ommonwealth of Massachusetts
O. Box 4405
unton, MA 02780

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COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

RESPONSE REQUIRED!

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Commonwealth of Massachusetts
Executive Office of Health
and Human Services
Office of Medicaid
www.mass.gov/masshealth

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

Date: 06/09/2023
SSN:
MEC:
NUM: Type: **ACA TRANS**
Medicaid ID :

PMER-TRANS

Dear

You need to respond to this notice in order to renew your MassHealth coverage.

Our records show that you or someone in your household is 65 or will be 65 soon. Different MassHealth rules apply to people 65 years of age or older. Now that you or someone in your household will be in this age category, MassHealth needs more information to renew your eligibility.

What do I need to do?

Fill out the enclosed **Eligibility Review for Seniors and Certain People Needing Long-Term-Care Services** form. Make sure to answer all the questions on the form and sign it. Respond to us with the completed form and any other documents we need by 07/24/2023.

We may contact you by mail after we get your renewal to ask about the information on your form. We will let you know by mail if your coverage will change or end. MassHealth will not make any changes to your coverage while we process your application.

If you do not send your form back to us by 07/24/2023, you may lose your coverage.

continued...

How can I complete my renewal?

You can complete your renewal in the following ways.

1. **By Mail of Fax** - complete the included paper renewal form and send it to MassHealth.

   Mail it to
   MassHealth Enrollment Center
   P.O. Box 290794
   Charlestown, MA 02780
   Fax it to **(617) 887-8799**

2. **By Phone** - you can complete your renewal by phone by calling MassHealth Customer Service at (800)841-2900, TTY/TDD: 711.

3. **Schedule an Appointment** - schedule an appointment with a MassHealth representative by using our online scheduling tool at www.mass.gov/masshealthappointment

What if I have questions?

Go to www.mass.gov/info-details/senior-guide-and-application-for-health-care-coverage for more information. You can also call us at **(800)841-2900, TTY/TDD: 711.**

Call us at (800)841-2900 (TTY/TDD: 711) if you are a parent or caretaker of a child under the age of 19 who lives with you. You may need to fill out a different application, called the Application for Health and Dental Coverage and Help Paying Costs (ACA-3), instead of this form.

Thank You,

MassHealth

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

HOW TO APPLY

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

Mail or **fax** your filled-out, signed application to

MassHealth Enrollment Center
PO Box 290794
Charlestown, MA 02129-0214
Fax: (617) 887-8799

Visit a MassHealth Enrollment Center (MEC).

To schedule an appointment with a MassHealth representative or to apply in person, go to **www.mass.gov/masshealth/appointment**.

In order to get any benefits you are entitled to as quickly as possible, you may send us any documentation you have that verifies all household income and assets.

You can use this application to apply for the Supplemental Nutrition Assistance Program (SNAP). SNAP is a federal program that helps you buy food each month. If you are interested, check the box on page 1 then read and sign the SNAP rights and responsibilities on pages 19-23. Your application will then be sent automatically to the Department of Transitional Assistance. You do not have to apply for the SNAP Program to be considered for MassHealth.

MASSHEALTH and the HEALTH SAFETY NET | Who Can Use This Application

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

- an individual 65 years of age or older and living at home and
  - not the parent of a child under 19 years of age who lives with you; or
  - not an adult relative living with and taking care of a child younger than 19 years of age 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;
- an individual of any age and need long-term-care services in a medical institution or nursing facility; or
- an individual who is eligible under certain programs to get long-term-care services to live at home; or
- a member of a married couple living with your spouse, and
  - both you and your spouse are applying for health coverage;
  - there are no children under 19 years of age living with you; and
  - one spouse is 65 years of age or older and the other spouse is under 65 years of age. (Please see Step 9 of the application.)

If you meet any of the following exceptions, you should complete the Application for Health and Dental Coverage and Help Paying Costs (ACA-3). To obtain a copy of this application, call us at (800) 841-2900. TDD/TTY: 711.

- You are the parent of a child under 19 years of age who lives with you, or
- You are an adult relative living with and taking care of a child younger than 19 years of age when neither parent is living in the home.

You will also need to fill out a Long-Term-Care Supplement if you are

- in an institution, such as a nursing home, chronic hospital, or other medical institution (You may have to pay a monthly payment, called a patient-paid amount, to the long-term-care facility. For more information, see page 13 in the Senior Guide.);
- in an acute hospital waiting for placement in a long-term-care facility; or
- living in your home and applying for or getting long-term-care services under a Home- and Community-Based Services Waiver.

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 Authorized Representative Designation Form at the end of this application.

MASSACHUSETTS HEALTH CONNECTOR | Who Can Use This Application

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

- are 65 years of age or older;
- are not otherwise eligible for MassHealth;
- are not getting Medicare; and
- do not have access to an affordable health plan that meets the minimum value requirement.*

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

The Health Connector uses Modified Adjusted Gross Income (MAGI) rules to determine eligibility.

WHAT YOU NEED WHEN YOU APPLY

The following MUST be sent with the application when applying for MassHealth, the Health Safety Net, and the Massachusetts Health Connector

SOCIAL SECURITY NUMBER (SSN)

You must give us an SSN or proof that anyone on this application has also applied for an SSN. There are exceptions for anyone who

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

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

PROOF OF INCOME, ASSETS, AND INSURANCE

We will attempt to verify some of this information through electronic data matches and will notify you if we need further proof. It may speed up the processing of your application if you send proof of these items with it.

- Proof of all current income before deductions, such as copies of pay stubs or pension check stubs (You do not have to send proof of social security or SSI income, but you must fill out the social security and SSI income information, if applicable.)
- Proof of all assets, such as bank accounts and life insurance policies
- Copies of your current health insurance premium bills (such as Medex) if you are applying for long-term-care services in a medical facility. (You do not have to send copies of your Medicare cards.)
- Policy numbers for any current health coverage
- Information about any other health insurance available to your household

PROOF OF CITIZENSHIP/NATIONAL STATUS

We will try to verify this information through electronic data matches. We will notify you if we need further proof. It may speed up the processing of your application if you send proof of these items with it.

- Proof of U.S. citizenship/national status and proof of identity, such as U.S. passports or U.S. naturalization papers. You can also prove U.S. citizenship with a U.S. public birth certificate. You can also prove identity with a driver's license or some other form of government-issued card. We may be able to prove your identity through the Massachusetts Registry of Motor Vehicles records if you have a Massachusetts driver's license or a Massachusetts ID card. Once you give MassHealth proof of your U.S. citizenship/national status and identity, you will not have to give us this proof again. You must give us proof of identity for all household members who are applying. **Seniors and disabled persons who get or can get Medicare or Supplemental Security Income (SSI), or disabled persons who get Social Security Disability (SSDI), do not have to give proof of their U.S. citizenship/national status and identity.** (See Section 9 in the Senior Guide for complete information about acceptable forms of proof.)
- A copy of both sides of all immigration cards (or other documents that show immigration status) for you or your spouse if you or your spouse are not U.S. citizens/nationals and are applying for MassHealth (except for MassHealth Limited), the Health Safety Net, or the Health Connector plans.

For more information on immigration statuses and document types, please see page 32.

WHY 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 www.MAhealthconnector.org. To view MassHealth's privacy policy, go to www.mass.gov/service-details/masshealth-member-privacy-information.

WHAT HAPPENS NEXT and WHERE TO GET HELP

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

If you need more information about how to apply, or if you need another copy of Supplement C: Personal-Care Attendant for your spouse who is also applying, call us at (800) 841-2900. TDD/TTY: 711. This application is available in Spanish. Please call the number above to request one.

If you have any questions about any form or the information you need to send, please call us at (800) 841-2900. TDD/TTY: 711.

To find resources and information related to the coronavirus for MassHealth applicant and members, go to www.mass.gov/coronavirus-disease-covid-19-and-masshealth.

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

Please Print Clearly. Be sure to answer all questions. Fill out all parts of the application, along with all supplements that apply. If you need more space, attach a separate piece of paper to the application. Put Person 1's name and social security number at the top of any attached paper. For each member in your household, please put the name(s) of the individual(s) under the program or programs they want to apply for. Please see the Senior Guide to learn more about coverage under these programs.

Please list the names of everyone who is applying for health coverage on this application.

☐ **MassHealth or the Health Safety Net (HSN)**
(If living at home, or in a rest home, an assisted living facility, a continuing care retirement community, or life care community, fill out this application and any supplements that apply to you or any household member.) MassHealth will check if anyone applying for health coverage on this application is eligible for MassHealth or the HSN.

You: _____

Spouse: _____

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

You: _____

Spouse: _____

☐ **Health Connector Programs**
Health coverage through the Massachusetts Health Connector is not MassHealth. If you have Medicare, you will not be eligible for any cost sharing or Advance Premium Tax Credits, and you cannot purchase a plan through the Health Connector, unless you were enrolled in a Health Connector plan when you became eligible for Medicare. The only time you should apply for Health Connector programs if you have Medicare is if you are not enrolled in Medicare yet but would have to pay for your Medicare Part A premium. In this case, you may be eligible for a Health Connector plan.

You: _____

Spouse: _____

NOTE: PACE – Program of All-inclusive Care for the Elderly
Some MassHealth members may be eligible to enroll in the Program of All-Inclusive Care for the Elderly (PACE), which provides members access to a wide range of medical, social, recreational, and wellness services through a center-based model. See page 10 of the Senior Guide for more information.

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 17-23 and sign on page 23 to proceed with the application.

STEP 1 Person 1 (YOU)—Tell us about YOURSELF.

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) 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. Street address ☐ Check this box if homeless. You must provide a mailing address.			4. Apartment or unit number
5. City	6. State	7. ZIP code	8. County

9. Is this a hospital, nursing facility, or other institution? ☐ Yes ☐ No
If **Yes**, facility name

10. Mailing address ☐ Check if same as street address.			11. Apartment or unit number
12. City	13. State	14. ZIP code	15. County

16. Phone number | 17. Other phone number

18. Email | 19. # of people listed on the application

20. What is your preferred language, if not English? Spoken _____ Written _____

21. 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

STEP 2 Person 1

1. First name, middle name, last name, and suffix | 2. Gender ☐ Male ☐ Female | 3. Relationship to you SELF

4. Are you applying for health or dental coverage for YOURSELF? ☐ Yes ☐ No

If **Yes**, answer all the questions below in Step 2 for Person 1 (yourself).

If **No**, answer Question 16 (accommodations), then go to the Income Information section on page 4.

5. Optional What is your race or ethnicity? _____ Please see page 32.
MassHealth is committed to providing equitable care for all members regardless of race, ethnicity, or language spoken. Please complete this question to help us meet your language and cultural needs. Know that your response is voluntary, confidential, and will not impact your eligibility or be used for any discriminatory purpose.

6. Do you have a social security number (SSN)? ☐ Yes ☐ No (optional if **not** applying)
We need a social security number (SSN) for every person applying for health coverage who has one. There are exceptions for anyone who has a religious exemption as described in federal law, who is eligible only for a nonwork SSN, or who is not eligible for an SSN. 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. For more details on how we use your social security number, please refer to the Senior Guide for Health Care Coverage. If someone needs help getting a SSN, call the Social Security Administration at (800) 772-1213, TTY: (800) 325-0778, or go to socialsecurity.gov.

If **Yes**, give us the number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

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

Is your name on this application the same as your name on your social security card? ☐ Yes ☐ No

If **No**, what name is on your social security card?

First name, middle name, last name, and suffix

7. If you get an Advance Premium Tax Credit (APTC), do you agree to file a federal tax return for the tax year that the credits are received? ☐ Yes ☐ No
You may not have needed or chosen to file a tax return in the past, but you will have to file a federal income tax return for any year that you get an APTC. You must check **Yes** to question 7 to be eligible for ConnectorCare or APTCs to help pay for your health insurance. **You do NOT need to file a tax return to apply for or to get MassHealth or HSN, if you qualify.**

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

You must file a joint federal tax return with your spouse for the year for which you are applying to get certain programs (ConnectorCare or APTCs) unless you are a victim of domestic abuse or abandonment or you will file taxes as Head of Household. If you will file taxes as Head of Household, you should answer **No** to question 7a ("Are you legally married?"). One way you may qualify as Head of Household is to live apart from your spouse and claim another person as a dependent. See IRS Publication 501 or consult a tax professional for tax filing information. You will only need to include yourself and any dependents on this application.

a. Are you legally married? ☐ Yes ☐ No
If **No**, skip to question 7c.
If **Yes**, list name of spouse and date of birth. _____

b. Do you plan to file a joint federal tax return with your spouse for the tax year for which you are applying? ☐ Yes ☐ No

c. Will you claim any dependents on your federal income tax return for the year which you are applying? ☐ Yes ☐ No
You will claim a personal exemption deduction on your federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments. List name(s) and date(s) of birth of dependents.

_____

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

Tax filer date of birth _____ How are you related to the tax filer? _____

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

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

Who else does the tax filer claim as dependents?

_____

e. Are you filing taxes separately because you are a victim of domestic abuse or abandonment? ☐ Yes ☐ No

Optional I filed a federal income tax return with the Internal Revenue Service (IRS) for every year that I received an Advance Premium Tax Credit (APTC). When I filed, I included IRS Form 8962, which had information about the tax credit I received, so the IRS could reconcile my APTC. ☐ Yes ☐ No

Answer **Yes** if: 1. You have received an APTC or ConnectorCare in the past, and
2. The statement is true for all people listed in the household.

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

If **Yes**, are you a naturalized, derived, or acquired citizen (not born in the US)? ☐ Yes ☐ No

Alien number _____ Naturalization or citizenship certificate number _____

9. If you are a noncitizen, do you have an eligible immigration status? ☐ Yes ☐ No
See page 32, "Immigration Statuses and Document Types" for help. If **No** or **no response**, you may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN). Go to Question 10.

a. If **Yes**, do you have an immigration document? ☐ Yes ☐ No
It may help us to process this application faster if you include a copy of your immigration document with the application. We will try to verify your immigration status through an electronic data match. Please list all the immigrations statuses and/or conditions that have applied to you since you entered the U.S. If you need more space, attach another sheet of paper.

Status award date (mm/dd/yyyy) _____ (For battered persons, enter the date the petition was approved.)

Immigration status _____ Immigration document type _____
Choose one or more document status and type from the list on page 32.

Document ID number _____ Alien number _____

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

b. Did you use the same name on this application that you did to get your immigration status? ☐ Yes ☐ No
If **No**, what name did you use? First, middle, last, and suffix _____

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

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

e. Optional Are you a: ☐ victim of severe trafficking, ☐ a spouse, child, sibling, or parent of a trafficking victim ☐ a battered spouse, ☐ a child or the parent of battered spouse?

10. Are you living in Massachusetts, and do you either intend to reside here, even if you do not have a fixed address, or have you entered Massachusetts with a job commitment or seeking employment? ☐ Yes ☐ No

If you are visiting in Massachusetts for personal pleasure or for the purposes of receiving medical care in a setting other than a nursing facility, you must answer **No** to this question.

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

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

12. Are you pregnant? ☐ Yes ☐ No
If **Yes**, how many babies are you expecting? _____ What is the expected due date? _____

13. 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

14. Do you rent or own your property? ☐ Rent ☐ Own

15. DISABILITY Answer this question if you are under age 65 or age 65 or older and working.
Do you have a disability (including a disabling mental health condition) that has lasted or is expected to last for at least 12 months? (If legally blind, answer **Yes**.) ☐ Yes ☐ No Name: _____

16. Do you need reasonable accommodation(s) because of a disability or injury? ☐ Yes ☐ No
If **No**, go to the next question. If **Yes**, answer questions a and b.

a. Condition
☐ Low vision ☐ Blind ☐ Deaf ☐ Hard of hearing ☐ Developmentally disabled ☐ Intellectually disabled
☐ Physically disabled ☐ Other (Please explain.) _____

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

17. Are you applying because of an accident or injury that someone else might be responsible for? ☐ Yes ☐ No

a. Did someone else cause your injury, illness, or disability, or could someone else's insurance or your own insurance, other than health insurance (like homeowner's or auto insurance) cover it? ☐ Yes ☐ No

b. Have you filed a lawsuit, a workers' compensation claim, or an insurance claim for this accident or injury? ☐ Yes ☐ No

18. Did you ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No
If **No**, go to Income Information. If **Yes**, answer questions a and b.

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

b. Do you (check one): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home? ☐ live in someone else's home?

INCOME INFORMATION (You may send proof of all household income with this application.)

19. Do you have any income? ☐ Yes ☐ No
If you don't have income, skip to question 30.

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

20. Employer name and address | Federal Tax ID#

21. a. Wages/tips (before taxes) $ _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly (Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)

b. Income effective date _____

22. Average number of hours worked each WEEK _____

23. Are you seasonally employed? ☐ Yes ☐ No. If yes, which months do you work in a calendar year?
☐ Jan. ☐ Feb. ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

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

24. Are you self-employed? ☐ Yes ☐ No

a. If **Yes**, what type of work do you do? _____

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

c. How many hours do you work per week? _____

OTHER INCOME

25. 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 or Supplemental Security Income (SSI).

☐ Social Security benefits $_____ How often? _____
☐ Retirement or Pension $_____ How often? _____
☐ Annuities $_____ How often? _____
☐ Trusts $_____ How often? _____
☐ Unemployment $_____ How often? _____
☐ Interest, dividends, and other investment income $_____ How often? _____
☐ Royalty income $_____ How often? _____
☐ Alimony received $_____ How often? _____
If this person is receiving alimony payments from a divorce, separation agreement, or court order that was finalized before January 1, 2019, enter the amount of those payments here. $_____
☐ Federal veteran's benefits $_____ How often? _____
☐ Military retirement pay $_____ How often? _____
☐ Other taxable income (include type) $_____ How often? _____ Type _____
☐ Capital gains: On average, how much net income or loss will you get from this capital gain each month?
$ _____ /profit or $ _____ /loss
☐ Net farming or fishing income: $ _____ /**profit** or $ _____ /**loss** How many hours each week? _____
☐ Lottery and Gambling Winnings $ _____ Effective Date _____
How often? ☐ One time only ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly
Non–cash prizes are not counted as qualified lottery and gambling winnings do not incorporate any losses in the amount.

RENTAL INCOME

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

If **Yes**, **send proof** of current rental income, such as a written statement from each tenant, a copy of the lease, or a current federal tax return. Also **send proof** of all of the following expenses, if applicable, for the last 12 months: mortgage, taxes, utilities (gas/electric), heat, water/sewer, insurance, condo or co-op fee, repairs and maintenance.

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

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

Address _____ Unit #_____
Amount of Income _____ Amount of Loss _____ Owner-occupied? ☐ Yes ☐ No
Address _____ Unit #_____
Amount of Income _____ Amount of Loss _____ Owner-occupied? ☐ Yes ☐ No

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

ONE-TIME-ONLY INCOME

27. Have you or will you receive income during this calendar year as a one-time only payment? ☐ Yes ☐ No
An example might include a lump-sum pension payment.
If **Yes**: Type _____ Amount $ _____ Month Received _____ Year received _____

28. Will you receive income during the next calendar year as a one-time only payment? ☐ Yes ☐ No
If **Yes**: Type _____ Amount $ _____ Month Received _____ Year received _____

DEDUCTIONS

29. What deductions do you report on your income tax return?
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. Check all that apply. Your deductions should be what you report on your federal income tax return in the section "Adjusted Gross Income." For each deduction you select, give the yearly amount. You can enter up to the maximum deduction amount allowed by the IRS.

- ☐ Educator expense: Yearly amount $_____
- ☐ Certain business expenses of reservists, performing artists, or fee-based government officials: Yearly amount $_____
- ☐ Health Savings Account deduction: Yearly amount $_____
- ☐ Moving expenses for members of the Armed Forces: Yearly amount $_____
- ☐ Deductible part of self-employment tax: Yearly amount $_____
- ☐ Contribution to self-employed SEP, SIMPLE, and qualified plans: Yearly amount $_____
- ☐ Self-employed health insurance deduction: Yearly amount $_____
- ☐ Penalty on early withdrawal of savings: Yearly amount $_____
- ☐ Alimony paid: alimony payments for a divorce, separation agreement, or court order that was finalized before January 1, 2019, enter the amount of those payments here. Yearly amount $_____
- ☐ Individual Retirement Account (IRA) deduction: Yearly amount $_____
- ☐ Student loan deduction (interest only, not total payment): Yearly amount $_____
- ☐ None

YEARLY INCOME

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

31. 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—Spouse or other people in this household

Fill out this part for your spouse who lives with you or anyone included on your federal income tax return, if you file one.

If you have to include more than two people on this application, make a copy of blank information pages for Step 2 Person 2 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. You can also download pages for additional persons at mass.gov/masshealth.

1. First name, middle name, last name, and suffix	2. Date of birth	3. Gender ☐ Male ☐ Female

4. Relationship to Person 1	5. Does this person live with Person 1? ☐ Yes ☐ No. If **No**, provide street address

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

6. Is this a hospital, nursing facility, or other institution? ☐ Yes ☐ No
If **Yes**, facility name

7. Mailing address ☐ Check if same as street address.	8. Apartment or unit number

9. City	10. State	11. ZIP code	12. County

13. What is this person's preferred language, if not English? Spoken _____ Written _____

14. **Optional** What is your race or ethnicity? _____ Please see page 32.
MassHealth is committed to providing equitable care for all members regardless of race, ethnicity, or language spoken. Please complete this question to help us meet your language and cultural needs. Know that your response is voluntary, confidential, and will not impact your eligibility or be used for any discriminatory purpose.

15. Is this person applying for health or dental coverage? ☐ Yes ☐ No
If **Yes**, answer all the questions below in Step 2 for Person 2
If **No**, answer Question 26 (accommodations), then go to the Income Information section on page 9.

16. Does this person have a social security number (SSN)? ☐ Yes ☐ No (optional if **not** applying)
We need a social security number (SSN) for every person applying for health coverage who has one. For important SSN information and how to apply for SSN, please see instructions for Question 6 under Person 1.

If **Yes**, give us the number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

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

Is the name on this application the same as the name on their social security card? ☐ Yes ☐ No

If **No**, what name is on this person's social security card?

First name, middle name, last name, and suffix

17. If this person gets an Advance Premium Tax Credit (APTC), does this person agree to file a federal tax return for the tax year that the credits are received? ☐ Yes ☐ No
They may not have needed or chosen to file a tax return in the past, but this person will have to file a federal income tax return for any year that they get an APTC. You must check **Yes** to question 17 to be eligible for ConnectorCare or APTCs to help pay for this person's health insurance. **This person does NOT need to file a tax return to apply for or to get MassHealth or HSN, if they qualify.**

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

This person must file a joint federal tax return with a spouse for the year for which this person is applying to get certain programs (ConnectorCare or APTCs) unless this person is a victim of domestic abuse or abandonment or they will file taxes as Head of Household. If this person will file taxes as Head of Household, they should answer **No** to question 17a ("Are you legally married?"). One way this person may qualify as Head of Household is to live apart from their spouse and claim another person as a dependent. See IRS Publication 501 or consult a tax professional for tax filing information. This person will only need to include themself and any dependents on this application.

a. Is this person legally married? ☐ Yes ☐ No
If **No**, skip to question 17c.
If **Yes**, list name of spouse and date of birth. _____

b. Does this person plan to file a joint federal tax return with a spouse for the tax year for which this person is applying?
☐ Yes ☐ No

c. Will this person claim any dependents on this person's federal income tax return for the year for which this person is applying? ☐ Yes ☐ No
This person will claim a personal exemption deduction on their federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments.

List name(s) and date(s) of birth of dependents.

_____

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

Tax filer date of birth _____ How is this person related to the tax filer? _____

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

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

Who else does the tax filer claim as dependents?

_____

e. Is this person filing taxes separately because they are a victim of domestic abuse or abandonment? ☐ Yes ☐ No

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

If **Yes**, are they a naturalized, derived, or acquired citizen (not born in the U.S.)? ☐ Yes ☐ No

Alien number _____ Naturalization or citizenship certificate number _____

19. If this person is a noncitizen, do they have an eligible immigration status? ☐ Yes ☐ No
See page 32, "Immigration Statuses and Document Types" for help. If **No** or **no response**, you may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN). Go to Question 20.

a. If **Yes**, does this person have an immigration document? ☐ Yes ☐ No
It may help us to process this application faster if you include a copy of their immigration document with the application. We will try to verify this person's immigration status through an electronic data match. Please list all the immigration statuses and/or conditions that have applied to this person since they entered the U.S. If you need more space, attach another sheet of paper.

Status award date (mm/dd/yyyy) _____ (For battered persons, enter the date the petition was approved.)

Immigration status _____ Immigration document type _____
Choose one or more document status and types from the list on page 32.

Document ID number _____ Alien number _____

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

b. Did this person use the same name on this application to get their immigration status? ☐ Yes ☐ No
If **No**, what name did this person use? First, middle, last, and suffix _____

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

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

e. **Optional** Is this person a: ☐ victim of severe trafficking, ☐ a spouse, child, sibling, or parent of a trafficking victim ☐ a battered spouse, ☐ a child or the parent of battered spouse?

20. Is this person living in Massachusetts, and does this person either intend to reside here, even if they do not have a fixed address, or has this person entered Massachusetts with a job commitment or seeking employment? ☐ Yes ☐ No

If this person is visiting in Massachusetts for personal pleasure or for the purposes of receiving medical care in a setting other than a nursing facility, you must answer no to this question.

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

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

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

23. 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

24. Does this person rent or own their property? ☐ Rent ☐ Own

25. **DISABILITY** Answer this question if this person is under age 65 or age 65 or older and working.
Does this person have a disability (including a disabling mental health condition) that has lasted or is expected to last for at least 12 months? (If legally blind, answer **Yes**.) ☐ Yes ☐ No Name: _____

26. Does this person need reasonable accommodation(s) because of a disability or injury? ☐ Yes ☐ No
If **No**, go to the next question. If **Yes**, answer questions a and b.

a. Condition
☐ Low vision ☐ Blind ☐ Deaf ☐ Hard of hearing ☐ Developmentally disabled ☐ Intellectually disabled
☐ Physically disabled ☐ Other (Please explain.) _____

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

27. Is this person applying because of an accident or injury that someone else might be responsible for? ☐ Yes ☐ No

a. Did someone else cause this person's injury, illness, or disability, or could someone else's insurance or this person's own insurance, other than health insurance (like homeowner's or auto insurance) cover it? ☐ Yes ☐ No

b. Has this person filed a lawsuit, a workers' compensation claim, or an insurance claim for this accident or injury?
☐ Yes ☐ No

28. Did this person ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No
If **No**, go to Income Information. If **Yes**, answer questions a and b.

a. When did this person last get SSI? (mm/yyyy) _____

b. Does this person (check one): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home? ☐ live in someone else's home?

INCOME INFORMATION (You may send proof of all household income with this application.)

29. Does this person have any income? ☐ Yes ☐ No
If this person does not have income, skip to question 40.

CURRENT JOB | If this person has more jobs and needs more space, attach another sheet of paper.

30. Employer name and address | Federal Tax ID#

31. a. Wages/tips (before taxes) $ _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly (Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)
b. Income effective date _____

32. Average number of hours worked each WEEK _____

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

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

34. Is this person self-employed? ☐ Yes ☐ No

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

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

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

OTHER INCOME

35. 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 or Supplemental Security Income (SSI).

- ☐ Social Security benefits $_____ How often? _____
- ☐ Retirement or Pension $_____ How often? _____
- ☐ Annuities $_____ How often? _____
- ☐ Trusts $_____ How often? _____
- ☐ Unemployment $_____ How often? _____
- ☐ Interest, dividends, and other investment income $_____ How often? _____
- ☐ Royalty income $_____ How often? _____
- ☐ Alimony received $_____ How often? _____
  If this person is receiving alimony payments from a divorce, separation agreement, or court order that was finalized before January 1, 2019, enter the amount of those payments here. $_____
- ☐ Federal veteran's benefits $_____ How often? _____
- ☐ Military retirement pay $_____ How often? _____
- ☐ Other taxable income (include type) $_____ How often? _____ Type _____
- ☐ Capital gains: On average, how much net income or loss will this person get from this capital gain each month?
  $ _____ /profit or $ _____ /loss
- ☐ Net farming or fishing income: $ _____ /**profit** or $ _____ /**loss** How many hours each week? _____
- ☐ Lottery and Gambling Winnings $ _____ Effective Date _____
  How often? ☐ One time only ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly
  Non–cash prizes are not counted as qualified lottery and gambling winnings do not incorporate any losses in the amount.

RENTAL INCOME

36. Does this person get rental income? ☐ Yes ☐ No

If **Yes**, **send proof** of current rental income, such as a written statement from each tenant, a copy of the lease, or a current federal tax return. Also **send proof** of all of the following expenses, if applicable, for the last 12 months: mortgage, taxes, utilities (gas/electric), heat, water/sewer, insurance, condo or co-op fee, repairs and maintenance.

a. What type of real estate does this person own? ☐ one-family ☐ two-family ☐ three-family
☐ other (describe): _____

b. How much **monthly** rental income or loss does this person get from each rental unit from the real estate indicated above? (List each rental unit and address separately.)

Address _____ Unit #_____

Amount of Income _____ Amount of Loss _____ Owner-occupied? ☐ Yes ☐ No

Address _____ Unit #_____

Amount of Income _____ Amount of Loss _____ Owner-occupied? ☐ Yes ☐ No

c. Does this person pay for heat or utilities for their tenant? ☐ Yes ☐ No

ONE-TIME-ONLY INCOME

37. Has or will this person receive income during this calendar year as a one-time only payment? ☐ Yes ☐ No
An example might be a lump-sum pension payment.
If **Yes**: Type: _____ Amount $ _____ Month Received _____ Year received _____

38. Will this person receive income during the next calendar year as a one-time only payment? ☐ Yes ☐ No
If **Yes**: Type: _____ Amount $ _____ Month Received _____ Year received _____

DEDUCTIONS

39. What deductions does this person report on their income tax return?
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. Check all that apply. This person's deductions should be what they report on their federal income tax return in the section "Adjusted Gross Income." For each deduction selected, give the yearly amount. You can enter up to the maximum deduction amount allowed by the IRS.

- ☐ Educator expense: Yearly amount $_____
- ☐ Certain business expenses of reservists, performing artists, or fee-based government officials: Yearly amount $_____
- ☐ Health Savings Account deduction: Yearly amount $_____
- ☐ Moving expenses for members of the Armed Forces: Yearly amount $_____
- ☐ Deductible part of self-employment tax: Yearly amount $_____
- ☐ Contribution to self-employed SEP, SIMPLE, and qualified plans: Yearly amount $_____
- ☐ Self-employed health insurance deduction: Yearly amount $_____
- ☐ Penalty on early withdrawal of savings: Yearly amount $_____
- ☐ Alimony paid: alimony payments for a divorce, separation agreement, or court order that was finalized before January 1, 2019, enter the amount of those payments here. Yearly amount $_____
- ☐ Individual Retirement Account (IRA) deduction: Yearly amount $_____
- ☐ Student loan deduction (interest only, not total payment): Yearly amount $_____
- ☐ None

YEARLY INCOME

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

41. 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.

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

Are you or is anyone in your household an American Indian or Alaska Native? ☐ Yes ☐ No

If **No**, skip to Step 4. If **Yes**, complete the rest of this application, including **Supplement B: American Indian or Alaska Native Household Member.**

STEP 4 Previous Medical Bills

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

If **Yes**, fill out the rest of this section. We may be able to pay for these bills. If **No**, go to **Step 5: Assets**.

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

If **Yes,** what is the earliest date for which you need MassHealth? (mm/dd/yyyy) _____
(You must give us proof of all income and assets owned during that time period.)

Please list below any individuals requesting payment of previous medical bills. You must give us proof of all income and assets owned during that time period.

Name _____ Earliest date requested _____
Name _____ Earliest date requested _____

STEP 5 Assets | You **must** fill out all blocks for each asset you and/or your spouse own.

If you live in the community and you want help with medical bills up to three months before the month you apply, you must tell us about any open and closed accounts for that period. If you are applying for long-term care, you must also give us information about all assets you or your spouse owned in the past 60 months. If you need more space, attach another sheet of paper.

BANK ACCOUNTS

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

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

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

   If you answered **Yes** to **any** of these questions, fill out this section. If you answered **No** to **all** of these questions, go to the next section **(REAL ESTATE)**.

Send a copy of your passbooks updated within 45 days and/or **a copy** of your current account statements. Please see the Senior Guide for information about financial institutions charging for copies of statements. If applying for nursing facility coverage, please provide account statements for the past 60 months.

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

* Enter the account balance on the date of admission to medical institution, hospital, or nursing facility.

REAL ESTATE

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

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

   If you answered **Yes** to any of these questions, fill out this section. If **No**, go to the next section **(LIFE INSURANCE)**.

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

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

LIFE INSURANCE

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

   If **Yes**, fill out this section. If **No**, go to the next section **(SECURITIES BROKERAGE ACCOUNTS (STOCKS/BONDS/OTHER))**.

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

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

SECURITIES BROKERAGE ACCOUNTS (STOCKS/BONDS/OTHER)

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

   If **Yes**, fill out this section. If **No**, go to the next section **(ANNUITIES)**.

Send proof of current value (except cash).

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

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

ANNUITIES

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

   If **Yes**, fill out this section. To be eligible, you may be required to name the Commonwealth as a remainder beneficiary. (See the Senior Guide for more information.) If **No**, go to the next section **(ASSISTED LIVING/OTHER)**.

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

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

ASSISTED LIVING/OTHER

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

   If **Yes**, fill out this section. If **No**, go to the next section **(VEHICLES/MOBILE HOMES)**.

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

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

VEHICLES/MOBILE HOMES

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

   If **Yes**, fill out this section. If **No**, go to the next section **(PREPAID BURIAL PLANS/TRUSTS)**.

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

(You) Type of vehicle	Year/make/model	Fair-market value $	Amount owed $
Mobile home address			
(Your spouse) Type of vehicle	Year/make/model	Fair-market value $	Amount owed $
Mobile home address			

PREPAID BURIAL PLANS

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

   If **Yes**, fill out this section. If **No**, go to the next section **(TRUSTS)**.

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

(You) Burial contract ☐ Yes (Amount $) ☐ No		Burial trust ☐ Yes (Amount $) ☐ No	
Life insurance for burial ☐ Yes (Amount $) ☐ No		Burial-only account ☐ Yes (Amount $) ☐ No	
Burial plot ☐ Yes ☐ No	Insurance company		Policy number
Bank name		Account number	
(Your spouse) Burial contract ☐ Yes (Amount $) ☐ No		Burial trust ☐ Yes (Amount $) ☐ No	
Life insurance for burial ☐ Yes (Amount $) ☐ No		Burial-only account ☐ Yes (Amount $) ☐ No	
Burial plot ☐ Yes ☐ No	Insurance company		Policy number
Bank name		Account number	

TRUSTS

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

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

    If you answered **Yes** to any of these questions, fill out this section.
    If you answered **No** to these questions, go to **STEP 6: Health Insurance Information**

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

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

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

STEP 6 Health Insurance Information

MassHealth regulations require members to obtain and maintain available health insurance, including health insurance available through an employer. In order to determine continued MassHealth eligibility for you and members of your household, we may request additional information from you and your employer about your access to employer sponsored health insurance coverage. You must cooperate in providing information necessary to maintain eligibility, including evidence of obtaining or maintaining available health insurance, or your MassHealth benefits may be terminated. See the Senior Guide for more information.

1. Is anyone listed on this application offered health coverage from a job but not enrolled in it? ☐ Yes ☐ No
   Answer **Yes** even if this insurance is from another person's job, like a spouse, even if this person does not live in the household.
   If **Yes**, you will need to complete and include **Supplement D: Health Coverage from Jobs**, and the rest of this application.

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

2. Does anyone qualify for or is anyone enrolled in the following types of health coverage? ☐ Yes ☐ No
   If **Yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have.

   Answer **Yes** even if this insurance is from another person, like a spouse, even if the person does not live in the household.

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

   Name _____ Medicare claim number _____

   When did coverage start? (mm/dd/yyyy) _____

   a. Does this person have a Medicare Part D plan? ☐ Yes ☐ No

      If **Yes**, when did coverage start? (mm/dd/yyyy) _____

   b. Does this person have a Medigap/Medicare supplemental policy? ☐ Yes ☐ No

      If **Yes**, name of coverage plan _____ When did coverage start? (mm/dd/yyyy) _____

   Name _____ Medicare claim number _____

   When did coverage start? (mm/dd/yyyy) _____

   a. Does this person have a Medicare Part D plan? ☐ Yes ☐ No

      If **Yes**, when did coverage start? (mm/dd/yyyy) _____

   b. Does this person have a Medigap/Medicare supplemental policy? ☐ Yes ☐ No

      If **Yes**, name of coverage plan _____ When did coverage start? (mm/dd/yyyy) _____

   Do any of the persons above want to apply for help paying for the Medicare Part B premiums? ☐ Yes ☐ No

   If **Yes**, name(s) _____

If you check any of the following programs provide details below.

- ☐ Qualifies for **Peace Corps**
- ☐ Qualifies for **TRICARE** (Do not check if you have direct care or Line of Duty.)
- ☐ Enrolled in **Veterans Affairs (VA) health programs**
- ☐ **MassHealth**
- ☐ **Other coverage** (including COBRA and retiree health plans)

Name(s) of covered household members

Policy number or Member ID	Start date and end date? (mm/dd/yyyy)

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

Name of employer	Plan name

Name(s) of covered household members

Policy number or Member ID	Start date and end date? (mm/dd/yyyy)

STEP 7 Health Reimbursement Arrangements

Is anyone in the household offered Health Reimbursement Arrangements (HRAs) from their employer? ☐ Yes ☐ No

Name(s) of individual	Date of Birth

Employer Name

Federal Tax ID

Type of HRA offered by employer ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
☐ Individual Coverage Health Reimbursement Arrangement (ICHRA)

Start date	End date	Enter the maximum yearly self-only coverage benefit amount:

If you have a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) do you intend to use QSEHRA family coverage benefits from your employer? ☐ Yes ☐ No

If you have QSEHRA, enter the maximum yearly family coverage benefit amount through the QSEHRA:

Does anyone in the household intend to accept an Individual Coverage Health Reimbursement Arrangement (ICHRA) benefit from their employer? ☐ Yes ☐ No

Name(s) of individual	Date of Birth

Employer Name

Federal Tax ID

Type of HRA offered by employer ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
☐ Individual Coverage Health Reimbursement Arrangement (ICHRA)

Start date	End date	Enter the maximum yearly self-only coverage benefit amount:

If you have a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) do you intend to use QSEHRA family coverage benefits from your employer? ☐ Yes ☐ No

If you have QSEHRA, enter the maximum yearly family coverage benefit amount through the QSEHRA:

Does anyone in the household intend to accept an Individual Coverage Health Reimbursement Arrangement (ICHRA) benefit from their employer? ☐ Yes ☐ No

STEP 8 Personal-Care-Attendant Services

For people 65 years of age or older who are not going to be in a long-term-care facility

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

1. Do you or your spouse need the services of a personal-care attendant? ☐ Yes ☐ No
   If **Yes**, fill out this section and answer all questions. If **No**, go to **STEP 10: Read and sign this application**.

2. Have you or your spouse had the services of a personal-care attendant **paid for by MassHealth** within the last six months? ☐ Yes ☐ No
   If **Yes**, go to **STEP 10: Read and sign this application**. If **No**, answer the following questions in this section.

3. Do you or your spouse have a permanent or long-lasting disability? You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No

   a. If **Yes**, does your (or your spouse's) disability keep you (or your spouse) from being able to do your (or your spouse's) daily living activities, like bathing, eating, toileting, dressing, etc., unless someone physically helps you (or your spouse)? You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No

   b. If **Yes**, do you (or your spouse) plan to contact a MassHealth personal-care-management (PCM) agency to ask for personal-care-attendant services? You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No

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

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

Each spouse who answered "Yes" to all parts of Question 3 above must fill out their own Supplement C: Personal-Care Attendant. One copy is enclosed. If you need a second copy, call MassHealth Customer Service at (800) 841-2900, TDD/TTY: 711. If you (or your spouse) do not send us your filled-out PCA supplement(s), we will determine your MassHealth eligibility as if you do not need PCA services.

STEP 9 Additional *(Optional)* Coverage – For married persons under 65 years of age

Fill out this section ONLY if you are married and living with your spouse. One spouse applying must be under 65 years of age, with no children under 19 years of age in the household. Answer these questions for the spouse who is under 65 years of age.

If this section applies to you and you want more information about income standards and other information that may apply, call us to get a Senior Guide at (800) 841-2900. TDD/TTY: 711. If this section does not apply, go to **Step 10: Read and sign this application.**

BREAST OR CERVICAL CANCER *(OPTIONAL)* (Only for persons under 65 years of age.)

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

   If **Yes**, we will send you a certificate to be filled out by your doctor to prove your breast or cervical cancer diagnosis. Then MassHealth can see if your MassHealth benefits give you the most coverage possible.

   Name: _____

HIV INFORMATION *(OPTIONAL)* (Only for persons under 65 years of age.)

2. Are you HIV positive? ☐ Yes ☐ No
   If you are HIV positive, you may be eligible for additional coverage or benefits.

   Name: _____

STEP 10 Read and sign this application

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

FOR MASSHEALTH AND HEALTH CONNECTOR APPLICANTS

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. I may have to pay a premium for health coverage for myself 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 I am a certain American Indian or Alaska Native, I 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, 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, after notice and an opportunity to appeal, MassHealth may place a lien against any real estate owned by eligible MassHealth members or in which the member has a legal interest. If the individual is receiving long-term care in a nursing facility or other medical institution and MassHealth determines that the member is not reasonably expected to return home. If MassHealth puts a lien against such property and the property is later sold, money from the sale of that property may be used to repay MassHealth for medical services provided.
10. To the extent permitted by law, and unless exceptions apply, for any eligible person age 55 or older, or any eligible person regardless of age for whom MassHealth helps pay for long-term care in a nursing home or other medical institution, MassHealth will seek money from the eligible person's estate after death for the total cost of care. For more information on estate recovery, visit mass.gov/EstateRecovery.
11. Eligible persons must tell the health care program(s) in which they enroll about any changes in their or their household's income or employment, household size, health insurance coverage, health insurance premiums, and immigration status, or about changes in any other information on this application and any supplements to it within 10 calendar days of learning of the change. Eligible persons can make changes by calling **(800) 841-2900**. TDD/TTY: 711. 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 PO Box 4405 Taunton, MA 02780**.
    - Fax the change information to **(857) 323-8300**.
12. MassHealth, the Massachusetts Health Connector, and the Health Safety Net will obtain from eligible persons' current and former employers and health insurers all information about health insurance coverage for 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.
13. MassHealth, the Massachusetts Health Connector, and the Health Safety Net may get records or data about persons listed on this application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Revenue, and the Registry of Motor Vehicles, as well as private data sources including financial institutions, 1) to prove any information given on this application and any supplements, or other information given once a person becomes a member, 2) to document medical services claimed or provided to such persons, and 3) to support continued eligibility.
14. In connection with the eligibility and enrollment process, MassHealth, the Massachusetts Health Connector, and the Health Safety Net may send notices that contain personal information about persons listed on this application to other persons on this application, or otherwise communicate such information to such persons.
15. Under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by going to **www.hhs.gov/ocr/office/file**.
16. I agree to allow the Massachusetts Health Connector to use income data, including information from tax returns to determine my eligibility in future years. Review the Health Connector Privacy Policy for more information about how the Health Connector uses your tax information. The Massachusetts Health Connector will send me a notice and let me make changes to my eligibility application. I understand that if I am eligible for an Advance Premium Tax Credit (APTC) and/or ConnectorCare, these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or ConnectorCare may impact my annual 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.
17. I agree MassHealth or anyone acting on its behalf may contact me including via mail, email, call, or text for any communications about my relationship with MassHealth

or my healthcare needs, benefits, eligibility, or coverage using the contact information I provide, now or in the future, or information we obtain from a reliable data source. I also agree that MassHealth may use the same information to contact me to distribute information related to other health and welfare benefits I may be eligible to receive. These calls and texts may be made using automated technology, such as with an automatic telephone dialing system or artificial or pre-recorded voice messages. Standard message and data rates may apply.

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. I understand that the Senior Guide to Health Care Coverage contains important information about this application.
- I have permission from all persons listed on this application (or their parent or other legally authorized representative) to submit this application. I also have permission to act on their behalf to complete this application and any related eligibility process. This may include, for example:
  - providing personal information about them, including health, health coverage, and income information, seeing such information as may be provided by the Massachusetts 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 how to communicate with the Massachusetts Health Connector, MassHealth, or 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 the 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 STEP 10.
- I have told or will tell anyone listed on this application (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 Massachusetts Health Connector will treat any electronic or faxed signature, or copy of signature with the same effect as an original signature.
- I understand that MassHealth
  - is allowed to ask for SSNs under federal and state law;
  - uses SSNs to check income and other information to see who is eligible for help with health coverage costs;
  - uses SSNs to detect fraud, to see if anyone is getting duplicate benefits, or to see if others should be paying for services;
  - matches the SSN of anyone in the household who is applying and anyone who has or who can get health insurance for anyone in the household with the files of agencies and financial institutions.
- I understand that if MassHealth pays part of anyone's health insurance premiums, MassHealth will add the SSN or the SSN of that policyholder to the State Comptroller's vendor file.
- I understand that the policyholder in my household must have a valid SSN before getting a payment from MassHealth.
- 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.

If someone does not have an SSN or needs help getting one, call the Social Security Administration at (800) 772-1213, TTY: (800) 325-0778, or go to www.socialsecurity.gov. For a full explanation on how we use your social security number, please refer to the Senior Guide to Health Care Coverage.

FOR SUPPLEMENTAL NUTRITIONAL ASSISTANCE PROGRAM (SNAP) APPLICANTS

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS

If you checked the box on page 1, MassHealth will send this application to the Department of Transitional Assistance (DTA). **This will serve as your application for SNAP!** If you are eligible, your SNAP will start from the date DTA receives this MassHealth application. By signing below, you agree that you have read and agree to your SNAP Rights, Responsibilities, and Penalties under the program.

You may be eligible for SNAP benefits within 7 days of when DTA gets this application if:

- Your income and money in the bank add up to less than your monthly housing expenses, or
- Your monthly income is less than $150, and your money in the bank is $100 or less, or
- You are a migrant worker and your money in the bank is $100 or less.

For more information about SNAP in Massachusetts, go to mass.gov/SNAP.

Department of Transitional Assistance (DTA) Notice of Rights, Responsibilities and Penalties

This notice lists rights and responsibilities for all DTA programs. You must follow the rules for programs you apply for.

Please read these pages and keep them for your records.

Let DTA know if you have any questions.

I swear under penalty of perjury that:

- I have read the information in this form, or someone read it to me.
- My answers in this form are true and complete to the best of my knowledge.
- I will give DTA information that is true and complete to the best of my knowledge during my interview and in the future.

I understand that:

- giving false or misleading information is fraud,
- misrepresenting or withholding facts to get DTA benefits is fraud,
- fraud is considered an Intentional Program Violation (IPV), and
- if DTA thinks I committed fraud, DTA can pursue civil and criminal penalties against me.

I also understand that:

- DTA will verify the information I give with my application. If any information is false, DTA may deny my benefits.
- I may also be subject to criminal prosecution for providing false information.
- If DTA gets information from a reliable source about a change in my household, my benefit amount may change.
- By signing this form, I give DTA permission to verify my eligibility for benefits, including:
  - Get information from other state or federal agencies, local housing authorities, out-of-state welfare departments, financial institutions, and Equifax Workforce Solutions (the Work Number). I also give these agencies permission to share information about my household's eligibility for benefits with DTA.
  - If DTA uses information from Equifax about my household earned income, I have the right to a free copy of my Equifax report if I request it within 60 days of DTA's decision. I have the right to question the information in the report. I may contact Equifax at: Equifax Workforce Solutions, 11432 Lackland Road, St. Louis, MO 63146, 1-800-996-7566 (toll free).
- I have a right to a copy of my application, including the information that DTA uses to decide about my household's eligibility and benefit amount. I can ask DTA for an electronic copy of the completed application.

How will DTA use my information?

By signing below, I give DTA permission to get information from and share information about me and members of my household with:

- Banks, schools, government, employers, landlords, utility companies and other agencies to check if I am eligible for benefits.
- Electric, gas and telephone companies so I can get utility discounts. The companies cannot share my information or use it for any other purpose.
- The Department of Housing and Community Development to enroll me in the Heat & Eat Program. This program helps people get the most SNAP benefits possible.
- The Department of Early and Secondary Education so my children can get free school meals.
- The Woman, Infants and Children (WIC) Program so that any children under age 5 or a pregnant woman in my household can get WIC.
- The United States Citizenship and Immigration Services (USCIS), to verify my immigration status. Information from USCIS may affect my household's eligibility and amount of DTA benefits.

Note: Even if you are not eligible for benefits due to immigration status, DTA will not report you to immigration authorities unless you show DTA a final order of deportation.

- The Department of Revenue (DOR) to verify my eligibility for income-based tax credits, such as Earned Income and Limited Income, and to see if I am eligible for "No Tax Status" or hardship status.
- The Department of Children and Families (DCF) to coordinate services offered jointly by DTA and DCF.

How does DTA use Social Security Numbers (SSNs)?

DTA is allowed to ask for SSNs under The Food and Nutrition Act of 2008 (7 U.S.C. 2011-2036) for SNAP and under M.G.L. c. 18 Section 33 for TAFDC and EAEDC. DTA uses SSNs to:

- Check the identity and eligibility of each household member I apply for through data matching programs.
- Monitor compliance with program rules.
- Collect money if DTA claims I got benefits that I was not eligible for.
- Help law enforcement agencies catch people hiding from the law.

I understand that I do not have to give DTA the SSN of any non-citizen in my household, including myself, who does not want benefits. The income of a non-citizen may count even if the non-citizen does not get benefits.

Right to an Interpreter

I understand that:

- I have a right to a free professional interpreter provided by DTA if I prefer to communicate in a language other than English.
- If I have a DTA hearing, I can ask DTA to give me a free professional interpreter, or if I prefer, I can bring someone to interpret for me. If I need DTA to give me an interpreter for a hearing, I must call the Division of Hearings at least one week before the hearing date.

Right to Register to Vote

I understand that:

- I have the right to register to vote through DTA.
- DTA will help me fill out the voter registration application form if I want help.
- I can fill out the voter registration application form in private.
- Applying to register or declining to register to vote will not affect my DTA benefits.

Employment Opportunities

I agree that DTA may share my name and contact information with employment and training providers, including:

- SNAP Path Work providers or DTA specialists for SNAP clients; and

- Contracted Employment and Training providers or Full Engagement Workers for TAFDC clients.

SNAP clients may voluntarily participate in education and employment training services through the SNAP Path to Work program.

Citizenship Status

I swear that all members of my household applying for DTA benefits are either U.S. citizens, or lawfully residing noncitizens.

Supplemental Nutrition Assistance Program

I understand that:

- DTA manages the SNAP program in Massachusetts.
- When I file an application with DTA (by phone, online, in person, or by mail or fax), DTA has 30 days from the date it got my application to decide if I am eligible.
  - If I am eligible for expedited (emergency) SNAP, DTA has to give me SNAP and make sure I have an Electronic Benefit Transfer (EBT) card within 7 days from the date they got my application.
  - I have a right to speak to a DTA supervisor if:

    DTA says I am not eligible for emergency SNAP benefits, and I disagree.

    I am eligible for emergency SNAP benefits, but do not get my benefits by the 7th day after I applied for SNAP.

    I am eligible for emergency SNAP benefits but do not get my EBT card by the 7th day after I applied for SNAP.
- When I get SNAP, I have to meet certain rules. When I am approved for SNAP, DTA will give me a copy of the "Your Right to Know" brochure and the SNAP Program brochure. I will read the brochures or have someone read them to me. If I have any questions or need help reading or understanding this information, I can call DTA at 1-877-382-2363.
- Telling DTA about changes in my household:
  - If I am a SNAP Simplified Reporting household, I do not have to report most changes to DTA until the Interim Report or Recertification is due. The only things I have to report sooner are:

    If my household's income goes over the gross income threshold (listed on my approval notice). I have to report this by the 10th day of the month after the month my income went over the threshold.

    If I have to meet the Able-Bodied Adults Without Dependents (ABAWD) Work Rules and my work hours drop below 20 hours per week.
  - If everyone in my household is 60 or older, disabled, or under 18 years old, and no one has earnings from work, the only things I have to report are:

    If someone starts working, or

    Someone joins or leaves my household.

    I have to report these changes by the 10th day of the month after the month of the change.
  - If I get SNAP through Transitional Benefits Alternative (TBA) because my TAFDC stopped, I do not have to report any changes to DTA for the 5 months that I get TBA.
  - If I get SNAP through Bay State CAP, I do not have to report any changes to DTA.

If I and everyone in my household gets cash assistance (TAFDC or EAEDC), I must report certain changes to DTA within 10 days of the change. See When do I need to tell DTA about changes in my household? under Transitional Aid to Families with Dependent Children (TAFDC) and Emergency Aid to the Elderly, Disabled, and Children (EAEDC) below.

I may get more SNAP benefits if I report and give DTA proofs for the following, at any time:

- Child or other dependent care costs, shelter costs, and/or utility costs;
- Child support that I (or someone in my household) is legally required to pay to a non-household member; and
- Medical costs for members of my household, including myself, who are 60 or older or disabled.

Work rules for SNAP clients: If you get SNAP benefits and are between the ages of 16 and 59 you may need to meet general SNAP work rules or the ABAWD work rules unless you are exempt. DTA will tell me and members of my household if we need to meet any Work Rules, what the exemptions are, and what will happen if we do not meet the rules.

If you are under the SNAP Work Rules, you must:

- Register for work at application and when you recertify for SNAP. You register when you sign the SNAP application or recertification form.
- Give DTA information about your employment status when DTA asks.
- Report to an employer if referred by DTA.
- Accept a job offer (unless you have a good reason not to).
- Not quit a job of more than 30 hours a week without a good reason.
- Cut your work hours to less than 30 hours a week without a good reason.

SNAP Rules

- Do not give false information or hide information to get SNAP benefits.
- Do not trade or sell SNAP benefits.
- Do not alter EBT cards to get SNAP benefits you are not eligible for.
- Do not use SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco.
- Do not use someone else's SNAP benefits or EBT card unless you are an authorized representative, or the recipient has given you permission to use their card on their behalf.

SNAP Penalty Warnings

I understand that if I or any member of my SNAP household intentionally breaks any of the rules listed above, that person will not be eligible for SNAP for one year after the first violation, two years after the second violation and forever after the third violation. That person may also be fined up to $250,000, imprisoned up to 20 years, or both. They may also be subject to prosecution under Federal and State laws.

I also understand the following penalties. If I or a member of my SNAP household:

- Commit a cash program Intentional Program Violation (IPV) they will be ineligible for SNAP for the same period they are ineligible for cash assistance.

- Make a fraudulent statement about their identity or residency to get multiple SNAP benefits at the same time they will be ineligible for SNAP for ten years.
- Trade (buy or sell) SNAP benefits for a controlled substance/ illegal drug(s), they will be ineligible for SNAP for two years for the first finding, and forever for the second finding.
- Trade (buy or sell) SNAP benefits for firearms, ammunition or explosives, they will be ineligible for SNAP forever.
- Make an offer to sell SNAP benefits or an EBT card online or in person the State may pursue an IPV against them.
- Pay for food purchased on credit they will be ineligible for SNAP.
- Buy products with SNAP benefits with the intent to discard the contents and return containers for cash they will be ineligible for SNAP.
- Flee to avoid prosecution, custody or confinement after conviction for a felony they will be ineligible for SNAP.
- Violate probation or parole, where law enforcement is actively seeking to arrest them they will be ineligible for SNAP.

Anyone who became a convicted felon after February 7, 2014 is ineligible for SNAP benefits if they are a fleeing felon or are violating probation or parole - in accordance with 7 CFR §273.11(n) - and were convicted as an adult of:

1. Aggravated sexual abuse under section 2241 of title 18, U.S.C.;
2. Murder under section 1111 of title 18, U.S.C.;
3. Any offense under chapter 110 of title 18, U.S.C.;
4. A Federal or State offense involving sexual assault, as defined in section 40002(a) of the 1994 VAWA (42 U.S.C. 13925a); or
5. An offense under State law determined by the Attorney General to be substantially similar to an offense described in this list.

Nondiscrimination Statement

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 1-800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination:

- Complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: ascr.usda.gov/complaint_filing_cust.html, and at any USDA office. You can ask for a copy of the complaint form by calling (866) 632-9992; or
- Write a letter addressed to USDA and put in the letter all of the information requested in the form.

Submit your completed form or letter to USDA by:

- mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue SW Washington, DC 20250-9410; or
- fax: (202) 690-7442; or
- email: program.intake@usda.gov

This institution is an equal opportunity provider.

Transitional Aid to Families with Dependent Children (TAFDC) and Emergency Aid to the Elderly, Disabled, and Children (EAEDC)

TAFDC and EAEDC are cash assistance programs. To learn more and to apply, visit DTAConnect.com or call your local DTA office. This information only applies to households who are applying for or get TAFDC or EAEDC.

When do I need to tell DTA about changes in my household?

I must tell DTA about changes that could affect my TAFDC or EAEDC (cash benefits) within 10 days, except that I do not have to tell DTA about a change in my earnings of less than $100 per month. This includes changes in my income, assets, address, who I live with, family size, work, and health insurance.

How do I get health insurance?

- If I get TAFDC or EAEDC, I will get MassHealth too.
- If I am denied TAFDC or EAEDC, MassHealth will use my information to see if I am eligible for health insurance.
- If my EAEDC stops, I need to apply for MassHealth separately. To ask for an application call 1-800-841-2900.

If I get MassHealth, I agree that MassHealth may collect:

- money owed to me from another source for my medical care, and
- medical support from the absent parent of any child under age 19 who gets MassHealth benefits.

Are there special rules if I am eligible only because of an accident or injury?

If my family gets benefits from MassHealth or DTA because of an accident or injury, I must use any money I get for the accident or injury to pay them back. The money could be from an insurance policy, a settlement, or any other source. This applies even if I do not know what the possible sources of money are yet.

I agree to cooperate with MassHealth and DTA by:

- Filing claims for money from other sources.
- Telling MassHealth and DTA right away about-any insurance claim, lawsuit, or other process to get money.
- Giving MassHealth and DTA new information when I get it.

If I don't cooperate, MassHealth and DTA may stop or deny my benefits. I agree that MassHealth and DTA may:

- Share information about my benefits to collect money to repay those benefits.
- See all records about money I might get due to the accident or injury, such as records at the Department of Industrial Accidents.

If I am getting EAEDC because I have a disability or I am over 65 years old, I have to apply for federal Supplemental Security Income (SSI) benefits. If I am approved for SSI benefits that

cover the same time that I got EAEDC, the Social Security Administration will send some of my retroactive SSI to DTA to repay the EAEDC.

Important Notice About the Law and Your Benefits

An Intentional Program Violation (IPV) is intentionally giving a false or misleading statement or misrepresenting, hiding, or withholding facts, either orally or in writing, in order to establish or maintain eligibility for TAFDC or EAEDC benefits, or to gain benefits to which I am not entitled.

If I am found guilty of an IPV by a court of law, an administrative disqualification hearing, or by signing a waiver, I will be disqualified from receiving TAFDC or EAEDC benefits for a period of:

- 6 months for the first violation
- 12 months for the second violation
- forever for the third violation

In addition, other laws may apply.

Prohibitions on EBT Card Purchases

I understand it is illegal to use TAFDC or EAEDC funds held on an electronic benefit transfer (EBT) card to pay for the following: alcoholic beverages; tobacco products; lottery tickets; adult oriented material or performances; gambling; firearms and ammunition; vacation services; tattoos; body piercings; jewelry; televisions; stereos; video games or consoles at rent-to-own stores; recreational marijuana; court-ordered fees; fines; bail or bail bonds.

Prohibitions on Where I may Use My EBT Card

I understand it is illegal to use my electronic benefit transfer (EBT) card at the following locations: adult bookstores; adult paraphernalia stores or adult oriented performance establishments; ammunitions dealers; casinos; gambling casinos or gaming establishments; cruise ships; firearms dealers; jewelry stores; liquor stores; manicure shops or aesthetic shops; cash transmittal agencies to foreign countries; recreational marijuana stores or tattoo parlors.

Penalties for prohibited EBT card cash purchases

- First Offense: I must pay back DTA the amount spent.
- Second Offense: I must pay back DTA the amount spent and will lose cash benefits for two months.
- Third Offense: must pay back DTA the amount spent and will lose cash benefits permanently.

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 the 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 applicants 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			

Send us your completed application.

Mail or fax your filled-out, signed application to

MassHealth Enrollment Center
PO Box 290794
Charlestown, MA 02129-0214
Fax: (617) 887-8799

Visit a MassHealth Enrollment Center (MEC).

To apply in person or to schedule an appointment with a MassHealth representative, go to **www.mass.gov/masshealth/appointment**.

Voter Registration

The form to register to vote is included with this application or can be found at www.sec.state.ma.us. More information on how to register to vote can also be found at www.sec.state.ma.us. If you have any questions about the voter registration process, or if you need help filling out the form, please visit a local MassHealth Enrollment Center or call the MassHealth Customer Service Center at **(800) 841-2900**. TDD/TTY: 711.

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.

SUPPLEMENT A Long-Term Care / Home- and Community-Based Service Waiver

- Do you need long-term-care services in a **nursing home type facility**? ☐ Yes ☐ No
  If **Yes**, you must answer all questions and fill out all sections of this supplement.
- Are you applying for or getting long-term-care services at home under a **Home- and Community-Based Services Waiver**? ☐ Yes ☐ No
  If **Yes**, you need to fill out "Resource Transfers" and "Long –Term Care Insurance".

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

Applicant/Member Information

Last name, first name, middle initial	Social security number

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

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

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

Living expenses of the spouse and family members living at home

(Do not complete this section if you are applying for a Home- and Community-Based Service Waiver.)

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

Send proof of your spouse's current living expenses.

Spouse's last name, first name, middle initial	Social security number

2. How much does your spouse pay each month for:
   Rent? _____ Mortgage (principal and interest)? _____
   Homeowner's/tenant's insurance? _____ Real estate taxes? _____
   Required maintenance charge for a condo or co-op? _____ Room and board for assisted living? _____
3. Does your spouse pay for heat? ☐ Yes ☐ No
4. Does your spouse pay for utilities? ☐ Yes ☐ No
5. Is a child, parent, brother, and/or sister living with your spouse? ☐ Yes ☐ No

   If **Yes**, fill out this section. If **No**, go to the next section (Resource Transfers).

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

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

Resource Transfers (resources include both income and assets)

6. In the past 60 months:

   a. Has any property that was available or belonged to you or your spouse been transferred into or out of a trust? ☐ Yes ☐ No

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

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

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

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

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

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

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

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

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

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

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

   Name of facility _____

   Address of facility _____ Amount $ _____

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

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

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

      Name of person _____

      Address _____

Real Estate

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

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

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

If **Yes**, fill out the following information and answer questions 9 through 15. If **No**, answer question 15 only.

Name and address of person(s) on ownership papers _____

_____

Description and address of property location _____

_____

Type of ownership (Check one.)

☐ Individual *(Fair-market value)* $ _____ ☐ Tenancy in common *(Fair-market value)* $ _____

☐ Joint tenancy *(Fair-market value)* $ _____ ☐ Life estate *(Fair-market value)* $ _____

Name and address of person(s) on ownership papers _____

_____

Description and address of property location _____

_____

Type of ownership (Check one.)

☐ Individual *(Fair-market value)* $ _____ ☐ Tenancy in common *(Fair-market value)* $ _____

☐ Joint tenancy *(Fair-market value)* $ _____ ☐ Life estate *(Fair-market value)* $ _____

9. Do you have a spouse? ☐ Yes ☐ No. If **Yes**, fill out this section.

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

10. Do you have a permanently and totally disabled or blind child? ☐ Yes ☐ No. If **Yes**, fill out this section.

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

11. Do you have a child under 21 years of age? ☐ Yes ☐ No. If **Yes**, fill out this section.

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

12. Do you have a brother or sister with a legal interest in the home who was living in the home for at least one year immediately before your admission to the medical institution? ☐ Yes ☐ No. If **Yes**, fill out this section.

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

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

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

14. Do you have a dependent relative? ☐ Yes ☐ No. If **Yes**, fill out this section.

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

Describe the relationship and the nature of the dependency: _____

_____

15. Do you intend to return to your home? ☐ Yes ☐ No
(Do not answer this question if you are applying for a Home- and Community-Based Service Waiver.)

16. Do you or your spouse own or have a legal interest in **other** real estate not listed in #8 above? ☐ Yes ☐ No

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

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

Long-Term-Care Insurance

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

If **Yes**, fill out this section. If **No**, go to the next section (Tax Returns).

Send a copy of the policy.

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

Tax Returns

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

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

If yes, you must **send copies** of these returns. If you did not keep copies of one or more of these returns, **you must send in a filled-out and signed IRS Form 4506**. Form 4506 is included at the end of this application.

SIGN THIS SUPPLEMENT.

By signing this supplement below, I hereby certify under the pains and penalties of perjury that the submissions and statements I have made in this supplement 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 supplement as an authorized representative, you must submit an Authorized Representative Designation Form (ARD) to us for us to process this application. It is important to complete this form as this is the only way we may speak to you about this application.

Signature of applicant/member or authorized representative	Print name	Date

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

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

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

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or Urban Indian Health Programs. They also may not have to pay cost sharing 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.

AI/AN Person 1

1. Name (first, middle, last)

2. Member of a federally recognized tribe?
   ☐ Yes ☐ No
   If **Yes**, tribe name _____

3. Member of a Massachusetts-recognized tribe?
   ☐ Yes ☐ No
   If **Yes**, tribe name _____

4. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs?
   ☐ Yes ☐ No
   If **No**, is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Program, or through a referral from one of these programs?
   ☐ Yes ☐ No

5. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from
   - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations); or
   - Money from selling things that have cultural significance.

   $ _____ How often? _____

AI/AN Person 2

1. Name (first, middle, last)

2. Member of a federally recognized tribe?
   ☐ Yes ☐ No
   If **Yes**, tribe name _____

3. Member of a Massachusetts-recognized tribe?
   ☐ Yes ☐ No
   If **Yes**, tribe name _____

4. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs?
   ☐ Yes ☐ No
   If **No**, is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Program, or through a referral from one of these programs?
   ☐ Yes ☐ No

5. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from
   - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations); or
   - Money from selling things that have cultural significance.

   $ _____ How often? _____

SUPPLEMENT C Personal-Care Attendant

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

Send to: MassHealth Enrollment Center
PO Box 4405
Taunton, MA 02780

Or Fax to: (857) 323-8300

Applicant/Member information

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

Information about your health problems

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

1. _____
2. _____
3. _____

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

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

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

Caregiver information

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

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

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

X _____ _____ _____
Signature of applicant/member or authorized representative | Print name | Date

SUPPLEMENT D Health Coverage from Jobs

Answer these questions if someone in the household is eligible for health coverage from a job, whether or not they are enrolled in the coverage. Attach a copy of this page for each job that offers coverage.

TELL US ABOUT THE JOB THAT OFFERS COVERAGE.

EMPLOYEE INFORMATION

1. Employee name (first, middle, last)

2. Employee social security number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

3. a. Is at least one person on this application currently eligible for or enrolled in coverage offered by this employer, or will at least one person on this application become eligible within the next 3 months? ☐ Yes ☐ No
If the answer to 3a is **Yes**, continue. If the answer to 3a is **no**, stop here and skip the rest of Supplement D.

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

EMPLOYER INFORMATION

4. Employer name

5. Federal Tax ID (if known)
___ ___ - ___ ___ ___ ___ ___ ___ ___

6. Employer address

7. Employer phone number
( )

8. City

9. State

10. ZIP code

11. Who can we contact about employee heath coverage at this job?

12. Phone number (if different from above)

13. Email address

TELL US ABOUT HEALTH PLANS OFFERED BY THIS EMPLOYER.

14. a. What is the name of the lowest cost individual health plan offered to the employee?

b. Does the health plan offered by the employer meet the minimum value standard for coverage? ☐ Yes ☐ No

c. How much would this employee pay in premiums for this plan? $ _____

d. How often would the employee pay this amount? _____

15. a. What is the name of the lowest cost health plan to cover the other household members who qualify through the employer?
_____

b. Does this health plan offered by the employer meet the minimum value standard for coverage? ☐ Yes ☐ No

c. How much would this employee pay in premiums for this plan? $ _____

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

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

a. Employer will not offer health coverage. Coverage end date (mm/dd/yyyy) _____

b. The person plans to drop employer's health coverage. Coverage end date (mm/dd/yyyy) _____

c. Employer will start offering health coverage to employees or change the premium for the lowest-cost individual or family health plans that are available and meet the minimum value standard.* (Premium should reflect the discount for wellness programs.)

How much would this employee pay in premiums for this plan? $ _____ How often? _____

Date of change (mm/dd/yyyy) _____

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

Immigration Statuses and Document Types

Question 9a/19a on the application asks noncitizens about their immigration status and about the type or types of immigration documents they have to support their immigration status. Please refer to the following lists to fill out Question 9a/19a. If you need further help, details can be found online at www.MAhealthconnector.org/immigration-document-types.

Eligible Immigration Statuses

In the "Immigration Status" section of Question9a/19a write in any status that applies to you or members of your household. You may write in more than one status.

- Amerasian
- Granted asylum
- Cuban Haitian entrant
- Deportation withheld
- Native American born in Canada or non-US territories
- Refugee
- Victim of severe trafficking or their spouse, child, sibling, or parent
- Iraqi special immigrant
- Afghan special immigrant or certain Afghan evacuees
- Conditional entrant granted before 1980
- Veteran or active-duty member of military or their spouse or dependent
- COFA Migrant
- Lawful permanent resident
- Granted parole for at least one year
- Battered spouse or child (or their parent or child)
- Nonimmigrant status (visa)
- Granted parole for less than one year
- Granted temporary resident status
- Granted Temporary Protected Status (TPS) or applicant for TPS with employment authorization
- Granted employment authorization under 8 CFR 274a(12)(c)
- Family unity beneficiaries
- Deferred enforced departure
- Deferred Action Status except for Deferred Action for Childhood Arrivals Process (DACA)
- Granted an administrative stay of removal under 8 CFR 241
- Approved visa petition with a pending application for adjustment of status
- Applicant for asylum or for withholding of removal with employment authorization
- Applicant (for at least 180 days) under age 14 for asylum or for withholding of removal
- Granted withholding of removal under the Convention Against Torture
- Applicant for Special Immigrant Juvenile (SIJ) status
- Applicant or granted status under Deferred Action for Childhood Arrivals (DACA)
- I have a document but do not have any status listed above (Person Residing Under Color of Law, PRUCOL)

Immigration Document Types

In the "Immigration Document Type" section of Question 9a/19a, write in any document type you or members of your household have. You may list more than one immigration document type.

- Reentry Permit (I-327)
- Permanent Resident Card ("green card," I-551)
- Refugee Travel Document (I-571)
- Employment Authorization Card (I-766)
- Machine Readable Immigrant Visa (with temporary I-551 language)
- Temporary I-551 stamp (on passport or I-94, I-94A
- Arrival Departure Record (I-94, I-94A) issued by U.S. Citizenship and Immigration Services
- Arrival Departure Record in unexpired foreign passport (I-94)
- Unexpired foreign passport
- Certificate of Eligibility for Nonimmigrant (F1) Student Status (I-20)
- Certificate of Eligibility for Exchange Visitor (J1) Status (DS2019)
- Notice of Action (I-797)/Other-with Alien Number
- Notice of Action (I-797)/Other-with I-94 Number

RACE OR ETHNICITY (OPTIONAL) Choose the option(s) that best describe you. Write in all that apply.
Please specify in Question 5 on page 2 and Question 14 on page 7.

American Indian or Alaska Native (Complete Step 3 and Supplement B)

Black or African-American

White or Caucasian

Hispanic, Latino, or Spanish origin

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

Asian

- Asian Indian
- Chinese
- Japanese
- Korean
- Vietnamese
- Other Asian

Pacific Islander

- Filipino
- Guamanian or Chamorro
- Native Hawaiian
- Samoan
- Other Pacific Islander

Choose not to answer

For any race or ethnicity not listed here, please specify in Question 5 on page 2 and Question 14 on page 7.

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, or upon the death of the applicant or member. 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). 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. We sometimes refer to this person or organization as a "Section I authorized representative."
2. If you cannot designate an authorized representative in writing and you do not have an existing authorized representative or other person who is authorized by law to act on your behalf, a person (not an organization) who certifies that they will act responsibly on your behalf can be your authorized representative if that person fills out Section II of this form. We sometimes refer to this person as a "Section II authorized representative."
3. An authorized representative can also be someone who has been appointed by law to act on your behalf, or on behalf of the estate of an applicant or member who has died. 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 has authority to represent you, or the estate of a deceased applicant or member. We sometimes refer to this person as a "Section III authorized representative."
4. A **Section III** authorized representative may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the personal representative of the estate.

What can an authorized representative do?

A **Section I** or **II** authorized representative may

- fill out your application or renewal 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.

What a **Section III** authorized representative is authorized to do for you (or for the estate of a deceased applicant or member) will depend on the wording of the legal appointment.

Please note: Eligibility notices may include information about other members of an applicant's or member's household. If there are multiple people in your household we may not be able to send copies of some of your notices to your authorized representative unless each household member has also designated the same authorized representative by completing a separate Authorized Representative Designation Form.

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.

Applicant's/Member's Name	Applicant's/Member's date of birth (mm/dd/yyyy)

MassHealth ID number _ _ _ _ _ _ _ _ _ _ _ _ **OR** last four digits of the Applicant's/Member's SSN _ _ _ _

Applicant's/Member's email 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 (mm/dd/yyyy)

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 (mm/dd/yyyy)

Authorized representative's printed name	Authorized representative's email 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 (mm/dd/yyyy)

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

Email 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 the applicant or member set forth below cannot provide written designation and to the best of my knowledge does not otherwise have an individual who can act on his or her behalf such as an existing authorized representative, guardian, conservator, personal representative of the estate, holder of power of attorney, or an invoked health-care proxy. In addition, I certify that I am sufficiently aware of this applicant's or member's circumstances to assume responsibility for the accuracy 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 rights and responsibilities as this person's authorized representative (as explained earlier in this form). 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 they may remove or replace me as their 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.

If I am also a provider, staff member, or volunteer affiliated with an organization, and I am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I further 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 CFR part 431 subpart F., 42 CFR §477.10, and 45 CFR §155.260(f).

Applicant's/Member's Name	Applicant's/Member's date of birth (mm/dd/yyyy)
MassHealth ID number _ _ _ _ _ _ _ _ _ _ _ _ _ **OR** last four digits of the 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 email address

If the Section II authorized representative is affiliated with an organization, and is acting in such capacity, an individual authorized to act on behalf of the organization, such as an officer, must sign below to indicate the organization's acknowledgment of and agreement with the representations and warranties made above.

Officer's Name	Officer's Title
Officer's Signature	Date (mm/dd/yyyy)

SECTION 3 Authorized Representative Designation (if appointed by law)

To be filled out by an authorized representative appointed by law (with authority to act on behalf of the applicant or member in making decisions related to health care including, but not limited to, a guardian, conservator, personal representative of the estate of an applicant or member, holder of power of attorney, or an invoked health care proxy.) 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.

Applicant's/Member's Name	Applicant's/Member's date of birth (mm/dd/yyyy)
MassHealth ID number _ _ _ _ _ _ _ _ _ _ _ _ _ **OR** last four digits of the 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 email address

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 mail, fax, or phone. See our contact information below. 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.

The authority of a **Section I** or **Section II** authorized representative will end upon the death of the applicant or member.

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

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

How do I submit this form?

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

If you are already getting benefits, you must submit the form to us at the time you want to designate an authorized representative, or you want the declared designation to end, by

- Mailing your form to

  Health Insurance Processing Center
  PO Box 4405
  Taunton, MA 02780;
- Faxing your form to **(857) 323-8300**; or
- Calling us at **(800) 841-2900**, TDD/TTY: **711**.

Form **4506**

(Novmeber 2020)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506, visit *www.irs.gov/form4506*.**

OMB No. 1545-0429

Tip. You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T, Request for Transcript of Tax Return,** or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax return is being sent to the third party, ensure that lines 5 through 7 are completed before signing. (see instructions).

6 **Tax return requested.** Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ _____

Note: If the copies must be certified for court or administrative proceedings, check here . . . . . ☐

7 **Year or period requested.** Enter the ending date of the tax year or period using the mm/dd/yyyy format (see instructions).

____/____/____ ____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____ ____/____/____

8	**Fee.** There is a $43 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order.**	
a	Cost for each return	$
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . . . . ☐

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ _____ _____ _____
Signature (see instructions) Date

▶ _____ _____
Print/Type name **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ _____
Spouse's signature Date

▶ _____
Print/Type name

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506 and its instructions, go to *www.irs.gov/form4506*.

General Instructions

Caution: Do not sign this form unless all applicable lines, *including lines 5 through 7*, have been completed.

Designated Recipient Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information received pursuant to the taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate (on line 5) a third party to receive the tax return.

How long will it take? It may take up to 75 calendar days for us to process your request.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year or period and the chart below shows two different addresses, send your request based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:	Mail to:
Florida, Louisiana, Mississippi, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301
Alabama, Arkansas, Delaware, Georgia, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, South Carolina, Tennessee, Vermont, Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maryland, Michigan, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, West Virginia, Wyoming	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Chart for all other returns

For returns not in Form 1040 series, if the address on the return was in:	Mail to:
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409

Specific Instructions

Line 1b. Enter the social security number (SSN) or individual taxpayer identification number (ITIN) for the individual listed on line 1a, or enter the employer identification number (EIN) for the business listed on line 1a. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B,Change of Address or Responsible Party — Business, with Form 4506.

Line 7. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 return, or 03/31/2017 for a first quarter Form 941 return.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, *including lines 5 through 7*, are completed before signing.

You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5a. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. If you request a copy of a tax return, sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 16 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

Do not send the form to this address. Instead, see *Where to file* on this page.

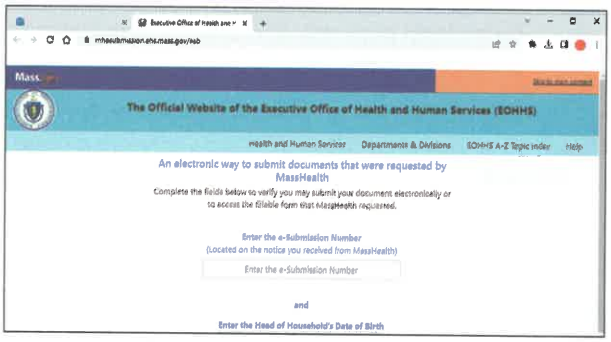
Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

IMPORTANT: YOU COULD LOSE YOUR HEALTH COVERAGE IF YOU DO NOT RESPOND TO THIS NOTICE

You **NEED TO RESPOND TO THIS NOTICE** to make sure you stay covered and get the best health coverage you qualify for. Respond before the deadline listed in this notice or **you could lose your health insurance coverage.**

HOW TO RENEW

Online – if your renewal notice has an E-Submission number you can submit your renewal online via document upload or fillable form. This is the **fastest way** to renew your coverage.



By Mail or Fax – complete the included paper renewal form and submit it to MassHealth.

Mail to:
MassHealth Enrollment Center
PO Box 290794
Charlestown, MA 02129-0214

Fax to:
Central Processing Unit
(617) 887-8799

By Phone – you can complete your renewal by phone by calling MassHealth Customer Service at (800) 841-2900 (TDD/TTY: 711)

Schedule an Appointment – schedule an appointment with a MassHealth representative by using our online scheduling tool at www.mass.gov/masshealthappointment.

Note: If you are the **parent of a child under 19 years of age who lives with you *or* if you are the adult relative living with and taking care of a child under 19 years of age when neither parent lives in the home**, you should complete the Application for Health and Dental Coverage and Help Paying Costs (ACA-3). Call MassHealth Customer Service at (800) 841-2900 (TDD/TTY: 711) to learn more.

You don't have to wait to speak with a customer service representative, and you can call 24 hours a day to find out when your renewal is due or if MassHealth needs more information to complete your application. At the prompt, enter your MassHealth Member Identification Number and Date of Birth. If you owe documents a message will inform you of what is owed and the due date.

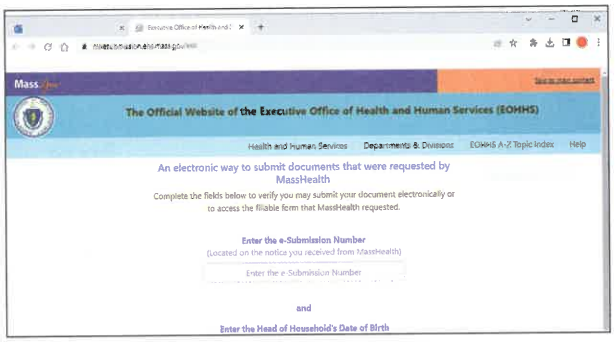
Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

IMPORTANTE: USTED PODRÍA PERDER SU COBERTURA DE SALUD SI NO RESPONDE A ESTE AVISO

Usted **DEBE RESPONDER A ESTE AVISO** para garantizar que siga cubierto y que obtenga la mejor cobertura de salud a la que califique. Responda antes de la fecha límite indicada en este aviso o **usted podría perder su cobertura del seguro de salud.**

CÓMO RENOVAR LA COBERTURA

En línea: si su aviso de renovación tiene un número de presentación electrónica (*E-Submission*), usted puede enviar su renovación en línea cargando un documento o un formulario para rellenar. Esta es la **manera más rápida** de renovar su cobertura.



Por correo postal o fax: complete el formulario de renovación impreso adjunto y envíelo a MassHealth.

Por correo postal a:
MassHealth Enrollment Center
PO BOX 290794
Charlestown, MA 02129-0214

Por fax a:
Central Processing Unit
(617) 887-8799

Por teléfono: puede completar su renovación por teléfono llamando al Servicio al cliente de MassHealth al (800) 841-2900 (TDD/TTY: 711).

Programe una cita: reserve una cita con un representante de MassHealth usando nuestra herramienta de programación de citas en línea en www.mass.gov/masshealthappointment.

Nota: Si es **el padre o la madre de un menor de 19 años que vive con usted *o* si es el pariente adulto que convive con un menor de 19 años y cuida del mismo cuando ninguno de los padres vive en el hogar**, usted debe completar la *Solicitud de Massachusetts para la cobertura de salud y dental, y ayuda para pagar los costos* (ACA-3). Llame al Servicio al cliente de MassHealth al (800) 841-2900 (TDD/TTY: 711) para informarse más.

No tiene que esperar para hablar con un representante del servicio al cliente y puede llamar durante las 24 horas para informarse de cuándo se vence la renovación o si MassHealth necesita más información para tramitar su solicitud. Cuando le indiquen, ingrese su número de identificación de afiliado de MassHealth y su fecha de nacimiento. Si nos faltan documentos, le informaremos con un mensaje cuáles nos debe enviar y la fecha límite.

Massachusetts Official Mail-In

Voter Registration Form

William Francis Galvin
Secretary of the Commonwealth

How to use this form

1. Confirm your citizenship.
2. Print your name: last name, first name, middle name or initial.
3. Print your former name, if applicable.
4. Print the address where you live now: number and street name or rural route number and box number (do not provide a post office box number), apartment number, city or town and full zip code. Use the map† at right if you cannot otherwise identify your address.
5. Print the address where you receive all your mail, if it is different from the address entered on #4.
6. Print your date of birth: month, day and year. If you are 16 or 17 years old, you will be pre-registered until you are old enough to vote. You will be notified by mail when you become eligible to vote.
7. Federal law requires that you provide your driver's license number to register to vote. If you do not have a current and valid Massachusetts driver's license, you must provide the last four digits of your social security number. If you have neither, you must write "none" in the box.
8. It is optional to provide your telephone number. If you include your telephone number and do not check "unlisted" it will be a public record.
9. Check a party, 'no party' or print a political designation (not a party).
10. Print the address where you were last registered to vote.
11. If a person is helping you because you are physically unable to sign this form, that assisting person must print their name and address and has the option to print their telephone number.
12. Read the oath.
13. Print today's date.
14. Sign your name.

This form may be mailed or hand-delivered to your city or town hall. If mailed, fold the form, tape it closed, place a first class stamp on it, print your city or town name and zip code for that city or town hall and drop into any mailbox.

You can use this form to:

- register or pre-register to vote in Massachusetts; and/or
- update your name, address, and political party.

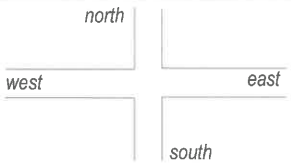
To register or pre-register to vote in Massachusetts you must:

- **BE A U.S. CITIZEN**; and
- be a Massachusetts resident; and
- be at least 16 years old.

Penalty for Illegal Registration: Fine of not more than $10,000 or imprisonment for not more than five years or both.
-Massachusetts General Laws, chapter 56 section 8.

Identification To Be Provided

Section 7 requires you to include your driver's license number or the last 4 digits of your social security number on this application. This information will be verified through the Registry of Motor Vehicles and the Commissioner of Social Security. If the information cannot be verified or you do not provide this information, you must provide identification either with this application or at your polling location when you go to vote. Sufficient identification includes a copy of a current and valid photo identification, current utility bill, bank statement, government check, paycheck or other government document showing your name and address.



†*Using landmarks, draw the location of the place where you live if you cannot describe that location as a number and street or as a rural route and box number.*

Print all information in black ink. Follow above instructions for proper delivery.

1 **Check one**: Are you a Citizen of the United States of America? ☐ Yes ☐ No NOTE: If you checked "no," do not complete this form.

2 Full name: *last name* *first name* *middle name or initial* *Jr. Sr. II III IV (circle one if appropriate)*

3 Former name: *last name* *first name* *middle name or initial* *Jr. Sr. II III IV (circle one if appropriate)*

4 Address where you live now (*street number / street name / rural route number & box number / apartment number / city or town / zip code*):

5 Address where you receive all your mail (if different from #4):

6 Date of birth: *month day year*

7 Identification #: *license # or last 4 digits of SSN*

8 Telephone (optional): ☐ *Check if unlisted*

9 Party enrollment or designation (check one): ☐ *Democratic* ☐ *Republican* ☐ *Libertarian* ☐ *No Party (unenrolled)* ☐ *Political Designation (not a political party)*:

10 Address at which you were last registered to vote(*street number / street name / rural route number & box number / apartment number / city or town / zip code*):

11 If the applicant is unable to sign this form, give the name, address and telephone number (optional) of the person helping the applicant:
name *address* *telephone number (optional)*

12 **I hereby swear (affirm)** that I am the person named above, that the above information is true, that **I AM A CITIZEN OF THE UNITED STATES**, that I am at least 16 years old and I understand that I must be 18 years old to be eligible to vote, that I am not a person under a guardianship which prohibits my registering to vote, that I am not temporarily or permanently disqualified by law from voting because of corrupt practices in respect to elections, that I am not currently incarcerated for a felony conviction, and that I consider this residence to be my home. Signed under the penalty of perjury.

13 Today's date: *month day year*

14 Signed: *Sign your name here.*

Agency Designation: BBA

Rev. 12/6/22

Return Address

name

number and street

MA

city or town zip code

Place First Class Stamp Here

Board of Registrars or Election Commission

City or Town Hall

MA

YOUR CITY OR TOWN ZIP CODE FOR CITY OR TOWN HALL

Fold along dotted line.

If you do not hear from your local election officials in 2 or 3 weeks, please call them!

To participate in...

- *state primaries*
- *state elections*
- *city and town preliminaries*
- *city and town elections*
- *regularly scheduled town meetings*
- *special town meetings*

at least 10 days before

You must register...

DEADLINES FOR VOTER REGISTRATION

This form must be received by the local Board of Registrars or Election Commission or postmarked on or before the deadline for voter registration (listed below) for that election, primary, preliminary or town meeting.

Check to make sure that you have completed all the information on the voter registration affidavit on the opposite side!

Place tape here to close. Do not use staples.

IMPORTANT INFORMATION ABOUT VOTER REGISTRATION

Dear Applicant or Member:

The National Voter Registration Act of 1993 requires MassHealth to give you the opportunity to register to vote. A voter registration application is enclosed. This letter itself is not a voter registration application. If you are not a U.S. citizen, you are not eligible to vote and you should not fill out a voter registration application.

To register to vote, fill out the enclosed Massachusetts voter registration application and send it to the local election official in your city or town, or bring it into any MassHealth Enrollment Center.
If you have any questions about registering to vote, or if you need help filling out the voter registration application, call the telephone numbers listed below or speak with a customer service representative.

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 whether 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, your right to privacy in deciding whether to register or in applying to register to vote, or 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 need additional voter registration applications, please contact one of the numbers above.

IN-OFFICE VOTER PREFERENCE FORM: This portion of the form is to be completed during in-office transactions only.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?
Yes [ ] No [ ]

Signature:_____Date: _____

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

INFORMACIÓN IMPORTANTE ACERCA DEL REGISTRO DE VOTANTES

Estimado solicitante o miembro:

La Ley Nacional de Registro de Votantes de 1993 requiere que MassHealth le dé la oportunidad para registrarse para votar. Se adjunta una solicitud de registro de votantes. La carta en sí misma no es una solicitud de registro de votantes. Si usted no es un ciudadano de EE.UU., no es elegible para votar por lo que no debe completar una solicitud de registro de votantes.

Para registrarse para votar, complete la solicitud de registro de votantes de Massachusetts adjunta y envíela al funcionario electoral de su ciudad o pueblo, o tráigalo a cualquier Centro de Inscripción de MassHealth.
Si tiene preguntas sobre cómo registrarse para votar, o si necesita ayuda para completar la solicitud de registro de votantes, llame a los números telefónicos detallados a continuación o hable con un representante de servicio al cliente.

Centro de Servicio al Cliente de MassHealth al 1-800-841-2900
(TTY: 1-800-497-4648 para personas sordas, con dificultad auditiva o discapacidad del habla).

Inscribirse para votar o declinar registrarse a votar no afectará la cantidad de asistencia que le brindará la agencia. Si desea obtener ayuda para completar el formulario de solicitud de registro de votantes, le ayudaremos. A usted le corresponde tomar la decisión de buscar o aceptar ayuda. Puede llenar el formulario de solicitud en privado.

Si cree que alguien ha interferido con su derecho para registrarse o declinar registrarse a votar, con su derecho a la privacidad al momento de decidir si se registra o al solicitar registrarse a votar, o su derecho a elegir su partido político u otra preferencia política, puede presentar una denuncia a: Secretary of the Commonwealth, Elections Division, One Ashburton Place, Room 1705, Boston, MA 02108, tel: 617-727-2828 o 1-800-462-8683.

Si necesita más solicitudes del registro de votantes, comuníquese con unos de los números mencionados arriba.

FORMULARIO INTERNO DE PREFERENCIA DEL VOTANTE: Esta porción del formulario debe completarse solamente en transacciones dentro de la oficina.

Si no está registrado para votar en su lugar de residencia actual, le gustaría registrarse para votar el día de hoy?
Sí [ ] No [ ]

Firma: _____ Fecha: _____

SI NO MARCA NINGUNA DE LAS CASILLAS, SE CONSIDERARÁ QUE ELIGIÓ NO REGISTRARSE PARA VOTAR EL DÍA DE HOY.

This information is important. It should be translated right away.
We can translate it for you free of charge.
Call us at (800) 841-2900. TDD/TTY: 711.

Esta información es importante y debe ser traducida inmediatamente. Podemos traducirla para usted gratuitamente. Llámenos al (800) 841-2900 o por TDD/TTY: 711. (Spanish)

Esta informação é importante. Deverá ser traduzida imediatamente. Nós podemos traduzí-la para você gratuitamente. Entre em contato conosco no (800) 841-2900. TDD/TTY: 711. (Brazilian Portuguese)

此處的資訊十分重要，應立即翻譯。我們可以免費爲您翻譯。請撥打電話號碼 (800) 841-2900 (TDD/TTY: 711)，與我們聯繫。 (Chinese)

Enfòmasyon sa enpòtan. Yo fèt pou tradwi li tou swit. Nou kapab tradwi li pou ou gratis. Rele nou nan (800) 841-2900. TDD/TTY: 711. (Haitian Creole)

Những tin tức này thật quan trọng. Tin tức này cần phải thông dịch liền. Chúng tôi có thể thông dịch cho quý vị miễn phí. Xin gọi cho chúng tôi tại số (800) 841-2900. TDD/TTY: 711. (Vietnamese)

Эта информация очень важна. Ее нужно перевести немедленно. Мы можем перевести ее для вас бесплатно. Позвоните нам по телефону (800) 841-2900. TDD/TTY: 711. (Russian)

هذه المعلومات هامة. يجب ترجمتها فوراً. يمكننا ترجمتها لك مجاناً. اتصل بنا على الرقم 2900-841 (800). TDD/TTY: 711. (Arabic)

នេះគឺជាព័ត៌មានសំខាន់ៗ វាគួរតែបានបកប្រែភ្លាមៗ។ យើងអាចបកប្រែជូនសំរាប់អ្នកដាយឥតគិតថ្លៃឡើយ។ សូមទូរស័ព្ទមកយើង តាមលេខ (800) 841-2900។ TDD/TTY: 711។ (Khmer)

Cette information est importante. Prière de la traduire immédiatement. Nous pouvons vous la traduire gratuitement. Appelez-nous au (800) 841-2900. TDD/TTY: 711. (French)

Questa informazione e importante. Si pregha di tradurla inmediatamente. Possiamo tradurla per voi gratuitamente. Chiammate all (800) 841-2900. TDD/TTY: 711. (Italian)

이 정보는 중요합니다. 이는 즉시 번역해야 합니다. 저희는 귀하를 위해 이를 무료로 번역해드릴 수 있습니다. 일반 전화인 경우 (800) 841-2900로, TDD/TTY 전화인 경우 711로 연락해 주십시오. (Korean)

Αυτή η πληροφορία είναι σημαντική και πρέπει να μεταφραστεί άμεσα. Μπορούμε να τη μεταφράσουμε για εσάς δωρεάν. Καλέστε μας στον αριθμό (800) 841-2900. TDD/TTY: 711. (Greek)

To jest ważna informacja. Powinna zostać niezwłocznie przetłumaczona. My tłumaczymy dla Państwa bezpłatnie. Prosimy do nas zadzwonić pod nr (800) 841-2900. TDD/TTY: 711. (Polish)

यह जानकारी महत्वपूर्ण है। इसका अनुवाद भलीभांति किया जाना चाहिए। हम आपके लिए इसका अनुवाद निशुल्क कर सकते हैं। हमें (800) 841-2900। TDD/TTY: 711 पर कॉल करें। (Hindi)

આ માહિતી મહત્વની છે. તેનું તરત જ અનુવાદ થવું જોઇએ. અમે વિના મૂલ્યે તમારા માટે તેમ કરી શકીએ છીએ. અમને (800) 841-2900. TDD/TTY: 711 પર કૉલ કરો. (Gujarati)

ຂໍ້ມູນນີ້ສຳຄັນ. ມັນມີຄວາມຈຳເປັນຕ້ອງແປເລີຍ. ພວກເຮົາ ສາມາດຊ່ວຍແປໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາພວກເຮົາໄດ້ທີ່ (800) 841-2900. TDD/TTY: 711. (Lao)

This information is available in alternative formats such as braille and large print.
To get a copy, please call us at (800) 841-2900. TDD/TTY: 711.

UNIV-14-0522

MassHealth

MassHealth complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, creed, sexual orientation or sex (including gender identity and gender stereotyping). MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation or sex (including gender identity and gender stereotyping).

MassHealth provides

→ free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, braille, accessible electronic formats, and other formats)

→ free language services to people whose primary language is not English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact us at (800) 841-2900. TDD/TTY: 711.

If you believe that MassHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping), you can file a grievance with: Section 1557 Compliance Coordinator, 1 Ashburton Place, 11th Floor, Boston, Massachusetts 02108, Phone: (617) 573-1704, TTY: (617) 573-1696, Fax: (617) 889-7862, or email at: Section1557Coordinator@state.ma.us. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Compliance Coordinator can help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, by mail at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or by phone at (800) 368-1019, (800) 537-7697 (TDD).

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.