Massachusetts Health Plans

State Training Manual

Heartland FINANCIAL
AN INTEGRITY COMPANY

Table of Contents

Heartland FINANCIAL AN INTEGRITY COMPANY

Available Plans

Commonwealth Care

Commonwealth Care is a program provided by the state for households with incomes below 300% of poverty level, and that are not offered coverage from anywhere else.

Commonwealth Care Plan Decision Tool 2012

The monthly plan costs and co-payments will vary depending on client's income.

Step 1: Find the FPL (Federal Poverty Level) corresponding to your income and family size.

	A	B	C	D	E
Family Size	**Annual (Yearly) Salary Before Taxes**				
1 person	$11,172 or less	Up to $16,764	Up to $22,344	Up to $27,936	Up to $33,516
2 people	$15,132 or less	Up to $22,704	Up to $30,264	Up to $37,836	Up to $45,396
3 people	$19,092 or less	Up to $28,644	Up to $38,184	Up to $47,736	Up to $57,276
4 people	$23,052 or less	Up to $34,584	Up to $46,104	Up to $57,636	Up to $69,156
5 people	$27,012 or less	Up to $40,524	Up to $54,024	Up to $67,536	Up to $81,036
6 people	$30,972 or less	Up to $46,464	Up to $61,944	Up to $77,436	Up to $92,916
7 people	$34,932 or less	Up to $52,404	Up to $69,864	Up to $87,336	Up to $104,796

Commonwealth Care - Three Plan Types

Depending on the household income level, client may qualify for one of three plan types.

Step 2: Find your plan and monthly premiums

Column from Step 1	Your FPL	Your Plan	Your monthly premium cost
A	Less than 100%	Type 1	$0
B	100.1% – 150%	Type 2A	$0 - $28.00
C	150.1% – 200%	Type 2B	$40.00 - $81.00
D	200.1% – 250%	Type 3A	$78.00 - $138.00
E	250.1% – 300%	Type 3B	$118.00 - $182.00

*Exact monthly amount will depend on your city/town of residence.

Heartland FINANCIAL AN INTEGRITY COMPANY

Commonwealth Care Plan Type 1

Copayment amounts are the same for all health plans. Plan Type 1 Members: please note changes to preventive services and contraceptive prescriptions benefits and copays. *Effective October 1, 2011*

Benefit	Copay
Outpatient care	
Preventive services	$0
Office visit to your primary care provider (PCP)	$0
Office visit to a specialist	$0
Radiology, imaging (x-rays), lab work	$0
Outpatient surgery at a hospital or ambulatory surgery center	$0
Abortion	$0
Inpatient care	
Hospital stay, may include surgery, x-rays, lab services, and room and board (copay is per stay)	$0
Emergency care	
Emergency room visit	$0
Prescription drugs	
30 day supply from a pharmacy	
• Generic drug	$1*/3.65
• Drug on your plan's preferred list	$3.65
• Drug not on your plan's preferred lis.	$3.65
Contraceptive prescriptions (medication and devices)	$0
Alcohol, drug abuse and mental health care	
Outpatient or office visit	$0
Inpatient care (copay is per stay)	$0
Methadone maintenance (dosing, counseling, screens)	$0
Dental Preventive and emergency dental services only	
• Diagnostic (Exams, xrays), Preventive (cleanings, fluoride), extractions, emergency care visits, treatment of complication – surgery, anesthesia, professional visit	$0
Vision	
Eye exam every 24 months	$0
Free glasses every 24 months	$0
Diabetes care	
Office visit to PCP or podiatrist for routine foot care (may include foot orthotics)	$0
Visit to specialist (may include foot orthotics)	$0
Rehabilitation services	
Extended inpatient care (100 total days per year)	$0
• In a skilled nursing facility	$0
• In a rehabilitation hospital or chronic disease hospital (copay is per stay)	$0
Physical therapy, speech or hearing therapy, pulmonary or occupational therapy (need plan approval for more than 20 visits)	$0
Cardiac rehabilitation	$0
Home health care	$0
Maternity and family planning	
Outpatient office visit	$0
Other benefits	
Ambulance (emergency only)	$0
Prosthetics, oxygen and respiratory therapy equipment, other durable medical equipment	$0
Hospice	$0
Maximum copays	
Maximum amount a member will need to pay for all prescriptions in a benefit year **	$200
Maximum amount a member will need to pay for services excluding prescription drugs in a benefit year **	$0

* *Limited to generic prescription drugs for high blood pressure, high cholesterol and diabetes*
** *The benefit year is from July 1, 2011 – June 30, 2012.*

PTI

Heartland FINANCIAL
AN INTEGRITY COMPANY

Commonwealth Care Plan Type 2

Copayment amounts are the same for all health plans. Plan Type 2 Members: please note changes to preventive services, contraceptive prescriptions and high cost imaging copays. *Effective July 1, 2011*

Benefit	Copay
Outpatient care	
Preventive services	$0
Office visit to your primary care provider (PCP)	$10
Office visit to a specialist	$18
Radiology, x-rays, lab work	$0
Imaging (MRI, CAT and PET)	$30
Outpatient surgery at a hospital or ambulatory surgery center	$50
Abortion	$50
Inpatient care	
Hospital stay, may include surgery, x-rays, lab services, and room and board (copay is per stay)	$50 *
Emergency care	
Emergency room visit (no copay if you are admitted to the hospital)	$50
Prescription drugs	
30 day supply from a pharmacy	
• Generic drug	$10
• Drug on your plan's preferred list	$20
• Drug not on your plan's preferred list	$40
3-month supply, by mail	
• Generic drug	$20
• Drug on your plan's preferred list	$40
• Drug not on your plan's preferred list	$120
Contraceptive prescriptions (medication and devices)	$0
Alcohol, drug abuse and mental health care	
Outpatient or office visit	$10
Inpatient care (copay is per stay)	$50 *
Methadone maintenance (dosing, counseling, screens)	$0
Vision	
Eye exam every 24 months	$10
Free glasses every 24 months	$0
Diabetes care	
Office visit to PCP or podiatrist for routine foot care (may include foot orthotics)	$5
Visit to specialist (may include foot orthotics)	$10
Rehabilitation services	
Extended inpatient care (100 total days per year)	
• In a skilled nursing facility	$0
• In a rehabilitation hospital or chronic disease hospital (copay is per stay)	$50 *
Physical therapy, speech or hearing therapy, pulmonary or occupational therapy (need plan approval for more than 20 visits)	$10
Cardiac rehabilitation	$0
Home health care	$0
Maternity and family planning	
Outpatient office visit	$0
Other benefits	
Ambulance (emergency only)	$0
Prosthetics, oxygen and respiratory therapy equipment, other durable medical equipment	$0
Hospice	$0
Maximum copays	
Maximum amount a member will need to pay for all prescriptions in a benefit year **	$500
Maximum amount a member will need to pay for services excluding prescription drugs in a benefit year **	$750

* *Copay waived if transferred from another inpatient unit*

** *The benefit year is from July 1, 2011 – June 30, 2012.*

PT2

Heartland FINANCIAL
AN INTEGRITY COMPANY

Commonwealth Care Plan Type 3

Copayment amounts are the same for all health plans. Plan Type 3 Members: please note changes to preventive services, contraceptive prescriptions and high cost imaging copays. *Effective July 1, 2011*

Benefit	Copay
Outpatient care	
Preventive services	$0
Office visit to your primary care provider (PCP)	$15
Office visit to a specialist	$22
Radiology, x-rays, lab work	$0
Imaging (MRI, CAT and PET)	$60
Outpatient surgery at a hospital or ambulatory surgery center	$125
Abortion	$100
Inpatient care	
Hospital stay, may include surgery, x-rays, lab services, and room and board (copay is per stay)	$250 *
Emergency care	
Emergency room visit (no copay if you are admitted to the hospital)	$100
Prescription drugs	
30 day supply from a pharmacy	
• Generic drug	$12.50
• Drug on your plan's preferred list	$25
• Drug not on your plan's preferred list	$50
3-month supply, by mail	
• Generic drug	$25
• Drug on your plan's preferred list	$50
• Drug not on your plan's preferred list	$150
Contraceptive prescriptions (medication and devices)	$0
Alcohol, drug abuse and mental health care	
Outpatient or office visit	$15
Inpatient care (copay is per stay)	$250 *
Methadone maintenance (dosing, counseling, screens)	$0
Vision	
Eye exam every 24 months	$20
Free glasses every 24 months	$0
Diabetes care	
Office visit to PCP or podiatrist for routine foot care (may include foot orthotics)	$10
Visit to specialist (may include foot orthotics)	$20
Rehabilitation services	
Extended inpatient care (100 total days per year)	
• In a skilled nursing facility	$0
• In a rehabilitation hospital or chronic disease hospital (copay is per stay)	$250 *
Physical therapy, speech or hearing therapy, pulmonary or occupational therapy (need plan approval for more than 20 visits)	$20
Cardiac rehabilitation	$0
Home health care	$0
Maternity and family planning	
Outpatient office visit	$0
Other benefits	
Ambulance (emergency only)	$0
Prosthetics, oxygen and respiratory therapy equipment, other durable medical equipment	10%
Hospice	$0
Maximum copays	
Maximum amount a member will need to pay for all prescriptions in a benefit year **	$800
Maximum amount a member will need to pay for services excluding prescription drugs in a benefit year **	$1500

* *Copay waived if transferred from another inpatient unit*

** *The benefit year is from July 1, 2011– June 30, 2012.*

PT3

MassHealth

The MassHealth program provides comprehensive health insurance - or help in paying for private health insurance—to a wide range of people who meet the eligibility rules. Eligibility is based primarily on income levels and family size

2012 MassHealth Income Standards and Federal Poverty Guidelines (Table A)

Family Size	MassHealth Income Standards		100% Federal Poverty Level		120% Federal Poverty Level		133% Federal Poverty Level		135% Federal Poverty Level	
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
1	$522	$6,264	$931	$11,172	$1,117	$13,404	$1,239	$14,868	$1,257	$15,084
2	$650	$7,800	$1,261	$15,132	$1,513	$18,156	$1,677	$20,124	$1,703	$20,436
3	$775	$9,300	$1,591	$19,092			$2,116	$25,392		
4	$891	$10,692	$1,921	$23,052			$2,555	$30,660		
5	$1,016	$12,192	$2,251	$27,012			$2,994	$35,928		
6	$1,141	$13,692	$2,581	$30,972			$3,433	$41,196		
7	$1,266	$15,192	$2,911	$34,932			$3,872	$46,464		
8	$1,383	$16,596	$3,241	$38,892			$4,311	$51,732		
For each additional person add	+$133	+$1,596	$330	$3,960			$439	$5,268		

(see additional table that follows)

2012 MassHealth Income Standards and Federal Poverty Guidelines (Table B)

Family Size	150% Federal Poverty Level		200% Federal Poverty Level		250% Federal Poverty Level		300% Federal Poverty Level		400% Federal Poverty Level	
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
1	$1,397	$16,764	$1,862	$22,344	$2,328	$27,936	$2,793	$33,516	$3,724	$44,688
2	$1,892	$22,704	$2,522	$30,264	$3,153	$37,836	$3,783	$45,396	$5,044	$60,528
3	$2,387	$28,644	$3,182	$38,184	$3,978	$47,736	$4,773	$57,276	$6,364	$76,368
4	$2,882	$34,584	$3,842	$46,104	$4,803	$57,636	$5,763	$69,156	$7,684	$92,208
5	$3,377	$40,524	$4,502	$54,024	$5,628	$67,536	$6,753	$81,036	$9,004	$108,048
6	$3,872	$46,464	$5,162	$61,944	$6,453	$77,436	$7,743	$92,916	$10,324	$123,888
7	$4,367	$52,404	$5,822	$69,864	$7,278	$87,336	$8,733	$104,796	$11,644	$139,728
8	$4,862	$58,344	$6,482	$77,784	$8,103	$97,236	$9,723	$116,676	$12,964	$155,568
For each additional person add	$495	$5,940	$660	$7,920	$825	$9,900	$990	$11,880	$1,320	$15,840
			Institutional Income Standard $72.80							

MassHealth Types

MassHealth Standard

In MassHealth Standard, covered services include the ones listed below. There may be some limits.

- inpatient hospital services
- outpatient services: hospitals, clinics, doctors, dentists, family planning, and vision care
- medical services: lab tests, X rays, therapies, pharmacy services*, eyeglasses, hearing aids, medical equipment and supplies, adult day health, and adult foster care
- behavioral health (mental health and substance abuse) services
- well-child screenings (for children under the age of 21): including medical, vision, dental, hearing, behavioral health (mental health and substance abuse), and developmental screens, as well as shots
- long-term-care services at home or in a long-term-care facility, including home-health services
- transportation services
- quit-smoking services

MassHealth Standard - Additional services for children under the age of 21

Children, teens, and young adults under the age of 21 who are determined eligible for MassHealth Standard are also eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, which include all medically necessary services covered by Medicaid law.

MassHealth Standard – Populations served

A client may be able to get MassHealth Standard if they are:

- pregnant;
- under age 19;
- a parent living with your children under age 19*;
- disabled according to the standards set by federal law. This means you have a mental or physical condition that limits or keeps you from working for at least 12 months. MassHealth decides if you meet the disability standards; or
- eligible based on special income and asset rules under Section 1931 or the Social Security Act, which lets you keep these benefits for up to 12 months after you have gone back to work or gotten a raise, no matter how much your new earnings are. *

*These benefits are also available for parents and caretaker relatives who are aged 65 or older.

MassHealth Standard – Eligibility criteria

Income standards:

- for pregnant women: 200% of the federal poverty level
- for children under age one: 200% of the federal poverty level
- for children aged one through 18: 150% of the federal poverty level
- for parents or caretaker relatives of children under age 19: 133% of the federal poverty level
- for disabled adults: 133% of the federal poverty level

MassHealth Common Health (for disabled persons)

A client may be able to get MassHealth CommonHealth if they are:

- a disabled child under age 18; or
- a disabled person aged 18 or older who:
  - works 40 hours or more a month; or
  - is under age 65 and is not working, or if working meets certain state and federal rules.

MassHealth determines if you are disabled under state and federal law. For an adult, this generally means you have a physical or mental condition that severely limits your ability to work or to do certain activities for at least 12 months.

MassHealth Common Health - Eligibility

There is no income limit for MassHealth Common Health.

If monthly income before taxes and deductions is above 100% of the federal poverty level, the client may have to pay a premium, or meet a one-time only deductible.

MassHealth Family Assistance (for children of those on Commonwealth Care)

MassHealth Family Assistance offers coverage to children, some working adults, and people who are HIV positive who cannot get MassHealth Standard or MassHealth CommonHealth.

MassHealth Family Assistance - Populations served

If a clients has children under age 19 who live with them, MassHealth Family Assistance:

- pays part of a family's health-insurance premiums if they have or can get qualified health insurance from their employer; or
- allows client to enroll their children in a health plan through MassHealth if they do not have and cannot get other health insurance.

The monthly premium to enroll a child in a health plan is $12 per eligible child, but no more than $84 total for a family. Note: Members of federally recognized American Indian tribes or Alaska Natives do not have to pay premiums.

% of Federal Poverty Level (FPL)	Estimated Member Share
Above 150% to 200%	$12 per child ($36 per family group maximum)
Above 200% to 250%	$20 per child ($60 per family group maximum)
Above 250% to 300%	$28 per child ($84 per family group maximum)

For clients who are HIV positive and under age 65, MassHealth Family Assistance may pay part or all of their health-insurance premium. If they have or can get group health insurance from their employer or other source (they will have to pay a member share), and may:

- be provided certain medical services not covered by their health insurance; or
- allowed to enroll in the Primary Care Clinician (PCC) Plan if they do not have other health insurance.

MassHealth Family Assistance – Eligibility

Clients may be able to get MassHealth Family Assistance if they are:

- aged one through 18; or
- under age 65 and working and they:
  - are not eligible for MassHealth Standard or MassHealth Common Health;
  - work for a qualified employer who participates in the Insurance Partnership;
  - have employer-sponsored health insurance that meets MassHealth standards; and
  - pay part of the cost of that health insurance; or
- under age 65 and HIV positive and not eligible for MassHealth Standard or MassHealth Common Health.

Their family's income before taxes and deductions can be no more than 200% of the federal poverty level.

Adult household members who are enrolled in Commonwealth Care will have their children enrolled in this program with income up to 300% of the federal poverty level.

If the adults in the family enroll in Commonwealth Care, the premiums listed above are waived.

MassHealth Essential (out of work for more than 1 year – 100% free)

Populations served

Clients may be eligible for MassHealth Essential if they are under the age of 65 and:

- are currently not working;
- have not worked in more than one year or, if they have worked, they have not earned enough to collect unemployment;
- are not eligible to collect unemployment benefits;
- have an immigration status that prevents them from getting MassHealth Standard, are long-term unemployed, and meet MassHealth disability rules; and
- are not eligible for MassHealth Basic.

Note: The following people are not eligible for MassHealth Essential:

- a college student who can get health insurance from his or her college or university; and
- a person whose spouse works more than 100 hours a month.

MassHealth Essential - Eligibility

The family's income before taxes and deductions can be no more than 100% of the federal poverty level.

Premium Assistance (employed · given for each child covered)

Premium Assistance is a payment on behalf of a child toward the cost of the employer-sponsored health insurance premium. This payment is usually sent to the family. So if they are getting it taken out pre-tax it can really help out the family in question. The amount given is usually around $170.00 per month per child.

Premium Assistance - Populations served

a) An adult whose spouse and/or children receive MassHealth benefits must enroll in a couple or family health insurance policy, if offered; if their employer contributes at least 50 percent of the premium cost for that coverage.
b) The family income must be under 200% of poverty level.

Insurance Partnership

(sole proprietors under 15 employees/no corps/credit for each employee enrolled)

The Insurance Partnership makes health insurance more affordable for qualified small businesses and their employees. The Insurance Partnership is not a health-insurance plan. It is a program that can help pay for the insurance owners offer to their employees.

Under the Insurance Partnership, small businesses that provide health insurance to their qualified employees can have part of their costs paid for by the Commonwealth of Massachusetts.

The Insurance Partnership will pay you as much as $1000 a year for each qualified employee, including the owner, if they meet the employee qualifications. The amount depends on the tier of coverage chosen by the employee.

Tier of coverage Insurance Partnership pays the business:

Monthly / Annually

- Individual $33.33 / $400
- Couple $66.66 / $800
- One adult & one child $66.66 / $800
- Family $83.33 / $1,000

Insurance Partnership - How it works

The total amount of an Insurance Partnership payment depends on the number of qualified employees the client/employer has, and the tier of coverage their employees have.

Each month, the Commonwealth pays the total amount of the Insurance Partnership payment to the employer's health-insurance intermediary or directly to them.

Either way, they pay less!

Insurance Partnership – How a business qualifies

If the owner answers YES to these questions, their business may qualify for the Insurance Partnership.

- Do you employ no more than 50 full-time workers?
- Do you now, or do you later plan to offer comprehensive health insurance to your employees?
- Do you now, or do you later plan to pay at least 50% of the cost of that insurance?
- You cannot be incorporated; you must be self-employed Schedule C ?

Are they self-employed?

Self-employed individuals and couples are not eligible for Insurance Partnership employer payments. But they may qualify for the Insurance Partnership as an employee.

Criteria for employee eligibility

Employees (full- or part-time) are eligible to participate in the Insurance Partnership if they:

- are aged 19 through 64;
- live in Massachusetts;
- have not been offered health insurance by you in the past six months and have not been eligible for health insurance through their spouse's employer in the past six months; and
- have a gross (pre-tax) annual family income that meets program standards.

Employee income standards

Their employee's gross family income (before taxes and other deductions) must be no more than 300% of the federal poverty level (FPL). These amounts are adjusted annually.

The employee's share is reduced to a low monthly rate. In most cases, the monthly cost to the employee will be as follows.

For Families Without Children		
Income	**Covered Adult**	**Couple**
At or below 150% of the FPL	No premium	No premium
Greater than 150% of the FPL and at or below 200% of the FPL	$27	$54
Greater than 200% of the FPL and at or below 250% of the FPL	$53	$106
Greater than 250% of the FPL and at or below 300% of the FPL	$80	$160

For Families With Children		
Income	**Per child**	**Maximum**
At or below 150% of the FPL	No premium	No premium
Greater than 150% of the FPL and at or below 200% of the FPL	$12	$36
Greater than 200% of the FPL and at or below 250% of the FPL	$20	$60
Greater than 250% of the FPL and at or below 300% of the FPL	$28	$84

Individual circumstances may vary. In some cases, the cost may be higher. For more information about the Insurance Partnership, call 1-800-399-8285 or 1-781-830-8282.

Medical Security Plan (Federal – managed by unemployment office)

The Medical Security Plan is a federal program managed by the unemployment office. A client must be receiving unemployment to qualify for this plan.

Premium Assistance Plan (reimbursement takes several months)

If a client has the option of continuing participation in COBRA, the former employer's plan or a health insurance plan the client previously purchased on their own, they may receive monthly subsidies in the form of reimbursement of their premium payments. Here's how this plan works:

- Client must be responsible for 100% payment of the monthly premium.
- Client may receive 80% of the actual premium paid, or up to $1,200 per month for a family plan and up to $500 per month for an individual plan.
- Client must collect at least 10 days of unemployment insurance benefits for any month they are requesting reimbursement.

If eligible, they will be enrolled in the Premium Assistance plan with the same type of coverage (family or individual) they have on their existing plan. They must continue to pay their health insurance premiums each month. The Medical Security Program will reimburse them upon receipt of a claim form with proof of payment.

Direct Coverage Plan

If the client does not have the option of continuing a health insurance plan in which they were enrolled or if they did not previously have health insurance prior to applying for unemployment insurance benefits, they may be eligible to be enrolled in a Managed Care Organization (MCO) plan. The MCO plan covers office visits and screenings, wellness visits for infants and children, hospital care, and treatment for mental health and substance abuse, and prescription drug coverage.

There are some co-payments required and the client must choose a primary care physician (PCP).

They may be required to pay a weekly premium based on their family income and size. Failure to pay their premium will result in a loss of health care coverage for the client and their family. Weekly premium cost will range between $0 and $27 per covered individual.

Families with income less than 150% of the Federal Poverty Income Guidelines (FPIG), children 19 and under, disabled individuals and pregnant women are exempt from premiums.

Client may apply for a premium waiver at any time. Client may request recalculation of their premium once in any two-month period.

Network Health Extend income eligibility guidelines

Rates effective 1/1/2012 – 12/31 2012

	If your yearly income (before taxes) is:				
And your family size is:	***equal to or less than***	***between***	***between***	***between***	***between***
1	$14,856	$14,857 - $16,755	$16,756 - $22,340	$22,341 - $27,925	$27,926 - $44,680
2	$20,123	$20,124 - $22,695	$22,696 - $30,260	$30,261 - $37,825	$37,826 - $60,520
3	$25,390	$25,391 - $28,635	$28,636 - $38,180	$38,181 - $47,725	$47,726 - $76,360
4	$30,657	$30,658 - $34,575	$34,576 - $46,100	$46,101 - $57,625	$57,626 - $92,200
5	$35,923	$35,924 - $40,515	$40,516 - $54,020	$54,021 - $67,525	$67,526 - $108,040
6	$41,190	$41,191 - $46,455	$46,456 - $61,940	$61,941 - $77,425	$77,426 - $123,880
7	$46,457	$46,458 - $52,395	$52,396 - $69,860	$69,861 - $87,325	$87,326 - $139,720
8	$51,724	$51,725 - $58,335	$58,336 - $77,780	$77,781 - $97,225	$97,226 - $155,560
Then your plan type is:	**Plan Type I**	**Plan Type IIa**	**Plan Type IIb**	**Plan Type IIIa**	**Plan Type IIIb**
And your weekly premium per covered individual is:	**$0.00**	**$0.00**	**$9.00**	**$18.00**	**$27.00**

Heartland FINANCIAL AN INTEGRITY COMPANY

Benefit and co-payment summary for Plan Type I

COVERED SERVICES	CO-PAYMENTS	BENEFIT LIMIT
OUTPATIENT MEDICAL CARE		
Abortion Services	No co-payment	
Community Health Center Visits • Primary Care Provider (PCP) • Specialist	 No co-payment No co-payment	
Office Visits (preventive and non-preventive services) • Primary Care Provider (PCP) • Specialist • Eye Care (vision care)	 No co-payment No co-payment No co-payment	Coverage for routine eye exams for members once every 24 months (once every 12 months for diabetics) from network ophthalmologists or optometrists. One pair of eyeglasses once every 24 months is also covered; choose from free frame selection, or choose any other frame up to a maximum credit of $80.
Diabetic Specialty Care	No co-payment	
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	No co-payment	
Laboratory Services	No co-payment	
Radiology Services	No co-payment	Prior authorization required for some services
High-cost Imaging Services (MRI, CT, PET)	No co-payment	Prior authorization required
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and Board (includes deliveries/surgeries/radiology services/labs)	No co-payment	Inpatient medical care covered according to medical necessity and subject to prior authorization

COVERED SERVICES	CO-PAYMENTS	BENEFIT LIMIT
PHARMACY		
Pharmacy	$1 generic and select over-the-counter drugs for diabetes, high blood pressure, and high cholesterol (Tier 1) $3.65 generic and select over-the-counter drugs (Tier 1) $3.65 brand-name drugs (Tier 2)	**1-month supply** Co-payments are for first-time prescriptions and refills. Select over-the-counter drugs may be covered with a prescription. Supplies for diabetes and asthma are covered with a prescription and don't have a co-payment.
Contraceptives	No co-payment	
EMERGENCY CARE		
Emergency Care	No co-payment	
MENTAL HEALTH AND/OR SUBSTANCE ABUSE		
Inpatient Mental Health and/or Substance Abuse	No co-payment	Inpatient mental health and/or substance abuse services covered according to medical necessity and subject to prior authorization
Outpatient Mental Health and/or Substance Abuse Methadone Treatment (dosing, counseling, labs)	No co-payment No co-payment	After 26 visits per benefit year (January 1 – December 31), prior authorization required No co-payments for methadone-related services
REHABILITATION SERVICES		
Cardiac Rehabilitation	No co-payment	Requires prior authorization
Home Health Care	No co-payment	Requires prior authorization
Inpatient Skilled Nursing Facility (SNF)	No co-payment	Maximum of 100 calendar days total per benefit year (January 1 – December 31) at

COVERED SERVICES	CO-PAYMENTS	BENEFIT LIMIT
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	No co-payment	either (or at a combination of) an inpatient skilled nursing facility or an inpatient rehabilitation hospital; requires prior authorization
Short-term Outpatient Rehabilitation	No co-payment	Requires prior authorization
Physical/Occupational/Speech Therapy	No co-payment	Requires prior authorization
OTHER BENEFITS		
Ground Ambulance	No co-payment	Emergency transport only; nonemergency transport covered if medically necessary and with prior authorization
Durable Medical Equipment (DME)	No co-payment	Requires prior authorization
Supplies	No co-payment	
Prosthetics	No co-payment	Requires prior authorization
Oxygen and Respiratory Therapy Equipment	No co-payment	Requires prior authorization
Hospice	No co-payment	Requires prior authorization
Orthotics	No co-payment	Requires prior authorization; shoe inserts for people with diabetes only
Podiatry	No co-payment	Medically necessary non-routine foot care covered; routine foot care services for people with diabetes only
Vision	No co-payment	Coverage for routine eye exams for members once every 24 months (once every 12 months for diabetics) from network ophthalmologists or optometrists. One pair of eyeglasses once every 24 months is also covered; choose from

COVERED SERVICES	CO-PAYMENTS	BENEFIT LIMIT
		free frame selection, or choose any other frame up to a maximum credit of $80.
Wellness • Preventive visits • Contraceptives • Family Planning • Nutrition Counseling • Prenatal Care • Nurse Midwife	 No co-payment No co-payment No co-payment No co-payment No co-payment No co-payment	Requires prior authorization
CO-PAYMENT MAXIMUMS		
Yearly Co-payment Maximum per Benefit Year per Member		Pharmacy $250

Benefit and co-payment summary for Plan Type II

COVERED SERVICES	CO-PAYMENTS	BENEFIT LIMIT
OUTPATIENT MEDICAL CARE		
Abortion Services	$50 co-payment	
Community Health Center Visits • Primary Care Provider (PCP) • Specialist	 $10 co-payment $18 co-payment	
Office Visits • Preventive care services (inclusive of family planning visits) • Non-preventive office visits • Primary Care Provider (PCP) • Specialist • Eye Care (vision care)	 No co-payment $10 co-payment $18 co-payment $10 co-payment	Coverage for routine eye exams for members once every 24 months (once every 12 months for diabetics) from network ophthalmologists or optometrists. One pair of eyeglasses once every 24 months is also covered; choose from free frame selection, or choose any other frame up to a maximum credit of $80.
Diabetic Specialty Care	$10 co-payment	Co-payment is for services diabetic members get from a specialist (other than routine services a podiatrist provides, see Podiatry)
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	$50 co-payment	

COVERED SERVICES	CO-PAYMENTS	BENEFIT LIMIT
Laboratory Services	No co-payment	
Radiology Services	No co-payment	Prior authorization required for some services
High-cost Imaging Services (MRI, CT, PET)	$30 co-payment	Prior authorization required
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and Board (includes deliveries/surgeries/radiology services/labs)	$50 co-payment	Co-payments waived if transferred from another inpatient unit Inpatient medical care covered according to medical necessity and subject to prior authorization
PHARMACY		
Medication via Pharmacy	$10 generic and select over-the-counter drugs (Tier 1) $20 preferred brand-name drugs (Tier 2) $40 non-preferred brand-name drugs (Tier 3)	**1-month supply** Co-payments are for first-time prescriptions and refills. Select over-the-counter medications may be covered with a prescription. Supplies for diabetes and asthma are covered and don't have a co-payment.
Medication via Mail	$20 generic and select over-the-counter drugs (Tier 1) $40 preferred brand-name drugs (Tier 2) $120 non-preferred brand-name drugs (Tier 3)	**3-month supply** Co-payments are for first-time prescriptions and refills. Select over-the-counter medications may be covered with a prescription. Supplies for diabetes are covered and don't have a co-payment.
Contraceptives	No co-payment	
EMERGENCY CARE		
Emergency Care	$50 co-payment	Co-payment waived if admitted to a hospital's inpatient unit

COVERED SERVICES	CO-PAYMENTS	BENEFIT LIMIT
MENTAL HEALTH AND/OR SUBSTANCE ABUSE		
Inpatient Mental Health and/or Substance Abuse	$50 co-payment	Inpatient mental health and/or substance abuse services covered according to medical necessity and subject to prior authorization Co-payment waived if transferred from another inpatient unit
Outpatient Mental Health and/or Substance Abuse Methadone Treatment (dosing, counseling, labs)	$10 co-payment No co-payment	After 26 visits per benefit year (January 1 – December 31), prior authorization required No co-payments for methadone-related services
REHABILITATION SERVICES		
Cardiac Rehabilitation	No co-payment	Requires prior authorization
Home Health Care	No co-payment	Requires prior authorization
Inpatient Skilled Nursing Facility (SNF)	No co-payment	Maximum of 100 calendar days total per benefit year (January 1 – December 31) at either (or at a combination of) an inpatient skilled nursing facility or an inpatient rehabilitation hospital Co-payment waived if transferred from another inpatient unit
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	$50 co-payment	
Short-term Outpatient Rehabilitation	$10 co-payment	Maximum of 20 sessions (combined) of physical therapy, occupational therapy, and speech therapy with prior authorization; additional sessions require medical review and prior authorization
Physical/Occupational/Speech Therapy	$10 co-payment	
OTHER BENEFITS		
Ground Ambulance	No co-payment	Emergency transport only; nonemergency transport covered if medically necessary and with prior authorization
Durable Medical Equipment (DME)	No co-payment	Requires prior authorization
Supplies	No co-payment	

COVERED SERVICES	CO-PAYMENTS	BENEFIT LIMIT
Prosthetics	No co-payment	Requires prior authorization
Oxygen and Respiratory Therapy Equipment	No co-payment	Requires prior authorization
Hospice	No co-payment	Requires prior authorization
Orthotics	No co-payment	Requires prior authorization; shoe inserts for diabetics only
Podiatry	$18 co-payment (non-diabetic)	Medically necessary non-routine foot care covered
• People with diabetes	$10 co-payment (non-routine diabetic) $5 co-payment	Routine foot care services for diabetics only
Vision	$10 co-payment (optometrist) $18 co-payment (ophthalmologist)	Coverage for routine eye exams for members once every 24 months (once every 12 months for diabetics) from network ophthalmologists or optometrists. One pair of eyeglasses once every 24 months is also covered; choose from free frame selection, or choose any other frame up to a maximum credit of $80.
Wellness • Preventive visits • Contraceptives • Family Planning • Nutrition Counseling • Prenatal Care • Nurse Midwife	 No co-payment No co-payment No co-payment No co-payment No co-payment No co-payment	Requires prior authorization
CO-PAYMENT MAXIMUMS		
Yearly Co-payment Maximum per Benefit Year per Member		Pharmacy $500 All other co-payments $750

Benefit and co-payment summary for Plan Type III

COVERED SERVICES	CO-PAYMENTS	BENEFIT LIMIT
OUTPATIENT MEDICAL CARE		
Abortion Services	$100 co-payment	
Community Health Center Visits • Primary Care Provider (PCP) • Specialist	 $15 co-payment $22 co-payment	
Office Visits • Preventive care services (inclusive of family planning visits) • Non-preventive office visits • Primary Care Provider (PCP) • Specialist • Eye Care (vision care)	 No co-payment $15 co-payment $22 co-payment $20 co-payment	Coverage for routine eye exams for members once every 24 months (once every 12 months for diabetics) from network ophthalmologists or optometrists. One pair of eyeglasses once every 24 months is also covered; choose from free frame selection, or choose any other frame up to a maximum credit of $80.
Diabetic Specialty Care	$20 co-payment	Co-payment is for services diabetic members get from a specialist (other than routine services a podiatrist provides, see Podiatry)
Outpatient Surgery (outpatient hospital/ambulatory surgery centers)	$125 co-payment	
Laboratory Services	No co-payment	
Radiology Services	No co-payment	Prior authorization required for some services
High-cost Imaging Services (MRI, CT, PET)	$60 co-payment	Prior authorization required
INPATIENT MEDICAL CARE		
Inpatient Medical Care Room and Board (includes deliveries/surgeries/radiology services/labs)	$250 co-payment	Co-payments waived if transferred from another inpatient unit Inpatient medical care covered according to medical necessity and subject to prior authorization

COVERED SERVICES	CO-PAYMENTS	BENEFIT LIMIT
PHARMACY		
Medication via Pharmacy	$12.50 generic and select over-the-counter drugs (Tier 1) $25 preferred brand-name drugs (Tier 2) $50 non-preferred brand-name drugs (Tier 3)	**1-month supply** Co-payments are for first-time prescriptions and refills. Select over-the-counter medications may be covered with a prescription. 10% of cost for diabetes and asthma supplies
Medication via Mail	$25 generic and select over-the-counter drugs (Tier 1) $50 preferred brand-name drugs (Tier 2) $150 non-preferred brand-name drugs (Tier 3)	**3-month supply** Co-payments are for first-time prescriptions and refills. Select over-the-counter medications may be covered with a prescription. 10% of cost for diabetes supplies
Contraceptives	No co-payment	
EMERGENCY CARE		
Emergency Care	$100 co-payment	Co-payment waived if admitted to an inpatient unit of a hospital
MENTAL HEALTH AND/OR SUBSTANCE ABUSE		
Inpatient Mental Health and/or Substance Abuse	$250 co-payment	Inpatient mental health and/or substance abuse services covered according to medical necessity and subject to prior authorization Co-payment waived if transferred from another inpatient unit
Outpatient Mental Health and/or Substance Abuse Methadone Treatment (dosing, counseling, labs)	$15 co-payment No co-payment	After 26 visits per benefit year (January 1 – December 31), prior authorization required No co-payments for methadone-related services
REHABILITATION SERVICES		
Cardiac Rehabilitation	No co-payment	Requires prior authorization

COVERED SERVICES	CO-PAYMENTS	BENEFIT LIMIT
Home Health Care	No co-payment	Requires prior authorization
Inpatient Skilled Nursing Facility (SNF)	No co-payment	Maximum of 100 calendar days total per benefit year (January 1 – December 31) at either (or at a combination of) inpatient skilled nursing facility or inpatient rehabilitation hospital Co-payment waived if transferred from another inpatient unit
Inpatient Rehabilitation Hospital or Chronic Disease Hospital	$250 co-payment	
Short-term Outpatient Rehabilitation	$20 co-payment	Maximum of 20 sessions (combined) of physical therapy, occupational therapy, and speech therapy with prior authorization; additional sessions require medical review and prior authorization
Physical/Occupational/Speech Therapy	$20 co-payment	
OTHER BENEFITS		
Ground Ambulance	No co-payment	Emergency transport only; nonemergency transport covered if medically necessary and with prior authorization
Durable Medical Equipment (DME)	10% of cost	Requires prior authorization
Supplies	10% of cost	
Prosthetics	10% of cost	Requires prior authorization
Oxygen and Respiratory Therapy Equipment	10% of cost	Requires prior authorization
Hospice	No co-payment	Requires prior authorization
Orthotics	No co-payment	Requires prior authorization; shoe inserts for diabetics only
Podiatry	$22 co-payment (non-diabetic)	Medically necessary non-routine foot care covered

COVERED SERVICES	CO-PAYMENTS	BENEFIT LIMIT
• People with diabetes	$20 co-payment (non-routine diabetic) $10 co-payment	Routine foot care services for diabetics only
Vision	$20 co-payment (optometrist) $22 co-payment (ophthalmologist)	Coverage for routine eye exams for members once every 24 months (once every 12 months for diabetics) from network ophthalmologists or optometrists. One pair of eyeglasses once every 24 months is also covered; choose from free frame selection, or choose any other frame up to a maximum credit of $80.
Wellness • Preventive visits • Contraceptives • Family Planning • Nutrition Counseling • Prenatal Care • Nurse Midwife	 No co-payment No co-payment No co-payment No co-payment No co-payment No co-payment	Requires prior authorization
CO-PAYMENT MAXIMUMS		
Yearly Co-payment Maximum per Benefit Year per Member	Pharmacy All other co-payments	$800 $1,500

Health Safety Net (within 300% of poverty level – temporary coverage)

What is the Health Safety Net?

The Health Safety Net is a fund set up to help pay for health services for certain low income uninsured and underinsured individuals. The Health Safety Net used to be called the Uncompensated Care Pool (UCP), or Free Care.

Where can I use the Health Safety Net?

You can use the Health Safety Net at hospitals and community health centers. However, at most hospitals, the doctors bill separately. The Health Safety Net will pay for hospital facility charges (for example beds, nurses, and equipment), but you may have to pay bills for the doctors and for services like lab tests and x-rays. Be sure to check with your doctor first to see if the Health Safety Net will cover all the services you receive, or just some.

How long will I be eligible for the Health Safety Net?

You may have Health Safety Net eligibility for up to a year, but you may receive review forms before the year is over.

I have a letter that says I am eligible for Commonwealth Care. What happens if I do not enroll in Commonwealth Care? Can I still get health services from the Health Safety Net?

If you have been determined eligible for Commonwealth Care, you have 90 days of HSN eligibility starting on your date of application to enroll in a Commonwealth Care plan. If you do not enroll within this time period, you will no longer be eligible for HSN.

I have a deductible listed for my Health Safety Net. Where should I send that payment?

You can pay your deductible to the hospital or community health center after you get services. The hospital or community health center will bill you for the amount that you owe. It is very important to keep track of your payments so that you have a record of when you reach your deductible.

I have Medicare. Am I still eligible for the Health Safety Net?

Yes, if you have Medicare, the Health Safety Net can still pay for services that Medicare does not cover, as long as you get the care at a hospital or community health center. The Health Safety Net pays for your services after Medicare or any other insurance you may have has already been billed.

What are the co-payments for the Health Safety Net?

Patients ages 19 and older who use the Health Safety Net have to pay co-payments for prescription drugs. The copayment amounts are $1 for a generic drug and $3 for a brand-name drug.

Where can I fill my prescriptions with the Health Safety Net?

HSN has a limited number of CHC or hospital outpatient pharmacies in its network and each requires that your prescription be written by a clinician who works at that affiliated facility. In most cases, you will need to see a doctor at the hospital or community health center where the pharmacy is located in order to have your prescription filled there. The Health Safety Net will not pay for prescriptions you get filled at a local retail pharmacy (for example, CVS, Walgreens, etc.) unless they have a special agreement with a neighboring Community Health Center.

I have private insurance with a high hospital deductible. Am I eligible for the Health Safety Net?

Yes, as long as you qualify based on your income. Your provider will first bill your insurance for services. Then your provider will bill you for any deductible required for the Health Safety Net. Only afterwards, will the hospital be able to bill the Health Safety Net for the deductible required by your private insurance. The Health Safety Net will pay for deductibles and coinsurance, but not for co-payments required by private insurance plans.

I had Commonwealth Care, but did not pay my premium. Am I eligible for the Health Safety Net?

No. Patients who fail to pay their Commonwealth Care premiums are not eligible for the Health Safety Net. You may be able to work out a payment plan with the Connector, even after termination. Please contact the Connector at 1-877-MA-ENROLL for more information.

Qualification

Family Size

Who counts in the household?

Everyone potentially counts as long as they are not a child 19 years of age or older. They would count as their own household.

What is a household?

A household is everyone living under one roof that has a connection with someone else. A couple that has been together for years but is not married could be put together to make a household. If they have no tax return together and they have separate addresses you may count them as separate households. Any children that the adults living in the household have custody of are to be counted. If it is a case of split custody like a 50/50 the children would have to go with one or the other custodial parent.

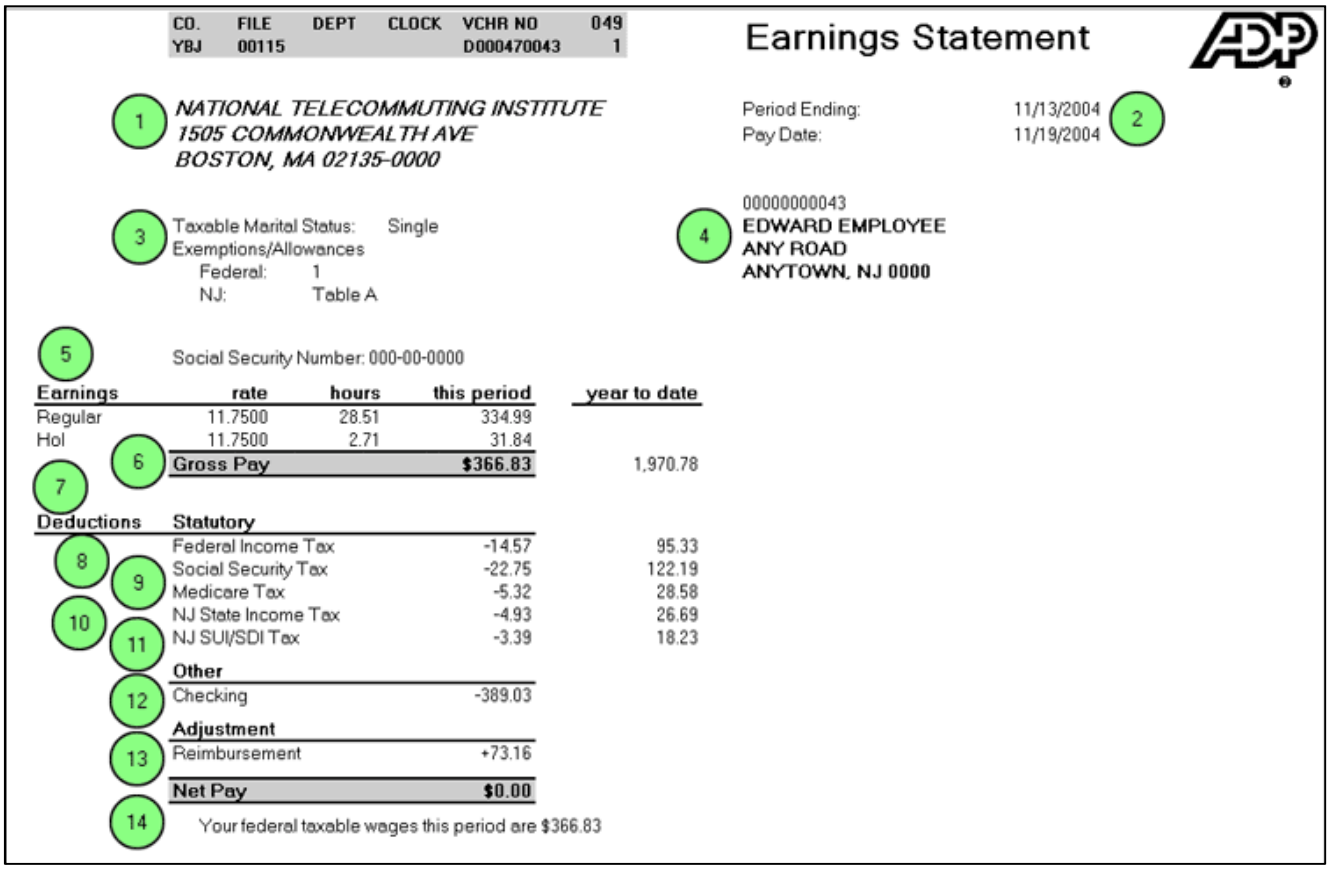
What if a married couple is separated?

In these situations they would count as two households and we would require a letter of separation signed by at least one party.

Household Income

Do they work for someone?

All paychecks received in the household will be counted as income. This includes income made from one of the children. If they receive tips from their position those would count. You will be asking for the GROSS paycheck including tips. This means before taxes are taken out.



CO.	FILE	DEPT	CLOCK	VCHR NO	049
YBJ	00115			D000470043	1

Earnings Statement

ADP

1 *NATIONAL TELECOMMUTING INSTITUTE*
1505 COMMONWEALTH AVE
BOSTON, MA 02135-0000

Period Ending: 11/13/2004
Pay Date: 11/19/2004
2

3 Taxable Marital Status: Single
Exemptions/Allowances
Federal: 1
NJ: Table A

4 00000000043
EDWARD EMPLOYEE
ANY ROAD
ANYTOWN, NJ 0000

5 Social Security Number: 000-00-0000

Earnings	rate	hours	this period	year to date
Regular	11.7500	28.51	334.99	
Hol	11.7500	2.71	31.84	
6 Gross Pay			$366.83	1,970.78

7 Deductions

Statutory		
8 Federal Income Tax	-14.57	95.33
9 Social Security Tax	-22.75	122.19
Medicare Tax	-5.32	28.58
10 NJ State Income Tax	-4.93	26.69
11 NJ SUI/SDI Tax	-3.39	18.23
Other		
12 Checking	-389.03	
Adjustment		
13 Reimbursement	+73.16	
Net Pay	$0.00	

14 Your federal taxable wages this period are $366.83

You would normally just be looking at #6 in the example above, unless there are tips involved and then those need to be included in earnings well.

Insurance offered from employer?

If a client is offered insurance from their employer then we will not be able to get them onto Commonwealth Care. The only way to get them coverage is if they are PT and don't qualify for the health plan at the employer. If they are a student you have to make sure they are not active at school since the school offers a health plan.

Do they own their own business?

Self-Employed

If they are a self-employed person the income you use is their net amount from their Federal Schedule C. If they have more than one entity you must count each separately from the other. The reason for this is that the state doesn't use negative numbers they assign a $1.00 value when negatives are found.

Example: The issue is if a client has two self-employed companies and one he made $50K, and at the other he made negative $20K. The balance on line 12 of the 1040 is $30K. As a single it would look like he qualified. This is incorrect since the state gives negatives a $1.00 figure. The state would say his actual figure was $50,001.00. This would put him well over the limit. See example Schedule C that follows.

S-Corp, Partnership, and LLC

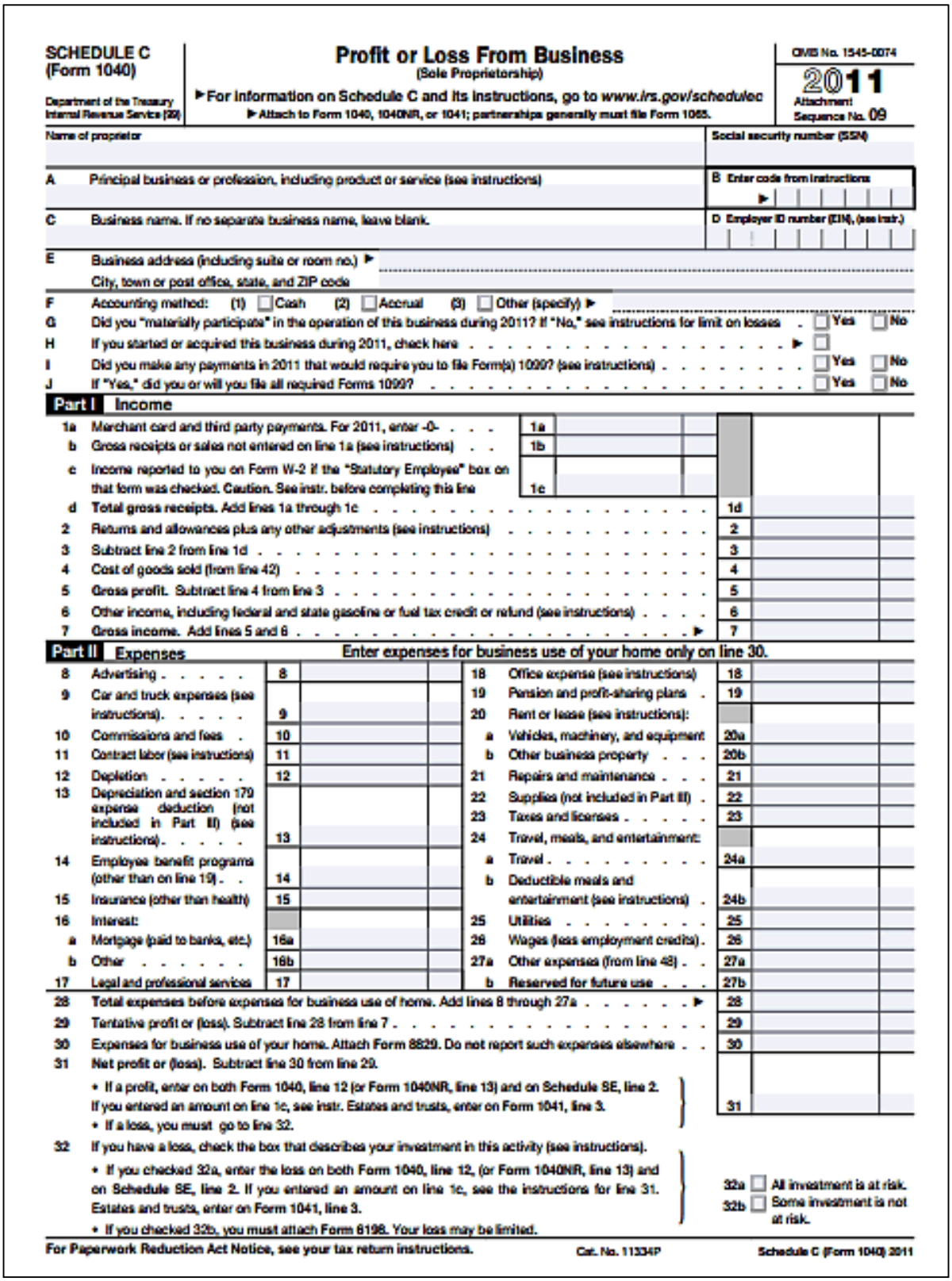
These 3 entities are linked to the shareholders personal tax return. So if one of these businesses has a profit or loss when the corporate return is filled a K-1 is sent to the shareholder for their percentage of ownership.

Example: A landscape company is a LLC and has 4 partners. Each partner has a 25% share. If the company made $100K at the end of the year each partner would get a K-1 for $25K.

This income is reported on Federal Tax form Schedule E page 2. Each of these entities is counted separately from one another and the same rule applies as with Self Employed. Each entity is listed on line 28. See example of Schedule E page 2 that follows.

C-Corp

C-Corp's are not attached to the shareholders in any way. If the company makes a profit then the company pays the tax on the profit. It in no way reflects on the shareholder of officers of the company's income tax return. So the officer can cut a check to themselves as an officer for whatever they choose. Warning if a husband and wife both get checks from the same company it throws up a red flag and the state will ask for corporate returns.



SCHEDULE C (Form 1040)

Department of the Treasury Internal Revenue Service (99)

Profit or Loss From Business

(Sole Proprietorship)

▶ For information on Schedule C and its instructions, go to www.irs.gov/schedulec

▶ Attach to Form 1040, 1040NR, or 1041; partnerships generally must file Form 1065.

OMB No. 1545-0074

2011

Attachment Sequence No. 09

Name of proprietor | Social security number (SSN)

A Principal business or profession, including product or service (see instructions) | B Enter code from instructions ▶

C Business name. If no separate business name, leave blank. | D Employer ID number (EIN), (see instr.)

E Business address (including suite or room no.) ▶

City, town or post office, state, and ZIP code

F Accounting method: (1) ☐ Cash (2) ☐ Accrual (3) ☐ Other (specify) ▶

G Did you "materially participate" in the operation of this business during 2011? If "No," see instructions for limit on losses . ☐ Yes ☐ No

H If you started or acquired this business during 2011, check here ▶ ☐

I Did you make any payments in 2011 that would require you to file Form(s) 1099? (see instructions) ☐ Yes ☐ No

J If "Yes," did you or will you file all required Forms 1099? ☐ Yes ☐ No

Part I Income

1a	Merchant card and third party payments. For 2011, enter -0-	1a		
b	Gross receipts or sales not entered on line 1a (see instructions)	1b		
c	Income reported to you on Form W-2 if the "Statutory Employee" box on that form was checked. Caution. See instr. before completing this line	1c		
d	Total gross receipts. Add lines 1a through 1c			1d
2	Returns and allowances plus any other adjustments (see instructions)			2
3	Subtract line 2 from line 1d			3
4	Cost of goods sold (from line 42)			4
5	Gross profit. Subtract line 4 from line 3			5
6	Other income, including federal and state gasoline or fuel tax credit or refund (see instructions)			6
7	Gross income. Add lines 5 and 6 ▶			7

Part II Expenses

Enter expenses for business use of your home only on line 30.

8	Advertising	8		18	Office expense (see instructions)	18	
9	Car and truck expenses (see instructions)	9		19	Pension and profit-sharing plans	19	
10	Commissions and fees	10		20	Rent or lease (see instructions):		
11	Contract labor (see instructions)	11		a	Vehicles, machinery, and equipment	20a	
12	Depletion	12		b	Other business property	20b	
13	Depreciation and section 179 expense deduction (not included in Part III) (see instructions)	13		21	Repairs and maintenance	21	
				22	Supplies (not included in Part III)	22	
				23	Taxes and licenses	23	
14	Employee benefit programs (other than on line 19)	14		24	Travel, meals, and entertainment:		
				a	Travel	24a	
15	Insurance (other than health)	15		b	Deductible meals and entertainment (see instructions)	24b	
16	Interest:			25	Utilities	25	
a	Mortgage (paid to banks, etc.)	16a		26	Wages (less employment credits)	26	
b	Other	16b		27a	Other expenses (from line 48)	27a	
17	Legal and professional services	17		b	Reserved for future use	27b	

28	Total expenses before expenses for business use of home. Add lines 8 through 27a ▶		28
29	Tentative profit or (loss). Subtract line 28 from line 7		29
30	Expenses for business use of your home. Attach Form 8829. Do not report such expenses elsewhere		30
31	Net profit or (loss). Subtract line 30 from line 29.		
	• If a profit, enter on both Form 1040, line 12 (or Form 1040NR, line 13) and on Schedule SE, line 2. If you entered an amount on line 1c, see instr. Estates and trusts, enter on Form 1041, line 3.		31
	• If a loss, you must go to line 32.		
32	If you have a loss, check the box that describes your investment in this activity (see instructions).		
	• If you checked 32a, enter the loss on both Form 1040, line 12, (or Form 1040NR, line 13) and on Schedule SE, line 2. If you entered an amount on line 1c, see the instructions for line 31. Estates and trusts, enter on Form 1041, line 3.		32a ☐ All investment is at risk. 32b ☐ Some investment is not at risk.
	• If you checked 32b, you must attach Form 6198. Your loss may be limited.		

For Paperwork Reduction Act Notice, see your tax return instructions. Cat. No. 11334P Schedule C (Form 1040) 2011

Heartland FINANCIAL AN INTEGRITY COMPANY

Schedule E (Form 1040) 2011 Attachment Sequence No. 13 Page 2

Name(s) shown on return. Do not enter name and social security number if shown on other side. Your social security number

Caution. The IRS compares amounts reported on your tax return with amounts shown on Schedule(s) K-1.

Part II Income or Loss From Partnerships and S Corporations Note. If you report a loss from an at-risk activity for which any amount is not at risk, you must check the box in column (e) on line 28 and attach Form 6198. See instructions.

27 Are you reporting any loss not allowed in a prior year due to the at-risk or basis limitations, a prior year unallowed loss from a passive activity (if that loss was not reported on Form 8582), or unreimbursed partnership expenses? If you answered "Yes," see instructions before completing this section. ☐ Yes ☐ No

28	(a) Name	(b) Enter P for partnership; S for S corporation	(c) Check if foreign partnership	(d) Employer identification number	(e) Check if any amount is not at risk
A			☐		☐
B			☐		☐
C			☐		☐
D			☐		☐

	Passive Income and Loss		Nonpassive Income and Loss		
	(f) Passive loss allowed (attach Form 8582 if required)	(g) Passive income from Schedule K-1	(h) Nonpassive loss from Schedule K-1	(i) Section 179 expense deduction from Form 4562	(j) Nonpassive income from Schedule K-1
A					
B					
C					
D					
29a Totals					
b Totals					

30	Add columns (g) and (j) of line 29a	30	
31	Add columns (f), (h), and (i) of line 29b	31	( )
32	Total partnership and S corporation income or (loss). Combine lines 30 and 31. Enter the result here and include in the total on line 41 below	32	

Part III Income or Loss From Estates and Trusts

33	(a) Name	(b) Employer identification number
A		
B		

	Passive Income and Loss		Nonpassive Income and Loss	
	(c) Passive deduction or loss allowed (attach Form 8582 if required)	(d) Passive income from Schedule K-1	(e) Deduction or loss from Schedule K-1	(f) Other income from Schedule K-1
A				
B				
34a Totals				
b Totals				

35	Add columns (d) and (f) of line 34a	35	
36	Add columns (c) and (e) of line 34b	36	( )
37	Total estate and trust income or (loss). Combine lines 35 and 36. Enter the result here and include in the total on line 41 below	37	

Part IV Income or Loss From Real Estate Mortgage Investment Conduits (REMICs)—Residual Holder

38	(a) Name	(b) Employer identification number	(c) Excess inclusion from Schedules Q, line 2c (see instructions)	(d) Taxable income (net loss) from Schedules Q, line 1b	(e) Income from Schedules Q, line 3b

39	Combine columns (d) and (e) only. Enter the result here and include in the total on line 41 below	39	

Part V Summary

40	Net farm rental income or (loss) from Form 4835. Also, complete line 42 below	40	
41	Total income or (loss). Combine lines 26, 32, 37, 39, and 40. Enter the result here and on Form 1040, line 17, or Form 1040NR, line 18 ▶	41	
42	Reconciliation of farming and fishing income. Enter your gross farming and fishing income reported on Form 4835, line 7; Schedule K-1 (Form 1065), box 14, code B; Schedule K-1 (Form 1120S), box 17, code U; and Schedule K-1 (Form 1041), line 14, code F (see instructions)	42	
43	Reconciliation for real estate professionals. If you were a real estate professional (see instructions), enter the net income or (loss) you reported anywhere on Form 1040 or Form 1040NR from all rental real estate activities in which you materially participated under the passive activity loss rules	43	

Schedule E (Form 1040) 2011

Heartland FINANCIAL AN INTEGRITY COMPANY

Taxable Interest & Dividends

Taxable interest & dividends (Line 8 and 9 on Federal 1040 tax form) both count towards the yearly household income calculation.

******* Money Finder Moment - Don't Miss It *******

IRA Distributions, Pensions and Annuities

IRA distribution, pensions and annuities (Line 15 and 16 Federal 1040). If you are seeing money here it is because they took a one-time distribution or a spouse is older and taking their retirement.

******* Another Money Finder Moment. Not as likely, but Possible *******

See Federal Form 1040 that follows.

Real Estate

Real Estate is reported on the (Federal Schedule E, page 1). The rule with real estate is that the state combines all properties and just looks at the net of all the properties combined. You will find most property owners don't show a profit. See Schedule E (Line 26) that follows.

Social Security

Social Security will be encountered in a couple areas. Those who are collecting due to disability and have not received Medicare A&B yet or if a spouse who is older and collecting SS. In both situations the income counts towards the household's income.

Child Support & Alimony

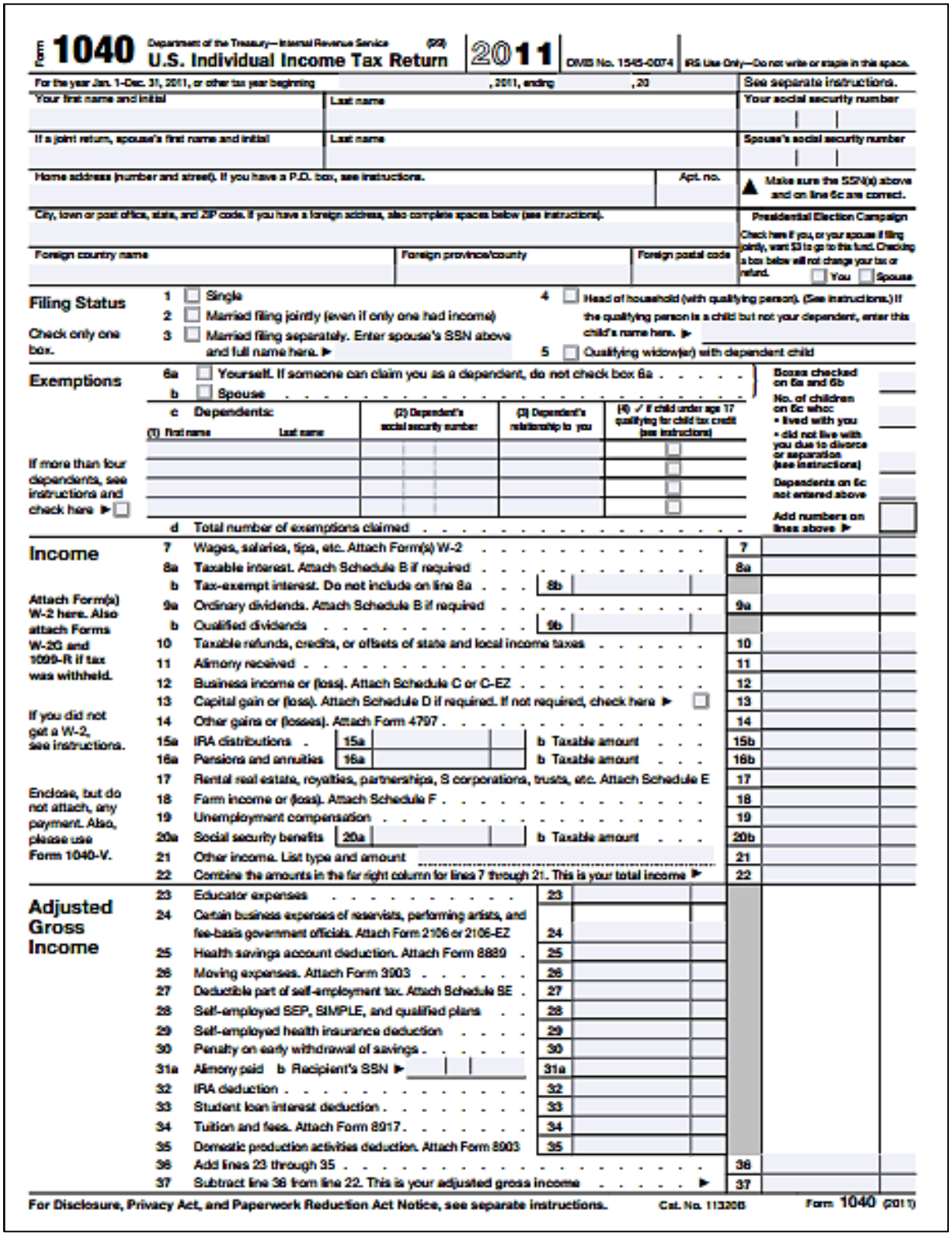
Child support and alimony are both counted towards household income.

Unemployment

If unemployment is being received the only way to get a non-unemployment plan MSP (Medical Security Plan) is to get a letter saying that the person collecting is not eligible for MSP. That letter along with a copy of the weekly unemployment check would allow them to apply.

One Time Money?

Capital Gains, IRA or Annuity Distribution are all forms of one time money reaching a household. These do not count towards the household income.



Form **1040** Department of the Treasury—Internal Revenue Service (99) **U.S. Individual Income Tax Return** **2011** OMB No. 1545-0074 IRS Use Only—Do not write or staple in this space.

For the year Jan. 1–Dec. 31, 2011, or other tax year beginning , 2011, ending , 20 See separate instructions.

Your first name and initial | Last name | Your social security number

If a joint return, spouse's first name and initial | Last name | Spouse's social security number

Home address (number and street). If you have a P.O. box, see instructions. | Apt. no. | Make sure the SSN(s) above and on line 6c are correct.

City, town or post office, state, and ZIP code. If you have a foreign address, also complete spaces below (see instructions). | Presidential Election Campaign

Foreign country name | Foreign province/county | Foreign postal code

Check here if you, or your spouse if filing jointly, want $3 to go to this fund. Checking a box below will not change your tax or refund. ☐ You ☐ Spouse

Filing Status Check only one box.

1 ☐ Single
2 ☐ Married filing jointly (even if only one had income)
3 ☐ Married filing separately. Enter spouse's SSN above and full name here. ▶
4 ☐ Head of household (with qualifying person). (See instructions.) If the qualifying person is a child but not your dependent, enter this child's name here. ▶
5 ☐ Qualifying widow(er) with dependent child

Exemptions

6a ☐ Yourself. If someone can claim you as a dependent, do not check box 6a
b ☐ Spouse
c Dependents: (1) First name Last name | (2) Dependent's social security number | (3) Dependent's relationship to you | (4) ✓ if child under age 17 qualifying for child tax credit (see instructions)

If more than four dependents, see instructions and check here ▶ ☐

d Total number of exemptions claimed

Boxes checked on 6a and 6b
No. of children on 6c who:
• lived with you
• did not live with you due to divorce or separation (see instructions)
Dependents on 6c not entered above
Add numbers on lines above ▶

Income

Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.

If you did not get a W-2, see instructions.

Enclose, but do not attach, any payment. Also, please use Form 1040-V.

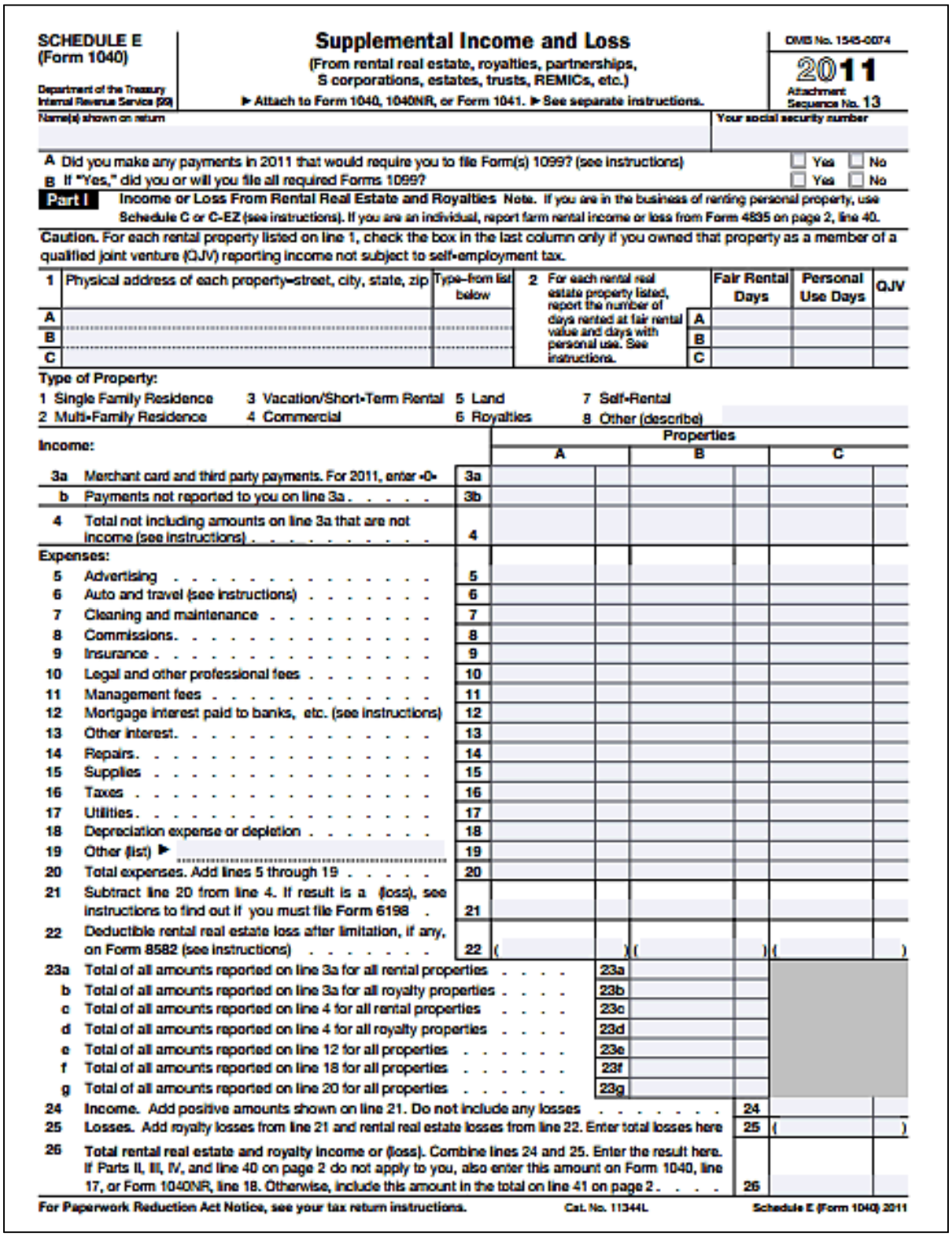
7	Wages, salaries, tips, etc. Attach Form(s) W-2		7
8a	Taxable interest. Attach Schedule B if required		8a
b	Tax-exempt interest. Do not include on line 8a	8b	
9a	Ordinary dividends. Attach Schedule B if required		9a
b	Qualified dividends	9b	
10	Taxable refunds, credits, or offsets of state and local income taxes		10
11	Alimony received		11
12	Business income or (loss). Attach Schedule C or C-EZ		12
13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ ☐		13
14	Other gains or (losses). Attach Form 4797		14
15a	IRA distributions 15a	b Taxable amount	15b
16a	Pensions and annuities 16a	b Taxable amount	16b
17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E		17
18	Farm income or (loss). Attach Schedule F		18
19	Unemployment compensation		19
20a	Social security benefits 20a	b Taxable amount	20b
21	Other income. List type and amount		21
22	Combine the amounts in the far right column for lines 7 through 21. This is your total income ▶		22

Adjusted Gross Income

23	Educator expenses	23	
24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24	
25	Health savings account deduction. Attach Form 8889	25	
26	Moving expenses. Attach Form 3903	26	
27	Deductible part of self-employment tax. Attach Schedule SE	27	
28	Self-employed SEP, SIMPLE, and qualified plans	28	
29	Self-employed health insurance deduction	29	
30	Penalty on early withdrawal of savings	30	
31a	Alimony paid b Recipient's SSN ▶	31a	
32	IRA deduction	32	
33	Student loan interest deduction	33	
34	Tuition and fees. Attach Form 8917	34	
35	Domestic production activities deduction. Attach Form 8903	35	
36	Add lines 23 through 35		36
37	Subtract line 36 from line 22. This is your adjusted gross income ▶		37

For Disclosure, Privacy Act, and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 11320B Form 1040 (2011)

Heartland FINANCIAL AN INTEGRITY COMPANY



SCHEDULE E (Form 1040)

Department of the Treasury Internal Revenue Service (99)

Supplemental Income and Loss

(From rental real estate, royalties, partnerships, S corporations, estates, trusts, REMICs, etc.)

▶ Attach to Form 1040, 1040NR, or Form 1041. ▶ See separate instructions.

OMB No. 1545-0074

2011

Attachment Sequence No. 13

Name(s) shown on return

Your social security number

A Did you make any payments in 2011 that would require you to file Form(s) 1099? (see instructions) ☐ Yes ☐ No

B If "Yes," did you or will you file all required Forms 1099? ☐ Yes ☐ No

Part I Income or Loss From Rental Real Estate and Royalties Note. If you are in the business of renting personal property, use Schedule C or C-EZ (see instructions). If you are an individual, report farm rental income or loss from Form 4835 on page 2, line 40.

Caution. For each rental property listed on line 1, check the box in the last column only if you owned that property as a member of a qualified joint venture (QJV) reporting income not subject to self-employment tax.

	1 Physical address of each property—street, city, state, zip	Type—from list below	2 For each rental real estate property listed, report the number of days rented at fair rental value and days with personal use. See instructions.		Fair Rental Days	Personal Use Days	QJV
A				A			
B				B			
C				C			

Type of Property:

1 Single Family Residence 3 Vacation/Short-Term Rental 5 Land 7 Self-Rental

2 Multi-Family Residence 4 Commercial 6 Royalties 8 Other (describe)

Income:		Properties A	Properties B	Properties C
3a Merchant card and third party payments. For 2011, enter -0-	3a			
b Payments not reported to you on line 3a	3b			
4 Total not including amounts on line 3a that are not income (see instructions)	4			
Expenses:				
5 Advertising	5			
6 Auto and travel (see instructions)	6			
7 Cleaning and maintenance	7			
8 Commissions	8			
9 Insurance	9			
10 Legal and other professional fees	10			
11 Management fees	11			
12 Mortgage interest paid to banks, etc. (see instructions)	12			
13 Other interest	13			
14 Repairs	14			
15 Supplies	15			
16 Taxes	16			
17 Utilities	17			
18 Depreciation expense or depletion	18			
19 Other (list) ▶	19			
20 Total expenses. Add lines 5 through 19	20			
21 Subtract line 20 from line 4. If result is a (loss), see instructions to find out if you must file Form 6198	21			
22 Deductible rental real estate loss after limitation, if any, on Form 8582 (see instructions)	22	( )	( )	( )

23a Total of all amounts reported on line 3a for all rental properties	23a		
b Total of all amounts reported on line 3a for all royalty properties	23b		
c Total of all amounts reported on line 4 for all rental properties	23c		
d Total of all amounts reported on line 4 for all royalty properties	23d		
e Total of all amounts reported on line 12 for all properties	23e		
f Total of all amounts reported on line 18 for all properties	23f		
g Total of all amounts reported on line 20 for all properties	23g		
24 Income. Add positive amounts shown on line 21. Do not include any losses	24		
25 Losses. Add royalty losses from line 21 and rental real estate losses from line 22. Enter total losses here	25	( )	
26 Total rental real estate and royalty income or (loss). Combine lines 24 and 25. Enter the result here. If Parts II, III, IV, and line 40 on page 2 do not apply to you, also enter this amount on Form 1040, line 17, or Form 1040NR, line 18. Otherwise, include this amount in the total on line 41 on page 2	26		

For Paperwork Reduction Act Notice, see your tax return instructions. Cat. No. 11344L Schedule E (Form 1040) 2011

Heartland FINANCIAL AN INTEGRITY COMPANY

Citizenship

Are there any citizenship requirements?

Only citizens and those with a permanent resident card are allowed to enroll in state programs.

Forms

There are a number of forms you will use daily to enroll clients in state health programs. You will find examples of the various forms we use on the pages that follow. You will need to become very familiar with these forms and their use.

Eligibility Review Form

Page 1 Eligibility Review Form (Fill in all household members' information)

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

Eligibility Review Form

HealthConnector CommonwealthCare

FOR OFFICE USE ONLY
Date received:

MassHealth will use the information on this form to review your eligibility for **MassHealth**, the **Children's Medical Security Plan (CMSP)**, **Healthy Start**, **Commonwealth Care**, and the **Health Safety Net**. You do not have to be a U.S. citizen/national to get these benefits. **Please print clearly.** Please answer **all** questions and fill out all sections that apply to you and your family. If you need more space to finish any section on this form, please use a separate sheet of paper (include your name and social security number), and attach it to this form. See enclosed notice for other instructions and important information.

Head of Household

1.

Last name	First name	MI	Street address	City	State	Zip

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

Does this person want benefits? ☐ yes ☐ no If **yes**, is this person a U.S. citizen/national? ☐ yes ☐ no	Social security number*	Date of birth / /	Gender ☐ M ☐ F	Race *(optional)*

Spoken language choice	Written language choice	Ethnicity *(optional)*	Telephone numbers *(List work number only if we can call you at work.)* Home/Cell: ( ) Work: ( )

Other Family Members

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

2.

Last name	First name	MI	Does this person want benefits? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen/national? ☐ yes ☐ no	Social security number*	Date of birth / /

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

3.

Last name	First name	MI	Does this person want benefits? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen/national? ☐ yes ☐ no	Social security number*	Date of birth / /

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

4.

Last name	First name	MI	Does this person want benefits? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen/national? ☐ yes ☐ no	Social security number*	Date of birth / /

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

5.

Last name	First name	MI	Does this person want benefits? ☐ yes ☐ no	If **yes**, is this person a U.S. citizen/national? ☐ yes ☐ no	Social security number*	Date of birth / /

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

Pregnancy

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

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

American Indian/Alaska Native

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

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

If **yes**, names: _____

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

ERV-5 (Rev. 01/11)

1

Heartland FINANCIAL AN INTEGRITY COMPANY

Page 2 Eligibility Review Form (This is where you report job information)

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

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

Working Income (You must fill out this section.)

1. **Name**

▶ Is this person currently working or seasonally employed? **(You must answer this question.)** . . . . . ☐ yes ☐ no
If **yes**, fill out the **Employer Information** section below.
If **no**, answer the next two questions below. You do not have to fill out the "Employer Information" section below.

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

Employer Information

Employer name, address, and telephone number	Type of work *(Check all that apply.)*		For office use only (indicate weekly, biweekly, semimonthly, or monthly)	
	☐ full-time	☐ day labor	$	
	☐ part-time	☐ seasonal yearly wage: $ _____	$	
	☐ self-employed	☐ sheltered workshop yearly wage: $ _____		

Number of hours per week	Weekly pay before deductions	Date began getting this amount of pay	HID		
	$	/ /		Hrs.	
				Hrs.	

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

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

☒ **Send proof** of income, like a copy of two recent pay stubs. If self-employed, see the MassHealth Member Booklet for information about the needed proof.

2. **Name**

▶ Is this person currently working or seasonally employed? **(You must answer this question.)** . . . . . ☐ yes ☐ no
If **yes**, fill out the **Employer Information** section below.
If **no**, answer the next two questions below. You do not have to fill out the "Employer Information" section below.

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

Employer Information

Employer name, address, and telephone number	Type of work *(Check all that apply.)*		For office use only (indicate weekly, biweekly, semimonthly, or monthly)	
	☐ full-time	☐ day labor	$	
	☐ part-time	☐ seasonal yearly wage: $ _____	$	
	☐ self-employed	☐ sheltered workshop yearly wage: $ _____		

Number of hours per week	Weekly pay before deductions	Date began getting this amount of pay	HID		
	$	/ /		Hrs.	
				Hrs.	

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

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

☒ **Send proof** of income, like a copy of two recent pay stubs. If self-employed, see the MassHealth Member Booklet for information about the needed proof.

2

Page 3 Eligibility Review Form (Rental income and all other income is reported here)

Nonworking Income (You must fill out this section.)

Rental Income

REN

▶ Do you or any family member get rental income? **(You must answer this question.)** . . . . . ☐ yes ☐ no
If **yes**, enter the monthly amount of rental income (before taxes and deductions) on this line. $ _____

Name of person getting rental income

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

✉ **Send proof of rental income.**

Unemployment Benefits

UNI

▶ Are you or any family member getting an unemployment check? **(You must answer this question.)** . . . . . ☐ yes ☐ no
If **yes**, fill out this section and answer all questions. If **no**, go to the next section (*Other Nonworking Income*).

✉ **Send proof of unemployment benefits.**

Name of person getting unemployment benefits

▶ Is this check from the Commonwealth of Massachusetts? . . . . . ☐ yes ☐ no CC
If **yes**, in the 12 months before this person became unemployed, did this person work for an employer in Massachusetts? . . . . ☐ yes ☐ no CC
(Do not include federal employers, such as the U.S. Postal Service.)
Note: You must enter the monthly amount of unemployment benefits (before taxes and deductions) on this line. $ _____

Other Nonworking Income

UNI

▶ Do you or any family member have any other income? **(You must answer this question.)** . . . . . ☐ yes ☐ no
If **yes**, fill out this section.
If **no**, go to the next section (*College Student*).

▶ Please describe the source of the income (where it comes from) for each family member. If anyone has more than one source, list on separate lines.

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

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

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

College Student (You must fill out this section.)

▶ Are you or any family member a college student? **(You must answer this question.)** . . . . . ☐ yes ☐ no
If **yes**, fill out this section and answer all questions.
If **no**, go to the next section (*Health Insurance You Have Now and Subsidized Health Insurance You May Be Eligible For*).

Name

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

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

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

▶ Do you or any family member get Medicare benefits? . . . . . ☐ yes ☐ no
If **yes**, name(s): _____ Claim number(s): _____
▶ Do you or any family member have health insurance other than Medicare? . . . . . ☐ yes ☐ no
If **yes**, fill out both **Part A** and **Part B** on page 4.
If **no**, fill out only **Part B** on page 4.

3

Please go to the next page. ▶

Heartland FINANCIAL AN INTEGRITY COMPANY

Page 4 Eligibility Review Form (This will only be used for Premium Assistance)

Health Insurance You Have Now and Subsidized Health Insurance You May Be Eligible For (cont.)

HIN

Part A: Health Insurance You Have Now

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

Names of covered family members

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

Policy start date / /

Policy number

Group number (if known)

Employer or union name

Policyholder contribution to premium costs *(Complete one.)*

$ _____ per week $ _____ per quarter $ _____ per month

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

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

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

Part B: Subsidized Health Insurance You May Be Eligible For

SIA

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

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

▶ Are you or any family member in one of the uniformed services? . . . . . ☐ yes ☐ no

If **yes**, fill out the section below.

(The uniformed services are the Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Services, National Oceanic and Atmospheric Administration, and the National Guard or Reserves.)

Name: _____

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

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

Name: _____

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

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

HIV Information (optional)

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

▶ Do you or any family member who is HIV positive want to apply for these benefits? . . . . . ☐ yes ☐ no

If **yes**, fill out this section. If **no**, go to the next section *(Injury, Illness, or Disability)*.

☒ **Send proof** of income, U.S. citizenship/national status and identity, or qualified alien status to see if you can get benefits for up to 60 days while we wait for you to send us proof of your HIV-positive status. For more information, see the MassHealth Member Booklet.

Name(s): _____

For office use only

Injury, Illness, or Disability

▶ Do you or any family member have an injury, illness, or disability (including a disabling mental-health condition)? (If legally blind, answer **yes**.) . . . . . ☐ yes ☐ no

If **yes**, fill out this section. If **no**, go to the next section *(Accident or Injury)*.

Name	For office use only: Supp to DES	Dis type
▶ Does this person have an injury, illness, or disability (including a disabling mental-health condition) that has lasted or is expected to last for at least 12 months? . . . . . ☐ yes ☐ no		
▶ Does this person get money from Social Security for a disability? . . . . . ☐ yes ☐ no		
▶ Has this person ever gotten Supplemental Security Income (SSI)? . . . . . ☐ yes ☐ no		
▶ Is this person legally blind? . . . . . ☐ yes ☐ no		
☒ If **yes, send a copy** of the Certificate of Blindness.		

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

4

Page 5 Eligibility Review Form (This is used for single parent family households)

Accident or Injury

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

If **yes, you must answer all three questions in this section.**

If **no**, go to the next section *(Absent Parent)*.

Name	For office use only
▶ Are you or any family member getting or applying for benefits because of an accident or injury that someone else might be responsible for? . . . . . ☐ yes ☐ no ▶ Do you or any family member have an injury, illness, or disability that was caused by someone else, or that could be covered by someone else's insurance or the family member's own insurance, other than health insurance (like homeowner's or auto insurance)? . . . . . ☐ yes ☐ no ▶ Has a lawsuit, a workers' compensation claim, or an insurance claim for an accident or injury been filed for you or any family member who is getting or applying for benefits? . . . . . ☐ yes ☐ no	

Absent Parent

▶ Has any child in the household been adopted by a single parent or has a parent who is deceased or unknown?. . . . . ☐ yes ☐ no

▶ Does any child in the family have a parent who does not live with you who is not included in the previous question? . . . . . ☐ yes ☐ no

If **no**, go to the next section *(U.S. Citizenship/National Status and Immigration Status)*.

PART A—Cooperation

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

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

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

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

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

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

Name	Name
Name	Name

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

5

Page 6 Eligibility Review Form (Used to gather what info you can on absent parent. *Custodial parent signs)

Absent Parent (cont.)

ABS

PART C—Good Cause

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

If **yes**, list the name(s) of the child or children whose absent parent(s) you do not want to give us information about, and check one of the boxes below for the reason that applies to the child or children.
If **no**, fill out Part D—Absent-Parent Information—on the next page.

Name(s): _____

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

Name(s): _____

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

PART D—Absent-Parent Information (if known)

1.

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

► Is there a medical-support order? . . . . . ☐ yes ☐ no
Relationship to child: ☐ mother ☐ father ☐ other: _____ Driver's license number:* _____
Names of children of this absent parent: _____
Name and address of absent-parent's employer: _____

*Required, if obtainable and one has been issued.

2.

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

► Is there a medical-support order? . . . . . ☐ yes ☐ no
Relationship to child: ☐ mother ☐ father ☐ other: _____ Driver's license number:* _____
Names of children of this absent parent: _____
Name and address of absent-parent's employer: _____

*Required, if obtainable and one has been issued.

PART E—Signature for Absent Parent section

I am the parent whom the child lives with (custodial parent) or legal guardian, and I understand that by signing below I assign my rights and give permission to MassHealth and DOR to go after medical support from the absent parent of any child under age 19 who is living with me and applying for or getting MassHealth. I also agree to cooperate with MassHealth and DOR in this process, as explained in Part A—Cooperation—on page 5. I certify under penalty of perjury that the information in this section is correct and complete to the best of my knowledge.

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

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

U.S. Citizenship/National Status and Immigration Status

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

U.S. citizens

► For applicants or members **born in Massachusetts** who want help getting proof of their U.S. citizenship, please fill out **the section on the next page for the family member who is applying for or getting benefits, was born in Massachusetts, and wants help getting proof of his or her U.S. citizenship through the Massachusetts Registry of Vital Records and Statistics.**

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

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

6

Please go to the next page. ►

Page 7 Eligibility Review Form (Only needed if a permanent resident)

U.S. Citizenship/National Status and Immigration Status (cont.)

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

Persons who are not U.S. citizens/nationals

- If you or any family member applying for or getting MassHealth or Commonwealth Care answers no to all three of the following questions and fits any of the immigration status codes listed below, numbered 1 through 17, **you must fill out the chart below.**

List *all* immigration statuses that have applied to each person since that person entered the U.S.

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

See the MassHealth Member Booklet for a more complete description of immigration statuses.

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

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

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

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

- If you or any other family member applying for or getting benefits does not fit any of the immigration status codes listed above, numbered 1 through 17, you or that family member may get only one or more of the following: MassHealth Limited, Healthy Start, CMSP, or the Health Safety Net.
  Note: Family members who want to get only one or more of the following: MassHealth Limited, CMSP, Healthy Start, or the Health Safety Net, do not have to give us a social security number. We will not match their names with any other agency including the Department of Homeland Security (DHS). You do not need to send proof of their immigration status. **But you must list their names below.** MassHealth Limited pays for emergency services only. See the MassHealth Member Booklet for more information.
- List below the names of family members who want to get only one or more of the following: MassHealth Limited, Healthy Start, CMSP, or the Health Safety Net.

Names	For office use only	Names	For office use only

7

You must read page 8 carefully, and sign and date it ▶

Page 8 Eligibility Review Form (***Signature page. If two adults in household, BOTH must sign.)

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

This form will be used to review your eligibility for MassHealth, the Children's Medical Security Plan (CMSP), Healthy Start, Commonwealth Care, and the Health Safety Net.

I give permission for my current and former employers and health insurers to release to MassHealth, the Commonwealth Health Insurance Connector Authority ("the Health Connector"), and the Division of Health Care Finance and Policy any and all information they have about my health-insurance coverage and health-insurance coverage for members of my family group. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to me or members of my family group.

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

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

If I or any members of my family are found to be eligible for assistance through MassHealth, the Health Connector, or the Division of Health Care Finance and Policy, I give permission to MassHealth, the Health Connector (Commonwealth Care), or the Division of Health Care Finance and Policy (the Health Safety Net) to get any records or data: (1) to prove any information given on this review form, or other information I give while I am a member; (2) to document medical services claimed or provided; and (3) to support continued eligibility.

I understand that if I am aged 55 or older, MassHealth may be able to get back money from my estate after I die. Under current practice, this does not apply to Commonwealth Care.

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

I understand that if I or any members of my family are eligible for MassHealth, CMSP, Healthy Start, Commonwealth Care, or the Health Safety Net, I must tell MassHealth of any changes in my or my family's income or employment, family size, health-insurance coverage, health-insurance premiums, and immigration status, or of changes in any other information I gave on this review form within 10 calendar days of learning of the change.

I also understand that by signing below, I give permission to MassHealth to go after and collect third-party payments for medical care and medical support from the parent of any child under age 19 who is getting or applying for benefits.

If I or any members of my family are eligible for MassHealth or CMSP, I understand that I may have to pay a premium set by MassHealth. I also understand that if I fail to pay the premium, MassHealth may refer my past due balance to the State Intercept Program (SIP). If I am a certain American Indian or Alaska Native eligible for MassHealth Family Assistance, I may not have to pay any premiums under MassHealth Family Assistance. If I or any members of my family are eligible for Commonwealth Care, I understand that I may have to pay a premium set by the Health Connector.

I certify that I have read or had read to me the information on this review form, including the enclosed information about filling out the form, and the information in the MassHealth Member Booklet, and that I understand my rights and responsibilities. I further certify under the penalty of perjury that the information on this review form is correct and complete to the best of my knowledge.

If you are acting on behalf of someone in filling out this review form, the enclosed MassHealth Eligibility Representative Designation Form must also be filled out and sent back with this review form. Your signature on this review form as an eligibility representative certifies that the information on this review form is correct and complete to the best of your knowledge.

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

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

X _____ _____

Signature of member/applicant or eligibility representative — Date

X _____ _____

Signature of member/applicant or eligibility representative — Date

8

Income Verification

You will need one paystub from any job held, lower the better. If they have any income other than paystub you will need the current year Federal tax return. If the current year Federal tax return puts them over the income guideline, but during the current year their income has dropped a YTD profit and loss may be completed and it will trump the last year's tax return. Alimony requires a copy of the court order. Child support requires proof in the form of a letter and a canceled check or court order. Pensions, Social Security, Annuities and Unemployment will require statements showing the monthly amount being received.

Citizenship and Identity

Citizenship and identity can be proven two ways.

1. Passport

2. Birth Certificate and Driver's License

(Note: children will need a student id if over 14 with no license)

Bank Draft Form

Strategic Transitions

CONTACT PERSON	EMPLOYER	
STREET ADDRESS		EFFECTIVE DATE
E-MAIL ADDRESS	CELL PHONE NUMBER	CONTACT NUMBER

1. **One Time Enrollment Fee:** $ _____
2. **Monthly Administration & Consulting Fee (This fee is collected after approval):** $ _____
3. **AFLAC Premium Deduction:** $ _____

TODAYS TOTAL: $ _____ **NEXT MONTHS TOTAL:** $ _____

PAYMENT OPTIONS:

☐ ELECTRONIC FUNDS TRANSFER **(Fill out EFT Authorization Form below)**

MONTHLY PAYMENT: Please EFT my bank account for the monthly premium, administration fee and association dues. This will occur between the 15th & 20th of the month prior to the next months coverage. **There is a $10 insufficient funds fee**

☐ CHECK OR MONEY ORDER

INITIAL PAYMENT: I am paying my first month's premium, administration fee, association dues and one time enrollment fee via check/money order. I am sending my check or money order with my completed Enrollment Form. **There is a $10 insufficient funds fee**

MONTHLY PAYMENT: I would like to receive a monthly invoice to pay my monthly premium, administration fee and association dues.

I understand an **additional monthly billing fee of $10** will be charged to me to receive a monthly invoice.

ACCOUNT HOLDER SIGNATURE (REQUIRED if paying via EFT)	PRINT NAME	DATE
X		

EFT AUTHORIZATION FORM

BANK NAME	BANK ROUTING NUMBER	BANK ACCOUNT NUMBER

Voided check is required and must be legible. No monthly charge for EFT.

PLEASE ATTACH A CHECK MARKED

VOID

TO ENSURE ACCURACY

I understand this authority is to remain in full force and effect until the company has received written notification from me of its termination in such time and such manner as to afford the company and depositor a reasonable opportunity to act on it. I have the right to stop payment of a debit entry (deduction) by notification to HPS three business days or more before this payment is scheduled to be made. Please be aware that your bank statement will reflect the debit as (HealthPlan)

Rep Name	Date	Phone

Heartland FINANCIAL AN INTEGRITY COMPANY

Disclaimer Form

I agree to use Strategic Transitions ("ST") as my designated representative to the state.

I fully understand that these resources are available to me through the state of MA, and it is something I can do independently.

I understand that I am paying ST for a service. ST will take my application and process it.

There is a onetime fee for the submittal of this application. This is a non-refundable application fee.

This covers ST following your application through the system from application to approval.

If for some reason your application is not approved you will get a refund of the application fee.

Strategic Transitions will charge me a monthly service charge for as long as I use their services.

This monthly service charge includes:

1. Allows you to call us for any questions you may have.
2. We will discuss and help you handle any correspondence from the state you receive.
3. We will process your Eligibility Review yearly.
4. We will have any and all dealings necessary on your behalf with MassHealth.
5. We will provide any information you may require to enroll and handle any issues that may arise during the year.

If I no longer require there services I will give them a written notice 30 day in advance of termination via mail, e-mail, or fax. If termination occurs within 4 months an early termination fee will apply.

Applicant: _____

Signature: _____ Date: _____

Heartland FINANCIAL
AN INTEGRITY COMPANY

Designated Representative Form

This form allows us to discuss matters with the state on behalf of the client.

SECTION I: Eligibility 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.

I certify that I have chosen the following person to be my eligibility representative, and that I understand the duties and responsibilities this person will have (as explained on the other side of this form).

Eligibility representative name: Strategic Transitions

Eligibility representative address: P.O. Box 51074 New Bedford, MA 02645

Eligibility representative telephone no: (774)722-3387 Relationship to you: Representative

My name: My SSN: My date of birth:

My signature: Date:

Part B—to be filled out by eligibility representative

I certify that I know enough about the above applicant or member to take responsibility for the correctness of the statements made during the eligibility process, and that I understand my duties and responsibilities as this person's eligibility representative (as explained on the other side of this form).

Eligibility representative signature: Date:

Why do we offer this service?

The answer to that question is simple. It is to make money!

The best part about making money with this service is that we are doing a great service for our clients. Aside from finding them a plan that will be very inexpensive and offering great coverage, we deal with all the hard aspects of acquiring their coverage. We also help the client enroll in the program and provide help if they need it during the year. We also complete their yearly review to ensure they stay approved for the plan available to them.

All in all, a great deal for our valued clients.