



# **Office of the Inspector General**

## **Commonwealth of Massachusetts**

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Inspector General

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# **Ongoing Review of MassHealth and Noncustodial Parents' Health Insurance**

**February 28, 2014**

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**Appendix A: Application for Health Coverage and Help Paying Costs Instructions**

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## *Executive Summary*

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For the past three years, the Legislature has directed the Office of the Inspector General (“Office”) to study the administration of the Massachusetts Medicaid program (“Medicaid”) by MassHealth, the state entity that runs the program. This year, pursuant to Section 160 of Chapter 38 of the Acts of 2013, the Office continued its examination of Medicaid and MassHealth’s obligation to ensure that Medicaid is the payer of last resort.

In situations where one parent has custody of a dependent child, the courts will often enter a health insurance order requiring the noncustodial parent to provide health insurance for the child and/or the custodial parent. Even absent a court order, parents have an obligation to provide health insurance for their children. Furthermore, under federal regulations, MassHealth has an obligation to identify alternate sources of health insurance for Medicaid recipients, such as a noncustodial parent’s commercial health insurance.

On March 1, 2013, the Office issued its *Report Pursuant to Section 182 of Chapter 139 of the Acts of 2012: Assessing MassHealth’s Identification and Recovery of Noncustodial Parents’ Health Insurance*. That report examined two issues important to the financial well being of Medicaid:

1. How MassHealth gathers and verifies information from custodial parents regarding the availability of commercial health insurance from noncustodial parents; and
2. To what extent MassHealth uses that information to obtain commercial health insurance coverage for a Medicaid recipient.

The Office found that MassHealth did not collect enough information about noncustodial parents’ health insurance and did not utilize the information it did collect.

Since last year’s review, MassHealth has made progress in addressing the Office’s concerns. MassHealth adopted the Office’s recommendations to simplify and add new language to the Medicaid application, and to require custodial parents to answer all of the questions on the *Absent Parent/Non-Custodial Parent Form*, used to obtain noncustodial parent information. In addition, MassHealth and the Department of Revenue’s Child Support Enforcement Division (“DOR/CSE”) began a pilot project to determine whether it is cost effective for MassHealth to refer cases to DOR/CSE to determine noncustodial parents’ responsibility to obtain and provide health insurance.

This year, following up on its 2013 report, the Office reviewed a sample of 500 households for which a custodial parent indicated on the Medicaid application that a court had issued an order requiring a noncustodial parent to provide health insurance for the custodial parent and/or dependent children. The Office reviewed the available court orders for the sampled households and determined which orders required noncustodial parents to provide Medicaid recipients with

health insurance.<sup>1</sup> The Office also gathered Medicaid payment information for the 500 households from the Office of the State Auditor (“Auditor”),<sup>2</sup> and used the actual payment information to estimate the potential financial impact on the entire Massachusetts Medicaid program.

The Office also evaluated whether MassHealth could utilize existing resources to identify noncustodial parents who have commercial health insurance that could cover their dependent children and/or the custodial parent. Finally, the Office reviewed MassHealth’s response to the Office’s 2013 recommendations; this included monitoring MassHealth’s pilot project with DOR/CSE, described above.

The Office found:

1. MassHealth paid \$1.5 million in claims and other health care costs on behalf of the 500 households sampled that a noncustodial parent’s health insurance policy should have covered during hospital fiscal year 2011;<sup>3</sup>
2. Extrapolating from those actual claims to all cases in which a recipient reported that a health insurance order exists, MassHealth could potentially be spending as much as \$17.5 million annually for health care that a noncustodial parent’s health insurance plan should have covered. This figure could be even greater if MassHealth pursues health insurance orders for appropriate cases where no order is currently in place; and
3. MassHealth has access to commercial health insurance information that it could use to identify noncustodial parents who have, or who have access to, employer-sponsored health insurance.

Based on these findings, the Office makes the following recommendations:

1. MassHealth should amend its Medicaid application to require identifying information, including Social Security numbers, for custodial and noncustodial parents for all the children included in the application;
2. MassHealth should use its current data verification and matching processes to independently verify applicants’ answers to questions about noncustodial parents;
3. MassHealth should use the vendor it currently uses for Medicaid eligibility determinations to identify noncustodial parents with (or with access to) employer-sponsored insurance;

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<sup>1</sup> The Office appreciates the assistance of the County Registrars of Probate and their staffs, as well as the staff of the Administrative Office of the Probate and Family Court, in identifying cases and locating court records.

<sup>2</sup> The Office appreciates the Auditor’s assistance in assembling and providing this information, which was essential to the Office’s claims analysis.

<sup>3</sup> Hospital fiscal year 2011 ran from October 1, 2010 to September 30, 2011.

4. MassHealth and DOR/CSE should formalize the process for MassHealth referrals to DOR/CSE, which can then initiate proceedings against noncustodial parents to obtain health insurance coverage for the dependent child and/or custodial parent;
5. MassHealth should continue the process of simplifying and clarifying the Medicaid application form; and
6. The Legislature should consider funding a data-match system that would allow MassHealth and DOR/CSE to easily identify when a court orders a noncustodial parent to provide health insurance to a custodial parent and/or dependent children.

The Office does not suggest that any current recipients are ineligible for Medicaid. Even when a recipient is added to a noncustodial parent's health insurance, it is likely that the recipient would maintain Medicaid as a secondary insurance. The recommendations above, however, could make a positive financial impact on MassHealth and would help ensure that Medicaid is the payor of last resort.

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## ***Background***

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### **I. Office of the Inspector General**

Created in 1981, the Office was the first state inspector general's office in the country. The Office's mission is to prevent and detect fraud, waste and abuse in the expenditure of public funds. The Office investigates allegations of fraud, waste and abuse at all levels of government; conducts programmatic reviews to identify systemic vulnerabilities and opportunities for improvement; and provides assistance to the public and private sectors to help prevent fraud, waste and abuse in government spending. The Office also offers comprehensive training and certification programs designed to promote excellence in public procurement and to enhance public purchasing officials' ability to operate effectively.

### **II. The Medicaid Program**

The Medicaid program was created in 1965 for the purpose of providing medical assistance to low-income Americans, particularly children, through a shared state-federal commitment. Today, Medicaid is an entitlement program that finances medical care, as well as long-term care, for tens of millions of Americans. Each state administers its own version of Medicaid under federal and state laws and regulations.

#### **A. Federal Regulations**

MassHealth must administer Medicaid pursuant to a number of basic federal guidelines that beneficiaries must meet and mandates with which the state must comply. The federal law governing the administration of the Medicaid program underwent significant changes as a result of the Patient Protection and Affordable Care Act of 2010 ("ACA"). In January 2013, new federal regulations regarding Medicaid were proposed to comply with the ACA.<sup>4</sup>

#### **1. Payor of last resort and identification of third-party liability**

The federal government has determined that Medicaid must be the payor of last resort. This means that Medicaid must ensure that it is paying only for individuals who have no other source of payment for their health care, or that Medicaid pays last when other insurance does not cover the full cost of medical services.<sup>5</sup> To carry out this mandate, federal regulations require that MassHealth take "reasonable measures" to determine if any other entity is legally liable to pay for health care services.<sup>6</sup> Although there are a number of different sources of third-party legal liability, for this report the Office focused on noncustodial parents' commercial health insurance.

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<sup>4</sup> Medicaid, Children's Health Insurance Programs, and Exchanges, 78 Fed. Reg. 4594-01, 4628 (proposed January 22, 2013) (to be codified at 42 C.F.R. pt. 433).

<sup>5</sup> 42 CFR § 433.138(b).

<sup>6</sup> *Id.* § 433.138(a).

To meet the “reasonable measures” standard under federal regulations, MassHealth must:

[D]uring the initial application and each redetermination process, obtain from the applicant or recipient such health insurance information as would be useful in identifying legally liable third-party resources so that the agency may process claims under the third-party liability payment procedures . . . . Health insurance information may include, but is not limited to, the name of the policyholder, his or her relationship to the applicant or recipient, the social security number (SSN) of the policyholder, and the name and address of insurance company and policy number.<sup>7</sup>

The federal regulations further require MassHealth to use the Social Security number and information regarding the custodial and noncustodial parents’ employer(s) to determine the availability of employer-sponsored health insurance.<sup>8</sup>

In situations with a custodial parent and a noncustodial parent, courts will often enter a health insurance order requiring one parent to provide health insurance for the child and/or the other parent. To ensure that it is using reasonable measures to determine if there is any other entity that is legally liable to pay for health care services, MassHealth has an obligation to gather information that will identify whether commercial health insurance is available to cover a recipient, as well as whether a health insurance order exists.

## **2. Assignment of rights and cooperation**

The Center for Medicare and Medicaid Services (“CMS”), the federal agency that oversees the state’s administration of Medicaid, now requires a streamlined application process as a part of the implementation of the ACA. States must now set up the Medicaid application process so that a single member of a household may apply for Medicaid for all members of his immediate household. CMS refers to the applicant as the single signer; the single signer does not have to be a parent, relative or legal guardian of the child on the Medicaid application, and need not be related to the other adults on that application.

The applicant must assign to the Medicaid agency (in this case, MassHealth) his rights to any third-party payments for medical health care, such as payments he receives under a legal settlement or a court order. He must also assign the rights of each individual in the household for whom he can legally make such an assignment. The applicant must also agree to cooperate with MassHealth to: (1) establish paternity for any child born out of wedlock listed on the application; and (2) obtain health insurance for himself and any other person for whom the individual can legally assign rights.<sup>9</sup>

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<sup>7</sup> Id. § 433.138(b)(1).

<sup>8</sup> Id. § 433.138(d)(1)(i-ii). Federal regulations also require MassHealth to enter into agreements with other entities to identify additional potential sources of third party liability, such as workers’ compensation and motor vehicle accident coverage. Id. § 433.138(d)(4)(i-ii).

<sup>9</sup> Medicaid, Children’s Health Insurance Programs, and Exchanges, 78 Fed. Reg. at 4628.

In this context, “cooperation” means that MassHealth may require the individual to come to a MassHealth office to provide information or evidence; appear as a witness at a court or other proceeding; provide information, or attest to lack of information, under penalty of perjury; pay MassHealth any support or medical care funds he has received; and take any other reasonable steps to assist in securing medical support and payments, and in identifying and providing information to assist MassHealth in pursuing any liable third party (such as health insurance from a noncustodial parent).<sup>10</sup>

### **3. Good cause for refusal to cooperate**

MassHealth may waive the cooperation requirements if it determines that there is good cause for an individual’s refusal to cooperate. To do so, MassHealth must find that cooperation is not in the best interest of a child. Similarly, for an individual who is applying only for himself, MassHealth may waive cooperation if it determines that cooperation would result in reprisal against, and cause physical or emotional harm to, the individual.<sup>11</sup> When MassHealth waives cooperation, it must do so in a manner that is consistent with the federal child support enforcement program.<sup>12</sup>

### **B. MassHealth Categories and Coverage<sup>13</sup>**

Although the federal government partially funds Medicaid, the Commonwealth is responsible for administering the program. As the administrator, MassHealth must ensure that the program meets both federal and state mandates. With permission from the federal government, the Commonwealth may create programs that broaden health care services to include individuals who do not meet all the federal Medicaid standards.

MassHealth currently administers seven different types of Medicaid programs and three additional non-Medicaid benefits programs. The MassHealth Medicaid programs are:

1. Standard: for pregnant women, children, parents and caretaker relatives, young adults, disabled individuals, certain persons who are HIV positive, individuals with breast or cervical cancer, independent foster care adolescents, Department of Mental Health clients, and medically frail individuals;
2. CommonHealth: for disabled adults, young adults, and disabled children who are not eligible for MassHealth Standard;
3. CarePlus: for adults 21 through 64 years of age who are not eligible for MassHealth Standard;

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<sup>10</sup> 42 CFR § 433.147(b).

<sup>11</sup> *Id.* § 433.147(c)(2).

<sup>12</sup> *Id.* § 433.147(c & d).

<sup>13</sup> All Code of Massachusetts Regulations (CMR) citations in this report reference the CMR in effect as of January 1, 2014.

4. Family Assistance: for children, young adults, certain noncitizens and persons who are HIV positive who are not eligible for MassHealth Standard, CommonHealth, or CarePlus;<sup>14</sup>
5. Small Business Employee Premium Assistance: for adults or young adults who:
  - a. work for small employers;
  - b. are not eligible for MassHealth Standard, CommonHealth, Family Assistance, or CarePlus;
  - c. do not have anyone in their premium billing family group who is otherwise receiving a premium assistance benefit; and
  - d. have been determined ineligible for a Qualified Health Plan with a Premium Tax Credit due to access to affordable employer-sponsored insurance coverage;
6. Limited: for certain lawfully present immigrants, nonqualified permanent residents under color of law and certain other noncitizens; and
7. Senior Buy-In: for certain Medicare beneficiaries.<sup>15</sup>

The three non-Medicaid benefits programs are:

1. the Children's Medical Security Plan, which provides certain uninsured children and adolescents with primary and preventive medical and dental coverage;
2. the Healthy Start Program, which provides health insurance to low-income, uninsured pregnant women to improve access to early, comprehensive and continuous prenatal care to improve the health of newborns and their mothers; and
3. the Health Safety Net, which provides care for uninsured and underinsured individuals who are otherwise not eligible for MassHealth programs.

MassHealth also assists in the administration of the eligibility process for Commonwealth Care, a state program that offers affordable health insurance to uninsured Massachusetts adults who meet certain income and other requirements but who do not qualify for Medicaid.

### **C. MassHealth Application**

In October 2013, MassHealth rolled out a new form for people to use to apply for health care benefits. Specifically, the new Application for Health Coverage and Help Paying Costs Instructions form ("ACA-2") replaced MassHealth's previous application, the Medical Benefit Request form ("MBR"). The ACA-2 now serves as the entry point for all individuals, families and small business employees in the Commonwealth to access the state's health care programs,

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<sup>14</sup> Some limited aspects of this program do not fall within Medicaid.

<sup>15</sup> 130 CMR § 505.001(A).

including Medicaid, the Health Connector health plans<sup>16</sup> and the Health Safety Net. See Appendix A for the ACA-2. Applicants must answer all the questions in the ACA-2 and provide any other required information, including proof of citizenship for any member of the household who is applying for Medicaid.

As of the writing of this report, an individual can complete the ACA-2 in one of three ways: (1) by downloading the paper application form from the MassHealth website and then mailing or faxing the form to MassHealth; (2) by telephone; or (3) in person at one of the four MassHealth Enrollment Centers. Although there is an online application for Medicaid on the Health Connector's website, according to MassHealth the online system is not reliably making eligibility determinations at this time. MassHealth has stated that this is due to a backlog in change requests for the vendor hired to implement the new ACA-compliant Health Connector website. As of the release of this report, MassHealth did not have a timeline for when the online system will be making eligibility determinations, but stated it is working with its vendors to address the issues as quickly as possible.

If MassHealth does receive an application submitted through the Health Connector's website, there is a manual process to ensure that the application complies with the ACA. For this report, the Office focused on the process that is currently in place for paper, telephone and in-person applications.

### **1. ACA-2 questions regarding other insurance and noncustodial parents**

The ACA-2 asks for information regarding other health insurance. Specifically, the application asks if any household member has Medicare, health insurance from the U.S. military, or any other type of health insurance, including insurance from a "parent who is not living in the household" (that is, a noncustodial parent). If the applicant responds affirmatively to any of these questions, the ACA-2 instructs him to provide detailed information aimed at identifying the other insurance. This includes asking for the policyholder's name, Social Security number and contribution to premium costs, as well as the insurance company's name, policy type, policy start date, policy number, covered services, and the names of covered family members. If the applicant responds negatively to all of the questions regarding other health insurance, the ACA-2 directs the applicant to answer four questions regarding the noncustodial parents of the children listed on the application:<sup>17</sup>

1. Was any child in the household adopted by a single parent?
2. Does any child in the household have a parent who has died?
3. Does any child in the household have a parent who is unknown?

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<sup>16</sup> According to its website, the Health Connector is meant to be "Massachusetts' health insurance marketplace, where individuals, families and small businesses can shop among the state's leading health insurance carriers and choose the right plan to meet their needs and budget." See [www.mahealthconnector.info/portal/site/connector](http://www.mahealthconnector.info/portal/site/connector).

<sup>17</sup> By contrast, if the applicant answers affirmatively to any questions about other insurance, the applicant is not directed to answer any questions about noncustodial parents.

4. Does any child in the household have a parent who does not live with the child and who is not included in the previous questions?

If the applicant answers “yes” to questions three or four, MassHealth will send a separate form to the custodial parent to fill out and return. This stand-alone form is called the *Absent Parent/Noncustodial Parent Form* (“NCP-1”).<sup>18</sup> See Appendix B for the NCP-1.

## **2. The ACA-2’s rights, responsibilities and signature pages**

The final section of the ACA-2 states: “On behalf of myself and all persons listed on this application, I understand, represent and agree” to 17 enumerated rights and responsibilities. The rights and responsibilities include authorizing MassHealth to pursue a third party, such as a noncustodial parent, when a Medicaid recipient has a health insurance order that requires the noncustodial parent to provide health insurance. The applicant, and anyone listed on the application whose rights they can legally assign, must also cooperate with MassHealth in “establishing third-party support and obtaining third-party payments.” In addition, the parent or legal guardian, who may or may not be the person applying for Medicaid, must agree to cooperate with efforts to “collect medical support from the noncustodial parent,” unless he believes that cooperation would result in harm to the child or himself.

By signing the Medicaid application, the applicant attests, under the pains and penalties of perjury, that he has permission to submit the application on behalf of all adults and minor children listed. The applicant also attests that he will inform all of the individuals listed that he has submitted an application for Medicaid on their behalf. Finally, the applicant must assert, under the pains and penalties of perjury, that the information about himself and all household members is “correct and complete” to the best of the applicant’s knowledge.

## **3. NCP-1 and questions regarding noncustodial parents**

As indicated above, MassHealth sends the NCP-1 to the custodial parent of the child listed on the ACA-2 if the applicant states that the child’s parent (1) is unknown; or (2) does not live with the child. The custodial parent must fill out and sign the form for all of the children who have a noncustodial parent.

The custodial parent must also agree to cooperate with MassHealth and the Department of Revenue’s Child Support Enforcement Division (“DOR/CSE”) “in collecting medical support from noncustodial parents,” unless there is good cause for not cooperating. The NCP-1 therefore asks the custodial parent to indicate whether any of the following situations apply:

1. Adoption of the child is in process.
2. The child was a result of sexual abuse or assault.

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<sup>18</sup> MassHealth uses the terms “noncustodial parent” and “absent parent” interchangeably. The NCP-1 form took the place of the Supplement B in the prior version of the application (the MBR).

3. Cooperation is not in the best interest of the child (for example, cooperation could result in serious physical or emotional harm to the custodial parent and/or the child).
4. The custodial parent adopted the child as a single parent.
5. The child's noncustodial parent is deceased.
6. The custodial parent does not know the identity of the child's noncustodial parent.
7. The custodial parent is pregnant and not married to the child's father.

If the custodial parent indicates that one of these seven situations applies, MassHealth considers there to be "good cause" for not cooperating and the custodial parent does not need to provide any information about the noncustodial parent. If none of the situations is applicable, the custodial parent must complete the remaining sections of the NCP-1 for each dependent child who is receiving Medicaid.

In particular, the applicant must provide the noncustodial parent's name, address, telephone number, Social Security number (if it exists and the applicant can obtain it), date of birth, driver's license number, gender, and employer's name and address. The NCP-1 also asks about the noncustodial parent's health insurance. First, the form asks if the noncustodial parent has insurance that currently covers dependents and/or the custodial parent. If the answer is "yes," the NCP-1 prompts the custodial parent to provide the policyholder's name, the insurance company's name, the policy number, and the group number. Next, the NCP-1 asks if a court has issued an order for the noncustodial parent to provide health insurance for the child or the custodial parent. If the custodial parent answers "yes," the form asks "where and when" the court issued that order. The NCP-1 requires the custodial parent to provide this information for each of the children on whose behalf the custodial parent is completing the NCP-1.

Once the custodial parent receives the NCP-1, he then has 90 days to complete and return the form to MassHealth.<sup>19</sup> During these 90 days, the custodial parent receives provisional Medicaid coverage if he meets all of the other eligibility requirements. If the custodial parent does not return the NCP-1 within that timeframe, MassHealth closes the custodial parent's coverage. However, if the custodial parent returns the NCP-1 within 90 days, but it is incomplete, MassHealth sends the custodial parent a second verification form ("VC-1") to obtain the missing information. The custodial parent then receives an additional 90 days to complete and return the VC-1 to MassHealth. Thus, the custodial parent could potentially receive provisional Medicaid coverage for up to 180 days without providing the required noncustodial parent information.<sup>20</sup>

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<sup>19</sup> 130 CMR §§ 502.001(B), 502.003.

<sup>20</sup> MassHealth only terminates the custodial parent's Medicaid. Children and other adults in the household remain on Medicaid, regardless of whether the custodial parent has provided the required information about the dependent children's noncustodial parent. Also, pregnant women cannot lose eligibility for failing to provide the required information.

#### **D. MassHealth Eligibility Determination Process**

As part of the eligibility determination process, MassHealth's regulations permit it to take data from the ACA-2 and match it with information held by other agencies and information sources. These agencies and information sources may include, but are not limited to: Division of Unemployment Assistance, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veterans' Services, Department of Revenue, Bureau of Special Investigations, Social Security Administration, Federal Data Services Hub, Systematic Alien Verification for Entitlements, Department of Transitional Assistance, and commercial health insurance carriers.<sup>21</sup>

In addition to its responsibility for obtaining complete information and matching that information with other sources, MassHealth is responsible for reviewing the accuracy of the information that it collects. In particular, MassHealth regulations refer to its Quality Control Division, which "periodically conducts an independent review of eligibility factors in a sampling of case files."<sup>22</sup>

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<sup>21</sup> 130 CMR § 502.004.

<sup>22</sup> 130 CMR § 501.010(C).



## ***Findings***

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### **I. Review of MassHealth and Health Insurance Orders**

The Office evaluated whether pursuing noncustodial parents' health insurance could have a meaningful financial impact on Massachusetts' Medicaid program. The Office concluded that it could. Specifically, the Office examined a sample of cases in which a court had ordered a noncustodial parent to provide health insurance for a Medicaid recipient (either the custodial parent and/or dependent child). The Office found that in hospital fiscal year 2011,<sup>23</sup> MassHealth paid up to \$1.5 million in claims that a noncustodial parents' health insurance policy should have covered.

#### **A. Methodology**

To perform its review, the Office began with a "snapshot" of MassHealth's Medicaid database (referred to as "MA21") from May 2011. MassHealth uses MA21 to determine eligibility and to maintain information for every individual in the Medicaid programs that it administers.<sup>24</sup> The data showed that as of May 2011, MassHealth had information (such as name and address) about noncustodial parents for 232,563 Medicaid recipients (including both dependent children and custodial parents). The data also contained information that 15,503 recipients (again, both dependent children and custodial parents) had reported the existence of a court order requiring the noncustodial parent to provide health insurance to the recipient.<sup>25</sup> From those 15,503 recipients, the Office selected a statistically valid, random sample of 500 households, representing 1,352 individual Medicaid recipients.

The Office then reviewed files at Probate and Family Courts throughout Massachusetts to determine if the 500 households in the sample in fact had valid court orders requiring the noncustodial parent to provide health insurance to a dependent child or custodial parent. The Office identified court records associated with 338 of the 500 households in the sample. The Office could not locate court files or orders for the remaining 162 households.<sup>26</sup> Of the 338 households with court records, the Office could not review files for 56 households because the court had impounded the records. The Office examined the case files for the remaining 282

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<sup>23</sup> In Massachusetts, hospitals operate on a fiscal year that runs from October 1 to September 30.

<sup>24</sup> To comply with the Affordable Care Act, MassHealth planned to transition by January 1, 2014 to a new system for determining Medicaid eligibility. That system, called the Health Insurance Exchange/Integrated Eligibility System ("HIX/IES"), will eventually fully integrate eligibility determinations for a variety of state health and human services programs. As of the writing of this report, HIX/IES had not been fully implemented due to technical issues with the vendor. The issues and recommendations set forth in this report are equally relevant to the current MA21 system and the new HIX/IES system.

<sup>25</sup> This does not mean that the remaining recipients did not have a health insurance order from a court. In the May 2011 snapshot, the vast majority of applicants did not answer questions on the application about health insurance orders.

<sup>26</sup> There are several reasons that the Office could not locate a court order. For example, the order could have been issued in another state, or there could have been an error on the application that misidentified the parties to the court order.

households to look for documentation pertaining to the provision of health care coverage for the custodial parents and the dependent children who were Medicaid recipients at the time of the sample.

The Office categorized the documentation that it found in the case files of the 282 households into five groups:

1. An “Unconditional Order” compels the noncustodial parent to obtain or continue to provide health care insurance for a dependent child or custodial parent.
2. A “Conditional Order” compels the noncustodial parent to provide health care insurance if and when it is available at a reasonable cost.
3. A “Head of Household Order” (“HOH Order”) compels the head of the household (*i.e.*, the custodial parent) to provide health care insurance to dependent children.
4. An “Other” designation describes a unique circumstance regarding health care coverage, such as a judicial order that a family remain on Medicaid.
5. A “No Order” designation describes cases with no order on file pertaining to health care.

The Office then worked closely with the Office of the State Auditor (“Auditor”) to obtain Medicaid claims data for the 500 households in the sample for hospital fiscal year 2011. The Auditor was instrumental in enabling the Office to review the possible fiscal impact on MassHealth for the sample households that had health insurance orders. The claims data included the amount that MassHealth paid for each of the 1,352 individual Medicaid recipients in the 500 households included in the sample.<sup>27</sup> The Office received additional data from MassHealth to identify whether any noncustodial parents’ health insurance policies already covered any recipients in the sample. The Office then performed a fiscal impact analysis utilizing the claims, court orders and MassHealth data.

**B. MassHealth Paid Over \$1.5 Million in Claims for Dependent Children and Custodial Parents Who Had Health Insurance Orders Mandating that the Noncustodial Parent Provide Health Insurance.**

As detailed above, the Office found and reviewed court case files for 778 recipients, representing 282 households, from the sample population. The Office eliminated 46 recipients because they indicated good cause for not cooperating with MassHealth to obtain health insurance from the

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<sup>27</sup> In this report, the term “claims” includes capitation payments. A capitation payment is a payment MassHealth makes periodically to a managed care organization (“MCO”) on behalf of a recipient who is enrolled in the MCO. MassHealth makes the payment regardless of whether the recipient receives services during the period covered by the payment. 42 C.F.R. § 438.2.

noncustodial parent.<sup>28</sup> The remaining 732 recipients were the focus of the Office's fiscal analysis.

Of the remaining 732 recipients, 182 fell into one of three categories: HOH Order (78 recipients), No Order (71 recipients), and Other (33 recipients). The Office eliminated these cases from the review of claims paid because there was no order in place for a noncustodial parent to provide health insurance coverage for the dependent child and/or custodial parent. The Office further refined its analysis using the data obtained for MassHealth, which indicated that 73 recipients were already enrolled in a noncustodial parent's employer-sponsored health insurance. Because the noncustodial parent was providing health insurance as required, the Office removed these recipients from its sample.

The Office focused the rest of its analysis on the remaining 477 recipients, from 208 households, with health insurance orders. Of these recipients, 237 had an Unconditional Order and 240 had a Conditional Order. After performing a financial analysis for these individual recipients, the Office found that MassHealth paid claims totaling \$1,518,703.72 for this population during hospital fiscal year 2011.

TABLE 1: Total Cost of Claims Paid by MassHealth			
Type of Health Insurance Order	# of Households	# of Recipients	Total Payments
<b>Conditional</b>	107	240	\$760,862.83
<b>Unconditional</b>	101	237	\$757,840.89
<b>Total</b>	<b>208</b>	<b>477</b>	<b>\$1,518,703.72</b>

As detailed above, the Office drew its sample from the 15,503 recipients who had reported the existence of a court order obligating a noncustodial parent to provide health insurance. Extrapolating from the statistically valid sample to claims for the 15,503 recipients who reported court orders, the expected average cost of claims that may be subject to an Unconditional Order is in the range of about \$8.7 million per year. Extrapolating from the statistically valid sample to claims for this same group, the expected average cost of claims that may be subject to a Conditional Order is in the range of about \$8.8 million per year, for a total of \$17.5 million annually.

The extrapolated totals are estimates and may not represent dollars that MassHealth might recover because in many cases the noncustodial parent cannot obtain insurance, or in other cases Medicaid would have paid for some portion of the claims as the secondary insurer. However, the total potential impact could also be much higher, because the analysis accounts only for the 15,503 recipients who disclosed the existence of a health insurance order. As of May 2011, MassHealth had information concerning noncustodial parents for approximately 232,563 Medicaid recipients (both dependent children and custodial parents). The majority of recipients

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<sup>28</sup> There are instances where a health insurance order may be in place before a Medicaid member claims good cause. In those cases, MassHealth will not enforce the health insurance order because the good cause exemption takes precedence. The Office therefore removed these 46 recipients from the sample.

had left blank all questions on the application asking about health insurance orders. Thus, because other recipients may have – or could obtain – health insurance orders, the financial impact on MassHealth could exceed the figures discussed above.

## **II. Evaluation of MassHealth’s Resources to Identify Employer-sponsored Health Insurance**

MassHealth contracts with a vendor to perform many of its eligibility determinations for the Medicaid program. The vendor performs data matches using several public and private databases, including a database containing information about members of more than 1,000 commercial health insurance companies. Currently, however, MassHealth does not have the vendor perform data matches to identify noncustodial parents who have, or who have access to, employer-sponsored health insurance.<sup>29</sup>

The Office therefore sought to determine whether such a match would be beneficial. The Office requested data from the vendor to identify custodial parents enrolled in Medicaid in 2013 who met the following criteria:

1. has Medicaid primary coverage;
2. has indicated that a child in the family has a parent who does not live with the child;
3. has not indicated that there is “good cause” to decline to help MassHealth get medical support from a noncustodial parent of a child;
4. has provided the Social Security number for the noncustodial parent; and
5. has indicated that there is a health insurance order against a noncustodial parent.

The Office further requested that the vendor provide data identifying whether any of the noncustodial parents (1) have employer-sponsored health insurance, and if so, whether any of their children were covered by that policy; or (2) have access to, but are not enrolled in, employer-sponsored health insurance.

MassHealth’s vendor provided the Office with a randomly selected sample of 500 households that met the criteria.<sup>30</sup> The sample data showed that only 19 of the noncustodial parents had enrolled their dependent child in employer-sponsored health insurance. Of the remaining 480, there were 133 noncustodial parents (or 26.6% of the sample) who had, or had access to, employer-sponsored health insurance but had not enrolled their children. The vendor could not locate employer-sponsored health insurance for the remaining 347 noncustodial parents.

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<sup>29</sup> The vendor does use information about Medicaid recipients to identify those who also have some other form of health insurance (for instance, a custodial parent’s health insurance). This match will not, however, identify situations in which a noncustodial parent has health insurance but has not included the dependent children or custodial parent on that insurance.

<sup>30</sup> The sample included one record that contained blank fields regarding the noncustodial parent.

The fact that the data match found 26.6% of the sample with, or with access to, employer-sponsored health insurance highlights the benefit of matching all noncustodial parents against the vendor's commercial health insurance database. If applied to the total population of noncustodial parents, including cases where the custodial parent did not indicate that a health insurance order was in place, the results could be substantial. In short, these results demonstrate that (1) MassHealth can perform data matches to identify noncustodial parents who have (or have access to) employer-sponsored health insurance; and (2) it is worthwhile to perform these data matches.

### **III. Update on the Office's 2013 Recommendations**

The Office reviewed MassHealth's efforts to address the recommendations in the Office's 2013 report. In general, MassHealth has made progress in the past year but it could do more to ensure that, in the appropriate circumstances, recipients are added to the noncustodial parents' health insurance.

#### **A. The Office Recommended that MassHealth Simplify the Language on, and Add New Questions to, the Medicaid Application.**

In its 2013 report, the Office recommended that MassHealth make the Medicaid application, now called the ACA-2, more accessible to applicants by simplifying language and adding new questions. In response to this recommendation, MassHealth added the check box "I don't know" to allow the applicant to complete all the answers on the application. MassHealth also simplified the language that asks the applicant if there is a health insurance order for the noncustodial parent to provide health insurance. However, there are two recommendations that MassHealth did not implement: (1) adding a question asking if the noncustodial parent is currently married; and (2) requiring that the custodial parent give MassHealth a copy of any health insurance orders issued by a court.<sup>31</sup> The Office still believes MassHealth should implement these changes.

In the past year, MassHealth necessarily focused on the ACA, including ensuring that its new application forms are ACA-compliant. In the coming year, MassHealth could strengthen its ability to obtain information about noncustodial parents by clarifying and simplifying its forms. As an example, the ACA-2 asks applicants four preliminary questions about the noncustodial parents of the dependent children included in the application. MassHealth sends out a follow-up form (the NCP-1) to gather information about the noncustodial parents based on the applicants' answers to those four questions.

However, MassHealth does not direct every applicant to answer the four preliminary questions. Instead, the form instructs applicants to answer those questions only if they answered "no" to a series of insurance questions unrelated to noncustodial parents.<sup>32</sup> For instance, one question asks if any member of the household has Medicare. The fact that one member of the household may be eligible for Medicare has no bearing on the need to identify the noncustodial parents for the

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<sup>31</sup> If the noncustodial parent is married, it could provide insight into that parent's access to health insurance.

<sup>32</sup> In certain limited exceptions, the insurance information could pertain to a noncustodial parent.

dependent children included in the application. MassHealth should make it clear that all applicants need to answer the four preliminary questions.

Similarly, the ACA-2 states that if the applicant answers “no” to the first two preliminary questions about noncustodial parents, then he should go to the next section of the application. However, there is no direction on what he should do if he answers “yes” to either question. This sort of ambiguity can be confusing when filling out complex forms.

As a final example, the NCP-1 asks whether the noncustodial parent has an insurance policy that covers dependents. The form should go a step further and ask if the noncustodial parent has access to insurance that would cover dependents. This is an important piece of information that could lead to coverage for some Medicaid recipients.

**B. The Office Recommended that MassHealth Require Applicants to Answer All of the Questions on Supplement B and Any Other Questions Related to the Noncustodial Parents’ Health Insurance.**

The Office also recommended that MassHealth require applicants to answer all of the questions on Supplement B (now known as NCP-1) to the Medicaid application. Supplement B asked the custodial parent to provide extensive information about the noncustodial parent, including information aimed at identifying the availability of commercial health insurance. Before the Office’s 2013 report, however, MassHealth considered Supplement B to be complete if the custodial parent signed it and answered three questions about the noncustodial parent: name, the names of the noncustodial parent’s children, and the noncustodial parent’s relationship to the children (*i.e.*, mother or father).<sup>33</sup> Consequently, the Office found that applicants frequently did not provide important information about noncustodial parents. Table 2 shows the number of applications that had blanks for various fields on Supplement B.

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<sup>33</sup> Appropriately, MassHealth also considered the form to be complete if there was good cause for not providing the information and in other limited circumstances not pertinent here.

TABLE 2: MassHealth Data Collection for May 2011*		
Required Field on Supplement B	Count of Fields Left Blank	% of Total
Date of Birth	61,629	42%
Address	100,714	68%
Last Name	26,160	18%
Social Security number	108,298	73%
Employer Name	127,129	86%
Health Insurance Court Order	97,226	66%
Gender	7,078	5%
Last Name of Child of Noncustodial Parent	0	0%
First Name of Child of Noncustodial Parent	0	0%
<b>Total Blank Fields</b>	<b>147,394</b>	
<b>Total MassHealth Caseload</b>	<b>1,301,764</b>	
*Excludes recipients with good cause not to provide the information.		

Since the Office's 2013 report, MassHealth has demonstrated a commitment to collect information relevant to the identification of the noncustodial parent. As noted earlier, MassHealth now requires that the information requested on the NCP-1 be provided within 180 days of receiving the NCP-1. This timeframe includes the initial 90 days after MassHealth sends the NCP-1 to the custodial parent and the additional 90 days after MassHealth sends the second request (the VC-1). Moreover, if the custodial parent does not provide the noncustodial parent information within that timeframe, MassHealth is supposed to terminate the custodial parent's Medicaid coverage.<sup>34</sup>

The Office still has concerns regarding the collection of data. For example, although the custodial parent is supposed to complete the information on the NCP-1 within 90 days, the NCP-1 does not list any timeframe for returning the form to MassHealth. See Appendix B.

Also, the Social Security number is a vital piece of data to identify the noncustodial parent and his access to health insurance. However, many applicants do not know the noncustodial parent's Social Security number. MassHealth has other data elements available to it that would allow it to identify the noncustodial parent's Social Security number. MassHealth has stated, however, that federal regulations do not authorize state Medicaid agencies to use information on the Medicaid application, such as the noncustodial parent's name and date of birth, to obtain a noncustodial parent's Social Security number from a third-party data source (such as from the

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<sup>34</sup> MassHealth only removes the custodial parent from Medicaid. Children and other adults in the household remain on Medicaid, regardless of whether the custodial parent has provided the required information about the dependent children's noncustodial parent. Also, pregnant women cannot lose eligibility for failing to provide the required information.

Social Security Administration).<sup>35</sup> The Office believes the regulations allow for the identification of the noncustodial parent's Social Security number.

It is important that MassHealth collect, verify and act on information about noncustodial parents and their health insurance. Collection of accurate and timely information is crucial to ensuring that Medicaid is used appropriately. Further, identification of the noncustodial parent's Social Security number will assist in appropriately shifting some of the responsibility of providing health care to noncustodial parents.

**C. The Office Recommended that MassHealth Expand Its Efforts to Use Noncustodial Parent Information to Evaluate Opportunities to Get Medicaid Recipients Coverage Through Noncustodial Parents' Health Insurance.**

The third recommendation that the Office made was for MassHealth to make better use of the information that it receives regarding noncustodial parents. In response to this recommendation, MassHealth has taken some steps to better use the information on the ACA-2 and NCP-1 to pursue noncustodial parents' health insurance for Medicaid recipients.

Historically, MassHealth has not referred cases to the Department of Revenue's Child Support Enforcement Division ("DOR/CSE") to initiate proceedings against noncustodial parents to obtain health insurance orders for dependent children and custodial parents. Since 2009, MassHealth and DOR/CSE have periodically considered such referrals, but have not yet adopted any rules or procedures for determining when referrals are appropriate. After the Office identified its concern last year about the lack of referrals, MassHealth and DOR/CSE revived their collaboration and created a pilot project designed to identify those instances in which it would be cost-effective for MassHealth to pursue noncustodial parents' health insurance by referring cases for DOR/CSE to initiate proceedings to obtain health insurance orders.

The pilot focused on households that listed a noncustodial parent on a Medicaid application filed after mid-2011. As an initial matter, the pilot excluded all households that met any of the following criteria:

1. The custodial parent did not make an assignment of rights to MassHealth;
2. The custodial parent claimed good cause for not assisting MassHealth in pursuing a health insurance order;

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<sup>35</sup> MassHealth referred the Office to a federal regulation, 42 CFR § 433.138, as its reason for not using data to identify the noncustodial parent's Social Security number. That regulation provides that state Medicaid agencies must "incorporate into the eligibility case file the names and Social Security numbers of absent or custodial parents of Medicaid beneficiaries to the extent such information is available." *Id.* § 433.138(c). The same regulation also states that if a state Medicaid agency determines that an individual is eligible for Medicaid, the agency "must . . . obtain from the applicant or beneficiary such health insurance information as would be useful in identifying legally liable third-party resources." *Id.* § 433.138(b)(1). The regulation also indicates that health insurance information "may include, but is not limited to" the individual's name, relationship to the child, and the Social Security number of the health insurance policyholder. *Id.*



3. The custodial parent did not provide enough information about the noncustodial parent to make it cost-effective for MassHealth and DOR/CSE to pursue a health insurance order; or
4. The noncustodial parent was receiving assistance from a public program (*e.g.*, Medicaid, Medicare, Commonwealth Care, or Transitional Aid to Families with Dependent Children).

About 13,700 Medicaid households met none of these criteria. Selecting from this group of households, MassHealth sent DOR/CSE a random sample of 355 households, which were associated with 373 noncustodial parents. DOR/CSE matched the 355 households against its case file and excluded any active cases it was already pursuing.<sup>36</sup> This reduced the sample to 206 households associated with 224 noncustodial parents. DOR/CSE obtained the Social Security numbers for 148 of these 224 noncustodial parents because the custodial parent had, on the Medicaid application, either provided the Social Security number or provided enough other identifying information (*e.g.*, the noncustodial parent's birth date, address, and/or employer name) so that DOR/CSE could obtain the Social Security number.

Once DOR/CSE obtained the 148 noncustodial parents' Social Security numbers, it matched them against its first quarter 2013 state wage file<sup>37</sup> and found that 56 noncustodial parents had reported earnings for that quarter. After further investigation, DOR/CSE eliminated 20 of these cases because circumstances had changed, causing the cases to fall short of legal criteria for a health insurance order. This left 36 cases out of the original sample of 373 noncustodial parents potentially eligible for a health insurance order. As of the writing of this report, DOR/CSE was able to provide the Office with the status of the 36 cases that matched the criteria and the wage file: five cases are in litigation; three custodial parents did not cooperate with DOR/CSE's efforts and were reported to MassHealth for noncooperation; 22 cases are still under review awaiting additional information, confirmation or verification of information provided; and six cases met federal case-closing criteria.<sup>38</sup>

The results in a short period of time demonstrate that MassHealth has the potential to hold noncustodial parents accountable for providing health insurance for their children. Based on the results to date of the pilot program, MassHealth and DOR/CSE have indicated they are committed to ongoing collaboration and using the lessons learned from the pilot program to create a more effective and efficient referral process. With continued cooperation between MassHealth and DOR/CSE, more cases may be identified and greater enforcement will lead to lower costs to MassHealth.

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<sup>36</sup> DOR/CSE receives referral cases from other state agencies, such as those provided by the Department of Transitional Assistance, that administer public benefits programs. Thus, DOR/CSE already had cases involving households in the sample because it received a referral for those households from a different state agency.

<sup>37</sup> The state wage file is the database maintained by the Massachusetts Department of Revenue that collects quarterly wage reports from employers throughout the state.

<sup>38</sup> Federal case-closing criteria are reasons for which the state child support agency, in this case DOR/CSE, may close a child support case. There are 13 reasons delineated in the regulation for which a case may be closed. 45 CFR § 303.11.

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## ***Recommendations***

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Based on the findings above, the Office makes the following recommendations for MassHealth to strengthen its efforts to identify noncustodial parents, verify the existence of health insurance coverage and take steps to add recipients to the noncustodial parent's health insurance policy whenever appropriate. The Office does not suggest that any such recipients are ineligible for Medicaid. Even when a recipient is added to a noncustodial parent's health insurance, it is likely that the recipient would maintain Medicaid as a secondary insurance. The recommendations below, however, could make a positive financial impact on MassHealth and would help ensure that Medicaid is the payor of last resort.

### **I. MassHealth Should Continue to Identify Noncustodial Parents' Health Insurance.**

Federal regulations require MassHealth to take "reasonable measures" to determine if there is any other source, including health insurance from a noncustodial parent, to pay for a Medicaid recipient's health care. MassHealth should continue its current efforts, and should also take additional steps to identify noncustodial parents who have, or have access to, commercial health insurance that could cover their dependent children and/or the custodial parent.

#### **A. MassHealth Should Ask for the Name, Date of Birth and Social Security Number of the Custodial and Noncustodial Parents for Each Dependent Child Listed as a Household Member in Part 2: *Tell Us About Other People in This Household* of the Medicaid Application.**

The Office recommends that MassHealth ask the applicant for the name, date of birth and Social Security number of both the custodial and noncustodial parents for each child in Part 2: *Tell us about other people in this household* of the ACA-2 (the initial application). The application should ask whether the applicant is seeking benefits for any children under the age of 19, and if she is, the application should ask for information about the children's parent(s). The Office recommends that MassHealth ask for this information so that it may begin the process of identifying other health insurance which may cover recipients. Obtaining this information at the beginning of the eligibility process is important because under the current model, MassHealth may not get this basic and fundamental information until six months after the family has been found eligible for benefits.

Also, it is important to ask about both parents because under the ACA, any adult in the household may apply for Medicaid on behalf of the entire household; thus, the person filling out the application may not be a parent of the children listed on the application. Further, as demonstrated by the vendor match the Office requested and DOR/CSE's pilot project, Social Security numbers are central to determining whether a parent is enrolled in, or has access to, employer-sponsored health insurance.

The Office recognizes MassHealth's concerns that it cannot require immediate cooperation from custodial parents to obtain a health insurance order. The Office believes there are ways to request the necessary information without conflicting with federal regulations. MassHealth

could consider, for example, requesting the information on the application and granting provisional benefits if the information is not provided.

**B. MassHealth Should Use its Current Data Verification and Matching Processes to Independently Verify Applicants' Answers to NCP-1 Questions.**

The proposed federal regulations for the streamlined single signer application for Medicaid require that state agencies determine eligibility before the applicant cooperates in establishing paternity and obtaining a health insurance order.<sup>39</sup> In light of this mandate and the related requirement that Medicaid agencies provide provisional Medicaid coverage before an applicant cooperates, early data verification and matching is even more crucial. MassHealth already uses data matches with other state and federal agencies to verify applicant information. It should use these same databases to verify the noncustodial parent's information. The databases could also be used to obtain crucial identifying information, such as Social Security numbers, that are often missing from the NCP-1. This would allow MassHealth to more efficiently determine if the noncustodial parent has employer-sponsored health insurance.

**C. MassHealth Should Utilize its Vendor to Identify Noncustodial Parents With, or With Access to, Employer-sponsored Insurance that Does Not Currently Cover the Dependent Child or Custodial Parent.**

The Office recommends that MassHealth work more closely with its vendor and expand its efforts to detect whether a noncustodial parent has health insurance but does not insure his dependent child or the custodial parent. Given that MassHealth may have paid potentially \$17.5 million in claims for recipients who had a health insurance order on file, MassHealth would benefit from using all of the tools at its disposal to locate other health insurance. Moreover, the vendor match – which found that 26.6% for the noncustodial parents in the sample had, or had access to, employer-sponsored health insurance – demonstrates the importance of data matches. In particular, the vendor could match noncustodial parents' information against its database of commercial health insurance. Finally, MassHealth should explore other data matches that its vendor could utilize to identify other sources of health insurance.

**D. MassHealth Should Refer More Cases to DOR/CSE and Should Explore Additional Methods of Obtaining Health Insurance Coverage from Noncustodial Parents.**

MassHealth should evaluate all avenues for ensuring that, in the appropriate circumstances, recipients are added to the noncustodial parent's insurance. For example, MassHealth should continue its collaboration with DOR/CSE and adopt formal policies and procedures for referring cases to DOR/CSE. Consistent with its mandate to take reasonable measures to identify other sources of health care coverage, MassHealth should explore other options in addition to DOR/CSE referrals. MassHealth could, for instance, examine adopting procedures for requesting noncustodial parents to add dependents to their health insurance.

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<sup>39</sup> Medicaid, Children's Health Insurance Programs, and Exchanges, 78 Fed. Reg. at 4628.

## **II. MassHealth Should Consider Simplifying and Clarifying its Forms.**

As set forth above, the application and verification forms that MassHealth uses could be clearer and could request additional information. For example, the application should direct all applicants to answer the preliminary questions about noncustodial parents. Similarly, the NCP-1 asks if the noncustodial parent has insurance that covers dependents. The form should go a step further and ask if the noncustodial parent has access to insurance that could cover dependents. Also, MassHealth should update the forms to allow a legal guardian of a child to provide information regarding both parents. Currently, the NCP-1 is organized so that applicants can only provide information about one parent per child. Since legal guardians can fill out the NCP-1, and because each parent could have access to health insurance, the form should be adjusted.

## **III. The Legislature Should Consider Funding to Allow the Courts to Develop a Data-Match System that Would Allow MassHealth and DOR/CSE to Identify When a Court Issues a Health Insurance Order.**

The Office's review of court files across the Commonwealth illustrated the need for a formal process for MassHealth and DOR/CSE to identify and obtain health insurance orders. The Office obtained court files for 338 of the 500 households in its sample. Gathering these court files required time-intensive research at courts or through direct communication with court staff. It would not be cost-effective for MassHealth to perform this research for all recipients.

MassHealth and the Probate and Family Courts should explore developing a data match that would allow MassHealth to identify whether a recipient is the subject of a health insurance order. This system could provide another tool to augment MassHealth's referrals to DOR/CSE. Specifically, it would allow MassHealth and DOR/CSE to focus on enforcement when a court has ordered a noncustodial parent to provide health insurance, but that parent has not done so. In order for MassHealth to ensure it is the payor of last resort, it must collect the relevant information. This would be another source for MassHealth to utilize.

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***Appendix A: Application for Health Coverage and Help Paying Costs  
Instructions***

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# Application for Health Coverage and Help Paying Costs Instructions

Commonwealth of Massachusetts | EOHS



**Please read these instructions before you fill out the application.**



**Apply faster online!** Go to: [MAhealthconnector.org](http://MAhealthconnector.org). You will get results quickly. You can create a secure online account where you can see copies of notices and get important news fast.

Please read the attached Member Booklet carefully before you fill out the application. Keep the booklet.

It may answer questions you have later.

## Use this application to apply for subsidized health coverage

This is your application for MassHealth, the Children's Medical Security Plan (CMSP), the Massachusetts Health Connector (Health Connector), and the Health Safety Net (HSN). MassHealth gives health care coverage and helps pay for health insurance premiums for families, children, and individuals. The kind of health coverage you get depends on your household size, income, and other circumstances. This information helps us make sure everyone gets the best coverage. Fill out all information for each person in your household.

The Massachusetts Health Connector is the state's marketplace for health and dental insurance. The Health Connector can help you shop and enroll in insurance plans from leading health insurers in the state. You can also find out through the Health Connector if you are eligible for any programs that help you pay for health insurance premiums and lower your out-of-pocket health care costs. For more information about programs that are available through the Health Connector, see pages 3 and 18-19 in the Member Booklet.

After you fill out your application and submit it, we will review it. If you are eligible, you will get the most complete coverage available.

## Who can use this application

This application is for people who need health insurance and help paying for it, and who:

- live in Massachusetts,
- are not living in or about to go into a nursing home, and
- are under age 65.

This application may also be used by people of any age who are:

- parents of children under age 19,
- adult relatives living with and taking care of children under age 19 when neither parent is living in the home, or

- disabled and either:

- work 40 or more hours a month or are currently working and have worked at least 240 hours in the six months immediately before the month of the application, or
- not working (only if under age 65).

If this application is not for you, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

## Tell us about your household

Tell us about all household members who live with you. If you file taxes, we need to know about everyone on your tax return. If you do not file taxes, list all of the household members who are applying for coverage.

## Do include

- Yourself
- Your spouse
- Your natural, adoptive, or step children under age 19
- Your unmarried partner if you have children together who are under age 19
- Your unmarried partner's children who live with you and who are under age 19, if you include your unmarried partner
- Anyone you include on your tax return (even if they do not live with you)
- Anyone your unmarried partner included on his or her tax return (even if they do not live with you), if you include your unmarried partner
- Anyone else under age 19 who you live with and take care of

## You do not have to include

- Your unmarried partner, unless you have children together
- Your unmarried partner's children, unless they live with you
- Your parents who you live with and who file their own taxes (if you are aged 19 or older)
- Other adult relatives who you do not claim as a tax dependent

## Filling out the application

Start with yourself, and then add other adults and children. If you have more than four people in your household including yourself, you will need to make copies of the pages for Person 4 before you fill them out, and attach them to the application.

Generally, you do not need to give us the immigration statuses, or the social security security numbers (SSNs) of household members who are not applying. However, you must give us an SSN or proof that one has been applied for for every household member who is applying, unless one of the following exceptions applies.

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

We need social security numbers (SSNs) for all other persons applying for health coverage. An SSN is optional for persons not applying for health coverage, but giving us an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone does not have an SSN or needs help getting one, call the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778 for people who are deaf, hard of hearing, or speech disabled), or go to [socialsecurity.gov](http://socialsecurity.gov). Please see the Member Booklet for more information.

We keep the information provided to us private, and only use and disclose it in accordance with applicable law, unless you give us permission to share information, or allow another person to represent you.

We will try to prove your information and determine eligibility with matches through federal data sources, such as the Social Security Administration (SSA), the Internal Revenue Service (IRS), the Department of Homeland Security (DHS), and state data sources, such as the Department of Revenue (DOR), the Registry of Motor Vehicles (RMV), and other state-run public programs. If we are not able to prove your information or need more information, we will contact you. We may give you provisional coverage for up to 90 days during the time period that we are waiting for proof of information (other than a determination of disability). See the Member Booklet for more information about disability.

## To help us see if you are eligible:

- fill out the application completely,
- be sure to tell us in Part 3 about health insurance you may be able to get through your job,
- answer all questions in Part 5 and in Supplement C about any health insurance that you may have now, and
- fill out the parts of Supplement A that apply, if you answer **yes** to any questions about injury, illness, disability, accommodation, or applying due to an accident or injury caused by someone else. Do not leave any answer blank.

When we get the signed and dated application, we will review it. If we need more information after we complete the data matches, we will contact you. Once we get all needed information, we will make a decision about your eligibility. We will send you a written notice about this decision. If you need medical care and you pay for it before you get an approval notice from us, you may be able to get a refund from your health care provider for what you paid.

To start filling out this application, go to page 1.

**Remember, you must read, sign, and date the Rights and Responsibilities and Signature pages (Part 7, pages 17-19) after you have filled out the application.**



### You can submit your application in any of the following ways.

- Sign on to your account at [www.MAhealthconnector.org](http://www.MAhealthconnector.org). You can create an online account if you do not already have one.
- Send your filled-out, signed application to:  
Health Insurance Processing Center  
P.O. Box 4405  
Taunton, MA 02780.
- Fax your filled-out, signed application to:  
617-887-8770.
- Call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).



**If you have any questions about this application or the information you need to send, please call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).**



# Application for Health Coverage and Help Paying Costs

Commonwealth of Massachusetts | EOHHS



**Please print clearly.** Be sure to answer all questions. Fill out all parts of the application and all supplements that apply. If you need more space, attach a separate piece of paper to the application. Put your name and social security number at the top of the paper.

We need one adult in your household to be the contact person for your application.

## PART 1 Tell us about you (Person 1)—Fill out this part for yourself.

1. First name    Middle initial    Last name			Suffix (ex., Jr.)	Relationship to you <b>SELF</b>
2. Home street address			Apt. #	
City			State	Zip code
3. Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Mailing address (if different from home address)			
City			State	Zip code
5. Telephone number	Other telephone number	6. Email address		
7. Date of birth (mm/dd/yyyy)	8. Gender <input type="checkbox"/> M <input type="checkbox"/> F	9. Written language choice	10. Spoken language choice	

We need social security numbers for every person applying for health insurance who has one. An SSN is optional for persons not applying for health insurance, but giving us an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone needs help getting an SSN, call the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778 for people who are deaf, hard of hearing, or speech disabled), or go to [socialsecurity.gov](https://www.ssa.gov). Please see the application instructions or the Member Booklet for more information.

11. Do you have a social security number (SSN)? ☐ Yes ☐ No  
If **yes**, give us the number. \_\_\_\_\_ – \_\_\_\_\_ – \_\_\_\_\_ (Optional, if **not** applying)  
If **no**, check one of the reasons below.  
☐ Applied, but have not received SSN    ☐ Religious exemption    ☐ Only eligible for nonwork SSN  
☐ Not eligible to get SSN    ☐ Eligible for SSN, but have not applied

12. Will you file a federal income tax return next year? ☐ Yes ☐ No  
(You can still apply for health coverage even if you do not file a federal income tax return.)  
If **yes**, answer 12.a., 12.b., and 12.c. If **no**, answer 12.c.  
12.a. Will you file jointly with a spouse? ☐ Yes ☐ No If **yes**, name of spouse: \_\_\_\_\_  
12.b. Will you claim any dependents on your income tax return? ☐ Yes ☐ No  
If **yes**, list name(s) of dependents: \_\_\_\_\_  
12.c. Will someone else claim you as a dependent on his or her tax return? ☐ Yes ☐ No  
If **yes**, name of tax filer: \_\_\_\_\_ How are you related to the tax filer? \_\_\_\_\_

13. Are you pregnant? ☐ Yes ☐ No  
13.a. If **yes**, how many children are you expecting? \_\_\_\_\_ 13.b. What is the due date? (mm/dd/yyyy) \_\_\_\_\_

14. Are you applying for health coverage for yourself? ☐ Yes ☐ No

If **no**, go to **Part 2: Tell us about other people in this household** on page 3. If **yes**, answer all questions below for Person 1 (yourself).

15. Are you living in Massachusetts and planning to stay? ☐ Yes ☐ No

16. Do you live with at least one child under age 19? ☐ Yes ☐ No

16.a. If **yes**, are you the main person taking care of this child? ☐ Yes ☐ No

17. Are you in jail or prison? ☐ Yes ☐ No

If **no**, go to the next question.

17.a. If **yes**, are you (Check one.):

☐ Convicted? What is your expected release date? (mm/dd/yyyy) \_\_\_\_\_ ☐ Not convicted? (For example: confined only)

18. Did you age out of foster care at the age of 18 or older? ☐ Yes ☐ No

“Aging out” means the individual was in the custody of the state child welfare agency when he or she turned 18 years of age, or older if the individual decided to stay in placement after age 18.

19. Are you a U.S. citizen, national, or naturalized U.S. citizen? ☐ Yes ☐ No

If **yes**, go to Question 20.

19.a. If **no**, do you have an eligible immigration status? (See the Member Booklet for more information.) ☐ Yes ☐ No ☐ No response

If **no** or **no response**, you may get only one or more of the following: MassHealth Limited, the Children’s Medical Security Plan (CMSP), or the Health Safety Net (HSN). Go to Question 20.

19.b. If **yes**, do you have an immigration document? ☐ Yes ☐ No

We will try to prove your immigration status. Please list all the immigration statuses and/or conditions that have applied to you since you entered the U.S. (See the Member Booklet for more information about immigration statuses and documents.)

Immigration status

Date status awarded ( mm/dd/yyyy)	Immigration document type	Document ID number
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19.c. Did you come to live in the U.S. before August 22, 1996? ☐ Yes ☐ No

19.d. Did you use a different name to get your immigration status? ☐ Yes ☐ No If **yes**, what is it?

First name	Middle name	Last name	Suffix (ex., Jr.)
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19.e. Are you an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

19.f. Are you a spouse or unremarried surviving spouse of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

19.g. Are you an unmarried dependent child of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

20. Do you have an injury, illness, or disability (including a disabling mental health condition) that has lasted or is expected to last for at least 12 months? (If legally blind, answer **yes**.) ☐ Yes ☐ No

If **no**, go to the next question. If **yes**, fill out **Part A of Supplement A: Illness, Disability, or Accommodation** on page 21.

21. Do you or any household member need reasonable accommodation(s) because of a disability or injury? ☐ Yes ☐ No

If **no**, go to the next question. If **yes**, fill out **Part B of Supplement A: Illness, Disability, or Accommodation** on page 21.

22. Are you applying because of an accident or injury that someone else might be responsible for? ☐ Yes ☐ No

If **no**, go to the next question. If **yes**, fill out **Part C of Supplement A: Illness, Disability, or Accommodation** on page 21.

23. Do you have breast or cervical cancer? ☐ Yes ☐ No (Optional)

MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.

If **no**, go to the next question. If **yes**, we will send you a certificate to be filled out by your doctor to prove your breast or cervical cancer diagnosis. Then MassHealth can see if your MassHealth benefits give you the most coverage possible.

24. Are you HIV positive? ☐ Yes ☐ No (Optional) If you are HIV positive, you may be eligible for additional coverage or benefits.  
If **no**, go to the next question. If **yes**, you will need to give us proof of your HIV-positive status. Then MassHealth can see if your MassHealth benefits give you the most coverage possible.
25. Did you ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No  
25.a. When did you last get SSI? (mm/yyyy) \_\_\_\_\_  
25.b. Do you (Please check one.): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home?  
☐ live and share expenses with another or others (not a spouse)? ☐ live in an assisted living facility? ☐ live in someone else's home?
26. Check the box below that best describes you. (Optional)  
☐ American Indian/Alaska Native (Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))  
☐ American Indian/Alaska Native (Other Tribal Nation) ☐ Asian ☐ Black or African American ☐ Hispanic/Latino/Black  
☐ Hispanic/Latino/White ☐ Hispanic/Latino/Other ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other
27. If you are an American Indian or Alaska Native, fill out **Supplement B: American Indian (AI)/Alaska Native (AN)** on page 23. American Indians and Alaska Natives may not have to pay cost sharing and may get special monthly enrollment periods.
- Go to **Part 2** to add other household members, if needed, or go to **Part 3: Current Job and Income Information** on page 9.

## PART 2 Tell us about other people in this household

Fill out this part for your spouse or partner and children who live with you and/or anyone included on your federal income tax return, if you file one. See the application instructions for more information about who to include. If you do not file an income tax return, remember to add other persons who live with you.

### Person 2

1. First name    Middle initial    Last name			Suffix (ex., Jr.)		Relationship to you		
2. Home street address			Apt. #				
City			State		Zip code		
3. Is Person 2 homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No		4. Mailing address (if different from home address)					
City		State		Zip code			
5. Telephone number		6. Date of birth (mm/dd/yyyy)		7. Gender <input type="checkbox"/> M <input type="checkbox"/> F		8. Written language choice	
						9. Spoken language choice	

We need social security numbers for every person applying for health insurance who has one. Please see the application instructions or the Member Booklet for more information.

10. Does Person 2 have a social security number (SSN)? ☐ Yes ☐ No  
If **yes**, give us the number. \_\_\_\_\_ – \_\_\_\_\_ – \_\_\_\_\_ (Optional, if **not** applying)  
If **no**, check one of the reasons below.  
☐ Applied, but have not received SSN ☐ Religious exemption ☐ Only eligible for nonwork SSN  
☐ Not eligible to get SSN ☐ Eligible for SSN, but have not applied
11. Will Person 2 file a federal income tax return next year? ☐ Yes ☐ No  
(Person 2 can still apply for health coverage even if he or she does not file a federal income tax return.)  
If **yes**, answer 11.a., 11.b., and 11.c. If **no**, answer 11.c.  
11.a. Will Person 2 file jointly with a spouse? ☐ Yes ☐ No If **yes**, name of spouse: \_\_\_\_\_  
11.b. Will Person 2 claim any dependents on his or her income tax return? ☐ Yes ☐ No  
If **yes**, list name(s) of dependents: \_\_\_\_\_  
11.c. Will someone else claim Person 2 as a dependent on his or her tax return? ☐ Yes ☐ No  
If **yes**, name of tax filer: \_\_\_\_\_ How is Person 2 related to the tax filer? \_\_\_\_\_

12. Is Person 2 pregnant? ☐ Yes ☐ No

12.a. If **yes**, how many children is she expecting? \_\_\_\_\_ 12.b. What is the due date? (mm/dd/yyyy) \_\_\_\_\_

13. Is Person 2 applying for health coverage? ☐ Yes ☐ No

If **no**, go to **Person 3** or **Part 3: Current Job and Income Information** on page 9. If **yes**, answer all questions below for Person 2.

14. Is Person 2 living in Massachusetts and planning to stay? ☐ Yes ☐ No

15. Does Person 2 live with at least one child under age 19? ☐ Yes ☐ No

15.a. If **yes**, is Person 2 the main person taking care of this child? ☐ Yes ☐ No

16. Is Person 2 in jail or prison? ☐ Yes ☐ No

If **no**, go to the next question.

16.a. If **yes**, is Person 2 (Check one.):

☐ Convicted? What is his or her expected release date? (mm/dd/yyyy) \_\_\_\_\_ ☐ Not convicted? (For example: confined only)

17. Did Person 2 age out of foster care at the age of 18 or older? ☐ Yes ☐ No

**"Aging out" means the individual was in the custody of the state child welfare agency when he or she turned 18 years of age, or older if the individual decided to stay in placement after age 18.**

18. Is Person 2 a U.S. citizen, national, or naturalized U.S. citizen? ☐ Yes ☐ No

If **yes**, go to Question 19.

18.a. If **no**, does Person 2 have an eligible immigration status? (See the Member Booklet for more information.) ☐ Yes ☐ No ☐ No response

If **no** or **no response**, Person 2 may get only one or more of the following: MassHealth Limited, the Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN). Go to Question 19.

18.b. If **yes**, does Person 2 have an immigration document? ☐ Yes ☐ No

**We will try to prove Person's 2 immigration status. Please list all the immigration statuses and/or conditions that have applied to Person 2 since he or she entered the U.S. (See the Member Booklet for more information about immigration statuses and documents.)**

Immigration status

Date status awarded ( mm/dd/yyyy)	Immigration document type	Document ID number
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18.c. Did Person 2 come to live in the U.S. before August 22, 1996? ☐ Yes ☐ No

18.d. Did Person 2 use a different name to get his or her immigration status? ☐ Yes ☐ No If **yes**, what is it?

First name	Middle name	Last name	Suffix (ex., Jr.)
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18.e. Is Person 2 an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

18.f. Is Person 2 a spouse or unremarried surviving spouse of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

18.g. Is Person 2 an unmarried dependent child of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

19. Does Person 2 have an injury, illness, or disability (including a disabling mental health condition) that has lasted or is expected to last for at least 12 months? (If legally blind, answer **yes**.) ☐ Yes ☐ No

If **no**, go to the next question. If **yes**, fill out **Part A of Supplement A: Illness, Disability, or Accommodation** on page 21.

20. Is Person 2 applying because of an accident or injury that someone else might be responsible for? ☐ Yes ☐ No

If **no**, go to the next question. If **yes**, fill out **Part C of Supplement A: Illness, Disability, or Accommodation** on page 21.



21. Does Person 2 have breast or cervical cancer? ☐ Yes ☐ No (Optional)

MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.

If **no**, go to the next question. If **yes**, we will send a certificate to be filled out by Person 2's doctor to prove his or her breast cancer or her cervical cancer diagnosis. Then MassHealth can see if Person 2's MassHealth benefits give him or her the most coverage possible.

22. Is Person 2 HIV positive? ☐ Yes ☐ No (Optional)

If Person 2 is HIV positive, he or she may be eligible for additional coverage or benefits.

If **no**, go to the next question. If **yes**, Person 2 will need to give us proof of his or her HIV-positive status. Then MassHealth can see if Person 2's MassHealth benefits give him or her the most coverage possible.

23. Did Person 2 ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No

23.a. When did Person 2 last get SSI? (mm/yyyy) \_\_\_\_\_

23.b. Does Person 2 (Please check one.): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home?

☐ live and share expenses with another or others (not a spouse)? ☐ live in an assisted living facility? ☐ live in someone else's home?

24. Check the box below that best describes Person 2. (Optional)

☐ American Indian/Alaska Native (Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))

☐ American Indian/Alaska Native (Other Tribal Nation) ☐ Asian ☐ Black or African American ☐ Hispanic/Latino/Black

☐ Hispanic/Latino/White ☐ Hispanic/Latino/Other ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other

25. If Person 2 is an American Indian or Alaska Native, fill out **Supplement B: American Indian (AI)/Alaska Native (AN)** on page 23. American Indians or Alaska Natives may not have to pay cost sharing and may get special monthly enrollment periods. Continue adding other household members, if needed, or go to **Part 3: Current Job and Income Information** on page 9.

### Person 3

1. First name    Middle initial    Last name			Suffix (ex., Jr.)	Relationship to Person 1
2. Home street address			Apt. #	Relationship to Person 2
City			State	Zip code
3. Is Person 3 homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Mailing address (if different from home address)			
City			State	Zip code
5. Telephone number	6. Date of birth (mm/dd/yyyy)	7. Gender <input type="checkbox"/> M <input type="checkbox"/> F	8. Written language choice	9. Spoken language choice

We need social security numbers for every person applying for health insurance who has one. Please see the application instructions or the Member Booklet for more information.

10. Does Person 3 have a social security number (SSN)? ☐ Yes ☐ No

If **yes**, give us the number. \_\_\_\_\_ – \_\_\_\_\_ – \_\_\_\_\_ (Optional, if **not** applying)

If **no**, check one of the reasons below.

☐ Applied, but have not received SSN ☐ Religious exemption ☐ Only eligible for nonwork SSN

☐ Not eligible to get SSN ☐ Eligible for SSN, but have not applied

11. Will Person 3 file a federal income tax return next year? ☐ Yes ☐ No

(Person 3 can still apply for health coverage even if he or she does not file a federal income tax return.)

If **yes**, answer 11.a., 11.b., and 11.c. If **no**, answer 11.c.

11.a. Will Person 3 file jointly with a spouse? ☐ Yes ☐ No If **yes**, name of spouse: \_\_\_\_\_

11.b. Will Person 3 claim any dependents on his or her income tax return? ☐ Yes ☐ No

If **yes**, list name(s) of dependents: \_\_\_\_\_

11.c. Will someone else claim Person 3 as a dependent on his or her tax return? ☐ Yes ☐ No

If **yes**, name of tax filer: \_\_\_\_\_ How is Person 3 related to the tax filer? \_\_\_\_\_

12. Is Person 3 pregnant? ☐ Yes ☐ No

12.a. If **yes**, how many children is she expecting? \_\_\_\_\_ 12.b. What is the due date? (mm/dd/yyyy) \_\_\_\_\_

13. Is Person 3 applying for health coverage? ☐ Yes ☐ No

If **no**, go to **Person 4** or **Part 3: Current Job and Income Information** on page 9. If **yes**, answer all questions below for Person 3.

14. Is Person 3 living in Massachusetts and planning to stay? ☐ Yes ☐ No

15. Does Person 3 live with at least one child under age 19? ☐ Yes ☐ No

15.a. If **yes**, is Person 3 the main person taking care of this child? ☐ Yes ☐ No

16. Is Person 3 in jail or prison? ☐ Yes ☐ No

If **no**, go to the next question.

16.a. If **yes**, is Person 3 (Check one.):

☐ Convicted? What is his or her expected release date? (mm/dd/yyyy) \_\_\_\_\_ ☐ Not convicted? (For example: confined only)

17. Did Person 3 age out of foster care at the age of 18 or older? ☐ Yes ☐ No

**"Aging out" means the individual was in the custody of the state child welfare agency when he or she turned 18 years of age, or older if the individual decided to stay in placement after age 18.**

18. Is Person 3 a U.S. citizen, national, or naturalized U.S. citizen? ☐ Yes ☐ No

If **yes**, go to Question 19.

18.a. If **no**, does Person 3 have an eligible immigration status? (See the Member Booklet for more information.) ☐ Yes ☐ No ☐ No response

If **no** or **no response**, Person 3 may get only one or more of the following: MassHealth Limited, the Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN). Go to Question 19.

18.b. If **yes**, does Person 3 have an immigration document? ☐ Yes ☐ No

**We will try to prove Person's 3 immigration status. Please list all the immigration statuses and/or conditions that have applied to Person 3 since he or she entered the U.S. (See the Member Booklet for more information about immigration statuses and documents.)**

Immigration status

Date status awarded ( mm/dd/yyyy)	Immigration document type	Document ID number
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18.c. Did Person 3 come to live in the U.S. before August 22, 1996? ☐ Yes ☐ No

18.d. Did Person 3 use a different name to get his or her immigration status? ☐ Yes ☐ No If **yes**, what is it?

First name	Middle name	Last name	Suffix (ex., Jr.)
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18.e. Is Person 3 an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

18.f. Is Person 3 a spouse or unremarried surviving spouse of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

18.g. Is Person 3 an unmarried dependent child of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

19. Does Person 3 have an injury, illness, or disability (including a disabling mental health condition) that has lasted or is expected to last for at least 12 months? (If legally blind, answer **yes**.) ☐ Yes ☐ No

If **no**, go to the next question. If **yes**, fill out **Part A of Supplement A: Illness, Disability, or Accommodation** on page 21.

20. Is Person 3 applying because of an accident or injury that someone else might be responsible for? ☐ Yes ☐ No

If **no**, go to the next question. If **yes**, fill out **Part C of Supplement A: Illness, Disability, or Accommodation** on page 21.



21. Does Person 3 have breast or cervical cancer? ☐ Yes ☐ No (Optional)

MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.

If **no**, go to the next question. If **yes**, we will send a certificate to be filled out by Person 3's doctor to prove his or her breast cancer or her cervical cancer diagnosis. Then MassHealth can see if Person 3's MassHealth benefits give him or her the most coverage possible.

22. Is Person 3 HIV positive? ☐ Yes ☐ No (Optional)

If Person 3 is HIV positive, he or she may be eligible for additional coverage or benefits.

If **no**, go to the next question. If **yes**, Person 3 will need to give us proof of his or her HIV-positive status. Then MassHealth can see if Person 3's MassHealth benefits give him or her the most coverage possible.

23. Did Person 3 ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No

23.a. When did Person 3 last get SSI? (mm/yyyy) \_\_\_\_\_

23.b. Does Person 3 (Please check one.): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home?

☐ live and share expenses with another or others (not a spouse)? ☐ live in an assisted living facility? ☐ live in someone else's home?

24. Check the box below that best describes Person 3. (Optional)

☐ American Indian/Alaska Native (Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))

☐ American Indian/Alaska Native (Other Tribal Nation) ☐ Asian ☐ Black or African American ☐ Hispanic/Latino/Black

☐ Hispanic/Latino/White ☐ Hispanic/Latino/Other ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other

25. If Person 3 is an American Indian or Alaska Native, fill out **Supplement B: American Indian (AI)/Alaska Native (AN)** on page 23. American Indians or Alaska Natives may not have to pay cost sharing and may get special monthly enrollment periods. Continue adding other household members, if needed, or go to **Part 3: Current Job and Income Information** on page 9.

If you have more than three people to add, make a copy of Person 4's blank information pages (pages 7-9) before you fill them out.

#### Person 4

1. First name    Middle initial    Last name		Suffix (ex., Jr.)	Relationship to Person 1
2. Home street address		Apt. #	Relationship to Person 2
City	State	Zip code	Relationship to Person 3
3. Is Person 4 homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Mailing address (if different from home address)		
City	State	Zip code	
5. Telephone number	6. Date of birth (mm/dd/yyyy)	7. Gender <input type="checkbox"/> M <input type="checkbox"/> F	8. Written language choice
		9. Spoken language choice	

We need social security numbers for every person applying for health insurance who has one. Please see the application instructions or the Member Booklet for more information.

10. Does Person 4 have a social security number (SSN)? ☐ Yes ☐ No

If **yes**, give us the number. \_\_\_\_\_ – \_\_\_\_\_ – \_\_\_\_\_ (Optional, if **not** applying)

If **no**, check one of the reasons below.

☐ Applied, but have not received SSN ☐ Religious exemption ☐ Only eligible for nonwork SSN

☐ Not eligible to get SSN ☐ Eligible for SSN, but have not applied

11. Will Person 4 file a federal income tax return next year? ☐ Yes ☐ No

(Person 4 can still apply for health coverage even if he or she does not file a federal income tax return.)

If **yes**, answer 11.a., 11.b., and 11.c. If **no**, answer 11.c.

11.a. Will Person 4 file jointly with a spouse? ☐ Yes ☐ No If **yes**, name of spouse: \_\_\_\_\_

11.b. Will Person 4 claim any dependents on his or her income tax return? ☐ Yes ☐ No

If **yes**, list name(s) of dependents: \_\_\_\_\_

11.c. Will someone else claim Person 4 as a dependent on his or her tax return? ☐ Yes ☐ No

If **yes**, name of tax filer: \_\_\_\_\_ How is Person 4 related to the tax filer? \_\_\_\_\_

12. Is Person 4 pregnant? ☐ Yes ☐ No

12.a. If **yes**, how many children is she expecting? \_\_\_\_\_ 12.b. What is the due date? (mm/dd/yyyy) \_\_\_\_\_

13. Is Person 4 applying for health coverage? ☐ Yes ☐ No

If **no**, go to **Part 3: Current Job and Income Information** on page 9. If **yes**, answer all questions below for Person 4.

14. Is Person 4 living in Massachusetts and planning to stay? ☐ Yes ☐ No

15. Does Person 4 live with at least one child under age 19? ☐ Yes ☐ No

15.a. If **yes**, is Person 4 the main person taking care of this child? ☐ Yes ☐ No

16. Is Person 4 in jail or prison? ☐ Yes ☐ No

If **no**, go to the next question.

16.a. If **yes**, is Person 4 (Check one.):

☐ Convicted? What is his or her expected release date? (mm/dd/yyyy) \_\_\_\_\_ ☐ Not convicted? (For example: confined only)

17. Did Person 4 age out of foster care at the age of 18 or older? ☐ Yes ☐ No

**"Aging out" means the individual was in the custody of the state child welfare agency when he or she turned 18 years of age, or older if the individual decided to stay in placement after age 18.**

18. Is Person 4 a U.S. citizen, national, or naturalized U.S. citizen? ☐ Yes ☐ No

If **yes**, go to Question 19.

18.a. If **no**, does Person 4 have an eligible immigration status? (See the Member Booklet for more information.) ☐ Yes ☐ No ☐ No response

If **no** or **no response**, Person 4 may get only one or more of the following: MassHealth Limited, the Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN). Go to Question 19.

18.b. If **yes**, does Person 4 have an immigration document? ☐ Yes ☐ No

**We will try to prove Person's 4 immigration status. Please list all the immigration statuses and/or conditions that have applied to Person 4 since he or she entered the U.S. (See the Member Booklet for more information about immigration statuses and documents.)**

Immigration status

Date status awarded ( mm/dd/yyyy)	Immigration document type	Document ID number
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18.c. Did Person 4 come to live in the U.S. before August 22, 1996? ☐ Yes ☐ No

18.d. Did Person 4 use a different name to get his or her immigration status? ☐ Yes ☐ No If **yes**, what is it?

First name	Middle name	Last name	Suffix (ex., Jr.)
------------	-------------	-----------	-------------------

18.e. Is Person 4 an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

18.f. Is Person 4 a spouse or unremarried surviving spouse of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

18.g. Is Person 4 an unmarried dependent child of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

19. Does Person 4 have an injury, illness, or disability (including a disabling mental health condition) that has lasted or is expected to last for at least 12 months? (If legally blind, answer **yes**.) ☐ Yes ☐ No

If **no**, go to the next question. If **yes**, fill out **Part A of Supplement A: Illness, Disability, or Accommodation** on page 21.

20. Is Person 4 applying because of an accident or injury that someone else might be responsible for? ☐ Yes ☐ No

If **no**, go to the next question. If **yes**, fill out **Part C of Supplement A: Illness, Disability, or Accommodation** on page 21.

21. Does Person 4 have breast or cervical cancer? ☐ Yes ☐ No (Optional)

MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.

If **no**, go to the next question. If **yes**, Person 4 will send a certificate to be filled out by Person 4's doctor to prove his or her breast cancer or her cervical cancer diagnosis. Then MassHealth can see if Person 4's MassHealth benefits give him or her the most coverage possible.

22. Is Person 4 HIV positive? ☐ Yes ☐ No (Optional)

If Person 4 is HIV positive, he or she may be eligible for additional coverage or benefits.

If **no**, go to the next question. If **yes**, Person 4 will need to give us proof of his or her HIV-positive status. Then MassHealth can see if Person 4's MassHealth benefits give him or her the most coverage possible.

23. Did Person 4 ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No

23.a. When did Person 4 last get SSI? (mm/yyyy) \_\_\_\_\_

23.b. Does Person 4 (Please check one.): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home?

☐ live and share expenses with another or others (not a spouse)? ☐ live in an assisted living facility? ☐ live in someone else's home?

24. Check the box below that best describes Person 4. (Optional)

☐ American Indian/Alaska Native (Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))

☐ American Indian/Alaska Native (Other Tribal Nation) ☐ Asian ☐ Black or African American ☐ Hispanic/Latino/Black

☐ Hispanic/Latino/White ☐ Hispanic/Latino/Other ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other

25. If Person 4 is an American Indian or Alaska Native, fill out **Supplement B: American Indian (AI)/Alaska Native (AN)** on page 23. American Indians or Alaska Natives may not have to pay cost sharing and may get special monthly enrollment periods. Continue adding other household members, if needed, or go to **Part 3: Current Job and Income Information**.

## PART 3 Current Job and Income Information

We use your income to see if you are eligible for health coverage. See the Member Booklet. If you are self-employed, and pay yourself wages, fill out both the Current Job and Self-employed income sections.

### About You (Person 1)

1. (Check all that apply.)

☐ Employed (Go to **Current Job 1**.) ☐ Self-employed (Go to **Self-employed income**.) ☐ Not employed (Go to **Money from other sources** section.)

### Current Job 1

2. Employer name

Employer address	City	State	Zip code
Employer telephone	Employer Identification Number (EIN—if you know)		

3. Does this job offer health insurance? ☐ Yes ☐ No

If **yes**, check one.

☐ This job offers health insurance now.

☐ This job will offer health insurance, starting \_\_\_\_\_ (mm/dd/yyyy).

3.a. If this job offers health insurance now or will at a later date, can the health plan cover an employee's spouse or dependent(s)?

☐ Yes List the name(s): \_\_\_\_\_ ☐ No

• How much will the employee pay for the lowest-cost individual health plan? \$ \_\_\_\_\_

How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly

• If an employee joins a program to stop smoking or using tobacco, how much money could he or she save on the monthly premium? \$ \_\_\_\_\_

• Does the health insurance plan(s) offered by the employer meet the "minimum value" standard? ☐ Yes ☐ No

**Minimum value** means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

3.b. What changes will this job make for the next year? (if you know)

- ☐ This job will stop offering health insurance.
- ☐ This job will start offering health insurance to employees or change the premium for the lowest-cost available plan.
- How much will the employee's premiums be (for an individual plan)? \$ \_\_\_\_\_  
How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
  - Date of change: \_\_\_\_\_ (mm/dd/yyyy)

3.c. ☐ No health insurance plans offered by the employer will meet the "minimum value" standard.

**Minimum value** means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

4. Does this employer have 50 or fewer full-time employees? ☐ Yes ☐ No

If **yes**, we may be able to help you pay for your coverage. For more information, see the Member Booklet for description of coverage.

5. Is this job a sheltered workshop? ☐ Yes ☐ No

6. How much do you currently earn in gross wages, less pre-tax deductions? \$ \_\_\_\_\_

6.a. How often are you paid? (Check one.) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6.b. About how many hours do you work each WEEK? \_\_\_\_\_

6.c. When did you begin getting this income? \_\_\_\_\_ (mm/dd/yyyy)

7. If this is a seasonal job, check the months you work.

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

### Self-employed Income

8. a. (Check one.) ☐ Partnership ☐ S-Corporation ☐ Self-employed

8.b. Business name: \_\_\_\_\_

8.c. What is your expected yearly income from this source, less any business expenses? (Do not include your wages and tips.) \$ \_\_\_\_\_

8.d. Date you began getting this income \_\_\_\_\_ (mm/dd/yyyy)

### Current Job 2 (If none, go to Money from other sources section.)

9. Employer name

Employer address	City	State	Zip code
Employer telephone	Employer Identification Number (EIN—if you know)		

10. Does this job offer health insurance? ☐ Yes ☐ No

If **yes**, check one.

- ☐ This job offers health insurance now.
- ☐ This job will offer health insurance, starting \_\_\_\_\_ (mm/dd/yyyy).

10.a. If this job offers health insurance now or will at a later date, can the health plan cover an employee's spouse or dependent(s)?

☐ Yes List the name(s): \_\_\_\_\_ ☐ No

- How much will the employee pay for the lowest-cost individual health plan? \$ \_\_\_\_\_  
How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
- If an employee joins a program to stop smoking or using tobacco, how much money could he or she save on the monthly premium? \$ \_\_\_\_\_
- Does the health insurance plan(s) offered by the employer meet the "minimum value" standard? ☐ Yes ☐ No

**Minimum value** means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

10.b. What changes will this job make for the next year? (if you know)

- ☐ This job will stop offering health insurance.
- ☐ This job will start offering health insurance to employees or change the premium for the lowest-cost available plan.
- How much will the employee's premiums be (for an individual plan)? \$ \_\_\_\_\_  
How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
  - Date of change: \_\_\_\_\_ (mm/dd/yyyy)

10.c. ☐ No health insurance plans offered by the employer will meet the "minimum value" standard.

**Minimum value** means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

11. Does this employer have 50 or fewer full-time employees? ☐ Yes ☐ No

If **yes**, we may be able to help you pay for your coverage. For more information, see the Member Booklet for description of coverage.

12. Is this job a sheltered workshop? ☐ Yes ☐ No

13. How much do you currently earn in gross wages, less pre-tax deductions? \$ \_\_\_\_\_

13.a. How often are you paid? (Check one.) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

13.b. About how many hours do you work each WEEK? \_\_\_\_\_

13.c. When did you begin getting this income? \_\_\_\_\_ (mm/dd/yyyy)

14. If this is a seasonal job, check the months you work.

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

### Self-employed Income

15. a. (Check one.) ☐ Partnership ☐ S-Corporation ☐ Self-employed

15.b. Business name: \_\_\_\_\_

15.c. What is your expected yearly income from this source, less any business expenses? (Do not include your wages and tips.) \$ \_\_\_\_\_

15.d. Date you began getting this income \_\_\_\_\_ (mm/dd/yyyy)

### Money from other sources

16. Do you get money from other sources? ☐ Yes ☐ No

Check all of the sources, give the amount, and how often you get it.

(You do not need to tell us about child support, nontaxable veterans' payments, or Supplemental Security Income (SSI).)

<input type="checkbox"/> Unemployment	\$ _____	How often? _____	<input type="checkbox"/> Trusts	\$ _____	How often? _____
<input type="checkbox"/> Pension or annuity	\$ _____	How often? _____	<input type="checkbox"/> Interest	\$ _____	How often? _____
<input type="checkbox"/> Social Security	\$ _____	How often? _____	<input type="checkbox"/> Net farming/fishing	\$ _____	How often? _____
<input type="checkbox"/> Net rental income	\$ _____	How often? _____	<input type="checkbox"/> Royalty	\$ _____	How often? _____
<input type="checkbox"/> Capital gains	\$ _____	How often? _____	<input type="checkbox"/> Alimony received	\$ _____	How often? _____
<input type="checkbox"/> Gambling proceeds	\$ _____	How often? _____	<input type="checkbox"/> Conservation easement	\$ _____	How often? _____
<input type="checkbox"/> Taxable veterans' money	\$ _____	How often? _____	<input type="checkbox"/> Taxable retirement income	\$ _____	How often? _____
<input type="checkbox"/> Taxable military retirement pay	\$ _____	How often? _____	<input type="checkbox"/> Tax-excluded foreign income	\$ _____	How often? _____
<input type="checkbox"/> Ordinary or qualified dividend	\$ _____	How often? _____			
<input type="checkbox"/> Tax refund, credit, or offset of state or local income taxes	\$ _____	How often? _____			
<input type="checkbox"/> Other income (Specify:)	_____	\$ _____	How often? _____		

## Deductions allowed on federal tax return

All or part of certain expenses can be deducted from income so that you do not pay taxes on them. These amounts are not counted in your income, and may lower the cost of your health coverage.

17. Do you have any of the deductible expenses below? ☐ Yes ☐ No

If **yes**, please check all of the types you have, fill in the deductible amount, and how often you have this expense.

Do not include an expense that you already claimed under self-employment income above.

<input type="checkbox"/> Alimony paid	\$ _____	How often? _____
<input type="checkbox"/> Student loan interest	\$ _____	How often? _____
<input type="checkbox"/> Business expenses	\$ _____	How often? _____
<input type="checkbox"/> IRA contribution	\$ _____	How often? _____
<input type="checkbox"/> Contributions to taxable retirement income	\$ _____	How often? _____
<input type="checkbox"/> Deductible part of self-employment tax	\$ _____	How often? _____
<input type="checkbox"/> Educator expenses	\$ _____	How often? _____
<input type="checkbox"/> Health savings account contributions (deduction)	\$ _____	How often? _____
<input type="checkbox"/> Moving expenses	\$ _____	How often? _____
<input type="checkbox"/> Penalty on early withdrawal of savings	\$ _____	How often? _____
<input type="checkbox"/> Self-employment health insurance	\$ _____	How often? _____
<input type="checkbox"/> Self-employment retirement plan	\$ _____	How often? _____
<input type="checkbox"/> Tuition and other school-related costs	\$ _____	How often? _____
<input type="checkbox"/> Other tax deductions (Type): _____	\$ _____	How often? _____

## Total income (Person 1)

18. Do you expect your total income (including earned income and money from other sources) to be the same next year? ☐ Yes ☐ No

(If you are not sure, answer **no** to this question.)

If **no**, what do you expect your total income to be next year? \$ \_\_\_\_\_

## Person 2

(If you have income to report for more than two persons, make a copy of pages 12-15 before you fill them out.)

19. Name: \_\_\_\_\_

20. (Check all that apply.)

☐ Employed (Go to **Current Job 1**.) ☐ Self-employed (Go to **Self-employed income**.) ☐ Not employed (Go to **Money from other sources** section.)

## Current Job 1

21. Employer name \_\_\_\_\_

Employer address	City	State	Zip code
Employer telephone	Employer Identification Number (EIN—if you know)		

22. Does this job offer health insurance? ☐ Yes ☐ No

If **yes**, check one.

☐ This job offers health insurance now.

☐ This job will offer health insurance, starting \_\_\_\_\_ (mm/dd/yyyy).

22.a. If this job offers health insurance now or will at a later date, can the health plan cover an employee's spouse or dependent(s)?

- ☐ Yes List the name(s): \_\_\_\_\_ ☐ No
- How much will the employee pay for the lowest-cost individual health plan? \$ \_\_\_\_\_  
How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
  - If an employee joins a program to stop smoking or using tobacco, how much money could he or she save on the monthly premium? \$ \_\_\_\_\_
  - Does the health insurance plan(s) offered by the employer meet the "minimum value" standard? ☐ Yes ☐ No

**Minimum value** means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

22.b. What changes will this job make for the next year? (if you know)

- ☐ This job will stop offering health insurance.
- ☐ This job will start offering health insurance to employees or change the premium for the lowest-cost available plan.
- How much will the employee's premiums be (for an individual plan)? \$ \_\_\_\_\_  
How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
  - Date of change: \_\_\_\_\_ (mm/dd/yyyy)

22.c. ☐ No health insurance plans offered by the employer will meet the "minimum value" standard.

**Minimum value** means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

23. Does this employer have 50 or fewer full-time employees? ☐ Yes ☐ No

If **yes**, we may be able to help pay for this coverage. For more information, see the Member Booklet for description of coverage.

24. Is this job a sheltered workshop? ☐ Yes ☐ No

25. How much does this person currently earn in gross wages, less pre-tax deductions? \$ \_\_\_\_\_

25.a. How often is this person paid? (Check one.) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

25.b. About how many hours does this person work each WEEK? \_\_\_\_\_

25.c. When did this person begin getting this income? \_\_\_\_\_ (mm/dd/yyyy)

26. If this is a seasonal job, check the months this person works.

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

### Self-employed Income

27.a. (Check one.) ☐ Partnership ☐ S-Corporation ☐ Self-employed

27.b. Business name: \_\_\_\_\_

27.c. What is this person's expected yearly income from this source, less any business expenses?  
(Do not include his or her wages and tips.) \$ \_\_\_\_\_

27.d. Date this person began getting this income \_\_\_\_\_ (mm/dd/yyyy)

### Current Job 2 (If none, go to Money from other sources section.)

28. Employer name

Employer address	City	State	Zip code
Employer telephone	Employer Identification Number (EIN—if you know)		

29. Does this job offer health insurance? ☐ Yes ☐ No

If **yes**, check one.

- ☐ This job offers health insurance now.
- ☐ This job will offer health insurance, starting \_\_\_\_\_ (mm/dd/yyyy).

29.a. If this job offers health insurance now or will at a later date, can the health plan cover an employee's spouse or dependent(s)?

☐ Yes List the name(s): \_\_\_\_\_ ☐ No

- How much will the employee pay for the lowest-cost individual health plan? \$ \_\_\_\_\_  
How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
- If an employee joins a program to stop smoking or using tobacco, how much money could he or she save on the monthly premium? \$ \_\_\_\_\_
- Does the health insurance plan(s) offered by the employer meet the "minimum value" standard? ☐ Yes ☐ No

**Minimum value** means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

29.b. What changes will this job make for the next year? (if you know)

- ☐ This job will stop offering health insurance.
- ☐ This job will start offering health insurance to employees or change the premium for the lowest-cost available plan.
- How much will the employee's premiums be (for an individual plan)? \$ \_\_\_\_\_  
How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
- Date of change: \_\_\_\_\_ (mm/dd/yyyy)

29.c. ☐ No health insurance plans offered by the employer will meet the "minimum value" standard.

**Minimum value** means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

30. Does this employer have 50 or fewer full-time employees? ☐ Yes ☐ No

If **yes**, we may be able to help pay for this coverage. For more information, see the Member Booklet for description of coverage.

31. Is this job a sheltered workshop? ☐ Yes ☐ No

32. How much does this person currently earn in gross wages, less pre-tax deductions? \$ \_\_\_\_\_

32.a. How often is this person paid? (Check one.) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

32.b. About how many hours does this person work each WEEK? \_\_\_\_\_

32.c. When did this person begin getting this income? \_\_\_\_\_ (mm/dd/yyyy)

33. If this is a seasonal job, check the months you work.

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

### Self-employed Income

34. a. (Check one.) ☐ Partnership ☐ S-Corporation ☐ Self-employed

34.b. Business name: \_\_\_\_\_

34.c. What is this person's expected yearly income from this source, less any business expenses?  
(Do not include his or her wages and tips.) \$ \_\_\_\_\_

34.d. Date this person began getting this income \_\_\_\_\_ (mm/dd/yyyy)

### Money from other sources

35. Does this person get money from other sources? ☐ Yes ☐ No

Check all of the sources, give the amount, and how often this person gets it.

(You do not need to tell us about child support, nontaxable veterans' payments, or Supplemental Security Income (SSI).)

- |  |          |                  |
|--|----------|------------------|
| <input type="checkbox"/> Unemployment            | \$ _____ | How often? _____ |
| <input type="checkbox"/> Pension or annuity      | \$ _____ | How often? _____ |
| <input type="checkbox"/> Social Security         | \$ _____ | How often? _____ |
| <input type="checkbox"/> Net rental income       | \$ _____ | How often? _____ |
| <input type="checkbox"/> Capital gains           | \$ _____ | How often? _____ |
| <input type="checkbox"/> Gambling proceeds       | \$ _____ | How often? _____ |
| <input type="checkbox"/> Taxable veterans' money | \$ _____ | How often? _____ |



<input type="checkbox"/> Taxable military retirement pay	\$ _____	How often? _____
<input type="checkbox"/> Trusts	\$ _____	How often? _____
<input type="checkbox"/> Interest	\$ _____	How often? _____
<input type="checkbox"/> Net farming/fishing	\$ _____	How often? _____
<input type="checkbox"/> Royalty	\$ _____	How often? _____
<input type="checkbox"/> Alimony received	\$ _____	How often? _____
<input type="checkbox"/> Conservation easement	\$ _____	How often? _____
<input type="checkbox"/> Taxable retirement income	\$ _____	How often? _____
<input type="checkbox"/> Tax-excluded foreign income	\$ _____	How often? _____
<input type="checkbox"/> Ordinary or qualified dividend	\$ _____	How often? _____
<input type="checkbox"/> Tax refund, credit, or offset of state or local income taxes	\$ _____	How often? _____
<input type="checkbox"/> Other income (Specify): _____	\$ _____	How often? _____

### Deductions allowed on federal tax return

All or part of certain expenses can be deducted from income so that this person does not pay taxes on them. These amounts are not counted in this person's income, and may lower the cost of his or her health coverage.

36. Does this person have any of the deductible expenses below? ☐ Yes ☐ No

If **yes**, please check all of the types he or she has, fill in the deductible amount, and how often this person has this expense.

Do not include an expense that he or she already claimed under self-employment income above.

<input type="checkbox"/> Alimony paid	\$ _____	How often? _____
<input type="checkbox"/> Student loan interest	\$ _____	How often? _____
<input type="checkbox"/> Business expenses	\$ _____	How often? _____
<input type="checkbox"/> IRA contribution	\$ _____	How often? _____
<input type="checkbox"/> Contributions to taxable retirement income	\$ _____	How often? _____
<input type="checkbox"/> Deductible part of self-employment tax	\$ _____	How often? _____
<input type="checkbox"/> Educator expenses	\$ _____	How often? _____
<input type="checkbox"/> Health savings account contributions (deduction)	\$ _____	How often? _____
<input type="checkbox"/> Moving expenses	\$ _____	How often? _____
<input type="checkbox"/> Penalty on early withdrawal of savings	\$ _____	How often? _____
<input type="checkbox"/> Self-employment health insurance	\$ _____	How often? _____
<input type="checkbox"/> Self-employment retirement plan	\$ _____	How often? _____
<input type="checkbox"/> Tuition and other school-related costs	\$ _____	How often? _____
<input type="checkbox"/> Other tax deductions (Type): _____	\$ _____	How often? _____

### Total income (Person 2)

37. Do you expect Person 2's total income (including earned income and money from other sources) to be the same next year? ☐ Yes ☐ No

(If you are not sure, answer **no** to this question.)

If **no**, what do you expect Person 2's total income to be next year? \$ \_\_\_\_\_

## PART 4 Additional Questions to Apply for Immediate Coverage

Do you or any household member want to apply for immediate coverage? ☐ Yes ☐ No

If **yes**, you must fill out this part.

**NOTE:** Effective 1/1/2014, the Affordable Care Act will change eligibility rules for MassHealth and Commonwealth Care. If you want coverage before 1/1/2014, you will need to give us additional information so we can determine the best coverage that is available to you.

### 1. Long-term unemployment

If you indicated in **Part 3** that you or any household member is not employed or is getting unemployment compensation, you must fill out this part.

Name of person: \_\_\_\_\_

Has this person worked in the last 12 months before the date of application? ☐ Yes ☐ No

If **yes**, how much did this person earn in the last 12 months before taxes and deductions?

**Note:** If you answered **yes** to this question, you must enter a dollar amount on this line. \$ \_\_\_\_\_

Is this person getting unemployment benefits? ☐ Yes ☐ No

If **yes**, is this check from the Commonwealth of Massachusetts? ☐ Yes ☐ No

If **yes**, in the 12 months before this person became unemployed, did this person work for an employer in Massachusetts? ☐ Yes ☐ No

(Do not include federal employers, like the U.S. Postal Service.)

Enter the monthly amount of unemployment benefits (before taxes and deductions). \$ \_\_\_\_\_

### 2. College student

Are you or any household member a college student? (You must answer this question.) ☐ Yes ☐ No

If **yes**, fill out this part and answer all questions.

If **no**, go to **Part 5: Health Insurance You Have Now** on page 17.

Name of college student \_\_\_\_\_

Is this person eligible for health insurance from college? ☐ Yes ☐ No

Is this person a college student in Massachusetts with at least 75% of a full-time schedule? ☐ Yes ☐ No

(**Note:** If you are not sure that this person has 75% of a full-time schedule, contact the school to find out if the number of credits the student is taking would require the student to get the health insurance the school offers to students.)

If **yes**, is this student planning to get health insurance coverage from the school, but is waiting for coverage to start? ☐ Yes ☐ No

If **yes**, what is the date that the health insurance coverage starts? \_\_\_\_\_ (mm/dd/yyyy)

### 3. Subsidized health insurance you may be eligible for

Are you or any household member in one of the uniformed services? ☐ Yes ☐ No

(The uniformed services are the Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Services, National Oceanic and Atmospheric Administration, and the National Guard or Reserves.)

Name of person \_\_\_\_\_

Active Duty? ☐ Yes ☐ No

Retiree? ☐ Yes ☐ No

Reserves? ☐ Yes ☐ No

Medal of Honor? ☐ Yes ☐ No

Have you or any household member served in the U.S. military, or can you be considered a dependent of someone who has served in the U.S. military?

☐ Yes, I have served. Name: \_\_\_\_\_

☐ Yes, I am a dependent of someone who has served. Name: \_\_\_\_\_

☐ No, I am neither a veteran nor a dependent. Name: \_\_\_\_\_

## PART 5 Health Insurance You Have Now

Please answer the questions below about **health insurance**, and follow the instructions. If someone has enrolled in one of the health insurance plans below, but the benefits have not yet started, check **yes** to the question. MassHealth may be able to help pay premiums.

1. Does any household member have Medicare? ☐ Yes ☐ No  
If **yes**, fill out **Part A of Supplement C: Health Insurance** on page 21.
2. Does any household member have federal health insurance provided by the U.S. military (Veterans' Affairs or TRICARE) or other federal coverage? ☐ Yes ☐ No  
If **yes**, fill out **Part B of Supplement C: Health Insurance** on page 21.
3. Does any household member currently have any other type of health insurance (This includes insurance through an employer, union, college or university, former employer (COBRA), and coverage bought by a household member or parent who is not living in the household)? ☐ Yes ☐ No  
If **yes**, fill out **Part C of Supplement C: Health Insurance** on page 21.

If you answered **no** to all three questions above, go to **Part 6: Noncustodial Parent**.

## PART 6 Noncustodial Parent

1. Was any child in the household adopted by a single parent? ☐ Yes ☐ No
2. Does any child in the household have a parent who has died? ☐ Yes ☐ No
3. Does any child in the household have a parent who is unknown? ☐ Yes ☐ No
4. Does any child in the household have a parent who does not live with the child and who is not included in the previous questions? ☐ Yes ☐ No

If the answer to questions #1 and #2 is **no** for all children in the household, go to **Part 7: Rights and Responsibilities and Signature Page**.

If the answer to question #3 or #4 is **yes**, we will send a form to the child's custodial parent to fill out and return to us. This form asks questions about any parents who do not live with the child. Go to **Part 7: Rights and Responsibilities and Signature Page**.

## PART 7 Rights and Responsibilities and Signature Page

On behalf of myself and all persons listed on this application, I understand, represent, and agree as follows.

1. MassHealth may require eligible persons to enroll in available employer-sponsored health insurance if that insurance meets the criteria for MassHealth payment of premium assistance.
2. Employers of eligible persons may be notified and billed in accordance with MassHealth regulations for any services that hospitals or community health centers provide to these persons that are paid for by the Health Safety Net.
3. Health coverage premiums must be paid for all persons listed on this application who are applying. Failure to pay any premium due may result in the State deducting the amount owed from the tax refunds of responsible persons. If any person applying is a certain American Indian or Alaska Native, MassHealth premiums may not have to be paid.
4. MassHealth has the right to pursue and get money from third parties who may be obligated to pay for health services provided to eligible persons enrolled in MassHealth programs. These third parties may include other health insurers, spouses, or parents obligated to pay for medical support, or individuals obligated to pay under accident settlements. Eligible persons must cooperate with MassHealth in establishing third-party support and obtaining third-party payments for themselves and anyone whose rights they can legally assign. Eligible persons may be exempted from this obligation if they believe and tell MassHealth that cooperation could result in harm to them or anyone whose rights they can legally assign.
5. A parent and/or guardian of minor children must agree to cooperate with state efforts to collect medical support from a noncustodial parent unless they believe and tell MassHealth that cooperation will harm the children or the parent or guardian.
6. Eligible persons who are injured in an accident, or in some other way, and get money from a third party because of that accident or injury must use that money to repay MassHealth or the Health Safety Net for certain services provided.
7. Eligible persons must tell MassHealth or the Health Safety Net, in writing, within 10 calendar days, or as soon as possible, about any insurance claims or lawsuits filed because of an accident or injury.
8. The status of this application may be shared with a hospital, community health center, other medical provider, or federal or state agencies when necessary for treatment, payment, operations, or the administration of the programs listed above.

9. To the extent permitted by law, MassHealth may place a lien against any real estate owned by eligible persons or in which eligible persons have a legal interest. If MassHealth puts a lien against that property and it is sold, money from the sale of that property may be used to repay MassHealth for medical services provided.
10. To the extent permitted by law, for any eligible person aged 55 or older, or for any eligible person for whom MassHealth helps pay for care in a nursing home, MassHealth may seek money from the eligible person's estate after death.
11. Eligible persons must tell the health care program(s) in which they enroll about any changes in their or their household's income or employment, household size, health insurance coverage, health insurance premiums, and immigration status, or about changes in any other information on this application and any supplements to it within 10 calendar days of learning of the change. Eligible persons can make changes by calling 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled). A change in information could affect eligibility for these persons or for persons in their household.\*
12. MassHealth, the Massachusetts Health Connector, and the Health Safety Net will obtain from eligible persons' current and former employers and health insurers all information about health insurance coverage for these persons. 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 these persons or members of their household.
13. MassHealth and the Massachusetts Health Connector may get any records or data: 1) to prove any information given on this application and any supplements, or other information once an individual becomes a member, 2) to document medical services claimed or provided, and 3) to support continued eligibility.

**(For renewal of coverage in future years)**

14. MassHealth and the Health Safety Net will use income data, including information from tax returns to determine eligibility. The Massachusetts Health Connector will use these data to the extent the applicant authorizes. The Health Connector will send the individual a notice, let him or her make any changes, and allow the individual to opt out at any time.

On behalf of all persons applying for health coverage, I: (Check one.)

☐ permit use of the data for the next five years; or

☐ permit use of the data for: (Check one.)

☐ one year, ☐ two years, ☐ three years, ☐ four years

☐ do not permit the Health Connector to use tax data to renew my eligibility for help paying for health coverage.

(MassHealth will still use this information. If you are not applying for MassHealth, choosing this option may affect you being able to get help paying for health coverage at renewal.)

15. If you are acting on behalf of someone in filling out this application and any supplements, you must also fill out and send the enclosed MassHealth Authorized Representative Designation Form with this application. Your signature on this application and any supplements as an authorized representative certifies that the information on this application and any supplements, including those submitted with this application as well as any other forms or documents that may be submitted to or required by MassHealth, is correct and complete to the best of your knowledge.
16. If I think that the Health Connector or MassHealth has made a mistake in eligibility for me and/or other household members, I have the right to appeal or file a grievance. If I disagree with the action taken by MassHealth or the Health Connector, I have the right to appeal and ask for a hearing before an impartial hearing officer. I can also ask for a hearing if I did not receive a notice telling me about the action that was taken. To find out how to appeal, please call 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled). I understand that I may be eligible to continue getting benefits while my appeal is being decided. I may have a lawyer or other person represent me, but I may also represent myself. The Health Connector or MassHealth will not pay for anyone to represent me. Additional information about appeals will be provided with any notices I receive, as well as during the appeal process.
17. Under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by going to [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).

\* You can also report changes in any of the following ways.

- Sign on to your account at [www.MAhealthconnector.org](http://www.MAhealthconnector.org). You can create an online account if you do not already have one.
- Send the change information to: Health Insurance Processing Center  
P.O. Box 4405  
Taunton, MA 02780.
- Fax the change information to: 617-887-8770.

**I certify under the penalties of perjury that:**

- I have read or have had read to me the information on this application, including any supplements and instruction pages, and understand that the Member Booklet contains important information;
- I have permission to submit this application for all adults and all minor children listed on this application and as allowed by any legal documents I have submitted with this application;
- I understand my rights and responsibilities and the rights and responsibilities of all persons for whom I am submitting this application, as explained in the rights and responsibilities before this signature page;
- I have told or will tell all persons for whom I am submitting this application about these rights and responsibilities so they also understand their rights and responsibilities;
- I understand and agree that the Health Connector and MassHealth will treat electronic, faxed, telephonic, or copies of signatures with the same force and effect as an original signature(s);
- The information I have supplied is correct and complete to the best of my knowledge about myself and other members of my household; and
- I may be subject to penalties under federal law if I intentionally provide false or untrue information.


**X** \_\_\_\_\_  
Signature of applicant or authorized representative                      Print name                      Date

**For certified application counselors, navigators, agents, and brokers only.**  
Fill out this section if you are a certified application counselor, navigator, agent, or broker filling out this application for someone else.

\_\_\_\_\_  
Application start date (mm/dd/yyyy)                      First name, middle initial, last name, suffix

\_\_\_\_\_  
Organization name

Send the filled-out application to:



**Health Insurance Processing Center**  
**P.O. Box 4405**  
**Taunton, MA 02780**





## SUPPLEMENT A

### Illness, Disability, or Accommodation



#### Part A

If you answered **yes** to Question 20 in **Part 1** or Question 19 in **Part 2** about having an injury, illness, or disability that has lasted or may last for at least 12 months, answer the next three questions.

1. Does this person get money from Social Security for a disability? ☐ Yes ☐ No

If **yes**, name(s): \_\_\_\_\_

2. Did this person ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No

If **yes**, name(s): \_\_\_\_\_

3. Is this person legally blind? ☐ Yes ☐ No

If **yes**, name(s): \_\_\_\_\_

#### Part B

If you answered **yes** to Question 21 in **Part 1** about you or any household member needing reasonable accommodation because of a disability or injury, check all that apply below, and list name(s).

##### 1. Condition

☐ Low vision—Name(s): \_\_\_\_\_

☐ Blind—Name(s): \_\_\_\_\_

☐ Deaf—Name(s): \_\_\_\_\_

☐ Hard of hearing—Name(s): \_\_\_\_\_

☐ Developmentally disabled—Name(s): \_\_\_\_\_

☐ Intellectually disabled—Name(s): \_\_\_\_\_

☐ Physically disabled—Name(s): \_\_\_\_\_

☐ Other (Please explain.)—Name(s): \_\_\_\_\_

##### 2. Accommodation

☐ Text telephone (TTY)—Name(s): \_\_\_\_\_

☐ Large print publications—Name(s): \_\_\_\_\_

☐ American Sign Language interpreter—Name(s): \_\_\_\_\_

☐ Video Relay Service (VRS)—Name(s): \_\_\_\_\_

☐ Communication Access Real-time Translations (CART)—Name(s): \_\_\_\_\_

☐ Publications in Braille—Name(s): \_\_\_\_\_

☐ Assistive listening device—Name(s): \_\_\_\_\_

☐ Publications in electronic format—Name(s): \_\_\_\_\_

☐ Other (Please explain.)—Name(s): \_\_\_\_\_

#### Part C

If you answered **yes** to Question 22 in **Part 1** or Question 20 in **Part 2** about applying because of an accident or injury that someone else may be responsible for, answer the next two questions.

1. Did someone else cause this person's injury, illness, or disability, or could someone else's insurance or this person's own insurance, other than health insurance (like homeowner's or auto insurance) cover it? ☐ Yes ☐ No

If **yes**, name the injured person(s): \_\_\_\_\_

2. Has this person filed a lawsuit, a workers' compensation claim, or an insurance claim for this accident or injury? ☐ Yes ☐ No

If **yes**, name the injured person(s): \_\_\_\_\_







## SUPPLEMENT B

### American Indian (AI)/Alaska Native (AN)



Fill out this supplement if you or any household member is an American Indian or Alaska Native.

American Indians and Alaska Natives who enroll in MassHealth can also get services from the Indian Health Services, tribal health programs, or urban Indian health programs.

If you or any household members are American Indians or Alaska Natives, you may not have to pay cost sharing and may get special monthly enrollment periods. To make sure you and your household members get the most help possible, please fill out this supplement.

#### AI/AN Person 1

Name: First Middle initial Last Suffix

1. Is this person a member of a federally recognized tribe? ☐ Yes ☐ No

If **yes**, check the box that applies.

- ☐ American Indian/Alaska Native (Mashpee Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))  
☐ American Indian/Alaska Native (Other Tribal Nation)

2. Did this person ever get a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No

3. If **no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No

Certain money received may not be counted for MassHealth. List the combined income from the following sources.

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance  
\$ \_\_\_\_\_ How often? ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other (Explain) \_\_\_\_\_

#### AI/AN Person 2

Name: First Middle initial Last Suffix

1. Is this person a member of a federally recognized tribe? ☐ Yes ☐ No

If **yes**, check the box that applies.

- ☐ American Indian/Alaska Native (Mashpee Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))  
☐ American Indian/Alaska Native (Other Tribal Nation)

2. Did this person ever get a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No

3. If **no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No

Certain money received may not be counted for MassHealth. List the combined income from the following sources.

- Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance  
\$ \_\_\_\_\_ How often? ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other (Explain) \_\_\_\_\_





## SUPPLEMENT C Health Insurance



### Part A: Medicare

Fill out this part if any household member answered **yes** to having Medicare in the health insurance part (Part 5).

1. Name:	Medicare claim number:	When did coverage start? (mm/dd/yyyy)
1.a. Does this person have a Medicare Part D plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , when did coverage start? (mm/dd/yyyy) _____		
1.b. Does this person have a Medigap/Medicare supplemental policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name of coverage plan: _____ When did coverage start? (mm/dd/yyyy) _____		
2. Name:	Medicare claim number:	When did coverage start? (mm/dd/yyyy)
2.a. Does this person have a Medicare Part D plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , when did coverage start? (mm/dd/yyyy) _____		
2.b. Does this person have a Medigap/Medicare supplemental policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name of coverage plan: _____ When did coverage start? (mm/dd/yyyy) _____		
3. Do any of the persons above want to apply for help paying for the Medicare Part B premiums? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , name(s): _____ _____		

### Part B: Federal health insurance benefits

Fill out this part if any household member answered **yes** in the health insurance part (Part 5) to having federal health insurance provided by the U.S. military (Veterans' Affairs or TRICARE) or other federal coverage.

Name of insurance plan or policy:	Policyholder name:
Names of covered household members: _____ _____	
Claim/policy number:	When did coverage start? (mm/dd/yyyy)

### Part C: Other health insurance

Fill out this part if any household member answered **yes** in the health insurance part (Part 5) to having any other type of health insurance.

This includes insurance through an employer, union, college or university, former employer (COBRA), and coverage bought by a household member or parent who is not living in the household.

1. Name of insurance plan or policy:	Policyholder name:	Date of birth: (mm/dd/yyyy)	SSN (if you know):
Names of covered household members: _____ _____			
Policy number:	Group number (if you know):	When did coverage start? (mm/dd/yyyy)	

Source: (Check one.)

☐ Employer-sponsored (give employer name): \_\_\_\_\_ ☐ Union-sponsored (give union name): \_\_\_\_\_  
☐ College/university ☐ COBRA ☐ Retiree ☐ Coverage provided by someone outside household  
☐ Other (Please explain.): \_\_\_\_\_

Type of coverage this plan provides: (Check all that apply.)

☐ Doctor's visits and hospitalizations ☐ Vision coverage ☐ Dental coverage ☐ Pharmacy coverage ☐ Catastrophic only

Premium cost:

\$

Premium frequency: (Check one.)

☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

2. Name of insurance plan or policy:

Policyholder name:

Date of birth: (mm/dd/yyyy)

SSN (if you know):

Names of covered household members:

\_\_\_\_\_  
\_\_\_\_\_

Policy number:

Group number (if you know):

When did coverage start? (mm/dd/yyyy)

Source: (Check one.)

☐ Employer-sponsored (give employer name): \_\_\_\_\_ ☐ Union-sponsored (give union name): \_\_\_\_\_  
☐ College/university ☐ COBRA ☐ Retiree ☐ Coverage provided by someone outside household  
☐ Other (Please explain.): \_\_\_\_\_

Type of coverage this plan provides: (Check all that apply.)

☐ Doctor's visits and hospitalizations ☐ Vision coverage ☐ Dental coverage ☐ Pharmacy coverage ☐ Catastrophic only

Premium cost:

\$

Premium frequency: (Check one.)

☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

***Appendix B: Absent Parent/Non-Custodial Parent Form***

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## Absent Parent/Non-Custodial Parent Form

Commonwealth of Massachusetts | EOHHS

### Instructions

This form is being sent to you because you recently completed an application for certain state health plans such as MassHealth and indicated in that application that one or more of the children in your household has a non-custodial parent. A non-custodial parent is a parent who does not live with his or her child.

This form must be filled out and signed by the custodial parent or legal guardian of the children listed on the application for health care coverage. You must provide the requested information for each child who has a non-custodial parent.

To get MassHealth, you agree to cooperate with MassHealth and the Child Support Enforcement Division of the Massachusetts Department of Revenue ("DOR") in collecting medical support from non-custodial parents. This means that you must fill out this form to help us identify the non-custodial parent who has to pay for medical care for you and your children. Cooperation also means that you may have to, among other things:

- appear at a state or local office to provide relevant information;
- appear as a witness at a court or other proceeding;
- provide information under penalty of perjury including information about the identity, location, and employment of a non-custodial parent;
- pay to MassHealth any support or medical care funds received that are covered by the assignment of rights; and
- take any other reasonable steps to assist in establishing paternity and securing medical support and payments and in identifying and providing information to help us pursue liable third parties.

Your eligibility could be affected if you do not fill out this form in its entirety and do not meet the exceptions described below.

Please fax or mail to:

Electronic Document Management Center  
P.O. Box 1231  
Taunton, MA 02780  
Fax: 617-887-8777

### Important

MassHealth will not deny or terminate your child's MassHealth benefits if you do not cooperate, but your eligibility will be impacted. Even if you are not required to establish paternity, paternity establishment may result in financial benefits for the child such as Social Security dependents' benefits, pension benefits, veterans benefits, and possible rights of inheritance. You can ask for child-support-enforcement services if you want help getting the absent parent to pay for health insurance or child support for the child. To do this, call DOR at 1-800-332-2733, or go to [www.mass.gov/dor](http://www.mass.gov/dor) and click on "Child Support." The child's MassHealth benefits will not be affected if you choose to ask for these services or not. If you ask for these services, you will have to cooperate with DOR.

### Non-custodial-Parent Information

Please provide the following information for each child on the application who has a non-custodial parent. We have provided space for three children and three non-custodial parents. If you need more room, please make a copy of this form or use a separate piece of paper.

If you are applying for benefits for an unborn child, you do not need to give us information about the non-custodial parent of the unborn child at this time.

**Name of child #1:**

First name

Middle name

Last name

Do any of the following apply to this child?

- ☐ Adoption of this child is in process.
- ☐ This child was a result of sexual abuse or assault.
- ☐ Cooperation, as defined on page 1, is not in the best interest of this child  
(for example, cooperation could result in serious physical or emotional harm to me and/or the child).
- ☐ I adopted this child as a single parent.
- ☐ The non-custodial parent of this child is deceased.
- ☐ I do not know who the non-custodial parent of this child is.
- ☐ I am not married to the father of this child AND I am currently pregnant.

If you checked any of the boxes above, you do not have to provide information for this child's non-custodial parent. Please provide non-custodial parent information for any other child(ren) and sign at the end of this form.

**Name of non-custodial parent** for child #1: ☐ I do not know

First name

Middle name

Last name

Non-custodial parent's relationship to child:

☐ mother ☐ father

Gender:

☐ M ☐ FDate of birth: (mm/dd/yyyy) ☐ I do not knowSocial security number: ☐ I do not knowDriver's license number: ☐ I do not knowAddress: ☐ I do not knowTelephone number: ☐ I do not knowEmployer name and address: ☐ I do not knowDoes the non-custodial parent have insurance that covers dependents? ☐ Yes ☐ No ☐ I do not knowIf **yes**, please provide the following information.

Policyholder name:

Insurance company:

Policy number:

Group number:

Has a court issued an order for the non-custodial parent to provide health insurance for the child? ☐ Yes ☐ No ☐ I do not knowIf **yes**, where and when was the order issued? ☐ I do not knowHas a court issued an order for the non-custodial parent to provide health insurance for you, the custodial parent? ☐ Yes ☐ No ☐ I do not knowIf **yes**, where and when was the order issued? ☐ I do not know



**Name of child #2:**

First name

Middle name

Last name

Do any of the following apply to this child?

- ☐ Adoption of this child is in process.
- ☐ This child was a result of sexual abuse or assault.
- ☐ Cooperation, as defined on page 1, is not in the best interest of this child  
(for example, cooperation could result in serious physical or emotional harm to me and/or the child).
- ☐ I adopted this child as a single parent.
- ☐ The non-custodial parent of this child is deceased.
- ☐ I do not know who the non-custodial parent of this child is.
- ☐ I am not married to the father of this child AND I am currently pregnant.

If you checked any of the boxes above, you do not have to provide information for this child's non-custodial parent. Please provide non-custodial parent information for any other child(ren) and sign at the end of this form.

**Name of non-custodial parent** for child #2: ☐ I do not know

First name

Middle name

Last name

Is this the same non-custodial parent named for the first child above? If so, check here and skip the rest of this section. ☐ Make sure to sign this form.

Non-custodial parent's relationship to child:

☐ mother ☐ father

Gender:

☐ M ☐ FDate of birth: (mm/dd/yyyy) ☐ I do not knowSocial security number: ☐ I do not knowDriver's license number: ☐ I do not knowAddress: ☐ I do not knowTelephone number: ☐ I do not knowEmployer name and address: ☐ I do not knowDoes the non-custodial parent have insurance that covers dependents? ☐ Yes ☐ No ☐ I do not knowIf **yes**, please provide the following information.

Policyholder name:

Insurance company:

Policy number:

Group number:

Has a court issued an order for the non-custodial parent to provide health insurance for the child? ☐ Yes ☐ No ☐ I do not knowIf **yes**, where and when was the order issued? \_\_\_\_\_ ☐ I do not knowHas a court issued an order for the non-custodial parent to provide health insurance for you, the custodial parent? ☐ Yes ☐ No ☐ I do not knowIf **yes**, where and when was the order issued? \_\_\_\_\_ ☐ I do not know

**Name of child #3:**

First name

Middle name

Last name

Do any of the following apply to this child?

- ☐ Adoption of this child is in process.
- ☐ This child was a result of sexual abuse or assault.
- ☐ Cooperation, as defined on page 1, is not in the best interest of this child  
(for example, cooperation could result in serious physical or emotional harm to me and/or the child).
- ☐ I adopted this child as a single parent.
- ☐ The non-custodial parent of this child is deceased.
- ☐ I do not know who the non-custodial parent of this child is.
- ☐ I am not married to the father of this child AND I am currently pregnant.

If you checked any of the boxes above, you do not have to provide information for this child's non-custodial parent. Please provide non-custodial parent information for any other child(ren) and sign at the end of this form.

**Name of non-custodial parent** for child #3: ☐ I do not know

First name

Middle name

Last name

Is this the same non-custodial parent named for the first and/or second child above? If so, check here and skip the rest of this section. ☐

Make sure to sign this form.

Non-custodial parent's relationship to child:

☐ mother ☐ father

Gender:

☐ M ☐ FDate of birth: (mm/dd/yyyy) ☐ I do not knowSocial security number: ☐ I do not knowDriver's license number: ☐ I do not knowAddress: ☐ I do not knowTelephone number: ☐ I do not knowEmployer name and address: ☐ I do not knowDoes the non-custodial parent have insurance that covers dependents? ☐ Yes ☐ No ☐ I do not knowIf **yes**, please provide the following information.

Policyholder name:

Insurance company:

Policy number:

Group number:

Has a court issued an order for the non-custodial parent to provide health insurance for the child? ☐ Yes ☐ No ☐ I do not knowIf **yes**, where and when was the order issued? \_\_\_\_\_ ☐ I do not knowHas a court issued an order for the non-custodial parent to provide health insurance for you, the custodial parent? ☐ Yes ☐ No ☐ I do not knowIf **yes**, where and when was the order issued? \_\_\_\_\_ ☐ I do not know**Signature**

I certify under penalty of perjury that I am the custodial parent or legal guardian of the minor child(ren) listed on this form, that I have provided all the information I have or can reasonably get, and that the information in this form is correct and complete to the best of my knowledge.

**X**

Signature of custodial parent or legal guardian

Print name

Date