

# Massachusetts Application for Health and Dental Coverage and Help Paying Costs



## HOW TO APPLY



You can submit your application in any of the following ways.

- **Sign on to your account at [MAhealthconnector.org](http://MAhealthconnector.org).**  
You can create an online account if you do not already have one.  
**Applying online may be a faster way for you to get coverage than mailing a paper application.**
- **Mail** your filled-out, signed application to  
Health Insurance Processing Center  
P.O. Box 4405  
Taunton, MA 02780.
- **Fax** your filled-out, signed application to 1-857-323-8300.
- **Call** the MassHealth Customer Service Center at **1-800-841-2900**  
(TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled)  
or **1-877-MA ENROLL (877-623-6765)**.
- **Visit** a MassHealth Enrollment Center (MEC) to apply in person. See the **Member Booklet for Health and Dental Coverage and Help Paying Costs** for a list of MEC addresses.

## THINGS TO KNOW



**Use this application to see what coverage choices you may qualify for.**

- Low- or no-cost coverage from MassHealth, including the Children's Medical Security Plan (CMSP), the Health Connector, or the Health Safety Net (HSN). You may qualify for a low- or no-cost program, even if you earn as much as \$97,000 a year (for a household of four).
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A tax credit that can help pay your premiums for health coverage right away.
- Certain life events allow you to get coverage during a special enrollment period with the Health Connector, even though open enrollment has ended. See Supplement D for a list of these life events. Please fill out Supplement D if one of these events applies to you or someone on your application. If you are not sure, you should fill out the supplement.



**Who can use this application?**

This application is for people who need health or dental coverage and help paying for it, and who

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

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

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





### Who can use this application? (cont.)

If this application is not for you, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648).

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

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

If someone is helping you fill out this application, you may need to fill out a separate form that gives that person permission to act on your behalf. See the **Authorized Representative Designation Form** at the end of this application.



### What you may need to apply

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



### Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We will keep all the information you provide private and secure, as required by law.** To view the Health Connector's Privacy Policy, go to [MAhealthconnector.org](http://MAhealthconnector.org). To view the MassHealth Privacy Policy see the Member Booklet or go to [www.mass.gov/eohhs/gov/laws-regs/privacy-security/masshealth/member-information/notice-of-privacy-practices.html](http://www.mass.gov/eohhs/gov/laws-regs/privacy-security/masshealth/member-information/notice-of-privacy-practices.html).



### What happens next?

You will get instructions on the next steps to complete your application. If you do not hear from us, visit [MAhealthconnector.org](http://MAhealthconnector.org) or call the MassHealth Customer Service Center at **1-800-841-2900** (TTY: 1-800-497-4648). Filling out this application does not mean you have to buy health coverage.



### Get help with this application

**Phone:** please call the MassHealth Customer Service Center for help with this application or if you need interpreter services.

**The MassHealth Customer Service Center 1-800-841-2900** (TTY: 1-800-497-4648)

### General instructions



- Please **print clearly and answer all questions completely**. There are a few sections where you may be instructed to skip some questions. Other than those exceptions, blank or incomplete answers will slow down the processing of your application.
- You can download pages for additional persons at [www.mass.gov/masshealth](http://www.mass.gov/masshealth). Click on "Apply for MassHealth." Then, under "Applicants 64 Years of Age and Younger and Families," click on "Massachusetts Application for Health and Dental Coverage and Help Paying Costs—Additional Persons." Be sure to tell us how each person is related to each other person. We need this information to determine eligibility.
- Please send **all** pages of your application. For example, include sections for Persons 3 and 4, even if you have not completed them. Otherwise, we cannot tell if your application is missing completed pages.

# Massachusetts Application for Health and Dental Coverage and Help Paying Costs



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

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

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

SSN # (optional if not applying for yourself)

Date of birth

2. Home address

No home address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. County

8. Mailing address  Check if same as home address.

9. Apartment or suite number

10. City

11. State

12. ZIP code

13. County

14. Phone number

15. Other phone number

# of people listed on the application

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

17. What is your e-mail address?

18. Is anyone on this application in prison or jail?  Yes  No

If yes, who? Enter the name here: \_\_\_\_\_

Will this person be released within 30 days of submitting this application?  Yes  No

## STEP 2 Tell us about your household.

### Who do you need to include on this application?

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

#### DO Include

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

### You DO NOT have to include

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

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

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

**STEP 2 Person 1.** (This section is to gather more information about the contact person named on page 1. Please complete this section for that person.)

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

1. First name, middle name, last name, and suffix		2. Relationship to you <b>SELF</b>
3. Date of birth (mm/dd/yyyy)		4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

5. We need a social security number (SSN) 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](http://socialsecurity.gov). Please see the Member Booklet for more information.

Do you have a social security number (SSN)?  Yes  No

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

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

6. Are you planning to file a federal income tax return **NEXT YEAR**? You can still apply for health coverage even if you did not file a federal income tax return. However, you must file a tax return to get help paying for coverage through a tax credit or ConnectorCare plan.

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

a. Are you married?  Yes  No

b. Will you file jointly with a spouse?  Yes  No. You must file a joint federal tax return next year to get a tax credit or ConnectorCare plan. If you are a victim of domestic violence or are an abandoned spouse, you should indicate that you file taxes as “single” in order to be considered for a tax credit even if that is not how you actually file. You will only need to include yourself and any dependents on this application.

If **yes**, list name of spouse. \_\_\_\_\_

c. Will you claim any dependents on your tax return?  Yes  No. You must claim a personal exemption deduction on your 2015 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Health Connector and whose premium for coverage is paid in whole or in part by advance payments.

If **yes**, list name(s) and date(s) of birth of dependents.  
\_\_\_\_\_

d. Will you be claimed as a dependent on someone’s tax return?  Yes  No. If you are claimed by someone else as a dependent on their 2015 federal income tax return, this may affect your ability to receive a premium tax credit. If you are younger than age 21 and claimed by a parent who does not live with you, answer no.

If **yes**, please list the name of the tax filer. \_\_\_\_\_

Date of birth \_\_\_\_\_ How are you related to the tax filer? \_\_\_\_\_

Is the tax filer married, filing a joint return?  Yes  No

Who else does the tax filer claim as dependents?  
\_\_\_\_\_

7. Are you applying for health or dental coverage for **YOURSELF**? (Even if you have coverage, there might be a program with better coverage or lower costs.)

Yes. If **yes**, answer all the questions below.  No. If **no**, go to **Current Job and Income Information** on page 4.

**STEP 2 / Person 1 (continued)**

8. Are you a Massachusetts resident who intends to reside in Massachusetts, even if you do not have a fixed address?  
 Yes  No

9. Are you a U.S. citizen or U.S. national?  Yes  No  
If **yes**, are you a naturalized citizen (not born in the US)?  Yes  No  
Registration number \_\_\_\_\_ Naturalization or citizenship certificate number \_\_\_\_\_

10. If you are a noncitizen, do you have an eligible immigration status? (See the Member Booklet or [MAhealthconnector.org](http://MAhealthconnector.org) for more information.)  Yes  No  No response

If **no** or **no response**, you may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN). It may help us to process this application faster if you include a copy of this person's immigration document with the application. Go to question 11.

a. If **yes**, do you have an immigration document?  Yes  No  
It may help us process your application faster if you include a copy of your immigration document with your application.

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 Member Booklet for more information about immigration statuses and documents.

Immigration status \_\_\_\_\_ Status award date\* (mm/dd/yyyy) \_\_\_\_\_

Immigration document type \_\_\_\_\_ Document ID number \_\_\_\_\_

Alien number \_\_\_\_\_ Passport or document expiration date (mm/dd/yyyy) \_\_\_\_\_

Country \_\_\_\_\_

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

b. Did you arrive in the U.S. after August 22, 1996?  Yes  No

c. Did you use the same name on this application that you did to get your immigration status?  Yes  No  
If **no**, what name did you use?

First name, middle name, last name, and suffix \_\_\_\_\_

d. Are you an honorably discharged veteran or an active-duty member of the U.S. military, or the spouse or child of an honorary discharged veteran or an active-duty member of the US military?  Yes  No

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

Name(s) and date(s) of birth of child(ren) \_\_\_\_\_

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

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

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

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

**STEP 2 / Person 1 (continued)**

15. Are you pregnant?  Yes  No  
a. If **yes**, how many babies are you expecting? \_\_\_\_\_  
b. What is your expected due date? \_\_\_\_\_
16. Were you ever in foster care?  Yes  No  
a. If **yes**, in what state were you in foster care? \_\_\_\_\_  
b. Were you getting health care through a state Medicaid program?  Yes  No
17. Do you have breast or cervical cancer? (Optional)  Yes  No  
MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.
18. Are you HIV positive? (Optional)  Yes  No  
MassHealth has special coverage rules for people who are HIV positive.

**Current Job and Income Information**

If any income in this section is not steady from month to month, please provide the average income for the time period (per week, per month, etc.)

- Employed (Go to question 19.)     Self-employed (Go to question 29.)     Not employed (Go to question 30.)

**CURRENT JOB 1**

19. Employer name and address \_\_\_\_\_
20. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Yearly  
(Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)
21. Average number of hours worked each WEEK \_\_\_\_\_
22. Is this job a sheltered workshop?  Yes  No
23. Are you seasonally employed?  Yes  No. If **yes**, how many months do you work each calendar year? \_\_\_\_\_

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

24. Employer name and address \_\_\_\_\_
25. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Yearly  
(Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)
26. Average number of hours worked each WEEK \_\_\_\_\_
27. Is this job a sheltered workshop?  Yes  No
28. Are you seasonally employed?  Yes  No. If **yes**, how many months do you work each calendar year? \_\_\_\_\_

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

29. Are you self employed?  Yes  No  
a. If **yes**, what type of work do you do? \_\_\_\_\_  
b. On average, how much net income (profits after business expenses are paid) will you get from this self-employment each month? \$ \_\_\_\_\_ per month

**OTHER INCOME**

30. Check all that apply, and give the amount and how often you get it. **NOTE: You do not need to tell us about child support, non-taxable veteran’s payments, or Supplemental Security Income (SSI).**

- None
- Social security benefits \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Unemployment \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Retirement \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Capital gains \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Investment income \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Net rental or royalty income \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Net farming or fishing income \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Alimony received \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Other income \$ \_\_\_\_\_ How often? \_\_\_\_\_ Type \_\_\_\_\_

**DEDUCTIONS**

31. Check all that apply. Give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE:** You should not include a cost that you already considered in your answers to net self-employment income, net rental or royalty income, or net farming or fishing income.

- Alimony paid \$ \_\_\_\_\_ How often? \_\_\_\_\_  Student loan interest \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Other tax deductions (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). **Do not include any type of deduction that is not listed in this section.**  
Type \_\_\_\_\_ \$ \_\_\_\_\_ How often? \_\_\_\_\_

**YEARLY INCOME**

- 32. What is your total expected income for the current calendar year?  
\_\_\_\_\_
- 33. What is your total expected income for next calendar year, if different?  
\_\_\_\_\_

 **THANKS! This is all we need to know about you. Go to Step 2 Person 2 to add another household member, if needed. Otherwise, go to Step 3 American Indian or Alaska Native (AI/AN) Household Member(s).**

## STEP 2 Person 2

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

1. First name, middle name, last name, and suffix		2. Relationship to Person 1
Does this person live with Person 1? <input type="checkbox"/> Yes <input type="checkbox"/> No		If <b>no</b> , list address.
3. Date of birth (mm/dd/yyyy)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
5. We need a social security number (SSN) 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), or go to <a href="http://socialsecurity.gov">socialsecurity.gov</a> . Please see the Member Booklet for more information.		
Does this person have a social security number (SSN)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If <b>yes</b> , give us the number (optional if <b>not</b> applying) _____ - _____ - _____		
If <b>no</b> , check one of the following reasons. <input type="checkbox"/> Just applied <input type="checkbox"/> Noncitizen exception <input type="checkbox"/> Religious exception		
6. Does this person plan to file a federal income tax return <b>NEXT YEAR</b> ? This person can still apply for health coverage even if he or she did not file a federal income tax return. However, this person must file a tax return to get help paying for coverage through a tax credit or ConnectorCare plan.		
<input type="checkbox"/> Yes. If <b>yes</b> , please answer questions a–c. <input type="checkbox"/> No. If <b>no</b> , skip to question d.		
a. Is this person married? <input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Will this person file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No This person must file a joint federal tax return next year to get a tax credit or ConnectorCare plan. If this person is a victim of domestic violence or is an abandoned spouse, this person should indicate that he or she files taxes as “single” to be considered for a tax credit even if that is not how this person actually files. You only need to include this person and any of his or her dependents on this application. If <b>yes</b> , list name of spouse. _____		
c. Will this person claim any dependents on his or her tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No This person must claim a personal exemption deduction on his or her 2015 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Health Connector and whose premium for coverage is paid in whole or in part by advance payments. If <b>yes</b> , list name(s) and date(s) of birth of dependents. _____		
d. Will this person be claimed as a dependent on someone’s tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If this person is claimed by someone else as a dependent on their 2015 federal income tax return, this may affect his or her ability to receive a premium tax credit. (If this person is younger than the age of 21 and claimed by a parent who does not live with him or her, answer no.) If <b>yes</b> , please list the name of the tax filer. _____ Date of birth _____ How is this person related to the tax filer? _____ Is the tax filer married, filing a joint return? <input type="checkbox"/> Yes <input type="checkbox"/> No Who else does the tax filer claim as dependents? _____		

**STEP 2 / Person 2 (continued)**

7. Is this person applying for health or dental coverage? Even if this person has coverage, there might be a program with better coverage or lower costs.

- Yes. If **yes**, answer all the questions below.
- No. If **no**, go to **Current Job and Income Information** on page 8.

8. Is this person a Massachusetts resident who intends to reside in Massachusetts, even if he or she does not have a fixed address?  Yes  No

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

If **yes**, is this person a naturalized citizen (not born in the US)?  Yes  No

Registration number \_\_\_\_\_ Naturalization or citizenship certificate number \_\_\_\_\_

10. If this person is a noncitizen, does this person have an eligible immigration status? (See the Member Booklet or **MAhealthconnector.org** for more information.)  Yes  No  No response

If **no** or **no response**, this person may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children’s Medical Security Plan (CMSP), or the Health Safety Net (HSN). It may help us to process this application faster if you include a copy of this person's immigration document with the application. Go to question 11.

a. If **yes**, does this person have an immigration document?  Yes  No

We will try to prove immigration status for this person. Please list all the immigration statuses and/or conditions that have applied to this person 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 \_\_\_\_\_

Alien number \_\_\_\_\_ Passport or document expiration date (mm/dd/yyyy) \_\_\_\_\_

Country \_\_\_\_\_

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

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

c. Did this person use the same name on this application that this person did to get his or her immigration status?  Yes  No  
If **no**, what name did this person use?

First name, middle name, last name, and suffix \_\_\_\_\_

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

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

Name(s) and date(s) of birth of child(ren) \_\_\_\_\_

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Hispanic, Latino, or Spanish origin                                 | <input type="checkbox"/> Asian Indian              | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> Cuban   | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Mexican, Mexican-American, or Chicano                               | <input type="checkbox"/> Chinese                   | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Puerto Rican  | <input type="checkbox"/> Filipino                  | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Other Hispanic/Latino/Spanish _____                                 | <input type="checkbox"/> Guamanian or Chamorro     | <input type="checkbox"/> White or Caucasian     |
| <input type="checkbox"/> American Indian or Alaska Native (complete step 3 and Supplement B) | <input type="checkbox"/> Japanese                  | <input type="checkbox"/> Other                  |
|  | <input type="checkbox"/> Korean                    |   |
|  | <input type="checkbox"/> Native Hawaiian           |   |

**STEP 2 / Person 2 (continued)**

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

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

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

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

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

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

**Current Job and Income Information**

If any income in this section is not steady from month to month, please provide the average income for the time period (per week, per month, etc.)

Employed (Go to question 19.)  Self-employed (Go to question 29.)  Not employed (Go to question 30.)

**CURRENT JOB 1**

19. Employer name and address

20. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Yearly  
(Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)

21. Average number of hours worked each WEEK \_\_\_\_\_ 22. Is this job a sheltered workshop?  Yes  No

23. Is this person seasonally employed?  Yes  No. If **yes**, how many months does this person work each calendar year? \_\_\_\_

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

24. Employer name and address

25. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Yearly  
(Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)

26. Average number of hours worked each WEEK \_\_\_\_\_ 27. Is this job a sheltered workshop?  Yes  No

28. Is this person seasonally employed?  Yes  No. If **yes**, how many months does this person work each calendar year? \_\_\_\_

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

29. Is this person self employed?  Yes  No  
a. If **yes**, what type of work does this person do? \_\_\_\_\_  
b. On average, how much net income (profits after business expenses are paid) will this person get from this self-employment each **month**? \$ \_\_\_\_\_ per month

**OTHER INCOME**

30. Check all that apply, and give the amount and how often this person gets it. **NOTE: You do not need to tell us about child support, non-taxable veteran's payment, or Supplemental Security Income (SSI).**

- None
- Social security benefits \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Unemployment \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Retirement \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Capital gains \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Investment income \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Net rental or royalty income \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Net farming or fishing income \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Alimony received \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Other income \$ \_\_\_\_\_ How often? \_\_\_\_\_ Type \_\_\_\_\_

**DEDUCTIONS**

31. Check all that apply. Give the amount and how often this person gets it.

If this person pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE: Do not include a cost that you already considered in your answers to net self-employment income, net rental or royalty income, or net farming or fishing income.**

- Alimony paid \$ \_\_\_\_\_ How often? \_\_\_\_\_  Student loan interest \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Other tax deductions (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). **Do not include any type of deduction that is not listed in this section.**
- Type \_\_\_\_\_ \$ \_\_\_\_\_ How often? \_\_\_\_\_

**YEARLY INCOME**

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

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

 **THANKS! This is all we need to know about this person. Go to Step 2 Person 3 to add another household member, if needed. Otherwise, go to Step 3 American Indian or Alaska Native (AI/AN) Household Member(s).**

## STEP 2 Person 3

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

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

2. Relationship to Person 1 \_\_\_\_\_

Relationship to Person 2 \_\_\_\_\_

Does this person live with Person 1?  Yes  No

If no, list address. \_\_\_\_\_

3. Date of birth (mm/dd/yyyy) \_\_\_\_\_

4. Sex  Male  Female

5. We need a social security number (SSN) 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), or go to [socialsecurity.gov](http://socialsecurity.gov). Please see the Member Booklet for more information.

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

If yes, give us the number (optional if not applying) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

6. Does this person plan to file a federal income tax return **NEXT YEAR**? This person can still apply for health coverage even if he or she did not file a federal income tax return. However, this person must file a tax return to get help paying for coverage through a tax credit or ConnectorCare plan.

Yes. If yes, please answer questions a–c.  No. If no, skip to question d.

a. Is this person married?  Yes  No

b. Will this person file jointly with a spouse?  Yes  No

This person must file a joint federal tax return next year to get a tax credit or ConnectorCare plan. If this person is a victim of domestic violence or are is an abandoned spouse, this person should indicate that he or she files taxes as “single” to be considered for a tax credit even if that is not how this person actually files. You only need to include this person and any of his or her dependents on this application.

If yes, list name of spouse. \_\_\_\_\_

c. Will this person claim any dependents on his or her tax return?  Yes  No

This person must claim a personal exemption deduction on his or her 2015 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Health Connector and whose premium for coverage is paid in whole or in part by advance payments.

If yes, list name(s) and date(s) of birth of dependents. \_\_\_\_\_

d. Will this person be claimed as a dependent on someone’s tax return?  Yes  No

If this person is claimed by someone else as a dependent on their 2015 federal income tax return, this may affect his or her ability to receive a premium tax credit. (If this person is younger than the age of 21 and claimed by a parent who does not live with him or her, answer no.)

If yes, please list the name of the tax filer. \_\_\_\_\_

Date of birth \_\_\_\_\_ How is this person related to the tax filer? \_\_\_\_\_

Is the tax filer married, filing a joint return?  Yes  No

Who else does the tax filer claim as dependents? \_\_\_\_\_

**STEP 2 / Person 3 (continued)**

7. Is this person applying for health or dental coverage? Even if this person has coverage, there might be a program with better coverage or lower costs.  
 Yes. If **yes**, answer all the questions below.  
 No. If **no**, go to **Current Job and Income Information** on page 12.

8. Is this person a Massachusetts resident who intends to reside in Massachusetts, even if he or she does not have a fixed address?  Yes  No

9. Is this person a U.S. citizen or U.S. national?  Yes  No  
If **yes**, is this person a naturalized citizen (not born in the US)?  Yes  No  
Registration number \_\_\_\_\_ Naturalization or citizenship certificate number \_\_\_\_\_

10. If this person is a noncitizen, does this person have an eligible immigration status? (See the Member Booklet or [MAhealthconnector.org](http://MAhealthconnector.org) for more information.)  Yes  No  No response

If **no** or **no response**, this person may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children’s Medical Security Plan (CMSP), or the Health Safety Net (HSN). It may help us to process this application faster if you include a copy of this person's immigration document with the application. Go to question 11.

a. If **yes**, does this person have an immigration document?  Yes  No  
We will try to prove immigration status for this person. Please list all the immigration statuses and/or conditions that have applied to this person 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 \_\_\_\_\_  
Alien number \_\_\_\_\_ Passport or document expiration date (mm/dd/yyyy) \_\_\_\_\_  
Country \_\_\_\_\_

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

b. Did this person arrive in the U.S. after August 22, 1996?  Yes  No  
c. Did this person use the same name on this application that this person did to get his or her immigration status?  Yes  No  
If **no**, what name did this person use?

First name, middle name, last name, and suffix \_\_\_\_\_

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

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

Name(s) and date(s) of birth of child(ren) \_\_\_\_\_

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Hispanic, Latino, or Spanish origin                                 | <input type="checkbox"/> Asian Indian              | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> Cuban   | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Mexican, Mexican-American, or Chicano                               | <input type="checkbox"/> Chinese                   | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Puerto Rican  | <input type="checkbox"/> Filipino                  | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Other Hispanic/Latino/Spanish _____                                 | <input type="checkbox"/> Guamanian or Chamorro     | <input type="checkbox"/> White or Caucasian     |
| <input type="checkbox"/> American Indian or Alaska Native (complete step 3 and Supplement B) | <input type="checkbox"/> Japanese                  | <input type="checkbox"/> Other                  |
|  | <input type="checkbox"/> Korean                    |   |
|  | <input type="checkbox"/> Native Hawaiian           |   |

**STEP 2 / Person 3 (continued)**

13. Does this person have an injury, illness, or disability (including a disabling mental health condition) that has lasted or is expected to last for at least 12 months? If legally blind, answer yes.  Yes  No
14. Does this person need reasonable accommodation because of a disability or an injury?  Yes  No  
If **yes**, complete the rest of this application, including Supplement C: Accommodation.
15. Is this person pregnant?  Yes  No  
a. If **yes**, how many babies is she expecting? \_\_\_\_\_  
b. What is the expected due date? \_\_\_\_\_
16. Was this person ever in foster care?  Yes  No  
a. If **yes**, in what state was this person in foster care? \_\_\_\_\_  
b. Was this person getting health care through a state Medicaid program?  Yes  No
17. Does this person have breast or cervical cancer? (Optional)  Yes  No  
MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.
18. Is this person HIV positive? (Optional)  Yes  No  
MassHealth has special coverage rules for people who are HIV positive.

**Current Job and Income Information**

If any income in this section is not steady from month to month, please provide the average income for the time period (per week, per month, etc.)

- Employed (Go to question 19.)     Self-employed (Go to question 29.)     Not employed (Go to question 30.)

**CURRENT JOB 1**

19. Employer name and address \_\_\_\_\_
20. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Yearly  
(Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)
21. Average number of hours worked each WEEK \_\_\_\_\_
22. Is this job a sheltered workshop?  Yes  No
23. Is this person seasonally employed?  Yes  No. If **yes**, how many months does this person work each calendar year? \_\_\_\_\_

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

24. Employer name and address \_\_\_\_\_
25. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Yearly  
(Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)
26. Average number of hours worked each WEEK \_\_\_\_\_
27. Is this job a sheltered workshop?  Yes  No
28. Is this person seasonally employed?  Yes  No. If **yes**, how many months does this person work each calendar year? \_\_\_\_\_

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

29. Is this person self employed?  Yes  No  
a. If **yes**, what type of work does this person do? \_\_\_\_\_  
b. On average, how much net income (profits after business expenses are paid) will this person get from this self-employment each month? \$ \_\_\_\_\_ per month

**OTHER INCOME**

30. Check all that apply, and give the amount and how often this person gets it. **NOTE: You do not need to tell us about child support, non-taxable veteran's payment, or Supplemental Security Income (SSI).**

- None
- Social security benefits \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Unemployment \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Retirement \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Capital gains \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Investment income \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Net rental or royalty income \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Net farming or fishing income \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Alimony received \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Other income \$ \_\_\_\_\_ How often? \_\_\_\_\_ Type \_\_\_\_\_

**DEDUCTIONS**

31. Check all that apply. Give the amount and how often this person gets it.

If this person pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE: Do not include a cost that you already considered in your answers to net self-employment income, net rental or royalty income, or net farming or fishing income.**

- Alimony paid \$ \_\_\_\_\_ How often? \_\_\_\_\_  Student loan interest \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Other tax deductions (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). **Do not include any type of deduction that is not listed in this section.**
- Type \_\_\_\_\_ \$ \_\_\_\_\_ How often? \_\_\_\_\_

**YEARLY INCOME**

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

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

 **THANKS! This is all we need to know about this person. Go to Step 2 Person 4 to add another household member, if needed. Otherwise, go to Step 3 American Indian or Alaska Native (AI/AN) Household Member(s).**

## Step 2 Person 4 (If more than 4 People, this is Person \_\_\_\_\_ )

If you have to include more than four people on this application, make a copy of blank information pages for Step 2 Person 4 BEFORE you fill them out. When filling out the additional pages please be sure to tell us how each person is related to each other person on the application. We need this information to determine eligibility.

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

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

2. Relationship to Person 1 \_\_\_\_\_

Relationship to Person 2 \_\_\_\_\_

Relationship to Person 3 \_\_\_\_\_

Does this person live with Person 1?  Yes  No

If no, list address. \_\_\_\_\_

3. Date of birth (mm/dd/yyyy) \_\_\_\_\_

4. Sex  Male  Female

5. We need a social security number (SSN) 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), or go to [socialsecurity.gov](http://socialsecurity.gov). Please see the Member Booklet for more information.

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

If yes, give us the number (optional if not applying) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

6. Does this person plan to file a federal income tax return **NEXT YEAR**? This person can still apply for health coverage even if he or she did not file a federal income tax return. However, this person must file a tax return to get help paying for coverage through a tax credit or ConnectorCare plan.

Yes. If yes, please answer questions a–c.  No. If no, skip to question d.

a. Is this person married?  Yes  No

b. Will this person file jointly with a spouse?  Yes  No

This person must file a joint federal tax return next year to get a tax credit or ConnectorCare plan. If this person is a victim of domestic violence or is an abandoned spouse, this person should indicate that he or she files taxes as “single” to be considered for a tax credit even if that is not how this person actually files. You only need to include this person and any of his or her dependents on this application.

If yes, list name of spouse. \_\_\_\_\_

c. Will this person claim any dependents on his or her tax return?  Yes  No

This person must claim a personal exemption deduction on his or her 2015 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Health Connector and whose premium for coverage is paid in whole or in part by advance payments.

If yes, list name(s) and date(s) of birth of dependents. \_\_\_\_\_

d. Will this person be claimed as a dependent on someone’s tax return?  Yes  No

If this person is claimed by someone else as a dependent on their 2015 federal income tax return, this may affect his or her ability to receive a premium tax credit. (If this person is younger than the age of 21 and claimed by a parent who does not live with him or her, answer no.)

If yes, please list the name of the tax filer. \_\_\_\_\_

Date of birth \_\_\_\_\_ How is this person related to the tax filer? \_\_\_\_\_

Is the tax filer married, filing a joint return?  Yes  No

Who else does the tax filer claim as dependents? \_\_\_\_\_

**STEP 2 / Person 4 (continued)**

7. Is this person applying for health or dental coverage? Even if this person has coverage, there might be a program with better coverage or lower costs.
- Yes. If **yes**, answer all the questions below.
- No. If **no**, go to **Current Job and Income Information** on page 16.

8. Is this person a Massachusetts resident who intends to reside in Massachusetts, even if he or she does not have a fixed address?  Yes  No

9. Is this person a U.S. citizen or U.S. national?  Yes  No
- If **yes**, is this person a naturalized citizen (not born in the US)?  Yes  No
- Registration number \_\_\_\_\_ Naturalization or citizenship certificate number \_\_\_\_\_

10. If this person is a noncitizen, does this person have an eligible immigration status? (See the Member Booklet or [MAhealthconnector.org](http://MAhealthconnector.org) for more information.)  Yes  No  No response

If **no** or **no response**, this person may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children’s Medical Security Plan (CMSP), or the Health Safety Net (HSN). It may help us to process this application faster if you include a copy of this person's immigration document with the application. Go to question 11.

- a. If **yes**, does this person have an immigration document?  Yes  No
- We will try to prove immigration status for this person. Please list all the immigration statuses and/or conditions that have applied to this person 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 \_\_\_\_\_
- Alien number \_\_\_\_\_ Passport or document expiration date (mm/dd/yyyy) \_\_\_\_\_
- Country \_\_\_\_\_

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

- b. Did this person arrive in the U.S. after August 22, 1996?  Yes  No
- c. Did this person use the same name on this application that this person did to get his or her immigration status?  Yes  No
- If **no**, what name did this person use?
- First name, middle name, last name, and suffix \_\_\_\_\_
- d. Is this person an honorably discharged veteran or an active-duty member of the U.S. military, or the spouse or child of an honorary discharged veteran or an active-duty member of the US military?  Yes  No

11. Does this person live with at least one child younger than the age of 19, and is this person the main person taking care of this child(ren)?  Yes  No
- Name(s) and date(s) of birth of child(ren) \_\_\_\_\_

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Hispanic, Latino, or Spanish origin                                 | <input type="checkbox"/> Asian Indian              | <input type="checkbox"/> Other Asian            |
| <input type="checkbox"/> Cuban   | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Mexican, Mexican-American, or Chicano                               | <input type="checkbox"/> Chinese                   | <input type="checkbox"/> Samoan                 |
| <input type="checkbox"/> Puerto Rican  | <input type="checkbox"/> Filipino                  | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Other Hispanic/Latino/Spanish _____                                 | <input type="checkbox"/> Guamanian or Chamorro     | <input type="checkbox"/> White or Caucasian     |
| <input type="checkbox"/> American Indian or Alaska Native (complete step 3 and Supplement B) | <input type="checkbox"/> Japanese                  | <input type="checkbox"/> Other                  |
|  | <input type="checkbox"/> Korean                    |   |
|  | <input type="checkbox"/> Native Hawaiian           |   |

**STEP 2 / Person 4 (continued)**

13. Does this person have an injury, illness, or disability (including a disabling mental health condition) that has lasted or is expected to last for at least 12 months? If legally blind, answer yes.  Yes  No
- 
14. Does this person need reasonable accommodation because of a disability or an injury?  Yes  No  
If **yes**, complete the rest of this application, including Supplement C: Accommodation.
- 
15. Is this person pregnant?  Yes  No  
a. If **yes**, how many babies is she expecting? \_\_\_\_\_  
b. What is the expected due date? \_\_\_\_\_
- 
16. Was this person ever in foster care?  Yes  No  
a. If **yes**, in what state was this person in foster care? \_\_\_\_\_  
b. Was this person getting health care through a state Medicaid program?  Yes  No
- 
17. Does this person have breast or cervical cancer? (Optional)  Yes  No  
MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.
- 
18. Is this person HIV positive? (Optional)  Yes  No  
MassHealth has special coverage rules for people who are HIV positive.
- 

**Current Job and Income Information**

If any income in this section is not steady from month to month, please provide the average income for the time period (per week, per month, etc.)

- Employed (Go to question 19.)  Self-employed (Go to question 29.)  Not employed (Go to question 30.)

**CURRENT JOB 1**

19. Employer name and address \_\_\_\_\_
- 
20. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Yearly  
(Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)
- 
21. Average number of hours worked each WEEK \_\_\_\_\_ 22. Is this job a sheltered workshop?  Yes  No
- 
23. Is this person seasonally employed?  Yes  No. If **yes**, how many months does this person work each calendar year? \_\_\_\_\_

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

24. Employer name and address \_\_\_\_\_
- 
25. Wages/tips (before taxes) \$ \_\_\_\_\_  Weekly  Every 2 weeks  Twice a month  Monthly  Yearly  
(Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)
- 
26. Average number of hours worked each WEEK \_\_\_\_\_ 27. Is this job a sheltered workshop?  Yes  No
- 
28. Is this person seasonally employed?  Yes  No. If **yes**, how many months does this person work each calendar year? \_\_\_\_\_

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

29. Is this person self employed?  Yes  No  
a. If **yes**, what type of work does this person do? \_\_\_\_\_  
b. On average, how much net income (profits after business expenses are paid) will this person get from this self-employment each month? \$ \_\_\_\_\_ per month

**OTHER INCOME**

30. Check all that apply, and give the amount and how often this person gets it. **NOTE: You do not need to tell us about child support, non-taxable veteran's payment, or Supplemental Security Income (SSI).**

- None
- Social security benefits \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Unemployment \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Retirement \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Capital gains \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Investment income \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Net rental or royalty income \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Net farming or fishing income \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Alimony received \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Other income \$ \_\_\_\_\_ How often? \_\_\_\_\_ Type \_\_\_\_\_

**DEDUCTIONS**

31. Check all that apply. Give the amount and how often this person gets it.

If this person pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. **NOTE: Do not include a cost that you already considered in your answers to net self-employment income, net rental or royalty income, or net farming or fishing income.**

- Alimony paid \$ \_\_\_\_\_ How often? \_\_\_\_\_  Student loan interest \$ \_\_\_\_\_ How often? \_\_\_\_\_
- Other tax deductions (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). **Do not include any type of deduction that is not listed in this section.**
- Type \_\_\_\_\_ \$ \_\_\_\_\_ How often? \_\_\_\_\_

**YEARLY INCOME**

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

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



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

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

1. Are you or is anyone in your household an American Indian or Alaska Native?

- No. If **no**, skip to Step 4.
- Yes. If **yes**, complete the rest of this application, including Supplement B.

Name(s) of person(s) \_\_\_\_\_

American Indians and Alaska Natives who enroll in health coverage can also get services from the Indian Health Service, tribal health programs, or Urban Indian Health Programs. If you or any household members are American Indians or Alaska Natives, you may not have to pay premiums or copayments, and may get special monthly enrollment periods.

## STEP 4 Your Household's Health Coverage

Complete Question 1 about health coverage that any person in the household **has now**. Complete Question 2 about health insurance **available** to a household member from a job, whether or not the employed person lives in the household.

1. Is anyone **enrolled** now in any of the following types of health coverage?  Yes  No

If **yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have.

**Medicare.**

Name(s) of person(s) covered \_\_\_\_\_

**TRICARE** (Do not check if you have direct care or Line of Duty.)

Name(s) of person(s) covered \_\_\_\_\_

**VA health care programs**

Name(s) of person(s) covered \_\_\_\_\_

**Peace Corps**

Name(s) of person(s) covered \_\_\_\_\_

**Employer insurance**

Name(s) of person(s) covered \_\_\_\_\_

Name of health insurance \_\_\_\_\_ Policy number \_\_\_\_\_

Is this COBRA coverage?  Yes  No

Is this a retiree health plan?  Yes  No

**Other coverage**

Name(s) of person(s) covered \_\_\_\_\_

Name(s) of health insurance \_\_\_\_\_ Policy number \_\_\_\_\_

Is this a limited-benefit plan (like a school accident policy)?  Yes  No

2. Is anyone listed on this application offered health coverage from a job but not enrolled in it? This includes a job for a household member or an individual who is not in the household, such as a non-custodial parent. This question is about coverage that is **available** but in which eligible household members are **not enrolled**.

Yes. If **yes**, you will need to complete and include Supplement A: Health Coverage from Jobs, and the rest of this application.

Is this a state employee benefit plan?  Yes  No

No. If **no**, continue to Step 5.

## STEP 5 Parental Information

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

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

If **yes**, name(s) of child(ren) \_\_\_\_\_

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

If **yes**, name(s) of child(ren) \_\_\_\_\_

3. Does any child have a parent whose identity is unknown?  Yes  No

If **yes**, name(s) of child(ren) \_\_\_\_\_

4. Does any child have a parent who does not live with the child and who is not included in the previous questions?  Yes  No

If **yes**, name(s) of child(ren) \_\_\_\_\_

## STEP 6 Read and sign this application.

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

1. MassHealth may require eligible persons to enroll in available employer-sponsored health insurance if that insurance meets the criteria for MassHealth payment of premium assistance.
2. Employers of eligible persons may be notified and billed in accordance with MassHealth regulations for any services that hospitals or community health centers provide to such persons that are paid for by the Health Safety Net.
3. Eligible persons may have to pay a premium for health coverage for themselves and others listed on this application. Failure to pay any premium due may result in the state deducting the amount owed from the tax refunds of responsible persons. If an eligible person is a certain American Indian or Alaska Native, such person may not have to pay premiums for MassHealth.
4. MassHealth has the right to pursue and get money from third parties who may be obligated to pay for health services provided to eligible persons enrolled in MassHealth programs. Such third parties may include other health insurers, spouses, or parents obligated to pay for medical support, or individuals obligated to pay under accident settlements. Eligible persons must cooperate with MassHealth in establishing third-party support and obtaining third-party payments for themselves and anyone whose rights they can legally assign. Eligible persons may be exempted from this obligation if they believe and tell MassHealth that cooperation could result in harm to them or anyone whose rights they can legally assign.
5. A parent and/or guardian of minor children must agree to cooperate with state efforts to collect medical support from an absent parent unless they believe and tell MassHealth that cooperation will harm the children or the parent or guardian.
6. Eligible persons who are injured in an accident, or in some other way, and get money from a third party because of that accident or injury must use that money to repay MassHealth or the Health Safety Net for certain services provided.
7. Eligible persons must tell MassHealth or the Health Safety Net, in writing, within 10 calendar days, or as soon as possible, about any insurance claims or lawsuits filed because of an accident or injury.
8. The status of this application may be shared with a hospital, community health center, other medical provider, or federal or state agencies when necessary for treatment, payment, operations, or the administration of the programs listed above.
9. To the extent permitted by law, MassHealth may place a lien against any real estate owned by eligible persons or in which eligible persons have a legal interest. If MassHealth puts a lien against such property and it is sold, money from the sale of that property may be used to repay MassHealth for medical services provided.
10. To the extent permitted by law, for any eligible person age 55 or older, or 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. MassHealth, the Health Connector, and the Health Safety Net will obtain from eligible persons' current and former employers and health insurers all information about health insurance coverage for such persons. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to such persons or members of their household.
12. MassHealth, the Health Connector, and the Health Safety Net may get records or data about persons listed on this application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Revenue, and the Registry of Motor Vehicles, as well as private data sources, 1) to prove any information given on this application and any supplements, or other information given once a person becomes a member, 2) to document medical services claimed or provided to such persons, and 3) to support continued eligibility.
13. To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health Connector to use income data, including information from tax returns for the next coverage year (2016). The Health Connector will send me a notice, let me make changes, and I can opt out at any time. I understand that if I am eligible for an Advance Premium Tax Credit (APTC) and/or Reduced Copays and Deductibles these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or Reduced Copays and Deductibles may impact my 2015 tax liability. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.
14. In connection with the eligibility and enrollment process, MassHealth, the Health Connector, and the Health Safety Net may send notices that contain personal information about persons listed on this application to other persons on this application, or otherwise communicate such information to such persons.
15. Under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by going to [www.hhs.gov/ocr/office/file](http://www.hhs.gov/ocr/office/file).
16. Eligible persons must tell the health care program(s) in which they enroll about any changes in their or their household's income or employment, household size, health insurance coverage, health insurance premiums, and immigration status, or about changes in any other information on this application and any supplements to it within 10 calendar days of learning of the change. Eligible persons can make changes by calling **1-888-665-9993** (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled). A change in information could affect eligibility for such persons or for persons in their household.

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

- Sign on to your account at **MAhealthconnector.org**.  
You can create an online account if you do not already have one.
- Send the change information to **Health Insurance Processing Center  
P.O. Box 4405  
Taunton, MA 02780.**
- Fax the change information to **1-857-323-8300**.

17. No one applying for health coverage on this application is in prison or in jail except as set forth below. If someone applying for health coverage is in prison or jail, write their name below and answer the following three questions.

\_\_\_\_\_ is in prison or jail.

Is this person awaiting trial?  Yes  No

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

Is this person an inmate who will be admitted to a hospital for at least 24 hours and then returned to prison or jail?  Yes  No

**I AGREE TO THE FOLLOWING STATEMENTS.**

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

**Sign this application.**

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

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

**Signature of Person 1 or authorized representative**

Print name	Date
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## For enrollment assisters only

Complete this section if you are an enrollment assister and filling out this application for someone else. Navigators must fill out a Navigator Designation Form if they have not done so already. Certified Application Counselors must fill out a Certified Application Counselor Designation Form if they have not done so already.

Date (mm/dd/yyyy)	Check one <input type="checkbox"/> Navigator <input type="checkbox"/> Certified Application Counselor
First name, middle name, last name and suffix	
Organization name	Organization identification number

## STEP 7 Send us your completed application.

Mail your signed application to:

**Health Insurance Processing Center  
PO Box 4405  
Taunton, MA 02780; or**

Fax to:

**1-857-323-8300**

### Voter Registration

The form to register to vote is included with this application or can be found at [www.sec.state.ma.us](http://www.sec.state.ma.us). More information on how to register to vote can also be found at [www.sec.state.ma.us](http://www.sec.state.ma.us). If you have any questions about the voter registration process, or if you need help filling out the form, please visit a local MassHealth Enrollment Center or call the MassHealth Customer Service Center at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, with your right to privacy in deciding to register or in applying to register to vote, or with your right to choose your own political party or other political preference, you may file a complaint with:

**Secretary of the Commonwealth, Elections Division  
One Ashburton Place  
Room 1705  
Boston, MA 02108**

**Tel: 617-727-2828 or 1-800-462-8683.**

If you or anyone else in your application are not registered to vote where you live now, would you like to apply to register to vote today?  Yes  No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.





You DO NOT need to answer these questions unless someone in the household is eligible for health coverage from a job, but is **not enrolled in the coverage**. Attach a copy of this page for each job that offers coverage. If all eligible household members are **enrolled** in coverage offered by an employer, make sure that **Step 4, question 2** is complete, and skip this supplement.

**Tell us about the job that offers coverage.**

**EMPLOYEE Information**

1. Employee name (first, middle, last ) _____	2. Employee social security number ____-____-____
--	--

**EMPLOYER Information**

3. Employer name _____	4. Employer identification number (if known) ____-____-____
5. Employer address _____	6. Employer phone number (     )
7. City _____	8. State     9. ZIP code

10. Who can we contact about employee health coverage at this job?  
\_\_\_\_\_

11. Phone number (if different from above) _____	12. E-mail address _____
---	-----------------------------

13. **Is this person currently eligible for coverage offered by this employer, or will this person become eligible within the next 3 months?**

**Yes** (continue)     **No** (Stop here and skip the rest of Supplement A.)

a. If this person is in a waiting or probationary period, when can this person enroll in coverage? (mm/dd/yyyy) \_\_\_\_\_

List the names of anyone else on this application who is eligible for coverage from this job.

Name \_\_\_\_\_ Name \_\_\_\_\_ Name \_\_\_\_\_

**Tell us about the health plan offered by this employer.**

14. Does the employer offer a health plan that meets the minimum value standard\*?  Yes  No

15. a. What is the name of the lowest cost self-only health plan offered to the employee? \_\_\_\_\_

b. Is the lowest cost plan that meets the minimum value standard\* that is offered to the employee affordable as defined by the Affordable Care Act?  Yes  No

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

16. What change will the employer make for the new plan year (if known)?

Employer will not offer health coverage.

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.\* (Premium should reflect the discount for wellness programs.)

a. How much would the employee have to pay in premiums for this plan? \$ \_\_\_\_\_

b. How often?  Weekly  Every 2 weeks  Twice a month  Once a month  Quarterly  Yearly

Date of change (mm/dd/yyyy) \_\_\_\_\_

\*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).



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

**Tell us about your American Indian or Alaska Native household member(s).**

American Indians and Alaska Natives can get services from the Indian Health Service, tribal health programs, or Urban Indian Health Programs. They also may not have to pay premiums or copayments and may get special monthly enrollment periods. Answer the following questions to make sure your household gets the most help possible.

**NOTE:** If you have more people to include, make a copy of this page and attach it.

**AI/AN Person 1**

- 
1. Name (first, middle, last) \_\_\_\_\_
  
  2. Member of a federally recognized tribe?  
 Yes  No  
**If yes,** tribe name and state affiliation \_\_\_\_\_
  
  3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs?  
 Yes  No  
**If no,** is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Programs, or through a referral from one of these programs?  
 Yes  No
  
  4. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from
    - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;
    - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations); or
    - Money from selling things that have cultural significance.
 \$ \_\_\_\_\_ How often? \_\_\_\_\_

**AI/AN Person 2**

- 
1. Name (first, middle, last) \_\_\_\_\_
  
  2. Member of a federally recognized tribe?  
 Yes  No  
**If yes,** tribe name and state affiliation \_\_\_\_\_
  
  3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs?  
 Yes  No  
**If no,** is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Programs, or through a referral from one of these programs?  
 Yes  No
  
  4. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from
    - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;
    - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations); or
    - Money from selling things that have cultural significance.
 \$ \_\_\_\_\_ How often? \_\_\_\_\_

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

1. Condition

- 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 (ASL) 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): \_\_\_\_\_



You must complete and submit an application for health insurance along with this form. Do not submit this form by itself.

- Complete this form if anyone on this application needs to get health insurance after the open enrollment period has ended.
- Certain life events allow you to get coverage during a special enrollment period with the Health Connector, even though the open enrollment has ended.
- You can enroll any time of year without one of the life events below if
  - you qualify for MassHealth;
  - you now qualify for a ConnectorCare plan through the Health Connector after not qualifying in the past, or after applying for the first time; or
  - you are a member of a federally recognized tribe or you are an Alaska Native shareholder.
- If you have not had any of the life events below, you do not have to fill out this form.

**Life events: Tell us about any of the following changes in your household.**

1. Someone lost health coverage within the last 60 days, or expects to lose it within the next 60 days

Name(s) \_\_\_\_\_

Date coverage ended or will end (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Check one:  Check here if coverage ended because of not paying premiums  
 Check here if coverage ended because you chose to cancel coverage

2. Someone added a household member because of a marriage within the last 60 days.

Name(s) \_\_\_\_\_

Date of marriage (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

3. Someone was born, adopted, or placed in foster or court order care within the last 60 days.

Name(s) \_\_\_\_\_

Date of birth, adoption, foster care, or court order care (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

4. Someone gained an eligible immigration status within the last 60 days.

Name(s) \_\_\_\_\_

Date that status was awarded (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

5. Someone in the household had a divorce, annulment, or legal separation within the last 60 days.

Name(s) \_\_\_\_\_

Date of divorce, annulment, separation (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

6. There was a death in the household within the last 60 days

Name(s) \_\_\_\_\_

Date of death (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

7. Someone moved to Massachusetts within the last 60 days, or expects to move to Massachusetts within the next 60 days.

Name(s) \_\_\_\_\_

Date of move (mm/dd/yyyy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Visit [MAhealthconnector.org](http://MAhealthconnector.org) or call 1-877 MA ENROLL (1-877-623-6765) or  
 TTY: 1-877-623-7773, Monday through Friday, 8:00 a.m. to 6:00 p.m.

# Authorized Representative Designation Form



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

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

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

## You can choose someone to help you.

You may choose an authorized representative to help you get health care coverage through programs offered by MassHealth and the Health Connector. You can do this by filling out this form (the Authorized Representative Designation Form) or a sufficiently similar designation document. You or a representative can sign for yourself and for any of your dependent children under the age of 18 for whom you are the custodial parent.

**You are not required to have a representative in order to apply for or receive benefits.**

## Who can help me?

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

## What can an authorized representative do?

An authorized representative may

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



## How does an authorized representative designation end?

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

- Mailing a letter notifying us that the designation has ended to  
**Health Insurance Processing Center  
P. O. Box 4405  
Taunton, MA 02780;**
- Faxing a letter notifying us that the designation has ended to **1-857-323-8300**; or
- Calling us at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

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

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

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

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

## How do I submit this form?

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

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

- Mailing your form to  
**Health Insurance Processing Center  
P. O. Box 4405  
Taunton, MA 02780;**
- Faxing your form to **1-857-323-8300**; or
- Calling us at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

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

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

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

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

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

Applicant's/Member's signature	Date
Authorized representative's name	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	

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

#### **B1. COMPLETE IF AUTHORIZED REPRESENTATIVE IS A PERSON.**

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

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

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

#### **B2. COMPLETE IF AUTHORIZED REPRESENTATIVE IS AN ORGANIZATION.**

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

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

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

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

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

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

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

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

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

Applicant's/Member's name

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

## SECTION 3 Authorized Representative Designation (if appointed by law)

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

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

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

Applicant's/Member's name

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