

MASSHEALTH RENEWAL APPLICATION FOR CERTAIN SENIORS LIVING IN THE COMMUNITY

Commonwealth of Massachusetts | EOHHS



FOR MASSHEALTH USE ONLY: Application received date ___ / ___ / _____

This information is used to determine if you are still eligible for your current benefits. If you need additional services, contact MassHealth at (800) 841-2900.

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

Mail or fax your filled-out, signed renewal application to
MassHealth Enrollment Center
PO Box 4405
Taunton, MA 02780-0968

Fax: (857) 323-8300

Hand deliver your filled-out, signed renewal application to

MassHealth Enrollment Center
The Schrafft Center
529 Main Street, Suite 1M
Charlestown, MA 02129-0214

Access the MassHealth e-Submission system at <https://mhesubmission.ehs.mass.gov/esb> to fill out and upload your renewal application using your e-Submission Reference number

In order to get any benefits you are entitled to as quickly as possible, you may send us any documentation you have that verifies all household income and assets.

Please list the names of everyone who is renewing health coverage on this application.

MassHealth or the Health Safety Net (HSN)

(If living at home, or in a rest home, an assisted living facility, a continuing care retirement community, or life care community, fill out this application and any supplements that apply to you or any household member.) MassHealth will check if anyone applying for health coverage on this application is eligible for MassHealth or the HSN.

You: _____

Spouse: _____

Supplemental Nutrition Assistance Program (SNAP)

Check this box if you want this renewal application to be sent to the Department of Transitional Assistance to serve as an application for SNAP benefits. You must read the rights and responsibilities on pages 19-36 (if needed) and sign on page 4 to proceed with the application. The Supplemental Nutrition Assistance Program (SNAP) is a federal program that helps you buy healthy food each month.

PART A

HOUSEHOLD INFORMATION

(REQUIRED)

1. Household Size: How many people are in your household (including yourself)? _____

You (Person 1) – Tell us about yourself

First Name _____ Last Name _____

Date of Birth _____

Social Security No. or MassHealth ID _____

2. Residential Address (required, unless homeless):

Address _____

City _____ State ____ Zip Code _____

3. Is your residential address the same as your mailing address? Yes No

If No, please enter your mailing address below (if applicable):

Address _____

City _____ State ____ Zip Code _____

4. Phone No. _____

5. Are you homeless? (optional) Yes No

If you check yes, you must enter a mailing address above.

6. Has your citizenship or immigration status changed in the last 12 months or since your last renewal or application? Yes No

If it has changed, please send us a copy of your current citizenship or immigration documents.

PERSON 2 – Spouse

First Name _____ Last Name _____

Date of Birth _____

Social Security No. or MassHealth ID _____

1. Residential Address (required, unless homeless):

Address _____

City _____ State ____ Zip Code _____

2. Is your residential address the same as your mailing address? Yes No

If No, please enter your mailing address below (if applicable):

Address _____

City _____ State ____ Zip Code _____

3. Phone No. _____

4. Are you homeless? (optional) Yes No

If you check yes, you must enter a mailing address above.

5. Has your citizenship or immigration status changed in the last 12 months or since your last renewal or application? Yes No

If it has changed, please send us a copy of your current citizenship or immigration documents.

For enrollment assisters only

Complete this section if you are an enrollment assister and are filling out this application for someone else. Navigators must fill out a Navigator Designation Form if they have not done so already. Certified Application Counselors must fill out a Certified Application Counselor Designation Form if they have not done so already.

Check one

Navigator Certified Application Counselor

First name, middle name, last name, and suffix

Email address _____

Organization name _____

Organization identification number _____

Organization phone number _____

PART B

RESOURCES (INCOME/ASSETS)

6. Income

Income from Working:

You \$ _____ weekly bi-weekly
 twice a month monthly quarterly yearly
Your spouse \$ _____ weekly bi-weekly
 twice a month monthly quarterly yearly

Social Security:

You \$ _____ Your spouse \$ _____

Retirement/Pension/Annuity:

You \$ _____ Your spouse \$ _____

Rental Income:

You \$ _____ Your spouse \$ _____

Veterans or Military:

You \$ _____ Your spouse \$ _____

Mutual funds:

You \$ _____ Your spouse \$ _____

Other (please specify): _____

You \$ _____ Your spouse \$ _____

Total Income:

You \$ _____ Your spouse \$ _____

7. Assets

Bank accounts (includes checking, savings, credit union, certificates of deposit, personal needs accounts, trust accounts, money market accounts, retirement accounts (IRAs, Keogh, 401K))

Bank/institution/company name

Account/policy number _____

Name(s) on Account _____

Current amount/value _____

Life insurance

Bank/institution/company name

Account/policy number _____

Name(s) on Account _____

Cash Surrender Value _____

Securities/other (includes stocks, bonds, savings bonds, mutual funds, cash)

Bank/institution/company name

Account/policy number _____

Name(s) on Account _____

Current amount/value _____

Annuities*

Bank/institution/company name

Account/policy number _____

Name(s) on Account _____

Current amount/value _____

* Annuities purchased on or after February 8, 2006, may make you ineligible for payment of long-term-care services, unless certain conditions are met. To be eligible, you may be required to name the Commonwealth as a remainder beneficiary.

Trust and other assets (please specify)

Bank/institution/company name

Account/policy number _____

Name(s) on Account _____

Current amount/value _____

Burial-only accounts / burial contracts / burial trusts

Bank/institution/company name

Account/policy number _____

Name(s) on Account _____

Current amount/value _____

Vehicle(s)

Year _____ Make _____ Model _____

Real Estate**

Address _____

Property type _____

** If you applied for MassHealth on or after January 1, 2006, and the equity interest in your principal place of residence is over \$750,000, you may be ineligible for payment of long-term-care services at home unless certain conditions are met.

8. Have you received any of these payments?

Reimbursement from Medicare for premiums now being paid by MassHealth Yes No

Supplemental COVID relief payments from the government Yes No

Reimbursement of an overpayment from a nursing facility or institution Yes No

9. Other Health Insurance

Insurance Company _____

Policy Holder _____

Covered Members _____

Type _____ Policy Number _____

Start Date _____ Premium Amount _____

Sign this renewal application.

Signature of Person 1 or authorized representative

_____ Date _____

Print name:

By signing, you agree to and understand the following

- By signing this renewal application, I hereby certify that I have read and agree to the Rights and Responsibilities included in this application on pages 4 through 5.
- I hereby certify under the pains and penalties of perjury that the submissions and statements I have made in this renewal application are true and complete to the best of my knowledge, and I agree to accept and comply with the rights and responsibilities of MassHealth.
- If I have checked the SNAP box on page 3 of this renewal application I am applying for the Supplemental Nutritional Assistance Program (SNAP). I certify that I understand and agree to the rights, rules, and penalties of the SNAP program, as outlined below. I ask that MassHealth send my information, including Protected Health Information subject to the Health Insurance Portability and Accountability Act (HIPAA), to the Department of Transitional Assistance for the purpose of applying for SNAP benefits.

For Masshealth applicants

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 such persons that are paid for by the Health Safety Net.
3. I may have to pay a premium for health coverage for myself and others listed on this application. Failure to pay any premium due may result in the state deducting the amount owed from the tax refunds of responsible persons. If I am a certain American Indian or Alaska Native, I may not have to pay premiums for MassHealth.
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. Such 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 an absent 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, after notice and an opportunity to appeal, MassHealth may place a lien against any real estate owned by an eligible MassHealth member or in which the eligible member has a legal interest, if the member is receiving long-term care in a nursing facility or other medical institution and MassHealth determines that the member is not reasonably expected to return home. If MassHealth puts a lien against such property and the property is later 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, and unless exceptions apply, for any eligible person age 55 or older, or any eligible person regardless of age for whom MassHealth helps pay for long-term care in a nursing home or other medical institution, MassHealth will seek money from the eligible person's estate after death for the total cost of care. For more information on estate recovery, visit mass.gov/EstateRecovery.
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 (800) 841-2900; TTY: 711 for people who are deaf, hard of hearing, or speech disabled. A change in information could affect eligibility for such persons or for persons in their household.

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

- Send the change information to
Health Insurance Processing Center
PO Box 4405
Taunton, MA 02780.

- Fax the change information to (857) 323-8300.

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 such 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 such persons or members of their household.

13. MassHealth, the Massachusetts Health Connector, and the Health Safety Net may get records or data about persons listed on this application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service,

the Department of Homeland Security, the Department of Revenue, and the Registry of Motor Vehicles, as well as private data sources, including financial institutions, 1) to prove any information given on this application and any supplements, or other information given once a person becomes a member, 2) to document medical services claimed or provided to such persons, and 3) to support continued eligibility.

14. In connection with the eligibility and enrollment process, MassHealth, the Massachusetts Health Connector, and the Health Safety Net may send notices that contain personal information about persons listed on this application to other persons on this application, or otherwise communicate such information to such persons.
15. 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/complaints/index.html.
16. I agree to allow the Massachusetts Health Connector to use income data, including information from tax returns, to determine my eligibility in future years. Review the Health Connector Privacy Policy for more information about how the Health Connector uses your tax information. The Massachusetts Health Connector will send me a notice and let me make changes to my

eligibility application. I understand that if I am eligible for an Advance Premium Tax Credit (APTC) and/or ConnectorCare, these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or ConnectorCare may impact my annual tax liability. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.

I AGREE TO THE FOLLOWING STATEMENTS.

For MassHealth Applicants

I have read or have had read to me the information on this application, including any supplements and instruction pages, and I understand that the Senior Guide to Health Care Coverage contains important information.

I have permission from all persons listed on this application (or their parent or other legally authorized representative) to submit this application and to act on their behalf to complete this application and any ongoing or subsequent eligibility process and activity, including, for example:

- providing personal information about them, including health, health coverage, and income information, seeing such information as may be provided by the Massachusetts Health Connector, MassHealth, and the Health Safety Net, and providing consent on their behalf to the use and disclosure of their information as described in this application;

- making choices about coverage options and methods of communication with the Massachusetts Health Connector, MassHealth, and the Health Safety Net;
- making changes to the application or related eligibility documents and providing information about any change in their circumstances; and
- providing consent on their behalf to use government and private sources to verify information as described in this application.

I understand my rights and responsibilities and the rights and responsibilities of all persons listed on this application as explained above.

I have told or will tell all such persons (or their parent or legally authorized representative, if applicable) about these rights and responsibilities so they understand them.

I understand and agree that MassHealth, the Health Safety Net, and the Massachusetts Health Connector will treat electronic, faxed, 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 persons listed on this application.

I may be subject to penalties under federal law if I intentionally provide false or untrue information.

For Supplemental Nutritional Assistance Program (SNAP) applicants

Supplemental Nutrition Assistance Program (SNAP) benefits

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

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

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

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

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

This notice lists rights and responsibilities for all DTA programs. You must follow the rules for programs you apply for.

Please read these pages and keep them for your records.

Let DTA know if you have any questions.

I swear under penalty of perjury that:

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

I understand that:

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

I also understand that:

- DTA will verify the information I give with my application. If any information is false, DTA may deny my benefits.
- I may also be subject to criminal prosecution for providing false information.

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

How will DTA use my information?

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

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

Note: Even if you are not eligible for benefits due to immigration status, DTA will not report you to immigration authorities unless you show DTA a final order of deportation.

- The Department of Revenue (DOR) to verify my eligibility for income-based tax credits, such as Earned Income and Limited Income, and to see if I am eligible for “No Tax Status” or hardship status.

- The Department of Children and Families (DCF) to coordinate services offered jointly by DTA and DCF.

How does DTA use Social Security Numbers (SSNs)?

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

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

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

Right to an Interpreter

I understand that:

- I have a right to a free professional interpreter provided by DTA if I prefer to communicate in a language other than English.
- If I have a DTA hearing, I can ask DTA to give me a

free professional interpreter, or if I prefer, I can bring someone to interpret for me. If I need DTA to give me an interpreter for a hearing, I must call the Division of Hearings at least one week before the hearing date.

Right to Register to Vote

I understand that:

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

Employment Opportunities

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

- SNAP Path Work providers or DTA specialists for SNAP clients; and
- Contracted Employment and Training providers or Full Engagement Workers for TAFDC clients.

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

Citizenship Status

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

Supplemental Nutrition Assistance Program

I understand that:

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

I am eligible for emergency SNAP benefits, but do not get my benefits by the 7th day after I applied for SNAP.

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

- When I get SNAP, I have to meet certain rules. When I am approved for SNAP, DTA will give me a copy of the “Your Right to Know” brochure and the SNAP Program brochure. I will read the brochures or have someone read them to me. If I have any questions or need help reading or understanding this information, I can call DTA at 1-877-382-2363.
- Telling DTA about changes in my household:
 - If I am a SNAP Simplified Reporting household, I do not have to report most changes to DTA until the Interim Report or Recertification is due. The only things I have to report sooner are:

If my household’s income goes over the gross income threshold (listed on my approval notice). I have to report this by the 10th day of the month after the month my income went over the threshold.

If I have to meet the Able-Bodied Adults Without Dependents (ABAWD) Work Rules and my work hours drop below 20 hours per week.
 - If everyone in my household is 60 or older, disabled, or under 18 years old, and no one has earnings from work, the only things I have to report are:

If someone starts working, or

Someone joins or leaves my household.

I have to report these changes by the 10th day of the month after the month of the change.

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

If I and everyone in my household gets cash assistance (TAFDC or EAEDC), I must report certain changes to DTA within 10 days of the change. See When do I need to tell DTA about changes in my household? under Transitional Aid to Families with Dependent Children (TAFDC) and Emergency Aid to the Elderly, Disabled, and Children (EAEDC) below.

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

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

Work rules for SNAP clients: If you get SNAP benefits and are between the ages of 16 and 59 you may need to meet general SNAP work rules or the ABAWD work rules unless you are exempt. DTA will tell me and members of

my household if we need to meet any Work Rules, what the exemptions are, and what will happen if we do not meet the rules.

If you are under the SNAP Work Rules, you must:

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

SNAP Rules

- Do not give false information or hide information to get SNAP benefits.
- Do not trade or sell SNAP benefits.
- Do not alter EBT cards to get SNAP benefits you are not eligible for.
- Do not use SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco.

- Do not use someone else's SNAP benefits or EBT card unless you are an authorized representative, or the recipient has given you permission to use their card on their behalf.

SNAP Penalty Warnings

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

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

- Commit a cash program Intentional Program Violation (IPV) they will be ineligible for SNAP for the same period they are ineligible for cash assistance.
- Make a fraudulent statement about their identity or residency to get multiple SNAP benefits at the same time they will be ineligible for SNAP for ten years.
- Trade (buy or sell) SNAP benefits for a controlled substance/illegal drug(s), they will be ineligible for SNAP for two years for the first finding, and forever for the second finding.

- Trade (buy or sell) SNAP benefits for firearms, ammunition or explosives, they will be ineligible for SNAP forever.
- Make an offer to sell SNAP benefits or an EBT card online or in person the State may pursue an IPV against them.
- Pay for food purchased on credit they will be ineligible for SNAP.
- Buy products with SNAP benefits with the intent to discard the contents and return containers for cash they will be ineligible for SNAP.
- Flee to avoid prosecution, custody or confinement after conviction for a felony they will be ineligible for SNAP.
- Violate probation or parole, where law enforcement is actively seeking to arrest them they will be ineligible for SNAP.

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

1. Aggravated sexual abuse under section 2241 of title 18, U.S.C.;
2. Murder under section 1111 of title 18, U.S.C.;
3. Any offense under chapter 110 of title 18, U.S.C.;
4. A Federal or State offense involving sexual assault, as defined in section 40002(a) of the 1994 VAWA (42 U.S.C. 13925a); or

5. An offense under State law determined by the Attorney General to be substantially similar to an offense described in this list.

Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotope, American Sign Language, etc.), should contact the Agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 1-800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination:

- Complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: ascr.usda.gov/complaint_filing_cust.html, and at any USDA office. You can ask for a copy of the complaint form by calling (866) 632-9992; or

- Write a letter addressed to USDA and put in the letter all of the information requested in the form.

Submit your completed form or letter to USDA by:

- mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue SW Washington, DC 20250-9410; or
- fax: (202) 690-7442; or
- email: program.intake@usda.gov

This institution is an equal opportunity provider.

Transitional Aid to Families with Dependent Children (TAFDC) and Emergency Aid to the Elderly, Disabled, and Children (EAEDC)

TAFDC and EAEDC are cash assistance programs. To learn more and to apply, visit DTAConnect.com or call your local DTA office. This information only applies to households who are applying for or get TAFDC or EAEDC.

When do I need to tell DTA about changes in my household?

I must tell DTA about changes that could affect my TAFDC or EAEDC (cash benefits) within 10 days, except that I do not have to tell DTA about a change in my earnings of less than \$100 per month. This includes changes in my income, assets, address, who I live with, family size, work, and health insurance.

How do I get health insurance?

- If I get TAFDC or EAEDC, I will get MassHealth too.
- If I am denied TAFDC or EAEDC, MassHealth will use my information to see if I am eligible for health insurance.
- If my EAEDC stops, I need to apply for MassHealth separately. To ask for an application call 1-800-841-2900.

If I get MassHealth, I agree that MassHealth may collect:

- money owed to me from another source for my medical care, and
- medical support from the absent parent of any child under age 19 who gets MassHealth benefits.

Are there special rules if I am eligible only because of an accident or injury?

If my family gets benefits from MassHealth or DTA because of an accident or injury, I must use any money I get for the accident or injury to pay them back. The money could be from an insurance policy, a settlement, or any other source. This applies even if I do not know what the possible sources of money are yet.

I agree to cooperate with MassHealth and DTA by:

- Filing claims for money from other sources.
- Telling MassHealth and DTA right away about-any insurance claim, lawsuit, or other process to get money.

- Giving MassHealth and DTA new information when I get it.

If I don't cooperate, MassHealth and DTA may stop or deny my benefits. I agree that MassHealth and DTA may:

- Share information about my benefits to collect money to repay those benefits.
- See all records about money I might get due to the accident or injury, such as records at the Department of Industrial Accidents.

If I am getting EAEDC because I have a disability or I am over 65 years old, I have to apply for federal Supplemental Security Income (SSI) benefits. If I am approved for SSI benefits that cover the same time that I got EAEDC, the Social Security Administration will send some of my retroactive SSI to DTA to repay the EAEDC.

Important Notice About the Law and Your Benefits

An Intentional Program Violation (IPV) is intentionally giving a false or misleading statement or misrepresenting, hiding, or withholding facts, either orally or in writing, in order to establish or maintain eligibility for TAFDC or EAEDC benefits, or to gain benefits to which I am not entitled.

If I am found guilty of an IPV by a court of law, an administrative disqualification hearing, or by signing a waiver, I will be disqualified from receiving TAFDC or EAEDC benefits for a period of:

- 6 months for the first violation
- 12 months for the second violation
- forever for the third violation

In addition, other laws may apply.

Prohibitions on EBT Card Purchases

I understand it is illegal to use TAFDC or EAEDC funds held on an electronic benefit transfer (EBT) card to pay for the following: alcoholic beverages; tobacco products; lottery tickets; adult oriented material or performances; gambling; firearms and ammunition; vacation services; tattoos; body piercings; jewelry; televisions; stereos; video games or consoles at rent-to-own stores; recreational marijuana; court-ordered fees; fines; bail or bail bonds.

Prohibitions on Where I may Use My EBT Card

I understand it is illegal to use my electronic benefit transfer (EBT) card at the following locations: adult bookstores; adult paraphernalia stores or adult oriented performance establishments; ammunitions dealers; casinos; gambling casinos or gaming establishments; cruise ships; firearms dealers; jewelry stores; liquor stores; manicure shops or aesthetic shops; cash transmittal agencies to foreign countries; recreational marijuana stores or tattoo parlors.

Penalties for prohibited EBT card cash purchases

- First Offense: I must pay back DTA the amount spent.

- Second Offense: I must pay back DTA the amount spent and will lose cash benefits for two months.
- Third Offense: must pay back DTA the amount spent and will lose cash benefits permanently.

Send us your completed application.

Mail your signed application to:

MassHealth Enrollment Center
PO Box 4405
Taunton, MA 02780-0968
Fax: (857) 323-8300

Hand deliver your signed application to:

MassHealth Enrollment Center
The Shrafft Center
529 Main Street, Suite 1M
Charlestown, MA 02129

AUTHORIZED REPRESENTATIVE DESIGNATION FORM

Commonwealth of Massachusetts | EOHHS



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

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

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

You can choose someone to help you.

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

Who can help me?

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

to act on your behalf, a person (not an organization) who certifies that they will act responsibly on your behalf can be your authorized representative if that person fills out Section II of this form. We sometimes refer to this person as a “Section II authorized representative.”

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

What can an authorized representative do?

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

- fill out your application or renewal forms;
- fill out other MassHealth or Health Connector eligibility or enrollment forms;
- give proof of information reported on these forms;

- report changes in income, address, or other circumstances;
- get copies of all of your MassHealth and Health Connector eligibility and enrollment notices; and
- act on your behalf in all other matters with MassHealth and the Health Connector.

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

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

SECTION 1

AUTHORIZED REPRESENTATIVE DESIGNATION

(if applicant or member is able to sign)

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

Applicant's/Member's Name

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

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

Applicant's/Member's email address

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

Applicant's/Member's signature

Date (mm/dd/yyyy)

_____ ___/___/___

Authorized representative's name

Authorized representative's phone number

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

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

B1. Complete if authorized representative is a person.

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

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

Authorized representative's signature _____ Date (mm/dd/yyyy) ____/____/____

Authorized representative's printed name

Authorized representative's email address

B2. Complete if authorized representative is an organization.

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

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

Signature of provider, staff member, or volunteer
completing form

Date (mm/dd/yyyy) __/__/____

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

Email of provider, staff member, or volunteer completing form

Authorized representative organization name

SECTION 2

AUTHORIZED REPRESENTATIVE DESIGNATION

**(if applicant or member cannot provide
written designation)**

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

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

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

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

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

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

Applicant's/Member's name

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

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

Authorized representative's signature

Date (mm/dd/yyyy) ___/___/_____

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

Authorized representative's phone number

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

Authorized representative's email address

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

Officer's Name _____

Officer's Title _____

Officer's Signature _____

Date (mm/dd/yyyy) __/__/____

SECTION 3 AUTHORIZED REPRESENTATIVE DESIGNATION

(if appointed by law)

To be filled out by an authorized representative appointed by law (as explained earlier on this form). Please print, except for signature. **Please submit a copy of the applicable legal document with this form.**

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

Applicant's/Member's name

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

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

Authorized representative's signature

Date (mm/dd/yyyy) __/__/____

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

Authorized representative's phone number

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

Authorized representative's email address

How does an authorized representative designation end?

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

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

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

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

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

How do I submit this form?

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

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

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