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 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 (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.

Print Clear

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	
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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 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:

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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.
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- 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.
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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	Floor #	Suite #
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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

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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.