Commonwealth of Massachusetts  
Executive Office of Health and Human Services

MassHealth Adult Disability Supplement

## 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. UMass Disability Evaluation Services (DES) will review your disability application for MassHealth. It is very important that you complete this Disability Supplement.

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

* your medical and mental health providers. These may include doctors, psychologists, therapists, social workers, physical therapists, chiropractors, hospitals, health centers, and clinics from whom you receive or have received treatment; and
* yourself: your work history for the past 15 years, your educational background, and your daily activities.

Completing the Disability Supplement will give us this information and will help us 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 / UMASS Medical DES   
  P.O. Box 2796   
  Worcester, MA 01613-2796

DES will ask for your medical and treatment records from the providers you have listed. 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. Your eligibility will be determined more quickly if all items on the supplement are filled in.

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 (800) 841-2900 (TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled).

If you need help with this form, you can call the UMass Disability Evaluation Services (DES) Help Line at (888) 497-9890. Fill in every section of this form. If you do not fill in every section, we may not be able to decide if you are disabled.

## Information about you

Male  
Female

Last name  
First name  
MI

Social security number  
Street address  
Apartment number/suite  
City   
Zip code

Date of birth (mm/dd/yyy)

Home phone   
Cell phone   
Work/other phone

We may need to schedule a doctor’s appointment for you. What are the best times for you to go to an appointment? Please check all the times that are good for you.  
Any time is ok  
Monday A.M.   
Tuesday A.M.  
Wednesday A.M.   
Thursday A.M.  
Friday A.M.  
Monday P.M.  
Tuesday P.M.  
Wednesday P.M.  
Thursday P.M.  
Friday P.M.

Did you apply for Social Security or SSI/SSDI benefits? yes no  
If yes, did you see a doctor for an exam?  
Doctor’s name  
Date of exam

# Part 1. Your health problems

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

SAMPLE  
List your medical and/or mental health problems. Depression  
Describe the symptoms or pain related to each health problem. Very tired all the time. Hard to get out of bed in the morning. I cry a lot during the day. I can’t control when I cry.  
Date when problem started. April 2010  
Medications/treatment None

SAMPLE  
List your medical and/or mental health problems. Back pain  
Describe the symptoms or pain related to each health problem. Pain starts in my lower back and goes down my leg  
Date when problem started. June 2007  
Medications/treatment Skelexin

List your medical and/or mental health problems.  
Describe the symptoms or pain related to each health problem.  
Date when problem started.  
Medications/treatment

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Describe the symptoms or pain related to each health problem.  
Date when problem started.  
Medications/treatment

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Describe the symptoms or pain related to each health problem.  
Date when problem started.  
Medications/treatment

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

# Part 2. Information about all your medical and mental health providers

Did you get any health care in the past year? yes no

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

If you are receiving treatment from only one facility, list only that facility.

Name of medical and mental health providers   
Reason for visit  
Was this visit in the past year? yes no

Name of medical and mental health providers   
Reason for visit  
Was this visit in the past year? yes no

Name of medical and mental health providers   
Reason for visit  
Was this visit in the past year? yes no

Name of medical and mental health providers   
Reason for visit  
Was this visit in the past year? yes no

Name of medical and mental health providers   
Reason for visit  
Was this visit in the past year? 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 (TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled) or download the form at [www.mass.gov/service-details/masshealth-member-forms](http://www.mass.gov/service-details/masshealth-member-forms).

# Part 3. Where you live

Where do you live? (Check one.)  
House or apartment  
Group home  
State facility  
Nursing home  
Rehabilitation hospital  
Homeless  
Other (describe)

# Part 4. What you can do

Are you right handed?  
left handed?

Do your medical or mental health problems make it hard for you to do any of the following things?

SAMPLE  
Dress and bathe  
If yes, check here   
If yes, please explain below. My shoulder pain makes it hard for me to lift my arm over my head. This makes it hard to put on shirts or wash my hair.

SAMPLE  
Do regular housework  
If yes, check here   
If yes, please explain below. When I am depressed, I don’t care if my house is clean.

Sit   
If yes, check here  
If yes, please explain below.

Stand  
If yes, check here  
If yes, please explain below.

Walk  
If yes, check here  
If yes, please explain below.

Bend  
If yes, check here  
If yes, please explain below.

Reach  
If yes, check here  
If yes, please explain below.

Lift  
If yes, check here  
If yes, please explain below.

Remember  
If yes, check here  
If yes, please explain below.

See  
If yes, check here  
If yes, please explain below.

Hear  
If yes, check here  
If yes, please explain below.

Use your hands  
If yes, check here  
If yes, please explain below.

Dress and bathe  
If yes, check here  
If yes, please explain below.

Do regular housework  
If yes, check here  
If yes, please explain below.

Listen to music  
If yes, check here  
If yes, please explain below.

Watch TV  
If yes, check here  
If yes, please explain below.

Use a computer  
If yes, check here  
If yes, please explain below.

Read  
If yes, check here  
If yes, please explain below.

Talk on the phone  
If yes, check here  
If yes, please explain below.

Go outside  
If yes, check here  
If yes, please explain below.

Go for a walk  
If yes, check here  
If yes, please explain below.

Go shopping  
If yes, check here  
If yes, please explain below.

Go to the doctor  
If yes, check here  
If yes, please explain below.

Visit friends and family  
If yes, check here  
If yes, please explain below.

Go to school  
If yes, check here  
If yes, please explain below.

Handle money/use an ATM  
If yes, check here  
If yes, please explain below.

Drive a car  
If yes, check here  
If yes, please explain below.

Take a bus, train, or taxi  
If yes, check here  
If yes, please explain below.

Play sports  
If yes, check here  
If yes, please explain below.

Other (describe)  
If yes, check here  
If yes, please explain below.

# Part 5. Your language

Do you speak English? yes no limited  
Do you understand English? yes no limited  
Do you read English? yes no limited  
Do you write English? yes no limited  
What is your first language?  
Can you read in your first language? yes no limited  
Can you write in your first language? yes no no limited

# Part 6. School

1. Check the highest grade of school you finished.  
0  
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  
Were you in special education? yes no not sure

Did you finish more than 12 years of school? 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 Building trades  
Year   
Finished yes no  
Certified/Licensed yes no

Type of training Electronics  
Year   
Finished yes no  
Certified/Licensed yes no

Type of training Cooking  
Year   
Finished yes no  
Certified/Licensed yes no

Type of training Auto mechanics  
Year   
Finished yes no  
Certified/Licensed yes no

Type of training Computers  
Year   
Finished yes no  
Certified/Licensed yes no

Type of training Hairdressing  
Year   
Finished? yes no  
Certified/Licensed yes no

Type of training Cosmetology  
Year   
Finished yes no  
Certified/Licensed yes no

Type of training Nurse’s aide  
Year   
Finished yes no  
Certified/Licensed yes no

Type of training Secretarial  
Year   
Finished yes no  
Certified/Licensed yes no

Type of training Other (describe)  
Year   
Finished yes no  
Certified/Licensed yes no

# Part 7. Your work

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 15 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. Add a piece of paper if you need more space. You can attach a resume if you have one.

Here is a sample

SAMPLE  
Job title Packer  
Dates worked From (Month/Year): March 2012 To (Month/Year): May 2012  
Job duties (List everything you did.): Put three golf balls into a small box. Packed 24 small boxes into a case. Sealed the case with packing tape. Loaded cases onto a platform.  
How many hours did you work each week? 40  
How much did you make an hour? $9.00/hour  
Reason for leaving: Moved

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?  
Reason for leaving

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?  
Reason for leaving

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?  
Reason for leaving

Check each of the things you do in your job. If you do not work, check each thing you did in your last job.  
Doing paperwork  
Using a computer  
Assembling  
Operating machines  
Filing  
Serving people  
Counting & packing  
Construction   
Using phone  
Driving a car or truck  
Moving things  
Cleaning  
Using office machines  
Using cash register  
Driving a forklift  
Using power tools  
Using hand tools  
Other (please describe):

Circle the number of hours you do each thing in your job. If you do not work, circle the number of hours you did each thing in your last job.

Activity Walk or stand  
Hours in a Day  
0  
1  
2  
3  
4  
5  
6  
7  
8

Activity Sit  
Hours in a Day  
0  
1  
2  
3  
4  
5  
6  
7  
8

Activity Reach  
Hours in a Day  
0  
1  
2  
3  
4  
5  
6  
7  
8

Check the weight you lift or carry most:  
Less than 10 lbs.  
10 lbs.  
20 lbs.  
25 lbs.  
50 lbs.   
100 lbs.  
More than 100 lbs.

Check the heaviest weight you lift:  
Less than 10 lbs.  
10 lbs.  
20 lbs.  
25 lbs.  
50 lbs.   
100 lbs.  
More than 100 lbs.

# Part 8. Your comments

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

# Part 9. 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.

Signature of Applicant/Guardian/Authorized Representative

Date

Authorized Representative

If this form is being filled out by someone with the legal authority to act on behalf of the applicant/member (such as the parent of an adult disabled child or spouse, an authorized representative, or a legal guardian), give us the following information.

Signature of person filling out this form

Print name

Authority of person filling out this form on behalf of the applicant/member

DES may send copies of notices to the authorized representative. This area does not authorize release of medical records.

You may choose an authorized representative to help you with some or all of the responsibilities of applying for or getting health benefits.

You can do this by filling out a MassHealth Authorized Representative Designation Form (ARD). To ask for an ARD form, call the MassHealth Customer Service Center at (800) 841-2900 (TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled).

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 on page 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) if needed?

AUTHORIZATION TO RELEASE   
PROTECTED HEALTH INFORMATION

# This is the only release accepted by MassHealth Disability Evaluation Services

APPLICANT: If you do not fully fill out this Authorization to Release Protected Health Information, the MassHealth Disability Evaluation Services (DES) will not be able to make a disability determination for you. You may lose or have your MassHealth benefits reduced.

# Instructions

This MassHealth Authorization to Release Protected Health Information helps us get sensitive health information from your health care provider so that the MassHealth Disability Evaluation Service (DES) can make a disability determination.

Please read the instructions carefully before you fill out this form. If you leave any sections of this form blank, this permission will not be valid, and the health care provider will not be able to share your information with the MassHealth DES. If the health care provider does not share protected health information with the MassHealth DES, we will not be able to make a disability determination.

General instructions for filling out the MassHealth Authorization to Release Protected Health Information

You must follow these instructions when filling out the MassHealth Authorization to Release Protected Health Information forms. The health care providers will not send protected health information to the MassHealth DES if you do not fill out the forms the right way. We need copies of your protected health information to make a disability determination.

1. Sign and date a separate MassHealth Authorization to Release Protected Health Information form for each doctor, hospital, health center, clinic, or other health care provider you listed in Part 2 of the Disability Supplement.

2. All MassHealth Authorization to Release Protected Health Information forms must be filled out in black or blue ink and must be originals. No copies or stamps of signatures are permitted. Forms filled out and signed in pencil are not permitted.

3. Only one signature may appear on a line.

4. If this form is for a child younger than age 18, one parent or legal guardian must sign for the child.

5. Legal guardians must attach a complete copy of the document that gives them the authority to act on behalf of the applicant/member.

If you need help completing the MassHealth Authorization to Release Protected Health Information, call a DES representative at (800) 888-3420.

# 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 MassHealth Disability Evaluation Services (DES). This form will allow my doctors to share my protected health information with MassHealth (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 by DES. If so, it may not be subject to federal or state law protecting its confidentiality.
* I also understand that certain health information has special protections for sensitive information. This health information includes records about HIV infection, AIDS, genetic testing, and psychological or psychiatric conditions. This 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 / Member 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  
City, State, Zip  
Telephone Number

# SECTION 3: Sensitive Medical Information to be Shared with DES

I authorize the release of my entire medical record. Check YES or NO for EACH of the following options.

⬜ Yes ⬜ No Mental or Psychiatric Health Information

⬜ Yes ⬜ No HIV, AIDS, Sexually Transmitted Disease Information

⬜ Yes ⬜ No Genetic Testing. See MGL c. 111 § 70G

⬜ Yes ⬜ No Substance Use Information

⬜ Yes ⬜ No Other (please specify):

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/Member or Legal Representative  
Date

Relationship to Applicant/Member or authority to act for Applicant/Member   
Date

Please attach a complete copy of the document that gives this person the authority to act on behalf of the applicant/member.

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 DES, PO Box 2796, Worcester, MA 01613. This authorization expires one (1) year from the signature date.

END OF THE DOCUMENT.

MADS-MR-0721