MASSACHUSETTS APPLICATION FOR HEALTH AND DENTAL COVERAGE AND HELP PAYING COSTS

Commonwealth of Massachusetts | EOHHS

ACA-3-LP-0325

How to Apply

You can submit your application in any of the following ways.

- Sign on to your account at MAhealthconnector.org. You can create an online account if you do not already have one. **Applying online may be a faster way for you to get coverage than mailing a paper application.**
- Mail your filled-out, signed application to
  Health Insurance Processing Center
  PO Box 4405
  Taunton, MA 02780.
- Fax your filled-out, signed application to (857) 323-8300.
- Call us at (800) 841-2900, TTY/TTD: 711, or (877) MA ENROLL ([877] 623-6765).
- Visit a MassHealth Enrollment Center (MEC). To apply in person or to schedule an appointment with a MassHealth representative, go to mass.gov/masshealth/appointment. See the Member Booklet for Health and Dental Coverage and Help Paying Costs for a list of MEC addresses.
- You can use this application to apply for the Supplemental Nutrition Assistance Program (SNAP). SNAP is a federal program that helps you buy food each month. If you are interested, check the box on page 1, then read and sign the SNAP rights and responsibilities on pages 78-91. Your application will then be sent automatically to the Department of Transitional Assistance. You do not have to apply for SNAP to be considered for MassHealth.

Use this application to see what coverage choices you may qualify for.

- Affordable coverage from MassHealth, the Health Safety Net (HSN), the Children's Medical Security Plan (CMSP), or the Health Connector. You may qualify for one of these programs no matter what your income.
- Affordable private health insurance plans that offer comprehensive coverage.
- A tax credit that can help pay your premiums for health coverage.

Who can use this application?

This application is for people who need health or dental coverage and help paying for it, and who

- ive in Massachusetts and reside in the community, and
- are younger than 65.

This application may also be used by people of any age who are

- parents of children younger than 19 or
- adult relatives living with and taking care of children younger than 19 when neither parent is living in the home.

If this application is not for you, call us at (800) 841-2900, TDD/TTY: 711.

This application is available in other languages. Please call the number above to request one.

Apply even if you or your child already has health coverage, including coverage from MassHealth or the Health Connector. We need to know about all members of your household to decide if you're eligible.

If someone is helping you fill out this application, you may need to fill out a separate form that gives that person permission to act on your behalf. See the Authorized Representative Designation Form at the end of this application.

What you may need to apply

- Social Security numbers (SSNs). You must give us an SSN or proof that anyone on this application has also applied for an SSN. There are exceptions for anyone who
  - has a religious exemption as described in federal law,
  - is eligible only for a nonwork SSN, or
  - is not eligible for an SSN.
- Federal tax returns, if you file.
- Information about citizenship/national status or immigration status.
- Employer and income information for everyone in your household (for example, from paystubs or wage statements).
- Information about any job-related or other health insurance that you are currently enrolled in or have access to.

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. We will keep all the information you provide private and secure, as required by law. To view the Health Connector's Privacy Policy, go to mahealthconnector.org/site-policies/privacy-policy. To view the MassHealth Privacy Policy, see the Member Booklet or mass.gov/service-details/masshealth-member-privacy-information.

What happens next?

You will get instructions on the next steps to complete your eligibility process. If you're eligible for MassHealth and have to enroll in a health plan, we will notify you. Then you can choose a plan by going to mass.gov/how-to/enroll-in-a-masshealth-health-plan-individuals-and-families-younger-than-65. Filling out this application does not mean you have to buy health coverage. If you need help choosing a health plan, you can learn more by going to MassHealthChoices.com.

Get help with this application

Phone: Please call us for help with this application or if you need interpreter services. (800) 841-2900, TDD/TTY: 711.

General instructions

- Please **print clearly and answer all questions completely**. There are a few questions you may be told to skip. Other than those exceptions, blank or incomplete answers will slow down the processing of your application.
- You can download pages for additional people at mass.gov/masshealth. Be sure to tell us how each person is related to each other person. We need this information to determine eligibility.
- It is not necessary to send blank pages for Step 2 if you do not have that many people in your household. Please make sure that you indicate in Section 1 the number of people applying, and send all other sections even if they are blank or partially blank.
- MassHealth or the Massachusetts Health Connector will send a Request for Information if we need any additional information or proof to make an eligibility decision. If we send a Request for Information notice, the individual has 90 days to send the requested proof. MassHealth may provide provisional benefits during this 90-day period to eligible applicants younger than 21 and to those who self-attest to pregnancy, HIV positive status, or breast or cervical cancer. MassHealth benefits may not be provided to a person 21 or older until all income in the MAGI household is verified, unless that person is pregnant, has HIV, or is in active treatment for breast or cervical cancer.

- Include any proof of household income. This is the fastest way to get your benefits.

MASSACHUSETTS APPLICATION FOR HEALTH AND DENTAL COVERAGE AND HELP PAYING COSTS

Commonwealth of Massachusetts | EOHHS

The Supplemental Nutrition Assistance Program (SNAP) is a federal program that helps you buy healthy food each month.

☐ Check this box if you want this application to be sent to the Department of Transitional Assistance as an application for SNAP benefits. You must read the rights and responsibilities on pages 78-91 and sign on page 92 to proceed with the application.

What happens after you apply for SNAP benefits?

- DTA will call you soon for a phone interview and to check if you can get emergency SNAP within 7 days.
- DTA will work with you to verify information about your case.
- You will get an Electronic Benefit Transfer (EBT) card to access benefits, if approved.
- You will receive a notice about your decision within 30 days.

If you are applying for or getting long-term-care services at home under a Home- and Community-Based Services Waiver, or if you are in a nursing home or chronic hospital, please select that program. We will need more information and will contact you for additional processing.

☐ Long-Term Care and/or

☐ Home- and Community-Based Services Waiver

STEP 1 PERSON 1

Tell us about yourself. Please print clearly.

We need one adult in the household to be the contact person for your application. This person should be someone who appears on the application, not a third party who wishes to serve as a contact for the applicant(s). Please see the Authorized Representative Designation (ARD) Form at the end of this application to establish a third-party contact..

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

   _____

2. Date of birth ___ / ___ / _____

3. What is your email address?

   _____

☐ No home address. Note: if you check this box, you must provide a mailing address.

4. Street address _____
5. Apartment or unit number _____
6. City _____ 7. State ____
8. ZIP code _____ 9. County _____
10. Mailing address ☐ Check if same as home address.

    _____
11. Apartment or unit number _____
12. City _____ 13. State ____
14. ZIP code _____ 15. County _____
16. Phone number _____
17. Other phone number _____
18. # of people listed on the application _____
19. What is your preferred language, if not English?
    Spoken _____ Written _____
    Preferred written language may be used by MassHealth and the Health Connector to communicate with you. If you do not answer, we will send your notices in English.
20. Is anyone on this application in prison or jail? Please select **No** if this person will be released in the next 60 days. ☐ Yes ☐ No
    If **Yes**, who? Enter the name here:

    _____
    If **Yes**, is this person awaiting trial? ☐ Yes ☐ No

The amount of help or type of program you may qualify for depends on the number of people in your household and their incomes. This information helps us make sure everyone gets the coverage they may be eligible for.

Complete Step 2 for yourself and all additional household members who live with you, or anyone on your same federal income tax return if you file one. If you do not file a tax return, remember to still add household members who live with you.

For enrollment assisters only

Complete this section if you are an enrollment assister and are filling out this application for someone else. Navigators must fill out a Navigator Designation Form if they have not done so already. Certified Application Counselors must fill out a Certified Application Counselor Designation Form if they have not done so already.

Check one

☐ Navigator

☐ Certified Application Counselor

First name, middle name, last name, and suffix

_____

Email address _____

Organization name _____

Organization identification number _____

Organization phone number _____

STEP 2
TELL US ABOUT YOUR HOUSEHOLD.

Who should be included on this application?

Tell us about all the household members who live with you. If you file taxes, we need to know about everyone on your tax return. You do not need to file taxes to get MassHealth, the Health Safety Net, or the Children's Medical Security Plan, if you qualify.

DO Include

- Yourself and your spouse (if married)
- Your natural, adoptive, or stepchildren younger than 19
- Your unmarried partner who lives with you if you have children together who are younger than 19
- Your unmarried partner's children who live with you and who are younger than 19, if you also include this partner
- Anyone you include on your tax return (even if they do not live with you)
- Anyone your unmarried partner includes on their tax return (even if they do not live with you), if you also include your unmarried partner
- Anyone else you live with and take care of who is younger than 19

DO NOT include

- Your unmarried partner, unless you have children together
- Your unmarried partner's children, unless they live with you or your unmarried partner included them on their tax return
- Your parents whom you live with if your parents file their own taxes and do not claim you as tax dependent (if you are 19 or older)
- Other adult relatives whom you do not claim as tax dependents

STEP 2 PERSON 1

This section is to gather more information about the contact person named on page 2.

Complete Step 2 for yourself and all additional household members who live with you, or anyone on your same federal income tax return if you file one. See page 5 for more information about who to include. If you do not file a tax return, remember to still add household members who live with you.

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

   _____

2. Relationship to you __**SELF**__

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

4. What was your sex assigned at birth?
   ☐ Male ☐ Female
   This is usually the sex that was originally listed on your birth certificate.

Optional: MassHealth is committed to providing equitable care for all members regardless of race, ethnicity, gender, sexual orientation, or language spoken. Please complete questions 5 through 9 to help us meet your language and cultural needs. Your response is voluntary and will not impact your eligibility or be used for any discriminatory purpose.

5. Which best describes your current gender identity?

Gender identity is how a person defines and understands their gender as a man, a woman, nonbinary, gender nonconforming, transgender, or something else. 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 your current sexual orientation? Select up to five options.

Sexual orientation describes how a person defines their physical and/or emotional attraction to others.

☐ 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. Are you of Hispanic or Latino origin or descent?

Hispanic or Latino refers to someone of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

☐ Yes, Hispanic or Latino
☐ No, not Hispanic or Latino
☐ Don't know ☐ Choose not to answer

8. Race (see page 99) _____

Race refers to a person's self-identification with one or more social groups. You may report multiple races.

9. Ethnicity (see page 100) _____

Ethnicity refers to your background, heritage, culture, ancestry, or the country where you or your family were born.

---

10. Do you 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. There are exceptions for anyone who has a religious exemption as described in federal law, who is eligible only for a nonwork SSN, or who is not eligible for an SSN. An SSN is optional for persons not applying for health coverage, but giving us an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If you need help getting an SSN, call the Social Security Administration at (800) 772-1213, TTY: (800) 325-0778, or go to socialsecurity.gov. For more details on how we use your Social Security number, please see the Member Booklet.

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

If **No**, check one of the following reasons.
☐ Illness exception ☐ Just applied
☐ Noncitizen exception ☐ Religious exception

Is your name on this application the same as your name on your social security card? ☐ Yes ☐ No

If **no**, what name is on your Social Security card?
First name, middle name, last name, and suffix

_____

11. If you get an Advance Premium Tax Credit (APTC), do you agree to file a federal tax return for the tax year when the credits are received? ☐ Yes ☐ No

Individuals may not have needed or chosen to file a tax return in the past, but they will have to file a federal income tax return for any year that they get an APTC. They must check "Yes" to question 11 to be eligible for ConnectorCare or APTCs to help pay for their health insurance. ***You do NOT need to file a tax return to apply for or to get MassHealth, CMSP, or HSN, if you qualify.***

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

Individuals must file a joint federal tax return with their spouse for the year for which they are applying to get certain programs (ConnectorCare or APTCs) unless they are a victim of domestic abuse or abandonment or they will file taxes as Head of Household. If an individual will file taxes as Head of Household, they should answer No to question 11a ("Are you legally married?"). One way a person may qualify as Head of Household is to live apart from their spouse and claim another person as a dependent. See IRS Publication 501 or consult a tax professional for tax filing

information. They will only need to include themself and any dependents on this application.

a. Are you legally married? ☐ Yes ☐ No
If **No**, skip to question 11c.
If **Yes**, list the spouse's name and date of birth.

_____

b. Do you plan to file a joint federal tax return with your spouse for the tax year for which you are applying?
☐ Yes ☐ No

c. Will you claim any dependents on your federal Illness exception income tax return for the year for which you are applying? ☐ Yes ☐ No.
You will claim a personal exemption deduction on your federal income tax return for any individual who is listed on this application as a dependent and 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 dependents' names and birth dates.

_____

d. Will you be claimed as a dependent on someone else's federal income tax return for the year for which you are applying? ☐ Yes ☐ No

If you are claimed by someone else as a dependent on their federal income tax return, this may affect whether you can receive a premium tax credit. Do not answer **Yes** to this question if you are 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 are you 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. Are you filing taxes separately because you are a victim of domestic abuse or abandonment?
☐ Yes ☐ No

Optional: I filed a federal income tax return with the Internal Revenue Service (IRS) for at least one year in the past two years that I received an Advance Premium Tax Credit (APTC) to lower my monthly premium payments, including if I was enrolled in ConnectorCare. I included the tax forms showing the tax credits I received when I filed my tax return so the IRS could calculate how much Advance Premium Tax Credit I was eligible to receive based on my final income for the year. ☐ Yes ☐ No

Answer **Yes** if:
1. You have received an APTC or ConnectorCare in the past, and
2. The statement is true for all people listed in the household.

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

13. Are you a US citizen or US national? ☐ Yes ☐ No
    If **Yes**, are you a naturalized, derived, or acquired citizen (not born in the US)? ☐ Yes ☐ No
    Alien number _____
    Naturalization or citizenship certificate number
    _____

14. If you are a noncitizen, do you have an eligible immigration status? ☐ Yes ☐ No
    If no, go to Question 15.

See page 96, "Immigration Statuses and Document Types" for help. *If **No** or **no response**, you may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN).*

a. If Yes, do you have an immigration document?
   ☐ Yes ☐ No

   It may help us to process this application faster if you include a copy of immigration documents for everyone who is applying. We will try to verify immigration status through an electronic data match. Please list all the immigration statuses or conditions that have applied to everyone on this application since they entered the US. If you need more space, attach another sheet of paper.

   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 statuses and types from the list on page 96.
Document ID number _____
Alien number _____
Passport or document expiration date (mm/dd/yyyy) ___/___/_____
Country _____

b. Did you use the same name on this application that you did to get your immigration status? ☐ Yes ☐ No
If **No**, what name did you use?
First name, middle name, last name, and suffix
_____

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

d. Are you 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** Are you 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. Do you live with at least one child younger than 19, and are you the main person taking care of this child or children? ☐ Yes ☐ No
    Name(s) and date(s) of birth of child or children

    _____

16. Are you living in Massachusetts, and you either intend to reside here, even if you do not have a fixed address, or have you entered Massachusetts with a job commitment or seeking employment? ☐ Yes ☐ No

    If you are visiting Massachusetts for personal pleasure or to receive medical care in a setting other than a nursing facility, you must answer **No** to this question.

17. Do you 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. Do you 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. Are you pregnant? ☐ Yes ☐ No
    If **Yes**, how many babies are you expecting? ____ ,
    What is your expected due date? ___/___/____

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

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

22. Were you ever in foster care? ☐ Yes ☐ No

    a. If **Yes**, in what state were you in foster care? _____

    b. Did you get healthcare through a state Medicaid program? ☐ Yes ☐ No

INCOME INFORMATION

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

23. Do you have any income? ☐ Yes ☐ No
If you don't have any income, skip to Question 37.

EMPLOYMENT

If you need 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:** Are you self-employed?
☐ Yes ☐ No

a. If **Yes**, what type of work do you 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 do you work per week? _____

OTHER INCOME

33. Check all that apply. State the amount and how often you get 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 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? _____
Type _____

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

☐ Capital gains: On average, how much net income or loss will you 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. Have you or will you 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 you 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 you report on your income tax return?

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. Check all that apply. Your deductions should be what you report on your federal income tax return in the section "Adjusted Gross Income." For each deduction you select, give the yearly amount. You can enter up to the maximum deduction amount allowed by the IRS.

- ☐ 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

37. What is your total expected income for the current calendar year? _____

38. What is your total expected income for next calendar year, if different? _____

THANKS! This is all we need to know about you. Go to Step 2 Person 2 to add another household member, if needed. Otherwise, go to Step 3: American Indian or Alaska Native (AI/AN) Household Member(s).

STEP 2 PERSON 2

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

   _____

2. Relationship to Person 1 _____
   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 (see page 99) _____

9. Ethnicity (see page 100) _____

---

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 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 _____
    Choose one or more document statuses and types from the list on page 96.
    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. Go to Step 2 Person 3 to add another household member, if needed. Otherwise, go to Step 3: American Indian or Alaska Native (AI/AN) Household Member(s).

STEP 2 PERSON 3

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

   _____

2. Relationship to Person 1 _____
   Person 2 _____
   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 (see page 99) _____

9. Ethnicity (see page 100) _____

---

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 _____
    Choose one or more document statuses and types from the list on page 96.
    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. Go to Step 2 Person 4 to add another household member, if needed. Otherwise, go to Step 3 American Indian or Alaska Native (AI/AN) Household Member(s).

STEP 2 PERSON 4
(If more than 4 people, this is 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. 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 _____
   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 (see page 99) _____

9. Ethnicity (see page 100) _____

---

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 _____
       Choose one or more document statuses and types from the list on page 96.
       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. Please go to Step 3: American Indian or Alaska Native (AI/AN) Household Member(s).

STEP 3
AMERICAN INDIAN OR ALASKA NATIVE (AI/AN) HOUSEHOLD MEMBER(S)

Are you or is anyone in your household an American Indian or Alaska Native? ☐ Yes ☐ No

If **No**, skip to Step 4.

If **Yes**, complete the rest of this application, including Supplement B: American Indian or Alaska Native Household Member.

STEP 4
PREVIOUS MEDICAL BILLS

Do you or anyone on this application have bills for medical services they got in the three months before submitting this application? ☐ Yes ☐ No

If **Yes**, MassHealth may be able to pay for these bills if you were eligible during the requested time period. You may need to give MassHealth proof of income, family size, address, disability, pregnancy, or health insurance during the requested time period.

Please list below any individuals requesting payment of previous medical bills.

Name _____

Earliest date requested _____

Any change in circumstances during this time?
☐ Yes ☐ No

Name _____

Earliest date requested _____

Any change in circumstances during this time?
☐ Yes ☐ No

STEP 5
YOUR HOUSEHOLD'S HEALTH COVERAGE

MassHealth regulations require members to obtain and maintain available health insurance, including health insurance available through an employer. In order to determine continued MassHealth eligibility for you and members of your household, we may request additional information from you and your employer about your access to employer-sponsored health insurance coverage. We may also share information about you and members of your household with your employer(s) and /or health insurer(s) to confirm this information. You must cooperate in providing information necessary to maintain eligibility, including evidence of obtaining or maintaining available health insurance, or your MassHealth benefits may end. See the Member Booklet for more information.

1. Is anyone listed on this application offered health coverage from a job but not enrolled in it?
   ☐ Yes ☐ No
   If **Yes** check the type of coverage and write the person(s)' name(s) next to the coverage they have. Answer **Yes** even if this insurance is from another person's job, like a spouse, even if the person does not live in the household. If Yes, you will need to complete and include Supplement A: Health Coverage from Jobs, and the rest of this application.

Names of persons offered insurance.

_____

2. Does anyone qualify for or is anyone enrolled in any of the following types of health coverage?
☐ Yes ☐ No
If **Yes**, check the type of coverage and write the person's name next to the coverage they have. Answer **Yes** even if this insurance is from another person, like a spouse, even if the person does not live in the household.

☐ Enrolled in **Medicare** or qualifies for Medicare Part A with no premium.
Name(s) of person(s) covered

_____

Start date ___/___/_____ End date ___/___/_____
Medicare ID# _____

☐ Qualifies for **Peace Corps** health benefits
Name(s) of person(s) covered

_____

Start date ___/___/_____ End date ___/___/_____
Policy # or Member ID _____

☐ Qualifies for **TRICARE** or a Federal Employees' health benefit program.
Start date ___/___/_____ End date ___/___/_____
Name(s) of person(s) covered

_____

☐ Enrolled in a **Veterans Affairs (VA) health program**
Start date ___/___/_____ End date ___/___/_____
Name(s) of person(s) covered

_____

☐ **MassHealth**
Names(s) of person(s) covered

_____

☐ Enrolled in **employer coverage**. If anyone on this application is enrolled in employer coverage, you must complete and include **Supplement A: Health Coverage from Jobs**.
Name of employer _____
Names of covered household members

_____
Plan name _____
Policy # or Member ID _____
Start date ___/___/_____ End date ___/___/_____

☐ **Other coverage** (including COBRA or Retiree health plans)
Name(s) of person(s) covered

_____
Start date ___/___/_____ End date ___/___/_____
Policy # or Member ID _____

STEP 6

HEALTH REIMBURSEMENT ARRANGEMENTS

Is anyone in the household offered Health Reimbursement Arrangements (HRAs) from their employer? ☐ Yes ☐ No

Name(s) of individual _____

Date of Birth ___ /___ /_____

Employer Name _____

Federal Tax ID _____

Type of HRA offered by employer

- ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
- ☐ Individual Coverage Health Reimbursement Arrangement (ICHRA)

Start date ___ /___ /_____ End date ___ /___ /_____

Enter the maximum yearly self-only coverage benefit amount _____

If you have a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) do you intend to use QSEHRA family coverage benefits from your employer? ☐ Yes ☐ No

If you have QSEHRA, enter the maximum yearly family coverage benefit amount through the QSEHRA _____

Does anyone in the household intend to accept an Individual Coverage Health Reimbursement Arrangement (ICHRA) benefit from their employer? ☐ Yes ☐ No

---

Is anyone in the household offered Health Reimbursement Arrangements (HRAs) from their employer? ☐ Yes ☐ No

Name(s) of individual _____

Date of Birth ___ /___ /_____

Employer Name _____

Federal Tax ID _____

Type of HRA offered by employer

- ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
- ☐ Individual Coverage Health Reimbursement Arrangement (ICHRA)

Start date ___ /___ /_____ End date ___ /___ /_____

Enter the maximum yearly self-only coverage benefit amount _____

If you have a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) do you intend to use QSEHRA family coverage benefits from your employer? ☐ Yes ☐ No

If you have QSEHRA, enter the maximum yearly family coverage benefit amount through the QSEHRA _____

Does anyone in the household intend to accept an Individual Coverage Health Reimbursement Arrangement (ICHRA) benefit from their employer? ☐ Yes ☐ No

STEP 7
PARENTAL INFORMATION.

Please answer these questions for any child younger than the age of 18 who is listed on this application but who does not have two custodial parents also listed on this application.

1. Was any child adopted by a single parent?
   ☐ Yes ☐ No

   If **Yes**, name(s) of child or children

   _____

2. Does any child have a parent who has died?
   ☐ Yes ☐ No

   If **Yes**, name(s) of child or children

   _____

3. Does any child have a parent whose identity is unknown?
   ☐ Yes ☐ No

   If **Yes**, name(s) of child or children

   _____

4. Does any child have a parent who does not live with the child and who is not included in the previous questions?
   ☐ Yes ☐ No

   If **Yes**, name(s) of child or children

   _____

STEP 8
READ AND SIGN THIS APPLICATION

For MassHealth and Health Connector Applicants

On behalf of myself and all persons listed on this application, I understand, represent, and agree as follows.

1. MassHealth may require eligible persons to enroll in available employer-sponsored health insurance if that insurance meets the criteria for MassHealth payment of premium assistance.
2. Employers of eligible persons may be notified and billed in accordance with MassHealth regulations for any services that hospitals or community health centers provide to such persons that are paid for by the Health Safety Net.
3. I may have to pay a premium for health coverage for myself and others listed on this application. Failure to pay any premium due may result in the state deducting the amount owed from the tax refunds of responsible persons. If I am a certain American Indian or Alaska Native, I may not have to pay premiums for MassHealth.
4. MassHealth has the right to pursue and get money from third parties who may be obligated to pay for health services provided to eligible persons enrolled in MassHealth programs. Such third parties may include other health insurers, spouses, or parents obligated to pay

for medical support, or individuals obligated to pay under accident settlements. Eligible persons must cooperate with MassHealth in establishing third-party support and obtaining third-party payments for themselves and anyone whose rights they can legally assign. Eligible persons may be exempted from this obligation if they believe and tell MassHealth that cooperation could result in harm to them or anyone whose rights they can legally assign.

5. A parent and/or guardian of minor children must agree to cooperate with state efforts to collect medical support from an absent parent unless they believe and tell MassHealth that cooperation will harm the children or the parent or guardian.
6. Eligible persons who are injured in an accident, or in some other way, and get money from a third party because of that accident or injury must use that money to repay MassHealth or the Health Safety Net for certain services provided.
7. Eligible persons must tell MassHealth or the Health Safety Net, in writing, within 10 calendar days, or as soon as possible, about any insurance claims or lawsuits filed because of an accident or injury.
8. The status of this application may be shared with a hospital, community health center, other medical provider, or federal or state agencies when necessary for treatment, payment, operations, or the administration of the programs listed above.

9. To the extent permitted by law, after notice and an opportunity to appeal, MassHealth may place a lien against any real estate owned by an eligible MassHealth member or in which the eligible member has a legal interest, if the member is receiving long-term care in a nursing facility or other medical institution and MassHealth determines that the member is not reasonably expected to return home. If MassHealth puts a lien against such property and the property is later sold, money from the sale of that property may be used to repay MassHealth for medical services provided.
10. To the extent permitted by law, and unless exceptions apply, for any eligible person 55 or older receiving long-term services and supports (LTSS), or any eligible person regardless of age for whom MassHealth helps pay for long-term care in a nursing home or other medical institution, MassHealth will seek money from the eligible person's estate after death for the total cost of care as permitted by law. For more information on estate recov-ery, visit mass.gov/EstateRecovery.
11. To the extent permitted by law, MassHealth will seek money from a Special Needs Trust belonging to an eligible individual after death for the total cost of care. The total cost of care includes the cost MassHealth paid directly for care (Fee for Service) and the total amount it paid to a health plan (like an Accountable Care Organization or a One Care plan) for care, regardless of what services the member may have received.

12. Eligible persons must tell the healthcare program(s) in which they enroll about any changes in their or their household's income or employment, household size, health insurance coverage, health insurance premiums, and immigration status, or about changes in any other information on this application and any supplements to it within 10 calendar days of learning of the change. Eligible persons can make changes by calling (800) 841-2900, TTY/TTD: 711. A change in information could affect eligibility for such persons or for persons in their household. You can also report changes in any of the following ways.
    - Sign in to your account at MAhealthconnector.org. You can create an online account if you do not already have one.
    - Send the change information to Health Insurance Processing Center
      PO Box 4405
      Taunton, MA 02780
    - Fax the change information to (857) 323-8300.
13. MassHealth, the Massachusetts Health Connector, and the Health Safety Net will obtain from eligible persons' current and former employers and health insurers all information about health insurance coverage for such persons. MassHealth may share information about me and members of my household with my employer(s) and/or health insurers to obtain this information. This includes, but is not limited to, information about policies, premiums,

coinsurance, deductibles, and covered benefits that are, may be, or should have been available to such persons or members of their household.

14. MassHealth, the Massachusetts Health Connector, and the Health Safety Net may get records or data about persons listed on this application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Revenue, and the Registry of Motor Vehicles, as well as private data sources, including financial institutions, 1) to prove any information given on this application and any supplements, or other information given once a person becomes a member, 2) to document medical services claimed or provided to such persons, and 3) to support continued eligibility.
15. In connection with the eligibility and enrollment process, MassHealth, the Massachusetts Health Connector, and the Health Safety Net may send notices that contain personal information about persons listed on this application to other persons on this application, or otherwise communicate such information to such persons.
16. Under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by going to hhs.gov/ocr/complaints/index.html.

17. I agree to allow the Massachusetts Health Connector to use income data, including information from tax returns, to determine my eligibility in future years. Review the Health Connector Privacy Policy for more information about how the Health Connector uses your tax information. The Massachusetts Health Connector will send me a notice and let me make changes to my eligibility application. I understand that if I am eligible for an Advance Premium Tax Credit (APTC) or ConnectorCare, these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC or ConnectorCare may impact my annual tax liability. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.
18. I agree that MassHealth or anyone acting on its behalf may contact me including via mail, email, call, or text for any communications about my relationship with MassHealth or my healthcare needs, benefits, eligibility, or coverage using the contact information I provide, now or in the future, or information obtained from a reliable data source. I also agree that MassHealth may use the same information to contact me to distribute information about other health and welfare benefits I may be eligible to receive. These calls and texts may be made using automated technology, such as with an automatic telephone dialing system or artificial or pre-recorded voice messages. Standard message and data rates may apply.

19. I have read or have had read to me the information on this application, including any supplements and instructions. I understand that the Member Booklet contains important information about this application.
20. I have permission from all persons listed on this application (or their parent or other legally authorized reprsentative) to submit this application. I also have permission to act on their behalf to complete this application and any related eligibility process. This may include, for example:
    - providing personal information about them, including health, health coverage, and income information, seeing such information as may be provided by the Massachusetts Health Connector, MassHealth, and the Health Safety Net, and providing consent on their behalf to the use and disclosure of their information as described in this application;
    - making choices about coverage options and how to communicate with the Massachusetts Health Connector, MassHealth, or the Health Safety Net;
    - making changes to the application or related eligibility documents and providing information about any change in their circumstances; and
    - providing consent on their behalf to use government and private sources to verify the information described in this application.

21. I understand my rights and responsibilities and the rights and responsibilities of all persons listed on this application as explained in this Step 8.
22. I have told or will tell anyone listed on this application (or their parent or legally authorized representative, if applicable) about these rights and responsibilities so they understand them.
23. I understand and agree that MassHealth, the Health Safety Net, and the Massachusetts Health Connector will treat any electronic or faxed signature, or copy of a signature, with the same effect as an original signature.
24. I understand that MassHealth
    - is allowed to ask for SSNs under federal and state law;
    - uses SSNs to check income and other information to see who is eligible for help with health coverage costs;
    - uses SSNs to detect fraud, to see if anyone is getting duplicate benefits, or to see if others should be paying for services;
    - matches the SSN of anyone in the household who is applying and anyone who has or who can get health insurance for anyone in the household with the files of agencies and financial institutions.
25. I understand that if MassHealth pays part of anyone's health insurance premiums, MassHealth will add the SSN or the SSN of that policyholder to the State Comptroller's vendor file.

26. I understand that the policyholder in my household must have a valid SSN before getting a payment from MassHealth.
27. The information I have supplied is correct and complete to the best of my knowledge about myself and other persons listed on this application.
28. I may be subject to penalties under federal law if I intentionally provide false or untrue information.

If someone does not have an SSN or needs help getting one, call the Social Security Administration at (800) 772-1213, TTY: (800) 325-0778, or go tosocialsecurity.gov. For a full explanation on how we use your Social Security number, please refer to the Member Booklet for Health and Dental Coverage and Help Paying Costs.

For Supplemental Nutritional Assistance Program (SNAP) applicants

Supplemental Nutrition Assistance Program (SNAP) benefits

If you checked the box on page 1, MassHealth will send this application to the Department of Transitional Assistance (DTA). This will serve as your application for SNAP! If you are eligible, your SNAP will start from the date DTA receives this MassHealth application. By signing below, you agree that you have read and agree to your SNAP Rights, Responsibilities, and Penalties under the program.

You may be eligible for SNAP benefits within 7 days of DTA receipt of your information if:

- Your income and money in the bank add up to less than your monthly housing expenses, or
- Your monthly income is less than $150, and your money in the bank is $100 or less, or
- You are a migrant worker and your money in the bank is $100 or less.

For more information about SNAP in Massachusetts, go to mass.gov/SNAP.

Department of Transitional Assistance (DTA) Notice of Rights, Responsibilities and Penalties

This notice lists rights and responsibilities for the SNAP program.

I swear under penalty of perjury that:

- I have read the information in this form, or someone read it to me.
- My answers in this form are true and complete to the best of my knowledge.
- I will give DTA information that is true and complete to the best of my knowledge during my interview and in the future.

I understand that:

- giving false or misleading information is fraud,

- misrepresenting or withholding facts to get DTA benefits is fraud,
- fraud is considered an Intentional Program Violation (IPV), and
- if DTA thinks I committed fraud, DTA can pursue civil and criminal penalties against me.

I also understand that:

- DTA will verify the information I give with my application. If any information is false, DTA may deny my benefits.
- I may also be subject to criminal prosecution for providing false information.
- If DTA gets information from a reliable source about a change in my household, my benefit amount may change.
- By signing this form, I give DTA permission to verify my eligibility for benefits, including:

  Get information from other state or federal agencies, local housing authorities, out-of-state welfare departments, financial institutions, and Equifax Workforce Solutions (the Work Number). I also give these agencies permission to share information about my household's eligibility for benefits with DTA.

  If DTA uses information from Equifax about my household earned income, I have the right to a free copy of my Equifax report if I request it within 60 days of DTA's decision. I have the right to question the

information in the report. I may contact Equifax at: Equifax Workforce Solutions, 11432 Lackland Road, St. Louis, MO 63146, 1-800-996-7566 (toll free).

- I have a right to a copy of my application, including the information that DTA uses to decide about my household's eligibility and benefit amount. I can ask DTA for an electronic copy of the completed application.

How will DTA use my information?

By signing below, I give DTA permission to get information from and share information about me and members of my household with:

- Banks, schools, government, employers, landlords, utility companies and other agencies to check if I am eligible for benefits.
- Electric, gas and telephone companies so I can get utility discounts. The companies cannot share my information or use it for any other purpose.
- The Department of Housing and Community Development to enroll me in the Heat & Eat Program. This program helps people get the most SNAP benefits possible.
- The Department of Early and Secondary Education so my children can get free school meals.
- The Woman, Infants and Children (WIC) Program so that any children under age 5 or a pregnant woman in my household can get WIC.

- The United States Citizenship and Immigration Services (USCIS), to verify my immigration status. Information from USCIS may affect my household's eligibility and amount of DTA benefits.

  Note: Even if you are not eligible for benefits due to immigration status, DTA will not report you to immigration authorities unless you show DTA a final order of deportation.
- The Department of Revenue (DOR) to verify my eligibility for income-based tax credits, such as Earned Income and Limited Income, and to see if I am eligible for "No Tax Status" or hardship status.
- The Department of Children and Families (DCF) to coordinate services offered jointly by DTA and DCF.

How does DTA use Social Security Numbers (SSNs)?

DTA is allowed to ask for SSNs under The Food and Nutrition Act of 2008 (7 U.S.C. 2011-2036) for SNAP and under M.G.L. c. 18 Section 33 for TAFDC and EAEDC. DTA uses SSNs to:

- Check the identity and eligibility of each household member I apply for through data matching programs.
- Monitor compliance with program rules.
- Collect money if DTA claims I got benefits that I was not eligible for.

- Help law enforcement agencies catch people hiding from the law.

I understand that I do not have to give DTA the SSN of any non-citizen in my household, including myself, who does not want benefits. The income of a non-citizen may count even if the non-citizen does not get benefits.

Right to an Interpreter

I understand that:

- I have a right to a free professional interpreter provided by DTA if I prefer to communicate in a language other than English.
- If I have a DTA hearing, I can ask DTA to give me a free professional interpreter, or if I prefer, I can bring someone to interpret for me. If I need DTA to give me an interpreter for a hearing, I must call the Division of Hearings at least one week before the hearing date.

Right to Register to Vote

I understand that:

- I have the right to register to vote through DTA.
- DTA will help me fill out the voter registration application form if I want help.
- I can fill out the voter registration application form in private.
- Applying to register or declining to register to vote will not affect my DTA benefits.

Employment Opportunities

I agree that DTA may share my name and contact information with employment and training providers, including:

- SNAP Path Work providers or DTA specialists for SNAP clients; and
- Contracted Employment and Training providers or Full Engagement Workers for TAFDC clients.

SNAP clients may voluntarily participate in education and employment training services through the SNAP Path to Work program.

Citizenship Status

I swear that all members of my household applying for DTA benefits are either U.S. citizens, or lawfully residing noncitizens.

Supplemental Nutrition Assistance Program

I understand that:

- DTA manages the SNAP program in Massachusetts.
- When I file an application with DTA (by phone, online, in person, or by mail or fax), DTA has 30 days from the date it got my application to decide if I am eligible.

  If I am eligible for expedited (emergency) SNAP, DTA has to give me SNAP and make sure I have an Electronic Benefit Transfer (EBT) card within 7 days from the date they got my application.

I have a right to speak to a DTA supervisor if:

- DTA says I am not eligible for emergency SNAP benefits, and I disagree.
- I am eligible for emergency SNAP benefits, but do not get my benefits by the 7th day after I applied for SNAP.
- I am eligible for emergency SNAP benefits but do not get my EBT card by the 7th day after I applied for SNAP.

- When I get SNAP, I have to meet certain rules. When I am approved for SNAP, DTA will give me a copy of the "Your Right to Know" brochure and the SNAP Program brochure. I will read the brochures or have someone read them to me. If I have any questions or need help reading or understanding this information, I can call DTA at 1-877-382-2363.
- Telling DTA about changes in my household:

  If I am a SNAP Simplified Reporting household, I do not have to report most changes to DTA until the Interim Report or Recertification is due. The only things I have to report sooner are:

  - If my household's income goes over the gross income threshold (listed on my approval notice).

    I have to report this by the 10th day of the month after the month my income went over the threshold.
  - If I have to meet the Able-Bodied Adults Without Dependents (ABAWD) Work Rules and my work hours drop below 20 hours per week.

If everyone in my household is 60 or older, disabled, or under 18 years old, and no one has earnings from work, the only things I have to report are:

- If someone starts working, or
- Someone joins or leaves my household.

- I have to report these changes by the 10th day of the month after the month of the change.

If I get SNAP through Transitional Benefits Alternative (TBA) because my TAFDC stopped, I do not have to report any changes to DTA for the 5 months that I get TBA.

If I get SNAP through Bay State CAP, I do not have to report any changes to DTA.

If I and everyone in my household gets cash assistance (TAFDC or EAEDC), I must report certain changes to DTA within 10 days of the change.

I may get more SNAP benefits if I report and give DTA proofs for the following, at any time:

- Child or other dependent care costs, shelter costs, and/or utility costs;
- Child support that I (or someone in my household) is legally required to pay to a non-household member; and
- Medical costs for members of my household, including myself, who are 60 or older or disabled.

Work rules for SNAP clients:

If you get SNAP benefits and are between the ages of 16 and 59 you may need to meet general SNAP work rules

or the ABAWD work rules unless you are exempt. DTA will tell me and members of my household if we need to meet any Work Rules, what the exemptions are, and what will happen if we do not meet the rules.

If you are under the SNAP Work Rules:

- You must register for work at application and when you recertify for SNAP. You register when you sign the SNAP application or recertification form.
- You must give DTA information about your employment status when DTA asks.
- You must report to an employer if referred by DTA.
- You must accept a job offer (unless you have a good reason not to).
- You must mot quit a job of more than 30 hours a week without a good reason.
- You must not cut your work hours to less than 30 hours a week without a good reason.

SNAP Rules

Do not give false information or hide information to get SNAP benefits.

Do not trade or sell SNAP benefits.

Do not alter EBT cards to get SNAP benefits you are not eligible for.

Do not use SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco.

Do not use someone else's SNAP benefits or EBT card unless you are an authorized representative, or the recipient has given you permission to use their card on their behalf.

SNAP Penalty Warnings

I understand that if I or any member of my SNAP household intentionally breaks any of the rules listed above, that person will not be eligible for SNAP for one year after the first violation, two years after the second violation and forever after the third violation. That person may also be fined up to $250,000, imprisoned up to 20 years, or both. They may also be subject to prosecution under Federal and State laws.

I also understand the following penalties. If I or a member of my SNAP household:

- Commit a cash program Intentional Program Violation (IPV) they will be ineligible for SNAP for the same period they are ineligible for cash assistance.
- Make a fraudulent statement about their identity or residency to get multiple SNAP benefits at the same time they will be ineligible for SNAP for ten years.
- Trade (buy or sell) SNAP benefits for a controlled substance/illegal drug(s), they will be ineligible for SNAP for two years for the first finding, and forever for the second finding.
- Trade (buy or sell) SNAP benefits for firearms, ammunition or explosives, they will be ineligible for SNAP forever.

- Make an offer to sell SNAP benefits or an EBT card online or in person the State may pursue an IPV against them.
- Pay for food purchased on credit they will be ineligible for SNAP.
- Buy products with SNAP benefits with the intent to discard the contents and return containers for cash they will be ineligible for SNAP.
- Flee to avoid prosecution, custody or confinement after conviction for a felony they will be ineligible for SNAP.
- Violate probation or parole, where law enforcement is actively seeking to arrest them they will be ineligible for SNAP.

Anyone who became a convicted felon after February 7, 2014 is ineligible for SNAP benefits if they are a fleeing felon or are violating probation or parole - in accordance with 7 CFR §273.11(n) - and were convicted as an adult of:

1. Aggravated sexual abuse under section 2241 of title 18, U.S.C.;
2. Murder under section 1111 of title 18, U.S.C.;
3. Any offense under chapter 110 of title 18, U.S.C.;
4. A Federal or State offense involving sexual assault, as defined in section 40002(a) of the 1994 VAWA (42 U.S.C. 13925a); or
5. An offense under State law determined by the Attorney General to be substantially similar to an offense described in this list.

Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g. Braille, large print, audiotape, American Sign Language), should contact the Agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete Form AD-3027, the USDA Program Discrimination Complaint Form, which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. mail:
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. fax:
   (833) 256 1665 or (202)-690-7442; or
3. email:
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

- Complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: ascr.usda.gov/complaint_filing_cust.html, and at any USDA office. You can ask for a copy of the complaint form by calling 1-866-632-9992; or
- Write a letter addressed to USDA and put in the letter all of the information requested in the form.
- Submit your completed form or letter to USDA by:

  mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue SW Washington, DC 20250-9410; or

  fax: 1-202-690-7442; or

  email: program.intake@usda.gov

This institution is an equal opportunity provider.

SIGN THIS APPLICATION—Required

By signing this application below, I hereby certify under the pains and penalties of perjury that the submissions and statements I have made in this application are true and complete to the best of my knowledge, and I agree to accept and comply with the above rights and responsibilities of the MassHealth and Health Connector programs.

If I have indicated that I am applying for the Supplemental Nutritional Assistance Program (SNAP) on page 1 of this application, I certify that I understand and agree to the rights, rules, and penalties of the SNAP program, as outlined above. I ask that MassHealth send my information, including Protected Health Information subject to the Health Insurance Portability and Accountability Act (HIPAA), to the Department of Transitional Assistance (DTA) for the purpose of applying for SNAP benefits.

Important: For MassHealth and Health Connector applicants only. If you are submitting this application as an authorized representative, you must submit an **Authorized Representative Designation Form (ARD)** to us or have a form on record for us to process this application. The ARD is at the end of this application.

Signature of Person 1 or authorized representative or responsible party

_____

Print name _____ Date ___/___/_____

If you are younger than 18, are you an emancipated minor? ☐ Yes ☐ No

If **No**, we need a responsible party who is at least 18 years old to sign this application on your behalf. Please provide that person's information below.

First name _____ Middle name _____
Last name _____ Suffix _____
Social Security Number __ __ __ - __ __ - __ __ __ __
Relationship to you _____ Date of birth ___/___/_____
Street address _____
Apartment/Unit # _____ City _____
ZIP code _____ County _____
Phone _____ Ext. ____ Phone type _____
Second phone _____ Ext. ____ Phone type _____
Email address _____

STEP 9
SEND US YOUR COMPLETED APPLICATION.

Mail your signed application to:

Health Insurance Processing Center
PO Box 4405
Taunton, MA 02780; or

Fax to: **(857) 323-8300**

VOTER REGISTRATION INFORMATION ON THIS PAGE

Voter Registration Information

The form to register to vote is included with this application or can be found at sec.state.ma.us. More information on how to register to vote can also be found at sec.state.ma.us. If you have any questions about the voter registration process, or if you need help filling out the form, please visit a local MassHealth Enrollment Center or call the MassHealth Customer Service Center at (800) 841-2900, TTY/TTD: 711

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, with your right to privacy in deciding to register or in applying to register to vote, or with your right to choose your own political party or other political preference, you may file a complaint with:

Secretary of the Commonwealth,
Elections Division
One Ashburton Place
Room 1705
Boston, MA 02108
Tel: (617) 727-2828 or (800) 462-8683.

If you or anyone else in your application are not registered to vote where you live now, would you like to apply to register to vote today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

IMMIGRATION STATUSES AND DOCUMENT TYPES

Question 14a on the application asks noncitizens about their immigration status and about the type or types of immigration documents they have to support their immigration status. Please refer to the following lists to fill out Question 14a.

If you need further help, details can be found online at MAhealthconnector.org/immigration-document-types.

Eligible Immigration Statuses

In the “Immigration Status” section of Question 14a, write in any status that applies to you or members of your household. You may write in more than one status.

- Amerasian
- Granted asylum
- Cuban Haitian entrant
- Deportation withheld
- Native American born in Canada or non-US territories
- Refugee
- Victim of severe trafficking or their spouse, child, sibling or parent
- Iraqi special immigrant
- Afghan special immigrant or certain Afghan evacuees
- Conditional entrant granted before 1980

- Veteran or active-duty member of military or their spouse or dependent
- COFA migrant
- Lawful permanent resident
- Granted parole for at least one year
- Battered spouse or child (or their parent or child)
- Nonimmigrant status (visa)
- Granted parole for less than one year
- Granted temporary resident status
- Granted Temporary Protected Status (TPS) or applicant for TPS with employment authorization
- Granted employment authorization under 8 CFR 274a(12)(c)
- Family unity beneficiaries
- Deferred enforced departure
- Deferred Action Status except for Deferred Action for Childhood Arrivals Process (DACA)
- Granted an administrative stay of removal under 8 CFR 241
- Approved visa petition with a pending application for adjustment of status
- Applicant for asylum or for withholding of removal with employment authorization
- Applicant (for at least 180 days) under age 14 for asylum or for withholding of removal

- Granted withholding of removal under the Convention Against Torture
- Applicant for Special Immigrant Juvenile (SIJ) status
- Applicant or granted status under Deferred Action for Childhood Arrivals (DACA)
- I have a document but do not have any status listed above (Person Residing Under Color of Law, PRUCOL)

Immigration Document Types

In the "Immigration Document Type" section of Question 14a, write in any document type you or members of your household have. You may list more than one immigration document type.

- Reentry Permit (I-327)
- Permanent Resident Card ("green card," I-551)
- Refugee Travel Document (I-571)
- Employment Authorization Card (I-766)
- Machine Readable Immigrant Visa (with temporary 1-551 language)
- Temporary I-551 stamp (on passport or I-94, I-94A)
- Arrival/Departure Record (I-94, I-94A)
- Arrival/Departure Record in unexpired foreign passport (I-94)
- Foreign passport
- Certificate of Eligibility for Nonimmigrant Student Status (I-20)

- Certificate of Eligibility for Exchange Visitor Status (DS2019)
- Notice of Action (I-797)
- Document indicating withholding of removal (or withholding of deportation)
- Administrative order staying removal issued by the Department of Homeland Security
- Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Resident of American Samoa Card
- USCIS Notice of Receipt (I-797C)
- US Visas (such as B1/B2, R-Visa, Border Crossing Card, J/F/M)

RACE (Optional)

Choose the options that best describe you. Write in all that apply. Please specify in Questions 8 and 9 on pages 9, 23, 36, and 49.

- American Indian or Alaska Native (Complete Step 3 and Supplement B)
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Race is not listed here (please specify)
- Don’t know
- Choose not to answer

ETHNICITY

- African
- African American
- American
- Asian Indian
- Brazilian
- Cambodian
- Cape Verdean
- Caribbean Islander
- Central American
- Chinese
- Colombian
- Cuban
- Dominican
- Eastern European
- European
- Filipino
- Guatemalan
- Haitian
- Honduran
- Japanese
- Korean
- Laotian/Lao
- Mexican
- Middle Eastern or North African
- Portuguese
- Puerto Rican
- Russian
- Salvadoran
- South American
- Vietnamese
- Ethnicity is not listed (please specify)
- Don’t know
- Choose not to answer

SUPPLEMENT A
HEALTH COVERAGE FROM JOBS

Answer these questions if someone in the household is eligible for health coverage from a job whether or not they are enrolled in the coverage. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

EMPLOYEE INFORMATION

1. Employee name (first, middle, last)

   _____

2. Employee Social Security number

   ___ ___ ___ - ___ ___ - ___ ___ ___ ___

3. a. Is at least one person on this application currently eligible for or enrolled in coverage offered by this employer, or will at least one person on this application become eligible within the next 3 months? ☐ Yes ☐ No

If the answer to 3a is **Yes**, continue. If the answer to 3a is **No**, stop here and skip the rest of Supplement A.

b. If any person is in a waiting or probationary period, when can this person enroll in coverage? (mm/dd/yyyy) ___/___/_____

EMPLOYER INFORMATION

4. Employer name _____
5. Federal Tax ID (if known) _____
6. Employer address

   _____
7. Employer phone number _____
8. City _____
9. State _____
10. ZIP code _____
11. Who can we contact about employee health coverage at this job?

    _____
12. Phone number (if different from above)

    _____
13. Email address _____

TELL US ABOUT HEALTH PLANS OFFERED BY THIS EMPLOYER.

14. a. What is the name of the lowest cost individual health plan offered to the employee?*****

    _____

    b. Does the health plan offered by the employer meet the minimum value standard for coverage?
    ☐ Yes ☐ No

    c. How much would this employee pay in premiums for this plan? $ _____

    d. How often would this employee pay this amount?

    _____

15. a. What is the name of the lowest cost health plan to cover the other household members who qualify through the employer?

    _____

    b. Does this health plan offered by the employer meet the minimum value standard for coverage?
    ☐ Yes ☐ No

    c. How much would this employee pay in premiums for this plan? $ _____

    d. How often would this employee pay this amount?

    _____

16. What change will the employer make for the new plan year (if known)?

    a. Employer will not offer health coverage. Coverage end date (mm/dd/yyyy) ___/___/_____

    b. The person plans to drop employer's health coverage. Coverage end date (mm/dd/yyyy) ___/___/_____

    c. Employer will start offering health coverage to employees or change the premium for the lowest-cost individual or family health plans that are available and meet the minimum value standard.* (Premium should reflect the discount for wellness programs.)

    How much would this employee pay in premiums for this plan? $ _____ How often? _____

    Date of change (mm/dd/yyyy) ___/___/_____

***** An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is at least 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

SUPPLEMENT B
AMERICAN INDIAN OR ALASKA NATIVE HOUSEHOLD MEMBER (AI/AN)

Complete this supplement if you or a household member are an American Indian or Alaska Native.

Tell us about your American Indian or Alaska Native household member(s).

American Indians and Alaska Natives can get services from the Indian Health Service, tribal health programs, or Urban Indian Health Programs. They also may not have to pay premiums or copayments and may get special monthly enrollment periods. Answer the following questions to make sure your household gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

AI/AN Person 1

1. Name (first, middle, last)

   _____

2. Member of a federally recognized tribe?
   ☐ Yes ☐ No
   If **Yes**, tribe name

   _____

3. Member of a Massachusetts-recognized tribe?
   ☐ Yes ☐ No
   If **Yes**, tribe name

   _____

4. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs?
   ☐ Yes ☐ No
   If **No,** is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Program, or through a referral from one of these programs? ☐ Yes ☐ No

5. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from
   - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;

- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations); or
- Money from selling things that have cultural significance. $_____ How often?_____

AI/AN Person 2

1. Name (first, middle, last)

   _____

2. Member of a federally recognized tribe?
   ☐ Yes ☐ No
   If **Yes**, tribe name

   _____

3. Member of a Massachusetts-recognized tribe?
   ☐ Yes ☐ No
   If **Yes**, tribe name

   _____

4. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs? ☐ Yes ☐ No
   If **No,** is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Program, or through a referral from one of these programs? ☐ Yes ☐ No

5. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from
   - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations); or
   - Money from selling things that have cultural significance. $_____ How often?_____

SUPPLEMENT C
ACCOMMODATION

If you answered Yes to Question 18 in Step 2 about yourself or any household member needing reasonable accommodation because of a disability or injury, check all that apply below, and list name(s).

1. Condition

☐ Blind—Name(s):

_____

☐ Deaf—Name(s):

_____

☐ Developmentally disabled—Name(s):

_____

☐ Hard of hearing—Name(s):

_____

☐ Intellectually disabled—Name(s):

_____

☐ Low vision—Name(s):

_____

☐ Physically disabled—Name(s):

_____

☐ Other (Please explain.)—Name(s):

_____

2. Accommodation

☐ Text telephone (TTY/TTD)—Name(s):

_____

☐ Large print publications—Name(s):

_____

☐ American Sign Language (ASL) interpreter Name(s):

_____

☐ Video Relay Service (VRS)—Name(s):

_____

☐ Communication Access Real-time Translations (CART)—Name(s):

_____

☐ Publications in Braille—Name(s):

_____

☐ Assistive listening device—Name(s):

_____

☐ Publications in electronic format—Name(s):

_____

☐ Other (Please explain.)—Name(s):

_____

AUTHORIZED REPRESENTATIVE DESIGNATION FORM

Commonwealth of Massachusetts | EOHHS

You can submit this form if you would like to designate an authorized representative to act on your behalf. If an authorized representative signed your application for you, or if you are an authorized representative applying on behalf of someone else, you **MUST** submit this form for the application to be processed.

You do not need to fill out this form if you live in an institution and want copies of eligibility notices sent to you and to your spouse who still lives at home. We will do that automatically.

Note: An authorized representative has the authority to act on an applicant's or member's behalf in all matters with MassHealth and the Health Connector, and will receive personal information about the applicant or member until we receive a cancellation notice terminating their authority, or upon the death of the applicant or member. Their authority will not automatically terminate once we process your application.

You can choose someone to help you.

You may choose an authorized representative to help you get health care coverage through programs offered by MassHealth and the Health Connector. You can do this by filling out this form (the Authorized Representative Designation Form). You or a representative can sign for yourself and for any of your dependent children under the age of 18 for whom you are the custodial parent. **You are not required to have a representative in order to apply for or receive benefits.**

Who can help me?

1. An authorized representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose an authorized representative if you want one. Neither MassHealth nor the Health Connector will choose an authorized representative for you. You must designate in writing (fill out Section I, Part A) the person or organization who you want to be your authorized representative. Your authorized representative must also fill out Section I, Part B. We sometimes refer to this person or organization as a "Section I authorized representative."
2. If you cannot designate an authorized representative in writing and you do not have an existing authorized representative or other person who is authorized by law

to act on your behalf, a person (not an organization) who certifies that they will act responsibly on your behalf can be your authorized representative if that person fills out Section II of this form. We sometimes refer to this person as a "Section II authorized representative."

3. An authorized representative can also be someone who has been appointed by law to act on your behalf, or on behalf of the estate of an applicant or member who has died. This person must fill out Section III and either you or this person must submit to us, together with this form, a copy of the applicable legal document stating that this person has authority to represent you, or the estate of a deceased applicant or member. We sometimes refer to this person as a "Section III authorized representative."
4. **Section III** authorized representative may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the personal representative of the estate.

What can an authorized representative do?

A **Section I** or **II** authorized representative may

- fill out your application or renewal forms;
- fill out other MassHealth or Health Connector eligibility or enrollment forms;
- give proof of information reported on these forms;

- report changes in income, address, or other circumstances;
- get copies of all of your MassHealth and Health Connector eligibility and enrollment notices; and
- act on your behalf in all other matters with MassHealth and the Health Connector.

What a **Section III** authorized representative is authorized to do for you (or for the Estate of a deceased applicant or member) will depend on the wording of the legal appointment.

Please note: Eligibility notices may include information about other members of an applicant's or member's household. If there are multiple people in your household we may not be able to send copies of some of your notices to your authorized representative unless each household member has also designated the same authorized representative by completing a separate Authorized Representative Designation Form.

SECTION 1
AUTHORIZED REPRESENTATIVE DESIGNATION
(if applicant or member is able to sign)

Part A—to be filled out by applicant or member. Please print, except for signature.

Applicant's/Member's Name

_____

Applicant's/Member's date of birth (mm/dd/yyyy) __/__/____

MassHealth ID number __ __ __ __ __ __ __ __ __ __ __ __ OR
last four digits of the Applicant's/Member's SSN __ __ __ __

Applicant's/Member's email address

_____

I certify that I have chosen the following person or organization to be the authorized representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form).

Applicant's/Member's signature Date (mm/dd/yyyy)

_____ __/__/____

Authorized representative's name

_____

Authorized representative's phone number

_____

Authorized representative's address (mailing address, city, state, zip)

_____

Part B—to be filled out by authorized representative. Please print, except for signature.

B1. Complete if authorized representative is a person.

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to me by MassHealth or the Health Connector.

If I am also a provider, staff member, or volunteer affiliated with an organization, and am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10 and 45 C.F.R. § 155.260(f).

Authorized representative's signature Date (mm/dd/yyyy)

_____ ___/___/_____

Authorized representative's printed name

_____

Authorized representative's email address

_____

B2. Complete if authorized representative is an organization.

I certify, on behalf of the organization set forth below, that such organization will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to the organization by MassHealth or the Health Connector.

I, the provider, staff member, or volunteer of the organization set forth below, completing this form, certify on behalf of myself and on behalf of the organization I represent, that any providers, staff members, or volunteers acting on behalf of the organization in connection with this authorized representative designation will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information, and conflicts of interest, including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10 and 45 C.F.R. § 155.260(f).

Signature of provider, staff member, or volunteer completing form

_____

Date (mm/dd/yyyy) __/__/____

Printed name of provider, staff member, or volunteer completing form

_____

Email of provider, staff member, or volunteer completing form

_____

Authorized representative organization name

_____

SECTION 2
AUTHORIZED REPRESENTATIVE DESIGNATION
(if applicant or member cannot provide written designation)

To be filled out by authorized representative. Please print, except for signature. Please provide a separate form for each applicant or member.

An organization is not eligible to be an authorized representative under this section.

I certify that the applicant or member set forth below cannot provide written designation and to the best of my knowledge does not otherwise have an individual who can act on his or her behalf such as an existing authorized representative, guardian, conservator, personal representative of the estate, holder of power of attorney, or an invoked health-care proxy. In addition, I certify that I am sufficiently aware of this applicant's or member's circumstances to assume responsibility for the accuracy of the statements made on his or her behalf during the eligibility process and in other communications with MassHealth or the Health Connector, that I understand my rights and responsibilities as this person's authorized representative (as explained earlier in this form). If this person can understand, I have told the person that

MassHealth and the Health Connector will send me a copy of all MassHealth and Health Connector eligibility and enrollment notices and this person agrees to this, and I have told this person that they may remove or replace me as their authorized representative at any time by the methods described earlier in this form.

I further certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth below that is provided to me by MassHealth or the Health Connector.

If I am also a provider, staff member, or volunteer affiliated with an organization, and I am acting in my capacity as a provider, staff member, or volunteer in connection with my designation an authorized representative, I further certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentially of information and conflicts of interest including those set forth at 42 CFR part 431 subpart F., 42 CFR §477.10, and 45 CFR §155.260(f).

Applicant's/Member's name

_____

Applicant's/Member's date of birth (mm/dd/yyyy) __/__/____

MassHealth ID number __ __ __ __ __ __ __ __ __ __ __ __ OR last four digits of the Applicant's/Member's SSN __ __ __ __

Authorized representative's signature

_____

Date (mm/dd/yyyy) ___/___/_____

Authorized representative's name (first, middle, last)

_____

Authorized representative's phone number

_____

Authorized representative's address
(mailing address, city, state, zip)

_____

Authorized representative's email address

_____

If the Section II authorized representative is affiliated with an organization, and is acting in such capacity, an individual authorized to act on behalf of the organization, such as an officer, must sign below to indicate the organization's acknowledgment of and agreement with the representations and warranties made above.

Officer's Name _____

Officer's Title _____

Officer's Signature _____

Date (mm/dd/yyyy) __/__/____

SECTION 3
AUTHORIZED REPRESENTATIVE DESIGNATION
(if appointed by law)

To be filled out by an authorized representative appointed by law (as explained earlier on this form). Please print, except for signature. **Please submit a copy of the applicable legal document with this form.**

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member as set forth below, that is provided to me by MassHealth or the Health Connector.

Applicant's/Member's name

_____

Applicant's/Member's date of birth (mm/dd/yyyy) __/__/____

MassHealth ID number __ __ __ __ __ __ __ __ __ __ __ __ OR last four digits of the Applicant's/Member's SSN __ __ __ __

Authorized representative's signature

_____

Date (mm/dd/yyyy) __/__/____

Authorized representative's name (first, middle, last)

_____

Authorized representative's phone number

_____

Authorized representative's address
(mailing address, city, state, zip)

_____

Authorized representative's email address

_____

How does an authorized representative designation end?

If you decide that you no longer want a **Section I** or **Section II** authorized representative, you must notify us at the time you want the designation to end by mail, fax, or phone. See our contact information below. If you mail or fax this notice to us, the notice must include your name, address, and date of birth, the name of your authorized representative, a statement that the designation has ended and your signature or, if you cannot provide written notice, the signature of someone acting on your behalf (in the case of a **Section II** authorized representative only).

In addition, if your authorized representative notifies us that such person or organization is no longer acting on your behalf, we will no longer recognize the person or organization as your authorized representative.

The authority of a **Section I** or **Section II** authorized representative will end upon the death of the applicant or member.

A **Section III** authorized representative's designation ends when his or her legal appointment ends. The authorized representative must notify us as instructed above.

In addition, an authorized representative's designation for a minor child ends on the child's 18th birthday.

How do I submit this form?

If you are applying for health benefits, send your filled-out Authorized Representative Designation Form to us with your application.

If you are already getting benefits, you must submit the form to us at the time you want to designate an authorized representative, or you want the declared designation to end, by

- Mailing your form to
  Health Insurance Processing Center
  PO Box 4405
  Taunton, MA 02780;
- Faxing your form to **(857) 323-8300**; or
- Calling us at **(800) 841-2900**, TDD/TTY: **711**.