Massachusetts Application for Health and Dental Coverage and Help Paying Costs

Commonwealth of Massachusetts | EOHHS

THINGS TO KNOW

HOW TO APPLY

You can submit your application 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.
  Applying online may be a faster way for you to get coverage than mailing a paper application.
- **Mail** your filled-out, signed application to

  Health Insurance Processing Center
  P.O. Box 4405
  Taunton, MA 02780.
- **Fax** your filled-out, signed application to 617-887-8770.
- **Call** the MassHealth Customer Services Center at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled) or **1-877-MA ENROLL (877-623-6765)**.
- **Visit** a MassHealth Enrollment Center (MEC) to apply in person. See the Member Booklet for a list of MEC addresses.

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

- Low- or no-cost coverage from MassHealth, including the Children's Medical Security Plan (CMSP), the Health Connector, or the Health Safety Net (HSN). You may qualify for a low- or no-cost program, even if you earn as much as $95,000 a year (for a household of four).
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A new tax credit that can help pay your premiums for health coverage right away.

Who can use this application?

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

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

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

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

THINGS TO KNOW

Who can use this application? (cont.)

If this application is not for you, call the MassHealth Customer Services Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

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

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

If someone is helping you fill out this application, you may need to fill out a separate form that gives that person permission to act on your behalf. See **Supplement C: Authorized Representative Designation Form** on page 19.

What you may need to apply

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

Why do we ask for this information?

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

What happens next?

- You will get instructions on the next steps to complete your application. If you do not hear from us, visit MAhealthconnector.org or call the MassHealth Customer Services Center at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled). Filling out this application does not mean you have to buy health coverage.

Get help with this application

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

  The MassHealth Customer Services Center
  1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled)

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STEP 1 Tell us about yourself.

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

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

2. Home address Check here if you are homeless. ☐			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address (if different from home address)			9. Apartment or suite number
10. City	11. State	12. ZIP code	13. County
14. Phone number	15. Other telephone number		
16. What is your preferred spoken or written language (if not English)?	17. What is your e-mail address?		

STEP 2 Tell us about your household.

Who do you need to include on this application?

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

DO Include

- yourself;
- your spouse;
- your children under 19;
- your unmarried partner who needs health coverage;
- your unmarried partner if you have children together who are under the age of 19;
- anyone your unmarried partner included on his or her tax return (even if they do not live with you), if you also include your unmarried partner;
- anyone you include on your tax return, even if they are over the age of 19 or do not live with you; and
- anyone else under 19 who you take care of and lives with you.

You DO NOT have to include

- your unmarried partner who does not need health coverage, unless you have children together;
- your unmarried partner's children unless they live with you;
- your parents who live with you, but file their own tax return (if you are over 19); or
- other adult relatives who file their own tax return.

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

COMPLETE STEP 2 FOR EACH PERSON IN YOUR HOUSEHOLD. Start with yourself, then add other adults and children. If you have more than three people in your household, including yourself, you will need to make copies of the pages for Person 3 before you fill them out, and attach them to the application. Be sure to tell us how each person is related to each other person. We need this information to determine eligibility.

STEP 2 Person 1 (Start with yourself.)

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

1. First name, middle name, last name, and suffix	2. Relationship to you **SELF**
3. Date of birth (mm/dd/yyyy)	4. Sex ☐ Male ☐ Female

5. We need a social security number (SSN) for every person applying for health coverage who has one. An SSN is optional for persons not applying for health coverage, but giving us an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone needs help getting an SSN, call the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778 for people who are deaf, hard of hearing, or speech disabled), or go to socialsecurity.gov. Please see the Member Booklet for more information.

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

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

   If no, check one of the reasons below.

   ☐ Just applied ☐ Noncitizen exception ☐ Religious exception

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

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

7. Are you a Massachusetts resident? ☐ Yes ☐ No

   a. Do you intend to reside in Massachusetts, even if you do not have a fixed address? ☐ Yes ☐ No

   b. Are you temporarily living outside Massachusetts? ☐ Yes ☐ No

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

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

   a. Will you file jointly with a spouse? ☐ Yes ☐ No You must file a joint federal tax return next year to get a tax credit or ConnectorCare plan. If you are a victim of domestic violence or are an abandoned spouse, you should indicate that you file taxes as "single" in order to be considered for a tax credit. You will only need to include yourself and any dependents on this application.

      If yes, list name of spouse. _____

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

      If yes, list name(s) of dependents. _____

   c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No If you are claimed by someone else as a dependent on their 2015 federal income tax return, this may affect your ability to receive a premium tax credit.

      If yes, please list the name of the tax filer. _____

      How are you related to the tax filer? _____

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

   If yes, are you a naturalized citizen? ☐ Yes ☐ No Naturalization or citizenship number _____

STEP 2 Person 1 (cont.)

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

    If no or **no response**, you may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN).

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

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

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

       Immigration document type _____ Document ID number _____

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

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

    b. Have you lived in the U.S. since August 22, 1996? ☐ Yes ☐ No

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

       First name, middle name, last name, and suffix _____

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

11. Do you live with at least one child under the age of 19, and are you the main person taking care of this child(ren)?

    ☐ Yes ☐ No Name(s) of child(ren) _____

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

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

14. Are you HIV positive? (Optional) ☐ Yes ☐ No
    MassHealth has special coverage rules for people who are HIV positive.

15. Are you pregnant? ☐ Yes ☐ No

    a. **If yes,** how many babies are expected during this pregnancy? _____

    b. What is your expected due date? _____

16. Were you ever in foster care? ☐ Yes ☐ No

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

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

    ☐ American Indian or Alaska Native

    ☐ Asian Indian
    ☐ Black or African American
    ☐ Chinese
    ☐ Filipino
    ☐ Guamanian or Chamorro
    ☐ Japanese
    ☐ Korean
    ☐ Native Hawaiian

    ☐ Other Asian
    ☐ Other Pacific Islander
    ☐ Samoan
    ☐ Vietnamese
    ☐ White or Caucasian
    ☐ Other
    _____

STEP 2 Person 1 (cont.)

Current Job and Income Information

☐ **Employed** (Go to question 18.) ☐ **Self-employed** (Go to question 28.) ☐ **Not employed** (Go to question 29.)

CURRENT JOB 1

18. Employer name and address

19. Wages/tips (before taxes) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly **$** _____

20. Average number of hours worked each WEEK _____ | 21. Is this job a sheltered workshop? ☐ Yes ☐ No

22. Are you seasonally employed? ☐ Yes ☐ No

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

23. Employer name and address

24. Wages/tips (before taxes) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly **$** _____

25. Average number of hours worked each WEEK _____ | 26. Is this job a sheltered workshop? ☐ Yes ☐ No

27. Are you seasonally employed? ☐ Yes ☐ No

28. **If self-employed, answer the following questions.**

a. Type of work _____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? **$** _____

OTHER INCOME

29. 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, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Social security benefits $ _____ How often? _____

☐ Unemployment $ _____ How often? _____

☐ Retirement $ _____ How often? _____

☐ Capital gains $ _____ How often? _____

☐ Investment income $ _____ How often? _____

☐ Net rental or royalty income $ _____ How often? _____

☐ Net farming or fishing income $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Other income $ _____ How often? _____ Type _____

STEP 2 Person 1 (cont.)

DEDUCTIONS

30. Check all that apply, and give the amount and how often you get it.

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

☐ Alimony paid $ _____ How often? _____ ☐ Student loan interest $ _____ How often? _____

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

Type _____ $ _____ How often? _____

YEARLY INCOME

31. Your total income this year	32. Your total income next year (if you think it will be different)

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

STEP 2 Person 2

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

1. First name, middle name, last name, and suffix	2. Relationship to Person 1
Does this person live with Person 1? ☐ Yes ☐ No	**If no,** list address.
3. Date of birth (mm/dd/yyyy)	4. Sex ☐ Male ☐ Female

5. We need a social security number for every person applying for health coverage who has one. Please see the Member Booklet for more information.

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

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

If no, check one of the reasons below.

☐ Just applied ☐ Noncitizen exception ☐ Religious exception

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

☐ **Yes. If yes,** answer all the questions below.

☐ **No. If no,** go to **Current Job and Income Information** on page 7.

7. Is this person a Massachusetts resident? ☐ Yes ☐ No

a. Does this person intend to reside in Massachusetts, even if he or she does not have a fixed address? ☐ Yes ☐ No

b. Is this person temporarily living outside Massachusetts? ☐ Yes ☐ No

STEP 2 Person 2 (cont.)

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

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

   a. Will this person file jointly with a spouse? ☐ Yes ☐ No This person must file a joint federal tax return next year to get a tax credit or ConnectorCare plan. If this person is a victim of domestic violence or is an abandoned spouse, this person should indicate that he or she files taxes as "single" in order to be considered for a tax credit. This person will only need to include himself or herself and any dependents on this application.

      If yes, list name of spouse. _____

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

      If yes, list name(s) of dependents. _____

   c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No If this person is claimed by someone else as a dependent on their 2015 federal income tax return, this may affect his or her ability to receive a premium tax credit.

      If yes, please list the name of the tax filer. _____

      How is this person related to the tax filer? _____

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

   If yes, is this person a naturalized citizen? ☐ Yes ☐ No Naturalization or citizenship number _____

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

    If no or **no response**, this person may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN).

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

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

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

       Immigration document type _____ Document ID number _____

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

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

    b. Has this person lived in the U.S. since August 22, 1996? ☐ Yes ☐ No

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

       First name, middle name, last name, and suffix _____

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

11. Does this person live with at least one child under the age of 19, and is this person the main person taking care of this child(ren)?

    ☐ Yes ☐ No Name(s) of child(ren) _____

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

STEP 2 Person 2 (cont.)

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

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

15. Is this person pregnant? ☐ Yes ☐ No
    a. **If yes,** how many babies are expected during this pregnancy? _____
    b. What is this person's expected due date? _____

16. Was this person ever in foster care? ☐ Yes ☐ No

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

- ☐ Hispanic, Latino, or Spanish origin
  - ☐ Cuban
  - ☐ Mexican, Mexican-American, or Chicano
  - ☐ Puerto Rican
  - ☐ Other Hispanic/Latino/ Spanish _____
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White or Caucasian
- ☐ Other
  _____

Current Job and Income Information

☐ **Employed** (Go to question 18.) ☐ **Self-employed** (Go to question 28.) ☐ **Not employed** (Go to question 29.)

CURRENT JOB 1

18. Employer name and address

19. Wages/tips (before taxes) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly **$** _____

20. Average number of hours worked each WEEK _____

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

22. Is this person seasonally employed? ☐ Yes ☐ No

CURRENT JOB 2 If this person has more jobs and needs more space, attach another sheet of paper.

23. Employer name and address

24. Wages/tips (before taxes) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly **$** _____

25. Average number of hours worked each WEEK _____

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

27. Is this person seasonally employed? ☐ Yes ☐ No

28. **If this person is self-employed, answer the following questions.**
    a. Type of work _____
    b. How much net income (profits once business expenses are paid) will this person get from this self-employment this month? **$** _____

STEP 2 Person 2 (cont.)

OTHER INCOME

29. 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, veteran's payment, or Supplemental Security Income (SSI).

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

DEDUCTIONS

30. Check all that apply, and give the amount and how often this person gets it.

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

☐ Alimony paid $ _____ How often? _____ ☐ Student loan interest $ _____ How often? _____

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

Type _____ $ _____ How often? _____

YEARLY INCOME

31. Total income this year for this person	32. Total income next year for this person (if you think it will be different)

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

STEP 2 Person 3 (if more than 3 People, this is Person _____)

If you have more than three people to include with this application, make a copy of blank information pages for Step 2 Person 3 BEFORE you fill them out. When filling out the additional pages please be sure to tell us how each person is related to each other person on the application. We need this information to determine eligibility.

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

1. First name, middle name, last name, and suffix | 2. Relationship to Person 1

Does this person live with Person 1? ☐ Yes ☐ No | **If no,** list address.

Relationship to Person 2 | 3. Date of birth (mm/dd/yyyy) | 4. Sex ☐ Male ☐ Female

5. We need a social security number for every person applying for health coverage who has one. Please see the Member Booklet for more information.

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

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

   If no, check one of the reasons below.

   ☐ Just applied ☐ Non-citizen exception ☐ Religious exception

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

   ☐ **Yes. If yes,** answer all the questions below.

   ☐ **No. If no,** go to **Current Job and Income Information** on page 11.

7. Is this person a Massachusetts resident? ☐ Yes ☐ No

   a. Does this person intend to reside in Massachusetts, even if he or she does not have a fixed address? ☐ Yes ☐ No

   b. Is this person temporarily living outside Massachusetts? ☐ Yes ☐ No

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

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

   a. Will this person file jointly with a spouse? ☐ Yes ☐ No This person must file a joint federal tax return next year to get a tax credit or ConnectorCare plan. If this person is a victim of domestic violence or is an abandoned spouse, this person should indicate that he or she files taxes as "single" in order to be considered for a tax credit. This person will only need to include himself or herself and any dependents on this application.

      If yes, list name of spouse. _____

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

      If yes, list name(s) of dependents. _____

STEP 2 Person 3 (if more than 3 People, this is Person _____) (cont.)

c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No If this person is claimed by someone else as a dependent on their 2015 federal income tax return, this may affect his or her ability to receive a premium tax credit.

If yes, please list the name of the tax filer. _____

How is this person related to the tax filer? _____

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

If yes, is this person a naturalized citizen? ☐ Yes ☐ No Naturalization or citizenship number _____

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

If no or **no response**, this person may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN).

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

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

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

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

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

b. Has this person lived in the U.S. since August 22, 1996? ☐ Yes ☐ No

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

First name, middle name, last name, and suffix _____

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

11. Does this person live with at least one child under the age of 19, and is this person the main person taking care of this child(ren)?

☐ Yes ☐ No Name(s) of child(ren) _____

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

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

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

15. Is this person pregnant? ☐ Yes ☐ No

a. **If yes,** how many babies are expected during this pregnancy? _____

b. What is this person's expected due date? _____

16. Was this person ever in foster care? ☐ Yes ☐ No

STEP 2 Person 3 (if more than 3 People, this is Person _____) (cont.)

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

- ☐ Hispanic, Latino, or Spanish origin
  - ☐ Cuban
  - ☐ Mexican, Mexican-American, or Chicano
  - ☐ Puerto Rican
  - ☐ Other Hispanic/Latino/ Spanish _____
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White or Caucasian
- ☐ Other

_____

Current Job and Income Information

☐ **Employed** (Go to question 18.) ☐ **Self-employed** (Go to question 28.) ☐ **Not employed** (Go to question 29.)

CURRENT JOB 1

18. Employer name and address

19. Wages/tips (before taxes) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly **$** _____

20. Average number of hours worked each WEEK _____

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

22. Is this person seasonally employed? ☐ Yes ☐ No

CURRENT JOB 2 If this person has more jobs and needs more space, attach another sheet of paper.

23. Employer name and address

24. Wages/tips (before taxes) ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly **$** _____

25. Average number of hours worked each WEEK _____

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

27. Is this person seasonally employed? ☐ Yes ☐ No

28. **If this person is self-employed, answer the following questions.**

a. Type of work _____

b. How much net income (profits once business expenses are paid) will this person get from this self-employment this month? **$** _____

STEP 2 Person 3 (if more than 3 People, this is Person _____) (cont.)

OTHER INCOME

29. 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, veteran's payment, or Supplemental Security Income (SSI).

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

DEDUCTIONS

30. Check all that apply, and give the amount and how often this person gets it.

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

☐ Alimony paid $ _____ How often? _____ ☐ Student loan interest $ _____ How often? _____

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

Type _____ $ _____ How often? _____

YEARLY INCOME

31. Total income this year for this person	32. Total income next year for this person (if you think it will be different)

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

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

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

☐ **No. If No,** skip to Step 4.

☐ **Yes. If yes,** go to Supplement B. Name(s) of person(s) _____

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

STEP 4 Your Household's Health Coverage

1. Is anyone enrolled in health coverage now from the following?

☐ **Yes. If yes,** check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **No.**

☐ Medicare _____

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

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer insurance _____

Name of health insurance _____

Policy number _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other _____

Name of health insurance _____

Policy number _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. Is anyone listed on this application offered health coverage from a job?

☐ **Yes. If yes,** you will need to complete and include Supplement A.

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

☐ **No. If no, continue to Step 5.**

STEP 5 Read and sign this application.

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

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

STEP 5 Read and sign this application. (cont.)

16. Eligible persons must tell the health care program(s) in which they enroll about any changes in their or their household's income or employment, household size, health insurance coverage, health insurance premiums, and immigration status, or about changes in any other information on this application and any supplements to it within 10 calendar days of learning of the change. Eligible persons can make changes by calling **1-888-665-9993** (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled). A change in information could affect eligibility for such persons or for persons in their household.

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

    - Sign on to your account at MAhealthconnector.org.
      You can create an online account if you do not already have one.
    - Send the change information to **Health Insurance Processing Center**
      P.O. Box 4405
      Taunton, MA 02780.
    - Fax the change information to **617-887-8770**.

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

    _____ is in prison or jail. Is this person awaiting trial? ☐ Yes ☐ No

I AGREE TO THE FOLLOWING STATEMENTS.

- I have read or have had read to me the information on this application, including any supplements and instruction pages, and I understand that the Member Booklet contains important information.
- I have permission from all persons listed on this application (or their parent or other legally authorized representative) to submit this application and to act on their behalf to complete this application and any ongoing or subsequent eligibility process and activity, including, for example:
  - providing personal information about them, including health, health coverage, and income information, seeing such information as may be provided by the Health Connector, MassHealth, and the Health Safety Net, and providing consent on their behalf to the use and disclosure of their information as described in this application;
  - making choices about coverage options and methods of communication with the Health Connector, MassHealth, and the Health Safety Net;
  - making changes to the application or related eligibility documents and providing information about any change in their circumstances; and
  - providing consent on their behalf to use government and private sources to verify information as described in this application.
- I understand my rights and responsibilities and the rights and responsibilities of all persons listed on this application as explained in this Step 5.
- I have told or will tell all such persons (or their parent or legally authorized representative, if applicable) about these rights and responsibilities so they understand them.
- I understand and agree that MassHealth, the Health Safety Net, and the Health Connector will treat electronic, faxed, or copies of signatures with the same force and effect as an original signature(s).
- The information I have supplied is correct and complete to the best of my knowledge about myself and other persons listed on this application.
- I may be subject to penalties under federal law if I intentionally provide false or untrue information.

Sign this application.

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

Important: If you are submitting this application as an authorized representative, you must submit an **Authorized Representative Designation Form** (**Supplement C** on page 19) to us or have a form on record for us to process this application.

Signature of Person 1 or authorized representative	Print name	Date

STEP 5 Read and sign this application. (cont.)

For enrollment assisters only

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

Date (mm/dd/yyyy)	Check one ☐ Navigator ☐ Certified Application Counselor

First name, middle name, last name and suffix

Organization name	Organization identification number

STEP 6 Send us your completed application.

Mail your signed application to:

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

Fax to:

617-887-8770

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 Services Center at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

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

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

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

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

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

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

SUPPLEMENT A Health Coverage from Jobs

You DO NOT need to answer these questions unless someone in the household is eligible for health coverage from a job. 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 ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER INFORMATION

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

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

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

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

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

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

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

Name _____ Name _____ Name _____

Tell us about the health plan offered by this employer.

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

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (do not include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he or she received the maximum discount for any tobacco cessation programs and did not receive any other discounts based on wellness programs.

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

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

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

☐ Employer will not offer health coverage.

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

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

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

Date of change (mm/dd/yyyy) _____

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

SUPPLEMENT B American Indian or Alaska Native Household 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 and state affiliation

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?

   ☐ Yes ☐ No

   If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?

   ☐ Yes ☐ No

4. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from

   - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations); or
   - Money from selling things that have cultural significance.

   $ _____ How often? _____

AI/AN Person 2

1. Name (first, middle, last)

2. Member of a federally recognized tribe?

   ☐ Yes ☐ No

   If yes, tribe name and state affiliation

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?

   ☐ Yes ☐ No

   If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs?

   ☐ Yes ☐ No

4. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from

   - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations); or
   - Money from selling things that have cultural significance.

   $ _____ How often? _____

SUPPLEMENT C Authorized Representative Designation Form

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

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

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

You can choose someone to help you.

You may choose an authorized representative to help you get health care coverage through programs offered by MassHealth and the Health Connector. You can do this by filling out this form (the Authorized Representative Designation Form) or a sufficiently similar designation document. You or a representative can sign for yourself and for any of your dependent children under the age of 18 for whom you are the custodial parent.
You are not required to have a representative in order to apply for or receive benefits.

Who can help me?

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

What can an authorized representative do?

An authorized representative may

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

How does an authorized representative designation end?

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

- Mailing a letter notifying us that the designation has ended to

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

- Faxing a letter notifying us that the designation has ended to **(617) 887-8770**; or
- Calling us at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

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

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

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

In addition, an authorized representative's designation for a minor child ends on the child's 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 by doing the following.

- Mailing your form to

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

- Faxing your form to **(617) 887-8770**; or
- Calling us at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

SECTION 1 Authorized Representative Designation

(if applicant or member is able to sign)

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

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

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

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

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

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

B1. COMPLETE IF AUTHORIZED REPRESENTATIVE IS A PERSON.

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

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

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

B2. COMPLETE IF AUTHORIZED REPRESENTATIVE IS AN ORGANIZATION.

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

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

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

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

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

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

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

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

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

Applicant's/Member's name

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

SECTION 3 Authorized Representative Designation (if appointed by law)

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

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

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

Applicant's/Member's name

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