Request for the Family Assistance Long-term Services and Supports Pathway

Complete this form if you meet all the following requirements.

- You are enrolled in or applying for Family Assistance (FA), as described at 130 CMR 505.005 and 130 CMR 519.013.
- You require a nursing facility (NF) level of care, as defined in 130 CMR 456.409.
- You are admitted to an Acute Inpatient Hospital, Acute Psychiatric Hospital, or a Chronic Disease and Rehabilitation Hospital (CDRH); or were admitted to a hospital immediately preceding their short-term stay at an NF/CDRH.
- You require long-term services and supports (LTSS) in a facility or in the community.

If additional information or proof is needed to make an eligibility decision, MassHealth will send a Request for Information (RFI) notice to the member's mailing address and the member will have to respond by the date on the notice.

If you have additional questions about this form, or if there are additional changes in circumstance that the member needs to report, please contact MassHealth Customer Service at (**800) 841-2900, TDD/TTY: 711** or the Assister line.

Certified Application Counselor Contact Information

Complete this section if you are a Certified Application Counselor (CAC) and are filling out this application for someone else. CACs must fill out a Certified Application Counselor Designation Form if they have not done so already.

CAC name: _____ CAC email address: _____

Organization name: _____ Organization identification number: _____

Organization phone: _____

Tell Us About Yourself

To be completed by the member

Member information

First Name: _____ Last Name: _____

Date of Birth: _____ MassHealth ID (if available): _____

(Optional) Last 4 digits of Social Security Number (if available): _____

Read and Sign This Form

To be completed by the member

I need LTSS in the community or in a facility and am requesting the FA LTSS Pathway.

By signing below, I swear under the pains and penalties of perjury that everything on this form is true and complete to the best of my knowledge. I know that if I lie on this form, my health coverage might end, and I might have to repay the health benefits I received.

…… ……

Signature of applicant, member, or authorized representative Date (MM/DD/YYYY)

Return Signed Form

Return this signed form in one of these 3 ways.

- Mail your filled-out, signed form to
  Health Insurance Processing Center
  PO Box 4405
  Taunton, MA 02780

- Fax your filled-out, signed application to (857) 323-8300.
- Call us at (800) 841-2900, TDD/TTY: 711, or (877) MA ENROLL ([877] 623-6765).