MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

HELP WITH MEDICARE COSTS

MEDICARE SAVINGS PROGRAMS

This application is to see if you are eligible for help paying your Medicare Part B premiums, Medicare Part A premiums if you have them, or Part A or B copays or deductibles.

What may be covered depends on your and your spouse's (if you are married) income.

If you are eligible for a Medicare Savings Program, you will also be enrolled in Medicare Part D Extra Help. Extra Help may help with prescription drug costs.

You can use this application to apply for the Supplemental Nutrition Assistance Program (SNAP). SNAP is a federal program that helps you buy food each month. If you are interested, check the box on page 1 of the application, read the SNAP rights and responsibilities on pages 3 through 6, and sign on page 2. Your application will then be sent automatically to the Department of Transitional Assistance (DTA). You do not have to apply for the SNAP Program to be considered for the Medicare Savings Programs.

How much can I have in assets?

There is no asset limit for Medicare Savings Programs in Massachusetts.

How much can I have in income?

If your income is at or below the amounts listed here, you may qualify for help from one of several Medicare Savings Programs.

You are a	Your income is at or below*
single individual	$2,935 /month
married couple	$3,966 /month

***Income limits change each year on March 1**.

You can find up-to-date information about income limits at www.mass.gov/info-details/program-financial-guidelines-for-certain-masshealth-applicants-and-members.

There are certain deductions that MassHealth may subtract from your gross income when we calculate your countable income. These deductions are described in regulations 130 CMR 520.012 through 520.014.

If I am eligible for one of the Medicare Savings Programs, how do I get paid?

If MassHealth finds that you are eligible for payment of all your Medicare Part B premium, we will tell Medicare.

If your Medicare Part B premium is deducted from your Social Security benefit, your Medicare premium will no longer be deducted. This means that the amount of your Social Security benefit will increase by the amount that used to be deducted to pay for your Medicare Part B premium.

If you are eligible for Medicare Part B but not yet getting it (or if you are paying your Medicare Part B premium in some other way, like getting a quarterly bill from Medicare), MassHealth will start paying this bill for you.

It will take several months for your Social Security benefit to increase or for MassHealth to start paying your Medicare bill. You will be paid back the amount you paid Medicare for your Part B premiums back to the month you became eligible for a Medicare Savings Program. You will get this refund the same way you now get your Social Security benefits.

When does coverage begin?

You will get a notice in the mail about your coverage and when it starts. Your coverage may begin in the month we process your application or as early as three months before that.

If you are not eligible, the notice will give you the reason(s) you are not eligible. If you think the decision is wrong, you have the right to appeal it. Information about how to appeal is on the back of the written notice.

How we use your Social Security number

Unless one of the exceptions listed below applies, you must give us a Social Security number (SSN), or proof that one has been applied for, for every household member who is applying unless the following exceptions apply.

Exceptions

You don't have to give us an SSN or proof that one has been applied for if you or any member of your household

- has a religious exemption as described in federal law;
- is eligible only for a nonwork SSN; or
- is not eligible for an SSN.

We use your SSN to check information you have given us. We also use them to detect fraud, to see if anyone is getting duplicate benefits, or to see if others (a third party) should be paying for services.

We may match the SSN of anyone in your household who is applying, and anyone who has or who can get health insurance for any such persons, with the files of agencies, including the following:

- Internal Revenue Service
- Social Security Administration
- Systematic Alien Verification for Entitlements
- Centers for Medicare & Medicaid Services
- Registry of Motor Vehicles
- Department of Revenue (DOR)
- Department of Transitional Assistance
- Department of Industrial Accidents
- Department of Unemployment Assistance
- Department of Veterans' Services, Human Resources Division
- Bureau of Special Investigations
- Department of Public Health, Registry of Vital Records and Statistics
- banks
- other financial institutions

Files may also be matched with social service agencies in this state and other states, as well as computer files of insurance companies, employers, and managed care organizations. Additionally, MassHealth may get your financial records (and, if applicable, those of your household

members) from banks and other financial institutions to verify your financial resources and otherwise determine your eligibility while you are a MassHealth member.

How do I apply for the Medicare Savings Programs?

1. To apply for the Medicare Savings Programs, fill out the attached application. Include information about your spouse too, if they live with you.
2. Sign the filled-out application, and

   Send it to: **MassHealth Enrollment Center**
   PO Box 4405
   Taunton, MA 02780-0968

   Fax it to: **(857) 323-8300**

   Hand-deliver it to:
   MassHealth Enrollment Center
   The Schrafft Center
   529 Main St., Suite 1M
   Charlestown, MA 02120

3. When we get the application, we will review it. If we need more information, we will write to you or call you. Once we get all the information we need, we will decide if you can get benefits (and if your spouse can, if they are applying too).

4. A voter registration form is included with your application. You do not need to register to vote to get a Medicare Savings Program.
5. If you want someone to act on your behalf as your authorized representative, use the enclosed Authorized Representative Designation Form (ARD) to tell us.

Please note that this application is for Medicare Savings Programs only. If you would like to apply for all MassHealth programs (including help with payment of Medicare costs) through a single application, contact MassHealth at (800) 841-2900, TDD/TTY:711 if you are deaf or hard of hearing or have a speech disability, to request a full application, or download the appropriate application at www.mass.gov/lists/applications-to-become-a-masshealth-member.

Privacy and Confidentiality

MassHealth is committed to keeping your personal information confidential. All personal information we have about any applicant or member, including medical data, health status, and the personal information you give us during your application for and receipt of benefits, is confidential. This information may not be used or released for purposes not related to the administration of MassHealth without your permission unless required by law or a court order.

You can give us your written permission to use your personal health information for a specific purpose or to share it with

a specific person or organization. You can also give us your permission to share your personal information with your authorized representative, Certified Application Counselor (CAC), or Navigator, if you have one, by filling out an ARD, a Certified Application Counselor Designation Form, or a Navigator Designation Form.

Permission to Share Information

If you want us to share your personal health information, including sending copies of your eligibility notices, with someone who is not your authorized representative, you can do this by giving us written permission.

To learn more about how MassHealth may use your information, what your rights are, and how you can give us permission to share your information, see the Permission to Share Information and MassHealth Notice of Privacy Practices forms in the Important Forms section, below.

Authorized Representative

An authorized representative is someone you choose to help you get health care coverage through programs offered by MassHealth. You can do this by filling out an ARD. An authorized representative may fill out your application or eligibility review forms; give proof of information given on any forms; report changes in your income, address, or other circumstances; get copies of all MassHealth eligibility

notices sent to you; and act on your behalf in all other matters with MassHealth.

An authorized representative can be a friend, family member, or other person or organization you choose to help you. It is up to you to choose an authorized representative, if you want one. MassHealth will not choose an authorized representative for you.

You must designate in writing on the ARD the person or organization you want to be your authorized representative. This form is included in the application packet. In most cases, your authorized representative must also fill out this form. Please see the instructions on the form for more details.

An authorized representative can also be someone who is acting responsibly on your behalf if you cannot designate an authorized representative in writing because of a mental or physical condition, or has been appointed by law to act on your behalf or on behalf of your estate. This person must fill out the applicable parts of the ARD. If this person has been appointed by law to represent you, either you or this person must also submit to MassHealth a copy of the applicable legal document stating that this person is lawfully representing you or your estate. This person may be a legal guardian; conservator; holder of power of attorney; health care proxy; or, if the applicant or member has died, the estate's administrator or executor.

Important Forms

The following forms can be found on our website at www.mass.gov/lists/hipaa-forms-for-masshealth-members.

- MassHealth Notice of Privacy Practices form
- Permission to Share Information form
- ARD

You can also call us at (800) 841-2900, TDD/TTY: 711, to ask for any of these forms.

Reporting Changes

If there are any changes in your living situation, including but not limited to income, assets, address, health insurance, immigration status, or disability status, you must tell us within 10 calendar days of the changes or as soon as possible. If you do not tell us about these changes, you may lose your benefits. You can tell us about any changes by calling (800) 841-2900, TDD/TTY: 711.

Other Benefits

MassHealth can pay for medical services directly, and may also pay your Medicare copays and deductibles if you are eligible. You may be able to get these benefits if your income and assets are under certain amounts, or if you have a disability and are younger than 65. Call us at (800) 841-2900, TDD/TTY: 711, to learn about these benefits.

You can also call this number if you have any questions about the Medicare Savings Programs.

Most members that have Medicare and MassHealth or Medicare and a Medicare Savings Program can get help with prescription drug costs through Medicare. To get more information, call Medicare at (800) 633-4227, TDD/TTY: (877) 486-2048, or visit www.medicare.gov.

Prescription Advantage offers help with prescription drug costs. To learn more about these benefits, call the Executive Office of Elder Affairs toll free at (800) 243-4636, TDD/TTY: (877) 610-0241.

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MEDICARE SAVINGS PROGRAMS APPLICATION

FOR PEOPLE WHO ARE ELIGIBLE FOR MEDICARE

Who can use this application?

People of any age who receive Medicare and are only seeking help with payment of their Medicare premiums and cost sharing.

If you want to apply for other MassHealth benefits, or for assistance with Medicare costs, you can call MassHealth Customer Service at (800) 841-2900, TDD/TTY: 711 for people who are deaf or hard of hearing or have a speech disability, to ask for a different application. Or you can download the appropriate application at www.mass.gov/lists/applications-to-become-a-masshealth-member.

SNAP

SNAP is a federal program that helps you buy healthy food each month.

☐ Check this box if you want this application to be sent to the Department of Transitional Assistance to serve as an application for SNAP benefits. You must read the rights and responsibilities on pages 3 through 6 and sign on page 2 to proceed with the application.

General Information

Who is applying? ☐ You ☐ You and your spouse

If you and your spouse live together, you must also give us information about your spouse even if they are not applying for benefits.

You

Last name .....

First name .....

Middle initial .....

Street address .....

City .....

State .....

ZIP .....

Mailing address (if different from above) ☐ Homeless

.....

City .....

State .....

ZIP .....

Date of birth .....

Gender ☐ M ☐ F

Telephone number.....

Preferred spoken language .....

Preferred written language .....

SSN .....

Medicare claim number number .....

Are you a US citizen or US national?

☐ Yes ☐ No

If Yes, are you a naturalized, derived, or acquired citizen (not born in the US)?

☐ Yes ☐ No

Alien number .....

Naturalization or citizenship certificate number

.....

If you are a noncitizen, do you have an eligible immigration status? “ See 130 CMR 518.000 for more information “

☐ Yes ☐ No

If Yes, do you have an immigration document?

☐ Yes ☐ No

It may help us to process this application faster if you include a copy of your immigration document with the application. Please list all the immigrations statuses and/or conditions that have applied to you since you entered the US. If you need more space, attach another sheet of paper.

Status award date (mm/dd/yyyy) .....

(For battered people, enter the date the petition was approved.)

Immigration status .....

Immigration document type .....

Document ID number .....

Alien number .....

Passport or document expiration date (mm/dd/yyyy)

.....

Country.....

Did you use the same name on this application that you did to get your immigration status?

☐ Yes ☐ No

If No, what name did you use? First name, middle name, last name, and suffix

Did you arrive in the US after August 22, 1996?

☐ Yes ☐ No

Are you an honorably discharged veteran or active-duty member of the US military, or the spouse or child of an honorably discharged veteran or an active-duty member of the US military?

☐ Yes ☐ No

Optional: Are you: a victim of severe trafficking, a spouse, child, sibling or parent of a trafficking victim, a battered spouse, a child or parent of a battered spouse?

Your Spouse

Last name .....

First name .....

Middle initial .....

Date of birth.....

Gender ☐ M ☐ F

Telephone number

Preferred spoken language .....

Preferred written language .....

SSN .....

Medicare claim number.....

Are you a US citizen or US national?

☐ Yes ☐ No

If Yes, are you a naturalized, derived, or acquired citizen (not born in the US)?

☐ Yes ☐ No

Alien number.....

Naturalization or citizenship certificate number

.....

If you are a noncitizen, do you have an eligible immigration status? " See 130 CMR 518.000 for more information "

☐ Yes ☐ No

If Yes, do you have an immigration document?

☐ Yes ☐ No

It may help us to process this application faster if you include a copy of your immigration document with the application. Please list all the immigrations statuses and/or conditions that have applied to you since you entered the US. If you need more space, attach another sheet of paper.

Status award date (mm/dd/yyyy) .....
(For battered people, enter the date the petition was approved.)

Immigration status.....

Immigration document type .....

Document ID number .....

Alien number .....

Passport or document expiration date (mm/dd/yyyy)

.....

Country.....

Did you use the same name on this application that you did to get your immigration status?

☐ Yes ☐ No

If No, what name did you use? First name, middle name, last name, and suffix .....

Did you arrive in the US after August 22, 1996?

☐ Yes ☐ No

Are you an honorably discharged veteran or active-duty member of the US military, or the spouse or child of an honorably discharged veteran or an active-duty member of the US military?

☐ Yes ☐ No

Optional: Are you: a victim of severe trafficking, a spouse, child, sibling or parent of a trafficking victim, a battered spouse, a child or parent of a battered spouse?

☐ Yes ☐ No

Income

Fill out this section for you and your spouse. List the gross monthly income (before taxes and other deductions, such as the Medicare Part B premium).

Source of income Social Security
Gross monthly income before taxes and deductions

Your $ .....

Your spouse's $ .....

Source of income Pensions
Gross monthly income before taxes and deductions

Your $ .....

Your spouse's $ .....

Source of income Federal veterans' benefits
Gross monthly income before taxes and deductions

Your $ .....

Your spouse's $ .....

Source of income Annuities or trusts
Gross monthly income before taxes and deductions

Your $ .....

Your spouse's $ .....

Source of income Dividends and/or interest
Gross monthly income before taxes and deductions

Your $ .....

Your spouse's $ .....

Source of income Income from a job (before deductions)

Your $ .....

Your spouse's $ .....

Gross monthly income before taxes and deductions

Your $ .....

Your spouse's $ .....

Source of income Rental income (after expenses)
Gross monthly income before taxes and deductions
Gross monthly income before taxes and deductions

Your $ .....

Your spouse's $ .....

Source of income Other (please specify)
Gross monthly income before taxes and deductions

Your $ .....

Your spouse's $ .....

Sign this application.

Signature of applicant or Authorized Representative

.....

Date .....

Signature of Spouse or Authorized Representative

.....

Date .....

Both you and your spouse must sign if your spouse lives with you.

By signing, you agree to and understand the following:

- By signing this application, I hereby certify that I have read and agree to the rights and responsibilities included in this application on pages 3 through 6.
- 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 rights and responsibilities of the Medicare Savings Program.
- If I have checked the SNAP box on page 1 of this application, I am applying for SNAP. I certify that I understand and agree to the rights, rules, and penalties of SNAP, as outlined below. I ask that MassHealth

send my information, including protected health information subject to the Health Insurance Portability and Accountability Act (HIPAA), to the Department of Transitional Assistance for the purpose of applying for SNAP benefits.

Important—For Medicare Savings Program Applicants Only

If you are submitting this application as an authorized representative, you must submit an ARD to us or have a form on record for us to process this application. The ARD is at the end of this application.

Voter registration information is enclosed in this packet.

You do not need to register to vote to get a Medicare Savings Program.

For Medicare Savings Program Applicants

You give permission to MassHealth to get any records or data to prove any information given on this application. You understand that you must tell MassHealth of any changes in information you gave on this application. You further certify under the penalty of perjury that the information on this application is correct and complete to the best of your knowledge.

Important—For Medicare Savings Program Applicants Only

If you are acting on behalf of someone in filling out this application, you must fill out the enclosed ARD and send it back with this application. Your signature on this application as an authorized representative certifies that the information on this application is correct and complete to the best of your knowledge.

If you think MassHealth's eligibility decision is wrong, you have the right to appeal. If you are denied benefits, you will get information on how to appeal.

MassHealth will obtain from your current and former health insurers all information about health insurance coverage for you and your spouse. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to you and your spouse.

MassHealth may get records or data about you and your spouse listed on this application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, DOR, and the Registry of Motor Vehicles, as well as private data sources including financial institutions, 1) to prove any information given on this application and any supplements, or other information given once you or your spouse becomes a member, 2) to

document medical services claimed or provided to you or your spouse, and 3) to support continued eligibility.

For Supplemental Nutritional Assistance Program (SNAP) applicants

Supplemental Nutrition Assistance Program (SNAP) benefits

If you checked the box on page 1, MassHealth will send this application to the Department of Transitional Assistance (DTA). **This will serve as your application for SNAP!** ! If you are eligible, your SNAP will start from the date DTA receives this MassHealth application. By signing below, you agree that you have read and agree to your SNAP Rights, Responsibilities, and Penalties under the program.

You may be eligible for SNAP benefits within 7 days of when DTA gets this application if:

- Your income and money in the bank add up to less than your monthly housing expenses, or
- Your monthly income is less than $150, and your money in the bank is $100 or less, or
- You are a migrant worker and your money in the bank is $100 or less.

For more information about SNAP in Massachusetts, go to mass.gov/SNAP.

Department of Transitional Assistance (DTA) Notice of Rights, Responsibilities and Penalties

This notice lists rights and responsibilities for the SNAP program.

Please read these pages and keep them for your records.

Let DTA know if you have any questions.

I swear under penalty of perjury that:

- I have read the information in this form, or someone read it to me.
- My answers in this form are true and complete to the best of my knowledge.
- I will give DTA information that is true and complete to the best of my knowledge during my interview and in the future.

I understand that:

- giving false or misleading information is fraud,
- misrepresenting or withholding facts to get DTA benefits is fraud,
- fraud is considered an Intentional Program Violation (IPV), and
- if DTA thinks I committed fraud, DTA can pursue civil and criminal penalties against me.

I also understand that:

- DTA will verify the information I give with my application. If any information is false, DTA may deny my benefits.
- I may also be subject to criminal prosecution for providing false information.
- If DTA gets information from a reliable source about a change in my household, my benefit amount may change.
- By signing this form, I give DTA permission to verify my eligibility for benefits, including:
  - Get information from other state or federal agencies, local housing authorities, out-of-state welfare departments, financial institutions, and Equifax Workforce Solutions (the Work Number). I also give these agencies permission to share information about my household's eligibility for benefits with DTA.
  - If DTA uses information from Equifax about my household earned income, I have the right to a free copy of my Equifax report if I request it within 60 days of DTA's decision. I have the right to question the information in the report. I may contact Equifax at: Equifax Workforce Solutions, 11432 Lackland Road, St. Louis, MO 63146, 1-800-996-7566 (toll free).
- I have a right to a copy of my application, including the information that DTA uses to decide about my household's eligibility and benefit amount. I can ask DTA for an electronic copy of the completed application.

How will DTA use my information?

By signing below, I give DTA permission to get information from and share information about me and members of my household with:

- Banks, schools, government, employers, landlords, utility companies and other agencies to check if I am eligible for benefits.
- Electric, gas and telephone companies so I can get utility discounts. The companies cannot share my information or use it for any other purpose.
- The Department of Housing and Community Development to enroll me in the Heat & Eat Program. This program helps people get the most SNAP benefits possible.
- The Department of Early and Secondary Education so my children can get free school meals.'
- The Woman, Infants and Children (WIC) Program so that any children under age 5 or a pregnant woman in my household can get WIC.
- The United States Citizenship and Immigration Services (USCIS), to verify my immigration status. Information from USCIS may affect my household's eligibility and amount of DTA benefits.

  Note: Even if you are not eligible for benefits due to immigration status, DTA will not report you to

immigration authorities unless you show DTA a final order of deportation.

- The Department of Revenue (DOR) to verify my eligibility for income-based tax credits, such as Earned Income and Limited Income, and to see if I am eligible for "No Tax Status" or hardship status.
- The Department of Children and Families (DCF) to coordinate services offered jointly by DTA and DCF.

How does DTA use Social Security Numbers (SSNs)?

DTA is allowed to ask for SSNs under The Food and Nutrition Act of 2008 (7 U.S.C. 2011-2036) for SNAP and under M.G.L. c. 18 Section 33 for TAFDC and EAEDC. DTA uses SSNs to:

- Check the identity and eligibility of each household member I apply for through data matching programs.
- Monitor compliance with program rules.
- Collect money if DTA claims I got benefits that I was not eligible for.
- Help law enforcement agencies catch people hiding from the law.

I understand that I do not have to give DTA the SSN of any non-citizen in my household, including myself, who does not want benefits. The income of a non-citizen may count even if the non-citizen does not get benefits.

Right to an Interpreter

I understand that:

- I have a right to a free professional interpreter provided by DTA if I prefer to communicate in a language other than English.
- If I have a DTA hearing, I can ask DTA to give me a free professional interpreter, or if I prefer, I can bring someone to interpret for me. If I need DTA to give me an interpreter for a hearing, I must call the Division of Hearings at least one week before the hearing date.

Right to Register to Vote

I understand that:

- I have the right to register to vote through DTA.
- DTA will help me fill out the voter registration application form if I want help.
- I can fill out the voter registration application form in private.
- Applying to register or declining to register to vote will not affect my DTA benefits.

Employment Opportunities

I agree that DTA may share my name and contact information with employment and training providers, including:

- SNAP Path Work providers or DTA specialists for SNAP clients; and

- Contracted Employment and Training providers or Full Engagement Workers for TAFDC clients.

SNAP clients may voluntarily participate in education and employment training services through the SNAP Path to Work program.

Citizenship Status

I swear that all members of my household applying for DTA benefits are either U.S. citizens, or lawfully residing noncitizens.

Supplemental Nutrition Assistance Program

I understand that:

- DTA manages the SNAP program in Massachusetts.
- When I file an application with DTA (by phone, online, in person, or by mail or fax), DTA has 30 days from the date it got my application to decide if I am eligible.
  - If I am eligible for expedited (emergency) SNAP, DTA has to give me SNAP and make sure I have an Electronic Benefit Transfer (EBT) card within 7 days from the date they got my application.
  - I have a right to speak to a DTA supervisor if:
    - DTA says I am not eligible for emergency SNAP benefits, and I disagree.
    - I am eligible for emergency SNAP benefits, but do not get my benefits by the 7th day after I applied for SNAP.

    - I am eligible for emergency SNAP benefits but do not get my EBT card by the 7th day after I applied for SNAP

- When I get SNAP, I have to meet certain rules. When I am approved for SNAP, DTA will give me a copy of the "Your Right to Know" brochure and the SNAP Program brochure. I will read the brochures or have someone read them to me. If I have any questions or need help reading or understanding this information, I can call DTA at (877) 382-2363.
- **Telling DTA about changes in my household:**
  - If I am a SNAP Simplified Reporting household, I do not have to report most changes to DTA until the Interim Report or Recertification is due. The only things I have to report sooner are:
    - If my household's income goes over the gross income threshold (listed on my approval notice).
    - I have to report this by the 10th day of the month after the month my income went over the threshold.
    - If I have to meet the Able-Bodied Adults Without Dependents (ABAWD) Work Rules and my work hours drop below 20 hours per week.
  - If everyone in my household is 60 or older, disabled, or under 18 years old, and no one has earnings from work, the only things I have to report are:
    - If someone starts working, or

- Someone joins or leaves my household.
- I have to report these changes by the 10th day of the month after the month of the change.

– If I get SNAP through Transitional Benefits Alternative (TBA) because my TAFDC stopped, I do not have to report any changes to DTA for the 5 months that I get TBA.

– If I get SNAP through Bay State CAP, I do not have to report any changes to DTA.

If I and everyone in my household gets cash assistance (TAFDC or EAEDC), I must report certain changes to DTA within 10 days of the change.

I may get more SNAP benefits if I report and give DTA proofs for the following, at any time:

- Child or other dependent care costs, shelter costs, and/or utility costs;
- Child support that I (or someone in my household) is legally required to pay to a non-household member; and
- Medical costs for members of my household, including myself, who are 60 or older or disabled.

Work rules for SNAP clients: If you get SNAP benefits and are between the ages of 16 and 59 you may need to meet general SNAP work rules or the ABAWD work rules unless you are exempt. DTA will tell me and members of my household if we need to meet any Work Rules, what the exemptions are, and what will happen if we do not meet the rules.

If you are under the SNAP Work Rules:

- You must register for work at application and when you recertify for SNAP. You register when you sign the SNAP application or recertification form.
- You must give DTA information about your employment status when DTA asks.
- You must report to an employer if referred by DTA.
- You must accept a job offer (unless you have a good reason not to).
- You must not quit a job of more than 30 hours a week without a good reason.
- You must not cut your work hours to less than 30 hours a week without a good reason.

SNAP Rules

- Do not give false information or hide information to get SNAP benefits.
- Do not trade or sell SNAP benefits.
- Do not alter EBT cards to get SNAP benefits you are not eligible for.
- Do not use SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco.
- Do not use someone else's SNAP benefits or EBT card unless you are an authorized representative, or the recipient has given you permission to use their card on their behalf.

SNAP Penalty Warnings

I understand that if I or any member of my SNAP household intentionally breaks any of the rules listed above, that person will not be eligible for SNAP for one year after the first violation, two years after the second violation and forever after the third violation. That person may also be fined up to $250,000, imprisoned up to 20 years, or both. They may also be subject to prosecution under Federal and State laws.

I also understand the following penalties. If I or a member of my SNAP household:

- Commit a cash program Intentional Program Violation (IPV) they will be ineligible for SNAP for the same period they are ineligible for cash assistance.
- Make a fraudulent statement about their identity or residency to get multiple SNAP benefits at the same time they will be ineligible for SNAP for ten years.
- Trade (buy or sell) SNAP benefits for a controlled substance/illegal drug(s), they will be ineligible for SNAP for two years for the first finding, and forever for the second finding.
- Trade (buy or sell) SNAP benefits for firearms, ammunition or explosives, they will be ineligible for SNAP forever.
- Make an offer to sell SNAP benefits or an EBT card online or in person the State may pursue an IPV against them.

- Pay for food purchased on credit they will be ineligible for SNAP.
- Buy products with SNAP benefits with the intent to discard the contents and return containers for cash they will be ineligible for SNAP.
- Flee to avoid prosecution, custody or confinement after conviction for a felony they will be ineligible for SNAP.
- Violate probation or parole, where law enforcement is actively seeking to arrest them they will be ineligible for SNAP.

Anyone who became a convicted felon after February 7, 2014 is ineligible for SNAP benefits if they are a fleeing felon or are violating probation or parole – in accordance with 7 CFR §273.11(n) - and were convicted as an adult of

1. Aggravated sexual abuse under section 2241 of title 18, U.S.C.;
2. Murder under section 1111 of title 18, U.S.C.;
3. Any offense under chapter 110 of title 18, U.S.C.;
4. A Federal or State offense involving sexual assault, as defined in section 40002(a) of the 1994 VAWA (42 U.S.C. 13925a); or
5. An offense under State law determined by the Attorney General to be substantially similar to an offense described in this list.

Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g. Braille, large print, audiotape, American Sign Language), should contact the Agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete Form AD-3027, the USDA Program Discrimination Complaint Form, which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. **fax:**
   (833) 256 1665 or (202) 690-7442; or
3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

AUTHORIZED REPRESENTATIVE DESIGNATION FORM

Commonwealth of Massachusetts | EOHHS

You can submit this form if you would like to designate an authorized representative to act on your behalf. If an authorized representative signed your application for you, or if you are an authorized representative applying on behalf of someone else, you **MUST** submit this form for the application to be processed.

You do not need to fill out this form if you live in an institution and want copies of eligibility notices sent to you and to your spouse who still lives at home. We will do that automatically.

Note: An authorized representative has the authority to act on an applicant's or member's behalf in all matters with MassHealth and the Health Connector, and will receive personal information about the applicant or member until we receive a cancellation notice terminating their authority, or upon the death of the applicant or member. Their authority will not automatically terminate once we process your application.

You can choose someone to help you.

You may choose an authorized representative to help you get health care coverage through programs offered by MassHealth and the Health Connector. You can do this by filling out this form (the Authorized Representative Designation Form). You or a representative can sign for yourself and for any of your dependent children under the age of 18 for whom you are the custodial parent. **You are not required to have a representative in order to apply for or receive benefits.**

Who can help me?

1. An authorized representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose an authorized representative if you want one. Neither MassHealth nor the Health Connector will choose an authorized representative for you. You must designate in writing (fill out Section I, Part A) the person or organization who you want to be your authorized representative. Your authorized representative must also fill out Section I, Part B. We sometimes refer to this person or organization as a "Section I authorized representative."
2. If you cannot designate an authorized representative in writing and you do not have an existing authorized representative or other person who is authorized by law to act on your behalf, a person (not an organization) who

certifies that they will act responsibly on your behalf can be your authorized representative if that person fills out Section II of this form. We sometimes refer to this person as a "Section II authorized representative."

3. An authorized representative can also be someone who has been appointed by law to act on your behalf, or on behalf of the estate of an applicant or member who has died. This person must fill out Section III and either you or this person must submit to us, together with this form, a copy of the applicable legal document stating that this person has authority to represent you, or the estate of a deceased applicant or member. We sometimes refer to this person as a "Section III authorized representative."
4. **Section III** authorized representative may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the personal representative of the estate.

What can an authorized representative do?

A **Section I** or **II** authorized representative may

- fill out your application or renewal forms;
- fill out other MassHealth or Health Connector eligibility or enrollment forms;
- give proof of information reported on these forms;
- report changes in income, address, or other circumstances;

- get copies of all of your MassHealth and Health Connector eligibility and enrollment notices; and
- act on your behalf in all other matters with MassHealth and the Health Connector.

What a **Section III** authorized representative is authorized to do for you (or for the Estate of a deceased applicant or member) will depend on the wording of the legal appointment.

Please note: Eligibility notices may include information about other members of an applicant's or member's household. If there are multiple people in your household we may not be able to send copies of some of your notices to your authorized representative unless each household member has also designated the same authorized representative by completing a separate Authorized Representative Designation Form.

SECTION 1
AUTHORIZED REPRESENTATIVE DESIGNATION
(if applicant or member is able to sign)

Part A—to be filled out by applicant or member. Please print, except for signature.

Applicant's/Member's Name

.....

Applicant's/Member's date of birth (mm/dd/yyyy)

.....

MassHealth ID number .....
OR last four digits of the Applicant's/Member's SSN

.....

Applicant's/Member's email address

.....

I certify that I have chosen the following person or organization to be the authorized representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form).

Applicant's/Member's signature

.....

Date (mm/dd/yyyy)

.....

Authorized representative's name

.....

Authorized representative's phone number

.....

Authorized representative's address
(mailing address, city, state, zip)

.....

Part B—to be filled out by authorized representative. Please print, except for signature.

B1. Complete if authorized representative is a person.

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to me by MassHealth or the Health Connector.

If I am also a provider, staff member, or volunteer affiliated

with an organization, and am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10 and 45 C.F.R. § 155.260(f).

Authorized representative's signature

.....

Date (mm/dd/yyyy)

.....

Authorized representative's printed name

.....

Authorized representative's email address

.....

B2. Complete if authorized representative is an organization.

I certify, on behalf of the organization set forth below, that such organization will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to the organization by MassHealth or the Health Connector.

I, the provider, staff member, or volunteer of the organization set forth below, completing this form, certify on behalf of myself and on behalf of the organization I represent, that any providers, staff members, or volunteers acting on behalf of the organization in connection with this authorized representative designation will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information, and conflicts of interest, including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10 and 45 C.F.R. § 155.260(f).

Signature of provider, staff member, or volunteer completing form

.....

Date (mm/dd/yyyy) .....

Printed name of provider, staff member, or volunteer completing form

.....

Email of provider, staff member, or volunteer completing form

.....

Authorized representative organization name

.....

SECTION 2
AUTHORIZED REPRESENTATIVE DESIGNATION
(if applicant or member cannot provide written designation)

To be filled out by authorized representative. Please print, except for signature. Please provide a separate form for each applicant or member.

An organization is not eligible to be an authorized representative under this section.

I certify that the applicant or member set forth below cannot provide written designation and to the best of my knowledge does not otherwise have an individual who can act on his or her behalf such as an existing authorized representative, guardian, conservator, personal representative of the estate, holder of power of attorney, or an invoked health-care proxy. In addition, I certify that I am sufficiently aware of this applicant's or member's circumstances to assume responsibility for the accuracy of the statements made on his or her behalf during the eligibility process and in other communications with MassHealth or the Health Connector, that I understand my rights and responsibilities as this person's authorized representative (as explained earlier in this form). If this person can understand, I have told the person that

MassHealth and the Health Connector will send me a copy of all MassHealth and Health Connector eligibility and enrollment notices and this person agrees to this, and I have told this person that they may remove or replace me as their authorized representative at any time by the methods described earlier in this form.

I further certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth below that is provided to me by MassHealth or the Health Connector.

If I am also a provider, staff member, or volunteer affiliated with an organization, and I am acting in my capacity as a provider, staff member, or volunteer in connection with my designation an authorized representative, I further certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentially of information and conflicts of interest including those set forth at 42 CFR part 431 subpart F., 42 CFR §477.10, and 45 CFR §155.260(f).

Applicant's/Member's name

.....

Applicant's/Member's date of birth (mm/dd/yyyy)

.....

MassHealth ID number .....
OR
last four digits of the Applicant's/Member's SSN .....

Authorized representative's signature

.....

Date (mm/dd/yyyy) .....

Authorized representative's name (first, middle, last)

.....

Authorized representative's phone number

.....

Authorized representative's address
(mailing address, city, state, zip)

.....

Authorized representative's email address

.....

If the Section II authorized representative is affiliated with an organization, and is acting in such capacity, an individual authorized to act on behalf of the organization, such as an officer, must sign below to indicate the organization's acknowledgment of and agreement with the representations and warranties made above.

Officer's Name .....

Officer's Title .....

Officer's Signature .....

Date (mm/dd/yyyy) .....

SECTION 3
AUTHORIZED REPRESENTATIVE DESIGNATION
(if appointed by law)

To be filled out by an authorized representative appointed by law (with authority to act on behalf of the applicant or member in making decisions related to health care including, but not limited to, a guardian, conservator, personal representative of the estate of an applicant or member, holder of power of attorney, or an invoked health care proxy.) Please print, except for signature. **Please submit a copy of the applicable legal document with this form.**

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member as set forth below, that is provided to me by MassHealth or the Health Connector.

Applicant's/Member's name

.....

Applicant's/Member's date of birth (mm/dd/yyyy)

.....

MassHealth ID number .....

OR last four digits of the Applicant's/Member's SSN

.....

Authorized representative's signature

.....

Date (mm/dd/yyyy) .....

Authorized representative's name (first, middle, last)

.....

Authorized representative's phone number

.....

Authorized representative's address
(mailing address, city, state, zip)

.....

Authorized representative's email address

.....

How does an authorized representative designation end?

If you decide that you no longer want a **Section I** or **Section II** authorized representative, you must notify us at the time you want the designation to end by mail, fax, or phone. See our contact information below. If you mail or fax this notice to us, the notice must include your name, address, and date of birth, the name of your authorized representative, a statement that the designation has ended and your signature or, if you cannot provide written notice, the signature of someone acting on your behalf (in the case of a **Section II** authorized representative only).

In addition, if your authorized representative notifies us that such person or organization is no longer acting on your behalf, we will no longer recognize the person or organization as your authorized representative.

The authority of a **Section I** or **Section II** authorized representative will end upon the death of the applicant or member.

A **Section III** authorized representative's designation ends when his or her legal appointment ends. The authorized representative must notify us as instructed above.

In addition, an authorized representative's designation for a minor child ends on the child's 18th birthday.

How do I submit this form?

If you are applying for health benefits, send your filled-out Authorized Representative Designation Form to us with your application.

If you are already getting benefits, you must submit the form to us at the time you want to designate an authorized representative, or you want the declared designation to end, by

- Mailing your form to
  Health Insurance Processing Center
  PO Box 4405
  Taunton, MA 02780;
- Faxing your form to **(857) 323-8300**; or
- Calling us at **(800) 841-2900**, TDD/TTY: **711**.