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

Commonwealth of Massachusetts | EOHHS

HOW TO APPLY
Please identify which program each household member is applying for on page 1 of the application. You can submit your application in any of the following ways.

Mail or fax your filled-out, signed application to
MassHealth Enrollment Center
Central Processing Unit
P.O. Box 290794
Charlestown, MA 02129-0214.
Fax: 617-887-8799

Hand deliver your filled-out, signed application to
MassHealth Enrollment Center
Central Processing Unit
The Schrafft Center
529 Main Street, Suite 1M
Charlestown, MA 02129-0214.

MASSHEALTH and the HEALTH SAFETY NET
Who Can Use This Application

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

- aged 65 or older and living at home;
- any age and need long-term-care services in a medical institution or nursing facility;
- eligible under certain programs to get long-term-care services to live at home; or
- a member of a married couple living with your spouse, and
  - both you and your spouse are applying for health coverage;
  - there are no children under 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 see Part 8 of the application.)

You will also need to fill out a Long-Term-Care Supplement 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 20 in the Senior Guide.);
- in an acute hospital waiting for placement in a long-term-care facility; or
- living in your home and applying for or getting long-term-care services under a Home- and Community-Based Services Waiver.

If someone is helping you fill out this application, you may need to fill out a separate form that gives that person permission to act on your behalf. See Authorized Representative Designation Form on page 33.

MASSACHUSETTS HEALTH CONNECTOR
Who Can Use This Application

This is your application for health coverage if you live in Massachusetts, your income is at or below 400% of the federal poverty level, and you:

- are aged 65 or older and living at home;
- are not otherwise eligible for MassHealth;
- are not getting Medicare;
- do not have access to an affordable health plan that meets the minimum value requirement*; and
- file federal income taxes.

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

The Health Connector uses Modified Adjusted Gross Income (MAGI) rules to determine eligibility. See the Senior Guide for more information.
**WHAT YOU NEED TO APPLY**
The following **MUST** be sent with the application when applying for MassHealth, Health Safety Net, and the Massachusetts Health Connector

**Social Security Number (SSN)**
- You must give us an SSN or proof that one has been applied for for every household member who is applying, unless one of the following exceptions applies.
  - You or any household member has a religious exemption as described in federal law.
  - You or any household member is eligible only for a nonwork SSN.
  - You or any household member is not eligible for an SSN.

Unless an exception applies, we need SSNs for all persons applying for health coverage. An SSN is optional for persons not applying for health coverage, but giving us an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone does not have an SSN or needs help getting one, call the Social Security Administration at 1-800-772-1213 (TTY: 1-800-325-0778 for people who are deaf, hard of hearing, or speech disabled), or go to socialsecurity.gov. Please see the Senior Guide for more information.

We keep the information provided to us private, and only use and disclose it in accordance with applicable law. You can view the Privacy Policy of the Health Connector and MassHealth on their respective websites.

**Proof of income, assets, and insurance**
- Proof of all current income before deductions, like copies of pension check stubs. (You do not have to send proof of social security or SSI income, but you must fill out the social security and SSI income information, if applicable.)
- Proof of all assets, like bank accounts and life insurance policies.
- 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.)

**Proof of citizenship/national status**
- Proof of U.S. citizenship/national status and proof of identity, like U.S. passports or U.S. naturalization papers. You can also prove U.S. citizenship with a U.S. public birth certificate. You can also prove identity with a driver’s license or some other form of government-issued card. We may be able to prove your identity through the Massachusetts Registry of Motor Vehicles records if you have a Massachusetts driver’s license or a Massachusetts ID card. Once you give MassHealth proof of your U.S. citizenship/national status and identity, you will not have to give us this proof again. You must give proof of identity for all household members who are applying.

Seniors and disabled persons who get or can get Medicare or Supplemental Security Income (SSI), or disabled persons who get Social Security Disability (SSDI), do not have to give proof of their U.S. citizenship/national status and identity. (See pages 48-50 in the Senior Guide for complete information about acceptable proofs.)

- A copy of both sides of all immigration cards (or other documents that show immigration status) for you or your spouse if you or your spouse are not U.S. citizens/nationals and are applying for MassHealth (except for MassHealth Limited), the Health Safety Net, or the Health Connector plans.

**WHAT HAPPENS NEXT**
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.

**WHERE TO GET HELP**
If you need more information about how to apply, or if you need another copy of the Personal Care Attendant Supplement for your spouse who is also applying, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled). This application is available in Spanish. Please call the number above to request one.

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

If this application is not for you, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).
Please Print Clearly. Be sure to answer all questions. Fill out all parts of the application and all supplements that apply. If you need more space, attach a separate piece of paper to the application. Put Person 1’s name and social security number at the top of any attached paper.

For each member in your household, please put the name(s) of the individual(s) under the program or programs he or she wants to apply for. Please see the Senior Guide to learn more about coverage under these programs.

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

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

You:  
Spouse:  

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

You:  
Spouse:  

☐ Health Connector Programs
Health coverage through the Massachusetts Health Connector is not MassHealth. If you have Medicare and apply for a plan through the Health Connector, you will not be eligible for any cost sharing or tax credits. You will be responsible for the full price of the plan. We will see if you are eligible for MassHealth before determining if you can get cost sharing or tax credits through the Health Connector.

You:  
Spouse:  

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

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

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

<table>
<thead>
<tr>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Marital status</th>
<th>Gender [ ] M [ ] F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home street address</td>
<td>Apt. #</td>
<td>City</td>
</tr>
<tr>
<td>Is this a hospital, nursing facility, or other institution? [ ] Yes [ ] No</td>
<td>Facility name</td>
<td></td>
</tr>
<tr>
<td>Mailing address (if different from home address)</td>
<td>Apt. #</td>
<td>City</td>
</tr>
<tr>
<td>Do you rent on own your property? [ ] Rent [ ] Own</td>
<td>Are you homeless? [ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Telephone number</td>
<td>Email address</td>
<td>Written language choice</td>
</tr>
<tr>
<td>Is anyone on this application in prison or jail? [ ] Yes [ ] No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Are you applying for health coverage for YOURSELF?
   □ Yes. If yes, answer all the questions below in PART 1 for Person 1 (yourself).
   □ No. If no, go to PART 2: Tell us about other people in this household on page 4.

3. We need a social security number (SSN) for every person applying for health coverage who has one.
   Do you have a social security number (SSN)? □ Yes □ No
   If yes, give us the number (optional if not applying) _______ - _______ - _______
   If no, check one of the following reasons:
   □ Just applied □ Noncitizen exception □ Religious exception

   If yes, go to question 6

5. If you are a noncitizen, do you have an eligible immigration status (see the Senior Guide or MAhealthconnector.org for more information)? □ Yes □ No □ No response
   If no or no response, you may get only one or more of the following: MassHealth Limited or the Health Safety Net (HSN).
   a. If yes, do you have an immigration document? □ Yes □ No
      We will try to prove your immigration status. Please list all the immigration statuses and/or conditions that have applied to you since you entered the U.S. See the Senior Guide for more information about immigration statuses and documents.
      Immigration status ________________________________ Status award date* (mm/dd/yyyy) ____________
      Immigration document type ________________________ Document ID number ____________________________
      Alien number ________________________________ Passport or document expiration date (mm/dd/yyyy) ____________
      * For battered persons, the status award date is the date the petition was approved as properly filed.
   b. Have you lived in the U.S. since August 22, 1996? □ Yes □ No
   c. Did you use the same name on this application that you did to get your immigration status? □ Yes □ No
      If no, what name did you use?
      First name, middle name, last name, and suffix ________________________________
   d. Are you an honorably discharged veteran or an active-duty member of the U.S. military, or the spouse or child of an honorably discharged veteran or an active-duty member of the U.S. military? □ Yes □ No

6. Are you planning to file a federal income tax return NEXT YEAR? You can still apply for health coverage even if you did not file a federal income tax return. However, you must file a tax return to get help paying for coverage through a tax credit or ConnectorCare plan.
   □ Yes. If yes, please answer questions a–c. □ No. If no, skip to question d.
   a. Are you married? □ Yes □ No
   b. Will you file jointly with a spouse? □ Yes □ No. You must file a joint federal tax return next year to get a tax credit or ConnectorCare plan. If you are a victim of domestic violence or are an abandoned spouse, you should indicate that you file taxes as “single” in order to be considered for a tax credit even if that is not how you actually file. You will only need to include yourself and any dependents on this application.
      If yes, list name of spouse. ________________________________
   c. Will you claim any dependents on your tax return? □ Yes □ No. You must claim a personal exemption deduction on your 2015 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Health Connector and whose premium for coverage is paid in whole or in part by advance payments.
      If yes, list name(s) and date(s) of birth of dependents. ________________________________
d. Will you be claimed as a dependent on someone’s tax return? □ Yes □ No. If you are claimed by someone else as a dependent on his or her 2015 federal income tax return, this may affect your ability to receive a premium tax credit. If you are younger than age 21 and claimed by a parent who does not live with you, answer no.

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

Date of birth __________________________ How are you related to the tax filer? __________________________

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

Who else does the tax filer claim as dependents?

7. Are you a Massachusetts resident who intends to reside in Massachusetts even if you do not have a fixed address? □ Yes □ No

8. Do you need reasonable accommodation(s) because of a disability or injury? □ Yes □ No

If no, go to the next question. If yes, fill out Part B of the **Illness, Disability, or Accommodation Supplement** on page 29.

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

If no, go to the next question. If yes, fill out Part C of the **Illness, Disability, or Accommodation Supplement** on page 29.

10. Did you ever get Supplemental Security Income (SSI)? □ Yes □ No

If no, go to question 11. If yes, answer questions a—b.

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

b. Do you (Please check one):

□ live alone? □ live with a spouse? □ live in a rest home? □ live in someone else’s home?

□ live and share expenses with another or others (not a spouse)? □ live in an assisted living facility?

11. Check the box below that best describes you (optional—check all that apply.)

□ Hispanic, Latino, or Spanish origin □ Asian Indian □ Other Asian

□ Cuban □ Black or African American □ Other Pacific Islander

□ Mexican, Mexican-American, or Chicano □ Chinese □ Samoan

□ Puerto Rican □ Filipino □ Vietnamese

□ Other Hispanic/Latino/□ Guamanian or Chamorro □ White or Caucasian

□ Spanish __________________________ □ Japanese □ Other

□ American Indian or Alaska Native □ Korean □ Other

□ Native Hawaiian

If you are an American Indian or Alaska Native, fill out the **American Indian (AI)/Alaska Native (AN) Supplement** on page 25. American Indians and Alaska Natives may not have to pay premiums or copayments, and may get special monthly enrollment periods.
### PART 2  Person 2—Spouse or other people in this household

Fill out this part for your **spouse** who lives with you and/or anyone included on your federal income tax return, if you file one. See the application instructions for more information about who to include. If you do not file an income tax return, remember to add other persons who live with you.

If you have more than one person to add, make a copy of person 2’s blank information (pages 4-6) before you fill them out, or go to **Part 3: Current Job and Income Information** on page 6.

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

<table>
<thead>
<tr>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Marital status</th>
<th>Relationship to Person 1</th>
<th>Gender</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home street address</td>
<td>Apt. #</td>
<td>City</td>
<td>State</td>
<td>Zip code</td>
<td></td>
</tr>
<tr>
<td>Is this a hospital, nursing facility, or other institution?</td>
<td>Yes</td>
<td>No</td>
<td>Facility name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mailing address (if different from home address)</td>
<td>Apt. #</td>
<td>City</td>
<td>State</td>
<td>Zip code</td>
<td></td>
</tr>
<tr>
<td>Does Person 2 rent or own their property?</td>
<td>Rent</td>
<td>Own</td>
<td>Is Person 2 homeless?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

| Telephone number | Email address | Written language choice | Spoken language choice |

2. **Is Person 2 applying for health coverage?**

- [ ] Yes. If yes, answer all the questions below.
- [ ] No. If no, go to **Part 3: Current Job and Income Information** on page 6.

3. We need a Social Security number (SSN) for every person applying for health coverage who has one. An SSN is optional for persons not applying for health coverage, but giving us an SSN can speed up the application process.

   Does Person 2 have a social security number (SSN)?
   - [ ] Yes
   - [ ] No

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

   **If no,** check one of the following reasons:
   - [ ] Just applied
   - [ ] Noncitizen exception
   - [ ] Religious exception

4. Is Person 2 a U.S. citizen, U.S. national, or naturalized U.S. citizen? [ ] Yes [ ] No

5. If Person 2 is a noncitizen, does he or she have an eligible immigration status (see the Senior Guide or [MAhealthconnector.org](http://www.MAhealthconnector.org) for more information)?

   - [ ] Yes
   - [ ] No
   - [ ] No response

   **If no or no response,** he or she may get only one or more of the following: MassHealth Limited or the Health Safety Net (HSN).

   a. **If yes,** does Person 2 have an immigration document? [ ] Yes [ ] No

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

   - [ ] Immigrant status __________________________ Status award date* (mm/dd/yyyy) __________________________
   - [ ] Immigration document type __________________________ Document ID number __________________________
   - [ ] Alien number __________________________ Passport or document expiration date (mm/dd/yyyy) __________________________

   * For battered persons, the status award date is the date the petition was approved as properly filed.
b. Has Person 2 lived in the U.S. since August 22, 1996?  ☐ Yes  ☐ No

c. Did Person 2 use the same name on this application that this person did to get his or her immigration status?  
☐ Yes  ☐ No  If no, what name did this person use?  
First name, middle name, last name, and suffix ______________________________

d. Is Person 2 an honorably discharged veteran or an active-duty member of the U.S. military, or the spouse or child of an honorably discharged veteran or an active-duty member of the U.S. military?  ☐ Yes  ☐ No

6. Does Person 2 plan to file a federal income tax return NEXT YEAR? Person 2 can still apply for health coverage even if he or she did not file a federal income tax return. However, Person 2 must file a tax return to get help paying for coverage through a tax credit or ConnectorCare plan.

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

a. Is Person 2 married?  ☐ Yes  ☐ No

b. Will Person 2 file jointly with a spouse?  ☐ Yes  ☐ No. Person 2 must file a joint federal tax return next year to get a tax credit or ConnectorCare plan. If Person 2 is a victim of domestic violence or is an abandoned spouse, Person 2 should indicate that he or she files taxes as “single” in order to be considered for a tax credit even if that is not how Person 2 actually files. You will only need to include Person 2 and any dependents on this application.

If yes, list name of spouse. ______________________________

6. c. Will Person 2 claim any dependents on his or her tax return?  ☐ Yes  ☐ No. Person 2 must claim a personal exemption deduction on his or her 2015 federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Health Connector and whose premium for coverage is paid in whole or in part by advance payments.

If yes, list name(s) and date(s) of birth of dependents. ______________________________

6. d. Will Person 2 be claimed as a dependent on someone’s tax return?  ☐ Yes  ☐ No. If Person 2 is claimed by someone else as a dependent on their 2015 federal income tax return, this may affect his or her ability to receive a premium tax credit. (If Person 2 is younger than age 21 and claimed by a parent who does not live with him or her, answer no.)

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

Date of birth ______________________________  How is Person 2 related to the tax filer? ______________________________

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

Who else does the tax filer claim as dependents? ______________________________

7. Is Person 2 a Massachusetts resident who intends to reside in Massachusetts even if her or she does not have a fixed address?  ☐ Yes  ☐ No

8. Does Person 2 need reasonable accommodation(s) because of a disability or injury?  ☐ Yes  ☐ No

If no, go to the next question.  If yes, fill out Part B of the Illness, Disability, or Accommodation Supplement on page 29.

9. Is Person 2 applying because of an accident or injury that someone else might be responsible for?  ☐ Yes  ☐ No

If no, go to the next question.  If yes, fill out Part C of the Illness, Disability, or Accommodation Supplement on page 29.

10. Did Person 2 ever get Supplemental Security Income (SSI)?  ☐ Yes  ☐ No

If no, go to question 11.  If yes, answer questions a—b.

a. When did Person 2 last get SSI? (mm/yyyy) ______________________________

b. Does Person 2 (Please check one):

☐ live alone?  ☐ live with a spouse?  ☐ live in a rest home?  ☐ live in someone else’s home?

☐ live and share expenses with another or others (not a spouse)?  ☐ live in an assisted living facility?
PART 2 Person 2—Tell us about other people in this household. (cont.)

11. Check the box below that best describes Person 2 (optional—check all that apply.)

- Hispanic, Latino, or Spanish origin
- Cuban
- Mexican, Mexican-American, or Chicano
- Puerto Rican
- Other Hispanic/Latino/Spanish
- Other Asian
- Asian Indian
- Black or African American
- Chinese
- Filipino
- Guamanian or Chamorro
- Japanese
- Korean
- Native Hawaiian
- Other

If Person 2 is an American Indian or Alaska Native, fill out the American Indian (AI)/Alaska Native (AN) Supplement on page 25. American Indians and Alaska Natives may not have to pay premiums or copayments, and may get special monthly enrollment periods.

PART 3 Current Job and Income Information—Person 1

- Employed (Go to question 1.)
- Self-employed (Go to question 11.)
- Not employed (Go to question 12.)

**CURRENT JOB 1 (PERSON 1)**

1. Employer name and address

2. Wages/tips (before taxes) $ ____________
   - Weekly
   - Every 2 weeks
   - Twice a month
   - Monthly
   - Yearly
   (Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)

3. Average number of hours worked each WEEK ____________

4. Is this job a sheltered workshop? □ Yes □ No

5. Are you seasonally employed? □ Yes □ No. If yes, how many months do you work each calendar year? ____________

**CURRENT JOB 2 (PERSON 1)** *(If you have more jobs and need more space, attach another sheet of paper.)*

6. Employer name and address

7. Wages/tips (before taxes) $ ____________
   - Weekly
   - Every 2 weeks
   - Twice a month
   - Monthly
   - Yearly
   (Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)

8. Average number of hours worked each WEEK ____________

9. Is this job a sheltered workshop? □ Yes □ No

10. Are you seasonally employed? □ Yes □ No. If yes, how many months do you work each calendar year? ____________

**SELF-EMPLOYMENT** *(PERSON 1)* *(If self-employed, answer the following questions. If you need more space, attach another sheet of paper.)*

11. Are you self employed? □ Yes □ No
   a. If yes, what type of work do you do?
   b. On average, how much net income (profits after business expenses are paid) will you get from this self-employment each month? $ ____________ per month
MONEY FROM OTHER SOURCES (PERSON 1)

12. Do you get money from other sources? □ Yes □ No
   Check all of the sources, give the amount, and how often you get it. (You do not need to tell us about Supplemental Security Income (SSI).)
   □ Social security benefits $ ____________ How often? □ Monthly □ Other ____________
   □ Pension $ ____________ How often? □ Monthly □ Other ____________
   □ Annuities $ ____________ How often? □ Monthly □ Other ____________
   □ Trusts $ ____________ How often? □ Monthly □ Other ____________
   □ Unemployment $ ____________ How often? □ Monthly □ Other ____________
   □ Capital gains $ ____________ How often? □ Monthly □ Other ____________
   □ Interest $ ____________ How often? □ Monthly □ Other ____________
   □ Alimony received $ ____________ How often? □ Monthly □ Other ____________
   □ Taxable veteran’s money $ ____________ How often? □ Monthly □ Other ____________
   □ Taxable military retirement pay (not paid through the Veterans’ Administration) $ ____________ How often? □ Monthly □ Other ____________
   □ Other income (type): $ ____________ How often? □ Monthly □ Other ____________

RENTAL INCOME (PERSON 1)

13. Do you get rental income? (You must answer this question.) □ Yes □ No If yes, send proof of current rental income, like a written statement from each tenant or a copy of the lease, or a current federal tax return.
   Send proof of all of the following expenses, if applicable, for the last 12 months:
   • mortgage • taxes • utilities (gas/electric) • heat
   • water/sewer • insurance • condo or co-op fee • repairs and maintenance
   a. What type of real estate do you own? □ one-family □ two-family □ three-family □ other (describe): ____________
   b. 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
   c. Do you pay for heat and/or utilities for your tenant? □ Yes □ No

DEDUCTIONS (PERSON 1)

14. Check all that apply. Give the amount and how often you get it.
   If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. NOTE: You should not include a cost that you already considered in your answers to net self-employment income, net rental or royalty income, or net farming or fishing income.
   □ Alimony paid $ _______ How often? ____________ □ Student loan interest $ _______ How often? ____________
   □ Other tax deductions (business expenses, IRA contributions, contributions to taxable retirement income, deductible part of self-employment tax, educator expenses, health savings account contributions (deduction), moving expenses, penalty on early withdrawal of savings, self-employment health insurance, self-employment retirement plan, and tuition and other school-related costs). Do not include any type of deduction that is not listed in this section.
      Type _____________________________ $ _______ How often? ____________

YEARLY INCOME (PERSON 1)

15. What is your total expected income for the current calendar year? ____________
16. What is your total expected income for next calendar year, if different? ____________
PART 4 Current Job and Income Information—Person 2

About Person 2

If you have income to report for more than two persons, make a copy of pages 8-9 before you fill them out.

Person #__________ Name: ___________________________________________________________________________________

☐ Employed (Go to question 1.) ☐ Self-employed (Go to question 11.) ☐ Not employed (Go to question 12.)

CURRENT JOB 1 (PERSON 2)

1. Employer name and address

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

3. Average number of hours worked each WEEK ____________

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

5. Is Person 2 seasonally employed? ☐ Yes ☐ No. If yes, how many months does he or she work each calendar year? ______

CURRENT JOB 2 (PERSON 2) (If Person 2 has more jobs and need more space, attach another sheet of paper.)

6. Employer name and address

7. Wages/tips (before taxes) $__________ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
   (Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)

8. Average number of hours worked each WEEK ____________

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

10. Is Person 2 seasonally employed? ☐ Yes ☐ No. If yes, how many months does he or she work each calendar year? ______

SELF-EMPLOYMENT (PERSON 2) (If self-employed, answer the following questions. If you need more space, attach another sheet of paper.)

11. Is Person 2 self employed? ☐ Yes ☐ No
   a. If yes, what type of work does Person 2 do? _______________________________________________________________________
   b. On average, how much net income (profits after business expenses are paid) will Person 2 get from this self-employment each month? $________________________ per month

MONEY FROM OTHER SOURCES (PERSON 2)

12. Does Person 2 get money from other sources? ☐ Yes ☐ No
   Check all of the sources, give the amount, and how often Person 2 gets it. (You do not need to tell us about Supplemental Security Income (SSI).)
   ☐ Social security benefits $__________ How often? ☐ Monthly ☐ Other _________
   ☐ Pension $__________ How often? ☐ Monthly ☐ Other _________
   ☐ Annuities $__________ How often? ☐ Monthly ☐ Other _________
   ☐ Trusts $__________ How often? ☐ Monthly ☐ Other _________

Page 8

APPLICATION FOR HEALTH COVERAGE FOR SENIORS AND PEOPLE NEEDING LONG-TERM-CARE-SERVICES

SACA-2 (Rev. 03/15)
PART 4  Current Job and Income Information—Person 2 (cont.)

☐ Unemployment  $ __________ How often?  ☐ Monthly  ☐ Other __________
☐ Capital gains  $ __________ How often?  ☐ Monthly  ☐ Other __________
☐ Interest  $ __________ How often?  ☐ Monthly  ☐ Other __________
☐ Alimony received  $ __________ How often?  ☐ Monthly  ☐ Other __________
☐ Taxable veteran’s money  $ __________ How often?  ☐ Monthly  ☐ Other __________
☐ Taxable military retirement pay (not paid through the Veterans’ Administration)  $ __________ How often?  ☐ Monthly  ☐ Other __________
☐ Other income (type): ______________  $ __________ How often?  ☐ Monthly  ☐ Other __________

RENTAL INCOME (PERSON 2)

13. Does Person 2 get rental income? (You must answer this question.) ☐ Yes  ☐ No  If yes, send proof of current rental income, like a written statement from each tenant or a copy of the lease, or a current federal tax return.

Send proof of all of the following expenses, if applicable, for the last 12 months:
- mortgage
- taxes
- utilities (gas/electric)
- heat
- water/sewer
- insurance
- condo or co-op fee
- repairs and maintenance

a. What type of real estate does Person 2 own?  ☐ one-family  ☐ two-family  ☐ three-family
☐ other (describe): ______________

b. How much monthly rental income does Person 2 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

c. Does Person 2 pay for heat and/or utilities for his or her tenant?  ☐ Yes  ☐ No

DEDUCTIONS (PERSON 2)

14. Check all that apply. Give the amount and how often Person 2 gets it.
If Person 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. NOTE: You should not include a cost that you already considered in your answers to net self-employment income, net rental or royalty income, or net farming or fishing income.

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

☐ Other tax deductions (business expenses, IRA contributions, contributions to taxable retirement income, deductible part of self-employment tax, educator expenses, health savings account contributions (deduction), moving expenses, penalty on early withdrawal of savings, self-employment health insurance, self-employment retirement plan, and tuition and other school-related costs). Do not include any type of deduction that is not listed in this section.
Type ______________  $ __________ How often? __________

YEARLY INCOME (PERSON 2)

15. What is Person 2’s total expected income for the current calendar year?

16. What is Person 2’s total expected income for next calendar year, if different?
### PART 5 Previous Medical Bills

1. Do you or your spouse have bills for medical services you got in the three months before the month we got your application?  
   - Yes  
   - No  
   **If no**, go to **Part 6: Health Insurance You Have Now**.  
   **If yes**, fill out the rest of this section. We may be able to pay for these bills.  
   a. Do you or your spouse want to apply for MassHealth for that time period?  
      - Yes  
      - No  
      **If yes**, what is the earliest date for which you need MassHealth? (mm/dd/yyyy) ______________  
      (You must give us proof of all income and assets owned during that time period.)

### PART 6 Health Insurance You Have Now

Please answer the questions below about **health insurance**, and follow the instructions. If someone has enrolled in one of the health insurance plans below, but the benefits have not yet started, check **yes** to the question. MassHealth may be able to help pay premiums.

1. Do you or any household member have Medicare?  
   - Yes  
   - No  
   **If yes**, fill out **Part A** of the **Health Insurance Supplement** on page 27.

2. Do you or any household member have federal health insurance provided by the U.S. military (Veterans’ Affairs or TRICARE) or other federal coverage?  
   - Yes  
   - No  
   **If yes**, fill out **Part B** of the **Health Insurance Supplement** on page 27.

3. Do you or any household member currently have any other type of health insurance? (This includes insurance through an employer, union, college or university, former employer (COBRA), and coverage bought by you or any household member who is not living in the household.)  
   - Yes  
   - No  
   **If yes**, fill out **Part C** of the **Health Insurance Supplement** on page 27.
PART 7 Assets

You MUST fill out all blocks for each asset you and/or your spouse own.

If you live in the community and you want help with medical bills up to three months before the month you apply, you must tell us about any open and closed accounts for that period.

If you are applying for long-term care, you must also give us information about all assets you or your spouse owned in the past 60 months. If you have a spouse at home, you also need to fill out the shaded blocks, and the Long-Term-Care Supplement on page 21.

**BANK ACCOUNTS**

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

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

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

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

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

<table>
<thead>
<tr>
<th>Name on account</th>
<th>Name of bank/institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account number</td>
<td>Account type</td>
</tr>
<tr>
<td>Account open</td>
<td>Account closed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name on account</th>
<th>Name of bank/institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account number</td>
<td>Account type</td>
</tr>
<tr>
<td>Account open</td>
<td>Account closed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name on account</th>
<th>Name of bank/institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account number</td>
<td>Account type</td>
</tr>
<tr>
<td>Account open</td>
<td>Account closed</td>
</tr>
</tbody>
</table>

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

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

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

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

<table>
<thead>
<tr>
<th>Address</th>
<th>Type of property</th>
<th>Current value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

LIFE INSURANCE

3. 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).

<table>
<thead>
<tr>
<th>Name(s) of owner(s)</th>
<th>Insurance company</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy number</td>
<td>Face value $</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Name(s) of owner(s)</td>
<td>Insurance company</td>
</tr>
<tr>
<td>Policy number</td>
<td>Face value $</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECURITIES (STOCKS/BONDS/OTHER)

4. Do you or your spouse own any stocks, bonds, savings bonds, mutual funds, securities, assets held in safe-deposit boxes, cash not in the bank, options, or future contracts? □ Yes □ No
   If yes, fill out this section. If no, go to the next section (ANNUITIES).

   Send proof of current value (except cash).

<table>
<thead>
<tr>
<th>Owner(s) name(s)</th>
<th>Company name</th>
<th>Account number</th>
<th>Current value</th>
<th>Value on admission date*</th>
<th>Joint asset?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Stocks</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Bonds</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Savings bonds</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Mutual funds</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Options</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Future contracts</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

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

5. Did you or your spouse or someone on your or your spouse’s behalf purchase or in any way change an annuity?  
   - [ ] Yes  
   - [ ] No  

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

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

<table>
<thead>
<tr>
<th>Name(s) of owner(s)</th>
<th>Name of institution issuing the annuity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract number</td>
<td>Date purchased (mm/dd/yyyy)</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>Name(s) of owner(s)</td>
<td>Name of institution issuing the annuity</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract number</td>
<td>Date purchased (mm/dd/yyyy)</td>
</tr>
</tbody>
</table>

### ASSISTED LIVING/OTHER

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

   **If yes**, fill out this section. **If no**, go to the next section [VEHICLES/MOBILE HOMES].  

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

<table>
<thead>
<tr>
<th>Name of facility</th>
<th>Address of facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount of deposit</td>
<td>Date deposit given to facility (mm/dd/yyyy)</td>
</tr>
<tr>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

### VEHICLES/MOBILE HOMES

7. Do you or your spouse own any vehicles, like cars, vans, trucks, recreational vehicles, mobile homes, or boats?  
   - [ ] Yes  
   - [ ] No  

   **If yes**, fill out this section. **If no**, go to the next section [PREPAID BURIAL PLANS/TRUSTS].  

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

<table>
<thead>
<tr>
<th>(You) Type of vehicle</th>
<th>Year/make/model</th>
<th>Fair-market value $</th>
<th>Amount owed $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobile home address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Your spouse) Type of vehicle</td>
<td>Year/make/model</td>
<td>Fair-market value $</td>
<td>Amount owed $</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobile home address</td>
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</table>
**PREPAID BURIAL PLANS/TRUSTS**

8. 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.

<table>
<thead>
<tr>
<th>(You) Burial contract</th>
<th>Burial trust</th>
<th>Burial plot</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes (Amount $ )</td>
<td>☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

Life insurance for burial  
☐ Yes (Total face value $ ) ☐ No  

Insurance company  
Policy number  
Bank name  
Account number

<table>
<thead>
<tr>
<th>(Your spouse) Burial contract</th>
<th>Burial trust</th>
<th>Burial plot</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes (Amount $ ) ☐ No</td>
<td>☐ Yes (amount $ ) ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

Life insurance for burial  
☐ Yes (Total face value $ ) ☐ No  

Insurance company  
Policy number  
Bank name  
Account number

**TRUSTS**

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

a. 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 Part 8: Additional (Optional) Coverage

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

<table>
<thead>
<tr>
<th>Trust name</th>
<th>Revocable? ☐ Yes ☐ No</th>
<th>Current trust principal $</th>
<th>Trust principal on admission date* $</th>
<th>Trustee(s)</th>
<th>Grantor(s)/Donor(s)</th>
<th>Beneficiaries</th>
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<tbody>
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</tr>
<tr>
<td>Trust name</td>
<td>Revocable? ☐ Yes ☐ No</td>
<td>Current trust principal $</td>
<td>Trust principal on admission date* $</td>
<td>Trustee(s)</td>
<td>Grantor(s)/Donor(s)</td>
<td>Beneficiaries</td>
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</tbody>
</table>

* Enter the trust principal on the date of admission to medical institution.
PART 8 Additional (Optional) Coverage

For married persons under age 65

Fill out this section ONLY if you are married and living with your spouse. One spouse applying must be under age 65, and no children under age 19 live with you.

If this section applies to you and you want more information about income standards and other information that may apply, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled) to get a Senior Guide. If this section does not apply, go to Part 9: Personal-Care-Attendant Services.

BREAST OR CERVICAL CANCER (OPTIONAL) (ONLY FOR PERSONS UNDER 65 YEARS OF AGE)

1. Do you have breast or cervical cancer? □ Yes □ No
   MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.
   If yes, we will send you a certificate to be filled out by your doctor to prove your breast or cervical cancer diagnosis. Then MassHealth can see if your MassHealth benefits give you the most coverage possible.
   Name: _____________________________

HIV INFORMATION (OPTIONAL) (ONLY FOR PERSONS UNDER 65 YEARS OF AGE)

2. Are you HIV positive? □ Yes □ No
   If you are HIV positive, you may be eligible for additional coverage or benefits.
   If yes, you will need to give us proof of your HIV-positive status. Then MassHealth can see if your MassHealth benefits give you the most coverage possible.
   Name: _____________________________

DISABILITY (ONLY FOR PERSONS UNDER 65 YEARS OF AGE)

3. Do you have a disability (including a disabling mental health condition) that has lasted or is expected to last for at least 12 months? (If legally blind, answer yes.) □ Yes □ No
   Name: _____________________________
   If yes, you will need to complete Part A of the Illness, Disability, or Accommodation Supplement on page 29, and the rest of this application.
PART 9 Personal-Care-Attendant Services

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

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

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

2. Have you or your spouse had the services of a personal-care attendant paid for by MassHealth within the last six months?  □ Yes □ No
   If yes, go to Part 10. If no, answer the following questions in this section.

3. Do you or your spouse have a permanent or long-lasting disability?  You □ Yes □ No  Your spouse □ Yes □ No
   a. If yes, does your (or your spouse’s) disability keep you (or your spouse) from being able to do your (or your spouse’s) daily living activities, like bathing, eating, toileting, dressing, etc., unless someone physically helps you (or your spouse)?  You □ Yes □ No  Your spouse □ Yes □ No
   b. If yes, do you (or your spouse) plan to contact a MassHealth personal-care-management (PCM) agency to ask for personal-care-attendant services?  You □ Yes □ No  Your spouse □ Yes □ No

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

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

Each spouse who answered yes to all parts of Question 3 above must fill out his or her own Personal-Care-Attendant Supplement. One copy is enclosed. If you need a second copy, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled) to ask for one. If you (or your spouse) do not send us your filled-out PCA supplement(s), we will determine your MassHealth eligibility as if you do not need PCA services.

PART 10 Read and sign this application

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

1. MassHealth may require eligible persons to enroll in available employer-sponsored health insurance if that insurance meets the criteria for MassHealth payment of premium assistance.

2. Employers of eligible persons may be notified and billed in accordance with MassHealth regulations for any services that hospitals or community health centers provide to such persons that are paid for by the Health Safety Net.

3. Eligible persons may have to pay a premium for health coverage for themselves and others listed on this application. Failure to pay any premium due may result in the state deducting the amount owed from the tax refunds of responsible persons. If an eligible person is a certain American Indian or Alaska Native, such person may not have to pay premiums for MassHealth.

4. MassHealth has the right to pursue and get money from third parties who may be obligated to pay for health services provided to eligible persons enrolled in MassHealth programs. Such third parties may include other health insurers, spouses, or parents obligated to pay for medical support, or individuals obligated to pay under accident settlements. Eligible persons must cooperate with MassHealth in establishing third-party support and obtaining third-party payments for themselves and anyone whose rights they can legally assign. Eligible persons may be exempted from this obligation if they believe and tell MassHealth that cooperation could result in harm to them or anyone whose rights they can legally assign.

5. A parent and/or guardian of minor children must agree to cooperate with state efforts to collect medical support from an absent parent unless they believe and tell MassHealth that cooperation will harm the children or the parent or guardian.
6. Eligible persons who are injured in an accident, or in some other way, and get money from a third party because of that accident or injury must use that money to repay MassHealth or the Health Safety Net for certain services provided.

7. Eligible persons must tell MassHealth or the Health Safety Net, in writing, within 10 calendar days, or as soon as possible, about any insurance claims or lawsuits filed because of an accident or injury.

8. The status of this application may be shared with a hospital, community health center, other medical provider, or federal or state agencies when necessary for treatment, payment, operations, or the administration of the programs listed above.

9. To the extent permitted by law, MassHealth may place a lien against any real estate owned by eligible persons or in which eligible persons have a legal interest. If MassHealth puts a lien against such property and it is sold, money from the sale of that property may be used to repay MassHealth for medical services provided.

10. To the extent permitted by law, for any eligible person age 55 or older, or any eligible person for whom MassHealth helps pay for care in a nursing home, MassHealth may seek money from the eligible person’s estate after death.

11. MassHealth, the Health Connector, and the Health Safety Net will obtain from eligible persons’ current and former employers and health insurers all information about health insurance coverage for such persons. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to such persons or members of their household.

12. MassHealth, the Health Connector, and the Health Safety Net may get records or data about persons listed on this application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Revenue, and the Registry of Motor Vehicles, as well as private data sources, 1) to prove any information given on this application and any supplements, or other information given once a person becomes a member, 2) to document medical services claimed or provided to such persons, and 3) to support continued eligibility.

13. To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Health Connector to use income data, including information from tax returns for the next coverage year (2016). The Health Connector will send me a notice, let me make changes, and I can opt out at any time. I understand that if I am eligible for an Advance Premium Tax Credit (APTC) and/or Reduced Copays and Deductibles these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or Reduced Copays and Deductibles may impact my 2015 tax liability. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.

14. In connection with the eligibility and enrollment process, MassHealth, the Health Connector, and the Health Safety Net may send notices that contain personal information about persons listed on this application to other persons on this application, or otherwise communicate such information to such persons.

15. Under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by going to www.hhs.gov/ocr/office/file.

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

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

- Sign on to your account at MAhealthconnector.org. You can create an online account if you do not already have one.
- Send the change information to Health Insurance Processing Center P.O. Box 4405 Taunton, MA 02780.
- Fax the change information to 1-857-323-8300.

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

- ____________________________ is in prison or jail.
- Is this person awaiting trial? □ Yes □ No
- Is this person being released within 30 days of submitting this application? □ Yes □ No
- Is this person an inmate who will be admitted to a hospital for at least 24 hours and then returned to prison or jail? □ Yes □ No
- Is this person a member of their household? □ Yes □ No

□ Yes □ No
I AGREE TO THE FOLLOWING STATEMENTS.

- I have read or have had read to me the information on this application, including any supplements and instruction pages, and I understand that the Senior Guide contains important information.
- I have permission from all persons listed on this application (or their parent or other legally authorized representative) to submit this application and to act on their behalf to complete this application and any ongoing or subsequent eligibility process and activity, including, for example:
  - providing personal information about them, including health, health coverage, and income information, seeing such information as may be provided by the Health Connector, MassHealth, and the Health Safety Net, and providing consent on their behalf to the use and disclosure of their information as described in this application;
  - making choices about coverage options and methods of communication with the Health Connector, MassHealth, and the Health Safety Net;
  - making changes to the application or related eligibility documents and providing information about any change in their circumstances; and
  - providing consent on their behalf to use government and private sources to verify information as described in this application.
- I understand my rights and responsibilities and the rights and responsibilities of all persons listed on this application as explained in Part 10.
- I have told or will tell all such persons (or their parent or legally authorized representative, if applicable) about these rights and responsibilities so they understand them.
- I understand and agree that MassHealth, the Health Safety Net, and the Health Connector will treat electronic, faxed, or copies of signatures with the same force and effect as an original signature(s).
- The information I have supplied is correct and complete to the best of my knowledge about myself and other persons listed on this application.
- I may be subject to penalties under federal law if I intentionally provide false or untrue information.

Sign this application.

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

Important: If you are submitting this application as an authorized representative, you must submit an Authorized Representative Designation Form (ARD) to us or have a form on record for us to process this application. The ARD is at the end of this application.

| Signature of Person 1 or authorized representative | Print name | Date |

Certified application counselors, navigators, agents, and brokers ONLY.

Fill out this section if you are a certified application counselor, navigator, agent, or broker filling out this application for someone else.

| First name, middle initial, last name, suffix | Organization name |
Send us your completed application.

Mail your signed application to:
MassHealth Enrollment Center
Central Processing Unit
PO Box 290794
Charlestown, MA 02129-0214; or
Fax: 617-887-8799

Hand deliver your signed application to:
MassHealth Enrollment Center
Central Processing Unit
The Shraffts Center
529 Main Street, Suite 1M
Charlestown, MA 02129

Voter Registration

The form to register to vote is included with this application or can be found at www.sec.state.ma.us. More information on how to register to vote can also be found at www.sec.state.ma.us. If you have any questions about the voter registration process, or if you need help filling out the form, please visit a local MassHealth Enrollment Center or call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

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

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

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

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

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

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

- Do you need long-term-care services in a nursing home type facility?  Yes  No  
  If yes, you must answer all questions and fill out all sections of this supplement.

- Are you applying for or getting long-term-care services at home under a Home- and Community-Based Services Waiver?  Yes  No  
  If yes, you only need to fill out the “Resource Transfers” section on page 22.

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

Applicant/Member Information

<table>
<thead>
<tr>
<th>Last name, first name, middle initial</th>
<th>Social security number</th>
</tr>
</thead>
</table>

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

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

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

Living expenses of the spouse and family members living at home

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

Send proof of your spouse’s current living expenses.

| Spouse’s last name, first name, middle initial | Social security number |

2. How much does your spouse pay each month for:

   - Rent?  
   - Mortgage (principal and interest)?  
   - Homeowner’s/tenant’s insurance?  
   - Real estate taxes?  
   - Required maintenance charge for a condo or co-op?  
   - Room and board for assisted living?  

3. Does your spouse pay for heat?  Yes  No

4. Does your spouse pay for utilities?  Yes  No

5. Is a child, parent, brother, and/or sister living with your spouse?  Yes  No

   If yes, fill out this section.  If no, go to the next section (Resource Transfers).

Send proof of their monthly income before deductions.

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Social security number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Monthly income before deductions $</th>
</tr>
</thead>
</table>
**Name**  
**Social security number**

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

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

6. In the past 60 months:
   
   a. Has any property that was available or belonged to you or your spouse been transferred into or out of a trust?  
      ☐ Yes  ☐ No
   
   b. Did you, your spouse, or someone on your behalf transfer income or the right to income?  
      ☐ Yes  ☐ No
   
   c. Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real estate?  
      ☐ Yes  ☐ No
   
   d. Did you, your spouse, or someone on your behalf change the deed or the ownership of any real estate, including creating a life estate, even if the life estate was purchased in another person’s residence?  
      ☐ Yes  ☐ No
   
   e. If you purchased a life estate in another person’s home, did you live in the home for at least one year after you purchased the life estate?  
      ☐ Yes  ☐ No
   
   f. Did you, your spouse, or someone on your behalf add another name to the deed of any property you own?  
      ☐ Yes  ☐ No
   
   g. Did you, your spouse, or someone on your behalf receive or give anyone a mortgage, loan, or promissory note on any property or other asset?  
      ☐ Yes  ☐ No
   
   h. Did you, your spouse, or someone on your behalf purchase or in any way change an annuity?  
      ☐ Yes  ☐ No

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

<table>
<thead>
<tr>
<th>Description of asset/income</th>
<th>Date of transfer (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transferred to whom</td>
<td>Relationship to you or your spouse</td>
</tr>
<tr>
<td>Description of asset/income</td>
<td>Date of transfer (mm/dd/yyyy)</td>
</tr>
<tr>
<td>Transferred to whom</td>
<td>Relationship to you or your spouse</td>
</tr>
<tr>
<td>Description of asset/income</td>
<td>Date of transfer (mm/dd/yyyy)</td>
</tr>
<tr>
<td>Transferred to whom</td>
<td>Relationship to you or your spouse</td>
</tr>
</tbody>
</table>

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

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

   **Name of facility** ____________________________  
   **Address of facility** ____________________________  
   **Amount $** __________

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

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

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

      **Name of person** ____________________________  
      **Address** ____________________________
Real Estate

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

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

8. Do you or your spouse own or have a legal interest in your home, including a life estate?  
   - Yes  
   - No  
   If yes, fill out the following information and answer questions 8 through 15. If no, answer question 15 only.

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

   Description and address of property location __________________________
   __________________________

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

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

   Description and address of property location __________________________
   __________________________

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

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

   Name __________________________
   Is this person living in your home?  
   - Yes  
   - No

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

    Name __________________________
    Is this person living in your home?  
    - Yes  
    - No

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

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

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

    Name __________________________
    Is this person living in your home?  
    - Yes  
    - No

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

    Name __________________________
    Is this person living in your home?  
    - Yes  
    - No

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

    Name __________________________
    Is this person living in your home?  
    - Yes  
    - No

    Describe the relationship and the nature of the dependency: __________________________
15. Do you intend to return to your home? □ Yes □ No

16. Do you or your spouse own or have a legal interest in other real estate not listed in #7 above? □ Yes □ No
   If yes, please describe the property and list its address below.

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

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

**Long-Term-Care Insurance**

17. Do you or your spouse have long-term-care insurance? □ Yes □ No
   If yes, fill out this section. If no, go to the next section (Tax Returns).

   **Send a copy** of the policy.

<table>
<thead>
<tr>
<th>Company name/Policy number</th>
<th>Policyholder name</th>
<th>Effective date (mm/dd/yyyy)</th>
<th>Premium amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Tax Returns**

18. Did you or your spouse file U.S. income tax returns in the last two years? (Check one.)
   □ Yes, both years □ Yes, one of these years □ No, neither year

   If yes, you must send copies of these returns. If you did not keep copies of one or more of these returns, you must send in a filled-out and signed Form 4506. Form 4506 is included as part of the Long-Term-Care Supplement if you need to use it.

**Sign this supplement.**

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

**Important:** If you are submitting this supplement as an authorized representative, you must submit an Authorized Representative Designation Form (ARD) to us for us to process this application. It is important to complete this form as this is the only way we may speak to you about this application.

| Signature of applicant/member or authorized representative | Print name | Date |
Tell us about your American Indian or Alaska Native household member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or Urban Indian Health Programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your household gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

**AI/AN Person 1**

1. Name (first, middle, last)

2. Member of a federally recognized tribe?
   - Yes [ ] No [ ]
   - If yes, tribe name and state affiliation

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs?
   - Yes [ ] No [ ]
   - If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Programs, or through a referral from one of these programs?
   - Yes [ ] No [ ]

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

**AI/AN Person 2**

1. Name (first, middle, last)

2. Member of a federally recognized tribe?
   - Yes [ ] No [ ]
   - If yes, tribe name and state affiliation

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs?
   - Yes [ ] No [ ]
   - If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Programs, or through a referral from one of these programs?
   - Yes [ ] No [ ]

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

Fill out this part if any household member answered yes to having Medicare in the health insurance part (Part 6).

1. Name: ________________________________ Medicare claim number: ________________________________
   When did coverage start? (mm/dd/yyyy) ________________________________
   a. Does this person have a Medicare Part D plan? □ Yes □ No
   If yes, when did coverage start? (mm/dd/yyyy) ________________________________
   b. Does this person have a Medigap/Medicare supplemental policy? □ Yes □ No
   If yes, name of coverage plan: ________________________________ When did coverage start? (mm/dd/yyyy) ________________________________

2. Name: ________________________________ Medicare claim number: ________________________________
   When did coverage start? (mm/dd/yyyy) ________________________________
   a. Does this person have a Medicare Part D plan? □ Yes □ No
   If yes, when did coverage start? (mm/dd/yyyy) ________________________________
   b. Does this person have a Medigap/Medicare supplemental policy? □ Yes □ No
   If yes, name of coverage plan: ________________________________ When did coverage start? (mm/dd/yyyy) ________________________________

3. Do any of the persons above want to apply for help paying for the Medicare Part B premiums? □ Yes □ No
   If yes, name(s): ________________________________

Part B: Federal health insurance benefits

Fill out this part if any household member answered yes in the health insurance part (Part 6) to having federal health insurance provided by the U.S. military (Veterans’ Affairs or TRICARE) or other federal coverage.

1. Name of insurance plan or policy: ________________________________ Policyholder name: ________________________________
   Names of covered household members: ________________________________
   Claim/policy number: ________________________________ When did coverage start? (mm/dd/yyyy) ________________________________

Part C: Other health insurance

Fill out this part if any household member answered yes in the health insurance part (Part 6) to having any other type of health insurance. This includes insurance through an employer, union, college or university, former employer (COBRA), and coverage bought by a household member or parent who is not living in the household.

1. Name of insurance plan or policy: ________________________________ Policyholder name: ________________________________
   Date of birth: (mm/dd/yyyy) ________________________________ SSN (if you know): ________________________________
   Names of covered household members: ________________________________
   Policy number: ________________________________ Group number (if you know): ________________________________
   When did coverage start? (mm/dd/yyyy) ________________________________
Source: (Check one.)

☐ Employer-sponsored (give employer name): ____________________________

☐ Union-sponsored (give union name): ____________________________

☐ College/university   ☐ COBRA   ☐ Retiree   ☐ Coverage provided by someone outside household

☐ Other (Please explain.): ____________________________

Type of coverage this plan provides: (Check all that apply.)

☐ Doctor’s visits and hospitalizations   ☐ Vision coverage   ☐ Dental coverage

☐ Pharmacy coverage   ☐ Catastrophic only

Premium cost: $ ____________________________

Premium frequency: (Check one.)

☐ Weekly   ☐ Every two weeks   ☐ Twice a month   ☐ Monthly   ☐ Quarterly   ☐ Yearly

2. Name of insurance plan or policy: ____________________________ Policyholder name: ____________________________

Date of birth: (mm/dd/yyyy) ____________________________ SSN (if you know): ____________________________

Names of covered household members: ____________________________

Policy number: ____________________________ Group number (if you know): ____________________________

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

Source: (Check one.)

☐ Employer-sponsored (give employer name): ____________________________

☐ Union-sponsored (give union name): ____________________________

☐ College/university   ☐ COBRA   ☐ Retiree   ☐ Coverage provided by someone outside household

☐ Other (Please explain.): ____________________________

Type of coverage this plan provides: (Check all that apply.)

☐ Doctor’s visits and hospitalizations   ☐ Vision coverage   ☐ Dental coverage

☐ Pharmacy coverage   ☐ Catastrophic only

Premium cost: $ ____________________________

Premium frequency: (Check one.)

☐ Weekly   ☐ Every two weeks   ☐ Twice a month   ☐ Monthly   ☐ Quarterly   ☐ Yearly
Illness, Disability, or Accommodation Supplement

Part A

If you answered yes to Question 3 in Part 8 about having an injury, illness, or disability that has lasted or may last for at least 12 months, answer the next three questions.

1. Does this person get money from Social Security for a disability? □ Yes □ No
   If yes, name(s): ____________________________________________

2. Did this person ever get Supplemental Security Income (SSI)? □ Yes □ No
   If yes, name(s): ____________________________________________

3. Is this person legally blind? □ Yes □ No □ If yes, send a copy of the Certificate of Blindness.
   If yes, name(s): ____________________________________________

Part B

If you answered yes to Questions 8 in Parts 1 and/or 2 about you or any household member needing reasonable accommodation because of a disability or injury, check all that apply below, and list name(s).

1. Condition
   □ Low vision—Name(s): _______________________________________
   □ Blind—Name(s): ____________________________________________
   □ Deaf—Name(s): ____________________________________________
   □ Hard of hearing—Name(s): __________________________________
   □ Developmentally disabled—Name(s): __________________________
   □ Intellectually disabled—Name(s): _____________________________
   □ Physically disabled—Name(s): _________________________________
   □ Other (Please explain.)—Name(s): ____________________________

2. Accommodation
   □ Text telephone (TTY)—Name(s): _____________________________
   □ Large print publications—Name(s): ____________________________
   □ American Sign Language interpreter—Name(s): __________________
   □ Video Relay Service (VRS)—Name(s): __________________________
   □ Communication Access Real-time Translations (CART)—Name(s): ________________
   □ Publications in Braille—Name(s): _____________________________
   □ Assistive listening device—Name(s): __________________________
   □ Publications in electronic format—Name(s): _____________________
   □ Other (Please explain.)—Name(s): ____________________________

Part C

If you answered yes to Question 9 in Parts 1 and/or 2 about applying because of an accident or injury that someone else may be responsible for, answer the next two questions.

1. Did someone else cause this person’s injury, illness, or disability, or could someone else’s insurance or this person’s own insurance, other than health insurance (like homeowner’s or auto insurance) cover it? □ Yes □ No
   If yes, name the injured person(s): ______________________________

2. Has this person filed a lawsuit, a workers’ compensation claim, or an insurance claim for this accident or injury? □ Yes □ No
   If yes, name the injured person(s): ______________________________
**Personal-Care-Attendant Supplement**

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

**Applicant/Member information**

Last name  | First name  | MI  | Telephone number ( )
---|---|---|---

Social security number  | Date of birth (mm/dd/yyyy)  | Gender  | M  | F

Street address  | City  | State  | Zip

**Information about your health problems**

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

1. 
2. 
3. 

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

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

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

**Caregiver information**

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

<table>
<thead>
<tr>
<th>Caregiver name</th>
<th>Relationship to you (like relative, neighbor, personal-care attendant)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Caregiver name</th>
<th>Relationship to you (like relative, neighbor, personal-care attendant)</th>
</tr>
</thead>
</table>

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

X________

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

Send to: MassHealth Enrollment Center  
P.O. Box 1231  
Taunton, MA 02780  
Or Fax to: 617-887-8777
You can submit this form if you would like to designate an authorized representative to act on your behalf. If an authorized representative signed your application for you, or if you are an authorized representative applying on behalf of someone else, you **MUST** submit this form for the application to be processed.

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

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

You can choose someone to help you.

You may choose an authorized representative to help you get health care coverage through programs offered by MassHealth and the Health Connector. You can do this by filling out this form (the Authorized Representative Designation Form) or a sufficiently similar designation document. You or a representative can sign for yourself and for any of your dependent children under the age of 18 for whom you are the custodial parent.

You are not required to have a representative in order to apply for or receive benefits.

Who can help me?

1. An authorized representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose an authorized representative if you want one. Neither MassHealth nor the Health Connector will choose an authorized representative for you. You must designate in writing (fill out Section I, Part A) the person or organization who you want to be your authorized representative. Your authorized representative must also fill out Section I, Part B.

2. If, because of a mental or physical condition, you cannot designate an authorized representative in writing, a person (not an organization) who is acting responsibly on your behalf can be your authorized representative if that person certifies, by filling out Section II, that you are not able to provide a written designation, and that he or she is acting responsibly on your behalf.

3. An authorized representative can also be someone who has been appointed by law to act on your behalf. This person must fill out Section III and either you or this person must submit to us, together with this form, a copy of the applicable legal document stating that this person is lawfully representing you.

4. A person appointed by law to act on behalf of the estate of an applicant or member who has died can also serve as an authorized representative by following the instructions above. An authorized representative under Section III may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the estate’s administrator or executor. What this person is authorized to do for you or for the applicant or member’s estate will depend on the wording of the legal appointment.

What can an authorized representative do?

An authorized representative may

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

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

- Mailing a letter notifying us that the designation has ended to
  
  Health Insurance Processing Center
  P. O. Box 4405
  Taunton, MA 02780;

- Faxing a letter notifying us that the designation has ended to 1-857-323-8300; or
- Calling us at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

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

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

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

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

How do I submit this form?

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

If you are already getting benefits, you must submit the form to us at the time you want to designate an authorized representative by doing the following.

- Mailing your form to
  
  Health Insurance Processing Center
  P. O. Box 4405
  Taunton, MA 02780;

- Faxing your form to 1-857-323-8300; or
- Calling us at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).
**SECTION 1**  **Authorized Representative Designation (if applicant or member is able to sign)**

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

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

<table>
<thead>
<tr>
<th>Applicant’s/Member’s Name</th>
<th>SSN (if you have one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>___ ___ ___ - ___ ___ - ___ ___ ___</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Applicant’s/Member’s e-mail address</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Applicant’s/Member’s signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Authorized representative’s name</th>
<th>Authorized representative’s phone number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Authorized representative’s address (mailing address, city, state, zip)</th>
</tr>
</thead>
</table>

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

**B1. COMPLETE IF AUTHORIZED REPRESENTATIVE IS A PERSON.**

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

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

<table>
<thead>
<tr>
<th>Authorized representative’s signature</th>
<th>Date</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Authorized representative’s printed name</th>
<th>Authorized representative’s e-mail address</th>
</tr>
</thead>
</table>

**B2. COMPLETE IF AUTHORIZED REPRESENTATIVE IS AN ORGANIZATION.**

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

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

<table>
<thead>
<tr>
<th>Signature of provider, staff member, or volunteer completing form</th>
<th>Date</th>
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<table>
<thead>
<tr>
<th>Printed name of provider, staff member, or volunteer completing form</th>
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</table>

<table>
<thead>
<tr>
<th>E-mail of provider, staff member, or volunteer completing form</th>
<th>Authorized representative organization name</th>
</tr>
</thead>
</table>
**SECTION 2**

**Authorized Representative Designation**

(if applicant or member cannot provide written designation)

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

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

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

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

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

<table>
<thead>
<tr>
<th>Applicant’s/Member’s name</th>
<th>Applicant’s/Member’s date of birth (mm/dd/yyyy)</th>
<th>Applicant’s/Member’s SSN</th>
</tr>
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<tr>
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<th>Date (mm/dd/yyyy)</th>
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<table>
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<tr>
<th>Authorized representative’s name (first, middle, last)</th>
<th>Authorized representative’s phone number</th>
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<tbody>
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<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorized representative’s address (mailing address, city, state, zip)</th>
<th>Authorized representative’s e-mail address</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**SECTION 3**

**Authorized Representative Designation**

(if appointed by law)

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

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

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

<table>
<thead>
<tr>
<th>Applicant’s/Member’s name</th>
<th>Applicant’s/Member’s date of birth (mm/dd/yyyy)</th>
<th>Applicant’s/Member’s SSN</th>
</tr>
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<tbody>
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<td>__________ - __________ - __________</td>
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<thead>
<tr>
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<th>Authorized representative’s e-mail address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Request for Copy of Tax Return

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

1a Name shown on tax return. If a joint return, enter the name shown first.

1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)

2a If a joint return, enter spouse’s name shown on tax return.

2b Second social security number or individual taxpayer identification number if joint tax return

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

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

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

### Caution
If the tax return is being mailed to a third party, ensure that you have filled in lines 6 and 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax return to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party’s authority to disclose your return information, you can specify this limitation in your written agreement with the third party.

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

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

7 Year or period requested. Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

8 Fee. There is a $50 fee for each return requested. Full payment must be included with your request or it will be rejected. Make your check or money order payable to “United States Treasury.” Enter your SSN, ITIN, or EIN and “Form 4506 request” on your check or money order.

| a | Cost for each return | $ 50.00 |
| b | Number of returns requested on line 7 | |
| c | Total cost. Multiply line 8a by line 8b | |

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

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

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

Phone number of taxpayer on line 1a or 2a

### For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 41721E Form 4506 (Rev. 9-2013)
Section references are to the Internal Revenue Code unless otherwise noted.

**Future Developments**
For the latest information about Form 4506 and its instructions, go to www.irs.gov/form4506 Information about any recent developments affecting Form 4506, Form 4506T and Form 4506T-EZ will be posted on that page.

**General Instructions**
Caution. Do not sign this form unless all applicable lines have been completed.

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

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

**Tip.** Use Form 4506-T, Request for Transcript of Tax Return, to request tax return transcripts, tax account information, V-2 information, 1099 information, verification of non-filing, and records of account.

**Automated transcript request.** You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on “Order a Return or Account Transcript” or call 1-800-908-9946.

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

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

**Chart for individual returns (Form 1040 series)**

<table>
<thead>
<tr>
<th>State/Year</th>
<th>Address Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, or P.O. or F.P.O. address</td>
<td></td>
</tr>
<tr>
<td>Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin</td>
<td></td>
</tr>
</tbody>
</table>

**Specific Instructions**

**Line 1b.** Enter your employer identification number (EIN) if you are requesting a copy of a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

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

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

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

**Signature and date.** Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. If you completed line 5 requesting the return be sent to a third party, the IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

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

**Corporations.** Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer.
Massachusetts Official
Mail-In Agency Voter Registration Form

How to use this form

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

How to use this form

You can use this form to:
• register to vote in Massachusetts; and/or
• change your name or address for voter registration only; and/or
• join a party, change from one party to another or leave a party.

To register to vote in Massachusetts you must:
• BE A U.S. CITIZEN; and
• be a Massachusetts resident; and
• be at least 18 years old on or before the next election.

Penalty for Illegal Registration: Fine of not more than $10,000 or imprisonment for not more than five years or both.

- Massachusetts General Laws, chapter 56 section 8.

Identification To Be Provided

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

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

Check all that apply:
Are you a Citizen of the United States of America? ☐ Yes ☐ No
Will you be 18 years of age or older on or before Election Day? ☐ Yes ☐ No

NOTE: If you checked “no” to either of these questions, do not complete this form.

Full name: ☐ Miss ☐ Mrs. ☐ Mr.
last name first name middle name or initial.

Former name (if applicable): ☐ Miss ☐ Mrs. ☐ Mr.
last name first name middle name or initial.

Address where you live now (street number, street name, rural route number and box number):
street number / street name / rural route number and box number apartment number city or town zip code + 4-digit

Address where you receive all your mail (if different from #4):
street number / street name / rural route number and box number apartment number city or town zip code + 4-digit

Date of birth: month day year

Identification #: license # or last four digits of your Social Security #

Telephone (optional): ☐ Check if unlisted
( ) __________

Party enrollment or designation (check one): ☐ Democratic ☐ Republican ☐ Green-Rainbow
☐ United Independent Party ☐ No Party (unenrolled) ☐ Political Designation (not a political party):

Address at which you were last registered to vote:
street number / street name / rural route number and box number / post office box apartment number city or town state zip code + 4-digit

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

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

Today’s date: month day year

Signed: Sign your name here.

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

DEADLINES FOR VOTER REGISTRATION

To participate in... You must register...

state primaries
state elections
city and town preliminaries
city and town elections
regularly scheduled town meetings

special town meetings

at least 20 days before
at least 10 days before

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