Massachusetts Application for Health and Dental Coverage and Help Paying Costs

Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP) is a federal program that helps you buy healthy food each month.

☐ Check this box if you want this application to be sent to the Department of Transitional Assistance to serve as an application for SNAP benefits. You must read the rights and responsibilities on pages 20-25 and sign on page 26 to proceed with the application.

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

We need one adult in the household to be the contact person for your application. Please note that this should be someone who appears on the application, not a third party who wishes to serve as a contact for the applicant(s). Please see the Authorized Representative Designation (ARD) Form at the end of this application to establish a third-party contact.

1. First name, middle name, last name, and suffix			2. Date of birth
3. What is your email address?			
☐ No home address. Note: if you check this box, you must provide a mailing address.			
4. Street address			5. Apartment or unit number
6. City	7. State	8. ZIP code	9. County
10. Mailing address ☐ Check if same as home address.			11. Apartment or unit number
12. City	13. State	14. ZIP code	15. County
16. Phone number	17. Other phone number		18. # of people listed on the application

19. What is your preferred language, if not English? Spoken ______________________ Written ______________________

20. Is anyone on this application in prison or jail? ☐ Yes ☐ No
Please select **No** if this person will be released in the next 60 days.
If **Yes**, who? Enter the name here: ______________________
If **Yes**, is this person awaiting trial? ☐ Yes ☐ No

FOR ENROLLMENT ASSISTERS ONLY

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

Check one ☐ Navigator ☐ Certified Application Counselor		
First name, middle name, last name, and suffix	Email address	
Organization name	Organization identification number	Organization phone number

SIGN THIS APPLICATION — REQUIRED.

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 of the MassHealth and Health Connector programs.

If I have indicated that I am applying for the Supplemental Nutritional Assistance Program (SNAP) on page 1 of this application, I certify that I understand and agree to the rights, rules, and penalties of the SNAP program, as outlined above. I ask that MassHealth send my information, including Protected Health Information subject to the Health Insurance Portability and Accountability Act (HIPAA), to the Department of Transitional Assistance (DTA) for the purpose of applying for SNAP benefits.

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

Signature of Person 1 or authorized representative or responsible party	Print name
....	Date

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

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

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

STEP 8 Send us your completed application.

Mail your signed application to: **Health Insurance Processing Center**; or Fax to: **(857) 323-8300**
PO Box 4405
Taunton, MA 02780

VOTER REGISTRATION INFORMATION

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

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 (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.