



MassHealth Long-Term-Care Eligibility Review

Please **print clearly**. Please answer **all** questions and fill out **all** sections. If you need more space to finish a section, please use a separate sheet of paper (include your name and MassHealth ID number), and attach it to this form. **Please attach proof of all your income and assets.**

| Section I: Member Information | | | |
|-------------------------------|-----|---|--|
| Last name | | First name | MI |
| | | | MassHealth ID number or Social Security Number |
| Street address | | | City |
| State | Zip | Are you a U.S. citizen/national? <input type="checkbox"/> yes <input type="checkbox"/> no | Telephone number Home/Cell: |

| Section II: Member Income Information (Send proof of all income before taxes and deductions, except social security and SSI income.) | | |
|--|--------|--------------------|
| Type of income | Amount | How often received |
| Earned | \$ | |
| Social security | \$ | |
| Veterans' benefits (federal, state, or city) | \$ | |
| Retirement/Pensions | \$ | |
| Annuities | \$ | |
| Dividends/Interest | \$ | |
| Trusts | \$ | |
| Rental | \$ | |
| Other: | \$ | |

| Section III: Asset Information (Send most current statement for all assets.) | | | |
|---|-------------------------------|-----------------------|--|
| Type | Bank/Institution/Company name | Account/Policy number | Current amount |
| Bank accounts (includes checking, savings, credit union, certificates of deposit, personal needs accounts, trust accounts, money market accounts, retirement accounts (IRAs, Keogh, 401k)) | | | \$ |
| | | | \$ |
| | | | \$ |
| | | | \$ |
| Life Insurance | | | Face Value \$ Cash Surrender Value \$ |
| Securities/Other (includes stocks, bonds, savings bonds, mutual funds, cash) | | | \$ |
| Annuities | | | \$ |

Section III: Asset Information (Send most current statement for all assets.)

Did you, your spouse, or someone on your behalf purchase or in any way change an annuity since your last review? yes no
If you answered yes to the question above, you must send us proof of this information.

Annuities purchased and/or other annuity transactions on or after February 8, 2006, may make you ineligible for payment of long-term-care services, unless certain conditions are met. To be eligible, you may be required to name, and maintain the Commonwealth as a remainder beneficiary.

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

| | | |
|---|--|---|
| Real estate (primary/other residences) | Description: Address: Type of ownership: <input type="checkbox"/> sole ownership <input type="checkbox"/> joint ownership <input type="checkbox"/> tenants in common <input type="checkbox"/> life estate <input type="checkbox"/> other: | Assessed value: \$ Current Market Value: \$ |
| | Description: Address: Type of ownership: <input type="checkbox"/> sole ownership <input type="checkbox"/> joint ownership <input type="checkbox"/> tenants in common <input type="checkbox"/> life estate <input type="checkbox"/> other: | Assessed value: \$ Current Market Value: \$ |

Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or real estate? yes no

Did you, your spouse, or someone on your behalf change the deed or the ownership of any real estate, including creating a life estate, even if the life estate was purchased in another person's residence? yes no

If you transferred or changed your ownership interest in real estate, please give us a copy of the new deed showing the change.

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

| | Year/make/model: | Amount owed | Fair market value |
|-----------------|------------------|-------------|-------------------|
| Vehicles | | \$ | \$ |
| | | \$ | \$ |

| | |
|---|----|
| Burial-only accounts/burial contracts/burial | \$ |
|---|----|

| | | |
|---------------|---|----------------------------|
| Trusts | Revocable? <input type="checkbox"/> yes <input type="checkbox"/> no | Current trust principal \$ |
|---------------|---|----------------------------|

Have you created or changed any trusts since your last review? yes no

If yes, send proof of your new or updated trust

Section IV: Spouse/Dependent InformationDo you have a spouse or dependents living at home? yes no

Spouse's last name, first name, middle initial

Social security number

How much does your spouse pay each month for:

Rent \$

Mortgage (principal and interest) \$

Homeowner's/tenant's insurance \$

Real estate taxes \$

Required Maintenance charge for a condo or co-op \$

Room and board for assisted living \$

Does your spouse pay for heat? yes noDoes your spouse pay for utilities? yes no**Send proof of your spouse's monthly living expenses, and gross monthly income. A deduction may be allowed for their maintenance needs.**

Is a child, parent, brother, and/or sister living with your spouse?

 yesIf **Yes**, fill out this section. noIf **No**, go to the next section.**Send proof of your dependent's gross monthly income . A deduction may be allowed for their maintenance needs. These persons must be related to you or your spouse, and one of you must claim them as dependents on your federal income tax return.**

Name

Social security number

Relationship

Date of birth (mm/dd/yyyy)

Monthly Income before deductions

\$

Name

Social security number

Relationship

Date of birth (mm/dd/yyyy)

Monthly Income before deductions

\$

Section V: Health Insurance Information (List all health-insurance policies you have, including Medex, BC/BS, AARP (include Rx in title description), HMO, or other policies. Do not list Medicare or MassHealth.)

| Insurance Company | Type | Policy number | Start Date | Premium Amount |
|-------------------|------|---------------|------------|----------------|
| | | | | \$ |
| | | | | \$ |
| | | | | \$ |

Have you started or stopped any health insurance in the past year? yes no

If yes, please provide the policy information and coverage end date.

Note: You must submit a copy of your current premium bill.

Do you have long-term-care insurance? yes no

If yes, please send a copy of the policy and a statement showing proof of the cost

Section VI: Signature (You and/or your eligibility representative must read this page carefully, then sign and date it at the bottom.)

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

1. MassHealth may require eligible persons to enroll in available employer-sponsored health insurance if that insurance meets the criteria for MassHealth payment of premium assistance.
2. Employers of eligible persons may be notified and billed in accordance with MassHealth regulations for any services that hospitals or community health centers provide to such persons that are paid for by the Health Safety Net.
3. I may have to pay a premium for health coverage for myself and others listed on this application. Failure to pay any premium due may result in the state deducting the amount owed from the tax refunds of responsible persons. If I am a certain American Indian or Alaska Native, I may not have to pay premiums for MassHealth.
4. MassHealth has the right to pursue and get money from third parties who may be obligated to pay for health services provided to eligible persons enrolled in MassHealth programs. Such third parties may include other health insurers, spouses, or parents obligated to pay for medical support, or individuals obligated to pay under accident settlements. Eligible persons must cooperate with MassHealth in establishing third-party support and obtaining third-party payments for themselves and anyone whose rights they can legally assign. Eligible persons may be exempted from this obligation if they believe and tell MassHealth that cooperation could result in harm to them or anyone whose rights they can legally assign.
5. A parent and/or guardian of minor children must agree to cooperate with state efforts to collect medical support from an absent parent unless they believe and tell MassHealth that cooperation will harm the children or the parent or guardian.
6. Eligible persons who are injured in an accident, or in some other way, and get money from a third party because of that accident or injury must use that money to repay MassHealth or the Health Safety Net for certain services provided.
7. Eligible persons must tell MassHealth or the Health Safety Net, in writing, within 10 calendar days, or as soon as possible, about any insurance claims or lawsuits filed because of an accident or injury.
8. The status of this application may be shared with a hospital, community health center, other medical provider, or federal or state agencies when necessary for treatment, payment, operations, or the administration of the programs listed above.
9. To the extent permitted by law, after notice and an opportunity to appeal, MassHealth may place a lien against any real estate owned by an eligible MassHealth member or in which eligible the member has a legal interest, if the member is receiving long-term care in a nursing facility or other medical institution and MassHealth determines that the member is not reasonably expected to return home. If MassHealth puts a lien against such property and the property is later sold, money from the sale of that property may be used to repay MassHealth for medical services provided.
10. To the extent permitted by law, and unless exceptions apply, for any eligible person age 55 or older, or any eligible person regardless of age for whom MassHealth helps pay for long-term care in a nursing home or other medical institution, MassHealth will seek money from the eligible person's estate after death for the total cost of care. For more information on estate recovery, visit mass.gov/EstateRecovery.
11. Eligible persons must tell the health care program(s) in which they enroll about any changes in their or their household's income or employment, household size, health insurance coverage, health insurance premiums, and immigration status, or about changes in any other information on this application and any supplements to it within 10 calendar days of learning of the change. Eligible persons can make changes by calling (800) 841-2900; TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled. A change in information could affect eligibility for such persons or for persons in their household.

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

- Sign on to your account at MAhealthconnector.org. You can create an online account if you do not already have one.
 - Send the change information to Health Insurance Processing Center P.O. Box 4405, Taunton, MA 02780.
 - Fax the change information to (857) 323-8300.
12. MassHealth, the Massachusetts Health Connector, and the Health Safety Net will obtain from eligible persons' current and former employers and health insurers all information about health insurance coverage for such persons. This includes, but is not limited to, information about policies, premiums, coinsurance, deductibles, and covered benefits that are, may be, or should have been available to such persons or members of their household.

Section VI: Signature (You and/or your eligibility representative must read this page carefully, then sign and date it at the bottom.)

13. MassHealth, the Massachusetts Health Connector, and the Health Safety Net may get records or data about persons listed on this application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Revenue, and the Registry of Motor Vehicles, as well as private data sources, including financial institutions, 1) to prove any information given on this application and any supplements, or other information given once a person becomes a member, 2) to document medical services claimed or provided to such persons, and 3) to support continued eligibility.
14. In connection with the eligibility and enrollment process, MassHealth, the Massachusetts Health Connector, and the Health Safety Net may send notices that contain personal information about persons listed on this application to other persons on this application, or otherwise communicate such information to such persons.
15. Under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by going to www.hhs.gov/ocr/complaints/index.html.
16. I agree to allow the Massachusetts Health Connector to use income data, including information from tax returns, to determine my eligibility in future years. Review the Health Connector Privacy Policy for more information about how the Health Connector uses your tax information. The Massachusetts Health Connector will send me a notice and let me make changes to my eligibility application. I understand that if I am eligible for an Advance Premium Tax Credit (APTC) and/or ConnectorCare, these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or ConnectorCare may impact my annual tax liability. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.

I AGREE TO THE FOLLOWING STATEMENTS.

For MassHealth and Health Connector Applicants

- I have read or have had read to me the information on this application, including any supplements and instruction pages, and I understand that the Member Booklet contains important information.
- I have permission from all persons listed on this application (or their parent or other legally authorized representative) to submit this application and to act on their behalf to complete this application and any ongoing or subsequent eligibility process and activity, including, for example:
 - providing personal information about them, including health, health coverage, and income information, seeing such information as may be provided by the Massachusetts Health Connector, MassHealth, and the Health Safety Net, and providing consent on their behalf to the use and disclosure of their information as described in this application;
 - making choices about coverage options and methods of communication with the Massachusetts Health Connector, MassHealth, and the Health Safety Net;
 - making changes to the application or related eligibility documents and providing information about any change in their circumstances; and
 - providing consent on their behalf to use government and private sources to verify information as described in this application.
- I understand my rights and responsibilities and the rights and responsibilities of all persons listed on this application as explained in this Step 7.
- I have told or will tell all such persons (or their parent or legally authorized representative, if applicable) about these rights and responsibilities so they understand them.
- I understand and agree that MassHealth, the Health Safety Net, and the Massachusetts Health Connector will treat electronic, faxed, or copies of signatures with the same force and effect as an original signature(s).
- The information I have supplied is correct and complete to the best of my knowledge about myself and other persons listed on this application.
- I may be subject to penalties under federal law if I intentionally provide false or untrue information.

If you are submitting this application as an authorized representative, you must submit an Authorized Representative Designation Form (ARD) to us or have a form on record for us to process this application. Your signature on this review as an eligibility representative certifies that the information on this review is correct and complete to the best of your knowledge.

.....
Signature of member or eligibility representative

.....
Print Name

.....
Date