Commonwealth of Massachusetts  
Executive Office of Health and Human Services

MassHealth Child Disability Supplement

MassHealth  
Health Connector

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

For your child to get MassHealth based on his or her 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 his or her educational background.

Completing the Disability Supplement will give us this information and will help us make a quick decision.

Please read the following instructions before beginning.

* Print or write clearly and complete the supplement to the best of your ability.
* Sign and date an Authorization to Release Protected Health Information Form for each medical and mental health provider you list on the supplement.
* After you have filled out the supplement, submit it to  
  Disability Evaluation Services / UMASS Medical DES, P.O. Box 2796, Worcester, MA 01613-2796

DES will ask for your child’s medical and treatment records from the providers you have listed. If you have any of the following, please send a copy with this form: your child’s medical records, Individualized Family Services Plan (IFSP), Individualized Educational Plan (IEP), 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. Your child’s eligibility will be decided more quickly if all items on the supplement are filled in.

This is not an application for medical benefits. If you have not already completed 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 (800) 841-2900 (TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled).

Your child’s eligibility will be decided more quickly if all items on the supplement are filled in.

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

# Information about your child

Male  
Female

Last name  
First name  
MI  
Social security number

Street address  
Apt. #  
City/town  
Zip code

Date of birth (mm/dd/yyyy)

Home phone   
Cell phone   
Work/other 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 family

Mother: Last name First name MI Daytime phone

Father: Last name First name MI Daytime phone

Street address (include apartment or suite number)  
City/town  
State  
Zip code

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? yes no

If no, which parent does not live with the child mother father   
What is his or her address?

# 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 any of his or her problems since the problems started. A medical or mental health provider may include a doctor, psychologist, therapist, social worker, physical therapist, chiropractor, hospital, health center, and clinic from which 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 and mental health providers  
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 theAuthorization to Release Protected Health Information Form, call a MassHealth Customer Service (800) 841-2900 (TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled) or download the form at www.mass.gov/service-details/masshealth-member-forms.

Does your child have a scheduled hospital visit within the next 12 months? yes no  
If yes, please complete the following.

Where  
When  
Why

Where  
When  
Why

Where  
When  
Why

# 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

Does your child attend school? yes no  
If yes, name of school

If no, does your child get home services through the school system? yes no  
If yes, please explain.

Is there an Individualized Education Plan (IEP) for your child? yes no  
If yes, we need a copy of the most recent IEP   
included with this supplement   
I will send a copy.   
I will complete a MassHealth Authorization to Release Protected Health Information Form so that MassHealth can request a copy.

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

Name of agency Department of Child and Family Services  
Contact person & telephone number  
Name  
Phone   
Address

Name of agency Department of Developmental Services  
Contact person & telephone number  
Name  
Phone   
Address

Name of agency Department of Education  
Contact person & telephone number  
Name  
Phone   
Address

Name of agency Department of Mental Health  
Contact person & telephone number  
Name  
Phone number  
Address

Name of agency Department of Public Health  
Contact person & telephone number  
Name  
Phone number  
Address

Name of agency Massachusetts Commission for the Blind  
Contact person & telephone number  
Name   
Phone number  
Address

Name of agency Community Case Management  
Contact person & telephone number  
Name  
Phone number  
Address

Name of agency Other  
Contact person & telephone number  
Name  
Phone number  
Address

# Part 3. Your child’s activities of daily living

Movement and general hygiene: Please indicate your child’s function level by putting a checkmark in one of the columns for each activity.

Activity Walk  
Independent  
With assistance  
Is not able

Activity Crawl  
Independent  
With assistance  
Is not able

Activity Sit up   
Independent  
With assistance  
Is not able

Activity Turn  
Independent  
With assistance  
Is not able

Activity Bathing  
Independent  
With assistance  
Is not able

Activity Dressing  
Independent  
With assistance  
Is not able

Sight, hearing, and speech: Please indicate your child’s function level.

Activity Sight  
Good  
Fair  
Poor  
None

Activity Hearing  
Good  
Fair  
Poor  
None

Activity Speech  
Good  
Fair  
Poor  
None

Toileting: Please indicate your child’s function level.

Function Bladder control  
Yes  
No  
Other (such as catheter, colostomy)

Function Bowel control   
Yes  
No  
Other (such as catheter, colostomy)

Feeding: Please indicate how your child is fed and note how often and for how long.  
Function Oral   
Feedings per day   
Minutes per feeding

Function Gastrostomy or jejunostomy tube (circle one)   
Feedings per day   
Minutes per feeding

Function Nasogastric tube  
Feedings per day   
Minutes per feeding

Does your child need any special diet or formula? yes no  
If yes, please explain.

Does your child receive parenteral (intravenous) nutrition? yes no  
If yes, please describe solutions and frequency

# Part 4 Your child’s medical condition

Respiratory:   
Does your child require any of the following aids?

Aid Suction – bulb Yes No  
Frequency

Aid Suction – machine Yes No  
Frequency

Aid Oxygen Yes No  
Number of hours per day:   
Liter flow

Aid Humidification Yes No  
Number of hours per day  
Liter flow

Aid Chest physical therapy Yes No  
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

How is your child’s care provided?  
by a home health agency  
by an independent nurse provider

Please note the type of caregiver  
registered nurse (RN)  
licensed practical nurse (LPN)  
home health aide

Are there any additional nursing services you feel would benefit your child? yes no  
If yes, please describe.

Therapies

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

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

Type of therapy Speech   
Number of visits per week at home  
Number of visits per week at school  
Provider agency

Type of therapy Physical  
Number of visits per week at home  
Number of visits per week at school  
Provider agency

Type of therapy Respiratory  
Number of visits per week at home  
Number of visits per week at school  
Provider agency

Type of therapy Occupational  
Number of visits per week at home  
Number of visits per week at school  
Provider agency

Type of therapy Other  
Number of visits per week at home  
Number of visits per week at 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

Equipment and supplies: Please indicate whether your child needs any of the following items.

Ventilator  
Apnea monitor  
Prone stander  
Orthopedic shoes  
Generator  
Cardiac monitor  
Feeding pump/pole  
Shoe lifts  
Ambu bag  
Nebulizer  
Walker  
Tracheostomy tubes  
Suction machine  
I.V. pump  
Body jacket   
Gastrostomy tubes  
Oxygen compressor  
Wheelchair Braces  
Feeding bags/tubing  
Oxygen tanks  
Hospital bed  
Splints  
I.V. tubing  
Nasogastric tubes  
Syringes  
Formula  
Intravenous fluids  
Dialysis  
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.

Signature of parent/guardian  
Date

## Authorized Representative Information Section

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

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

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 (such as an authorized representative), you must fill out and submit an ARD and give us the following information.

Signature of person filling out this form  
Print name   
Authority of person filling out this form on behalf of the child

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

REMINDER

Did you remember to

complete an Authorization to Release Protected Health Information Form for

* each medical provider listed on page 2?
* each mental health provider listed on page 2?
* your child’s Individualized Education Plan (if not provided with this supplement and you cannot send us a copy)?

sign all Authorization to Release Protected Health Information Forms?

sign this Disability Supplement above?

include a completed and signed Authorized Representative Designation Form (ARD) if needed?

MADS-C/MR COMBO-0721

AUTHORIZATION TO RELEASE   
PROTECTED HEALTH INFORMATION

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

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

# Instructions

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

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

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

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

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

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

3. Only one signature may appear on a line.

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

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

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

# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This request for protected health information supports this individual’s application for public benefits. Under M.G.L.c.112 § 12CC, there must be no charge for the release of the requested records. Under statute, the records must be produced within 30 days.

By filling out and signing this Authorization to Release Protected Health Information, I authorize my health care provider to share my protected health information with MassHealth Disability Evaluation Services (DES). This form will allow my doctors to share my protected health information with MassHealth (DES) to determine my eligibility for disability services.

* I understand that some information used or shared as part of this authorization could be re-shared by DES. If so, it may not be subject to federal or state law protecting its confidentiality.
* I also understand that certain health information has special protections for sensitive information. This health information includes records about HIV infection, AIDS, genetic testing, and psychological or psychiatric conditions. This health information is protected under state and federal law and cannot be shared without my written consent unless otherwise allowed by law. 42 CFR part 2 does not allow a program that provides substance use disorder diagnosis, treatment, or referral for treatment to share health information that it creates, receives, or acquires about me without my authorization.

# SECTION 1: MassHealth Applicant / Member Information

Name  
Date of Birth  
Street address  
City, State, Zip  
Telephone Number

# SECTION 2: Healthcare Provider Information

Name of doctor, health center, or other health care provider  
Street address  
City, State, Zip  
Telephone Number

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

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

⬜ Yes ⬜ No Mental or Psychiatric Health Information

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

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

⬜ Yes ⬜ No Substance Use Information

⬜ Yes ⬜ No Other (please specify):

This authorization is good from 12 months before the signature date through its expiration. This authorization expires 12 months from the signature date.

Signature of Applicant/Member or Legal Representative  
Date

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

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

Unless action has already been taken in reliance upon it, or during a contestability period under applicable law, I understand that I may revoke this authorization at any time by sending a written request to DES, PO Box 2796, Worcester, MA 01613. This authorization expires one (1) year from the signature date.

END OF THE DOCUMENT.

MADS-MR-0721