MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Senior Medical Benefit Request
for Seniors and People Needing Long-Term-Care Services
Instruction Page

HealthConnector
CommonwealthCare

Please read these instructions before you fill out the application.

Dear Applicant:

This is your application for MassHealth and the Health Safety Net* if you live in Massachusetts and:

- are aged 65 or older and living at home;
- are any age and need long-term-care services in a medical institution;
- are eligible under certain programs to get long-term-care services to live at home; or
- are a member of a married couple living with your spouse and
  - both you and your spouse are applying for MassHealth; and
  - there are no children under age 19 living with you; and
  - one spouse is 65 years of age or older and the other spouse is under 65 years of age. (Please read page 11.)

You will also need to fill out Supplement A: Long-Term-Care Questions (see blue sheet) if you are:

- in an institution, like 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 11 in the *MassHealth and You* 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.

This application is also used to apply for **Commonwealth Care**. Commonwealth Care is a program administered by the Commonwealth Health Insurance Connector Authority ("the Health Connector") for certain seniors who are not eligible for MassHealth or Medicare.

Commonwealth Care helps pay for health-insurance premiums for health plans that are approved by the Health Connector. For more information, see page 22 in the *MassHealth and You* guide.

After your application is filled out and reviewed, **MassHealth will give you the most complete coverage that you qualify for.**

There is a different application for you, called a Medical Benefit Request (MBR), if you are:

- any age and both disabled and working 40 or more hours a month or you are currently working and have worked at least 240 hours in the six months before the date of application, and not living with your spouse aged 65 years or older;
- under age 65 and not in a medical institution, and you do not need long-term-care services; or
- aged 65 or older and a parent or caretaker relative of children under age 19.

To get the MBR, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

* Information you provide on this application will be used to determine low-income patient status for provider payments from the Health Safety Net.

This application package contains:

- a Senior Medical Benefit Request (orange form);
- the *MassHealth and You* guide, which explains who is eligible for MassHealth, Commonwealth Care, and the Health Safety Net, what the income and asset rules are, what medical services you can get under MassHealth, and what your rights and responsibilities are;
- a MassHealth Eligibility Representative Designation Form (If you want someone to act on your behalf, you can use this form to tell us who this person is.);
- an IRS Form 4506; and
- a Personal-Care-Attendant Supplement (gold form).

When you fill out the Senior Medical Benefit Request, remember to:

- Read carefully the *MassHealth and You* guide before you fill out the application. Keep the guide. It may answer questions you have later.
- Answer all questions and fill out all sections that apply to you on the application and, if necessary, the gold form. If you need more space, use a separate sheet of paper (include your name and social security number), and attach it to the application.
- Send proof of all current income before deductions, like copies of pension check stubs. (You do not have to send proof of social security or SSI income, but you must fill out that section of the application.) If you are a disabled working adult, please see the "CommonHealth" section of the MassHealth Member Booklet.
- Send proof of all assets, like bank accounts and life-insurance policies.
- Send proof of U.S. citizenship/national status and proof of identity, like U.S. passports or U.S. naturalization papers. You can also prove U.S. citizenship with a U.S. birth certificate or a U.S. hospital birth record. You can also prove your identity with a driver's license or some other form of government-issued identity 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 proof of identity for all family 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 pages 28-29 in the *MassHealth and You* guide for complete information about acceptable proofs.)
- Send 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 or Commonwealth Care, except for MassHealth Limited or the Health Safety Net.
- Send copies of your current health-insurance premium bills (like 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.)
- Please remember when filling out the "Health Insurance" section on pages 4 and 5, that:
  - Part A is for listing the health insurance you have now, and Part B is for health insurance you may be eligible for; and
  - you will not be eligible for Commonwealth Care if you have or can get insurance from a government insurance program including, but not limited to: Medicare, TRICARE (dependents of the military), Medical Security Program (through the Division of Unemployment Assistance), or student health insurance from a Massachusetts school.
- Please give us a social security number (SSN) or proof that you have applied for an SSN for you and your spouse. Applicants for MassHealth Limited do not need to provide a social security number or proof of an application for a social security number.
- Sign and date all the forms after you finish filling them out. If you are married, your spouse must also sign.
- Submit a filled-out MassHealth Eligibility Representative Designation Form, if you are filling out this application as an eligibility representative or if you want someone to act on your behalf.

If you are applying for health benefits,

either **send** your filled-out Senior Medical Benefit Request to

MassHealth Enrollment Center
Central Processing Unit
P.O. Box 290794
Charlestown, MA 02129-0214

or **hand deliver** it to

MassHealth Enrollment Center
Central Processing Unit
Schrafft's Center
529 Main Street, Suite 1M
Charlestown, MA 02129

If you need more information about how to apply, or if you need another copy of the Personal-Care-Attendant Supplement for your spouse who is also applying, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

If you want us to share information about your MassHealth eligibility (including copies of notices we send you) with someone other than your eligibility representative, if you have one, please call MassHealth. We can give you a MassHealth Permission to Share Information Form.

If you have any questions about any form or the information you need to send, please call a MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled).

When we get your filled-out, signed, and dated application, we will review it. If more information is needed, we will write or call you. **Once we get all needed information, we will make a decision about your eligibility. We will send you a written notice about this decision.** If you are determined eligible for MassHealth, show this notice right away to any health-care provider if you already 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.

MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Senior Medical Benefit Request
for Seniors and People Needing Long-Term-Care Services

HealthConnector CommonwealthCare

For office use only
Date received:

This is an application for **MassHealth**, **Commonwealth Care**, and the **Health Safety Net.** You do not have to be a U.S. citizen/national to get these benefits. **Please print clearly**. Please answer **all** questions and fill out all sections and any supplements that apply to you. If you need more space to finish any section on this form, please use a separate sheet of paper (include your name and social security number), and attach it to this form.

You MUST answer ALL three questions in the following section.

Are you or your spouse applying for:

1. MassHealth or the Health Safety Net while still living at home, in a rest home, in an assisted-living facility, a continuing-care retirement community, or a life-care community?
   You ☐ yes ☐ no **Your spouse** ☐ yes ☐ no
2. MassHealth while still living at home or in one of the living situations described in question #1 above AND also either applying for or getting services under a Home- and Community-Based Services Waiver, PACE (Program of All-Inclusive Care for the Elderly), or SCO (Senior Care Options)?
   You ☐ yes ☐ no **Your spouse** ☐ yes ☐ no
3. MassHealth because you are living in a medical institution, like a nursing home or chronic hospital?
   You ☐ yes ☐ no **Your spouse** ☐ yes ☐ no

If you are applying for or getting long-term-care services at home under a Home- and Community-Based Services Waiver, or in a nursing home or chronic hospital, you **must** also fill out all or part of the blue sheet (Supplement A: Long-Term-Care Questions) at the end of this application.

Head of Household/Applicant

HOH

Last name	First name	MI	Street address	City	State	Zip

Mailing address (*if different from street address or if living in a shelter*) ☐ homeless

City State Zip

Marital status ☐ single ☐ married ☐ separated ☐ widowed ☐ divorced	Is this person a U.S. citizen/national? ☐ yes ☐ no	Gender ☐ M ☐ F

Social security number*	Date of birth /	Race (*optional*)	Ethnicity (*optional*)

Spoken language choice	Written language choice	E-mail

Telephone numbers Home: Cell: Work:

Name and address of hospital, nursing facility, or other institution (if applicable)

Date of admission	Were you placed here by another state? ☐ yes ☐ no	If yes, what state?

Spouse Information

HOH

Last name	First name	MI	Social security number*

Is this person applying? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen/national? ☐ yes ☐ no	Date of birth	Gender ☐ M ☐ F

Race (*optional*)	Ethnicity (*optional*)	Spoken language choice	Written language choice

Address, if different from head of household

Is this a hospital, nursing facility, or other institution? ☐ yes ☐ no

* Applicants must provide a social security number if one has been provided. Applicants for MassHealth Limited are not required to provide a social security number or proof of application for a social security number.

Residency (You must fill out this section.) MAR

Are you and all members of your household who are applying for benefits living in Massachusetts with the intention to stay? ☐ yes ☐ no

If **no**, list the names of the members of your household (including yourself)* who are applying and who are **not** residents of Massachusetts and who intend to leave.

*Do not include infants born in Massachusetts who have not left the state.

Previous Medical Bills RET

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 the next section (*Previous Assistance*).

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?
(You must give us proof of all income and assets owned during that time period.)

Previous Assistance SSI

Have you or your spouse ever gotten Supplemental Security Income (SSI)? You ☐ yes ☐ no Your spouse ☐ yes ☐ no

If **yes**, fill out the rest of this section. If **no**, go to the next section (*Personal-Care-Attendant Services*).

When did you or your spouse last get SSI? You Your spouse

Do you (Please check one.) ☐ live in own home? ☐ share expenses with another/others? ☐ live in someone else's home?
☐ live in a rest home? ☐ live in an assisted-living facility?

Personal-Care-Attendant Services (for people aged 65 or older who are not going into a long-term-care facility) PCA

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 *MassHealth and You* 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 the next section (*Working Income*).
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 the next section (*Working Income*). 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
   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
   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 his or her own Personal-Care-Attendant Supplement (gold form). One copy is enclosed. If you need a second copy, call MassHealth Customer Service at 1-800-841-2900 to ask for one. If you (or your spouse) do not send us your filled–out PCA supplement(s) (gold form), we will determine your MassHealth eligibility as if you do not need PCA services.

Please go to the next page ►

General instructions for filling out the Working Income, Nonworking Income, AND College Student sections

Each person who has income and/or is aged 19 or older must fill out all sections on this page and the next page (page 4).

Working Income (You must fill out this section.)

EIN

Name

Is this person currently working or seasonally employed? **(You must answer this question.)** ☐ yes ☐ no

If **yes**, fill out the **Employer Information** section below.
If **no**, answer the next two questions below. You do not have to fill out the "Employer Information" section below.

Has this person worked in the last 12 months before the date of application? ☐ yes ☐ no

If **yes**, how much did this person earn in the last 12 months before taxes and deductions? **Note:** If you answered **"yes"** to this question, you **MUST** enter a dollar amount on this line. $ If **no**, go to the next section *(Nonworking Income)*.

Employer Information Employer name

Employer address, and telephone number

Type of work (*Check all that apply.*) ☐ full-time ☐ day labor ☐ part-time ☐ seasonal yearly wage: $
☐ self-employed ☐ sheltered workshop yearly wage: $

Number of hours per week Weekly pay before deductions $ Date began getting this amount of pay

Is health insurance offered that would cover doctors' visits and hospitalizations? ☐ yes ☐ no
(Answer **yes** even if you cannot get it now, chose not to sign up for it, or dropped insurance that was available.)

If you answered **no** to the above question, was health insurance offered in the last six months? ☐ yes ☐ no

Send proof of income, like a copy of one recent pay stub. If self-employed, see the *MassHealth and You* guide for information about the needed proof.

For office use only (indicate weekly, biweekly, semimonthly, or monthly) HID $ _____ Hrs _____ $ _____ Hrs _____

Nonworking Income (You must fill out this section.)

Rental Income Do you or your spouse get rental income? (**You must answer this question**.) ☐ yes ☐ no

REN

If **yes**, fill out this section.
If **no**, go to the next section (*Unemployment Benefits*).

Name(s):

Send proof of current rental income, like a written statement from each tenant or a copy of the lease, or a current federal tax return.

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

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

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

Address Unit # Amount $ Owner-occupied? yes no

Address Unit # Amount $ Owner-occupied? yes no

Do you pay for heat and/or utilities for your tenant? ☐ yes ☐ no

Unemployment Benefits Are you or your spouse getting an unemployment check? **(You must answer this question.)** ☐ yes ☐ no

UIN

If **yes**, fill out this section and answer all questions.
If **no**, go to the next section (*Other Nonworking Income*)

Is this check from the Commonwealth of Massachusetts? You yes no Your spouse yes no CC

If **yes**, in the 12 months before this person became unemployed, did this person work for an employer in Massachusetts? (Do not include federal employers, like the U.S. Postal Service.) You yes no Your spouse yes no CC

Enter the monthly amount of unemployment benefits (before taxes and deductions). You $ Your spouse $

Send proof of unemployment benefits.

Please go to the next page ►

Other Nonworking Income Do you or your spouse have any other income? **(You must answer this question.)** ☐ yes ☐ no

If **yes**, fill out this section.
If **no**, go to the next section (*College Student*)

Please describe the source of the income (where it comes from) for you and your spouse. If you or your spouse have more than one source, list on separate lines.

Send proof. Some types of other income are: (You do not have to send proof of social security or SSI income.)

- alimony
- annuities
- child support
- dividends or interest
- pensions
- retirement
- social security
- SSI
- trusts
- veterans' benefits (federal, state, or city)
- workers' compensation
- other (*Please describe below.*)

Name	Type of income (all that apply from list above)
Source (where the income comes from)	Monthly amount before taxes $
Name	Type of income (all that apply from list above)
Source (where the income comes from)	Monthly amount before taxes $
Name	Type of income (all that apply from list above)
Source (where the income comes from)	Monthly amount before taxes $

College Student (You must fill out this section.)

Are you or your spouse member a college student? **(You must answer this question.)** ☐ yes ☐ no

If **yes**, fill out this section and answer all questions.
If **no**, go to the next section (*Health Insurance You Have Now and Subsidized Health Insurance You May Be Eligible For*).

Name

Are you or your spouse eligible for health insurance from college? ☐ yes ☐ no CC

Are you or your spouse a college student at a school in Massachusetts with at least 75% of a full-time schedule? ☐ yes ☐ no

Note: If you are not sure you or your spouse have 75% of a full-time schedule, contact the school to find out if the number of credits you or your spouse is taking would require you or your spouse to get the health insurance the school offers to students.)

If **yes**, are you or your spouse planning to get health-insurance coverage from the school, but are waiting for the coverage to start? ☐ yes ☐ no CC

If **yes**, what is the date that the school health-insurance coverage starts? CC

Health Insurance You Have Now and Subsidized Health Insurance You May Be Eligible For HIN

Even if you or your spouse have other health insurance, MassHealth may be able to help you pay your premiums. Health insurance can be from an employer, an absent parent, a union, a school, Medicare, or Medicare supplemental insurance, like Medex. **All applicants must fill out the health insurance section. Do not include MassHealth or any health plan you enrolled in through Commonwealth Care when answering the questions below.**

Do you or your spouse get Medicare benefits? ☐ yes ☐ no

If **yes**, name(s):

Claim number(s):

Do you or your spouse have health insurance other than Medicare? ☐ yes ☐ no

If **yes**, fill out both **Part A** and **Part B** on the next page.
If **no**, fill out only **Part B** on the next page.

Send copies of your or your spouse's current health-insurance premium bills if you or your spouse are applying for long-term-care services in a medical facility.

Please go to the next page ►

Part A: Health Insurance You Have Now

1. Policyholder name | Date of birth

Social security number* | Insurance company name

Policy type (*Check one.*) ☐ individual ☐ couple (two adults) ☐ dual (one adult, one child) ☐ family | Policy start date

Policy number | Group number (if known)

Employer or union name

Policyholder contribution to premium costs (*Complete one.*) $ per week | $ per quarter | $ per month

Insurance type (*Check one.*) ☐ employer or union subsidized (employer or union pays some or all of the insurance cost) ☐ TRICARE
☐ other federal or state subsidized (government pays some or all of the insurance cost) ☐ student health insurance through school
☐ nonsubsidized, like self-employment or COBRA (policyholder pays total insurance cost) ☐ Medical Security Program

Names of covered family members

Insurance coverage (*Check all that apply.*) ☐ doctors' visits and hospitalizations ☐ catastrophic only ☐ vision only ☐ pharmacy only ☐ dental only

If you or your spouse have long-term-care insurance, **send a copy** of the policy.

2. Policyholder name | Date of birth

Social security number* | Insurance company name

Policy type (*Check one.*) ☐ individual ☐ couple (two adults) ☐ dual (one adult, one child) ☐ family | Policy start date

Policy number | Group number (if known)

Employer or union name

Policyholder contribution to premium costs (*Complete one.*) $ per week | $ per quarter | $ per month

Insurance type (*Check one.*) ☐ employer or union subsidized (employer or union pays some or all of the insurance cost) ☐ TRICARE
☐ other federal or state subsidized (government pays some or all of the insurance cost) ☐ student health insurance through school
☐ nonsubsidized, like self-employment or COBRA (policyholder pays total insurance cost) ☐ Medical Security Program

Names of covered family members

Insurance coverage (*Check all that apply.*) ☐ doctors' visits and hospitalizations ☐ catastrophic only ☐ vision only ☐ pharmacy only ☐ dental only

If you or your spouse have long-term-care insurance, **send a copy** of the policy.

Part B: Subsidized Health Insurance You May Be Eligible For

Are you or your spouse in one of the uniformed services? ☐ yes ☐ no

If **yes**, fill out the section below. (The uniformed services are the Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Services, National Oceanic and Atmospheric Administration, and the National Guard or Reserves.)

1. Name:

Active Duty? ☐ yes ☐ no | Retiree? ☐ yes ☐ no | Reserves? ☐ yes ☐ no | Medal of Honor? ☐ yes ☐ no

2. Name:

Active Duty? ☐ yes ☐ no | Retiree? ☐ yes ☐ no | Reserves? ☐ yes ☐ no | Medal of Honor? ☐ yes ☐ no

Have you or your spouse served in the U.S. military or can you be considered a dependent of someone who has served in the U.S. military?

☐ Yes, I have served. Name: _____

☐ Yes, I am a dependent of someone who has served. Name: _____

☐ No, I am neither a veteran nor a dependent.

* Required, if obtainable and one has been issued, whether or not this person is applying.

Please go to the next page ►

American Indian/Alaska Native

Certain American Indians and Alaska Natives may not have to pay MassHealth premiums and copays.

Are you or your spouse who is applying a federally recognized American Indian or Alaska Native who is eligible to receive or has received services from an Indian health-care provider or from a non-Indian health-care provider through referral from an Indian health-care provider? ☐ yes ☐ no

If **yes**, name of person(s):

Accident or Injury Information

Do you or your spouse need health care because of an accident or injury? ☐ yes ☐ no

If **yes, you must answer all three questions in this section.**
If **no**, go to the next section (Assets).

Name

Are you or your spouse applying because of an accident or injury that someone else might be responsible for? ☐ yes ☐ no

Do you or your spouse have an injury, illness, or disability that was caused by someone else, or that could be covered by someone else's insurance or the family member's own insurance, other than health insurance (like homeowner's or auto insurance)? ☐ yes ☐ no

Has a lawsuit, a workers' compensation claim, or an insurance claim for an accident or injury been filed for you or your spouse who is applying? ☐ yes ☐ no

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 have a spouse at home, you also need to fill out the shaded blocks.

Bank Accounts

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

Do you or your spouse have any retirement accounts, including individual retirement accounts (IRAs), Keogh, or pension funds? ☐ yes ☐ no

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 (Life Insurance).

Send a copy of your passbooks updated within 45 days and/or **a copy** of your current account statements. Please see the *MassHealth and You* guide for information about financial institutions charging for copies of statements.

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

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

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

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

Please go to the next page ►

Assets (cont.)

Life Insurance

ATT

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 (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 (Stocks/Bonds/Other)

ATT

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

Annuities

ATT

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 *MassHealth and You* 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

Name(s) of owner(s)	
Name of institution issuing the annuity	
Contract number	Date purchased

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

Please go to the next page ►

Assets (cont.)

Assisted Living/Other

ATT

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 (Real Estate).

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

Real Estate

ATT

Do you or your spouse own or have a legal interest in your primary residence? You ☐ yes ☐ no Your spouse ☐ yes ☐ no

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 (Vehicles/Mobile Homes).

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: $

Vehicles/Mobile Homes

ATT

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 $
Your spouse Type of vehicle	Year/make/model	Fair-market value $	Amount owed $

Prepaid Burial Plans/Trusts

ATT

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	Burial plot ☐ yes ☐ no
Life insurance for burial ☐ yes (total face value: $) ☐ no	Burial-only account ☐ yes (amount: $) ☐ no	

Your spouse		
Burial contract ☐ yes (amount: $) ☐ no	Burial trust ☐ yes (amount: $) ☐ no	Burial plot ☐ yes ☐ no
Life insurance for burial ☐ yes (total face value: $) ☐ no	Burial-only account ☐ yes (amount: $) ☐ no	

Please go to the next page ►

Assets (cont.)

Trusts

ATT

Are you or your spouse the grantor/donor, trustee, or beneficiary of any trusts? ☐ yes ☐ no

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 the next section (*U.S. Citizenship/National Status and Immigration Status*).

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.

U.S. Citizenship/National Status and Immigration Status

QAC

The U.S. citizenship/national status of parents does not affect the eligibility of their children.

If you and your spouse **are** U.S. citizens/nationals, you do not have to fill out the rest of this section. Go to the section called "Accommodations for People with a Disability or Injury." If you want help getting proof of your U.S. citizenship, and you were **born in Massachusetts**, please fill out **Supplement B** (see red sheet). If you want help getting proof of your U.S. citizenship, and you were **born outside Massachusetts**, MassHealth may be able to help you. Please call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled). If you and your spouse **are not** U.S. citizens/nationals, and you are applying, you must fill out the rest of this section (continues on next page).

1. Are you or your spouse a veteran of the United States Armed Forces with an honorable discharge, or did you or your spouse serve under U.S. command during World War II or in Vietnam? ☐ yes ☐ no
   If **yes**, list names and go to the section called "Accommodations for People with a Disability or Injury."
   Names:
   If **no**, go to the next question.
2. Are you or your spouse the widow or widower of a veteran described above? ☐ yes ☐ no
   If **yes**, list names and go to the section called "Accommodations for People with a Disability or Injury."
   Names:
   If **no**, go to the next question.
3. Are you or your spouse a victim of domestic abuse and no longer living with the abuser? ☐ yes ☐ no
   If **yes**, list names and go to the section called "Accommodations for People with a Disability or Injury."
   Names:
   If **no**, you must fill out the next section (Immigration Status).

Please go to the next page ►

Immigration Status

QAC

List all immigration statuses that have applied to you or your spouse since entering the U.S.

Send copies of both sides of all immigration cards (or other documents that show immigration status).

Note: If you and your spouse are applying for only MassHealth Limited, you do not need to give us a social security number. We will not match your names with any other agency including the Department of Homeland Security (DHS). You do not have to list your names on this page or send proof of your immigration status. MassHealth Limited pays for emergency services only. See the MassHealth + You guide for more information.

Use these codes to describe your immigration status in the chart below.

4. Amerasian admitted pursuant to Section 584 of Public Law 100-202
5. Granted asylum
6. Conditional entrant
7. Cuban/Haitian entrant
8. Deportation withheld
9. Legal permanent resident
10. Native American with at least 50% American Indian blood born in Canada
11. Granted parole
12. Refugee
13. Person with a visitor visa/other
14. Person residing under color of law (PRUCOL), including temporary protected status and applicant asylum
15. Victim of severe forms of trafficking*
16. Iraqi Special Immigrant
17. Afghan Special Immigrant

* Human trafficking for prostitution or involuntary servitude

Name		
Status codes (List all that apply.)	Date status awarded	U.S. entry date

Name		
Status codes (List all that apply.)	Date status awarded	U.S. entry date

Accommodations for People with a Disability or Injury

ACC

Do you or your spouse who is applying for MassHealth have any special circumstances or a disability? ☐ yes ☐ no

Name

If **yes**, please check all that apply.
☐ low vision ☐ blind ☐ deaf ☐ developmentally disabled ☐ intellectually disabled ☐ physically disabled ☐ hard of hearing
☐ other _____

As a result, does the person you identified need support services/reasonable accommodations to communicate with MassHealth? ☐ yes ☐ no

If **yes**, please check all that apply.
☐ text telephone (TTY) ☐ large-print publications ☐ American Sign Language interpreter ☐ Video Relay Service (VRS)
☐ Communication Access Real-time Translations (CART) ☐ publications in Braille ☐ assistive listening device
☐ publications in electronic format ☐ other (please describe) _____

Please go to the next page ►

Fill out this section ONLY if you are a member of a married couple living with your spouse and: one spouse is under age 65 and applying and no children under age 19 are living with you.

If this section applies to you and you want more information about income standards and other information that may apply to you, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled) to get a MassHealth Member Booklet. If this section does not apply to you, go to the next page.

HIV Information (optional) (only for persons under 65 years of age)

MassHealth may give benefits to people who are HIV positive who might not otherwise be eligible.

HIV

Do you want to apply for these benefits? ☐ yes ☐ no

If **yes**, fill out this section.
If **no**, go to the next section (Disability (only for persons under 65 years of age)).

Send proof of income, U.S. citizenship/national status and identity, or qualified alien status to see if you can get benefits for up to 60 days while we wait for you to send us proof of your HIV-positive status. For more information, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled) and ask for a MassHealth Member Booklet.

Name:

Disability (only for persons under 65 years of age)

PDI/ DDU

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

If **yes**, fill out this section and answer the next three questions.
If **no**, go to next page.

Name:

Does this person get money from Social Security for a disability? ☐ yes ☐ no

Has this person ever gotten Supplemental Security Income (SSI)? ☐ yes ☐ no

Is this person legally blind? ☐ yes ☐ no

If **yes**, **send a copy** of the Certificate of Blindness.

Please go to the next page ►

This is an application for MassHealth, Commonwealth Care, and the Health Safety Net.

You, your spouse, and/or your eligibility representative must read this page carefully, then sign and date it at the bottom.

I give permission for my current and former employers and health insurers to release to MassHealth, the Commonwealth Health Insurance Connector Authority ("the Health Connector"), and the Health Safety Net (administered by the Executive Office of Health and Human Services) any and all information they have about my health-insurance coverage and health-insurance coverage for my spouse. 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 me or my spouse.

I and my spouse understand that our employers may be notified and billed, in accordance with the regulations of the Health Safety Net, with regard to any services I and my spouse and any of our dependents may get from hospitals or community health centers that are paid for by the Health Safety Net.

If I or my spouse is found to be eligible for assistance through MassHealth, the Health Connector, or the Health Safety Net, I give permission to MassHealth, the Health Connector (Commonwealth Care), or the Health Safety Net to get any records or data: (1) to prove any information given on this application and any supplements, or other information I give once I am a member; (2) to document medical services claimed or provided; and (3) to support continued eligibility.

I understand that in some cases, MassHealth may place a lien against any real estate that I have a legal interest in. If MassHealth puts a lien against my property and I sell it, I may need to use money I get from the sale of that property to repay MassHealth for medical services that I get.

I understand that if I am aged 55 or older, or I am any age and MassHealth helps pay for my care in a nursing home, MassHealth may be able to get back money from my estate after I die. Under current practice, this does not apply to Commonwealth Care.

I understand that annuity transactions, including purchases and selecting or changing payment plans, entered into on or after February 8, 2006, require that certain conditions are met and that I may not be eligible for payment of long-term-care services unless I provide proof that those conditions have been met. I also understand that the Commonwealth of Massachusetts may be required to be named as a remainder beneficiary of annuities for the total amount of medical assistance paid for the institutionalized individual. I further understand that the Commonwealth may not be removed as the beneficiary, and that eligibility may be ended and benefits recovered if the Commonwealth's position as a remainder beneficiary is not maintained.

I understand that if I or my spouse is in an accident, or we are injured in some other way, and get money from a third party because of that accident or injury, we will need to use that money to repay: (1) MassHealth (for MassHealth) or the Health Connector or my current health insurer (for Commonwealth Care) for certain medical services provided (For MassHealth, these certain medical services are explained in the *MassHealth and You* guide. For Commonwealth Care, these certain medical services must have been provided to me by my health insurer.); or (2) the Health Safety Net for medical services reimbursed for me and my spouse by the Health Safety Net. I also understand that I must tell MassHealth (for MassHealth), my health insurer (for Commonwealth Care), or the Health Safety Net in writing, within 10 calendar days, or as soon as possible, if I file any insurance claim or lawsuit because of an accident or injury to me or my spouse applying for benefits.

I understand that if I or my spouse is eligible for MassHealth, Commonwealth Care, or the Health Safety Net, I must tell MassHealth of any changes in my or my spouse's income or employment, assets, health-insurance coverage, health-insurance premiums, and immigration status, or of changes in any other information I gave on this application and any supplements within 10 calendar days of learning of the change.

I also understand that by signing below, I give permission to MassHealth to go after and collect third-party payments for medical care and medical support from my spouse who is living at home and refuses to cooperate or whose whereabouts is unknown.

If I or my spouse is eligible for Commonwealth Care, I understand that I may have to pay a premium set by the Health Connector.

I certify that I have read or have had read to me the information on this application, including any supplements and instruction pages attached to it, and the information in the *MassHealth and You* guide, and that I understand my rights and responsibilities. I further certify under penalty of perjury that the information on this application and any supplements, including those submitted with this application as well as any other supplements, forms, or documents that may be submitted to or required by MassHealth, is correct and complete to the best of my knowledge.

If you are acting on behalf of someone in filling out this application and any supplements, the enclosed MassHealth Eligibility Representative Designation Form must also be filled out and sent back with this application. Your signature on this application and any supplements as an eligibility representative certifies that the information on this application and any supplements, including those submitted with this application as well as any other supplements, forms, or documents that may be submitted to or required by MassHealth, is correct and complete to the best of your knowledge.

If you think MassHealth's decision about whether you are eligible is wrong, you have the right to appeal or file a grievance. If you are denied benefits, you will get information about how to appeal a MassHealth decision and also how to file a grievance about any Health Safety Net decision.

X _____ _____ _____

Signature of applicant or eligibility representative | Print name | Date

X _____ _____ _____

Signature of applicant or eligibility representative | Print name | Date

MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Supplement A:
Long-Term-Care Questions

For office use only. Head of household name:

Head of household SSN:

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 only need to fill out the "Resource Transfers" section on page 15.

Please print clearly. Answer all questions and fill out all sections. 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.

Head of Household/Applicant Information

GAR SMN

Last name	First name	MI	Social security number

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

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 (Long-Term-Care Insurance).

Send proof of your spouse's current living expenses.

1. 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? $

2. Does your spouse pay for heat? ☐ yes ☐ no
3. Does your spouse pay for utilities? ☐ yes ☐ no
4. 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 (Long-Term-Care Insurance).

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	Monthly income before deductions $

Name	Social security number

Relationship	Date of birth	Monthly income before deductions $

Long-Term-Care Insurance

LIN

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 (Real Estate).

Send a copy of the policy.

Company name/Policy number	Policyholder name

Effective date	Premium amount $

Company name/Policy number	Policyholder name

Effective date	Premium amount $

Please go to the next page ►

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 $802,000, you may be ineligible for payment of long-term-care services, unless certain conditions are met.

1. 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 2 through 4.

   If **no**, answer question 4 only.

   Name and address of person(s) on ownership papers

   Description and address of property location

   Type of ownership (Check one.) ☐ Individual ☐ Tenancy in common ☐ Joint tenancy ☐ 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 ☐ Tenancy in common ☐ Joint tenancy ☐ Life estate | Fair-market value $

2. Do you have a spouse? ☐ yes ☐ no

   If you answered yes, fill out this section.

   Name: | Is this person living in your home? ☐ yes ☐ no

   Do you have a permanently and totally disabled or blind child? ☐ yes ☐ no

   If you answered yes, fill out this section.

   Name: | Is this person living in your home? ☐ yes ☐ no

   Do you have a child under 21 years of age? ☐ yes ☐ no

   If you answered yes, fill out this section.

   Name: | Date of birth | Is this person living in your home? ☐ yes ☐ no

   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 you answered yes, fill out this section.

   Name: | Is this person living in your home? ☐ yes ☐ no

   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 you answered yes, fill out this section.

   Name: | Is this person living in your home? ☐ yes ☐ no

   Do you have a dependent relative? ☐ yes ☐ no

   If you answered yes, fill out this section.

   Name: | Is this person living in your home? ☐ yes ☐ no

   Describe the relationship and the nature of the dependency:

3. Do you intend to return to your home? ☐ yes ☐ no
4. Do you or your spouse own or have a legal interest in **other** real estate not listed in #1 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.

Please go to the next page ►

Tax Returns

SUP

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 Form 4506**. Form 4506 is included as part of the Long-Term-Care Supplement if you need to use it.

Resource Transfers (resources include both income and assets)

SUP

1. 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

2. In the past 60 months:
   a. Did you, your spouse, or someone on your behalf transfer income or the right to income? ☐ yes ☐ no
   b. 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
   c. 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
   d. 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
   e. Did you, your spouse, or someone on your behalf add another name to the deed of any property you own? ☐ yes ☐ no
   f. 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
   g. Did you, your spouse, or someone on your behalf purchase or in any way change an annuity? ☐ yes ☐ no

3. In the past 60 months, has any property that was available or belonged to you or your spouse been transferred into or out of a trust? ☐ 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		Dates of transfer
Transferred to whom	Relationship to you or your spouse	Amount of transfer $
Description of asset/income		Dates of transfer
Transferred to whom	Relationship to you or your spouse	Amount of transfer $
Description of asset/income		Dates of transfer
Transferred to whom	Relationship to you or your spouse	Amount of transfer $

Please go to the next page ►

MassHealth
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Supplement B:

Help Getting Proof of U.S. Citizenship for Persons Born in Massachusetts

For office use only. Head of household name:
Head of household SSN:

Fill out one section below for EACH family member who is applying, was born in Massachusetts, and wants help getting proof of his or her U.S. citizenship through the Massachusetts Registry of Vital Records and Statistics. RVS

Note: When filling out the sections below, be sure to print each family member's name as it would appear on his or her birth certificate.

Applicant's current last name	First	MI	Suffix (ex., "Jr.")
Applicant's last name at time of birth (*if different*)	First	MI	Suffix (ex., "Jr.")
Date of birth	Gender at time of birth (*if different*)		
Massachusetts hospital name	Massachusetts city of birth		
Mother's/Coparent's last name (*at time of applicant's birth*)	First	MI	Mother's maiden name
Father's/Coparent's last name (*at time of applicant's birth*)	First	MI	Suffix (ex., "Jr.")

Applicant's current last name	First	MI	Suffix (ex., "Jr.")
Applicant's last name at time of birth (*if different*)	First	MI	Suffix (ex., "Jr.")
Date of birth	Gender at time of birth (*if different*)		
Massachusetts hospital name	Massachusetts city of birth		
Mother's/Coparent's last name (*at time of applicant's birth*)	First	MI	Mother's maiden name
Father's/Coparent's last name (*at time of applicant's birth*)	First	MI	Suffix (ex., "Jr.")

Applicant's current last name	First	MI	Suffix (ex., "Jr.")
Applicant's last name at time of birth (*if different*)	First	MI	Suffix (ex., "Jr.")
Date of birth	Gender at time of birth (*if different*)		
Massachusetts hospital name	Massachusetts city of birth		
Mother's/Coparent's last name (*at time of applicant's birth*)	First	MI	Mother's maiden name
Father's/Coparent's last name (*at time of applicant's birth*)	First	MI	Suffix (ex., "Jr.")