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 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

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/masshealth/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, we will review 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).
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

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? ____________________________

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
- American Indian or Alaska Native (complete Step 3 and Supplement B)
- Korean
- Cuban
- Asian Indian
- Native Hawaiian
- Other Asian
- Mexican, Mexican-American, or Chicano
- Black or African American
- Other Pacific Islander
- Puerto Rican
- Chinese
- Samoan
- Other Hispanic/Latino/Spanish
- Filipino
- Vietnamese
- Guamanian or Chamorro
- White or Caucasian
- Japanese
- 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 Chicoano  
[ ] Puerto Rican  
[ ] Other Hispanic/Latino/Spanish  
[ ] American Indian or Alaska Native (complete Step 3 and Supplement B)

[ ] 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  

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?  

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

34. Employer name and address  

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?

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
   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? _______

YEARY 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.

<table>
<thead>
<tr>
<th>Name on account</th>
<th>Account type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of bank/institution</td>
<td>Account number</td>
</tr>
<tr>
<td>Current balance $</td>
<td>Balance on admission date* $</td>
</tr>
<tr>
<td>Date account closed (mm/dd/yyyy)</td>
<td>Amount on the date account closed $</td>
</tr>
<tr>
<td>Name on account</td>
<td>Account type</td>
</tr>
<tr>
<td>Name of bank/institution</td>
<td>Account number</td>
</tr>
<tr>
<td>Current balance $</td>
<td>Balance on admission date* $</td>
</tr>
</tbody>
</table>

* 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.

<table>
<thead>
<tr>
<th>Address</th>
<th>Type of property</th>
<th>Current value $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Type of property</td>
<td>Current value $</td>
</tr>
</tbody>
</table>

**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).

<table>
<thead>
<tr>
<th>Name(s) of owner(s)</th>
<th>Insurance company</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy number</td>
<td>Face value $</td>
</tr>
<tr>
<td>Name(s) of owner(s)</td>
<td>Insurance company</td>
</tr>
<tr>
<td>Policy number</td>
<td>Face value $</td>
</tr>
</tbody>
</table>
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).

<table>
<thead>
<tr>
<th>Owner(s) name(s)</th>
<th>Company name</th>
<th>Account number</th>
<th>Current value</th>
<th>Value on admission date*</th>
<th>Joint asset?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>Yes No</td>
</tr>
<tr>
<td>Stocks</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>Yes No</td>
</tr>
<tr>
<td>Bonds</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>Yes No</td>
</tr>
<tr>
<td>Savings bonds</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>Yes No</td>
</tr>
<tr>
<td>Mutual funds</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>Yes No</td>
</tr>
<tr>
<td>Options</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>Yes No</td>
</tr>
<tr>
<td>Future contracts</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>Yes No</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>Yes No</td>
</tr>
</tbody>
</table>

* 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.

<table>
<thead>
<tr>
<th>(You) Type of vehicle</th>
<th>Year/make/model</th>
<th>Fair-market value $</th>
<th>Amount owed $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mobile home address

<table>
<thead>
<tr>
<th>(Your spouse) Type of vehicle</th>
<th>Year/make/model</th>
<th>Fair-market value $</th>
<th>Amount owed $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>(You) Burial contract</th>
<th>Yes ☐ (Amount $ ) ☐ No</th>
<th>Burial trust</th>
<th>Yes ☐ (Amount $ ) ☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life insurance for burial</td>
<td>Yes ☐ (Amount $ ) ☐ No</td>
<td>Burial-only account</td>
<td>Yes ☐ (Amount $ ) ☐ No</td>
</tr>
<tr>
<td>Burial plot</td>
<td>Yes ☐ ☐ No</td>
<td>Insurance company</td>
<td>Policy number</td>
</tr>
<tr>
<td>Bank name</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(Your spouse) Burial contract</th>
<th>Yes ☐ (Amount $ ) ☐ No</th>
<th>Burial trust</th>
<th>Yes ☐ (Amount $ ) ☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life insurance for burial</td>
<td>Yes ☐ (Amount $ ) ☐ No</td>
<td>Burial-only account</td>
<td>Yes ☐ (Amount $ ) ☐ No</td>
</tr>
<tr>
<td>Burial plot</td>
<td>Yes ☐ ☐ No</td>
<td>Insurance company</td>
<td>Policy number</td>
</tr>
<tr>
<td>Bank name</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Trust name</th>
<th>Revocable?</th>
<th>Yes ☐ No ☐</th>
<th>Current trust principal $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust principal on admission date* $</td>
<td>Trustee(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grantor(s)/Donor(s)</td>
<td>Beneficiaries</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trust name</th>
<th>Revocable?</th>
<th>Yes ☐ No ☐</th>
<th>Current trust principal $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust principal on admission date* $</td>
<td>Trustee(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grantor(s)/Donor(s)</td>
<td>Beneficiaries</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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.
   □ 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?  □ 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)?
      □ 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?  □ 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: 

Page 16 SACA-2 (Rev. 07/17) APPLICATION FOR HEALTH COVERAGE FOR SENIORS AND PEOPLE NEEDING LONG-TERM-CARE-SERVICES
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.

Read and sign this application
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 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

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
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
- 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

<table>
<thead>
<tr>
<th>Last name, first name, middle initial</th>
<th>Social security number</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Date of admission (mm/dd/yyyy)</th>
<th>Were you placed here by another state?  □ Yes  □ No</th>
<th>If yes, what state?</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Spouse’s last name, first name, middle initial</th>
<th>Social security number</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Social security number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Monthly income before deductions $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Social security number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Monthly income before deductions $</th>
</tr>
</thead>
</table>
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.

<table>
<thead>
<tr>
<th>Description of asset/income</th>
<th>Date of transfer (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transferred to whom</td>
<td>Relationship to you or your spouse</td>
</tr>
<tr>
<td>Description of asset/income</td>
<td>Date of transfer (mm/dd/yyyy)</td>
</tr>
<tr>
<td>Transferred to whom</td>
<td>Relationship to you or your spouse</td>
</tr>
<tr>
<td>Description of asset/income</td>
<td>Date of transfer (mm/dd/yyyy)</td>
</tr>
<tr>
<td>Transferred to whom</td>
<td>Relationship to you or your spouse</td>
</tr>
</tbody>
</table>

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
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.

Applicant/Member information

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>MI</th>
<th>Telephone number ( )</th>
<th>Social security number</th>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Gender □ M □ F</th>
</tr>
</thead>
</table>

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.

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

Caregiver information

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

<table>
<thead>
<tr>
<th>Caregiver name</th>
<th>Relationship to you (like relative, neighbor, personal-care attendant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver name</td>
<td>Relationship to you (like relative, neighbor, personal-care attendant)</td>
</tr>
</tbody>
</table>

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 health 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, or upon the death of the applicant or member. Their authority will not automatically terminate once we process your application.

You can choose someone to help you.

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

Who can help me?

1. An authorized representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose an authorized representative if you want one. Neither MassHealth nor the Health Connector will choose an authorized representative for you. You must designate in writing (fill out Section I, Part A) the person or organization who you want to be your authorized representative. Your authorized representative must also fill out Section I, Part B. We sometimes refer to this person or organization as a “Section I authorized representative.”

2. If you cannot designate an authorized representative in writing and you do not have an existing authorized representative or other person who is authorized by law to act on your behalf, a person (not an organization) who certifies that he or she will act responsibly on your behalf can be your authorized representative if that person fills out Section II of this form. We sometimes refer to this person as a “Section II authorized representative.”

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

4. A Section III authorized representative may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the personal representative of the estate.

What can an authorized representative do?

A Section I or II authorized representative may

• fill out your application or renewal forms;
• fill out other MassHealth or Health Connector eligibility or enrollment forms;
• give proof of information reported on these forms;
• report changes in income, address, or other circumstances;
• get copies of all of your MassHealth and Health Connector eligibility and enrollment notices; and
• act on your behalf in all other matters with MassHealth and the Health Connector.

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

Please note: Eligibility notices may include information about other members of an applicant’s or member’s household. If there are multiple people in your household we may not be able to send copies of some of your notices to your authorized representative unless each household member has also designated the same authorized representative by completing a separate Authorized Representative Designation Form.
SECTION 1  Authorized Representative Designation (if applicant or member is able to sign)

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

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

<table>
<thead>
<tr>
<th>Applicant’s/Member’s Name</th>
<th>SSN (if you have one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- - - - - - - -</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Applicant’s/Member’s email address</th>
</tr>
</thead>
</table>

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).

<table>
<thead>
<tr>
<th>Applicant’s/Member’s signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Authorized representative’s name</th>
<th>Authorized representative’s phone number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Authorized representative’s address (mailing address, city, state, zip)</th>
</tr>
</thead>
</table>

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).

<table>
<thead>
<tr>
<th>Authorized representative’s signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Authorized representative’s printed name</th>
<th>Authorized representative’s email address</th>
</tr>
</thead>
</table>

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).

<table>
<thead>
<tr>
<th>Signature of provider, staff member, or volunteer completing form</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Printed name of provider, staff member, or volunteer completing form</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Email of provider, staff member, or volunteer completing form</th>
<th>Authorized representative organization name</th>
</tr>
</thead>
</table>

Authorized representative organization name
**SECTION 2**

**Authorized Representative Designation**

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

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

**AN ORGANIZATION IS NOT ELIGIBLE TO BE AN AUTHORIZED REPRESENTATIVE UNDER THIS SECTION.**

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

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

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

<table>
<thead>
<tr>
<th>Applicant’s/Member’s name</th>
<th>Applicant’s/Member’s date of birth (mm/dd/yyyy)</th>
<th>Applicant’s/Member’s SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>___ ___ <em><strong>-</strong></em> ___ ___</td>
</tr>
<tr>
<td>Authorized representative’s signature</td>
<td>Date (mm/dd/yyyy)</td>
<td></td>
</tr>
<tr>
<td>Authorized representative’s name (first, middle, last)</td>
<td>Authorized representative’s phone number</td>
<td></td>
</tr>
<tr>
<td>Authorized representative’s address (mailing address, city, state, zip)</td>
<td>Authorized representative’s email address</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Officer’s Name</th>
<th>Officer’s Title</th>
<th>Officer’s Signature</th>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
</table>
SECTION 3 Authorized Representative Designation (if appointed by law)

To be filled out by an authorized representative appointed by law (with authority to act on behalf of the applicant or member in making decisions related to health care including, but not limited to, a guardian, conservator, personal representative of the estate of an applicant or member, holder of power of attorney, or an invoked health care proxy.) 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.

<table>
<thead>
<tr>
<th>Applicant’s/Member’s name</th>
<th>Applicant’s/Member’s SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant’s/Member’s date of birth (mm/dd/yyyy)</td>
<td></td>
</tr>
<tr>
<td>Authorized representative’s signature</td>
<td>Date (mm/dd/yyyy)</td>
</tr>
<tr>
<td>Authorized representative’s name (first, middle, last)</td>
<td>Authorized representative’s phone number</td>
</tr>
<tr>
<td>Authorized representative’s address (mailing address, city, state, zip)</td>
<td>Authorized representative’s email address</td>
</tr>
</tbody>
</table>

How does an authorized representative designation end?

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

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

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

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

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

How do I submit this form?

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

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

- Mailing your form to
  Health Insurance Processing Center
  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).
**Form 4506**

**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.

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.

**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.

<table>
<thead>
<tr>
<th>a</th>
<th>Cost for each return</th>
</tr>
</thead>
<tbody>
<tr>
<td>b</td>
<td>Number of returns requested on line 7</td>
</tr>
<tr>
<td>c</td>
<td>Total cost. Multiply line 8a by line 8b</td>
</tr>
</tbody>
</table>

### 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.

**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: This form must be received by IRS 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.

**Sign Here**

<table>
<thead>
<tr>
<th>Signature (see instructions)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title (if line 1a above is a corporation, partnership, estate, or trust)</td>
<td>Date</td>
</tr>
<tr>
<td>Spouse’s signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 41721E

Form 4506 (Rev. 7-2017)
Chart for all other returns
If you lived in or your business was in:

Mail to:

Internal Revenue Service
RAIVS Team
P.O. Box 9941
Mail Stop 6734
Ogden, UT 84409

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

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

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. 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 testatory 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
111 Constitution Ave., NW, IR-6526
Washington, DC 20224.

Do not send the form to this address. Instead, see Where to file on this page.
This form must be received by the local Board of Registrars or Election Commission or postmarked on or before the deadline for voter registration (listed below) for that election, primary, preliminary or town meeting.

DEADLINES FOR VOTER REGISTRATION

To participate in... You must register...

- state primaries
- state elections
- city and town preliminaries
- city and town elections
- regularly scheduled town meetings
- at least 20 days before

- special town meetings
- at least 10 days before

If you do not hear from your local election officials in 2 or 3 weeks, please call them!
# Massachusetts Official Mail-In Agency Voter Registration Form

## How to use this form

1. Confirm your citizenship.
2. Print your name: last name, first name, middle name or initial.
3. Print your former name, if applicable.
4. Print the address where you live now: number and street name or rural route number and box number (do not provide a post office box number), apartment number, city or town and full zip code. Use the map† at right if you cannot otherwise identify your address.
5. Print the address where you receive all your mail, if it is different from the address entered on #4.
6. Print your date of birth: month, day and year. If you are 16 or 17 years old, you will be pre-registered until you are old enough to vote. You will be notified by mail when you become eligible to vote.
7. Federal law requires that you provide your driver’s license number to register to vote. If you do not have a current and valid Massachusetts driver’s license, you must provide the last four digits of your social security number. If you have neither, you must write “none” in the box.
8. It is optional to provide your telephone number. If you include your telephone number and do not check “unlisted” it will be a public record.
9. Check a party, ‘no party’ or print a political designation (not a party).
10. Print the address where you were last registered to vote.
11. If a person is helping you because you are physically unable to sign this form, that assisting person must print his or her name and address and has the option to print his or her telephone number.
12. Read the oath.
13. Print today’s date.
14. Sign your name. This form may be mailed or hand-delivered to your city or town hall. If mailed, fold the form, tape it closed, place a first class stamp on it, print your city or town name and zip code for that city or town hall and drop into any mailbox. Print all information in black ink. Follow above instructions for proper delivery.

## Identification To Be Provided

Section 7 requires you to include your driver’s license number or the last 4 digits of your social security number on this application. This information will be verified through the Registry of Motor Vehicles and the Commissioner of Social Security. If the information cannot be verified or you do not provide this information, you must provide identification either with this application or at your polling location when you go to vote. Sufficient identification includes a copy of a current and valid photo identification, current utility bill, bank statement, government check, paycheck or other government document showing your name and address.

### Address where you live now (street number / street name / rural route number & box number / apartment number / city or town / zip code):

### Address where you receive all your mail (if different from #4):

### Date of birth: month day year

### Identification #: license # or last 4 digits of SSN

### Telephone (optional): Check if unlisted

### Party enrollment or designation (check one):

- [ ] Democratic
- [ ] Republican
- [ ] Libertarian
- [ ] No Party (unenrolled)
- [ ] Political Designation (not a political party)

### Address at which you were last registered to vote (street number / street name / rural route number & box number / apartment number / city or town / zip code):

### If the applicant is unable to sign this form, give the name, address and telephone number (optional) of the person helping the applicant:

<table>
<thead>
<tr>
<th>name</th>
<th>address</th>
<th>telephone number (optional)</th>
</tr>
</thead>
</table>

**I hereby swear (affirm) that I am the person named above, that the above information is true, that I AM A CITIZEN OF THE UNITED STATES, that I am at least 16 years old and I understand that I must be 18 years old to be eligible to vote, that I am not a person under a guardianship which prohibits my registering to vote, that I am not temporarily or permanently disqualified by law from voting because of corrupt practices in respect to elections, that I am not currently incarcerated for a felony conviction, and that I consider this residence to be my home. Signed under the penalty of perjury.**

**Today’s date: month day year**

**Signed:** Sign your name here.

**Agency Designation:** BBA