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. 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. These 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 a MassHealth 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).

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 Middle initial			Social security number
Street address			Apt. #
City	State	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

Please go to the next page. ►

Information about your family

Mother: Last name First name Middle initial	Daytime phone
Father: Last name First name Middle initial	Daytime phone

Street address	Apt. #

City	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	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 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.

Part 1. Your child's health issues and medical providers (continued)

Does your child have a scheduled hospital visit within the next 12 months? ☐ yes ☐ no

If **yes**, please complete the following.

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	Contact person & telephone number	Address
Department of Child and Family Services	Name Phone	
Department of Developmental Services	Name Phone	
Department of Education	Name Phone	
Department of Mental Health	Name Phone	
Department of Public Health	Name Phone	
Massachusetts Commission for the Blind	Name Phone	
Community Case Management	Name Phone	
Other	Name Phone	

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	Independent	With assistance	Is not able
Walk			
Crawl			
Sit up			
Turn			
Bathing			
Dressing			

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

Activity	Good	Fair	Poor	None
Sight				
Hearing				
Speech				

Toileting: Please indicate your child's function level.

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

Feeding: Please indicate how your child is fed and note how often and for how long.

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

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	Yes	No		
Suction - bulb			Frequency	
Suction - machine			Frequency	
Oxygen			Number of hours per day	Liter flow
Humidification			Number of hours per day	Liter flow
Chest physical therapy			Times per day	

Part 4. Your child's medical condition (continued)

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	Number of visits per week at home	Number of visits per week at school	Provider agency
Speech			
Physical			
Respiratory			
Occupational			
Other _____			

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

☐ 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 authorized 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?

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

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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 M.G.L. 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.

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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 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 M.G.L. 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.