# 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.**

## 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

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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   
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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

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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   
Stand  
Reach   
Sit  
Bend  
Handle big objects  
Handle small 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.

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   
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Reach   
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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. 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   
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. 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   
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?

# 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, 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 health information from your health care provider so that DES can make a disability decision.

**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.

If you need help completing the 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 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

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

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.