MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

ASSISTANCE WITH MEDICARE COSTS

MEDICARE SAVINGS (ALSO KNOWN AS BUY-IN) PROGRAMS

Please note that this application is for Medicare Savings (Buy-In) Programs only and will not be used to determine eligibility for other MassHealth programs.

This packet contains a separate form to apply for the Supplemental Nutrition Assistance Program (SNAP). If you would like to apply for SNAP, please complete the form that comes with this application. You do not have to complete the SNAP form to get help with Medicare costs.

What are the Medicare Savings (Buy-In) programs?

The MassHealth Medicare Savings (Buy-In) programs help pay some of the out-of-pocket costs of Medicare. The Buy-In programs can also help get Medicare Part B for people who only have Medicare Part A. If you are in a Buy-In program, you will also be automatically enrolled in the Medicare Part D Extra Help program, which can help with pharmacy costs.

How much can I have in income and assets?

For INDIVIDUALS IF your countable assets are less than or equal to $15,940	
AND your monthly income before taxes and deductibles is less than or equal to…	THEN you will be eligible for…
$1,396	Senior Buy-In
$1,771	Buy-In
For a MARRIED COUPLE who live together IF your countable assets are less than or equal to $23,920	
AND your monthly income before taxes and deductibles is less than or equal to…	THEN you will be eligible for…
$1,888	Senior Buy-In
$2,396	Buy-In

MassHealth allows certain deductions from earned and unearned gross income. These deductions are described in 130 CMR 520.012 through 520.014.

Some examples of countable assets are bank accounts, securities, investments, a second car, and cash. Countable and noncountable assets are described at 130 CMR 520.007 through 520.008.

The income limit amounts are effective March 1, 2021.
The asset limit amounts are effective January 1, 2021.

For the most updated information about income and asset limits, go to www.mass.gov/service-details/program-financial-guidelines-for-certain-masshealth-applicants-and-members..

Medicare Savings (Buy-In) Program Benefits

MassHealth Senior Buy-In

MassHealth Senior Buy-In may pay for Part B Medicare premiums (and for Part A premiums for those who have one) and for the deductibles and coinsurance under Part A and Part B.

MassHealth Buy-In

MassHealth Buy-In may pay for the Medicare Part B premium.

If I am eligible for one of the Medicare Savings (Buy-In) programs, how do I get paid?

If MassHealth finds that you are eligible for payment of your Medicare Part B premium, we will tell Medicare.

If your Medicare Part B premium is deducted from your social security benefit, your monthly benefit will be adjusted so that your Medicare premium is no longer deducted. This means that the amount of your social security benefit will increase by the amount that had been deducted to pay for your Medicare Part B premium.

If you are eligible for, but not yet getting Medicare Part B, or if you are paying your Medicare Part B premium in some other way, such as getting a quarterly bill from Medicare, MassHealth will start paying this bill for you.

It will take several months to adjust your social security benefit or to pay your bill. However, you will get a refund for the amount you paid for your Medicare Part B premium back to the month you became eligible for MassHealth Buy-In or Senior Buy-In. You will get this refund in the same way as you now get your social security benefits.

When does coverage begin?

If you are eligible for **MassHealth Senior Buy-In**, your coverage begins in the month after we process your application. If you are eligible for **Buy-In**, in most cases the coverage begins as early as three months before your application month.

You will get a written notice that tells you about your coverage and when it starts. If you are not eligible, the notice will give you the reason(s) you are not eligible. If you think the decision is wrong, you have the right to appeal it. Information about how to appeal is on the back of the written notice.

How we use your social security number

Unless one of the exceptions listed below applies, you must give us a social security number (SSN) or proof that one has been applied for, for every household member who is applying.

Exceptions

You don’t have to give us an SSN or proof that one has been applied for if you or any member of your household

- has a religious exemption as described in federal law.
- is eligible only for a nonwork SSN.
- is not eligible for an SSN.

We use SSNs to check information you have given us. We also use them to detect fraud, to see if anyone is getting duplicate benefits, or to see if others (a “third party”) should be paying for services.

We may match the SSN of anyone in your household who is applying and anyone who has or who can get health insurance for any such persons with the files of agencies, including the following:

- Internal Revenue Service
- Social Security Administration
- Systematic Alien Verification for Entitlements
- Centers for Medicare & Medicaid Services
- Registry of Motor Vehicles
- Department of Revenue
- Department of Transitional Assistance
- Department of Industrial Accidents
- Division of Unemployment Assistance
- Department of Veterans' Services, Human Resource Division
- Bureau of Special Investigations
- Bureau of Vital Statistics (Department of Public Health)
- Banks
- Other financial institutions

Files may also be matched with social service agencies in this state and other states, and computer files of insurance companies, employers, and managed care organizations. Additionally, MassHealth may obtain your financial records (and, if applicable, those of your household members) from banks and other financial institutions in order to verify your financial resources and otherwise determine your eligibility while you are a MassHealth member.

How do I apply for the Medicare Savings (Buy-In) programs?

1. To apply for the MassHealth Buy-In programs, fill out the attached application. Include information about your spouse too, if he or she lives with you.
2. Sign the filled-out application, and

   send it to: **MassHealth Enrollment Center**
   P.O. Box 290794
   Charlestown, MA 02129-0214

   or fax it to: **(857) 323-8300**

3. When we get the application, we will review it for completeness. If we need more information, we will write to you or call. Once we get all information, we will decide if you are eligible. We will also decide if your spouse is eligible.
4. A voter registration form is included with your application. (You do not need to register to vote to get a MassHealth Buy-In program.)
5. If you want someone to act on your behalf as your authorized representative, use the enclosed Authorized Representative Designation Form to tell us.

Please note that this application is for the MassHealth Buy-In programs only. If you would like to apply for all MassHealth programs (including the Buy-In programs) through a single application, contact MassHealth at the number above to request a full application.

Privacy and Confidentiality

MassHealth is committed to keeping your personal information confidential. All personal information we have about any applicant or member, including medical data, health status, and the personal information you give us during your application for and receipt of benefits, is confidential. This information may not be used or released for purposes not related to the administration of MassHealth without your permission unless required by law or a court order.

You can give us your written permission to use your personal health information for a specific purpose or to share it with a specific person or organization. You can also give us your permission to share your personal information with your authorized representative, Certified Application Counselor (CAC), or Navigator, if you have one, by filling out an Authorized Representative Designation Form, a Certified Application Counselor Designation Form, or a Navigator Designation Form.

Permission to Share Information

If you want us to share your personal health information, including sending copies of your eligibility notices, with someone who is not your authorized representative, you can do this by giving us written permission.

To learn more about how MassHealth may use your information, what your rights are, and how you can give us

permission to share your information, see the Permission to Share Information and the MassHealth Notice of Privacy Practices forms in the Important Forms section, below.

Authorized Representative

An authorized representative is someone you choose to help you get health care coverage through programs offered by MassHealth. You can do this by filling out the Authorized Representative Designation Form (ARD). An authorized representative may fill out your application or eligibility review forms, give proof of information given on these eligibility forms, report changes in your income, address, or other circumstances, get copies of all MassHealth eligibility notices sent to you, and act on your behalf in all other matters with MassHealth.

An authorized representative can be a friend, family member, or other person or organization you choose to help you. It is up to you to choose an authorized representative, if you want one. MassHealth will not choose an authorized representative for you.

You must designate in writing on the Authorized Representative Designation Form the person or organization you want to be your authorized representative. This form is included in the application packet. In most cases, your authorized representative must also fill out this form. Please see the instructions on the form for more details.

An authorized representative can also be someone who is acting responsibly on your behalf if you cannot designate an authorized representative in writing because of a mental or physical condition, or has been appointed by law to act on your behalf or on behalf of your estate. This person must fill out the applicable parts of the Authorized Representative Designation Form. If this person has been appointed by law to represent you, either you or this person must also submit to MassHealth a copy of the applicable legal document stating that this person is lawfully representing you or your estate. This person may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or if the applicant or member has died, the estate's administrator or executor.

Important Forms

The following forms can be found on our website at www.mass.gov/lists/hipaa-forms-for-masshealth-members

- MassHealth – Notice of Privacy Practices
- Permission to Share Information
- Authorized Representative Designation (ARD)

You can also call us at (800) 841-2900; TTY: (800) 497-4648 to ask for any of these forms.

Reporting Changes

If there are any changes in your living situation, including but not limited to income, assets, address, health insurance, immigration status, or disability status, you must tell us within 10 calendar days of the changes or as soon as possible. If you do not tell us about these changes, you may lose your benefits. You can tell us about any changes by calling (800) 841-2900, TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled.

Other benefits

MassHealth offers other health care benefits that pay for medical services directly, and may also pay your Medicare copayments and deductibles. You may be eligible for these benefits if your income and assets are under certain amounts, or if you are disabled and younger than 65. Call us at (800) 841-2900, TTY: (800) 497-4648 to learn about these benefits. You should also call this number if you have any questions about the MassHealth Buy-In programs.

Most **Medicare** members on MassHealth or the Buy-In programs can get help with prescription drug costs through Medicare. To get more information, call Medicare at (800) 633-4227, TTY: (877) 486-2048, or visit www.medicare.gov.

Prescription Advantage offers help with prescription drug costs. To learn more about these benefits, call the Executive Office of Elder Affairs toll free at (800) 243-4636, TTY: (877) 610-0241.

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MEDICARE SAVINGS (BUY-IN) PROGRAMS APPLICATION

FOR PEOPLE WHO ARE ELIGIBLE FOR MEDICARE

Who can use this application?

Individuals of any age who are receiving Medicare and are only seeking help with payment of their Medicare premiums and cost sharing.

If you want to apply for other MassHealth benefits, (as well as assistance with Medicare costs), call MassHealth Customer Service at (800) 841-2900, TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled for a different application.

Please print clearly and fill out all sections.

General Information

Who is applying? ☐ you ☐ you and your spouse

If you and your spouse live together, you must also give us information about your spouse even if he or she is not applying for benefits.

You

Last name ______________________________

First name ______________________________ MI _____

Street address ______________________________

City ____________________ State _____ Zip __________

Mailing address (if different from above) ☐ homeless

____

City ____________________ State _____ Zip __________

Date of birth ___ /___ /_____ Gender ☐ M ☐ F

Telephone number (____) ____________________

Preferred spoken language ______________________________

Preferred written language ______________________________

Social security number ______________________________

Medicare claim number ______________________________

Your Spouse

Last name ______________________________

First name ______________________________ MI _____

Date of birth ___ /___ /_____ Gender ☐ M ☐ F

Telephone number (____) ____________________

Preferred spoken language ____________________
Preferred written language ____________________
Social security number ____________________
Medicare claim number ____________________

Income

Fill out this section for you and your spouse. List the gross monthly income (before taxes and other deductions, such as the Medicare Part B premium).

Your and your spouse's gross monthly income before taxes and deductions

Your gross monthly income from **social security** before taxes and deductions $ __________

Your spouse's gross monthly income from **social security** before taxes and deductions $ __________

Your gross monthly income from **pensions** before taxes and deductions $ __________

Your spouse's gross monthly income from **pensions** before taxes and deductions $ __________

Your gross monthly income from **Federal veterans' benefits** before taxes and deductions $ __________

Your spouse's gross monthly income from **Federal veterans' benefits** before taxes and deductions $ __________

Your gross monthly income from **annuities or trusts** before taxes and deductions $ ___________

Your spouse's gross monthly income from **annuities or trusts** before taxes and deductions $ ___________

Your gross monthly income from **dividends and/or interest** before taxes and deductions $ ___________

Your spouse's gross monthly income from **dividends and/or interest** before taxes and deductions $ ___________

Your gross monthly **income from a job** (before deductions) $ ___________

Your spouse's gross monthly **income from a job** (before deductions) $ ___________

Your gross monthly **rental income** (after expenses) before taxes and deductions $ ___________

Your spouse's gross monthly **rental income** (after expenses) before taxes and deductions $ ___________

Your other (please specify)

____

gross monthly income before taxes and deductions $ ___________

Your spouse's other (please specify)

____

gross monthly income before taxes and deductions $ ___________

Assets

Savings accounts

Your savings accounts	$ ___________
Your spouse's savings accounts	$ ___________
Your and your spouse's savings accounts	$ ___________

Checking accounts

Your checking accounts	$ ___________
Your spouse's checking accounts	$ ___________
Your and your spouse's checking accounts	$ ___________

Second car (first car is noncountable)

Your second car	$ ___________
Your spouse's second car	$ ___________
Your and your spouse's second car	$ ___________

Certificates of deposits

Your certificates of deposits	$ ___________
Your spouse's certificates of deposits	$ ___________
Your and your spouse's certificates of deposits	$ ___________

Stocks

Your stocks	$ ___________
Your spouse's stocks	$ ___________
Your and your spouse's stocks	$ ___________

Bonds

Your bonds $ ____________

Your spouse's bonds $ ____________

Your and your spouse's bonds $ ____________

Your mutual funds

Your mutual funds $ ____________

Your spouse's mutual funds $ ____________

Your and your spouse's mutual funds $ ____________

Other (please specify) ____________________________________

Your other assets $ ____________

Your spouse's other assets $ ____________

Your and your spouse's other assets $ ____________

Total assets listed in this section

Your total assets $ ____________

Your spouse's total assets $ ____________

Your and your spouse's total assets $ ____________

Signature

Please read the following carefully. Then sign and date the bottom of this page. Both you and your spouse must sign if your spouse lives with you. By signing, you agree to and understand the following.

You give permission to MassHealth to get any records or data to prove any information given on this application. You understand that you must tell MassHealth of any changes in information you gave on this application. You further certify under the penalty of perjury that the information on this application is correct and complete to the best of your knowledge.

If you are acting on behalf of someone in filling out this application, the enclosed Authorized Representative Designation Form must also be filled out and sent back with this application. Your signature on this application as an authorized representative certifies that the information on this application is correct and complete to the best of your knowledge.

If you think MassHealth's decision about whether you are eligible is wrong, you have the right to appeal. If you are denied benefits, you will get information on how to appeal.

MassHealth will obtain from your current and former health insurers all information about health insurance coverage for you and your spouse. 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 you and your spouse.

MassHealth may get records or data about you and your spouse 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 you or your spouse becomes a member, 2) to document medical services claimed or provided to you or your spouse , and 3) to support continued eligibility

____

Signature of applicant or authorized representative

Print name ___________________________________

Date ___ /___ /_____

____

Signature of applicant's spouse or authorized representative

Print name ___________________________________

Date ___ /___ /_____

Voter registration information is enclosed in this packet.

Once you have filled out and signed this form, **send** it to

MassHealth Enrollment Center
P.O. Box 290794
Charlestown, MA 02129-0214

OR **fax** it to: (857) 323-8300

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 he or she 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.

Please note: Your social security number (SSN) is required if one has been issued.

Applicant's/Member's Name

____

SSN (if you have one) ___ ___ ___ - ___ ___ -___ ___ ___ ___

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

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

______________________________ ___/___/_____

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

________________________________   ___/___/_____

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 ___/___/_____

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 he or she may remove or replace me as his or her 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).

Please note that the applicant's or member's social security number (SSN) is required if one has been issued.

Applicant's/Member's name

____

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

___/___/_____

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.

Please note that the applicant's or member's social security number (SSN) is required if one has been issued.

Applicant's/Member's name

____

Applicant's/Member's date of birth (mm/dd/yyyy)
___/___/_____

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
P.O. Box 4405
Taunton, MA 02780;
- Faxing your form to **(857) 323-8300**; or
- Calling us at **(800) 841-2900**, TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS

Do you want to share your information with the Department of Transitional Assistance (DTA) to start an application for SNAP benefits?

- If YES, please complete and sign the SNAP application. By signing this application, you agree that you have read and agree to the SNAP rights, responsibilities and penalties.
- If NO, stop here. Do not complete the rest of this application for SNAP benefits.

IMPORTANT:

DTA will act on this SNAP application on the date that DTA receives it. If eligible, your SNAP benefits will go back to the date of this application.

If you are currently living in a nursing home or other long term care facility, you are not eligible for SNAP benefits.

You may be eligible for emergency SNAP benefits within 7 days of DTA getting this application if:

- your income and money in the bank add up to less than your monthly housing costs, 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.

Contact DTA immediately if you need emergency SNAP benefits. For more information, go to mass.gov/SNAP.

1. First name, middle name, and last name

   ____

2. Date of birth ___/___/_____

3. Gender _________

4. Social Security Number (SSN) ______________________
   Noncitizens not applying for SNAP do not need to give SSN.

5. Address: street, city, state, ZIP code, apartment or unit number ____

6. ☐ Check this box if homeless. You must provide a mailing address.

7. Mailing address: ☐ Check if same as street address.

   ____

8. Phone number, __________________________________

9. Email address ____________________________________

10. Race/Ethnicity
    This information is collected to make sure everyone is treated fairly. Your answer is voluntary, and it will not affect your eligibility or benefit amount.

Ethnicity: Hispan ic or Latino ☐ Yes ☐ No

Race: (check all applicable)

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

Signature _______________________________

Print name _______________________ Date ___/___/_____

NOTICE OF RIGHTS, RESPONSIBILITIES AND PENALTIES (PLEASE READ CAREFULLY)

I certify that I have read, or have had read to me, the information in this application. My answers to the questions in this application are true and complete to the best of my knowledge. I also certify that information I provide to the Department during the application interview and in the future will also be true and complete to the best of my knowledge. I understand that giving false or misleading information is fraud. I also understand that misrepresenting or withholding facts to establish SNAP eligibility is fraud. This results in an Intentional Program Violation (IPV) and is punishable by civil and criminal penalties.

I understand that the Department of Transitional Assistance (DTA) administers SNAP. Further, I understand that DTA has 30 days from the date of application to process my application. Further, I understand that:

- The Food and Nutrition Act of 2008 (7 U.S.C. 2011-2036) allows DTA to use my Social Security Number (SSN) and the SSN of each household member I apply for. DTA uses this information to determine my household's eligibility for SNAP. DTA verifies this information through computer matching programs. I understand that DTA uses it to monitor compliance with program regulations.
- Most of the time, households under the SNAP Simplified Reporting rules have to tell DTA changes at Interim Report (IR) and recertification with the exception of:
    - If my household's income exceeds the gross income threshold
    - If I am under the able-bodied adult without dependents (ABAWD) work requirements and my work hours drop below 20 hours weekly
    - If my household only contains elderly and/or disabled adults, and a household member starts receiving earned income or the household composition changes
- If I am under SNAP Simplified Reporting rules and there is a change that I am required to report under these rules, I must report the change no later than the 10th

day following the end of the calendar month in which the change occurred.

- If DTA receives verified information about my household, my benefit amount may change.
- If I am not under the SNAP Simplified Reporting rules or Transitional Benefits Alternative (TBA) rules, I must report to DTA changes to my household that may affect our eligibility. I understand that I must report these changes to DTA in person, in writing, or by phone within 10 days of the change. For example, you must report changes in your household's income, size, or address.
- I have a right to speak to a supervisor if DTA finds me ineligible for emergency SNAP benefits and I disagree. I may speak to a supervisor if I am eligible for emergency SNAP benefits but do not get my benefits by the seventh calendar day after I applied for SNAP. I may speak to a supervisor if I am eligible for emergency SNAP benefits but do not get my Electronic Benefit Transfer (EBT) card by the seventh calendar day after I applied for SNAP.
- I may receive more SNAP benefits if I report and give verification to DTA of:
    - child or other dependent care costs, shelter costs, and/or utility costs
    - legally-obligated child support to a nonhousehold member
- If I am 60 years or older or if I am disabled and I pay for medical costs, I can report and give verification of these

costs to DTA. This may make me eligible for a deduction and increase my SNAP benefits.

- Unless they meet an exemption, all SNAP recipients between the ages of 16 and 59 are work registered and subject to General SNAP Work Requirements. SNAP recipients between the ages of 18 and 49 may also be subject to the ABAWD Work Program requirements. DTA will inform nonexempt household members of the work requirements. DTA will inform nonexempt household members of exceptions and penalties for noncompliance.
- Most SNAP recipients may voluntarily participate in education and employment training services through the SNAP Path to Work program. DTA will give referrals to the SNAP Path to Work program if appropriate.
- DTA may also share the names and contact information of SNAP recipients with SNAP Path to Work providers for recruitment purposes. I understand that members of my household may be contacted by DTA SNAP Path to Work specialists or contracted providers to explore SNAP Path to Work participation options. For more information about the SNAP Path to Work program, visit www.snappathtowork.org.

I understand that the information I give with my application will be subject to verification to determine if it is true. If any information is false, DTA may deny my SNAP benefits. I may also be subject to criminal prosecution for providing false information.

I understand that by signing this application I give DTA permission to verify and investigate the information I give that relates to my eligibility for SNAP benefits, including permission to:

- Get documents to prove information on this application with other state agencies, federal agencies, local housing authorities, out-of-state welfare departments, financial institutions and from Equifax Workforce Solutions. I also give permission to these agencies to give DTA information about my household that concerns my SNAP benefits.
- Contact third parties to verify information related to eligibility on my behalf. This includes, but is not limited to, employers, landlords, and utility companies.
- If applicable, verify my immigration status through the United States Citizenship and Immigration Services (USCIS). I understand that DTA may check information from my SNAP application with USCIS. Any information received from USCIS may affect my household's eligibility and amount of SNAP benefits.
- Share information about me and my dependents under age 19 with the Department of Elementary and Secondary Education (DESE). DESE will certify my dependents for school breakfast and lunch programs.
- Share information about me, my dependents under age 5 and anyone pregnant in my household with the Department of Public Health (DPH). DPH refers these individuals to the Women, Infants and Children (WIC) Program for nutrition services.

- Share information, along with the Massachusetts Executive Office of Health and Human Services, about my eligibility for SNAP with electric companies, gas companies, and eligible phone and cable carriers to certify my eligibility for discount utility rates.
- Share my information with the Department of Housing and Community Development (DHCD) for the purpose of enrolling me in the Heat & Eat Program.
- Share information about me and my dependents with the Department of Revenue (DOR) for the purpose of verifying my eligibility for income-based tax credits as determined by DOR, including Earned Income and Limited Income and determining if I am eligible for “No Tax Status” or hardship status.

DTA may deny, stop, or lower my benefits based on information from Equifax Workforce Solutions. I have the right to a free copy of my report from Equifax if I request it within 60 days of DTA’s decision. I have the right to question the accuracy or completeness of the information in my report. I may contact Equifax at: Equifax Workforce Solutions, 11432 Lackland Road, St. Louis, MO 63146, 1-800-996-7566 (toll free).

I understand that I will get a copy of the “Your Right to Know” brochure and the SNAP Program brochure. I will read or have read to me the brochures and I must understand their contents and my rights and responsibilities. If I have any questions about the brochures

or any of this information, I will contact DTA. If I have trouble reading or understanding any of this information, I will contact DTA. DTA can be reached at: (877) 382-2363.

I understand that DTA must offer to give me a copy of the completed application that includes the information that DTA has used or will use to determine my household's eligibility and benefit allotment. Further, I understand that I have the option of requesting a copy of the completed application in an electronic format.

I swear that all members of my SNAP household requesting SNAP benefits are either U.S. citizens or lawfully residing noncitizens.

SNAP Penalty Warning

I understand that if I or any member of my SNAP household intentionally breaks any of the rules listed below, 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. S/he may also be subject to prosecution under other applicable Federal and State laws. These rules are:

- 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 to get.

- 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.

I also understand the following penalties:

- Individuals who commit a cash program Intentional Program Violation (IPV) will be ineligible for SNAP for the same period the individual is ineligible from cash assistance.
- Individuals who make a fraudulent statement about their identity or residency to get multiple SNAP benefits at the same time will be ineligible for SNAP for ten years.
- Individuals who trade (buy or sell) SNAP benefits for a controlled substance/illegal drug(s), will be ineligible for SNAP for two years for the first finding, and forever for the second finding.
- Individuals who trade (buy or sell) SNAP benefits for firearms, ammunition, or explosives will be ineligible for SNAP forever.
- The State may pursue an IPV against an individual who makes an offer to sell SNAP benefits or an EBT card online or in person.
- Individuals who are fleeing to avoid prosecution, custody, or confinement after conviction for a felony, or are violating probation or parole, are ineligible for SNAP.
- Individuals who became a convicted felon after February

7, 2014 are ineligible for SNAP benefits if they do not comply with the terms of the sentence 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 clause (1), (2), or (3).

- Paying for food purchased on credit is not allowed and can result in disqualification from SNAP.
- Individuals may not buy products with SNAP benefits with the intent to discard the contents and return containers for cash.

Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed,

disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), 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. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Right to an Interpreter

I understand that I have a right to an interpreter provided by DTA if no adult in my SNAP household is able to speak or understand English. I also understand that I can get an interpreter for any DTA fair hearing or bring one of my own. If I need 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 I have the right to register to vote at DTA. I understand that DTA will help me fill out the voter registration application form if I want help. I am allowed to fill out the voter registration application form in private. I understand that applying to register or declining to register to vote will not affect the amount of benefits I get from DTA.