Getting Started

You can fill out the Medical Benefit Request (MBR) on your computer, then print it. Or, you can print a blank copy and fill it out by hand. Make sure you sign and date the MBR on page 6. Then send it with proof of your income and proof of your U.S. citizenship/national status and identity to the address listed on the MBR instruction page.

To fill out the MBR on-line, use the mouse to **click** on the first field you want to fill out **on each page**. Type the necessary information, then press the Tab key to move to the next field, or use the mouse to click on the next field. To fill a check box, click on the box using the mouse, or tab to the field, and when the box has a dotted line around it, press the enter key. If you need to go back to another field, click on that field with your mouse. To go from one page to the next, tab to "Please go to the next page.", and when highlighted, press tab, or use the mouse to click on the first field on each page.

After you print the filled-out MBR, YOU MUST click on the "Clear entire form" button at the bottom of page 6. This will remove all the information you entered on the MBR so no one can see your personal information.

Fill out Form **Print Blank Form**

Click here to get to the "Applications and Member Forms" page.

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

Medical Benefit Request Instruction Page

NOTE: Information entered into this form cannot be saved, so be sure to print a copy of the filled-out form before closing it.

Please read these instructions before you fill out the application.

Dear Applicant:

This is your application for **MassHealth**, the **Children's Medical Security Plan (CMSP)**, **Healthy Start**, and the **Health Safety Net***. MassHealth gives health-care coverage and helps pay for health-insurance premiums for families, children, and individuals. The kind of coverage you get depends on your family size, income, and other circumstances. After your application is filled out and reviewed, MassHealth will give you **the most complete coverage that you qualify for**.

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 adults who are not eligible for MassHealth. Commonwealth Care helps pay for health-insurance premiums for health plans that are approved by the Health Connector. For more information, see pages 3 and 21 in the MassHealth Member Booklet.

This application is for people who live in Massachusetts, are not living in or 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, or who are adult relatives living with and taking care of children under age 19 when neither parent is living in the home, or who are disabled and 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 MassHealth application. If this application is not for you, call 1-888-665-9993 (TTY: 1-888-665-9997 for people with partial or total hearing loss).

Please list only one family group on an application. A family group can be parents, stepparents, or adoptive parents of any age and any of their children under age 19 who are all living together. If no parents are living at home, a family group may be siblings under age 19, or children under age 19 and an adult related by blood, adoption, or marriage, or a spouse or former spouse of one of those relatives who are all living together. A family group can also be an individual or a married couple who are living together with no children under the age of 19. If more than one family group lives in your home, each family group must fill out a separate application. MassHealth will send all eligibility notices to the person who is your "head of household," and to your eligibility representative, if you have one.

Please read the attached MassHealth Member Booklet carefully before you fill out the application. Keep the booklet. It may answer questions you have later.

When you fill out the application, be sure to:

- Answer **all** questions, and fill out all sections and any supplements that apply to you and your family.
- **Sign and date the application.** The head of household, all applicants aged 18 or older, and all parents of any age who have children living with them must sign.
- Send proof of all income, like copies of two recent pay stubs. (You do not have to send proof of social security or SSI income.)
- Send proof of your HIV-positive status only if you want to see if you are eligible for MassHealth because you are HIV positive.
- Send proof of U.S. citizenship/national status and proof of identity, like U.S. passports or U.S. naturalization papers. U.S. citizenship may also be proved with a U.S. birth certificate or a U.S. hospital birth record. Identity may also be proved with a driver's license, some other form of government-issued identity card, or a school identification card. We may be able to prove your identity through the Massachusetts Registry of Motor Vehicles records if you have a Massachusetts driver's license or a Massachusetts ID card. Once you give MassHealth proof of your U.S. citizenship/national status and identity, you will not have to give us this proof again. You must give us proof of identity for all 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.** A child born to a mother who was getting MassHealth on the date of the child's birth does not have to give proof of U.S. citizenship/national status and identity. (See pages 28-29 in the MassHealth Member Booklet for complete information about acceptable proofs.)
- Send a copy of both sides of all immigration cards (or other documents that show immigration status) for every family member who is not a U.S. citizen/national and who is applying for MassHealth or Commonwealth Care, except for MassHealth Limited, CMSP, Healthy Start, or the Health Safety Net. (See Supplement C.)
- Give us a social security number (SSN) or proof that you have applied for an SSN for every family member who is applying for MassHealth or Commonwealth Care. However, you do not need to give us an SSN or proof you applied for an SSN to get MassHealth Limited, CMSP, Healthy Start, or the Health Safety Net.

* **This information will be used to determine low-income patient status for provider payments from the Health Safety Net.**

over ►

Sign and date the application after you fill it out. Send the application and all other needed papers to:

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

The information you give us is kept confidential, as required by state and federal laws. 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 to get a MassHealth Permission to Share Information Form.

When filling out this application, please remember the following.

- Make sure you fill out the application correctly and completely. If we need to contact you to get more information because we do not understand what you entered on the application, it will take us longer to decide if you are eligible or not for health benefits.
- Make sure on pages 2 and 3 of the application in the sections "Working Income," "Nonworking Income," and "College Student" that **each family member who has income and/or is aged 19 or older fills out each of these sections correctly**.
- Please remember when filling out the "Health Insurance" section on page 4, 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);
    - Fishing Partnership Health Plan; or
    - student health insurance from a Massachusetts school.
- Make sure on page 5 of the application in the section "Injury, Illness, or Disability" that you answer "yes" or "no" to **both** questions. Do not leave any answer blank.
- If you answer "yes" to the question on page 5 of the application in the section "Absent Parent," then you **must** fill out Supplement B according to the instructions for Supplement B. If the other parent of the child is living in the same household as the child but does not want to apply for MassHealth, make sure to list that parent on page 1 of the application in the section "Other Family Members."

If you have any questions about this application or the information you need to send, please call MassHealth at 1-888-665-9993 (TTY: 1-888-665-9997 for people with partial or total hearing loss).

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.

To start filling out this application, please turn to page 1 of this application.
Remember, you must read, sign, and date page 6 after you have filled out the application.

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

Medical Benefit Request

This form is valid only if it has not been changed in any way, other than by entering the information requested.

IMPORTANT: Please do not leave this information on your computer screen where unauthorized persons may be able to read confidential personal information.

To fill out this form on your computer screen, use the mouse to click in the first form field (last name), type your entry, then press the Tab key to go to the next field.

This is an application for **MassHealth**, the **Children's Medical Security Plan (CMSP)**, **Healthy Start**, **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 and your family. 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.

Head of Household

HOH

1.

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

Is this person applying? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen/national? ☐ yes ☐ no	Social security number* Type all nine digits without hyphens or	Date of birth mm/dd/yy	Gender ☐ M ☐ F	Race *(optional)*	C ☐ I ☐

Spoken language choice	Written language choice	Ethnicity *(optional)*	Telephone numbers *(List work number only if we can call you at work.)* Home/Cell: Work: Area code and phone number (without parentheses, spaces, or hyphens).

Other Family Members

▶ List all other members of your family group. *Do not repeat head of household information in this section.* See instruction page for description of a family group.

2.

Last name	First name	MI	Is this person applying? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen/national? ☐ yes ☐ no	Social security number*	Date of birth	C ☐ I ☐

Gender ☐ M ☐ F	Race *(optional)*	Spoken language choice	Written language choice	Ethnicity *(optional)*	Relationship to head of household

3.

Last name	First name	MI	Is this person applying? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen/national? ☐ yes ☐ no	Social security number*	Date of birth	C ☐ I ☐

Gender ☐ M ☐ F	Race *(optional)*	Spoken language choice	Written language choice	Ethnicity *(optional)*	Relationship to head of household

4.

Last name	First name	MI	Is this person applying? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen/national? ☐ yes ☐ no	Social security number*	Date of birth	C ☐ I ☐

Gender ☐ M ☐ F	Race *(optional)*	Spoken language choice	Written language choice	Ethnicity *(optional)*	Relationship to head of household

5.

Last name	First name	MI	Is this person applying? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen/national? ☐ yes ☐ no	Social security number*	Date of birth	C ☐ I ☐

Gender ☐ M ☐ F	Race *(optional)*	Spoken language choice	Written language choice	Ethnicity *(optional)*	Relationship to head of household

Pregnancy

PRG

▶ Are you or any family member pregnant? . . . . . ☐ yes ☐ no

Name	Are you or this person pregnant with ☐ 1 baby? ☐ twins? ☐ triplets? If more, how many?_____	Due date

American Indian/Alaska Native

NAT

Family members under the age of 19 who are Alaska Natives or members of a federally recognized American Indian tribe who get MassHealth Family Assistance may not have to pay any premiums for this coverage.

▶ Are you or any family member who is under the age of 19 an Alaska Native or a member of a federally recognized American Indian tribe? . . ☐ yes ☐ no

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

*Required, if one has been issued and this person is applying for MassHealth or Commonwealth Care, except for MassHealth Limited, CMSP, Healthy Start, or the Health Safety Net.

Visitors (You must fill out this section.)

VIS

- Are you or any member of your household visiting Massachusetts from another U.S. state, U.S. territory, or a foreign country? . . ☐ yes ☐ no
  If **yes**, name of person(s): _____
- Are you or any member of your household applying for benefits due to an unexpected emergency medical condition or situation that occurred after your arrival in Massachusetts and that prevents you from leaving Massachusetts? . . . . . ☐ yes ☐ no
  If **yes**, name of person(s): _____

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

Each family member who has income and/or is aged 19 or older must fill out all sections on this page and the next page (page 3).

Working Income (You must fill out this section.)

EIN

1. **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, address, and telephone number	Type of work *(Check all that apply.)*		**For office use only** (indicate weekly, biweekly, semimonthly, or monthly)	
	☐ 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	HID		
	$			Hrs.	
				Hrs.	

- 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 two recent pay stubs. If self-employed, see the MassHealth Member Booklet for information about the needed proof.

2. **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, address, and telephone number	Type of work *(Check all that apply.)*		**For office use only** (indicate weekly, biweekly, semimonthly, or monthly)	
	☐ 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	HID		
	$			Hrs.	
				Hrs.	

- 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 two recent pay stubs. If self-employed, see the MassHealth Member Booklet for information about the needed proof.

Please go to the next page. ▶

Nonworking Income (You must fill out this section.)

Rental Income

REN

▶ Do you or any family member get rental income? **(You must answer this question.)** . . . . . ☐ yes ☐ no

If **yes**, enter the monthly amount of rental income (before taxes and deductions) on this line. $ _____

Name of person getting rental income

If **no**, go to the next section (*Unemployment Benefits*).

☒ **Send proof** of rental income.

Unemployment Benefits

UIN

▶ Are you or any family member getting an unemployment check? **(You must answer this question.)** . . . . . ☐ yes ☐ no

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

Name of person getting unemployment benefits		
Is this check from the Commonwealth of Massachusetts?	☐ yes ☐ no	☐ yes ☐ no
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.)	☐ yes ☐ no	☐ yes ☐ no
Enter the monthly amount of unemployment benefits (before taxes and deductions).	$	$

☒ **Send proof** of unemployment benefits.

Other Nonworking Income

UIN

▶ Do you or any family member 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 each family member. If anyone has 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	For office use only
			$	
			$	
			$	

College Student (You must fill out this section.)

STU

▶ Are you or any family 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 of college student		
Is this person eligible for health insurance from college?	☐ yes ☐ no	☐ yes ☐ no
Is this person a college student in Massachusetts with at least 75% of a full-time schedule? (Note: If you are not sure that this person has 75% of a full-time schedule, contact the school to find out if the number of credits the student is taking would require the student to get the health insurance the school offers to students.)	☐ yes ☐ no	☐ yes ☐ no
If yes, is this student planning to get health-insurance coverage from the school, but is waiting for coverage to start?	☐ yes ☐ no	☐ yes ☐ no
If yes, what is the date that the health-insurance coverage starts?		

Please go to the next page. ▶

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

HIN

Even if you or any family member 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 any family member get Medicare benefits? . . . . . ☐ yes ☐ no

If **yes**, name(s): _____ Claim number(s): _____

▶ Do you or any family member have health insurance other than Medicare? . . . . . ☐ yes ☐ no

If **yes**, fill out both **Part A** and **Part B** below.

If **no**, fill out only **Part B** below.

Part A: Health Insurance You Have Now

1.

Policyholder name	Date of birth	Social security number*	Insurance company name

Names of covered family members

_____

_____

_____

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

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

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

2.

Policyholder name	Date of birth	Social security number*	Insurance company name

Names of covered family members

_____

_____

_____

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

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

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

Part B: Subsidized Health Insurance You May Be Eligible For

SIA

▶ Are you or any family member who is aged 19 or older currently earning 50% or more of the family's total income from working in the commercial fishing industry? . . . . . ☐ yes ☐ no

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

▶ Are you or any family member 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.)

Name: _____

Active Duty? ☐ yes ☐ no Retiree? ☐ yes ☐ no

Reserves? ☐ yes ☐ no Medal of Honor? ☐ yes ☐ no

Name: _____

Active Duty? ☐ yes ☐ no Retiree? ☐ yes ☐ no

Reserves? ☐ yes ☐ no Medal of Honor? ☐ yes ☐ no

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

Please go to the next page. ▶

General instructions for filling out the Injury, Illness, or Disability, Absent Parent, and U.S. Citizenship/National Status and Immigration Status sections below

The HIV section is optional. You must answer all questions in each of the three sections below the HIV section.

HIV Information (optional)

HIV

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

- Do you or any family member who is HIV positive want to apply for these benefits? . . . . . ☐ yes ☐ no
  If **yes**, fill out this section.

☒ **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, see the MassHealth Member Booklet.

Name(s): _____ **For office use only**

Injury, Illness, or Disability

- Do you or any family member 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
- Do you or any family member need health care because of an accident or injury? . . . . . ☐ yes ☐ no

If you answered **yes to either of these two questions**, you must fill out **Supplement A** (the blue sheet).

Absent Parent

- Has any child in the household been adopted by a single parent or has a parent who is deceased or unknown? . . . . . ☐ yes ☐ no
- Does any child in the family have a parent who does not live with you who is not included in the previous question? . . . . . ☐ yes ☐ no

If you answered **yes** to either of these questions, you must fill out **Supplement B** (the yellow sheet).

U.S. Citizenship/National Status and Immigration Status

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

U.S. citizens

- For applicants **born in Massachusetts** who want help getting proof of their U.S. citizenship, please fill out **Supplement D** (the red sheet).

  For applicants **born outside Massachusetts** who want help getting proof of their U.S. citizenship, MassHealth may be able to help you. Please call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss).

Persons who are not U.S. citizens/nationals

- If you or any other family member applying for MassHealth or Commonwealth Care fits any of the immigration status codes on **Supplement C** (the orange sheet), numbered 1 through 17, you must fill out **Supplement C**.
- If you or any other family member applying for benefits does not fit any of the immigration status codes on **Supplement C** (the orange sheet), numbered 1 through 17, you or that family member may get only one or more of the following: MassHealth Limited, Healthy Start, CMSP, or the Health Safety Net. **You do not have to fill out Supplement C.**

  Note: Family members who want to get only one or more of the following: MassHealth Limited, CMSP, Healthy Start, or the Health Safety Net, do not have to give us a social security number. We will not match their names with any other agency including the Department of Homeland Security (DHS). You do not need to send proof of their immigration status. **But you must list their names below.** MassHealth Limited pays for emergency services only. See the MassHealth Member Booklet for more information.
- List below the names of family members who want to get only one or more of the following: MassHealth Limited, Healthy Start, CMSP, or the Health Safety Net.

Names	For office use only	Names	For office use only

You must read page 6 carefully, and sign and date it. ▶

Please read this page carefully, then sign and date the bottom of the page.

This is an application for MassHealth, the Children's Medical Security Plan (CMSP), Healthy Start, Commonwealth Care, and the Health Safety Net.

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 Division of Health Care Finance and Policy any and all information they have about my health-insurance coverage and health-insurance coverage for members of my family group. 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 members of my family group.

I understand that MassHealth may enroll me in available employer-sponsored health insurance if that insurance meets the criteria for MassHealth payment of premium assistance.

I and my spouse understand that our employers may be notified and billed, in accordance with the regulations of the Division of Health Care Finance and Policy, 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 any members of my family are found to be eligible for assistance through MassHealth, the Health Connector, or the Division of Health Care Finance and Policy, I give permission to MassHealth, the Health Connector (Commonwealth Care), or the Division of Health Care Finance and Policy (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 if I am aged 55 or older, 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 if I or any members of my family are 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, CMSP, and Healthy Start) 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 Member Booklet. For Commonwealth Care, these certain medical services must have been provided to me by my health insurer.); or (2) the Division of Health Care Finance and Policy for medical services reimbursed for me and any family members by the Health Safety Net. I also understand that I must tell MassHealth (for MassHealth, CMSP, and Healthy Start), my health insurer (for Commonwealth Care), or the Division of Health Care Finance and Policy (for 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 any family members applying for benefits.

I understand that if I or any members of my family are eligible for MassHealth, CMSP, Healthy Start, Commonwealth Care, or the Health Safety Net, I must tell MassHealth of any changes in my or my family's income or employment, family size, 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 the parent of any child under age 19 who is applying for benefits.

If I or any members of my family are eligible for MassHealth or CMSP, I understand that I may have to pay a premium set by MassHealth. I also understand that if I fail to pay the premium, MassHealth may refer my past due balance to the State Intercept Program (SIP). If I am a certain American Indian or Alaska Native eligible for MassHealth Family Assistance, I may not have to pay any premiums under MassHealth Family Assistance. If I or any members of my family are 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 Member Booklet, and that I understand my rights and responsibilities. I further certify under the penalty of perjury that the information on this application and any supplements 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 as an eligibility representative certifies that the information on this application and any supplements 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.

The head of household, all persons aged 18 or older, and all parents of any age who have children living with them who are applying for MassHealth, CMSP, Healthy Start, Commonwealth Care, or the Health Safety Net, must read this page carefully, and sign and date below. If you are signing below as an eligibility representative, a filled-out MassHealth Eligibility Representative Designation Form must also be submitted.

X _____ _____

Signature of applicant or eligibility representative — Date

X _____ _____

Signature of applicant or eligibility representative — Date

Clear entire form.

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Supplement A: Injury, Illness, or Disability Questions

HealthConnector CommonwealthCare

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

Leave this page blank if you answered NO to all the injury, illness, and disability questions on page 5.

Fill out this page if you answered YES to either of the two injury, illness, and disability questions on page 5.

Injury, Illness, or Disability

PDI/DDU

Fill out this section for you or any family member who has an injury, illness, or disability (including a disabling mental-health condition).

1. Name

For office use only
Supp to DES | Dis type

- ▶ 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? ☐ yes ☐ no
- ▶ 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.

2. Name

For office use only
Supp to DES | Dis type

- ▶ 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? ☐ yes ☐ no
- ▶ 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.

Accident or Injury

TPR

Fill out this section if you or any family member need health care because of an accident or injury. **You must answer all three questions.**

1. Name — **For office use only**

- ▶ Are you or any family member applying because of an accident or injury that someone else might be responsible for? ☐ yes ☐ no
- ▶ Do you or any family member 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 any family member who is applying? ☐ yes ☐ no

2. Name — **For office use only**

- ▶ Are you or any family member applying because of an accident or injury that someone else might be responsible for? ☐ yes ☐ no
- ▶ Do you or any family member 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 any family member who is applying? ☐ yes ☐ no

If you need more space, please use the back of this page.

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Supplement B: Absent-Parent Questions and Assignment of Rights

HealthConnector CommonwealthCare

Do not fill out this supplement if you answered NO to both of the absent-parent questions on page 5.
Fill out this supplement only if you answered YES to either of the absent-parent questions on page 5.
Please read Part A of Supplement B before you fill out Parts B, C, and D, and sign Part E.

Absent Parent

ABS

PART A—Cooperation

To get MassHealth for **you and a child who is living with you**, you must cooperate with the Child Support Enforcement Division of the Massachusetts Department of Revenue (DOR) to establish paternity and enforce a medical-support order, unless you have Good Cause not to cooperate. You must also assign your rights for medical support to MassHealth. Cooperation means that you may have to give information about the identity, location, and employment of the absent parent, appear for appointments with DOR staff and the Court, submit to paternity testing, give information, and take any other action necessary to help DOR in establishing paternity, and establishing, changing, or enforcing a child medical-support order. "Good Cause" is a legal term that means if you cooperated by giving us information about the absent parent, it would not be in the best interests of the child for any of the reasons listed in Part C—Good Cause—on the next page. If you think that you have Good Cause for not cooperating, fill out Part C—Good Cause—on the next page, and do not fill out Part D—Absent-Parent Information—on the next page.

If you do not want to make a Good Cause claim, and you do not cooperate by filling out Part D—Absent-Parent Information—on the next page, your MassHealth eligibility could be affected.

To get MassHealth **only for the child who is living with you** and not for yourself, you do not have to cooperate with DOR, assign your rights for medical support to MassHealth, or give information about the absent parent. Also, if a **pregnant** family member is applying for benefits for an unborn child, you do not need to give us information about the absent parent of the unborn child at this time. This means that you do not have to fill out Part B, C, D, or E of this supplement for that unborn child. Please read the next paragraph about child-support-enforcement services.

Even if you are applying for MassHealth only for the child who is living with you, you can ask for child-support-enforcement services if you want help getting the absent parent to pay for health insurance or child support for the child. To do this, you can call DOR at 1-800-332-2733, or go to **www.mass.gov/dor** and click on "Child Support." The child's MassHealth coverage will not be affected if you choose to ask for these services or not. If you ask for these services, you will have to cooperate with DOR.

PART B—Names of children who have been adopted by a single parent or have a parent who is deceased or unknown

Please list the name(s) of the child or children who have been adopted by a single parent or have a parent who is deceased or unknown.

Name	Name
Name	Name

If all of the children in the household are named in this section, go to Part E. Otherwise, go to Part C.

Please go to the next page. ▶

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Supplement B:
Absent-Parent Questions and Assignment of Rights

HealthConnector CommonwealthCare

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

Absent Parent (cont.)

PART C—Good Cause

▶ Is there any reason (Good Cause) not to help us get medical support from an absent parent? . . . . . ☐ yes ☐ no

If **yes**, list the name(s) of the child or children whose absent parent(s) you do not want to give us information about, and check one of the boxes below for the reason that applies to the child or children.

If **no**, fill out Part D—Absent-Parent Information—below.

Name(s): _____ Name(s): _____

☐ Cooperation could result in serious physical or emotional harm to a family member or his or her child, or the applicant or member.
☐ Adoption of the child is in process.
☐ The child was a result of sexual abuse or assault.

☐ Cooperation could result in serious physical or emotional harm to a family member or his or her child, or the applicant or member.
☐ Adoption of the child is in process.
☐ The child was a result of sexual abuse or assault.

PART D—Absent-Parent Information (if known)

1.

Name	Social security number*	Date of birth	Gender ☐ M ☐ F
Address		Telephone number	

▶ Is there a medical-support order? . . . . . ☐ yes ☐ no

Relationship to child: ☐ mother ☐ father ☐ other: _____ Driver's license number:* _____

Names of children of this absent parent: _____

Name and address of absent-parent's employer: _____

*Required, if obtainable and one has been issued.

2.

Name	Social security number*	Date of birth	Gender ☐ M ☐ F
Address		Telephone number	

▶ Is there a medical-support order? . . . . . ☐ yes ☐ no

Relationship to child: ☐ mother ☐ father ☐ other: _____ Driver's license number:* _____

Names of children of this absent parent: _____

Name and address of absent-parent's employer: _____

*Required, if obtainable and one has been issued.

PART E—Signature

I am the parent whom the child lives with (custodial parent) or legal guardian, and I understand that by signing below I assign my rights and give permission to MassHealth and DOR to go after medical support from the absent parent of any child under age 19 who is living with me and applying for MassHealth. I also agree to cooperate with MassHealth and DOR in this process, as explained in Part A—Cooperation—of this supplement. I certify under penalty of perjury that the information in this supplement is correct and complete to the best of my knowledge.

**Signature of custodial parent or legal guardian: _____ Date: _____

**Required, only if you are applying for yourself and the child who is living with you.

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Supplement C:
Questions for Immigrants

HealthConnector CommonwealthCare

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

Leave this page blank if all family members who are applying **are** U.S. citizens/nationals.

Fill out this page if any family member is applying for MassHealth or Commonwealth Care and is **not** a U.S. citizen/national.

1. Are you or any family member on active duty, or a veteran of the United States Armed Forces with an honorable discharge, or did you or any family member serve under U.S. command during World War II or in Vietnam? . . . . . ☐ yes ☐ no
   If **yes**, you may stop here, but list applicable family members.
   Names: _____
   If **no**, go to the next question.
2. Are you or any family member the spouse, widow or widower, or dependent of a person on active duty or a veteran described above? . . . . . ☐ yes ☐ no
   If **yes**, you may stop here, but list applicable family members.
   Names: _____
   If **no**, go to the next question.
3. Are you or any family member a victim of domestic abuse and no longer living with the abuser? . . . . . ☐ yes ☐ no
   If **yes**, you may stop here, but list applicable family members.
   Names: _____
   If **no**, you must fill out the rest of this page *(Immigration Status)*.

Immigration Status

QAC

Fill out the chart below for each member of the family who is **not** a U.S. citizen/national and who is applying for MassHealth or Commonwealth Care.
List *all* immigration statuses that have applied to each person since that person entered the U.S.

☒ **Send copies** of both sides of all immigration cards (or other documents that show immigration status).
See the MassHealth Member Booklet for a more complete description of immigration statuses.

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 for asylum *(See the MassHealth Member Booklet for more information.)*
15. Victim of severe forms of trafficking
16. Iraqi Special Immigrant
17. Afghan Special Immigrant

Name	Status codes (List all that apply.) a	b	c	d	Date status awarded a	b	c	d	U.S. entry date	For office use only

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

Health Connector CommonwealthCare

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.

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.")

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