MassHealth for Seniors and Individuals Seeking Long-Term-Care Services (LTC) Part 1

Webinar Objectives

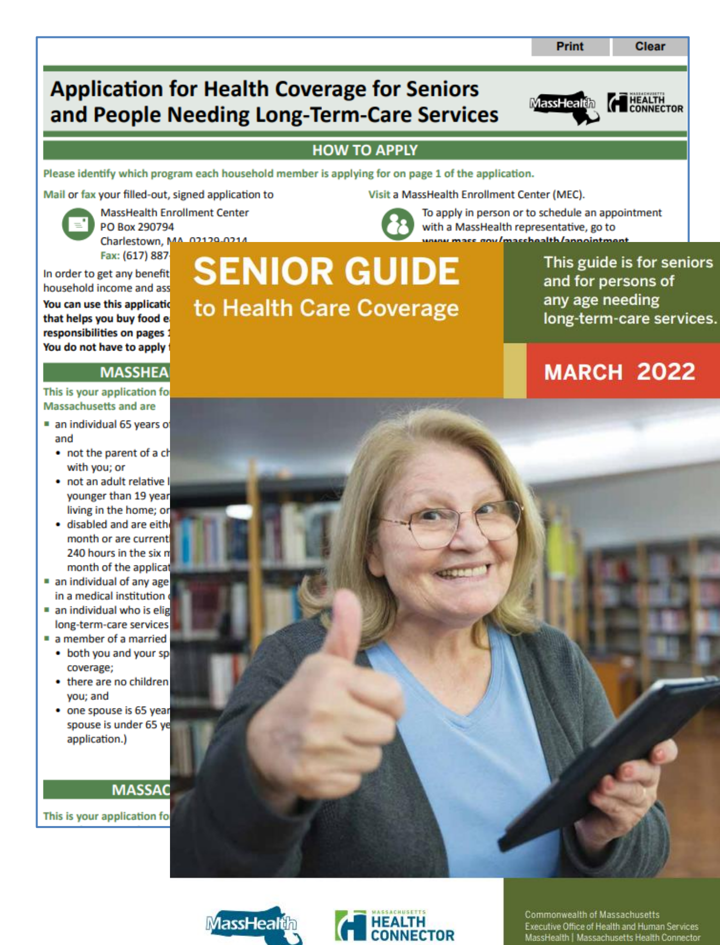
In this session, you will be able to

- Explain who can use the Application for Health Coverage for Seniors and People Needing Long-Term-Care Services (SACA-2) and the Medicare Savings Program (MassHealth Buy-In) Applications
- Describe eligibility requirements
- Demonstrate how to complete each section of the SACA-2 and MassHealth Buy-In application
- Identify what documents are required and how to submit them
- Discuss best practices for handling SACA-2 applications

MassHealth Mission

MassHealth's mission is to improve the health outcomes of our diverse members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence and quality of life.

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



Who Should Use this Application

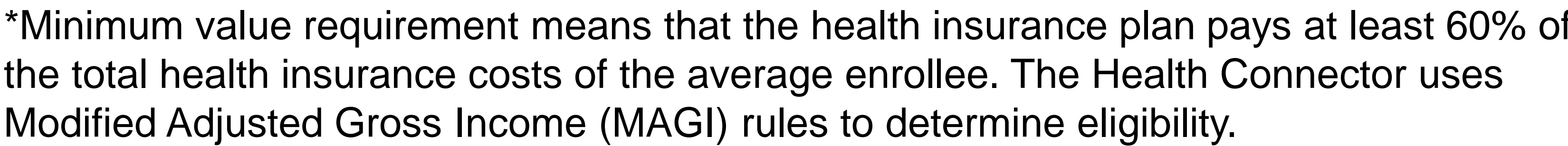
MassHealth

- MA residents
- An individual 65 or older and living at home
- Disabled and are either working 40 or more hours a month or are currently working and have worked at least 240 hours in the six months immediately before the month of the application
- An individual of **<u>any age</u>** and need long-term-care services in a medical institution or nursing facility

- An individual who is eligible under certain programs to get long-term-care services to live at home
- A member of a married couple living with the spouse, and both are applying for health coverage
  - one spouse is 65 years of age or older and the other spouse is under 65 years of age

Health Connector Eligible

- If the applicant live in Massachusetts, and they
  - are 65 years of age or older
  - are not otherwise eligible for MassHealth
  - are not getting Medicare, and
  - do not have access to an affordable health plan that meets the minimum value requirement*

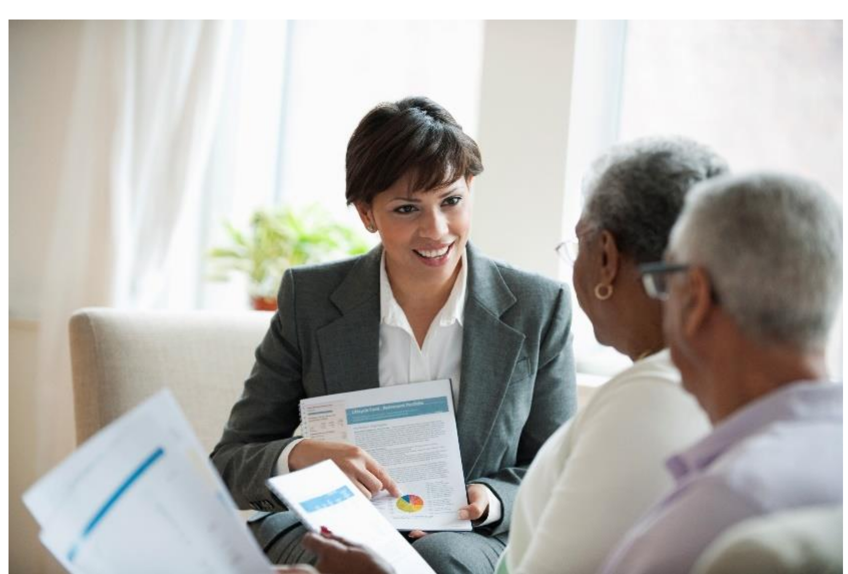


*Minimum value requirement means that the health insurance plan pays at least 60% of the total health insurance costs of the average enrollee. The Health Connector uses Modified Adjusted Gross Income (MAGI) rules to determine eligibility.

Who Should NOT Use the SACA-2 Application

- An individual ages 65 or older and is the parent of a child under 19 years of age who lives with them
- An adult relative living with and taking care of a child younger than 19 years of age when neither parent is living in the home

MassHealth Eligibility



Universal Requirements

Six universal requirements that all members and applicants must meet (130 CMR 503.000 & 130 CMR 517.000):

1. Massachusetts Residency
2. Providing or applying for a Social Security Number
3. Assignment of Rights to Medical Support and Third Party Payments: cooperating with those that may be legally obligated for someone to pay for their care
   - Good Cause for Non-Cooperation
4. Assignment of Third Party Recoveries: an applicant/member must inform MassHealth when involved in an accident, or suffers from an illness or injury, or other loss that has resulted or may result in a lawsuit or insurance claim
5. Potential Sources of Health Care: MassHealth is payor of last resort
6. Utilization of Potential Benefits

Other Eligibility Factors

- The following additional factors are considered when determining eligibility
  - Citizenship or immigration status
  - Categorical (disability)
  - Financial (income, assets)
    - **Single Individual**
      - Eligibility based on available income and assets, which are compared to the appropriate income and asset limits
    - **Married Individuals**
      - Couples living together: Eligibility based on their (joint) income and assets, which are compared to income and asset limits

Other Eligibility Factors (continued)

  - Exception:
    - When either one or both spouses are eligible as a Frail Elder under the Home and Community Based Waiver program, only income of appropriate individual(s) is counted
- <u>Couples not living together</u>
  - Residing apart other than admission to a medical institution
  - Assets and income mutually available only through the end of the month of separation
- MassHealth initiates information matches with federal and state data sources

Coverage Types

MassHealth

- Standard
- CommonHealth
- Family Assistance
- Medicare Savings Program (MSP) (also known as MassHealth Buy-In)
  - MassHealth Senior Buy-In
  - MassHealth Buy-In
- Limited*
- Health Safety Net*

* Coverage types not considered as insurance for tax purposes

Application for Health Coverage for Seniors and People Needing Long-Term-Care Services or SACA-2

Who is Applying?

Please Print Clearly. Be sure to answer all questions. Fill out all parts of the application, along with all supplements that apply. If you need more space, attach a separate piece of paper to the application. Put Person 1's name and social security number at the top of any attached paper. For each member in your household, please put the name(s) of the individual(s) under the program or programs he or she wants to apply for. Please see the Senior Guide to learn more about coverage under these programs.

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

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

You: ______________________

Spouse: ______________________

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

You: ______________________

Spouse: ______________________

☐ **Health Connector Programs**
Health coverage through the Massachusetts Health Connector is not MassHealth. If you have Medicare, you will not be eligible for any cost sharing or Advance Premium Tax Credits, and you cannot purchase a plan through the Health Connector, unless you were enrolled in a Health Connector plan when you became eligible for Medicare. The only time you should apply for Health Connector programs if you have Medicare is if you are not enrolled in Medicare yet but would have to pay for your Medicare Part A premium. In this case, you may be eligible for a Health Connector plan.

You: ______________________

Spouse: ______________________

NOTE: PACE – Program of All-inclusive Care for the Elderly
Some MassHealth members may be eligible to enroll in the Program of All-Inclusive Care for the Elderly (PACE), which provides members access to a wide range of medical, social, recreational, and wellness services through a center-based model. See page 10 of the Senior Guide for more information.

Supplemental Nutrition Assistance Program (SNAP)
The Supplemental Nutrition Assistance Program (SNAP) is a federal program that helps you buy healthy food each month.
☐ Check this box if you want this application to be sent to the Department of Transitional Assistance to serve as an application for SNAP benefits. You must read the rights and responsibilities on pages 17-23 and sign on page 23 to proceed with the application.

- SNAP checkbox- provide applicants for MassHealth the opportunity to apply for the Supplemental Nutritional Assistance Program (SNAP) benefits

SACA-2: Step 1- Head of Household

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

We need one adult in the household to be the contact person for your application. Please note that this should be someone who appears on the application, not a third party who wishes to serve as a contact for the applicant(s). Please see the Authorized Representative Designation (ARD) at the end of this application, to establish a third-party contact.

1. First name, middle name, last name, and suffix
2. Date of birth
3. Street address ☐ Check this box if homeless. You must provide a mailing address.
4. Apartment or unit numbe
5. City
9. Is this a hospital, nursing facility, or other institution? ☐ Yes ☐
If **Yes**, facility name
10. Mailing address ☐ Check if same as street address.
11. Apartment or unit number
12. City
13. State
14. ZIP code
15. County

*** All Required Fields**

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SACA – 2: Step 2

*** Required Field**

16. Phone number
17. Other phone number
18. Email
19. # of people listed on the application
20. What is your preferred language, if not English? Spoken ______ Written ______
21. Is anyone on this application in prison or jail? ☐ Yes ☐ No
    Please select **No** if this person will be released in the next 60 days.
    If **Yes**, who? Enter the name here: ______
    If **Yes**, is this person awaiting trial? ☐ Yes ☐ No

FOR ENROLLMENT ASSISTERS ONLY

Complete this section if you are an enrollment assister and are filling out this application for someone else. Navigators must fill out a Navigator Designation Form if they have not done so already. Certified Application Counselors must fill out a Certified Application Counselor Designation Form if they have not done so already.

Check one ☐ Navigator ☐ Certified Application Counselor

First name, middle name, last name, and suffix	Email address

Organization name	Organization identification number	Organization phone number

SACA-2: Step 2: Applicant

STEP 2 Person 1

1. First name, middle name, last name, and suffix	2. Gender ☐ Male ☐ Female	3. Relationship to you SELF

4. Are you applying for health or dental coverage for YOURSELF? ☐ Yes ☐ No

   If **Yes**, answer all the questions below in Step 2 for Person 1 (yourself).

   If **No**, answer Question 16 (accommodations), then go to the Income Information section on page 4.

5. Optional What is your race or ethnicity? ______ Please see page 32.
   MassHealth is committed to providing equitable care for all members regardless of race, ethnicity, or language spoken. Please complete this question to help us meet your language and cultural needs. Know that your response is voluntary, confidential, and will not impact your eligibility or be used for any discriminatory purpose.

6. Do you have a social security number (SSN)? ☐ Yes ☐ No (optional if **not** applying)
   We need a social security number (SSN) for every person applying for health coverage who has one. There are exceptions for anyone who has a religious exemption as described in federal law, who is eligible only for a nonwork SSN, or who is not eligible for an SSN. An SSN is optional for persons not applying for health coverage, but giving us an SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone needs help getting an SSN, call the Social Security Administration at (800) 772-1213 (TTY: (800) 325-0778) or go to socialsecurity.gov. For more details on how we use your social security number, please refer to the Senior Guide for Health Care Coverage.

   If **Yes**, give us the number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

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

   Is your name on this application the same as your name on your social security card? ☐ Yes ☐ No

   If **No**, what name is on your social security card? ______
   First name, middle name, last name, and suffix

7. If you get an Advance Premium Tax Credit (APTC), do you agree to file a federal tax return for the tax year that the credits are received? ☐ Yes ☐ No
   You may not have needed or chosen to file a tax return in the past, but you will have to file a federal income tax return for any year that you get an APTC. You must check **Yes** to question 7 to be eligible for ConnectorCare or APTCs to help pay for your health insurance. **You do NOT need to file a tax return to apply for or to get MassHealth or HSN, if you qualify.**

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

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*** All Required Fields**

*** Required fields, if applying**

Does applicant/ member get APTC?

SACA-2: Step 2: APTC

You must file a joint federal tax return with your spouse for the year for which you are applying to get certain programs (ConnectorCare or APTCs) unless you are a victim of domestic abuse or abandonment or you will file taxes as Head of Household. If you will file taxes as Head of Household, you should answer **No** to question 7a ("Are you legally married?"). One way you may qualify as Head of Household is to live apart from your spouse and claim another person as a dependent. See IRS Publication 501 or consult a tax professional for tax filing information. You will only need to include yourself and any dependents on this application.

a. Are you legally married? ☐ Yes ☐ No
If **No**, skip to question 7c.
If **Yes**, list name of spouse and date of birth. ______

b. Do you plan to file a joint federal tax return with your spouse for the tax year for which you are applying? ☐ Yes ☐ No

c. Will you claim any dependents on your federal income tax return for the year which you are applying? ☐ Yes ☐ No
You will claim a personal exemption deduction on your federal income tax return for any individual listed on this application as a dependent who is enrolled in coverage through the Massachusetts Health Connector and whose premium for coverage is paid in whole or in part by advance payments. List name(s) and date(s) of birth of dependents.
______

d. Will you be claimed as a dependent on someone else's federal income tax return for the year for which you are applying?
☐ Yes ☐ No
If you are claimed by someone else as a dependent on their federal income tax return, this may affect your ability to receive a premium tax credit. Do not answer **Yes** to this question if you are a child under the age of 21 being claimed by a noncustodial parent. If **Yes**, please list the name of the tax filer. ______

Tax filer date of birth ______ How are you related to the tax filer? ______

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

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

Who else does the tax filer claim as dependents?
______

e. Are you filing taxes separately because you are a victim of domestic abuse or abandonment? ☐ Yes ☐ No

Optional

I filed a federal income tax return with the Internal Revenue Service (IRS) for every year that I received an Advance Premium Tax Credit (APTC). When I filed, I included IRS Form 8962, which had information about the tax credit I received, so the IRS could reconcile my APTC. ☐ Yes ☐ No

Answer **Yes** if: 1. You have received an APTC or ConnectorCare in the past, and
2. The statement is true for all people listed in the household.

Required, if Yes to Q7

SACA-2: Step 2: Citizen and Immigration

8. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

If **Yes**, are you a naturalized citizen (not born in the US)? ☐ Yes ☐ No

Alien number ______ Naturalization or citizenship certificate number ______

9. If you are a noncitizen, do you have an eligible immigration status? ☐ Yes ☐ No

See page 32, "Immigration Statuses and Document Types" for help. If **No** or **no response**, you may get only one or more of the following: MassHealth Standard (if pregnant), MassHealth Limited, the Children's Medical Security Plan (CMSP), or the H... Safety Net (HSN). Go to Question 10.

a. If **Yes**, do you have an immigration document? ☐ Yes ☐ No

It may help us to process this application faster if you include a copy of your immigration document with the applica... will try to verify your immigration status through an electronic data match. Please list all the immigrations statuses and/or conditions that have applied to you since you entered the U.S. If you need more space, attach another sheet of paper.

Status award date (mm/dd/yyyy) ______ (For battered persons, enter the date the petition was approved.)

Immigration status ______ Immigration document type ______

Choose one or more document status and type from the list on page 32.

Document ID number ______ Alien number ______

Passport or document expiration date (mm/dd/yyyy) ______ Country ______

b. Did you use the same name on this application that you did to get your immigration status? ☐ Yes ☐ No

If **No**, what name did you use? First, middle, last, and suffix ______

c. Did you arrive in the U.S. after August 22, 1996? ☐ Yes ☐ No

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

e. Optional Are you a: ☐ victim of severe trafficking, ☐ a spouse, child, sibling, or parent of a trafficking victim ☐ a battered spouse, ☐ a child or the parent of battered spouse?

*** Required fields, if applying**

Citizenship/Immigration

- US citizen: an individual who:
  - Was born in the U. S. or its territories

  or

  - Was born of a parent who is a U. S. Citizen

  or

  - Is a naturalized citizen
- Immigration Status

Qualified Noncitizen
- **Protected Noncitizens**

Nonqualified Individual Lawfully Present

Qualified Noncitizen Barred

PRUCOL or Person Residing Under Color of Law

Other Noncitizen

Verification of Eligibility Factors

- MassHealth require verification of the following eligibility factors to make a final eligibility determination:
  - Citizenship or Immigration
    - Copy of both side of immigration card
    - MassHealth will not accept self-declaration
- MassHealth initiates information matches with federal and state data sources
- **Reasonable Opportunity**
  - The individual has 90-days from receipt of the RFI notice for immigration documents to provide all requested verifications.
  - If an individual is having difficulty providing the requested documentation, they may request a **90-day reasonable opportunity extension**
    - Must be requested before the original RFI period expires

Some Examples of Immigration Document Types

- Certificate of U.S. Citizenship (Form N-560 or N-561)
- Certificate of Naturalization (Form N-550 or N-570)
- U.S. Passport
- Reentry Permit (I-327)
- Alien number: The alien number (also cal' ' '' registration number or USCIS number) ca on the immigration document.
- Card number
- I-94 number
- Unexpired Passport number
- Resource: [Immigration Document Types - Massachusetts Health Connector (mahealthconnector.org)]

Certificate of Naturalization (Form N-550 or N-570)

Permanent Resident Card ("Green Card," I-551)

Residency and Other Household Members

MassHealth

10. Are you living in Massachusetts, and do you either intend to reside here, even if you do not hav[e] entered Massachusetts with a job commitment or seeking employment? ☐ Yes ☐ No

If you are visiting in Massachusetts for personal pleasure or for the purposes of receiving medical care in a setting other than a nursing facility, you must answer **No** to this question.

*** Required field**

11. Do you live with at least one child younger than age 19, and are you the main person taking care of this child or children?
☐ Yes ☐ No

Names(s) and date(s) of birth of child(ren) ______

Does this apply?

12. Are you pregnant? ☐ Yes ☐ No
If **Yes**, how many babies are you expecting? _____ W

If "YES" complete all applicable fields

13. Were you ever in foster care? ☐ Yes ☐ No

a. If **Yes**, in what state were you in foster care? _____

b. Were you getting health care through a state Medicaid program? ☐ Yes ☐ No

14. Do you rent or own your property? ☐ Rent ☐ Own

*** Required field**

Residency

- MassHealth require verification of eligibility factors to make a final eligibility determination of residency
- Massachusetts residents or intend to reside in MA, with or without a fixed home address, entered Massachusetts with a job commitment or seeking employment
- Individuals who are not Massachusetts residents are not eligible for MassHealth or other health care benefits that are funded by the Commonwealth of Massachusetts. If individuals are visiting Massachusetts for personal pleasure, such as for vacation, or for the purposes of receiving medical care in a setting other than a nursing facility, they do not meet residency requirements

Massachusetts

Verification of Residency

- Data match
- If unable to data match, submit one of the following documents:
  - A copy of the deed and record of the most recent mortgage payment or a copy of the property tax bill from the most recent year, if the mortgage was paid in full
  - A current utility bill or work order dated within the past 60 days
  - A statement from a homeless shelter or homeless service provider
  - School records, nursery school or day care records
  - A Section 8 agreement
  - A homeowners' insurance agreement
  - Proof of enrollment of custodial dependent in public school
  - Copy of the lease and record of the most recent rent payment
  - Or an affidavit supporting residency

Disability

15. DISABILITY Answer this question if you are under age 65 or age 65 or older and working.
Do you have a disability (including a disabling mental health condition) that has lasted or is expected to last for at least 12 months?
(If legally blind, answer **Yes**.) ☐ Yes ☐ No Name: ____

Does this apply?

16. Do you need reasonable accommodation(s) because of a disability or injury? ☐ Yes ☐ No
If **No**, go to the next question. If **Yes**, answer questions a and b.

a. Condition
☐ Low vision ☐ Blind ☐ Deaf ☐ Hard of hearing ☐ Developmentally disabled ☐ Intellectually disabled
☐ Physically disabled ☐ Other (Please explain.) ____

b. Accommodation
☐ Text telephone (TTY) ☐ Large-print publications ☐ American Sign Language interpreter ☐ Video Relay Service
☐ Communication Access Real-time Translations (CART) ☐ Publications in braille ☐ Assistive listening device
☐ Publications in electronic format ☐ Other (Please explain.)

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

a. Did someone else cause your injury, illness, or disability, or could someone else's insurance or your own insurance, other than health insurance (like homeowner's or auto insurance) cover it? ☐ Yes ☐ No

b. Have you filed a lawsuit, a workers' compensation claim, or an insurance claim for this accident or injury? ☐ Yes ☐ No

"Yes" or "No"

18. Did you ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No
If **No**, go to Income Information. If **Yes**, answer questions a and b.

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

b. Do you (check one): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home? ☐ live in someone else's home?

If "YES" complete all applicable fields

Assignment of Rights to Medical Support and Third-Party Payments

MassHealth

Assignment of Rights to Medical Support and Third-Party Payments

- Applicant/member must:
  - Assign to MassHealth certain rights to medical support
  - Provide information to help pursue any medical support and source of third-party payments including information on non-custodial parents
  - Assign rights to recover money from settlements due to accident, illness, or injury
- Applicant must inform MassHealth when an individual/household member:
  - Is involved in an accident, or
  - Suffers from illness or injury or other loss that may result in a lawsuit or insurance claim
- MassHealth and Disability - Disability determination by either:
  - SSDI determined, MA Commission for the Blind
    - Data match
  - MassHealth disability determination process (DES)
    - Need to complete the Disability Supplement

Income Information

INCOME INFORMATION (You may send proof of all household income with this application.)

19. Do you have any income? ☐ Yes ☐ No
    If you don't have income, skip to question 30.

CURRENT JOB | If you have more jobs and need more space, attach another sheet of paper.

Does this apply?

20. Employer name and address | Federal Tax ID#

21. a. Wages/tips (before taxes) $ ______ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly
    ☐ Yearly (Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)
    b. Income effective date ______

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Does this apply?

22. Average number of hours worked each WEEK ______

23. Are you seasonally employed? ☐ Yes ☐ No If yes, which months do you work in a calendar year?
    ☐ Jan. ☐ Feb. ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ Sept. ☐ Oct. ☐ Nov. ☐ Dec.

SELF-EMPLOYMENT | If self-employed, answer the following questions. If you need more space, atta...

Does this apply?

24. Are you self-employed? ☐ Yes ☐ No
    a. If **Yes**, what ty...
    b. On average, h... month,
       or, how much ... ss?
    c. How many ho...

Must answer "Yes" or "No"

If "YES" complete all applicable fields

Other Income

OTHER INCOME

25. Check all that apply, and give the amount and how often you get it.
NOTE: You do not need to tell us about child support or Supplemental Security Income (SSI).

- ☐ Social Security benefits $______ How often received? ____________
- ☐ Retirement or Pension $______ How often received? ____________
- ☐ Annuities $______ How often received? ____________
- ☐ Trusts $______ How often received? ____________
- ☐ Unemployment $______ How often received? ____________
- ☐ Interest, dividends, and other investment income $______ How often received? ____________
- ☐ Royalty income $______ How often received? ____________
- ☐ Alimony received $______ How often received? ____________
  If this person is receiving alimony payments from a divorce, separation agreement, or court order that was finalized before January 1, 2019, enter the amount of those payments here. $______
- ☐ Federal veteran's benefits $______ How often received? ____________ Taxable? ☐ Yes ☐ No
- ☐ Taxable military retirement pay $______ How often received? ____________
- ☐ Other taxable income (include type) $______ How often received? ____________ Type ____________
- ☐ Capital gains: On average, how much net income or loss will you get from this capital gain each month? $ ______ /profit or $ ______ /loss
- ☐ Net farming or fishing income: On average, how much net income (profits after business expenses are paid) or loss will you get from this business each **month**? $ ______ **/profit** or $ ______ **/loss**
- ☐ Lottery and Gambling Winnings $ ______ Effective Date ____________
  How often ☐ One time only ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly
  Non–cash prizes are not counted as qualified lottery and gambling winnings do not incorporate any losses in the amount.

Does this apply?

Rental and One-time Income

*** All REQUIRED**

RENTAL INCOME

26. Do you get rental income? **(You must answer this question.)** ☐ Yes ☐ No

If **Yes, send proof** of current rental income, such as a written statement from each tenant, a copy of the lease, or a current federal tax return. Also **send proof** of all of the following expenses, if applicable, for the last 12 months: mortgage, taxes, utilities (gas/electric), heat, water/sewer, insurance, condo or co-op fee, repairs and maintenance.

a. What type of real estate do you own? ☐ one-family ☐ two-family ☐ three-family ☐ other (describe): ____________

b. How much **monthly** rental income or loss do you get from each rental unit from the real estate indicated above? (List each rental unit and address separately.)

Address ______________________________ Unit # ______

Amount of Income ____________ Amount of Loss ____________ Owner-occupied? ☐ Yes ☐ No

Address ______________________________ Unit # ______

Amount of Income ____________ Amount of Loss ____________ Owner-occupied? ☐ Yes ☐ No

c. Do you pay for heat or utilities for your tenant? ☐ Yes ☐ No

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ONE-TIME-ONLY INCOME

27. Have you or will you receive income during this calendar year as a one-time only payment? ☐ Yes ☐ No
Examples of one-time only income include a lump pension payment or a one-time capital gain.
If **Yes**: Type ____________________ Amount $ __________ Month Received ____________________ Year received ________

28. Will you receive income during the next calendar year as a one-time only payment? ☐ Yes ☐ No
If **Yes**: Type ____________________ Amount $ __________ Month Received ____________________ Year received ________

Income: Countable Income

- **Countable income** is less than or equal to 100% of the federal poverty level (FPL)
  - Unless individual is eligible for a waiver program
  - Includes:

Individuals earned and unearned income

Spouse's income (unless under the Frail Elder Waiver)

- And without regard to any deductions (gross amount)
- Earned Income: wages, self-employment, income from roomers and boarders
- Unearned Income: social security benefits, railroad retirement benefits, federal veteran's benefits, rental income, interest/dividend income, lump sum payment, annuities

Income: Non-Countable Income

- Income of any individual who is a recipient of EAEDC or SSI
- Income from disabled adult children
- Income from the Pickle amendment
- Income-in-kind (example- free rent)
- Money received from a loan secured by equity in the home of an individual 60 or older (reverse mortgage)
- Veterans' aid and attendance benefits, state veterans' benefits, unreimbursed medical expenses, housebound benefits and community residents
- Social security cost of living adjustments until the subsequent FPL adjustments for members who are community residents
- Retroactive social security and SSI benefit payments
- Any other income considered non-countable under Title XIX
- Certain income derived from an asset or resource that is non-countable according to ARRA regulations

Income: Deductible

- Deductible - If income is too high to be determined eligible for MassHealth Standard, Family Assistance, or Limited, the individual will have a deductible
  - To meet the deductible: have medical bills that equal or are greater than the amount of the deductible
    - Medical bills: May use medical bills for applicant and their spouse
      - MassHealth will not pay for these medical bills—they are the individual's responsibility
      - The bills used cannot be for services that are covered by other insurance that the applicant or their spouse may have

Income: Deductible (continued)

- One month income deductible:
  - Applicants or members who is over income may establish eligibility by meeting a deductible
    - Community residents whose income exceeds 100% FPL
    - Community residents who are eligible for the Increased Unearned Income Disregard
    - Former SSI who are not eligible under the Pickle Amendment
  - Deductible Period:
    - A 6-month period that starts the 1st day of the month of the application OR
    - May begin up to 3-months before the 1st day of the month of the application

Community Unearned-income Deductions

- Deduction from gross unearned income is allowed only for:
  - applicants and members 65 and older
  - Applicant or member receiving personal-care attendant services paid for by MassHealth, or have been determined by MassHealth, through initial screening or by prior authorization, to be in need of personal-care attendant services; and
  - Prior to applying the deduction, have countable income that is over 100% of FPL
- MassHealth will redetermine eligibility without this deduction if:
  1. after 90 days from the date of the eligibility approval notice, the person is not receiving personal-care attendant services paid for by the MassHealth or has not submitted, upon request proof of efforts to obtain personal-care attendant services; or
  2. MassHealth denies the prior-authorization request for PCA services

Community Unearned-income Deductions (continued)

- If countable income, prior to applying the deduction, is greater than 133% of FPL, eligibility is determined under Financial Standards Not Met

- In addition to business expenses, MassHealth allows the deductions listed below from the total gross unearned income. These deductions do not apply to the income of a community spouse
- Allowable deductions:
  - A deduction of $20 per individual or married couple; or
  - In determining eligibility for MassHealth Standard, a deduction that is equivalent to the difference between the applicable MassHealth deductible-income standard and 133% of FPL
    - This deduction includes, and is not in addition to, the $20 disregard

Rental Income and Business Expenses

- Countable Rental Income:
  - The amount remaining after allowable business expenses have been subtracted
  - If property is owner occupied, amounts must be pro-rated
- Business Expenses: Allowable deductions include:
  - Carrying charges incurred within the last 12 months:
  - Mortgage, Taxes, Insurance, Water & sewage, Heat & utilities
  - Non-Cosmetic Maintenance and repairs incurred within the last 12 months
    - Expenses prorated over a 12-month period
    - If owner occupied and repairs for entire house, must prorate
    - If repairs for rented property only, entire amount allowed

* MassHealth regulations: 130 CMR 520.010

Deductions

- For community applicants under 65 years of age, or for those individuals aged 65 or older who are seeking Health Connector benefits, MAGI is used to calculate income
- Allowable deductions from countable income:

DEDUCTIONS

29. What deductions do you report on your income tax return? If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. Check all that apply. Your deductions should be what you report on your federal income tax return in the section "Adjusted Gross Income." For each deduction you select, give the yearly amount. You can enter up to the maximum deduction amount allowed by the IRS.

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

SACA-2: Step 2: Spouse or Other People in this Household

YEARLY INCOME

30. Did you receive unemployment benefits in this calendar year? ☐ Yes ☐ No

31. What is your total expected income for the current calendar year?

32. What is your total expected income for next calendar year, if different?

THANKS! This is all we need to know about you. Go to Step 2 Person 2 to add another household member, if needed. Otherwise, go to Step 3 American Indian or Alaska Native (AI/AN) Household Member(s).

Must answer "Yes" or "No"

STEP 2 Person 2—Spouse or other people in this household

Does this apply?

Fill out this part for your spouse who lives with you or anyone included on your federal income tax return, if you file one.

If you have to include more than two people on this application, make a copy of blank information pages for Step 2 Person 2 BEFORE you fill them out. When filling out the additional pages please be sure to tell us how each person is related to each other person on the application. We need this information to determine eligibility. You can also download pages for additional persons at mass.gov/masshealth.

1. First name, middle name, last name, and suffix	2. Date of birth	3. Gender ☐ Male ☐ Female

4. Relationship to Person 1	5. Does this person live with Person 1? ☐ Yes ☐ No. If **No**, provide street address

☐ No street address. Note: if you check this box, you must provide a mailing address.

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SACA-2: Step 3: AI/AN
Step 4: Previous Medical Bills

STEP 3 American Indian or Alaska Native (AI/AN) Household Member(s)

Are you or is anyone in your household an American Indian or Alaska Native?

If **No**, skip to Step 4. If **Yes**, complete the rest of this application, including Su
Household Member.

Names(s) of person(s) ______________________

American Indians and Alaska Natives who enroll in health coverage can also get services from the Indian Health Service, tribal health programs, or Urban Indian Health Programs. If you or any household members are American Indians or Alaska Natives, you may not have to pay premiums or copayments, and may get special monthly enrollment periods.

Does this apply?

- **If applicable, complete Supplement B**

STEP 4 Previous Medical Bills

Do you or your spouse have bills for medical servic

☐ Yes ☐ No

If **No**, go to Step 5: Assets. If **Yes,** fill out the re

Do you or your spouse want to apply for MassHealth for that time period? ☐ Yes ☐ No

If **Yes,** what is the earliest date for which you need MassHealth? (mm/dd/yyyy) ______________

(You must give us proof of all income and assets owned during that time period.)

Does this apply?

- **If applicable- complete and submit medical bills, income and asset owned during the time period**

Previous Medical Bills

- 90-Day Retroactive Eligibility
  - Applicants and members can request coverage to go back 90-days depending on the benefit the member is eligible for; may begin the first day of the third month prior to the month of application, providing the applicant was eligible during that time
  - Determination must be within MassHealth Time Standards
  - For deceased individuals: determined
    - From the date of death, BUT
    - Not earlier than the third month prior to the month of application
  - May be approved if covered medical services were received during such a period and applicant/member would have been eligible at that time
- MassHealth Senior Buy-In (Qualified Medicare Beneficiary (QMB)):
  - No Retro – Coverage begins on the first day of the calendar month following the date of MassHealth's eligibility determination

SACA-2: Step 5: Assets

STEP 5 Assets | You **must** fill out all blocks for each asset you and/or your spouse own.

If you live in the community and you want help with medical bills up to three months before the month you apply, you must tell us about any open and closed accounts for that period. If you are applying for long-term care, you must also give us information about all assets you or your spouse owned in the past 60 months. If you need more space, attach another sheet of paper.

BANK ACCOUNTS

1. Do you or your spouse have any bank accounts or certificates of deposit, including checki market, and personal needs allowance (PNA) accounts? ☐ Yes ☐ No
   a. Do you or your spouse have any retirement accounts, including individual retirement accounts (IRAs), Keogh, or pension funds? ☐ Yes ☐ No
   b. Have you or your spouse or a joint owner closed any accounts in the past 60 months, including any accounts you had owned jointly with anyone else? ☐ Yes ☐ No

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

Must answer "Yes" or "No

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

Name on account		Account type
Name of bank/institution		Account number
Current balance $	Balance on admission date* $	☐ Account open ☐ Account closed
Date account closed (mm/dd/yyyy)	Amount on the date account closed $	
Name on account		Account type
Name of bank/institution		Account number
Current balance $	Balance on admission date* $	☐ Account open ☐ Account closed
Date account closed (mm/dd/yyyy)	Amount on the date account closed $	

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

Types of Asset: Real Estate/ Life Insurance

REAL ESTATE

2. Do you or your spouse own or have a legal interest in your primary residence?
   You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No

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

   If you answered **Yes** to any of these questions, fill out this section. If

Send

Addr

Type

Addr

Type

Must answer "Yes" or "No

LIFE INSURANCE

4. Do you or your spouse **own** any life insurance? ☐ Yes ☐ No

   If **Yes**, fill out this section. If **No**, go to the next section **(SECURITIES BROKERAGE ACCOUNTS (STOCKS/BONDS/OTHER))**.

Send a copy of the first page of all life-insurance policies. If total face value of all policies exceeds $1,500 per person, also **send a letter** from the insurance company showing the current cash-surrender value (for all policies except term policies).

Name(s) of owner(s)					
Insurance company					
Policy number		Face value $		Insurance type	
Name(s) of owner(s)					
Insurance company					
Policy number		Face value $		Insurance type	

Types of Assets: Stocks/Bonds/Annuities

Does this apply?

SECURITIES BROKERAGE ACCOUNTS (STOCKS/BONDS/OTHER)

5. Do you or your spouse own any stocks, bonds, savings bonds, mutual funds, securities, assets held in safe-deposit boxes, cash not in the bank, options, or future contracts? ☐ Yes ☐ No

If **Yes**, fill out this section. If **No**, go to the next section **(ANNUITIES)**.

Must answer "Yes" or "No

Send proof of current value (except cash).

	Owner(s) name(s)	Company name	Account number	Current value	Value on admission date*	Joint asset?
Cash				$	$	☐ Yes ☐ No
Stocks				$	$	☐ Yes ☐ No
Bonds						
Savings bonds						
Mutual funds						
Options						
Future contract						
Other						

* Enter the accou

ANNUITIES

6. Did you or your spouse or someone on your or your spouse's behalf purchase or in any way change an annuity? ☐ Yes ☐ No

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

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

Name(s) of owner(s)	
Name of institution issuing the annuity	
Contract number	Date purchased (mm/dd/yyyy)
Name(s) of owner(s)	
Name of institution issuing the annuity	
Contract number	Date purchased (mm/dd/yyyy)

Vehicles/Mobile Homes

ASSISTED LIVING/OTHER

Does this apply?

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

If **Yes**, fill out this section. If **No**, go to the next section (**VEHICLES/MOBILE HO**

Must answer "Yes" or "No

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

Name of facility	
Address of facility	
Amount of deposit $	Date deposit given to facility (mm/dd/yyyy)

VEHICLES/MOBILE HOMES

Must answer "Yes" or "No

8. Do you or your spouse own any vehicles, like cars, vans, trucks, recreational vehicles, mobile homes, or boats? ☐ Yes ☐ No

If **Yes**, fill out this section. If **No**, go to the next section (**PREPAID BURIAL PLANS/TRUSTS**).

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

(You) Type of vehicle	Year/make/model	Fair-market v\[...\] $
Mobile home address		
(Your spouse) Type of vehicle	Year/make/model	Fair-market v\[...\]
Mobile home address		

Prepaid Burial Plans

PREPAID BURIAL PLANS

Does this apply?

9. Do you or your spouse have any prepaid burial contracts or trusts, ... ank accounts set aside for funeral expenses? ☐ Yes ☐ No

Must answer "Yes" or "No

If **Yes**, fill out this section. If **No**, go to the next section **(TRUSTS)**.

Send a copy of the trust contract, trust instrument, insurance policy, or burial-only account.

(You) Burial contract ☐ Yes (Amount $) ☐ No	Burial trust ☐ Yes (Amount $) ☐ No
Life insurance for burial ☐ Yes (Amount $) ☐ No	Burial-only account ☐ Yes (Amount $) ☐ No
Burial plot ☐ Yes ☐ No | Insurance company	Policy number
Bank name	Account number
(Your spouse) Burial contract ☐ Yes (Amount $) ☐ No	Burial trust ☐ Yes (Amount $) ☐ No
Life insurance for burial ☐ Yes (Amount $) ☐ No	Burial-only account ☐ Yes (Amount $) ☐ No
Burial plot ☐ Yes ☐ No | Insurance company	Policy number
Bank name	Account number

Trusts

TRUSTS

Does this apply?

10. Are you or your spouse the grantor/donor, trustee, or beneficiary

Must answer "Yes" or "No

11. Have you, your spouse, or someone else on your behalf, including a court or administrative body, contributed income or assets owned by you or your spouse to a trust? ☐ Yes ☐ No

If you answered **Yes** to any of these questions, fill out this section.
If you answered **No** to these questions, go to **STEP 6: Health Insurance Information**

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

Trust name		Revocable? ☐ Yes ☐ No	Current trust principal $
Trust principal on admission date* $	Trustee(s)		
Grantor(s)/Donor(s)		Beneficiaries	
Trust name		Revocable? ☐ Yes ☐ No	Current trust principal $
Trust principal on admission date* $	Trustee(s)		
Grantor(s)/Donor(s)		Beneficiaries	

*Enter the trust principal on the date of admission to medical institution.

Asset Limits

- Asset Limits – MassHealth Standard, Family Assistance & Limited:
  - Individual - $2,000 or less
  - Married couple living together in the community - $3,000 or less
- MassHealth looks at the current value of any assets owned by the applicant or member and compares them to the asset limits
- If married and live with their spouse, MassHealth counts the value of assets owned by the applicant or member and their spouse
- Information about assets and other figures that MassHealth uses: www.mass.gov/servicedetails/program-financial-guidelines-for-certainmasshealth-applicants-and-members

Countable Assets

- Countable Assets (MassHealth Regulation: 130 CMR 520.000)
  - Countable assets include, but are not limited to- cash on hand- monies available to the individual or spouse
  - The value of bank accounts such as savings/checking accounts, trusts, CDs
  - IRAs, Keogh Plans, Pension Plans, Annuities
  - Securities – i.e: stocks, bonds
  - Vehicles – one vehicle per Community household is exempt
  - Real Estate – other than principal residence
  - Life Insurance – Total Cash Surrender Value (CSV) if Face Value exceeds $1,500 per individual, total CSV is counted
    - Cash Surrender Value – the amount of money owed to the owner upon cancellation of the policy
    - Face Value – the value of the policy
  - Retroactive SSI/RSDI benefits retained after the grace period

Noncountable Assets

- Primary home (if it is located in Massachusetts)
- An SSI recipient's assets
- Loans or grants
- One vehicle for each household
- Certain Life Insurance policies
- Life insurance policies for both applicant and spouse if the total face value for each is $1,500 or less (Face value of term policies is not counted)
- Burial plots
- Up to $1,500 per person for applicant/member and spouse that is specifically set aside for funeral and burial expenses
  - This amount must be in separate, identifiable accounts; or
  - may be in the form of life insurance policies specifically set up for funeral and burial expenses if the total face value for each is $1,500 or less
  - an irrevocable burial trust or prepaid irrevocable burial contract set up in reasonable amounts for future payment of funeral or burial expenses

Noncountable Assets (continued)

- Veterans' Payments
  - Aid & Attendance
  - Unreimbursed medical expenses
  - Housebound benefits
- Certain Trusts
- Any other asset considered non-countable for Title XIX eligibility
- For Native Americans and Alaska Natives, any asset or resource that is considered non-countable according to the American Recovery and Reinvestment Act (ARRA) of 2009

SACA-2: Step 6: Health Insurance Information

STEP 6 Health Insurance Information

MassHealth regulations require members to obtain and maintain available health insurance, including health insurance available through an employer. In order to determine continued MassHealth eligibility for you and members of your household request additional information from you and your employer about your access to employer sponsored health insurar You must cooperate in providing information necessary to maintain eligibility, including evidence of obtaining or mai available health insurance, or your MassHealth benefits may be terminated. See the Senior Guide for more information.

Does this apply?

1. Is anyone listed on this application offered health coverage from a job but not enrolled in it? ☐ Yes ☐ No
   Answer **Yes** even if this insurance is from another person's job, like a spouse, even if this person does not live in the household.
   If **Yes**, you will need to complete and include **Supplement D: Health Coverage from Jobs**, and the rest of this application.

   Is this a state employee benefit plan? ☐ Yes ☐ No

2. Does anyone qualify for or is anyone enrolled in the following types of health coverage? ☐ Yes ☐ No
   If **Yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have.

Must answer "Yes" or "No"

Answer **Yes** even if this insurance is from another person, like a spouse, even if the person does not live in the household.

☐ Enrolled in Medicare or qualifies for a Medicare Part A plan with no premium

Name ______ Medicare claim number ______

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

a. Does this person have a Medicare Part D plan? ☐ Yes ☐ No
   If **Yes**, when did coverage start? (mm/dd/yyyy) ______

b. Does this person have a Medigap/Medicare supplemental policy? ☐ Yes ☐ No
   If **Yes**, name of coverage plan ______ When did coverage start? (mm/dd/yyyy) ______

Name ______ Medicare claim number ______

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

a. Does this person have a Medicare Part D plan? ☐ Yes ☐ No
   If **Yes**, when did coverage start? (mm/dd/yyyy) ______

b. Does this person have a Medigap/Medicare supplemental policy? ☐ Yes ☐ No
   If **Yes**, name of coverage plan ______ When did coverage start? (mm/dd/yyyy) ______

Do any of the persons above want to apply for help paying for the Medicare Part B premiums? ☐ Yes ☐ No

If **Yes**, name(s) ______

If you check any of the following programs provide details below.

☐ Qualifies for **Peace Corps**
☐ Qualifies for **TRICARE** (Do not check if you have direct care or Line of Duty
☐ Enrolled in **Veterans Affairs (VA) health programs**
☐ **MassHealth**
☐ **Other coverage** (including COBRA and retiree health plans)

Name(s) of covered household members

Policy number or Member ID ______ Start date and end date? (mm/dd/yyyy) ______

☐ Enrolled in employer coverage. If anyone on this application is enrolled in employer coverage, you must complete and include **Supplement D: Health Coverage from Jobs.**

Name of employer ______ Plan name ______

Name(s) of covered household members ______

Policy number or Member ID ______ Start date and end date? (mm/dd/yyyy) ______

SACA-2: Step 7: HRA

Does this apply?

STEP 7 Health Reimbursement Arrangements

Is anyone in the household offered Health Reimbursement Arrangements (HRAs) from their employer? ☐ Yes ☐ No

Name(s) of individual		Date of Birth	
Employer Name			
Federal Tax ID			

Type of HRA offered by employer ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
☐ Individual Coverage Health Reimbursement Arrangement (ICHRA)

Start date		End date		Enter the maximum yearly self-only coverage benefit amount:	

If you have a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) do you intend to use QSEHRA family coverage benefits from your employer? ☐ Yes ☐ No

If you have QSEHRA, enter the maximum yearly family coverage benefit amount through the QSEHRA:

Does anyone in the household intend to accept an Individual Coverage Health Reimbursement Arrangement (ICHRA) benefit from their employer? ☐ Yes ☐ No

Name(s) of individual		Date of Birth	
Employer Name			
Federal Tax ID			

If "YES" complete all applicable fields

Type of HRA offered by employer ☐ Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
☐ Individual Coverage Health Reimbursement Arrangement (ICHRA)

Start date		End date		Enter the maximum yearly self-only coverage benefit amount:	

If you have a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) do you intend to use QSEHRA family coverage benefits from your employer? ☐ Yes ☐ No

If you have QSEHRA, enter the maximum yearly family coverage benefit amount through the QSEHRA:

Does anyone in the household intend to accept an Individual Coverage Health Reimbursement Arrangement (ICHRA) benefit from their employer? ☐ Yes ☐ No

SACA-2: Step 8: PCA Services

STEP 8 Personal-Care-Attendant Services

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

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

1. Do you or your spouse need the services of a personal-care attendant? ☐ Yes ☐ No

   If **Yes**, fill out this section and answer all questions. If **No**, go to **STEP 10: Read and sign this application**.

Does this apply?

2. Have you or your spouse had the services of a personal-care attendant **paid for by MassHealth** within the last six months? ☐ Yes ☐ No

   If **Yes**, go to **STEP 10: Read and sign this application**. If **No**, answer the following questions in this section.

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If "YES" complete all applicable fields

3. Do you or your spouse have a permanent or long-lasting disability? You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No

   a. If **Yes**, does your (or your spouse's) disability keep you (or your spouse) from being able to do your (or your spouse's) daily living activities, like bathing, eating, toileting, dressing, etc., unless someone physically helps you (or your spouse)? You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No

   b. If **Yes**, do you (or your spouse) plan to contact a MassHealth personal-care-management (PCM) agency to ask for personal-care-attendant services? You ☐ Yes ☐ No Your spouse ☐ Yes ☐ No

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

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

Each spouse who answered "Yes" to all parts of Question 3 above must fill out their own Supplement C: Personal-Care Attendant. One copy is enclosed. If you need a second copy, call MassHealth Customer Service at (800) 841-2900, TTY: (800) 497-4648 to ask for one. If you (or your spouse) do not send us your filled-out PCA supplement(s), we will determine your MassHealth eligibility as if you do not need PCA services.

PCA Services

Who can get MassHealth PCA services?

- To get PCA services, applicant or member must:
  - have a permanent or long-lasting disability
  - need someone to physically help the applicant or member with daily living activities like (mobility, bathing/grooming, dressing/undressing, passive range-of-motion, exercises, taking medications, eating, and toileting) which the applicant or member cannot do by themself
  - have a doctor's written authorization that the applicant to member need PCA services; and
  - get prior authorization from MassHealth
- Not everyone can get MassHealth PCA services
- Resources: MassHealth PCA Program, MassHealth PCA Program Handbook

SACA-2: Step 9: Additional (Optional) Coverage

STEP 9 Additional *(Optional)* Coverage – For married persons under 65 years of age

Fill out this section ONLY if you are married and living with your spouse. One spouse applying must be under 65 years of age, with no children under 19 years of age in the household. Answer these questions for the spouse who is under 65 years of age.

If this section applies to you and you want more information about income standards and other information that may apply, call us at (800) 841-2900, TTY: (800) 497-4648 to get a Senior Guide. If this section does not apply, go to Step 10: Read and sign this application.

BREAST OR CERVICAL CANCER *(OPTIONAL)* (Only for persons under 65 years of age.)

1. Do you have breast or cervical cancer? ☐ Yes ☐ No
   MassHealth has special coverage rules for people who need treatment for breast or cervical cancer.

   If **Yes**, we will send you a certificate to be filled out by your doctor to prove your breast or cervical cancer diagnosis. Then MassHealth can see if your MassHealth benefits give you the most coverage possible.

   Name: ______

HIV INFORMATION *(OPTIONAL)* (Only for persons under 65

2. Are you HIV positive? ☐ Yes ☐ No
   If you are HIV positive, you may be eligible for additional coverag

   Name: ______

Does this apply?

- ONLY Complete if spouse is under age 65 and have no children under age 19 in the household

Step 10: Rights and Responsibilities

STEP 10 Read and sign this application

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

FOR MASSHEALTH AND HEALTH CONNECTOR APPLICANTS

1. MassHealth may require eligible persons to enroll in available em... insurance m... premium as... the amount owed from the tax refunds of responsible

2. Employers c... in accordanc... services that... provide to s... Safety Net.

3. I may have t... myself and c... pay any pren...

FOR SUPPLEMENTAL NUTRITIONAL ASSISTANCE PROGRAM (SNAP) APPLICANTS

SUPPLEMENTAL NUTRITION ASSISTANCE PR...

If you checked the box on page 1, MassHealth w... **serve as your application for SNAP!** If you are e... By signing below, you agree that you have read...

You may be eligible for SNAP benefits w... gets this application if:

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

For more information about SNAP in Massachu... gov/SNAP.

Sign this application.

Sign this application -Required

By signing this application below, I hereby certify under the pains and penalties of perjury that the submissions and ... ents I have made in this application are true and complete to the best of my knowledge, and I agree to accept and com... ve rights ... Program (SN... P pro... alth ... (HIPAA), to the Department of Transitional Assistance (DTA) for the pu...

For MassHealth and Health Connector applicants only

If you are submitting this application as an authorized representative, ... Representative Designation Form (ARD) to us or have a form on record for us to process this applic... end of this application.

* Required Field

PLEASE SIGN & DATE

Signature of Person 1 or authorized representative or responsible par...	...name
	Date

If you are under 18 years of age, are you an emancipated minor? ☐ Yes ☐ No

If **No**, we need a responsible party who is at least 18 years old to sign this application on your behalf. Please provide that person's information below.

First name	Middle name	Last name	Suffix
Social Security Number	Relationship to you	Date of birth	
Street address	Apartment/Unit #		
City	State	Zip code	County
Phone	Ext.	Phone type	
Second phone	Ext.	Phone type	
Email address			

Long –Term Care Supplement

- Applicants will also need to fill out a Long-Term-Care Supplement if they are:
  - in an institution, such as a nursing home, chronic hospital, or other medical institution (applicants or members may have to pay a monthly payment, called a patient-paid amount, to the long-term care facility)
  - in an acute hospital waiting for placement in a long-term care facility, or
  - living in their home and applying for or getting long- term-care services under a Home- and Community-Based Services Waiver
- Resource: Long-Term-Care Application Checklist [LTC AC (09/18)]

SACA-2: Supplement A: LTC/HCBSW (slide 1 of 3)

SUPPLEMENT A Long-Term Care / Home- and Community-Based Service Waiver — MassHealth — HEALTH CONNECTOR

- Do you need long-term-care services in a **nursing home type facility**? ☐ Yes ☐ No
  If **Yes**, you must answer all questions and fill out all sections of this supplement.
- Are you applying for or getting long-term-care services at home under a **Home- and Community-Ba**
  ☐ Yes ☐ No
  If **Yes**, you need to fill out "Resource Transfers" and "Long –Term Care Insurance".

Please print clearly. If you need more space to finish any section, please use a separate sheet of paper (include yo r name and social security number), and attach it to this supplement.

Does this apply?

Applicant/Member Information

Last name, first name, middle initial	Social security number
Name and address of hospital, nursing facility, or other institution	
Date of admission (mm/dd/yyyy)	Were you placed here by another state? ☐ Yes ☐ No If **Yes**, what state?

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

Living expenses of the spouse and family members living at home

(Do not complete this section if you are applying for a Home- and Community-Based Service Waiver.)

Your spouse living at home may be able to keep some of your
living expenses. **If you do not have a spouse**, go to the next se
Send proof of your spouse's current living expenses.

Spouse's last name, first name, middle initial

2. How much does your spouse pay each month for:
   Rent? ______ Mortgage (principal and interest)? ______
   Homeowner's/tenant's insurance? ______ Real estate taxes? ______
   Required maintenance charge for a condo or co-op? ______ Room and board for assisted living? ______
3. Does your spouse pay for heat? ☐ Yes ☐ No
4. Does your spouse pay for utilities? ☐ Yes ☐ No
5. Is a child, parent, brother, and/or sister living with your spouse? ☐ Yes ☐ No
   If **Yes**, fill out this section. If **No**, go to the next section (Resource Transfers).
   Send proof of their monthly income before deductions. A deduction may be allowed for their maintenance needs. These persons must be related to you or your spouse, and one of you must claim them as dependents on your federal income tax return.

Name	Social security number

fers (resources include both income and assets)

onths:

longed to you or your spouse been transferred into or

r behalf transfer income or the right to income? ☐ Yes ☐ No

r spouse, or someone on your behalf transfer, change ownership in, give away, or
ts, including your home or other real estate? ☐ Yes ☐ No

r spouse, or someone on your behalf change the deed or the ownership of any real
ding creating a life estate, even if the life estate was purchased in another person's residence? ☐ Yes ☐ No

ased a life estate in another person's home, did you live in the home for at least
er you purchased the life estate? ☐ Yes ☐ No

r spouse, or someone on your behalf add another name to the deed of any property you own? ☐ Yes ☐ No

r spouse, or someone on your behalf receive or give anyone a mortgage, loan,
y note on any property or other asset? ☐ Yes ☐ No

r spouse, or someone on your behalf purchase or in any way change an annuity? ☐ Yes ☐ No

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

/income		Date of transfer (mm/dd/yyyy)
n	Relationship to you or your spouse	Amount of transfer $

If "YES" complete ALL applicable Fields, including: "Resource Transfers" and "Long-Term Care Insurance"

pouse, or someone acting on your behalf given a deposit to any health care or residential facility,
living facility, a continuing care retirement community, or life care community? ☐ Yes ☐ No

e name and address of the facility, the amount of the deposit, answer the following questions,
opy of the contract you signed with the facility and any documents about this deposit.

y ______ Amount $ ______

lity still have the deposit? ☐ Yes ☐ No

ty return the deposit? ☐ Yes ☐ No

s the name and address of the person who got the deposit from the facility.

son ______

SACA-2: Supplement A: LTC/HCBSW (slide 2 of 3)

Real Estate

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

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

8. Do you or your spouse own or have a legal interest in your home, including a life estate? ☐ Yes ☐ No
   If **Yes**, fill out the following information and answer questions 9 through 15. If **No**, answer question 15 onl
   Name and address of person(s) on ownership papers ______
   Description and address of property location ______
   Type of ownership (Check one.)
   ☐ Individual *(Fair-market value)* $ ______ ☐ Tenancy in common *(Fair-market value)* $ ______
   ☐ Joint tenancy *(Fair-market value)* $ ______ ☐ Life estate *(Fair-market value)* $ ______
   Name and address of person(s) on ownership papers ______
   Description and address of property location ______
   Type of ownership (Check one.)
   ☐ Individual *(Fair-market value)* $ ______ ☐ Tenancy in common *(Fair-market value)* $ ______
   ☐ Joint tenancy *(Fair-market value)* $ ______ ☐ Life estate *(Fair-market value)* $ ______
9. Do you have a spouse? ☐ Yes ☐ No. If **Yes**, fill out this section.
   Name ______ Is this person living in your home? ☐ Yes ☐ No
10. Do you have a permanently and totally disabled or blind child? ☐ Yes ☐ No. If **Yes**, fill out this section.
    Name ______ Is this person living in your home? ☐ Yes ☐ No
11. Do you have a child under 21 years of age? ☐ Yes ☐ No. If **Yes**, fill out this section.
    Name ______ Date of birth (mm/dd/yyyy) ______ Is this person living in your home? ☐ Yes ☐ No
12. Do you have a brother or sister with a legal interest in the home who was living in the home for at least one year immediately before your admission to the medical institution? ☐ Yes ☐ No. If **Yes**, fill out this section.
    Name ______ Is this person living in your home? ☐ Yes ☐ No
13. Do you have a son or daughter who has lived in the home for at least the last two years before your admission to the medical institution and has provided care to you that allowed you to live in the home? ☐ Yes ☐ No. If **Yes**, fill out this section.
    Name ______ Is this person living in your home? ☐ Yes ☐ No
14. Do you have a dependent relative? ☐ Yes ☐ No. If **Yes**, fill out this section.
    Name ______ Is this person living in your home? ☐ Yes ☐ No
    Describe the relationship and the nature of the dependency: ______
15. Do you intend to return to your home? ☐ Yes ☐ No
    (Do not answer this question if you are applying for a Home- and Community-Based Service Waiver.)

Does this apply?
Complete all questions if seeking LTC or HCBSW

- MassHealth recorded liens and estate recovery are two distinct methods of recovery of MassHealth payments. In some cases, both may apply
  - A lien is a legal claim on assets that allows MassHealth to recover the cost of care paid on the member's behalf

SACA-2: Supplement A: LTC/HCBSW (slide 3 of 3)

Long-Term-Care Insurance

17. Do you or your spouse have long-term-care insurance? ☐ Yes ☐ No

If **Yes**, fill out this section. If **No**, go to the next s

Send a copy of the policy.

Complete all questions if seeking LTC or HCBSW

Company name/Policy number		
Policyholder name	Effective date (mm/dd/yyyy)	Premium amount $
Company name/Policy number		
Policyholder name	Effective date (mm/dd/yyyy)	Premium amount $

Tax Returns

18. Did you or your spouse file U.S. income tax returns in the last two years? (Check one.)

☐ Yes, both years ☐ Yes, one of these years ☐ No, neither year

If yes, you must **send copies** of these returns. If you did not keep copies of one or more of these returns, **you must send in a filled-out and signed IRS Form 4506**. Form 4506 is included at the end of this application.

SACA-2: Supplement A: LTC/HCBSW – Signature

SIGN THIS SUPPLEMENT.

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

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

Signature of applicant/member or authorized representative	Print name	...ate

PLEASE SIGN & DATE

* All Required Field

Long-Term Care Services

- MassHealth Standard
  - Citizens, Protected Noncitizens, and Qualified Noncitizens
  - Pregnant Women ANY Immigration Status
  - Children/Young Adults under 21 who are Citizens, Qualified Noncitizens, Qualified Noncitizens Barred and Noncitizens Legally Present
- MassHealth Family Assistance
  - Citizen, Qualified Noncitizen, and Protected Noncitizen disabled adult younger than age 65 or adult age 65 and older
  - Citizen, Qualified Noncitizen, Protected Noncitizen, Qualified Noncitizen Barred, and Individual Lawfully Present children and young adults younger than age 21
  - Citizen, Qualified Noncitizen, Protected Noncitizen, Qualified Noncitizen Barred, Individuals Lawfully Present, PRUCOL, and Other Noncitizen pregnant women
  - Resource: Pathway to Short-Term and Long-Term-Care for Family Assistance Members at a Chronic Disease and Rehabilitation Hospital or Nursing Facility

Long-Term Care Services: Retroactive Eligibility

- Retroactive eligibility
  - May be requested at any time
  - May begin the first day of the third month prior to the month of application, providing the applicant was eligible during that time
  - Determination must be within MassHealth Time Standards
- Retroactive eligibility (continue)
  - For deceased individuals: determined
    - From the date of death but
    - Not earlier than the third month prior to the month of application
  - May be approved if covered medical services were received during such a period <u>and</u>
  - Applicant or member would have been eligible at that time

LTC Eligibility Criteria

- Under 21 who are Citizens, Qualified Noncitizens, Qualified Noncitizens Barred and Noncitizens Legally Present or over 65, or
- Applicants between 21 - 64 and meet Title XVI disability standards or be pregnant (pregnant any immigration status)
- Determined medically eligible for nursing facility services by MassHealth or its agents (LTC Screening)
- Contribute to the cost of care (Patient Paid Amount (PPA))
- Countable assets:
  - Single individual: $2,000 or less
  - Married couples where one member of the couple is institutionalized: have assets less than or equal to applicable standards

Status Change for a Member in a Nursing Facility or SC-1

- Complete by nursing home or chronic hospital advising admission, discharge, or death

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

Status Change for a Member in a Nursing Facility or Chronic Disease and Rehabilitation Inpatient Hospital
(Admission or Discharge of MassHealth Members)

SECTION 1 (Items 1 through 12 must be completed.) PLEASE PRINT OR TYPE

1. Provider ID/Service Location
2. Provider Name
3. Provider Telephone Number
4. Provider Address
5. Reason for Submission ☐ New SC-1 ☐ Change to Existing SC-1
6. Member Last Name
7. Member First Name
8. Middle Initial
9. Member Home Address
10. Member Date of Birth
11. Member Gender ☐ Female ☐ Male
12. Member ID or SSN (Provide SSN only if member ID is not available.)

SECTION 2 (
13. Type of St
☐ Admit
☐ Both a
14. Type of Be
☐ Facilit
☐ Chron
18. Discharge
☐ Disch
☐ Disch
☐ Disch

SECTION 3 (
19. MassHeal
21. Length of
☐ Short
☐ More
☐ Short

Complete It
23. Certificat member'
26. Public Ra $
30. Does mer Elderly (
32. Does mer 100-day
34. Is the nur attached
35. Signature

INSTRUCTIONS FOR COMPLETING THE SC-1 FORM		
Please see instructions below for the fields that are not self-explanatory. For all items with check boxes, please make sure you check one box. As noted below, some fields are required to be completed.		
SECTION 1		
Items 1 through 12 are required to be completed on all SC-1 forms.		
Item 1	Provider ID/Service Location	Enter the nine-digit provider ID followed by the one-character location code.
Item 12	Member ID or SSN	Enter the 12-digit MassHealth member ID number. Enter the social security number (SSN) only if member ID is not available.
SECTION 2		
Item 13 is required to be completed. • If Item 13 is "Admit," items 14-16 are required to be completed. • If Item 13 is "Discharge," items 17-18 are required to be completed. • If Item 13 is "Both admit and discharge," items 14-18 are required to be completed.		
Item 18	Discharge Reason	Select the reason for discharge. If none of the reasons explains the situation clearly, use the other field to explain.
SECTION 3		
• If Item 13 is "Admit" or "Both admit and discharge," items 19-22 and 26-33 are required to be completed. • If Item 21 is "Short-term (six months or less)," items 23-25 are required to be completed. • Items 34-35 are required to be completed on all SC-1 forms.		
Item 19	MassHealth Requested Payment Date	Enter the start date for which MassHealth payment is requested.
Item 20	Reason for MassHealth Requested Payment Date	Describe the reason for the request date in Item 19 (e.g., Medicare days ended, private pay ended).

SACA-2: Supplement B: AI or AN Household Member

SUPPLEMENT B American Indian or Alaska NativeHousehold Member (AI/AN) — MassHealth — Massachusetts Health Connector

Complete this supplement if you or a household member are an American Indian or Alaska Native.

Tell us about your American Indian or Alaska Native household member(s).

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

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

AI/AN Person 1

1. Name (first, middle, last)
2. Member of a federally recognized tribe?
   ☐ Yes ☐ No
   If **Yes**, tribe name ________
3. Member of a Massachusetts-recognized tribe?
   ☐ Yes ☐ No
   If **Yes**, tribe name ________
4. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs?
   ☐ Yes ☐ No
   If **No**, is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Program, or through a referral from one of these programs?
   ☐ Yes ☐ No
5. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from
   - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations); or

AI/AN Person 2

1. Name (first, middle, last)
2. Member of a federally recognized tribe?
   ☐ Yes ☐ No
   If **Yes**, tribe name ________
3. Member of a Massachusetts-recognized tribe?
   ☐ Yes ☐ No
   If **Yes**, tribe name ________
4. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or Urban Indian Health Program, or through a referral from one of these programs?
   ☐ Yes ☐ No
   If **No**, is this person eligible to get services from the Indian Health Service, tribal health programs, or Urban Indian Health Program, or through a referral from one of these programs?
   ☐ Yes ☐ No
5. Certain money received may not be counted for MassHealth. List any income (amount and how often) reported on your application that includes money from
   - Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties;
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of the Interior (including reservations and former reservations); or

Does this apply?

- American Indians and Alaska Natives can get services from the Indian Health Services, tribal programs, or Urban Indian Health Programs
- May not have to pay cost sharing and get special monthly enrollment periods

SACA-2: Supplement C: PCA

SUPPLEMENT C Personal-Care Attendant

MassHealth | HEALTH CONNECTOR

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

Send to: MassHealth Enrollment Center
PO Box 4405
Taunton, MA 02780
Or Fax to: (857) 323-8300

Does this apply?

Applicant/Member information

Last name	First name	MI
Social security number	Date of birth (mm/dd/yyyy)	
Street address	City	State / ZIP

Information about your health problems

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

1. ______
2. ______
3. ______

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

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

If "YES" complete all fields

Daily l...

Mobility (m... approved m...

Taking medi...

Bathing (tub... general groo...

Dressing/Ur...

Range-of-m... by moving t...

Eating

Toileting (lik... getting cloth...

Caregiver...

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

Caregiver name	Relationship to you (like relative, neighbor, personal-care attendant)
Caregiver name	Relationship to you (like relative, neighbor, personal-care attendant)

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

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

PLEASE SIGN & DATE

- Mail Supplement C: PCA to: MEC
  P.O Box 4405
  Taunton, MA 02780
  or fax: 857-323-8300
- Complete all fields and Sign and Date

SACA-2: Supplement D: Health Coverage from Jobs

SUPPLEMENT D Health Coverage from Jobs

MassHealth | HEALTH CONNECTOR

Answer these questions if someone in the household is eligible for health coverage from a job, whether or not they are enrolled in the coverage. Attach a copy of this page for each job that offers coverage.

TELL US ABOUT THE JOB THAT OFFERS COVERAGE.

Does this apply?

EMPLOYEE INFORMATION

1. Employee name (first, middle, last)
2. Employee social security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

3. a. Is at least one person on this application currently eligible for or enrolled in coverage offered by this employer, or will at least one person on this application become eligible within the next 3 months? ☐ Yes ☐ No
If the answer to 3a is **Yes**, continue. If the answer to 3a is **no**, stop here and skip the rest of Supplement D.
b. If any person is in a waiting or probationary period, when can this person enroll in coverage? (mm/dd/yyyy) ___________

EMPLOYER INFORMATION

4. Employer name
5. Federal Tax ID (if known) ___ ___ - ___ ___ ___ ___ ___ ___ ___
6. Employer address
7. Employer phone number
8. City
9. State
10. ZIP code
11. Who can we contact about employee heath coverage at this job?
12. Phone number (if different from above)
13. Email address

TELL US ABOUT THE HEALTH PLAN OFFERED BY THIS EMPLOYER.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No
15. a. What is the name of the lowest cost self-only health plan offered to the employee? ___________
b. Does the health plan offered by the employer meet the minimum value standard for coverage? ☐ Yes ☐ No
c. How much does the employee have to pay in premiums for the lowest cost plan that meets the minimum value standard? Only tell us about the cost of the individual (self-only) health plans, not the cost of a family health plan. $ ___________
d. How often would the em

16. What change will the empl

If "YES" complete all fields

- Does someone in the household have access or is eligible for health coverage from a job?

Medicare Savings (MassHealth Buy-In) Program Application

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

Medicare Savings (Buy-In) Programs Application

for people who are eligible for Medicare

Who can use this application?

Individuals of any age who are receiving Medicare and are only seeking help with payment of their Medicare premiums and cost sharing.
If you want to apply for other MassHealth benefits, (as well as assistance with Medicare costs), call MassHealth Customer Service at (800) 841-2900, TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled for a different application. Please print clearly and fill out all sections.

Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP) is a federal program that helps you buy healthy food each month.
☐ Check this box if you want this application to be sent to the Department of Transitional Assistance to serve as an application for SNAP benefits. You must read the rights and responsibilities on pages 3 through 7 and sign on page 2 to proceed with the application.

General Information

Who is applying? ☐ you ☐ you and your spouse
If you and your spouse live together, you must also give us information about your spouse even if he or she is not applying for benefits.

You Last name | First name | MI
Street address | City | State | Zip
Mailing address (*if different from above*) ☐ homeless | City | State | Zip
Date of birth / / | Gender ☐M ☐F | Telephone number ( )
Preferred spoken language | Preferred written language
Social security number | Medicare claim number

Your Spouse Last name | First name | MI
Date of birth / / | Gender ☐M ☐F | Telephone number ( )
Preferred spoken language | Preferred written language
Social security number | Medicare claim number

Income

Fill out this section for you and your spouse. List the gross monthly income (before taxes and other deductions, such as the Medicare Part B premium).

Source of income	Gross monthly income before taxes and deductions.	
Social security	Your $	Your spouse's $
Pensions	Your $	Your spouse's $
Federal veterans' benefits	Your $	Your spouse's $
Annuities or trusts	Your $	Your spouse's $
Dividends and/or interest	Your $	Your spouse's $
Income from a job (before deductions)	Your $	Your spouse's $
Rental income (after expenses)	Your $	Your spouse's $
Other (please specify)	Your $	Your spouse's $

1 MHBI-03-22

MassHealth Buy-In

Medicare Savings Programs (also known as the "MassHealth Buy-in" Programs) help older residents and people living with disabilities save money on their Medicare coverage.

Senior Buy-In (Qualified Medicare Beneficiaries (QMB))

- QMB: Countable income is less than or equal to 130% of FPL
- MassHealth pays for Medicare Part B premium
- MassHealth pays for Medicare Part A premium (if member has Part A premium)
- MassHealth pays for Medicare Part A and B cost sharing (co-insurance and deductibles)
- Automatic eligibility for Medicare Part D Extra Help

Buy-In (Specified Low Income Medicare Beneficiaries (SLMB) and Qualifying Individuals (QI))

- SLMB: Countable income is greater than 130% and less than or equal to 150% of FPL
- QI: Countable income is less than or equal to 165% of FPL
- MassHealth pays for Medicare Part B premium
- Automatic eligibility for Medicare Part D Extra Help

Eligibility: Income and Assets

For Individuals If countable assets are less than or equal to $16,800	
Monthly income before taxes and deductibles is less than or equal to	Then eligible for
$1,473	Senior Buy-In
$1,869	Buy-In

For Married Couple living together If countable assets are less than or equal to $25,200	
Monthly income before taxes and deductibles is less than or equal to	Then eligible for
$1,984	Senior Buy-In
$2,518	Buy-In

Note: The income amounts may change yearly on March 1st, and the asset/resource amounts may change yearly on January 1.

MassHealth Buy-In Application: General Information

- Information of who's applying and household members
  - SSN
  - Spouse's information if they are applying
  - Medicare card number

General Information

Who is applying? ☐ you ☐ you and your spouse

If you and your spouse live together, you must also give us information about your spouse even if he or she is not applying f

*** All REQUIRED**

You	Last name	First name	MI

Street address	City	State	Zip
Mailing address (*if different from above*) ☐ homeless	City	State	Zip

Date of birth / /	Gender ☐M ☐F	Telephone number ( )

Preferred spoken language	Preferred written language
Social security number	Medicare claim number

Your Spouse	Last name	First name	MI

Date of birth / /	Gender ☐M ☐F	Telephone number ( )

Preferred spoken language	Preferred written language
Social security number	Medicare claim number

MassHealth Buy-In Application: Income

- Complete/provide **ALL** applicable sources of income

Income

Fill out this section for you and your spouse. List the gross monthly income (before taxes and other deductions, such as the Medicare Part B premium).

Source of income	Gross monthly income before taxes and deductions.	
Social security	Your $ ____	Your spouse's $ ____
Pensions	Your $ ____	Your spouse's $ ____
Federal veterans' benefits	Your $ ____	Your spouse's $ ____
Annuities or trusts	Your $ ____	Your spouse's $ ____
Dividends and/or interest	Your $ ____	Your spouse's $ ____
Income from a job (before deductions)	Your $ ____	Your spouse's $ ____
Rental income (after expenses)	Your $ ____	Your spouse's $ ____
Other (please specify) ____	Your $ ____	Your spouse's $ ____

*** REQUIRED if it applies**

1

MHBI-0322

Earned Income

Applicants or members applying solely for MassHealth Senior Buy-in (QMB) or MassHealth Buy-in for Specified Low Income Medicare Beneficiaries (SLMB), or MassHealth Buy-in for Qualifying Individuals (QI)

- Verifications include:
  - one recent pay stub
  - a signed statement from the employer
  - the most recent U.S. tax return or self-employment income records
  - for room and board: a statement signed by both parties stating the amount and frequency of payments; or
  - other reliable evidence

Unearned Income

- Include (but is not limited to): social security benefits, railroad retirement benefits, pensions, annuities, federal veterans' benefits, rental income, interest, and dividend income
- Gross rental income is the countable rental-income amount received less business expenses
  - The applicant or member must verify gross unearned income
- Verifications include:
  - a recent pay stub showing gross income
  - a statement from the income source when matching is not available
  - for rental income: a written statement from the tenant or a copy of the lease; or
  - other reliable evidence

MassHealth Buy-In Application: Asset

- Assets – what type of assets does the applicant have

Assets

Fill out this section for you and your spouse.

* REQUIRED if it applies

Source			
Savings accounts	Your $ ____	Your spouse's $ ____	You and your spouse $ ____
Checking accounts	Your $ ____	Your spouse's $ ____	You and your spouse $ ____
Second car (first car is noncountable)	Your $ ____	Your spouse's $ ____	You and your spouse $ ____
Certificates of deposit	Your $ ____	Your spouse's $ ____	You and your spouse $ ____
Stocks	Your $ ____	Your spouse's $ ____	You and your spouse $ ____
Bonds	Your $ ____	Your spouse's $ ____	You and your spouse $ ____
Mutual funds	Your $ ____	Your spouse's $ ____	You and your spouse $ ____
Other (please specify) ____	Your $ ____	Your spouse's $ ____	You and your spouse $ ____
Total assets	Your $ ____	Your spouse's $ ____	You and your spouse $ ____

MassHealth Buy-In Application: Sign and Submit

- Mail to: MassHealth Enrollment Center

  PO Box 290794

  Charlestown, MA 02129-0214

- Fax to:

  (857) 323-8300

Sign this application.

PLEASE SIGN & DATE

X ______________________________ ________
Signature of applicant or Authorized Representative Date

X ______________________________ ________
Signature of Spouse or Authorized Representative Date

Both you and your spouse must sign if your spouse lives with you.
By signing, you agree to and understand the following

By signing this application, I hereby certify that I have read and agree to the Rights and Responsibilities included in this application on pages 3 though 7.

I hereby certify under the pains and penalties of perjury that the submissions and statements I have made in this application are true and complete to the best of my knowledge, and I agree to accept and comply with the rights and responsibilities of the Medicare Savings Program (Buy-In).

If I have checked the SNAP box on page 1 of this application I am applying for the Supplemental Nutritional Assistance Program (SNAP). I certify that I understand and agree to the rights, rules, and penalties of the SNAP program, as outlined below. I ask that MassHealth send my information, including Protected Health Information subject to the Health Insurance Portability and Accountability Act (HIPAA), to The Department of Transitional Assistance for the purpose of applying for SNAP benefits.

Important:
(For Medicare Savings Program (Buy-In) applicants only)

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

Program Effective Date

MassHealth **Senior Buy-In** goes into effect:

- first day of the calendar month following the date of the MassHealth eligibility determination

MassHealth **Buy-In** goes into effect:

- up to three calendar months before the month of application

Notices and Forms

Notices and Forms (continued)

- **Request For Information (RFI):** MassHealth may initiate information matches with other agencies and sources when an application is received, at annual renewal, and periodically, in order to update or verify eligibility
- **MassHealth Renewals**: MassHealth is required to renew households annually. Automatic and prepopulated renewals may be completed for eligible households. Households not auto renewed are sent letters to heads of households explaining that their family should submit the renewal within 45 days of being notified
- **Disability Supplement**: If an individual claims they have an injury, illness, or disability expected to last at least 12 months, MassHealth will send a disability supplement. Individuals that are deemed disabled through the Social Security Administration, or Massachusetts Commission for the Blind, do not have to submit these supplements

Application Date and Missing Information

- Date of Application is the date the application is received by MassHealth
  - If denied for SSI within 30 days of applying for MassHealth, the date of the MassHealth application will be the date of the SSI application
- Missing information or incomplete applications
  - Applicant or members must respond to requests of information for unanswered questions within 15-days of the date of the notice
  - If responses to all unanswered questions are not received within the 15-days, the application received date will not be used for the eligibility start date
  - If the required information is received after the 15-day, the eligibility start date will be the date the information was received provided that if the required response is submitted more than one year after the initial incomplete application, needs a new application

MassHealth Application Process

MassHealth

- MassHealth Eligibility Decision
  - MassHealth has 45 days from the received date of the application to make an eligibility decision
- RFI notice
  - what information is needed
  - examples of acceptable proofs
  - the latest date MassHealth can accept the proofs to establish eligibility
- If all proofs are not received by the due date
  - MassHealth will use information that was supplied through systematic matching, determine eligibility, and send a notice explaining eligibility
  - If no information is available electronically, and proof is received at a later date, proof may be accepted, but the eligibility start date may be impacted

When to Submit a New MassHealth Application

- RFI
  - Requested information must be received within 30-days of the date of the notification
  - For members 65 or older living in the community, or for members of any age needing long-term care services:
    - If the case has been closed for 30-days or less, the member provides MassHealth with any required, outstanding verifications on the case. A new application or review form is not required to reopen the case
    - If the case has been closed for more than 30-days, a new application is required

When to Submit a New MassHealth Application (continued)

- If the case has been denied for excess Assets, the member can submit proof of Asset reduction
  - If the member provides proof of asset reduction less than 30-days from the denial notice date, the Eligibility date will be based on the original Application Date
  - If the member provides proof of asset reduction after 30-days of denial notice, the eligibility date will be the date of the when the Asset Reductions Verification is received
  - If the member provides proof of asset reductions after 61--days, a new application is needed

Application Completion Tips and Reminders

Ensuring Completeness of Application

- Use the latest version of the application
- **Answer all questions, write, and print clearly**
  - Answer **"Yes" or "No"** to all questions
    - If **"Yes"** make sure to send documents
- Sign **AND** date the application(s)

The following can cause delays in processing and determining an application include:

- No or wrong address; if homeless use the mailing address of shelter, if applicable
- No information, or only partially complete page(s), using not-applicable (N/A), crossed out questions
- Faxing or mailing copies of documents that are too small or too dark or light to read, rendering them unreadable
- Only listing the name of the other spouse, not completing a Person page for each member of the household or those applying
- Missing or incomplete information: income, asset, immigration status

Reminders and Tips

- Not faxing **all pages** (both sides of the application) or faxing to the incorrect number or location

When faxing or mailing

- Use the MassHealth Mail/Fax Coversheet
- Put identifying information on documents such as name, D.O.B, and or SSN
- Do not refax or remail documents
  - Once you submit an application, annual review or other materials, do not submit the same item repeatedly
  - You can fax it or mail it – but don't do both
- Submitting duplicate documents adds to workload resulting in delays to processing
  - Please allow time for initial processing after document submission

Resources

MassHealth Senior Regulations

- MassHealth Eligibility Regulations
  - MassHealth General Policy 130 CMR 515.000
    - Estate Recovery and Real Estate Liens 130 CMR 515.012
  - The Eligibility Process 130 CMR 516.000
  - Universal Eligibility Requirements 130 CMR 517.000
  - Citizenship and Immigration 130 CMR 518.000
  - MassHealth Financial Eligibility 130 CMR 520.000
- Mass.gov/MassHealth
  - MassHealth Estate Recovery

Figures Used to Determine Eligibility

- Program financial guidelines for certain MassHealth applicants and members
  - The below are list of factsheet figures used to determine eligibility for certain MassHealth applicants and members aged 65 and older or those of any age who are in or are entering a long-term-care facility and their spouses who reside in the community
    - Eligibility figures for residents of a long-term-care facility
    - Eligibility figures — community residents aged 65 or older
    - Figures Used to Determine Minimum-Monthly-Maintenance-Needs Allowance (MMMNA)
    - MassHealth Income Standards and Federal Poverty Guidelines
    - SSI Payment Standards 2022
- Calculating the Value of a Life Estate and Remainder Interest for Individuals and Couples

Health Connector and Medicare

When a Health Connector member is found to be enrolled in Medicare, they are no longer eligible for the same Health Connector benefits.

- As a best practice, once someone is *eligible* for Medicare, they should take action to enroll as soon as possible. They also need to disenroll from Health Connector coverage as this does not happen automatically. Taking these actions will help them avoid paying Medicare penalties for late enrollment and also help avoid being responsible for paying back any Advance Premium Tax Credits (APTCs) used for Health Connector coverage
- Individuals do not qualify for APTCs once they become eligible for Medicare
  - There is an exception to this rule. People who must pay for Medicare Part A have the option to stay enrolled in a Health Connector plan and continue receiving any subsidies they qualify for or to take Medicare and leave Health Connector coverage. Download and review the job aid that includes the Health Connector's general guidance about helping someone newly enrolled in Medicare

Resources (continued)

[MassHealth Member Forms]

- MassHealth Asset Assessment for Potential MassHealth Eligibility: A form used to determine the amount of a person's assets when that person wants to find out if he or she may be eligible for MassHealth long-term-care benefits
- Personal-Care-Attendant Supplement: A form for persons who need personal-care-attendant services
- U.S. Citizenship/National Status Requirements for MassHealth and ConnectorCare Plans and Premium Tax Credits Identity Requirements for MassHealth, ConnectorCare Plans and Premium Tax Credits, and the Health Safety Net: A form that provides complete information about acceptable proofs of U.S. citizenship/national status and identity
- Affidavit to Verify Massachusetts Residency [AFF-MR] (10/19)
- Affidavit to Verify Zero Income [AFF-ZI] (10/19)

Resources: Long-Term-Care

MassHealth Member Forms

- Long-Term-Care Supplement [LTC-SUPP (03/20)]: A form for persons applying for or already receiving long-term-care services

Long-Term-Care Application Checklist [LTC AC (09/18)]

Long-Term-Care Application Checklist

Helpful tips for applying for MassHealth Long-Term-Care (LTC) benefits

You must fill out the **Application for Health Coverage for Seniors and People Needing Long-Term-Care Services** (SACA-2) and the Long-Term-Care Supplement. In order to get any benefits you are entitled to as quickly as possible, you should include any documentation you have that verifies your income, assets, citizenship or immigration status, and other health insurance. Use the following charts as a guide to completing the application. Additional information may be requested.

Ensure the following steps have been taken:	✓	N/A
"Long-Term Care" is selected on page 1 of the application.		
All questions are answered "yes" or "no" for you and your spouse (if married, even if spouse is not applying).		
Application is signed by you or your Authorized Representative Designee (ARD). Note: if signed by an ARD, the ARD form must be completed and sent with the application.		
Long-Term-Care Supplement completed and signed by you or your Authorized Representative Designee (ARD)		
Disability supplement and medical records release forms have been completed and mailed separately (individuals under the age of 65 only).		
Submission of Status Change (SC-1) form (to be submitted by nursing facility staff)		
Submission of Level of Care (LOC) indicating clinical eligibility (to be submitted by nursing facility staff)		

Verifications to include with this application for you and your spouse (if married, even if spouse is not applying, unless noted otherwise):	✓	N/A
Proof of citizenship or immigration status (this is not needed for a non-applying spouse)		
Proof of income, before taxes are taken out, for all types of income received (except for Social Security income for the applicant)		
Current bank statement(s) from 60 months prior to admission date to the present, for all open accounts		
A copy of the deed(s), current tax bill(s), and proof of amount owed on all property owned, including life estates		
A copy of the first page of all life-insurance policies or a letter from the insurance company showing the current cash-surrender value (for all policies except term policies)		
Current value of any securities (stocks, bonds, or other)		
A copy of all annuity contracts. For each annuity owned, give us proof from the annuity company of the full value of the annuity, less any penalties and fees if it can be cashed in.		
Proof of any deposit given to a health-care or residential facility		
A copy of the registration for all vehicles (including fair market value at time of admission)		
Proof of any prepaid burial plans, accounts, or trusts		
All trust documentation (including the trust(s), schedule of beneficiaries, any deeds, and bank statements that are held by the trust)		
Current copy of all health insurance cards and current premiums		
Proof of any resource transfers within the last 60 months from the date of application		

LTC AC (09/18) 1

Resources: COVID-19 and MassHealth

- Coronavirus Disease (COVID-19) and MassHealth | Mass.gov

  Find resources and information related to the coronavirus for MassHealth applicants, members, and providers.

MassHealth Self-Service System

NO TIME TO WAIT?

Use the MassHealth self-service system to....

- **Verify your MassHealth coverage or health plan coverage**
- **Request an application**
- **Confirm transportation benefits (PT-1 form)**
- **Get premium billing information**

This service is available 24 hours a day, seven days a week. If you need to speak with someone, our Customer Service representatives are available Monday through Friday from 8 a.m. till 5 p.m.

Call **1-800-841-2900** **TTY: 711**
and follow the option to the information you want.

WE'RE READY TO HELP!

Certified Application Counselors (CACs): When calling this Interactive Voice Response (IVR) System, you must be actively working with a member. The member must already be on the phone or physically with you when you call the IVR System.

PT-1 refers to authorization for non-emergency transportation