

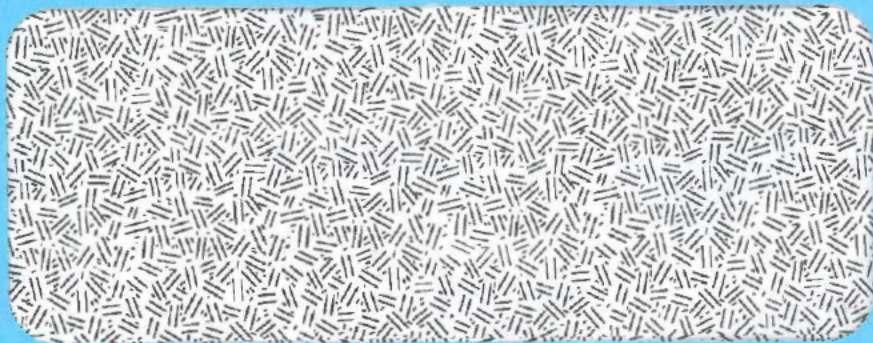
**Commonwealth of Massachusetts**

P.O. Box 4405

Taunton, MA 02780

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**COMMONWEALTH OF MASSACHUSETTS**

**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

**RESPONSE REQUIRED!**

**¡SE REQUIERE RESPUESTA! RESPOSTA NECESSÁRIA! REPONS OBLIGATWA! 要求回復**



Health Insurance Processing Center  
P.O. Box 4405  
Taunton, MA 02780-0419

You can get this information in large print and braille. Call (800) 841-2900 from Monday through Friday, 8:00 A.M. to 5:00 P.M. TDD/TTY: 711.



T071 P148 002300 20230308 8 \*\*\*\*\*AUTO\*\*5-DIGIT 02139



ATTN. [REDACTED]  
[REDACTED]  
[REDACTED]

Because this date is earlier than April 1, 2023, the deadline below is not enforceable. Only dates of April 1, 2023 or later have enforceable deadlines that may result in MassHealth members losing their current coverage

Date: March 07, 2023  
Notice ID: 0029997994 / NON AUTO-RENEWAL  
Member ID: [REDACTED]  
SSN: [REDACTED]

Attn: [REDACTED] Re: Notice sent to [REDACTED]

**Important Notice about your health coverage**

Dear [REDACTED]

Your household needs to complete the annual eligibility renewal to find out if you and members of your household can still get health coverage through MassHealth, the Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN).

**IMPORTANT!**  
**Your household must renew by 04/21/2023 or your MassHealth, CMSP, or HSN benefits may end or decrease.**

The fastest way to renew your household's health coverage is through our website at [MAhealthconnector.org](https://www.mahealthconnector.org). You can create an account by going to:

[https://www.mahix.org/individual/code/\[REDACTED\]](https://www.mahix.org/individual/code/[REDACTED])





We reviewed your information to see if we could automatically renew health coverage for you and members of your household. We are not able to renew the current coverage for your household using the information we have. **You need to act now to renew health coverage for your household. If you do not act your household's MassHealth, CMSP, or HSN benefits may end or decrease.**

**What do you need to do?**

Please complete your annual eligibility renewal by doing one of the following:

- **Online:** The fastest way to renew health coverage for your household is online through our website at [MAhealthconnector.org](http://MAhealthconnector.org).

Go to <https://www.mahix.org/individual/code/██████████> and you will be able to create an account and see your renewal information. Go to the *My Eligibility* section of the website and follow the instructions listed there. Renewing your household's information online is the only way to get a real-time, automatic decision to see if you still qualify.

**OR**

- **Paper:** Please review and follow the instructions on the attached form called the *Massachusetts Renewal Application for Health and Dental Coverage and Help Paying Costs* included with this letter

Fax all pages to  
1-857-323-8300

**OR**

Mail all pages to:

Commonwealth of Massachusetts  
Health Insurance Processing Center  
P.O. Box 4405  
Taunton, MA 02780

**OR**

- **Phone:** Call us at (800) 841-2900. TDD/TTY: 711. We can help you complete your household renewal over the phone.

**OR**

- **In person:** Call us at (800) 841-2900 TDD/TTY: 711 to find a MassHealth Enrollment Center (MEC) near you. You can also look in the Member Booklet for a list of MEC addresses.

**What happens next?**

We will continue your household's **current** coverage for up to 45 days from the date of this letter while we wait for you to renew your information. Once we process your completed renewal



application, we will send you another letter to let you know if you and members of your household still qualify for health coverage through MassHealth, CMSP, or the HSN. If you do not qualify for health coverage through MassHealth, CMSP, or the HSN, we will determine if you qualify for coverage through the Health Connector.

We will check the information you give us with available federal and state data sources. We will keep the information provided to us private, and will only use and disclose it in accordance with applicable law. If we need further information, we will contact you.

### What else do you need to know?

- Throughout the year, you must report any change in your household's information to MassHealth as soon as possible, but **no later than 10 days**, from the date of the change. This includes any changes to your household's income, address, phone number, household size, job, or health insurance.
- The **Member Booklet** explains income rules, premiums, copays and covered services for MassHealth. It also explains in more detail how we count your household members and income. To get a copy of the Member Booklet, you can go to [www.mass.gov/masshealth-member-library](http://www.mass.gov/masshealth-member-library) or you can call **MassHealth Customer Service at (800) 841-2900. TDD/TTY: 711.**
- You can find your household's health insurance information at [MAhealthconnector.org](http://MAhealthconnector.org) on the **My Eligibility** page. You must log into your account using your username and password. You can create an account if you don't already have one.

### What if you have questions?

If you have questions or need more information, go to [MAhealthconnector.org](http://MAhealthconnector.org) or call **MassHealth Customer Service at (800) 841-2900. TDD/TTY: 711.**

Thank you.

MassHealth

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**For Official Use Only:**  
Page Count: \_\_\_\_\_  
Initials: \_\_\_\_\_ Date: \_\_\_\_\_



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## Massachusetts Renewal Application for Health and Dental Coverage and Help Paying Costs



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### Instructions

1. Read the information listed in this renewal application about you and the members of your household carefully. If the information is incorrect, cross it out and write the correct information in the **Updated Information** column. If there is missing information for you or your household members write it in the **Updated Information** column.
2. “No Data Available” next to a question means that you or current household members did not need to answer the question when you applied for coverage. If circumstances have changed and you have new information to report, write it in the **Updated Information** column.
3. Answer **all** questions for you and your household members.
4. If you have a new household member, fill out all the questions in the separate form that came in your envelope called the *Massachusetts Application for Health and Dental Coverage and Help Paying Costs—Additional Persons*
5. **IMPORTANT: You must sign the last page of the renewal application. Your application cannot be processed if it is not signed.**
6. Send **ALL PAGES** to  
Commonwealth of Massachusetts  
Health Insurance Processing Center  
P.O. Box 4405  
Taunton, MA 02780  
Fax to 1-857-323-8300

### Supplemental Nutrition Assistance Program (SNAP)

- The Supplemental Nutrition Assistance Program (SNAP) is a federal program that helps you buy healthy food each month. Check this box if you want this application to be sent to the Department of Transitional Assistance to serve as an application for SNAP benefits. You must read the rights and responsibilities listed at the end of this renewal application and sign the last page to proceed with the application for SNAP benefits.

General Information		
Person 1 (Head of Household)— General Information	Current Information	Updated Information
Name (First Name, Middle Name, Last Name)	██████████ ██████████	
SSN	██████████	
Sex	██████	
Date of Birth	██████████	
Home Address	██████████ ██████████ ██████████	
Are you living outside of Massachusetts temporarily?	No Data Available	
If temporarily living outside of the state, where will you be living in Massachusetts?	No Data Available	
Mailing Address	██████████ ██████████ ██████████	
Primary Phone Number	██████████	
Second Phone Number	None	
Email	██████████	
Preferred Spoken Language	English	
Preferred Written Language	English	
Are you seeking to continue coverage NEXT YEAR?*	Yes	
<i>NOTE: If you have coverage today and still need it for the next year, answer yes.</i>		
Is this individual a US Citizen or US National?	Yes	
Is this person a naturalized, derived, or acquired citizen?	No	

General Information		
Person 1 (Head of Household)— General Information	Current Information	Updated Information
<p>Are you living in Massachusetts, and do you either intend to reside here, even if you do not have a fixed address, or have you entered Massachusetts with a job commitment or seeking employment?</p> <p>If you are visiting in Massachusetts for personal pleasure or for the purposes of receiving medical care in a setting other than a nursing facility, you must answer no to this question.</p>	Yes	



**Household Relationships**

**Instructions:** Below are the household relationships we have for you and your household on file. Please review the information below. If you have any changes to your own or your household's relationships please cross out the information if it is incorrect and write the correct information in the Updated Information Column.

Name	Date of Birth	Relationship	With Member	Updated Information
[REDACTED]	[REDACTED]	No Data Available	No Data Available	

**Tax Filing Information**

**Instructions:** Below is the tax filing information we have for you and your household on file. Please review the information below. If you have any changes to your own or your household's tax filing status please cross out the information if it is incorrect and write the correct information in the Updated Information Column.

Tax Filing Information		
Person 1— Tax Filing Information	Current Information	Updated Information
Person 1 (HOH)	██████████	
Date of Birth	██████████	
If you get an Advance Premium Tax Credit (APTC) do you agree to file a federal tax return for the tax year that the credits are received? <b>Note:</b> You may not have needed or chosen to file a federal income tax return in the past, but you will have to file a federal income tax return for any year that you get an Advance Premium Tax Credit. <b>You must say 'Yes' to get ConnectorCare or Advance Premium Tax Credit to help pay for your health insurance. You do NOT need to file a tax return to get MassHealth CMSP, or HSN, if you qualify.</b>	Yes	
a. Do you plan to file a joint federal income tax return with your spouse for the tax year for which you are applying? <b>Important:</b> You must file a joint income tax return with your spouse to qualify for certain programs (ConnectorCare or APTC), unless you are a victim of domestic abuse or abandonment or will file taxes as Head of Household.	No Data Available	
Will you claim any dependents on your federal income tax return?	No	
Will you be claimed as a dependent on someone else's federal income tax return?	No	

Questions? Visit [MAhealthconnector.org](http://MAhealthconnector.org) or call (800) 841-2900. TDD/TTY: 711.

<b>Tax Filing Information</b>		
<b>Person 1— Tax Filing Information</b>	<b>Current Information</b>	<b>Updated Information</b>
a. Tax filer's Name	No Data Available	
b. Tax filer's Date of birth	No Data Available	
c. Is Tax filer married, filing a joint return?	No Data Available	
i. Spouse's Name	No Data Available	
ii. Spouse's Date of birth	No Data Available	
Does Tax Filer and or Spouse of Tax Filer plan to file income tax jointly?	No Data Available	
Does Tax Filer and or Spouse of Tax Filer claim any other dependent for next year?	No Data Available	
a. Dependent's Name	No Data Available	
b. Dependent's Date of birth	No Data Available	

**Additional Information**

**Instructions:** Below is additional information we have for you and your household on file. Please review the information below. If you have any changes to you or your household's information, please cross out the information that is incorrect and write the correct information in the Updated Information Column.

Additional Information		
Person 1— Additional Information	Current Information	Updated Information
<b>Person 1 (HOH)</b>	██████████	
<b>Date of Birth</b>	██████████	
Does this person live with at least one child under age 19 and is he/she the main person taking care of that child?	No	
a. Name of child	No Data Available	
b. Date of birth of child	No Data Available	
Is this person of Hispanic, Latin or Spanish origin? (optional)	No Data Available	
a. Ethnicity (optional)	No Data Available	
b. Race(optional)	████████████████████	
Does this person have an injury, illness, or disability (including mental health condition) that has lasted or is expected to last for at least 12 months? If legally blind, answer YES	No	
Is this person an American Indian/ Alaska Native? Note: If you are newly attesting to being an American Indian or Alaskan Native, please complete Supplement B: American Indian/ Alaskan Native.	No Data Available	
a. Tribe Name?	No Data Available	
b. State affiliation of tribe?	No Data Available	
Was this person ever in foster care?	No	
Does this person have breast or cervical cancer? (optional)	No	
Is this person HIV positive? (optional)	No	

<b>Additional Information</b>		
<b>Person 1— Additional Information</b>	<b>Current Information</b>	<b>Updated Information</b>
<p>Does this person or anyone listed on the application have bills for medical services they got in the three months before the month we got their application?</p> <p>If you need more space copy this page and attach it to the renewal form when you return it.</p>		
a. Name(s) of individual		
b. What is the earliest date this person needs MassHealth?		
c. Did this person have any change in circumstances during this time?		
<p>Does this person need reasonable accommodation because of a disability or an injury?</p> <p>If you are newly attesting to needing reasonable accommodations, please complete Supplement C: Accommodations.</p>	No Data Available	
Is this person incarcerated?	No	
Is this person awaiting trial?	No Data Available	

**INCOME INFORMATION**

**Instructions:** Below is the income information we have for you and your household on file. Please review the information below. If you have any changes to your current income, please cross out the information if it is incorrect and write the correct information in the Updated Information Column. If you have a new job or source of income please fill in the blank section below entitled **Updated Income Information**.

INCOME INFORMATION		
Person 1— Income Information	Current Information	Updated Information
Person 1 (HOH)	[REDACTED]	
Date of Birth	[REDACTED]	
Does this person have Income?	Yes	
<b>Job Income</b>		
Name of Employer	[REDACTED]	
Federal Tax ID	No Data Available	
Employer Address	[REDACTED]	
How much does this person get paid (before taxes are taken out)? Note: You should also tell us here about a one-time amount you got from a current or former employer this month. If you have seasonal income please enter the monthly amount received	\$ [REDACTED]	
Income Effective Date	07/09/20[REDACTED]	
How often does this person get this amount?	Every two weeks	
The month and year in which income is earned	No Data Available	
Average number of hours worked each WEEK	47.0	
If seasonally employed, the months in which the income is earned.	No Data Available	
<b>INCOME DEDUCTIONS: What deductions does this person report on their income tax return?</b>	None	
Person 1's (HOH) annual income for THIS YEAR is	\$ [REDACTED]	

**Updated Income Information**

**Instructions:** Use this section if there are additional jobs or income that you or any of your household members now have. If you need more space copy this page and attach it to the renewal form when you return it.

UPDATED INCOME INFORMATION		
Questions	New Job/Income1	New Job/Income2
Member Name		
Date of Birth		
New Job		
Employer Name and Address		
Wages/tips (before taxes)		
Income Effective Date		
Frequency you get paid (weekly, bi-weekly, monthly, seasonally, semi-monthly)		
Average number of hours worked each week		
Are you seasonally employed? If yes, answer question a. below.		
a. If yes, how many months do you work each calendar year?		
Are you newly self-employed? If yes, answer questions a. and b. below.		
a. If yes, what type of work do you do?		
b. On average, how many months do you work each calendar year?		
Income Effective Date		
Other Income		
Member Name		
Date of Birth		

UPDATED INCOME INFORMATION		
Questions	New Job/Income1	New Job/Income2
<b>Type of Income</b> In the space provided to the right, please list the type of income: Social Security, unemployment, retirement, capital gains, investment income, net rental or royalty income, net farming or fishing income, alimony received, lottery and gambling winnings, or other		
a. Amount		
b. Income Effective Date		
c. How Often? - If one time, please list month and year it was received		
<b>Type of Income</b> In the space provided to the right, please list the type of income: Social Security, unemployment, retirement, capital gains, investment income, net rental or royalty income, net farming or fishing income, alimony received, lottery and gambling winnings, or other		
a. Amount		
b. Income Effective Date		
c. How Often? - If one time, please list month and year it was received		
<b>Type of Income</b> In the space provided to the right, please list the type of income: Social Security, unemployment, retirement, capital gains, investment income, net rental or royalty income, net farming or fishing income, alimony received, lottery and gambling winnings, or other		
a. Amount		
b. Income Effective Date		
c. How Often? - If one time, please list month and year it was received		
<b>Type of Income</b> In the space provided to the right, please list the type of income: Social Security, unemployment, retirement, capital gains, investment income, net rental or royalty income, net farming or fishing income, alimony received, lottery and gambling winnings, or other		
a. Amount		
b. Income Effective Date		
c. How Often? - If one time, please list month and year it was received		
INCOME DEDUCTIONS		
Member Name		
Date of Birth		



UPDATED INCOME INFORMATION		
Questions	New Job/Income1	New Job/Income2
<p>Your deductions should be what you report on your federal income tax return in the section "Adjusted Gross Income."</p> <p>In the space provided to the right please list the type of deductions: (educator expenses; certain business expenses of reservists, performing artists, or fee-based government officials; health savings account deduction; moving expenses related to a job change ( for active duty service members only); deductible part of self-employment tax; contribution to self-employed SEP, SIMPLE, and qualified plans; self-employed health insurance deduction; penalty on early withdrawal of savings; alimony paid; Individual Retirement Account (IRA) deduction; student loan interest paid; higher education tuition and fees; and domestic production activities deduction).</p> <p>NOTE: Do not include any type of deduction that is not listed above. For each deduction you select, give the yearly amount. You can enter up to the maximum deduction amount allowed by the IRS.</p>		
<b>Type of Deduction</b>		
Yearly Amount		
<b>Type of Deduction</b>		
Yearly Amount		

**Health Insurance Information**

**Instructions:** Below is the health insurance information we have for you and your household on file. Please review the information below. If you have any changes to your current health insurance information, please cross out what is incorrect and write the correct information in the Updated Information Column. If you have access to new health insurance, please fill out the **Supplement A: Health Coverage from Jobs**.

Health Insurance Information		
Person 1 – Health Insurance Information	Current Information	Updated Information
Person 1 (HOH)	[REDACTED]	
Date of Birth	[REDACTED]	
Is this person or anyone listed on the application enrolled in Health Insurance?	No	
Is this person or anyone listed on the application eligible for health coverage through employer sponsored insurance (insurance offered through a job), MassHealth, Medicare, TRICARE Federal Employees Health Benefit Program, Peace Corps, VA Healthcare Program, or Other?	No Data Available	
Is the employer sponsored insurance from a Current Job, COBRA, or Retiree Health Plan?	No Data Available	
Employer Name	No Data Available	
Federal Tax ID	No Data Available	
Employer Address	No Data Available	
Employer Phone Number	No Data Available	
Email	No Data Available	
Coverage Start Date	No Data Available	
Health Plan Name	No Data Available	
Policy Number or Member ID	No Data Available	
Name of individual covered by this policy	No Data Available	

Health Insurance Information		
Person 1 – Health Insurance Information	Current Information	Updated Information
Does this person or anyone listed on the application expect any changes in his/her employer's health coverage for 2023? If yes, complete Supplement A: Health Coverage from Jobs	No Data Available	
Does the health plan offered by employer meet the "minimum value" standard for coverage?	No Data Available	
How much would this person pay in premiums to enroll in this plan and how often?	No Data Available	
Coverage End Date	No Data Available	
Is this person or anyone listed on the application offered health insurance coverage through Employer Sponsored Insurance (Insurance offered through a job) or Medicare?	No Data Available	
Is the employer sponsored insurance offered to you from a Current Job, COBRA, or Retiree Health Plan?	No Data Available	
Employer Name	No Data Available	
Federal Tax ID	No Data Available	
Employer Address	No Data Available	
Employer Phone Number	No Data Available	
Email	No Data Available	
Date coverage could start	No Data Available	
Name of individual covered by this policy	No Data Available	
Does this person or anyone listed on the application expect any changes in his/her employer's health coverage for 2023? If yes, complete Supplement A: Health Coverage from Jobs	No Data Available	

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<b>Health Insurance Information</b>		
<b>Person 1 – Health Insurance Information</b>	<b>Current Information</b>	<b>Updated Information</b>
Does the health plan offered by employer meet the “minimum value” standard for coverage?	No Data Available	
How much would this person pay in premiums to enroll in this plan and how often?	No Data Available	
Coverage End Date	No Data Available	

**Health Reimbursement Arrangement (HRA) Information**

**Instructions:** Below is the Health Reimbursement Arrangement (HRA) Information we have for you and your household on file. Review the information below. If you have any changes to your current HRA(s), cross out the information if it is incorrect and write the correct information in the Updated Information Column.

<b>Health Reimbursement Arrangement Information</b>		
<b>Health Reimbursement Arrangement (HRA) Information</b>	<b>Current Information</b>	<b>Updated Information</b>
Is anyone in the household offered Health Reimbursement Arrangements (HRAs) from their employer(s)?	No Data Available	
Name(s) of individual	No Data Available	
Date of Birth	No Data Available	
Employer Name	No Data Available	
Federal Tax ID	No Data Available	
Type of HRA offered by employer	No Data Available	
Start date	No Data Available	
End date	No Data Available	
Enter the maximum yearly self-only coverage benefit amount	No Data Available	
If you have a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) do you intend to use QSEHRA family coverage benefits from your employer?	No Data Available	
If you have QSEHRA, enter the maximum yearly family coverage benefit through the QSEHRA	No Data Available	
Does anyone in the household intend to accept an Individual Coverage Health Reimbursement Arrangement (ICHRA) benefit from their employer?	No Data Available	

**Supplement A: Health Coverage from Jobs**

**Instructions:** Complete the below information if someone in the household is newly eligible for health coverage from a job, but is not enrolled in the coverage. Attach a copy of this page for each job that offers coverage. If all eligible household members are enrolled in coverage offered by an employer, make sure that Health Insurance Information section above is complete, and skip this section.

Supplement A: Health Coverage from Jobs	
Health Coverage from Jobs Information	Information
Member Name	
Date of Birth	
Employer Name	
Employer Address	
City State, Zip Code	
Employer Phone Number	
Employer Identification Number (if known)	
Who can we contact about employee health coverage at this job?	
Phone number (if different from above)	
Email Address	
Is this person currently eligible for coverage offered by this employer, or will this person become eligible within the next 3 months? - Answer yes or no <b>Note:</b> if yes, please answer all the questions below	
Does the health plan offered by employer meet the "minimum value" standard for coverage?	
What change will the employer make in the new plan year (if known)?	<input type="checkbox"/> Employer will no longer offer coverage Coverage end date: _____  <input type="checkbox"/> The person will cancel coverage Coverage end date: _____
a. How much would the employee have to pay in premiums for this plan?	

Supplement A: Health Coverage from Jobs	
Health Coverage from Jobs Information	Information
b. How often?  <b>Note:</b> weekly, every two weeks, twice a month, once a month, yearly	
c. Date of change (mm/dd/yyyy)	

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

**Supplement B: American Indian/Alaskan Native Status**

**Instructions:** Complete this section if you or a household member are an American Indian or Alaska Native. American Indians and Alaska Natives can get services from the Indian Health Service, tribal health programs, or Urban Indian Health Programs. They also may not have to pay premiums or copayments and may get special monthly enrollment periods. Answer the following questions to make sure your household gets the most help possible. If you have more people to include, make a copy of this page and attach it.

Supplement B: American Indian/Alaskan Native Status		
American Indian/Alaskan Native Status	Member 1	Member 2
<b>Member Name</b>		
<b>Date of Birth</b>		
Member of federally recognized tribe? if yes please answer a. and b. below.		
a. If yes, Tribe name		
b. If yes, Tribe affiliation		
Member of Massachusetts-recognized tribe? if yes please answer a. and b. below.		
a. If yes, Tribe name		
b. If yes, Tribe affiliation		
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?		
a. 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?		
Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from <ul style="list-style-type: none"> <li>• Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;</li> <li>• 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</li> <li>• Money from selling things that have cultural significance</li> </ul>		
a. Income	\$	



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<b>Supplement B: American Indian/Alaskan Native Status</b>		
<b>American Indian/Alaskan Native Status</b>	<b>Member 1</b>	<b>Member 2</b>
b. How often? Note: weekly, every two weeks, twice a month, once a month, quarterly, yearly		

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**Supplement C: Accommodations**

**Instructions:** If you or anyone in your household answered Yes in Additional Information section needing reasonable accommodation because of a disability or injury, check all that apply below and list name(s):

1. Condition

- Blind – Name(s): \_\_\_\_\_
- Deaf – Name(s): \_\_\_\_\_
- Developmentally Disabled – Name(s): \_\_\_\_\_
- Hard of hearing – Name(s): \_\_\_\_\_
- Intellectually Disabled – Name(s): \_\_\_\_\_
- Low Vision – Name(s): \_\_\_\_\_
- Physically Disabled – Name(s): \_\_\_\_\_
- Other (Please explain) - Name(s): \_\_\_\_\_

2. Accommodation

- American Sign Language (ASL) interpreter – Name(s): \_\_\_\_\_
- Assistive Learning device – Name(s): \_\_\_\_\_
- Communication Access Real-time Translations (CART) – Name(s): \_\_\_\_\_
- Large print publications – Name(s): \_\_\_\_\_
- Publications in electronic format – Name(s): \_\_\_\_\_
- Publications in Braille – Name(s): \_\_\_\_\_
- Text telephone – Name(s): \_\_\_\_\_
- Video Relay Services (VRS) – Name(s): \_\_\_\_\_
- Other (Please explain) - Name(s): \_\_\_\_\_

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**Supplement D: Authorized Representative Designation Form**

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

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

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

**You can choose someone to help you.**

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

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

**Who can help me?**

- a. 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.
- b. 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.
- c. 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.
- d. 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 (800) 841-2900. TDD/TTY: 711.

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.

**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

Member’s Name	SSN (if you have one)
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Date of Birth (mm/dd/yyyy)	Member's e-mail address
I certify that I have chosen the following person or organization to be the authorized representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form).	
Member's Signature	Date
Authorized representative's name	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	

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

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

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to me by MassHealth or the Health Connector. If I am also a provider, staff member, or volunteer affiliated with an organization, and am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f).

Authorized representative's signature	Date
Authorized representative's printed name	Authorized representative's email address

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

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

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

**Section 2: Authorized Representative Designation (if applicant or member cannot provide written designation)**

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

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

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

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

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

Member’s Name	
Member’s Date of Birth (mm/dd/yyyy)	Member’s SSN
Authorized representative’s signature	Date (mm/dd/yyyy)
Authorized representative’s name (first, middle, last)	Authorized representative’s phone number

Authorized representative's Address (mailing address, city, state, zip)	Authorized representative's email address
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**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.

Member's Name	
Member's Date of Birth (mm/dd/yyyy)	Member's SSN
Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number
Authorized representative's Address (mailing address, city, state, zip)	Authorized representative's email address

**Voter Registration**

The form to register to vote is included with this renewal application or can be found at [www.sec.state.ma.us](http://www.sec.state.ma.us). More information on how to register to vote can also be found at [www.sec.state.ma.us](http://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 (800) 841-2900. TDD/TTY: 711.

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 whether 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.



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## **Important: You Must Read and Sign this Renewal Application For MassHealth and Health Connector Applicants**

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. I may have to pay a premium for health coverage for myself 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 I am a certain American Indian or Alaska Native, I 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, 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, after notice and an opportunity to appeal, MassHealth may place a lien against any real estate owned by eligible MassHealth members or in which the member has a legal interest, if the individual is receiving long-term care in a nursing facility or other medical institution and MassHealth determines that the member is not reasonably expected to return home. If MassHealth puts a lien against such property and the property is later 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, and unless exceptions apply, for any eligible person age 55 or older, or any eligible person regardless of age for whom MassHealth helps pay for long-term care in a nursing home or other medical institution, MassHealth will seek money from the eligible person's estate after death for the total cost of care. For more information on estate recovery, visit [www.mass.gov/EstateRecovery](http://www.mass.gov/EstateRecovery).
11. 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 (800) 841-2900. TDD/TTY: 711. 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](http://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 (857) 323-8300.
12. MassHealth, the Massachusetts 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.
  13. MassHealth, the Massachusetts 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, including financial institutions, 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.
  14. In connection with the eligibility and enrollment process, MassHealth, the Massachusetts 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](http://www.hhs.gov/ocr/office/file).
  16. I agree to allow the Massachusetts Health Connector to use income data, including information from tax returns, to determine my eligibility in future years. Review the Health Connector Privacy Policy for more information about how the Health Connector

uses tax information. The Massachusetts Health Connector will send me a notice and let me make changes to my eligibility application. I understand that if I am eligible for an Advance Premium Tax Credit (APTC) and/or ConnectorCare, these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or ConnectorCare may impact my annual 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.

**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 MassHealth Member Booklet contains important information and is available to me at [www.mass.gov/service-details/member-booklet-and-application-for-health-and-dental-coverage-and-help-paying-costs](http://www.mass.gov/service-details/member-booklet-and-application-for-health-and-dental-coverage-and-help-paying-costs).
- 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 Massachusetts 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, or
  - making choices about coverage options and methods of communication with the Massachusetts Health Connector, MassHealth, and the Health Safety Net, or
  - making changes to the application or related eligibility documents and providing information about any change in their circumstances, or
  - 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 above.
- 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 Massachusetts Health Connector will treat electronic, faxed, or copies of signature(s) 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; and
- I may be subject to penalties under federal law if I intentionally provide false or untrue information.

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**For Supplemental Nutritional Assistance Program (SNAP) applicants**

**Supplemental Nutrition Assistance Program (SNAP) benefits**

If you checked the box to apply for SNAP, MassHealth will send this application to the Department of Transitional Assistance (DTA). **This will serve as your application for SNAP!** If you are eligible, your SNAP will start from the date DTA receives this MassHealth application. By signing below, you agree that you have read and agree to your SNAP Rights, Responsibilities, and Penalties under the program.

You may be eligible for SNAP benefits within 7 days of DTA receipt of your information if:

- Your income and money in the bank add up to less than your monthly housing expenses, or
- Your monthly income is less than \$150, and your money in the bank is \$100 or less, or
- You are a migrant worker and your money in the bank is \$100 or less.

For more information about SNAP in Massachusetts, go to [mass.gov/SNAP](https://mass.gov/SNAP).

**Department of Transitional Assistance (DTA) Notice of Rights, Responsibilities and Penalties**

This notice lists rights and responsibilities for all DTA programs. You must follow the rules for programs you apply for.

Please read these pages and keep them for your records.

Let DTA know if you have any questions.

**I swear under penalty of perjury that:**

- I have read the information in this form, or someone read it to me.
- My answers in this form are true and complete to the best of my knowledge.
- I will give DTA information that is true and complete to the best of my knowledge during my interview and in the future.

**I understand that:**

- giving false or misleading information is fraud,
- misrepresenting or withholding facts to get DTA benefits is fraud,
- fraud is considered an Intentional Program Violation (IPV), and
- if DTA thinks I committed fraud, DTA can pursue civil and criminal penalties against me.

**I also understand that:**

- DTA will verify the information I give with my application. If any information is false, DTA may deny my benefits.
- I may also be subject to criminal prosecution for providing false information.
- If DTA gets information from a reliable source about a change in my household, my benefit amount may change.

- By signing this form, I give DTA permission to verify my eligibility for benefits, including:
  - Get information from other state or federal agencies, local housing authorities, out-of-state welfare departments, financial institutions, and Equifax Workforce Solutions (the Work Number). I also give these agencies permission to share information about my household's eligibility for benefits with DTA.
  - If DTA uses information from Equifax about my household earned income, I have the right to a free copy of my Equifax report if I request it within 60 days of DTA's decision. I have the right to question the information in the report. I may contact Equifax at: Equifax Workforce Solutions, 11432 Lackland Road, St. Louis, MO 63146, 1-800-996-7566 (toll free).
- I have a right to a copy of my application, including the information that DTA uses to decide about my household's eligibility and benefit amount. I can ask DTA for an electronic copy of the completed application.

### How will DTA use my information?

By signing below, I give DTA permission to get information from and share information about me and members of my household with:

- Banks, schools, government, employers, landlords, utility companies and other agencies to check if I am eligible for benefits.
- Electric, gas and telephone companies so I can get utility discounts. The companies cannot share my information or use it for any other purpose.
- The Department of Housing and Community Development to enroll me in the Heat & Eat Program. This program helps people get the most SNAP benefits possible.
- The Department of Early and Secondary Education so my children can get free school meals.
- The Woman, Infants and Children (WIC) Program so that any children under age 5 or a pregnant woman in my household can get WIC.
- The United States Citizenship and Immigration Services (USCIS), to verify my immigration status. Information from USCIS may affect my household's eligibility and amount of DTA benefits.

*Note: Even if you are not eligible for benefits due to immigration status, DTA will not report you to immigration authorities unless you show DTA a final order of deportation.*

- The Department of Revenue (DOR) to verify my eligibility for income-based tax credits, such as Earned Income and Limited Income, and to see if I am eligible for "No Tax Status" or hardship status.
- The Department of Children and Families (DCF) to coordinate services offered jointly by DTA and DCF.

### How does DTA use Social Security Numbers (SSNs)?

DTA is allowed to ask for SSNs under The Food and Nutrition Act of 2008 (7 U.S.C. 2011-2036) for SNAP and under M.G.L. c. 18 Section 33 for TAFDC and EAEDC. DTA uses SSNs to:

- Check the identity and eligibility of each household member I apply for through data matching programs.
- Monitor compliance with program rules.

- Collect money if DTA claims I got benefits that I was not eligible for.
- Help law enforcement agencies catch people hiding from the law.

I understand that I do not have to give DTA the SSN of any non-citizen in my household, including myself, who does not want benefits. The income of a non-citizen may count even if the non-citizen does not get benefits.

### **Right to an Interpreter**

I understand that:

- I have a right to a free professional interpreter provided by DTA if I prefer to communicate in a language other than English.
- If I have a DTA hearing, I can ask DTA to give me a free professional interpreter, or if I prefer, I can bring someone to interpret for me. If I need DTA to give me an interpreter for a hearing, I must call the Division of Hearings at least one week before the hearing date.

### **Right to Register to Vote**

I understand that:

- I have the right to register to vote through DTA.
- DTA will help me fill out the voter registration application form if I want help.
- I can fill out the voter registration application form in private.
- Applying to register or declining to register to vote will not affect my DTA benefits.

### **Employment Opportunities**

I agree that DTA may share my name and contact information with employment and training providers, including:

- SNAP Path Work providers or DTA specialists for SNAP clients; and
- Contracted Employment and Training providers or Full Engagement Workers for TAFDC clients.

SNAP clients may voluntarily participate in education and employment training services through the SNAP Path to Work program.

### **Citizenship Status**

I swear that all members of my household applying for DTA benefits are either U.S. citizens, or lawfully residing noncitizens.

### **Supplemental Nutrition Assistance Program (SNAP)**

I understand that:

- DTA manages the SNAP program in Massachusetts.
- When I file an application with DTA (by phone, online, in person, or by mail or fax), DTA has 30 days from the date it got my application to decide if I am eligible.
  - If I am eligible for expedited (emergency) SNAP, DTA has to give me SNAP and make sure I have an Electronic Benefit Transfer (EBT) card within 7 days from the date they got my application.

- I have a right to speak to a DTA supervisor if:
  - DTA says I am not eligible for emergency SNAP benefits, and I disagree.
  - I am eligible for emergency SNAP benefits, but do not get my benefits by the 7th day after I applied for SNAP.
  - I am eligible for emergency SNAP benefits but do not get my EBT card by the 7th day after I applied for SNAP.
- When I get SNAP, I have to meet certain rules. When I am approved for SNAP, DTA will give me a copy of the “Your Right to Know” brochure and the SNAP Program brochure. I will read the brochures or have someone read them to me. If I have any questions or need help reading or understanding this information, I can call DTA at 1-877-382-2363.
- **Telling DTA about changes in my household:**
  - If I am a SNAP Simplified Reporting household, I do not have to report most changes to DTA until the Interim Report or Recertification is due. The only things I have to report sooner are:
    - If my household’s income goes over the gross income threshold (listed on my approval notice).
      - I have to report this by the 10th day of the month after the month my income went over the threshold.
    - If I have to meet the Able-Bodied Adults Without Dependents (ABAWD) Work Rules and my work hours drop below 20 hours per week.
  - If everyone in my household is 60 or older, disabled, or under 18 years old, and no one has earnings from work, the only things I have to report are:
    - If someone starts working, or
    - Someone joins or leaves my household.
      - I have to report these changes by the 10th day of the month after the month of the change.
  - If I get SNAP through Transitional Benefits Alternative (TBA) because my TAFDC stopped, I do not have to report any changes to DTA for the 5 months that I get TBA.
  - If I get SNAP through Bay State CAP, I do not have to report any changes to DTA.

If I and everyone in my household gets cash assistance (TAFDC or EAEDC), I must report certain changes to DTA within 10 days of the change. See **When do I need to tell DTA about changes in my household?** under **Transitional Aid to Families with Dependent Children (TAFDC) and Emergency Aid to the Elderly, Disabled, and Children (EAEDC)** below.

I may get more SNAP benefits if I report and give DTA proofs for the following, at any time:

- Child or other dependent care costs, shelter costs, and/or utility costs;
- Child support that I (or someone in my household) is legally required to pay to a non-household member; and
- Medical costs for members of my household, including myself, who are 60 or older or disabled.

**Work rules for SNAP clients:** If you get SNAP benefits and are between the ages of 16 and 59 you may need to meet general SNAP work rules or the ABAWD work rules unless you are exempt. DTA will tell me and members of my household if we need to meet any Work Rules, what the exemptions are, and what will happen if we do not meet the rules.

If you are under the SNAP Work Rules, you must:

- Register for work at application and when you recertify for SNAP. You register when you sign the SNAP application or recertification form.
- Give DTA information about your employment status when DTA asks.
- Report to an employer if referred by DTA.
- Accept a job offer (unless you have a good reason not to).
- Not quit a job of more than 30 hours a week without a good reason.
- Cut your work hours to less than 30 hours a week without a good reason.

### SNAP Rules

Do not give false information or hide information to get SNAP benefits.

Do not trade or sell SNAP benefits.

Do not alter EBT cards to get SNAP benefits you are not eligible for.

Do not use SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco.

Do not use someone else's SNAP benefits or EBT card unless you are an authorized representative, or the recipient has given you permission to use their card on their behalf.

### SNAP Penalty Warnings

I understand that if I or any member of my SNAP household intentionally breaks any of the rules listed above, that person will not be eligible for SNAP for one year after the first violation, two years after the second violation and forever after the third violation. That person may also be fined up to \$250,000, imprisoned up to 20 years, or both. They may also be subject to prosecution under Federal and State laws.

I also understand the following penalties. If I or a member of my SNAP household:

- Commit a **cash program** Intentional Program Violation (IPV) they will be ineligible for SNAP for the same period they are ineligible for cash assistance.
- Make a fraudulent statement about their identity or residency to get multiple SNAP benefits *at the same time* they will be ineligible for SNAP for **ten years**.
- Trade (buy or sell) SNAP benefits for a controlled substance/illegal drug(s), they will be ineligible for SNAP for **two years** for the first finding, and **forever** for the second finding.
- Trade (buy or sell) SNAP benefits for firearms, ammunition or explosives, they will be ineligible for SNAP **forever**
- Make an offer to sell SNAP benefits or an EBT card online or in person the State may pursue an IPV against them.
- Pay for food purchased on credit they will be ineligible for SNAP.
- Buy products with SNAP benefits with the intent to discard the contents and return containers for cash they will be ineligible for SNAP.
- Flee to avoid prosecution, custody or confinement after conviction for a felony they will be ineligible for SNAP.



- Violate probation or parole, where law enforcement is actively seeking to arrest them they will be ineligible for SNAP.

Anyone who became a convicted felon after February 7, 2014 is ineligible for SNAP benefits if they are a fleeing felon or are violating probation or parole - in accordance with 7 CFR §273.11(n) - **and** were convicted as an adult of:

1. Aggravated sexual abuse under section 2241 of title 18, U.S.C.;
2. Murder under section 1111 of title 18, U.S.C.;
3. Any offense under chapter 110 of title 18, U.S.C.;
4. A Federal or State offense involving sexual assault, as defined in section 40002(a) of the 1994 VAWA (42 U.S.C. 13925a); or
5. An offense under State law determined by the Attorney General to be substantially similar to an offense described in this list.

**Nondiscrimination Statement**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 1-800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination:

- Complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office. You can ask for a copy of the complaint form by calling 1-866-632-9992; or
- Write a letter addressed to USDA and put in the letter all of the information requested in the form.

Submit your completed form or letter to USDA by:

- mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue SW Washington, D.C.20250-9410; or
- fax: 1-202-690-7442; or
- email: [program.intake@usda.gov](mailto:program.intake@usda.gov)

This institution is an equal opportunity provider.

**Transitional Aid to Families with Dependent Children (TAFDC) and Emergency Aid to the Elderly, Disabled, and Children (EAEDC)**

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TAFDC and EAEDC are cash assistance programs. To learn more and to apply, visit [DTAConnect.com](http://DTAConnect.com) or call your local DTA office. This information only applies to households who are applying for or get TAFDC or EAEDC.

**When do I need to tell DTA about changes in my household?**

I must tell DTA about changes that could affect my TAFDC or EAEDC (cash benefits) **within 10 days**, except that I do not have to tell DTA about a change in my earnings of less than \$100 per month. This includes changes in my income, assets, address, who I live with, family size, work, and health insurance.

**How do I get health insurance?**

- If I get TAFDC or EAEDC, I will get MassHealth too.
- If I am denied TAFDC or EAEDC, MassHealth will use my information to see if I am eligible for health insurance.
- If my EAEDC stops, I need to apply for MassHealth separately. To ask for an application call (800) 841-2900.

If I get MassHealth, I agree that MassHealth may collect:

- money owed to me from another source for my medical care, and
- medical support from the absent parent of any child under age 19 who gets MassHealth benefits.

**Are there special rules if I am eligible only because of an accident or injury?**

If my family gets benefits from MassHealth or DTA because of an accident or injury, I must use any money I get for the accident or injury to pay them back. The money could be from an insurance policy, a settlement, or any other source. This applies even if I do not know what the possible sources of money are yet.

I agree to cooperate with MassHealth and DTA by:

- Filing claims for money from other sources.
- Telling MassHealth and DTA right away about any insurance claim, lawsuit, or other process to get money.
- Giving MassHealth and DTA new information when I get it.

If I don't cooperate, MassHealth and DTA may stop or deny my benefits. I agree that MassHealth and DTA may:

- Share information about my benefits in order to collect money to repay those benefits.

See all records about money I might get due to the accident or injury, such as records at the Department of Industrial Accidents.

If I am getting EAEDC because I have a disability or I am over 65 years old, I have to apply for federal Supplemental Security Income (SSI) benefits. If I am approved for SSI benefits that cover the same time that I got EAEDC, the Social Security Administration will send some of my retroactive SSI to DTA to repay the EAEDC.

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### **Important Notice About the Law and Your Benefits**

An Intentional Program Violation (IPV) is intentionally giving a false or misleading statement or misrepresenting, hiding, or withholding facts, either orally or in writing, in order to establish or maintain eligibility for TAFDC or EAEDC benefits, or to gain benefits to which I am not entitled.

If I am found guilty of an IPV by a court of law, an administrative disqualification hearing, or by signing a waiver, I will be disqualified from receiving TAFDC or EAEDC benefits for a period of:

- 6 months for the first violation
- 12 months for the second violation
- forever for the third violation

In addition, other laws may apply.

### **Prohibitions on EBT Card Purchases**

I understand it is illegal to use TAFDC or EAEDC funds held on an electronic benefit transfer (EBT) card to pay for the following: alcoholic beverages; tobacco products; lottery tickets; adult oriented material or performances; gambling; firearms and ammunition; vacation services; tattoos; body piercings; jewelry; televisions; stereos; video games or consoles at rent-to-own stores; recreational marijuana; court-ordered fees; fines; bail or bail bonds.

### **Prohibitions on Where I may Use My EBT Card**

I understand it is illegal to use my electronic benefit transfer (EBT) card at the following locations: adult bookstores; adult paraphernalia stores or adult oriented performance establishments; ammunitions dealers; casinos; gambling casinos or gaming establishments; cruise ships; firearms dealers; jewelry stores; liquor stores; manicure shops or aesthetic shops; cash transmittal agencies to foreign countries; recreational marijuana stores or tattoo parlors.

### **Penalties for prohibited EBT card cash purchases**

- **First Offense:** I must pay back DTA the amount spent.
- **Second Offense:** I must pay back DTA the amount spent and will lose cash benefits for **two months.**
- **Third Offense:** must pay back DTA the amount spent and will lose cash benefits **permanently.**

### **Sign this Renewal Application — Required.**

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

If I have indicated that I am applying for the Supplemental Nutritional Assistance Program (SNAP) on this renewal application, I certify that I understand and agree to the rights, rules, and penalties of the SNAP program, as outlined above. I ask that MassHealth send my information, including Protected Health Information subject to the Health Insurance Portability and Accountability Act

(HIPAA), to the Department of Transitional Assistance (DTA) for the purpose of applying for SNAP benefits.

**Important: For MassHealth and Health Connector applicants only**

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 (HOH) or authorized representative	Print Name
	Date

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# MassHealth Renewals FAQ



## Q. How can I get one-on-one help?

A. You can get one-on-one assistance through any of the ways listed below.

- ▶ MassHealth Enrollment Center listed below for in-person help (no appointment needed).
  - ▶ Chelsea: 45 Spruce Street
  - ▶ Taunton: 21 Spring Street, Suite 4
  - ▶ Tewksbury: 367 East Street
  - ▶ Springfield: 88 Industry Avenue, Suite D
- ▶ Enrollment Event: Attend one of the events listed on the enclosed flyer.
- ▶ Enrollment Assistors: You can get free in-person help from a Navigator or a Certified Application Counselor. These people have been trained and certified to answer your questions and to help you complete your application. For a full list of Navigators and Certified Application Counselors, go to [www.MAhealthconnector.org/help-center](http://www.MAhealthconnector.org/help-center).

## Q. How do I access and update my renewal application online?

A. There are several ways.

- ▶ If you already have an account: Your username is included in your renewal letter. Go to [www.MAhealthconnector.org](http://www.MAhealthconnector.org), select Login and follow the instructions on the page. If you can't remember your password, use the Forgot Password link.
- ▶ If you do not have an account: Use the Invitation Code included in the renewal letter and enter the entire code into your web browser. Follow the prompts to set up an account and log in to access your application.
- ▶ If you aren't sure if you have an account: Do not set up a new online account or start a new online application. Call MassHealth Customer Service 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled) and they will assist you.

## Q. I reviewed my renewal application and I have no changes to report, what do I do?

A. Even if all of the information on your renewal application is correct and you have no updates to make, you still need to submit the renewal application online, by calling MassHealth Customer Service or by signing and mailing all of the pages back, on or before the due date in your letter.

## Q. I don't understand how to answer or how to complete sections in my renewal application. Where can I find more information?

A. Refer to the MassHealth member booklet on the MassHealth website ([www.mass.gov/masshealth](http://www.mass.gov/masshealth)) for guidance. You can also refer to the Getting Started guide at [www.MAhealthconnector.org](http://www.MAhealthconnector.org).

Note: Information provided in your income section of your renewal application should be for the current tax year. This should be what you are earning now and will report when you file your taxes next year.

## Q. Once I submit my renewal application, when will I know if I'm still covered?

A. Once we process your completed renewal application, we will send you another letter to let you know if you and your household still qualify for health coverage through MassHealth, Children's Medical Security Plan (CMSP), or the Health Safety Net (HSN). If you do not qualify for health coverage through MassHealth, CMSP, or the HSN, we will determine if you qualify for coverage through the Health Connector. If you qualify for a Health Connector plan, you will receive additional information on how to select and enroll in a health plan.

# Renovación de MassHealth

## Preguntas frecuentes



**P:** ¿Cómo puedo recibir ayuda personalizada?

**R:** Usted puede recibir asistencia personalizada a través de cualquiera de las siguientes maneras.

- ▶ Centros de inscripción de MassHealth para recibir ayuda en persona (no se necesita cita previa).
  - ▶ Chelsea: 45 Spruce Street
  - ▶ Taunton: 21 Spring Street, Suite 4
  - ▶ Tewksbury: 367 East Street
  - ▶ Springfield: 88 Industry Avenue, Suite D
- ▶ Evento de Inscripción: Asista a uno de los eventos mencionados en el volante adjunto.
- ▶ Asistentes de Inscripción: Usted puede recibir ayuda gratuita en persona de un Navegador o un Asesor Certificado de Solicitud. Estas personas han sido capacitadas y certificadas para responder a sus preguntas y para ayudarle a completar la solicitud. Para ver una lista completa de Navegadores y Asesores Certificados de Solicitud, vaya a [www.MAhealthconnector.org/help-center](http://www.MAhealthconnector.org/help-center).

**P:** ¿Cómo puedo tener acceso y actualizar mi solicitud de renovación en línea?

**R:** Existen numerosas maneras de hacerlo.

- ▶ Si usted ya tiene una cuenta: Su nombre de usuario ya está incluido en su carta de renovación. Vaya a [www.MAhealthconnector.org](http://www.MAhealthconnector.org), seleccione el botón "Login" y siga las instrucciones de la página. Si no puede recordar su contraseña, use el enlace "Forgot Password" (Olvidé la contraseña).
- ▶ Si usted no tiene una cuenta: Use el Código de invitación incluido en la carta de renovación y escriba el código completo en su navegador de internet. Siga las instrucciones para configurar la cuenta y registrarse para tener acceso a su solicitud.
- ▶ Si no está seguro de que ya tenga una cuenta: NO cree una nueva cuenta en línea NI empiece ninguna nueva solicitud en línea. Llame al Servicio al cliente de MassHealth al 1-800-841-2900 (TTY: 1-800-497-4648 para personas sordas, con dificultad auditiva o discapacidad del habla) y ellos lo asistirán.

**P:** Revisé mi solicitud de renovación y no tengo que reportar ningún cambio, ¿qué debo hacer?

**R:** Incluso si toda la información de su solicitud de renovación está correcta y usted no tiene que hacer ninguna actualización, usted de todas formas necesita presentar la solicitud de renovación en línea, llamando al Servicio al cliente de MassHealth o firmando y enviando por correo todas las páginas, a no más tardar del día de vencimiento que aparece en su carta.

**P:** No entiendo cómo responder ni cómo completar algunas secciones de mi solicitud de renovación. ¿Dónde puedo hallar más información?

**R:** Consulte el folleto para el afiliado de MassHealth en el sitio web de MassHealth ([www.mass.gov/masshealth](http://www.mass.gov/masshealth)) como guía. También puede consultar la guía "Getting Started" (Introducción) en [www.MAhealthconnector.org](http://www.MAhealthconnector.org).

Nota: La información dada en su sección de ingresos de su solicitud de renovación debe ser para el año fiscal actual. Esto debe ser lo que está ganando ahora y lo que usted reportará cuando declare sus impuestos el próximo año.

**P:** Una vez que yo presente mi solicitud de renovación, ¿cuándo sabré si aún tengo cobertura?

**R:** Una vez que procesemos su solicitud completa de renovación, le enviaremos otra carta para dejarle saber si usted y su hogar aún califican para la cobertura de salud a través de MassHealth, del Children's Medical Security Plan (CMSP, Plan de seguridad médica para niños) o de la Health Safety Net (HSN). Si usted no califica para la cobertura de salud a través de MassHealth, CMSP o HSN, nosotros determinaremos si usted califica para la cobertura a través de Health Connector. Si califica para un plan de Health Connector, usted recibirá información adicional sobre cómo seleccionar e inscribirse en un plan de salud.

**This information is important. It should be translated right away.  
We can translate it for you free of charge.  
Call us at (800) 841-2900. TDD/TTY: 711.**

Esta información es importante y debe ser traducida inmediatamente. Podemos traducirla para usted gratuitamente. Llámenos al (800) 841-2900 o por TDD/TTY: 711. (Spanish)

Esta informação é importante. Deverá ser traduzida imediatamente. Nós podemos traduzi-la para você gratuitamente. Entre em contato conosco no (800) 841-2900. TDD/TTY: 711. (Brazilian Portuguese)

此處的資訊十分重要，應立即翻譯。我們可以免費為您翻譯。請撥打電話號碼 (800) 841-2900 (TDD/TTY: 711)，與我們聯繫。(Chinese)

Enfòmasyon sa enpòtan. Yo fèt pou tradwi li tou swit. Nou kapab tradwi li pou ou gratis. Rele nou nan (800) 841-2900. TDD/TTY: 711. (Haitian Creole)

Những tin tức này thật quan trọng. Tin tức này cần phải thông dịch liền. Chúng tôi có thể thông dịch cho quý vị miễn phí. Xin gọi cho chúng tôi tại số (800) 841-2900. TDD/TTY: 711. (Vietnamese)

Эта информация очень важна. Ее нужно перевести немедленно. Мы можем перевести ее для вас бесплатно. Позвоните нам по телефону (800) 841-2900. TDD/TTY: 711. (Russian)

هذه المعلومات هامة. يجب ترجمتها فوراً. يمكننا ترجمتها لك مجاناً. اتصل بنا على الرقم (800) 841-2900. TDD/TTY: 711. (Arabic)

នេះគឺជាព័ត៌មានសំខាន់ៗ វាគួរតែបកប្រែឱ្យបានឆាប់ៗ។ យើងអាចបកប្រែវាសំរាប់អ្នក ដោយឥតគិតថ្លៃឡើយ។ សូមទូរស័ព្ទមកយើង តាមលេខ (800) 841-2900។ TDD/TTY: 711។ (Khmer)

Cette information est importante. Prière de la traduire immédiatement. Nous pouvons vous la traduire gratuitement. Appelez-nous au (800) 841-2900. TDD/TTY: 711. (French)

Questa informazione è importante. Si pregha di tradurla immediatamente. Possiamo tradurla per voi gratuitamente. Chiamate all (800) 841-2900. TDD/TTY: 711. (Italian)

이 정보는 중요합니다. 이는 즉시 번역해야 합니다. 저희는 귀하를 위해 이를 무료로 번역해드릴 수 있습니다. 일반 전화인 경우 (800) 841-2900로, TDD/TTY 전화인 경우 711로 연락해 주십시오. (Korean)

Αυτή η πληροφορία είναι σημαντική και πρέπει να μεταφραστεί άμεσα. Μπορούμε να τη μεταφράσουμε για εσάς δωρεάν. Καλέστε μας στον αριθμό (800) 841-2900. TDD/TTY: 711. (Greek)

To jest ważna informacja. Powinna zostać niezwłocznie przetłumaczona. My tłumaczymy dla Państwa bezpłatnie. Prosimy do nas zadzwonić pod nr (800) 841-2900. TDD/TTY: 711. (Polish)

यह जानकारी महत्वपूर्ण है। इसका अनुवाद भलीभांति किया जाना चाहिए। हम आपके लिए इसका अनुवाद नशुल्क कर सकते हैं। हमें (800) 841-2900। TDD/TTY: 711 पर कॉल करें। (Hindi)

આ માહિતી મહત્વની છે. તેનું તરત જ અનુવાદ થવું જોઈએ. અમે વાની મૂલ્યે તમારા માટે તેમ કરી શકીએ છીએ. અમને (800) 841-2900. TDD/TTY: 711 પર કોલ કરો. (Gujarati)

ຂໍ້ມູນນີ້ສຳຄັນ. ມັນມີຄວາມຈຳເປັນຕ້ອງແປເລີຍ. ພວກເຮົາ ສາມາດຊ່ວຍແປໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາພວກເຮົາໄດ້ທີ່ (800) 841-2900. TDD/TTY: 711. (Lao)

**This information is available in alternative formats such as braille and large print.  
To get a copy, please call us at (800) 841-2900. TDD/TTY: 711.**





MassHealth complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, creed, sexual orientation or sex (including gender identity and gender stereotyping). MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation or sex (including gender identity and gender stereotyping).

MassHealth provides

- free aids and services to people with disabilities to communicate effectively with us, such as:
  - ◆ Qualified sign language interpreters
  - ◆ Written information in other formats (large print, braille, accessible electronic formats, and other formats)
- free language services to people whose primary language is not English, such as:
  - ◆ Qualified interpreters
  - ◆ Information written in other languages

If you need these services, contact us at (800) 841-2900. TDD/TTY: 711.

If you believe that MassHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping), you can file a grievance with: Section 1557 Compliance Coordinator, 1 Ashburton Place, 11th Floor, Boston, Massachusetts 02108, Phone: (617) 573-1704, TTY: (617) 573-1696, Fax: (617) 889-7862, or email at: [Section1557Coordinator@state.ma.us](mailto:Section1557Coordinator@state.ma.us). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Compliance Coordinator can help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>, by mail at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or by phone at (800) 368-1019, (800) 537-7697 (TDD).

Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

## IMPORTANT INFORMATION ABOUT VOTER REGISTRATION

Dear Applicant or Member:

The National Voter Registration Act of 1993 requires MassHealth to give you the opportunity to register to vote. A voter registration application is enclosed. This letter itself is not a voter registration application. If you are not a U.S. citizen, you are not eligible to vote and you should not fill out a voter registration application.

To register to vote, fill out the enclosed Massachusetts voter registration application and send it to the local election official in your city or town, or bring it into any MassHealth Enrollment Center.

**If you have any questions about registering to vote, or if you need help filling out the voter registration application, call the telephone numbers listed below or speak with a customer service representative.**

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 whether 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, your right to privacy in deciding whether to register or in applying to register to vote, or 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 need additional voter registration applications, please contact one of the numbers above.

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**IN-OFFICE VOTER PREFERENCE FORM: This portion of the form is to be completed during in-office transactions only.**

If you are not registered to vote where you live now, would you like to apply to register to vote here today?  
Yes [ ] No [ ]

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

## INFORMACIÓN IMPORTANTE ACERCA DEL REGISTRO DE VOTANTES

Estimado solicitante o miembro:

La Ley Nacional de Registro de Votantes de 1993 requiere que MassHealth le dé la oportunidad para registrarse para votar. Se adjunta una solicitud de registro de votantes. La carta en sí misma no es una solicitud de registro de votantes. Si usted no es un ciudadano de EE.UU., no es elegible para votar por lo que no debe completar una solicitud de registro de votantes.

Para registrarse para votar, complete la solicitud de registro de votantes de Massachusetts adjunta y envíela al funcionario electoral de su ciudad o pueblo, o tráigalo a cualquier Centro de Inscripción de MassHealth.

**Si tiene preguntas sobre cómo registrarse para votar, o si necesita ayuda para completar la solicitud de registro de votantes, llame a los números telefónicos detallados a continuación o hable con un representante de servicio al cliente.**

Centro de Servicio al Cliente de MassHealth al 1-800-841-2900  
(TTY: 1-800-497-4648 para personas sordas, con dificultad auditiva o discapacidad del habla).

Inscribirse para votar o declinar registrarse a votar no afectará la cantidad de asistencia que le brindará la agencia. Si desea obtener ayuda para completar el formulario de solicitud de registro de votantes, le ayudaremos. A usted le corresponde tomar la decisión de buscar o aceptar ayuda. Puede llenar el formulario de solicitud en privado.

Si cree que alguien ha interferido con su derecho para registrarse o declinar registrarse a votar, con su derecho a la privacidad al momento de decidir si se registra o al solicitar registrarse a votar, o su derecho a elegir su partido político u otra preferencia política, puede presentar una denuncia a: Secretary of the Commonwealth, Elections Division, One Ashburton Place, Room 1705, Boston, MA 02108, tel: 617-727-2828 o 1-800-462-8683.

Si necesita más solicitudes del registro de votantes, comuníquese con unos de los números mencionados arriba.

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**FORMULARIO INTERNO DE PREFERENCIA DEL VOTANTE: Esta porción del formulario debe completarse solamente en transacciones dentro de la oficina.**

Si no está registrado para votar en su lugar de residencia actual, le gustaría registrarse para votar el día de hoy?

Sí [ ] No [ ]

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_

SI NO MARCA NINGUNA DE LAS CASILLAS, SE CONSIDERARÁ QUE ELIGIÓ NO REGISTRARSE PARA VOTAR EL DÍA DE HOY.

Check to make sure that you have completed all the information on the voter registration affidavit on the opposite side!

**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 10 days before

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

Fold along dotted line.

YOUR CITY OR TOWN \_\_\_\_\_ ZIP CODE FOR CITY OR TOWN HALL

MA

City or Town Hall

Board of Registrars or Election Commission

Place  
First Class  
Stamp Here



city or town \_\_\_\_\_ zip code

MA \_\_\_\_\_ number and street

name \_\_\_\_\_

Return Address

# Massachusetts Official Mail-In Voter Registration Form

## How to use this form



William Francis Galvin  
Secretary of the Commonwealth

1. Confirm your citizenship.
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. If you are 16 or 17 years old, you will be pre-registered until you are old enough to vote. You will be notified by mail when you become eligible to vote.
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 their name and address and has the option to print their telephone number.
12. Read the oath.
13. Print today's date.
14. Sign your name.

*This form may be mailed or hand-delivered to your city or town hall. If mailed, fold the form, tape it closed, place a first class stamp on it, print your city or town name and zip code for that city or town hall and drop into any mailbox.*

### You can use this form to:

- register or pre-register to vote in Massachusetts; and/or
- update your name, address, and political party.

### To register or pre-register to vote in Massachusetts you must:

- **BE A U.S. CITIZEN**; and
- be a Massachusetts resident; and
- be at least 16 years old.

**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

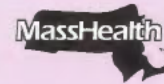
Section 7 requires you to include your driver's license number or the last 4 digits of your social security number on this application. This information will be verified through the Registry of Motor Vehicles and the Commissioner of Social Security. If the information cannot be verified or you do not 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.

north		†Using landmarks, draw the location of the place where you live if you cannot describe that location as a number and street or as a rural route and box number.
west	east	
south		

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

<b>1</b>	<b>Check one:</b> Are you a Citizen of the United States of America? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>NOTE:</b> If you checked "no," do not complete this form.				
<b>2</b>	Full name:	last name	first name	middle name or initial	Jr. Sr. II III IV (circle one if appropriate)
<b>3</b>	Former name:	last name	first name	middle name or initial	Jr. Sr. II III IV (circle one if appropriate)
<b>4</b>	Address where you live now (street number / street name / rural route number & box number / apartment number / city or town / zip code):				
<b>5</b>	Address where you receive all your mail (if different from #4):				
<b>6</b>	Date of birth: month day year	<b>7</b>	Identification #: license # or last 4 digits of SSN	<b>8</b>	Telephone (optional): <input type="checkbox"/> Check if unlisted
<b>9</b>	Party enrollment or designation (check one): <input type="checkbox"/> Democratic <input type="checkbox"/> Republican <input type="checkbox"/> No Party (unenrolled) <input type="checkbox"/> Political Designation (not a political party):				
<b>10</b>	Address at which you were last registered to vote (street number / street name / rural route number & box number / apartment number / city or town / zip code):				
<b>11</b>	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)				
<b>12</b>	I hereby swear (affirm) that I am the person named above, that the above information is true, that <b>I AM A CITIZEN OF THE UNITED STATES</b> , that I am at least 16 years old and I understand that I must be 18 years old to be eligible to vote, 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.				
<b>13</b>	Today's date: month day year	<b>14</b>	Signed: Sign your name here.		
				Agency Designation:	BBA

# Massachusetts Application for Health and Dental Coverage and Help Paying Costs— Additional Persons



Primary Contact from Step 1

**STEP 2** Person \_\_\_\_ . Use this Additional Persons form if you have more than four people to include with this application. When filling out the additional pages please be sure to tell us how each person is related to each other person on the application. We need this information to determine eligibility.

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

2. Relationship to Person 1	Relationship to Person 2	Relationship to Person 3
Relationship to Person 4	Relationship to Person 5	Relationship to Person 6

Does this person live with Person 1?  Yes  No

If **No**, list address. \_\_\_\_\_

3. Date of birth (mm/dd/yyyy) \_\_\_\_\_

4. Gender  Male  Female

5. **Optional** What is this person's race or ethnicity? \_\_\_\_\_

6. Does this person have a social security number (SSN)?  Yes  No (optional if **not** applying)  
We need a social security number (SSN) for every person applying for health coverage who has one.

For important SSN information and how to apply for SSN, please see instructions for Question 6 under Person 1.

If **Yes**, give us the number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

If **No**, check one of the following reasons.  Just applied  Noncitizen exception  Religious exception

Is the name on this application the same as the name on this person's social security card?  Yes  No

If **No**, what name is on this person's social security card? \_\_\_\_\_

\_\_\_\_\_  
First name, middle name, last name, and suffix

7. If this person gets an Advance Premium Tax Credit (APTC), does this person agree to file a federal tax return for the tax year that the credits are received?  Yes  No

See instructions for Question 7 under Person 1.

If **Yes**, please answer questions a–d. If **No**, skip to question d.

a. Is this person legally married?  Yes  No

If **No**, skip to question 7c.

If **Yes**, list name of spouse and date of birth. \_\_\_\_\_

b. Does this person plan to file a joint federal tax return with a spouse for the tax year for which this person is applying?  Yes  No

c. Will this person claim any dependents on this person's federal income tax return for the year for which this person is applying?  Yes  No

This person will claim a personal exemption deduction on their federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments. List the name(s) and date(s) of birth of dependents.  
\_\_\_\_\_  
\_\_\_\_\_

d. Will this person be claimed as a dependent on someone else's federal income tax return for the year for which this person is applying?  Yes  No

If this person is claimed by someone else as a dependent on their federal income tax return, this may affect this person's ability to receive a premium tax credit. Do not answer **Yes** to this question if this person is a child under the age of 21 being claimed by a noncustodial parent. If **Yes**, please list the name of the tax filer. \_\_\_\_\_

Tax filer date of birth \_\_\_\_\_ How is this person related to the tax filer? \_\_\_\_\_

- Lottery and gambling winnings: \$ \_\_\_\_\_ Effective Date \_\_\_\_\_  
How often?  One time only  Weekly  Every two weeks  Twice a month  Monthly  Yearly  
Non-cash prizes are not counted as qualified lottery and gambling winnings. Do not include any losses in the amount.

## ONE-TIME ONLY INCOME

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30. Has or will this person receive income during this calendar year as a one-time only payment?  Yes  No  
Examples might be a lump-sum pension payment or a one-time capital gain.  
If Yes: Type: \_\_\_\_\_ Amount \$ \_\_\_\_\_ Month Received \_\_\_\_\_ Year received \_\_\_\_\_
31. Will this person receive income during the next calendar year as a one-time only payment?  Yes  No  
If Yes: Type: \_\_\_\_\_ Amount \$ \_\_\_\_\_ Month Received \_\_\_\_\_ Year received \_\_\_\_\_

## DEDUCTIONS

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32. What deductions does he or she report on their income tax return?

See instructions for Question 33 under Person 1.

- Educator expense: Yearly amount \$ \_\_\_\_\_
- Certain business expenses of reservists, performing artists, or fee-based government officials: Yearly amount \$ \_\_\_\_\_
- Health Savings Account deduction: Yearly amount \$ \_\_\_\_\_
- Moving expenses for members of the Armed Forces: Yearly amount \$ \_\_\_\_\_
- Deductible part of self-employment tax: Yearly amount \$ \_\_\_\_\_
- Contribution to self-employed SEP, SIMPLE, and qualified plans: Yearly amount \$ \_\_\_\_\_
- Self-employed health insurance deduction: Yearly amount \$ \_\_\_\_\_
- Penalty on early withdrawal of savings: Yearly amount \$ \_\_\_\_\_
- Alimony paid for a divorce, separation agreement, or court order that was finalized before January 1, 2019:  
Yearly amount \$ \_\_\_\_\_
- Individual Retirement Account (IRA) deduction: Yearly amount \$ \_\_\_\_\_
- Student loan deduction (interest only, not total payment): Yearly amount \$ \_\_\_\_\_
- None

## YEARLY INCOME

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33. Did this person receive any unemployment benefits this calendar year?  Yes  No
34. What is your total expected income for the current calendar year?  
\_\_\_\_\_
35. What is your total expected income for next calendar year, if different?  
\_\_\_\_\_

**THANKS! This is all we need to know about this person. For additional copies of this form, the ACA-3-AP, go to [www.mass.gov/lists/applications-to-become-a-masshealth-member](http://www.mass.gov/lists/applications-to-become-a-masshealth-member). Click on Massachusetts Application for Health and Dental Coverage and Help Paying Costs—Additional Persons.**

Send your complete application to **Health Insurance Processing Center**  
**PO Box 4405**  
**Taunton, MA 02780**

or Fax to (857) 323-8300