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

Primary Contact from Step 1

STEP 2 Person __ . Use this Additional Persons form if you have more than four people to include with this application. When filling out the additional pages please be sure to tell us how each person is related to each other person on the application. We need this information to determine eligibility.

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

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

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

If **No**, list address.

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

5. Does this person have a social security number (SSN)? ☐ Yes ☐ No (optional if **not** applying)
We need a social security number (SSN) for every person applying for health coverage who has one. For important information on when SSN is optional, how we use SSN, and how to apply for SSN, please see instructions for Question 5 under Person 1.

If **Yes**, give us the number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

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

Is the name on this application the same as the name on this person's social security card? ☐ Yes ☐ No

If **No**, what name is on this person's social security card?

First name, middle name, last name, and suffix

6. If this person gets an Advance Premium Tax Credit (APTC), does this person agree to file a federal tax return for the tax year that the credits are received? ☐ Yes ☐ No
He or she may not have needed or chosen to file a tax return in the past, but this person will have to file a federal income tax return for any year that he or she gets an APTC. You must check **Yes** to question 6 to be eligible for ConnectorCare or APTCs to help pay for this person's health insurance. **This person does NOT need to file a tax return to apply for or to get MassHealth, CMSP, or HSN, if he or she qualifies.**

If **Yes**, please answer questions a–d. If **No**, skip to question d.

This person must file a joint federal tax return with a spouse for the year for which this person is applying to get certain programs (ConnectorCare or APTCs) unless this person is a victim of domestic abuse or abandonment or will file taxes as Head of Household. If this person will file taxes as Head of Household, he or she should answer **No** to question 6a ("Is this person legally married?"). One way this person may qualify as Head of Household is to live apart from his or her spouse and claim another person as a dependent. See IRS Publication 501 or consult a tax professional for tax filing information. This person will only need to include him- or herself and any dependents on this application.

a. Is this person legally married? ☐ Yes ☐ No
If **No**, skip to question 6c.
If **Yes**, list name of spouse and date of birth. _____

b. Does this person plan to file a joint federal tax return with a spouse for the tax year for which this person is applying?
☐ Yes ☐ No

c. Will this person claim any dependents on this person's federal income tax return for the year for which this person is applying? ☐ Yes ☐ No
This person will claim a personal exemption deduction on his or her 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. List the name(s) and date(s) of birth of dependents.

_____

d. Will this person be claimed as a dependent on someone else's federal income tax return for the year for which this person is applying? ☐ Yes ☐ No

If this person is claimed by someone else as a dependent on their federal income tax return, this may affect this person's ability to receive a premium tax credit. Do not answer **Yes** to this question if this person is a child under the age of 21 being claimed by a noncustodial parent. If **Yes**, please list the name of the tax filer. _____

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

Is the tax filer married, filing a joint return? ☐ Yes ☐ No
If **Yes**, list name of spouse and date of birth. _____

Who else does the tax filer claim as dependents? _____

e. Is this person filing taxes separately because they are a victim of domestic abuse or abandonment? ☐ Yes ☐ No

7. Is this person applying for health or dental coverage? ☐ Yes ☐ No
If **Yes**, answer all the questions below. If **No**, answer Questions 14 and 15, then go to **Income Information** on page 3.

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

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

Alien number _____ Naturalization or citizenship certificate number _____

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

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

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

Immigration status _____ Immigration document type _____

Document ID number _____ Alien number _____

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

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

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

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

e. **Optional** Is this person a: ☐ victim of severe trafficking, ☐ a spouse, child, sibling, or parent of a trafficking victim ☐ a battered spouse, ☐ a child or the parent of battered spouse?

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

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

11. **Optional** What is this person's race or ethnicity? _____

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

13. Does this person have an injury, illness, or disability (including a disabling mental health condition) that has lasted or is expected to last for at least 12 months? If legally blind, answer **Yes**. ☐ Yes ☐ No

14. Does this person need reasonable accommodation because of a disability or an injury? ☐ Yes ☐ No
If **Yes**, complete the rest of this application, including Supplement C: Accommodation.

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

16. **Optional** Does this person have breast or cervical cancer? ☐ Yes ☐ No (Special coverage rules may apply.)

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

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

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

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

19. Is this person in jail or prison? ☐ Yes ☐ No. Please select **No** if the individual will be released in the next 60 days.
If **Yes**, is this person awaiting trial? ☐ Yes ☐ No

INCOME INFORMATION (You may send proof of all household income with this application.)

20. Does this person have any income? ☐ Yes ☐ No
If this person doesn't have any income, skip to question 33.

21. Is this person's income steady from month to month? ☐ Yes ☐ No
If **No**, please provide the average income for the time period (per week, per month, etc.) for the questions below.

EMPLOYMENT | If this person needs more space, attach another sheet of paper.

22. **CURRENT JOB 1:** Employer name and address | Federal Tax ID#

23. 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 _____

24. Average number of hours worked each WEEK _____

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

26. **CURRENT JOB 2:** Employer name and address | Federal Tax ID#

27. 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 _____

28. Average number of hours worked each WEEK _____

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

30. **SELF-EMPLOYMENT:** Is this person self-employed? ☐ Yes ☐ No

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

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

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

OTHER INCOME

31. Check all that apply, and give the amount and how often this person gets it. **NOTE: You do not need to tell us about child support, nontaxable veteran's payments, Supplemental Security Income (SSI), or most workers' compensation income.**

☐ Social security benefits $ _____ How often received? _____

☐ Unemployment $ _____ How often received? _____

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

☐ Interest, dividends, and other investment income $ _____ How often received? _____

- ☐ Royalty income $ _____ How often received? _____
- ☐ Taxable veteran's benefits $ _____ How often received? _____
- ☐ Taxable military retirement pay $ _____ How often received? _____
- ☐ Alimony received $ _____ How often received? _____
- ☐ Other taxable income $ _____ How often received? _____ Type _____
- ☐ Net rental income: On average, how much net income (profits after rental expenses are paid) will you get from this rental each month, or how much will you lose from this rental each month? $ _____ month **profit** or $ _____ month **loss**
- ☐ Capital gains: On average, how much net income will you get from this capital gain each month, or how much will you lose from this capital gain each month? $ _____ month **profit** or $ _____ month **loss**
- ☐ Net farming or fishing income: On average, how much net income (profits after business expenses are paid) will you get from this business each month, or how much will you lose from this business each month? $ _____ month **profit** or $ _____ month **loss**

ONE-TIME ONLY INCOME

32. Has or will this person receive income during this calendar year as a one-time only payment? ☐ Yes ☐ No
    Examples might be a lump-sum pension payment or a one-time capital gain.
    If **Yes**: Type: _____ Amount $ _____ Month Received _____ Year received _____

33. Will this person receive income during the next calendar year as a one-time only payment? ☐ Yes ☐ No
    If **Yes**: Type: _____ Amount $ _____ Month Received _____ Year received _____

DEDUCTIONS

34. 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. What deductions does he or she report on their income tax return? Check all that apply. This person's deductions should be what they report on their federal income tax return in the section "Adjusted Gross Income." For each deduction selected, give the yearly amount. You can enter up to the maximum deduction amount allowed by the IRS.
    - ☐ None
    - ☐ Educator expenses $_____ Yearly amount
    - ☐ Certain business expenses of reservists, performing artists, or fee-based government officials $_____ Yearly amount
    - ☐ Health Savings Account deduction $_____ Yearly amount
    - ☐ Moving expenses related to a job change (for active duty service members only) $_____ Yearly amount
    - ☐ Deductible part of self-employment tax $_____ Yearly amount
    - ☐ Contribution to self-employed SEP, SIMPLE, and qualified plans $_____ Yearly amount
    - ☐ Self-employed health insurance deduction $_____ Yearly amount
    - ☐ Penalty on early withdrawal of savings $_____ Yearly amount
    - ☐ Alimony paid $_____ Yearly amount
    - ☐ Individual Retirement Account (IRA) deduction $_____ Yearly amount
    - ☐ Student loan interest paid (interest only, not total payment) $_____ Yearly amount
    - ☐ Higher education tuition and fees $_____ Yearly amount

YEARLY INCOME

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

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

THANKS! This is all we need to know about this person. For additional copies of this form, the ACA-3-AP, go to www.mass.gov/lists/applications-to-become-a-masshealth-member. Click on Massachusetts Application for Health and Dental Coverage and Help Paying Costs—Additional Persons.

Send your complete application to **Health Insurance Processing Center**
PO Box 4405
Taunton, MA 02780
or Fax to (857) 323-8300.