MassHealth Eligibility Review Form

Commonwealth of Massachu...
EOHHS
www.mass.gov/masshealth

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

HOH

1.

Last name	First name	MI	Street address	City	State	Zip

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

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 / /	Sex ☐ 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 / /

Sex ☐ 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 / /

Sex ☐ 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 / /

Sex ☐ 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 / /

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

Pregnancy

PRG

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

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

American Indian/Alaska Native

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.

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).

- **First:** Fill out the **Working Income** section below, including the health-insurance questions.
- **Second:** Fill out the **Nonworking Income** section on page 3 if you have other income like unemployment benefits, rental income, social security, or child support.
- **Third:** If **you are a college student**, you must fill out the **College Student** section on page 3.

Working Income (You must fill out this section.)

EIN

1. **Name**

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

▶ Has this person worked in the last 12 months before the date of 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 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.

Please go to the next page. ▶

Nonworking Income (You must fill out this section.)

▶ 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

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

☒ **Send proof of rental income.**

Unemployment Benefits

▶ 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

▶ 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

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

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

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

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

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

College Student (You must fill out this section.) STU

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

Name

▶ 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 HIN

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

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

Please go to the next page. ▶

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

HIN

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

Names of covered family members	Policy type *(Check one.)*	Policy start date / /	Policy number
	☐ individual ☐ couple (two adults) ☐ dual (one adult, one child) ☐ family	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.

[illegible] Health Insurance You May Be Eligible For

VIS

▶ 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: _____ Name: _____

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

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

HIV Information (optional)

HIV

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

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

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

PDI/DDU

▶ 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.

Please go to the next page. ▶

Accident or Injury

TPR

▶ 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

ABS

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

If **yes**, you **must read Part A**, and **fill out Parts B and C**, and **sign Part D**, if applicable.

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 B—Good Cause—below. If you think that you have Good Cause for not cooperating, fill out Part B—Good Cause—below, and do not fill out Part C—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 C—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, or D 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–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 C–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.

Please go to the next page. ▶

Absent Parent (cont.)

PART C–Absent-Parent Information (if known)

1.

Name	Social security number*	Date of birth / /	Sex ☐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 / /	Sex ☐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 D–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.

**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 **one section below for EACH 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).

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.")

Please go to the next page. ▶

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

OAC

▶ 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

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

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