MASSHEALTH
ADULT DISABILITY
SUPPLEMENT

Commonwealth of Massachusetts | EOHHS

MADS-A-LP_2025-05

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.

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

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

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 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: Building trades
Year _____ Did you finish? ☐ yes ☐ no
Are you certified or licensed? ☐ yes ☐ no

Type of training: Building trades
Year _____ Did you finish? ☐ yes ☐ no
Are you certified or licensed? ☐ yes ☐ no

Type of training: Building trades
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.

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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. ☐ 100 lbs. ☐ More than 100 lbs.

Check the heaviest weight you lifted (check one):
☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 25 lbs.
☐ 50 lbs. ☐ 100 lbs. ☐ More than 100 lbs.

How many hours did you do each of the following each day?
Walk ____ Stand ____ Reach ____ Sit ____ Bend ____
Handle big objects ____ Handle small objects ____

Reason for leaving

_____

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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. ☐ 100 lbs. ☐ More than 100 lbs.

Check the heaviest weight you lifted (check one):
☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 25 lbs.
☐ 50 lbs. ☐ 100 lbs. ☐ More than 100 lbs.

How many hours did you do each of the following each day?
Walk ____ Stand ____ Reach ____ Sit ____ Bend ____
Handle big objects ____ Handle small objects ____

Reason for leaving

_____

---

3. 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. ☐ 100 lbs. ☐ More than 100 lbs.

Check the heaviest weight you lifted (check one):

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

☐ 50 lbs. ☐ 100 lbs. ☐ More than 100 lbs.

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

Walk ____ Stand ____ Reach ____ Sit ____ Bend ____

Handle big objects ____ Handle small 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? _____

Check the weight you lifted or carried most often (check one):
☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 25 lbs.
☐ 50 lbs. ☐ 100 lbs. ☐ More than 100 lbs.

Check the heaviest weight you lifted (check one):
☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 25 lbs.
☐ 50 lbs. ☐ 100 lbs. ☐ More than 100 lbs.

How many hours did you do each of the following each day?
Walk ____ Stand ____ Reach ____ Sit ____ Bend ____
Handle big objects ____ Handle small 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?