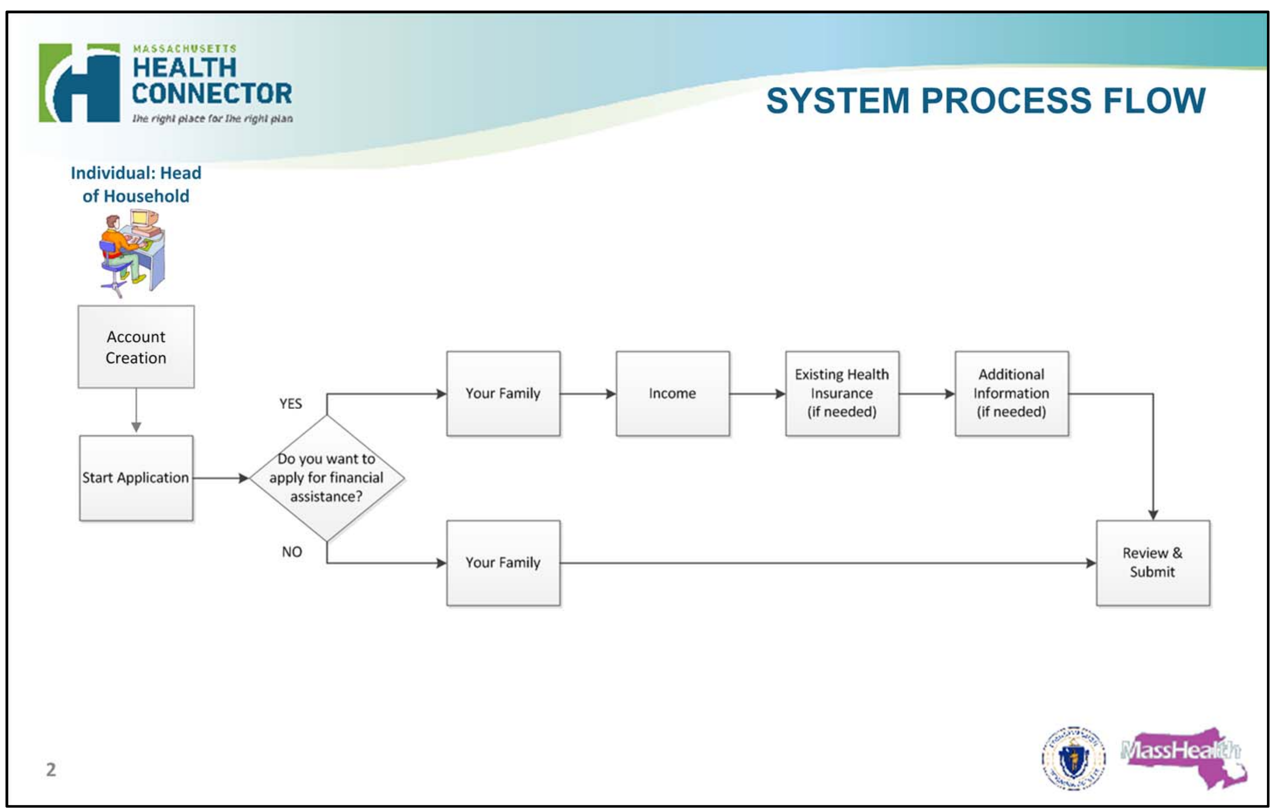
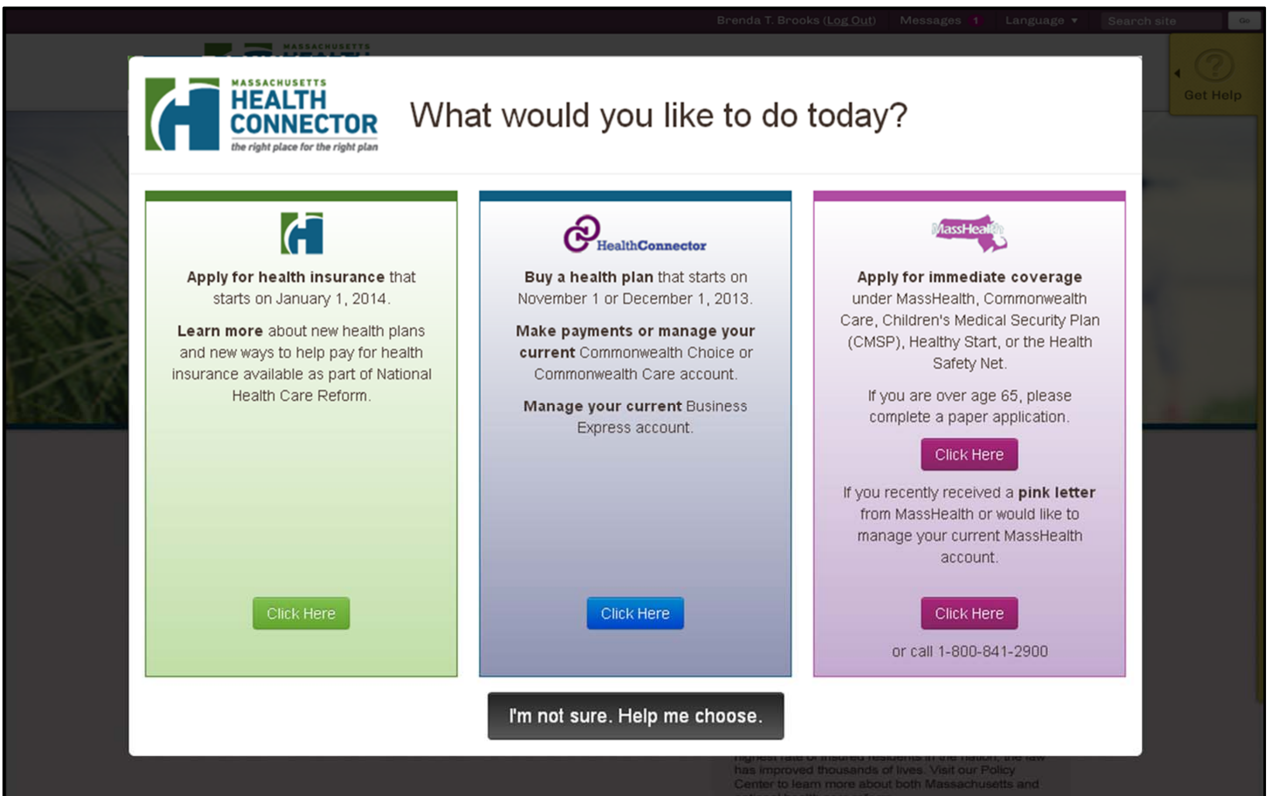
MASSACHUSETTS
HEALTH
CONNECTOR
the right place for the right plan
HIX Training Program
System Overview
Open Enrollment is October 1, 2013
through March 31, 2014
Individuals & Families
Small Businesses
Brokers
Welcome to the Massachusetts Health
MassHealth



This is a high-level overview of the process flow that we will be covering today. You will see this diagram throughout today's presentation as a way of indicating where we are in the process.

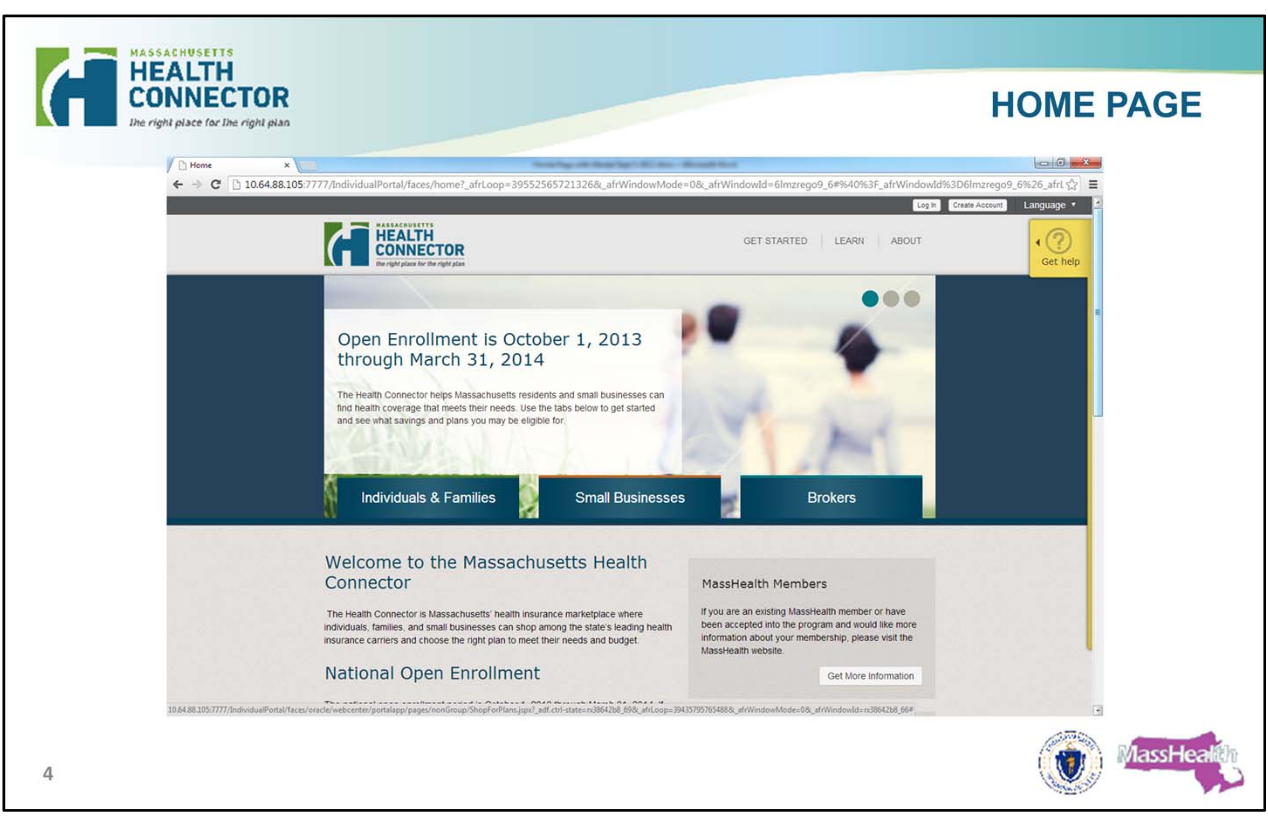
[provide brief walkthrough of steps]



This screen is what users see when they first come to the Massachusetts Health Connector website. It helps direct users to the new or old connector websites or other appropriate MassHealth websites. It is a temporary transition device and will only be live until December 2013.

- The Green **Click Here** button takes the user to the "new" Health Connector Homepage where you can buy a health plan for coverage effective January 1, 2014.
- The Blue **Click Here** button takes user to the legacy Health Connector Homepage where you can buy a health plan for 2013.
- The top purple **Click Here** button takes the user to Apply for MassHealth (on the MassHealth website)
- The bottom purple **Click Here** button redirects user to MassHealth My Account Page
- The **I'm not sure Help me Choose** button takes the user to a new page on the Health Connector Homepage containing additional details regarding these options.

HOME PAGE



MassHealth

Account Creation

CREATING A NEW ACCOUNT

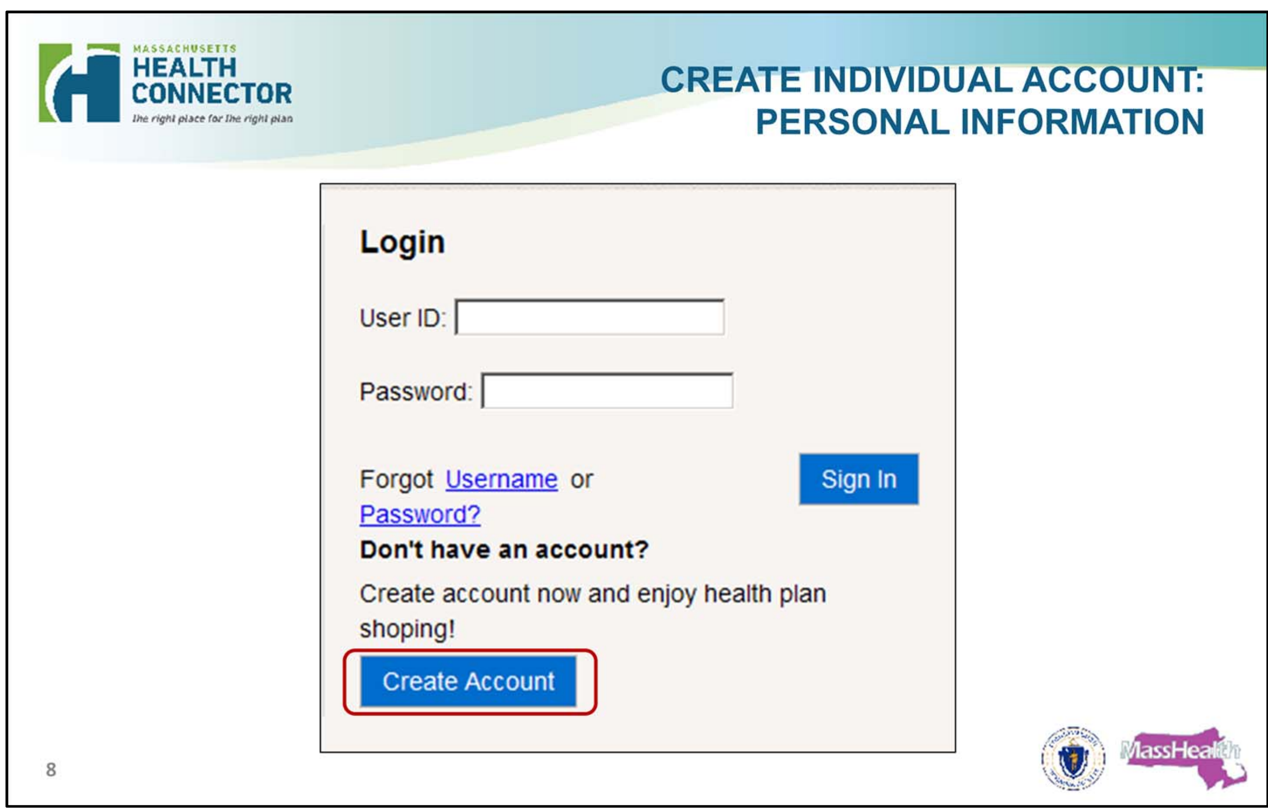
Creating a new account is a two step process:

- Enter name, date of birth, zip code, email, personal identification number, username and password
- Select security questions and answers, and agree to terms and conditions

CREATING A NEW ACCOUNT

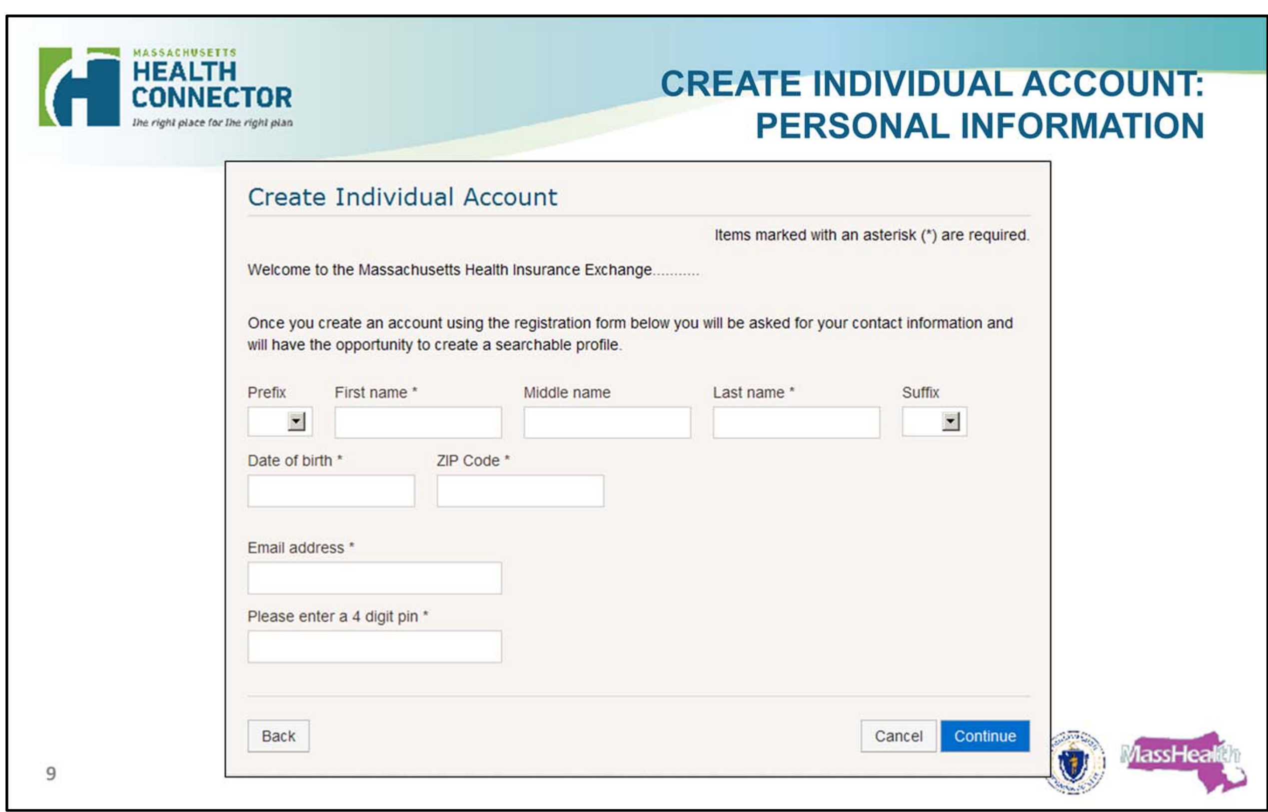
When users create an individual account, they encounter the following screens:

- User Account Page
- Create Individual Account – Input Personal Information
- Create Individual Account – Select Username and Password
- Create Individual Account – Setup Security Questions
- Account Creation Complete



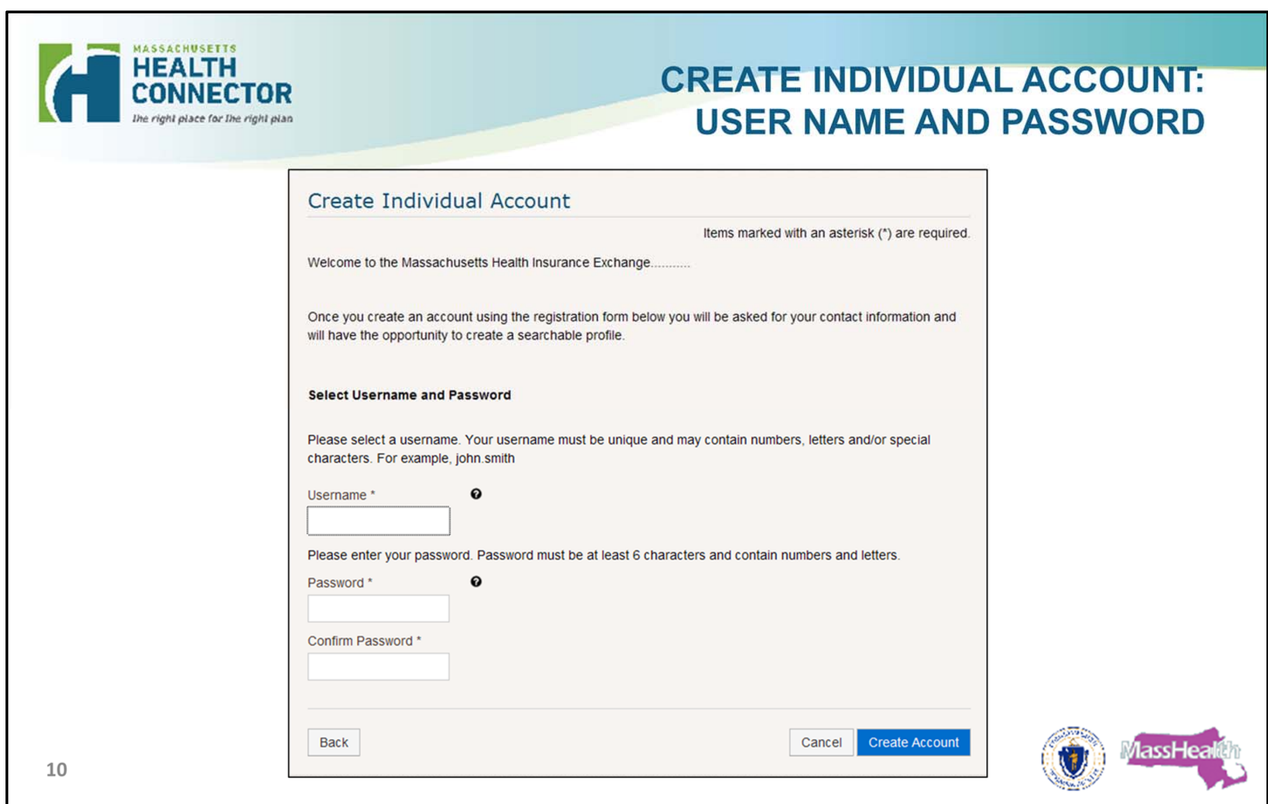
If the user already has created a user ID and password, this is where they will they sign in.

If they do not have an account, they click on the "Create Account" button and begin the account creation process.



The first step to creating an account is entering your personal information. The following fields are mandatory:

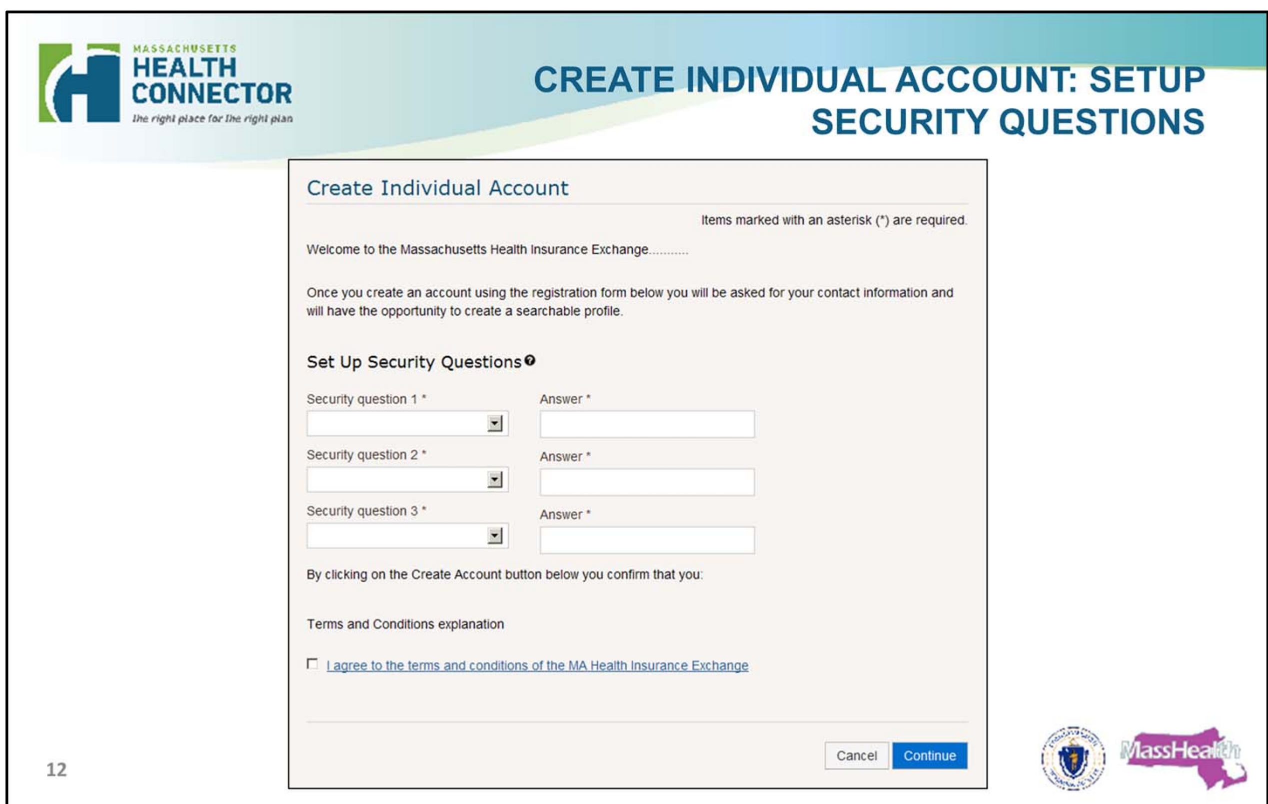
- First Name
- Last Name
- Date of Birth
- ZIP Code
- Email address
- 4-digit pin (of your choosing)



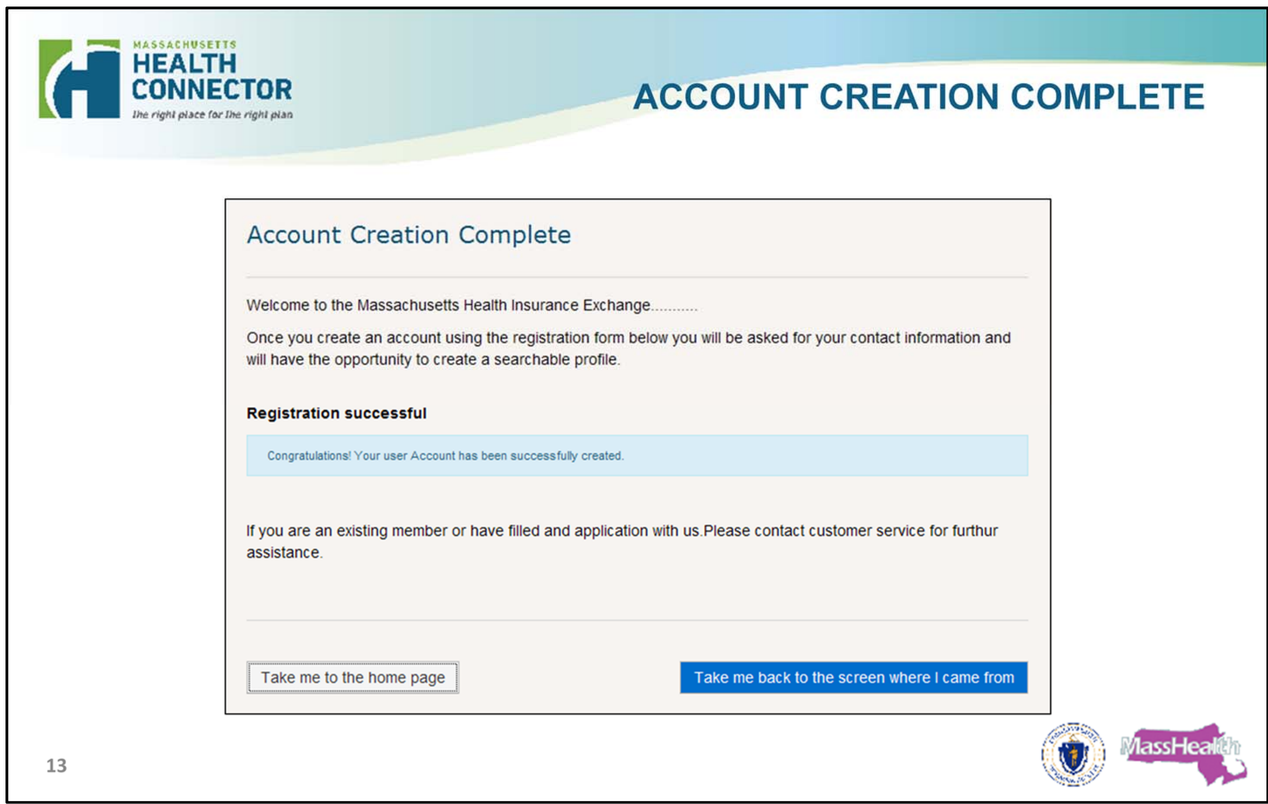
The next step is to create a username and password. If someone else already has the same username, the system will ask the user to create a different username.

Once you click the “Create Account” button, you move to the next steps in account creation, which are different depending on whether or not the user is known to the HIX system.

If the User is not Already Known to the System

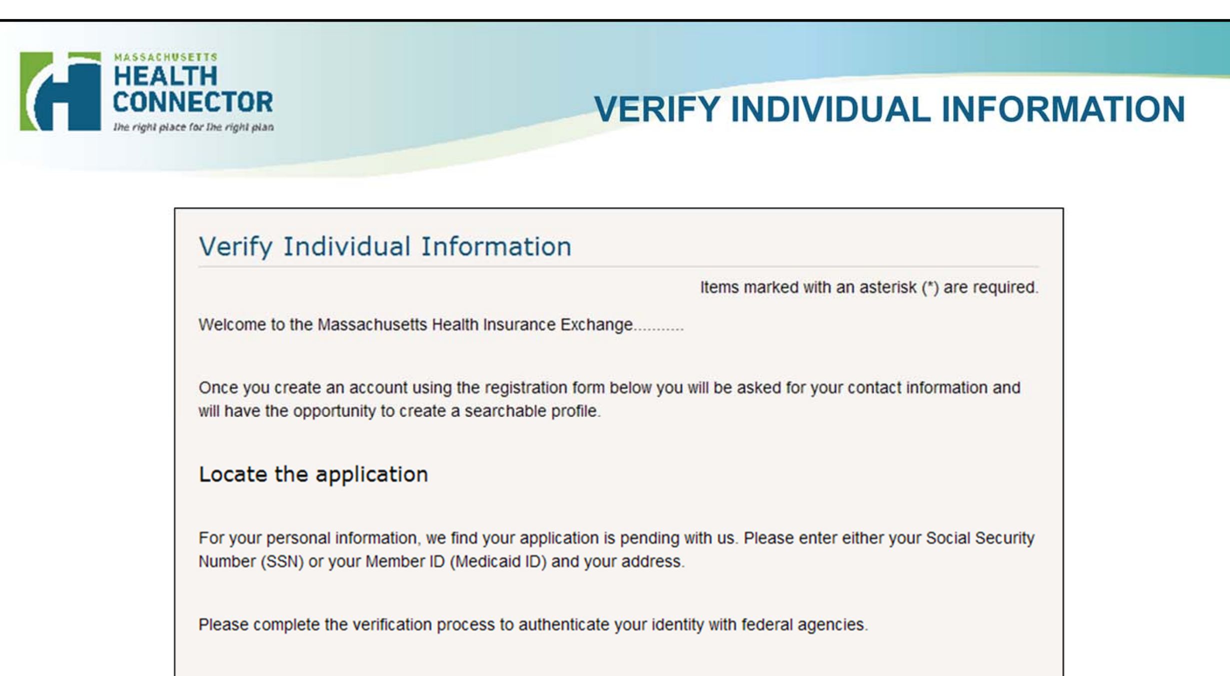


If the user is not already known to the system, the next step will be to set up answers to security questions. These are a pre-determined list of questions for which they create their own unique answers – if they need to reset their password, they will answer these security questions to help confirm their identity.



Once they complete the security questions, the account creation process is then complete.

If the User is Already Known to the System



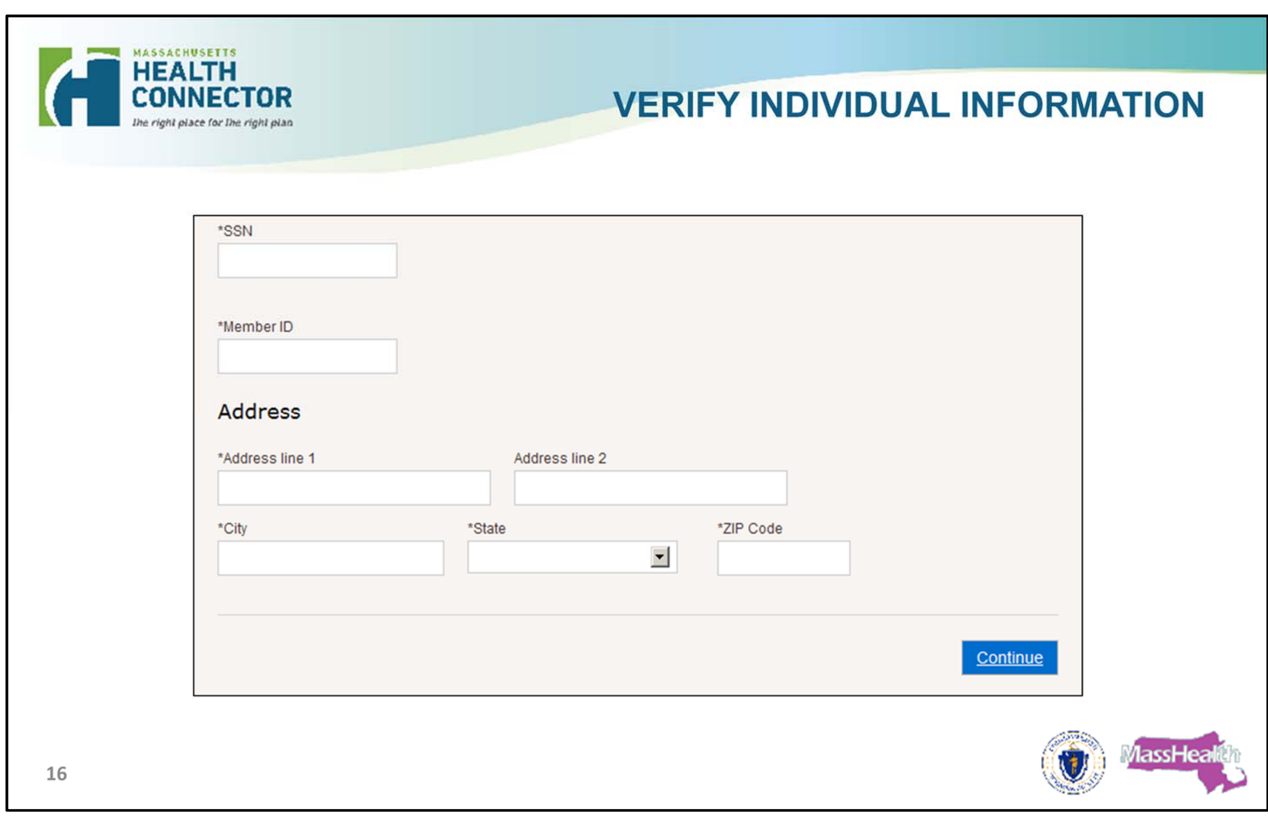
If the user is already known to the system (has an existing eligibility health insurance case), the account creation process is different. If this is the case, they will need to add their social security number or member ID in order to look up your account.

If they are on the system and are creating a new account, they would follow these steps:

1.Select **Yes** or **No** on the "Help Us Find Your Information" screen to indicate whether you have a **Social Security Number** or **Member ID**.

If you select **No**, you are returned the “Account Creation” screen and instructed to call Customer Service.

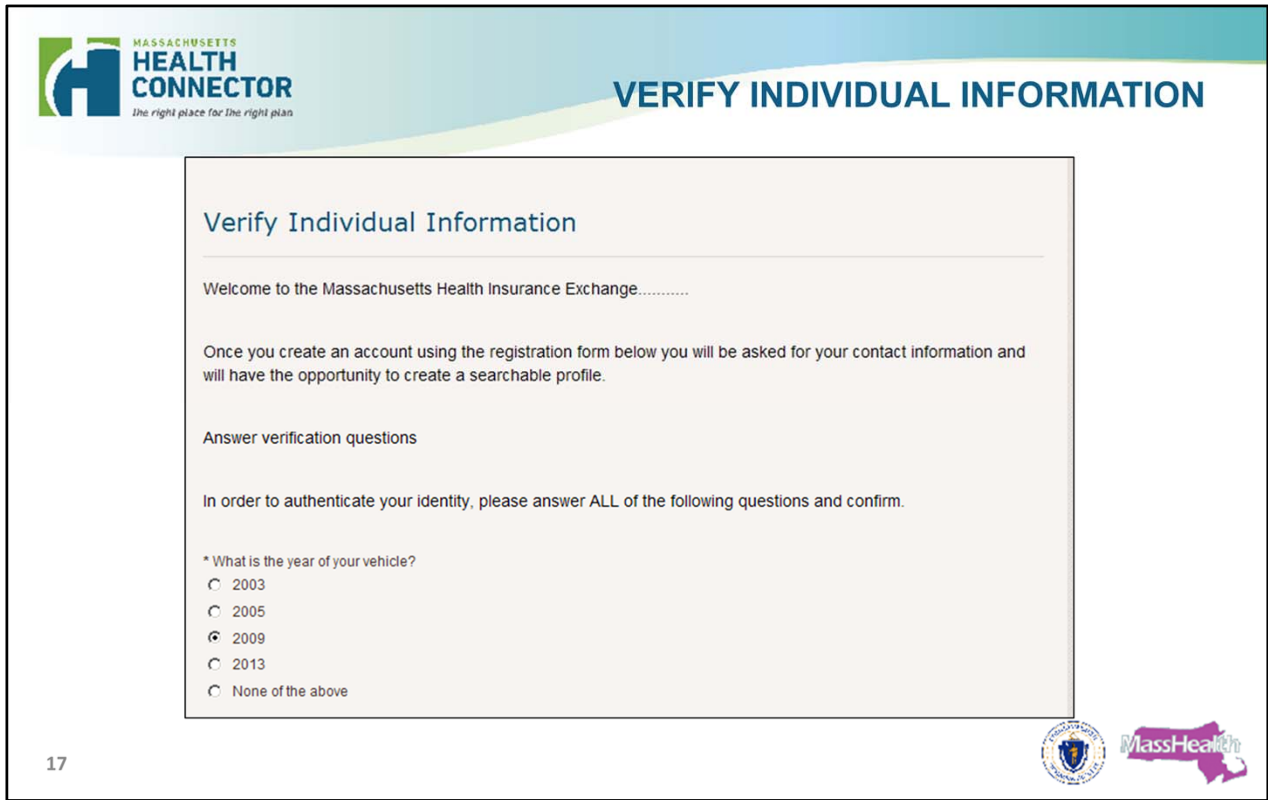
If you select **Yes**, the screen displays the following additional information for you to enter.



1.Enter your **SSN** or **Member ID**.

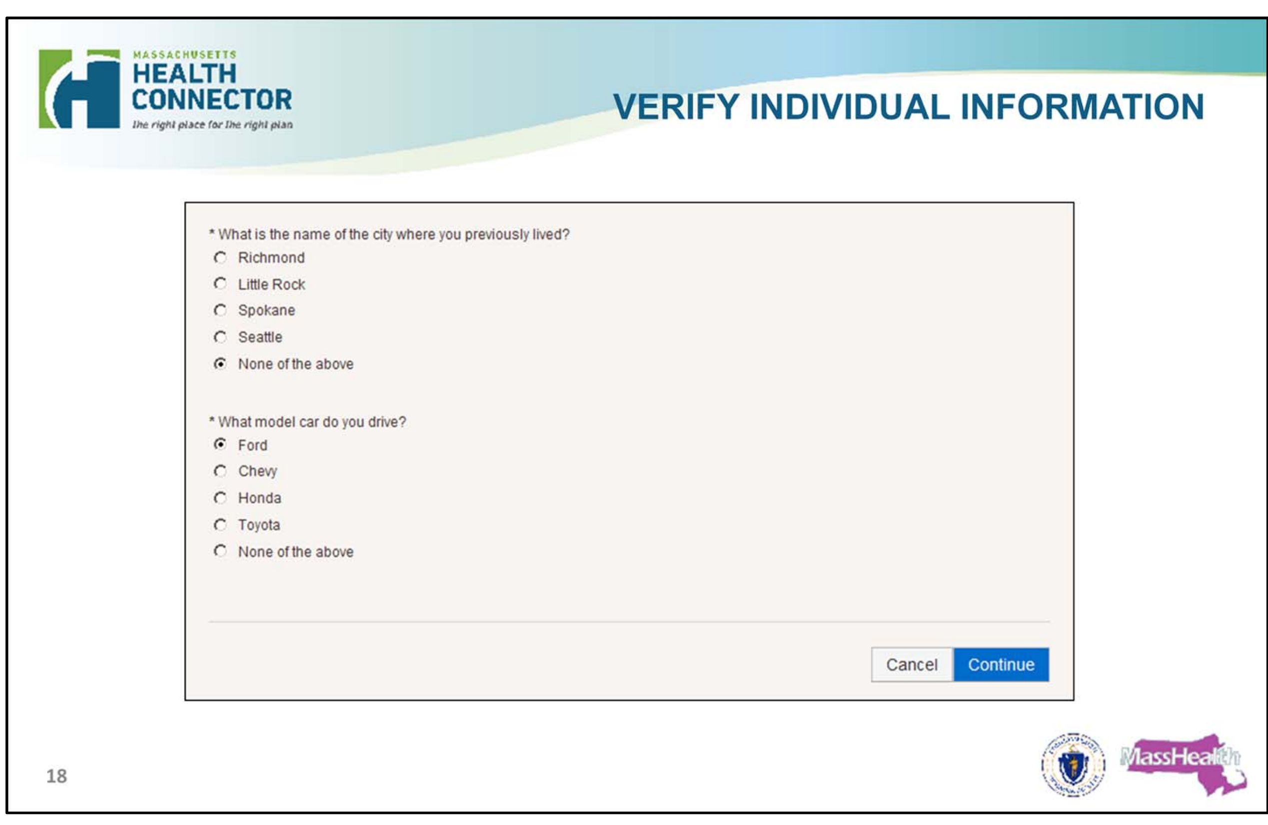
2.Enter your address including **Address Line 1**, **City**, **State** and **ZIP.**

3.Click **Continue**.



The user will then answer the Verification Questions, which are used to verify their identity against your existing account.

1. Answer all of the **Verification Questions**, selecting the best answer for each question.
2. Click **Continue** when done.
3. If account verification is not completed successfully, they will be instructed to call Customer Service.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VERIFY INDIVIDUAL INFORMATION
* What is the name of the city where you previously lived?
Richmond
Little Rock
Spokane
Seattle
None of the above
* What model car do you drive?
Ford
Chevy
Honda
Toyota
None of the above
Cancel
Continue
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ACCOUNT CREATION COMPLETE

Account Creation Complete

Welcome to the Massachusetts Health Insurance Exchange...........

Once you create an account using the registration form below you will be asked for your contact information and will have the opportunity to create a searchable profile.

Registration successful

Congratulations! Your user Account has been successfully created.

If you are an existing member or have filled and application with us.Please contact customer service for furthur assistance.

Take me to the home page

Take me back to the screen where I came from

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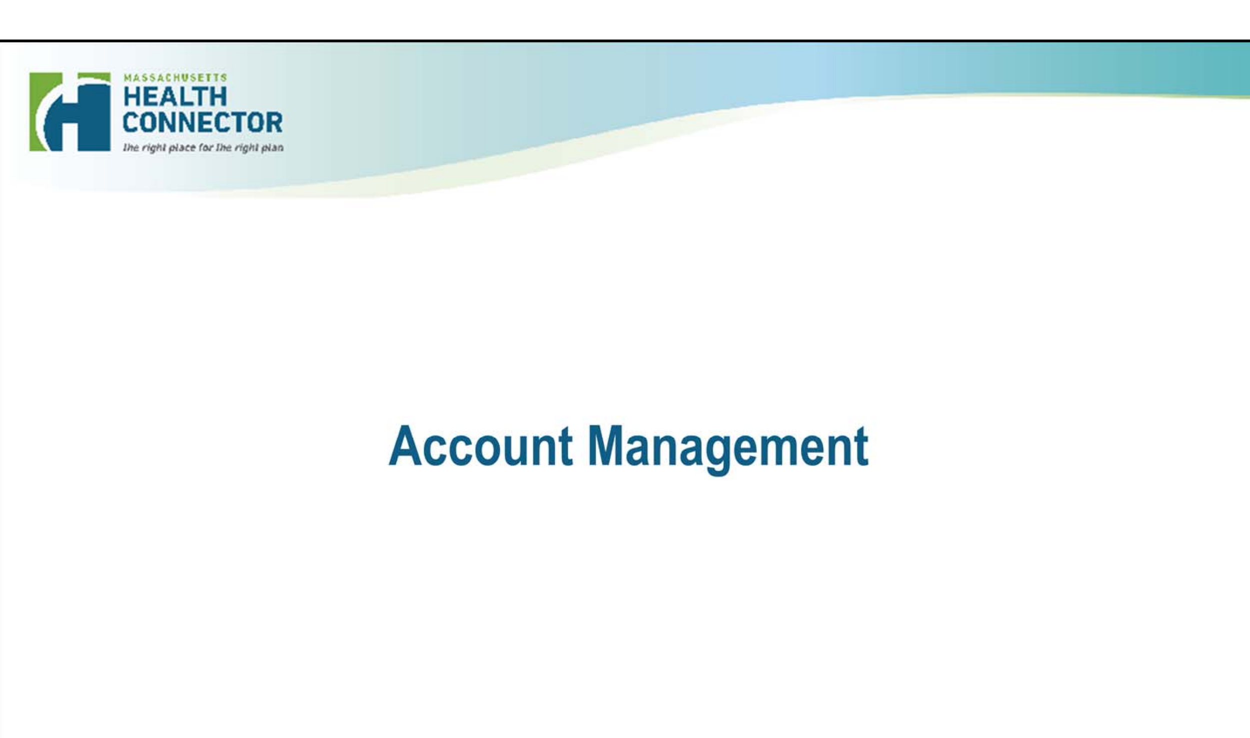
MassHealth

Account creation is now complete. They can either go to the home page or click **Take me back to the screen where I came from** to return to the screen they were previously viewing.


MASSACHUSETTS
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Account Management
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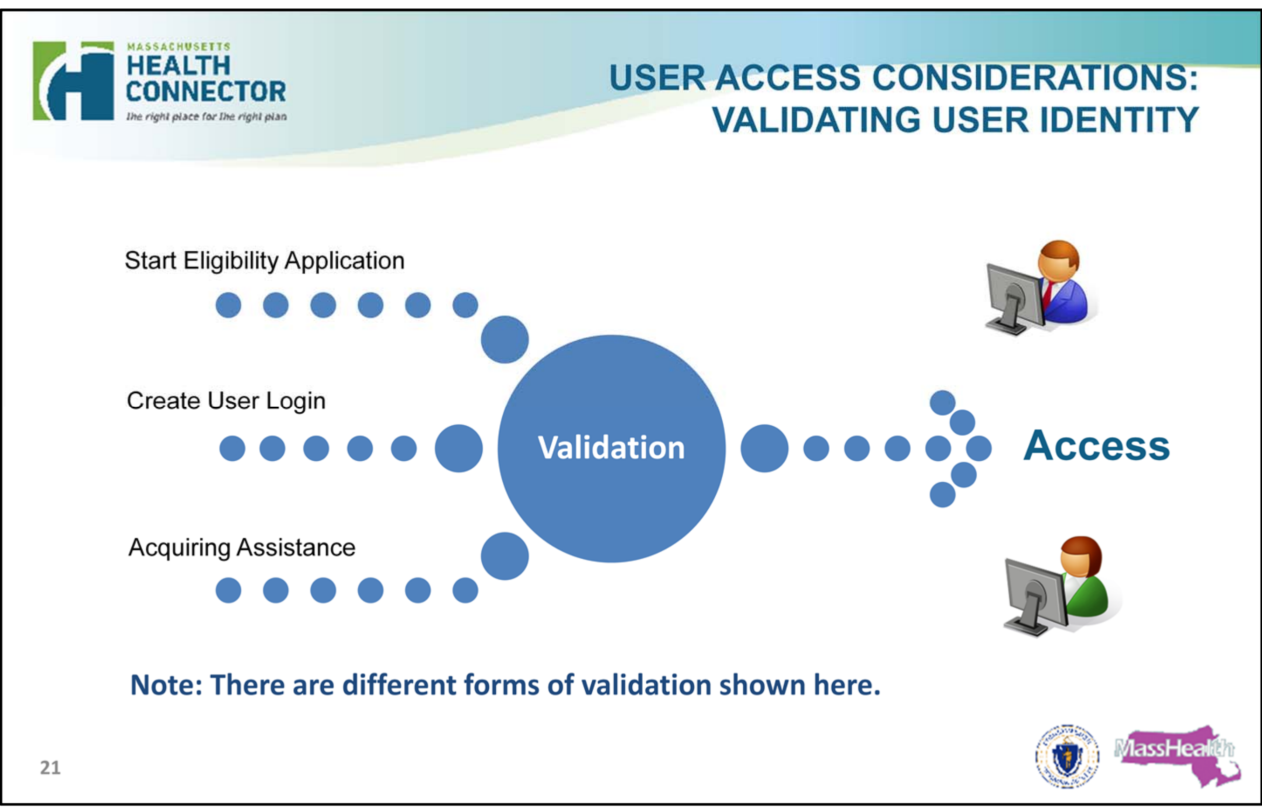
MassHealth



User identity must be validated before individuals can access the system, unless they are browsing anonymously. There are several ways this can happen.

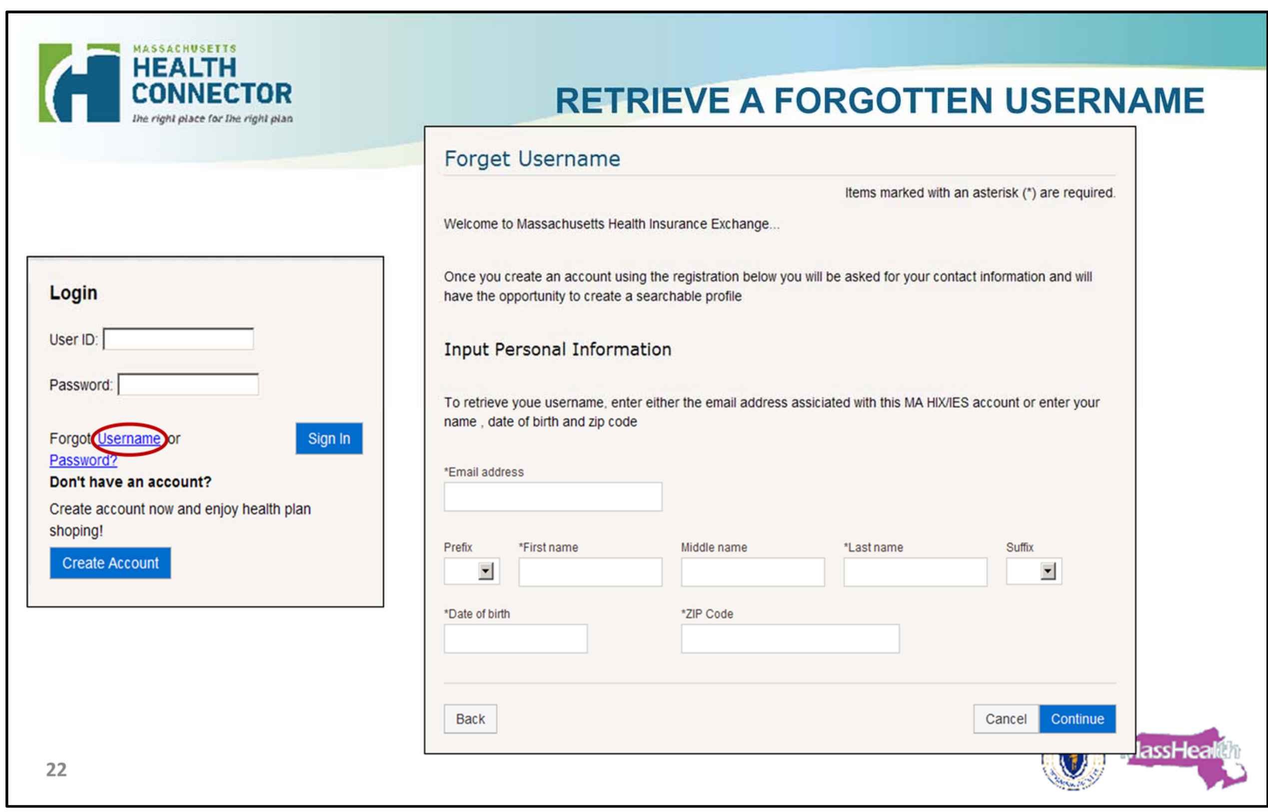
- When users start their eligibility application
- When they create a user log-in
- When they acquire assistance.

When you first create an account, the application collects information that can be used to uniquely identify you. The next time you log on, the Massachusetts Health Connector can validate your identity using this information.

During the account creation process you will be asked for your **Address**, **Social Security Number** and/or **Member ID**. The system sends this information to the Federal Data Services Hub (FDSH). Based on this information, FDSH sends back questions with possible answers. Once you answer the questions the FDSH sends a pass or fail decision back to the application.

If you access the system and click **Start Your Application**, the "Verify Individual Eligibility Application Information" screen appears. If you click **Continue** the system asks you to create a user account where the identify verification questions appear.

When a user requires assistance, a Customer Service Representative or Eligibility Worker can log in to the Massachusetts Health Connector and enter additional information for an individual or family member whose identity has been verified.

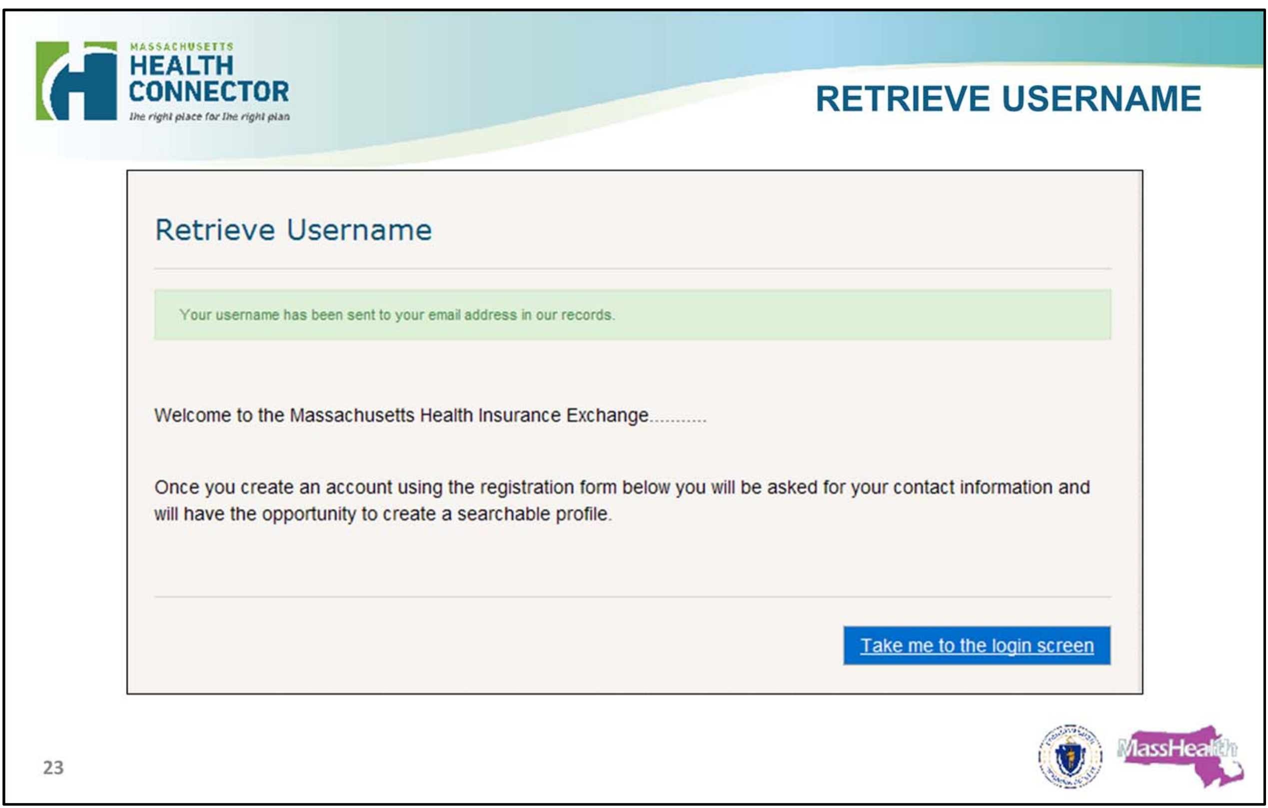


If the user forgets their username, follow these steps:

1.Click **Username** to display the "Forgotten Username" screen.

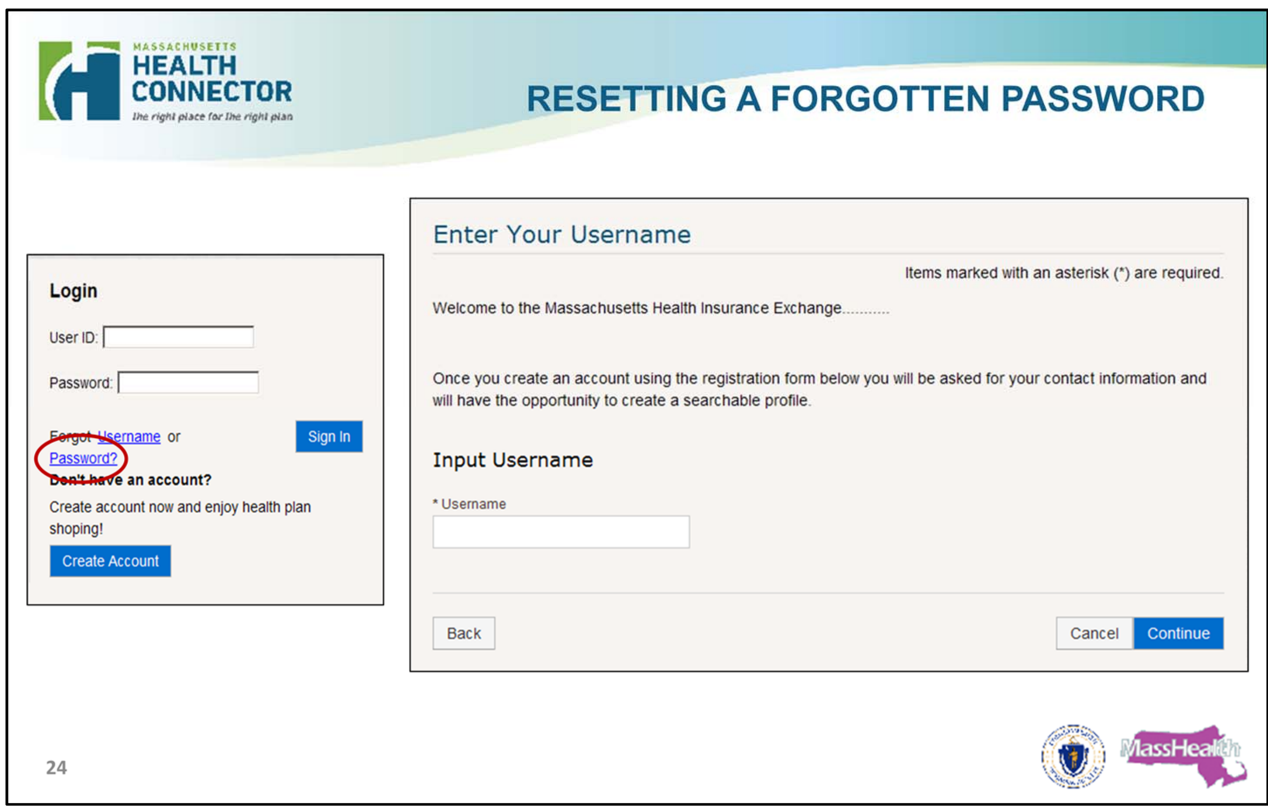
2.Enter your **Email Address** or the alternate required information: **First Name**, **Last Name**, **Date of Birth** and **Zip Code** on the "Forgotten Username" screen.

3.Click **Continue**.



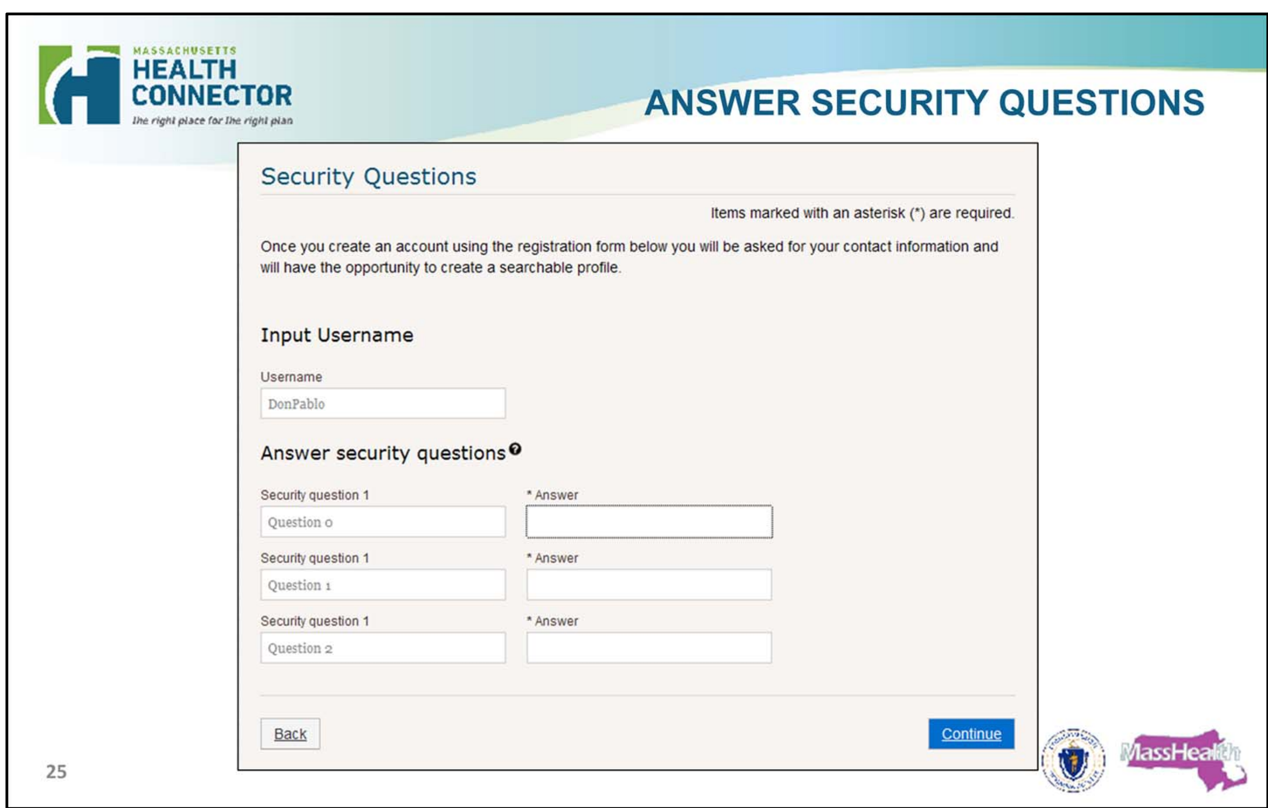
The "Retrieve Username" screen appears, and an email is sent with their username. Once they have that information, they should:

1. Click **Take me to the login screen**.
2. Log in with the username provided in the email, as well as their password.



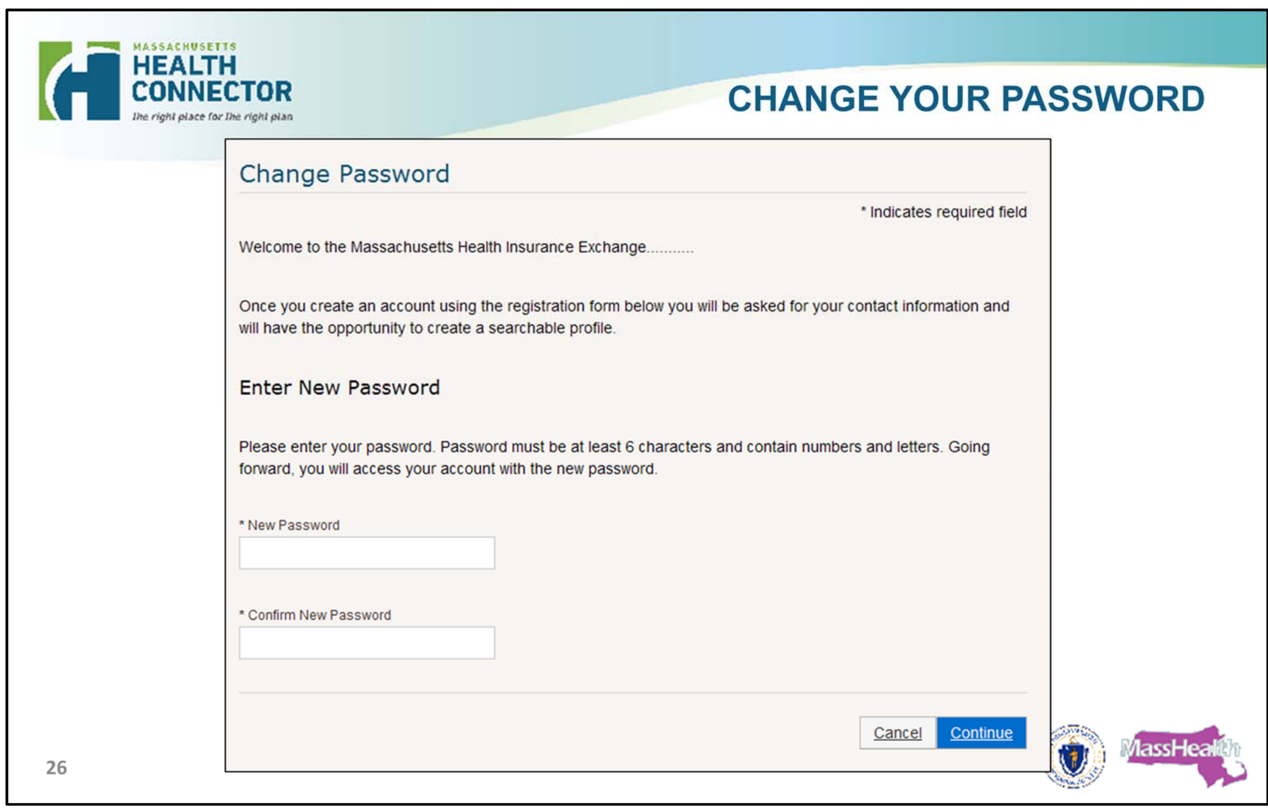
If they forget their password, the process is similar to retrieving your username.

1.Open the “User Account Page”.
2.Click the **Password** link. The "Enter your Username" screen appears.
3.Enter your **Username**.
4.Click **Continue**. The “Security Questions” screen appears (next slide).



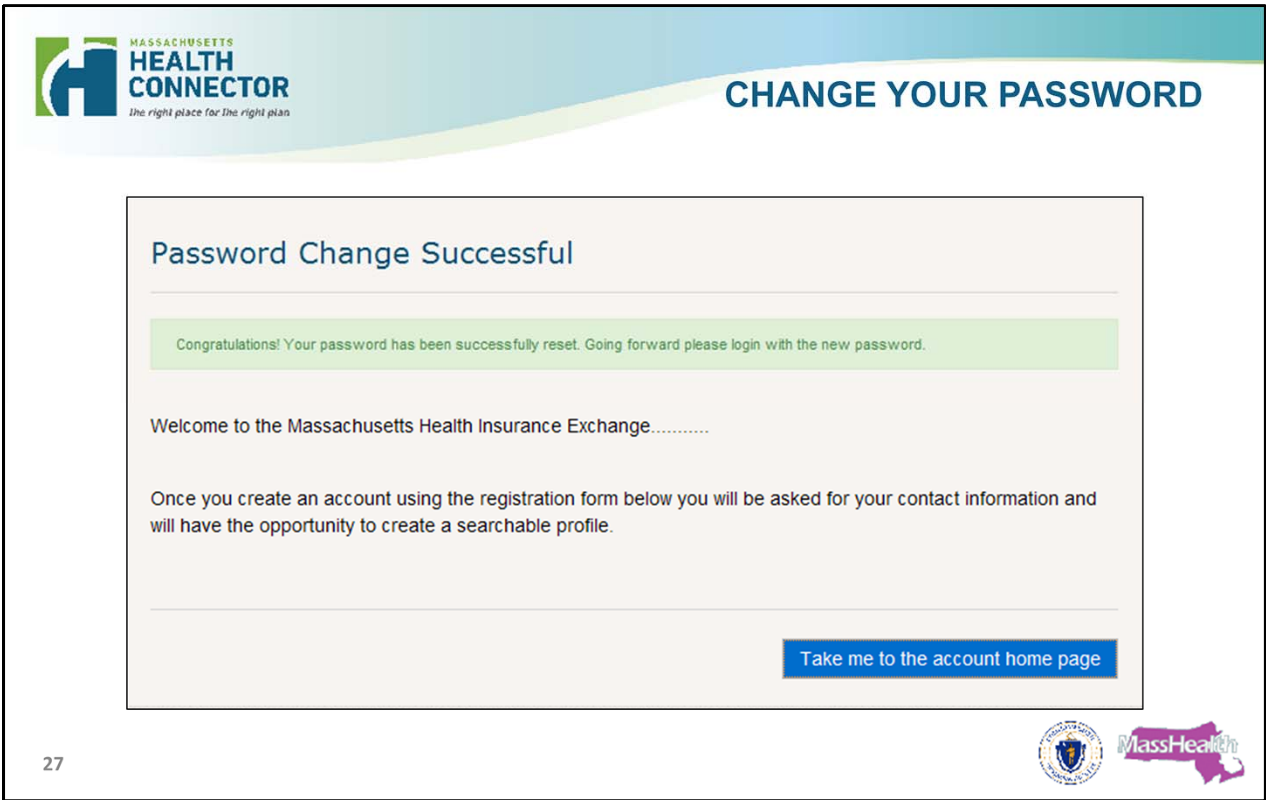
The next step in this process is to answer security questions. They should follow the steps below:

1. Enter the **Answer** to each of the three **Security Questions** you created during your account registration.
2. Click **Continue**.



If they answered the three questions correctly, the "Change Password" screen appears. They should follow the steps below:

1. Enter your **Current Password**.
2. Enter your **New Password**.
3. Re-enter your new password in the **Confirm New Password** field.



4. Click **Save and Continue**. The "Password change Successful" screen appears.
5. Click **Take me to account home page**, where you can log in with your new password (next slide).

ACCOUNT HOME PAGE: CHANGE PASSWORD BEFORE EXPIRATION

Users will also need to change their password when:

- They are notified that their account password is expiring or already expired (90 days).
- They want to change their password and/or security questions.

Once they create their account they can change their password on the "My Profile" screen.

Change Password

* Required Field.

Password must be at least 8 characters and must contain at least one upper case letter, one lower case letter, and one number or special character.

Current Password *

New Password *

Confirm New Password *

MANAGING A LOCKED ACCOUNT

- You can be locked out of the system any time you log in on the Account page and you have failed to enter the correct username and password more than three times.
- The system prompts you with an error message up to three times stating the following:
  - *Your username and password combination is incorrect.*
- If you fail more than three times your account page displays the following message:
  - *Your user account is locked*

UNLOCKING A USER ACCOUNT

Users can have their user account unlocked in one of two ways:

- They can enter their username and password and the system states that they are unable to log in; it gives them a wait time and the option to call Customer Service. Once the wait time has passed, the system automatically unlocks the account. At this time they can log in.
- They can call Customer Service if they do not want to wait.

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Screener Questionnaire

COMPLETING THE SCREENER QUESTIONNAIRE

The screener questionnaire is one of the first screens users encounter in the application. By answering the questions in this questionnaire, the system can begin determining their eligibility for a health insurance plan(s) and assistance paying for health insurance.

Based on determinations the application makes as they complete the questionnaire, they can do one of the following:

- Complete an application for financial assistance. Potential assistance might include any of the following:
  - QHP with Premium Tax Credits (PTC)
  - QHP with Cost Sharing Reduction (CSR)
  - MassHealth Insurance
- Begin browsing for QHPs if they are not eligible for financial assistance.

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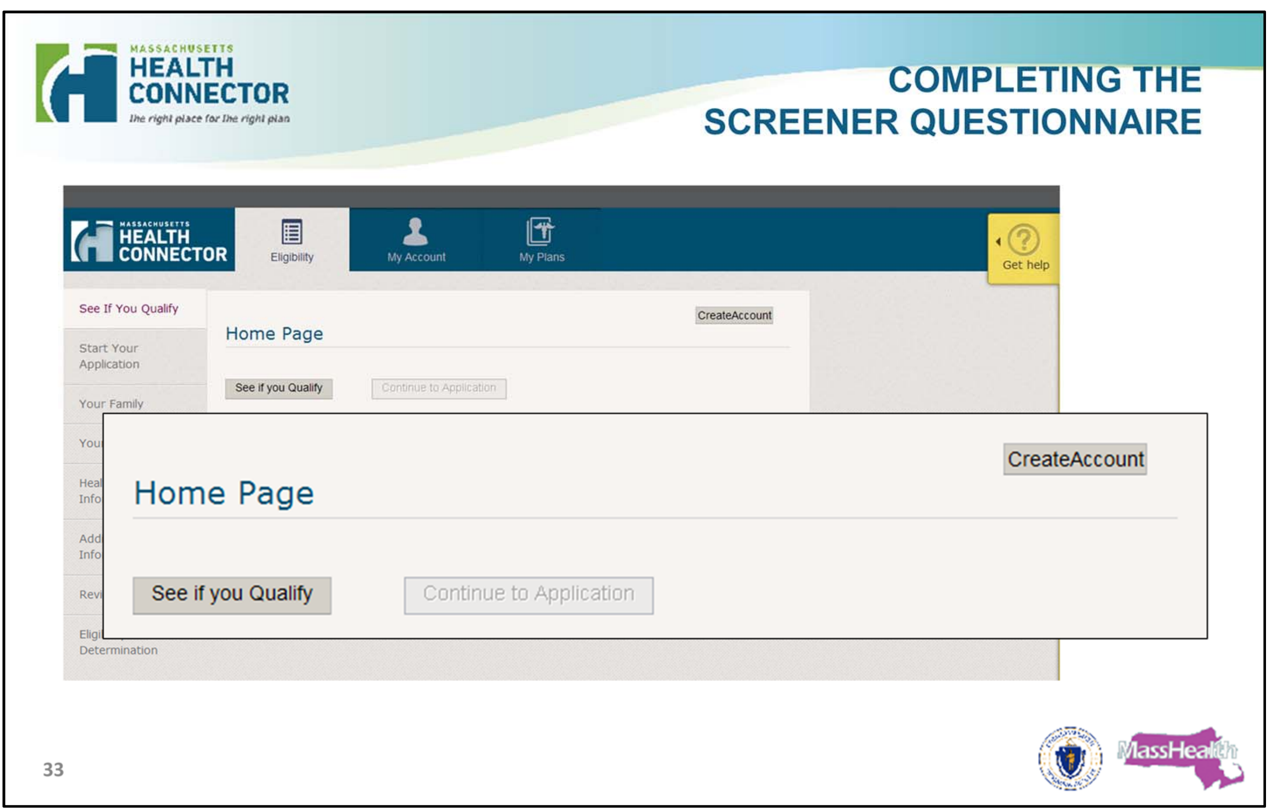
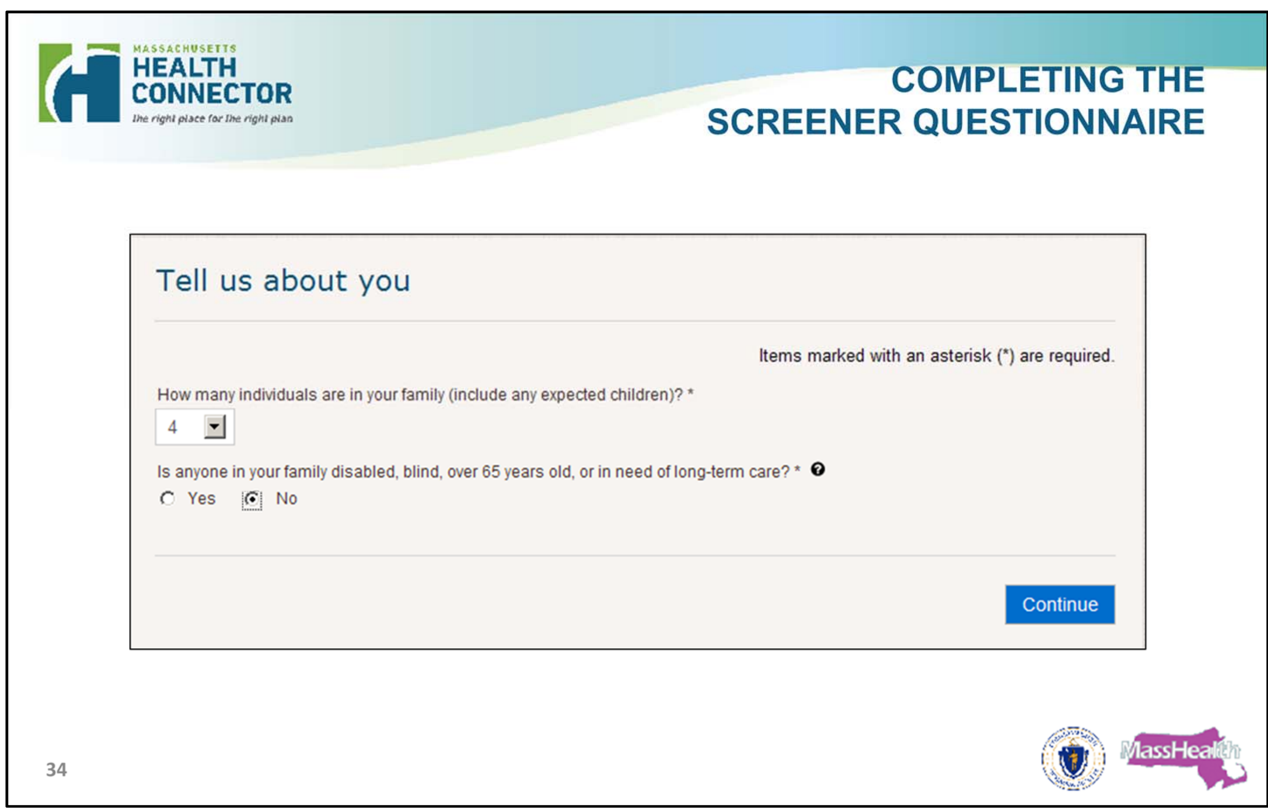


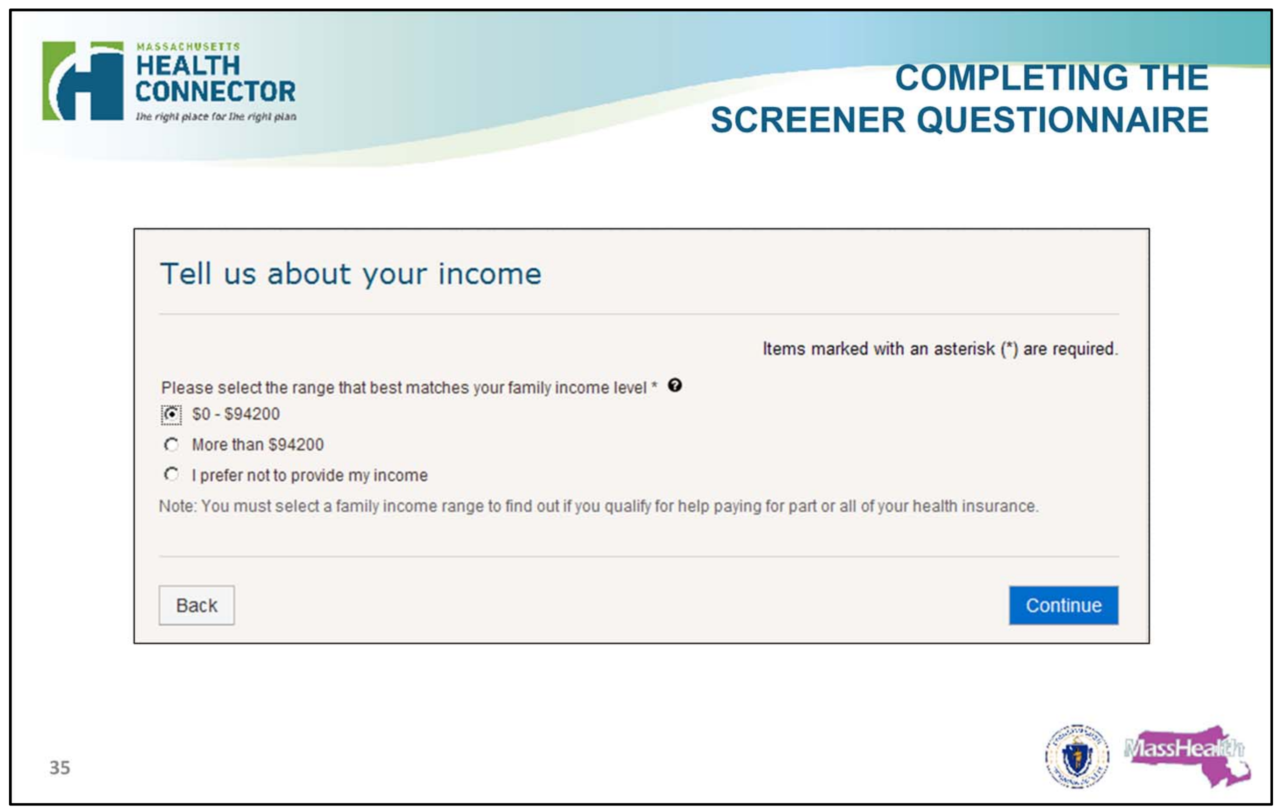
To complete the Screener Questionnaire:

- Access the Home page of the Individual and Families website of the Massachusetts Health Connector and click **See if you Qualify**.

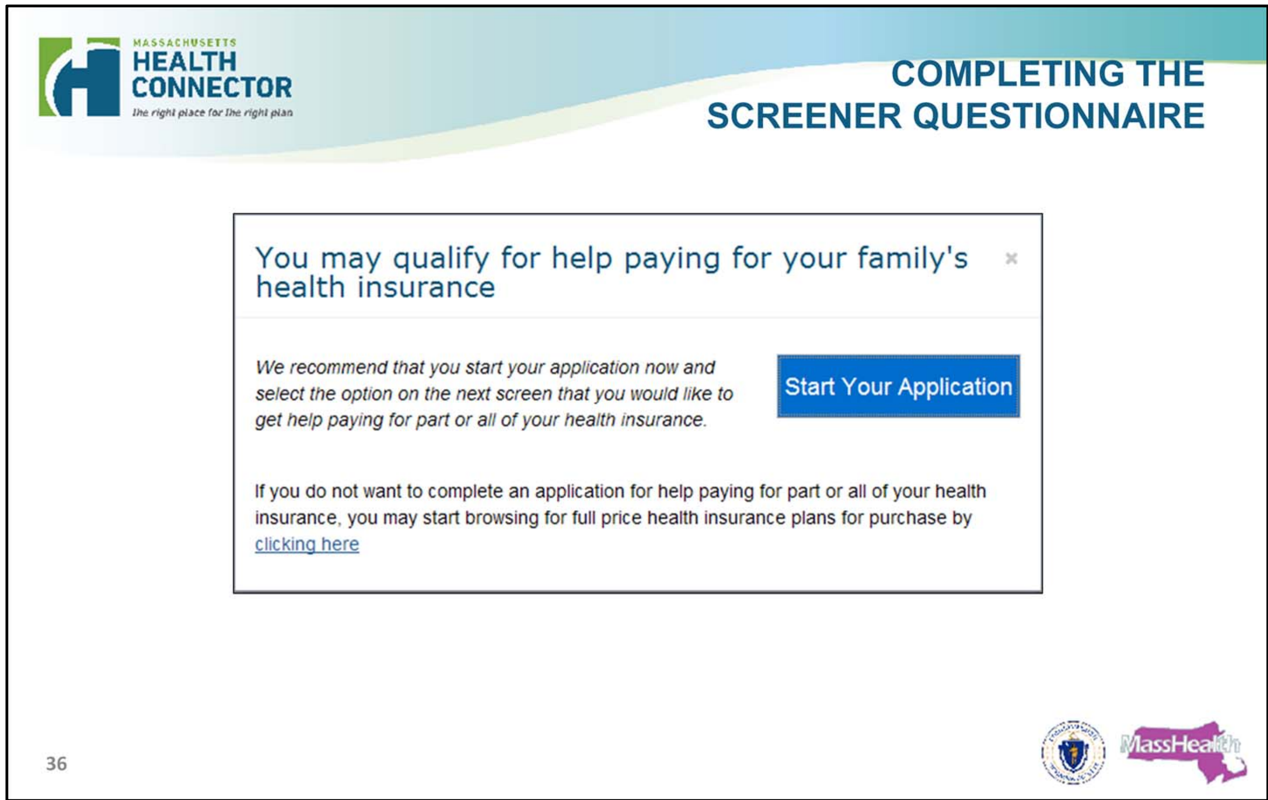


On the "Tell us about you" screen, do the following:

- Click the drop-down menu on the "Tell us about you" screen and select the number of family members.
- Select **Yes** or **No** to indicate if anyone is disabled, blind, over 65, or needs long term care. Click **Continue**.



On the "Tell us about your income" screen, select one of the financial ranges that matches your income. These values change annually, and vary based on your family's size.



- The Screener application may or may not come back with “You may qualify for help paying for your family’s health insurance.”
- Click “**Start Your Application**.

Individual (Head of Household)

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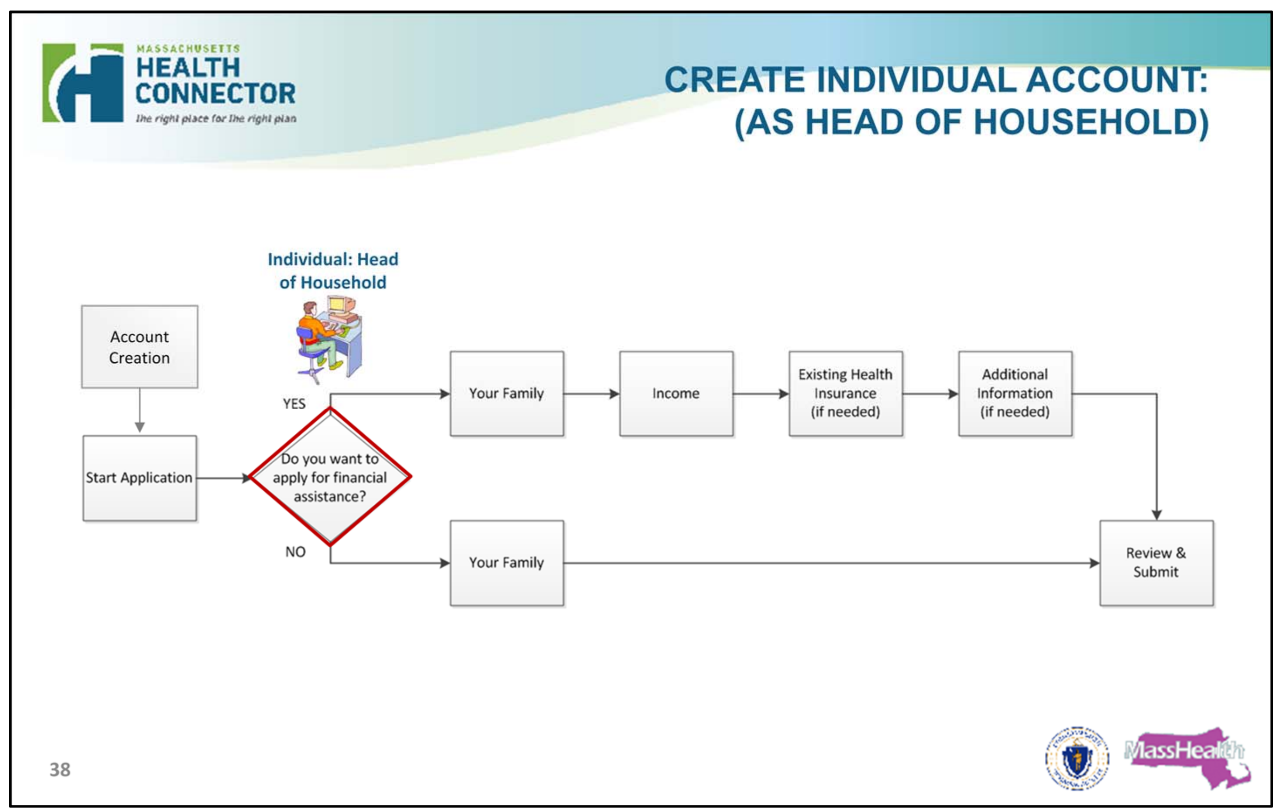

After answering the questions about applying for financial assistance (**Yes**) the user begins entering “Head of Household” information.

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START YOUR APPLICATION FOR HEALTH INSURANCE

Start Your Application For Health Insurance

Items marked with an asterisk (*) are required.

Would you or a member of your family like to get help paying for part or all of your health insurance? *

(•) Yes ( ) No What kind of help could my family get?

Back | Save & Continue

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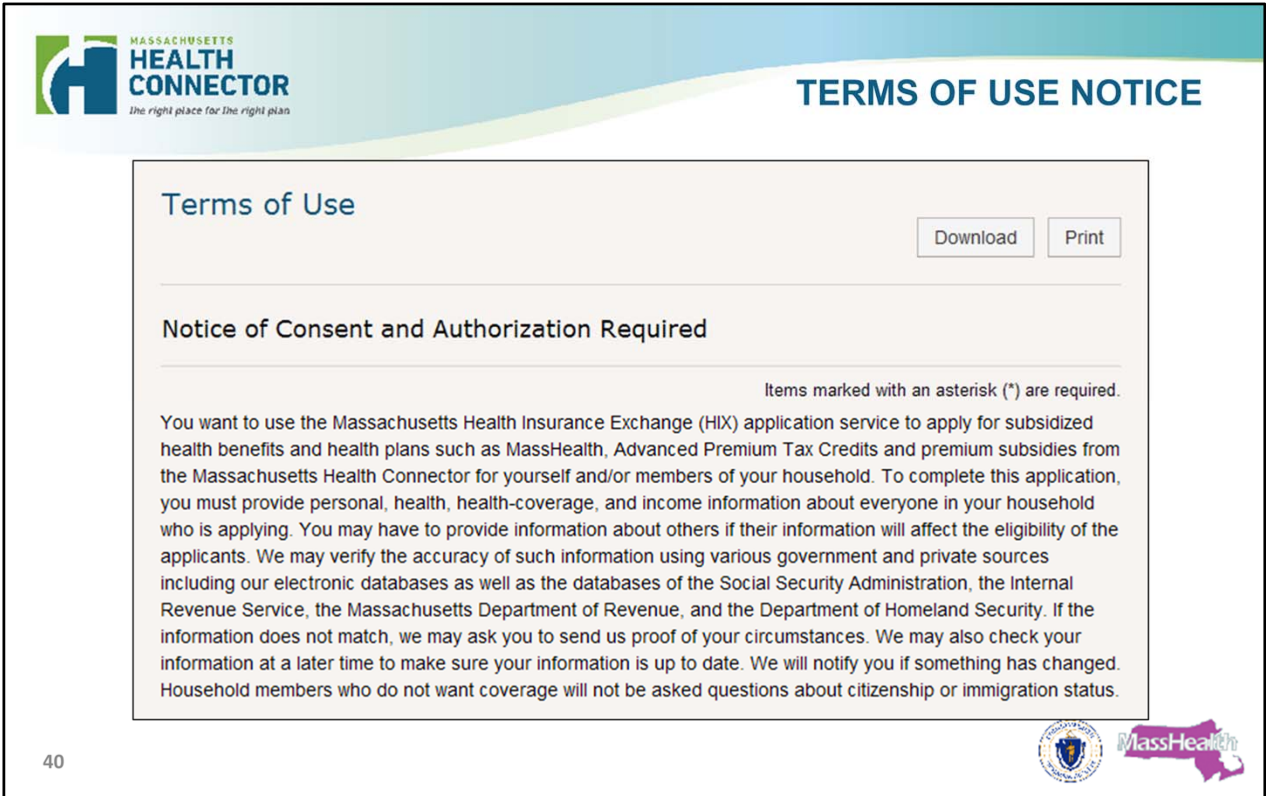
Before entering any information, the user would answer “Yes” to the question “Would you or a member of your family like to get helping paying for part or all of your health insurance?”

Then the user begins entering “Head of Household” information after the following Terms of Use screens.



The Terms of Use screen can be downloaded or printed and covers the terms of the online application process.

TERMS OF USE NOTICE

We will keep the information provided to us private and only use and disclose it in accordance with applicable law.

To proceed, you must give us certifications about your authority to complete the application and eligibility process on behalf of those individuals applying for benefits, and if applicable, your authority to provide and see information about others.

If applying for benefits for 1) yourself, 2) your own minor child or children, and/or 3) any minor or incapacitated person for whom you are either the legal guardian or for whom you have sufficient information to act responsibly on their behalf, then by electronically signing below, you will be certifying under penalty of perjury that you consent to the use of government and private sources to verify information about you and any such minor child and incapacitated person.

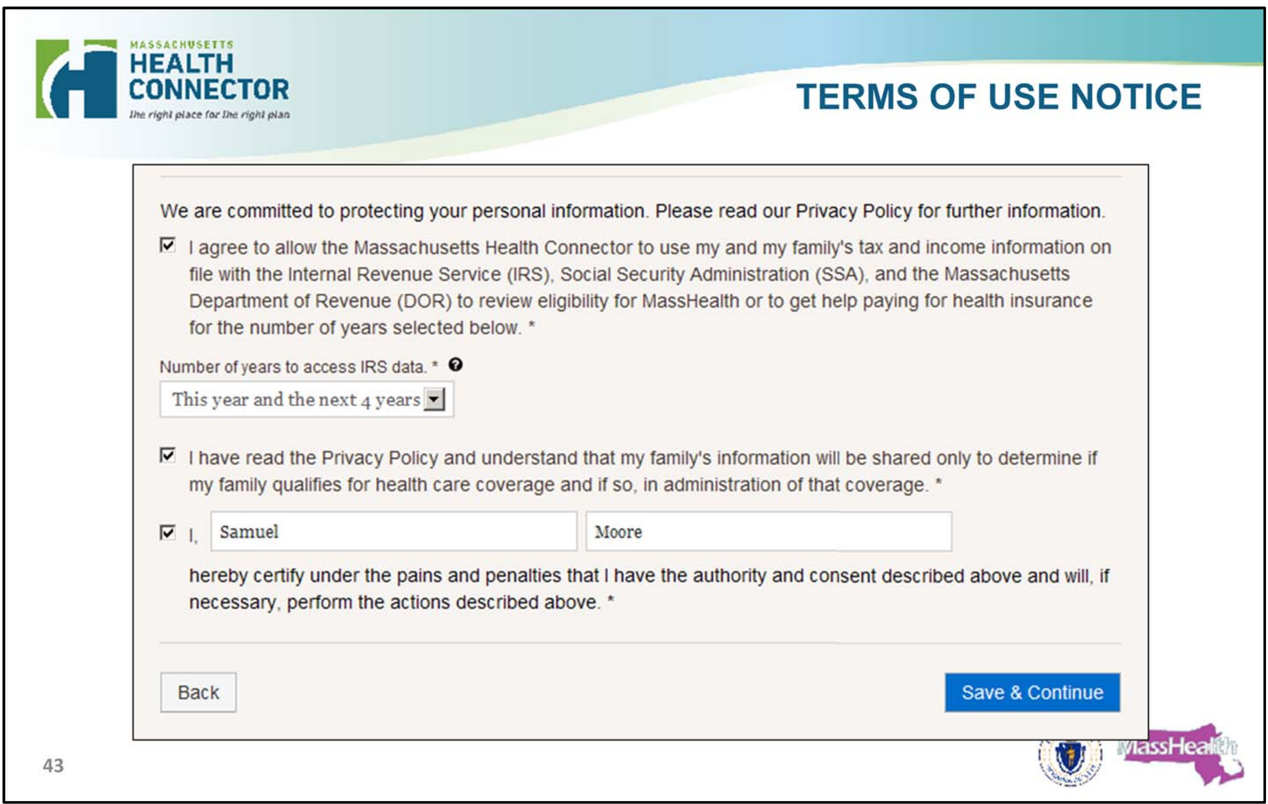
If applying for benefits on behalf of anyone else other than those described above, then by electronically signing below, you also will be certifying under penalty of perjury that you have consent and authorization from such individuals or, if applicable, their parent, guardian, or other legally authorized representative, to act on their behalf to complete this application and any ongoing or subsequent eligibility process and activity, including as examples:

TERMS OF USE NOTICE

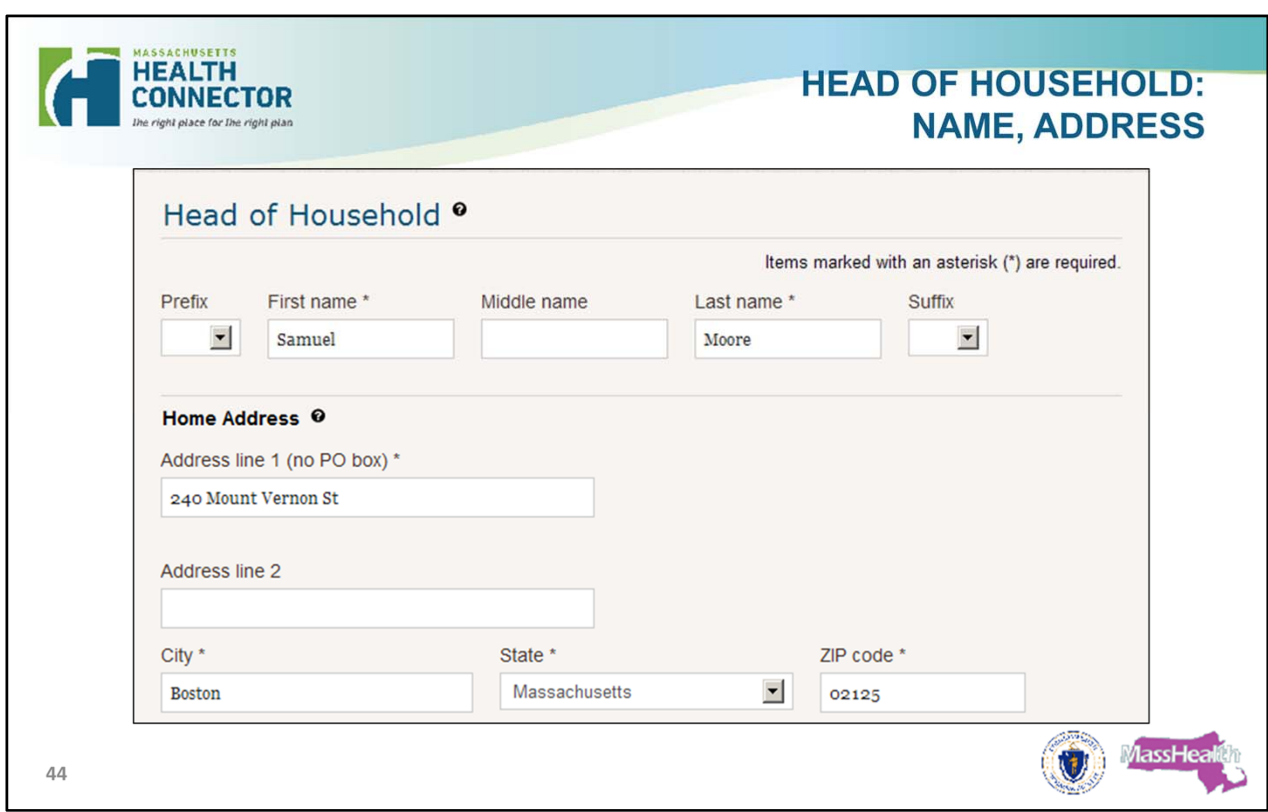
- providing personal, health, health-coverage and income information about them, and seeing such information as may be provided by us
- making choices about coverage options and methods of communication with us
- making changes to the application or related eligibility documents;
- completing and making changes to renewal forms and related documents
- providing information about any change in their circumstances; and
- providing consent on their behalf to use government and private sources to verify information provided in this application and related documents and as may be necessary for continued eligibility.

By signing electronically below, you also certify under penalty of perjury that

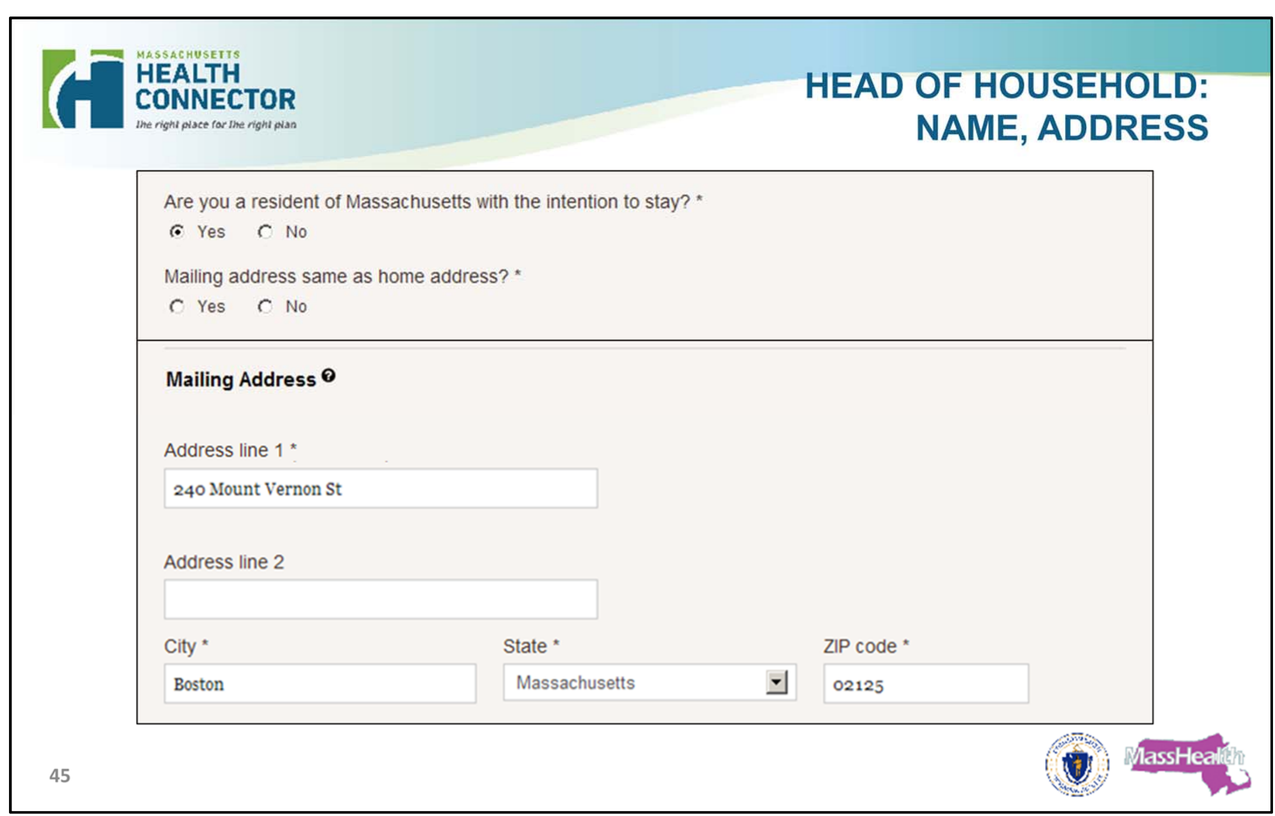
- you have the authorization of all individuals (or their authorized representatives) not seeking coverage but whose information is necessary for eligibility determinations for others on this application to see and provide their personal, health, health-coverage, and income information to us and consent to the use of private and government sources to verify such information;
- you have obtained sufficient information from all individuals for whom you are submitting this application or if applicable, from their parent or legally authorized representative, to act responsibly and provide accurate information in completing the application and other related eligibility documents and forms; and
- you have informed, or will inform as soon as possible, all adults in your household and the parent or legal guardian of any minor who is not your child about their rights and responsibilities as set forth in this application.
- you are either:
  - over eighteen years of age; or
  - younger than eighteen years of age and applying on behalf of yourself and/or your minor child.



The user must agree to the terms of use in order to continue the application process.



The Head of Household screen requires name, home address, and mailing address.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HEAD OF HOUSEHOLD:
NAME, ADDRESS
Are you a resident of Massachusetts with the intention to stay? *
Yes
No
Mailing address same as home address? *
Yes
No
Mailing Address
Address line 1 *
240 Mount Vernon St
Address line 2
City *
Boston
State *
Massachusetts
ZIP code *
02125
45
MassHealth

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CONFIRMING APPLICATION: DOB AND GENDER

Health Insurance Information

Are you applying for health care coverage? *

(•) Yes ( ) No

Date of birth(MM/DD/YYYY) *

2/19/1952

Gender *

(•) Male ( ) Female

We need Social Security Numbers (SSN) for everyone applying for health insurance who has one. A SSN is optional for people not applying for insurance, but providing a SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with insurance. For more information, call SSA - 1-800-772-1213 (TTY 1-800-325-0778) or visit http://ssa.gov.

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The Health Insurance Information requires the user to select **Yes** or **No** to indicate if you are applying, as well as your date of birth and gender.

CONFIRMING APPLICATION: SSN AND CITIZENSHIP STATUS

Do you have a Social Security number (SSN)? *

- (•) Yes
- ( ) No

Social Security Number (XXX-XX-XXXX) *

987-65-1234

Are you a U.S. citizen or national? *

- (•) Yes
- ( ) No

Are you a naturalized or derived citizen? *

- ( ) Yes
- (•) No

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This screen also requires your social security number and citizenship status. Social security numbers are required to be input for everyone who has one.

For the question "Are you a **US citizen or national**":

> Based on your answer to this question, the system displays additional questions and fields. All the questions are on the following slides. You may not see all the questions if they apply to your situation.

CITIZENSHIP/IMMIGRATION: OTHER POSSIBLE QUESTION FIELDS

- **Are you a US citizen or national?** Select **Yes** or **No**.
- **Do you have an eligible immigration status?** Select **Yes** or **No**. Question appears if you select No to the US citizen or national question.
- "If you do not have an eligible immigration status, then you might be eligible for MassHealth Limited, Health Safety Net, the Children's Medical Security Plan and coverage for pregnant women." This message appears if you select **No** to the eligible immigration status question.
- **Do you have an immigration document?** Select **Yes** or **No**. Question appears if you select **Yes** to eligible immigration status question.
- **Document Type**: Select from the drop-down menu. Field appears if you select **Yes** to the immigration document question. Depending on the document selected, the following fields and questions might appear (next slide):**Are you a US citizen or national?** Select **Yes** or **No**.

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CITIZENSHIP/IMMIGRATION: OTHER POSSIBLE QUESTION FIELDS

- **Alien Number**: enter up to 9 digits if you answered **No** to the question about **US citizen or national**.
- **Document Type**: select a document from the drop-down menu if you answered **Yes** to the question about naturalized or derived citizen.
- **Naturalization certificate number**: enter the 8 digit number if you selected **Naturalization Certificate** as the **Document Type**.
- **Certificate of Citizenship Number**: enter the 9 digit number if you selected **Certificate of Citizenship** as the **Document Type**.
- **I do not have one**: select the check box if you are a derived or naturalized citizen without a document or alien number.

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INCARCERATION, FOSTER CARE, NATIVE TRIBE; ADD FAMILY MEMBER

Are you incarcerated? *

Yes No

Are you a member of federally recognized American Indian or Alaska Native tribe? *

Yes No

Do you have any family members to add to your application? *

Yes No

Back Save & Continue

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Below are the following steps for this screen.

1. Select **Yes** or **No** to indicate if you are incarcerated.

   If you select **Yes** the screen displays the question, **What is the person's expected release date?** Enter the date or click the calendar to select the date.

2.Select **Yes** or **No** to indicate if you are a member of an **American Indian native tribe** or an **Alaskan native.**

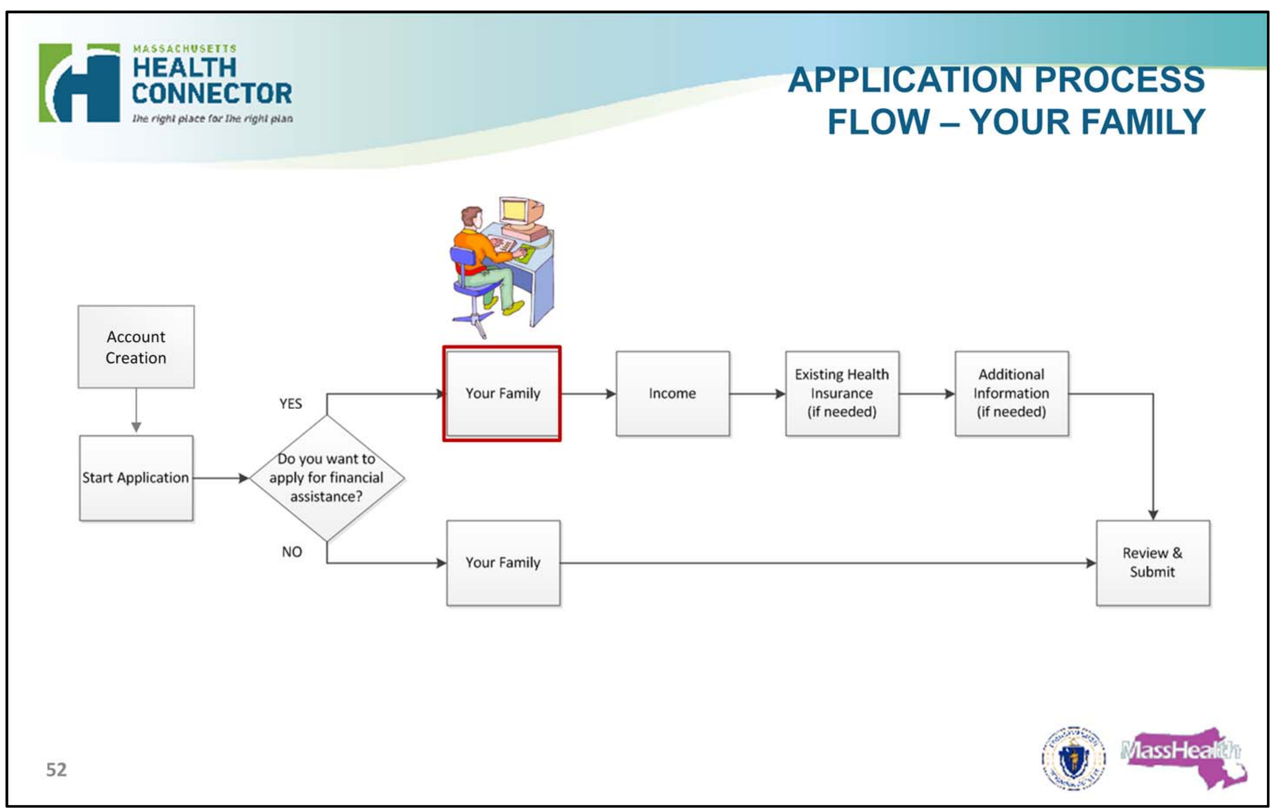
   American Indians and Alaskan Natives who enroll in healthcare coverage can also get services from the Indian Health Services, tribal health programs, or urban Indian health programs.

   If the user is American Indian or Alaskan Native, they may not have to pay cost sharing and may have special monthly enrollment periods. To make sure they receive the maximum financial help possible, please make sure that they answer this question.

   If you select **Yes** the following questions appear:

   - **Have you ever gotten a health service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs?** Select **Yes** or **No**.
   - **Are you eligible to get health services from Indian Health Services or a Tribal Health organization?** Select **Yes** or **No**. This question only appears if you answered **No** to the question above."

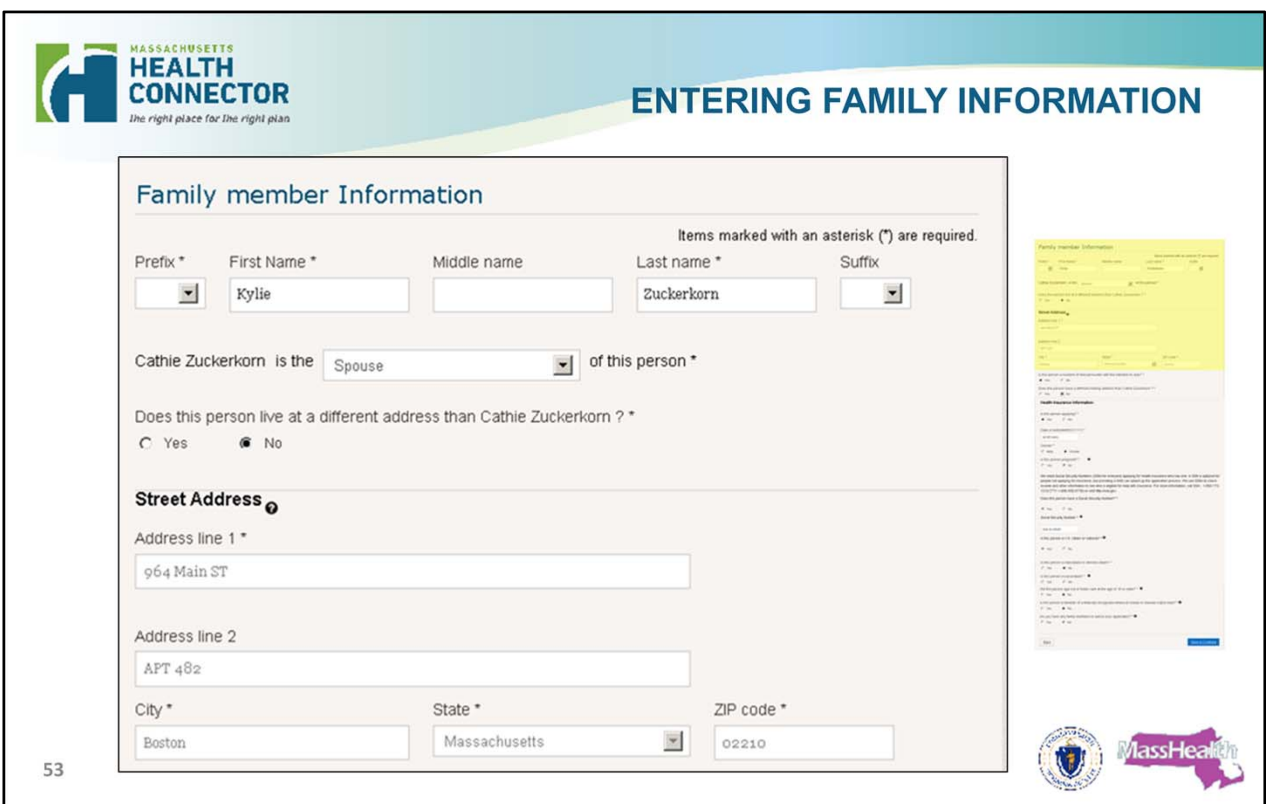
Other Family Members



After entering individual, head of household information the user begins entering family member information.

Entering Your Family information includes:

- Entering Personal Information for each family member
- Entering Family Health Insurance Needs
- Entering How Your Family Will File Taxes Next Year
- Reviewing the Family Summary



The user enters information on the "Family Information" screen if they indicated on the "Head of Household" screen that they have additional family members to add. This screen continues to appear for each additional family member until they indicate there are no more family members. The questions are similar to the questions on the "Head of Household" screen.

MASSACHUSETTS HEALTH CONNECTOR
The right place for the right plan

ENTERING FAMILY INFORMATION

Is this person a resident of Massachusetts with the intention to stay? *
Yes No

Does this person have a different mailing address than Cathie Zuckerkorn ? *
Yes No

Health Insurance Information

Is this person applying? *
Yes No

Date of birth(MM/DD/YYYY) *
9/16/1993

Gender *
Male Female

Is this person pregnant? *
Yes No

We need Social Security Numbers (SSN) for everyone applying for health insurance who has one. A SSN is optional for people not applying for insurance, but providing a SSN can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with insurance. For more information, call SSA - 1-800-772-1213 (TTY 1-800-325-0778) or visit http://ssa.gov.

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MassHealth

Follow the steps below on this screen:
1.Enter the family member's name and select the relationship to the head of household from the drop-down list.
2.Select **Yes** or **No** to answer the questions about **Massachusetts residency**, same **Address** as head of household, **Mailing Address** and **Application**.
3.Enter the **Date of birth** and select the **Gender** of the family member.
4.Select **Yes** or **No** to indicate if this family member is pregnant. Since this family member is female, the question about pregnancy appears. If the applicant is pregnant, the user is required to select the number of children expected.

MASSACHUSETTS HEALTH CONNECTOR
The right place for the right plan

ENTERING FAMILY INFORMATION

Does this person have a Social Security Number? *

Yes No

Social Security Number *

055-31-5636

Is this person a U.S. citizen or national? *

Yes No

Is this person a naturalized or derived citizen? *

Yes No

Is this person incarcerated? *

Yes No

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MassHealth

Follow the steps below on this screen:

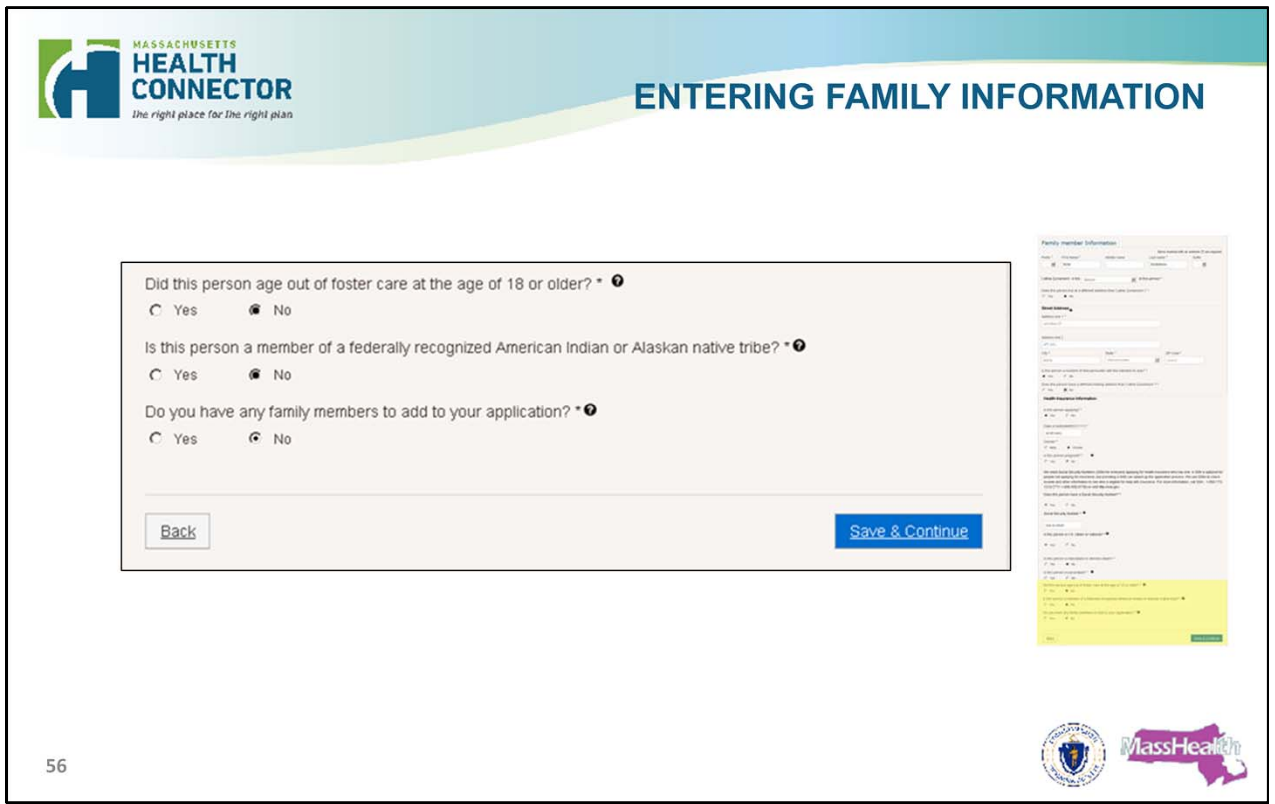
1.Select **Yes** or **No** to indicate if this applicant has a **Social security number** (SSN).

If you select **Yes**, a field appears to enter the SSN.

If you select **No**, you are asked if the family member has applied for an SSN, and if not, to select a **reason** why not.

2.Select **Yes** or **No** to answer the **US citizen or national** question and the **naturalized or derived citizen** question. There may be additional questions about document types and numbers based upon the answer to the above question.

3.Select **Yes** or **No** to answer the question about being **incarcerated**, and enter the date (if appropriate).



Follow the steps below on this screen:

1. Select Yes or No to answer the questions about "aging out" (in the custody of the state when you turned 18) of foster care.

2.Select Yes or No to indicate **American Indian** or **Alaskan native tribe** membership.

3.Select **Yes** or **No** to indicate if there are more family members to add to the application.

4.Click **Save and Continue**.

If there are more family members, the "Family Information" screen re-appears to collect information about the next family member.

If there are no more family members, one of the following screens appear: "Questions for Immigrants" or "Family Health Insurance Needs".

MASSACHUSETTS HEALTH CONNECTOR
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YOUR FAMILY: QUESTIONS FOR IMMIGRANTS

Questions for Immigrants

* Required Field.

We were unable to electronically verify the immigration status (es) provided.

List all immigration statuses each person has had since entering the U.S.

Family Member	Immimgration Status *	U.S. Entry Date *	Date status awarded *
JOHN EXCEL	Add Another Immigration Status		
JOHN EXCEL	Add Another Immigration Status		
JOHN EXCEL	Add Another Immigration Status		

Back   Save & Continue

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MassHealth

The user only sees the "Questions for Immigrants/Immigration Status" screen if they or a family member indicated that they are lawfully present, but the verification fails and the system is unable to determine your immigration status. If they do not see this screen, continue to the section titled Entering Family Health Insurance Needs.

MASSACHUSETTS HEALTH CONNECTOR
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FAMILY HEALTH INSURANCE NEEDS

Family Health Insurance Needs

Items marked with an asterisk (*) are required.

Does anyone in your family have breast or cervical cancer? (optional)
○ Yes ● No

Is anyone in your family HIV positive (optional)?
○ Yes ● No

Does anyone in your family have an injury, illness, or disability? * What does this mean?
○ Yes ● No

Does anyone in your family need long-term care services in a rest home, in an assisted living facility, a continuing-care retirement community, a life-care community or while still living at home?*
○ Yes ● No

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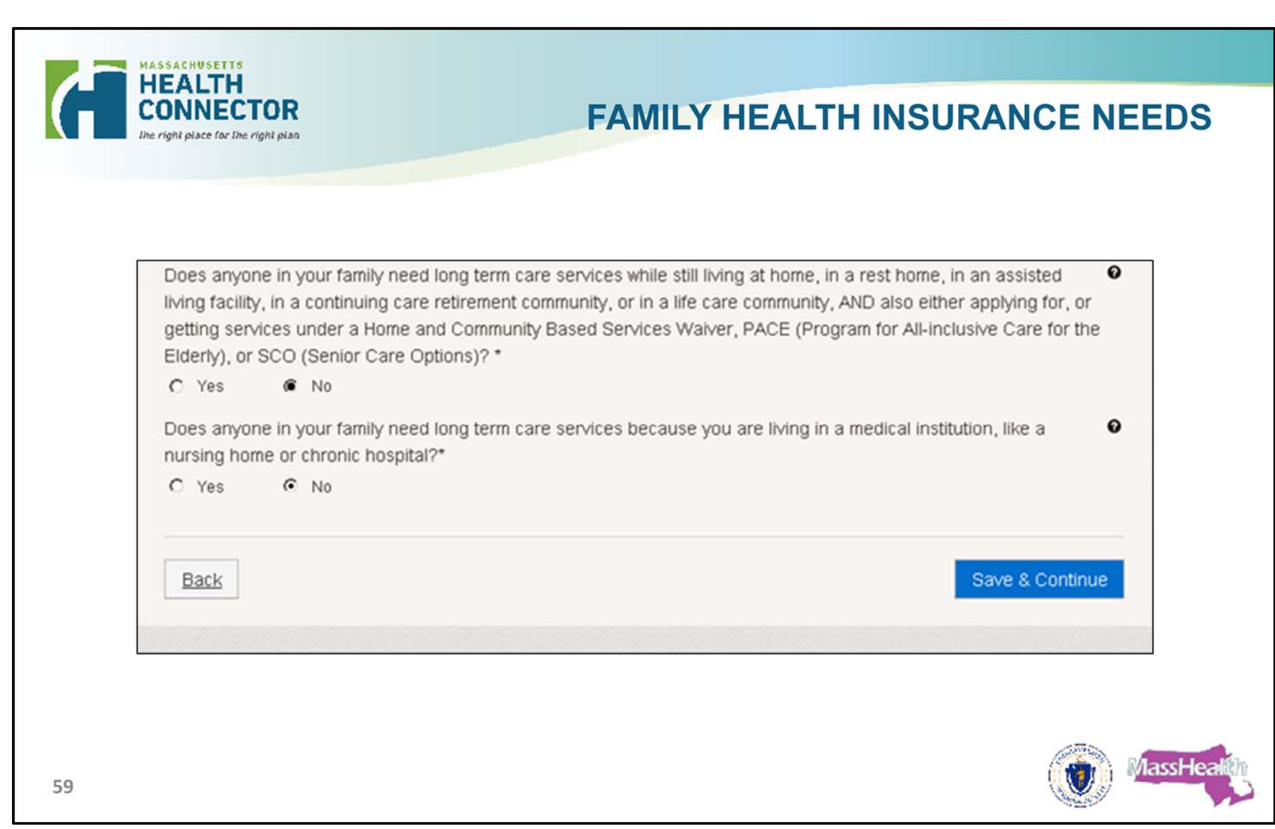
MassHealth

The "Family Health Insurance Needs" screen is illustrated in two parts, this slide and the next slide.

The screen asks a series of **Yes**/**No** questions about cervical or breast cancer, and HIV. It also asks about injury, illness, disability, long term care, liability and potential coverage under other insurance.


MASSACHUSETTS
HEALTH
CONNECTOR
The right place for the right plan
FAMILY HEALTH INSURANCE NEEDS
Does anyone in your family need long term care services while still living at home, in a rest home, in an assisted living facility, in a continuing care retirement community, or in a life care community, AND also either applying for, or getting services under a Home and Community Based Services Waiver, PACE (Program for All-inclusive Care for the Elderly), or SCO (Senior Care Options)? *
Yes
No
Does anyone in your family need long term care services because you are living in a medical institution, like a nursing home or chronic hospital?*
Yes
No
Back
Save & Continue
59
MassHealth

MASSACHUSETTS HEALTH CONNECTOR
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YOUR FAMILY: FILING TAXES NEXT YEAR

How will your household file your taxes for 2013?

We need to know how your family files taxes to find out if you or your family can get help paying for part or all of your health insurance.

Items marked with an asterisk (*) are required.

Family	Tax Filing Status*	What does Tax Filing Status mean?
Cathie Zuckerkorn	Tax Filer - Married Filing J	
Kylie Zuckerkorn	Tax Filer - Married Filing J	

Back   Save & Continue

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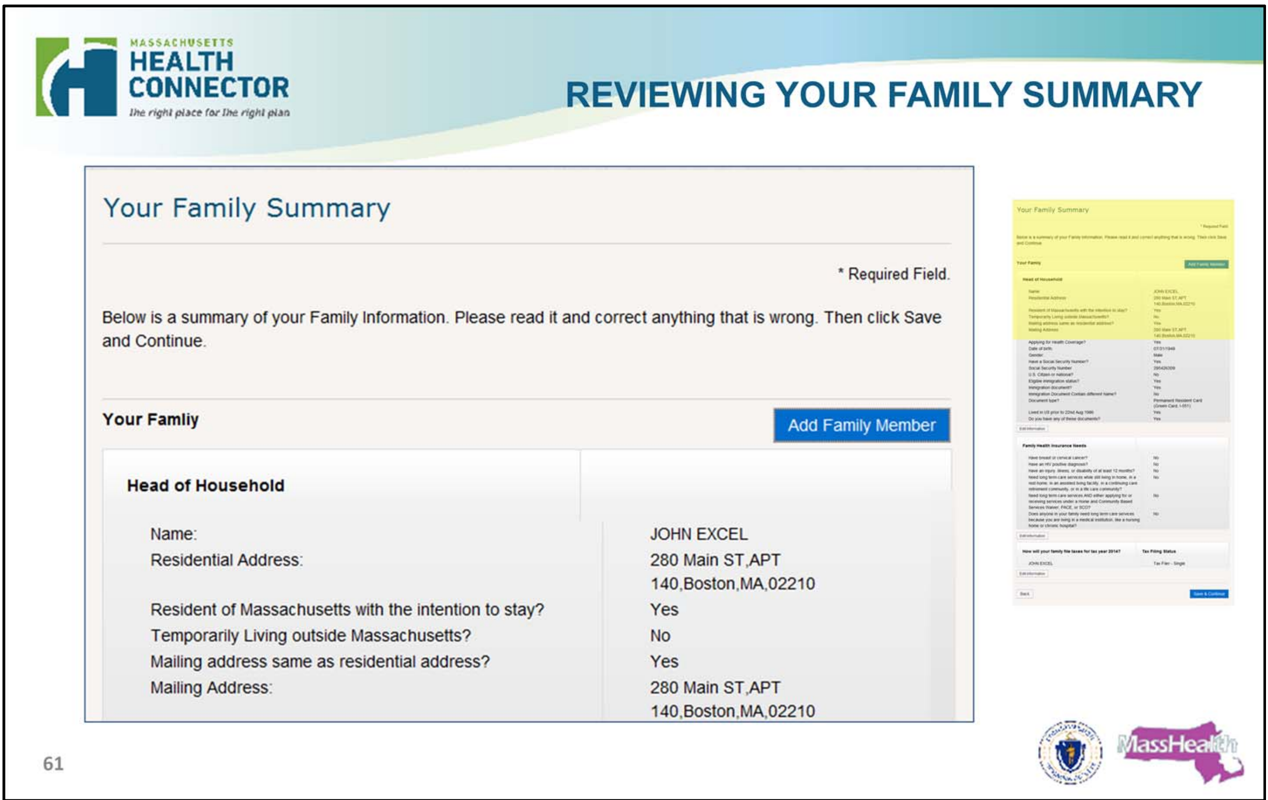
MassHealth

The system displays this screen after the "Family Health Insurance Needs" screen. Below are the next steps:

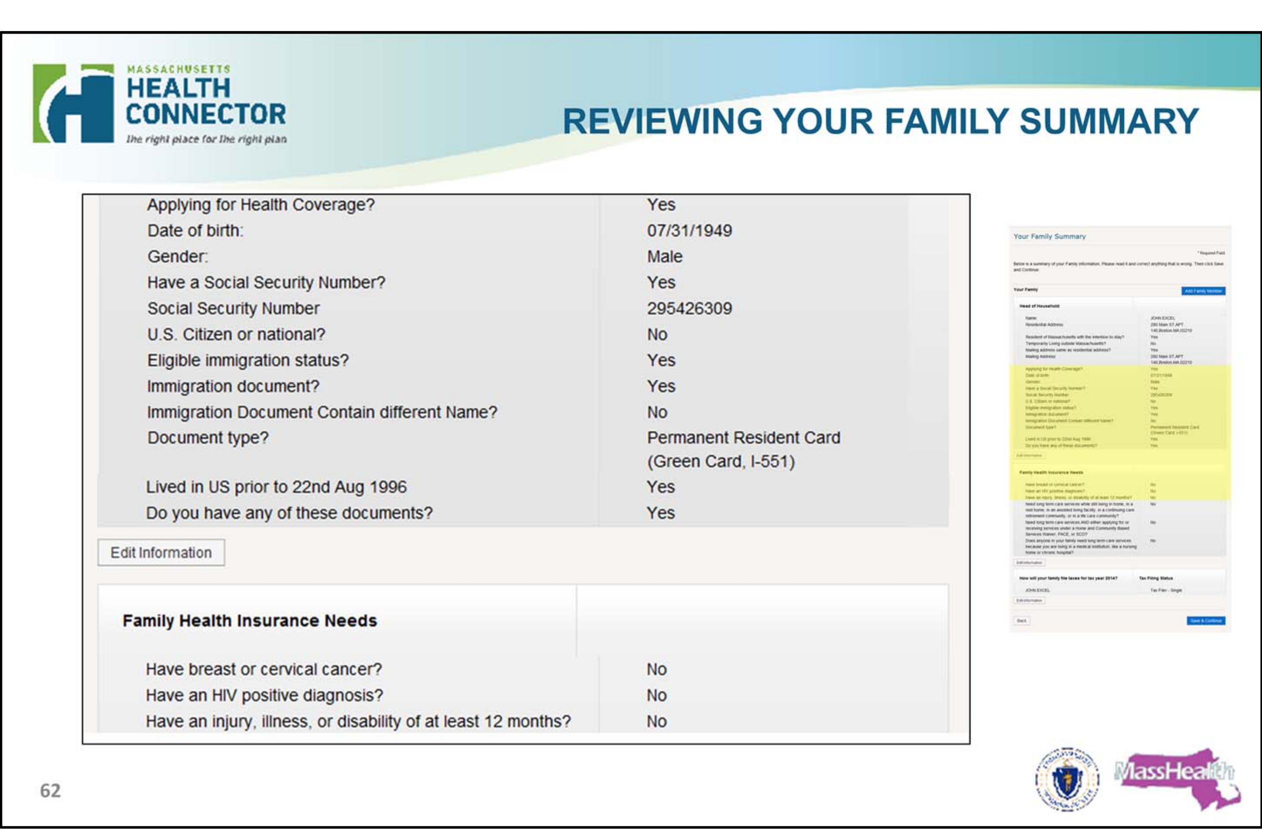
1.Click the drop-down list and select one of the tax filing statuses for each family member listed on the screen.

2.Click **What does Tax Filing Status mean** for an explanation of the six available tax filing statuses you can select from the drop-down list:

3.Click **Save and Continue**.



This screen provides a summary for each family member (split to fit on slide). The left column illustrates all the questions from the "Your Family" module, and the right column illustrates your responses. The user can choose to any information that you see on this screen, or hit Save & Continue.


MASSACHUSETTS
HEALTH
CONNECTOR
The right place for the right plan
REVIEWING YOUR FAMILY SUMMARY
Applying for Health Coverage? Yes
Date of birth: 07/31/1949
Gender: Male
Have a Social Security Number? Yes
Social Security Number 295426309
U.S. Citizen or national? No
Eligible immigration status? Yes
Immigration document? Yes
Immigration Document Contain different Name? No
Document type? Permanent Resident Card (Green Card, I-551)
Lived in US prior to 22nd Aug 1996 Yes
Do you have any of these documents? Yes
Edit Information
Family Health Insurance Needs
Have breast or cervical cancer? No
Have an HIV positive diagnosis? No
Have an injury, illness, or disability of at least 12 months? No
Your Family Summary
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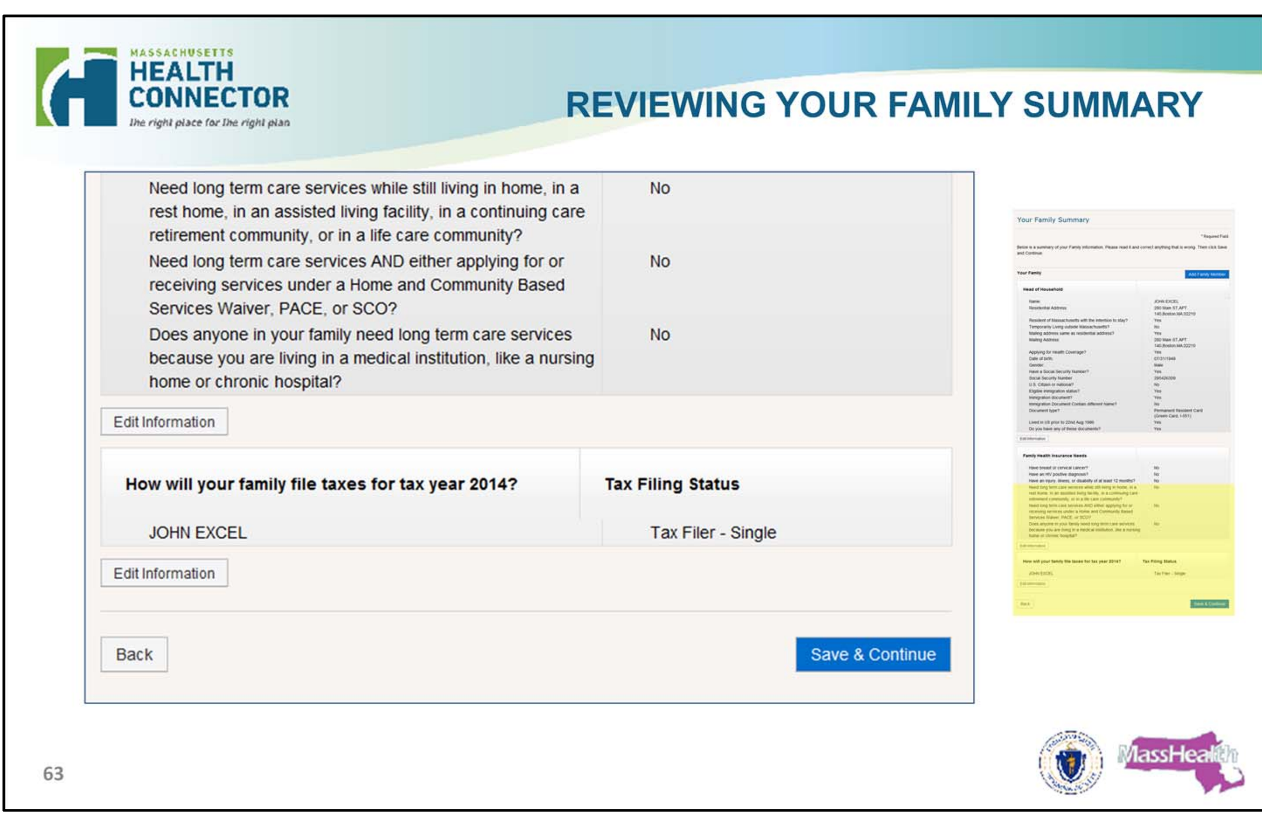
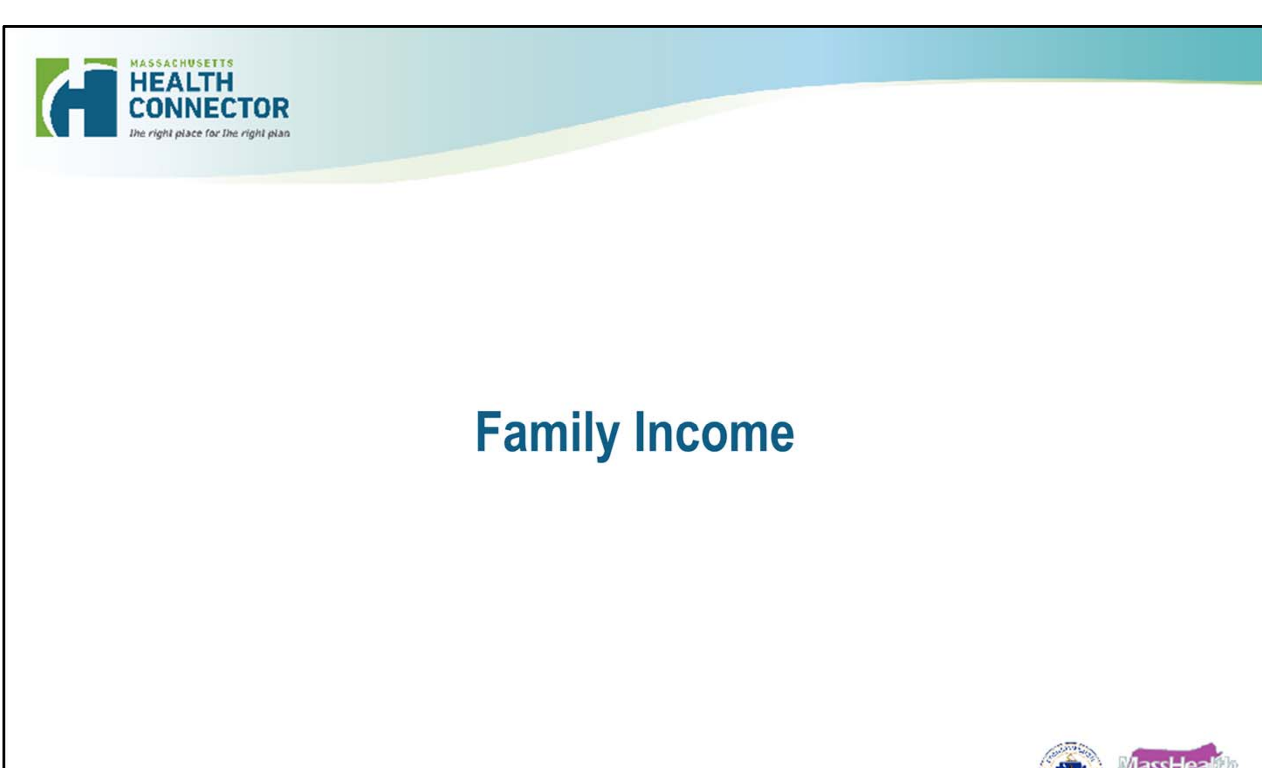
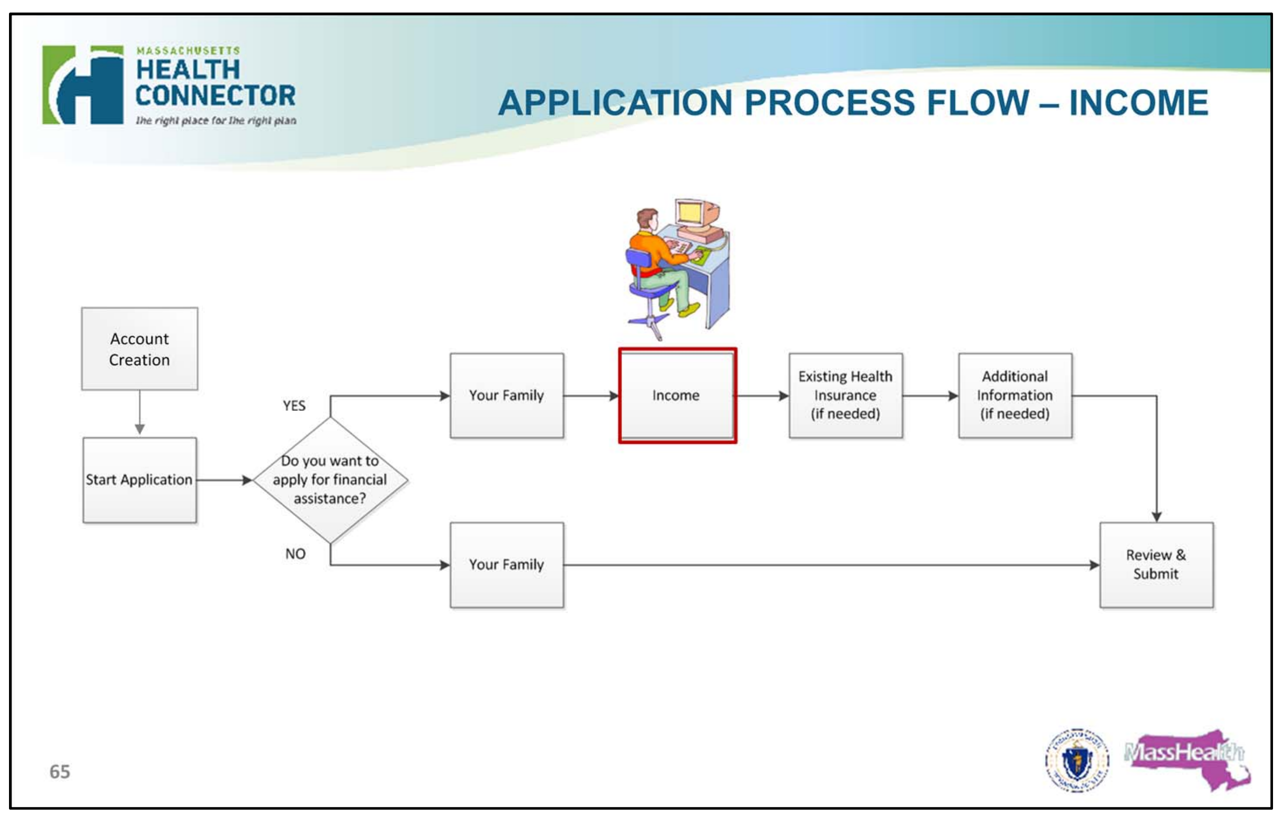
MassHealth

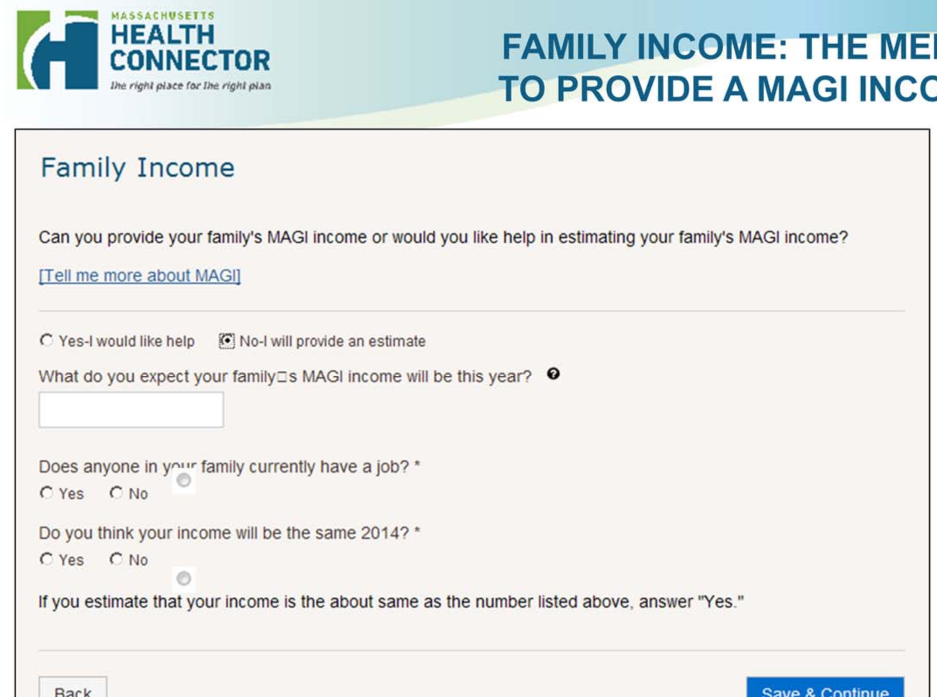

MASSACHUSETTS
HEALTH
CONNECTOR
The right place for the right plan
REVIEWING YOUR FAMILY SUMMARY
Need long term care services while still living in home, in a rest home, in an assisted living facility, in a continuing care retirement community, or in a life care community?
No
Need long term care services AND either applying for or receiving services under a Home and Community Based Services Waiver, PACE, or SCO?
No
Does anyone in your family need long term care services because you are living in a medical institution, like a nursing home or chronic hospital?
No
Edit Information
How will your family file taxes for tax year 2014?
Tax Filing Status
JOHN EXCEL
Tax Filer - Single
Edit Information
Back
Save & Continue
63
MassHealth


MASSACHUSETTS
HEALTH
CONNECTOR
The right place for the right plan
Family Income
64
MassHealth



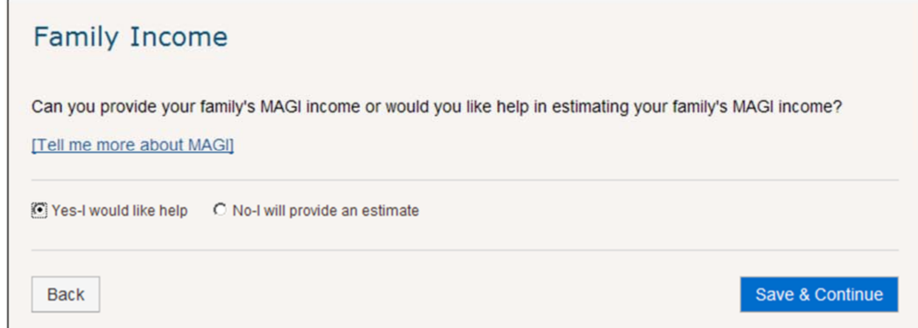
After entering family information, the user begins entering income information for each family member.
The responses provided determine the screens that appear next in the process.

FAMILY INCOME: THE MEMBER ELECTS TO PROVIDE A MAGI INCOME ESTIMATE



If the member elects to provide an estimate, and the amount is within a +/-10% range of their IRS tax data on file, the system proceeds to the “Income Summary” screen.

FAMILY INCOME: THE MEMBER ELECTS NOT TO PROVIDE A MAGI INCOME ESTIMATE



If the member elects to not provide an estimate, or the estimate they provide is not within a +/-10% range of their IRS tax data on file, the system proceeds to the "Tell Us More About Your Income" screen.

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TELL US MORE ABOUT YOUR INCOME

Tell us more about your income

* Required Field.

We found state income data available for some or all of your family members for this year. Please read this list and check all boxes that apply.

Does anyone in your family have Job Income to report (including self-employment)? *

[Tell me more about Job Income]

- Job
- Job - Seasonal
- Partnership / S-Corp
- Self-employment

Does anyone in your family receive income from one of the Other Income sources listed below? *

[Tell me more about Other Income]

- Alimony Payment
- Capital Gain

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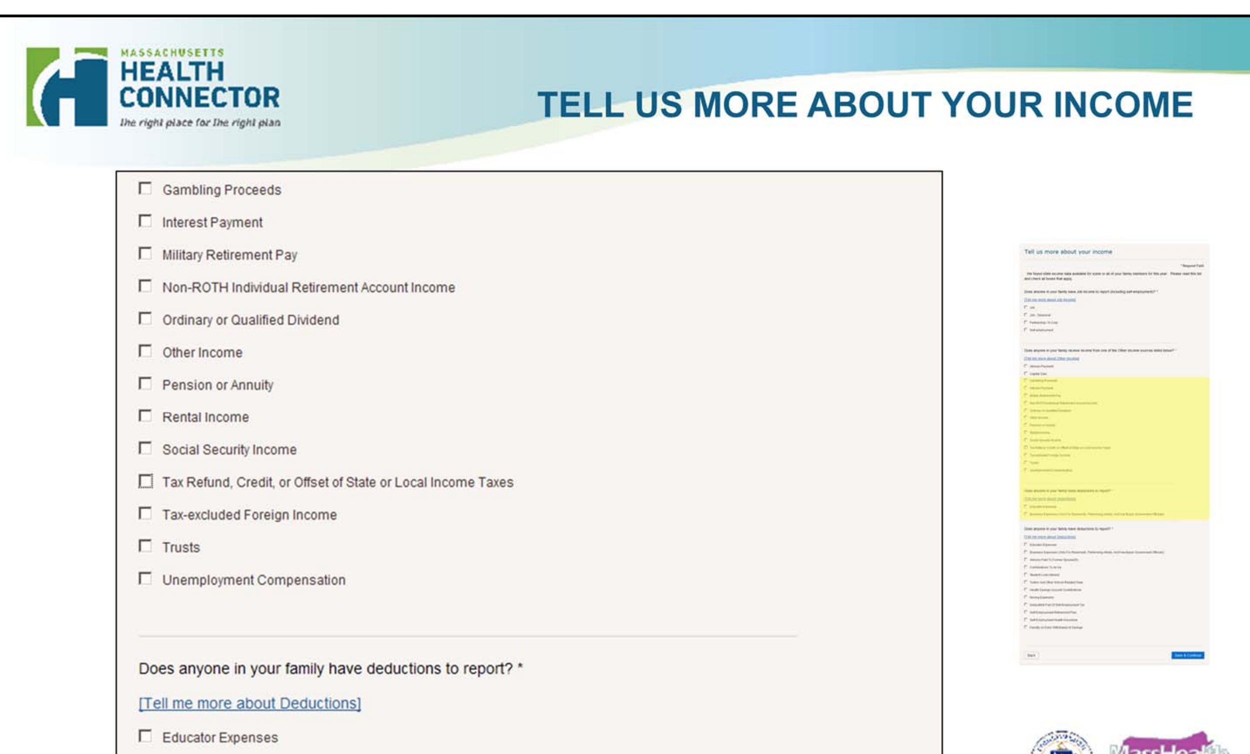
MassHealth

The "Tell us more about your income" screen has three sections for different types of income: "Job Income", "Other Income" and "Deductions". Each section has a "Tell me more about" link that displays a pop-up message describing specific incomes included in each of the income types. We will display these pop-up windows after we review this screen.


MASSACHUSETTS
HEALTH
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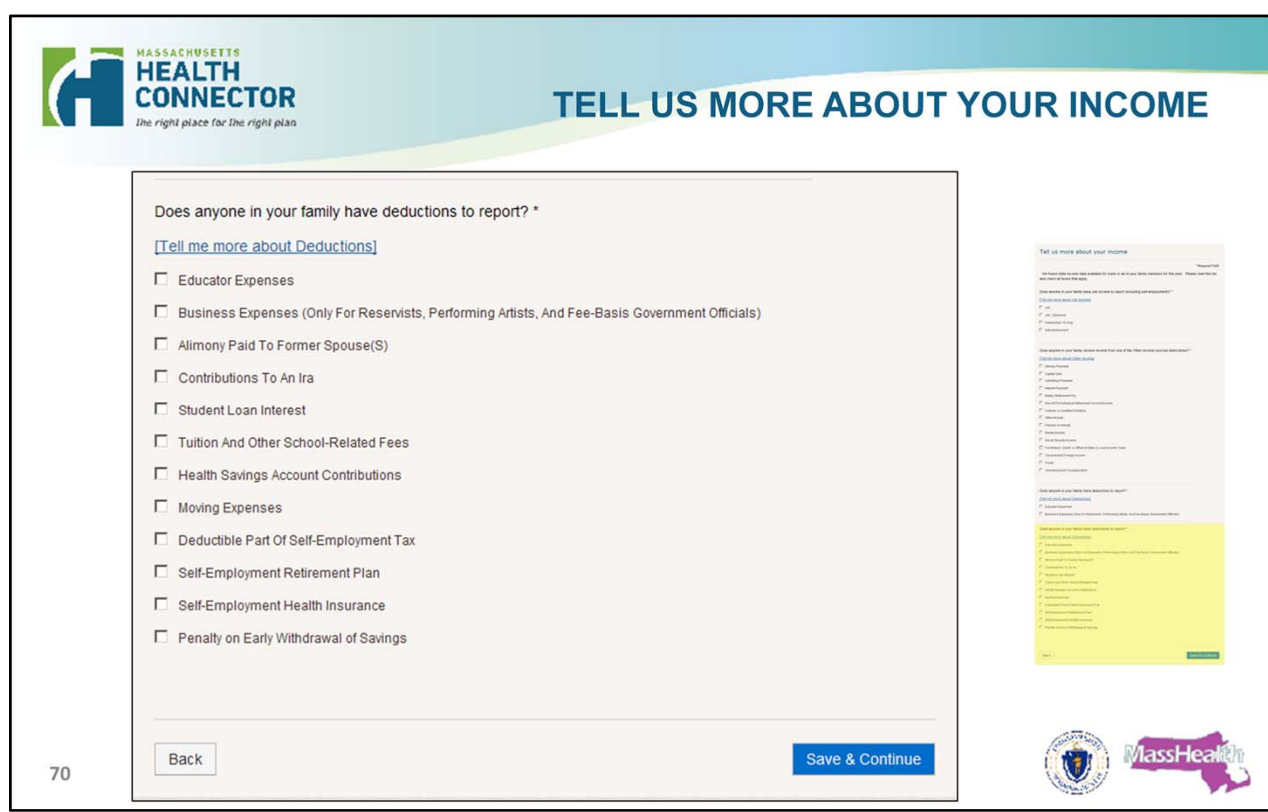
TELL US MORE ABOUT YOUR INCOME
Gambling Proceeds
Interest Payment
Military Retirement Pay
Non-ROTH Individual Retirement Account Income
Ordinary or Qualified Dividend
Other Income
Pension or Annuity
Rental Income
Social Security Income
Tax Refund, Credit, or Offset of State or Local Income Taxes
Tax-excluded Foreign Income
Trusts
Unemployment Compensation
Does anyone in your family have deductions to report? *
[Tell me more about Deductions]
Educator Expenses
Business Expenses (Only For Reservists, Performing Artists, And Fee-Basis Government Officials)
69
MassHealth


MASSACHUSETTS
HEALTH
CONNECTOR
The right place for the right plan
TELL US MORE ABOUT YOUR INCOME
Does anyone in your family have deductions to report? *
[Tell me more about Deductions]
Educator Expenses
Business Expenses (Only For Reservists, Performing Artists, And Fee-Basis Government Officials)
Alimony Paid To Former Spouse(S)
Contributions To An Ira
Student Loan Interest
Tuition And Other School-Related Fees
Health Savings Account Contributions
Moving Expenses
Deductible Part Of Self-Employment Tax
Self-Employment Retirement Plan
Self-Employment Health Insurance
Penalty on Early Withdrawal of Savings
Back
Save & Continue
70
MassHealth

POP-UP WINDOWS: TELL ME MORE

Tell me more about Job Income

Job Income includes:

- Job: Wages, Salaries, Tips, and/or Commission

- Job - Seasonal: If someone in your family receives wages that are not on a regular, year-round basis, please select this

- Job - Sheltered Workshop: This category applies only to persons with disabilities working in Sheltered Workshops, also known as Work Centers

- Partnership / S Corporation

- Self-Employment

Tell me more about Other Income

Income refers to all income that is not a direct result of labor:

- Alimony Payment

- Capital Gains: Do not include the sale of your primary residence if the net gains were less that $500,000 and you filing status is joint or married, or less than $250,000 and your filing status is single

- Gambling Proceeds

- Interest Payment

- Military Retirement Pay: Do not include any non-taxable veteran's disability retirement pay or benefits

Tell me more about Deductions

Some expenses are typcially allowed as tax deductions at the end of the year if you file taxes. Please report any expenses that apply to the categories listed below on this application so that we can accurately determine your MAGI:

- Alimony paid to former spouse(s)

- Business expenses (only for reservists, performing artists, and fee-basis government officials)

- Contributions to an IRA: Do not include contributions to a ROTH IRA

- Deductible part of self-employment tax: Do not list any amounts that you have already deducted in the self-employment Job Income section

- Educator expenses: Expenses claimed as deductions by teachers

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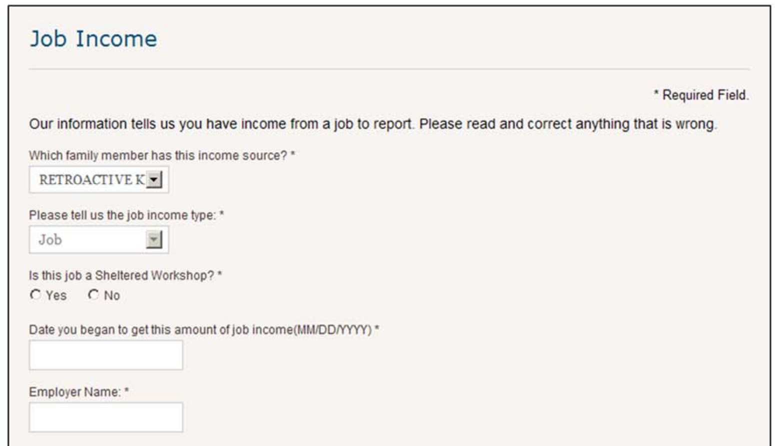
ENTERING EMPLOYMENT INFORMATION



If the user has a job, they complete this form and click **Save and Continue**. The system proceeds to the "Income Summary" screen.

If the user responds that they do not have a job, the system displays the "Tell Us More About Your Income" screen where they can answer questions about other income.

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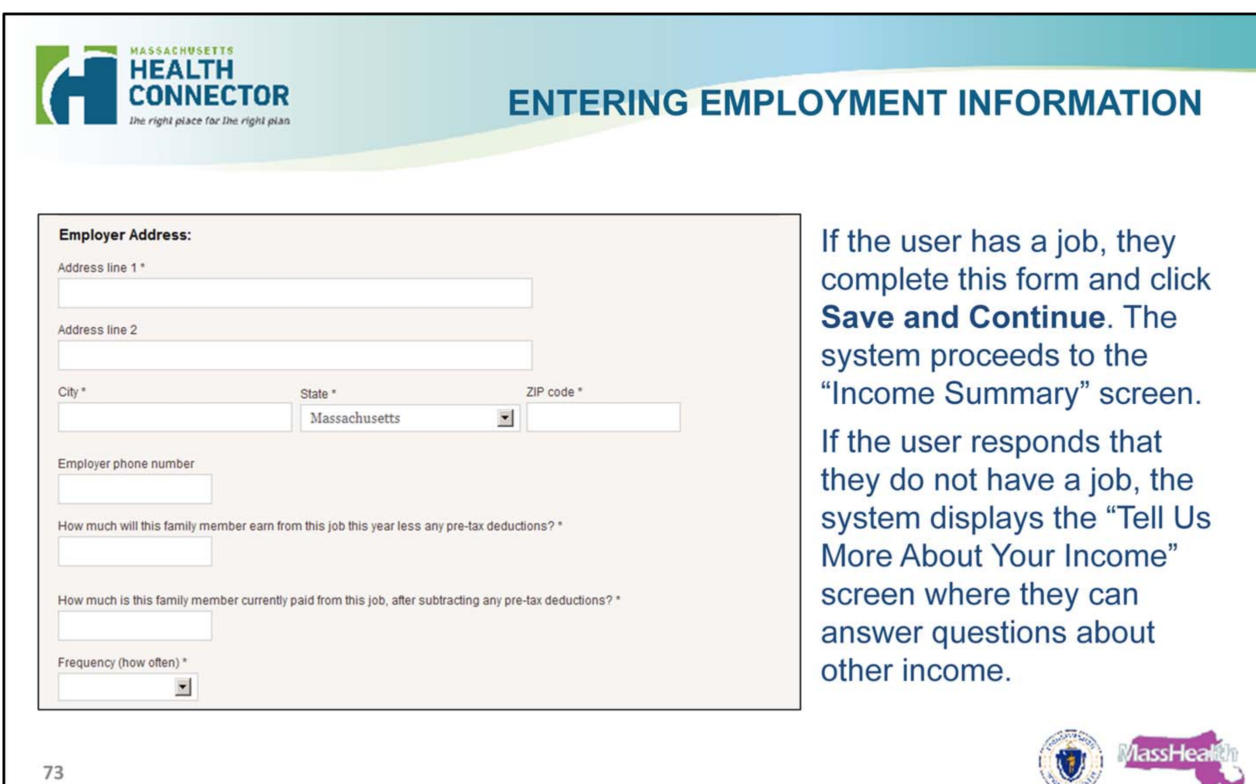
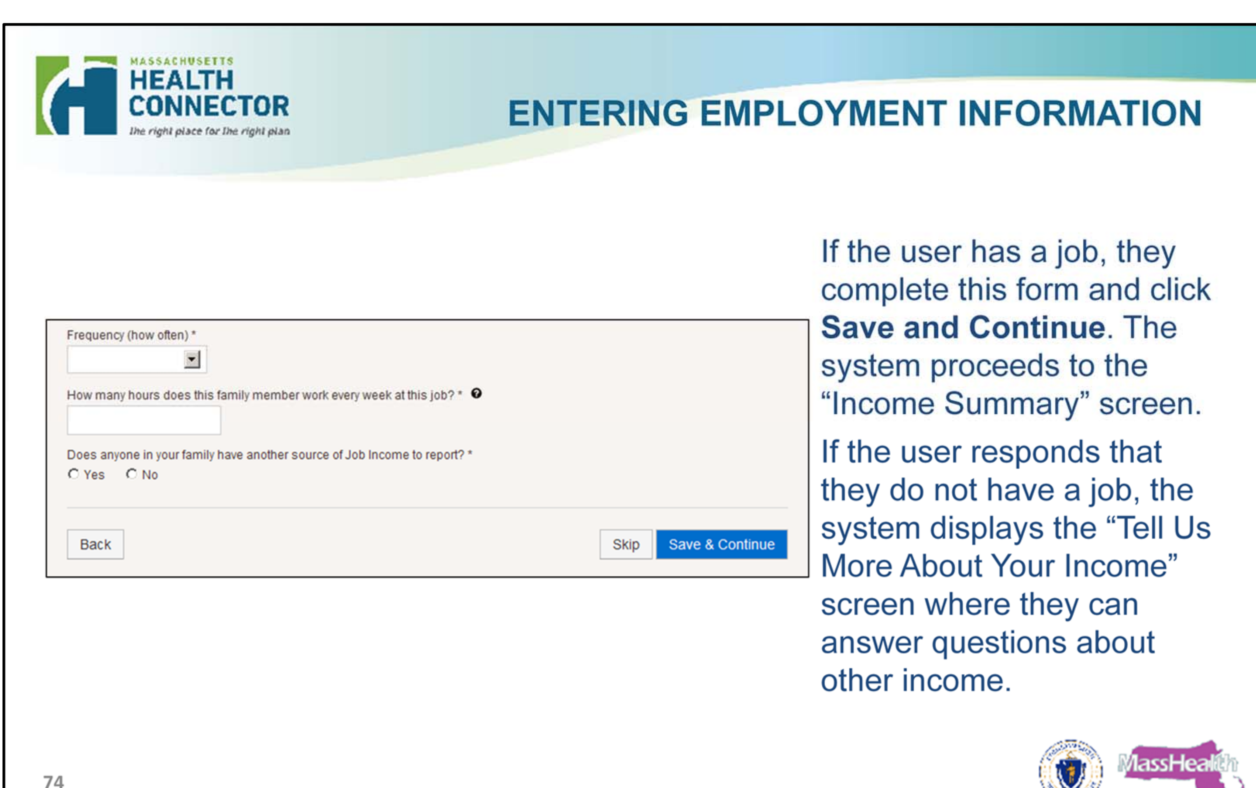

MASSACHUSETTS
HEALTH
CONNECTOR
The right place for the right plan
ENTERING EMPLOYMENT INFORMATION
Employer Address:
Address line 1 *
Address line 2
City *
State *
Massachusetts
ZIP code *
Employer phone number
How much will this family member earn from this job this year less any pre-tax deductions? *
How much is this family member currently paid from this job, after subtracting any pre-tax deductions? *
Frequency (how often) *
If the user has a job, they complete this form and click Save and Continue. The system proceeds to the "Income Summary" screen.
If the user responds that they do not have a job, the system displays the "Tell Us More About Your Income" screen where they can answer questions about other income.
73
MassHealth


MASSACHUSETTS
HEALTH
CONNECTOR
The right place for the right plan
ENTERING EMPLOYMENT INFORMATION
Frequency (how often) *
How many hours does this family member work every week at this job? *
Does anyone in your family have another source of Job Income to report? *
Yes
No
Back
Skip
Save & Continue
If the user has a job, they complete this form and click **Save and Continue**. The system proceeds to the "Income Summary" screen.
If the user responds that they do not have a job, the system displays the "Tell Us More About Your Income" screen where they can answer questions about other income.
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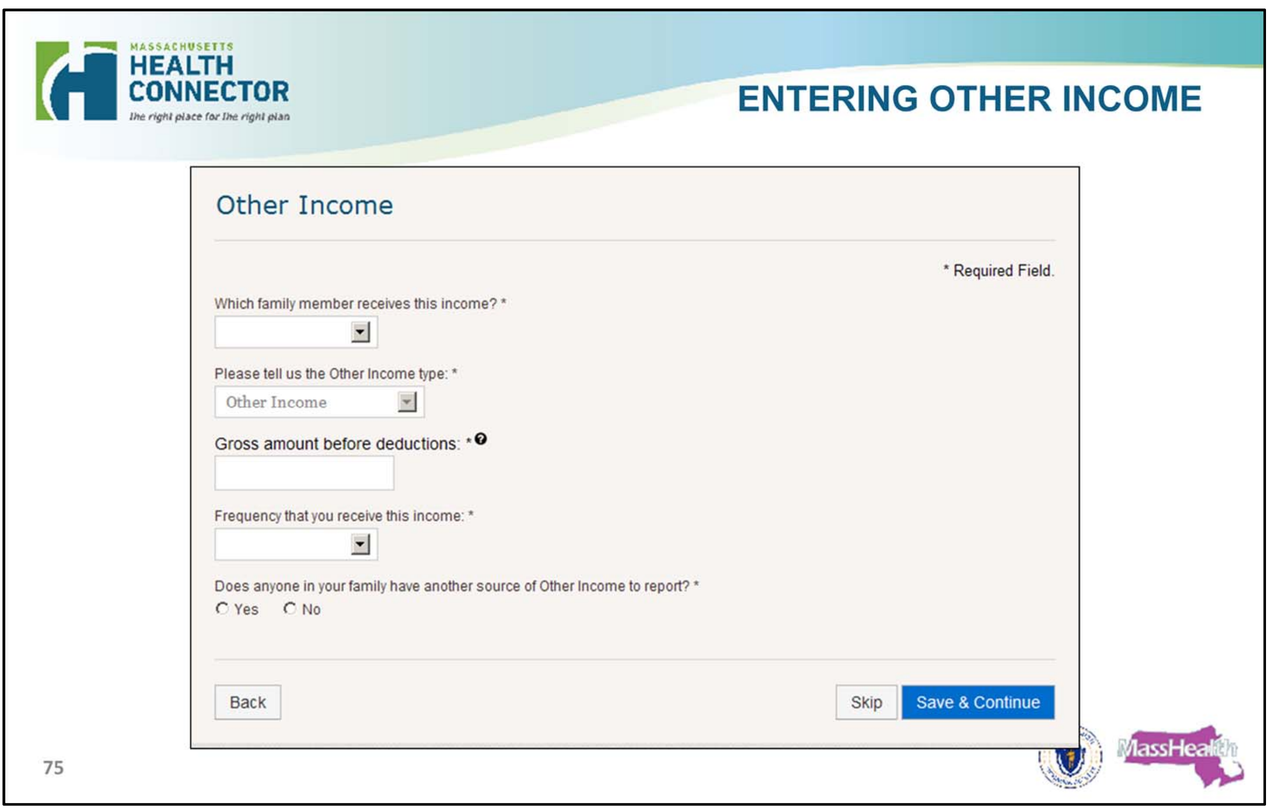
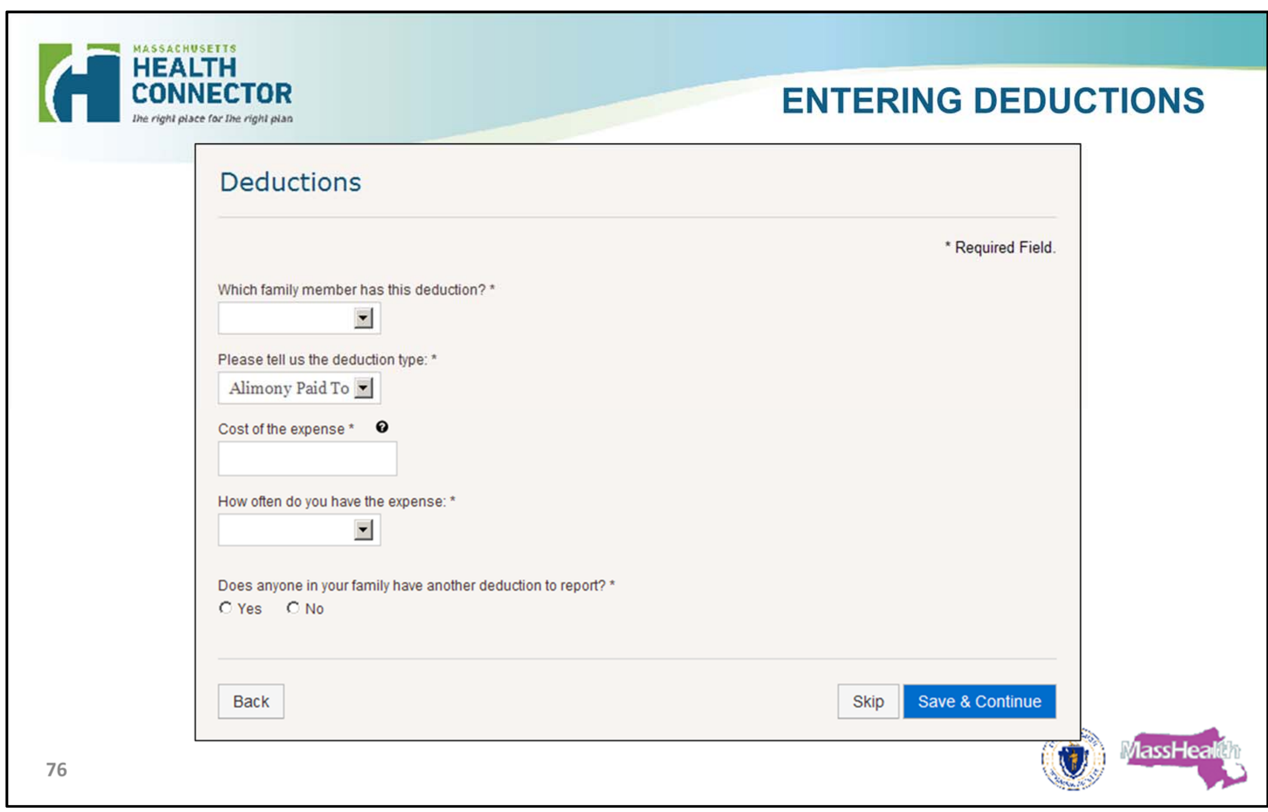
MassHealth



- The “Other Income” screen appears if the user indicated that anyone in the household has income other than a job.
- If they selected any **Other Income** on the "Tell us more about your income" screen, the system displays an "Other Income" screen for your type of other income.
- Some examples of other income include retirement income, social security payments, or unemployment compensation.



- If they selected any deductions on the "Tell us more about your income" screen the system displays a "Deductions" screen for their type of deduction.

MASSACHUSETTS HEALTH CONNECTOR
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REVIEWING CURRENT TOTAL MAGI SUMMARY

Current Total MAGI Summary

Below is a summary of your Current Total MAGI. Please read it and correct anything that is wrong. Then click Save and Continue.

RETROACTIVE KNOXVILLESPENCER's Income

Job Income	Income Source	Yearly Income from this Source	
	Job:ABC CORP	$12716	Edit

Add Another Job Income

Other Income	Income Source	Yearly Income from this Source	
	Other Income	$24000	Edit

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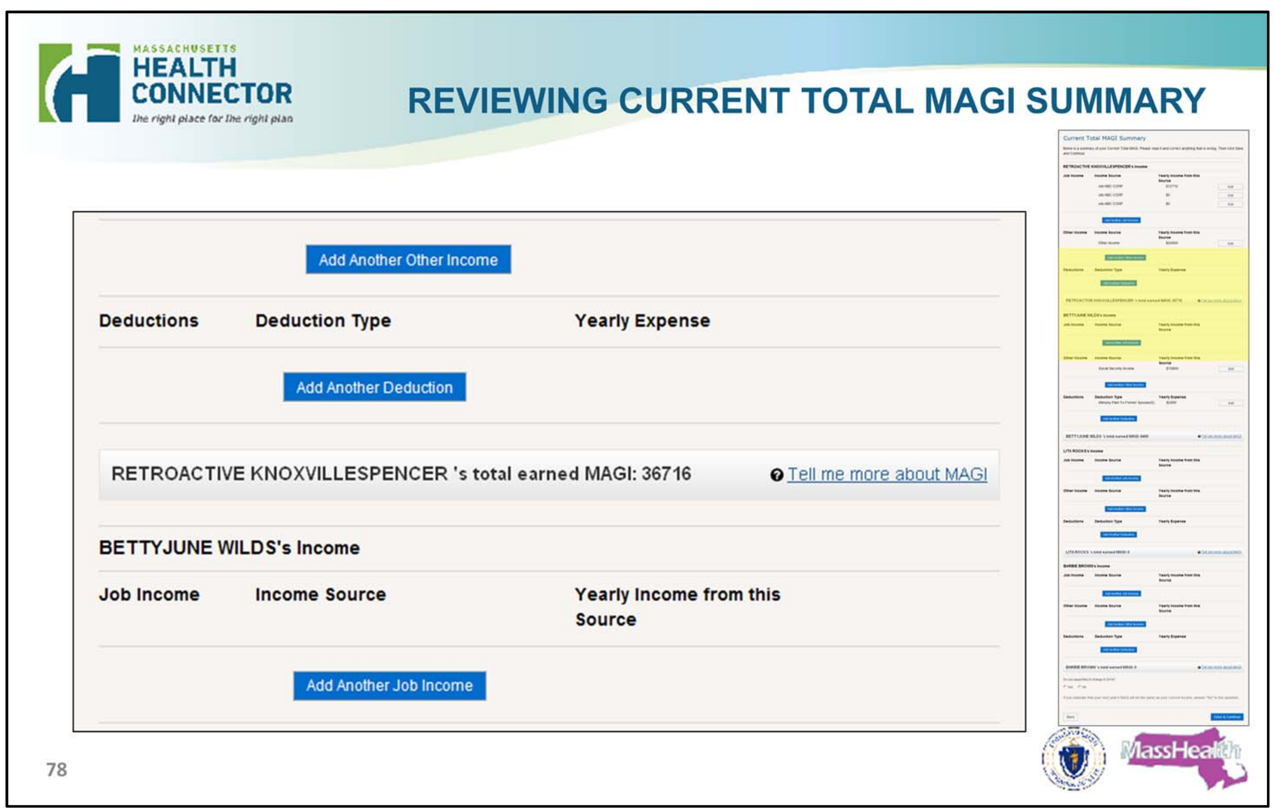
The "Current Total MAGI Summary" screen is pre-populated with income and deduction information for each family member. All family members including those with no income will be listed in this summary.

The information on this screen can be edited by clicking on the “Edit” button that appears next to it.


MASSACHUSETTS HEALTH CONNECTOR
The right place for the right plan
REVIEWING CURRENT TOTAL MAGI SUMMARY
Add Another Other Income
Deductions
Deduction Type
Yearly Expense
Add Another Deduction
RETROACTIVE KNOXVILLESPENCER 's total earned MAGI: 36716
Tell me more about MAGI
BETTYJUNE WILDS's Income
Job Income
Income Source
Yearly Income from this Source
Add Another Job Income
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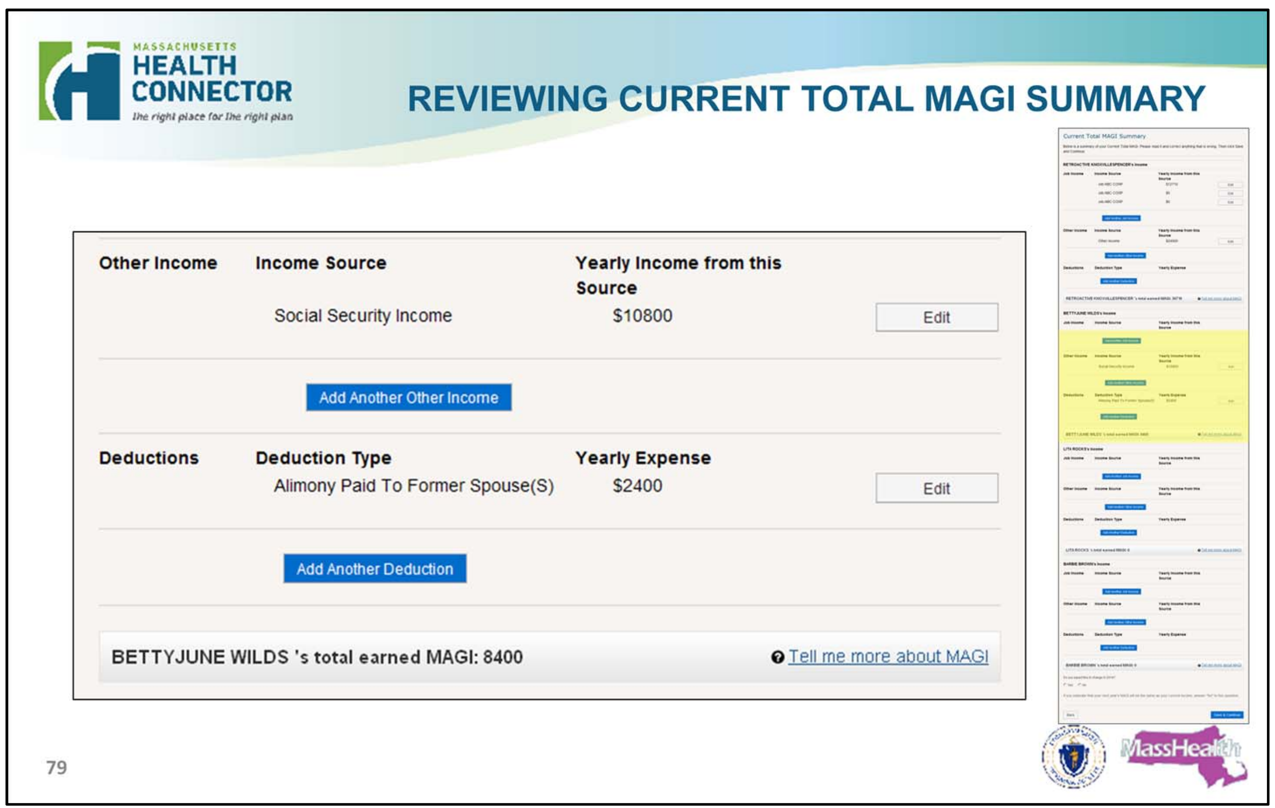
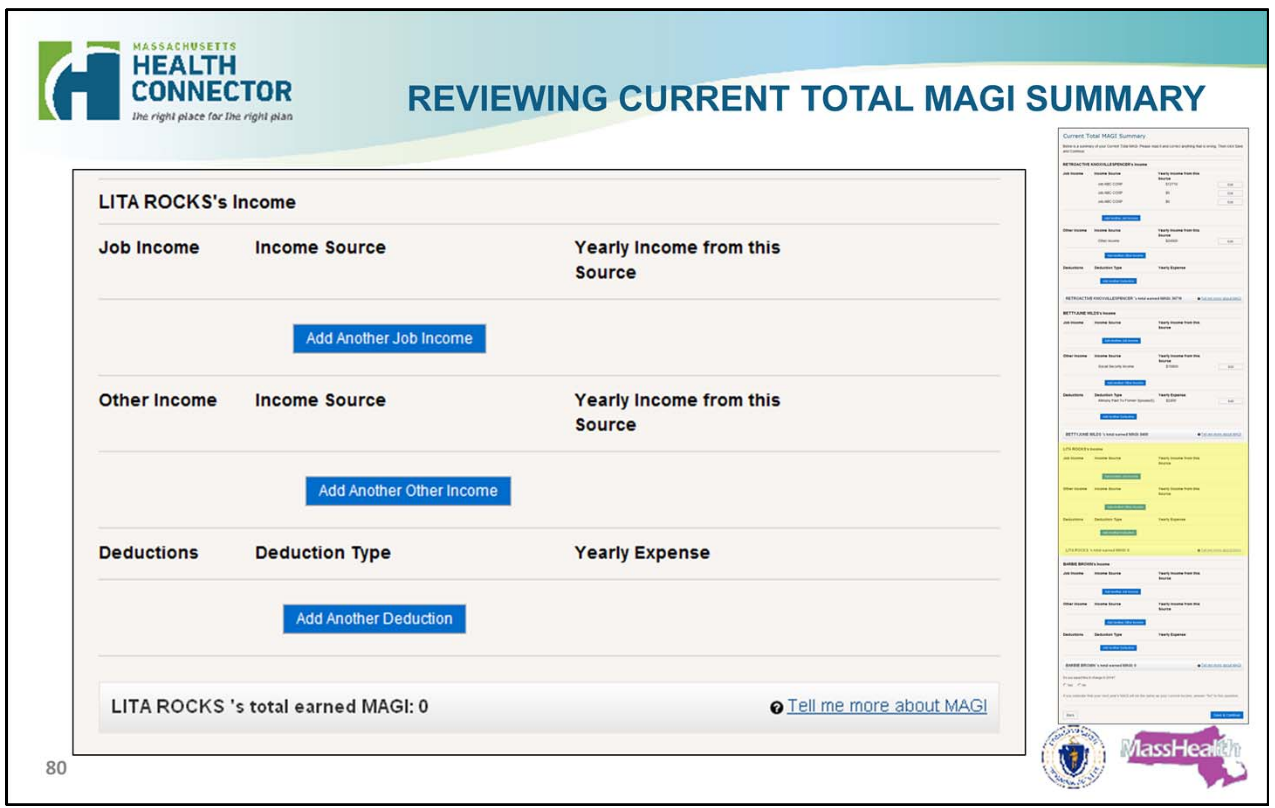
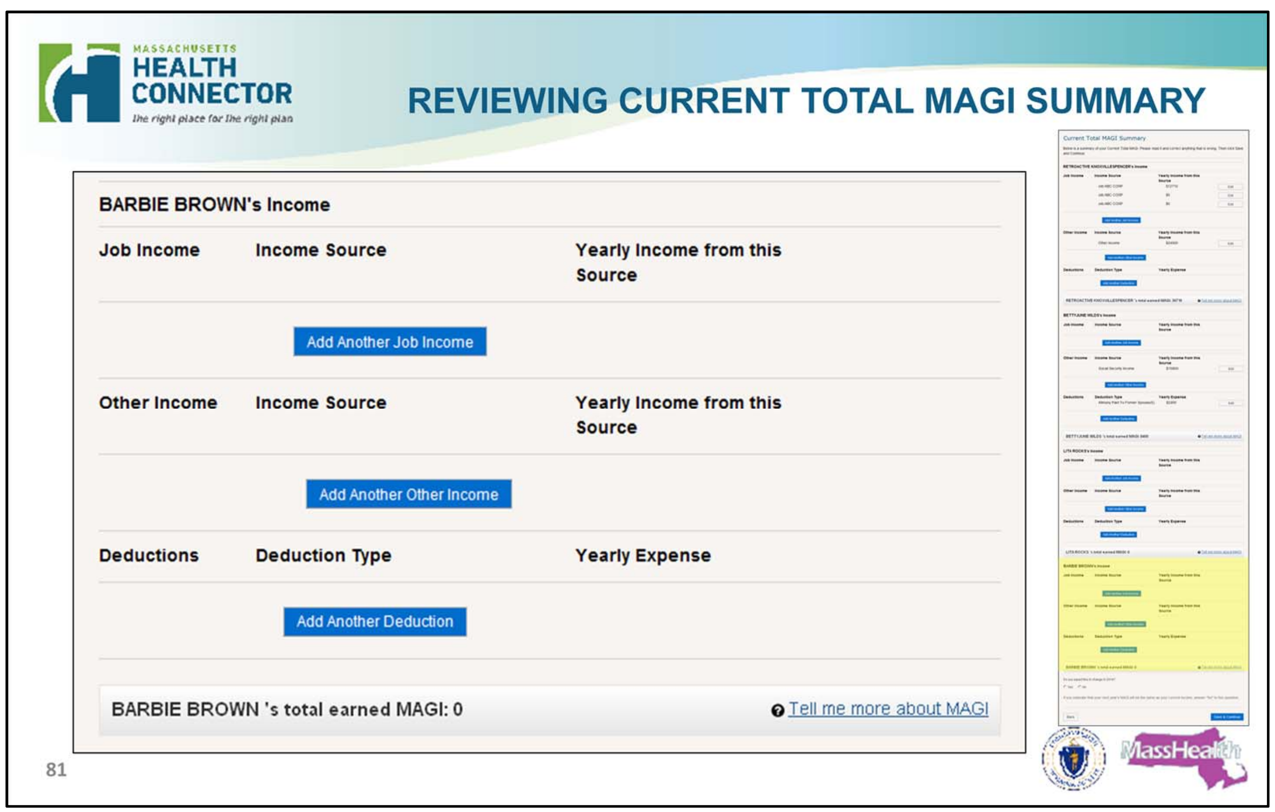
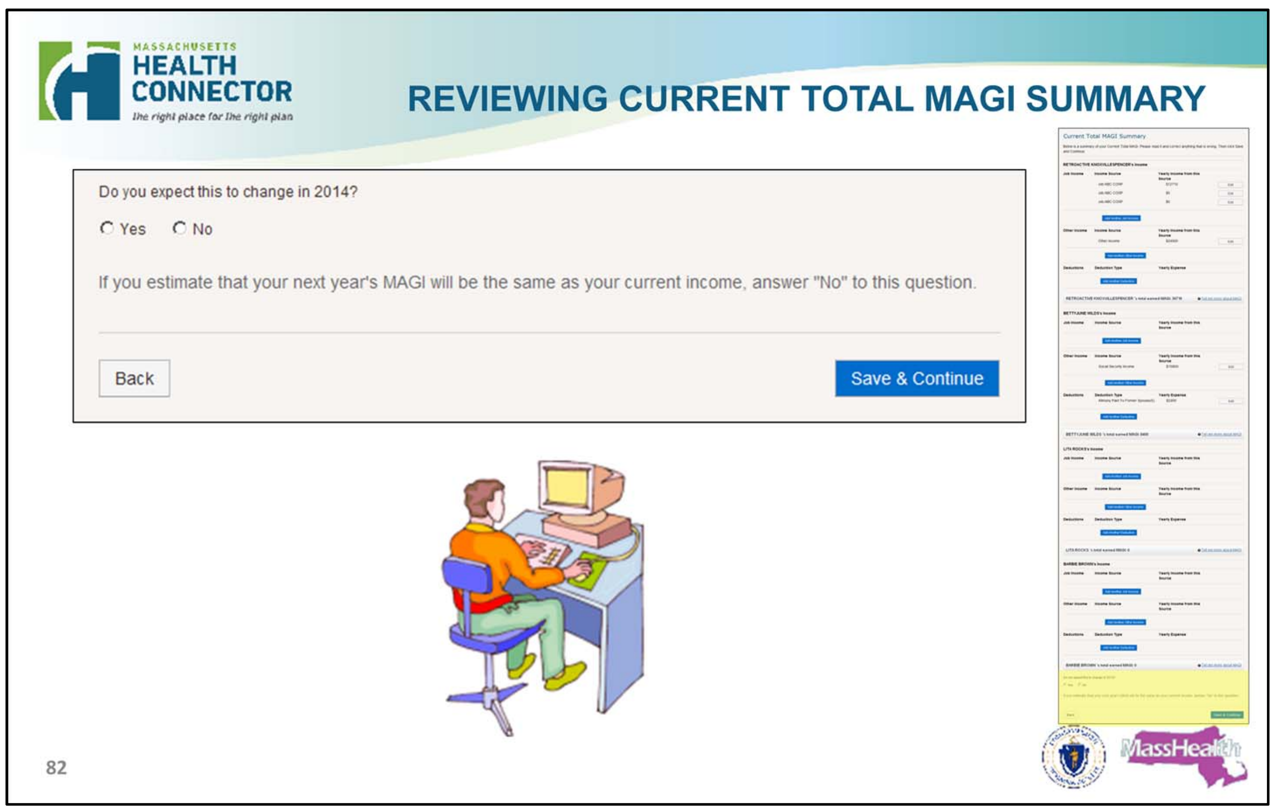
MassHealth


MASSACHUSETTS
HEALTH
CONNECTOR
The right place for the right plan
REVIEWING CURRENT TOTAL MAGI SUMMARY
Other Income
Income Source
Yearly Income from this Source
Social Security Income
$10800
Edit
Add Another Other Income
Deductions
Deduction Type
Yearly Expense
Alimony Paid To Former Spouse(S)
$2400
Edit
Add Another Deduction
BETTYJUNE WILDS 's total earned MAGI: 8400
Tell me more about MAGI
79
MassHealth



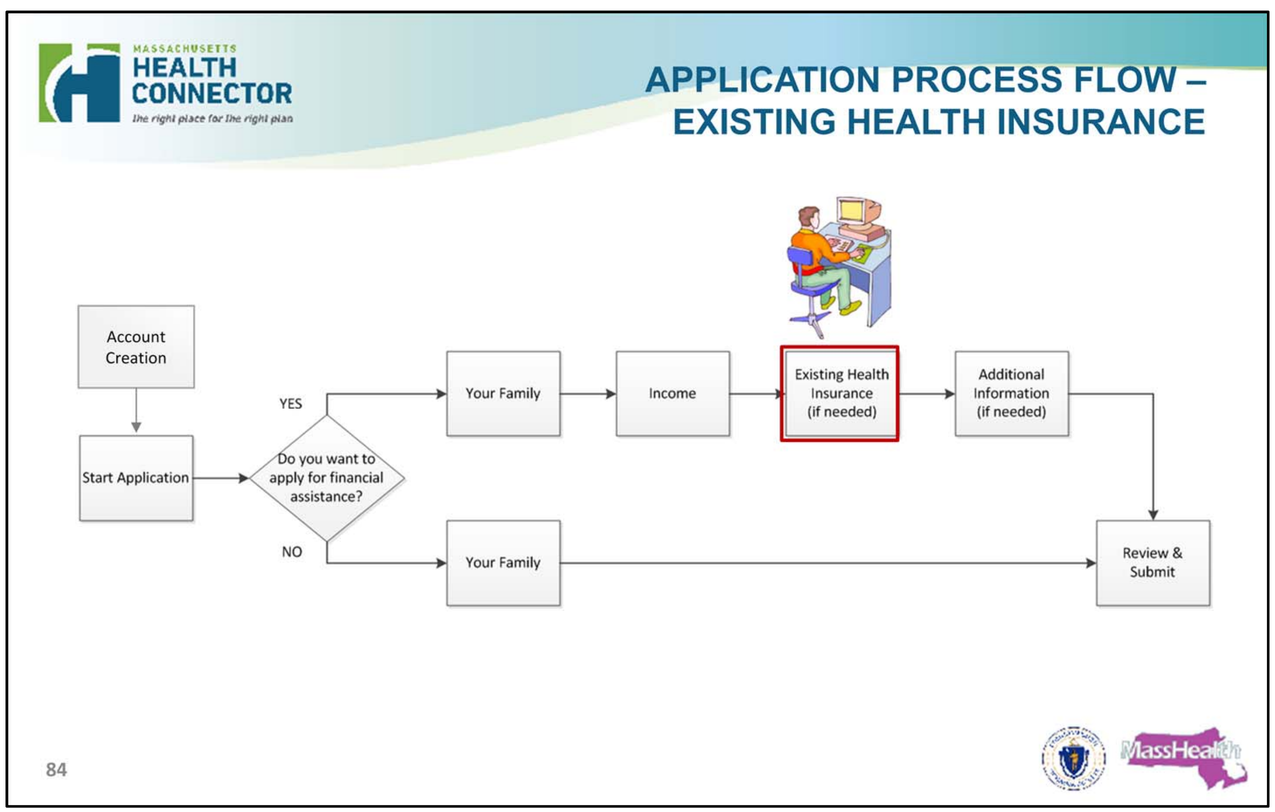
MASSACHUSETTS HEALTH CONNECTOR
The right place for the right plan
REVIEWING CURRENT TOTAL MAGI SUMMARY
LITA ROCKS's Income
Job Income
Income Source
Yearly Income from this Source
Add Another Job Income
Other Income
Income Source
Yearly Income from this Source
Add Another Other Income
Deductions
Deduction Type
Yearly Expense
Add Another Deduction
LITA ROCKS 's total earned MAGI: 0
Tell me more about MAGI
80
MassHealth


MASSACHUSETTS
HEALTH
CONNECTOR
The right place for the right plan
REVIEWING CURRENT TOTAL MAGI SUMMARY
BARBIE BROWN's Income
Job Income
Income Source
Yearly Income from this Source
Add Another Job Income
Other Income
Income Source
Yearly Income from this Source
Add Another Other Income
Deductions
Deduction Type
Yearly Expense
Add Another Deduction
BARBIE BROWN 's total earned MAGI: 0
Tell me more about MAGI
81
MassHealth



This question asks whether or not you expect your income to change in 2014. Answer “Yes” or “No” to this question.

Existing Health Insurance



With Income information completed, the user begins entering information on Existing Health information.
The responses provided to “Do you have health insurance” or “do you have access to health insurance” determines the screens the systems displays.

DO YOU HAVE ACCESS TO HEALTH INSURANCE

Do you have access to health insurance?

* Required Field.

Are you or any family members offered health insurance by an employer or union now? (Insurance that you're not currently enrolled in.) *

Yes No

Back | Save & Continue

Depending on your "Yes" or "No" response, the system displays one of the following screens:

- "Your Health Insurance Information Summary"
- "Access to Federal or State-sponsored Health Insurance"
- "Access to Private Health Insurance"

MASSACHUSETTS HEALTH CONNECTOR
The right place for the right plan

ACCESS TO HEALTH INSURANCE

Access to Health Insurance

You told us that you or your family members were offered health insurance by an employer or union that you're not currently enrolled in. Please tell us about this health insurance.

* Required Field.

Who in the household could be covered by this insurance policy? *

- [ ] RETROACTIVE KNOXVILLESPENCER
- [ ] BETTYJUNE WILDS
- [x] LITA ROCKS
- [ ] BARBIE BROWN

Employer / Union name * : Smithco

Federal tax identification number (FID) * : 719876456

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MassHealth

The following screens cover questions whether the user has access to insurance through an employer or union. This includes questions about the different family members who may eligible for different insurance coverage.

MASSACHUSETTS HEALTH CONNECTOR
The right place for the right plan

ACCESS TO HEALTH INSURANCE

Does this plan meet Minimum Value Requirements? *

Yes No

Is this coverage affordable for you? Can you afford this coverage? * [How do I determine if coverage is affordable for me?]

Yes No

Contribution to premium costs(what you pay) *

Dollar Amount *

400.00

Frequency *

Monthly

Can any other family members get coverage through another employer or union? *

Yes No

Back

Save & Continue

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MassHealth

Questions on these screens are accompanied by definitions for Minimum Value Requirements, as well as additional information determining whether coverage is affordable. The pop-up window on the next screen covers this in more detail.

DETERMINING IF COVERAGE IS AFFORDABLE

How do I determine if coverage is affordable for me?

Employer coverage is considered affordable for the employee and his/her spouse and/or dependents if the portion of the annual premium for the lowest-cost plan that meets minimum essential coverage requirements for self-only coverage is no more than 9.5% of the taxpayer's household income as calculated by the Exchange.

See the table below for more information.

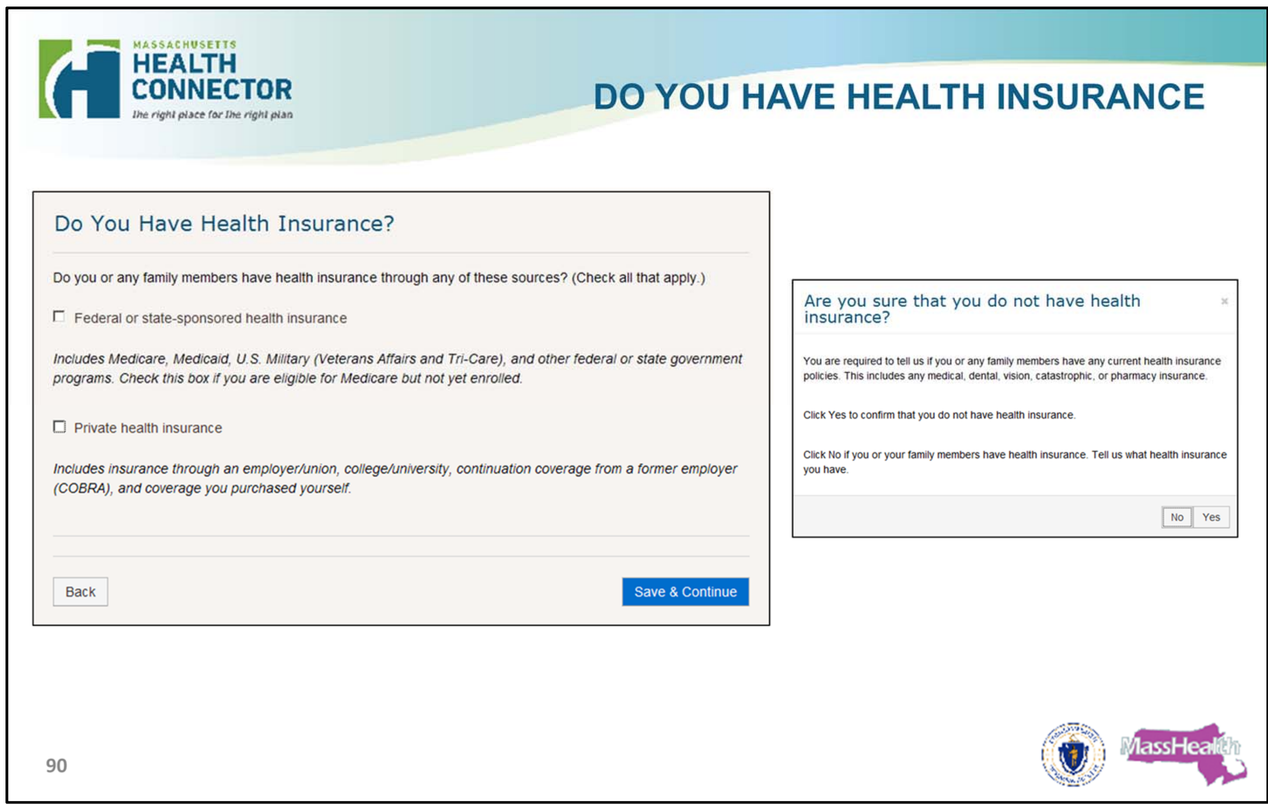
If your family's annual income is.....	and your contribution to premium costs for an individual plan is.....	
$10,000	Less than $950 per year	
$20,000	Less than $1900 per year	
$30,000	Less than $2850 per year	
$40,000	Less than $3800 per year	Your health insurance is affordable.
$50,000	Less than $4750 per year	
$60,000	Less than $5700 per year	
$70,000	Less than $6650 per year	
$80,000	Less than $7600 per year	
$90,000	Less than $8550 per year	
$100,000	Less than $9500 per year	

ACCESS TO FEDERAL OR STATE-SPONSORED HEALTH INSURANCE

The system only displays a "Federal or State Sponsored Insurance Information" screen if you selected **Federal or state-sponsored health insurance** on the "Do you have health insurance?" screen at the beginning of this lesson.

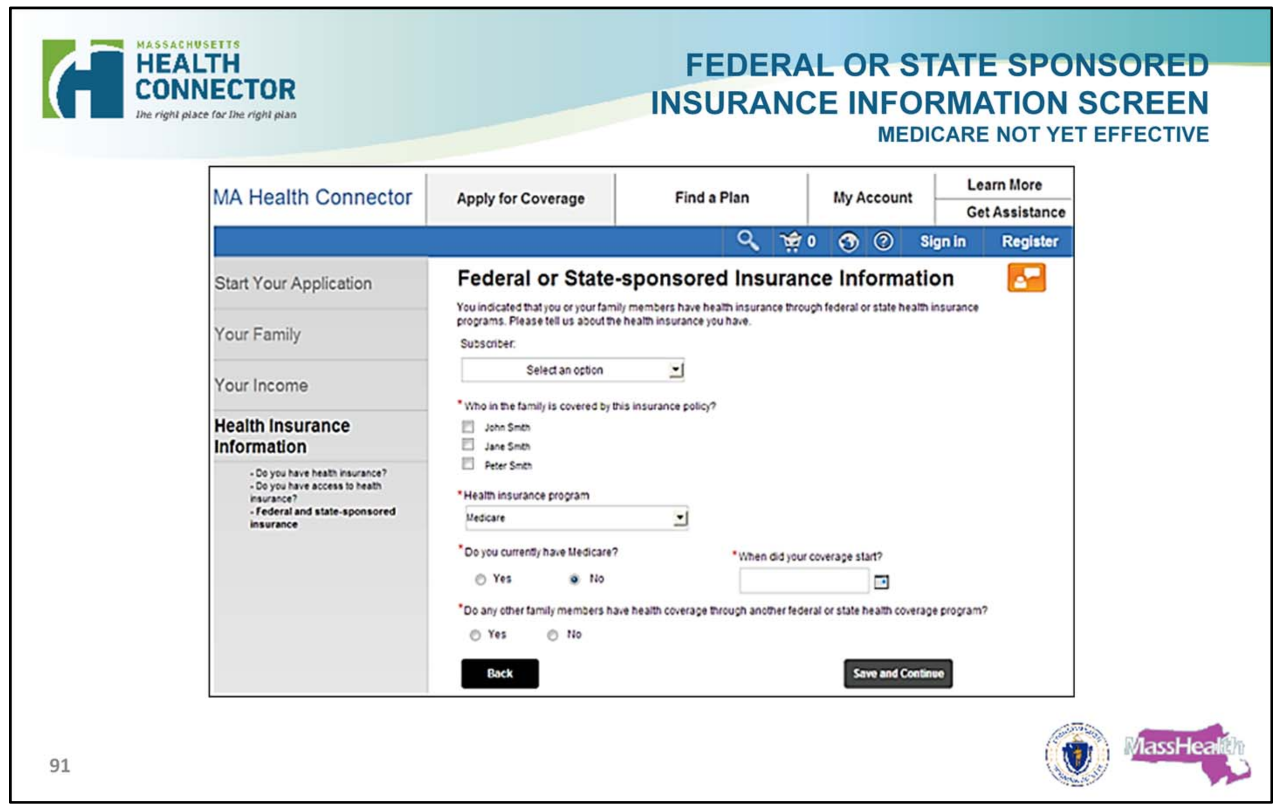
There are variations of the screen, based on your coverage:

- If you have Medicare, but the coverage is not yet active.
- If you have active Medicare coverage.
- If you have TRICARE or a Federal or State-sponsored insurance other than Medicare.



These screens cover questions about whether not the user currently has health insurance, either through federal or state-sponsored health insurance or private health insurance.

If they did not make a selection on the first screen (on the left), the system displays the pop-up window (on the right).
Click **Yes** or **No** on the pop-up window to indicate if you have health insurance.



On the "Federal or State-sponsored Insurance Information" screen, the user enters information for applicants who are eligible for Medicare, but for whom Medicare coverage is not yet active. Follow these steps:

1.Select the subscriber from the drop-down list, and select all family members who are covered by this insurance.

The **Health Insurance Program** field is pre-populated with **Medicare**.

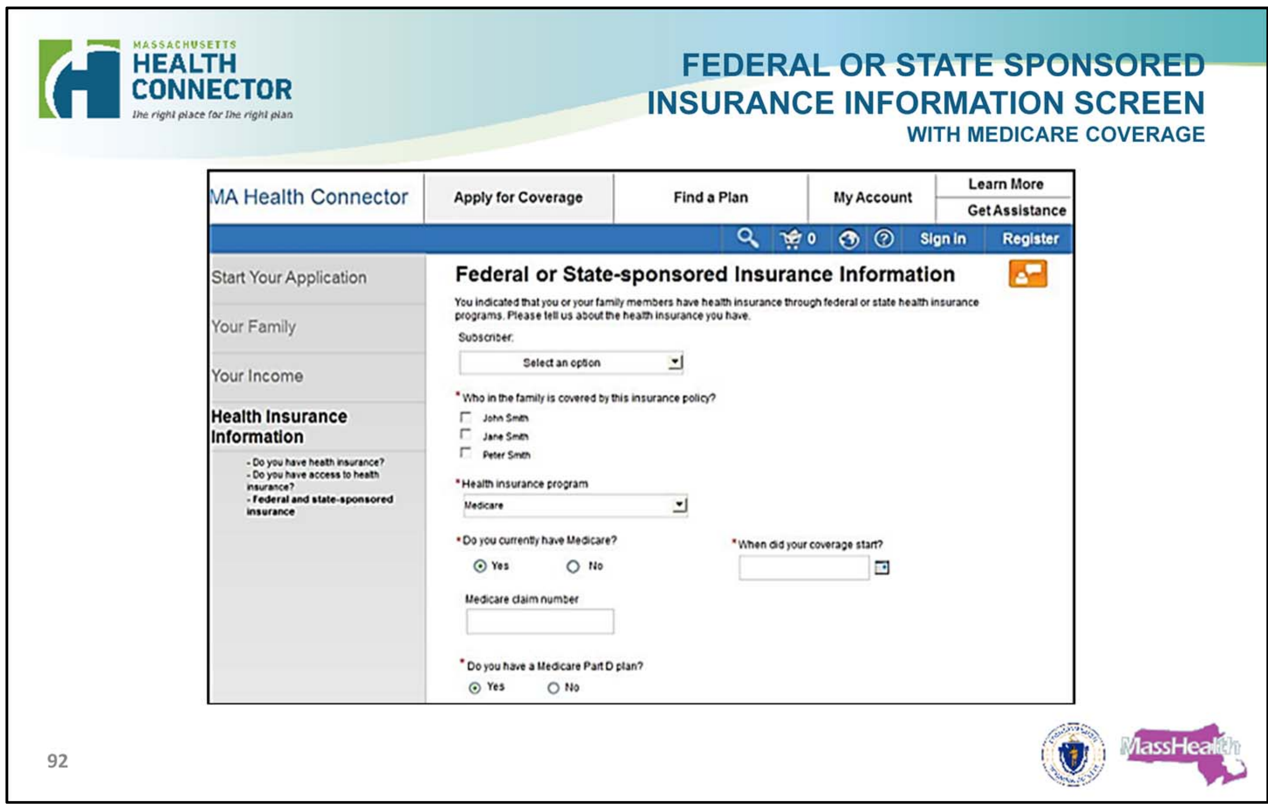
2.Select **No** to indicate you **currently do not have Medicare**.

3.Select **Yes** or **No** to indicate if other family members have **coverage through another federal or state health coverage program**.

4.Click **Save and Continue**.

If other family members have coverage, enter their insurance information on the next screen that appears.

If other family members don't have federal or state-sponsored insurance, the user is taken to the "Health Insurance Information Summary" screen. We'll see the “Health Insurance Information Summary” a bit later.



On the "Federal or State-sponsored Insurance Information" screen, the user enters information for applicants who are covered by Medicare. Follow the steps below:

1.Select the subscriber from the drop-down list.

2.Select all family members who are covered by this insurance.

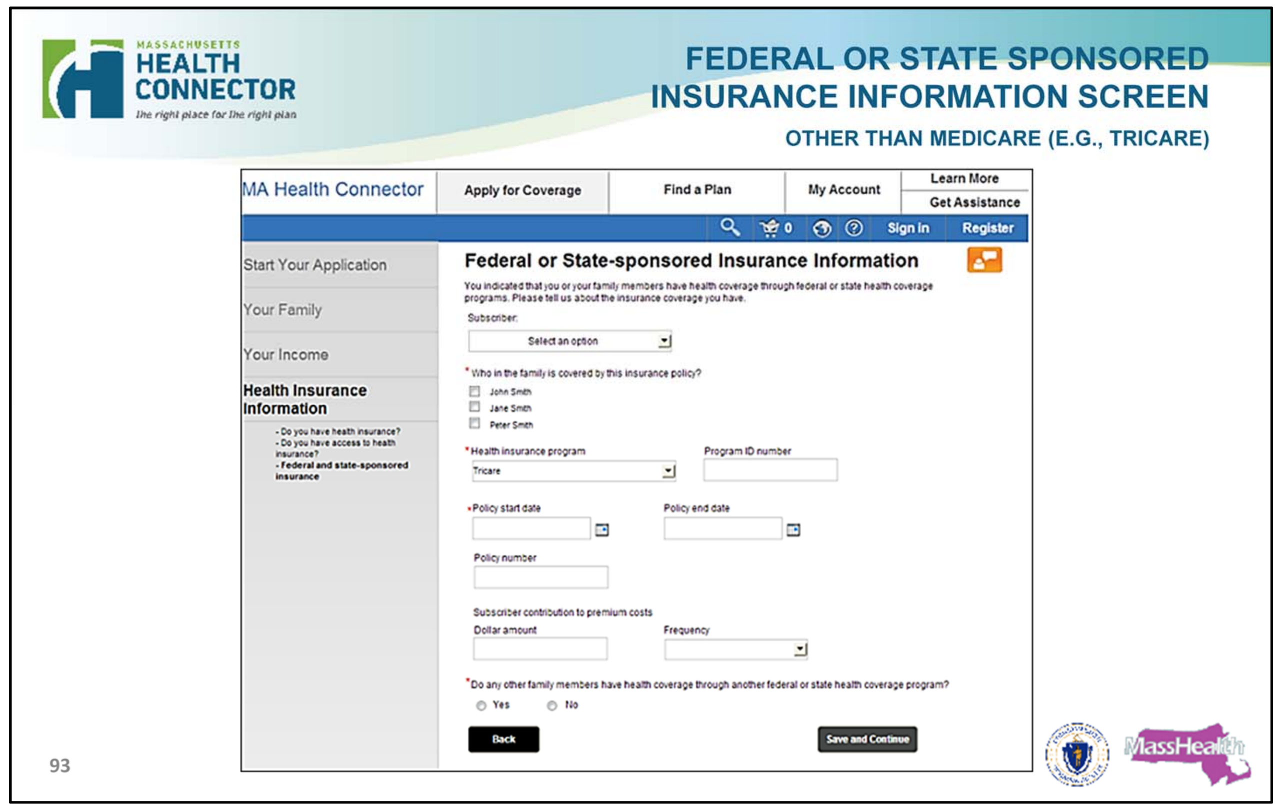
The Health insurance program field is pre-populated with Medicare.

3.Select **Yes** to indicate if you currently have coverage and enter the **coverage start date** or click the calendar and select the date.

4.Enter your **Medicare Claim Number**.

5.Select **Yes** or **No** to indicate if you have **Medicare Part D**.

If you select **Yes** enter the **Policy start date**, **Policy end date**, **Policy Number**, and **Dollar amount**. Select the **Frequency** of payment from the drop-down list.



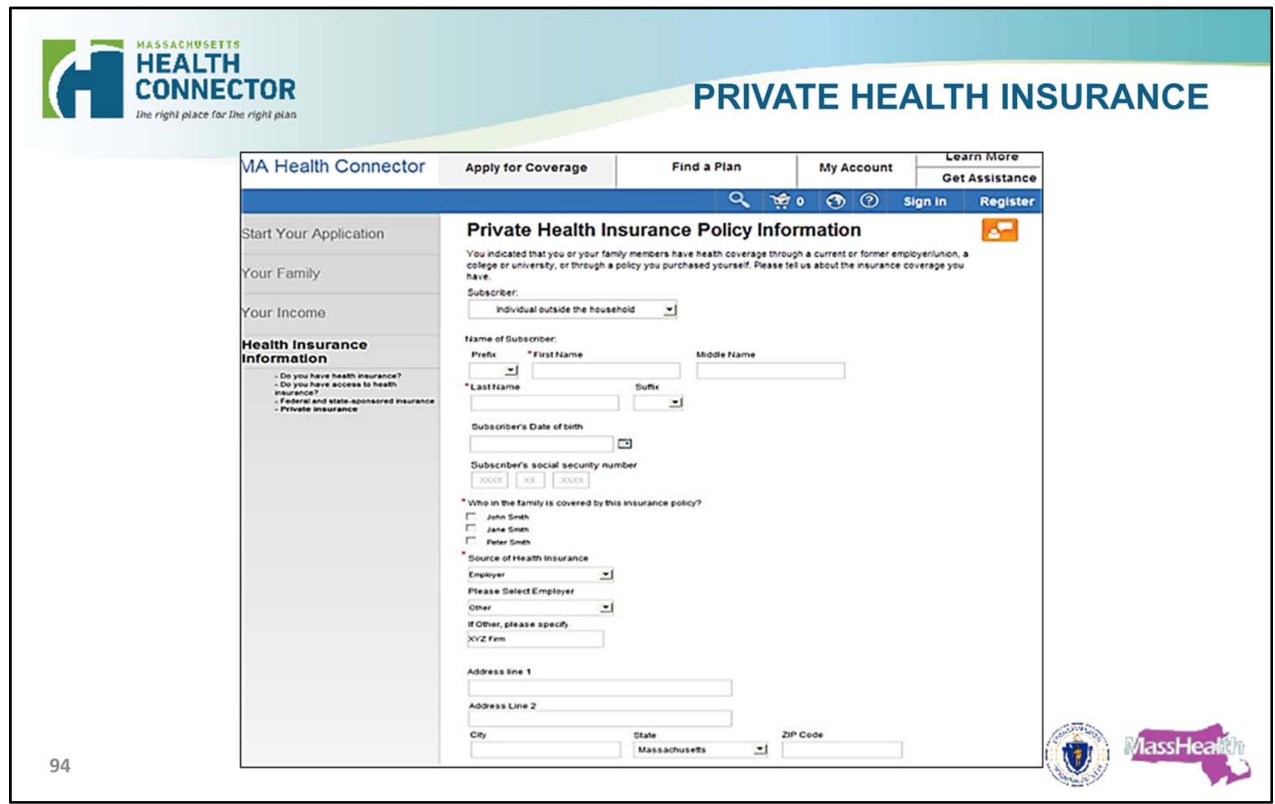
This screen identifies federal or state-sponsored coverage other than Medicare – for example TRICARE. The user should enter information on the "Federal or State-sponsored Insurance Information" screen for applicants who are covered by federally sponsored health insurance. Users should follow these steps:

1. Select the subscriber from the drop-down list, and select all family members who are covered by this insurance.

   The **Health insurance program** field is pre-populated with **TRICARE**. Enter the **Program ID number**.
2. Enter the **Policy start date** and **Policy end date**, or click the calendars to select the dates.
3. Enter the **Policy number** and **Dollar amount**.
4. Select the **Frequency** of payment from the drop-down menu.
5. Select **Yes** or **No** to indicate if other family members have federal or state coverage.
6. Click **Save and Continue**.

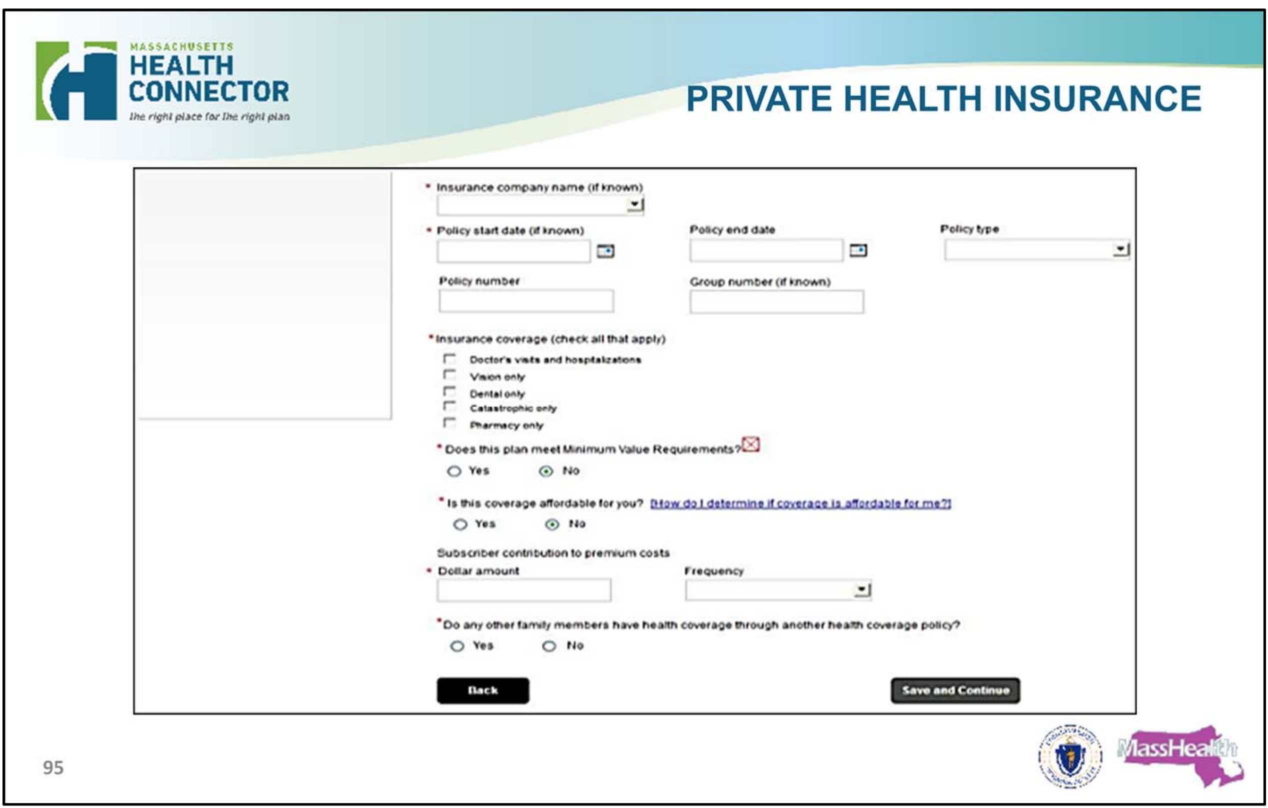
   If other family members have federal or state coverage, enter the insurance information on the next screen that appears.

   If other family members don't have federal or state coverage, you are taken to the "Health Insurance Information Summary" screen. Refer to “Reviewing Your Health Insurance Information Summary.”



This screen asks questions about private health insurance policies as follows:

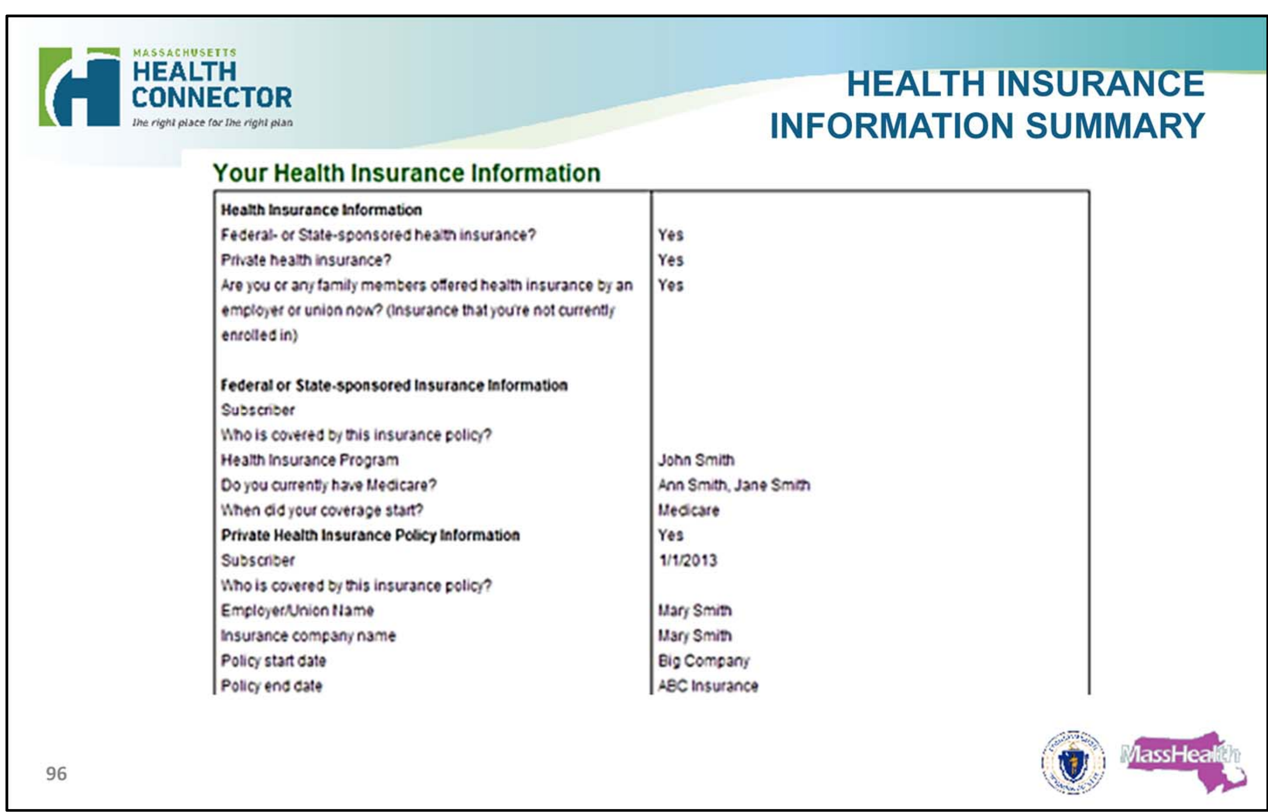
1.Select the subscriber from the drop-down list, and enter the **name**, **Date of birth** and **social security number**.
2.Select the family member(s) who is/are covered by this insurance
3.Select the **Source of Health Insurance**. If the source is an employer that does not appear on the drop-down list, select **Other** and enter the name in the field below.
4.Enter the source **address** in the address fields.



1. Select the Insurance company name from the drop-down list, and enter the **Policy start and end dates,** select the **Policy type** from the drop-down list, and enter the **Policy number** and **Group number**.
2. Select **the Insurance** coverage (services) of the policy.
3. Select **Yes** or **No** to indicate if the plan meets **Minimum Value Requirements**. An employer plan meets minimum value requirements if the plan's share of the total allowed costs of plan benefits is at least 60%. Contact your employer, plan administrator or carrier to find out if your plan meets minimum value requirements.
4. Select **Yes** or **No** to indicate if the plan is affordable for you.
5. Click **How do I determine if coverage is affordable for me** to display the "How do I determine if coverage is affordable for me" pop-up window (see next slide).
6. Enter the **Dollar amount** you contribute to the policy and select the **Frequency** with which you pay the premium from the drop-down list.
7. Select **Yes** or **No** to indicate if any other family members have coverage through another policy.
8. Click **Save and Continue**.

   If other family members have health insurance, enter the information on the next screen that appears.

   If other family members don't have insurance, refer to "Health Insurance Information Summary".



The system displays the "Your Health Insurance Information Summary" screen after you have entered all necessary health insurance information.

A summary is provided for each family member. The questions from the health insurance screens appear on the left, and your responses appear on the right.

HEALTH INSURANCE INFORMATION SUMMARY

Policy Type	1/1/2013
Policy Number	12/31/2013
Group Number	Individual
Insurance Coverage	222222-21
Insurance Type	4444-4433
Does this plan meet Minimum Value Requirements?	Doctor's Visits/Hospitalization
Is this coverage affordable for you?	Health insurance purchased by you
Contribution to premium costs- (Dollar Amount/Frequency)	No
Access to Health Insurance	No
Subscriber	$200/Month
Who is covered by this insurance policy?	
Employer/Union Name	Jim Smith
Federal tax identification number (FID)	Jim Smith
Does this plan meet Minimum Value Requirements?	Big Company
Is this coverage affordable for you?	33333333
Contribution to premium costs- (Dollar Amount/Frequency)	No
	No
	$200/Month

Edit Information

Back

Go to Application Summary

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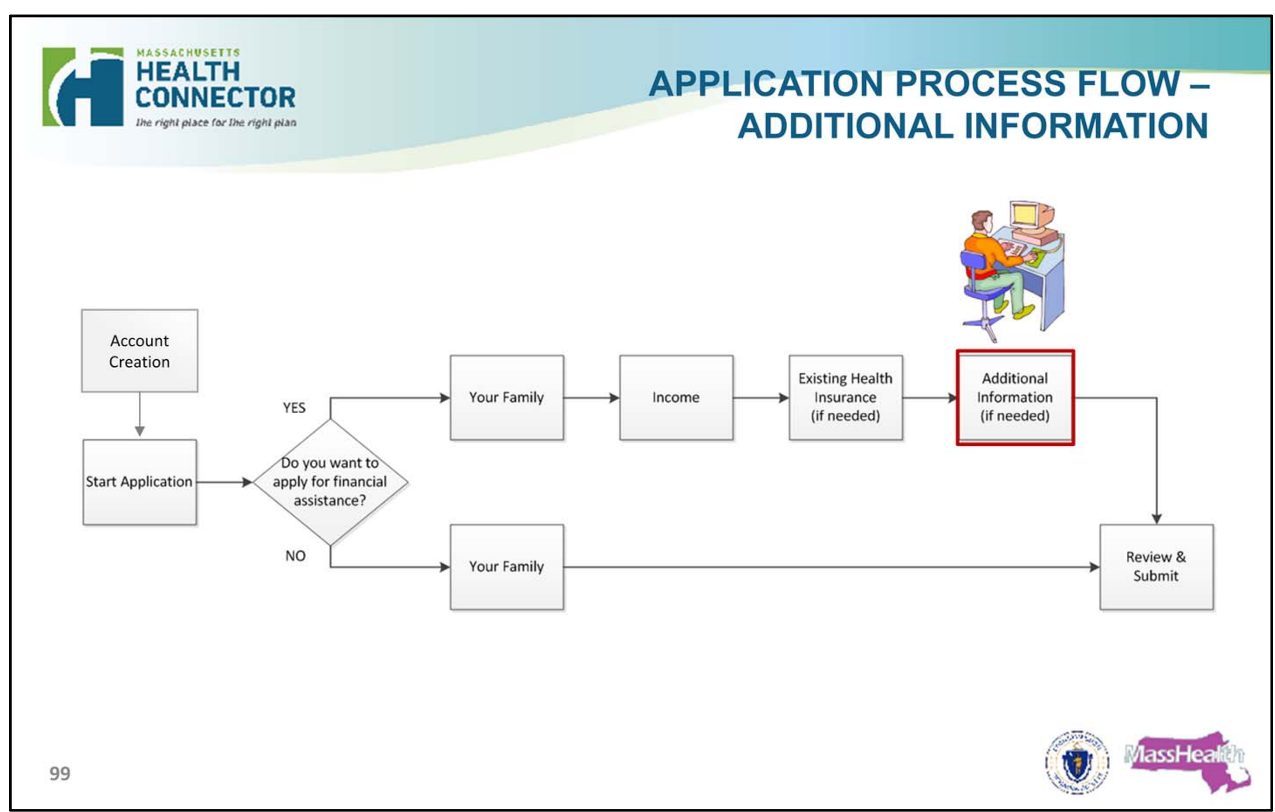
Additional Information



The next step in the application process is for the user to enter additional information, such as additional family information and questions about absent parents.

MASSACHUSETTS HEALTH CONNECTOR
The right place for the right plan

ADDITIONAL FAMILY INFORMATION
DETERMINE MAXIMUM FINANCIAL ASSISTANCE

Additional Family Member Information

* Required Field.

Please tell us more about

Is a resident of Massachusetts with the intention to stay? *

(•) Yes ( ) No

Is homeless? *

( ) Yes (•) No

Does have an injury, illness or disability (including a disabling mental-health condition) expected to last 12 months? *

( ) Yes (•) No

Which best describes

☐ American Indian/Alaska Native (Wampanoag)
☐ American Indian/Alaska Native (Wampanoag Tribe of Gay Head -Aquinnah)
☐ American Indian/Alaska Native (Other Tribal Nation)

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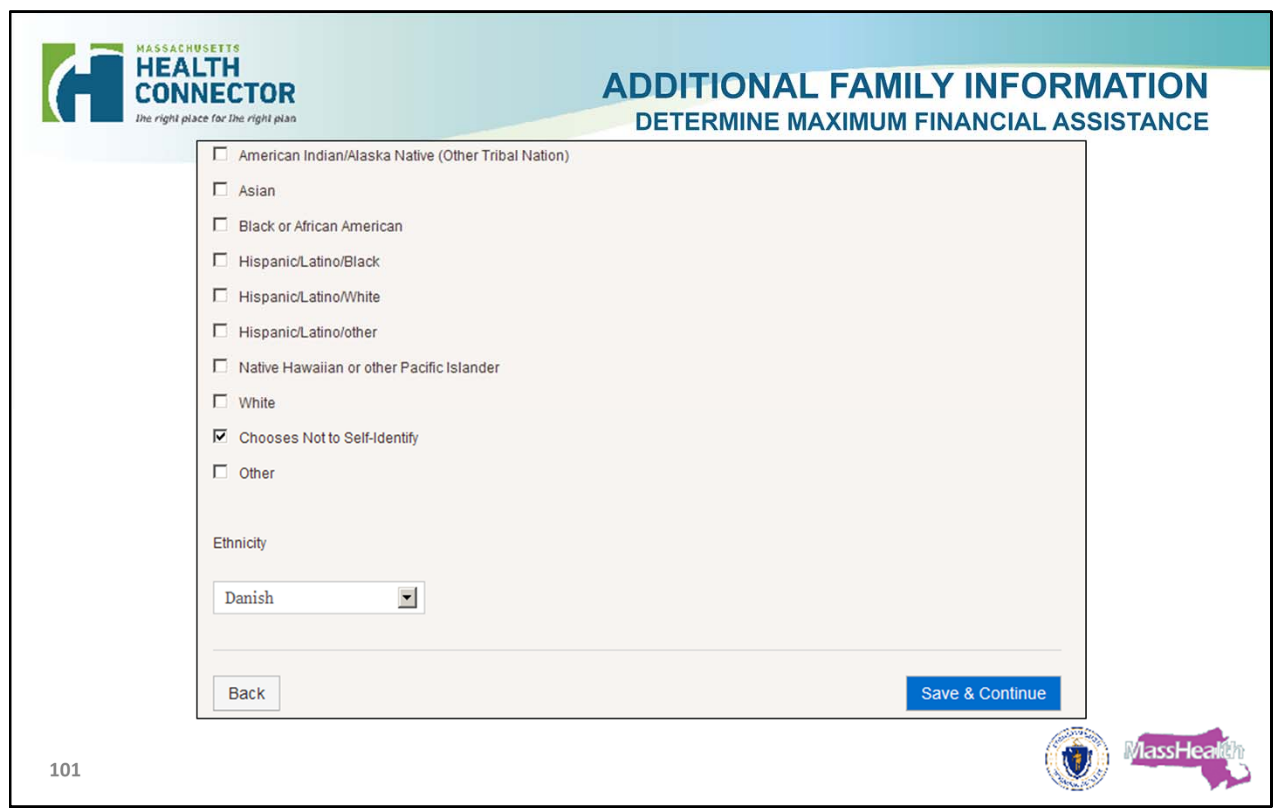
MassHealth

The following questions about Additional Family Member Information will provide additional information relevant to financial assistance.


MASSACHUSETTS
HEALTH
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ADDITIONAL FAMILY INFORMATION
DETERMINE MAXIMUM FINANCIAL ASSISTANCE
American Indian/Alaska Native (Other Tribal Nation)
Asian
Black or African American
Hispanic/Latino/Black
Hispanic/Latino/White
Hispanic/Latino/other
Native Hawaiian or other Pacific Islander
White
Chooses Not to Self-Identify
Other
Ethnicity
Danish
Back
Save & Continue
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ABSENT PARENT QUESTIONS

COOPERATION STATEMENT (IF NEEDED)

Absent Parent Questions

Assignment and Cooperation Statement

To get MassHealth for you and a child who is living with you, you must (1) assign your rights and the rights of your child for medical support (such as those from a child support order) and third-party payments for medical care (such as payments from car accidents), (2) agree to cooperate with MassHealth to collect such medical support and third-party payments for you and your child, and (3) agree to provide information to and help MassHealth to go after third parties who may be responsible for paying for your and your child□s medical care and services covered by MassHealth. If you are not married to the father of the child, you must agree with cooperate with MassHealth and the Child Support Enforcement Division of the Massachusetts Department of Revenue (DOR) to establish paternity and enforce a medical-support order.

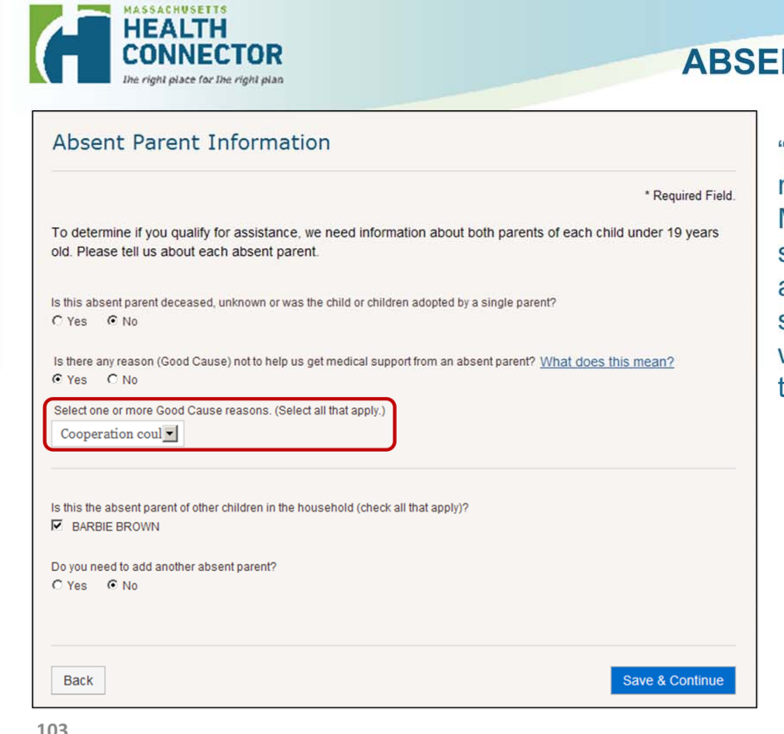
If you do not want to make a Good Cause claim, and you do not cooperate by filling out the Absent Parent Information on the next page, you might not qualify for MassHealth.

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

Back | Save & Continue

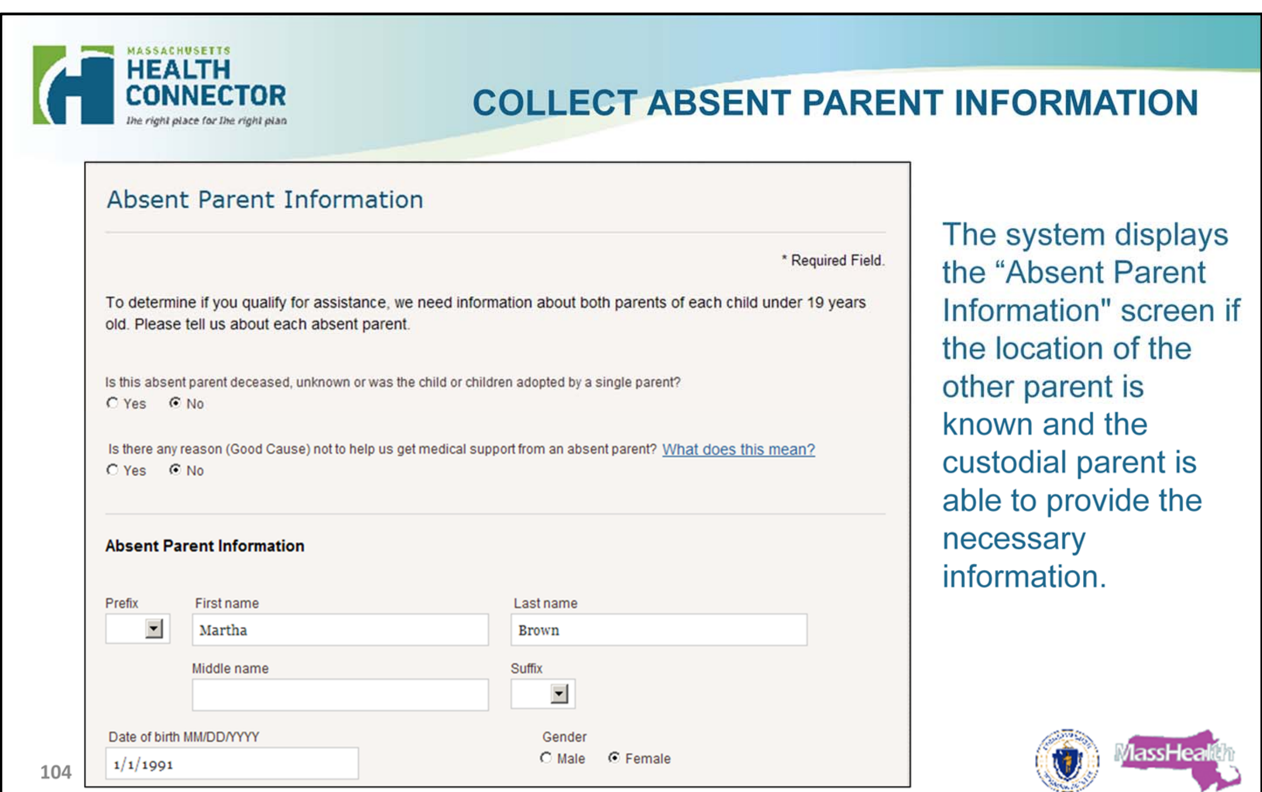
The system displays the “Absent Parent Cooperation Statement" screen if the eligibility application includes children under 19 years of age and there are not two parents in the household.

ABSENT PARENT QUESTIONS



"Good Cause" is a legal term that means you cooperated with the Massachusetts Health Connector in sharing information about the absent parent; establishing that seeking medical assistance/support would not be in the best interests of the child for the following reasons:

- Cooperation could result in serious physical or emotional harm
- Adoption of the child is in process
- The child was born after sexual abuse or an assault


MASSACHUSETTS
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COLLECT ABSENT PARENT INFORMATION
Absent Parent Information
* Required Field.
To determine if you qualify for assistance, we need information about both parents of each child under 19 years old. Please tell us about each absent parent.
Is this absent parent deceased, unknown or was the child or children adopted by a single parent?
Yes No
Is there any reason (Good Cause) not to help us get medical support from an absent parent? What does this mean?
Yes No
Absent Parent Information
Prefix
First name
Martha
Last name
Brown
Middle name
Suffix
Date of birth MM/DD/YYYY
1/1/1991
Gender
Male Female
The system displays the "Absent Parent Information" screen if the location of the other parent is known and the custodial parent is able to provide the necessary information.
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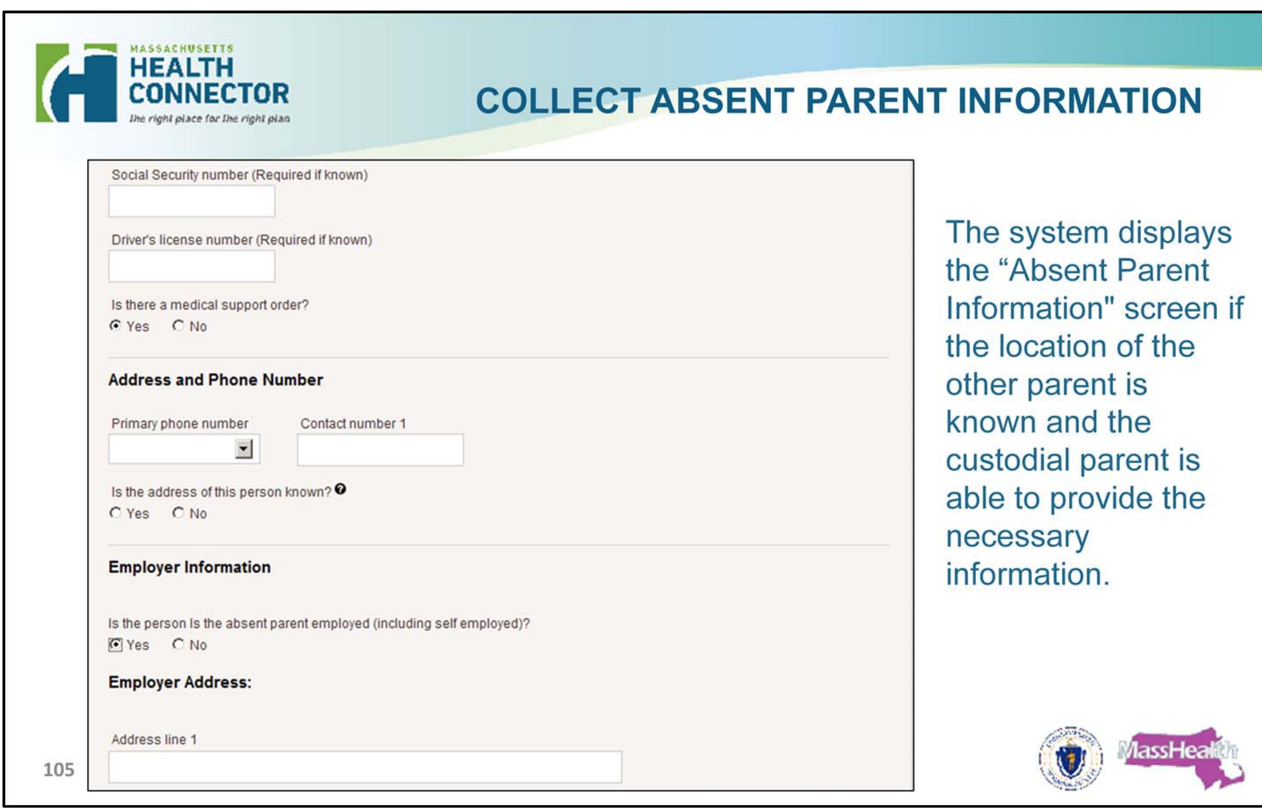
MassHealth


MASSACHUSETTS
HEALTH
CONNECTOR
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COLLECT ABSENT PARENT INFORMATION
Social Security number (Required if known)
Driver's license number (Required if known)
Is there a medical support order?
Yes No
Address and Phone Number
Primary phone number
Contact number 1
Is the address of this person known?
Yes No
Employer Information
Is the person Is the absent parent employed (including self employed)?
Yes No
Employer Address:
Address line 1
The system displays the "Absent Parent Information" screen if the location of the other parent is known and the custodial parent is able to provide the necessary information.
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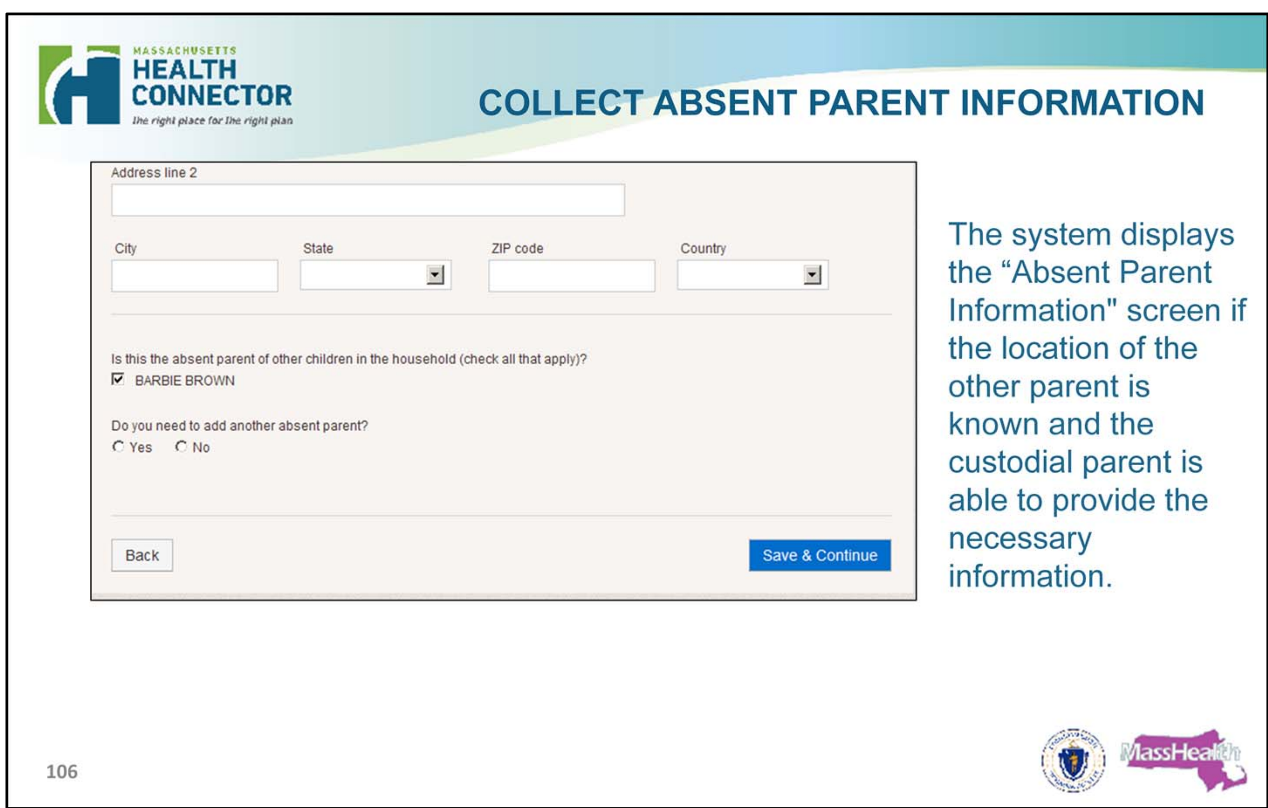
MassHealth


MASSACHUSETTS
HEALTH
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COLLECT ABSENT PARENT INFORMATION
Address line 2
City
State
ZIP code
Country
Is this the absent parent of other children in the household (check all that apply)?
BARBIE BROWN
Do you need to add another absent parent?
Yes
No
Back
Save & Continue
The system displays the "Absent Parent Information" screen if the location of the other parent is known and the custodial parent is able to provide the necessary information.
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MassHealth

ADDITIONAL FAMILY INFORMATION SUMMARY

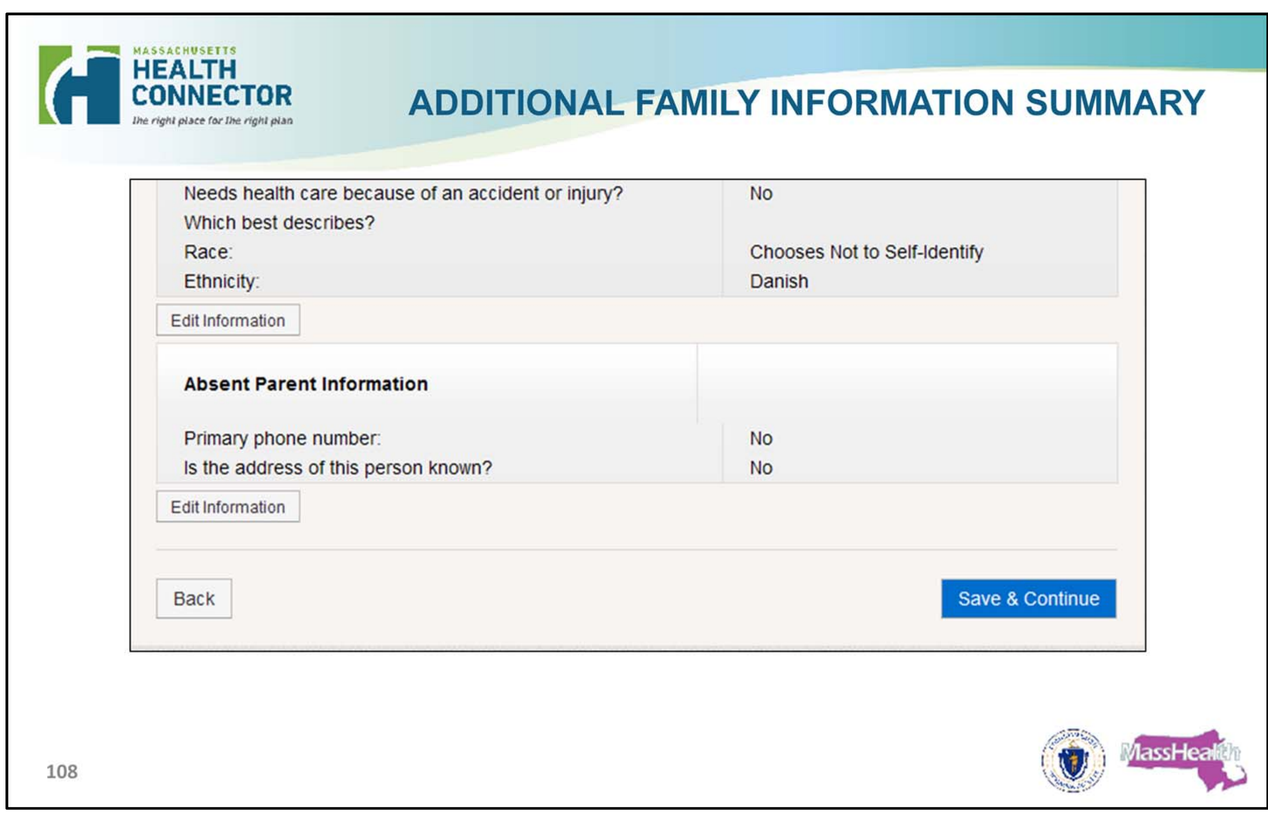
Your Additional Family Member Information Summary

Below is a summary of your Additional Family Information. Review and correct if needed. When you're done, click Go to Application Summary.

Carefully review the information on this page to ensure its accuracy. The following information contains updated information related to your account based on state and federal data sources. Make changes if necessary.

Note: The rightmost column indicates updated values. Information that has changed is marked with an asterisk (*) and has been highlighted.

Additional Family Information	
Resident of Massachusetts with the intention to stay?	Yes
Homeless?	No


MASSACHUSETTS
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ADDITIONAL FAMILY INFORMATION SUMMARY
Needs health care because of an accident or injury?
No
Which best describes?
Race:
Chooses Not to Self-Identify
Ethnicity:
Danish
Edit Information
Absent Parent Information
Primary phone number:
No
Is the address of this person known?
No
Edit Information
Back
Save & Continue
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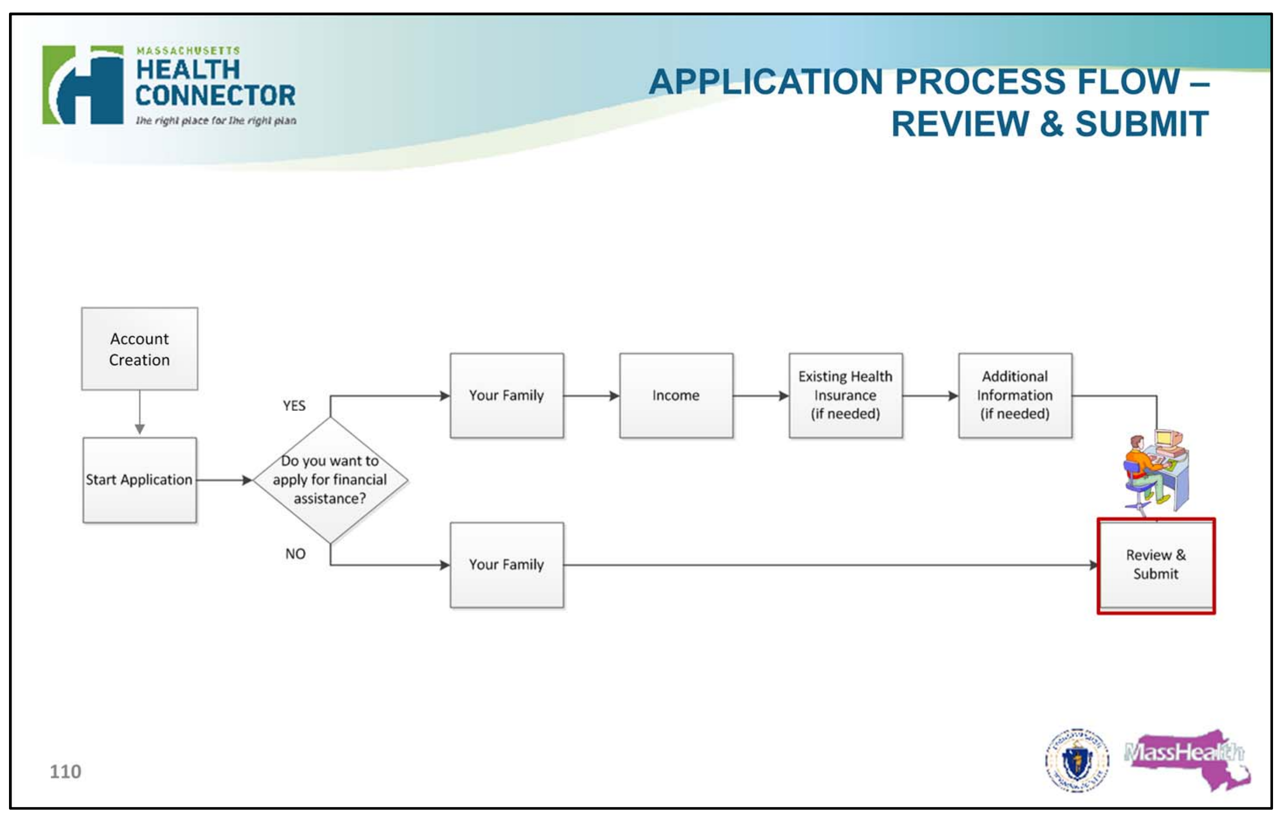
MassHealth

Review and Submit Application


MASSACHUSETTS
HEALTH
CONNECTOR
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APPLICATION PROCESS FLOW –
REVIEW & SUBMIT
Account Creation
Start Application
Do you want to apply for financial assistance?
YES
NO
Your Family
Income
Existing Health Insurance (if needed)
Additional Information (if needed)
Your Family
Review & Submit
110
MassHealth

APPLICATION REVIEW AND SUBMIT

- Reviewing the Application Summary
- Reviewing Rights and Responsibilities
- Entering Contact Preferences
- Providing an e-Signature
- Submitting the Application

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APPLICATION SUMMARY SCREEN

Application Summary

Below is a summary of your application. Read and correct anything that is wrong. Then click Save and Continue.

* Required Field.

Start Your Application For Health Insurance

Would you or a member of your family like to get help paying for part or all of your health insurance?	Yes

Edit Information

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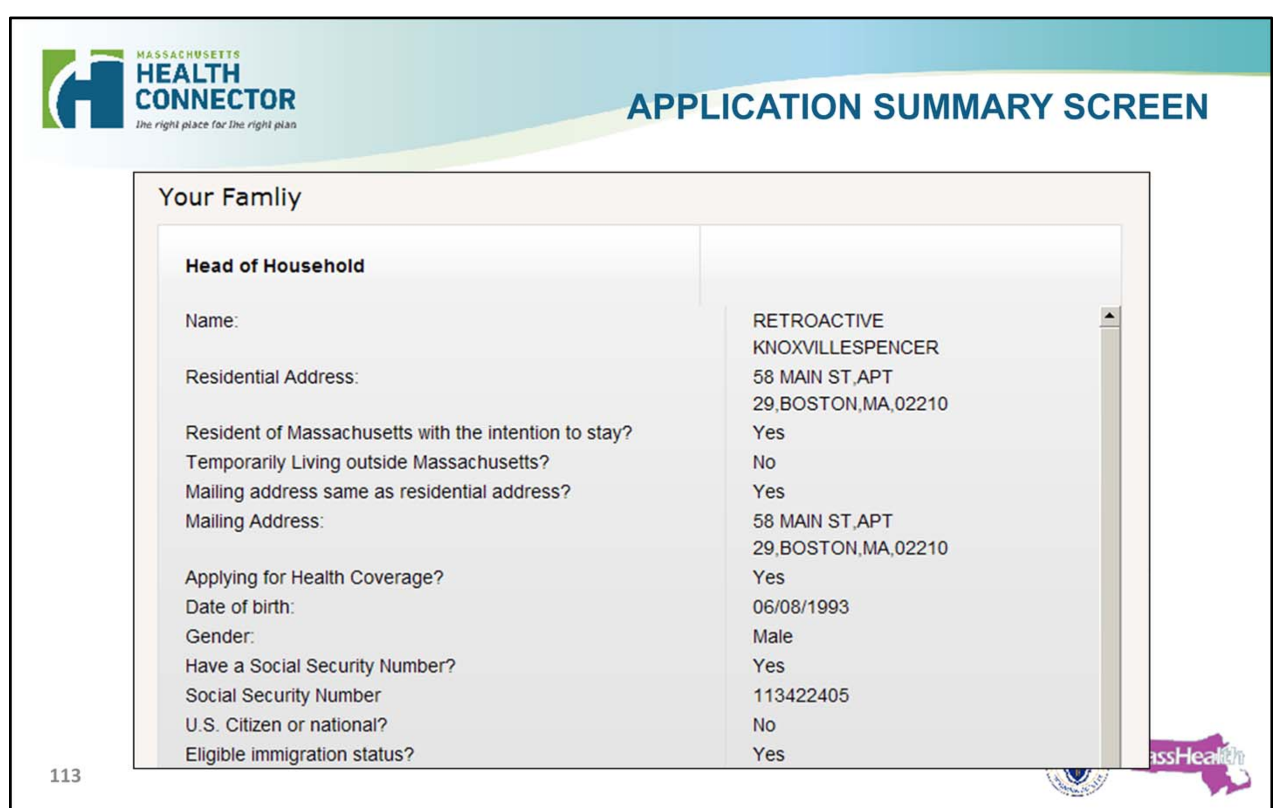
MassHealth

The application summary provides an opportunity to review the information the user has entered and allow them to make edits.


MASSACHUSETTS HEALTH CONNECTOR
The right place for the right plan
APPLICATION SUMMARY SCREEN
Your Famliy
Head of Household
Name:
RETROACTIVE KNOXVILLESPENCER
Residential Address:
58 MAIN ST,APT 29,BOSTON,MA,02210
Resident of Massachusetts with the intention to stay?
Yes
Temporarily Living outside Massachusetts?
No
Mailing address same as residential address?
Yes
Mailing Address:
58 MAIN ST,APT 29,BOSTON,MA,02210
Applying for Health Coverage?
Yes
Date of birth:
06/08/1993
Gender:
Male
Have a Social Security Number?
Yes
Social Security Number
113422405
U.S. Citizen or national?
No
Eligible immigration status?
Yes
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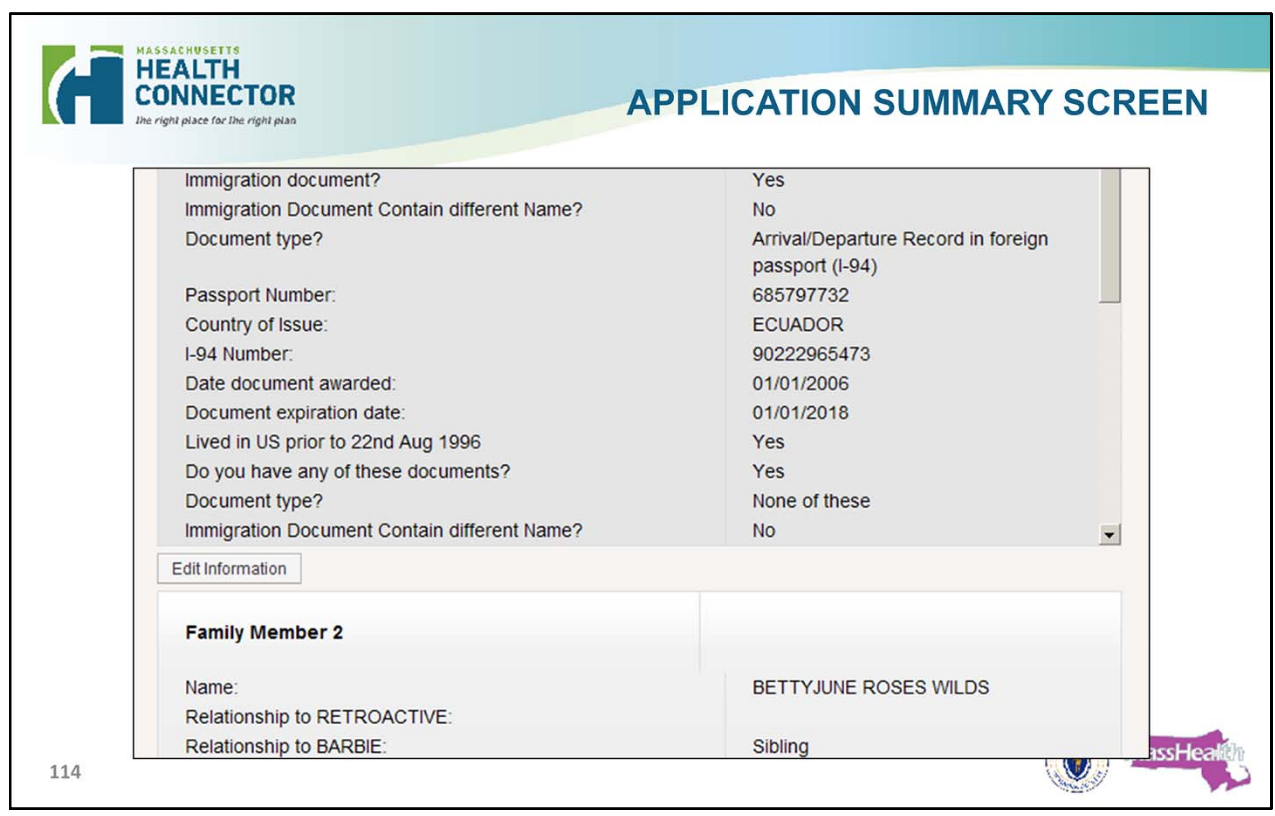
MASSACHUSETTS
HEALTH
CONNECTOR
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APPLICATION SUMMARY SCREEN
Immigration document? Yes
Immigration Document Contain different Name? No
Document type? Arrival/Departure Record in foreign passport (I-94)
Passport Number: 685797732
Country of Issue: ECUADOR
I-94 Number: 90222965473
Date document awarded: 01/01/2006
Document expiration date: 01/01/2018
Lived in US prior to 22nd Aug 1996 Yes
Do you have any of these documents? Yes
Document type? None of these
Immigration Document Contain different Name? No
Edit Information
Family Member 2
Name: BETTYJUNE ROSES WILDS
Relationship to RETROACTIVE:
Relationship to BARBIE: Sibling
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APPLICATION SUMMARY SCREEN

Lives at a different address than the Head of household?	Yes
Residential Address:	58 MAIN ST,APT 29,BOSTON,MA,02210
Resident of Massachusetts with the intention to stay?	Yes
Temporarily Living outside Massachusetts?	No
Different mailing address than the Head of Household?	No
Applying for Health Coverage?	Yes
Date of birth:	03/16/1993
Gender:	Female
Have a Social Security Number?	Yes
Social Security Number	017318908
U.S. Citizen or national?	Yes
Naturalization or Derived Citizen?	No
Incarcerated?	No
Aged out of Foster Care?	No
Federally recognized American Indian or Native Alaskan Tribe?	No

Edit Information

Remove Family Member

RIGHTS AND RESPONSIBILITIES AND E-SIGNATURE SCREENS

Rights & Responsibilities

* Required Field.

I understand that the information I give in this application for determining my eligibility may be used to determine if I qualify for services in each of these programs.

To the extent permitted by law, I understand that the programs I applied for may share with a hospital, community health center, other medical provider or other agency to which I apply the status of my application(s) when that is necessary for treatment, payment, operations or the administration of the program from which I am seeking services.

I understand that in some cases, MassHealth may place a lien against any real estate that I have a legal interest in. If MassHealth puts a lien against my property and I sell it, I may need to use money I get from the sale of that property to repay MassHealth for medical services that I get.

I understand that if I am aged 55 or older, or I am any age and MassHealth helps pay for my care in a nursing home, MassHealth may be able to get back money from my estate after I die. Under current practice, this does not apply to Reduced-cost Health Connector Plan.

I understand that If I am 55 or older, that after I die, MassHealth may be able to get back money from my estate. Under current practice, this does not apply to a commercial Health Connector plan.

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The Rights & Responsibilities screens display next. The user must agree to the last statement in order to complete the application by clicking the check box.

RIGHTS AND RESPONSIBILITIES AND E-SIGNATURE SCREENS

If I have applied for MassHealth, CMSP, Healthy Start or Reduced-cost Health Connector Plan and think the decision about whether I qualify is wrong, I understand that I have the right to appeal.

I certify that I have received these documents as part of my application for MassHealth, CMSP, Healthy Start, Commonwealth Care or the Health Safety Net: Instruction sheet for MassHealth, MassHealth Member Booklet and a MassHealth Eligibility Representative Designation Form.

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

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

RIGHTS AND RESPONSIBILITIES AND E-SIGNATURE SCREENS

Care Finance and Policy (the Health Safety Net) to get any records or data: (1) to prove any information given on this application and any supplements, or other information I give once I am a member; (2) to document medical services claimed or provided; and (3) to support continued eligibility.

I understand that if I or my spouse is in an accident, or we are injured in some other way, and get money from a third party because of that accident or injury, we will need to use that money to repay: (1) MassHealth (for MassHealth) or the Health Connector or my current health insurer (for Reduced-cost Health Connector Plan) for certain medical services provided (For MassHealth, these certain medical services are explained in the MassHealth and You guide. For Health Connector plans, these certain medical services must have been provided to me by my health insurer.); or (2) the Division of Healthcare Finance and Policy for medical services reimbursed for me and my spouse by the Health Safety Net. I also understand that I must tell MassHealth (for MassHealth), my health insurer (for Reduced-cost Health Connector Plans), or the Division of Healthcare Finance and Policy (for the Health Safety Net) in writing, within 10 calendar days, or as soon as possible, if I file any insurance claims or lawsuit because of an accident or injury to me or my spouse applying for benefits.

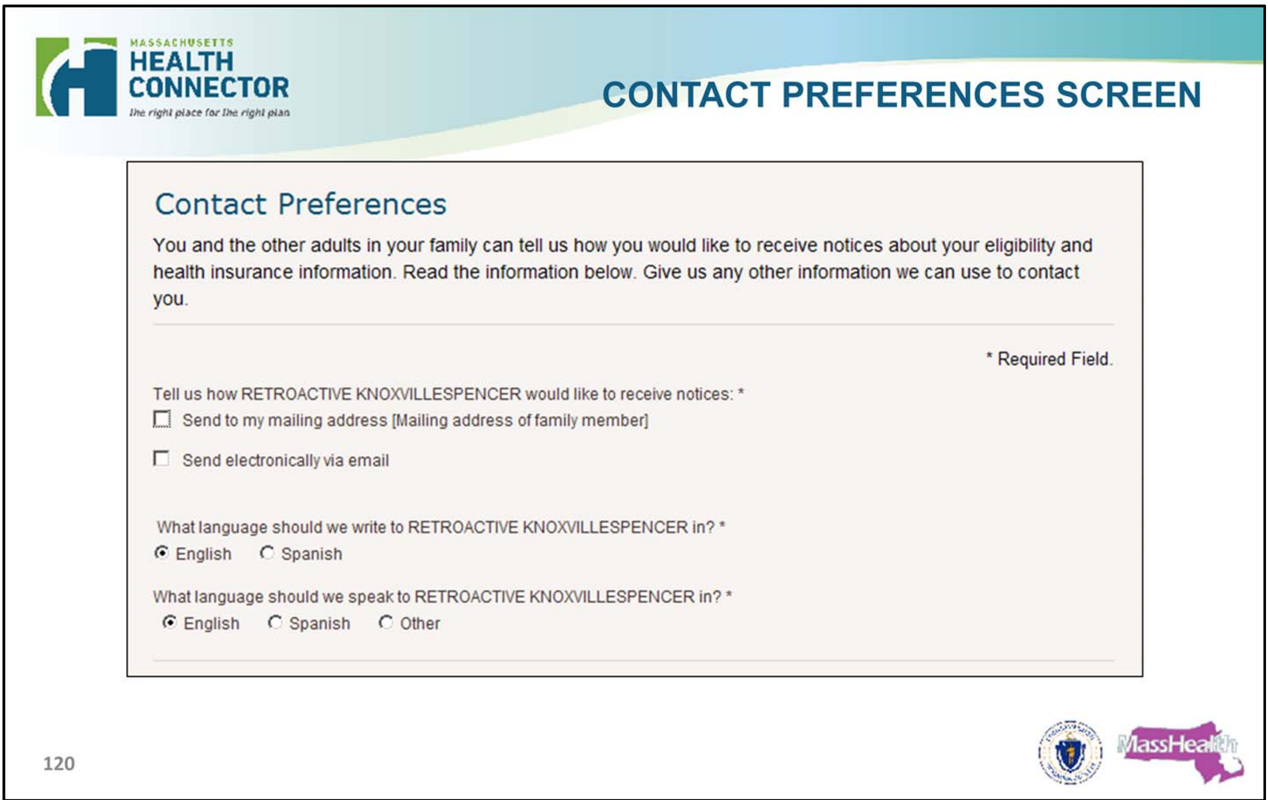
I understand that if I or my spouse are eligible for MassHealth, Commonwealth Care or the Health Safety Net, I must tell MassHealth of any changes in my or my spouse's income or employment, assets, health-insurance coverage, health-insurance premiums, and immigration status, or of changes in any other information I gave on this application and any supplements to it within 10 calendar days of learning of the change.

RIGHTS AND RESPONSIBILITIES AND E-SIGNATURE SCREENS

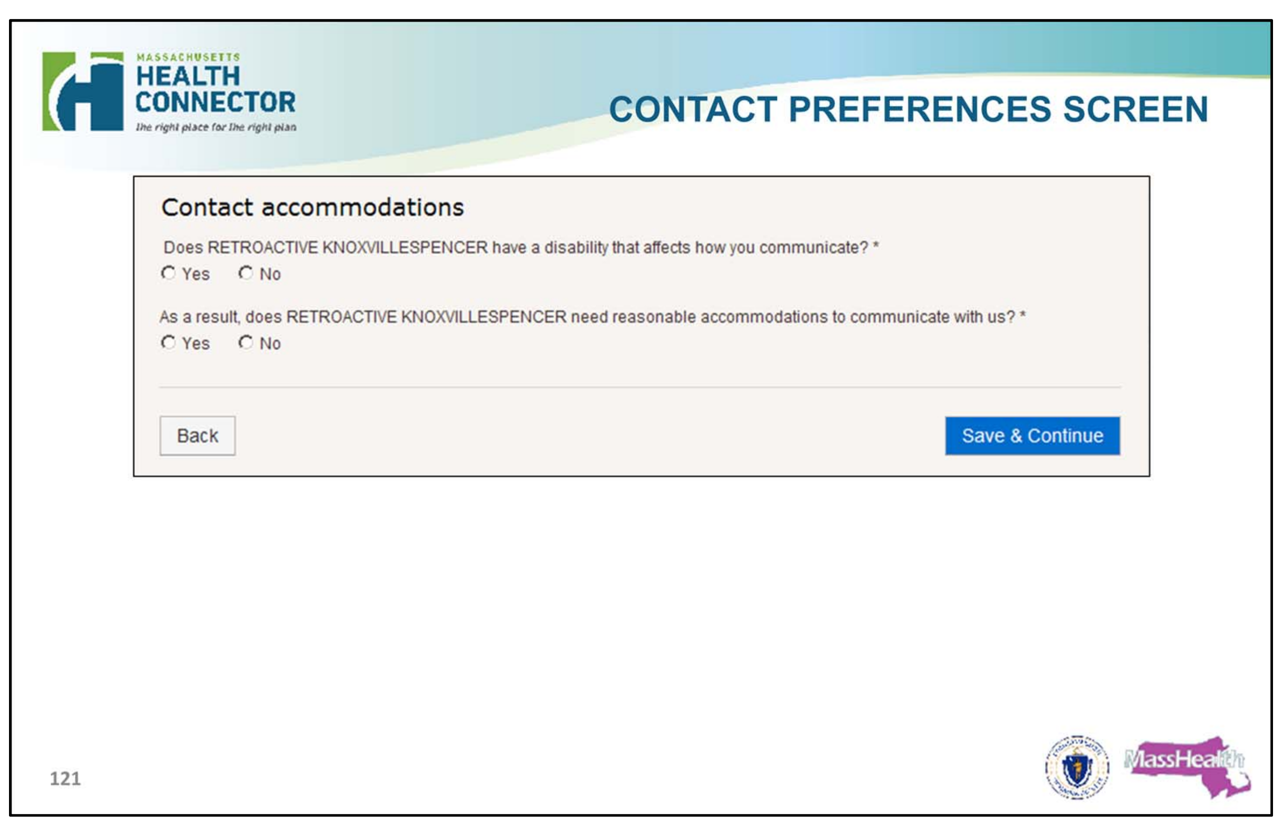
If I or my spouse is eligible for Reduced-cost Health Connector Plans, I understand that I may have to pay a premium set by the Health Connector.

☑ I certify that I have read or have had read to me the information on this application, including any supplements and instruction pages attached to it and the information in the MassHealth Member Booklet, and that I understand my rights and responsibilities. I agree that the Health Connector and MassHealth will treat faxed signature(s) with the same force and effect as an original signature(s). I further certify under the penalty of perjury that the information on this application and any supplements, including those submitted with this application as well as any other supplements, forms or documents that may be submitted to or required by the Health Connector and/or MassHealth, is correct and complete to the best of my knowledge. *

Back | Save & Continue



This screen displays the contact preferences for notifications about the user’s application.


MASSACHUSETTS
HEALTH
CONNECTOR
the right place for the right plan
CONTACT PREFERENCES SCREEN
Contact accommodations
Does RETROACTIVE KNOXVILLESPENCER have a disability that affects how you communicate? *
Yes No
As a result, does RETROACTIVE KNOXVILLESPENCER need reasonable accommodations to communicate with us? *
Yes No
Back
Save & Continue
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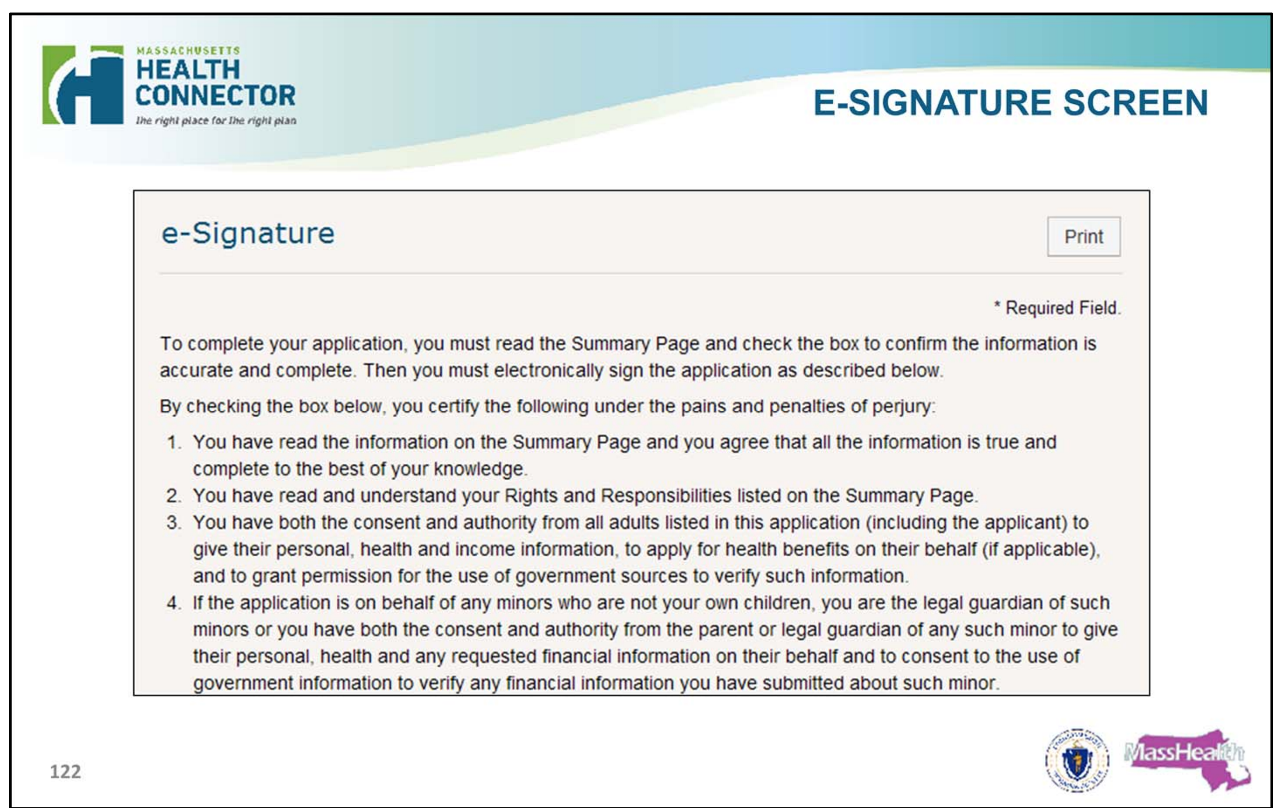
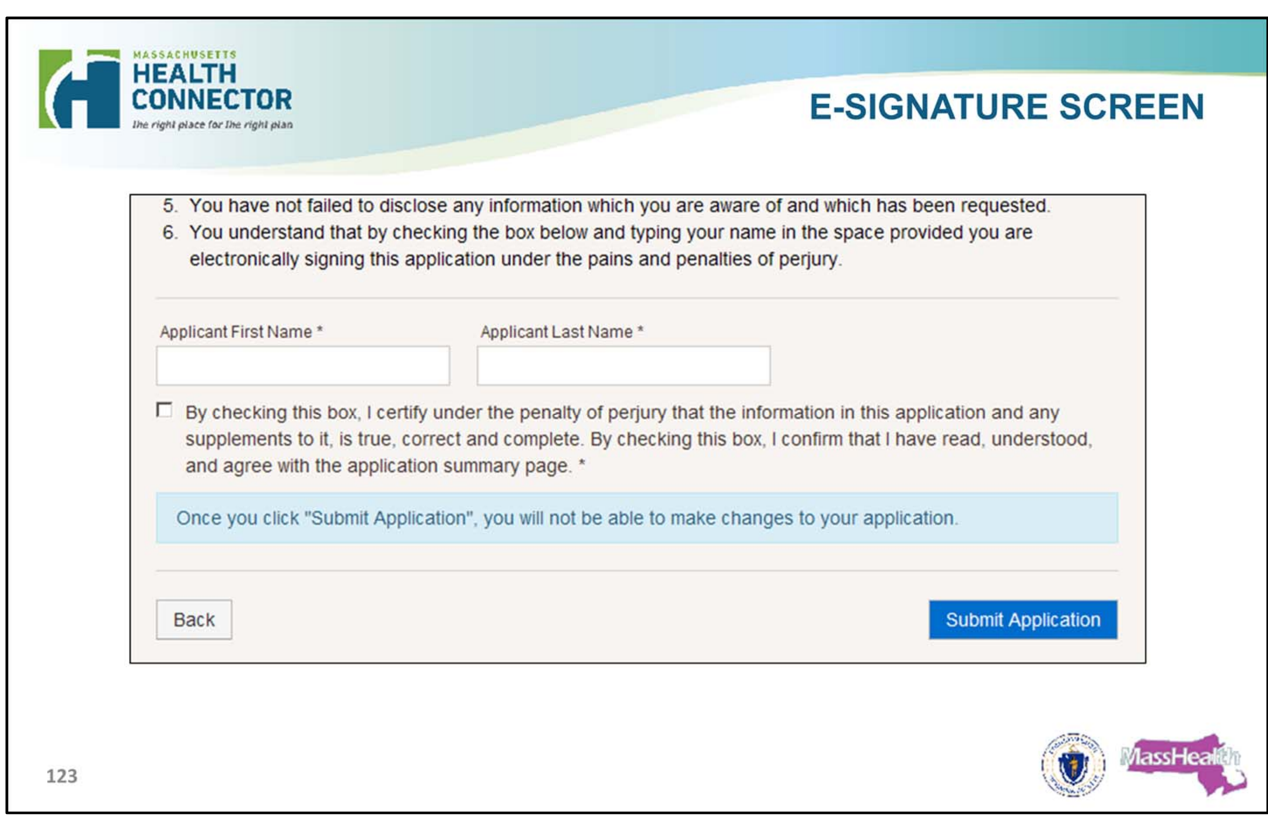
MassHealth



The e-signature process allows the user to sign the application electronically. It is the last step in the application process.


MASSACHUSETTS
HEALTH
CONNECTOR
The right place for the right plan
E-SIGNATURE SCREEN
5. You have not failed to disclose any information which you are aware of and which has been requested.
6. You understand that by checking the box below and typing your name in the space provided you are electronically signing this application under the pains and penalties of perjury.
Applicant First Name *
Applicant Last Name *
By checking this box, I certify under the penalty of perjury that the information in this application and any supplements to it, is true, correct and complete. By checking this box, I confirm that I have read, understood, and agree with the application summary page. *
Once you click "Submit Application", you will not be able to make changes to your application.
Back
Submit Application
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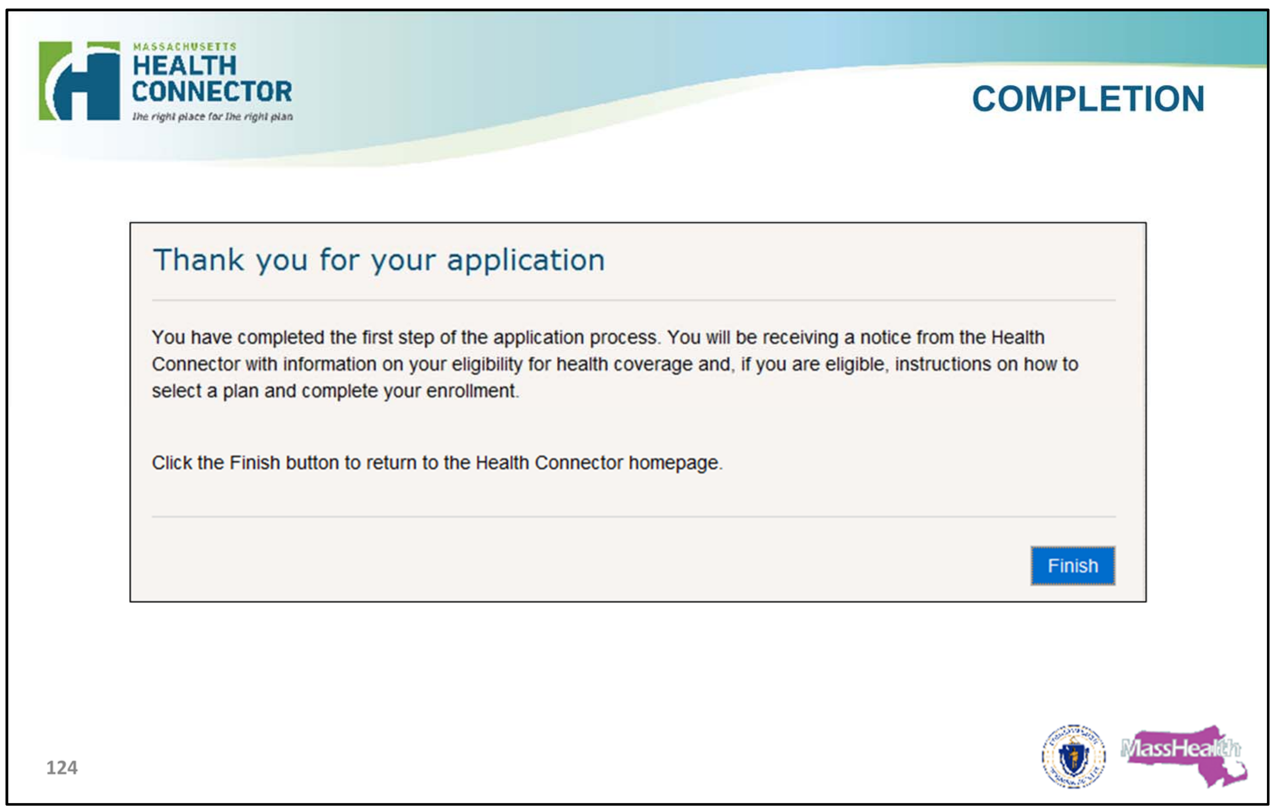
MassHealth



Application is now complete.

NEXT STEPS

- Attend MTF sessions scheduled during October:
  - October 8 in Chicopee, MA
  - October 10 in Tewksbury, MA
  - October 16 in Somerville, MA
  - October 18 in Marlborough, MA
- Attend Certified Application Counselor conference calls as scheduled
- Check your e-mail and the VG webpage for communication and updates
- Go to the Individual and Families portal and click the **Frequently Asked Questions** link.

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