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

## 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? 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 the 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 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/masshealth-member-applications](file:///\\ehs-clu-bos-081\File%20Services\policysupp\PKr\ACA_01-21\ACA-3-0121_Folder\ACA-3-AP-0121\www.mass.gov\lists\masshealth-member-applications). 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.

ACA-3-AP-0323

End of the application.