MassHealth
Adult Disability Supplement

Commonwealth of Massachusetts | Executive Office of Health and Human Services

Instructions for Completing the Supplement

You have indicated on your MassHealth application that you have a disability. Disability standards require that the disability has lasted or is expected to last at least 12 months. UMass Disability Evaluation Services (DES) will review your disability application for MassHealth. It is very important that you complete this Disability Supplement.

To get MassHealth based on your disability, you need to tell us about

- your medical and mental health providers. These may include doctors, psychologists, therapists, social workers, physical therapists, chiropractors, hospitals, health centers, and clinics from whom you receive or have received treatment; and
- yourself: your work history for the past 15 years, your educational background, and your daily activities.

Completing the Disability Supplement will give us this information and will help us make a quick decision.

Please read the following instructions before beginning.

- Print, or write clearly and complete the supplement to the best of your ability.
- Sign and date an Authorization to Release Protected Health Information Form for each medical and mental health provider you list on the supplement.
- After you have filled out the supplement, submit it to
  Disability Evaluation Services / UMASS Medical DES
  P.O. Box 2796
  Worcester, MA 01613-2796

DES will ask for your medical and treatment records from the providers you have listed. If you have any of your medical records, please send a copy with this form. If more information or tests are needed, a member of DES will get in touch with you. Your eligibility will be determined more quickly if all items on the supplement are filled in.

This is not an application for medical benefits. If you have not already completed a MassHealth application, you must fill one out in addition to this form. If you have any questions about how to apply, please call (800) 841-2900 (TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled).

If you need help with this form, you can call the UMass Disability Evaluation Services (DES) Help Line at (888) 497-9890.
Fill in every section of this form. If you do not fill in every section, we may not be able to decide if you are disabled.

Information about you ☐ Male ☐ Female

Last name First name Middle initial	Social security number

Street address	Apt. #

City	State	Zip code	Date of birth (mm/dd/yyyy)
		–	

Home phone	Cell phone	Work/other phone

We may need to schedule a doctor's appointment for you. What are the best times for you to go to an appointment?

Please check all the times that are good for you.

☐ Any time is ok	☐ Monday a.m.	☐ Tuesday a.m.	☐ Wednesday a.m.	☐ Thursday a.m.	☐ Friday a.m.
	☐ Monday p.m.	☐ Tuesday p.m.	☐ Wednesday p.m.	☐ Thursday p.m.	☐ Friday p.m.

Did you apply for Social Security or SSI/SSDI benefits? ☐ yes ☐ no

If **yes**, did you see a doctor for an exam?

Doctor's name _____ Date of exam ____/____/_____

Please go to the next page. ►

PART 1 Your health problems

List and describe all your medical and mental health problems. If you are getting treatment for the problem, please tell us what kind of treatment.

List your medical and/or mental health problems.	Describe the symptoms or pain related to each health problem.	Date when problem started.	Medications/ treatment
Depression	*Very tired all the time. Hard to get out of bed in the morning. I cry a lot during the day. I can't control when I cry.*	*April 2010*	*None*
Back pain	*Pain starts in my lower back and goes down my leg*	*June 2007*	*Skelexin*

Did any of your health problems start because of an accident or injury? ☐ yes ☐ no

If **yes**, please explain.

PART 2 Information about all your medical and mental health providers

Did you get any health care in the past year? ☐ yes ☐ no

If **yes**, please list every medical and mental health provider that treated you for any of your health problems since they started. A medical or mental health provider may include a doctor, psychologist, therapist, social worker, physical therapist, chiropractor, hospital, health center, and clinic from which you receive treatment. You can write on a separate piece of paper if you run out of space.

If you are receiving treatment from only one facility, list only that facility.

Name of medical and mental health providers	Reason for visit	Was this visit in the past year?
		☐ yes ☐ no
		☐ yes ☐ no
		☐ yes ☐ no
		☐ yes ☐ no

Please fill out an **Authorization to Release Protected Health Information Form** for each medical and mental health provider on this list. Be sure to sign and date each form. These release forms are at the end of this packet. If you need more copies of the Authorization to Release Protected Health Information Form, call MassHealth Customer Service at (800) 841-2900 (TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled) or download the form at www.mass.gov/service-details/masshealth-member-forms.

PART 3 Where you live

Where do you live? (Check one.)

☐ House or apartment ☐ Group home ☐ State facility ☐ Nursing home ☐ Rehabilitation hospital ☐ Homeless

☐ Other (describe) _____

Please go to the next page. ▶

PART 4 What you can do

Are you ☐ right handed? ☐ left handed?

Do your medical or mental health problems make it hard for you to do any of the following things?

	If yes, check here	If yes, please explain below.
Dress and bathe	✓	*My shoulder pain makes it hard for me to lift my arm over my head. This makes it hard to put on shirts or wash my hair.*
Do regular housework	✓	*When I am depressed, I don't care if my house is clean.*
Sit		
Stand		
Walk		
Bend		
Reach		
Lift		
Remember		
See		
Hear		
Use your hands		
Dress and bathe		
Do regular housework		
Listen to music		
Watch TV		
Use a computer		
Read		
Talk on the phone		
Go outside		
Go for a walk		
Go shopping		
Go to the doctor		
Visit friends and family		
Go to school		
Handle money/use an ATM		
Drive a car		
Take a bus, train, or taxi		
Play sports		
Other (describe)		

PART 5 Your language

Do you speak English? ☐ yes ☐ no ☐ limited

Do you understand English? ☐ yes ☐ no ☐ limited

Do you read English? ☐ yes ☐ no ☐ limited

Do you write English? ☐ yes ☐ no ☐ limited

What is your first language? _____

Can you read in your first language? ☐ yes ☐ no ☐ limited

Can you write in your first language? ☐ yes ☐ no ☐ limited

PART 6 School

Check the highest grade of school you finished.

☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ Associate's degree
☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐ Bachelor's degree

What year did you finish this grade? _____ Where did you go to school? _____

Did you repeat any grades? ☐ yes ☐ no

Were you in special education? ☐ yes ☐ no ☐ not sure

Did you finish more than 12 years of school? ☐ yes ☐ no

If **yes**, please list your degree and major _____

Did you get any other training? ☐ yes ☐ no

If **yes**, please fill out the sections below.

Type of training	Year	Finished	Certified/Licensed
Building trades		☐ yes ☐ no	☐ yes ☐ no
Electronics		☐ yes ☐ no	☐ yes ☐ no
Cooking		☐ yes ☐ no	☐ yes ☐ no
Auto mechanics		☐ yes ☐ no	☐ yes ☐ no
Computers		☐ yes ☐ no	☐ yes ☐ no
Hairdressing		☐ yes ☐ no	☐ yes ☐ no
Cosmetology		☐ yes ☐ no	☐ yes ☐ no
Nurse's aide		☐ yes ☐ no	☐ yes ☐ no
Secretarial		☐ yes ☐ no	☐ yes ☐ no
Other (describe)		☐ yes ☐ no	☐ yes ☐ no

PART 7 Your work

Do you work now? ☐ yes ☐ no

If **no**, when did you stop working? Date ___ /___ /_____

Did any of your medical or mental health conditions cause problems at work? ☐ yes ☐ no

If **yes**, please explain.

Part 7. Your work (continued)

List all your jobs from the last 15 years. Do the best that you can. If you do not know the exact dates, write your best guess. Start with the job you have now or your last job. Add a piece of paper if you need more space. You can attach a resume if you have one. Here is a sample.

Job title *Packer*	Dates worked: From (Month/Year) *March 2012*	To (Month/Year) *May 2012*
Job duties (List everything you did.) *Put three golf balls into a small box. Packed 24 small boxes into a case. Sealed the case with packing tape. Loaded cases onto a platform.*		
How many hours did you work each week? *40*	How much did you make an hour? *$9.00/hour*	
Reason for leaving *Moved*		

Job title	Dates worked: From (Month/Year)	To (Month/Year)
Job duties (List everything you did.)		
How many hours did you work each week?	How much did you make an hour?	
Reason for leaving		

Job title	Dates worked: From (Month/Year)	To (Month/Year)
Job duties (List everything you did.)		
How many hours did you work each week?	How much did you make an hour?	
Reason for leaving		

Job title	Dates worked: From (Month/Year)	To (Month/Year):
Job duties (List everything you did.)		
How many hours did you work each week?	How much did you make an hour?	
Reason for leaving		

Check each of the things you do in your job. If you do not work, check each thing you did in your last job.

- ☐ Doing paperwork
- ☐ Using a computer
- ☐ Assembling
- ☐ Operating machines
- ☐ Filing
- ☐ Serving people
- ☐ Counting & packing
- ☐ Construction
- ☐ Using phone
- ☐ Driving a car or truck
- ☐ Moving things
- ☐ Cleaning
- ☐ Using office machines
- ☐ Using cash register
- ☐ Driving a forklift
- ☐ Using power tools
- ☐ Using hand tools
- ☐ Other (please describe) _____

Circle the number of hours you do each thing in your job. If you do not work, circle the number of hours you did each thing in your last job.

Activity	Hours in a Day								
Walk or stand	0	1	2	3	4	5	6	7	8
Sit	0	1	2	3	4	5	6	7	8
Reach	0	1	2	3	4	5	6	7	8

Check the weight you lift or carry most.

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 25 lbs. ☐ 50 lbs. ☐ 100 lbs. ☐ More than 100 lbs.

Check the heaviest weight you lift.

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 25 lbs. ☐ 50 lbs. ☐ 100 lbs. ☐ More than 100 lbs.

PART 8 Your comments

Use this space to write any additional information about why you cannot work.

PART 9 Your signature and rights

THIS SECTION MUST BE COMPLETED.

You have the right to privacy. The information on this form is confidential. All possible precautions will be taken to ensure your privacy rights.

Signature of Applicant/Guardian/Authorized Representative _____

Date _____/_____/_____

Authorized Representative

If this form is being filled out by someone with the legal authority to act on behalf of the applicant/member (such as the parent of an adult disabled child or spouse, an authorized representative, or a legal guardian), give us the following information.

Signature of person filling out this form _____

Print name _____

Authority of person filling out this form on behalf of the applicant/member _____

DES may send copies of notices to the authorized representative. This area does not authorize release of medical records.

You may choose an authorized representative to help you with some or all of the responsibilities of applying for or getting health benefits.

You can do this by filling out a MassHealth Authorized Representative Designation Form (ARD). To ask for an ARD form, call MassHealth Customer Service at (800) 841-2900 (TTY: (800) 497-4648 for people who are deaf, hard of hearing, or speech disabled).

HELP WITH THIS FORM

Did you need help to fill out this form? ☐ yes ☐ no

If **yes**, why did you need help? _____

REMINDER

Did you remember to

- ☐ complete an Authorization to Release Protected Health Information Form for each medical or mental health provider listed on page 2?
- ☐ sign all Authorization to Release Protected Health Information Forms?
- ☐ sign this Disability Supplement above?
- ☐ include a completed and signed Authorized Representative Designation Form (ARD) if needed?

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This is the only release accepted by MassHealth Disability Evaluation Services

APPLICANT:

If you do not fully fill out this Authorization to Release Protected Health Information, the MassHealth Disability Evaluation Services (DES) will not be able to make a disability determination for you. You may lose or have your MassHealth benefits reduced.

Instructions

This MassHealth Authorization to Release Protected Health Information helps us get sensitive health information from your health care provider so that the MassHealth Disability Evaluation Service (DES) can make a disability determination.

Please read the instructions carefully before you fill out this form. If you leave any sections of this form blank, this permission will not be valid, and the health care provider will not be able to share your information with the MassHealth DES. If the health care provider does not share protected health information with the MassHealth DES, we will not be able to make a disability determination.

General instructions for filling out the MassHealth Authorization to Release Protected Health Information

You must follow these instructions when filling out the MassHealth Authorization to Release Protected Health Information forms. The health care providers will not send protected health information to the MassHealth DES if you do not fill out the forms the right way. We need copies of your protected health information to make a disability determination.

1. **Sign and date a separate MassHealth Authorization to Release Protected Health Information form** for each doctor, hospital, health center, clinic, or other health care provider you listed in Part 2 of the Disability Supplement.
2. All MassHealth Authorization to Release Protected Health Information forms **must be filled out in black or blue ink and must be originals**. No copies or stamps of signatures are permitted. Forms filled out and signed in pencil are not permitted.
3. Only one signature may appear on a line.
4. If this form is for a child younger than age 18, one parent or legal guardian must sign for the child.
5. Legal guardians must attach a complete copy of the document that gives them the authority to act on behalf of the applicant/member.

If you need help completing the MassHealth Authorization to Release Protected Health Information, call a DES representative at (800) 888-3420.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This request for protected health information supports this individual's application for public benefits. Under M.G.L.c.112 § 12CC, there must be no charge for the release of the requested records. Under statute, the records must be produced within 30 days.

By filling out and signing this Authorization to Release Protected Health Information, **I authorize my health care provider to share my protected health information with MassHealth Disability Evaluation Services (DES)**. This form will allow my doctors to share my protected health information with MassHealth (DES) to determine my eligibility for disability services.

- I understand that some information used or shared as part of this authorization could be re-shared by DES. If so, it may not be subject to federal or state law protecting its confidentiality.
- I also understand that certain health information has special protections for sensitive information. This health information includes records about HIV infection, AIDS, genetic testing, and psychological or psychiatric conditions. This health information is protected under state and federal law and cannot be shared without my written consent unless otherwise allowed by law. 42 CFR part 2 does not allow a program that provides substance use disorder diagnosis, treatment, or referral for treatment to share health information that it creates, receives, or acquires about me without my authorization.

SECTION 1: MassHealth Applicant / Member Information

Name | Date of Birth

Street address

City, State, Zip

Telephone Number ( )

SECTION 2: Healthcare Provider Information

Name of doctor, health center, or other health care provider

Street address

City, State, Zip

Telephone Number ( )

SECTION 3: Sensitive Medical Information to be Shared with DES

I authorize the release of my entire medical record. Check YES or NO for EACH of the following options.

☐ Yes ☐ No Mental or Psychiatric Health Information
☐ Yes ☐ No HIV, AIDS, Sexually Transmitted Disease Information
☐ Yes ☐ No Genetic Testing. See M.G.L. c. 111 § 70G
☐ Yes ☐ No Substance Use Information
☐ Yes ☐ No Other (please specify): _____

This authorization is good from 12 months before the signature date through its expiration. This authorization expires 12 months from the signature date.

_____ _____
Signature of Applicant/Member or Legal Representative Date

_____ _____
Relationship to Applicant/Member or authority to act for Applicant/Member Date

Please attach a complete copy of the document that gives this person the authority to act on behalf of the applicant/member.

Unless action has already been taken in reliance upon it, or during a contestability period under applicable law, I understand that I may revoke this authorization at any time by sending a written request to DES, PO Box 2796, Worcester, MA 01613. This authorization expires one (1) year from the signature date.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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Unless action has already been taken in reliance upon it, or during a contestability period under applicable law, I understand that I may revoke this authorization at any time by sending a written request to DES, PO Box 2796, Worcester, MA 01613. This authorization expires one (1) year from the signature date.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This is the only release accepted by MassHealth Disability Evaluation Services

APPLICANT:

If you do not fully fill out this Authorization to Release Protected Health Information, the MassHealth Disability Evaluation Services (DES) will not be able to make a disability determination for you. You may lose or have your MassHealth benefits reduced.

Instructions

This MassHealth Authorization to Release Protected Health Information helps us get sensitive health information from your health care provider so that the MassHealth Disability Evaluation Service (DES) can make a disability determination.

Please read the instructions carefully before you fill out this form. If you leave any sections of this form blank, this permission will not be valid, and the health care provider will not be able to share your information with the MassHealth DES. If the health care provider does not share protected health information with the MassHealth DES, we will not be able to make a disability determination.

General instructions for filling out the MassHealth Authorization to Release Protected Health Information

You must follow these instructions when filling out the MassHealth Authorization to Release Protected Health Information forms. The health care providers will not send protected health information to the MassHealth DES if you do not fill out the forms the right way. We need copies of your protected health information to make a disability determination.

1. **Sign and date a separate MassHealth Authorization to Release Protected Health Information form** for each doctor, hospital, health center, clinic, or other health care provider you listed in Part 2 of the Disability Supplement.
2. All MassHealth Authorization to Release Protected Health Information forms **must be filled out in black or blue ink and must be originals**. No copies or stamps of signatures are permitted. Forms filled out and signed in pencil are not permitted.
3. Only one signature may appear on a line.
4. If this form is for a child younger than age 18, one parent or legal guardian must sign for the child.
5. Legal guardians must attach a complete copy of the document that gives them the authority to act on behalf of the applicant/member.

If you need help completing the MassHealth Authorization to Release Protected Health Information, call a DES representative at (800) 888-3420.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This request for protected health information supports this individual's application for public benefits. Under M.G.L.c.112 § 12CC, there must be no charge for the release of the requested records. Under statute, the records must be produced within 30 days.

By filling out and signing this Authorization to Release Protected Health Information, **I authorize my health care provider to share my protected health information with MassHealth Disability Evaluation Services (DES)**. This form will allow my doctors to share my protected health information with MassHealth (DES) to determine my eligibility for disability services.

- I understand that some information used or shared as part of this authorization could be re-shared by DES. If so, it may not be subject to federal or state law protecting its confidentiality.
- I also understand that certain health information has special protections for sensitive information. This health information includes records about HIV infection, AIDS, genetic testing, and psychological or psychiatric conditions. This health information is protected under state and federal law and cannot be shared without my written consent unless otherwise allowed by law. 42 CFR part 2 does not allow a program that provides substance use disorder diagnosis, treatment, or referral for treatment to share health information that it creates, receives, or acquires about me without my authorization.

SECTION 1: MassHealth Applicant / Member Information

Name | Date of Birth

Street address

City, State, Zip

Telephone Number ( )

SECTION 2: Healthcare Provider Information

Name of doctor, health center, or other health care provider

Street address

City, State, Zip

Telephone Number ( )

SECTION 3: Sensitive Medical Information to be Shared with DES

I authorize the release of my entire medical record. Check YES or NO for EACH of the following options.

☐ Yes ☐ No Mental or Psychiatric Health Information
☐ Yes ☐ No HIV, AIDS, Sexually Transmitted Disease Information
☐ Yes ☐ No Genetic Testing. See M.G.L. c. 111 § 70G
☐ Yes ☐ No Substance Use Information
☐ Yes ☐ No Other (please specify): _____

This authorization is good from 12 months before the signature date through its expiration. This authorization expires 12 months from the signature date.

_____ _____
Signature of Applicant/Member or Legal Representative Date

_____ _____
Relationship to Applicant/Member or authority to act for Applicant/Member Date

Please attach a complete copy of the document that gives this person the authority to act on behalf of the applicant/member.

Unless action has already been taken in reliance upon it, or during a contestability period under applicable law, I understand that I may revoke this authorization at any time by sending a written request to DES, PO Box 2796, Worcester, MA 01613. This authorization expires one (1) year from the signature date.