



**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 most notices to you and to someone else. We call this person an “alternate reporter.” However, some notices will only go to you or your alternate reporter, not both of you. For example, the premium bills will only go to you.

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

What is your marital status?       Single/Never married       Married       Civil union  
 Separated       Divorced/Dissolved       Widowed

Spouse or CU Partner \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Last First M.I.

Is this person also applying?     Yes     No      Telephone # \_\_\_\_\_

Do you have children or stepchildren under age 21 living with you?     Yes – ages of children \_\_\_\_\_  
 No

Questions	Applicant	Spouse or Civil Union Partner
1. What is your date of birth?		
2. Are you a U.S. citizen? If no, include proof of immigrant status.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3a. Medicare claim number	_____	_____
3b. Part A (hospital coverage)	Begin Date: _____ Monthly Premium \$ _____	Begin Date: _____ Monthly Premium \$ _____
3c. Part B (medical coverage)	Begin Date: _____ Monthly Premium \$ _____	Begin Date: _____ Monthly Premium \$ _____
3d. Part C (managed care)	Begin Date: _____ Monthly Premium \$ _____	Begin Date: _____ Monthly Premium \$ _____
4. Have you chosen a Part D Prescription Drug Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4a. Plan name		
4b. Contract ID # on the bottom of your Medicare drug plan card	_____	_____
4c. Plan ID # on the bottom of your Medicare drug plan card	_____	_____
4d. Plan start date	___/___/_____	___/___/_____
4e. Monthly premium amount	\$ _____	\$ _____

Questions	Applicant	Spouse or Civil Union Partner
5. Have you applied for "Extra Help" for Part D through Social Security?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5a. If yes, date applied	___ / ___ / _____	___ / ___ / _____
5b. If granted, begin date	___ / ___ / _____	___ / ___ / _____
5c. If denied, what reason did Social Security give you?	<input type="checkbox"/> Over income <input type="checkbox"/> Over resources <input type="checkbox"/> Failed to cooperate <input type="checkbox"/> Other; Explain:	<input type="checkbox"/> Over income <input type="checkbox"/> Over resources <input type="checkbox"/> Failed to cooperate <input type="checkbox"/> Other; Explain:
6. Do you have insurance that covers prescription drugs? (Do not include prescription discount programs or Medicare information listed in #4 above).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6a. Name of insurance company		
6b. Address		
6c. Policy #		
6d. Date coverage began	___ / ___ / _____	___ / ___ / _____
6e. Does this drug coverage have an annual limit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6f. Has the annual limit been met?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you or your spouse or civil union partner have health insurance other than Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7a. Name of policy holder		
7b. Policy # _____ Group # _____	Services (check all that apply) <input type="checkbox"/> Doctors <input type="checkbox"/> Prescriptions <input type="checkbox"/> Hospitals <input type="checkbox"/> Major medical <input type="checkbox"/> Outpatient <input type="checkbox"/> Other _____	Names of people covered
7c. Date coverage began	___ / ___ / _____	___ / ___ / _____
7d. Premium \$_____ per _____		
7e. Name of insurance company		
7f. Company address & phone #		
<b>If you have more than one policy, check here and add a separate sheet of paper.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Have you or your spouse or civil union partner lost health insurance in the past 12 months? <b>Do not include Green Mountain Care plans (Dr. Dynasaur, VHAP, Premium Assistance or Pharmacy).</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of person	Date insurance ended	Reason why insurance ended
	___ / ___ / _____	
	___ / ___ / _____	

Please list all current gross income (before deductions such as taxes, Medicare premiums or other deductions) for yourself and your spouse or civil union partner, if he or she lives with you. Please answer all questions.

TYPE OF INCOME	APPLICANT Amount (before deductions)	SPOUSE OR CIVIL UNION PARTNER Amount (before deductions)
Social Security Retirement (SSA)	\$ _____ per mo. <input type="checkbox"/> None	\$ _____ per mo. <input type="checkbox"/> None
Social Security Disability (SSDI)	\$ _____ per mo. <input type="checkbox"/> None	\$ _____ per mo. <input type="checkbox"/> None
Supplemental Security Income (SSI)	\$ _____ per mo. <input type="checkbox"/> None	\$ _____ per mo. <input type="checkbox"/> None
Railroad Retirement	\$ _____ per mo. <input type="checkbox"/> None	\$ _____ per mo. <input type="checkbox"/> None
Veteran's Benefits	\$ _____ per mo. <input type="checkbox"/> None	\$ _____ per mo. <input type="checkbox"/> None
Pensions or Annuities	\$ _____ <input type="checkbox"/> None Income is received: <input type="checkbox"/> monthly <input type="checkbox"/> bi-monthly <input type="checkbox"/> quarterly <input type="checkbox"/> annually Date last received _____	\$ _____ <input type="checkbox"/> None Income is received: <input type="checkbox"/> monthly <input type="checkbox"/> bi-monthly <input type="checkbox"/> quarterly <input type="checkbox"/> annually Date last received _____
Interest or Dividends	\$ _____ per mo. <input type="checkbox"/> None	\$ _____ per mo. <input type="checkbox"/> None
Self-employment, including rental <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> None (If yes, please send a copy of your most recent federal income tax return, including all schedules and forms.)		

Does anyone have income from a job, internship or training program? <input type="checkbox"/> Yes <input type="checkbox"/> None				
Full Name	Date paid	Hours worked	Income before deductions	Tips and commissions
Paychecks are issued <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly Day of week _____			\$ _____	\$ _____
Employer's name and phone number				

Does anyone have income from a job, internship or training program? <input type="checkbox"/> Yes <input type="checkbox"/> None				
Full Name	Date paid	Hours worked	Income before deductions	Tips and commissions
Paychecks are issued <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly Day of week _____			\$ _____	\$ _____
Employer's name and phone number				

Other income in the last 30 days (such as unemployment, worker's compensation, or alimony) \$ _____ <input type="checkbox"/> None	\$ _____ <input type="checkbox"/> None
Type of Income _____	_____

EXPENSES	APPLICANT	SPOUSE OR CIVIL UNION PARTNER
	Amount	Amount
Do you pay for daycare for a child or an incapacitated adult? Name of child or incapacitated adult _____	\$ _____ per mo. <input type="checkbox"/> No	\$ _____ per mo. <input type="checkbox"/> No
Do you pay court-ordered child support or alimony?	\$ _____ per mo. <input type="checkbox"/> No	\$ _____ per mo. <input type="checkbox"/> No

## 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 the Department for Children and Families (DCF) 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. DCF will not share any information from this application except when needed for program administration. For more information see Release of Medical Records below.

If, on page 1, 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 on page 1 on the application. However, this written notice will not affect information the agencies have already released.

## Rights and Responsibilities (continued)

- 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).

DCF 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 DCF; and to make medical assistance payments.

### **Discrimination.**

DCF does not discriminate based on race, color, national origin, sex, age, disability, marital status, sexual orientation or place of birth. To file a discrimination complaint, write Health and Human Services, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201; call (202) 619-0403 or (202) 619-3257 (TDD); or write to DCF, ESD Deputy Commissioner, 103 S. Main Street, Waterbury, VT 05671-1201.

### **Decision on Application.**

DCF 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 the ESD Benefits Service Center at 1-800-479-6151, by calling Member Services at 1-800-250-8427 or by writing to the Human Services Board, 120 State Street, Montpelier, VT 05620-4301 (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.**

DCF 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 DCF to get it.

## Rights and Responsibilities (continued)

### **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 DCF 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 DCF 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 amount equal to the benefit wrongfully received. 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 DCF, ESD Deputy Commissioner, 103 S. Main Street, Waterbury, VT 05671-1201.

### **Assignment of Medical Support and Third Party Payments.**

As a condition of eligibility for health care assistance, I agree to assign to DCF all rights to medical support and to third party payments (such as insurance) for medical care. I agree to enroll in a group health plan if the state requires me to, and I understand the state may pay all or part of the premiums.

I also agree to cooperate in pursuing any actual or potential source of support or payments, including establishing paternity for my dependent children, if necessary. I understand that if I do not cooperate, my health care benefits will end although my children's health care will continue.

### **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 DCF-Economic Services Division address on the following page.

