



Application for Health Coverage and Help Paying Costs Instructions

Commonwealth of Massachusetts | EOHHS



Please read these instructions before you fill out the application.



Apply faster online! Go to: MAhealthconnector.org. You will get results quickly. You can create a secure online account where you can see copies of notices and get important news fast.

Please read the attached Member Booklet carefully before you fill out the application. Keep the booklet. It may answer questions you have later.

Use this application to apply for subsidized health coverage

This is your application for MassHealth, the Children's Medical Security Plan (CMSP), the Massachusetts Health Connector (Health Connector) plans, and the Health Safety Net (HSN). MassHealth gives health care coverage and helps pay for health insurance premiums for families, children, and individuals.

The Massachusetts Health Connector is the state's marketplace for health and dental insurance. The Health Connector can help you shop for and enroll in insurance plans from leading health insurers in the state. You can also find out through the Health Connector if you are eligible for any programs that help you pay for health insurance premiums and lower your out-of-pocket health care costs. For more information about programs that are available through the Health Connector, see pages 3 and 19-20 in the Member Booklet.

For information about the CMSP or the HSN, see page 18 for CMSP and pages 21-22 for HSN in the Member Booklet.

The kind of health coverage you get depends on your household size, income, and other circumstances. This information helps us make sure everyone gets the best coverage. Fill out all information for each person in your household. After you fill out your application and submit it, we will review it. If you are eligible, you will get the most complete coverage available.

Who can use this application

This application is for people who need health insurance and/or help paying for it, and who:

- live in Massachusetts,
- are not living in or about to go into a nursing home, and
- are under age 65.

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

- parents of children under age 19,
- adult relatives living with and taking care of children under age 19 when neither parent is living in the home, or
- disabled and either:
 - work 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 under age 65).

If this application is not for you, 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).

Tell us about your household

Tell us about all household members who live with you and are applying for health coverage. You must answer all questions and fill out all supplements (if applicable) for each household member who is applying.

Do include

- Yourself
- Your spouse
- Your natural, adoptive, or step children under age 19
- Your unmarried partner if you have children together who are under age 19
- Your unmarried partner's children who live with you and who are under age 19, if you also include your unmarried 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 under 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
- Your parents who you live with and who file their own taxes if they do not claim you as a tax dependent (if you are aged 19 or older)
- Other adult relatives who you do not claim as a tax dependent

Filling out the application

Start with yourself, and then add other adults and children. If you have more than four people in your household including yourself, you will need to make copies of the pages for Person 4 before you fill them out, and attach them to the application.

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 Member Booklet for more information.

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

We will try to prove your information and determine eligibility with matches through federal data sources, such as the Social Security Administration (SSA), the Internal Revenue Service (IRS), the Department of Homeland Security (DHS), and state data sources, such as the Department of Revenue (DOR), the Registry of Motor Vehicles (RMV), and other state-run public programs. If we are not able to prove your information or need more information, we will contact you. We may give you provisional coverage for up to 90 days during the time period that we are waiting for proof of information (other than a determination of disability). See the Member Booklet for more information about disability.

To help us see if you are eligible:

- fill out the application completely,
- be sure to tell us in Part 3 about health insurance you may be able to get through your job,
- fill out the parts of Supplement A that apply, if you answer yes to any questions about injury, illness, disability, accommodation, or applying due to an accident or injury caused by someone else; do not leave any answer blank,
- answer all questions in Part 4 and in Supplement C about any health insurance that you may have now, and
- fill out Supplement B, if you or any household member is an American Indian or Alaska Native.

Remember, you must read, sign, and date the Rights and Responsibilities and Signature pages (Part 6, pages 16-18) after you have filled out the application.

When we get the signed and dated application, we will review it. If we need more information after we complete the data matches, we will contact 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 need medical care and you pay for it before you get an approval notice from us, you may be able to get a refund from your health care provider for what you paid.

To start filling out this application, go to page 1.



You can submit your application 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 your filled-out, signed application to:
Health Insurance Processing Center
P.O. Box 4405
Taunton, MA 02780.
- Fax your filled-out, signed application to:
617-887-8770.
- 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 this application or the information you need to send, please 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).



Application for Health Coverage and Help Paying Costs



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 (Person 1).

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. #	
City			State	Zip code
3. Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> 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 Member Booklet 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 pregnant? Yes No

13.a. If yes, how many children are you expecting? _____ 13.b. What is the due date? (mm/dd/yyyy) _____

23. Do you have breast or cervical cancer? Yes No (Optional)

MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.

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

24. Are you HIV positive? Yes No (Optional) If you are HIV positive, you may be eligible for additional coverage or benefits.

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

25. Did you ever get Supplemental Security Income (SSI)? Yes No

If **no**, go to the next question. If **yes**, answer questions 25.a. and 25.b.

25.a. When did you last get SSI? (mm/yyyy) _____

25.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?

26. 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 _____

27. If you are an American Indian or Alaska Native, fill out **Supplement B: American Indian (AI)/Alaska Native (AN)** on page 20. 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 10.

PART 2 Tell us about other people in this household

Fill out this part for your spouse or partner and children who live 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.

Person 2

1. First name	Middle initial	Last name	Suffix (ex., Jr.)	Relationship to Person 1
2. Home street address			Apt. #	
City			State	Zip code
3. Is Person 2 homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Mailing address (if different from home address)			
City		State	Zip code	5. Telephone number
6. Email address	7. Date of birth (mm/dd/yyyy)	8. Gender <input type="checkbox"/> M <input type="checkbox"/> 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. Please see the application instructions or the Member Booklet 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 pregnant? Yes No

13.a. If **yes**, how many children is she expecting? _____ 13.b. What is the due date? (mm/dd/yyyy) _____

14. Is Person 2 applying for health coverage? Yes No

If **no**, go to **Person 3 or Part 3: Current Job and Income Information** on page 10. If **yes**, answer all questions below for Person 2.

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

16. Does Person 2 live with at least one child under age 19? Yes No

16.a. If **yes**, is Person 2 the main person taking care of this child? Yes No

17. Is Person 2 in jail or prison? Yes No

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

17.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) _____

18. Did Person 2 age out of foster care at the age of 18 or older? Yes No

If **yes**, was this person enrolled in Medicaid when he or she aged out of foster care? Yes No

"Aging out" means the individual was in the custody of a state child welfare agency in any state or of a tribe in any state when he or she turned 18 years of age, or older if the individual decided to stay in placement after age 18.

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

If **yes**, go to Question 20.

19.a. If **no**, does Person 2 have an eligible immigration status? (See the Member Booklet for more information.) Yes No No response

If **no** or **no response**, Person 2 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 20.

19.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 Member Booklet for more information about immigration statuses and documents.)

Immigration status

Status award date* (mm/dd/yyyy)	Immigration document type	Document ID number
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* For battered persons, status award date is date petition was approved as properly filed.

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

19.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.)
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19.e. Is Person 2 an honorably discharged veteran or an active-duty member of the U.S. military? Yes No

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

19.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

20. Does Person 2 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

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

21. 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.

22. 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.

23. Does Person 2 have breast or cervical cancer? Yes No (Optional)

MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.

If no, go to the next question. If yes, we will send a certificate to be filled out by Person 2's doctor to prove his or her breast cancer or her cervical cancer diagnosis. Then MassHealth can see if Person 2's MassHealth benefits give him or her the most coverage possible.

24. Is Person 2 HIV positive? Yes No (Optional)

If Person 2 is HIV positive, he or she may be eligible for additional coverage or benefits.

If no, go to the next question. If yes, Person 2 will need to give us proof of his or her HIV-positive status. Then MassHealth can see if Person 2's MassHealth benefits give him or her the most coverage possible.

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

If no, go to the next question. If yes, answer questions 25.a. and 25.b.

25.a. When did Person 2 last get SSI? (mm/yyyy) _____

25.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?

26. 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

27. If Person 2 is an American Indian or Alaska Native, fill out **Supplement B: American Indian (AI)/Alaska Native (AN)** on page 20. American Indians or Alaska Natives may not have to pay premiums or copayments, and may get special monthly enrollment periods. Continue adding other household members, if needed, or go to **Part 3: Current Job and Income Information** on page 10.

Person 3

1. First name	Middle initial	Last name	Suffix (ex., Jr.)	Relationship to Person 1
2. Home street address			Apt. #	Relationship to Person 2
City			State	Zip code
3. Is Person 3 homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Mailing address (if different from home address)			
City		State	Zip code	5. Telephone number
6. Email address	7. Date of birth (mm/dd/yyyy)	8. Gender <input type="checkbox"/> M <input type="checkbox"/> 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. Please see the application instructions or the Member Booklet for more information.

11. Does Person 3 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 3 file a federal income tax return next year? Yes No

(To get a tax credit, Person 3 must file taxes for the year he or she is requesting benefits. Person 3 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 3 file jointly with a spouse? Yes No If **yes**, name of spouse: _____
(If married, Person 3 must file federal taxes jointly for the year he or she is requesting benefits.)

12.b. Will Person 3 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 3 as a dependent on his or her tax return? Yes No
If **yes**, name of tax filer: _____ How is Person 3 related to the tax filer? _____

13. Is Person 3 pregnant? Yes No

13.a. If **yes**, how many children is she expecting? _____ 13.b. What is the due date? (mm/dd/yyyy) _____

14. Is Person 3 applying for health coverage? Yes No

If **no**, go to **Person 4 or Part 3: Current Job and Income Information** on page 10. If **yes**, answer all questions below for Person 3.

15. Is Person 3 living in Massachusetts and planning to stay? Yes No

16. Does Person 3 live with at least one child under age 19? Yes No

16.a. If **yes**, is Person 3 the main person taking care of this child? Yes No

17. Is Person 3 in jail or prison? Yes No

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

17.a. If **yes**, is Person 3 (Check one):

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

18. Did Person 3 age out of foster care at the age of 18 or older? Yes No

If **yes**, was this person enrolled in Medicaid when he or she aged out of foster care? Yes No

"Aging out" means the individual was in the custody of a state child welfare agency in any state or of a tribe in any state when he or she turned 18 years of age, or older if the individual decided to stay in placement after age 18.

19. Is Person 3 a U.S. citizen, national, or naturalized U.S. citizen? Yes No

If **yes**, go to Question 20.

19.a. If **no**, does Person 3 have an eligible immigration status? (See the Member Booklet for more information.) Yes No No response

If **no** or **no response**, Person 3 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 20.

19.b. If **yes**, does Person 3 have an immigration document? Yes No

We will try to prove Person 3's immigration status. Please list all the immigration statuses and/or conditions that have applied to Person 3 since he or she entered the U.S. (See the Member Booklet for more information about immigration statuses and documents.)

Immigration status

Status award date* (mm/dd/yyyy)	Immigration document type	Document ID number
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* For battered persons, status award date is date petition was approved as properly filed.

19.c. Did Person 3 come to live in the U.S. before August 22, 1996? Yes No

19.d. Did Person 3 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.)

19.e. Is Person 3 an honorably discharged veteran or an active-duty member of the U.S. military? Yes No

19.f. Is Person 3 a spouse or remarried surviving spouse of an immigrant who is an honorably discharged veteran or an active-duty member of the U.S. military? Yes No

19.g. Is Person 3 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

20. Does Person 3 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

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

21. Does Person 3 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.

22. Is Person 3 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.

23. Does Person 3 have breast or cervical cancer? Yes No (Optional)

MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.

If no, go to the next question. If yes, we will send a certificate to be filled out by Person 3's doctor to prove his or her breast cancer or her cervical cancer diagnosis. Then MassHealth can see if Person 3's MassHealth benefits give him or her the most coverage possible.

24. Is Person 3 HIV positive? Yes No (Optional)

If Person 3 is HIV positive, he or she may be eligible for additional coverage or benefits.

If no, go to the next question. If yes, Person 3 will need to give us proof of his or her HIV-positive status. Then MassHealth can see if Person 3's MassHealth benefits give him or her the most coverage possible.

25. Did Person 3 ever get Supplemental Security Income (SSI)? Yes No

If no, go to the next question. If yes, answer questions 25.a. and 25.b.

25.a. When did Person 3 last get SSI? (mm/yyyy) _____

25.b. Does Person 3 (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?

26. Check the box below that best describes Person 3. (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

27. If Person 3 is an American Indian or Alaska Native, fill out **Supplement B: American Indian (AI)/Alaska Native (AN)** on page 20. American Indians or Alaska Natives may not have to pay premiums or copayments, and may get special monthly enrollment periods. Continue adding other household members, if needed, or go to **Part 3: Current Job and Income Information** on page 10.

If you have more than three people to add, make a copy of Person 4's blank information pages (pages 7-9) before you fill them out.

Person 4

1. First name Middle initial Last name	Suffix (ex., Jr.)	Relationship to Person 1	
2. Home street address	Apt. #	Relationship to Person 2	
City	State	Zip code	Relationship to Person 3
3. Is Person 4 homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Mailing address (if different from home address)		

City	State	Zip code	5. Telephone number	
6. Email address	7. Date of birth (mm/dd/yyyy)	8. Gender <input type="checkbox"/> M <input type="checkbox"/> 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. Please see the application instructions or the Member Booklet for more information.

11. Does Person 4 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 4 file a federal income tax return next year? Yes No

(To get a tax credit, Person 4 must file taxes for the year he or she is requesting benefits. Person 4 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 4 file jointly with a spouse? Yes No If **yes**, name of spouse: _____

(If married, Person 4 must file federal taxes jointly for the year he or she is requesting benefits.)

12.b. Will Person 4 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 4 as a dependent on his or her tax return? Yes No

If **yes**, name of tax filer: _____ How is Person 4 related to the tax filer? _____

13. Is Person 4 pregnant? Yes No

13.a. If **yes**, how many children is she expecting? _____ 13.b. What is the due date? (mm/dd/yyyy) _____

14. Is Person 4 applying for health coverage? Yes No

If **no**, go to **Part 3: Current Job and Income Information** on page 10. If **yes**, answer all questions below for Person 4.

15. Is Person 4 living in Massachusetts and planning to stay? Yes No

16. Does Person 4 live with at least one child under age 19? Yes No

16.a. If **yes**, is Person 4 the main person taking care of this child? Yes No

17. Is Person 4 in jail or prison? Yes No

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

17.a. If **yes**, is Person 4 (Check one.):

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

18. Did Person 4 age out of foster care at the age of 18 or older? Yes No

If **yes**, was this person enrolled in Medicaid when he or she aged out of foster care? Yes No

"Aging out" means the individual was in the custody of a state child welfare agency in any state or of a tribe in any state when he or she turned 18 years of age, or older if the individual decided to stay in placement after age 18.

19. Is Person 4 a U.S. citizen, national, or naturalized U.S. citizen? Yes No

If **yes**, go to Question 20.

19.a. If **no**, does Person 4 have an eligible immigration status? (See the Member Booklet for more information.) Yes No No response

If **no** or **no response**, Person 4 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 20.

19.b. If **yes**, does Person 4 have an immigration document? Yes No

We will try to prove Person 4's immigration status. Please list all the immigration statuses and/or conditions that have applied to Person 4 since he or she entered the U.S. (See the Member Booklet 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.

19.c. Did Person 4 come to live in the U.S. before August 22, 1996? Yes No

19.d. Did Person 4 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.)
------------	-------------	-----------	-------------------

19.e. Is Person 4 an honorably discharged veteran or an active-duty member of the U.S. military? Yes No

19.f. Is Person 4 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

19.g. Is Person 4 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

20. Does Person 4 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

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

21. Does Person 4 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.

22. Is Person 4 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.

23. Does Person 4 have breast or cervical cancer? Yes No (Optional)

MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.

If no, go to the next question. If yes, Person 4 will send a certificate to be filled out by Person 4's doctor to prove his or her breast cancer or her cervical cancer diagnosis. Then MassHealth can see if Person 4's MassHealth benefits give him or her the most coverage possible.

24. Is Person 4 HIV positive? Yes No (Optional)

If Person 4 is HIV positive, he or she may be eligible for additional coverage or benefits.

If no, go to the next question. If yes, Person 4 will need to give us proof of his or her HIV-positive status. Then MassHealth can see if Person 4's MassHealth benefits give him or her the most coverage possible.

25. Did Person 4 ever get Supplemental Security Income (SSI)? Yes No

If no, go to the next question. If yes, answer questions 25.a. and 25.b.

25.a. When did Person 4 last get SSI? (mm/yyyy) _____

25.b. Does Person 4 (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?

26. Check the box below that best describes Person 4. (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 _____

27. If Person 4 is an American Indian or Alaska Native, fill out **Supplement B: American Indian (AI)/Alaska Native (AN)** on page 20. American Indians or Alaska Natives may not have to pay premiums or copayments, and may get special monthly enrollment periods. Continue adding other household members, if needed, or go to **Part 3: Current Job and Income Information** on page 10.

PART 3 Current Job and Income Information

We use your income to see if you are eligible for health coverage. See the Member Booklet. 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. For more information, see the Member Booklet for description of 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.a. (Check one.) Partnership S-Corporation Self-employed

8.b. Business name: _____

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

8.d. Date you began getting this income _____ (mm/dd/yyyy)

Current Job 2

(If none, go to Money from other sources section.)

9. Employer name

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

10. 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).

10.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.)

10.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)

10.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.)

11. 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. For more information, see the Member Booklet for description of coverage.

12. Is this job a sheltered workshop? Yes No

13. How much do you currently earn in gross wages, less pre-tax deductions? \$ _____

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

13.b. About how many hours do you work each WEEK? _____

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

14. 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

15. a. (Check one.) Partnership S-Corporation Self-employed

15.b. Business name: _____

15.c. What is your expected yearly income from this source, less any business expenses? (Do not include your wages and tips.) \$ _____

15.d. Date you began getting this income _____ (mm/dd/yyyy)

Money from other sources

16. 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).)

<input type="checkbox"/> Unemployment	\$ _____	How often? _____	<input type="checkbox"/> Ordinary or qualified dividend	\$ _____	How often? _____
<input type="checkbox"/> Pension	\$ _____	How often? _____	<input type="checkbox"/> Trusts	\$ _____	How often? _____
<input type="checkbox"/> Annuity	\$ _____	How often? _____	<input type="checkbox"/> Interest	\$ _____	How often? _____
<input type="checkbox"/> Social Security	\$ _____	How often? _____	<input type="checkbox"/> Net farming/fishing	\$ _____	How often? _____
<input type="checkbox"/> Net rental income	\$ _____	How often? _____	<input type="checkbox"/> Royalty	\$ _____	How often? _____
<input type="checkbox"/> Capital gains	\$ _____	How often? _____	<input type="checkbox"/> Alimony received	\$ _____	How often? _____
<input type="checkbox"/> Gambling proceeds	\$ _____	How often? _____	<input type="checkbox"/> Tax-excluded foreign income	\$ _____	How often? _____
<input type="checkbox"/> Taxable military retirement pay (not paid through the Veterans' Administration) \$ _____ How often? _____					
<input type="checkbox"/> Tax refund, credit, or offset of state or local income taxes \$ _____ How often? _____					
<input type="checkbox"/> Other income (Specify): _____ \$ _____ How often? _____					

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.

17. 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? _____

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)

18. 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 (Second adult)

(If you have income to report for more than two persons, make a copy of pages 12-15 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 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 pay for this coverage. For more information, see the Member Booklet for description of 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 from this job 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.a. (Check one.) Partnership S-Corporation Self-employed

8.b. Business name: _____

8.c. 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.d. Date this person began getting this income _____ (mm/dd/yyyy)

Current Job 2(If none, go to **Money from other sources** section.)

9. Employer name

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

10. Does this job offer health insurance? Yes NoIf **yes**, check one. This job offers health insurance now. This job will offer health insurance, starting _____ (mm/dd/yyyy).

10.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.)

10.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)

10.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.)

11. 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. For more information, see the Member Booklet for description of coverage.12. Is this job a sheltered workshop? Yes No

13. How much does this person currently earn in gross wages, less pre-tax deductions? \$ _____

13.a. How often is this person paid? (Check one.) Weekly Every 2 weeks Twice a month Monthly Yearly

13.b. About how many hours does this person work each WEEK? _____

13.c. When did this person begin getting this income? _____ (mm/dd/yyyy)

14. If this person's income from this job 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**15. a. (Check one.) Partnership S-Corporation Self-employed

15.b. Business name: _____

15.c. What is this person's expected yearly income from this source, less any business expenses?

(Do not include his or her wages and tips.) \$ _____

15.d. Date this person began getting this income _____ (mm/dd/yyyy)

Money from other sources

16. 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).)

<input type="checkbox"/> Unemployment	\$ _____	How often? _____	<input type="checkbox"/> Ordinary or qualified dividend	\$ _____	How often? _____
<input type="checkbox"/> Pension	\$ _____	How often? _____	<input type="checkbox"/> Trusts	\$ _____	How often? _____
<input type="checkbox"/> Annuity	\$ _____	How often? _____	<input type="checkbox"/> Interest	\$ _____	How often? _____
<input type="checkbox"/> Social Security	\$ _____	How often? _____	<input type="checkbox"/> Net farming/fishing	\$ _____	How often? _____
<input type="checkbox"/> Net rental income	\$ _____	How often? _____	<input type="checkbox"/> Royalty	\$ _____	How often? _____
<input type="checkbox"/> Capital gains	\$ _____	How often? _____	<input type="checkbox"/> Alimony received	\$ _____	How often? _____
<input type="checkbox"/> Gambling proceeds	\$ _____	How often? _____	<input type="checkbox"/> Tax-excluded foreign income	\$ _____	How often? _____
<input type="checkbox"/> Taxable military retirement pay (not paid through the Veterans' Administration) \$ _____ How often? _____					
<input type="checkbox"/> Tax refund, credit, or offset of state or local income taxes \$ _____ How often? _____					
<input type="checkbox"/> Other income (Specify): _____ \$ _____ How often? _____					

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.

17. 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.

<input type="checkbox"/> Alimony paid \$ _____	How often? _____	<input type="checkbox"/> Student loan interest \$ _____	How often? _____
<input type="checkbox"/> 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)

18. 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 Health Insurance You Have Now

Please answer the questions below about **health insurance**, and follow the instructions. If you or any household member 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 21.

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 21.

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, or a parent who is not living in the household.)
 Yes No

If **yes**, fill out **Part C of Supplement C: Health Insurance** on page 21.

If you answered **no** to all three questions above, go to **Part 5: Parental Information**.

PART 5 Parental Information

For all children in the household, please answer the following three questions.

1. Was any child in the household adopted by a single parent? Yes No

If **yes**, list child's(ren's) name(s):

2. Does any child in the household have a parent who has died? Yes No

If **yes**, list child's(ren's) name(s):

3. Does any child in the household have a parent who is unknown? Yes No

If **yes**, list child's(ren's) name(s):

If there are any children in the household who have a noncustodial parent (a parent who does not live with the child) **but are not listed above**, give us the following information.

Child's(ren's) name(s):

We will send a form to the child's(ren's) custodial parent to fill out and return to us. This form asks questions about any parents who do not live with the child.

Go to **Part 6: Rights and Responsibilities and Signature Page**.

PART 6 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. 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 1-888-665-9993 (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.*
12. 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.
13. 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.
14. 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)

15. 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.
16. 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.
17. 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.

18. 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.

19. 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 Member Booklet contains important information;
- I have permission to submit this application for and receive eligibility 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:



**Health Insurance Processing Center
P.O. Box 4405
Taunton, MA 02780 or fax to 617-887-8770.**



SUPPLEMENT A

Illness, Disability, or Accommodation



Part A

If you answered **yes** to Question 20 in **Parts 1 and/or 2** about you or any household member 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**, name(s): _____

Part B

If you answered **yes** to Question 21 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 22 in **Parts 1 and/or 2** about you or any household member 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		
<hr/>					
1. Is this person a member of a federally recognized tribe? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes , check the box that applies.					
<input type="checkbox"/> American Indian/Alaska Native (Mashpee Wampanoag) <input type="checkbox"/> American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))					
<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
3. Certain money received may not be counted for MassHealth. List the combined income from the following sources, if applicable.					
<ul style="list-style-type: none">• 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?	<input type="checkbox"/> Weekly	<input type="checkbox"/> Biweekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Other (Explain) _____

AI/AN Person 2

Name: First	Middle initial	Last	Suffix		
<hr/>					
1. Is this person a member of a federally recognized tribe? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes , check the box that applies.					
<input type="checkbox"/> American Indian/Alaska Native (Mashpee Wampanoag) <input type="checkbox"/> American Indian/Alaska Native (Wampanoag Tribe of Gay Head (Aquinnah))					
<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
3. Certain money received may not be counted for MassHealth. List the combined income from the following sources, if applicable.					
<ul style="list-style-type: none">• 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?	<input type="checkbox"/> Weekly	<input type="checkbox"/> Biweekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> 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 4).

1. Name:	Medicare claim number:	When did coverage start? (mm/dd/yyyy)
1.a. Does this person have a Medicare Part D plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , when did coverage start? (mm/dd/yyyy) _____		
1.b. Does this person have a Medigap/Medicare supplemental policy? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , when did coverage start? (mm/dd/yyyy) _____		
2.b. Does this person have a Medigap/Medicare supplemental policy? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 4) 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 4) 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)	

Source: (Check one.)

<input type="checkbox"/> Employer-sponsored (give employer name):	<input type="checkbox"/> Union-sponsored (give union name):
<input type="checkbox"/> College/university <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Coverage provided by someone outside household	
<input type="checkbox"/> Other (Please explain.):	

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

<input type="checkbox"/> Doctor's visits and hospitalizations	<input type="checkbox"/> Vision coverage	<input type="checkbox"/> Dental coverage	<input type="checkbox"/> Pharmacy coverage	<input type="checkbox"/> Catastrophic only
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Premium cost:

\$ 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.)

<input type="checkbox"/> Employer-sponsored (give employer name):	<input type="checkbox"/> Union-sponsored (give union name):
<input type="checkbox"/> College/university <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree <input type="checkbox"/> Coverage provided by someone outside household	
<input type="checkbox"/> Other (Please explain.):	

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

<input type="checkbox"/> Doctor's visits and hospitalizations	<input type="checkbox"/> Vision coverage	<input type="checkbox"/> Dental coverage	<input type="checkbox"/> Pharmacy coverage	<input type="checkbox"/> Catastrophic only
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Premium cost:

\$ Weekly Every two weeks Twice a month Monthly Quarterly Yearly