MASSHEALTH CHILD DISABILITY SUPPLEMENT

Commonwealth of Massachusetts | EOHHS

MADS-C-LP_2025-05

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

____

Daytime phone ________________________

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
INFORMATION ABOUT ALL YOUR MEDICAL AND MENTAL HEALTH 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 ___________

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
YOUR 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 ______________________________

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?