Massachusetts Application for Health and Dental Coverage and Help Paying Costs

HOW TO APPLY

You can submit your application 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.
  Applying online may be a faster way for you to get coverage than mailing a paper application.
- **Mail** your filled-out, signed application to

  Health Insurance Processing Center
  P.O. Box 4405
  Taunton, MA 02780.
- **Fax** your filled-out, signed application to 1-857-323-8300.
- **Call** us at **1-800-841-2900**
  (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled) or **1-877-MA ENROLL (877-623-6765)**.
- **Visit** a MassHealth Enrollment Center (MEC) to apply in person. See the **Member Booklet for Help with Health and Dental Coverage and Help Paying Costs** for a list of MEC addresses.

USE THIS APPLICATION TO SEE WHAT COVERAGE CHOICES YOU MAY QUALIFY FOR.

- Affordable coverage from MassHealth, the Children's Medical Security Plan (CMSP), the Health Connector, or the Health Safety Net (HSN). You may qualify for a one of these programs, even if you earn as much as $98,400 a year (for a household of four).
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A tax credit that can help pay your premiums for health coverage right away.
- Certain life events allow you to get coverage during a special enrollment period with the Health Connector, even if Open Enrollment has ended. See Supplement D: Special Enrollment Period Form, for a list of these life events. Please fill out Supplement D if one of these events applies to you or someone on your application. If you are not sure, you should fill out the supplement. MassHealth members are not limited to a special enrollment period.

WHO CAN USE THIS APPLICATION?

This application is for people who need health or dental coverage and help paying for it, whose income is within the income limits for a coverage type, and who

- live in Massachusetts;
- are not living in or not about to go into a nursing home; and
- are younger than age 65.

This application may also be used by people **of any age** who are

- parents of children younger than age 19;
- adult relatives living with and taking care of children younger than age 19 when neither parent is living in the home; or
- disabled and are either
  - working 40 or more hours a month or are currently working and have worked at least 240 hours in the six months immediately before the month of the application; or
  - not working (only if younger than age 65).

WHO CAN USE THIS APPLICATION? (CONT.)

If this application is not for you, call us at 1-800-841-2900 (TTY: 1-800-497-4648).

This application is available in Spanish. Please call the number above to request one.

Apply even if you or your child already has health coverage including coverage from Health Connector and MassHealth. You could qualify for lower-cost or no-cost coverage. We need to know about all members of your household to make a decision on your eligibility.

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 the **Authorized Representative Designation Form** at the end of this application.

WHAT YOU MAY NEED TO APPLY

- Social security numbers
- Document numbers for any legal immigrants who need coverage
- Employer and income information for everyone in your household (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health coverage
- Information about any job-related health insurance available to your household

WHY DO 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 the MassHealth Privacy Policy see the Member Booklet or go to www.mass.gov/eohhs/gov/laws-regs/privacy-security/masshealth/member-information/notice-of-privacy-practices.html.

WHAT HAPPENS NEXT?

You will get instructions on the next steps to complete your eligibility process. If you're eligible for a MassHealth plan, you can choose a plan by going to www.mass.gov/masshealth and clicking on the "MassHealth Members and Applicants" button, and then "Enroll in a Health Plan." If you do not hear from us, visit MAhealthconnector.org or call us at **1-800-841-2900** (TTY: 1-800-497-4648). Filling out this application does not mean you have to buy health coverage.

GET HELP WITH THIS APPLICATION

Phone: please call us for help with this application or if you need interpreter services. **1-800-841-2900** (TTY: 1-800-497-4648)

GENERAL INSTRUCTIONS

- Please **print clearly and answer all questions completely**. There are a few sections where you may be instructed to skip some questions. Other than those exceptions, blank or incomplete answers will slow down the processing of your application.
- You can download pages for additional persons at www.mass.gov/masshealth. Be sure to tell us how each person is related to each other person. We need this information to determine eligibility.
- It is not necessary to send blank pages for Step 2 if you do not have that many people in your household. Please make sure that you indicate in Section 1 the number of people applying, and send all other sections even if they are blank or partially blank.

Massachusetts Application for Health and Dental Coverage and Help Paying Costs

Step 1 Person 1. Tell us about yourself. Please print clearly.

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 at the end of this application to establish a third-party contact.

1. First name, middle name, last name, and suffix	2. Date of birth

3. What is your e-mail address?

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

4. Home address			5. Apartment or suite number
6. City	**7. State**	**8. ZIP code**	**9. County**
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. # of people listed on the application

19. What is your preferred spoken or written language (if not English)?

20. 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 Tell us about your household.

Who do you need to include on this application?

Tell us about all the household members who live with you. If you file taxes, we need to know about everyone on your tax return. You do not need to file taxes to get MassHealth.

DO Include

- Yourself and your spouse (if married)
- Your natural, adoptive, or step children younger than age 19
- Your unmarried partner who lives with you if you have children together who are younger than age 19
- Your unmarried partner's children who live with you and who are younger than age 19, if you also include this partner
- Anyone you include on your tax return (even if they do not live with you)
- Anyone your unmarried partner included on his or her tax return (even if they do not live with you), if you also include your unmarried partner
- Anyone else younger than age 19 who you live with and take care of

You DO NOT have to include

- Your unmarried partner, unless you have children together
- Your unmarried partner's children, unless they live with you or your unmarried partner included them on his or her tax return
- Your parents whom you live with and who file their own taxes if they do not claim you as tax dependent (if you are age 19 or older)
- Other adult relatives whom you do not claim as tax dependents

The amount of help or type of program you may qualify for depends on the number of people in your household and their incomes. This information helps us make sure everyone gets the coverage they may be eligible for.

COMPLETE STEP 2 FOR EACH PERSON IN YOUR HOUSEHOLD. Start with yourself, then add other adults and children.

STEP 2 Person 1.

This section is to gather more information about the contact person named on page 1. Please complete this section for that person.

Complete Step 2 for yourself and all additional household members who live with you, or anyone on your same federal income tax return if you file one. If you do not file a tax return, remember to still add household members who live with you.

1. First name, middle name, last name, and suffix	2. Relationship to you **SELF**
3. Date of birth (mm/dd/yyyy)	4. Gender ☐ Male ☐ Female

5. We need a social security number (SSN) for every person applying for health coverage who has one, 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 Member Booklet for more information.

   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

   Is your name on this application the same as your name on your Social Security card? ☐ Yes ☐ No

   If **no**, what name is on your Social Security card?

   First name, middle name, last name, and suffix

6. If you get an Advance Premium Tax Credit (APTC) for 2017, do you agree to file a federal tax return for tax year 2017?
   ☐ Yes ☐ No

You may not have needed or chosen to file a tax return in the past, but you will have to file a federal income tax return for any year that you get an APTC. You must check "Yes" to be eligible for ConnectorCare or APTCs to help pay for your health insurance. You do NOT need to file a tax return to get MassHealth, CMSP, 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 a joint federal tax return with your spouse for 2017?"), 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 a premium tax credit. Do not answer yes to this question if you are 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 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 applying for health or dental coverage for **YOURSELF**? ☐ Yes ☐ No
(Even if you have coverage, there might be a program with better coverage or lower costs.)

If **yes**, answer all the questions below. If **no**, answer Questions 14 and 15, then go to **Income Information** on page 4.

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

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

Alien number _____ Naturalization or citizenship certificate number _____

9. If you are a noncitizen, do you have an eligible immigration status? ☐ Yes ☐ No
See page 22, "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 an electronic data match. Please list all the immigration statuses 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 as properly filed.)

Immigration status _____ Immigration document type _____
Choose one or more document status and types from the list on page 22.

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 U.S. 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

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

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

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

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

☐ American Indian or Alaska Native (complete Step 3 and Supplement B)
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White or Caucasian
☐ Other _____

12. 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.

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

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

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

18. 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

INCOME INFORMATION

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**, skip to questions 32 and 33.

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, Supplemental Security Income (SSI), or most workers' compensation income.**

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

☐ Unemployment $ _____ How often/month received? _____

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

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

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

☐ Royalty income $ _____ How often/month received? _____

☐ 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

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

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

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

DEDUCTIONS

31. Check all that apply. Give the amount and how often 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: Do not include a cost already considered in the 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

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

33. 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

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

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

2. Relationship to Person 1 | Does this person live with Person 1? ☐ Yes ☐ No

If **no**, list address.

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

5. We need a social security number (SSN) for every person applying for health coverage who has one, 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 Member Booklet for more information.

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

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

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

6. If this person gets an Advance Premium Tax Credit (APTC) for 2017, does this person agree to file a federal tax return for tax year 2017? ☐ Yes ☐ No
He or she may not have needed or chosen to file a tax return in the past, but this person will have to file a federal income tax return for any year that he or she gets an APTC. You must check "Yes" 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 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 2017 to get certain programs unless this person is a victim of domestic abuse or abandonment. If this person is a victim of domestic abuse or is an abandoned spouse, he or she should answer "no" to question 6a ("Is this person legally married?") and "no" to question 6b ("Does this person plan to file a joint federal tax return with a spouse for 2017?"), even if that is not how this person actually files. This person will only need to include him- or herself and any dependents on this application.

STEP 2 Person 2 (continued)

a. Is this person legally married? ☐ Yes ☐ No

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

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

c. Will this person claim any dependents on this person's federal income tax return for 2017? ☐ Yes ☐ No
This person will claim a personal exemption deduction on his or her 2017 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments. If **yes**, list name(s) and date(s) of birth of dependents.

_____

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

Tax filer date of birth _____ How 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?

_____

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

If **yes**, answer all the questions below. If **no**, answer Questions 14 and 15, then go to **Income Information** on page 8.

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

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

Alien number _____ Naturalization or citizenship certificate number _____

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

a. If **yes**, does this person have an immigration document? ☐ Yes ☐ No
It may help us to process this application faster if you include a copy of this person's immigration document with the application. We will try to verify this person's immigration status through 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 _____
Choose one or more document status and types from the list on page 22.

Document ID number _____ Alien number _____

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

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

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

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

10. Does this person live with at least one child younger than 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. Race (optional—check all that apply.)

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

  _____
- ☐ American Indian or Alaska Native (complete Step 3 and Supplement B)
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White or Caucasian
- ☐ Other _____

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

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

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

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

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

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

18. Was this person ever in foster care? ☐ Yes ☐ No
    a. If **yes**, in what state was this person in foster care? _____
    b. Was this person getting health care through a state Medicaid program? ☐ Yes ☐ No

INCOME INFORMATION

Does this person have any income? ☐ Yes ☐ No

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

If **no**, skip to questions 32 and 33.

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

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

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

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

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

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

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

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

OTHER INCOME

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

☐ Social security benefits $ _____ How often/month received? _____
☐ Unemployment $ _____ How often/month received? _____
☐ Retirement or pension $ _____ How often/month received? _____ Source _____
☐ Capital gains $ _____ How often/month received? _____
☐ Interest, dividends, and other Investment income $ _____ How often/month received? _____
☐ Royalty income $ _____ How often/month received? _____
☐ Net rental income:
On average, how much net income (profits after rental expenses are paid) will this person get from this rental each month, or how much will this person lose from this rental each month? $ _____ month profit or $ _____ month loss
☐ Net farming or fishing income $ _____ How often/month received? _____
☐ Alimony received $ _____ How often/month received? _____
☐ Other taxable income $ _____ How often/month received? _____ Type _____

DEDUCTIONS

31. Check all that apply. Give the amount and how often this person gets it.
If this person pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE: Do not include a cost already considered in the 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 in this section.

Type _____ $ _____ How often? _____

YEARLY INCOME

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

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

THANKS! This is all we need to know about this person. Go to Step 2 Person 3 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 3

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

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

2. Relationship to Person 1	Relationship to Person 2	Does this person live with Person 1? ☐ Yes ☐ No

If **no**, list address.

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

5. We need a social security number (SSN) for every person applying for health coverage who has one, 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 Member Booklet for more information.

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

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

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

6. If this person gets an Advance Premium Tax Credit (APTC) for 2017, does this person agree to file a federal tax return for tax year 2017? ☐ Yes ☐ No
   He or she may not have needed or chosen to file a tax return in the past, but this person will have to file a federal income tax return for any year that he or she gets an APTC. You must check "Yes" 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 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 2017 to get certain programs unless this person is a victim of domestic abuse or abandonment. If this person is a victim of domestic abuse or is an abandoned spouse, he or she should answer "no" to question 6a ("Is this person legally married?") and "no" to question 6b ("Does this person plan to file a joint federal tax return with a spouse for 2017?"), even if that is not how this person actually files. This person will only need to include him- or herself and any dependents on this application.

   a. Is this person legally married? ☐ Yes ☐ No

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

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

   c. Will this person claim any dependents on this person's federal income tax return for 2017? ☐ Yes ☐ No
      This person will claim a personal exemption deduction on his or her 2017 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments. If **yes**, list name(s) and date(s) of birth of dependents.

      _____

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

Tax filer date of birth _____ How 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?

_____

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

If **yes**, answer all the questions below. If **no**, answer Questions 14 and 15, then go to **Income Information** on page 8.

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

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

Alien number _____ Naturalization or citizenship certificate number _____

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

a. If **yes**, does this person have an immigration document? ☐ Yes ☐ No
It may help us to process this application faster if you include a copy of this person's immigration document with the application. We will try to verify this person's immigration status through 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 _____
Choose one or more document status and types from the list on page 22.

Document ID number _____ Alien number _____

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

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

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

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

10. Does this person live with at least one child younger than 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. Race (optional—check all that apply.)

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

_____

☐ American Indian or Alaska Native (complete Step 3 and Supplement B)
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White or Caucasian
☐ Other _____

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

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

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

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

15. Is this person pregnant? ☐ Yes ☐ No

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

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

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

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

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

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

INCOME INFORMATION

Does this person have any income? ☐ Yes ☐ No

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

If **no**, skip to questions 32 and 33.

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

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

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

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

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

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

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

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

OTHER INCOME

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

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

    ☐ Unemployment $ _____ How often/month received? _____

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

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

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

    ☐ Royalty income $ _____ How often/month received? _____

    ☐ Net rental income:
    On average, how much net income (profits after rental expenses are paid) will this person get from this rental each month, or how much will this person lose from this rental each month? $ _____ month profit or $ _____ month loss

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

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

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

DEDUCTIONS

31. Check all that apply. Give the amount and how often this person gets it.
    If this person pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE: Do not include a cost already considered in the 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 in this section.

    Type _____ $ _____ How often? _____

YEARLY INCOME

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

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

THANKS! This is all we need to know about this person. Go to Step 2 Person 4 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 4 (If more than 4 people, this is Person ___)

If you have to include more than four people on this application, make a copy of blank information pages for Step 2 Person 4 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.

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

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

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

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

If no, list address.

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

5. We need a social security number (SSN) for every person applying for health coverage who has one, 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 Member Booklet for more information.

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

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

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

6. If this person gets an Advance Premium Tax Credit (APTC) for 2017, does this person agree to file a federal tax return for tax year 2017? ☐ Yes ☐ No
   He or she may not have needed or chosen to file a tax return in the past, but this person will have to file a federal income tax return for any year that he or she gets an APTC. You must check "Yes" 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 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 2017 to get certain programs unless this person is a victim of domestic abuse or abandonment. If this person is a victim of domestic abuse or is an abandoned spouse, he or she should answer "no" to question 6a ("Is this person legally married?") and "no" to question 6b ("Does this person plan to file a joint federal tax return with a spouse for 2017?"), even if that is not how this person actually files. This person will only need to include him- or herself and any dependents on this application.

   a. Is this person legally married? ☐ Yes ☐ No

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

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

   c. Will this person claim any dependents on this person's federal income tax return for 2017? ☐ Yes ☐ No
      This person will claim a personal exemption deduction on his or her 2017 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments. If **yes**, list name(s) and date(s) of birth of dependents.

      _____

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

      Tax filer date of birth _____ How 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?

_____

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

If **yes**, answer all the questions below. If **no**, answer Questions 14 and 15, then go to **Income Information** on page 8.

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

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

Alien number _____ Naturalization or citizenship certificate number _____

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

   a. If **yes**, does this person have an immigration document? ☐ Yes ☐ No
   It may help us to process this application faster if you include a copy of this person's immigration document with the application. We will try to verify this person's immigration status through 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 _____
   Choose one or more document status and types from the list on page 22.

   Document ID number _____ Alien number _____

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

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

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

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

10. Does this person live with at least one child younger than 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. Race (optional—check all that apply.)

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

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

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

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

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

15. Is this person pregnant? ☐ Yes ☐ No

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

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

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

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

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

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

INCOME INFORMATION

Does this person have any income? ☐ Yes ☐ No

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

If **no**, skip to questions 32 and 33.

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

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

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

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

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

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

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

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

OTHER INCOME

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

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

    ☐ Unemployment $ _____ How often/month received? _____

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

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

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

    ☐ Royalty income $ _____ How often/month received? _____

    ☐ Net rental income:
    On average, how much net income (profits after rental expenses are paid) will this person get from this rental each month, or how much will this person lose from this rental each month? $ _____ month profit or $ _____ month loss

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

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

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

DEDUCTIONS

31. Check all that apply. Give the amount and how often this person gets it.
    If this person pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE: Do not include a cost already considered in the 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 in this section.

    Type _____ $ _____ How often? _____

YEARLY INCOME

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

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

THANKS! This is all we need to know about this person. Please go to Step 3 American Indian or Alaska Native (AI/AN) Household Member(s).

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

1. 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 Your Household's Health Coverage

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 Member Booklet 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 the person does not live in the household.
   If **yes**, you will need to complete and include **Supplement A: Health Coverage from Jobs**, and the rest of this application.

   Name(s) of person(s) offered insurance _____

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

2. Does anyone qualify or is anyone **enrolled** in any of the following types of health coverage? ☐ Yes ☐ No
   If **yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have.
   Answer **yes**, even if this insurance is from another person, like spouse, even if the person does not live in the household.

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

   Name(s) of person(s) covered _____

   Start date _____ End date _____ Medicare ID # _____

   ☐ Qualifies for **Peace Corps** health benefits . . . . . Start date _____ End date _____

   Name(s) of person(s) covered _____

   ☐ Qualifies for **TRICARE** or a Federal Employees health benefit program. Start date _____ End date _____

   Name(s) of person(s) covered _____

   ☐ Enrolled in a **Veterans Affairs (VA) health program** . . . . . Start date _____ End date _____

   Name(s) of person(s) covered _____

   ☐ **MassHealth**

   Name(s) of person(s) covered _____

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

   Name of employer _____ Plan name _____

   Names of covered household members _____

   Policy # or Member ID _____ . . . . . Start date _____ End date _____

   ☐ **Other coverage** (including COBRA or Retiree health plans) . . . . . Start date _____ End date _____

   Name(s) of person(s) covered _____

   Policy # or Member ID _____

STEP 5 Parental Information

Please answer these questions for any child younger than the age of 18, who is listed on this application but who does not have two custodial parents also listed on this application.

1. Was any child adopted by a single parent? ☐ Yes ☐ No
   If **yes**, name(s) of child(ren) _____
2. Does any child have a parent who has died? ☐ Yes ☐ No
   If **yes**, name(s) of child(ren) _____
3. Does any child have a parent whose identity is unknown? ☐ Yes ☐ No
   If **yes**, name(s) of child(ren) _____
4. Does any child have a parent who does not live with the child and who is not included in the previous questions? ☐ Yes ☐ No
   If **yes**, name(s) of child(ren) _____

STEP 6 Read and sign this application.

On behalf of myself and all persons listed on this application, I understand, represent, and agree as follows.

1. MassHealth may require eligible persons to enroll in available employer-sponsored health insurance if that insurance meets the criteria for MassHealth payment of premium assistance.
2. Employers of eligible persons may be notified and billed in accordance with MassHealth regulations for any services that hospitals or community health centers provide to such persons that are paid for by the Health Safety Net.
3. Eligible persons may have to pay a premium for health coverage for themselves and others listed on this application. Failure to pay any premium due may result in the state deducting the amount owed from the tax refunds of responsible persons. If an eligible person is a certain American Indian or Alaska Native, such person may not have to pay premiums for MassHealth.
4. MassHealth has the right to pursue and get money from third parties who may be obligated to pay for health services provided to eligible persons enrolled in MassHealth programs. Such third parties may include other health insurers, spouses, or parents obligated to pay for medical support, or individuals obligated to pay under accident settlements. Eligible persons must cooperate with MassHealth in establishing third-party support and obtaining third-party payments for themselves and anyone whose rights they can legally assign. Eligible persons may be exempted from this obligation if they believe and tell MassHealth that cooperation could result in harm to them or anyone whose rights they can legally assign.
5. A parent and/or guardian of minor children must agree to cooperate with state efforts to collect medical support from an absent parent unless they believe and tell MassHealth that cooperation will harm the children or the parent or guardian.
6. Eligible persons who are injured in an accident, or in some other way, and get money from a third party because of that accident or injury must use that money to repay MassHealth or the Health Safety Net for certain services provided.
7. Eligible persons must tell MassHealth or the Health Safety Net, in writing, within 10 calendar days, or as soon as possible, about any insurance claims or lawsuits filed because of an accident or injury.
8. The status of this application may be shared with a hospital, community health center, other medical provider, or federal or state agencies when necessary for treatment, payment, operations, or the administration of the programs listed above.
9. To the extent permitted by law, MassHealth may place a lien against any real estate owned by eligible persons or in which eligible persons have a legal interest. If MassHealth puts a lien against such property and it is sold, money from the sale of that property may be used to repay MassHealth for medical services provided.
10. To the extent permitted by law, and unless exceptions apply, for any eligible person 55 years of age or older, or any eligible person for whom MassHealth helps pay for care in a nursing home, MassHealth will seek money from the eligible person's estate after death.
11. MassHealth, the Health Connector, and the Health Safety Net will obtain from eligible persons' current and former employers and health insurers all information about health insurance coverage for such persons. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to such persons or members of their household.
12. MassHealth, the Health Connector, and the Health Safety Net may get records or data about persons listed on this application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Revenue, and the Registry of Motor Vehicles, as well as private data sources, including financial institutions, 1) to prove any information given on this application and any supplements, or other information given once a person becomes a member, 2) to document medical services claimed or provided to such persons, and 3) to support continued eligibility.

13. To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Massachusetts Health Connector to use income data, including information from tax returns for the next three coverage years. The Massachusetts Health Connector will send me a notice and let me make changes. I understand that if I am eligible for an Advance Premium Tax Credit (APTC) or ConnectorCare, these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC or ConnectorCare may impact my tax liability for this year. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.
14. In connection with the eligibility and enrollment process, MassHealth, the Health Connector, and the Health Safety Net may send notices that contain personal information about persons listed on this application to other persons on this application, or otherwise communicate such information to such persons.
15. Under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by going to **www.hhs.gov/ocr/office/file**.
16. Eligible persons must tell the health care program(s) in which they enroll about any changes in their or their household's income or employment, household size, health insurance coverage, health insurance premiums, and immigration status, or about changes in any other information on this application and any supplements to it within 10 calendar days of learning of the change. Eligible persons can make changes by calling **1-800-497-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled). A change in information could affect eligibility for such persons or for persons in their household.

    You can also report changes in any of the following ways.

    - Sign on to your account at **MAhealthconnector.org**. You can create an online account if you do not already have one.
    - Send the change information to **Health Insurance Processing Center**
      P.O. Box 4405
      Taunton, MA 02780.
    - Fax the change information to **1-857-323-8300**.
17. No one applying for health coverage on this application is in prison or in jail except as set forth below. If someone applying for health coverage is in prison or jail, write their name below and answer the following three questions.

    _____ is in prison or jail.

    Is this person awaiting trial? ☐ Yes ☐ No

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

    Is this person an inmate who will be admitted to a hospital for at least 24 hours and then returned to prison or jail? ☐ 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 Member Booklet contains important information.
- I have permission from all persons listed on this application (or their parent or other legally authorized representative) to submit this application and to act on their behalf to complete this application and any ongoing or subsequent eligibility process and activity, including, for example:
  - providing personal information about them, including health, health coverage, and income information, seeing such information as may be provided by the Health Connector, MassHealth, and the Health Safety Net, and providing consent on their behalf to the use and disclosure of their information as described in this application;
  - making choices about coverage options and methods of communication with the Health Connector, MassHealth, and the Health Safety Net;
  - making changes to the application or related eligibility documents and providing information about any change in their circumstances; and
  - providing consent on their behalf to use government and private sources to verify information as described in this application.
- I understand my rights and responsibilities and the rights and responsibilities of all persons listed on this application as explained in this Step 6.
- I have told or will tell all such persons (or their parent or legally authorized representative, if applicable) about these rights and responsibilities so they understand them.
- I understand and agree that MassHealth, the Health Safety Net, and the Health Connector will treat electronic, faxed, or copies of signatures with the same force and effect as an original signature(s).
- The information I have supplied is correct and complete to the best of my knowledge about myself and other persons listed on this application.
- I may be subject to penalties under federal law if I intentionally provide false or untrue information.

SIGN THIS APPLICATION.

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

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

Signature of Person 1 or authorized representative or responsible party

Print name	Date

If you are under 18 years of age, are you an emancipated minor? ☐ Yes ☐ No

If **no**, we need a responsible party who is at least 18 years old to sign this application on your behalf. Please provide that person's information below.

First name	Middle name	Last name	Suffix
Social Security Number		Relationship to you	Date of birth
Street address	Apartment/Unit #		
City Zip code	County		
Phone	Ext.	Phone type	
Second phone	Ext.	Phone type	
Email address			

VOTER REGISTRATION INFORMATION ON THIS PAGE

STEP 7 Send us your completed application.

Mail your signed application to:

Health Insurance Processing Center
P.O. Box 4405
Taunton, MA 02780; or

Fax to:

1-857-323-8300

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 for people who are deaf, hard of hearing, or speech disabled).

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 9a 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 9a.

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 9a, 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-US 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 age 14 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 9a, 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 U.S. Citizenship and Immigration Services
- Arrival Departure Record in unexpired foreign passport (I-94)
- Unexpired foreign passport
- Certificate of Eligibility for Nonimmigrant (F1) Student Status (I-20)
- Certificate of Eligibility for Exchange Visitor (J1) Status (DS2019)
- Notice of Action (I-797)/Other-with Alien Number
- Notice of Action (I-797)/Other-with I-94 Number

SUPPLEMENT A 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.

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 A**.

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

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

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

c. How much did this employee pay in premiums to enroll in this plan, or how much does this employee pay for this plan?
$ _____

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

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).

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

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

TELL US ABOUT YOUR AMERICAN INDIAN OR ALASKA NATIVE HOUSEHOLD MEMBER(S).

American Indians and Alaska Natives can get services from the Indian Health Service, tribal health programs, or urban Indian health programs. They also may not have to pay premiums or copayments 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 it.

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 Accommodation

If you answered **yes** to Question 14 in Step 2 about yourself or any household member needing reasonable accommodation because of a disability or injury, check all that apply below, and list name(s).

1. Condition

- ☐ Blind—Name(s): _____
- ☐ Deaf—Name(s): _____
- ☐ Developmentally disabled—Name(s): _____
- ☐ Hard of hearing—Name(s): _____
- ☐ Intellectually disabled—Name(s): _____
- ☐ Low vision—Name(s): _____
- ☐ Physically disabled—Name(s): _____
- ☐ Other (Please explain.)—Name(s): _____

2. Accommodation

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

Authorized Representative Designation Form

You can submit this form if you would like to designate an authorized representative to act on your behalf. If an authorized representative signed your application for you, or if you are an authorized representative applying on behalf of someone else, you **MUST** submit this form for the application to be processed.

You do not need to fill out this form if you live in an institution and want copies of eligibility notices sent to you and to your spouse who still lives at home. We will do that automatically.

NOTE: An authorized representative has the authority to act on an applicant's or member's behalf in all matters with MassHealth and the Health Connector, and will receive personal information about the applicant or member until we receive a cancellation notice terminating their authority. Their authority will not automatically terminate once we process your application.

You can choose someone to help you.

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

Who can help me?

1. An authorized representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose an authorized representative if you want one. Neither MassHealth nor the Health Connector will choose an authorized representative for you. You must designate in writing (fill out Section I, Part A) the person or organization who you want to be your authorized representative. Your authorized representative must also fill out Section I, Part B.
2. If, because of a mental or physical condition, you cannot designate an authorized representative in writing, a person (not an organization) who is acting responsibly on your behalf can be your authorized representative if that person certifies, by filling out Section II, that you are not able to provide a written designation, and that he or she is acting responsibly on your behalf.
3. An authorized representative can also be someone who has been appointed by law to act on your behalf. This person must fill out Section III and either you or this person must submit to us, together with this form, a copy of the applicable legal document stating that this person is lawfully representing you.
4. A person appointed by law to act on behalf of the estate of an applicant or member who has died can also serve as an authorized representative by following the instructions above. An authorized representative under Section III may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the estate's administrator or executor. What this person is authorized to do for you or for the applicant or member's estate will depend on the wording of the legal appointment.

What can an authorized representative do?

An authorized representative may

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

How does an authorized representative designation end?

If you decide that you no longer want a **Section I** or **Section II** authorized representative, you must notify us at the time you want the designation to end by doing the following.

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

  Health Insurance Processing Center
  P. O. Box 4405
  Taunton, MA 02780;

- Faxing a letter notifying us that the designation has ended to **1-857-323-8300**; or
- Calling us at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

If you mail or fax this notice to us, the notice must include your name, address, and date of birth, the name of your authorized representative, a statement that the designation has ended and your signature or, if you cannot provide written notice, the signature of someone acting on your behalf (in the case of a Section II authorized representative only).

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

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

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

How do I submit this form?

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

If you are already getting benefits, you must submit the form to us at the time you want to designate an authorized representative by doing the following.

- Mailing your form to

  Health Insurance Processing Center
  P. O. Box 4405
  Taunton, MA 02780;

- Faxing your form to **1-857-323-8300**; or
- Calling us at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

SECTION 1 Authorized Representative Designation (if applicant or member is able to sign)

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

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

Applicant's/Member's Name	SSN (if you have one) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Date of birth (mm/dd/yyyy)	Applicant's/Member's e-mail address

I certify that I have chosen the following person or organization to be the authorized representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form).

Applicant's/Member's signature	Date
Authorized representative's name	Authorized representative's phone number

Authorized representative's address (mailing address, city, state, zip)

Part B—to be filled out by authorized representative. Please print, except for signature.

B1. COMPLETE IF AUTHORIZED REPRESENTATIVE IS A PERSON.

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to me by MassHealth or the Health Connector.

If I am also a provider, staff member, or volunteer affiliated with an organization, and am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f).

Authorized representative's signature	Date
Authorized representative's printed name	Authorized representative's e-mail address

B2. COMPLETE IF AUTHORIZED REPRESENTATIVE IS AN ORGANIZATION.

I certify, on behalf of the organization set forth below, that such organization will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to the organization by MassHealth or the Health Connector.

I, the provider, staff member, or volunteer of the organization set forth below, completing this form, certify on behalf of myself and on behalf of the organization I represent, that any providers, staff members, or volunteers acting on behalf of the organization in connection with this authorized representative designation will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information, and conflicts of interest, including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f).

Signature of provider, staff member, or volunteer completing form	Date

Printed name of provider, staff member, or volunteer completing form

E-mail of provider, staff member, or volunteer completing form	Authorized representative organization name

SECTION 2 Authorized Representative Designation
(if applicant or member cannot provide written designation)

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

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

I certify that I know enough about the applicant or member set forth below to take responsibility for the correctness of the statements made on his or her behalf during the eligibility process and in other communications with MassHealth or the Health Connector, that I understand my duties and responsibilities as this person's authorized representative (as explained earlier in this form), and that this person cannot provide written designation. If this person can understand, I have told the person that MassHealth and the Health Connector will send me a copy of all MassHealth and Health Connector eligibility and enrollment notices and this person agrees to this, and I have told this person that he or she may remove or replace me as his or her authorized representative at any time by the methods described earlier in this form.

I further certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth below that is provided to me by MassHealth or the Health Connector.

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

Applicant's/Member's name

Applicant's/Member's date of birth (mm/dd/yyyy)	Applicant's/Member's SSN ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	Authorized representative's e-mail address

SECTION 3 Authorized Representative Designation (if appointed by law)

To be filled out by an authorized representative appointed by law (as explained earlier on this form). Please print, except for signature. **Please submit a copy of the applicable legal document with this form.**

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member as set forth below, that is provided to me by MassHealth or the Health Connector.

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

Applicant's/Member's name

Applicant's/Member's date of birth (mm/dd/yyyy)	Applicant's/Member's SSN ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	Authorized representative's e-mail address