

# Getting Started

You can fill out the Senior Medical Benefit Request (SMBR) 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 SMBR on page 10. Then send it with proof of your income, assets, and U.S. citizenship/national status and identity to the one MassHealth Enrollment Center (listed on the SMBR instruction page) that is closest to where you live.

**To fill out the SMBR 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 hit enter, or use the mouse to click on the first field on each page.

**After you print the filled-out SMBR**, YOU MUST click on the "Clear entire form" button at the bottom of page 10. This will remove all the information you entered on the SMBR so no one can see your personal information.

### Please read these instructions before you fill out the application.

Dear Applicant:

This is your application for **MassHealth** and the **Uncompensated Care Pool\*** 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 9.)

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 the 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 Connector”) for certain seniors who are not eligible for MassHealth. Commonwealth Care helps pay for health-insurance premiums for health plans that are approved by the Connector. For more information, see page 22 in the *MassHealth and You* Guide.

After your application is filled out and reviewed, **you will be given 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, 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 the MassHealth Customer Service Center at **1-800-841-2900** (TTY: 1-800-497-4648 for people with partial or total hearing loss).

This application package contains:

- a Senior Medical Benefit Request (**orange form**);
- the **MassHealth and You** guide, which explains who is eligible for MassHealth, 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**).

\*This information will be used to determine low-income patient status for provider payments from the Uncompensated Care Pool.

## 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, 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.)
- 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. 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 or some other form of government-issued identity 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. **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 provide proof of their U.S. citizenship/national status and identity.** (See page 28 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 Uncompensated Care Pool.
- 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 answering the four questions in the "Health Insurance" section at the top of page 4, that:
  - if you have health insurance from your employer, you may still be eligible for Commonwealth Care; and
  - you will not be eligible for Commonwealth Care if you are currently eligible for any federal and/or state subsidized insurance program including, but not limited to: Medicare, TRICARE (dependents of the military), Medical Security Plan (through the Division of Unemployment Assistance), Fishing Partnership Health Plan, or student health insurance.
- 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.
- Send the filled-out Senior Medical Benefit Request and gold form, if needed, and any needed papers to the one MassHealth Enrollment Center (MEC) listed below that is closest to where you live.

Revere MEC	Taunton MEC
300 Ocean Avenue	21 Spring Street
Suite 4000	Suite 4
Revere, MA 02151	Taunton, MA 02780

Springfield MEC	Tewksbury MEC
333 Bridge Street	367 East Street
Springfield, MA 01103	Tewksbury, MA 01876

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 the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss).

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. MassHealth 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 with partial or total hearing loss).

# Senior Medical Benefit Request

## for Seniors and People Needing Long-Term-Care Services



**For office use only**

Screener I.D.: \_\_\_\_\_  
Date received: \_\_\_\_\_  
Interpreter code: \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Entry date: \_\_\_\_\_

This is an application for **MassHealth, Commonwealth Care**, and the **Uncompensated Care Pool**. You do not have to be a U.S. citizen/national to get MassHealth. Please print clearly. Answer **all** questions and fill out all sections. If you need more space to finish any section on this form, please use a separate sheet of paper and attach it to the application.



**You MUST answer ALL three questions in the following section.**

**Are you or your spouse applying for:**

- ▶ 1. MassHealth/the Uncompensated Care Pool 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 the 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 the 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) <input type="checkbox"/> homeless			
Marital status <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> widowed <input type="checkbox"/> divorced		Is this person a U.S. citizen/national? <input type="checkbox"/> yes <input type="checkbox"/> no		Social security number*		Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Race (optional)
Spoken language choice		Written language choice		Ethnicity (optional)	Telephone numbers (List work number only if we can call you at work.) 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? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, what state? _____								

**Spouse Information**

HOH

Last name		First name		MI	Is this person applying? If <b>yes</b> , is this person a U.S. citizen/national? <input type="checkbox"/> yes <input type="checkbox"/> no		Social security number*	
Date of birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Race (optional)	Spoken language choice		Written language choice		Ethnicity (optional)	
Address, if different from head of household					Is this a hospital, nursing facility, or other institution? <input type="checkbox"/> yes <input type="checkbox"/> no			

**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? <input type="checkbox"/> yes <input type="checkbox"/> no If <b>yes</b> , fill out the rest of this section. We may be able to pay for these bills. If <b>no</b> , go to the next section (Previous Assistance).	▶ Do you or your spouse want to apply for MassHealth for that time period? . . . . . <input type="checkbox"/> yes <input type="checkbox"/> no If <b>yes</b> , 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.)
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**Previous Assistance**

SSI

▶ Have you or your spouse ever gotten Supplemental Security Income (SSI)? . . . . . You <input type="checkbox"/> yes <input type="checkbox"/> no Your spouse <input type="checkbox"/> yes <input type="checkbox"/> no If <b>yes</b> , fill out the rest of this section. If <b>no</b> , 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 <input checked="" type="checkbox"/> one.) <input type="checkbox"/> live in own home? <input type="checkbox"/> share expenses with another/others? <input type="checkbox"/> live in someone else's home? <input type="checkbox"/> live in a rest home? <input type="checkbox"/> live in an assisted-living facility?
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\*Not required if applying for MassHealth Limited or the Uncompensated Care Pool.  
SMBR (Rev. 07/07)

**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.

▶ 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 (Income from Working).

▶ Have you or your spouse had the services of a personal-care attendant **paid for by MassHealth** within the last six months?  
 You . . . . .  yes  no  
 Your spouse . . . . .  yes  no  
 If **yes**, go to the next section (Income from Working).  
 If **no**, answer the following three questions in this section.

▶ 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 agency to ask for personal-care-attendant services?  
 You . . . . .  yes  no  
 Your spouse . . . . .  yes  no

(**Note:** You must contact the personal-care 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 the last three questions 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 the MassHealth Customer Service Center 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.

**Income from Working**

EIN

▶ Are you or your spouse currently working or seasonally employed? . . . . .  yes  no  
 If **yes**, fill out this section.  
 If **no**, go to the next section (Nonworking Income).

☒ **Send proof** of income, like a copy of two recent pay stubs. If self-employed, **send a copy** of your most recent federal tax return.

1. **Name**

Employer name, address, and telephone number		Type of work ( <i>Check all that apply.</i> ) <input type="checkbox"/> full-time <input type="checkbox"/> day labor <input type="checkbox"/> sheltered workshop <input type="checkbox"/> part-time <input type="checkbox"/> seasonal      yearly wage: \$ _____ <input type="checkbox"/> self-employed      yearly wage: \$ _____			<b>For office use only</b> (indicate weekly, biweekly, or monthly) \$ _____ \$ _____	
Is health insurance offered? ** <input type="checkbox"/> yes <input type="checkbox"/> no	Number of hours per week	Weekly pay before deductions \$ _____	Date began getting this amount of pay	<b>HID</b> Hrs. _____ Hrs. _____		

2. **Name**

Employer name, address, and telephone number		Type of work ( <i>Check all that apply.</i> ) <input type="checkbox"/> full-time <input type="checkbox"/> day labor <input type="checkbox"/> sheltered workshop <input type="checkbox"/> part-time <input type="checkbox"/> seasonal      yearly wage: \$ _____ <input type="checkbox"/> self-employed      yearly wage: \$ _____			<b>For office use only</b> (indicate weekly, biweekly, or monthly) \$ _____ \$ _____	
Is health insurance offered? ** <input type="checkbox"/> yes <input type="checkbox"/> no	Number of hours per week	Weekly pay before deductions \$ _____	Date began getting this amount of pay	<b>HID</b> Hrs. _____ Hrs. _____		

\*\* Check yes even if you cannot get it now.

## Nonworking Income

WIN

▶ Do you or any family member have any other income, including rental income? . . . . .  yes  no

If **yes**, fill out this section.

If **no**, go to the next section (Accident or Injury Information).

▶ 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 below.

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

- annuities
- veterans' benefits (federal)
- workers' compensation
- social security
- veterans' benefits (state or city)
- unemployment benefits
- pensions
- dividends or interest
- trusts
- retirement
- SSI
- roomer/boarder income
- 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
			\$	
			\$	
			\$	
			\$	

## Rental Income

REN

▶ Do you or your spouse have rental income? . . . . .  yes  no

If **yes**, fill out this section. Name(s): \_\_\_\_\_

If **no**, go to the next section (Accident or Injury Information).

☒ **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
- water/sewer
- taxes
- insurance
- utilities (gas/electric)
- condo or co-op fee
- heat
- 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

(List additional real estate on a separate sheet of paper and attach it to this application.)

## Accident or Injury Information

TPR

You must answer the following three questions about you or your spouse who needs health care because of an accident or injury.

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

If **yes**, names: \_\_\_\_\_

▶ 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

If **yes**, names: \_\_\_\_\_

▶ 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

If **yes**, names: \_\_\_\_\_

For office  
use only

Even if you or your spouse have other health insurance, MassHealth may be able to help you.

- ▶ Do you or your spouse have health insurance, like Medicare, TRICARE, Medical Security Plan, Fishing Partnership Health Plan, or student health insurance? . . . . .  yes  no  
(Please do not include MassHealth or any health plan you enrolled in through Commonwealth Care when answering this question.)
- ▶ Do you or your spouse have health insurance that covers doctors' visits and hospitalizations? . . . . .  yes  no  
(Do not include dental-only or vision-only policies.)
- ▶ Do you or your spouse have other insurance, like dental or vision, or long-term-care insurance? . . . . .  yes  no
- ▶ Have you or your spouse worked for an employer who offered health insurance in the last 6 months that would cover doctors' visits and hospitalizations? (If so, answer **yes** to this question even if you chose not to sign up for or dropped the insurance that was offered.) . . . . .  yes  no

If you answered **yes to any of the above four questions**, fill out the rest of this page. If **no**, go to the Assets section on page 5.

**Other Health Insurance (for example, HMO, dental, vision, long-term-care insurance)**

If you or your spouse have other health insurance, you may still be able to get MassHealth or Commonwealth Care. Health insurance can be from an employer or any other source.

- ▶ Do you or your spouse have other health insurance from an employer or any other source (other than Medicare, MassHealth, or insurance provided through Commonwealth Care)? . . . . .  yes  no

If **yes**, fill out this section.

- ☒ **Send copies** of your current health-insurance premium bills if you are applying for long-term-care services in a medical facility. If you have more than one policy, use a separate sheet of paper and attach it to this application. If you have long-term-care insurance, **send a copy** of the policy.

	You	Your spouse
Insurance company name		
Group number (if known)		
Employer or union name		
Policy start date		
Policy number		
Policyholder name		
Policyholder date of birth		
Policyholder social security number*		
Policy type (Check one.)	<input type="checkbox"/> individual <input type="checkbox"/> couple (2 adults) <input type="checkbox"/> family <input type="checkbox"/> dual (one adult, one child)	<input type="checkbox"/> individual <input type="checkbox"/> couple (2 adults) <input type="checkbox"/> family <input type="checkbox"/> dual (one adult, one child)
Policyholder contribution to premium costs	\$___ per week \$___ per month \$___ per quart	\$___ per week \$___ per month \$___ per quarter
Names of covered family members		
Insurance coverage (Check one.)	Insurance type (Check one.)	
<input type="checkbox"/> Doctors' visits and hospitalizations <input type="checkbox"/> Vision only <input type="checkbox"/> Dental only <input type="checkbox"/> Catastrophic only <input type="checkbox"/> Pharmacy only	<input type="checkbox"/> Employer or union subsidized (employer or union pays some or all of insurance cost) <input type="checkbox"/> Federal and/or state subsidized (like TRICARE, Medical Security Plan, Fishing Partnership Health Plan, or student health insurance—government pays some or all of insurance cost) <input type="checkbox"/> Nonsubsidized (like self-employed or COBRA—policyholder pays total insurance cost)	

**Other Possible Health Insurance**

We may be able to help you buy health insurance from your current or former employer. Please fill out this section if you answer **yes** to either question below, and you **do not** have health insurance.

- ▶ In the last 6 months, did you or your spouse work for a **former** employer who offered health insurance that would cover doctors' visits and hospitalizations? . . . . .  yes  no
- ▶ In the last 6 months, have you or your spouse had health insurance available to you from your **current** employer(s) that would cover doctors' visits and hospitalizations? (If so, answer **yes** to this question even if you chose not to sign up for or dropped the insurance that was available.) . . . . .  yes  no

Name	Employer telephone number
Employer name	<input type="checkbox"/> current <input type="checkbox"/> former Employer address

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

## Health Insurance (cont.)

### Medicare

NH

▶ Do you or your spouse who is applying get Medicare? . . . . .  yes  no  
If **yes**, fill out this section.

1.	Name	Claim number
2.	Name	Claim number

### Medicare Supplemental Insurance (for example, Medex or AARP)

NH

▶ Do you or your spouse have Medicare supplemental insurance? . . . . .  yes  no  
If **yes**, fill out this section.

	You	Your spouse
Insurance company name		
Policy number		
Policy start date		

## Assets

ATT

You must fill out all blocks for each asset you or your spouse own. If you need more space, please use a separate sheet of paper and attach it to this application.

- 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 last 36 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 last 36 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.

Name on account	Name of bank/institution	Account number	Account type
Current balance \$	Balance on admission date* \$	<input type="checkbox"/> Account open <input type="checkbox"/> 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* \$	<input type="checkbox"/> Account open <input type="checkbox"/> 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* \$	<input type="checkbox"/> Account open <input type="checkbox"/> 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* \$	<input type="checkbox"/> Account open <input type="checkbox"/> Account closed	Date account closed Amount on the date account closed \$

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

## 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
			\$	
			\$	
			\$	

### 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, or cash not in the bank? . . . . .  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				\$	\$	<input type="checkbox"/> yes <input type="checkbox"/> no
Stocks				\$	\$	<input type="checkbox"/> yes <input type="checkbox"/> no
Bonds				\$	\$	<input type="checkbox"/> yes <input type="checkbox"/> no
Savings bonds				\$	\$	<input type="checkbox"/> yes <input type="checkbox"/> no
Mutual funds				\$	\$	<input type="checkbox"/> yes <input type="checkbox"/> no
Options				\$	\$	<input type="checkbox"/> yes <input type="checkbox"/> no
Future contracts				\$	\$	<input type="checkbox"/> yes <input type="checkbox"/> no
Other				\$	\$	<input type="checkbox"/> yes <input type="checkbox"/> no

### Annuities

ATT

▶ Did you or your spouse or someone on your or your spouse's behalf purchase 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.

If **no**, go to the next section (Real Estate).

☒ **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.

**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, boats, or any other kind?  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	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		Your spouse	
Burial contract	<input type="checkbox"/> yes (amount: \$ _____)	<input type="checkbox"/> no	<input type="checkbox"/> yes (amount: \$ _____)	<input type="checkbox"/> no
Burial trust	<input type="checkbox"/> yes (amount: \$ _____)	<input type="checkbox"/> no	<input type="checkbox"/> yes (amount: \$ _____)	<input type="checkbox"/> no
Life insurance for burial	<input type="checkbox"/> yes (total face value: \$ _____)	<input type="checkbox"/> no	<input type="checkbox"/> yes (total face value: \$ _____)	<input type="checkbox"/> no
Burial-only account	<input type="checkbox"/> yes (amount: \$ _____)	<input type="checkbox"/> no	<input type="checkbox"/> yes (amount: \$ _____)	<input type="checkbox"/> no
Burial plot	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no

**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 (Assisted Living/Other).

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

Trust name	Revocable?	Current trust principal	Trust principal on admission date*	Trustee(s)	Grantor(s)/Donor(s)	Beneficiaries
	<input type="checkbox"/> yes <input type="checkbox"/> no	\$ _____	\$ _____			
	<input type="checkbox"/> yes <input type="checkbox"/> no	\$ _____	\$ _____			

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

**Assets (cont.)**

**Assisted Living/Other**

▶ 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, and the date it was given to the facility.  
If **no**, go to the next section (Citizenship).

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

Name of facility	Address of facility	Amount	Date
		\$	

**Citizenship**

If you and your spouse **are** U.S. citizens/nationals, you do not have to fill out the rest of this page. Go to page 9.

If you and your spouse **are not** U.S. citizens/nationals, and you are applying, you must fill out the rest of this 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**, you may stop here and go to page 9.  
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**, you may stop here and go to page 9.  
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**, you may stop here and go to page 9.  
If **no**, you must fill out the rest of this page (Immigration Status).

**Immigration Status**

OAC

▶ List all 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 or the Uncompensated Care Pool, you do not have 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.

Use these codes to describe your 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 temporary visa/other
- 14. Person residing under color of law (PRUCOL)
- 15. Victim of severe forms of trafficking

Name	Status codes (List all that apply.)	Date status awarded	U.S. entry date	<b>For office use only</b>

**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
- are applying for MassHealth, and
- have no children under age 19 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 the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss) to get a MassHealth Member Booklet. If this section does not apply to you, go to page 10.

**Not Working**

LTU

▶ Are you **unemployed**, only working from time to time, or retired? . . . . .  yes  no

If **yes**, fill out this section.

If **no**, go to the next section (HIV Information (optional)).

Name: \_\_\_\_\_

▶ Is this person getting unemployment benefits? . . . . .  yes  no

▶ Has this person worked in the past 12 months? . . . . .  yes  no

If **yes**, how much did this person earn in the past 12 months before taxes and deductions? \$ \_\_\_\_\_

▶ Is this person a college student? . . . . .  yes  no

If **yes**, is this person eligible for health insurance from the college?  yes  no

▶ Is your spouse working 100 hours or more a month? . . . . .  yes  no

**HIV Information (optional)**

HIV

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

▶ 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 the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss) and ask for a MassHealth Member Booklet.

Name: \_\_\_\_\_

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**Disability (only for persons under 65 years of age)**

DDU/

▶ Do you have a disability that has lasted or is expected to last for at least 12 months? (If legally blind, answer **yes**). . . . .  yes  no

If **yes**, answer the next three questions.

If **no**, go to page 10.

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.

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Supp to DES	Dis type

**This is an application for MassHealth, Commonwealth Care, and the Uncompensated Care Pool.**

**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 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 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 Uncompensated Care Pool.

I give permission to MassHealth to get any records or data to prove any information given on this application and any supplements, or other information I give to MassHealth once I am a member. If I or my spouse is found eligible for MassHealth, I give permission to MassHealth to get any medical records about medical services provided through MassHealth. If I or my spouse is found eligible for Commonwealth Care, I give permission to the Commonwealth Health Insurance Connector Authority ("the Connector") to get any records about medical services provided through that program.

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.

I understand that if I have purchased an annuity on or after February 8, 2006, I may not be eligible for payment of long-term-care services, unless certain conditions are met. I also understand that the Commonwealth may become a remainder beneficiary of any annuity that I or my spouse bought for the total amount of medical assistance paid for the institutionalized individual.

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 MassHealth for certain medical services provided, as explained in the *MassHealth and You* guide. I also understand that I must tell MassHealth in writing, within 10 days, if I or my spouse files any insurance claim or lawsuit because of an accident or injury to me or my spouse.

I understand that if I or my spouse are members of Commonwealth Care and we are in an accident, or injured in some other way, and get money from a third party because of that accident or injury, we may need to use that money to repay the Connector or my current health insurer for certain medical services provided, as explained in the *MassHealth and You* guide. I also understand that I must tell my health insurer in writing, within 10 days, if I file any insurance claim or lawsuit seeking benefits because of an accident or injury.

I understand that if I or my spouse is eligible for MassHealth, Commonwealth Care, or the Uncompensated Care Pool, 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 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 Connector.

I certify that I have read or have had read to me the information on this application and any supplements, 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 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 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 Uncompensated Care Pool decision.

X  
\_\_\_\_\_  
Signature of applicant or eligibility representative

\_\_\_\_\_  
Date

X  
\_\_\_\_\_  
Signature of applicant's spouse or spouse's eligibility representative

\_\_\_\_\_  
Date

# Supplement A: Long-Term-Care Questions

For office use only

Head of household/applicant name: \_\_\_\_\_

Head of household/applicant 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 the Home- and Community-Based Services Waiver?  yes  no

If **yes**, you only need to fill out the "Resource Transfers" section on page 13.

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 and attach it to this supplement.

## Head of Household/Applicant Information

Last name	First name	MI	Social security number
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▶ 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
				\$
				\$

## Long-Term-Care Insurance

▶ 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
			\$
			\$

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 \$750,000, 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.)	Fair-market value
		<input type="checkbox"/> Individual <input type="checkbox"/> Tenancy in common <input type="checkbox"/> Joint tenancy <input type="checkbox"/> Life estate	\$
		<input type="checkbox"/> Individual <input type="checkbox"/> Tenancy in common <input type="checkbox"/> Joint tenancy <input type="checkbox"/> Life estate	\$

2. Do you have a	If you answered yes, fill out this column and the next.	Is this person living in your home?
spouse? . . . . . <input type="checkbox"/> yes <input type="checkbox"/> no	Name:	<input type="checkbox"/> yes <input type="checkbox"/> no
permanently and totally disabled or blind child? . . . . . <input type="checkbox"/> yes <input type="checkbox"/> no	Name:	<input type="checkbox"/> yes <input type="checkbox"/> no
child under 21 years of age? . . . . . <input type="checkbox"/> yes <input type="checkbox"/> no	Name: Date of birth:	<input type="checkbox"/> yes <input type="checkbox"/> no
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? . . . . . <input type="checkbox"/> yes <input type="checkbox"/> no	Name:	<input type="checkbox"/> yes <input type="checkbox"/> no
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? . . . . . <input type="checkbox"/> yes <input type="checkbox"/> no	Name:	<input type="checkbox"/> yes <input type="checkbox"/> no
dependent relative? . . . . . <input type="checkbox"/> yes <input type="checkbox"/> no	Name: Describe the relationship and the nature of the dependency:	<input type="checkbox"/> yes <input type="checkbox"/> no

- ▶ 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.

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## Resource Transfers (resources include both income and assets)

1. In the last 36 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 give anyone a mortgage, loan, or promissory note on property you own? . . . . .  yes  no
  - g. Did you, your spouse, or someone on your behalf purchase an annuity on or after February 8, 2006? . . . . .  yes  no
2. In the last 60 months, has any property that was available or belonging 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
				\$
				\$
				\$

3. 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

## Tax Returns

- Did you or your spouse file U.S. income tax returns in the last two years? . . . . .  yes  no

If **yes**, you must **send copies** of these returns. If you did not keep copies of your tax returns for the last two years, **you must send a filled-out and signed Form 4506 to the Internal Revenue Service.** Form 4506 is included as part of this application.

