201P

Vermont Department for Children and Families
Economic Services Division

Pharmacy Programs Application

VPharm, VHAP-Pharmacy, VScript, VScript Expanded, and Healthy Vermonters Programs

This application is for programs that help Vermonters pay for prescription drugs. People who have a disability or are age 65 or older may be eligible for one of these programs. The Healthy Vermonters program helps people of all ages. **We will give you the best coverage we can.**

The maximum income limit for one person is about $3,600 per month, increasing with each additional household member. You may be required to pay a monthly premium of up to $50 per month for each person. **Please answer each question below for the people applying for coverage.**

Name ____________________________ (Last / First / Middle initial) Social Security no. ____________

Mailing address ____________________________ (Number / Street / PO Box or RD / City or Town / State / Zip code)

Marital status ☐ Single ☐ Married ☐ Civil union ☐ Separated ☐ Divorced ☐ Widowed Sex ☐ M ☐ F

Spouse or CU partner ____________________________ (Last / First / Middle initial) Social Security no. ____________

Is this person also applying? ☐ Yes ☐ No Telephone # ____________

Are any of your children or stepchildren who are 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.	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you have Medicare?	☐ Yes ☐ No	☐ Yes ☐ No
3a. Medicare claim number		
3b. Part A (hospital coverage)	Begin date Premium	Begin date Premium
3c. Part B (medical coverage)	Begin date Premium	Begin date Premium
3d. Part C (managed care)	Begin date Premium	Begin date Premium
3e. Part D (drug coverage)	Begin date Premium	Begin date Premium
4. Have you chosen a Part D Prescription Drug Plan?	☐ Yes ☐ No	☐ Yes ☐ No
4a. Plan name		
4b. Contract ID #		
4c. Plan ID #		
4d. Plan start date		
5. Have you applied for "extra help" for Part D through Social Security?	☐ Yes, granted ☐ Yes, denied ☐ No	☐ Yes, granted ☐ Yes, denied ☐ No
5a. If granted, begin date		
5b. If denied, what reason did Social Security give you?	☐ Over income ☐ Over resource ☐ Failed to cooperate ☐ Other; explain:	☐ Over income ☐ Over resource ☐ Failed to cooperate ☐ Other; explain:
6. If you did not apply, what was your reason?	☐ Over income ☐ Over resource ☐ Other; explain:	☐ Over income ☐ Over resource ☐ Other; explain:
7. Do you have insurance that covers prescription drugs? **(Do not include discount programs)**	☐ Yes ☐ No	☐ Yes ☐ No
7a. Name of insurance company		
7b. Address		
7c. Policy number		
7d. Date coverage began		
7e. Does this drug coverage have an annual limit?	☐ Yes ☐ No	☐ Yes ☐ No

Please complete the other side and sign this application ☛

8. Do you or your spouse or civil union partner have health insurance?	☐ Yes	☐ No
8a. Policy holder	Services (check all that apply)	Names of people covered
8b. Policy # ________ Group # ________	☐ Doctors ☐ Prescriptions	
8c. Date coverage began	☐ Hospitals ☐ Major Medical	
8d. Premium $________ per ________	☐ Outpatient ☐ Other________	
8e. Name of insurance company		
8f. Company address & phone #		

9. Have you or your spouse or civil union partner lost health insurance in the past 12 months? (Do not include state health care programs)	☐ Yes	☐ No
9a. Name of person	**9b.** Date insurance ended	**9c.** Reason why insurance ended

Please list all current gross income (before taxes, Medicare, and 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	$	per mo.	☐ None	$	per mo.	☐ None
Social Security disability	$	per mo.	☐ None	$	per mo.	☐ None
SSI	$	per mo.	☐ None	$	per mo.	☐ None
Railroad retirement	$	per mo.	☐ None	$	per mo.	☐ None
Veteran's benefits	$	per mo.	☐ None	$	per mo.	☐ None
Pensions or annuities	$	per mo.	☐ None	$	per mo.	☐ None
Interest or dividends	$	per mo.	☐ None	$	per mo.	☐ None
Self-employment, including rental	$	per yr.	☐ None	$	per yr.	☐ None
(If yes, please send copy of most recent federal income tax return including all schedules.)						
Wages in last 30 days	$		☐ None	$		☐ None
	Employer	Hrs. per wk.	Hourly wage	Employer	Hrs. per wk.	Hourly wage
Other income in last 30 days *(Such as unemployment, worker's compensation, or alimony)* *Please describe*________	$		☐ None	$		☐ None
Do you pay for day care for a child or an incapacitated adult?	$	per month	☐ No	$	per month	☐ No
Do you pay child support or alimony?	$	per month	☐ No	$	per month	☐ No

Please read the following rights and responsibilities and sign below:

The information I have provided is correct to the best of my knowledge. I understand this information may be verified. I understand that I must report all changes, such as changes in income, insurance, address, and household size. I understand the information I have given is private and cannot be seen by the public.

I understand that federal regulation requires that I provide my social security number and that it may be used to check my statements with other agencies, such as the Social Security Administration and the Internal Revenue Service, and for quality control reviews. This requirement may be waived for members of a religious organization that objects to furnishing a social security number.

I understand that intentionally making a false or misleading statement, or concealing or withholding facts, may result in paying the Department, in cash, the value of the prescription discounts I received and may subject me to civil or criminal prosecution.

I understand that I have the right to treatment that is fair and does not discriminate. I may not be treated differently because of race, color, national origin, marital status, sex, sexual orientation, age, religion, political beliefs, place of birth, or because of physical, mental, or emotional conditions. If I have a complaint about being treated differently, I may contact the Office for Civil Rights, Health and Human Services, Room 506-F, 200 Independence Avenue, S.W., Washington D.C. 20201. If I believe I have been discriminated against because of a disability, I may contact: Deputy Commissioner, Department for Children and Families, Economic Services Division, 103 South Main Street, Waterbury, VT 05671-1201.

I have reviewed the statements above about my rights and responsibilities and I understand them.

Signature of applicant, authorized representative or legal guardian	Date	Signature of person witnessing or helping to fill out this form	Telephone #

If you have an authorized representative or legal guardian, please provide:

Name: ________________________ Telephone #: ________________

Address: ____

After signing this form, please mail it to: ADPC, 103 South Main Street, Waterbury, VT 05671-1500

If you have questions or for current income levels, call Health Access Member Services at 1-800-250-8427.

To use telephone service for people with hearing disabilities, call 1-888-834-7898.

If you are struggling to make ends meet, call 1-800-287-0589 for a 3SquaresVT application.