Personal-Care-Attendant Supplement

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

Send to: MassHealth Enrollment Center
P.O. Box 4405
Taunton, MA 02780

Or Fax to: (857) 323-8300

Applicant/Member information

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

Information about your health problems

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

1. _____
2. _____
3. _____

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

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

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

Caregiver information

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

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

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

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