# MassHealth Child 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 your child has a disability. Disability standards require that the disability has lasted, or is expected to last, at least 12 months. To ensure your child’s MassHealth eligibility, Disability Evaluation Services (DES) will review your child’s Disability Supplement. It is very important that you complete this Disability Supplement in full.

For your child to get MassHealth based on their disability, you need to tell us about

* your child’s medical and mental health providers. Medical and mental health providers may include doctors, psychologists, therapists, social workers, physical therapists, chiropractors, hospitals, health centers, and clinics from whom your child has gotten or is getting treatment; and
* your child’s daily activities and their educational background.

**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 child’s medical and treatment records. If you have any of the following, please send a copy with this form: your child’s medical records, Individualized Family Services Plan (IFSP), Early Intervention (EI) records, Individualized Educational Plan (IEP), 504 Plan, testing, or other records that describe your child’s conditions. 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 child’s eligibility.

This is not an application for medical benefits. If you have not already completed an application for your child, 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, TDD/TTY: 711.

**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 child’s disability.**

### Information about your child

Sex assigned at birth
Male
Female

Which best describes your child’s current gender identity?
Male
Female
Transgender male/trans male
Transgender female/trans female
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
Child’s Date of birth (mm/dd/yyyy)

Street address Apt. #
City State Zip code

Home phone
Cell phone

Does your child have a pending application with Social Security? yes no

Does your child get Social Security? yes no

Does your child get MassHealth? yes no

### Information about your child’s family/guardians

Primary parent/guardian: Last name, First name, Middle initial
Daytime phone

Primary parent/guardian’s email address

Street address
Apt. #
City State Zip code

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

Does your family currently get MassHealth? yes no

If yes, under which program?
MassHealth
Supplemental Security Income (SSI)
Transitional Aid to Families with Dependent Child (TAFDC)
Other (please specify)

Does the child live with both parents/guardians? yes no

If no, which parent/guardian does not live with the child?
Name:

## PART 1 Your child’s health issues and medical providers

Please describe your child’s disabling condition and when it first became a problem.

Is your child’s developmental (functional) level age-appropriate? yes no

If no, what is the developmental age?

Is your child’s disability the result of an accident? yes no

If yes, please briefly explain.

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

If yes, please include the child’s primary care doctor and every medical and mental health provider that treated your child for their problems since they 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 your child got treatment. You can write on a separate piece of paper if you run out of space. If your child is getting treatment from only one facility, list only that facility.

Name of medical or mental health provider
Phone number
Date of most recent visit

Name of medical or mental health provider
Phone number
Date of most recent visit

Name of medical or mental health provider
Phone number
Date of most recent visit

Name of medical or mental health provider
Phone number
Date of most recent visit

Name of medical or mental health provider
Phone number
Date of most recent visit

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 (800) 841-2900, TDD/TTY: 711 or download the form at mass.gov/lists/masshealth-member-forms.

## PART 2 Your child’s education and other service providers

Is your child currently enrolled in a Department of Public Health Early Intervention Program? yes no

If yes, name of program.

Please submit a copy of these records with this supplement.

Does your child attend school? yes no

If yes, name of school

Is there an Individualized Education Plan (IEP) or 504 Plan for your child? yes no

If yes, we need a copy of the most recent IEP or 504 Plan included with this supplement.

If you need MassHealth to request a copy, complete a MassHealth Authorization to Release Protected Health Information Form.

Please identify the agencies currently providing services for your child. Please provide the contact person and the agency address.

Massachusetts Commission for the Blind
Contact person name & telephone number
Address

Community Case Management
Contact person name & telephone number
Address

Other
Contact person name & telephone number
Address

## PART 3 Your child’s activities of daily living

Please indicate your child’s functional level by putting a checkmark in one of the columns for each activity

Walk
Independent
With assistance
Is not able

Crawl
Independent
With assistance
Is not able

Sit up
Independent
With assistance
Is not able

Turn
Independent
With assistance
Is not able

Bathing
Independent
With assistance
Is not able

Dressing
Independent
With assistance
Is not able

Sight
Good
Fair
Poor
None

Hearing
Good
Fair
Poor
None

Speech
Good
Fair
Poor
None

Bladder control yes no
Other (such as catheter, colostomy)

Bowel control yes no
Other (such as catheter, colostomy)

Please indicate how your child is fed.

Oral
Gastrostomy tube or jejunostomy tube (check one)
Nasogastric tube
Parenteral (intravenous) nutrition

## PART 4 Your child’s medical condition

Respiratory

Does your child require any of the following aids? yes no

Ventilator: Number of hours per day

CPAP/BIPAP: Number of hours per day

Oxygen: Number of hours per day: Liter flow

Humidification: Number of hours per day Liter flow

Chest physical therapy: Times per day

Home nursing care

Does your child get skilled nursing care at home? yes no

If yes, how many hours per week?

Please describe care

Skilled therapy

Does your child get skilled therapy? yes no

If yes, please indicate the type, location, and agency providing services.

Speech: Number of visits per week at school
Number of visits per week outside of school
Provider agency

Physical: Number of visits per week at school
Number of visits per week outside of school
Provider agency

Respiratory: Number of visits per week at school
Number of visits per week outside of school
Provider agency

Occupational: Number of visits per week at school
Number of visits per week outside of school
Provider agency

Other: Number of visits per week at school
Number of visits per week outside of school
Provider agency

Medications

Please provide the following information for all medications your child takes on a regular basis.

Medication Dosage Frequency

Medication Dosage Frequency

Medication Dosage Frequency

Medication Dosage Frequency

Medication Dosage Frequency

Equipment and supplies

Please indicate whether your child needs any of the following items.

Apnea monitor

Braces

Cardiac monitor

Dialysis

Feeding bags/tubing

Feeding pump/pole

Formula

Gastrostomy tubes

Hospital bed

I.V. pump

I.V. tubing

Intravenous fluids

Nasogastric tubes

Nebulizer

Oxygen compressor

Oxygen tanks

Prone stander

Splints

Suction machine

Tracheostomy tubes

Ventilator

Walker

Wheelchair

Other (please list)

## PART 5 Other information

Please include any other information about your child’s care that would be helpful to know in considering your request for MassHealth for your child.

## PART 6 Signature and rights

#### THIS SECTION MUST BE COMPLETED.

Your child has the right to privacy. The information on this form is confidential. All possible precautions will be taken to ensure your child’s privacy rights.

#### Parent/Guardian Section

I understand the information contained in this supplement will be reviewed by MassHealth staff and its agents for the purpose of determining my child’s eligibility for medical benefits.

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 Parent/Guardian
Print name
Date

#### Authorized Representative Information Section

**Important:** If this form is being filled out by someone other than the parent or guardian who has the legal authority to act on behalf of the child, that individual must sign below and attach the corresponding, completed legal paperwork (for example, an Authorized Representative Designation Form (ARD) or guardianship 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 Authorized Representative
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 eligibility 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.

#### REMINDER

Did you remember to

* Complete an Authorization to Release Protected Health Information form for

- each medical provider listed in part 1?

- each mental health provider listed in part 1?

- your child’s Individualized Education Plan (IEP, IFSP, or EI)?

* Sign all Authorization to Release Protected Health Information forms?
* Sign this Disability Supplement above?
* Include a completed and signed Authorized Representative Designation form (ARD) or documents providing guardianship, 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.