Appendix

Forms/Notices Used in the MassHealth Eligibility Process, the Lien Process, and the Estate Recovery Process In Massachusetts
Contents

Statement of Intent to Return Home – sent by enrollment center workers to determine if the institutionalized applicant intends to return home. The form explains that the home will be considered a countable asset if they do not intend to return there.

Agreement to Sell Property - sent by enrollment center workers to applicants who have indicated they have no intent of returning home. As a condition of MassHealth eligibility, they must sign this form, agreeing to sell their property in the following nine months.

Statement of Expectation to Return Home – completed by the applicant’s physician who must indicate if there is a reasonable expectation that the applicant will return home in six months. If the answer is no, a lien will be placed on the applicant’s home.

Notice of Intent to Place a Lien – sent to applicants by enrollment center workers when their physician has indicated they are not expected to return home in six months. The notice reiterates exemption rules for dependent relatives living in the home and also summarizes repayment/recovery rules.

The MassHealth Lien – completed by the enrollment worker and sent to the lien coordinator once the MassHealth application is approved.

Status Change for a Member in a Long Term Care Facility or Rest Home - completed by the Long Term Care provider and sent to the appropriate MassHealth Enrollment Center whenever a MassHealth applicant or member is admitted or discharged.

Authorization to Release a MassHealth Lien - completed by enrollment workers and sent to the lien coordinator when a filed lien needs to be released because the spouse or other dependent relatives live in the property or the property was permissibly transferred.

Release of MassHealth Lien - completed by Estate Recovery Unit staff who effect the release of the lien without recovery after having received the Authorization to Release form from the enrollment center worker. This form is also used to release the lien after claims have been settled either during the member's lifetime or during the probate process.

Notice of Claim - completed by Estate Recovery Unit staff and filed in Probate Court. The Notice of Claim indicates the amount that will be claimed from the estate based on MassHealth payments made on behalf of the decedent.

Notice of Claim Cover Letter - sent by Estate Recovery Unit staff to the administrator/executor of the estate along with a copy of the Notice of Claim. The cover letter explains the process that must be followed if the estate wishes to dispute the validity of the claim or request a deferral or waiver of repayment.
MassHealth
Division of Medical Assistance

Statement of Intent to Return Home

MassHealth Enrollment Center

Address:__________________________________________

City/Town/Zip:_____________________________________

Name: ________________________

Address:_______________________

City/Town/Zip:__________________

SSN:__________________________

The Commonwealth of Massachusetts Division of Medical Assistance will determine if your home is a countable asset pursuant to regulations at 130 CMR 520.007(G). Your home is a countable asset if you do not intend to return there. Your home is not a countable asset if you do intend to return there. It may, however, be subject to a real estate lien pursuant to regulations at 130 CMR 515.012(A).

Please complete this form and return it within 10 days to the MassHealth Enrollment Center at the above address.

When did you leave your home?______________________________________________________

Why did you leave your home?_______________________________________________________

Do you intend to return home?     ___Yes     ___ No

If you do not intend to return home, when did you make that decision?________________________

_________________________     _______________________

Signature of Applicant/Member      Date

If you are completing this form for the applicant/member, please complete the following.

I certify under the pains and penalty of perjury that I have answered the above questions (please check one of the following):

__based on the intentions expressed to me by:__________________________  Name of Applicant/Member

__on behalf of:__________________________ who is incapable of expressing his/her intentions.  Name of Applicant/Member

________________________________________

Signature of Authorized Representative      Title/Relationship

Telephone Number      Date

MA-10 (Rev. 04/99)
MassHealth
Division of Medical Assistance

Agreement to Sell Property

MassHealth Enrollment Center

Address: __________________________
City/Town/Zip: ____________________

Date: ______________________

Name: ____________________________
Address: __________________________
City/Town/Zip: ____________________
SSN: _____________________________

The Commonwealth of Massachusetts Division of Medical Assistance has determined that pursuant to
regulations at 130 CMR 520.007(G), the equity value of your real estate at __________________________
is a countable asset in determining your eligibility for MassHealth.

We will exempt this property for a nine-month period if you agree to:
• take action to sell the property for no less than fair-market value or otherwise liquidate the equity value in the
  property to pay for your medical care;
• provide evidence, upon request from the Division, that you are trying to sell at no less than fair-market value, or
  liquidate the equity in the property to pay for your medical care;
• provide to the Division, on request, information on any offer you have received, including the date of the offer, the
  amount of the offer, and the identity of any real-estate agent conveying the offer;
• accept any offer of at least fair-market value; and
• notify the Division, within 10 days, of any sale or refinancing of the property.

To qualify for this exemption, you must sign and return this form to the MassHealth Enrollment Center
listed above within 30 days. If you have any questions, call your eligibility worker.

The Division may extend the nine-month exemption period if, at the end of the nine-month period, you:
• provide evidence that you have been unable to sell the property at fair-market value;
• provide information on each offer you have received and the reason for not accepting it; and
• continue to make good-faith efforts to sell the property in accordance with 130 CMR 520.007(G)(4).

Eligibility Worker ____________________________ Telephone Number ____________________________

Signature of Applicant ____________________________ Date ____________________________
Signature of Authorized Representative ____________________________ Date ____________________________

I hereby agree to dispose of real estate owned by me in accordance with the terms described above. I
understand that my eligibility for MassHealth will terminate when one of the following occurs:
• I sell the property for less than fair-market value;
• I reject an offer of at least fair-market value; or
• after nine months, I reject a reasonable offer that is equal to at least two-thirds of the fair-market value.

MA-15 (Rev. 04/99)
05-134-0499-80
MassHealth
Division of Medical Assistance

Statement of Expectation to Return Home

MassHealth Enrollment Center
Address:_____________________________________________
City/Town/Zip:________________________________________
Date:_____________________

Name:____________________________________
Address:__________________________________
City/Town/Zip:_____________________________
SSN:______________________________________

This form must be completed by a licensed physician and returned within 10 days to the MassHealth Enrollment Center at the above address.

Patient’s Name: _____________________________ SSN:___________________
Address of Nursing Facility:__________________________________________________
Address of Former Home:_____________________________________________________
Diagnosis:_________________________________________________________________
________________________________________________________________________

Is it reasonable to expect this patient to return home within six month?  ____ Yes  ____ No

_______________________________________   _______________________
Physician’s Signature       Date

________________________________________
Physician’s Name (please print)

_______________________________________________________________________
Address

_________________________________________
Telephone Number

MA-11 (Rev. 04/99)
05-125-0499-80
MassHealth
Division of Medical Assistance

Notice of Intent to Place a Lien

MassHealth Enrollment Center

Address: ____________________________________________

City/Town/Zip: ____________________________

Date: ______________________

Name: _________________________________________

Address: _________________________________________

City/Town/Zip SSN: _____________________________

The Commonwealth of Massachusetts Division of Medical Assistance, pursuant to regulations at 130 CMR 515.012(A), intends to place a lien against your property at the following address(es):

_____________________________________________________________________________________

Division of Medical Assistance regulations authorize the lien placement because:

• the Division has determined that you cannot reasonably be expected to be discharged from the nursing facility or other medical institution to your home; and

• none of the following relatives reside in the property:
  a. a spouse;
  b. a child under the age of 21, or a blind or permanently and totally disabled child; or
  c. a sibling who has an equity interest in the property and has been living in the house for at least one year prior to your admission to the nursing facility or other medical institution.

If you are discharged from the nursing facility or other medical institution and return home after the lien is placed, the Division will release the lien. If the property is sold during your lifetime, you must repay the Division from your share of the proceeds for the cost of all medical services provided on or after April 1, 1995. Any remaining proceeds will be used in determining your continued eligibility. Repayment of the cost of medical services may be deferred while any of the following relatives are still lawfully residing in the property:

• a sibling who has been residing in the property for at least one year immediately prior to your admission to the nursing facility or other medical institution; or

• a son or daughter who:
  a. has been residing in the property for at least two years immediately prior to your being admitted to the nursing facility or other medical institution;
  b. establishes to the satisfaction of the Division that he or she provided care that permitted you to reside at home during the two-year period prior to institutionalization; and
  c. has resided lawfully in the property on a continual basis while you have been in the nursing facility or other medical institution.

Whether or not a lien is placed, the Division may have the right to recover the amount of payment for medical benefits from your probate estate after your death. Recovery is limited to payment for all services that were provided:

• on or after March 22, 1991, regardless of your age, if you were institutionalized and the Division determined that you could not reasonably be expected to return home;

• on or after October 1, 1993, if you were aged 55 through 64; or

• while you were aged 65 or older.

If you disagree with the Division’s intention to place a lien, you have the right to a fair hearing. For information about appeal rights, see the other side of this form.

_________________________________________________           _____________________________
MassHealth Eligibility Worker              Telephone Number

MA-12 (Rev. 04/99)
MassHealth Lien

The Commonwealth of Massachusetts Division of Medical Assistance, pursuant to M.G.L. c. 118E, § 34 and regulations at 130 CMR 515.012(A), hereby asserts a lien for the cost of medical assistance paid or to be paid against all property and rights to all property in _________________ County, including the property more fully described below.

Ownership

Member’s Last Name    First Name     MI
SSN:______________________________

Location

Street Address     City/Town     Zip Code

County              District

Registration/Recording Information

Book       Page       OR       Certificate Number/Document Number

Return to:
Commonwealth of Massachusetts
Division of Medical Assistance
Lien Coordinator
Estate Recovery Unit
P.O. Box 15205
Worcester, MA 01615-0205

Signature

Printed name

MassHealth Enrollment Center (City/Town only)

Date

MA-13 (Rev. 08/03)
**Status Change for a Member in a Long Term Care Facility or Rest Home**

*(Admission or Discharge of MassHealth Member or SSI Recipient)*

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
<th>REG</th>
<th>MEC</th>
<th>Coverage type</th>
<th>Member’s last name</th>
<th>First name</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Name of facility submitting this notification</td>
<td>Address</td>
<td>Telephone</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3.</td>
<td>Provider number</td>
<td>4. Admit date</td>
<td>5. MassHealth request date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td><strong>A–Admit</strong> D–Discharge __R–Both admit and discharge</td>
<td>7. Member’s ID/SSN</td>
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</tbody>
</table>

**FOR MASSHEALTH USE ONLY**

<table>
<thead>
<tr>
<th></th>
<th>PPA Amount</th>
<th>Effective Date (MM/YY)</th>
<th>Retro PPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>PPA Amount</td>
<td>Effective Date (MM/YY)</td>
<td>Retro PPA</td>
</tr>
<tr>
<td>9.</td>
<td>Level of Care</td>
<td>10. MassHealth Start Date</td>
<td></td>
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<tr>
<td>11.</td>
<td>Discharge Reason</td>
<td>12. Worker CAN</td>
<td></td>
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<tr>
<td>13.</td>
<td>Discharge Date</td>
<td>14. Date of Death</td>
<td>15. Comments</td>
</tr>
</tbody>
</table>

Check all appropriate boxes:

16. A. Short term (6 months or less) ___  
   B. Long term (more than 6 months) ___  
   C. Short-term-care stay terminated; now long-term-care ___  
   D. Medicare upon admission ___  
   E. SCO (NF screening-notification form not needed) ___

17. Admitted from 18. Discharged to

Complete items 19 and 20 only if member’s expected stay is six months or less.

19. I certify that the above-named member’s expected length of stay is

20. Physician's signature Date

21. Signature of authorized representative completing this form Date

**NOTE:** Nursing-facility screening-notification form or admission-determination letter must be attached.

SEE REVERSE SIDE FOR INSTRUCTIONS FOR COMPLETING THIS FORM.
Instructions to Long Term Care Providers

The following instructions correspond to numbered items on the reverse side. Please Note: For SSI recipients, a copy of the SC-1 must be sent to the appropriate Social Security District Office.

1. Enter today’s date, the member’s region, MassHealth Enrollment Center, MassHealth coverage type, and name (please print).

2. Enter the name, address, and telephone number of the facility submitting this form.

3. Enter the seven-digit provider number.

4. Enter the date of admission.

5. Enter the date from which MassHealth payment is requested.

6. Enter the appropriate code: A for admitted, D for discharged, or R for both admitted and discharged.

7. Enter the member’s 10-digit MassHealth identification number, if known.

**ITEMS 8 THROUGH 12 ARE FOR INTERNAL MASSHEALTH USE ONLY.**

8. Enter the discharge date for the current discharge and if both admitting and discharging.

9. Enter the date of death, if applicable.

10. Use this space to enter any comments.

11. Check box 16A to indicate a short-term stay (six months or less), 16B to indicate a long-term stay, or 16C to indicate that the short-term stay is terminated and is now long term. Check 16D if the member is Medicare eligible upon admission. Check 16E if the member is admitted to nursing facility under SCO (nursing-facility screening-notification form not needed).

12. Enter where member is admitted from (i.e., home, name of acute or chronic hospital).

13. Enter where member is discharged to (i.e., home, name and address of acute or chronic hospital).

14. Enter the expected length of stay only if the expected stay is six months or less.

15. The physician must sign and date only if the expected stay is six months or less. For a long-term stay, no signature is required.

16. An authorized representative of the facility must sign and date this form.
MassHealth Enrollment Center
Authorization To Release a MassHealth Lien

The MassHealth Enrollment Center (MEC) at ____________________________, MA authorizes the release of the attached MassHealth lien for the following MassHealth member:

____________________________________              ___________________________________________
Member name (first, last)    Member SSN

A MassHealth Lien Release is requested for the following reason:

Relative Lives in the Property In accordance with MassHealth regulations at 130 CMR 515.012, one of the following relatives lives in the property:

☐ A spouse.
☐ A child under the age of 21, or a blind or permanently and totally disabled child.
☐ A sibling who has a legal interest in the property and has been living in the house for at least one year before the member’s admission to the medical institution.

Permissible Transfer In accordance with MassHealth regulations at 130 CMR 520.019(D)(6), the nursing-facility resident transferred the home he or she used as the principal residence at the time of the transfer, and the title to the home to one of the following persons.

☐ The spouse.
☐ The nursing-facility resident’s child who is under age 21, or who is blind or permanently and totally disabled.
☐ The nursing-facility resident’s sibling who has a legal interest in the nursing-facility resident’s home and was living in the nursing-facility resident’s home for at least one year immediately before the date of the nursing-facility resident’s admission to the nursing facility.
☐ The nursing-facility resident’s child [other than the child described in 130 CMR 520.019(D)(6)(b)] who was living in the nursing-facility resident’s home for at least two years immediately before the date of the nursing-facility resident’s admission to the institution, and who, as determined by MassHealth, provided care to the nursing-facility resident that permitted him or her to live at home rather than in a nursing facility.
☐ Other:_____________________________________________________________

I, hereby acknowledge that I have received all supporting documentation to substantiate the release of this MassHealth lien.

_________________________________________  ______________________________
Signature of MEC representative               Date

Lien released by:

___________________________________________   ________________________________
Signature of Estate Recovery Unit Lien Coordinator  Date

Lien–R (Rev. 07/04)
MassHealth  
Division of Medical Assistance  

Release of MassHealth Lien

The Commonwealth of Massachusetts Division of Medical Assistance hereby releases a lien, dated ___________, that it had asserted (or that had been asserted by the former Department of Public Welfare, now known as the Department of Transitional Assistance) pursuant to M.G.L. c. 118E § 34 and regulations at 130 CMR 515.012(A) for the cost of medical assistance paid or to be paid against all property and rights to all property described below.

### Ownership

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<tr>
<th>Member’s Last Name</th>
<th>First Name</th>
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SSN: ______________________________

### Location

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<tr>
<th>Street Address</th>
<th>City/Town</th>
<th>Zip Code</th>
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County       District

### Registration

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Case Specialist

Estate Recovery Unit  
P.O. Box 15205  
Worcester, MA 01615-0205

Date

MA-14 (Rev. 09/01)
NOTICE OF CLAIM

COMMONWEALTH OF MASSACHUSETTS

ESTATE RECOVERY UNIT

PROBATE COURT

To the Register of Probate for the County of ______________:

Please file the following Notice of Claim for the estate of MEMBER NAME, late of CITY/TOWN in said county.

To FIDUCIARY of _______________ in the County of ______________, Co-Administrator of the estate of NAME OF MEMBER,

To FIDUCIARY of _______________ in the County of ______________, Co-Administrator of the estate of NAME OF MEMBER,

To ___________________ of __________________ in the County of ________________,
Co-Administrator of the estate of _________________________.

This notice is given to you as required under the General Laws of Massachusetts, including but not limited to:

Section 20 of Chapter 202 of the General Laws

Section 32 of Chapter 118E of the General Laws

Section 9 of Chapter 197 of the General Laws

The estate of said NAME OF MEMBER is indebted to the Commonwealth of Massachusetts, MassHealth for the sum of $________ dollars under Section 31 of Chapter 118E of the General Laws for medical assistance (Medicaid) provided for the decedent.

COMMONWEALTH OF MASSACHUSETTS

By: ERUADMIN ERUADMIN, Administrator

__________________________________

Estate Recovery Program
P. O. Box 15205
Worcester, Massachusetts 01615-0205

Dated:
Enclosed please find a copy of the Notice of Claim that MassHealth has filed with the Probate Court. Please note that payment of this claim is due four months plus sixty days from the date the executor or administrator was appointed. Interest will then begin to accrue. Payment should be made by check payable to the “Commonwealth of Massachusetts, Estate Recovery Unit.” If there are not sufficient assets in the estate to satisfy the claim in full, MassHealth will accept what remains after payment of any funeral expenses and reasonable and necessary costs of administration.

If you believe that the claim is not valid, you have sixty days to send written notice by certified mail to MassHealth. If MassHealth disagrees, it will file suit against the executor or administrator within sixty days after it receives your notice, and a Court will determine the validity of MassHealth's claim.

Pursuant to 130 CMR 501.013(B) and 130 CMR 515.011(C), if the member was survived by a spouse, a blind or permanently and totally disabled child, or a child under 21 years of age, MassHealth will permit the estate to **defer** repaying this claim during the lifetime of the spouse, the blind or permanently and totally disabled child, or until the minor child reaches 21 years of age.

MassHealth will waive its claim if it determines that **all of the following conditions** exist as stated in 130 CMR 501.013(C) and 130 CMR 515.011(D):

1. A sale of real property would be required to satisfy a claim against the estate; and,

2. A person who was using the property as a principal place of residence on the date of the member’s death meets all of the following conditions:

   a. The person lived in the property on a continual basis for at least one year immediately before the now-deceased member became eligible for Mass Health or other assistance from MassHealth and continues to live in the property at the time MassHealth first presented its claim for recovery against the deceased member’s estate;
(b) the person was left an interest in the property under the deceased member’s will, inherited the property from the deceased recipient under the laws of intestacy;

(c) the person is not being forced to sell the property by other devisees or heirs at law; and

(d) at the time MassHealth first presented its claim for recovery against the deceased member’s estate, the gross annual income of the person’s family group, as defined in 130 CMR 501.001, was less than or equal to 133 percent of the applicable federal-poverty-level income standard for the appropriate family size.

If all of the above conditions are met a waiver will be granted on a conditional basis for two years from the date that MassHealth mails notice that the waiver requirements have been met, or from the date that a court of competent jurisdiction determines that the waiver requirements have been met. If at the end of that period, all circumstances and conditions that must exist for MassHealth to waive recovery still exist, including meeting the same income standards under 130 CMR 501.013(C)(2)(d), and the real property has not been sold or transferred, the waiver will become permanent and binding. If at any time during the two year period, the circumstances and conditions for the waiver no longer exist, including meeting the same income standards under 130 CMR 501.013(C)(2)(d), or the property is sold or transferred, or the person does not use the property as their primary residence, MassHealth will be notified and its claim will become due and payable in full.

MassHealth will request an annual review to ensure that the conditions set forth in 130 CMR 501.013 and 130 CMR 515.011 continue to exist. The individual requesting the waiver must furnish the required information and documentation for the periodic review. Failure to do so will result in the revocation of the conditional waiver and MassHealth’s claim will become due and payable in full.

If you wish to deny MassHealth’s claim, or believe that recovery should be waived, or repayment deferred, you are required to notify MassHealth in writing by certified mail within sixty days. If you are asking MassHealth to waive its claim under 130 CMR 501.013(C) and 130 CMR 515.011(D) or to defer repayment, you must state the specific circumstances and conditions, which exist and provide supporting documentation satisfactory to MassHealth. If MassHealth disagrees with your denial of its claim or denies your request for deferral or waiver, it will file suit within sixty days of receipt of your request, and a Court will determine the validity of the MassHealth’s claim.

Please address any notice to this office at the following address:

Estate Recovery Program
P.O. Box 15205
Worcester, Massachusetts 01615-9906

Thank you for your cooperation

Sincerely,

Enclosure