Massachusetts Application for Health and Dental Coverage and Help Paying Costs—Additional Persons

Primary Contact from Step 1

STEP 2 Person ___ .

Use this Additional Persons form if you have more than four people to include with this application. When filling out the additional pages please be sure to tell us how each person is related to each other person on the application. We need this information to determine eligibility.

Complete Step 2 for each additional person in your household who lives with you and for anyone on your same federal income tax return if you file one. See page 1 of the application for more information about whom to include. If you do not file a tax return, remember to still add household members who live with you.

1. First name, middle name, last name, and suffix

2. Relationship to Person 1	Relationship to Person 2	Relationship to Person 3

Does this person live with Person 1? ☐ Yes ☐ No

If no, list address.

3. Date of birth (mm/dd/yyyy)	4. Gender ☐ Male ☐ Female

5. We need a social security number (SSN) for every person applying for health coverage who has one. 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 needs help getting an SSN, call the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778), or go to **socialsecurity.gov**. Please see the Member Booklet for more information.

   Does this person have a social security number (SSN)? ☐ Yes ☐ No

   If **yes**, give us the number (optional if **not** applying) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

   If **no**, check one of the following reasons. ☐ Just applied ☐ Noncitizen exception ☐ Religious exception

6. If this person gets an Advance Premium Tax Credit for 2017, does this person agree to file a federal tax return for tax year 2017? ☐ Yes ☐ No

   He or she may not have needed or chosen to file a tax return in the past, but this person will have to file a federal income tax return for any year that he or she gets an Advance Premium Tax Credit. You must check "Yes" to be eligible for ConnectorCare or Advance Premium Tax Credits to help pay for this person's health insurance. This person does NOT need to file a tax return to get MassHealth benefits.

   If **yes**, please answer questions a–d. If **no**, skip to question d.

   a. Is this person married for tax filing purposes? ☐ Yes ☐ No

      If **yes**, list name of spouse and date of birth. _____

   b. Does this person plan to file a joint federal tax return with a spouse for 2017? ☐ Yes ☐ No

      This person must file a joint federal tax return with his or her spouse for 2017 to get certain programs, unless he or she is a victim of domestic abuse or abandonment. If this person is a victim of domestic abuse or is an abandoned spouse, this person should answer "no" to question 6a ("Is this person considered married for tax filing purposes?") and "no" to question 6b ("Does this person plan to file a joint federal tax return with a spouse for 2017?"), even if that is not how this person actually files. This person will only need to include him/herself and any dependents on this application.

   c. Will this person claim any dependents on this person's federal income tax return for 2017? ☐ Yes ☐ No

      This person will claim a personal exemption deduction on his or her 2017 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments.

      If **yes**, list name(s) and date(s) of birth of dependents.

      _____

d. Will this person be claimed as a dependent on someone else's federal income tax return for 2017? ☐ Yes ☐ No
If this person is claimed by someone else as a dependent on their 2017 federal income tax return, this may affect this person's ability to receive a premium tax credit. Do not answer yes to this question if this person is a child under the age of 21 being claimed by a noncustodial parent.

If **yes**, please list the name of the tax filer. _____

Tax filer date of birth _____ How this person related to the tax filer? _____

Is the tax filer married, filing a joint return? ☐ Yes ☐ No

If **yes**, list name of spouse and date of birth. _____

Who else does the tax filer claim as dependents? _____

7. Is this person applying for health or dental coverage? ☐ Yes ☐ No
(Even if he or she has coverage, there might be a program with better coverage or lower costs.)

If **yes**, answer all the questions below. If **no**, answer Questions 14 and 15, then go to **Income Information** on page 3.

8. Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No

If **yes**, is this person a naturalized citizen (not born in the U.S.)? ☐ Yes ☐ No

Alien number _____ Naturalization or citizenship certificate number _____

9. If this person is a noncitizen, does he or she have an eligible immigration status? ☐ Yes ☐ No
See page 22, "Immigration Statuses and Document Types" for help. If **no** or **no response**, this person may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN). Go to Question 10.

a. If **yes**, does this person have an immigration document? ☐ Yes ☐ No
It may help us to process this application faster if you include a copy of this person's immigration document with the application. We will try to verify this person's immigration status through electronic data match. Please list all the immigration statuses and /or conditions that have applied to him or her since this person entered the U.S. If you need more space, attach another sheet of paper.

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

Immigration status _____ Immigration document type _____
Choose status and types from the list of "Immigration Statuses and Document Types."

Document ID number _____ Alien number _____

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

b. Did this person use the same name on this application that he or she did to get this person's immigration status?
☐ Yes ☐ No
If **no**, what name did this person use? First, middle, last and suffix _____

c. Did this person arrive in the U.S. after August 22, 1996? ☐ Yes ☐ No

d. Is this person an honorably discharged veteran or active duty member of the U.S. military, or the spouse or child of an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

10. Does this person live with at least one child younger than the age of 19, and is this person the main person taking care of this child(ren)? ☐ Yes ☐ No

Name(s) and date(s) of birth of child(ren) _____

11. Race (optional—check all that apply.)

☐ Hispanic, Latino, or Spanish origin
- ☐ Cuban
- ☐ Mexican, Mexican-American, or Chicano
- ☐ Puerto Rican
- ☐ Other Hispanic/Latino/Spanish _____

☐ American Indian or Alaska Native (complete Step 3 and Supplement B)

☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean

☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White or Caucasian
☐ Other _____

12. Is this person living in Massachusetts, and does this person either intend to reside here, even if he or she does not have a fixed address, or has this person entered Massachusetts with a job commitment or seeking employment? ☐ Yes ☐ No
If this person is visiting in Massachusetts for personal pleasure or for the purposes of receiving medical care in a setting other than a nursing facility, you must answer no to this question.

13. Does this person 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

14. Does this person need reasonable accommodation because of a disability or an injury? ☐ Yes ☐ No

If **yes**, complete the rest of this application, including Supplement C: Accommodation.

15. Is this person pregnant? ☐ Yes ☐ No

If **yes**, how many babies is she expecting? _____ What is the expected due date? _____

16. Does this person have breast or cervical cancer? (Optional) ☐ Yes ☐ No
MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.

17. Is this person HIV positive? (Optional) ☐ Yes ☐ No
MassHealth has special coverage rules for people who are HIV positive.

18. Was this person ever in foster care? ☐ Yes ☐ No

a. If **yes**, in what state was this person in foster care? _____

b. Was this person getting health care through a state Medicaid program? ☐ Yes ☐ No

INCOME INFORMATION

Does this person have any income? ☐ Yes ☐ No

If **yes**, go to Current Job 1 for job income. Go to Self-Employment for self-employment income. For all other income, go to Other Income. If any income is not steady from month to month, please provide the average income for the time period (per week, per month, etc.).

If **no**, use this Additional Person form for each person you need to add. If this is the last person you have to add, go to Step 3.

CURRENT JOB 1

19. Employer name and address

20. Wages/tips (before taxes) **$** _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly (Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)

21. Average number of hours worked each WEEK _____ | 22. Is this job a sheltered workshop? ☐ Yes ☐ No

23. Is this person seasonally employed? ☐ Yes ☐ No. If **yes**, which months does this person work in a calendar year?
☐ Jan. ☐ Feb. ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

CURRENT JOB 2 | if you have more jobs and need more space, attach another sheet of paper.

24. Employer name and address

25. Wages/tips (before taxes) **$** _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly (Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)

26. Average number of hours worked each WEEK _____ | 27. Is this job a sheltered workshop? ☐ Yes ☐ No

28. Is this person seasonally employed? ☐ Yes ☐ No. If **yes**, which months does this person work in a calendar year?
☐ Jan. ☐ Feb. ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

SELF-EMPLOYMENT | If self-employed, answer the following questions. If you need more space, attach another sheet of paper.

29. Is this person self employed? ☐ Yes ☐ No

    a. If **yes**, what type of work does this person do? _____

    b. On average, how much net income (profits after business expenses are paid) will this person get from this self-employment each month, or, how much will this person lose from this self-employment each month? $_____/month **profit** OR $_____/month **loss**?

    c. How many hours does this person work per week? _____

OTHER INCOME

30. Check all that apply, and give the amount and how often this person gets it. If this person receives a one-time payment, please include the month in which it was received. **NOTE: You do not need to tell us about child support, nontaxable veteran's payments, or Supplemental Security Income (SSI).**

    ☐ Social security benefits $ _____ How often/month received? _____

    ☐ Unemployment $ _____ How often/month received? _____

    ☐ Retirement or pension $ _____ How often/month received? _____ Source _____

    ☐ Capital gains $ _____ How often/month received? _____

    ☐ Interest, dividends, and other Investment income $ _____ How often/month received? _____

    ☐ Net rental or royalty income $ _____ How often/month received? _____

    ☐ Net farming or fishing income $ _____ How often/month received? _____

    ☐ Alimony received $ _____ How often/month received? _____

    ☐ Other taxable income $ _____ How often/month received? _____ Type _____

DEDUCTIONS

31. Check all that apply. Give the amount and how often this person gets it.

    If this person pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE: You do not need to tell us about child support, nontaxable veteran's payments, Supplemental Security Income (SSI), or most workers' compensation.**

    ☐ Alimony paid $ _____ How often? _____ ☐ Student loan interest $ _____ How often? _____

    ☐ Other tax deductions (educator expenses; certain business expenses of reservists, performing artists, or fee-based government officials; health savings account deduction; moving expenses; deductible part of self-employment tax; contribution to self-employed SEP, SIMPLE, and qualified plans; self-employed health insurance deduction; penalty on early withdrawal of savings; Individual Retirement Account (IRA) deduction; higher education tuition and fees; and domestic production activities deduction). Enter the amount up to the maximum deductible allowed by the IRS. Do not include any type of deduction that is not listed above.

    Type _____ $ _____ How often? _____

YEARLY INCOME

32. What is this person's total expected income for the current calendar year?

33. What is this person's total expected income for next calendar year, if different?

THANKS! This is all we need to know about this person.

For additional copies of this form, the ACA-3-AP, go to www.mass.gov/masshealth and click on Apply for MassHealth. Under the Applicants 64 Years of Age and Younger and Families section, click on Massachusetts Application for Health and Dental Coverage and Help Paying Costs—Additional Persons.

Send your complete application to

Health Insurance Processing Center
PO Box 4405
Taunton, MA 02780; or

Fax to **1-857-323-8300.**