Application for Health Coverage for Seniors and People Needing Long-Term-Care Services

HOW TO APPLY

Please identify which program each household member is applying for on page 1 of the application.
You can submit your application in any of the following ways.

Mail or **fax** your filled-out, signed application to

MassHealth Enrollment Center
Central Processing Unit
P.O. Box 290794
Charlestown, MA 02129-0214

Fax: 617-887-8799

Hand deliver your filled-out, signed application to

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

MASSHEALTH and the HEALTH SAFETY NET | Who Can Use This Application

This is your application for health coverage if you live in Massachusetts and are

- an individual 65 years of age or older and living at home and
  - not the parent of a child under 19 years of age who lives with you; or
  - not an adult relative living with and taking care of a child younger than 19 years of age when neither parent is living in the home; or
- an individual of any age and need long-term-care services in a medical institution or nursing facility;
- an individual who is eligible under certain programs to get long-term-care services to live at home; or
- a member of a married couple living with your spouse, and
  - both you and your spouse are applying for health coverage;
  - there are no children under 19 years of age living with you; and
  - one spouse is 65 years of age or older and the other spouse is under 65 years of age. (Please see Step 8 of the application.)

If you meet any of the following exceptions, you should complete the Application for Health and Dental Coverage and Help Paying Costs (ACA-3). To obtain a copy of this application, call us at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

- You are the parent of a child under 19 years of age who lives with you, or
- You are an adult relative living with and taking care of a child younger than 19 years of age when neither parent is living in the home, or
- You are disabled and are either working 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;

You will also need to fill out a Long-Term-Care Supplement if you are

- in an institution, such as a nursing home, chronic hospital, or other medical institution (You may have to pay a monthly payment, called a patient-paid amount, to the long-term-care facility. For more information, see page 14 in the Senior Guide.);
- in an acute hospital waiting for placement in a long-term-care facility; or
- living in your home and applying for or getting long-term-care services under a Home- and Community-Based Services Waiver.

If someone is helping you fill out this application, you may need to fill out a separate form that gives that person permission to act on your behalf. See Authorized Representative Designation Form at the end of this application.

MASSACHUSETTS HEALTH CONNECTOR | Who Can Use This Application

This is your application for health coverage if you live in Massachusetts, your income is at or below 400% of the federal poverty level, and you

- are 65 years of age or older;
- are not otherwise eligible for MassHealth;
- are not getting Medicare; and
- do not have access to an affordable health plan that meets the minimum value requirement.*

* Minimum value requirement means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee.

The Health Connector uses Modified Adjusted Gross Income (MAGI) rules to determine eligibility. See the Senior Guide for more information.

WHAT YOU NEED WHEN YOU APPLY

The following MUST be sent with the application when applying for MassHealth, the Health Safety Net, and the Massachusetts Health Connector

SOCIAL SECURITY NUMBER (SSN)

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.

Unless an exception applies, **we need SSNs for all 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 www.socialsecurity.gov. Please see the Senior Guide for more information.

PROOF OF INCOME, ASSETS, AND INSURANCE

We will attempt to verify some of this information through electronic data matches and will notify you if we need further proof. It may speed up the processing of your application if you send proof of these items with it.

- Proof of all current income before deductions, such as copies of pay stubs or pension check stubs (You do not have to send proof of social security or SSI income, but you must fill out the social security and SSI income information, if applicable.)
- Proof of all assets, such as bank accounts and life insurance policies
- Copies of your current health insurance premium bills (such as Medex) if you are applying for long-term-care services in a medical facility. (You do not have to send copies of your Medicare cards.)
- Policy numbers for any current health coverage
- Information about any other health insurance available to your household

PROOF OF CITIZENSHIP/NATIONAL STATUS

We will try to verify this information through electronic data matches. We will notify you if we need further proof. It may speed up the processing of your application if you send proof of these items with it.

- Proof of U.S. citizenship/national status and proof of identity, such as U.S. passports or U.S. naturalization papers. You can also prove U.S. citizenship with a U.S. public birth certificate. You can also prove identity with a driver's license or some other form of government-issued card. We may be able to prove your identity through the Massachusetts Registry of Motor Vehicles records if you have a Massachusetts driver's license or a Massachusetts ID card. Once you give MassHealth proof of your U.S. citizenship/national status and identity, you will not have to give us this proof again. You must give us proof of identity for all household members who are applying. **Seniors and disabled persons who get or can get Medicare or Supplemental Security Income (SSI), or disabled persons who get Social Security Disability (SSDI), do not have to give proof of their U.S. citizenship/national status and identity.** (See Section 9 in the Senior Guide for complete information about acceptable forms of proof.)
- A copy of both sides of all immigration cards (or other documents that show immigration status) for you or your spouse if you or your spouse are not U.S. citizens/nationals and are applying for MassHealth (except for MassHealth Limited), the Health Safety Net, or the Health Connector plans.

For more information on immigration statuses and document types, please see page 20.

WHY WE ASK FOR THIS INFORMATION

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We will keep all the information you provide private and secure, as required by law.** To view the Health Connector's privacy policy, go to mahealthconnector.org. To view MassHealth's privacy policy, go to mass.gov/eohhs/gov/laws-regs/privacy-security/massshealth/member-information/notice-of-privacy-practices.html.

WHAT HAPPENS NEXT and WHERE TO GET HELP

When we get your filled-out, signed, and dated application, we will review it. If we need more information, we will write or call 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 are determined eligible for MassHealth, show this notice right away to any health care provider if you already paid for medical services that would be covered by MassHealth during your eligibility period. If the health care provider determines that MassHealth will pay for these services, the provider will refund what you paid.

If you need more information about how to apply, or if you need another copy of **Supplement C: Personal-Care Attendant** for your spouse who is also applying, call us at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled). This application is available in Spanish. Please call the number above to request one.

If you have any questions about any form or the information you need to send, please call us 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 for Seniors and People Needing Long-Term-Care Services

Please Print Clearly. Be sure to answer all questions. Fill out all parts of the application, along with all supplements that apply. If you need more space, attach a separate piece of paper to the application. Put Person 1's name and social security number at the top of any attached paper.
For each member in your household, please put the name(s) of the individual(s) under the program or programs he or she wants to apply for. Please see the Senior Guide to learn more about coverage under these programs.

Please list the names of everyone who is applying for 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: _____

☐ **Long-Term Care and/or**
☐ **Home- and Community-Based Services Waiver**
(If applying for or getting long-term-care services at home under an HCBS Waiver, or in a nursing home or chronic hospital, fill out this application and any supplements that apply to you or any household member, including all or part of the Long-Term-Care Supplement.)

You: _____

Spouse: _____

☐ **Health Connector Programs**
Health coverage through the Massachusetts Health Connector is not MassHealth. If you have Medicare, you will not be eligible for any cost sharing or Advance Premium Tax Credits, and you cannot purchase a plan through the Health Connector, unless you were enrolled in a Health Connector plan when you became eligible for Medicare. The only time you should apply for Health Connector programs if you have Medicare is if you are not enrolled in Medicare yet but would have to pay for your Medicare Part A premium. In this case, you may be eligible for a Health Connector plan.

You: _____

Spouse: _____

STEP 1 Person 1 (YOU)—Tell us about YOURSELF.

We need one adult in the household to be the contact person for your application. Please note that this should be someone who appears on the application, not a third party who wishes to serve as a contact for the applicant(s). Please see the Authorized Representative Designation (ARD) Form after page 29 to establish a third-party contact.

1. First name, middle name, last name, and suffix			2. Date of birth
3. Home address ☐ Check this box if homeless. You must provide a mailing address.			4. Apartment or suite number
5. City	6. State	7. ZIP code	8. County
9. Is this a hospital, nursing facility, or other institution? ☐ Yes ☐ No If yes, facility name			
10. Mailing address ☐ Check if same as home address.			11. Apartment or suite number
12. City	13. State	14. ZIP code	15. County
16. Phone number	17. Other phone number		
18. E-mail			19. # of people listed on the application
20. What is your preferred spoken or written language (if not English)?			

21. Is anyone on this application in prison or jail? ☐ Yes ☐ No

If **yes**, who? Enter the name here: _____

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	E-mail address	
Organization name	Organization identification number	Organization phone number

STEP 2 Person 1

1. First name, middle name, last name, and suffix	2. Gender ☐ Male ☐ Female	3. Relationship to you SELF

4. Are you applying for health or dental coverage for YOURSELF? ☐ Yes ☐ No

If **yes**, answer all the questions below in Step 2 for Person 1 (yourself).
If **no**, answer Question 15 (accommodations), then go to the Income Information section on page 4.

5. We need a social security number (SSN) for every person applying for health coverage who has one, including those applying for MassHealth Premium Assistance. 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 Senior Guide for more information.

   a. 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 following reasons. ☐ Just applied ☐ Noncitizen exception ☐ Religious exception

   b. Is your name on this application the same as your name on your social security card? ☐ Yes ☐ No

   If **no**, what name is on your social security card? _____
   First name, middle name, last name, and suffix

6. If you get an Advance Premium Tax Credit (APTC) for 2017, do you agree to file a federal tax return for tax year 2017?
   ☐ Yes ☐ No
   You may not have needed or chosen to file a tax return in the past, but you will have to file a federal income tax return for any year that you get an APTC. You must check "Yes" to be eligible for ConnectorCare or APTCs to help pay for your health insurance. You do NOT need to file a tax return to get MassHealth or HSN, if you qualify.

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

   You must file a joint federal tax return with your spouse for 2017 to get certain programs unless you are a victim of domestic abuse or abandonment. If you are a victim of domestic abuse or are an abandoned spouse, you should answer "No" to question 6a ("Are you legally married?") and "No" to question 6b ("Do you plan to file with your spouse?"), even if that is not how you actually file. You will only need to include yourself and any dependents on this application.

   a. Are you legally married? ☐ Yes ☐ No See IRS Publication 501 or consult a tax professional for tax filing information.

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

   b. Do you plan to file a joint federal tax return with your spouse for 2017? ☐ Yes ☐ No

c. Will you claim any dependents on your federal income tax return for 2017? ☐ Yes ☐ No
You will claim a personal exemption deduction on your 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 you be claimed as a dependent on someone else's federal income tax return for 2017? ☐ Yes ☐ No
If you are claimed by someone else as a dependent on their 2017 federal income tax return, this may affect your ability to receive an Advance Premium Tax Credit. Do not answer "Yes" to this question if you are a child under 21 years of age being claimed by a noncustodial parent.

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

Tax filer date of birth _____ How are you 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?

_____

To complete this section, read the following statement. Then check yes below the statement if:
1. You have received an APTC or ConnectorCare in the past, and
2. The statement is true for all people listed in the household.

Statement

I filed a federal income tax return with the Internal Revenue Service (IRS) for every year that I received an Advance Premium Tax Credit (APTC). When I filed, I included IRS Form 8962, which had information about the tax credit I received, so the IRS could reconcile my APTC. ☐ Yes ☐ No

7. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

If **yes**, are you a naturalized citizen (not born in the US)? ☐ Yes ☐ No

Alien number _____ Naturalization or citizenship certificate number _____

8. If you are a noncitizen, do you have an eligible immigration status? ☐ Yes ☐ No
See page 20, "Immigration Statuses and Document Types" for help. If **no** or **no response**, you 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**, do you have an immigration document? ☐ Yes ☐ No
It may help us to process this application faster if you include a copy of your immigration document with the application. We will try to verify your immigration status through electronic data match. Please list all the immigrations statuses and/or conditions that have applied to you since you 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 one or more document status and type from the list on page 20.

Document ID number _____ Alien number _____

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

b. Did you use the same name on this application that you did to get your immigration status? ☐ Yes ☐ No
If **no**, what name did you use? First, middle, last, and suffix _____

c. Did you arrive in the US after August 22, 1996? ☐ Yes ☐ No

d. Are you 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

9. Check the box below that best describes you (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 _____

10. Are you living in Massachusetts, and you either intend to reside here, even if you do not have a fixed address, or you have entered Massachusetts with a job commitment or seeking employment? ☐ Yes ☐ No

    If you are 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.

11. Do you live with at least one child younger than age 19, and are you the main person taking care of this child or children? ☐ Yes ☐ No

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

12. Are you pregnant? ☐ Yes ☐ No
    If **yes**, how many babies are you expecting? _____ What is the expected due date? _____

13. Were you ever in foster care? ☐ Yes ☐ No
    a. If **yes**, in what state were you in foster care? _____
    b. Were you getting health care through a state Medicaid program? ☐ Yes ☐ No

14. Do you rent or own your property? ☐ Rent ☐ Own

15. Do you need reasonable accommodation(s) because of a disability or injury? ☐ Yes ☐ No
    If **no**, go to the next question. If **yes**, answer questions a and b.
    a. Condition
    ☐ Low vision ☐ Blind ☐ Deaf ☐ Hard of hearing ☐ Developmentally disabled ☐ Intellectually disabled
    ☐ Physically disabled ☐ Other (Please explain.) _____
    b. Accommodation
    ☐ Text telephone (TTY) ☐ Large-print publications ☐ American Sign Language interpreter ☐ Video Relay Service
    ☐ Communication Access Real-time Translations (CART) ☐ Publications in braille ☐ Assistive listening device
    ☐ Publications in electronic format ☐ Other (Please explain.) _____

16. Are you applying because of an accident or injury that someone else might be responsible for? ☐ Yes ☐ No
    a. Did someone else cause your injury, illness, or disability, or could someone else's insurance or your own insurance, other than health insurance (like homeowner's or auto insurance) cover it? ☐ Yes ☐ No
    b. Have you filed a lawsuit, a workers' compensation claim, or an insurance claim for this accident or injury? ☐ Yes ☐ No

17. Did you ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No
    If **no**, go to Income Information. If **yes**, answer questions a and b.
    a. When did you last get SSI? (mm/yyyy) _____
    b. Do you (check one): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home? ☐ live in someone else's home?

INCOME INFORMATION

18. Do you 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**, go to Person 2 if you have individuals to add. If this application is only for you, go to Step 3.

CURRENT JOB 1

19. Employer name and address | Federal Tax ID#

20. a. 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.)
    b. Income effective date

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

23. Are you seasonally employed? ☐ Yes ☐ No. If yes, which months do you 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 | Federal Tax ID#

25. a. 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.)
    b. Income effective date

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

28. Are you seasonally employed? ☐ Yes ☐ No. If **yes**, which months do you 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. Are you self employed? ☐ Yes ☐ No

    a. If **yes**, what type of work do you do? _____

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

    c. How many hours do you work per week? _____

OTHER INCOME

30. Check all that apply, and give the amount and how often you get it. If you receive 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? _____
☐ Pension $_____ How often/month received? _____
☐ Annuities $_____ How often/month received? _____
☐ Trusts $_____ How often/month received? _____
☐ Unemployment $_____ How often/month received? _____
☐ Capital gains $_____ How often/month received? _____
☐ Interest, dividends, and other investment income $_____ How often/month received? _____
☐ Royalty income $_____ How often/month received? _____
☐ Net farming or fishing income $_____ How often/month received? _____
☐ Alimony received $_____ How often/month received? _____
☐ Taxable veteran's benefits $_____ How often/month received? _____
☐ Taxable military retirement pay (not paid through the Veterans' Administration) $_____ How often/month received? _____
☐ Other taxable income (include type) $_____ How often/month received? _____ Type _____

RENTAL INCOME

31. Do you get rental income? (**You must answer this question.**) ☐ Yes ☐ No

If **yes**, **send proof** of current rental income, such as a written statement from each tenant, a copy of the lease, or a current federal tax return. Also **send proof** of all of the following expenses, if applicable, for the last 12 months: mortgage, taxes, utilities (gas/electric), heat, water/sewer, insurance, condo or co-op fee, repairs and maintenance.

a. What type of real estate do you own? ☐ one-family ☐ two-family ☐ three-family ☐ other (describe): _____

b. How much monthly rental income do you get from each rental unit from the real estate indicated above, or how much will you lose from this rental this month? (List each rental unit and address separately.)

Address _____ Unit #_____
Amount of Income _____ Amount of Loss _____ Owner-occupied? ☐ Yes ☐ No

Address _____ Unit #_____
Amount of Income _____ Amount of Loss _____ Owner-occupied? ☐ Yes ☐ No

c. Do you pay for heat or utilities for your tenant? ☐ Yes ☐ No

DEDUCTIONS

32. Check all that apply. Give the amount and how often you get it.

If you pay 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 should not include a cost that you already considered in your answers to net self-employment income, net rental, or net farming or fishing income. Enter the amount up to the maximum deduction allowed by the IRS.

☐ 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 related to a job change; 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). **Do not include any type of deduction that is not listed above.**

Type _____ $ _____ How often? _____

YEARLY INCOME

33. What is your total expected income for the current calendar year?

34. What is your total expected income for next calendar year, if different?

THANKS! This is all we need to know about you. Go to Step 2 Person 2 to add another household member, if needed. Otherwise, go to Step 3 American Indian or Alaska Native (AI/AN) Household Member(s).

STEP 2 Person 2—Spouse or other people in this household

Fill out this part for your spouse who lives with you or anyone included on your federal income tax return, if you file one.

If you have to include more than two people on this application, make a copy of blank information pages for Step 2 Person 2 BEFORE you fill them out. 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. You can also download pages for additional persons at mass.gov/masshealth. Click on Apply for Health Coverage. Under the Individuals and Families, Including People with Disabilities section, click on Apply by Mail or Fax, then Applications for Individuals and Families (ACA-3), then on Massachusetts Application for Health and Dental Coverage and Help Paying Costs – Additional Persons.

1. First name, middle name, last name, and suffix	2. Date of birth	3. Gender ☐ Male ☐ Female
4. Relationship to Person 1	5. Does this person live with Person 1? ☐ Yes ☐ No If no, provide home address	

☐ No home address. Note: if you check this box, you must provide a mailing address.

6. Is this a hospital, nursing facility, or other institution? ☐ Yes ☐ No
If **yes**, facility name

7. Mailing address ☐ Check if same as home address.			8. Apartment or suite number
9. City	10. State	11. ZIP code	12. County

13. What is this person's preferred spoken or written language (if not English)?

14. Is this person applying for health or dental coverage? ☐ Yes ☐ No
If **yes**, answer all the questions below in Step 2 for Person 2
If **no**, answer Question 25 (accommodations), then go to the Income Information section on page 9.

15. We need a social security number (SSN) for every person applying for health coverage who has one, including those applying for MassHealth Premium Assistance. 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 Senior Guide for more information.

a. 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

b. Is this person's name on this application the same as the name on his or her social security card? ☐ Yes ☐ No

If **no**, what name is on your social security card? _____
First name, middle name, last name, and suffix

16. If this person gets an Advance Premium Tax Credit (APTC) for 2017, does he or she 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 will have to file a federal income tax return for any year that he or she gets an APTC. You must check "Yes" to be eligible for ConnectorCare or APTCs to help pay for his or her health insurance. You do NOT need to file a tax return to get MassHealth or HSN, if you qualify.

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

He or she 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 he or she is a victim of domestic abuse or is an abandoned spouse, you should answer "No" to question 16a ("Is this person legally married?") and "No" to question 16b ("Does this person plan to file with a spouse?"), even if that is not how he or she actually files. He or she will only need to include him- or herself and any dependents on this application.

a. Is this person legally married? ☐ Yes ☐ No
See IRS Publication 501 or consult a tax professional for tax filing information.

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

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

c. Will this person claim any dependents on his or her federal income tax return for 2017? ☐ Yes ☐ No
He or she 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.

_____

d. Will this person be claimed as a dependent on someone else's federal income tax return for 2017? ☐ Yes ☐ No.
If he or she is claimed by someone else as a dependent on their 2017 federal income tax return, this may affect his or her ability to receive an Advance Premium Tax Credit. Do not answer "Yes" to this question if this person is a child under 21 years of age being claimed by a noncustodial parent.

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

Tax filer date of birth _____ How are you 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?

_____

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

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

Alien number _____ Naturalization or citizenship certificate number _____

18. If this person is a noncitizen, does he or she have an eligible immigration status? ☐ Yes ☐ No
See page 20, "Immigration Statuses and Document Types" for help. If **no** or **no response**, you 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 22.

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 his or her immigration document with the application. We will try to verify this person's immigration status through electronic data match. Please list all the immigrations statuses and/or conditions that have applied to this person since he or she entered the U.S. If you need more space, attach another sheet of paper. For immigration status, choose one or more statuses from the list on page 20. Status award date (mm/dd/yyyy) _____ (For battered persons, enter the date the petition was approved.)

Immigration status _____ Immigration document type _____
Choose one or more document status and types from the list on page 20.

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 to get his or her 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

19. Check the box below that best describes this person (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 _____

20. 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.

21. Does this person live with at least one child younger than age 19, and are you the main person taking care of this child or children? ☐ Yes ☐ No

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

22. Is this person pregnant? ☐ Yes ☐ No
If **yes**, how many babies is she expecting? _____ What is the expected due date? _____

23. 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

24. Does this person rent or own his or her property? ☐ Rent ☐ Own

25. Does this person need reasonable accommodation(s) because of a disability or injury? ☐ Yes ☐ No
If **no**, go to the next question. If **yes**, answer questions a and b.

a. Condition

☐ Low vision ☐ Blind ☐ Deaf ☐ Hard of hearing ☐ Developmentally disabled ☐ Intellectually disabled
☐ Physically disabled ☐ Other (Please explain.) _____

b. Accommodation

☐ Text telephone (TTY) ☐ Large-print publications ☐ American Sign Language interpreter ☐ Video Relay Service
☐ Communication Access Real-time Translations (CART) ☐ Publications in braille ☐ Assistive listening device
☐ Publications in electronic format ☐ Other (Please explain.) _____

26. Is this person applying because of an accident or injury that someone else might be responsible for? ☐ Yes ☐ No

a. 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

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

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

If **no**, go to Income Information. If **yes**, answer questions a and b.

a. When did this person last get SSI? (mm/yyyy) _____

b. Does this person (check one): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home? ☐ live in someone else's home?

INCOME INFORMATION

28. 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**, go to Step 3, American Indian or Alaska Native.

CURRENT JOB 1

29. Employer name and address | Federal Tax ID#

30. a. 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.)
b. Income effective date

31. Average number of hours worked each WEEK _____ | 32. Is this job a sheltered workshop? ☐ Yes ☐ No

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

CURRENT JOB 2 | If this person has more jobs and needs more space, attach another sheet of paper.

34. Employer name and address | Federal Tax ID#

35. a. 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.)
b. Income effective date

36. Average number of hours worked each WEEK _____ | 37. Is this job a sheltered workshop? ☐ Yes ☐ No

38. Is this person seasonally employed? ☐ Yes ☐ No. If **yes**, which months does he or she 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.

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

a. If **yes**, what type of work does he or she 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 he or she lose from this self-employment each month? $_____/month **profit** OR $_____/month **loss**?

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

OTHER INCOME

40. Check all that apply, and give the amount and how often you get it. If you receive 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? _____
☐ Pension $_____ How often/month received? _____
☐ Annuities $_____ How often/month received? _____
☐ Trusts $_____ How often/month received? _____
☐ Unemployment $_____ How often/month received? _____
☐ Capital gains $_____ How often/month received? _____
☐ Interest, dividends, and other investment income $_____ How often/month received? _____
☐ Royalty income $_____ How often/month received? _____
☐ Net farming or fishing income $_____ How often/month received? _____
☐ Alimony received $_____ How often/month received? _____
☐ Taxable veteran's benefits $_____ How often/month received? _____
☐ Taxable military retirement pay (not paid through the Veterans' Administration) $_____ How often/month received? _____
☐ Other taxable income (include type) $_____ How often/month received? _____ Type _____

RENTAL INCOME

41. Does this person get rental income? ☐ Yes ☐ No

If yes, send proof of current rental income, such as a written statement from each tenant, a copy of the lease, or a current federal tax return. Also **send proof** of all of the following expenses, if applicable, for the last 12 months: mortgage, taxes, utilities (gas/electric), heat, water/sewer, insurance, condo or co-op fee, repairs and maintenance.

a. What type of real estate does this person own? ☐ one-family ☐ two-family ☐ three-family
☐ other (describe): _____

b. How much monthly rental income does this person get from each rental unit from the real estate indicated above, or how much will this person lose from this rental this month?

Address _____ Unit #_____
Amount of Income _____ Amount of Loss _____ Owner-occupied? ☐ Yes ☐ No

Address _____ Unit #_____
Amount of Income _____ Amount of Loss _____ Owner-occupied? ☐ Yes ☐ No

c. Does this person pay for heat or utilities for his or her tenant? ☐ Yes ☐ No

DEDUCTIONS

42. 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:** Do not include a cost already considered in answers to net self-employment income, net rental, or net farming or fishing income. Enter the amount up to the maximum deduction allowed by the IRS.

☐ 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 related to a job change; 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). **Do not include any type of deduction that is not listed above.**

Type _____ $ _____ How often? _____

YEARLY INCOME

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

44. 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.

STEP 3 American Indian or Alaska Native (AI/AN) Household Member(s)

Are you or is anyone in your household an American Indian or Alaska Native? ☐ Yes ☐ No

If **no**, skip to Step 4. If **yes**, complete the rest of this application, including **Supplement B: American Indian or Alaska Native Household Member.**

Names(s) of person(s) _____

American Indians and Alaska Natives who enroll in health coverage can also get services from the Indian Health Service, 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 premiums or copayments, and may get special monthly enrollment periods.

STEP 4 Previous Medical Bills

Do you or your spouse have bills for medical services you got in the three months before the month we got your application?
☐ Yes ☐ No

If **no**, go to **Step 5: Assets**. If **yes,** fill out the rest of this section. We may be able to pay for these bills.

Do you or your spouse want to apply for MassHealth for that time period? ☐ Yes ☐ No

If **yes,** what is the earliest date for which you need MassHealth? (mm/dd/yyyy) _____

(You must give us proof of all income and assets owned during that time period.)

STEP 5 Assets | You **must** fill out all blocks for each asset you and/or your spouse own.

If you live in the community and you want help with medical bills up to three months before the month you apply, you must tell us about any open and closed accounts for that period. If you are applying for long-term care, you must also give us information about all assets you or your spouse owned in the past 60 months. If you need more space, attach another sheet of paper.

BANK ACCOUNTS

1. Do you or your spouse have any bank accounts or certificates of deposit, including checking, savings, credit union, NOW, money-market, and personal needs allowance (PNA) accounts? ☐ Yes ☐ No

a. Do you or your spouse have any retirement accounts, including individual retirement accounts (IRAs), Keogh, or pension funds? ☐ Yes ☐ No

b. Have you or your spouse or a joint owner closed any accounts in the past 60 months, including any accounts you had owned jointly with anyone else? ☐ Yes ☐ No

If you answered **yes** to **any** of these questions, fill out this section. If you answered **no** to **all** of these questions, go to the next section **(REAL ESTATE)**.

Send a copy of your passbooks updated within 45 days and/or **a copy** of your current account statements. Please see the Senior Guide for information about financial institutions charging for copies of statements. If applying for nursing facility coverage, please provide account statements for the past 60 months.

Name on account		Account type
Name of bank/institution		Account number
Current balance $	Balance on admission date* $	☐ Account open ☐ Account closed
Date account closed (mm/dd/yyyy)	Amount on the date account closed $	
Name on account		Account type
Name of bank/institution		Account number
Current balance $	Balance on admission date* $	☐ Account open ☐ Account closed

* Enter the account balance on the date of admission to medical institution, hospital, or nursing facility.

REAL ESTATE

2. Do you or your spouse own or have a legal interest in your primary residence?
You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No

3. Do you or your spouse own or have a legal interest in any real estate **other than** your primary residence?
You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No

If you answered **yes** to any of these questions, fill out this section. **If no**, go to the next section **(LIFE INSURANCE)**.

Send a copy of the deed(s), current tax bill(s), and proof of amount owed on all property owned.

Address	
Type of property	Current value $
Address	
Type of property	Current value $

LIFE INSURANCE

4. Do you or your spouse **own** any life insurance? ☐ Yes ☐ No

If yes, fill out this section. **If no,** go to the next section **(SECURITIES BROKERAGE ACCOUNTS (STOCKS/BONDS/OTHER))**.

Send a copy of the first page of all life-insurance policies. If total face value of all policies exceeds $1,500 per person, also **send a letter** from the insurance company showing the current cash-surrender value (for all policies except term policies).

Name(s) of owner(s)		
Insurance company		
Policy number	Face value $	Insurance type
Name(s) of owner(s)		
Insurance company		
Policy number	Face value $	Insurance type

SECURITIES BROKERAGE ACCOUNTS (STOCKS/BONDS/OTHER)

5. Do you or your spouse own any stocks, bonds, savings bonds, mutual funds, securities, assets held in safe-deposit boxes, cash not in the bank, options, or future contracts? ☐ Yes ☐ No

   If yes, fill out this section. **If no**, go to the next section **(ANNUITIES)**.

Send proof of current value (except cash).

	Owner(s) name(s)	Company name	Account number	Current value	Value on admission date*	Joint asset?
Cash				$	$	☐ Yes ☐ No
Stocks				$	$	☐ Yes ☐ No
Bonds				$	$	☐ Yes ☐ No
Savings bonds				$	$	☐ Yes ☐ No
Mutual funds				$	$	☐ Yes ☐ No
Options				$	$	☐ Yes ☐ No
Future contracts				$	$	☐ Yes ☐ No
Other				$	$	☐ Yes ☐ No

* Enter the account balance on the date of admission to medical institution.

ANNUITIES

6. Did you or your spouse or someone on your or your spouse's behalf purchase or in any way change an annuity? ☐ Yes ☐ No

   If yes, fill out this section. To be eligible, you may be required to name the Commonwealth as a remainder beneficiary. (See the Senior Guide for more information.) **If no**, go to the next section **(ASSISTED LIVING/OTHER)**.

Send a copy of the contract. For each annuity owned, **give us proof** from the annuity company of the full value of the annuity less any penalties and fees if it can be cashed in.

Name(s) of owner(s)	
Name of institution issuing the annuity	
Contract number	Date purchased (mm/dd/yyyy)
Name(s) of owner(s)	
Name of institution issuing the annuity	
Contract number	Date purchased (mm/dd/yyyy)

ASSISTED LIVING/OTHER

7. Have you, your spouse, or someone acting on your behalf given a deposit to any health-care or residential facility, like an assisted-living facility, a continuing-care retirement community, or life-care community? ☐ Yes ☐ No

   If yes, fill out this section. **If no**, go to the next section **(VEHICLES/MOBILE HOMES)**.

Send a copy of the contract you signed with the facility and any documents about this deposit.

Name of facility	
Address of facility	
Amount of deposit $	Date deposit given to facility (mm/dd/yyyy)

VEHICLES/MOBILE HOMES

8. Do you or your spouse own any vehicles, like cars, vans, trucks, recreational vehicles, mobile homes, or boats? ☐ Yes ☐ No

   If yes, fill out this section. **If no**, go to the next section **(PREPAID BURIAL PLANS/TRUSTS)**.

Send a copy of the registration for each vehicle, and proof of the outstanding loan balance. For mobile homes, **send a copy** of the bill of sale. If you have a spouse at home, **send proof** of the fair-market value of each vehicle as of the date of admission to the medical institution.

(You) Type of vehicle	Year/make/model	Fair-market value $	Amount owed $
Mobile home address			
(Your spouse) Type of vehicle	Year/make/model	Fair-market value $	Amount owed $
Mobile home address			

PREPAID BURIAL PLANS

9. Do you or your spouse have any prepaid burial contracts or trusts, life insurance set up for funeral and burial expenses, or bank accounts set aside for funeral expenses? ☐ Yes ☐ No

   If yes, fill out this section. **If no**, go to the next section **(TRUSTS)**.

Send a copy of the trust contract, trust instrument, insurance policy, or burial-only account.

(You) Burial contract ☐ Yes (Amount $) ☐ No		Burial trust ☐ Yes (Amount $) ☐ No	
Life insurance for burial ☐ Yes (Amount $) ☐ No		Burial-only account ☐ Yes (Amount $) ☐ No	
Burial plot ☐ Yes ☐ No	Insurance company	Policy number	
Bank name		Account number	
(Your spouse) Burial contract ☐ Yes (Amount $) ☐ No		Burial trust ☐ Yes (Amount $) ☐ No	
Life insurance for burial ☐ Yes (Amount $) ☐ No		Burial-only account ☐ Yes (Amount $) ☐ No	
Burial plot ☐ Yes ☐ No	Insurance company	Policy number	
Bank name		Account number	

TRUSTS

10. Are you or your spouse the grantor/donor, trustee, or beneficiary of any trusts? ☐ Yes ☐ No

11. Have you, your spouse, or someone else on your behalf, including a court or administrative body, contributed income or assets owned by you or your spouse to a trust? ☐ Yes ☐ No

    If you answered **yes** to any of these questions, fill out this section.
    If you answered **no** to these questions, go to **STEP 6: Health Insurance Information**

Send a copy of the trust document(s), any amendments, documents showing financial activity, and the schedule of beneficiaries.

Trust name	Revocable? ☐ Yes ☐ No	Current trust principal $
Trust principal on admission date* $	Trustee(s)	
Grantor(s)/Donor(s)	Beneficiaries	
Trust name	Revocable? ☐ Yes ☐ No	Current trust principal $
Trust principal on admission date* $	Trustee(s)	
Grantor(s)/Donor(s)	Beneficiaries	

* Enter the trust principal on the date of admission to medical institution.

STEP 6 Health Insurance Information

MassHealth regulations require members to obtain and maintain available health insurance, including health insurance available through an employer. In order to determine continued MassHealth eligibility for you and members of your household, we may request additional information from you and your employer about your access to employer sponsored health insurance coverage. You must cooperate in providing information necessary to maintain eligibility, including evidence of obtaining or maintaining available health insurance or your MassHealth benefits may be terminated. See the Senior Guide for more information.

1. Is anyone listed on this application offered health coverage from a job but not enrolled in it? ☐ Yes ☐ No
   Answer **yes** even if this insurance is from another person's job, like a spouse, even if this person does not live in the household.
   If **yes**, you will need to complete and include **Supplement D: Health Coverage from Jobs**, and the rest of this application.

   Is this a state employee benefit plan? ☐ Yes ☐ No

2. Does anyone qualify for or is anyone enrolled in the following types of health coverage? ☐ Yes ☐ No
   If **yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have.

   Answer **yes** even if this insurance is from another person, like a spouse, even if the person does not live in the household.

   ☐ Enrolled in Medicare or qualifies for a Medicare Part A plan with no premium

   Name _____ Medicare claim number _____

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

   a. Does this person have a Medicare Part D plan? ☐ Yes ☐ No

      If **yes**, when did coverage start? (mm/dd/yyyy) _____

   b. Does this person have a Medigap/Medicare supplemental policy? ☐ Yes ☐ No

      If **yes**, name of coverage plan _____ When did coverage start? (mm/dd/yyyy) _____
      Name _____ Medicare ID number _____

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

   a. Does this person have a Medicare Part D plan? ☐ Yes ☐ No

      If **yes**, when did coverage start? (mm/dd/yyyy) _____

   b. Does this person have a Medigap/Medicare supplemental policy? ☐ Yes ☐ No

      If **yes**, name of coverage plan _____

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

   Do any of the persons above want to apply for help paying for the Medicare Part B premiums? ☐ Yes ☐ No

   If **yes**, name(s) _____

If you check any of the following programs provide details below.

- ☐ Qualifies for **Peace Corps**
- ☐ Qualifies for **TRICARE** (Do not check if you have direct care or Line of Duty.)
- ☐ Enrolled in **Veterans Affairs (VA) health programs**
- ☐ **MassHealth**
- ☐ **Other coverage** (including COBRA and retiree health plans)

Name(s) of covered household members

Policy number or Member ID	Start date and end date? (mm/dd/yyyy)

☐ Enrolled in employer coverage. If anyone on this application is enrolled in employer coverage, you must complete and include **Supplement D: Health Coverage from Jobs**.

Name of employer	Plan name

Name(s) of covered household members

Policy number or Member ID	Start date and end date? (mm/dd/yyyy)

STEP 7 Personal-Care-Attendant Services

For people 65 years of age or older who are not going to be in a long-term-care facility

To get more information about personal-care-attendant (PCA) services and how filling out this PCA section could affect the way we decide if you can get MassHealth if you do need PCA services, read the PCA section in the Senior Guide that is enclosed.

1. Do you or your spouse need the services of a personal-care attendant? ☐ Yes ☐ No

   If yes, fill out this section and answer all questions. **If no**, go to **STEP 9: Read and sign this application**.

2. Have you or your spouse had the services of a personal-care attendant **paid for by MassHealth** within the last six months? ☐ Yes ☐ No

   If yes, go to **STEP 9: Read and sign this application**. **If no**, answer the following questions in this section.

3. Do you or your spouse have a permanent or long-lasting disability? You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No

   a. **If yes,** does your (or your spouse's) disability keep you (or your spouse) from being able to do your (or your spouse's) daily living activities, like bathing, eating, toileting, dressing, etc., unless someone physically helps you (or your spouse)? You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No

   b. **If yes**, do you (or your spouse) plan to contact a MassHealth personal-care-management (PCM) agency to ask for personal-care-attendant services? You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No

Note: You must contact the PCM agency within 90 days of the date that MassHealth decides you are eligible for MassHealth or you will not be able to benefit from the special PCA rules.

MassHealth may not pay certain members of your family to be your personal-care attendant.

Each spouse who answered "Yes" to all parts of Question 3 above must fill out his or her own Supplement C: Personal-Care Attendant. One copy is enclosed. If you need a second copy, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-888-665-9997) to ask for one. If you (or your spouse) do not send us your filled-out PCA supplement(s), we will determine your MassHealth eligibility as if you do not need PCA services.

STEP 8 Additional *(Optional)* Coverage – For married persons under 65 years of age

Fill out this section ONLY if you are married and living with your spouse. One spouse applying must be under 65 years of age, with no children under 19 years of age in the household. Answer these questions for the spouse who is under 65 years of age.

If this section applies to you and you want more information about income standards and other information that may apply, call us at 1-800-841-2900 (TTY: 1-800-497-4648) to get a Senior Guide. If this section does not apply, go to **Step 9: Read and sign this application**.

BREAST OR CERVICAL CANCER *(OPTIONAL)* (Only for persons under 65 years of age.)

1. Do you have breast or cervical cancer? ☐ Yes ☐ No
   MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.

   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.

   Name: _____

HIV INFORMATION *(OPTIONAL)* (Only for persons under 65 years of age.)

2. Are you HIV positive? ☐ Yes ☐ No
   If you are HIV positive, you may be eligible for additional coverage or benefits.

   Name: _____

DISABILITY (Only for persons under 65 years of age.)

3. Do you have a 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

   Name: _____

STEP 9 Read and sign this application

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. Eligible persons may have to pay a premium for health coverage for themselves 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 an eligible person is a certain American Indian or Alaska Native, such person 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, 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 such 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, and unless exceptions apply, for any eligible person 55 years of age or older, or any eligible person for whom MassHealth helps pay for care in a nursing home, MassHealth will seek money from the eligible person's estate after death.
11. MassHealth, the 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.
12. MassHealth, the 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.
13. To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health Connector to use income data, including information from tax returns for the next three coverage years. The Health Connector will send me a notice, let me make changes, and I can opt out at any time. I understand that if I am eligible for an Advance Premium Tax Credit (APTC) and/or Reduced Copays and Deductibles these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or Reduced Copays and Deductibles may impact my 2017 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.
14. In connection with the eligibility and enrollment process, MassHealth, the 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/office/file**.

16. 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 **1-800-841-2900** (TTY: 1-800-497-4648). 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.

- Sign on to your account at **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 **1-857-323-8300**.

17. No one applying for health coverage on this application is in prison or in jail except as set forth below. If someone applying for health coverage is in prison or jail, write their name below and answer the following three questions.

_____ is in prison or jail.

Is this person awaiting trial? ☐ Yes ☐ No

Is this person being released within 30 days of submitting this application? ☐ Yes ☐ No

I AGREE TO THE FOLLOWING STATEMENTS.

- 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 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 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 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 in STEP 9.
- 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 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.

Sign this application.

By signing this application below, I hereby certify under the pains and penalties of perjury that the submissions and statements I have made in this application are true and complete to the best of my knowledge, and I agree to accept and comply with the above rights and responsibilities.

Important: If you are submitting this application as an authorized representative, you must submit an Authorized Representative Designation Form (ARD) to us or have a form on record for us to process this application. The ARD is at the end of this application.

Signature of Person 1 or authorized representative	Print name	Date

VOTER REGISTRATION INFORMATION ON NEXT PAGE

Send us your completed application.

Mail your signed application to:

MassHealth Enrollment Center
Central Processing Unit
PO Box 290794
Charlestown, MA 02129-0214; or

Fax: 617-887-8799

Hand deliver your signed application to:

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

Voter Registration

The form to register to vote is included with this application or can be found at **www.sec.state.ma.us**. More information on how to register to vote can also be found at **www.sec.state.ma.us**. If you have any questions about the voter registration process, or if you need help filling out the form, please visit a local MassHealth Enrollment Center or call the MassHealth Customer Service Center at **1-800-841-2900** (TTY: 1-800-497-4648).

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, with your right to privacy in deciding to register or in applying to register to vote, or with your right to choose your own political party or other political preference, you may file a complaint with:

Secretary of the Commonwealth, Elections Division
One Ashburton Place
Room 1705
Boston, MA 02108

Tel: 617-727-2828 or 1-800-462-8683.

If you or anyone else in your application are not registered to vote where you live now, would you like to apply to register to vote today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

IMMIGRATION STATUSES AND DOCUMENT TYPES

Question 8a (18a for person 2) on the application asks noncitizens about their immigration status and about the type or types of immigration documents they have to support their immigration status. Please refer to the following lists to fill out Question 8a/18a.

If you need further help, details can be found online at https://www.mahealthconnector.org/immigration-document-types.

Eligible Immigration Statuses

In the "Immigration Status" section of Question 8a/18a, write in any status that applies to you or members of your household. You may write in more than one status.

- Amerasian
- Granted asylum
- Cuban Haitian entrant
- Deportation withheld
- Native American born in Canada or non-U.S. territories
- Refugee
- Victim of severe trafficking or his or her spouse, child, sibling, or parent
- Iraqi special immigrant
- Afghan special immigrant
- Conditional entrant granted before 1980
- Veteran or active duty member of military or his or her spouse or dependent
- Lawful permanent resident
- Granted parole for at least one year
- Battered spouse or child (or his or her parent or child)
- Nonimmigrant status (visa)
- Granted parole for less than one year
- Granted temporary resident status
- Granted Temporary Protected Status (TPS) or applicant for TPS with employment authorization
- Granted employment authorization under 8 CFR 274a(12)(c)
- Family unity beneficiaries
- Deferred enforced departure
- Deferred Action Status except for Deferred Action for Childhood Arrivals Process (DACA)
- Granted an administrative stay of removal under 8 CFR 241
- Approved visa petition with a pending application for adjustment of status
- Applicant for asylum or for withholding of removal with employment authorization
- Applicant (for at least 180 days) under 14 years of age for asylum or for withholding of removal
- Granted withholding of removal under the Convention Against Torture
- Applicant for Special Immigrant Juvenile (SIJ) status
- Applicant or granted status under Deferred Action for Childhood Arrivals (DACA)
- I have a document but do not have any status listed above (Person Residing Under Color of Law, PRUCOL)

Immigration Document Types

In the "Immigration Document Type" section of Question 8a/18a, write in any document type you or members of your household have. You may list more than one immigration document type.

- Reentry Permit (I-327)
- Permanent Resident Card ("green card" I-551)
- Refugee Travel Document (I-571)
- Employment Authorization Card (I-766)
- Machine Readable Immigrant Visa (with temporary 1-551 language)
- Temporary I-551 stamp (on passport or I-94, I-94A
- Arrival Departure Record (I-94, I-94A) issued by US Citizenship and Immigration Services
- Arrival Departure Record in unexpired foreign passport (I-94)
- Unexpired foreign passport
- Certificate of Eligibility for Nonimmigrant (F1) Student Status (I-20)
- Certificate of Eligibility for Exchange Visitor (J1) Status (DS2019)
- Notice of Action (I-797)/Other-with Alien Number
- Notice of Action (I-797)/Other-with I-94 Number

SUPPLEMENT A Long-Term Care

- Do you need long-term-care services in a nursing home type facility? ☐ Yes ☐ No

  If yes, you must answer all questions and fill out all sections of this supplement.

- Are you applying for or getting long-term-care services at home under a Home- and Community-Based Services Waiver? ☐ Yes ☐ No

  If yes, you only need to fill out the "**Resource Transfers**" section on page 22.

Please print clearly. Answer all questions and fill out all sections. If you need more space to finish any section, please use a separate sheet of paper (include your name and social security number), and attach it to this supplement.

Applicant/Member Information

Last name, first name, middle initial	Social security number

Name and address of hospital, nursing facility, or other institution

Date of admission (mm/dd/yyyy)	Were you placed here by another state? ☐ Yes ☐ No **If yes**, what state?

1. Do you have to pay guardianship expenses for a court-appointed guardian? ☐ Yes ☐ No

Living expenses of the spouse and family members living at home

Your spouse living at home may be able to keep some of your income. Fill out the following information about your spouse's current living expenses. **If you do not have a spouse**, go to the next section **(Resource Transfers)**.

Send proof of your spouse's current living expenses.

Spouse's last name, first name, middle initial	Social security number

2. How much does your spouse pay each month for:

   Rent? _____ Mortgage (principal and interest)? _____

   Homeowner's/tenant's insurance? _____ Real estate taxes? _____

   Required maintenance charge for a condo or co-op? _____ Room and board for assisted living? _____

3. Does your spouse pay for heat? ☐ Yes ☐ No

4. Does your spouse pay for utilities? ☐ Yes ☐ No

5. Is a child, parent, brother, and/or sister living with your spouse? ☐ Yes ☐ No

   If yes, fill out this section. **If no,** go to the next section **(Resource Transfers)**.

   Send proof of their monthly income before deductions.
   A deduction may be allowed for their maintenance needs. These persons must be related to you or your spouse, and one of you must claim them as dependents on your federal income tax return.

Name		Social security number
Relationship	**Date of birth (mm/dd/yyyy)**	**Monthly income before deductions $**
Name		**Social security number**
Relationship	**Date of birth (mm/dd/yyyy)**	**Monthly income before deductions $**

Resource Transfers (resources include both income and assets)

6. In the past 60 months:

   a. Has any property that was available or belonged to you or your spouse been transferred into or out of a trust? ☐ Yes ☐ No

   b. Did you, your spouse, or someone on your behalf transfer income or the right to income? ☐ Yes ☐ No

   c. Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real estate? ☐ Yes ☐ No

   d. Did you, your spouse, or someone on your behalf change the deed or the ownership of any real estate, including creating a life estate, even if the life estate was purchased in another person's residence? ☐ Yes ☐ No

   e. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate? ☐ Yes ☐ No

   f. Did you, your spouse, or someone on your behalf add another name to the deed of any property you own? ☐ Yes ☐ No

   g. Did you, your spouse, or someone on your behalf receive or give anyone a mortgage, loan, or promissory note on any property or other asset? ☐ Yes ☐ No

   h. Did you, your spouse, or someone on your behalf purchase or in any way change an annuity? ☐ Yes ☐ No

   If you answered yes to any of the questions above, you must fill out the following, and **send us proof** of this information.

Description of asset/income		Date of transfer (mm/dd/yyyy)
Transferred to whom	Relationship to you or your spouse	Amount of transfer $
Description of asset/income		Date of transfer (mm/dd/yyyy)
Transferred to whom	Relationship to you or your spouse	Amount of transfer $
Description of asset/income		Date of transfer (mm/dd/yyyy)
Transferred to whom	Relationship to you or your spouse	Amount of transfer $

7. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, like an assisted living facility, a continuing care retirement community, or life care community? ☐ Yes ☐ No

   If yes, give us the name and address of the facility, the amount of the deposit, answer the following questions, and **send us a copy** of the contract you signed with the facility and any documents about this deposit.

   Name of facility _____

   Address of facility _____ Amount $ _____

   a. Does the facility still have the deposit? ☐ Yes ☐ No

   b. Did the facility return the deposit? ☐ Yes ☐ No

   If yes, give us the name and address of the person who got the deposit from the facility.

   Name of person _____

   Address _____

Real Estate

The answers to the following questions will be used to decide if: (1) your real estate will be counted as an asset; or (2) a lien will be placed against your real estate.

Note: If the equity interest in your principal place of residence is over a certain limit, you may be ineligible for payment of long-term-care services, unless certain conditions are met.

8. Do you or your spouse own or have a legal interest in your home, including a life estate? ☐ Yes ☐ No

If yes, fill out the following information and answer questions 9 through 15. If **no**, answer question 15 only.

Name and address of person(s) on ownership papers _____

_____

Description and address of property location _____

_____

Type of ownership (Check one.)

☐ Individual *(Fair-market value)* $ _____ ☐ Tenancy in common *(Fair-market value)* $ _____

☐ Joint tenancy *(Fair-market value)* $ _____ ☐ Life estate *(Fair-market value)* $ _____

Name and address of person(s) on ownership papers _____

_____

Description and address of property location _____

_____

Type of ownership (Check one.)

☐ Individual *(Fair-market value)* $ _____ ☐ Tenancy in common *(Fair-market value)* $ _____

☐ Joint tenancy *(Fair-market value)* $ _____ ☐ Life estate *(Fair-market value)* $ _____

9. Do you have a spouse? ☐ Yes ☐ No **If yes**, fill out this section.

Name _____ Is this person living in your home? ☐ Yes ☐ No

10. Do you have a permanently and totally disabled or blind child? ☐ Yes ☐ No **If yes**, fill out this section.

Name _____ Is this person living in your home? ☐ Yes ☐ No

11. Do you have a child under 21 years of age? ☐ Yes ☐ No **If yes**, fill out this section.

Name _____ Date of birth (mm/dd/yyyy) _____ Is this person living in your home? ☐ Yes ☐ No

12. Do you have a brother or sister with a legal interest in the home who was living in the home for at least one year immediately before your admission to the medical institution? ☐ Yes ☐ No If **yes**, fill out this section.

Name _____ Is this person living in your home? ☐ Yes ☐ No

13. Do you have a son or daughter who has lived in the home for at least the last two years before your admission to the medical institution and has provided care to you that allowed you to live in the home? ☐ Yes ☐ No If **yes**, fill out this section.

Name _____ Is this person living in your home? ☐ Yes ☐ No

14. Do you have a dependent relative? ☐ Yes ☐ No **If yes**, fill out this section.

Name _____ Is this person living in your home? ☐ Yes ☐ No

Describe the relationship and the nature of the dependency: _____

_____

15. Do you intend to return to your home? ☐ Yes ☐ No

16. Do you or your spouse own or have a legal interest in **other** real estate not listed in #8 above? ☐ Yes ☐ No

If yes, please describe the property and list its address below.

_____

_____

_____

If you need more space, please use a separate sheet of paper.

Long-Term-Care Insurance

17. Do you or your spouse have long-term-care insurance? ☐ Yes ☐ No

If yes, fill out this section. **If no**, go to the next section (**Tax Returns**).

Send a copy of the policy.

Company name/Policy number		
Policyholder name	Effective date (mm/dd/yyyy)	Premium amount $
Company name/Policy number		
Policyholder name	Effective date (mm/dd/yyyy)	Premium amount $

Tax Returns

18. Did you or your spouse file U.S. income tax returns in the last two years? (Check one.)

☐ Yes, both years ☐ Yes, one of these years ☐ No, neither year

If yes, you must **send copies** of these returns. If you did not keep copies of one or more of these returns, **you must send in a filled-out and signed IRS Form 4506**. Form 4506 is included at the end of this application.

SIGN THIS SUPPLEMENT.

By signing this supplement below, I hereby certify under the pains and penalties of perjury that the submissions and statements I have made in this supplement are true and complete to the best of my knowledge, and I agree to accept and comply with the above rights and responsibilities.

Important: If you are submitting this supplement as an authorized representative, you must submit an Authorized Representative Designation Form (ARD) to us for us to process this application. It is important to complete this form as this is the only way we may speak to you about this application.

Signature of applicant/member or authorized representative	Print name	Date

SUPPLEMENT B American Indian or Alaska Native Household Member (AI/AN)

Complete this supplement if you or a household member are an American Indian or Alaska Native.

Tell us about your American Indian or Alaska Native household member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or Urban Indian Health Programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your household gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

AI/AN Person 1

1. Name (first, middle, last)

2. Member of a federally recognized tribe?
   ☐ Yes ☐ No
   If yes, tribe name _____

3. Member of a Massachusetts-recognized tribe?
   ☐ Yes ☐ No
   If yes, tribe name _____

4. Has this person ever gotten 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
   If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Program, or through a referral from one of these programs?
   ☐ Yes ☐ No

5. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from
   - 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 the Interior (including reservations and former reservations); or
   - Money from selling things that have cultural significance.

   $ _____ How often? _____

AI/AN Person 2

1. Name (first, middle, last)

2. Member of a federally recognized tribe?
   ☐ Yes ☐ No
   If yes, tribe name _____

3. Member of a Massachusetts-recognized tribe?
   ☐ Yes ☐ No
   If yes, tribe name _____

4. Has this person ever gotten 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
   If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Program, or through a referral from one of these programs?
   ☐ Yes ☐ No

5. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from
   - 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 the Interior (including reservations and former reservations); or
   - Money from selling things that have cultural significance.

   $ _____ How often? _____

SUPPLEMENT C Personal-Care Attendant

Please print clearly. Fill out all sections. If you need more space to finish any section on this form, please use a separate sheet of paper (include name and social security number), and attach it to this form.

Send to: MassHealth Enrollment Center
P.O. Box 1231
Taunton, MA 02780

Or Fax to: 617-887-8777

Applicant/Member information

Last name	First name	MI	Telephone number ( )
Social security number	Date of birth (mm/dd/yyyy)		Gender ☐ M ☐ F
Street address	City	State	ZIP

Information about your health problems

List and describe below all your medical and mental health problems. Include anything that makes it hard for you to do daily living activities, like bathing, eating, toileting, dressing, etc., even if you are not getting treatment for the problem.

1. _____
2. _____
3. _____

Information about your daily living activities that you need physical (hands-on) help with

Please tell us in the chart below if you need hands-on help from another person to do the following daily living activities. If you check **yes** to any of the items below, tell us how often you need help.

Daily living activity	Do you need hands-on help?	How many times a **day** do you need hands-on help?	How many **days a week** do you need hands-on help?
Mobility (moving from bed to chair, walking, or using approved medical equipment)	☐ Yes ☐ No		
Taking medications	☐ Yes ☐ No		
Bathing (tub, bed bath, shower, or washing chair) or general grooming (like brushing teeth or combing hair)	☐ Yes ☐ No		
Dressing/Undressing	☐ Yes ☐ No		
Range-of-motion exercises (exercising joints by moving them)	☐ Yes ☐ No		
Eating	☐ Yes ☐ No		
Toileting (like getting on or off toilet, wiping yourself, getting clothes off and on, or changing diapers)	☐ Yes ☐ No		

Caregiver information

Please give us the name(s) and relationship to you of the person(s) who now helps you.

Caregiver name	Relationship to you (like relative, neighbor, personal-care attendant)
Caregiver name	Relationship to you (like relative, neighbor, personal-care attendant)

I certify, under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge.
If you are acting on behalf of someone in filling out this form, an Authorized Representative Designation Form must also be filled out and sent back with this form. Your signature on this form as an authorized representative certifies that the information on this form is correct and complete to the best of your knowledge.

X _____ _____ _____
Signature of applicant/member or authorized representative | Print name | Date

SUPPLEMENT D Health Coverage from Jobs

Answer these questions if someone in the household is eligible for health coverage from a job, whether or not they are enrolled in the coverage. Attach a copy of this page for each job that offers coverage.

TELL US ABOUT THE JOB THAT OFFERS COVERAGE.

EMPLOYEE INFORMATION

1. Employee name (first, middle, last)

2. Employee social security number
   ___ ___ ___ - ___ ___ - ___ ___ ___ ___

3. a. Is at least one person on this application currently eligible for or enrolled in coverage offered by this employer, or will at least one person on this application become eligible within the next 3 months? ☐ Yes ☐ No
   If the answer to 3a is **yes**, continue. If the answer to 3a is **no**, stop here and skip the rest of Supplement D.

   b. If any person is in a waiting or probationary period, when can this person enroll in coverage? (mm/dd/yyyy) _____

EMPLOYER INFORMATION

4. Employer name

5. Federal Tax ID (if known)
   ___ ___ - ___ ___ ___ ___ ___ ___ ___

6. Employer address

7. Employer phone number
   ( )

8. City

9. State

10. ZIP code

11. Who can we contact about employee heath coverage at this job?

12. Phone number (if different from above)

13. E-mail address

TELL US ABOUT THE HEALTH PLAN OFFERED BY THIS EMPLOYER.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. a. What is the name of the lowest cost self-only health plan offered to the employee? _____

    b. Is the lowest cost plan that meets the minimum value standard* that is offered to the employee affordable as defined by the Affordable Care Act? ☐ Yes ☐ No

    c. How much would the employee pay in premiums to enroll in this plan, or how much does the employee pay for this plan? ___

    d. How often would the employee pay this amount, or how often does the employee pay this amount? _____

To figure out whether a plan meets the minimum value standard* or if a plan is considered affordable, refer to the Member Booklet.

16. What change will the employer make for the new plan year (if known)?

☐ Employer will not offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs.)

   a. How much would the employee have to pay in premiums for this plan? $ _____

   b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

   Date of change (mm/dd/yyyy) _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is at least 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

Authorized Representative Designation Form

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. 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) or a sufficiently similar designation document. 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.
2. If, because of a mental or physical condition, you cannot designate an authorized representative in writing, a person (not an organization) who is acting responsibly on your behalf can be your authorized representative if that person certifies, by filling out Section II, that you are not able to provide a written designation, and that he or she is acting responsibly on your behalf.
3. An authorized representative can also be someone who has been appointed by law to act on your behalf. 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 is lawfully representing you.
4. A person appointed by law to act on behalf of the estate of an applicant or member who has died can also serve as an authorized representative by following the instructions above. An authorized representative under Section III may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the estate's administrator or executor. What this person is authorized to do for you or for the applicant or member's estate will depend on the wording of the legal appointment.

What can an authorized representative do?

An authorized representative may

- fill out your application or eligibility review 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.

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 doing the following.

- Mailing a letter notifying us that the designation has ended to

  Health Insurance Processing Center
  P. O. Box 4405
  Taunton, MA 02780;
- Faxing a letter notifying us that the designation has ended to **1-857-323-8300**; or
- Calling us at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

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.

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 by doing the following.

- Mailing your form to

  Health Insurance Processing Center
  P. O. Box 4405
  Taunton, MA 02780;
- Faxing your form to **1-857-323-8300**; or
- Calling us at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

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.

Please note: Your social security number (SSN) is required if one has been issued.

Applicant's/Member's Name	SSN (if you have one) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Date of birth (mm/dd/yyyy)	Applicant's/Member's e-mail 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
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
Authorized representative's printed name	Authorized representative's e-mail 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
Printed name of provider, staff member, or volunteer completing form	
E-mail 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 I know enough about the applicant or member set forth below to take responsibility for the correctness 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 duties and responsibilities as this person's authorized representative (as explained earlier in this form), and that this person cannot provide written designation. 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 he or she may remove or replace me as his or her 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.

Please note that the applicant's or member's social security number (SSN) is required if one has been issued.

Applicant's/Member's name	
Applicant's/Member's date of birth (mm/dd/yyyy)	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 e-mail address

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.

Please note that the applicant's or member's social security number (SSN) is required if one has been issued.

Applicant's/Member's name	
Applicant's/Member's date of birth (mm/dd/yyyy)	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 e-mail address

Form **4506**

(Rev. September 2015)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

► **Do not sign this form unless all applicable lines have been completed.**
► **Request may be rejected if the form is incomplete or illegible.**
► **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax return is being mailed to a third party, ensure that you have filled in lines 6 and 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax return to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your return information, you can specify this limitation in your written agreement with the third party.

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ► _____

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

_____ _____ _____ _____

_____ _____ _____ _____

8	**Fee.** There is a $50 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.**	
a	Cost for each return	$ 50.00
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☐

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** For tax returns being sent to a third party, this form must be received within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

► **Signature** (see instructions) | Date

► **Title** (if line 1a above is a corporation, partnership, estate, or trust)

► **Spouse's signature** | Date

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506*. Information about any recent developments affecting Form 4506, Form 4506-T and Form 4506T-EZ will be posted on that page.

General Instructions

Caution: Do not sign this form unless all applicable lines have been completed.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate (on line 5) a third party to receive the tax return.

How long will it take? It may take up to 75 calendar days for us to process your request.

Tip. Use Form 4506-T, Request for Transcript of Tax Return, to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of nonfiling, and records of account.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." or call 1-800-908-9946.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year or period and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming	Internal Revenue Service RAIVS Team Stop 37106 Fresno, CA 93888
Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia	Internal Revenue Service RAIVS Team Stop 6705 P-6 Kansas City, MO 64999

Chart for all other returns

If you lived in or your business was in:	Mail to:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team P.O. Box 145500 Stop 2800 F Cincinnati, OH 45250

Specific Instructions

Line 1b. Enter your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note: If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address. For a business address, file Form 8822-B, Change of Address or Responsible Party — Business.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the return be sent to a third party, the IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. If you request a copy of a tax return, sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

Do not send the form to this address. Instead, see *Where to file* on this page.