

#### Requesting a Waiver

You may use this form if you believe you experienced extreme financial hardship and feel you may qualify for a waiver of your copayment. You may seek a waiver of your copayment only if you do not pay monthly premiums for your health insurance. Only certain events are considered extreme financial hardship and they are listed in Section II.

To be considered for a waiver of your copayment, you must prove to us that you experienced at least one of the qualifying events listed in Section II. The maximum amount of time for which you could be granted a waiver is six months and it could be less. For details, please see 956 CMR 3.11(5)(d).

If you have a question or problem that does not fit within one of the circumstances listed in Section II, please call the Commonwealth Care Customer Service Center so we can assist you.

## **SECTION I: Clearly Print Your Information**

First Name	Initial	Last Name	
Mailing Address			
City	State	Zip	
Home Address (if different)			
Home Telephone	Gen	Gender	
Daytime Telephone (if different)			
Date of Birth	ID Number (Usually SS#)		

Name of Your Health Plan (if applicable)

# SECTION II: Qualifying Event (Check All that Apply)

- □ You are homeless, or more than 30 days behind in rent or mortgage payments, or have received a current eviction or foreclosure notice.
- □ You have a shut-off notice from your utility company (gas, electric, oil, water, or telephone), or one of your utilities has been shut off, or one or more of your utility companies is refusing to deliver services because you cannot pay.
- □ You had a large increase in expenses in the past six months due to domestic violence.

#### Rev. 052107

CW-A\_\_\_\_ CW-B\_\_\_\_\_ Commonwealth Care Customer Service Center P.O. Box 120089 Boston, MA 02112-9914 1-877-MA-ENROLL (1-877-623-6765) (TTY: 1-877-623-7773) Fax: 1-877-623-2155 / Business Hours Monday-Friday 8am-5pm Turn Over

# SECTION II: Continued

- □ You had a large increase in expenses in the past six months due to death of your spouse, family member, or partner with primary responsibility for child care.
- □ You had a large increase in expenses in the past six months due to the sudden responsibility for providing full care for an aging parent or other family member, including a major long illness of your child that requires a working parent to hire a full-time person to care for your child.
- □ You had a large increase in expenses in the past six months due to a fire, flood, natural disaster, or other unexpected natural or human-caused event causing large damage to you or, your home, or your property or personal possessions.
- □ While on Commonwealth Care and during the past 12 months, you have accrued medical and dental bills that are more than 7.5% of your annual income before taxes or your family's annual income before taxes and are not payable by someone else. These bills are for services provided to you or your family and are non-cosmetic and do not include premium payments.

SECTION III: Please Describe Why You Are Requesting a Copayment Waiver. (Attach additional sheets, if needed)



<u>Timelines for Filing a Waiver:</u>

You may file a Waiver Application at any time.

# Enrollee Payment While Application is Pending:

The first time we receive your properly completed Copayment Waiver Application, you will not be required to pay your copayment until the Connector has issued a decision on your Application. If you submit a second Copayment Waiver Application after the Connector has denied an earlier Application, then you may be required to pay all applicable copayments while the Connector considers your subsequent Application. If the Connector denies your Copayment Waiver Application, then you must immediately begin to pay all applicable copayments for the calendar year starting from the amount you reached at the time we received your Application. If your Application is denied and you appeal that decision, you will have to pay your copayments while you wait for a decision on your subsequent appeal.

#### Designation of Representative:

You may designate someone as your Representative for purposes of completing this Application. To designate a Representative to receive information on your behalf regarding your Copayment Waiver Application, you must submit a Representative Form that is signed by both you and/or your Representative. The Connector will accept this Representative only on the Representative Form. By designating this Representative, you are authorizing the Connector to share your personal health information with that Representative. To submit the *Representative* Form, call the Commonwealth Care Customer Service Center.

# Assistance with this Form:

Please mail or fax this Application, proof of your hardship, and any other materials for us to consider. Please send photocopies of your proof as we will not return originals. Keep a copy for your records.

Commonwealth Care Customer Service Center P.O. Box 120089 Boston, MA 02112-9914 1-877-MA-ENROLL Fax: 1-877-623-2155 Business Hours Monday-Friday 8am-5pm

If you need assistance in completing this Application, please contact the Commonwealth Care Customer Service Center. Please note that failure to properly complete this Application, may prevent your Application from being accepted. Only Connector approved formats will be accepted.

# SECTION IV: Proof of Hardship

You must attach evidence (proof) of your hardship. Evidence of your hardship must include copies (*do* not send originals as they will not be returned) of relevant documentation such as bills, receipts, or letters from your landlord, mortgage, and/or utility company. You must include evidence for each box you check in Section II.

# SECTION V: Proof of Hardship Attachments

Please list each of the attachments that you are including with this Application. If you need more space, please attach a separate sheet:

# SECTION VI: Copayment Waiver Request

What is your average monthly copayment expense? \$\_\_\_\_\_

What can you afford to pay each month? \$\_\_\_\_\_

# SECTION VII: Length of Waiver

It is the Connector's discretion, pursuant to our regulations, 956 CMR 3.11(5)(b) and (c), whether or not you will get a waiver of your copayment. The maximum amount of time you could be granted a waiver is six months and it could be less.

#### SECTION VIII: Member Certification

I certify that I have read, or had read to me, the information on this Copayment Waiver Application understand and that Ι тy rights and responsibilities. I further certify under the penalty of perjury that the information on this Application, and any attachments or supplements to it, are correct and complete to the best of my knowledge. I further authorize the release of my personal health information and other confidential data to the Connector and Connector contracted entities for the purpose of making a decision on my Copayment Waiver Application.

Signature (Sign)

Date

First Name and Last Name (Print)

□ Check here if you are a Representative signing on behalf of the named individual. [If so, you must fill out the Representative Form to receive information.]

Send this to the Commonwealth Care Customer Service Center with your proof. Keep a copy for your records.