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

Commonwealth of Massachusetts | EOHHS

Please read these instructions before you fill out the application.

Please read the attached Senior Guide carefully before you fill out the application. Keep the guide. It may answer questions you have later.

These instructions are in two parts.

- Part One is for information about applying for MassHealth and the Health Safety Net (HSN).
- Part Two is for information about applying for health coverage through the Massachusetts Health Connector.

Please make sure you identify, on page 1 of the application, which program each household member is applying for.

Part One—Applying for MassHealth and the Health Safety Net

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

- aged 65 or older and living at home;
- any age and need long-term-care services in a medical institution or nursing facility;
- eligible under certain programs to get long-term-care services to live at home; or
- a member of a married couple living with your spouse, and
  - both you and your spouse are applying for health coverage;
  - there are no children under age 19 living with you; and
  - one spouse is 65 years of age or older and the other spouse is under 65 years of age. (Please see Part 7 of the application.)
- You will also need to fill out Supplement D: Long-Term-Care Questions if you are:
  - in an institution, like a nursing home, chronic hospital, or other medical institution (You may have to pay a monthly payment, called a patient-paid amount, to the long-term-care facility. For more information, see page 20 in the Senior Guide.);
  - in an acute hospital waiting for placement in a long-term-care facility; or
  - living in your home and applying for or getting long-term-care services under a Home- and Community-Based Services Waiver.

There is a different application for you, called the Application for Health Coverage and Help Paying Costs (ACA-2), if you are:

- any age and both disabled and working 40 or more hours a month or you are currently working and have worked at least 240 hours in the six months before the date of application, and not living with your spouse aged 65 years or older;
- under age 65 and not in a medical institution, and you do not need long-term-care services; or
- aged 65 or older and a parent or caretaker relative of children under age 19.

To get the ACA-2, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

Part Two—Applying for Massachusetts Health Connector Plans

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

- are aged 65 or older and living at home;
- are not otherwise eligible for MassHealth;
- are not getting Medicare;
- do not have access to an affordable health plan that meets the minimum value requirement*; and
- file federal income taxes.

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

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

Part Three—Other Information

After your application is filled out and reviewed, we will give you the most complete health coverage that you qualify for.

After you fill out the Senior Application and any supplements that apply, the following **must be sent with the application**.

- Proof of all current income before deductions, like copies of pension check stubs. (You do not have to send proof of social security or SSI income, but you must fill out the social security and SSI income information, if applicable.)
- Proof of all assets, like bank accounts and life insurance policies.

Please go to the next page. ►

- Proof of U.S. citizenship/national status and proof of identity, like U.S. passports or U.S. naturalization papers. You can also prove U.S. citizenship with a U.S. public birth certificate. You can also prove identity with a driver's license or some other form of government-issued card. We may be able to prove your identity through the Massachusetts Registry of Motor Vehicles records if you have a Massachusetts driver's license or a Massachusetts ID card. Once you give MassHealth proof of your U.S. citizenship/national status and identity, you will not have to give us this proof again. You must give proof of identity for all household members who are applying. **Seniors and disabled persons who get or can get Medicare or Supplemental Security Income (SSI), or disabled persons who get Social Security Disability (SSDI), do not have to give proof of their U.S. citizenship/ national status and identity**. (See pages 48-51 in the Senior Guide for complete information about acceptable proofs.)
- A copy of both sides of all immigration cards (or other documents that show immigration status) for you or your spouse if you or your spouse are not U.S. citizens/nationals and are applying for MassHealth (except for MassHealth Limited), the Health Safety Net, or the Health Connector plans.
- Copies of your current health insurance premium bills (like Medex) if you are applying for long-term-care services in a medical facility. (You do not have to send copies of your Medicare cards.)

Generally, you do not need to give us the citizenship or immigration statuses, or the social security numbers (SSNs) of household members who are not applying.* However, you must give us an SSN or proof that one has been applied for for every household member who is applying, unless one of the following exceptions applies.

- You or any household member has a religious exemption as described in federal law.
- You or any household member is eligible only for a nonwork SSN.
- You or any household member is not eligible for an SSN.

Unless an exception applies, we need SSNs for all persons applying for health coverage. An SSN is optional for persons not applying for health coverage, but giving us an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone does not have an SSN or needs help getting one, call the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778 for people who are deaf, hard of hearing, or speech disabled), or go to socialsecurity.gov. Please see the Senior Guide for more information.

*Note: For long-term-care applications, MassHealth needs SSNs from the applicant's spouse, even if the spouse is not applying.

We keep the information provided to us private, and only use and disclose it in accordance with applicable law.

Please remember:

- Sign and date all the forms after you finish filling them out. If you are married, your spouse must also sign.
- Submit a filled-out Authorized Representative Designation Form, if you are filling out this application as an authorized representative or if you want someone to act on your behalf.

Submit your application as follows:

- **Send** your filled-out Senior Application to:
  MassHealth Enrollment Center
  Central Processing Unit
  P.O. Box 290794
  Charlestown, MA 02129-0214;

or

- **Hand deliver** it to:
  MassHealth Enrollment Center
  Central Processing Unit
  The Schrafft Center
  529 Main Street, Suite 1M
  Charlestown, MA 02129.

If you need more information about how to apply, or if you need another copy of the Personal Care Attendant Supplement for your spouse who is also applying, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

If you have any questions about any form or the information you need to send, please call a MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled).

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

Go to page 1 of the application. ►

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

Commonwealth of Massachusetts | EOHHS

Please print clearly. Be sure to answer all questions. Fill out all parts of the application and all supplements that apply. If you need more space, attach a separate piece of paper to the application. Put Person 1's name and social security number at the top of any attached paper.

We need one adult in your household to be the contact person for your application.

For each member in your household, please put the name(s) of the individual(s) under the program or programs he or she wants to apply for. Please see the Senior Guide to learn more about coverage under these programs.

1. **MassHealth or the Health Safety Net**
   (If living at home, or in a rest home, an assisted living facility, a continuing care retirement community, or life care community, fill out this application and any supplements that apply to you or any household member.) MassHealth will check if anyone applying for health coverage on this application is eligible for MassHealth or the Health Safety Net. Please list the names of everyone who is applying for health coverage on this application.
   Name(s): ____________________

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

3. **Health Connector Programs**
   Health coverage through the Massachusetts Health Connector is not MassHealth. If you have Medicare and apply for a plan through the Health Connector, you will not be eligible for any cost sharing or tax credits. You will be responsible for the full price of the plan.)
   Name(s): ____________________

PART 1 Tell us about you (Person 1)—Fill out this part for yourself.

1. First name Middle initial Last name		Suffix (ex., Jr.)	Relationship to you SELF
2. Home street address	Apt. #	Is this a hospital, nursing facility, or other institution? ☐ Yes ☐ No	
City	State	Zip code	
3. Are you homeless? ☐ Yes ☐ No	4. Mailing address (if different from home address)		
City		State	Zip code
5. Telephone number	Other telephone number	6. Email address	
7. Date of birth (mm/dd/yyyy)	8. Gender ☐ M ☐ F	9. Written language choice	10. Spoken language choice

We need a social security number for every person applying for health coverage who has one. 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 for people who are deaf, hard of hearing, or speech disabled), or go to socialsecurity.gov. Please see the application instructions or the Senior Guide for more information.

11. 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 reasons below.
☐ Applied, but have not received SSN ☐ Religious exemption ☐ Only eligible for nonwork SSN
☐ Not eligible to get SSN ☐ Eligible for SSN, but have not applied

12. Will you file a federal income tax return next year? ☐ Yes ☐ No (To get a tax credit, you must file taxes for the year you are requesting benefits. You can still apply for health coverage even if you do not file a federal income tax return.)

If **yes**, answer 12.a., 12.b., and 12.c. **If no, answer 12.c.**

12.a. Will you file jointly with a spouse? ☐ Yes ☐ No If **yes**, name of spouse: ______
(If married, you must file federal taxes jointly for the year you are requesting benefits.)

12.b. Will you claim any dependents on your income tax return? ☐ Yes ☐ No
If **yes**, list name(s) of dependents: ______

12.c. Will someone else claim you as a dependent on his or her tax return? ☐ Yes ☐ No
If **yes**, name of tax filer: ______ How are you related to the tax filer? ______

13. Are you applying for health coverage for yourself? ☐ Yes ☐ No
If **no**, go to **Part 2: Tell us about other people in this household** on page 3. If **yes**, answer all questions below for Person 1 (yourself).

14. Are you living in Massachusetts and planning to stay? ☐ Yes ☐ No

15. Are you in jail or prison? ☐ Yes ☐ No
If **no**, go to the next question.

15.a. If **yes**, are you (Check one.):
☐ Convicted? What is your expected release date? (mm/dd/yyyy) ______ ☐ Not convicted? (For example: confined only)

16. Are you a U.S. citizen, national, or naturalized U.S. citizen? ☐ Yes ☐ No
If **yes**, go to Question 17.

16.a. If **no**, do you have an eligible immigration status? (See the Senior Guide for more information.) ☐ Yes ☐ No ☐ No response

If **no** or **no response**, you may get only one or more of the following: MassHealth Limited or the Health Safety Net (HSN). Go to Question 17.

16.b. If **yes**, do you have an immigration document? ☐ Yes ☐ No

We will try to prove your immigration status. Please list all the immigration statuses and/or conditions that have applied to you since you entered the U.S. (See the Senior Guide for more information about immigration statuses and documents.)

Immigration status		
Status award date* (mm/dd/yyyy)	Immigration document type	Document ID number

*For battered persons, status award date is date petition was approved as properly filed.

16.c. Did you come to live in the U.S. before August 22, 1996? ☐ Yes ☐ No

16.d. Did you use a different name to get your immigration status? ☐ Yes ☐ No **If yes, what is it?**

First name	Middle name	Last name	Suffix (ex., Jr.)

16.e. Are you an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

16.f. Are you a spouse or unremarried surviving spouse of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

16.g. Are you an unmarried dependent child of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

17. Do you need reasonable accommodation(s) because of a disability or injury? ☐ Yes ☐ No
If **no**, go to the next question. If **yes**, fill out **Part B** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

18. Are you applying because of an accident or injury that someone else might be responsible for? ☐ Yes ☐ No
If **no**, go to the next question. **If yes**, fill out **Part C** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

19. Did you ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No
If **no**, go to question 20. If **yes**,answer questions 19.a. and 19.b.

Please go to the next page. ►

19.a. When did you last get SSI? (mm/yyyy) ______________

19.b. Do you (Please check one.): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home?
☐ live and share expenses with another or others (not a spouse)? ☐ live in an assisted living facility? ☐ live in someone else's home?

20. Check the box below that best describes you. (Optional)

☐ American Indian/Alaska Native (Mashpee Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))
☐ American Indian/Alaska Native (Other Tribal Nation) ☐ Asian ☐ Black or African American ☐ Hispanic/Latino/Black
☐ Hispanic/Latino/White ☐ Hispanic/Latino/Other ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other

21. If you are an American Indian or Alaska Native, fill out **Supplement B: American Indian (AI)/Alaska Native (AN)** on page 21. American Indians and Alaska Natives may not have to pay premiums or copayments, and may get special monthly enrollment periods.

Go to **Part 2** to add other household members, if needed, or go to **Part 3: Current Job and Income Information** on page 5.

PART 2 Tell us about other people in this household

Fill out this part for your spouse who lives with you and/or anyone included on your federal income tax return, if you file one. See the application instructions for more information about who to include. If you do not file an income tax return, remember to add other persons who live with you.

If you have more than one person to add, make a copy of Person 2's blank information pages (pages 3-4) before you fill them out, or go to **Part 3: Current Job and Income Information** on page 5.

Person 2

1. First name Middle initial Last name			Suffix (ex., Jr.)	Relationship to Person 1
2. Home street address		Apt. #	Is this a hospital, nursing facility, or other institution? ☐ Yes ☐ No	
City	State	Zip code		
3. Is Person 2 homeless? ☐ Yes ☐ No	4. Mailing address (if different from home address)			
City			State	Zip code
5. Telephone number	Other telephone number	6. Email address		
7. Date of birth (mm/dd/yyyy)	8. Gender	9. Written language choice	10. Spoken language choice	

We need a social security number for every person applying for health coverage who has one. Please see the application instructions or the Senior Guide for more information.

11. Does Person 2 have a social security number (SSN)? ☐ Yes ☐ No
If **yes**, give us the number. ________ – ________ – ________ (Optional, if **not** applying)
If **no**, check one of the reasons below.
☐ Applied, but have not received SSN ☐ Religious exemption ☐ Only eligible for nonwork SSN
☐ Not eligible to get SSN ☐ Eligible for SSN, but have not applied

12. Will Person 2 file a federal income tax return next year? ☐ Yes ☐ No (To get a tax credit, Person 2 must file taxes for the year he or she is requesting benefits. Person 2 can still apply for health coverage even if he or she does not file a federal income tax return.)
If **yes**, answer 12.a., 12.b., and 12.c. If **no**, answer 12.c.

12.a. Will Person 2 file jointly with a spouse? ☐ Yes ☐ No **If yes, name of spouse:** ______________
(If married, Person 2 must file federal taxes jointly for the year he or she is requesting benefits.)

12.b. Will Person 2 claim any dependents on his or her income tax return? ☐ Yes ☐ No
If **yes**, list name(s) of dependents: ______________

12.c. Will someone else claim Person 2 as a dependent on his or her tax return? ☐ Yes ☐ No

If **yes**, name of tax filer: ______________________ How is Person 2 related to the tax filer? ______________

13. Is Person 2 applying for health coverage? ☐ Yes ☐ No

If **no**, go to **Part 3: Current Job and Income Information** on page 5. If **yes**, answer all questions below for Person 2.

14. Is Person 2 living in Massachusetts and planning to stay? ☐ Yes ☐ No

15. Is Person 2 in jail or prison? ☐ Yes ☐ No

If **no**, go to the next question.

15.a. If **yes**, is Person 2 (Check one.):

☐ Convicted? What is his or her expected release date? (mm/dd/yyyy) ______________ ☐ Not convicted? (For example: confined only)

16. Is Person 2 a U.S. citizen, national, or naturalized U.S. citizen? ☐ Yes ☐ No

If yes, go to Question 17.

16.a. If **no**, does Person 2 have an eligible immigration status? (See the Senior Guide for more information.) ☐ Yes ☐ No ☐ No response

If **no** or **no response**, Person 2 may get only one or more of the following: MassHealth Limited or the Health Safety Net (HSN). Go to Question 17.

16.b. If **yes**, does Person 2 have an immigration document? ☐ Yes ☐ No

We will try to prove Person 2's immigration status. Please list all the immigration statuses and/or conditions that have applied to Person 2 since he or she entered the U.S. (See the Senior Guide for more information about immigration statuses and documents.)

Immigration status		
Status award date* (mm/dd/yyyy)	Immigration document type	Document ID number

*For battered persons, status award date is date petition was approved as properly filed.

16.c. Did Person 2 come to live in the U.S. before August 22, 1996? ☐ Yes ☐ No

16.d. Did Person 2 use a different name to get his or her immigration status? ☐ Yes ☐ No If **yes**, what is it?

First name	Middle name	Last name	Suffix (ex., Jr.)

16.e. Is Person 2 an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

16.f. Is Person 2 a spouse or unremarried surviving spouse of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

16.g. Is Person 2 an unmarried dependent child of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

17. Does Person 2 need reasonable accommodation(s) because of a disability or injury? ☐ Yes ☐ No

If **no**, go to the next question. If **yes**, fill out **Part B** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

18. Is Person 2 applying because of an accident or injury that someone else might be responsible for? ☐ Yes ☐ No

If **no**, go to the next question. If **yes**, fill out **Part C** of **Supplement A: Illness, Disability, or Accommodation** on page 19.

19. Did Person 2 ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No

If **no**, go to question 20. If **yes**, answer questions 19.a. and 19.b.

19.a. When did Person 2 last get SSI? (mm/yyyy) ______________

19.b. Does Person 2 (Please check one.): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home? ☐ live and share expenses with another or others (not a spouse)? ☐ live in an assisted living facility? ☐ live in someone else's home?

20. Check the box below that best describes Person 2. (Optional)

☐ American Indian/Alaska Native (Mashpee Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))
☐ American Indian/Alaska Native (Other Tribal Nation) ☐ Asian ☐ Black or African American ☐ Hispanic/Latino/Black
☐ Hispanic/Latino/White ☐ Hispanic/Latino/Other ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other

21. If Person 2 is an American Indian or Alaska Native, fill out **Supplement B: American Indian (AI)/Alaska Native (AN)** on page 21. American Indians and Alaska Natives may not have to pay premiums or copayments, and may get special monthly enrollment periods.

PART 3 Current Job and Income Information

We use your income to see if you are eligible for health coverage. See the Senior Guide. If you are self-employed, and pay yourself wages, fill out both the Current Job and Self-employed income sections.

About You (Person 1)

1. (Check all that apply.)

☐ Employed (Go to **Current Job 1**.) ☐ Self-employed (Go to **Self-employed income**.) ☐ Not employed (Go to **Money from other sources** section.)

Current Job 1

2. Employer name

Employer address	City	State	Zip code
Employer telephone	Employer Identification Number (EIN—if you know)		

3. Does this job offer health insurance? ☐ Yes ☐ No

If **yes**, check one.

☐ This job offers health insurance now.

☐ This job will offer health insurance, starting ______________ (mm/dd/yyyy).

3.a. If this job offers health insurance now or will at a later date, can the health plan cover an employee's spouse or dependent(s)?

☐ Yes List the name(s): ____ ☐ No

- How much will the employee pay for the lowest-cost individual health plan? $ __________

  How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
- If an employee joins a program to stop smoking or using tobacco, how much money could he or she save on the monthly premium? $ __________
- Does the health insurance plan(s) offered by the employer meet the "minimum value" standard? ☐ Yes ☐ No

Minimum value means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

3.b. What health insurance changes will this job make for the next year? (if you know)

☐ This job will stop offering health insurance.

☐ This job will start offering health insurance to employees or change the premium for the lowest-cost available plan.

- How much will the employee's premiums be (for an individual plan)? $ __________

  How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
- Date of change: ______________ (mm/dd/yyyy)

3.c. ☐ No health insurance plans offered by the employer will meet the "minimum value" standard.

Minimum value means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

4. Does this employer have 50 or fewer full-time employees? ☐ Yes ☐ No (If you do not know, answer **no** to this question.)

   If **yes**, we may be able to help you pay for your coverage.

5. Is this job a sheltered workshop? ☐ Yes ☐ No

6. How much do you currently earn in gross wages, less pre-tax deductions? $ ______________

   6.a. How often are you paid? (Check one.) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

   6.b. About how many hours do you work each WEEK? ______________

   6.c. When did you begin getting this income? ______________ (mm/dd/yyyy)

7. If your income from this job changes during the year (such as seasonal or contract employment), check the months you have worked or expect to work.

   ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

Self-employed Income

8. (Check one.) ☐ Partnership ☐ S-Corporation ☐ Self-employed

   8.a. Business name: ______

   8.b. What is your expected yearly income from this source, less any business expenses? (Do not include your wages and tips.) $ ______

   8.c. Date you began getting this income ______ (mm/dd/yyyy)

Money from other sources

9. Do you get money from other sources? ☐ Yes ☐ No

   Check all of the sources, give the amount, and how often you get it.
   (You do not need to tell us about child support, nontaxable veterans' payments, or Supplemental Security Income (SSI).)

Source	Amount	How often?	Source	Amount	How often?
☐ Unemployment	$	How often?	☐ Ordinary or qualified dividend	$	How often?
☐ Pension	$	How often?	☐ Interest	$	How often?
☐ Annuity	$	How often?	☐ Net farming/fishing	$	How often?
☐ Social Security	$	How often?	☐ Royalty	$	How often?
☐ Capital gains	$	How often?	☐ Alimony received	$	How often?
☐ Gambling proceeds	$	How often?	☐ Tax-excluded foreign income	$	How often?
☐ Taxable veterans' money	$	How often?	☐ Trusts	$	How often?

☐ Taxable military retirement pay (not paid through the Veterans' Administration) $ ______ How often? ______

☐ Tax refund, credit, or offset of state or local income taxes $ ______ How often? ______

☐ Other income (Specify:) ______ $ ______ How often? ______

Rental Income

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

    Send proof of current rental income, like a written statement from each tenant or a copy of the lease, or a current federal tax return.

    Send proof of all of the following expenses, if applicable, for the last 12 months:
    • mortgage • taxes • utilities (gas/electric) • heat • water/sewer • insurance • condo or co-op fee • repairs and maintenance

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

    10.b. How much monthly rental income do you get from each rental unit from the real estate indicated above? (List each rental unit and address separatley.)

Address	Unit #	Amount $	Owner-Occupied? ☐ Yes ☐ No
Address	Unit #	Amount $	Owner-Occupied? ☐ Yes ☐ No

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

Deductions allowed on federal tax return

All or part of certain expenses can be deducted from income so that you do not pay taxes on them. These amounts are not counted in your income, and may lower the cost of your health coverage.

11. Do you have any of the deductible expenses below? ☐ Yes ☐ No

    If **yes**, please check all of the types you have, fill in the deductible amount, and how often you have this expense.
    Do not include an expense that you already claimed under self-employment income above.

    ☐ Alimony paid $ ______ How often? ______

    ☐ Student loan interest $ ______ How often? ______

Please go to the next page. ▶

☐ Other tax deductions (such as business expenses, IRA contributions, contributions to taxable retirement income, deductible part of self-employment tax, educator expenses, health savings account contributions (deduction), moving expenses, penalty on early withdrawal of savings, self-employment health insurance, self-employment retirement plan, and tuition and other school-related costs)

Type: ______________________ $ ________ How often? ________

Type: ______________________ $ ________ How often? ________

Type: ______________________ $ ________ How often? ________

Total income (Person 1)

12. Do you expect your total income (including earned income and money from other sources) to be the same next year? ☐ Yes ☐ No
(If you are not sure, answer **no** to this question.)
If **no**, what do you expect your total income to be next year? $ ________ (Estimate)

Person 2

(If you have income to report for more than two persons, make a copy of pages 7-9 before you fill them out.)

Name:

1. (Check all that apply.)
☐ Employed (Go to **Current Job 1**.) ☐ Self-employed (Go to **Self-employed income**.) ☐ Not employed (Go to **Money from other sources** section.)

Current Job 1

2. Employer name

Employer address	City	State	Zip code
Employer telephone	Employer Identification Number (EIN—if you know)		

3. Does this job offer health insurance? ☐ Yes ☐ No
If **yes**, check one.
☐ This job offers health insurance now.
☐ This job will offer health insurance, starting ____________ (mm/dd/yyyy).

3.a. If this job offers health insurance now or at a later date, can the health plan cover an employee's spouse or dependent(s)?
☐ Yes List the name(s): ______________________ ☐ No

- How much will the employee pay for the lowest-cost individual health plan? $ ________
  How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
- If an employee joins a program to stop smoking or using tobacco, how much money could he or she save on the monthly premium? $ ________
- Does the health insurance plan(s) offered by the employer meet the "minimum value" standard? ☐ Yes ☐ No

Minimum value means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

3.b. What health insurance changes will this job make for the next year? (if you know)
☐ This job will stop offering health insurance.
☐ This job will start offering health insurance to employees or change the premium for the lowest-cost available plan.

- How much will the employee's premiums be (for an individual plan)? $ ________
  How often? (Check one.) ☐ Weekly ☐ Monthly ☐ Twice a month ☐ Yearly
- Date of change: ____________ (mm/dd/yyyy)

3.c. ☐ No health insurance plans offered by the employer will meet the "minimum value" standard.
Minimum value means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. (The employer or insurance company will know this information.)

Please go to the next page. ►

4. Does this employer have 50 or fewer full-time employees? ☐ Yes ☐ No (If you do not know, answer **no** to this question.)
If **yes**, we may be able to help pay for this coverage.

5. Is this job a sheltered workshop? ☐ Yes ☐ No

6. How much does this person currently earn in gross wages, less pre-tax deductions? $ ____________
   6.a. How often is this person paid? (Check one.) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
   6.b. About how many hours does this person work each WEEK? ____________
   6.c. When did this person begin getting this income? ____________ (mm/dd/yyyy)

7. If this person's income changes during the year (such as seasonal or contract employment), check the months this person has worked or expects to work.
☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

Self-employed Income

8. (Check one.) ☐ Partnership ☐ S-Corporation ☐ Self-employed
   8.a. Business name: ____________
   8.b. What is this person's expected yearly income from this source, less any business expenses?
   (Do not include his or her wages and tips.) $ ____________
   8.c. Date this person began getting this income ____________ (mm/dd/yyyy)

Money from other sources

9. Does this person get money from other sources? ☐ Yes ☐ No
Check all of the sources, give the amount, and how often this person gets it.
(You do not need to tell us about child support, nontaxable veterans' payments, or Supplemental Security Income (SSI).)

Source	Amount	How often?	Source	Amount	How often?
☐ Unemployment	$	How often?	☐ Ordinary or qualified dividend	$	How often?
☐ Pension	$	How often?	☐ Interest	$	How often?
☐ Annuity	$	How often?	☐ Net farming/fishing	$	How often?
☐ Social Security	$	How often?	☐ Royalty	$	How often?
☐ Capital gains	$	How often?	☐ Alimony received	$	How often?
☐ Gambling proceeds	$	How often?	☐ Tax-excluded foreign income	$	How often?
☐ Taxable veterans' money	$	How often?	☐ Trusts	$	How often?

☐ Taxable military retirement pay (not paid through the Veterans' Administration) $ ________ How often? ________
☐ Tax refund, credit, or offset of state or local income taxes $ ________ How often? ________
☐ Other income (Specify:) ____________ $ ________ How often? ________

Rental Income

10. Does Person 2 get rental income? (**You must answer this question.**) ☐ Yes ☐ No
Send proof of current rental income, like a written statement from each tenant or a copy of the lease, or a current federal tax return.
Send proof of all of the following expenses, if applicable, for the last 12 months:
• mortgage • taxes • utilities (gas/electric) • heat • water/sewer • insurance • condo or co-op fee • repairs and maintenance
   10.a. What type of real estate does this person own? ☐ one-family ☐ two-family ☐ three-family ☐ other (describe): ____________
   10.b. How much monthly rental income does this person get from each rental unit from the real estate indicated above? (List each rental unit and address separatley.)

Address	Unit #	Amount	Owner-Occupied?
Address	Unit #	Amount $	Owner-Occupied? ☐ Yes ☐ No
Address	Unit #	Amount $	Owner-Occupied? ☐ Yes ☐ No

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

Deductions allowed on federal tax return

All or part of certain expenses can be deducted from income so that this person does not pay taxes on them. These amounts are not counted in this person's income, and may lower the cost of his or her health coverage.

11. Does this person have any of the deductible expenses below? ☐ Yes ☐ No

If **yes**, please check all of the types he or she has, fill in the deductible amount, and how often this person has this expense.
Do not include an expense that he or she already claimed under self-employment income above.

☐ Alimony paid $ ________ How often? ________

☐ Student loan interest $ ________ How often? ________

☐ Other tax deductions (such as business expenses, IRA contributions, contributions to taxable retirement income, deductible part of self-employment tax, educator expenses, health savings account contributions (deduction), moving expenses, penalty on early withdrawal of savings, self-employment health insurance, self-employment retirement plan, and tuition and other school-related costs)

Type: ________________ $ ________ How often? ________

Type: ________________ $ ________ How often? ________

Type: ________________ $ ________ How often? ________

Total income (Person 2)

12. Do you expect Person 2's total income (including earned income and money from other sources) to be the same next year? ☐ Yes ☐ No
(If you are not sure, answer **no** to this question.)

If **no**, what do you expect Person 2's total income to be next year? $ ________ (Estimate)

PART 4 Previous Medical Bills

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

If **yes**, fill out the rest of this section. We may be able to pay for these bills. If **no**, go to **Part 5: Health Insurance You Have Now**.

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

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

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

PART 5 Health Insurance You Have Now

Please answer the questions below about **health insurance**, and follow the instructions. If someone has enrolled in one of the health insurance plans below, but the benefits have not yet started, check **yes** to the question. MassHealth may be able to help pay premiums.

1. Do you or any household member have Medicare? ☐ Yes ☐ No

If **yes**, fill out **Part A** of **Supplement C: Health Insurance** on page 23.

2. Do you or any household member have federal health insurance provided by the U.S. military (Veterans' Affairs or TRICARE) or other federal coverage? ☐ Yes ☐ No

If **yes**, fill out **Part B** of **Supplement C: Health Insurance** on page 23.

3. Do you or any household member currently have any other type of health insurance? (This includes insurance through an employer, union, college or university, former employer (COBRA), and coverage bought by you or any household member who is not living in the household.) ☐ Yes ☐ No

If **yes**, fill out **Part C** of **Supplement C: Health Insurance** on page 23.

PART 6 Assets

You must fill out all blocks for each asset you and/or your spouse own.

If you live in the community and you want help with medical bills up to three months before the month you apply, you must tell us about any open and closed accounts for that period.

If you are applying for long-term care, you must also give us information about all assets you or your spouse owned in the past 60 months. If you have a spouse at home, you also need to fill out the shaded blocks.

Bank Accounts

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

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

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

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

Send a copy of your passbooks updated within 45 days and/or **a copy** of your current account statements. Please see the Senior Guide for information about financial institutions charging for copies of statements.

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

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

Life Insurance

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

   If **yes**, fill out this section.

   If **no**, go to the next section (Securities (Stocks/Bonds/Other)).

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

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

Securities (Stocks/Bonds/Other)

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

   If **yes**, fill out this section.

   If **no**, go to the next section (Annuities).

Send proof of current value (except cash).

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

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

Annuities

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

   If **yes**, fill out this section. To be eligible, you may be required to name the Commonwealth as a remainder beneficiary. (See the Senior Guide for more information.)

   If **no**, go to the next section (Assisted Living/Other).

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

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

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

Assisted Living/Other

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

   If **yes**, fill out this section.

   If **no**, go to the next section (Real Estate).

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

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

Real Estate

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

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

   If you answered **yes** to any of these questions, fill out this section.

   If **no**, go to the next section (Vehicles/Mobile Homes).

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

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

Vehicles/Mobile Homes

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

   If **yes**, fill out this section.

   If **no**, go to the next section (Prepaid Burial Plans/Trusts).

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

You Type of vehicle	Year/make/model	Fair-market value $	Amount owed $
Your spouse Type of vehicle	Year/make/model	Fair-market value $	Amount owed $

Prepaid Burial Plans/Trusts

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

   If **yes**, fill out this section.

   If **no**, go to the next section (Trusts).

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

You

Burial contract ☐ Yes (amount $) ☐ No	Burial trust ☐ Yes (amount $) ☐ No	Burial plot ☐ Yes ☐ No

Life insurance for burial ☐ Yes (total face value $) ☐ No		Burial-only account ☐ Yes (amount $) ☐ No	
Insurance Company	Policy number	Bank name	Account number

Your spouse

Burial contract ☐ Yes (amount $) ☐ No	Burial trust ☐ Yes (amount $) ☐ No	Burial plot ☐ Yes ☐ No

Life insurance for burial ☐ Yes (total face value $) ☐ No		Burial-only account ☐ Yes (amount $) ☐ No	
Insurance Company	Policy number	Bank name	Account number

Trusts

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

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

   If you answered **yes** to any of these questions, fill out this section.

   If you answered **no** to these questions, go to **Part 7: Fill out this section ONLY....**

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

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

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

PART 7 Fill out this section ONLY if you are a member of a married couple living with your spouse and one spouse is under age 65 and applying and no children under age 19 are living with you.

If this section applies to you and you want more information about income standards and other information that may apply, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled) to get a Member Booklet. If this section does not apply, go to **Part 8: Personal-Care-Attendant Services**.

Breast or Cervical Cancer (optional) (only for persons under 65 years of age)

1. Do you have breast or cervical cancer? ☐ Yes ☐ No
   MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.
   If **yes**, we will send you a certificate to be filled out by your doctor to prove your breast or cervical cancer diagnosis. Then MassHealth can see if your MassHealth benefits give you the most coverage possible.

Name:

HIV Information (optional) (only for persons under 65 years of age)

2. Are you HIV positive? ☐ Yes ☐ No
   If you are HIV positive, you may be eligible for additional coverage or benefits.
   If **yes**, you will need to give us proof of your HIV-positive status. Then MassHealth can see if your MassHealth benefits give you the most coverage possible.

Name:

Disability (only for persons under 65 years of age)

3. Do you have a disability (including a disabling mental health condition) that has lasted or is expected to last for at least 12 months? (If legally blind, answer **yes**.) ☐ Yes ☐ No

Name:

PART 8 Personal-Care-Attendant Services (for people aged 65 or older who are not going into a long-term-care facility)

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

1. Do you or your spouse need the services of a personal-care attendant? ☐ Yes ☐ No
   If **yes**, fill out this section and answer all questions. If **no**, go to **Part 9: Rights and Responsibilities and Signature Page**.
2. Have you or your spouse had the services of a personal-care attendant **paid for by MassHealth** within the last six months? ☐ Yes ☐ No
   If **yes**, go to **Part 9**. If **no**, answer the following questions in this section.
3. Do you or your spouse have a permanent or long-lasting disability? You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No
   - 3.a. If **yes**, does your (or your spouse's) disability keep you (or your spouse) from being able to do your (or your spouse's) daily living activities, like bathing, eating, toileting, dressing, etc., unless someone physically helps you (or your spouse)? You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No
   - 3.b. If **yes**, do you (or your spouse) plan to contact a MassHealth personal-care-management (PCM) agency to ask for personal-care-attendant services? You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No

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

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

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

PART 9 Rights and Responsibilities and Signature Page

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 state regulations for any services that hospitals or community health centers provide to these persons that are paid for by the Health Safety Net.
3. Health coverage premiums must be paid for all persons listed on this application who are applying. Failure to pay any premium due may result in the State deducting the amount owed from the tax refunds of responsible persons. If any person applying is a certain American Indian or Alaska Native, MassHealth premiums may not have to be paid.
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. These 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 a noncustodial 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 property is sold, money from the sale of that property may be required to be used to repay MassHealth for medical services provided.
10. To the extent permitted by law, for any eligible person aged 55 or older, or for any eligible person for whom MassHealth helps pay for care in a nursing home, MassHealth may seek money from the eligible person's estate after death.
11. I understand that annuity transactions, including purchases and selecting or changing payment plans, entered into on or after February 8, 2006, require that certain conditions are met and that I may not be eligible for payment of long-term-care services unless I provide proof that those conditions have been met. I also understand that the Commonwealth of Massachusetts may be required to be named as a remainder beneficiary of annuities for the total amount of medical assistance paid for the institutionalized individual. I further understand that the Commonwealth may not be removed as the beneficiary, and that eligibility may be ended and benefits recovered if the Commonwealth's position as a remainder beneficiary is not maintained.
12. Eligible persons must tell the health care program(s) in which they enroll about any changes in their or their household's assets, 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 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled). A change in information could affect eligibility for these persons or for persons in their household.*
13. MassHealth, the Massachusetts 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 these 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 these persons or members of their household.
14. MassHealth, the Massachusetts Health Connector, and the Health Safety Net may get any records or data about persons listed on this application to document medical services claimed or provided to them. We will keep such information private, and only use and disclose it in accordance with applicable law.

15. MassHealth, the Massachusetts Health Connector, and the Health Safety Net may get records or data 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, to prove any information given on this application and any supplements, or other information once an individual becomes a member, and to support continued eligibility. We will keep all records and data provided to us private, and only use and disclose it in accordance with applicable law.

(For renewal of coverage in future years)

16. MassHealth, the Massachusetts Health Connector, and the Health Safety Net will use income data, including information from federal tax returns, to determine eligibility. To make it easier to check income at renewal time, I may authorize MassHealth, the Massachusetts Health Connector, and the Health Safety Net to use data from federal tax returns to redetermine eligibility in future years. MassHealth, the Massachusetts Health Connector, and the Health Safety Net will use this data to the extent I authorize, and will send me a notice, let me make any changes, and allow me to opt out at any time.

    On behalf of all persons applying for health coverage, I: (Check one.)

    ☐ permit use of the data for the next five years; or

    ☐ permit use of the data for: (Check one.)

    ☐ one year, ☐ two years, ☐ three years, ☐ four years

    ☐ do not permit the use of federal tax data to renew eligibility for help paying for health coverage.

17. MassHealth, the Health Connector, and the Health Safety Net may send notices and share information pertaining to the eligibility, renewal of eligibility or enrollment of persons listed on this application to me and to the other persons listed on this application.
18. If I am acting on behalf of someone in filling out this application and any supplements, I have filled out and sent the enclosed Authorized Representative Designation Form with this application or have such form on record. I understand that my signature on this application and any supplements as an authorized representative certifies that the information on this application and any supplements, including those submitted with this application as well as any other forms or documents that may be submitted to or required by MassHealth, the Health Connector, the Children's Medical Security Plan, or the Health Safety Net, is correct and complete to the best of my knowledge.
19. If I think that MassHealth or the Health Connector has made a mistake in eligibility for me and/or other applicants, I have the right to appeal or file a grievance. If I disagree with the action taken by MassHealth or the Health Connector, I have the right to appeal and ask for a hearing before an impartial hearing officer. I can also ask for a hearing if I did not receive a notice telling me about the action that was taken. To find out how to appeal, please call 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled). I understand that I may be eligible to continue getting benefits while my appeal is being decided. I may have a lawyer or other person represent me, but I may also represent myself. MassHealth or the Health Connector will not pay for anyone to represent me. Additional information about appeals will be provided with any notices I receive, as well as during the appeal process.
20. 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.

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

- Sign on to your account at www.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: 617-887-8770.

I certify under the penalties of perjury that:

- I have read or have had read to me the information on this application, including any supplements and instruction pages, and understand that the Senior Guide contains important information;
- I have permission to submit this application for and receive eligibility and enrollment information about all persons listed on this application and as may be allowed by any legal documents I have submitted with this application;
- I understand my rights and responsibilities and the rights and responsibilities of all persons for whom I am submitting this application, as explained in the rights and responsibilities before this signature page;
- I have told or will tell all persons for whom I am submitting this application about these rights and responsibilities so they also understand their rights and responsibilities;
- I understand and agree that MassHealth and the Health Connector will treat electronic, faxed, telephonic, 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 for whom I am submitting this application; and
- I may be subject to penalties under federal law if I intentionally provide false or untrue information.

X ______________________________ ______________________________ ______________

Signature of Person 1 or authorized representative | Print name | Date

Important: If you are submitting this application as an authorized representative, you must submit an **Authorized Representative Designation Form** to us for us to process this application.

For certified application counselors, navigators, agents, and brokers only.
Fill out this section if you are a certified application counselor, navigator, agent, or broker filling out this application for someone else.

____

First name, middle initial, last name, suffix

____

Organization name

Send the filled-out application to:

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

or

Hand deliver it to:

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

SUPPLEMENT A
Illness, Disability, or Accommodation

Part A

If you answered **yes** to Question 3 in **Part 7** about having an injury, illness, or disability that has lasted or may last for at least 12 months, answer the next three questions.

1. Does this person get money from Social Security for a disability? ☐ Yes ☐ No
   If **yes**, name(s): ______
2. Did this person ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No
   If **yes**, name(s): ______
3. Is this person legally blind? ☐ Yes ☐ No If **yes**, send a copy of the Certificate of Blindness.
   If **yes**, name(s): ______

Part B

If you answered **yes** to Question 17 in **Parts 1 and/or 2** about you or any household member needing reasonable accommodation because of a disability or injury, check all that apply below, and list name(s).

1. **Condition**

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

2. **Accommodation**

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

Part C

If you answered **yes** to Question 18 in **Parts 1 and/or 2** about applying because of an accident or injury that someone else may be responsible for, answer the next two questions.

1. Did someone else cause this person's injury, illness, or disability, or could someone else's insurance or this person's own insurance, other than health insurance (like homeowner's or auto insurance) cover it? ☐ Yes ☐ No
   If **yes**, name the injured person(s): ______
2. Has this person filed a lawsuit, a workers' compensation claim, or an insurance claim for this accident or injury? ☐ Yes ☐ No
   If **yes**, name the injured person(s): ______

SUPPLEMENT B
American Indian (AI)/Alaska Native (AN)

Fill out this supplement if you or any household member is an American Indian or Alaska Native.

American Indians and Alaska Natives who enroll in MassHealth can also get services from the Indian Health Services, 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. To make sure you and your household members get the most help possible, please fill out this supplement.

AI/AN Person 1

Name: First Middle initial Last Suffix

1. Is this person a member of a federally recognized tribe? ☐ Yes ☐ No
   If **yes**, check the box that applies.
   ☐ American Indian/Alaska Native (Mashpee Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))
   ☐ American Indian/Alaska Native (Other Tribal Nation)
2. Did this person ever get 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
   2.a. If **no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
3. Certain money received may not be counted for MassHealth. List the combined income from the following sources, if applicable.

- 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 Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

$ ________ How often? ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other (Explain) ________________

AI/AN Person 2

Name: First Middle initial Last Suffix

1. Is this person a member of a federally recognized tribe? ☐ Yes ☐ No
   If **yes**, check the box that applies.
   ☐ American Indian/Alaska Native (Mashpee Wampanoag) ☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))
   ☐ American Indian/Alaska Native (Other Tribal Nation)
2. Did this person ever get 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
   2.a. If **no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
3. Certain money received may not be counted for MassHealth. List the combined income from the following sources, if applicable.

- 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 Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

$ ________ How often? ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other (Explain) ________________

SUPPLEMENT C
Health Insurance

Part A: Medicare

Fill out this part if any household member answered **yes** to having Medicare in the health insurance part (**Part 5**).

1. Name:	Medicare claim number:	When did coverage start? (mm/dd/yyyy)

1.a. Does this person have a Medicare Part D plan? ☐ Yes ☐ No
If **yes**, when did coverage start? (mm/dd/yyyy) ____________

1.b. Does this person have a Medigap/Medicare supplemental policy? ☐ Yes ☐ No
If **yes**, name of coverage plan: ____________ When did coverage start? (mm/dd/yyyy) ____________

2. Name:	Medicare claim number:	When did coverage start? (mm/dd/yyyy)

2.a. Does this person have a Medicare Part D plan? ☐ Yes ☐ No
If **yes**, when did coverage start? (mm/dd/yyyy) ____________

2.b. Does this person have a Medigap/Medicare supplemental policy? ☐ Yes ☐ No
If **yes**, name of coverage plan: ____________ When did coverage start? (mm/dd/yyyy) ____________

3. Do any of the persons above want to apply for help paying for the Medicare Part B premiums? ☐ Yes ☐ No
If **yes**, name(s):

____

____

Part B: Federal health insurance benefits

Fill out this part if any household member answered **yes** in the health insurance part (**Part 5**) to having federal health insurance provided by the U.S. military (Veterans' Affairs or TRICARE) or other federal coverage.

Name of insurance plan or policy:	Policyholder name:

Names of covered household members:

____

____

Claim/policy number:	When did coverage start? (mm/dd/yyyy)

Part C: Other health insurance

Fill out this part if any household member answered **yes** in the health insurance part (**Part 5**) to having any other type of health insurance.
This includes insurance through an employer, union, college or university, former employer (COBRA), and coverage bought by a household member or parent who is not living in the household.

1. Name of insurance plan or policy:	Policyholder name:	Date of birth: (mm/dd/yyyy)	SSN (if you know):

Names of covered household members:

____

____

Policy number:	Group number (if you know):	When did coverage start? (mm/dd/yyyy)

Go to the next page. ►

Source: (Check one.)

☐ Employer-sponsored (give employer name): ____________ ☐ Union-sponsored (give union name): ____________

☐ College/university ☐ COBRA ☐ Retiree ☐ Coverage provided by someone outside household

☐ Other (Please explain.): ____________

Type of coverage this plan provides: (Check all that apply.)

☐ Doctor's visits and hospitalizations ☐ Vision coverage ☐ Dental coverage ☐ Pharmacy coverage ☐ Catastrophic only

Premium cost: $	Premium frequency: (Check one.) ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

2. Name of insurance plan or policy:	Policyholder name:	Date of birth: (mm/dd/yyyy)	SSN (if you know):

Names of covered household members:

____

____

Policy number:	Group number (if you know):	When did coverage start? (mm/dd/yyyy)

Source: (Check one.)

☐ Employer-sponsored (give employer name): ____________ ☐ Union-sponsored (give union name): ____________

☐ College/university ☐ COBRA ☐ Retiree ☐ Coverage provided by someone outside household

☐ Other (Please explain.): ____________

Type of coverage this plan provides: (Check all that apply.)

☐ Doctor's visits and hospitalizations ☐ Vision coverage ☐ Dental coverage ☐ Pharmacy coverage ☐ Catastrophic only

Premium cost: $	Premium frequency: (Check one.) ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

SUPPLEMENT D
Long-Term-Care Questions

- Do you need long-term-care services in a nursing home type facility? ☐ Yes ☐ No
  If **yes**, you must answer all questions and fill out all sections of this supplement.
- Are you applying for or getting long-term-care services at home under a Home- and Community-Based Services Waiver? ☐ Yes ☐ No
  If **yes**, you only need to fill out the "Resource Transfers" section on pages 27-28.

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

Applicant Information

GAR SMN

Last name	First name	MI	Social security number

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

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

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

Living expenses of the spouse and family members living at home

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

Send proof of your spouse's current living expenses.

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

Rent? $	Mortgage (principal and interest)? $	Homeowner's/tenant's insurance? $	Real estate taxes? $
Required maintenance charge for a condo or co-op? $		Room and board for assisted living? $	

3. Does your spouse pay for heat? ☐ Yes ☐ No
4. Does your spouse pay for utilities? ☐ Yes ☐ No
5. Is a child, parent, brother, and/or sister living with your spouse? ☐ Yes ☐ No
   If **yes**, fill out this section.
   If **no**, go to the next section (Long-Term-Care Insurance).

Send proof of their monthly income before deductions.

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

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

Long-Term-Care Insurance

LIN

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

   If **yes**, fill out this section.

   If **no**, go to the next section (Real Estate).

Send a copy of the policy.

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

Real Estate

ATT

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

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

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

   If **yes**, fill out the following information and answer questions 8 through 15.

   If **no**, answer question 15 only.

Name and address of person(s) on ownership papers	
Description and address of property location	
Type of ownership (Check one.) ☐ Individual ☐ Tenancy in common ☐ Joint tenancy ☐ Life estate	Fair-market value $
Name and address of person(s) on ownership papers	
Description and address of property location	
Type of ownership (Check one.) ☐ Individual ☐ Tenancy in common ☐ Joint tenancy ☐ Life estate	Fair-market value $

8. Do you have a spouse? ☐ Yes ☐ No

   If **yes**, fill out this section.

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

9. Do you have a permanently and totally disabled or blind child? ☐ Yes ☐ No

   If **yes**, fill out this section.

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

10. Do you have a child under 21 years of age? ☐ Yes ☐ No

    If **yes**, fill out this section.

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

11. Do you have a brother or sister with a legal interest in the home who was living in the home for at least one year immediately before your admission to the medical institution? ☐ Yes ☐ No

If **yes**, fill out this section.

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

12. Do you have a son or daughter who has lived in the home for at least the last two years before your admission to the medical institution and has provided care to you that allowed you to live in the home? ☐ Yes ☐ No

If **yes**, fill out this section.

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

13. Do you have a dependent relative? ☐ Yes ☐ No

If **yes**, fill out this section.

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

Describe the relationship and the nature of the dependency:

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

15. Do you or your spouse own or have a legal interest in **other** real estate not listed in #7 above? ☐ Yes ☐ No

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

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

Tax Returns

SUP

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

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

If **yes**, you must **send copies** of these returns. If you did not keep copies of one or more of these returns, **you must send in a filled-out and signed Form 4506**. Form 4506 is included as part of the Long-Term-Care Supplement if you need to use it.

Resource Transfers (resources include both income and assets)

SUP

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

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

Name of facility

Address of facility	Amount $

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

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

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

Name of person

Address

18. In the past 60 months:

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

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

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

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

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

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

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

19. In the past 60 months, has any property that was available or belonged to you or your spouse been transferred into or out of a trust? ☐ Yes ☐ No

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

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

SUPPLEMENT E
Personal-Care-Attendant

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

Applicant information

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

Information about your health problems

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

1.

2.

3.

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

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

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

Caregiver information

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

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

I certify, under penalty of perjury, that the information on this form is correct and complete to the best of my knowledge.

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

X________________________ Signature of applicant or authorized representative

________________________ Print name

____________ Date