

Common Estate Planning Documents

Last Will and Testament

I, _____ of _____ Massachusetts, make this my last Will and Testament (hereinafter my "Will") and hereby revoke all my previous wills and codicils.

ARTICLE I. APPOINTMENTS

A. Personal Representative. I nominate and appoint my (relation) _____, of _____ Massachusetts, as the Personal Representative of my Will. If _____ fails or ceases to so serve, then I nominate my (relation), _____ of _____ Massachusetts, to serve as my Personal Representative. I direct that whoever administers my estate shall have and may exercise all the rights, powers, duties, and discretions given to or imposed upon my Personal Representative by this Will.

B. Special Appointment. I direct the probate court having jurisdiction over my estate to appoint any Personal Representative named in this Will as Special Personal Representative upon appropriate application, and to authorize any Special Personal Representative to exercise all powers which the court is authorized to grant, including to the extent permissible, all powers granted to my Personal Representative by this Will.

C. No Surety or Bond. I direct that my Personal Representative be exempt from furnishing a bond or from giving surety on any bond required by law. My Personal Representative shall not receive compensation for his or her services.

ARTICLE II. DISPOSITIONS

A. Tangible Personal Property. I intend to dispose of all my property. I give all of my tangible personal property, including the contents of my home, to _____. The term "personal property" includes, but is not limited to, vehicles, household furniture, furnishings and assorted objects, objects of art, jewelry, and clothing.

I might leave a written statement or list disposing of items of tangible personal property. If I do and if my written statement is found and is identified as such by my Personal Representative no later than 30 days after the probate of this Will, then my written statement or list is to be given effect to the extent authorized by law and is to take precedence over any contrary devise(s) of the same item(s) of property in this Will.

B. Real Property. I direct that any interest that I may have in real property, including the property located at _____, **Massachusetts**, and all other interests in real estate, subject to any mortgages on such real estate outstanding at my death, shall pass to _____.

C. Residue. The term "Remainder" means all the remainder of my property, of whatever kind (whether real, personal, or mixed, and whether tangible or intangible) and wherever situated (including all lapsed bequests and devises which fail for any reason) not specifically disposed of herein. All applicable taxes and debts shall be paid out of the residue of my estate as described in Article III, below.

After taxes and debts have been paid, I give the rest and remainder of my estate to _____.

ARTICLE III. PAYMENT OF DEBTS, TAXES, ESTATE EXPENSES AND LEGACIES

All of my legally enforceable debts, funeral expenses, body disposal expenses, and expenses of administration, becoming payable because of my death, shall be paid out of the residue of my estate. Any other expenses occasioned by reason of my death shall be paid out of the residue. All Federal estate and State inheritance taxes, including interest and penalties thereon, shall be paid out of the residue.

Any Federal and State taxes payable with respect to property or proceeds passing outside this Will shall be proportionately borne and paid by the recipients thereof. In the event that any property or interest in property passing by reason of my death shall be encumbered by mortgage or lien, or shall be pledged to secure any obligation (whether the property or interest in property so encumbered or pledged shall be owned by me jointly or individually), it is my intention that such indebtedness shall not be charged to or paid from my estate, but that the devisee, legatee, joint owner taking by survivorship, or beneficiary receiving such property or interest in property shall take it subject to all encumbrances existing at the time of my death.

The foregoing provisions notwithstanding, no tax of any kind and none of my debts or the expenses of administering my estate shall be charged to, paid out of, or charged in reduction of any property with respect to which a deduction would otherwise be allowable for Federal estate tax purposes, as a charitable deduction or otherwise.

If the available assets are not sufficient for the payment of the above named financial obligations, then I authorize my personal representative to request such sums as are needed from _____.

ARTICLE IV. POWERS OF PERSONAL REPRESENTATIVE

In addition to the powers given to my Personal Representative by common law and statute, I grant to my Personal Representative the following discretionary powers with respect to my estate, which may be exercised without the need for court license or court approval.

A. General.

(i) To retain, without liability, any assets owned by me at the time of my death, for whatever period my Personal Representative deems advisable; and to acquire by purchase or otherwise, and retain for whatever period he or she deems proper, any property, real or personal, at such times and in such amounts as my Personal Representative shall determine;

(ii) To invest and reinvest in any assets, funds, income and property, both real and

personal, including mutual funds of the “load” and “no load” variety, regardless of whether any particular investment would be proper for a Personal Representative and regardless of the extent of diversification of the assets held hereunder;

(iii) To convey, sell, transfer, exchange, partition, mortgage, pledge, lease, assign, otherwise dispose of, or deal with any and all properties, real or personal, in my estate or trust. This power shall include, but shall not be limited to:

1. The power to sell and to grant options to purchase all or any part of my estate or trust, both real and personal, including the real estate located at _____

Massachusetts, at any time, at public or private sale, for such consideration, whether or not the highest possible consideration, and upon such terms, including credit, as my Personal Representative deems advisable, and to execute, acknowledge, and deliver deeds or other instruments in connection therewith. No purchaser shall be held to see to the application of the purchase money;

2. The power to lease any real estate for such term or terms and upon such provisions and conditions as my Personal Representative deems advisable, including the granting of options to renew, options to extend the term or terms, and options to purchase;

3. The power to sell, buy, mortgage (including reverse mortgages), retain or otherwise deal with any real property;

(iv) To pay, arbitrate, compromise, settle or otherwise adjust any claims, including taxes, asserted in favor of or against me, my estate, or any trust created hereunder, or my Personal Representative.

(v) To hold any securities or other property, both real and personal, in my Personal Representative’s name, in the name of such nominee as my Personal Representative shall select, or in the form of “street certificates,” without in any of such cases disclosing the fact that such property is held in a fiduciary capacity, and to indemnify any such nominee against any loss resulting from holding such property as nominee;

(vi) To make any elections permitted under any pension, profit sharing, employee stock ownership or other benefit plan;

(vii) To employ others in connection with the administration of my estate, or any trust created hereunder, including legal counsel, investment advisors, brokers, accountants and agents, notwithstanding the fact that my Personal Representative may receive a direct or indirect financial benefit as a result of such employment or may otherwise be affiliated with any of them; to determine whether or not to act on their advice; and to pay them reasonable compensation as an expense of the estate;

(viii) To vote any shares of stock or other securities in person or by proxy; to assert or waive any stockholder’s rights or privilege to subscribe for or otherwise acquire additional stock; to deposit securities in any voting trust or with any committee;

(ix) To extend or renew any indebtedness upon such terms and for such time or times as my Personal Representative deems appropriate; to borrow and to pledge or mortgage any property as collateral, and to make secured or unsecured loans. My Personal Representative is specifically authorized to make loans without interest to any beneficiary hereunder. No

individual or entity loaning property to my Personal Representative shall be held to see to the application of such property;

(x) To hold any asset of the estate or trust in bearer form or in the name of a nominee, without any indication of fiduciary capacity; and to deposit securities in a securities depository within or outside of Massachusetts; and

(xi) To take any action that my Personal Representative deems necessary to prevent, clean up, or otherwise respond to any violation or potential violation of any environmental law applicable to property in my estate or trust.

B. Distribution.

(i) Final distribution of my estate shall be made when my Personal Representative determines the time to be appropriate. Prior thereto, partial distributions may be made whenever my Personal Representative shall deem it advisable.

(ii) My Personal Representative shall in his or her sole and absolute discretion select assets or property to be distributed in satisfaction of any devise or bequest in my Will without respect to income tax basis of such assets or property. My Personal Representative is excused from any duty of impartiality with respect to the income tax basis of such property.

(iii) My Personal Representative may make distributions in cash or in kind (including non pro rata distributions of undivided interests in property), as such values as my Personal Representative shall determine; to make any income tax elections concerning in-kind distributions, and in making such distributions my Personal Representative may allocate assets to a particular beneficiary without regard to the basis of such assets;

(iv) My Personal Representative may make any separation into shares, in whole or in part, in kind and at values determined by my Personal Representative, with or without regard to tax basis, and may allocate different kinds and disproportionate amounts of property and undivided interests in property among the shares.

C. Taxes.

(i) My Personal Representative shall make such elections under the tax laws as my Personal Representative shall deem appropriate, including but not limited to, elections with respect to qualified terminable interest property, exemptions and the use of deductions as income tax or estate tax deductions, and to determine whether to make any adjustments between income and principal on account of any election so made.

(ii) My Personal Representative shall also in his or her absolute discretion determine the allocation of any GST exemption available to me at my death to property passing under this Will or otherwise. The determination of my Personal Representative with respect to any such elections or allocation, if made or taken in good faith, shall be conclusive and binding upon all affected persons, whether or not in being at the time of my passing.

D. No Contest Clause. If any beneficiary shall contest the probate or validity of this Will or any part of it, or shall institute or join in, except as a party defendant, any proceeding to contest the validity of this Will from being carried out in accordance with its terms, not

including a petition for instructions for the interpretation of this Will instituted in good faith and for probable cause, then all benefits provided for such beneficiary and his or her descendants are revoked and shall pass under my Will as if the beneficiary and his or her descendants had predeceased me.

E. Personal Representative's Discretion Controlling. Any decision by my Personal Representative with respect to any discretionary power under this document shall be final and binding on all persons interested, and with respect to any matter. My Personal Representative shall not be required to make any compensating adjustments between income or principal or among any beneficiaries, trustees, or any other person as a result of my Personal Representative's action or inaction.

F. Liability of Personal Representative. Unless due to my Personal Representative's own willful default or gross negligence, no Personal Representative shall be liable for said Personal Representative's acts or omissions or those of any co-Personal Representative or prior Personal Representative.

G. Personal Representative to Act in Unsupervised Administration. To the extent permitted by law, I direct that my Personal Representative act in unsupervised administration so as to administer my estate and trust with a minimum of court supervision. I direct that the representation by a guardian *ad litem* be dispensed with to the extent permitted by law, including representation of the interests of persons unborn, unascertained or legally incompetent to act in proceedings for the allowance of accounts hereunder.

H. Transactions with Related Parties. The powers of my Personal Representative to enter into any transaction shall in no way be limited by the fact that the same or another party to such transaction is a Personal Representative of my estate or of any other estate; a beneficiary of my estate or of any other estate; the estate of such beneficiary (whether living or deceased); or any Personal Representative of any such estate.

I. Accountings. Any successor Personal Representative is authorized (but not directed) to accept the assets delivered by or for a predecessor Personal Representative on the basis of the accounting therefore without requiring an audit or other independent accounting of the acts of such predecessor Personal Representative. Any successor Personal Representative shall not be liable for, or liable for failure to rectify, any act or omission of any predecessor Personal Representative.

ARTICLE VII. GUARDIANS FOR MINORS

ARTICLE VIII. TESTAMENTARY TRUST

ARTICLE IX. MISCELLANEOUS

A. Use of Words. The term "Personal Representative" shall include any special Personal Representative and any terms should be interpreted to comply with current drafting standards as well as the Massachusetts Uniform Probate Code. Whenever the context permits, the use of a particular gender shall include any other gender, and references to the singular or the plural shall be interchangeable. All references to the Internal Revenue Code shall mean the Internal Revenue Code of 1986 or any successor Code as the same may from time to time be

amended. All references to estate taxes shall include inheritance and other death taxes.

B. Omitted Relatives. Except to the extent to which I have included them in the provisions of this Will, I have intentionally, and not as a result of any accident, mistake or inadvertence omitted in this Will to provide for any relatives or for any descendants of a deceased relative.

C. Survivorship. If any beneficiary fails to survive me by ninety (90) days, then any bequest to that beneficiary shall pass as though the beneficiary predeceased me.

D. Interest of Beneficiaries. The interest of any beneficiary in any share or part of this Will or any trust created herein, both as to principal and income, shall not be alienable, assignable, attachable, transferable nor paid by way of anticipation, nor in compliance with any order, assignment, or covenant and shall not be applied to, or held liable for, any of his, her or their debts or obligations either in law or equity and shall not in any event pass to him, her, or their assignee under any instrument or under any insolvency or bankruptcy law, and shall not be subject to the interference or control of creditors, spouses or others.

E. Headings. The headings used throughout this Will have been inserted for administrative convenience only, and do not constitute matter to be construed in interpreting this Will.

F. Invalid Provisions. If any part of this Will is invalid, illegal, or inoperative for any reason, it is my intention that the remaining parts, so far as possible and reasonable, shall be effective and fully operative. My Personal Representative may seek and obtain court instructions for the purpose of carrying out as nearly as may be possible the intention of this Will as shown by the terms hereof, including any terms held invalid, illegal, or inoperative.

G. Dealing with Third Parties. Any third party dealing with any person or entity who has been designated the Personal Representative may rely upon the fact that such person or entity is, at the time of such dealing, fully authorized to act and has not ceased serving by reason of incompetency, removal or resignation, unless such third party is in receipt of written notice from the testatrix hereof or a licensed attorney at law of such incompetency, removal or resignation.

H. Governing Law. My estate is to be administered and enforced according to the laws of the Commonwealth of Massachusetts.

I, _____, the testator, sign my name to this instrument this _____ day of _____, 20____ and being first duly sworn, do hereby declare to the undersigned authority that I sign and execute this instrument as my Will and that I sign it willingly, that I execute it as my free and voluntary act for the purposes therein expressed, and that I am eighteen years of age or older, of sound mind, and under no constraint or undue influence.

We, _____, and _____, the witnesses, sign our names to this instrument, being first duly sworn, and do hereby declare to the undersigned authority

that the testator signs and executes this instrument as his/her Will and that (s)he signs it willingly, and that each of us, in the presence and hearing of the testator, hereby signs this Will as witness to the testator's signing, and that to the best of our knowledge the testator is eighteen years of age or older, of sound mind, and under no constraint or undue influence.

[Witness Name], Witness

Date & Address

[Witness Name], Witness

Date & Address

COMMONWEALTH OF MASSACHUSETTS

County of _____
_____, 20__

On this _____ day of _____, 20__, before me, the undersigned notary public, personally appeared the testator, **[Jane Doe]**, proved to me through satisfactory evidence of identification, which was _____, and the witnesses, _____ and _____, proved to me through satisfactory evidence of identification which were _____ and _____, to be the persons whose names are signed on the preceding or attached document in my presence.

[Notary Name], Notary Public My commission expires: **[Date]**

Durable Power of Attorney

I, _____, of _____, Massachusetts, hereby appoint _____ and if _____ dies, resigns or is determined by a physician in writing to be incapable of serving, then I appoint _____ instead, to serve as my agent and attorney-in-fact (hereinafter referred to as my attorney), for me and in my name and behalf to control and manage my property and affairs in all respects including full power and authority:

1. **GENERAL GRANT OF POWER.** To exercise or perform any act, power, duty, right or obligation whatsoever that I now have or may have hereafter acquire, in relation to any person, matter, transaction, or property, real or personal, tangible or intangible, now or owned or hereafter acquired by me, including, without limitation, the following specially enumerated powers. I grant to my attorney full power and authority to do everything necessary in exercising any of the powers herein granted as fully as I might or could do if personally present, with full power of substitution or revocation, hereby ratifying and confirming all that my attorney shall lawfully do or cause to be done by virtue of this power of attorney and the powers herein granted.
 - (a) **Powers of Collection and Payment.** To pay my current bills and just debts; to collect, receive, request, demand, sue for, recover, and hold all such sums of money, debts, dues, commercial paper, checks, drafts, accounts, deposits, legacies, bequests, devises, notes, interests, stock certificates, bonds, dividends, certificates of deposit, annuities, pension, profit sharing, retirement, social security, insurance and other contractual benefits and proceeds, all documents of title, all property and property rights and demands whatsoever, liquidated or unliquidated, now or hereafter owned by, or due, owing, payable or belonging to me, or in which I have or hereafter acquire an interest; to have, use, and take all lawful means for the collection and recovery thereof, and to adjust, sell, compromise, and agree for the same, and to execute and deliver for me, on my behalf, and in my name, all endorsements, releases, receipts, or other sufficient discharges for the same;
 - (b) **Power to Acquire and Sell.** To acquire, purchase, grant options to sell, mortgage (including a reverse mortgage), pledge, lease, transfer, assign, deliver, convey or otherwise dispose of real and personal property, tangible or intangible, or interests therein, on such terms and conditions as my attorney shall deem proper, and in connection therein, on such terms and conditions as my attorney shall deem proper, and in connection therewith to sign, seal, execute and deliver deeds, bills of sale, stock powers, and any other documents necessary or convenient to accomplish such action, and

no purchaser, transferee, or assignee shall be bound to see to the application of the proceeds;

- (c) **Management Powers.** To invest and reinvest, maintain, repair, improve, manage, insure, rent, lease, encumber, and in any manner to deal with any real or personal property, tangible or intangible, or any interests therein, that I now own or may hereafter acquire; to enter any premises leased by me and to care for any such premises and its contents, all upon such terms and conditions as my attorney shall deem proper;
- (d) **Banking Powers.** To make, receive, sign and endorse checks and drafts, deposit and withdraw funds, acquire and redeem certificates of deposit, in banks, savings, and loan associations and other institutions, execute or release such deeds of trust or other security agreements as may be necessary or proper in the exercise of the rights and powers herein granted; to open and close checking and savings accounts; to certify my taxpayer identification number;
- (e) **Voting Powers.** To exercise either in person or by general or limited proxy, any voting rights I have in relation to any shares of stock, any interest in any condominium, condominium association, condominium trust, real estate cooperative or other investment or interest of any type, or to refrain from exercising such rights;
- (f) **Business Interests.** To conduct or participate in any lawful business of whatever nature for me and in my name; to execute partnership agreements and amendments thereto; incorporate, reorganize, merge, consolidate, recapitalize, sell, liquidate, or dissolve any business; elect or employ officers, directors and agents; enter into or carry out the provisions of any agreement for the sale of any business interest or the stock therein; and exercise voting rights with respect to stock, either in person or by proxy, and exercise stock options;
- (g) **Investment Powers.** To open any investment accounts and with respect to any investment accounts and with respect to any investment accounts, whether presently opened or hereafter opened, to make purchases and sales (including short sales); to subscribe for and trade in stocks, bonds, options, or other securities, or limited partnership interests or investments and trust units, whether or not in negotiable form, issues or unissued, foreign exchange, commodities, and contracts relation to same (including commodity futures), on margin or otherwise, for my account and risk; to deliver or surrender securities on my account, or to instruct others to deliver or surrender securities to my attorney on my account; to order payment of moneys from my accounts and to receive and direct payments from my accounts; to sell, assign, endorse and transfer any stocks, bonds, options or other securities of any nature, at any time standing in my name and to execute any documents necessary to effectuate the foregoing; to receive any and all notices, calls for margin, or other demands with reference to my accounts; to make any and all agreements with reference to such accounts on my behalf;
- (h) **Tax Powers.** To prepare, sign and file joint, separate or single income tax returns or declarations of estimated tax for any year or years; to apply for and receive any refund due me, to receive any communications with respect to any tax, and to appear for me and represent me before any federal, state or municipal or other agency in connection with any tax matter; to prepare, sign and file gift tax returns with respect to gifts made by me

or by my attorney hereunder for any year or years; to consent to any gift and to utilize any gift-splitting provisions or other tax election; and to execute any Power of Attorney designation on forms required by the Internal Revenue Service or any state department of

revenue or taxation for three tax years prior to the date of this instrument and for all tax years thereafter;

- (i) **Safe Deposit Boxes.** To have access at any time or times to (and to enter by force if necessary) any safe deposit box rented by me, wheresoever located, to remove all or any part of the contents thereof, and to surrender or relinquish said safe deposit box; and any institution in which any such safe deposit box may be located shall not incur any liability to me or my estate as a result of permitting my attorney to exercise this power;
- (j) **Gift Making Powers.** To make gifts or transfers of any kind on my behalf to any individual as my attorney deems appropriate;
- (k) **Power to Act in Probate Proceedings.** To assent or to oppose the allowance of any probate or other accounts in which I maybe or become interested, and generally to act in any and all probate matters or proceedings in which I may become interested;
- (l) **Retirement Plan Powers.** To deal with all retirement plans in which I may have an interest, including, but not limited to, individual retirement accounts, Keogh, stock option, thrift, savings, 401(a), 403(b), 401(k), variable annuity pension, profit-sharing or other employee benefit plans, as well as settlement options and distributions, rollovers and voluntary contributions; in regard to these, to exercise in any manner any election or option thereunder and to make withdrawals therefrom; to become a participant in such a plan or to establish and Individual Retirement Account in my name, **to change the designation of beneficiary as long as such beneficiary is one of...** in effect for any such account or plan, to waive any rights which I may have with respect to any plan in which my spouse is a participant, to contribute to any existing account or plan in my name, and to roll over the proceeds of a lump-sum distribution from any qualified pension or plan into an Individual Retirement Account or another qualified pension or profit sharing plan;
- (m) **Insurance Powers.** To exercise all rights I may have with respect to any life insurance policy (whether on my life or that of another) or any annuity contract, or any interest in any such policy or contract, as fully as any owner of beneficiary of the same, to engage in any transaction and to exercise and enjoy all options, benefits, rights and privileges under such policy or contract, including powers to borrow upon the same, to pledge the same for loans, **to name a new or additional beneficiary or owner as long as such beneficiary or owner is one of...**, to surrender, assign, exchange or otherwise modify any such policy or contract, to elect settlement options, accumulate dividends or have dividends paid out, apply for waivers of premiums or disability income, and surrender the policy for cash value;
- (n) **Motor Vehicles.** To apply for a Certificate of Title upon, and endorse and transfer title thereto, any automobile or other motor vehicle and to represent in such transfer assignment that the title to said motor vehicle is free and clear of all liens and encumbrances except those specifically set forth in such transfer assignment;

- (o) **Governmental Entitlement Powers.** To deal with any and all state or federal agencies from whom I receive or may be entitled to receive governmental benefits of any description or amount in order to: (i) prepare and file all documents required by such agencies; (ii) to apply for any benefits to which I may be entitled; (iii) modify the amounts or terms of such entitlements; (iv) assert my rights against any curtailment or termination of benefits; (v) appeal or compromise any contested claim; (vi) effect a termination thereof;
 - (p) **Power to Designate a Substitute.** To appoint and substitute for my attorney any agents or attorney for any or all of the purposes herein enumerated, and to revoke their authority at his or her pleasure;
 - (q) **Powers to Provide for My Care.** To make such use of my personal and real property as is necessary to provide for my maintenance, transportation, and necessary medical, dental and surgical care, hospitalization and custodial care;
 - (r) **Contracts.** To enter into contracts of whatever nature or kind in my name;
 - (s) **Power to Hire and Pay for Services.** To retain such accountants, attorneys, social workers, consultants, clerks, employees, workers or other persons as my attorney shall deem appropriate in connection with the management of my property, person or affairs and to make payments from my assets for the fees of such persons so employed; and
 - (t) **Unenumerated Powers.** In addition to the foregoing, my attorney hereunder may act as my alter ego with respect to any and all possible matters and affairs not otherwise enumerated herein and which I as principal can do through an agent.
2. **HEALTH CARE DECISIONS AND FUNERAL PLANS.** To authorize my admission to any health care facility including any medical, nursing, residential or similar facility and to enter into agreements for my care and to authorize the release of my medical records in his or her discretion. To enter contracts for my funeral, burial or cremation and to pay in advance for such services; to establish a bank account designated as a funeral account on my behalf.
3. **COURT APPOINTED FIDUCIARIES.** If it is deemed necessary to seek appointment by a probate court of a guardian of my person or conservator of my estate, I hereby nominate my said attorney; _____ or if she or he is incapable of serving, my said successor attorney, _____ for appointment by such court to serve as such fiduciary. Nothing in this section shall be construed as a direction that such a petition be filed or such appointment be made, and it is my express wish that such action be taken only when and if absolutely necessary.
4. **COMPENSATION FOR MY ATTORNEY.** My attorney named herein, and his or her successor, shall be entitled to reasonable compensation for any expenses that are incurred and for the time, effort and services rendered as my attorney.
5. **THIRD PARTY RELIANCE.** Third parties may rely upon the representations of my attorney as to all matters pertaining to any power granted to my attorney, and no person who may act in

reliance upon the representation of my attorney or the authority granted to my attorney shall incur any liability to me or my estate as a result of permitting my attorney to exercise any power.

6. **INTERPRETATION AND GOVERNING LAW, BOND, PHOTOCOPIES.** This instrument is executed and delivered in the Commonwealth of Massachusetts, and the laws of the Commonwealth of Massachusetts shall govern all questions as to the validity of this power and the construction of its provisions. Nevertheless, I intend that this instrument be given full force and effect in any state or country in which I may find myself or in which I may own property, whether real or personal or in which my attorney finds it necessary or desirable, in his or her discretion, to exercise this power. I direct that my attorney not be required to give bond for any purpose, and if any bond is required, that no sureties be required. I direct that photocopies of this instrument shall have the same power and effect as the original.
7. **NON-LIMITATION ON POWERS.** This instrument is to be construed and interpreted as a general durable power of attorney. The enumeration of specific powers herein is not intended to, nor does it, limit or restrict the general powers herein granted to my attorney. For a third party to construe otherwise would be contrary to my intent.
8. **DISABILITY OR INCAPACITY OF PRINCIPAL.** This Durable Power of Attorney shall not be affected by my subsequent disability or incapacity, and shall be binding not only upon my but also upon my heirs, executors and administrators up to the time of the receipt by my said attorney of a written revocation signed by me or of reliable intelligence of my death. This Durable Power of Attorney shall remain in full force and effect until such time as I execute a written revocation thereof.
9. **REVOCATION OF PRIOR INSTRUMENTS.** If I have executed any Durable Powers of Attorney prior to the date of this instrument, I hereby revoke any such earlier documents and the powers conferred therein.
10. **REFUSAL TO HONOR POWER.** Should any third party, including any bank, trust company, insurance company, or any other third party, refuse to accept the validity of this Power of Appointment, and should I suffer any financial or personal damages as a result of such refusal, then I direct my attorney to bring whatever legal action he or she may deem appropriate to compensate me or my heirs of the damages suffered due to such refusal and for punitive damages if available.
11. **SUCCESSOR ATTORNEY.** Any party dealing with my successor attorney may rely upon his representation as to my original attorney's death, incapacity or resignation as conclusively correct. The terms of Article 5 above shall apply equally to those actions taken by my successor attorney and to third parties acting in reliance on representations of my successor attorney.
12. **SELF-DEALING.** Any and all of my attorneys are expressly authorized to engage in self-dealing.
13. **VALIDITY DESPITE PASSAGE OF TIME.** This instrument shall remain in full force despite the passage of time.

IN WITNESS WHEREOF, I have executed this Durable Power of Attorney this _____
day of _____, 20__.

I, Principal

We the undersigned, have witnessed the execution of this document by the Principal or at the direction of the Principal and state that the Principal appears to be at least eighteen years of age, of sound mind and under no constraint or undue influence. We have not been named as the Principal's agent or attorney-in-fact, or as successor agent or successor attorney-in-fact in this document.

Witness 1

Witness 2

THE COMMONWEALTH OF MASSACHUSETTS

[insert county where executed], ss.

On this ____ day of _____, 20__, before me, the undersigned notary public, personally appeared _____ as Principal of the within Durable Power of Attorney, proved to me through satisfactory evidence of identification, which was _____, to be the person whose name is subscribed to the within instrument. Also appeared before me the above-named witnesses, _____ and _____, proved to me through satisfactory evidence of identification, which was _____ and _____, respectively.

This Durable Power of Attorney was subscribed, sworn to and acknowledged before me by the said Principal and witnesses this _____ day of _____, 20__.

Notary Public

Health Care Proxy

TO MY FAMILY, DOCTORS, AND ALL THOSE CONCERNED WITH MY CARE:

1. APPOINTMENT

I, _____ (the Principal), residing at _____ Massachusetts, being a competent adult at least eighteen years of age or older, of sound mind and under no constraint or undue influence, hereby appoint the following person to be my HEALTH CARE AGENT under the terms of this document:

Name:

Address:

Telephone:

In doing so, I intend to create a Health Care Proxy according to Chapter 201D of the General Laws of Massachusetts. In making this appointment, I am giving my Health Care Agent the authority to make any and all health care decisions on my behalf, subject to any limitations I state in this document, in the event that I should at some future time become incapable of making health care decisions for myself.

2. ALTERNATE APPOINTMENT

I hereby appoint the following person to serve as my Health Care Agent in the event that my original Health Care Agent is not available, willing or competent to serve and is not expected to become available, willing or competent to make a timely decision given my medical circumstances, or in the event that my original Health Care Agent is disqualified from acting on my behalf:

Name:

Address:

Telephone:

3. POWERS GIVEN TO HEALTH CARE AGENT

A. I give my Health Care Agent full authority to make any and all health care decisions for me including decisions about life-sustaining treatment, subject only to any limitations I state below.

B. My Health Care Agent shall have authority to act on my behalf only if, when and for so long as a determination has been made that I lack the capacity to make or to

communicate health care decisions for myself. This determination shall be made in writing by my attending physician according to accepted standards of medical judgment and the requirements of Chapter 201D of the General Laws of Massachusetts.

C. My Agent is specifically prohibited from agreeing to any mandatory or binding arbitration agreement prior to a claim, controversy, dispute or disagreement arising with any assisted living or nursing facility, mental health facility, hospital or other medical facility in connection with my admission to or my receipt of goods or services from such facility. I further prohibit my Agent from waiving any right I or my Agent may have to a jury trial for any contract, tort or other claims prior to such claim, controversy, dispute or disagreement arising.

D. The authority of my Health Care Agent shall cease if my attending physician determines that I have regained capacity. The authority of my Health Care Agent shall recommence if I subsequently lose capacity and consent for treatment is required.

E. I shall be notified of any determination that I lack capacity to make or communicate health care decisions where there is any indication that I am able to comprehend this notice.

F. My Health Care Agent shall make health care decisions for me only after consultation with my health care providers and after full consideration of acceptable medical alternatives regarding diagnosis, prognosis, treatments and their side effects.

G. In exercising the authority granted to him or her herein, my Health Care Agent is instructed to try to discuss with me the specifics of any proposed decision regarding my medical care and treatment if that is possible and if I am able to communicate in any manner, even by blinking my eyes. My Health Care Agent shall make health care decisions for me only in accordance with my Health Care Agent's assessment of my wishes, including my religious and moral beliefs, or, if my wishes are unknown, in accordance with my Health Care Agent's assessment of my best interests.

H. My Health Care Agent shall have the right to receive any and all medical information necessary to make informed decisions regarding my health care, including any and all confidential medical information that I would be entitled to receive. I authorize and direct any health care professional or health care provider to give, disclose and release my Health Care Agent all individually identifiable health information (including, without limitation, my medical records). This release authority applies to any information governed by current and future laws, rules and regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (also known as HIPAA) and the Standards for Privacy of Individually Identifiable Health Information (also known as the Privacy Rule) promulgated pursuant to HIPAA. This authorization and direction is a consent to the release of such information. I intend that my Health Care

Agent be entitled to all health information in the same manner as if I personally were making the direction. The authority I have given in this paragraph shall expire in three (3) years after the date of my death unless validly revoked in writing and delivered to the health care provider being asked to honor this authorization prior to that date. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by my Health Care Agent and no longer protected by the Privacy Rule.

I. The decisions made by my Health Care Agent on my behalf shall have the same priority as my decisions would have, if I were competent, over decisions by any other person, including a person acting pursuant to a durable power of attorney, except for any limitation I state below or a specific Court Order overriding this Health Care Proxy.

J. If I object to a health care decision made by my Health Care Agent, my decision shall prevail unless it is determined by Court Order that I lack capacity to make health care decisions.

K. Nothing in this proxy shall preclude any medical procedure deemed necessary by my attending physician to provide comfort care or pain alleviation including but not limited to treatment with sedatives and painkilling drugs, nonartificial oral feeding, suction and hygienic care.

L. Limitations: I do not wish to limit my Health Care Agent's exercise of his or her discretion and judgment with respect to any decisions regarding my medical care. I give my Health Care Agent full and final authority and unlimited discretion to make medical decisions on my behalf consistent with the provisions of the previous paragraphs. Because I cannot anticipate in advance every possible medical situation I might be in and what choices I would make in each situation, and in order to guide my Health Care Agent in the process of making such difficult decisions and choices for me, I may from time to time write a memorandum or directive to indicate my preferences with respect to the administration, withholding or withdrawal of certain types of treatment. Any such memorandum or directive is intended to provide guidance for but not to dictate the choices or decisions of my Health Care Agent; and it shall not be conclusive or binding on my Health Care Agent.

M. My Health Care Agent shall not be liable to me or to my estate for the consequences of any decision my Agent makes on my behalf in the good faith exercise of the authority given to my Agent pursuant to this Health Care Proxy.

N. I specifically authorize my Health Care Agent to arrange and contract for my admission to a medical, nursing, residential or similar facility, to enter into agreements for my care, to apply for medical insurance coverage, third-party payments or governmental benefits to pay for my care.

O. I specifically authorize my Health Care Agent to employ and discharge medical personnel including physicians, psychiatrists, dentists, nurses, therapists, and health and personal aides.

P. I specifically authorize my Health Care Agent to give or withhold consent to any medical procedure, test or treatment, including surgery, even if this might hasten my death or be against conventional medical advice.

Q. I specifically authorize my Health Care Agent to consent on my behalf to my admission to a hospital for mental health treatment and to the administration of antipsychotic medications that may be recommended by any psychiatrist who is treating me.

4. REVOCATION

This Health Care Proxy shall be revoked upon any one of the following events:

A. My execution of a subsequent Health Care Proxy;

B. My notification to my Health Care Agent or a health care provider orally or in writing or by any other act evidencing a specific intent to revoke the Health Care Proxy; or

C. My divorce or legal separation from my spouse if my spouse is named as my Health Care Agent under this Health Care Proxy.

5. GOVERNING LAW

This document shall be governed by the laws of the Commonwealth of Massachusetts in all respects, including its validity, construction, interpretation, and termination. I intend for this Health Care Proxy to be honored in any jurisdiction where it may be presented and for any such jurisdiction to refer to Massachusetts law to interpret and determine the validity of this document and any of the powers granted under this document.

6. PHOTOCOPIES

My Health Care Agent is authorized to make photocopies of this document as frequently and in such quantity as my Health Care Agent shall deem appropriate. All photocopies shall have the same force and effect as any original.

7. SEVERABILITY

If any part of any provision of this document shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity only, without in any way affecting the remaining part of such provision or the remaining provisions of this document.

SIGNATURE OF PRINCIPAL

I sign this Health Care Proxy on _____, 20____ in the presence of two witnesses, neither of whom is my Health Care Agent or alternate Health Care Agent.

We the undersigned, have witnessed the execution of this document by the Principal or at the direction of the Principal and state that the Principal appears to be at least eighteen years of age, of sound mind and under no constraint or undue influence. We have not been named Health Care Agent or alternate Health Care Agent in this document.

Witness 1 Witness 2

THE COMMONWEALTH OF MASSACHUSETTS

[insert county where executed], ss.

On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ as Principal of the within Health Care Proxy, proved to me through satisfactory evidence of identification, which was _____, to be the person whose name is subscribed to the within instrument. Also appeared before me the above-named witnesses, _____ and _____, proved to me through satisfactory evidence of identification, which was _____ and _____, respectively.

This Health Care Proxy was subscribed, sworn to and acknowledged before me by the said Principal and witnesses this _____ day of _____, 20____.

Notary Public

Probate Administration Documents

FORMAL CHECKLIST

DECEDENT DIED WITH A WILL (TESTATE)	
Form/Document Name	Required or May Need
☐ Petition for Formal Probate of Will/Adjudication of Intestacy/ Appointment of PR (MPC 160)	REQUIRED
☐ Surviving Spouse, Children, Heirs at Law (MPC 162)	REQUIRED
☐ Devisees (MPC 163)	REQUIRED
☐ Original Will, if available, if not, a copy or statement of Will contents	REQUIRED
☐ Certified Copy of Death Certificate, if available or affidavit	REQUIRED
☐ Citation – Return of Service (MPC 560)	REQUIRED
☐ Decree and Order on Petition for Formal Adjudication (MPC 755)	REQUIRED
☐ Bond (MPC 801)	REQUIRED (only if seeking the appointment of a PR)
☐ Military Affidavit (MPC 470)	REQUIRED (unless the petition is assented to by all interested persons)
☐ Authenticated Copy of Will and Appointment	REQUIRED (for ancillary probate proceedings only)
☐ Assent and Waiver of Notice/Renunciation/Nomination/Waiver of Sureties (MPC 455)	MAY NEED
☐ Affidavit - as to cause of death (MPC 475) , execution (MPC 480) , domicile (MPC 485) , or no conflict of a Conservator	MAY NEED
☐ Proof of Guardianship/Conservatorship	MAY NEED
☐ Uniform Counsel Certification Form (CCF 4/07)	MAY NEED
DECEDENT DIED WITHOUT A WILL (INTESTATE)	
Form/Document Name	Required or May Need
☐ Petition for Formal Probate of Will/Adjudication of Intestacy/ Appointment of PR (MPC 160)	REQUIRED
☐ Surviving Spouse, Children, Heirs at Law (MPC 162)	REQUIRED
☐ Certified Copy of Death Certificate, if available or affidavit	REQUIRED
☐ Citation – Return of Service (MPC 560)	REQUIRED
☐ Decree and Order on Petition for Formal Adjudication (MPC 755)	REQUIRED
☐ Bond (MPC 801)	REQUIRED (only if seeking the appointment of a PR)
☐ Military Affidavit (MPC 470)	REQUIRED (unless the petition is assented to by all interested persons)
☐ Assent and Waiver of Notice/Renunciation/Nomination/Waiver of Sureties (MPC 455)	MAY NEED
☐ Affidavit - as to cause of death (MPC 475) , domicile (MPC 485) , or no conflict of a Conservator	MAY NEED
☐ Proof of Guardianship/Conservatorship	MAY NEED
☐ Uniform Counsel Certification Form (CCF 4/07)	MAY NEED

PETITION FOR FORMAL ☐ PROBATE OF A WILL ☐ ADJUDICATION OF INTESTACY ☐ APPOINTMENT OF A PERSONAL REPRESENTATIVE ☐ OTHER: _____ PURSUANT TO G. L. c. 190B, § 3-402 ☐ Original Form ☐ Amended Form	Docket No.	Commonwealth of Massachusetts The Trial Court Probate and Family Court
Estate of: _____ First Name Middle Name Last Name Date of Death: _____		_____ Division

I. GENERAL INFORMATION

The Petitioner(s) (hereafter "Petitioner"), an interested person, makes the following statements:

1. Information about the Decedent:

Name: _____ Age at death _____

First Name Middle Name Last Name

Also known as: _____

Name

Street Address: _____

(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

The Decedent was domiciled in _____ , _____ .

(City/Town) (State)

- ☐ A death certificate issued by a public officer is in the possession of the court or accompanies this Petition.
- ☐ A death certificate issued by a public officer is not in the possession of the court and does not accompany this Petition.
- The circumstances which make it impossible for a death certificate to be provided are (See G. L. c. 190B, §§ 3-402(b), 1-107):

2. Information about the Petitioner:

Name: _____

First Name M.I. Last Name

(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Mailing Address, if different: _____

(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Primary Phone #: _____ Email: _____

The Petitioner's interest in the estate is as follows (e.g., Personal Representative named in a will, surviving spouse, heir, devisee, Public Administrator, creditor, etc. See G. L. c. 190B, § 1-201(24)): _____

- 3. This Petition is filed within the time period permitted by law. See G. L. c. 190B, § 3-108. Three years or less have passed since the Decedent's death, or the following circumstances authorize tardy proceedings (*include statutory reference*):**

FORM ALERT: Do not use this form to file a late probate proceeding pursuant to G. L. c. 190B, § 3-108(4). Use form MPC 161.

4. Venue for this proceeding is proper in this county because on the date of death, the Decedent:

☐ was domiciled in this county. ☐ was not domiciled in Massachusetts, but had property located in this county at:

(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

5. ☐ The Petitioner shall give notice once by citation to the Division of Medical Assistance. To do so, the Petitioner shall send a copy of the citation when issued by the court together with a copy of this Petition and death certificate by certified mail at least fourteen (14) days before the return day to the Division of Medical Assistance, Estate Recovery Unit, P.O. Box 15205, Worcester, MA 01615-0205. For specific details, see the citation's Order of Notice.

II. PERSONS INTERESTED IN THE ESTATE

6. The Decedent's surviving spouse, children, heirs at law and devisees (if any), so far as known or ascertainable with reasonable diligence by the Petitioner are as stated in form [MPC 162 Surviving Spouse, Children, Heirs at Law](#) **AND** if the Decedent died with a will, form [MPC 163 Devisees](#) incorporated herein.

☐ There are additional heirs at law who are not known to the Petitioner.

FORM ALERT: Failure to submit this information will result in a delay in processing your case.

III. TESTACY STATUS

7. The Decedent died (*select one*):

☐ **Intestate (without a will)**

After the exercise of reasonable diligence, the Petitioner is unaware of any unrevoked testamentary instrument relating to property in Massachusetts, or ☐ see attached statement of why such an instrument is not being probated.

☐ **Testate (with a will)**

The date of the Decedent's last will is _____.

☐ The dates of all codicils are _____.

(*select one of the following*):

☐ The original will is in the possession of the court or accompanies this Petition.

☐ The original will is lost, destroyed or otherwise unavailable and

☐ a copy of the original will accompanies this Petition **OR**

☐ a statement of its contents is attached and incorporated herein.

☐ The will has been probated in the state or county of _____.

An authenticated copy of the will and proof of its probate are filed with this Petition.

The will and any codicils are referred to as the will. The Petitioner, to the best of his or her knowledge, believes the will was validly executed. After the exercise of reasonable diligence, the Petitioner is unaware of any instrument revoking the will and believes that the will is the Decedent's last will.

IV. APPOINTMENT OF PERSONAL REPRESENTATIVE

(*if requested*)

8. ☐ The Petitioner requests that the following qualified person, who is 18 years of age or older, be appointed Personal Representative: ☐ Self only. ☐ Self and other(s): ☐ Other(s):

Name of other(s):

First Name M.I. Last Name

(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Mailing Address, if different:

(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)

Primary Phone #: _____ Email: _____

9. *Select all that apply:*

- ☐ All or some of the nominees have priority for appointment:
- ☐ by statute. See G. L. c. 190B, § 3-203.
- ☐ by renunciation and/or nomination. Persons with higher or equal rights to appointment are:

_____ First Name _____ M.I. _____ Last Name

FORM ALERT: Any required renunciations/nominations using form [MPC 455](#) must accompany this Petition.

- ☐ The nominee(s) without priority for appointment are:

_____ First Name _____ M.I. _____ Last Name

- ☐ Persons with priority have failed to request appointment or to nominate the above nominee and administration is necessary.

10. *Select one of the following:*

- ☐ No court has appointed a Personal Representative and no such appointment proceeding is pending in Massachusetts or elsewhere.
- ☐ A court has appointed a Personal Representative, whose appointment has not been terminated, or an appointment proceeding is pending in the State of _____ and the Personal Representative's name and address is:

_____ First Name _____ M.I. _____ Last Name

_____ (Address) _____ (Apt, Unit, No. etc.) _____ (City/Town) _____ (State) _____ (Zip)

11. *Select one of the following:*

- ☐ A bond with sureties in the penal sum amount of \$ _____ has been or will be filed.
- ☐ A bond without sureties has been or will be filed and is permissible because:
- ☐ The will waives sureties on the bond and no interested person has demanded that a bond with sureties be filed.
- ☐ All devisees (if a will is filed) or heirs (if no will is filed) have waived sureties in writing using form MPC 455 and all waivers are filed with this Petition or are in the possession of the court.

FORM ALERT: All persons seeking appointment must file a bond using form [MPC 801](#).

12. The Petitioner requests (*Select one of the following*):

- ☐ Unsupervised administration
- ☐ The Decedent died intestate (without a will).
- ☐ The will directs unsupervised administration or is silent on the issue.
- ☐ The will directs supervised administration, but circumstances have changed since the execution of the will and there is no necessity for supervised administration because:

- ☐ Supervised administration
- ☐ The will directs supervised administration.
- ☐ The will directs unsupervised administration, but it is necessary for protection of persons interested in the estate because: _____
- ☐ No will directs supervised administration but it is necessary under the circumstances, specifically: _____

13. ☐ The appointment of a Special Personal Representative is necessary pursuant to G. L. c. 190B, § 3-614 (*See separate motion and affidavit filed with this Petition*).

V. RELIEF REQUESTED

Wherefore the Petitioner requests that the court:

- ☐ Admit the Decedent's will to formal probate and determine the heirs.
- ☐ Determine that the Decedent died without a will and determine the heirs.
- ☐ Determine the heirs of the Decedent.
- ☐ Appoint the nominee(s) as Personal Representative of the estate in a(n) ☐ unsupervised ☐ supervised administration to serve ☐ without ☐ with sureties on the bond and that Letters be issued.

The Petitioner also requests:

- ☐ A setting aside of prior informal findings as to testacy.
- ☐ A setting aside of prior informal appointment of Personal Representative.
- ☐ Other: _____

SIGNED UNDER THE PENALTIES OF PERJURY

I certify under the penalties of perjury that the foregoing statements are true to the best of my knowledge and belief.

Date: _____

Signature of Petitioner

Information on Attorney for Petitioner, if any

Signature of Attorney

(Print name)

(Address)

(Apt, Unit, No. etc.)

(City/Town)

(State)

(Zip)

Primary Phone #: _____

B.B.O. # _____

Email: _____

SURVIVING SPOUSE, CHILDREN, HEIRS AT LAW G. L. c. 190B, § 3-301 ☐ Original Form ☐ Amended Form	Docket No.	Commonwealth of Massachusetts The Trial Court Probate and Family Court
Estate of: _____ _____ _____ First Name Middle Name Last Name		_____ Division
Date of Death: _____		

FORM USE: This form must be used to identify a Decedent's surviving spouse, children and heirs at law. Heirs at law are persons entitled to receive the Decedent's property under the intestacy succession laws if there is no will. For dates of death on or after March 31, 2012, the Massachusetts Uniform Probate Code, G. L. c. 190B, § 2-101, et seq., should be consulted. For deaths prior to that date, see applicable law.

Instructions: Complete ALL applicable sections of this form. For step by step instructions on how to complete this form, click on the instructions link above or see Instructions MPC 958.

ALL PETITIONERS MUST COMPLETE LINE 1 AND LINE 2.

1. The Decedent ☐ did not leave a surviving spouse. ☐ left a **surviving** spouse:

NAME OF SURVIVING SPOUSE	ADDRESS (omit if since deceased)

2. a. The Decedent ☐ did not have children (*biological or adopted*). ☐ had the following children (*biological or adopted*):

NAME OF DECEDENT'S CHILD	ADDRESS (omit if deceased)	CHILD OF SURVIVING SPOUSE	A MINOR
		☐ Yes ☐ No	☐ Yes
		☐ Yes ☐ No	☐ Yes
		☐ Yes ☐ No	☐ Yes

☐ b. The surviving spouse has surviving descendants (children, grandchildren, etc.) who are **not** descendants of the Decedent.

Complete line 3 ONLY if the Decedent left children in line 2a who are also heirs at law.

3. ☐ a. All of the children listed in 2a **survived** the Decedent.
☐ b. The following children listed in 2a died **before** the Decedent:

NAME OF PREDECEASED CHILD	DATE OF DEATH

c. The predeceased child(ren) listed in 3b:

☐ did not leave surviving descendants (children, grandchildren, etc.) (*biological or adopted*).

☐ left the following surviving descendants (children, grandchildren, etc.) (*biological or adopted*):

NAME OF SURVIVING DESCENDANT OF PREDECEASED CHILD	ADDRESS (omit if since deceased)	RELATIONSHIP TO DECEDENT	A MINOR
			☐ Yes
			☐ Yes

Complete line 4 ONLY if the Decedent left NO surviving descendants (children, grandchildren, etc.). Otherwise STOP and go to line 7 and line 8.

4. The Decedent ☐ did not leave a surviving parent. ☐ left a surviving parent or parents:

NAME OF SURVIVING PARENT(S)	ADDRESS (omit if since deceased)

For deaths on or after March 31, 2012:

Complete line 5 ONLY if the Decedent left NO surviving spouse, descendants (children, grandchildren, etc.) or parents. Otherwise STOP and go to line 7 and line 8.

For deaths prior to March 31, 2012:

Complete line 5 ONLY if the Decedent left NO surviving descendants (children, grandchildren, etc.) or parents. Otherwise STOP and go to line 7 and line 8.

5. a. The Decedent ☐ did not leave a surviving sibling. ☐ left the following surviving sibling(s) (*biological or adopted, whole or half-blood*):

NAME OF SURVIVING SIBLING	ADDRESS (omit if since deceased)	A MINOR
		☐ Yes
		☐ Yes

- b. ☐ One or more of the Decedent's siblings died **before** the Decedent and left surviving descendants (*biological or adopted*):

NAME OF SURVIVING DESCENDANT OF PREDECEASED SIBLING	ADDRESS (omit if since deceased)	RELATIONSHIP TO DECEDENT	A MINOR
			☐ Yes

For deaths on or after March 31, 2012:

Complete line 6 ONLY if the Decedent left NO surviving spouse, descendants (children, grandchildren, etc.), parents, siblings or descendants of any predeceased sibling. Otherwise STOP and go to line 7 and line 8.

For deaths prior to March 31, 2012:

Complete line 6 ONLY if the Decedent left NO surviving descendants (children, grandchildren, etc.), parents, siblings or descendants of any predeceased sibling. Otherwise STOP and go to line 7 and line 8.

6. List the heirs as defined by the law in effect on the Decedent's date of death. (*Select one*):

- ☐ The heirs at law are as follows:

For assistance, see the Instructions and the [Massachusetts Degree of Kinship Chart \(MPC 960\)](#). See also line 7 and line 8.

NAME OF HEIR	ADDRESS (Omit if since deceased)	RELATIONSHIP TO DECEDENT	A MINOR
			☐ Yes
			☐ Yes

☐ After a reasonable diligent search, the heirs at law are unknown or unascertainable. (Requires a **formal** proceeding.)

ALL PETITIONERS MUST COMPLETE LINE 7 AND LINE 8, if applicable.

7. **NONE** of the Decedent's **heirs at law** (surviving spouse, children, etc.) are under a legal disability except for:

NAME OF HEIR AND RELATIONSHIP TO DECEDENT	LEGAL DISABILITY	REPRESENTED BY * (Guardian ad litem required unless waived. See Instructions)	NAME/ADDRESS OF REPRESENTATIVE (Provide docket number or proof of appointment for any court appointed fiduciary.)
	☐ Minor List age: _____ ☐ Incapacitated or protected person (adjudicated or alleged)	☐ Guardian ☐ Conservator ☐ Unrepresented*	
	☐ Minor List age: _____ ☐ Incapacitated or protected person (adjudicated or alleged)	☐ Guardian ☐ Conservator ☐ Unrepresented*	

8. **NONE** of the **heirs at law** (surviving spouse, children, etc.) who survived the Decedent are deceased **at the time of this filing** except for:

NAME OF SINCE DECEASED HEIR AND RELATIONSHIP TO DECEDENT	DATE OF DEATH	REPRESENTED BY	NAME/ADDRESS OF REPRESENTATIVE (Provide docket number or proof of appointment for any court appointed fiduciary.)
		☐ Personal Representative (Required for an informal proceeding) ☐ Unrepresented (Formal proceeding required)	
		☐ Personal Representative (Required for an informal proceeding) ☐ Unrepresented (Formal proceeding required)	

SIGNED UNDER THE PENALTIES OF PERJURY

I certify under the penalties of perjury that the foregoing statements are true to the best of my knowledge and belief.

Date: _____

Signature of Petitioner

(Print name)

DEVISEES G. L. c. 190B, § 3-301	Docket No.	Commonwealth of Massachusetts The Trial Court Probate and Family Court
☐ Original Form ☐ Amended Form		
Estate of: _____ _____ _____ First Name Middle Name Last Name		Division
Date of Death: _____		

Form Use: This form must be used to identify a Decedent's devisees. Devisees are persons, entities, charitable organizations, or trusts designated in a will to receive the Decedent's personal or real property. In the case of a devise to an existing trust or trustee, or to a trustee or trust established by the will, the trust or trustee is the devisee and the beneficiaries are not devisees. For additional information, the Massachusetts Uniform Probate Code, G. L. c. 190B should be consulted.

Instructions: Complete ALL applicable sections of this form. For step by step instructions on how to complete this form, click on the Instructions link above or see Instructions MPC 959.

ALL PETITIONERS MUST COMPLETE LINE 1 AND LINE 2.

1. The Decedent left a will dated _____ . ☐ The dates of all codicils are: _____ . The will and any codicils are referred to as the will.

2. The following devisees named in the will to inherit personal or real property **were living** at the time of the Decedent's death. *(Note: If the devisee is a trust, list the name of the trust and trustees. If any devisee is a charity, list the name of the charity and provide notice to the Massachusetts Attorney General. See G. L. c. 190B and Uniform Practice XXXIV).*

NAME OF DEVISEE	ADDRESS (omit if since deceased)	RELATIONSHIP TO DECEDENT	A MINOR
			☐ Yes
			☐ Yes
			☐ Yes

3. ☐ The following devisees named in the will to inherit personal or real property **were not living** at the time of the Decedent's death.

NAME OF PREDECEASED DEVISEE	DATE OF DEATH	RELATIONSHIP TO DECEDENT

4. ☐ If the will names one or more persons to take in place of the pre-deceased devisee, or if the anti-lapse statute (G. L. c. 190B, § 2-603) applies, list the contingent devisee(s). Do not include residuary devisees named elsewhere.

NAME OF CONTINGENT DEVISEE	ADDRESS (omit if since deceased)	RELATIONSHIP TO DECEDENT	A MINOR
			☐ Yes
			☐ Yes

ALL PETITIONERS MUST COMPLETE LINE 5 AND LINE 6, if applicable.

5. **NONE** of the devisees are under legal disability except for:

NAME OF DEVISEE	LEGAL DISABILITY	REPRESENTED BY <i>* (Guardian ad litem required unless waived. See Instructions)</i>	NAME/ADDRESS OF REPRESENTATIVE <i>(Provide docket number or proof of appointment for any court appointed fiduciary.)</i>
	☐ Minor List age: _____ ☐ Incapacitated or protected person <i>(adjudicated or alleged)</i> ☐ Unborn or unascertained	☐ Guardian ☐ Conservator ☐ Unrepresented*	
	☐ Minor List age: _____ ☐ Incapacitated or protected person <i>(adjudicated or alleged)</i> ☐ Unborn or unascertained	☐ Guardian ☐ Conservator ☐ Unrepresented*	

6. **NONE** of the devisees who survived the Decedent are deceased **at the time of this filing** except for:

NAME OF SINCE DECEASED DEVISEE	DATE OF DEATH	REPRESENTED BY	NAME/ADDRESS OF REPRESENTATIVE <i>(Provide docket number or proof of appointment for any court appointed fiduciary.)</i>
		☐ Personal Representative <i>(Required for an informal proceeding)</i> ☐ Unrepresented <i>(Formal proceeding required)</i>	
		☐ Personal Representative <i>(Required for an informal proceeding)</i> ☐ Unrepresented <i>(Formal proceeding required)</i>	

SIGNED UNDER THE PENALTIES OF PERJURY

I certify under the penalties of perjury that the foregoing statements are true to the best of my knowledge and belief.

Date: _____

Signature Of Petitioner

(Print name)

BOND ☐ Without sureties ☐ With personal sureties ☐ With corporate surety Bond #: _____	Docket No. _____	Commonwealth of Massachusetts The Trial Court Probate and Family Court
In the Interests of: _____ First Name Middle Name Last Name Incapacitated Person/Protected Person/Ward/Decedent/Trust		Division _____

The condition of this bond is the faithful discharge by the fiduciary of all duties according to law (for Public Administrators see G. L. c. 194, § 2). By executing this bond, a Personal Representative or Trustee submits personally to the jurisdiction of any court of the Commonwealth in any proceeding pertaining to the estate that may be instituted by any interested person. By executing this Bond, any other fiduciary submits personally to the jurisdiction of the Court which issued the Letters of Appointment. This bond is not void after the first recovery but may be proceeded against from time to time until the whole penalty is exhausted.

Estimated Value of Real Estate _____ Estimated Value of Personal Estate _____

Penal Sum of Bond (if applicable) _____

1. Fiduciary Name: _____

First Name
M.I.
Last Name

(Address)

(Apt, Unit, No. etc.)

(City/Town)

(State)

(Zip)

Primary Phone #: _____

2. Fiduciary Name: _____

First Name
M.I.
Last Name

(Address)

(Apt, Unit, No. etc.)

(City/Town)

(State)

(Zip)

Primary Phone #: _____

The undersigned fiduciary accepts appointment as _____
and stand(s) personally bound to the First Justice of said Court and his or her successors as obligee for the benefit of the persons interested in the estate and declare(s) the above estimates to be true and accurate to the best of his/her knowledge and belief.

Date _____

Signature of Fiduciary 1.

Date _____

Signature of Fiduciary 2.

In the Interests of:

First Name

Middle Name

Last Name

Docket No.

Persons who sign as sureties may be individually or collectively liable in the amount of the penal sum listed on page 1 for losses caused by improper administration of the estate by the fiduciary. By executing this Bond, we, the sureties, consent personally to the jurisdiction of this Court in any proceedings pertaining to fiduciary duties and naming the surety as a party.

Complete the following section if the bond is with personal surety.

Name: _____
First Name Middle Name Last Name

(Address Line)

(Apt, Unit, No. etc.)

_____, Massachusetts _____ Primary Phone #: _____
(City/Town) (Zip)

By signing this document I hereby certify under the penalties of perjury that I am a Massachusetts resident and that I possess sufficient unencumbered assets located in Massachusetts in excess of the penal sum.

Date _____
Signature

Name: _____
First Name Middle Name Last Name

(Address Line)

(Apt, Unit, No. etc.)

_____, Massachusetts _____ Primary Phone #: _____
(City/Town) (Zip)

By signing this document I hereby certify under the penalties of perjury that I am a Massachusetts resident and that I possess sufficient unencumbered assets located in Massachusetts in excess of the penal sum.

Date _____
Signature

Complete the following section if the bond is with corporate surety.

Bond #: _____ Penal Sum of Bond: _____

We, the undersigned surety company, a corporation duly organized by law under the state of _____
and having a usual place of business in Massachusetts at: _____
(Address)
_____ stand bound as surety in the aforesaid penal sum.

_____ by _____
Corporate Surety (name) Signature and Title

FOR COURT USE ONLY

_____, SS _____ examined and _____ approved
Date

Justice-Assistant-Judicial Case Manager-Assistant Register-Magistrate
of the Probate and Family Court

Estate of: _____ First Name Middle Name Last Name	Docket No.
---	------------

--OR--

C) ☐ An authenticated copy of the will and of the decree admitting it to probate in the Decedent's state or county of domicile at the death is filed. The authenticated copy is dated _____. The dates of all codicils are _____. The authenticated copy of the will and any codicils are referred to as the will.

Based on a preponderance of credible evidence presented, the court is satisfied that:

The will was duly admitted to probate by the state or country of _____, the Decedent's domicile at death.

--OR--

D) ☐ The will is not a valid will.

8. At the time of death, the Decedent's heirs at law were:

☐ identical to those persons stated in the ☐ original ☐ amended MPC 162 Surviving Spouse, Children, Heirs at Law dated: _____.

--OR--

☐ the following named persons (each and every heir at law must be named):

NAME	RELATIONSHIP TO DECEDENT

9. ☐ The following person is qualified to serve as Personal Representative pursuant to G. L. c. 190B, § 3-203:

_____ (First Name) _____ (M.I.) _____ (Last Name) _____ (Address) _____ (Apt, Unit, No. etc.)

Primary Phone #: _____ (City/Town) _____ (State) _____ (Zip)

_____ (First Name) _____ (M.I.) _____ (Last Name) _____ (Address) _____ (Apt, Unit, No. etc.)

Primary Phone #: _____ (City/Town) _____ (State) _____ (Zip)

Any will to which the requested appointment relates is being or has been probated.

Estate of:

First Name

Middle Name

Last Name

Docket No.

THE COURT DECREES AND ORDERS *(select only that requested on the Petition):*

TESTACY DETERMINATION

1. ☐ The Decedent died intestate.
☐ The will has not previously been admitted to probate and is hereby admitted to formal probate.
☐ The will is not admitted to formal probate. The Petition is dismissed with prejudice as to that instrument.

DETERMINATION OF HEIRS

2. The Decedent's heirs at law as of date of death are as found above.

APPOINTMENT OF PERSONAL REPRESENTATIVE

3. The aforementioned person is appointed or confirmed as Personal Representative.

4. The Personal Representative shall serve in a(n):

- ☐ Unsupervised Administration.
☐ Supervised Administration described as follows:

- ☐ without a surety on the bond because:

- ☐ The will waives the requirement of a surety bond.
☐ All of the heirs or all of the devisees have filed a written waiver of sureties on the bond.
☐ The Personal Representative is a bank or trust company.
☐ The court finds that sureties are not in the best interest of the estate.

- ☐ with ☐ personal ☐ corporate sureties on the bond in the penal sum amount of \$ _____

- ☐ A Demand for Sureties (MPC 360) has been filed.

- ☐ The Personal Representative's prior bond is re-examined and approved.

5. Letters of Authority shall issue; or

- ☐ previously issued Letters of Authority for the Personal Representative are confirmed.

6. **The court further orders:**

Date _____

☐ Justice

☐ Magistrate

INVENTORY	Docket No. _____	Commonwealth of Massachusetts The Trial Court Probate and Family Court
☐ Estate of: ☐ Conservatorship of: ☐ Other: _____ _____		_____ Division _____

After completing attached Schedules of Personal Property and Real Estate, insert the total from each Schedule on the line below.

I am the ☐ Conservator who is ☐ Temporary ☐ Permanent
☐ Personal Representative
☐ Special Personal Representative
☐ Public Administrator
☐ Receiver
☐ Other: _____

appointed on _____ and I certify that this Inventory contains a complete and
 accurate report of the estate's personal ^(date) property and real estate.

FOR CONSERVATORSHIPS

I have delivered a copy of this Inventory by ☐ delivery in hand ☐ first class mail postage prepaid
 to the Protected Person (if over 14) and to any parent or guardian who lives with the Protected Person

SUMMARY OF ATTACHED SCHEDULES (If you are completing this on-line, the totals will auto-fill.)
--

	TOTALS
SCHEDULE OF PERSONAL PROPERTY:	_____
SCHEDULE OF REAL ESTATE:	_____

SIGNED UNDER THE PENALTIES OF PERJURY

I certify under the penalties of perjury that the foregoing statements are true to the best of my knowledge and belief.

Date: _____ Signature of Fiduciary _____

Date: _____ Signature of Co-Fiduciary (if applicable) _____

Information on Attorney for Fiduciary

Signature of Attorney _____

_____ (Print name)

_____ (Address) _____ (Apt, Unit, No. etc.)

_____ (City/Town) _____ (State) _____ (Zip)

Primary Phone #: _____

B.B.O. # _____

Email: _____

SCHEDULE OF PERSONAL PROPERTY

Item No.	Account and Number	Description of Personal Property	Value
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
Total			

Note: LIST CURRENT BALANCE (IF ANY) OF ANY LOAN OR LIEN ON EACH ITEM. If necessary, attach additional pages and continue with Item No. 15 etc. until completed. Enter total values of all Personal Property items above, and insert same amount on "Schedule of Personal Property" line on front page of this Inventory.

SCHEDULE OF REAL ESTATE

Item No.	Description of Real Estate	Value
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
Total		

Note: INCLUDE THE STREET ADDRESS, TITLE REFERENCE, AND CURRENT BALANCE (IF ANY) OF ANY MORTGAGE OR LIEN FOR EACH ITEM OF REAL ESTATE. "Value" in the right column means fair market value without deduction for any mortgage or lien on the property. If necessary, attach additional pages, continuing with Item No. 15 etc. until completed. Enter total values of all Real Estate items above, and insert same amount on "Schedule of Real Estate" line on front page of this Inventory.



ACCOUNT

DOCKET NO.

**Massachusetts Trial Court
Probate and Family Court**☐ ESTATE OF: ☐ CONSERVATORSHIP OF: ☐ OTHER:

DIVISION

This is the: ☐ ANNUAL ACCOUNT

(State 1st, 2nd, etc.) _____

☐ FINAL ACCOUNT(Select why) ☐ Appointment terminated ☐ Estate closed ☐ Court Order dated: _____☐ AMENDED ACCOUNT

(Identify Account being amended by number and filing date) _____

☐ OTHER ACCOUNT

(Explain) _____

FOR THE REPORTING PERIOD FROM _____ TO _____
(MM/DD/YYYY) (MM/DD/YYYY)

ACCOUNTING FIDUCIARY'S INFORMATION

Name: _____
First Name MI Last NameAddress: _____
(Address) (Apt, Unit, No. etc.) (City/Town) (State) (Zip)Email: _____
Email Address

Primary Phone #: _____

SUMMARY OF SCHEDULES

(If you are completing this on-line, the totals will auto-fill.)

TOTAL

SCHEDULE A - Receipts and income

\$

SCHEDULE B - Payment and debts, administration expenses, taxes and distributions

\$

SCHEDULE C - Balance of assets on hand

\$

CONSERVATORS ONLY

For assistance on how to complete, file and distribute an Account, watch **Module 7: How to Complete the Conservator's Account** and **Module 8: How to File and Distribute Guardian and Conservator Reports** located on the Probate and Family Court's Office of Adult Guardianship and Conservatorship Oversight webpage at: <http://www.mass.gov/courts>.

1. Do you recommend that the conservatorship be continued? ☐ No (*explain*) ☐ Yes

2. If you recommend that the conservatorship be continued, do you recommend any changes in the scope of the conservatorship? ☐ No ☐ Yes (*explain*)

3. List the services provided to the Adult under conservatorship.

4. Were you required to file a Conservator's Financial Plan? ☐ No ☐ Yes

5. If you filed a Conservator's Financial Plan, do you recommend any changes to the Plan? ☐ No ☐ Yes (*explain*)

ALL FIDUCIARIES

I understand that I am required to maintain supporting documentation for all receipts and disbursements including detailed billing statements from any professional.

The proper Petition to allow this Account is ☐ filed with this Account ☐ already on file with the Court.

SIGNED UNDER THE PENALTIES OF PERJURY

I swear or affirm under oath that I have read this Account and that the statements contained in it are true and correct to the best of my knowledge and information.

Date _____

SIGNATURE OF FIDUCIARY

Attorney for Fiduciary:

Print Name

(Address)

(Apt, Unit, No. etc.)

(City/Town)

(State)

(Zip)

Primary Phone #: _____

BBO No.: _____

SCHEDULE A- RECEIPTS AND INCOME

If this is the first Account of a Personal Representative, enter the Inventory total of only the personal property in the “Amount Received” column on the line for “Balance of Inventory or Prior Account”. If it is the first Account of a Conservator, enter the Inventory total of both personal property and real estate in the “Amount Received” column on the line for “Balance of Inventory or Prior Account”.

If this is not the first Account, enter the Total (Book Value) balance from Schedule C in the last prior filed Account in the “Amount Received” column on the line for “Balance of Inventory or Prior Account”.

Item #	Date	Description of item received, include name of Payor	Sub-Total	Amount Received
		Balance of Inventory or Prior Account		
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				
26.				
27.				
Total				

SCHEDULE B- Payment of Debts, Administration Expenses, Taxes & Distributions

Item #	Date	Description of item Paid (include Name of Payee)	Sub-Total	Amount Paid
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				
26.				
27.				
			Total	

SCHEDULE C- Balance of Assets on hand at end of accounting period

Item #	Account and Number	Name of Financial Institution or Description of Asset	Market Value	Book Value
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				
26.				
27.				
			Total	

PETITION FOR ORDER OF COMPLETE SETTLEMENT PURSUANT TO G. L. c. 190B, § 3-1001 ☐ ORIGINAL FORM ☐ AMENDED FORM	Docket No. _____	Commonwealth of Massachusetts The Trial Court Probate and Family Court
Estate of: _____ First Name Middle Name Last Name Date of Death: _____	_____ Division	

I. GENERAL INFORMATION

The Petitioner(s) (hereafter "Petitioner") makes the following statements:

1. Information about the Petitioner:

Name: _____

First Name
Middle Name
Last Name

(Address)
(Apt, Unit, No. etc.)
(City/Town)
(State)
(Zip)

Mailing Address, if different: _____

(Address)
(Apt, Unit, No. etc.)
(City/Town)
(State)
(Zip)

Primary Phone #: _____

Interest of the Petitioner: ☐ Personal Representative Date of appointment: _____

☐ Other: _____

(relationship)

2. One year has passed since the appointment of the original Personal Representative or the Petitioner is the Personal Representative.

3. The time for presenting claims that arose prior to the Decedent's death has expired (i.e. one year from date of death; see G. L. c. 190B, § 3-803).

II. PERSONS INTERESTED IN THE ESTATE

4. The names and addresses of all interested persons and their interest in the estate are as follows:

NAME	ADDRESS (omit if since deceased)	INTEREST (e.g. heir, devisee, etc.)

ALL PETITIONERS MUST COMPLETE 5 AND 6, IF APPLICABLE

5. NONE of the interested persons listed in 4. are under a legal disability except for:

NAME	LEGAL DISABILITY	REPRESENTED BY <i>* (Motion and affidavit required to waive appointment of Guardian ad litem (GAL). See instructions for more information.)</i>	NAME/ADDRESS OF REPRESENTATIVE <i>(Provide docket number or proof of appointment for any court appointed fiduciary.)</i>
	☐ Minor List age: _____ ☐ Incapacitated Person <i>(adjudicated or alleged)</i> ☐ Protected Person <i>(adjudicated or alleged)</i>	☐ Unrepresented or only represented by the accountant (appointment of GAL requested) ☐ Independent Guardian ☐ Independent Conservator ☐ Parent of Minor* ☐ Holder of General Power of Appointment* (copy of proof attached) ☐ Virtual Representative* (list relationship) ☐ Non-Accounting co-fiduciary pursuant to Uniform Practice XVIA* FOR DISTRIBUTIONS PURSUANT TO § 3-915 ONLY: ☐ UTMA Custodian* (copy of proof attached) ☐ UCTA Custodian* (copy of proof attached) ☐ Agent under POA* (copy of proof attached) ☐ Other as authorized by G. L. c. 190B, § 3-915*: (list relationship)	

6. NONE of the interested persons who survived the decedent are deceased at the time of this filing except for:

NAME OF <u>SINCE</u> DECEASED INTERESTED PERSON	DATE OF DEATH	REPRESENTED BY	NAME/ADDRESS OF REPRESENTATIVE <i>(Provide docket number or proof of appointment for any court appointed fiduciary.)</i>
		☐ Unrepresented (NOTE: Publication is required ; Guardian ad <u>litem</u> may be appointed) ☐ Personal Representative	

III. ALLOWANCE OF THE FINAL ACCOUNT

(complete only if requesting)

7. ☐ A _____ and final account is on file with the court or accompanies this Petition.
(specify whether 1st, 2nd, etc.)

IV. DETERMINATION OF TESTACY

(complete only if requesting; you must also complete Section V)

8. ☐ Testacy has not been previously formally adjudicated. This Petition is filed within the time period permitted by law (G. L. c. 190B, § 3-108). Three (3) years or less have passed since the Decedent's death, or the following circumstances authorize tardy proceedings (include statutory reference):

9. The Decedent died (select one):

☐ **Intestate (without a will)**

After the exercise of reasonable diligence, the Petitioner is unaware of any unrevoked testamentary instrument relating to property in Massachusetts, or ☐ **see attached statement of why such an instrument is not being probated.**

☐ **Testate (with a will)**

The date of the Decedent's last will is _____.

☐ The dates of all codicils are _____.

(select one of the following):

☐ The original will is in the possession of the court or accompanies this Petition.

☐ The original will was informally admitted to probate on: _____ (date)

☐ The will has been probated in the state or country of _____.

An authenticated copy of the will and proof of its probate is in the possession of the court.

The will and any codicils are referred to as the will. The Petitioner, to the best of his or her knowledge, believes the will was validly executed. After the exercise of reasonable diligence, the Petitioner is unaware of any instrument revoking the will and believes that the will is the Decedent's last will.

FORM ALERT: Form MPC 163 Devisees must be on file with the court or accompany this Petition.

V. DETERMINATION OF HEIRS

(complete only if requesting or if Section IV is completed.)

10. ☐ The heirs at law of the estate have not been previously formally adjudicated by the court. The Decedent's surviving spouse, children, heirs at law, so far as known or ascertainable with reasonable diligence by the Petitioner are as stated in the attached MPC 162 Surviving Spouse, Children, Heirs at Law dated: _____ (date) incorporated herein.
- ☐ There are additional heirs at law who are not known to the Petitioner.

VI. OTHER REQUESTS AS AUTHORIZED BY G. L. c. 190B, § 3-1001

(complete only if requesting.)

11. ☐ The persons or entities entitled to distribution and the amounts to be distributed must be determined.

The Petitioner proposes the following:

NAME OF PROPOSED DISTRIBUTE	INTEREST	PROPOSED DISTRIBUTION

--	--	--

12. ☐ Provisions of the will which the Petitioner wants construed and the construction sought by the Petitioner are as provided in the attached statement.
13. ☐ Other (as authorized by G. L. c. 190B, § 3-1001):

VII. RELIEF REQUESTED

Wherefore the Petitioner requests that the court (select only as requested above):

- ☐ Approve the _____ and final account(s) as filed, including the distributions stated therein, and adjudicate a final settlement of the estate.
- ☐ Determine testacy and the heirs at law as stated herein.
- ☐ Determine the heirs at law of the Decedent.
- ☐ Determine and approve the distribution as proposed.
- ☐ Construe the will as provided in the attached statement.
- ☐ Other:

SIGNED UNDER THE PENALTIES OF PERJURY

I certify under the penalties of perjury that the foregoing statements are true to the best of my knowledge and belief.

Date: _____ Signature of Petitioner _____

Information on Attorney for Petitioner, if any

Signature of Attorney _____

(Print name)

(Address)

(Apt, Unit, No. etc.)

(City/Town)

(State)

(Zip)

Primary Phone #: _____

B.B.O. # _____

Email: _____

MassHealth Application

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



HOW TO APPLY

You can submit your application in any of the following ways.

Mail or fax your filled-out, signed application to
MassHealth Enrollment Center
PO Box 290794
Charlestown, MA 02129-0214

Fax (617) 887-8799

Online at mass.gov/how-to/apply-for-masshealth-coverage-for-seniors-and-people-of-any-age-who-need-long-term-care-services

To schedule an appointment with a MassHealth representative or to apply in person, go to mass.gov/masshealth/appointment.

To get the benefits you need, you may send us documentation that verifies your household income and assets.

You can use this application to apply for the Supplemental Nutrition Assistance Program (SNAP). SNAP is a federal program that helps you buy food each month. If you are interested, check the box on page 1, then read and sign the SNAP rights and responsibilities on pages 20-23. Your application will then be sent automatically to the Department of Transitional Assistance. You do not have to apply for SNAP to be considered for MassHealth.

MASSHEALTH and the HEALTH SAFETY NET | Who Can Use This Application

This is your application for health coverage if you live in Massachusetts and are

- an individual 65 or older and living at home and
 - not the parent of a child under 19 years old who lives with you, or
 - not an adult relative living with and taking care of a child younger than 19 years old when neither parent is living in the home, or
 - 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 any age 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 your spouse, and
 - both you and your spouse are applying for health coverage,
 - there are no children under 19 years old living with you, and
 - one spouse is 65 or older and the other spouse is under 65 years old. (See Step 9 of the application.)

If you meet any of the following exceptions, you should complete the Application for Health and Dental Coverage and Help Paying Costs (ACA-3). To obtain a copy of this application, call us at (800) 841-2900, TDD/TTY: 711.

- You are the parent of a child under 19 years old who lives with you, or
- You are an adult relative living with and taking care of a child younger than 19 years old when neither parent is living in the home.

You will also need to fill out a Long-Term-Care Supplement if you are

- In an institution, such as a nursing home, chronic hospital, or other medical institution (You may have to pay a monthly payment, called a patient-paid amount, to the long-term-care facility. For more information, see page 13 in the Senior Guide.)
- In an acute hospital waiting for placement in a long-term-care facility
- Living in your home and applying for or getting long-term-care services under a Home- and Community-Based Services Waiver

If someone is helping you fill out this application, you may need to fill out a separate form that gives that person permission to act on your behalf. See the Authorized Representative Designation Form (ARD) at the end of this application.

MASSACHUSETTS HEALTH CONNECTOR | Who Can Use This Application

This is your application for health coverage if you live in Massachusetts, and you

- are 65 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.



WHAT YOU NEED WHEN YOU APPLY

The following **MUST** be sent with the application when applying for MassHealth, the Health Safety Net (HSN), and the Massachusetts Health Connector.

SOCIAL SECURITY NUMBER (SSN)

You must give us an SSN or proof that anyone on this application has also applied for an SSN. There are exceptions for anyone who

- has a religious exemption as described in federal law,
- is eligible only for a nonwork SSN, or
- is not eligible for an SSN.

Unless an exception applies, **we need SSNs for all people applying** for health coverage. **An SSN is optional for people 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 does not have an SSN or needs help getting one, call the Social Security Administration at (800) 772-1213, TTY: (800) 325-0778, or go to www.socialsecurity.gov. See the Senior Guide for more information.

PROOF OF INCOME, ASSETS, AND INSURANCE

We will attempt to verify some of this information through electronic data matches and will notify you if we need further proof. It may speed up the processing of your application if you send proof of these items with it.

- Proof of all current income before deductions, such as copies of pay stubs or pension check stubs (You do not have to send proof of social security or SSI income, but you must fill out the social security and SSI income information, if applicable).
- Proof of all assets, such as bank accounts and life insurance policies.
- Copies of your current health insurance premium bills (such as Medex) if you are applying for long-term-care services in a medical facility. (You do not have to send copies of your Medicare cards).
- Policy numbers for any current health coverage.
- Information about any other health insurance available to your household.

PROOF OF CITIZENSHIP/NATIONAL STATUS

We will try to verify this information through electronic data matches. We will notify you if we need further proof. It may speed up the processing of your application if you send proof of these items with it.

- Proof of US citizenship/national status and proof of identity, such as US passports or US naturalization papers. You can also prove US citizenship with a US public birth certificate. You can also prove identity with a driver's license or some other form of government-issued card. We may be able to prove your identity through the Massachusetts Registry of Motor Vehicles if you have a Massachusetts driver's license or a Massachusetts ID card. Once you give MassHealth proof of your US citizenship/national status and identity, you will not have to give us this proof again. You must give us proof of identity for all household members who are applying. **Seniors and disabled persons who get or can get Medicare or Supplemental Security Income (SSI), or disabled persons who get Social Security Disability Insurance (SSDI), do not have to give proof of their US citizenship/national status and identity.** (See Section 9 in the Senior Guide for more information.)
- A copy of both sides of all immigration cards (or other documents that show immigration status) for you or your spouse if you or your spouse are not US citizens/nationals and are applying for MassHealth (except for MassHealth Limited), the Health Safety Net, or the Health Connector plans.

For more information on immigration statuses and document types, see page 32.

WHY WE ASK FOR THIS INFORMATION

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We will keep all the information you provide private and secure, as required by law.** To view the Health Connector's privacy policy, go to MAhealthconnector.org. To view MassHealth's privacy policy, go to mass.gov/service-details/masshealth-member-privacy-information.

WHAT HAPPENS NEXT and WHERE TO GET HELP

When we get your filled-out, signed, and dated application, we will review it. If we need more information, we will write or call you. Once we get what we need, we will make a decision about your eligibility and send you a written notice. If you are eligible for MassHealth, show this notice right away to any health care provider if you have paid for medical services that would be covered by MassHealth during your eligibility period. If the health care provider determines that MassHealth will pay for these services, the provider will refund what you paid.

If you need more information about how to apply, or if you need another copy of **Supplement C: Personal-Care Attendant** for your spouse who is also applying, call us at (800) 841-2900, TDD/TTY: 711. This application is available in other languages. Please call the number above to request one.

If you have any questions about any form or the information you need to send, please call us at (800) 841-2900, TDD/TTY: 711.

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



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 they want to apply for. 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 reductions or Advance Premium Tax Credits through the Health Connector, and you cannot purchase a health plan through the Health Connector, unless you were already 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 coverage through the Health Connector, which may include Advance Premium Tax Credits and ConnectorCare plans.

You: _____

Spouse: _____

NOTE: Program of All-inclusive Care for the Elderly (PACE)

Some MassHealth members may be eligible to enroll in the 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) 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 18-23 and sign on page 24 to proceed with the application.

What happens after you apply for SNAP benefits?

- DTA will call you soon for a phone interview and to check if you can get emergency SNAP within 7 days.
- DTA will work with you to verify information about your case.
- You will get an Electronic Benefit Transfer (EBT) card to access benefits, if approved.
- You will receive a notice about your decision within 30 days.

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

We need one adult in the household to be the contact person for your application. This person should be someone who appears on the application, not a third party who wishes to serve as a contact for the applicant(s). 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 (mm/dd/yyyy)	
3. Street address ☐ Check this box if homeless. You must provide a mailing address.			4. Apartment or unit number	
5. City	6. State	7. ZIP code	8. County	

9. Is this a hospital, nursing facility, or other institution? ☐ Yes ☐ No 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
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 _____ Your preferred written language may be used to communicate with you. If you do not answer, we will send notices in English.			
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. Certified Application Counselors must fill out a Certified Application Counselor Designation Form.

Check one ☐ Navigator ☐ Certified Application Counselor		
First name, middle name, last name, and suffix		Email address
Organization name	Organization identification number	Organization phone number

STEP 2 Person 1 —Tell us about your household.

1. First name, middle name, last name, and suffix		2. Relationship to you SELF
3. What was your sex assigned at birth? ☐ Male ☐ Female This is usually the sex that was originally listed on your birth certificate.		
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 20 (accommodations), then go to the Income Information section on page 5.		

QUESTIONS 5-9 ARE OPTIONAL: MassHealth is committed to providing equitable care for all members regardless of race, ethnicity, gender, sexual orientation or language spoken. Please complete questions 5-9 to help us meet your language and cultural needs. Your response is voluntary and will not impact your eligibility or be used for any discriminatory purpose.

5. Which describes best your current gender identity? Select up to five options.

Gender identity is how a person defines and understands their gender as a man, a woman, nonbinary, gender nonconforming, transgender, or something else.

☐ Male
 ☐ Female
 ☐ Transgender man/trans man
 ☐ Transgender woman/trans woman
☐ Genderqueer/gender nonconforming/non-binary; neither exclusively male nor female
☐ Gender identity is not listed here. Please specify _____
☐ Don't know ☐ Choose not to answer

6. Which of these describes your current sexual orientation? Select up to five options.

☐ Sexual orientation describes how a person defines their physical and/or emotional attraction to others.

☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, or questioning
☐ Sexual orientation is not listed. Please specify _____ ☐ Don't know ☐ Choose not to answer

7. Are you of Hispanic or Latino origin or descent?

☐ Hispanic or Latino refers to someone of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

☐ Yes, Hispanic or Latino ☐ No, not Hispanic or Latino ☐ Don't know ☐ Choose not to answer

8. Race (see page 32) _____

☐ Race refers to a person's self-identification with one or more social groups. Individuals may report multiple races.

9. Ethnicity (see page 32) _____

☐ Ethnicity refers to your background, heritage, culture, ancestry, or the country where you or your family were born.

10. 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. For more details on how we use your Social Security number, refer to the Senior Guide for Health Care Coverage. If you need help getting an SSN, call the Social Security Administration at (800) 772-1213, TTY: (800) 325-0778, or go to [socialsecurity.gov](https://www.socialsecurity.gov).

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

If **No**, check one of the following reasons. ☐ Illness exception ☐ 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

11. If you get an Advance Premium Tax Credit (APTC), do you agree to file a federal tax return for the tax year when 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 11 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.

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 11a ("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 11c.

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 who is listed on this application as a dependent and 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 dependents' name(s) and birth date(s). _____

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 whether you can 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 non-custodial 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 the spouse's name 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 each year in the past two years that I received an Advance Premium Tax Credit (APTC), to lower my monthly premium payment, including if I was enrolled in Connector Care. I included the tax forms showing the tax credits I received when I filed my tax return so the IRS could calculate how much Advance Premium Tax Credit, I was eligible to receive based on my final income for the year. ☐ 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.

12. Are you a US citizen or US national? ☐ Yes ☐ No

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

Alien number _____ Naturalization or citizenship certificate number _____

13. 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 Health Safety Net (HSN). Go to Question 14.

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 application.

We 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 US. 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 name, middle name, last name, and suffix _____

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

d. Are you an honorably discharged veteran or active-duty member of the US military, or the spouse or child of an honorably discharged veteran or an active-duty member of the US 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 parent of a battered spouse?

14. Are you living in Massachusetts, and do you either intend to reside here, even if you do not have a fixed address, or have you entered Massachusetts with a job commitment or seeking employment? ☐ Yes ☐ No

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

15. 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) _____

16. Are you pregnant? ☐ Yes ☐ No

If **Yes**, how many babies are you expecting? _____ What is the expected due date? _____

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

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

b. Did you get health care through a state Medicaid program? ☐ Yes ☐ No

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

19. **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: _____

20. 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) _____

21. 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?

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

22. Do you have any income? ☐ Yes ☐ No If you don't have income, skip to question 34.

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

23. Employer name and address	Federal Tax ID#
-------------------------------	-----------------

24. 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 _____

25. Average number of hours worked each WEEK _____

26. 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, attach another sheet of paper.

27. Are you self-employed? ☐ Yes ☐ No

a. If **Yes**, what type of work do you do? _____

b. On average, how much net income (profits after business expenses are paid) will you get from this self-employment each month, or how much will you lose from this self-employment each month? \$_____/month **profit** or \$_____/month **loss**?

c. How many hours do you work per week? _____

OTHER INCOME

28. Check all that apply. State 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? _____

☐ Retirement or Pension \$_____ How often? _____

☐ Annuities \$_____ How often? _____

☐ Trusts \$_____ How often? _____

☐ Unemployment \$_____ How often? _____

☐ Interest, dividends, and other investment income \$_____ How often? _____

- ☐ Royalty income \$_____ How often? _____
- ☐ Alimony received \$_____ How often? _____
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? _____
- ☐ Military retirement pay \$_____ How often? _____
- ☐ Other taxable income (include type) \$_____ How often? _____ 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: \$ _____ /profit or \$ _____ /loss How many hours each week? _____
- ☐ 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.

RENTAL INCOME

29. 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

ONE-TIME-ONLY INCOME

30. Have you or will you receive income during this calendar year as a one-time only payment? ☐ Yes ☐ No
An example might include a lump-sum pension payment.

If **Yes**: Type _____ Amount \$ _____ Month received _____ Year received _____

31. 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 _____

DEDUCTIONS

32. 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

YEARLY INCOME

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

34. 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).

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

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 (mm/dd/yyyy)		
3. What was this person's sex assigned at birth? ☐ Male ☐ Female. This is usually the sex that was originally listed on your birth certificate.					
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.					
6. Is this a hospital, nursing facility, or other institution? ☐ Yes ☐ No If Yes , facility name					
7. Mailing address ☐ Check if same as street address.				8. Apartment or unit number	
9. City		10. State	11. ZIP code		12. County
13. What is this person's preferred language, if not English? Spoken _____ Written _____ Preferred written language may be used by MassHealth and the Health Connector to communicate with you. If you do not answer, we will send your notices in English					
14. Is this person applying for health or dental coverage? ☐ Yes ☐ No If Yes , answer all the questions below in Step 2 for Person 2 If No , answer Question 30 (accommodations), then go to the Income Information section on page 10.					

QUESTIONS 15-19 ARE OPTIONAL: See instructions for questions 5-9 under Person 1.

15. Which best describes this person's current gender identity? Select up to five options.

- ☐ Male ☐ Female ☐ Transgender man/trans man ☐ Transgender woman/trans woman
- ☐ Genderqueer/gender nonconforming/non-binary; neither exclusively male nor female
- ☐ Gender identity is not listed here (Please specify) _____
- ☐ Don't know ☐ Choose not to answer

16. Which of these describes this person's current sexual orientation? Select up to five options.

- ☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, or questioning
☐ Sexual orientation is not listed (Please specify) _____ ☐ Don't know ☐ Choose not to answer

17. Is this person of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino ☐ No, not Hispanic or Latino ☐ Don't know ☐ Choose not to answer

18. Race (see page 32)

19. Ethnicity (see page 32)

20. Does this person 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. For important SSN information and how to apply for SSN, see instructions for Question 10 under Person 1.

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

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

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

If **No**, what name is on this person's Social Security card? _____

First name, middle name, last name, and suffix

21. If this person gets an Advance Premium Tax Credit (APTC), does this person agree to file a federal tax return for the tax year that the credits are received? ☐ Yes ☐ No

They may not have needed or chosen to file a tax return in the past, but this person will have to file a federal income tax return for any year that they get an APTC. You must check **Yes** to question 21 to be eligible for ConnectorCare or APTCs to help pay for this person's health insurance. **This person does NOT need to file a tax return to apply for or to get MassHealth or HSN, if they qualify.**

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

This person must file a joint federal tax return with a spouse for the year for which this person is applying to get certain programs (ConnectorCare or APTCs) unless this person is a victim of domestic abuse or abandonment or they will file taxes as Head of Household. If this person will file taxes as Head of Household, they should answer **No** to question 21a ("Are you legally married?"). One way this person may qualify as Head of Household is to live apart from their spouse and claim another person as a dependent. See IRS Publication 501 or consult a tax professional for tax filing information. This person will only need to include themselves and any dependents on this application.

a. Is this person legally married? ☐ Yes ☐ No

If **No**, skip to question 21c.

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

b. Does this person plan to file a joint federal tax return with a spouse for the tax year for which this person is applying?
☐ Yes ☐ No

c. Will this person claim any dependents on this person's federal income tax return for the year for which this person is applying? ☐ Yes ☐ No

This person will claim a personal exemption deduction on their 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 dependents' name(s) and birth date(s). _____

d. Will this person be claimed as a dependent on someone else's federal income tax return for the year for which this person is applying? ☐ Yes ☐ No.

If this person is claimed by someone else as a dependent on their federal income tax return, this may affect their ability to receive a premium tax credit. Do not answer **Yes** to this question if this person is 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 is this person 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. Is this person filing taxes separately because they are a victim of domestic abuse or abandonment? ☐ Yes ☐ No

22. Is this person a US citizen or US national? ☐ Yes ☐ No

If **Yes**, are they a naturalized, derived, or acquired citizen (not born in the US)? ☐ Yes ☐ No

Alien number _____ Naturalization or citizenship certificate number _____

23. If this person is a noncitizen, do they 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 Health Safety Net (HSN). Go to Question 24.

a. If **Yes**, does this person have an immigration document? ☐ Yes ☐ No

It may help us to process this application faster if you include a copy of their immigration document with the application.

We will try to verify this person's immigration status through an electronic data match. Please list all the immigration statuses and/or conditions that have applied to this person since they entered the US. 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 types from the list on page 32.

Document ID number _____ Alien number _____

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

b. Did this person use the same name on this application to get their immigration status? ☐ Yes ☐ No

If **No**, what name did this person use? First name, middle name, last name, and suffix _____

c. Did this person arrive in the US after August 22, 1996? ☐ Yes ☐ No

d. Is this person an honorably discharged veteran or active-duty member of the US military, the spouse or child of an honorably discharged veteran, or an active-duty member of the US military? ☐ Yes ☐ No

e. **Optional** Is this person: ☐ 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?

24. Is this person living in Massachusetts, and does this person either intend to reside here, even if they do not have a fixed address, or has this person entered Massachusetts with a job commitment or seeking employment? ☐ Yes ☐ No

If this person is visiting 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.

25. Does this person live with at least one child younger than age 19, and is this person the main person taking care of this child or children? ☐ Yes ☐ No

Names(s) and date(s) of birth of child or children _____

26. Is this person pregnant? ☐ Yes ☐ No

If **Yes**, how many babies are they expecting? _____ What is the expected due date? _____

27. Was this person ever in foster care? ☐ Yes ☐ No

a. If **Yes**, in what state was this person in foster care? _____

b. Was this person getting healthcare through a state Medicaid program? ☐ Yes ☐ No

28. Does this person rent or own their property? ☐ Rent ☐ Own

29. **DISABILITY** Answer this question if this person is under age 65 or age 65 or older and working.

Does this person 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: _____

30. Does this person 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) _____

31. Did this person ever get Supplemental Security Income (SSI)? ☐ Yes ☐ No

If **No**, go to Income Information. If **Yes**, answer questions a and b.

- a. When did this person last get SSI? (mm/yyyy) _____
b. Does this person (check one): ☐ live alone? ☐ live with a spouse? ☐ live in a rest home? ☐ live in someone else's home?

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

32. Does this person have any income? ☐ Yes ☐ No If this person does not have income, skip to question 40.

CURRENT JOB | If this person has more jobs and needs more space, attach another sheet of paper.

33. Employer name and address	Federal Tax ID#
-------------------------------	-----------------

34. 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 _____

35. Average number of hours worked each WEEK _____

36. Is this person 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, attach another sheet of paper.

37. Is this person self-employed? ☐ Yes ☐ No
- a. If **Yes**, what type of work does this person do? _____
- b. On average, how much net income (profits after business expenses are paid) will this person get from this self-employment each month, or, how much will they lose from this self-employment each month? \$_____/month **profit** or \$_____/month **loss**?
- c. How many hours does this person work per week? _____

OTHER INCOME

38. Check all that apply., State the amount and how often this person gets it.

NOTE: You do not need to tell us about child support or Supplemental Security Income (SSI).

- ☐ Social Security benefits \$_____ How often? _____
☐ Retirement or Pension \$_____ How often? _____
☐ Annuities \$_____ How often? _____
☐ Trusts \$_____ How often? _____
☐ Unemployment \$_____ How often? _____
☐ Interest, dividends, and other investment income \$_____ How often? _____
☐ Royalty income \$_____ How often? _____
☐ Alimony received \$_____ How often? _____
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? _____
☐ Military retirement pay \$_____ How often? _____
☐ Other taxable income (include type) \$_____ How often? _____ Type _____

- ☐ Capital gains: On average, how much net income or loss will this person get from this capital gain each month?
\$ _____ /profit or \$ _____ /loss
- ☐ Net farming or fishing income: \$ _____ /profit or \$ _____ /loss How many hours each week? _____
- ☐ 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.

RENTAL INCOME

39. Does this person get rental income? ☐ 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 does this person own? ☐ one-family ☐ two-family ☐ three-family
☐ other (describe): _____
- b. How much **monthly** rental income or loss does this person 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. Does this person pay for heat or utilities for their tenant? ☐ Yes ☐ No

ONE-TIME-ONLY INCOME

40. Has or will this person receive income during this calendar year as a one-time only payment? ☐ Yes ☐ No

An example might be a lump-sum pension payment.

If **Yes**: Type: _____ Amount \$ _____ Month Received _____ Year received _____

41. Will this person receive income during the next calendar year as a one-time only payment? ☐ Yes ☐ No

If **Yes**: Type: _____ Amount \$ _____ Month Received _____ Year received _____

DEDUCTIONS

42. What deductions does this person report on their income tax return?

If this person pays 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. This person's deductions should be what they report on their federal income tax return in the section "Adjusted Gross Income." For each deduction selected, 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: If this person 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

YEARLY INCOME

43. What is this person's total expected income for the current calendar year?

44. What is this person's total expected income for next calendar year, if different?

THANKS! This is all we need to know about this person.

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? ☐ Yes ☐ No

If **No**, skip to Step 4. If **Yes**, complete the rest of this application, including **Supplement B: American Indian or Alaska Native Household Member**.

STEP 4 Previous Medical Bills

Do you or your spouse have bills for medical services you got in the three months before the month we got your application?

☐ Yes ☐ No

If **Yes**, MassHealth may be able to pay for these bills. If **No**, go to **Step 5: Assets**.

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.)

Please list below any individuals requesting payment of previous medical bills. You must give us proof of all income and assets owned during that time period.

Name	Earliest date requested	Any change in circumstances during this time? ☐ Yes ☐ No
Name	Earliest date requested	Any change in circumstances during this time? ☐ Yes ☐ No

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 checking, savings, credit union, NOW, money-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)**.

Send a copy of your passbooks updated within 45 days and/or **a copy** of your current account statements. 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.

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 **No**, go to the next section **(LIFE INSURANCE)**.

Send a copy of the deed(s), current tax bill(s), and proof of amount owed on all property owned.

Address	
Type of property	Current value \$

Address	
Type of property	Current value \$

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

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)**.

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				\$	\$	☐ Yes ☐ No
Savings bonds				\$	\$	☐ Yes ☐ No
Mutual funds				\$	\$	☐ Yes ☐ No
Options				\$	\$	☐ Yes ☐ No
Future contracts				\$	\$	☐ Yes ☐ No
Other				\$	\$	☐ Yes ☐ No

* Enter the account balance on the date of admission to medical institution.

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)

ASSISTED LIVING/OTHER

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 HOMES)**.

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

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, **send 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 date of admission to the medical institution.

(You) Type of vehicle	Year/make/model	Fair-market value \$	Amount owed \$
Mobile home address			
(Your spouse) Type of vehicle	Year/make/model	Fair-market value \$	Amount owed \$
Mobile home address			

PREPAID BURIAL PLANS

9. Do you or your spouse have any prepaid burial contracts or trusts, life insurance set up for funeral and burial expenses, or bank accounts set aside for funeral expenses? ☐ Yes ☐ 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

10. Are you or your spouse the grantor/donor, trustee, or beneficiary of any trusts? ☐ Yes ☐ 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.

STEP 6 Health Insurance Information

MassHealth regulations require members to obtain and maintain available health insurance, including health insurance available through an employer. To determine continued MassHealth eligibility for you and members of your household, we may request additional information from you and your employer about your access to employer sponsored health insurance coverage, and we may share information about you and members of your household with your employer(s) and /or health insurer(s) to confirm this information.

You must cooperate in providing information necessary to maintain eligibility, including evidence of obtaining or maintaining available health insurance, or your MassHealth benefits may be terminated. See the Senior Guide for more information.

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, 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.

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.

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) _____

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

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

STEP 8 Personal-Care-Attendant Services

For people 65 years 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 enclosed Senior Guide.

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**.

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.

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, TDD/TTY: 711. 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.

STEP 9 Additional (Optional) Coverage – For married persons under 65 years old

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

If this section applies to you and you want more information about income standards and other information that may apply, call us to get a Senior Guide at (800) 841-2900, TDD/TTY: 711. 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.)

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.

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 coverage or benefits.

Name: _____

STEP 10 For Masshealth and Health Connector applicants

READ AND SIGN THIS APPLICATION

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

- MassHealth may require eligible persons to enroll in available employer-sponsored health insurance if that insurance meets the criteria for MassHealth payment of premium assistance.
- Employers of eligible persons may be notified and billed in accordance with MassHealth regulations for any services that hospitals or community health centers provide to such persons that are paid for by the Health Safety Net.
- I may have to pay a premium for health coverage for myself and others listed on this application. Failure to pay any premium due may result in the state deducting the amount owed from the tax refunds of responsible persons. If I am a certain American Indian or Alaska Native, I may not have to pay premiums for MassHealth.
- MassHealth has the right to pursue and get money from third parties who may be obligated to pay for health services provided to eligible persons enrolled in MassHealth programs. Such third parties may include other health insurers, spouses, parents obligated to pay for medical support, or individuals obligated to pay under accident settlements. Eligible persons must cooperate with MassHealth in establishing third-party support and obtaining third-party payments for themselves and anyone whose rights they can legally assign. Eligible persons may be exempted from this obligation if they believe and tell MassHealth that cooperation could result in harm to them or anyone whose rights they can legally assign.
- A parent and/or guardian of minor children must agree to cooperate with state efforts to collect medical support from an absent parent unless they believe and tell MassHealth that cooperation will harm the children or the parent or guardian.
- Eligible persons who are injured in an accident, or in some other way, and get money from a third party because of that accident or injury must use that money to repay MassHealth or the Health Safety Net for certain services provided.
- Eligible persons must tell MassHealth or the Health Safety Net, in writing, within 10 calendar days, or as soon as possible, about any insurance claims or lawsuits filed because of an accident or injury.
- The status of this application may be shared with a hospital, community health center, other medical provider, or federal or state agencies when necessary for treatment, payment, operations, or the administration of the programs listed above.

9. To the extent permitted by law, after notice and an opportunity to appeal, MassHealth may place a lien against any real estate owned by eligible MassHealth members or in which the member has a legal interest. If the individual is receiving long-term care in a nursing facility or other medical institution and MassHealth determines that the member is not reasonably expected to return home. If MassHealth puts a lien against such property and the property is later sold, money from the sale of that property may be used to repay MassHealth for medical services provided.
10. To the extent permitted by law, and unless exceptions apply, for any eligible person age 55 or older receiving long-term services and supports (LTSS), or any eligible person regardless of age for whom MassHealth helps pay for long-term care in a nursing home or other medical institution, MassHealth will seek money from the eligible person's estate after death for the total cost of care permitted by law. For more information on estate recovery, visit mass.gov/EstateRecovery.
11. To the extent permitted by law, MassHealth will seek money from a Special Needs Trust belonging to an eligible individual after death for the total cost of care. The total cost of care includes the cost MassHealth paid directly for care (Fee for Service) and the total amount it paid to a health plan (like an Accountable Care Organization or a One Care plan) for care, regardless of what services the member may have received.
12. Eligible persons must tell the health care program(s) in which they enroll about any changes in their or their household's income or employment, household size, health insurance coverage, health insurance premiums, and immigration status, or about changes in any other information on this application and any supplements to it within 10 calendar days of learning of the change. Eligible persons can make changes by calling **(800) 841-2900**, TDD/TTY: 711. A change in information could affect eligibility for such persons or for persons in their household.

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

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

been available to such persons or members of their household.

14. MassHealth, the Massachusetts Health Connector, and the Health Safety Net may get records or data about persons listed on this application from federal and state data sources and programs, such as the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security, the Department of Revenue, and the Registry of Motor Vehicles, as well as private data sources including financial institutions, 1) to prove any information given on this application and any supplements, or other information given once a person becomes a member, 2) to document medical services claimed or provided to such persons, and 3) to support continued eligibility.
15. In connection with the eligibility and enrollment process, MassHealth, the Massachusetts Health Connector, and the Health Safety Net may send notices that contain personal information about persons listed on this application to other persons on this application, or otherwise communicate such information to such persons.
16. Under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by going to hhs.gov/ocr/office/file.
17. I agree to allow the Massachusetts Health Connector to use income data, including information from tax returns to determine my eligibility in future years. Review the Health Connector Privacy Policy for more information about how the Health Connector uses your tax information. The Massachusetts Health Connector will send me a notice and let me make changes to my eligibility application. I understand that if I am eligible for an Advance Premium Tax Credit (APTC) and/or ConnectorCare, these payments will be made directly to my selected insurance carrier(s). Acceptance of APTC and/or ConnectorCare may impact my annual tax liability. I will be given the option to apply all, some, or none of any APTC amount I may be eligible for to my monthly premium.
18. I agree MassHealth or anyone acting on its behalf may contact me including via mail, email, call, or text for any communications about my relationship with MassHealth or my healthcare needs, benefits, eligibility, or coverage using the contact information I provide, now or in the future, or information we obtain from a reliable data source. I also agree that MassHealth may use the same information to contact me to distribute information related to other health and welfare benefits I may be eligible to receive. These calls and texts may be made using automated technology, such as with an automatic telephone dialing system or artificial or pre-recorded voice messages. Standard message and data rates may apply.

19. I have read or have had read to me the information on this application, including any supplements and instruction. I understand that the Senior Guide to Health Care Coverage contains important information about this application.
 20. I have permission from all persons listed on this application (or their parent or other legally authorized representative) to submit this application. I also have permission to act on their behalf to complete this application and any related eligibility process. This may include, for example:
 - providing personal information about them, including health, health coverage, and income information, seeing such information as may be provided by the Massachusetts Health Connector, MassHealth, and the Health Safety Net, and providing consent on their behalf to the use and disclosure of their information as described in this application;
 - making choices about coverage options and how to communicate with the Massachusetts Health Connector, MassHealth, or the Health Safety Net;
 - making changes to the application or related eligibility documents and providing information about any change in their circumstances; and
 - providing consent on their behalf to use government and private sources to verify the information as described in this application.
 21. I understand my rights and responsibilities and the rights and responsibilities of all persons listed on this application as explained in STEP 10.
 22. I have told or will tell anyone listed on this application (or their parent or legally authorized representative, if applicable) about these rights and responsibilities so they understand them.
 23. I understand and agree that MassHealth, the Health Safety Net, and the Massachusetts Health Connector will treat any electronic or faxed signature, or copy of a signature, with the same effect as an original.
 24. I understand that MassHealth
 - is allowed to ask for SSNs under federal and state law;
 - uses SSNs to check income and other information to see who is eligible for help with health coverage costs;
 - uses SSNs to detect fraud, to see if anyone is getting duplicate benefits, or to see if others should be paying for services;
 - matches the SSN of anyone in the household who is applying and anyone who has or who can get health insurance for anyone in the household with the files of agencies and financial institutions.
 25. I understand that if MasHealth pays part of anyone's health insurance premiums, MassHealth will add the SSN or the SSN of that policyholder to the State Comptroller's vendor file.
 26. I understand that the policyholder in my household must have a valid SSN before getting a payment from MassHealth.
 27. The information I have supplied is correct and complete to the best of my knowledge about myself and other persons listed on this application.
 28. I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- If someone does not have an SSN or needs help getting one, call the Social Security Administration at (800) 772-1213, TTY: (800) 325-0778, or go to [socialsecurity.gov](https://www.socialsecurity.gov). For a full explanation on how we use your Social Security number, refer to the Senior Guide to Health Care Coverage.

FOR SUPPLEMENTAL NUTRITIONAL ASSISTANCE PROGRAM (SNAP) APPLICANTS

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) BENEFITS

If you checked the box on page 1, MassHealth will send this application to the Department of Transitional Assistance (DTA). **This will serve as your application for SNAP!** If you are eligible, your SNAP will start from the date DTA receives this MassHealth application. By signing below, you agree that you have read and agree to your SNAP Rights, Responsibilities, and Penalties under the program.

You may be eligible for SNAP benefits within 7 days of when DTA gets this application if:

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

For more information about SNAP in Massachusetts, go to mass.gov/SNAP.

Department of Transitional Assistance (DTA) Notice of Rights, Responsibilities and Penalties

This notice lists rights and responsibilities for the SNAP program. Read these pages and keep them for your records.

Let DTA know if you have any questions.

I swear under penalty of perjury that:

- I have read the information in this form, or someone read it to me.
- My answers in this form are true and complete to the best of my knowledge.
- I will give DTA information that is true and complete to the best of my knowledge during my interview and in the future.

I understand that:

- giving false or misleading information is fraud,
- misrepresenting or withholding facts to get DTA benefits is fraud,
- fraud is considered an Intentional Program Violation (IPV), and
- if DTA thinks I committed fraud, DTA can pursue civil and criminal penalties against me.

I also understand that:

- DTA will verify the information I give with my application. If any information is false, DTA may deny my benefits.
- I may also be subject to criminal prosecution for providing false information.
- If DTA gets information from a reliable source about a change in my household, my benefit amount may change.
- By signing this form, I give DTA permission to verify my eligibility for benefits, including:
 - Get information from other state or federal agencies, local housing authorities, out-of-state welfare departments, financial institutions, and Equifax Workforce Solutions (the Work Number). I also give these agencies permission to share information about my household's eligibility for benefits with DTA.
 - If DTA uses information from Equifax about my household earned income, I have the right to a free copy of my Equifax report if I request it within 60 days of DTA's decision. I have the right to question the information in the report. I may contact Equifax at: Equifax Workforce Solutions, 11432 Lackland Road, St. Louis, MO 63146, 1-800-996-7566 (toll free).
- I have a right to a copy of my application, including the information that DTA uses to decide about my household's eligibility and benefit amount. I can ask DTA for an electronic copy of the completed application.

How will DTA use my information?

By signing below, I give DTA permission to get information from and share information about me and members of my household with:

- Banks, schools, government, employers, landlords, utility companies and other agencies to check if I am eligible for benefits.
- Electric, gas, and telephone companies so I can get utility discounts. The companies cannot share my information or use it for any other purpose.
- The Department of Housing and Community Development to enroll me in the Heat & Eat Program. This program helps people get the most SNAP benefits possible.
- The Department of Early and Secondary Education so my children can get free school meals.
- The Woman, Infants, and Children (WIC) Program so that any children under age 5 or a pregnant woman in my household can get WIC.
- The United States Citizenship and Immigration Services (USCIS), to verify my immigration status. Information from USCIS may affect my household's eligibility and amount of DTA benefits.

Note: Even if you are not eligible for benefits due to immigration

status, DTA will not report you to immigration authorities unless you show DTA a final order of deportation.

- The Department of Revenue (DOR) to verify my eligibility for income-based tax credits, such as Earned Income and Limited Income, and to see if I am eligible for "No Tax Status" or hardship status.
- The Department of Children and Families (DCF) to coordinate services offered jointly by DTA and DCF.

How does DTA use Social Security Numbers (SSNs)?

DTA is allowed to ask for SSNs under The Food and Nutrition Act of 2008 (7 U.S.C. 2011-2036) for SNAP and under M.G.L. c. 18 Section 33 for TAFDC and EAEDC. DTA uses SSNs to:

- Check the identity and eligibility of each household member I apply for through data matching programs.
- Monitor compliance with program rules.
- Collect money if DTA claims I got benefits that I was not eligible for.
- Help law enforcement agencies catch people hiding from the law.

I understand that I do not have to give DTA the SSN of any non-citizen in my household, including myself, who does not want benefits. The income of a non-citizen may count even if the non-citizen does not get benefits.

Right to an Interpreter

I understand that:

- I have a right to a free professional interpreter provided by DTA if I prefer to communicate in a language other than English.
- If I have a DTA hearing, I can ask DTA to give me a free professional interpreter, or if I prefer, I can bring someone to interpret for me. If I need DTA to give me an interpreter for a hearing, I must call the Division of Hearings at least one week before the hearing date.

Right to Register to Vote

I understand that:

- I have the right to register to vote through DTA.
- DTA will help me fill out the voter registration application form if I want help.
- I can fill out the voter registration application form in private.
- Applying to register or declining to register to vote will not affect my DTA benefits.

Employment Opportunities

I agree that DTA may share my name and contact information with employment and training providers, including:

- SNAP Path Work providers or DTA specialists for SNAP clients; and
- Contracted Employment and Training providers or Full Engagement Workers for TAFDC clients.

SNAP clients may voluntarily participate in education and employment training services through the SNAP Path to Work program.

Citizenship Status

I swear that all members of my household applying for DTA benefits are either US citizens, or lawfully residing noncitizens.

Supplemental Nutrition Assistance Program

I understand that:

- DTA manages the SNAP program in Massachusetts.
- When I file an application with DTA (by phone, online, in person, or by mail or fax), DTA has 30 days from the date it got my application to decide if I am eligible.
 - If I am eligible for expedited (emergency) SNAP, DTA has to give me SNAP and make sure I have an Electronic Benefit Transfer (EBT) card within 7 days from the date they got my application.
 - I have a right to speak to a DTA supervisor if:
DTA says I am not eligible for emergency SNAP benefits, and I disagree.
I am eligible for emergency SNAP benefits but do not get my benefits by the 7th day after I applied for SNAP.
I am eligible for emergency SNAP benefits but do not get my EBT card by the 7th day after I applied for SNAP.
- When I get SNAP, I have to meet certain rules. When I am approved for SNAP, DTA will give me a copy of the “Your Right to Know” brochure and the SNAP Program brochure. I will read the brochures or have someone read them to me. If I have any questions or need help reading or understanding this information, I can call DTA at 1-877-382-2363.
- Telling DTA about changes in my household:
 - If I am a SNAP Simplified Reporting household, I do not have to report most changes to DTA until the Interim Report or Recertification is due. The only things I have to report sooner are:
If my household’s income goes over the gross income threshold (listed on my approval notice). I have to report this by the 10th day of the month after the month my income went over the threshold.
If I have to meet the Able-Bodied Adults Without Dependents (ABAWD) Work Rules and my work hours drop below 20 hours per week.
 - If everyone in my household is 60 or older, disabled, or under 18 years old, and no one has earnings from work, the only things I have to report are:
If someone starts working, or
Someone joins or leaves my household.
I have to report these changes by the 10th day of the month after the month of the change.
 - If I get SNAP through Transitional Benefits Alternative (TBA) because my TAFDC stopped, I do not have to report any changes to DTA for the 5 months that I get TBA.
 - If I get SNAP through Bay State CAP, I do not have to report any changes to DTA.

If I and everyone in my household gets cash assistance (TAFDC or EAEDC), I must report certain changes to DTA within 10 days of the change.

I may get more SNAP benefits if I report and give DTA proofs for the following, at any time:

- Child or other dependent care costs, shelter costs, and/or utility costs;
- Child support that I (or someone in my household) is legally required to pay to a non-household member; and
- Medical costs for members of my household, including myself, who are 60 or older or disabled.

Work rules for SNAP clients: If you get SNAP benefits and are between the ages of 16 and 59, you may need to meet general SNAP work rules or the ABAWD work rules unless you are exempt. DTA will tell me and members of my household if we need to meet any Work Rules, what the exemptions are, and what will happen if we do not meet the rules.

If you are under the SNAP Work Rules

- You must register for work at application and when you recertify for SNAP. You register when you sign the SNAP application or recertification form.
- You must give DTA information about your employment status when DTA asks.
- You must report to an employer if referred by DTA.
- You must accept a job offer (unless you have a good reason not to).
- You must not quit a job of more than 30 hours a week without a good reason.
- You must not cut your work hours to less than 30 hours a week without a good reason.

SNAP Rules

- Do not give false information or hide information to get SNAP benefits.
- Do not trade or sell SNAP benefits.
- Do not alter EBT cards to get SNAP benefits you are not eligible for.
- Do not use SNAP benefits to buy ineligible items, such as alcoholic drinks and tobacco.
- Do not use someone else’s SNAP benefits or EBT card unless you are an authorized representative, or the recipient has given you permission to use their card on their behalf.

SNAP Penalty Warnings

I understand that if I or any member of my SNAP household intentionally breaks any of the rules listed above, that person will not be eligible for SNAP for one year after the first violation, two years after the second violation, and forever after the third violation. That person may also be fined up to \$250,000, imprisoned up to 20 years, or both. They may also be subject to prosecution under Federal and State laws.

I also understand the following penalties. If I or a member of my SNAP household:

- Commit a cash program Intentional Program Violation (IPV), they will be ineligible for SNAP for the same period they are ineligible for cash assistance.
- Make a fraudulent statement about their identity or residency to get multiple SNAP benefits at the same time, they will be ineligible for SNAP for ten years.

- Trade (buy or sell) SNAP benefits for a controlled substance/ illegal drug(s), they will be ineligible for SNAP for two years for the first finding, and forever for the second finding.
- Trade (buy or sell) SNAP benefits for firearms, ammunition or explosives, they will be ineligible for SNAP forever.
- Make an offer to sell SNAP benefits or an EBT card online or in person, the State may pursue an IPV against them.
- Pay for food purchased on credit, they will be ineligible for SNAP.
- Buy products with SNAP benefits with the intent to discard the contents and return containers for cash they will be ineligible for SNAP.
- Flee to avoid prosecution, custody, or confinement after conviction for a felony, they will be ineligible for SNAP.
- Violate probation or parole, where law enforcement is actively seeking to arrest them, they will be ineligible for SNAP.

Anyone who became a convicted felon after February 7, 2014, is ineligible for SNAP benefits if they are a fleeing felon or are violating probation or parole - in accordance with 7 CFR §273.11(n) - and were convicted as an adult of:

1. Aggravated sexual abuse under section 2241 of title 18, U.S.C.;
2. Murder under section 1111 of title 18, U.S.C.;
3. Any offense under chapter 110 of title 18, U.S.C.;
4. A Federal or State offense involving sexual assault, as defined in section 40002(a) of the 1994 VAWA (42 U.S.C. 13925a); or
5. An offense under State law determined by the Attorney General to be substantially similar to an offense described in this list.

Nondiscrimination Statement

In accordance with Federal civil rights law and US Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g. Braille, large print, audiotope, American Sign Language), should contact the Agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete Form AD-3027, the USDA Program Discrimination Complaint Form, which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted by:

1. mail:
Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314, or
2. fax:
(833) 256-1665 or (202) 690-7442, or
3. email:
FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

This institution is an equal opportunity provider.

Sign this application — Required.

By signing this application below, 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 above rights and responsibilities of the MassHealth and the Health Connector programs.

If I have indicated that I am applying for the Supplemental Nutritional Assistance Program (SNAP) on page 1 of this application, I certify that I understand and agree to the rights, rules, and penalties of the SNAP program, as outlined above. 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 (DTA) for the purpose of applying for SNAP benefits.

Important: For MassHealth and Health Connector 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.

Signature of Person 1 or authorized representative or responsible party	Print name
	Date

If you are younger than 18, 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			

Send us your completed application.

Print

Clear



Mail or fax your filled-out, signed application to
MassHealth Enrollment Center
PO Box 290794
Charlestown, MA 02129-0214
Fax: (617) 887-8799



Visit a MassHealth Enrollment Center (MEC).
To apply in person or to schedule an appointment
with a MassHealth representative, go to
www.mass.gov/masshealth/appointment.

Voter Registration

The form to register to vote is included with this application or can be found at sec.state.ma.us. More information on how to register to vote can also be found at sec.state.ma.us. If you have any questions about the voter registration process, or if you need help filling out the form, visit a local MassHealth Enrollment Center or call the MassHealth Customer Service Center at **(800) 841-2900**, TDD/TTY: 711.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, with your right to privacy in deciding to register or in applying to register to vote, or with your right to choose your own political party or other political preference, you may file a complaint with:

Secretary of the Commonwealth, Elections Division
One Ashburton Place
Room 1705
Boston, MA 02108
Tel: (617) 727-2828 or (800) 462-8683.

If you or anyone else in your application are not registered to vote where you live now, would you like to apply to register to vote today? ☐ Yes ☐ No

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

SUPPLEMENT

Long-Term Care / Home- and Community-Based Service Waiver

- 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-Based Services Waiver**?
☐ 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, use a separate sheet of paper (include your name and Social Security number), and attach it to this supplement.

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 income. Fill out the following information about your spouse’s current living expenses. **If you do not have a spouse**, go to the next section (**Resource Transfers**).

Send proof of your spouse’s current living expenses.

Spouse's last name, first name, middle initial		Social Security number
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
Relationship	Date of birth (mm/dd/yyyy)	Monthly income before deductions \$
Name		Social Security number
Relationship	Date of birth (mm/dd/yyyy)	Monthly income before deductions \$

Resource Transfers (resources include both income and assets)

6. In the past 60 months:

- a. Has any property that was available or belonged to you or your spouse been transferred into or out of a trust? ☐ Yes ☐ No
- b. Did you, your spouse, or someone on your behalf transfer income or the right to income? ☐ Yes ☐ No
- c. Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real estate? ☐ Yes ☐ No
- d. Did you, your spouse, or someone on your behalf change the deed or the ownership of any real estate, including creating a life estate, even if the life estate was purchased in another person's residence? ☐ Yes ☐ No
- e. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate? ☐ Yes ☐ No
- f. Did you, your spouse, or someone on your behalf add another name to the deed of any property you own? ☐ Yes ☐ No
- g. Did you, your spouse, or someone on your behalf receive or give anyone a mortgage, loan, or promissory note on any property or other asset? ☐ Yes ☐ No
- h. Did you, your spouse, or someone on your behalf purchase or in any way change an annuity? ☐ Yes ☐ No

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

Description of asset/income		Date of transfer (mm/dd/yyyy)
Transferred to whom	Relationship to you or your spouse	Amount of transfer \$
Description of asset/income		Date of transfer (mm/dd/yyyy)
Transferred to whom	Relationship to you or your spouse	Amount of transfer \$
Description of asset/income		Date of transfer (mm/dd/yyyy)
Transferred to whom	Relationship to you or your spouse	Amount of transfer \$

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**, give us the name and address of the facility, the amount of the deposit, answer the following questions, and **send us a copy** of the contract you signed with the facility and any documents about this deposit.

Name of facility _____

Address of facility _____ Amount \$ _____

- a. Does the facility still have the deposit? ☐ Yes ☐ No
- b. Did the facility return the deposit? ☐ Yes ☐ No

If **Yes**, give us the name and address of the person who got the deposit from the facility.

Name of person _____

Address _____

Real Estate

The answers to the following questions will be used to decide if: (1) your real estate will be counted as an asset; or (2) a lien will 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 ineligible for payment of long-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 only.

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 old? ☐ 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.)

16. Do you or your spouse own or have a legal interest in **other** real estate not listed in Question 8 above? ☐ Yes ☐ No

If **Yes**, please describe the property and list its address below.

If you need more space, use a separate sheet of paper.

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 section (**Tax Returns**).

Send a copy of the policy.

Company name/Policy number

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

Policyholder name	Effective date (mm/dd/yyyy)	Premium amount \$
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Tax Returns

18. Did you or your spouse file US 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.

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 Authorized Representative Designation Form (ARD) to us for us to process this application. It is important to complete this form as this is the only way we may speak to you about this application.

Signature of applicant/member or authorized representative	Print name	Date
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SUPPLEMENT **B** American Indian or Alaska Native Household Member (AI/AN)

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
 - Money from selling things that have cultural significance.\$ _____ How often? _____

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
 - Money from selling things that have cultural significance.\$ _____ How often? _____

SUPPLEMENT Personal-Care Attendant

Please print clearly. Fill out all sections. If you need more space to finish any section on this form, use a separate sheet of paper (include name and 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

Applicant/Member information

Last name	First name	MI	Telephone number
Social Security number	Date of birth (mm/dd/yyyy)		Gender ☐ M ☐ F
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.

Daily living activity	Do you need hands-on help?	How many times a day do you need hands-on help?	How many days a week do you need hands-on help?
Mobility (moving from bed to chair, walking, or using approved medical equipment)	☐ Yes ☐ No		
Taking medications	☐ Yes ☐ No		
Bathing (tub, bed bath, shower, or washing chair) or general grooming (like brushing teeth or combing hair)	☐ Yes ☐ No		
Dressing/Undressing	☐ Yes ☐ No		
Range-of-motion exercises (exercising joints by moving them)	☐ Yes ☐ No		
Eating	☐ Yes ☐ No		
Toileting (like getting on or off toilet, wiping yourself, getting clothes off and on, or changing diapers)	☐ Yes ☐ No		

Caregiver information

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

SUPPLEMENT **D** Health Coverage from Jobs

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.

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 health coverage at this job?		
12. Phone number (if different from above)	13. Email address	

TELL US ABOUT HEALTH PLANS OFFERED BY THIS EMPLOYER.

14. a. What is the name of the lowest cost individual 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 would this employee pay in premiums for this plan? \$ _____	
d. How often would the employee pay this amount? _____	
15. a. What is the name of the lowest cost health plan to cover the other household members who qualify through the employer?	
b. Does this health plan offered by the employer meet the minimum value standard for coverage? ☐ Yes ☐ No	
c. How much would this employee pay in premiums for this plan? \$ _____	
d. How often would this employee pay this amount? _____	
16. What change will the employer make for the new plan year (if known)?	
a. Employer will not offer health coverage. Coverage end date (mm/dd/yyyy) _____	
b. The person plans to drop employer's health coverage. Coverage end date (mm/dd/yyyy) _____	
c. Employer will start offering health coverage to employees or change the premium for the lowest-cost individual or family health plans that are available and meet the minimum value standard.* (Premium should reflect the discount for wellness programs.)	
How much would this employee pay in premiums for this plan? \$ _____ How often? _____	
Date of change (mm/dd/yyyy) _____	

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is at least 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

Immigration Statuses and Document Types

Questions 13a and 23a on the application ask noncitizens about their immigration status and about the type or types of immigration documents they have to support their immigration status. Refer to the following lists to fill out Questions 13a and 23a. If you need further help, details can be found online at www.MAhealthconnector.org/immigration-document-types.

Eligible Immigration Statuses

In the “Immigration Status” section of Questions 13a and 23a, write in any status that applies to you or members of your household. You may write in more than one status.

- Amerasian
- Granted asylum
- Cuban Haitian entrant
- Deportation withheld
- Native American born in Canada or non-US territories
- Refugee
- Victim of severe trafficking or their spouse, child, sibling, or parent
- Iraqi special immigrant
- Afghan special immigrant or certain Afghan evacuees
- Conditional entrant granted before 1980
- Veteran or active-duty member of military or their spouse or dependent
- COFA Migrant
- Lawful permanent resident
- Granted parole for at least one year
- Battered spouse or child (or their parent or child)
- Nonimmigrant status (visa)
- Granted parole for less than one year
- Granted temporary resident status
- Granted Temporary Protected Status (TPS) or applicant for TPS with employment authorization
- Granted employment authorization under 8 CFR 274a(12)(c)
- Family unity beneficiaries
- Deferred enforced departure
- Deferred Action Status except for Deferred Action for Childhood Arrivals Process (DACA)
- Granted an administrative stay of removal under 8 CFR 241
- Approved visa petition with a pending application for adjustment of status
- Applicant for asylum or for withholding of removal with employment authorization
- Applicant (for at least 180 days) under 14 years old for asylum or for withholding of removal
- Granted withholding of removal under the Convention Against Torture
- Applicant for Special Immigrant Juvenile (SIJ) status
- Applicant or granted status under Deferred Action for Childhood Arrivals (DACA)
- I have a document but do not have any status listed above (Person Residing Under Color of Law, PRUCOL)
- Reentry Permit (I-327)
- Permanent Resident Card (“green card,” I-551)
- Refugee Travel Document (I-571)
- Employment Authorization Card (I-766)
- Machine Readable Immigrant Visa (with temporary I-551 language)
- Temporary I-551 stamp (on passport or I-94, I-94A)
- Arrival/Departure Record (I-94, I-94A)
- Arrival/Departure Record in unexpired foreign passport (I-94)
- Foreign passport
- Certificate of Eligibility for Nonimmigrant Student Status (I-20)
- Certificate of Eligibility for Exchange Visitor Status (DS2019)
- Notice of Action (I-797)
- Document indicating withholding of removal (or withholding of deportation)
- Administrative order staying removal issued by the Department of Homeland Security
- Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Resident of American Samoa Card
- USCIS Acknowledgement of Receipt (I-797C)
- US Visas (such as B1/B2, R-Visa, Border Crossing Card, J/F/M)

Immigration Document Types

In the “Immigration Document Type” section of Question 10a, write in any document type you or members of your household have. You may list more than one immigration document type.

RACE (OPTIONAL)

Choose the option(s) that best describe you. Write in all that apply. Please specify in Question 8 for Person 1 and Question 18 for Person 2.

Asian	Native Hawaiian or Other	White	Don’t know
Black or African American	Pacific Islander	Race is not listed here	Choose not to answer

ETHNICITY

African	Chinese	Honduran	Salvadoran
African American	Colombian	Japanese	South American
American	Cuban	Korean	Vietnamese
Asian Indian	Dominican	Laotian/Lao	Ethnicity is not listed
Brazilian	Eastern European	Mexican	(Please specify)
Cambodian	European	Middle Eastern or North African	Don’t know
Cape Verdean	Filipino	Portuguese	Choose not to answer
Caribbean Islander	Guatemalan	Puerto Rican	
Central American	Haitian	Russian	

Authorized Representative Designation Form



You can submit this form if you would like to designate an authorized representative to act on your behalf. If an authorized representative signed your application for you, or if you are an authorized representative applying on behalf of someone else, you **MUST** submit this form for the application to be processed.

You do not need to fill out this form if you live in an institution and want copies of eligibility notices sent to you and to your spouse who still lives at home. We will do that automatically.

Note: An authorized representative has the authority to act on an applicant's or member's behalf in all matters with MassHealth and the Health Connector, and will receive personal information about the applicant or member until we receive a cancellation notice terminating their authority, or upon the death of the applicant or member. Their authority will not automatically terminate once we process your application.

You can choose someone to help you.

You may choose an authorized representative to help you get health care coverage through programs offered by MassHealth and the Health Connector. You can do this by filling out this form (the Authorized Representative Designation Form). You or a representative can sign for yourself and for any of your dependent children under the age of 18 for whom you are the custodial parent. **You are not required to have a representative in order to apply for or receive benefits.**

Who can help me?

1. An authorized representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose an authorized representative if you want one. Neither MassHealth nor the Health Connector will choose an authorized representative for you. You must designate in writing (fill out Section I, Part A) the person or organization who you want to be your authorized representative. Your authorized representative must also fill out Section I, Part B. We sometimes refer to this person or organization as a "Section I authorized representative."
2. If you cannot designate an authorized representative in writing and you do not have an existing authorized representative or other person who is authorized by law to act on your behalf, a person (not an organization) who certifies that they will act responsibly on your behalf can be your authorized representative if that person fills out Section II of this form. We sometimes refer to this person as a "Section II authorized representative."
3. An authorized representative can also be someone who has been appointed by law to act on your behalf, or on behalf of the estate of an applicant or member who has died. This person must fill out Section III and either you or this person must submit to us, together with this form, a copy of the applicable legal document stating that this person has authority to represent you, or the estate of a deceased applicant or member. We sometimes refer to this person as a "Section III authorized representative."
4. A **Section III** authorized representative may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the personal representative of the estate.

What can an authorized representative do?

A **Section I** or **II** authorized representative may

- fill out your application or renewal forms;
- fill out other MassHealth or Health Connector eligibility or enrollment forms;
- give proof of information reported on these forms;
- report changes in income, address, or other circumstances;
- get copies of all of your MassHealth and Health Connector eligibility and enrollment notices; and
- act on your behalf in all other matters with MassHealth and the Health Connector.

What a **Section III** authorized representative is authorized to do for you (or for the estate of a deceased applicant or member) will depend on the wording of the legal appointment.

Please note: Eligibility notices may include information about other members of an applicant's or member's household. If there are multiple people in your household we may not be able to send copies of some of your notices to your authorized representative unless each household member has also designated the same authorized representative by completing a separate Authorized Representative Designation Form.

SECTION 1 Authorized Representative Designation (if applicant or member is able to sign)

Part A—to be filled out by applicant or member. Please print, except for signature.

Applicant's/Member's Name	Applicant's/Member's date of birth (mm/dd/yyyy)
MassHealth ID number _____ OR last four digits of the Applicant's/Member's SSN _____	
Applicant's/Member's email address	
I certify that I have chosen the following person or organization to be the authorized representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form).	
Applicant's/Member's signature	Date (mm/dd/yyyy)
Authorized representative's name	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	

Part B—to be filled out by authorized representative. Please print, except for signature.

B1. COMPLETE IF AUTHORIZED REPRESENTATIVE IS A PERSON.

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to me by MassHealth or the Health Connector.

If I am also a provider, staff member, or volunteer affiliated with an organization, and am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f).

Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's printed name	Authorized representative's email address

B2. COMPLETE IF AUTHORIZED REPRESENTATIVE IS AN ORGANIZATION.

I certify, on behalf of the organization set forth below, that such organization will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to the organization by MassHealth or the Health Connector.

I, the provider, staff member, or volunteer of the organization set forth below, completing this form, certify on behalf of myself and on behalf of the organization I represent, that any providers, staff members, or volunteers acting on behalf of the organization in connection with this authorized representative designation will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information, and conflicts of interest, including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f).

Signature of provider, staff member, or volunteer completing form	Date (mm/dd/yyyy)
Printed name of provider, staff member, or volunteer completing form	
Email of provider, staff member, or volunteer completing form	Authorized representative organization name

SECTION 2 Authorized Representative Designation (if applicant or member cannot provide written designation)

To be filled out by authorized representative. Please print, except for signature. Please provide a separate form for each applicant or member.

AN ORGANIZATION IS NOT ELIGIBLE TO BE AN AUTHORIZED REPRESENTATIVE UNDER THIS SECTION.

I certify that the applicant or member set forth below cannot provide written designation and to the best of my knowledge does not otherwise have an individual who can act on his or her behalf such as an existing authorized representative, guardian, conservator, personal representative of the estate, holder of power of attorney, or an invoked health-care proxy. In addition, I certify that I am sufficiently aware of this applicant's or member's circumstances to assume responsibility for the accuracy of the statements made on his or her behalf during the eligibility process and in other communications with MassHealth or the Health Connector, that I understand my rights and responsibilities as this person's authorized representative (as explained earlier in this form). If this person can understand, I have told the person that MassHealth and the Health Connector will send me a copy of all MassHealth and Health Connector eligibility and enrollment notices and this person agrees to this, and I have told this person that they may remove or replace me as their authorized representative at any time by the methods described earlier in this form.

I further certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth below that is provided to me by MassHealth or the Health Connector.

If I am also a provider, staff member, or volunteer affiliated with an organization, and I am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I further certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 42 CFR part 431 subpart F, 42 CFR §477.10, and 45 CFR §155.260(f).

Applicant's/Member's Name	Applicant's/Member's date of birth (mm/dd/yyyy)
MassHealth ID number _____ OR last four digits of the Applicant's/Member's SSN _____	
Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	Authorized representative's email address

If the Section II authorized representative is affiliated with an organization, and is acting in such capacity, an individual authorized to act on behalf of the organization, such as an officer, must sign below to indicate the organization's acknowledgment of and agreement with the representations and warranties made above.

Officer's Name	Officer's Title
Officer's Signature	Date (mm/dd/yyyy)

SECTION 3 Authorized Representative Designation (if appointed by law)

To be filled out by an authorized representative appointed by law (with authority to act on behalf of the applicant or member in making decisions related to health care including, but not limited to, a guardian, conservator, personal representative of the estate of an applicant or member, holder of power of attorney, or an invoked health care proxy.) Please print, except for signature.

Please submit a copy of the applicable legal document with this form.

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member as set forth below, that is provided to me by MassHealth or the Health Connector.

Applicant's/Member's Name	Applicant's/Member's date of birth (mm/dd/yyyy)
MassHealth ID number _____ OR last four digits of the Applicant's/Member's SSN _____	
Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	Authorized representative's email address

How does an authorized representative designation end?

If you decide that you no longer want a **Section I** or **Section II** authorized representative, you must notify us at the time you want the designation to end by mail, fax, or phone. See our contact information below. If you mail or fax this notice to us, the notice must include your name, address, and date of birth, the name of your authorized representative, a statement that the designation has ended and your signature or, if you cannot provide written notice, the signature of someone acting on your behalf (in the case of a **Section II** authorized representative only).

In addition, if your authorized representative notifies us that such person or organization is no longer acting on your behalf, we will no longer recognize the person or organization as your authorized representative.

The authority of a **Section I** or **Section II** authorized representative will end upon the death of the applicant or member.

A **Section III** authorized representative's designation ends when his or her legal appointment ends. The authorized representative must notify us as instructed above.

In addition, an authorized representative's designation for a minor child ends on the child's 18th birthday.

How do I submit this form?

If you are applying for health benefits, send your filled-out Authorized Representative Designation Form to us with your application. If you are already getting benefits, you must submit the form to us at the time you want to designate an authorized representative, or you want the declared designation to end, by

- Mailing your form to
Health Insurance Processing Center
PO Box 4405
Taunton, MA 02780;
- Faxing your form to **(857) 323-8300**; or
- Calling us at **(800) 841-2900**, TDD/TTY: **711**.

[Print](#)[Clear](#)

Request for Copy of Tax Return

- **Do not sign this form unless all applicable lines have been completed.**
► **Request may be rejected if the form is incomplete or illegible.**
► **For more information about Form 4506, visit www.irs.gov/form4506.**

OMB No. 1545-0429

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use [Get Transcript](#) to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return
3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions).	
4 Previous address shown on the last return filed if different from line 3 (see instructions).	
5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.	

Caution: If the tax return is being sent to the third party, ensure that lines 5 through 7 are completed before signing. (see instructions).

6 Tax return requested. Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ► _____	
Note: If the copies must be certified for court or administrative proceedings, check here ☐	
7 Year or period requested. Enter the ending date of the tax year or period using the mm/dd/yyyy format (see instructions). ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____	
8 Fee. There is a \$30 fee for each return requested. Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN, ITIN, or EIN and "Form 4506 request" on your check or money order	
a Cost for each return	\$ _____
b Number of returns requested on line 7	_____
c Total cost. Multiply line 8a by line 8b	\$ _____
9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here ☐	

Caution: Do not sign this form unless all applicable lines have been complete

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506. See instructions**

Phone number of taxpayer on line 1a or 2a

Sign Here	► Signature (see instructions)	Date
	► Print/Type name	Title (if line 1a above is a corporation, partnership, estate, or trust)
	► Spouse's signature	Date
	► Print/Type name	

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506 and its instructions, go to www.irs.gov/form4506.

General Instructions

Caution: Do not sign this form unless all applicable lines, *including lines 5 through 7*, have been completed.

Designated Recipient Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information received pursuant to the taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Internal Revenue Code, Section 6103(c), limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

Purpose of form. Use Form 4506 to request a copy of your tax return. You can also designate (on line 5) a third party to receive the tax return.

How long will it take? It may take up to 75 calendar days for us to process your request.

Where to file. Attach payment and mail Form 4506 to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual returns (Form 1040 series) and one for all other returns.

If you are requesting a return for more than one year or period and the chart below shows two different addresses, send your request based on the address of your most recent return.

Chart for individual returns (Form 1040 series)

If you filed an individual return and lived in:

Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address

Mail to:

Internal Revenue Service
RAIVS Team
Stop 6716 AUSC
Austin, TX 73301

Delaware, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, Vermont, Virginia, Wisconsin

Internal Revenue Service
RAIVS Team
Stop 6705 S-2
Kansas City, MO 64999

Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maryland, Michigan, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, West Virginia, Wyoming

Internal Revenue Service
RAIVS Team
P.O. Box 9941
Mail Stop 6734
Ogden, UT 84409

Chart for all other returns

For returns not in Form 1040 series, if the address on the return was in:

Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin

Mail to:

Internal Revenue Service
RAIVS Team
Stop 6705 S-2
Kansas City, MO 64999

Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address

Internal Revenue Service
RAIVS Team
P.O. Box 9941
Mail Stop 6734
Ogden, UT 84409

Specific Instructions

Line 1b. Enter the social security number (SSN) or individual taxpayer identification number (ITIN) for the individual listed on line 1a, or enter the employer identification number (EIN) for the business listed on line 1a. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, please include it on this line 3.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B, Change of Address or Responsible Party — Business, with Form 4506.

Line 7. Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 return, or 03/31/2017 for a first quarter Form 941 return.

Signature and date. Form 4506 must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506 within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, *including lines 5 through 7*, are completed before signing.



You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.

Individuals. Copies of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506 exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506 can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506 but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506 can be signed by any person who was a member of the partnership during any part of the tax period requested on line 7.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506 for a taxpayer only if this authority has been specifically delegated to the representative on Form 2848, line 5a. Form 2848 showing the delegation must be attached to Form 4506.

Privacy Act and Paperwork Reduction Act

Notice. We ask for the information on this form to establish your right to gain access to the requested return(s) under the Internal Revenue Code. We need this information to properly identify the return(s) and respond to your request. If you request a copy of a tax return, sections 6103 and 6109 require you to provide this information, including your SSN or EIN, to process your request. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506 will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form**, 10 min.; **Preparing the form**, 16 min.; and **Copying, assembling, and sending the form to the IRS**, 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506 simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224.

Do not send the form to this address. Instead, see *Where to file* on this page.

Massachusetts Official Mail-In Voter Registration Form

How to use this form

1. Confirm your citizenship.
2. Print your name: last name, first name, middle name or initial.
3. Print your former name, if applicable.
4. Print the address where you live now: number and street name or rural route number and box number (do not provide a post office box number), apartment number, city or town and full zip code. Use the map[†] at right if you cannot otherwise identify your address.
5. Print the address where you receive all your mail, if it is different from the address entered on #4.
6. Print your date of birth: month, day and year. If you are 16 or 17 years old, you will be pre-registered until you are old enough to vote. You will be notified by mail when you become eligible to vote.
7. Federal law requires that you provide your driver's license number to register to vote. If you do not have a current and valid Massachusetts driver's license, you must provide the last four digits of your social security number. If you have neither, you must write "none" in the box.
8. It is optional to provide your telephone number. If you include your telephone number and do not check "unlisted" it will be a public record.
9. Check a party, 'no party' or print a political designation (not a party).
10. Print the address where you were last registered to vote.
11. If a person is helping you because you are physically unable to sign this form, that assisting person must print their name and address and has the option to print their telephone number.
12. Read the oath.
13. Print today's date.
14. Sign your name.

This form may be mailed or hand-delivered to your city or town hall. If mailed, fold the form, tape it closed, place a first class stamp on it, print your city or town name and zip code for that city or town hall and drop into any mailbox.



William Francis Galvin
Secretary of the Commonwealth

You can use this form to:

- register or pre-register to vote in Massachusetts; and/or
- update your name, address, and political party.

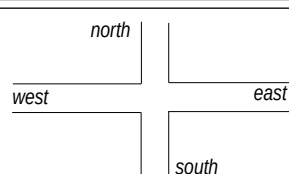
To register or pre-register to vote in Massachusetts you must:

- **BE A U.S. CITIZEN;** and
- be a Massachusetts resident; and
- be at least 16 years old.

Penalty for Illegal Registration: Fine of not more than \$10,000 or imprisonment for not more than five years or both.
-Massachusetts General Laws, chapter 56 section 8.

Identification To Be Provided

Section 7 requires you to include your driver's license number or the last 4 digits of your social security number on this application. This information will be verified through the Registry of Motor Vehicles and the Commissioner of Social Security. If the information cannot be verified or you do not provide this information, you must provide identification either with this application or at your polling location when you go to vote. Sufficient identification includes a copy of a current and valid photo identification, current utility bill, bank statement, government check, paycheck or other government document showing your name and address.



[†]Using landmarks, draw the location of the place where you live if you cannot describe that location as a number and street or as a rural route and box number.

Print all information in black ink. Follow above instructions for proper delivery.

1	Check one: Are you a Citizen of the United States of America? ☐ Yes ☐ No NOTE: If you checked "no," do not complete this form.		
2	Full name:	last name	first name middle name or initial Jr. Sr. II III IV (circle one if appropriate)
3	Former name:	last name	first name middle name or initial Jr. Sr. II III IV (circle one if appropriate)
4	Address where you live now (street number / street name / rural route number & box number / apartment number / city or town / zip code):		
5	Address where you receive all your mail (if different from #4):		
6	Date of birth: month day year	7 Identification #: license # or last 4 digits of SSN	8 Telephone (optional): ☐ Check if unlisted
9	Party enrollment or designation (check one): ☐ Democratic ☐ Republican ☐ Libertarian ☐ No Party (unenrolled) ☐ Political Designation (not a political party):		
10	Address at which you were last registered to vote (street number / street name / rural route number & box number / apartment number / city or town / zip code):		
11	If the applicant is unable to sign this form, give the name, address and telephone number (optional) of the person helping the applicant: name address telephone number (optional)		
12	I hereby swear (affirm) that I am the person named above, that the above information is true, that I AM A CITIZEN OF THE UNITED STATES, that I am at least 16 years old and I understand that I must be 18 years old to be eligible to vote, that I am not a person under a guardianship which prohibits my registering to vote, that I am not temporarily or permanently disqualified by law from voting because of corrupt practices in respect to elections, that I am not currently incarcerated for a felony conviction, and that I consider this residence to be my home. Signed under the penalty of perjury.		
13	Today's date: month day year	14 Signed: Sign your name here.	Agency Designation: BBA

Check to make sure that you have completed all the information on the voter registration affidavit on the opposite side!

This form must be received by the local Board of Registrars or Election Commission or postmarked on or before the deadline for voter registration (listed below) for that election, primary, preliminary or town meeting.

DEADLINES FOR VOTER REGISTRATION

To participate in...

You must register...

state primaries

state elections

city and town preliminaries

city and town elections

regularly scheduled town meetings

special town meetings

at least 10 days before

If you do not hear from your local election officials in 2 or 3 weeks, please call them!

Fold along dotted line.

ZIP CODE FOR CITY OR TOWN HALL

YOUR CITY OR TOWN

MA

City or Town Hall

Board of Registrars or Election Commission



Stamp Here

First Class

Place

city or town zip code

MA

number and street

name

Return Address