MassHealth
Adult Disability Supplement

Commonwealth of Massachusetts | Executive Office of Health and Human Services

Instructions for Completing the Supplement

You have indicated on your MassHealth application that you have a disability. Disability standards require that the disability has lasted, or is expected to last, at least 12 months. To ensure your MassHealth eligibility, Disability Evaluation Services (DES) will review your application, including this Disability Supplement.

To get MassHealth based on your disability, you need to tell us about

- your medical and mental health providers; and
- your work history for the past 5 years.

Fully completing the Disability Supplement will give us the information we need to make a quick decision.

Please read the following instructions before beginning.

- Print or write clearly and complete the supplement to the best of your ability.
- Sign and date an Authorization to Release Protected Health Information Form for each medical and mental health provider you list on the supplement.
- After you have filled out the supplement, submit it to
  Disability Evaluation Services (DES)
  PO Box 2796
  Worcester, MA 01613-2796

DES will ask the providers you listed for your medical and treatment records. If you have any of your medical records, please send a copy with this form. If more information or tests are needed, a member of DES will get in touch with you. Completely filling out this supplement will speed up the process of determining your eligibility.

This is not an application for medical benefits. If you have not already completed a MassHealth application, you must fill one out in addition to this form. If you have any questions about how to apply, please call MassHealth Customer Service at (800) 841-2900. Call TDD/TTY: 711 if you are deaf, hard of hearing, or speech disabled.

If you need help with this form, you can call a DES representative at (800) 888-3420. Fill in every section of this form. If you do not fill in every section, we may not be able to make a decision about your disability.

Print Clear

Information about you

Sex assigned at birth

- ☐ Male
- ☐ Female

Which best describes your current gender identity?

- ☐ Male
- ☐ Female
- ☐ Transgender man/trans man
- ☐ Transgender woman/trans woman
- ☐ Genderqueer/gender nonconforming/nonbinary/ neither exclusively male nor female
- ☐ Gender Identity not listed
  Please specify _____
- ☐ Don't know
- ☐ Choose not to answer

Last name, First name, Middle initial

Last 4 Digits of Social Security number	MassHealth Medicaid ID	Date of birth (mm/dd/yyyy)

Street address, Apt. #	City	State	Zip code

Home phone	Cell phone	Email address

Where do you live? (Check one.)

☐ House or apartment ☐ State facility ☐ Rehabilitation hospital ☐ Group home
☐ Nursing home ☐ Homeless ☐ Other (describe) _____

Did you apply for Social Security or SSI/SSDI benefits? ☐ yes ☐ no

Have you been awarded SSI/SSD? ☐ yes ☐ no

If you have a copy of the award letter, please attach it to this supplement.

PART 1 Your health issues

List and describe all your medical and mental health issues. If you are getting treatment for the issue, please tell us what kind of treatment.

Medical or mental health issue	
Describe related symptoms or pain	
Date when problem started	Medications/treatment

Medical or mental health issue	
Describe related symptoms or pain	
Date when problem started	Medications/treatment

Medical or mental health issue	
Describe related symptoms or pain	
Date when problem started	Medications/treatment

Did any of your health issues start because of an accident or injury? ☐ yes ☐ no
If **yes**, please explain.

Are you (check one): ☐ Right handed? ☐ Left handed?

PART 2 Information about all your medical and mental health providers

Please list every medical and mental health provider that treated you since your health issues started. A medical or mental health provider may include a doctor, psychologist, therapist, social worker, physical therapist, chiropractor, hospital, health center, or clinic from which you receive treatment. You can write on a separate piece of paper if you run out of space.

Name of medical or mental health provider	
Reason for visit	Was this visit in the last 12 months? ☐ yes ☐ no
Name of medical or mental health provider	
Reason for visit	Was this visit in the last 12 months? ☐ yes ☐ no
Name of medical or mental health provider	
Reason for visit	Was this visit in the last 12 months? ☐ yes ☐ no
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Reason for visit	Was this visit in the last 12 months? ☐ yes ☐ no
Name of medical or mental health provider	
Reason for visit	Was this visit in the last 12 months? ☐ yes ☐ no

Please fill out an **Authorization to Release Protected Health Information Form** for each medical and mental health provider on this list. Be sure to sign and date each form. These release forms are at the end of this packet. If you need more copies of the Authorization to Release Protected Health Information Form, call MassHealth Customer Service at (800) 841-2900, TDD/TTY: 711 or download the form at mass.gov/lists/masshealth-member-forms.

PART 3 Your language

Do you speak English? ☐ yes ☐ no

Do you understand English? ☐ yes ☐ no

Do you read English? ☐ yes ☐ no

Do you write English? ☐ yes ☐ no

What is your preferred language? _____

Can you read in your preferred language? ☐ yes ☐ no

Can you write in your preferred language? ☐ yes ☐ no

PART 4 School

Check the highest grade of school you finished.

☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

☐ GED ☐ Associate's degree ☐ Bachelor's degree

What year did you finish this grade? _____ Where did you go to school? _____

Did you repeat any grades? ☐ yes ☐ no

Did you receive any special help or accommodations in school? ☐ yes ☐ no ☐ not sure

Do you have a learning disability? ☐ yes ☐ no ☐ not sure

Were you in special education? ☐ yes ☐ no ☐ not sure

Did you complete school higher than 12th grade? ☐ yes ☐ no

If **yes**, please list your degree and major _____

Did you get any other training? ☐ yes ☐ no

If **yes**, please fill out the sections below.

Type of training

Year | Did you finish? ☐ yes ☐ no | Are you certified or licensed? ☐ yes ☐ no

Type of training

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Type of training

Year | Did you finish? ☐ yes ☐ no | Are you certified or licensed? ☐ yes ☐ no

PART 5 Your work for the past 5 years

Do you work now? ☐ yes ☐ no

If **no**, when did you stop working? Date ____ / ____ / _____

Did any of your medical or mental health conditions cause problems at work? ☐ yes ☐ no

If **yes**, explain

List all your jobs from the last 5 years. Do the best that you can. If you do not know the exact dates, write your best guess.
Start with the job you have now or your last job.
If you have other jobs to add (within the last 5 years), please include information with this form.

1. Job title: | Dates worked: From (Month/Year): | To (Month/Year):

Job duties (List everything you did.)

How many hours did you work each week? | How much did you make an hour?

Check the weight you lifted or carried most often (check one):

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 25 lbs. ☐ 50 lbs. ☐ Over 50 lbs.

Check the heaviest weight you lifted (check one):

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 25 lbs. ☐ 50 lbs. ☐ Over 50 lbs.

How many hours did you do each of the following each day?

Walk _____ Reach _____ Bend _____ Handle small objects _____

Stand _____ Sit _____ Handle big objects _____

Reason for leaving

2. Job title: | Dates worked: From (Month/Year): | To (Month/Year):

Job duties (List everything you did.)

How many hours did you work each week? | How much did you make an hour?

Check the weight you lifted or carried most often (check one):

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 25 lbs. ☐ 50 lbs. ☐ Over 50 lbs.

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Stand _____ Sit _____ Handle big objects _____

Reason for leaving

3. Job title: | Dates worked: From (Month/Year): | To (Month/Year):

Job duties (List everything you did.)

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How many hours did you do each of the following each day?

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Stand _____ Sit _____ Handle big objects _____

Reason for leaving

4. Job title: | Dates worked: From (Month/Year): | To (Month/Year):

Job duties (List everything you did.)

How many hours did you work each week? | How much did you make an hour?

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How many hours did you do each of the following each day?

Walk _____ Reach _____ Bend _____ Handle small objects _____

Stand _____ Sit _____ Handle big objects _____

Reason for leaving

PART 6 Your comments

Use this space to write any additional information about why you cannot work.

PART 7 Your signature and rights

THIS SECTION MUST BE COMPLETED.

You have the right to privacy. The information on this form is confidential. All possible precautions will be taken to ensure your privacy rights.

Important: If this form is being filled out by someone with the legal authority to act on behalf of the applicant, that individual must sign below and attach the corresponding, completed legal paperwork (for example, an Authorized Representative Designation Form (ARD), guardianship form, or power of attorney form).

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.

Signature of Applicant or Authorized Representative/Guardian _____

Print name _____ Date ____ / ____ / _____

To request an ARD form, call the MassHealth Customer Service Center at (800) 841-2900, TDD/TTY: 711. You can also download the form online at mass.gov/doc/authorized-representative-designation-form-1/download.

DES may send copies of notices to the authorized representative. Your signature does not authorize DES to receive your medical records. Please complete and sign the attached Authorization to Release Protected Health Information form.

HELP WITH THIS FORM

Did you need help to fill out this form? ☐ yes ☐ no

If **yes**, why did you need help?

_____

REMINDER

Did you remember to

- Complete an Authorization to Release Protected Health Information form for each medical or mental health provider listed in Part 2?
- Sign all Authorization to Release Protected Health Information forms?
- Sign this Disability Supplement above?
- Include a completed and signed Authorized Representative Designation form (ARD), guardianship form, or other legal paperwork, if needed?
- Call a DES representative at (800) 888-3420 if you need help with this form?

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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APPLICANT:

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Instructions

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Please read the instructions carefully before you begin. If you leave any sections of this form blank, or do not fill out the form the right way, the permission will not be valid. Your health care provider will not be able to share your protected health information with DES.

- Sign and date a **separate** Authorization to Release Protected Health Information form for **each** doctor, hospital, health center, clinic, or other health care provider you listed in the Disability Supplement.
- All Authorization to Release Protected Health Information forms must be filled out in black or blue ink and must be originals. Forms filled out and signed in pencil are not permitted. No copies or stamps of signatures are permitted. Electronic signatures are acceptable.
- Only one signature may appear on a line.
- Emailed, faxed, and mailed releases are accepted with valid signature.
- If this form is for a child younger than 18, one parent or legal guardian must sign for the child.
- Legal guardians must attach a complete copy of the form that gives them the authority to act on behalf of the applicant.

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This request for protected health information supports this individual's application for public benefits. Under M.G.L. c. 112 § 12CC, there must be no charge for the release of the requested records. Under statute, the records must be produced within 30 days.

By filling out and signing this Authorization to Release Protected Health Information, I authorize my health care provider to share my protected health information with Disability Evaluation Services (DES). This form will allow my doctors to share my protected health information with DES to determine my eligibility for disability services.

- I understand that some information used or shared as part of this authorization could be re-shared. If the information is re-shared, it may no longer be protected by federal or state confidentiality laws.
- I also understand that certain sensitive health information has special protections. This sensitive health information includes records about HIV infection, AIDS, genetic testing, and psychological or psychiatric conditions. This sensitive health information is protected under state and federal law and cannot be shared without my written consent unless otherwise allowed by law. 42 CFR part 2 does not allow a program that provides substance use disorder diagnosis, treatment, or referral for treatment to share health information that it creates, receives, or acquires about me without my authorization.

SECTION 1: MassHealth Applicant Information

Name	Date of birth
Street address	
City, State, Zip	Telephone number

SECTION 2: Healthcare Provider Information

Name of doctor, health center, or other health care provider		
Street address	Floor #	Suite #
City, State, Zip	Telephone number	

SECTION 3: Sensitive Medical Information to Be Shared with DES

Please check YES to indicate your permission to release the following information if present in your record.

- ☐ Yes Mental or Psychiatric Health Information
- ☐ Yes HIV, AIDS, Sexually Transmitted Disease Information
- ☐ Yes Genetic Testing. See M.G.L. c. 111 § 70G
- ☐ Yes Substance Use Information

This authorization is good from 12 months before the signature date through its expiration.
This authorization expires 12 months from the signature date.

Signature of Applicant or Legal Representative _____ Date _____

Relationship to Applicant or authority to act for Applicant _____

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Unless action has already been taken in reliance upon it, or during a contestability period under applicable law, I understand that I may revoke this authorization at any time by sending a written request to Disability Evaluation Services, PO Box 2796, Worcester, MA 01613.

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- ☐ Yes Substance Use Information

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Relationship to Applicant or authority to act for Applicant _____

If this form is being completed by a legal representative, please attach a complete copy of the document that gives you the authority to act on behalf of the applicant.

Unless action has already been taken in reliance upon it, or during a contestability period under applicable law, I understand that I may revoke this authorization at any time by sending a written request to Disability Evaluation Services, PO Box 2796, Worcester, MA 01613.