Commonwealth of Massachusetts
Executive Office of Health
and Human Services
Office of Medicaid
www.mass.gov/masshealth

Health Insurance Processing Center
P.O. Box 4405
Taunton MA 02780

Date: 12/21/2015
SSN: XXX-XX-3156
MEC: 510 Notice: 11231312
TYPE: DORH D14
Medicaid ID : 123123123123
Reference :

DOR1-HIX *000001*
JOHN SMITH
123 MAIN STREET
BOSTON MA 01010

Dear JOHN SMITH:

MassHealth Quality Control has received information that you may have a job that has not been reported to us. MassHealth members must report changes such as new jobs and incomes within 10 days of the change so that we can redetermine your eligibility for MassHealth or Health Safety Net (HSN).

Many working people can still get MassHealth or HSN even if their income goes up or their employer offers health insurance. We will make sure you and your family gets the most benefits you are eligible for.

Please complete, sign and return the attached Job Update form along with a copy of your most recent paystub(s) from each of your current jobs and return to the address below within 30 days of the date of this letter. We will use this information to determine your eligibility for MassHealth or HSN.

If you fail to send the information within 30 days of the date of this letter, your MassHealth benefits will end. You have the right to appeal our action.

Mail requested documentation to:

Health Insurance Processing Center
P.O. Box 4405
Taunton MA 02780

continued...

If you have other changes to tell us about, or if you have any questions about this letter, call a MassHealth Enrollment Center at the **toll-free number: 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled).**

Thank you.

MassHealth

continued...

DOR-2

Commonwealth of Massachusetts
Executive Office of Health
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Health Insurance Processing Center
P.O. Box 4405
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DOR2-HIX
JOHN SMITH
123 MAIN STREET
BOSTON MA 01010

Date: 12/21/2015
SSN: XXX-XX-3156
MEC: 510 Notice: 11231312
TYPE: DORH D14
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Job Update Form

Please enter your name and Social Security Number (SSN) directly below. You must complete all sections. Complete Section A (Current Income Information) and Section B (Yearly Income Information). Please put a check mark in the box further below that correctly describes your work situation and fill out that section. Also, fill out the Health Insurance section below, and sign and date the form.

EMPLOYEE NAME: _____ **EMPLOYEE SSN:** _____

A. CURRENT JOB INFORMATION (YOU MUST COMPLETE THIS SECTION):

( ) **I am currently working (fill out the following section(s)):**

1. **Current Job 1**
   Name of employer: _____
   Address of employer: _____

   a. Wages/Tips (before taxes) $_____ ( ) Weekly
   ( ) every 2 weeks ( ) Twice a month ( ) monthly ( ) Yearly
   (Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)
   b. How many hours a week do you work?
   c. Are you seasonally employed? ( ) yes ( ) no
   If yes, how many mpnths do you work each calendar year? _____
   d. Are you self-employed? ( ) yes ( ) no
   e. If yes, how much net income (profits after business expences are paid) will you get from this self-employment each month? $_____
   f. Is this job a sheltered workshop? ( ) yes ( ) no
   g. is health insurance offered that would cover doctors' visits and hospitalizations?
   (Answer **yes** even if you cannot get it now, chose not to sign up for it, or dropped insurance that was available.) ( ) yes ( ) no
   If you answered **no** to the last question, was health insurance offered in the last 6 months? ( ) yes ( ) no

continued...

2. Current Job 2

Name of employer: _____

Address of employer: _____

a. Wages/Tips (before taxes) $_____ ( ) Weekly
( ) every 2 weeks ( ) Twice a month ( ) monthly ( ) Yearly
(Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)

b. How many hours a week do you work?

c. Are you seasonally employed? ( ) yes ( ) no
If yes, how many mpnths do you work each calendar year? _____

d. Are you self-employed? ( ) yes ( ) no

e. If yes, how much net income (profits after business expences are paid) will you get from this self-employment each month? $_____

f. Is this job a sheltered workshop? ( ) yes ( ) no

g. is health insurance offered that would cover doctors' visits and hospitalizations?
(Answer **yes** even if you cannot get it now, chose not to sign up for it, or dropped insurance that was available.) ( ) yes ( ) no
If you answered **no** to the last question, was health insurance offered in the last 6 months? ( ) yes ( ) no

You must send us two recent pay stubs or other proof of income along with this filled-out and signed form, OR your family's MassHealth or Health Safety Net (HSN) benefits will stop.

( ) **I recently stopped working (within the last 6 months).**

When did you stop working? _____

( ) **I am receiving unemployment benefits. Send a copy of a recent check showing gross unemployment income.**

( ) **I have not worked within the last 6 months.**

B. YEARLY INCOME INFORMATION (You must complete this section):

1. What is your total expected income for the current calendar year?
$_____

2. What is your total expected income for next calendar year, if different?
$_____

C. HEALTH INSURANCE (You must complete this section):

1. Are you and/or members of your family currently enrolled in health insurance from your job?
( ) yes ( ) no
If yes, please fill out the section below and **send us a copy of both sides of the health-insurance card(s).**

a. Insurance company name: _____

b. Names of covered family members: _____

_____

c. Policy Number: _____

d. Is this COBRA coverage? ( ) yes ( ) no

e. is this a retiree health plan? ( ) yes ( ) no

continued...

D. SIGNATURE (You must complete this section):

I certify under the pains and penalty of perjury that what is stated on this form is correct and complete to the best of my knowledge.

Signature of working person or authorized representative _____ Date _____

Return this completed, signed form and proof of current income to:

Health Insurance Processing Center
P.O. Box 4405
Taunton, MA 02780

Job Update (Rev.12/15)