GreenMountainCare
A HEALTHIER STATE OF LIVING

202MED

Health Care Programs Application

Applying for these programs is a multi-step process. Start by filling out this form. Revised 12/16

First name, middle name, last name & suffix (Jr., Sr., III, etc.)		
Social Security number	Date of birth (mm/dd/yyyy)	
Phone number where you can be reached ( ) –	Town where you live	
Mailing address line 1		Apartment or suite number
Mailing address line 2 (If applicable, include an "in-care-of" person here.)		
City	State	ZIP code

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-250-8427x2.
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-250-8427x2.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-250-8427x2.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-250-8427x2.
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-250-8427x2.
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-250-8427x2.
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-250-8427x2.
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-250-8427x2.
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-250-8427x2.
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-250-8427x2.
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-250-8427x2.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-250-8427x2。
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-250-8427x2 まで、お電話にてご連絡ください。
ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-250-8427x2 ।
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-250-8427x2.

Green Mountain Care is the name of some of our health care programs for Vermonters. These health care programs are not associated with Vermont Health Connect. We will screen you for the health care program for which you are eligible. In order to do so, we may ask you for more information. If you are eligible, you may have to pay a premium based on your income. Green Mountain Health Care programs include:

- **Medicaid** – for individuals who are blind, have a disability, or are age 65 or older. If applying for Medicaid, answer all questions in this application.

  Medicaid for children or adults who are <u>not</u> blind, disabled, or age 65 or older must be applied for through Vermont Health Connect. Visit VermontHealthConnect.gov or call 1-855-899-9600.

- **Disabled Children's Home Care (DCHC) –** for children with disabilities who are living at home and would be eligible for Medicaid if living in an institution. Parents' income and resources are not counted when determining eligibility. However, we do need to know the child's income and resources. Please be sure to answer all questions in this application.

- **Pharmacy Program (VPharm) –** for Vermonters age 65 and older or disabled. Coverage ranges from full pharmacy coverage to supplemental coverage for those on Medicare. If applying for ONLY the Pharmacy Program (VPharm), answer questions 1-3, 5, 7-12, 19-26.

- **Healthy Vermonters Program (HVP)** – for all Vermonters <u>without</u> pharmacy coverage. This program provides a discount on some prescriptions. If applying for ONLY the Healthy Vermonters Program (HVP), answer questions 1-3, 5, 7-12, 19-26.

- **Medicare Savings Programs** – for individuals with Medicare to help pay for Medicare premiums, deductibles and co-pays. If applying for ONLY the Medicare Savings Programs, answer questions 1-3, 5, 7, 9, 19-25.

IMPORTANT: Be sure to read pages 9-11 before you sign and date the application.

We may ask you to provide proof of your citizenship and/or identify if we are not able to find you in the state's records, like Department of Motor Vehicles or birth records. ***Do not send anything at this time. We will tell you more about this after we get your application.***

Rights of People with Disabilities

Do you have a physical or mental or learning condition that makes it hard to do things we ask you to do? We can make changes to help you. The Americans with Disabilities Act (ADA) and Vermont law say that we must make changes so people with disabilities can get health and public benefits. These changes are called reasonable accommodations. Here are some examples of changes we can make:

- Someone can write down your answers if you can't.
- We can give you more time or help you get the documents you need to give us.
- You can have a support person with you when you talk to us.
- We can send documents with a larger print so you can read them.

If you need us to make changes so you can get the benefits you need, call 1-800-250-8427.

Applicant Information

1. Are you applying for benefits for yourself? ☐ YES ☐ NO

Gender:	**Citizenship status:**	**Marital status:**	**Program(s) you are applying for:**
☐ Female ☐ Male	☐ U.S. Citizen ☐ Legal Alien ☐ Refugee ☐ Asylee ☐ Other Country of Birth: _____	☐ Never Married/Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced/Dissolved ☐ Civil Union	☐ Medicaid ☐ Disabled Children's Home Care ☐ Pharmacy Program ☐ Healthy Vermonters Program ☐ Medicare Savings Program ☐ None *(see front page for descriptions)*

2. Do you have an Authorized Representative, Power of Attorney, Legal Guardian, Alternate Reporter, or Enrollment Assistor? ☐ YES ☐ NO

If you answered yes, check one: ☐ Authorized Representative ☐ Power of Attorney ☐ Legal Guardian ☐ Alternate Reporter ☐ Enrollment Assistor

☐ **I give permission to the Economic Services Division and the person or agency listed below to share information about me as stated in the Rights and Responsibilities confidentiality section (pgs. 9-11) of this application.**

Full name	Phone No. **( )**	**Home Cell Work** ☐ ☐ ☐
Address		
For legal guardian only: **Name of court** _____	**Date appointed**_____	

Sending letters (notices) or premium bills to someone else:

- **Legal guardian:** If you have a legal guardian, your notices and premium bills will only be mailed to them.
- **In care of:** We can mail your notices and bills in care of someone else. This means you will not get notices or bills.
- **Alternate Reporter:** We can mail notices to you and to someone else. We call this person an "alternate reporter."

If you have questions or would like one of these options, please call 1-800-250-8427.

Household Information

If you live alone, skip to question 4.

3. We need information about the people living in your household even if they are not asking for assistance. Please answer questions 3 to 27 for any people in the following groups:

- Your spouse or civil union partner.
- Your parents and siblings, if you are under age 21. If you are under age 21, a parent must sign this application.
- Your children under age 21 who are living with you.
- The parent of your child (even if you are not married) if you are living in the same household.

You do not have to give information about anyone else living with you who is not listed in one of the groups above. Send proof of immigration status for anyone applying who is not a U.S. citizen. People who are not applying do not have to give their social security number, citizenship, or immigration status.

MEMB

First name / Initial / Last name	Assistance applying for	Sex	Citizenship Status
1.	☐ Medicaid ☐ DCHC ☐ VPharm ☐ HVP ☐ Medicare Savings Programs ☐ None	☐ Female ☐ Male	☐ U.S. citizen ☐ Asylee ☐ Refugee ☐ Legal alien ☐ Other Country of birth _____
Relationship to you	**Marital Status** ☐ Never married/Single ☐ Civil union ☐ Married ☐ Divorced/dissolved ☐ Separated ☐ Widowed	**Birthdate**	**Social Security Number**
First name / Initial / Last name	**Assistance applying for**	**Sex**	**Citizenship Status**
2.	☐ Medicaid ☐ DCHC ☐ VPharm ☐ HVP ☐ Medicare Savings Programs ☐ None	☐ Female ☐ Male	☐ U.S. citizen ☐ Asylee ☐ Refugee ☐ Legal alien ☐ Other Country of birth _____
Relationship to you	**Marital Status** ☐ Never married/Single ☐ Civil union ☐ Married ☐ Divorced/dissolved ☐ Separated ☐ Widowed	**Birthdate**	**Social Security Number**
First name / Initial / Last name	**Assistance applying for**	**Sex**	**Citizenship Status**
3.	☐ Medicaid ☐ DCHC ☐ VPharm ☐ HVP ☐ Medicare Savings Programs ☐ None	☐ Female ☐ Male	☐ U.S. citizen ☐ Asylee ☐ Refugee ☐ Legal alien ☐ Other Country of birth _____
Relationship to you	**Marital Status** ☐ Never married/Single ☐ Civil union ☐ Married ☐ Divorced/dissolved ☐ Separated ☐ Widowed	**Birthdate**	**Social Security Number**
First name / Initial / Last name	**Assistance applying for**	**Sex**	**Citizenship Status**
4.	☐ Medicaid ☐ DCHC ☐ VPharm ☐ HVP ☐ Medicare Savings Programs ☐ None	☐ Female ☐ Male	☐ U.S. citizen ☐ Asylee ☐ Refugee ☐ Legal alien ☐ Other Country of birth _____
Relationship to you	**Marital Status** ☐ Never married/Single ☐ Civil union ☐ Married ☐ Divorced/dissolved ☐ Separated ☐ Widowed	**Birthdate**	**Social Security Number**
First name / Initial / Last name	**Assistance applying for**	**Sex**	**Citizenship Status**
5.	☐ Medicaid ☐ DCHC ☐ VPharm ☐ HVP ☐ Medicare Savings Programs ☐ None	☐ Female ☐ Male	☐ U.S. citizen ☐ Asylee ☐ Refugee ☐ Legal alien ☐ Other Country of birth _____
Relationship to you	**Marital Status** ☐ Never married/Single ☐ Civil union ☐ Married ☐ Divorced/dissolved ☐ Separated ☐ Widowed	**Birthdate**	**Social Security Number**

If you need to list more people, add an extra sheet of paper. Be sure to answer all of the above questions for each additional person.

4. Has anyone been known by another name, such as a maiden name or alias? ☐ Yes ☐ No ALIA

Current name: First name	Initial	Last name	Other name: First name	Initial	Last name
Current name: First name	Initial	Last name	**Other name:** First name	Initial	Last name

5. Is anyone living outside your home in a facility that is not a school or college? ☐ Yes ☐ No

Some examples are: Hospital Correctional Facility Residential Care Home
Nursing Home Treatment Facility Group Home INST

First name	Initial	Name of facility	Date of admission

6. Is anyone in high school, college, vocational school, or a training program? ☐ Yes ☐ No SCHL

First name	Initial	Name of school	Type of school	Expected completion date	Is health insurance offered?	Enrollment Status
					☐ Yes ☐ No	☐ full-time ☐ half-time ☐ less than half-time
					☐ Yes ☐ No	☐ full-time ☐ half-time ☐ less than half-time

7. Does anyone have a physical, mental, or emotional disability that limits activities such as working, going to school, or taking care of the children? ☐ Yes ☐ No DISA

First name	Initial	Caused by an accident?	Disability determination
		☐ Yes ☐ No	Have you applied for disability through Social Security? ☐ Yes ☐ No Has SSA determined you disabled? ☐ Yes ☐ No
		☐ Yes ☐ No	Have you applied for disability through Social Security? ☐ Yes ☐ No Has SSA determined you disabled? ☐ Yes ☐ No

8. Is anyone pregnant? ☐ Yes ☐ No PREG

First name	Initial	Expected due date	
			How many babies are expected? _____

Health Insurance Information

9. Is anyone who is applying covered by Medicare? ☐ Yes ☐ No MEDI

First name	Initial	Medicare claim number	
Part A:	**Part B:**	**Part C:**	**Part D:**
Start date _____	Start date _____	Start date _____	Start date _____
Premium $_____	Premium $_____	Premium $_____	Premium $_____

First name	Initial	Medicare claim number	
Part A:	**Part B:**	**Part C:**	**Part D:**
Start date _____	Start date _____	Start date _____	Start date _____
Premium $_____	Premium $_____	Premium $_____	Premium $_____

10a. Is anyone enrolled in a Medicare Part D prescription drug plan? ☐ **Yes** ☐ **No**

Contract and Plan ID numbers are found in the bottom right-hand corner of your Medicare drug plan card.

First name Initial	Plan name	Contract ID	Plan start date
		CMS- __ __ __ __ __ - __ __ __	
		CMS- __ __ __ __ __ - __ __ __	

10b. Has anyone applied for the Low-Income Subsidy or "Extra Help" available through Social Security for Medicare Part D prescription drug plan costs? ☐ **Yes** ☐ **No**

First name Initial	Date applied

11. Does anyone have health insurance, including veterans, military or Medicare supplement policies? ☐ **Yes** ☐ **No**

Include insurance for any child in your home even if they are covered by a parent not in your home.

- Do not include any Medicare information listed in question 9.
- Do not include Green Mountain Care programs (Medicaid and Pharmacy programs), or Medicaid/Dr. Dynasaur with Vermont Health Connect.
- List prescription plans separately.
- **Send copies of both sides of all insurance cards.** If you don't, it will cause application processing delays.

INSU

Name of policy holder 1.		Services Covered (check all that apply)	Names of people covered	Name, address, and phone number of insurance company
Policy number	Group number	☐ Doctors/Hospitals ☐ Vision ☐ Prescriptions ☐ Dental ☐ Outpatient		
Premium amount $ per	Date coverage began	☐ Other: _____		

Name of policy holder 2.		Services Covered (check all that apply)	Names of people covered	Name, address, and phone number of insurance company
Policy number	Group number	☐ Doctors/Hospitals ☐ Vision ☐ Prescriptions ☐ Dental ☐ Outpatient		
Premium amount $ per	Date coverage began	☐ Other: _____		

12. Has health insurance ended for anyone in the past 12 months or will health insurance end in the next 60 days? Do not include Green Mountain Care programs (Medicaid and Pharmacy Programs), or Medicaid/Dr. Dynasaur with Vermont Health Connect. ☐ **Yes** ☐ **No**

First name Initial	Date ended or date will end	Reason

If you lost your health insurance due to domestic violence, check here. ☐ **Yes**

13. Does anyone have unpaid medical or dental bills? The bills may help you become eligible for Medicaid. If the services were received in the last 3 months, we may be able to help you pay them. ☐ Yes ☐ No

Who has the unpaid medical bills?	Provide an estimate of charges incurred within the last 3 months	Provide an estimate of charges incurred more than 3 months ago
	$	$
	$	$

Resource Information

14. Does anyone have cash that is not in a bank, such as at home, on hand, or held by others? Include cash that is owned by children. ☐ Yes ☐ No CASH

First name	Initial	Amount	First name	Initial	Amount
		$			$

15. Does anyone have money in a bank, credit union, or other financial institution?
Include accounts that are owned or co-owned by children. ☐ Yes ☐ No BANK

Type	Name of owner and co-owner	Name of bank, credit union, or other financial institution	Account number	Balance or value
Savings Account				$
Savings Account				$
Checking Account				$
Checking Account				$
Christmas Club				$
IRA, Keogh Plan, 401K				$
Savings Bond or Trust				$
Certificate of Deposit (CD)				$
Pension or Retirement Account				$
Other _____				$

Does any portion of these savings come from money earned as a "Working Person with Disabilities"? ☐ Yes ☐ No

16. Does anyone own any vehicles? ☐ Yes ☐ No CARS

Type of vehicle	Name of owner and co-owner	Year, make, and model	Leased?	Amount owed	For DVHA use only Value
Car, truck, or van			☐ Yes ☐ No	$	$
Car, truck, or van			☐ Yes ☐ No	$	$
Car, truck, or van			☐ Yes ☐ No	$	$
Motorcycle or ATV				$	$
Snowmobile or jet ski				$	$
Trailer or boat				$	$
Camper or RV				$	$
Other_____				$	$

17. Does anyone own or jointly own land, mobile homes, buildings, or other real estate? ☐ Yes ☐ No
Do NOT list the home you live in. PROP

Name of owner and co-owner	Type of property	Location	Assessed value	Amount owed
			$	$
			$	$

18. Does anyone own, or jointly own, any other resources? ☐ **Yes** ☐ **No** STOK

Type of Resource	Name of owner and co-owner	Value
Life Insurance ☐ **Term** ☐ **Whole**		Face value $ Cash value $
Life Insurance ☐ **Term** ☐ **Whole**		Face value $ Cash value $
Life Insurance ☐ **Term** ☐ **Whole**		Face value $ Cash value $
Account set up for burial expenses **Is this irrevocable?** ☐ **Yes** ☐ **No**		$
Burial Plot		$
Stocks, Bonds, or Mutual Funds		$
Annuities		$
Trust Funds or Collections		$
Promissory or Mortgage Notes		$
Other _____		$

Income Information

19. Does anyone have income from a job, internship or training program? ☐ **Yes** ☐ **No**

- List income from the past 30 days before any deductions such as taxes, insurance, child support, or union dues.
- Include income of children (under age 21 and living with you) from a job or training program.
- If income has ended or you expect it to change in the next 30 days, attach a note explaining the change.

JINC

Full Name	Date paid	Hours worked	Income before deductions	Tips and commissions
Paychecks are issued ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Day of week _____			$	$
Employer's name and phone number				

Full Name	Date paid	Hours worked	Income before deductions	Tips and commissions
Paychecks are issued ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Day of week _____			$	$
Employer's name and phone number				

20. Does anyone get paid for taking care of children? ☐ **Yes** ☐ **No**

- If you claim income for providing day care on your taxes, answer question 22 below instead of this question.
- List income from the past 30 days before deductions.
- List the number of meals you provide **each month** for which you are not paid/reimbursed.

DCIN

First name Initial	Income before deductions	Breakfast	Lunch	Dinner	Snacks
	$ per				

21. Does anyone get paid for providing room or meals in your home? ☐ **Yes** ☐ **No**

Include payments from children.

RBIN

First name Initial	Payment	Name of person paying	Check all that apply
	$ per		☐ Room ☐ 1-2 meals per day ☐ 3 meals per day
	$ per		☐ Room ☐ 1-2 meals per day ☐ 3 meals per day

22. Does anyone have income from self-employment, such as farming, home party sales, logging, or property rental? ☐ **Yes** ☐ **No**

- Send a copy of your most recent federal tax return, including all forms and schedules.
- If you have not filed taxes and it is a new business, send income and expense records to date.
- If income has ended or you expect it to change in the next 30 days, attach a note explaining the change.

BUSI

First name Initial	Type of business	Date business began

23. Does anyone have unearned income? Some examples are: ☐ **Yes** ☐ **No**

Social Security	Unemployment	Worker's compensation	Money from others
Dividends or interest	SSI/AABD	Pensions or retirement	
Trusts or annuities	Child support	Insurance settlement	
Promissory/mortgage note	Veteran's compensation	Veteran's pension	

List *gross* income (before any deductions such as Medicare premiums, taxes, insurance, child support, or union dues). UNEA

First name Initial	Income before deductions	Type of income	Due to disability?
	$ per		☐ Yes ☐ No
	$ per		☐ Yes ☐ No
	$ per		☐ Yes ☐ No

24. If you have no income, tell us how your daily living expenses are paid. (If you don't, it may delay the processing of your application). _____

_____

_____

Expense Information

25. Does anyone pay court-ordered child support or alimony? ☐ **Yes** ☐ **No** DCEX

Name of person paying	Child support paid	Alimony paid	Names of children for whom support is paid
	$ per	$ per	
	$ per	$ per	

26. Does anyone pay for daycare? ☐ **Yes** ☐ **No** DCEX

Name of person paying	Amount paid	Name of child or adult in daycare	Reason for daycare
	$ per		☐ working ☐ looking for work ☐ going to school
	$ per		☐ working ☐ looking for work ☐ going to school

27. Does anyone pay for medical expenses not covered by insurance? ☐ **Yes** ☐ **No**

Some examples are: Pain relievers Hearing aid batteries Laxatives
Antacids Vitamins Sleep aids

FMED

First name	Initial	Product or service needed	How often	Average monthly cost
				$
				$
				$

Rights and Responsibilities

IMPORTANT: After reading the following Rights and Responsibilities and the Authorizations and Releases, be sure to sign and date the application. ***Unsigned applications cannot be processed and will be returned to you for your signature. You may lose some benefits.***

True and Complete Information

I understand information I provide to Department of Vermont Health Access (DVHA) will be subject to verification by federal and state officials to determine if it is correct. This means that sources other than members of my household may be contacted to verify my eligibility. I understand that if any information is not true I may be denied assistance.

Reporting Changes

I understand that I must report changes in information reported in this application within 10 days from when they happen by calling Member Services at 1-800-250-8427.

Confidentiality

Information in this application is confidential. DVHA will not share any information from this application except when needed for program administration. For more information, see Release of Medical Records below.

If, in Question 2 on this application, I give permission to share information about me to assist me with program enrollment, that permission covers the following kinds of information:

- Information or proofs needed to complete my application.
- The status of my application including the program(s) I am enrolled in and the effective date of enrollment.
- The reason I am not eligible for a benefit, if my application is denied or my benefits end.
- The effective date(s) of my renewal(s) for benefits and any outstanding information or verifications needed to complete my renewal.

This information will be used to help with my enrollment and continued eligibility in the programs I have applied for. I know that state federal privacy laws protect my records, I know:

- Why I am being asked to release this information.
- I do not have to give permission to release this information.
- Signing this permission is voluntary. If I choose not to sign, my enrollment in or eligibility for benefits will not be affected.
- If I do not give my permission, the information will not be released unless the law otherwise allows it.
- I may stop this permission to share information at any time with a written notice to the Economic Services Division and the person or agency listed in Question 2 on the application. However, this written notice will not affect information the agencies have already released.
- The person or agency that gets my information might pass it on to others. If so, it may no longer be protected by this permission form.
- If I do not stop this permission, it will be in effect as long as I am receiving the benefits that I have applied for in this application.
- I will be provided with a copy of this form.
- All of my questions about this permission have been answered.

Social Security Number

I understand that I must give the social security number of everyone in my household who is applying for assistance. Federal law requires this as a condition of eligibility. If I am a member of a religious organization that objects to furnishing a social security number, the Agency of Human Services may disregard this requirement (42 U.S.C. §1320b-7).

DVHA uses social security numbers for computer processing, child support enforcement, fraud investigation, audits, and Lifeline identification; to verify social security and supplemental security income; to prevent individuals from receiving duplicate benefits; to exchange information with agencies such as the Social Security Administration, Department of Labor, Internal Revenue Service, or private agencies to verify income, determine eligibility and benefits amounts, and collect claims; to determine the accuracy and reliability of information given to DVHA; and to make medical assistance payments.

Discrimination

DVHA does not exclude people from its programs or deny them benefits because of race, color, national origin, age, disability, or sex. DVHA provides free aids and services to people with disabilities so they can work with us more easily. DVHA provides free language services to people who need to speak a language that is not English, such as qualified interpreters and information written in other languages. If you believe that DVHA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with DVHA's Health Programs Civil Rights Coordinator.

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, a DVHA's Health Programs Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone.

Health Program Civil Rights Coordinator

DVHA Legal Department
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
Phone: (802) 241-0454
Fax: (802) 241-0260
E-mail: AHS.DVHALegal@vermont.gov

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Decision on Application

DVHA must make a decision on my application no later than 30 days after my application date (or 90 days if my Medicaid application is based on disability) unless delay is caused by physicians, an unexpected emergency or administrative problem beyond the Department's control, or me. If I do not get a decision within 30 days (or 90 days), I may call Member Services at 1-800-250-8427 for more information or to request a fair hearing.

Grievance Appeals & Complaints

I may ask for a fair hearing if benefits or services are denied, or I am not responded to with reasonable promptness by calling Member Services at 1-800-250-8427 or by writing to the Human Services Board, 14-16 Baldwin Street, 2nd Floor, Montpelier, VT 05633-4302 (3 V.S.A. §3091).

For health care program actions that, for example, deny, limit, reduce, or end a service or deny a request to go outside the provider network, I may also request an appeal in addition to or in place of a fair hearing. If I have a complaint, for example, about the quality of the health care service or the behavior of staff for matters not related to health care program action, I may be able to file a grievance. For more information on any of these choices, call Member Services at 1-800-250-8427.

Quality Control Review

DVHA may select my application for a quality control review. I agree to cooperate and give proof of required information. If I am not able to give the proof needed, I authorize DVHA to get it.

Medicare Part B payments

If I get Medicare Part B benefits while getting Medicaid, I want DVHA to make any payments for future Medicare Part B medical and other health services directly to physicians and medical suppliers. This means I will not have to sign a separate form each time I get a service.

Fleeing Prosecution

I certify that neither I nor any member of my household is fleeing prosecution or confinement for a felony or an attempt to commit a felony, or is violating a condition of probation or parole under a federal or state law. I understand DVHA must disclose information to law enforcement agencies to apprehend fleeing felons.

Benefits from Another State

If any member of my household gets health care benefits from another state or has been convicted in the past ten years of fraudulently misrepresenting residence in order to get benefits from two or more states, I must notify DVHA immediately by calling Member Services at 1-800-250-8427.

Fraud Penalties

I or any member of my household will be subject to prosecution for fraud or some other criminal offense for knowingly giving false, incorrect, incomplete, or misleading information in order to get, try to get, or help someone else get health care benefits. If convicted, penalties may include up to three years of imprisonment and/or a fine of up to $1000, or an amount equal to the benefit wrongfully received. Other federal or state penalties may also apply. (42 U.S.C. §1320a-7b; 33 V.S.A. §§141, 143)

Authorizations and Releases

Release of Medical Records

I agree that my health care providers and the Department of Vermont Health Access and its contractors and grantees may access, use and disclose my medical records when necessary for the purpose of administering state health care programs or when a hospital, health care provider, mental health provider, or pharmacy needs my medical records, including provider and prescription medication information, for my treatment, for payment of my treatment, and for health care operations.

I agree that my consent includes the re-disclosure of prescription medication information received from a drug or alcohol treatment program when such information is needed for purposes of treatment. I understand that my consent to the use of my medical records remains in place until my eligibility is reviewed. I also understand that I can revoke my consent to the release of my medical records by putting my revocation in writing and mailing it to DVHA Deputy Commissioner, NOB1 South, 280 State Drive, Waterbury, VT 05671-1010.

Consent to bill Medicaid if Child Receives Special Education Services.

I give permission to my child's school district to bill Medicaid for the specified services listed in his/her Individual Education Plan (IEP). I understand that if I refuse consent, my refusal only affects Medicaid billing of IEP services; my refusal does not relieve the school district of its responsibility to provide IEP services at no cost to me. I understand that I may revoke this consent to bill Medicaid for IEP services at any time. If I revoke this consent it will apply to billing for services from that date forward. I can revoke my consent by writing to the DVHA address on the following page.

Other Programs

Lifeline may provide a discount on your phone bill. A separate application is needed to determine eligibility for Lifeline. *To learn more about this program or to request an application, call toll free 1-800-479-6151. When requesting an application, ask for Lifeline.*

Weatherization: This program helps with insulation, caulking, or weather-stripping your home or apartment to lower your heating costs. *To learn more about this program, call (802) 241-0943.*

Fuel Assistance: This program helps to pay heating bills. *To learn more about this program or to request an application, call toll free 1-800-464-4343.*

3SquaresVT: This program helps to pay for food. If you have little or no money for food, you may be able to get emergency help. *To learn more about this program or to request an application, call toll free 1-800-479-6151.*

Voter Registration

If you are not registered to vote where you live now, would you like a voter registration application? ☐ Yes ☐ No

If you do not check either box, you will be considered to have decided not to register to vote at this time. Applying to register or declining to register to vote will not affect your eligibility for benefits or amount granted to you by this agency. If you would like help in filling out the voter registration application form, we will help you. The decision whether 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, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of State's Office at 128 State Street, Montpelier, VT 05633-1101, or call 1-802-828-2363.

WIC: The Special Supplemental Nutrition Program for Women, Infants, and Children offers health screening, nutrition education, and food for pregnant women, nursing women, and children under five. *To learn more about this program, call toll free 1-800-649-4357.*

Would you like someone from the WIC program to contact you? ☐ Yes ☐ No

Signature

You must sign here. Unsigned applications will not be processed and will be returned for a signature. You may lose some benefits.

I give my word, under penalty of perjury, that the information I give in this application is true and complete to the best of my knowledge and belief. I have read and I understand the Rights and Responsibilities and Authorizations and Releases included in this application and I agree to them.

Signature of applicant_____ Date_____

Signature of person helping you fill out this form_____ Date_____

Return this application to:

DVHA - Department of Vermont Health Access
Application and Document Processing Center
280 State Drive
Waterbury, VT 05671-1500

We will let you know if we need more information. You will hear from us within 30 days. For questions call 1-800-250-8427 (TTY/Relay Service: dial 711).

The applicant is responsible for the accuracy of all of the information given on this application including information about the applicant's husband, wife, or civil union partner.