizen, does he or she have an eligible immigration status? ☐ Yes ☐ No
See instructions for Question 10 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 _____
   Choose one or more document status and types.
   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 he or she did to get this person's immigration status? ☐ Yes ☐ No
   If **No**, what name did this person use?
   First, middle, last, and suffix

   _____

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

d. 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

e. **Optional** Is this person 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?

11. 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(ren)? ☐ Yes ☐ No
Name(s) and date(s) of birth of child(ren)

_____

12. Is this person living in Massachusetts, and does this person either intend to reside here, even if he or she does 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 in 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.

13. 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

14. 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.

15. Is this person pregnant? ☐ Yes ☐ No
    If **Yes**, how many babies is she expecting? _____ ,
    What is the expected due date? ___/___/_____

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

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

18. 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.)**

19. Does this person have any income? ☐ Yes ☐ No
    If this person does not have any income, skip to question 33.

**EMPLOYMENT**

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

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20. **CURRENT JOB 1:** Employer name and address

    _____

    _____

    Federal Tax ID# _____

21. a. Wages/tips (before taxes) $ _____

    ☐ Weekly ☐ Every 2 weeks ☐ Twice a month

    ☐ Monthly ☐ Quarterly ☐ Yearly

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

    b. Income effective date ___/___/_____

22. Average number of hours worked each WEEK ____

23. 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.

24. **CURRENT JOB 2:** 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 pre-tax 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. **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

29. Check all that apply, and give 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 received? _____

☐ Unemployment $ _____
How often received? _____

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

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

☐ Royalty income $ _____
How often received? _____

☐ Taxable veteran's benefits $ _____
How often received? _____

☐ Taxable military retirement pay $ _____
How often received? _____

☐ Alimony received
$ _____ How often received? _____

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. $ _____

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

☐ Net rental income: On average, how much net income (profits after rental expenses are paid) will you get from this rental each month, or how much will you lose from this rental each month?
$ _____ month profit or $ _____ month loss

☐ 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: On average, how much net income (profits after business expenses are paid) or loss will this person get from this business each month? $ _____ month profit or $ _____ month loss

## ONE-TIME ONLY INCOME

30. Has or will this person receive income during this calendar year as a one-time only payment?
☐ Yes ☐ No
Examples might be a lump-sum pension payment or a one-time capital gain.

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

31. 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

32. What deductions does he or she report on their income tax return?
See instructions for Question 33 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 for 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 deduction (interest only, not total payment): Yearly amount $ _____

☐ None

## YEARLY INCOME

33. Did this person receive any unemployment income in 2021? ☐ Yes ☐ No

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

35. 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.