Disabled Children's Home Care (DCHC) – Katie Beckett

Eligibility & New Application

Thursday, October 29, 2020

VERMONT
DEPARTMENT OF HEALTH

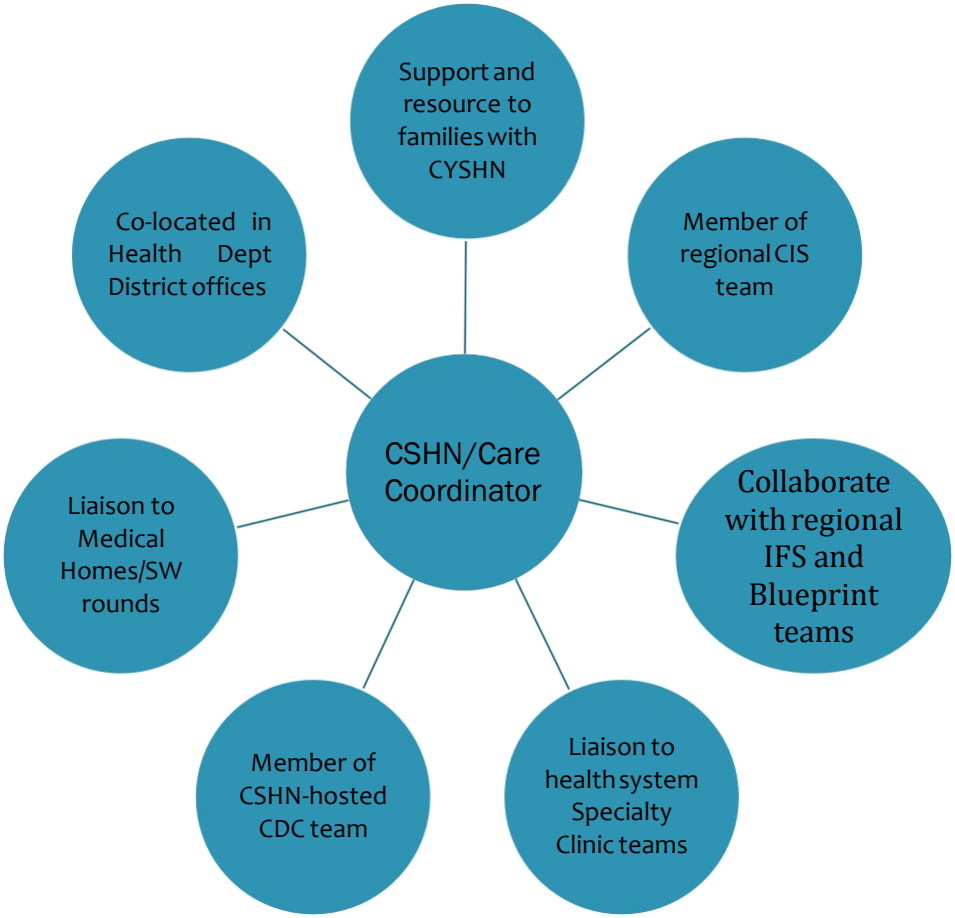
Children with Special Health Needs (CSHN)

CSHN is a free public health program for families, health care providers and communities. CSHN supports Vermont children and youth with special health needs by ensuring comprehensive, community-based and family-centered services.

https://www.healthvermont.gov/family/special-health-needs

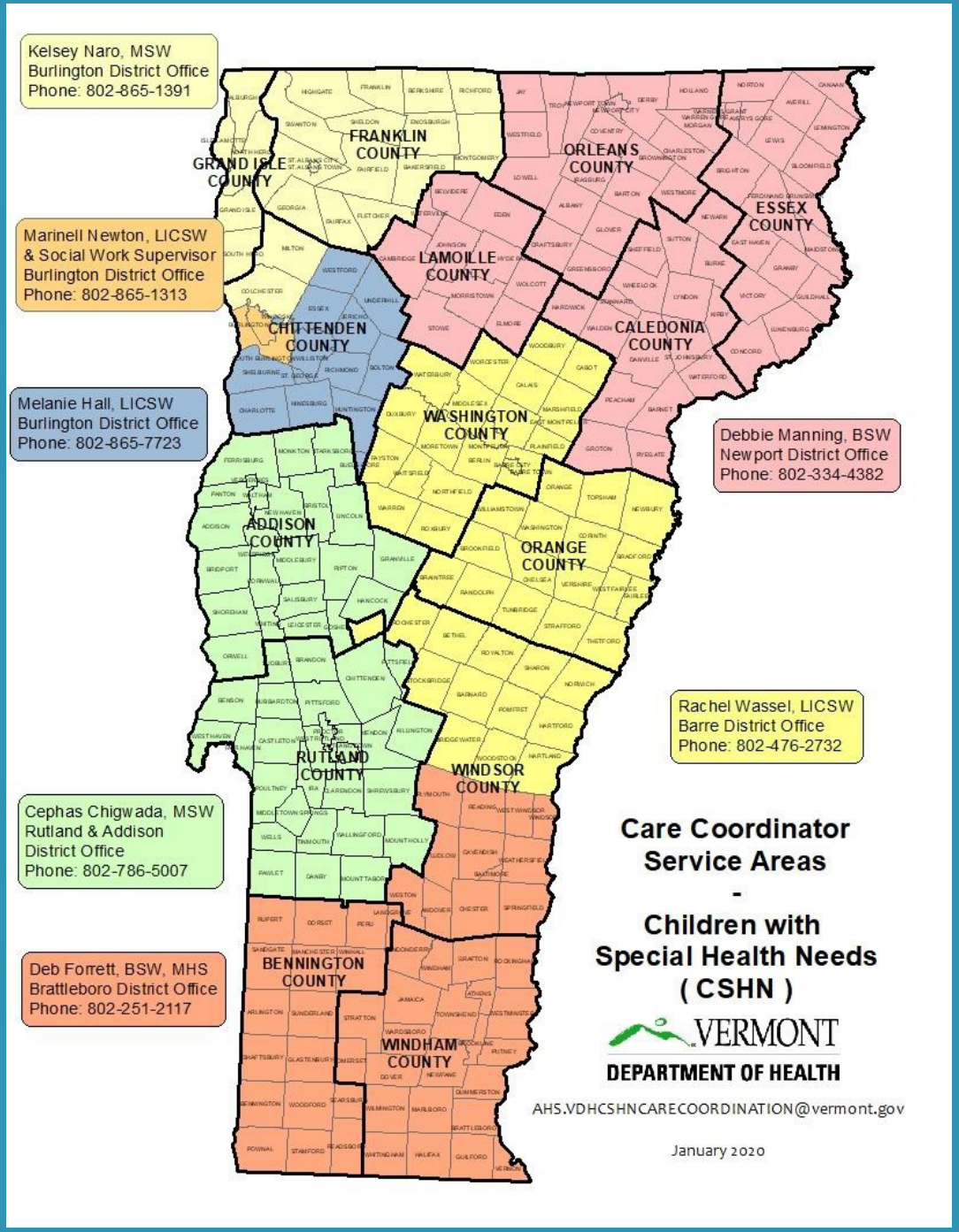
Presenter:
Betty Morse, Technical Assistance Specialist
Children with Special Health Needs (CSHN)
Vermont Department of Health

Care Coordination within a Statewide System of Care



CSHN Regional Medical Social Workers

https://www.healthvermont.gov/children-youth-families/children-special-health-needs/care-coordination



What are we talking about today?

- What is Disabled Children's Home Care (DCHC)?
- Who was Katie Beckett?
- Eligibility criteria
- Financial criteria
- Differences between Dr. Dynasaur Medicaid and DCHC
- Tips for filling out the application
- Yearly financial renewal
- Program medical review
- Appeal
- EPSDT

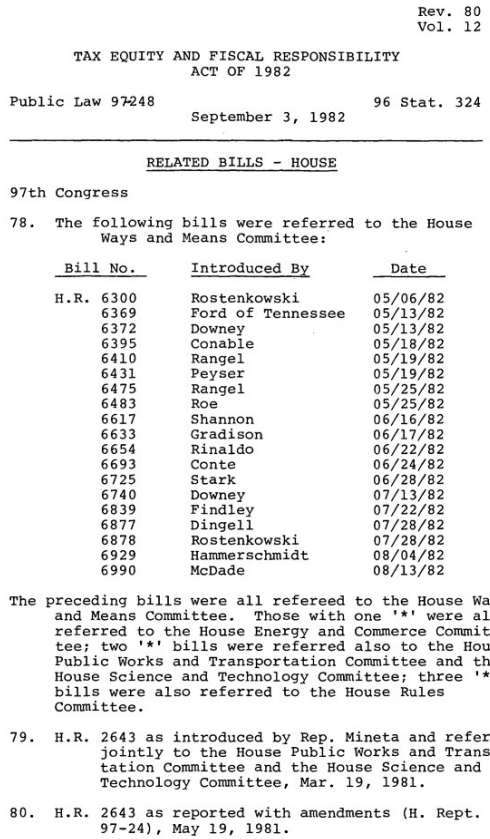
Disabled Children's Home Care (DCHC) – Katie Beckett

DCHC is a Green Mountain Care Program that allows certain children under the age of 19 who have long term disabilities, or complex medical needs that require a high level of care, to become eligible for Medicaid insurance even though their families' income is above the financial eligibility level for Dr. Dynasaur. With DCHC, only the child's income and resources are used to determine financial eligibility – not the family income.

Who was Katie Beckett?

- Girl from Iowa
- Spent the first three years of her life in the hospital
- Medicaid rules did not allow for payment because of a requirement about the coverage of equipment in the home
- Katie's parents advocated with local representatives and congressmen
- Support of Vice-President George H. Bush and President Ronald Reagan
- Discussions with Medicaid led to an exception to the home care policy

H.R.4961 - Tax Equity and Fiscal Responsibility Act of 1982



Rev. 80
Vol. 12

TAX EQUITY AND FISCAL RESPONSIBILITY
ACT OF 1982

Public Law 97-248 96 Stat. 324
September 3, 1982

RELATED BILLS - HOUSE

97th Congress

78. The following bills were referred to the House Ways and Means Committee:

Bill No.	Introduced By	Date
H.R. 6300	Rostenkowski	05/06/82
6369	Ford of Tennessee	05/13/82
6372	Downey	05/13/82
6395	Conable	05/18/82
6410	Rangel	05/19/82
6431	Peyser	05/19/82
6475	Rangel	05/25/82
6483	Roe	05/25/82
6617	Shannon	06/16/82
6633	Gradison	06/17/82
6654	Rinaldo	06/22/82
6693	Conte	06/24/82
6725	Stark	06/28/82
6740	Downey	07/13/82
6839	Findley	07/22/82
6877	Dingell	07/28/82
6878	Rostenkowski	07/28/82
6929	Hammerschmidt	08/04/82
6990	McDade	08/13/82

The preceding bills were all refereed to the House Ways and Means Committee. Those with one '*' were also referred to the House Energy and Commerce Committee; two '*' bills were referred also to the House Public Works and Transportation Committee and the House Science and Technology Committee; three '*' bills were also referred to the House Rules Committee.

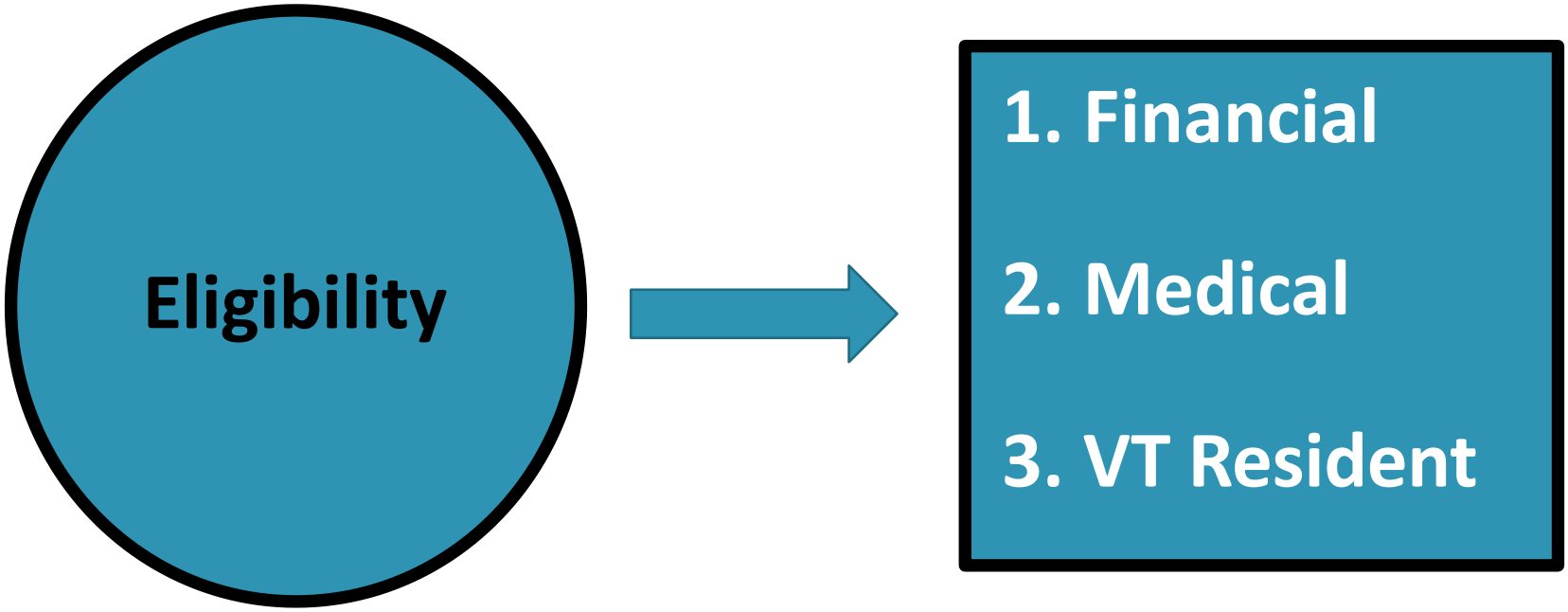
79. H.R. 2643 as introduced by Rep. Mineta and referred jointly to the House Public Works and Transportation Committee and the House Science and Technology Committee, Mar. 19, 1981.

80. H.R. 2643 as reported with amendments (H. Rept. 97-24), May 19, 1981.

Under 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), states are allowed to make Medicaid benefits available to eligible children with disabilities who would not ordinarily qualify for Supplemental Security Income (SSI) benefits because of parents' income or resources.

https://www.congress.gov/bill/97th-congress/house-bill/4961

Disabled Children's Home Care



Financial Eligibility

- Not over $2000.00 in income/resources

What about my child?

- Household income/resources are not counted
- Has home care costs that are less than the cost for care in a medical facility/residential center

Medical Eligibility

- Requires a level of care which compares to the level of care provided in a hospital, nursing home or residential center – “Institutional level of care”.
- Must qualify under Social Security Administration definition of disability
- www.ssa.gov/disability/professionals/bluebook/ChildhoodListings.htm

Dr. Dynasaur Medicaid

- Children under the age of 19
- Pregnant women with income below 213% FPL
- Household income below 317% FPL
- Could be a monthly premium
- Applied and renewed through Vermont Health Connect

Disabled Children's Home Care - Katie Beckett Medicaid

- Children under the age of 19
- Only child's income/resources are counted
- Require an "institutional level of care"
- Must qualify under Social Security Administration definition of disability
- Paper application package and renewal through DVHA/Green Mountain Care

Eligibility for Benefits Determined in Relation to 2020 Federal Poverty Level (FPL)

Upper FPL% and ***monthly*** income limits for:	Medicaid for Adults	Pregnant Women	Children under 19
Household Size*	133% of FPL + 5% disregard	208% of FPL + 5% disregard	312% of FPL + 5% disregard
1	$1,468.20	N/A	$3,371.20
2	$1,982.85	$3,060.85	$4,554.85
3	$2,498.50	$3,855.50	$5,738.50
4	$3,013.20	$4,651.20	$6,921.20
5	$3,528.85	$5,445.85	$8,104.85
6	$4,043.50	$6,241.50	$9,288.50
7	$4,559.20	$7,036.20	$10,472.20
8	$5,073.85	$7,831.85	$11,655.85

*Effective 1/1/14, Medicaid for Children and Adults (MCA) has no resource test. The FPL% limits listed above include the program threshold plus a 5% income disregard.

Eligibility requirements for the Aged, Blind and Disabled (MABD) can be found at http://www.greenmountaincare.org/mabd

Coverage to Care: Insuring Vermont Families

A comprehensive look at the different coverage options available for Vermonters through Vermont Health Connect and Green Mountain Care.

Presenter: Victoria Jarvis, Program Manager, In-Person Assisters, Vermont Health Connect.

Vermont Family Network workshop on October 1, 2020

- link to the video recording
- PowerPoint presentation

https://www.vermontfamilynetwork.org

Preparing

For everyone in your household, collect:

- Social Security numbers
- Employer and income information
- Information on any insurance you get through your job
- If you are a court appointed guardian, you will need to include a copy of the court guardianship document.

For the child applying for DCHC, collect:

- Names, address and phone numbers of your child's medical providers, specialists, therapists,
- In and out-patient hospitalizations & emergency room visits – Hospital name and dates
- Tests and x-rays with dates, who sent the child for these, and where they were done
- Medications and who prescribed them
- Name, address and phone number for childcare, early intervention staff, school and special education staff
- Child's height and weight

Proof of Identity, Citizenship and Residency

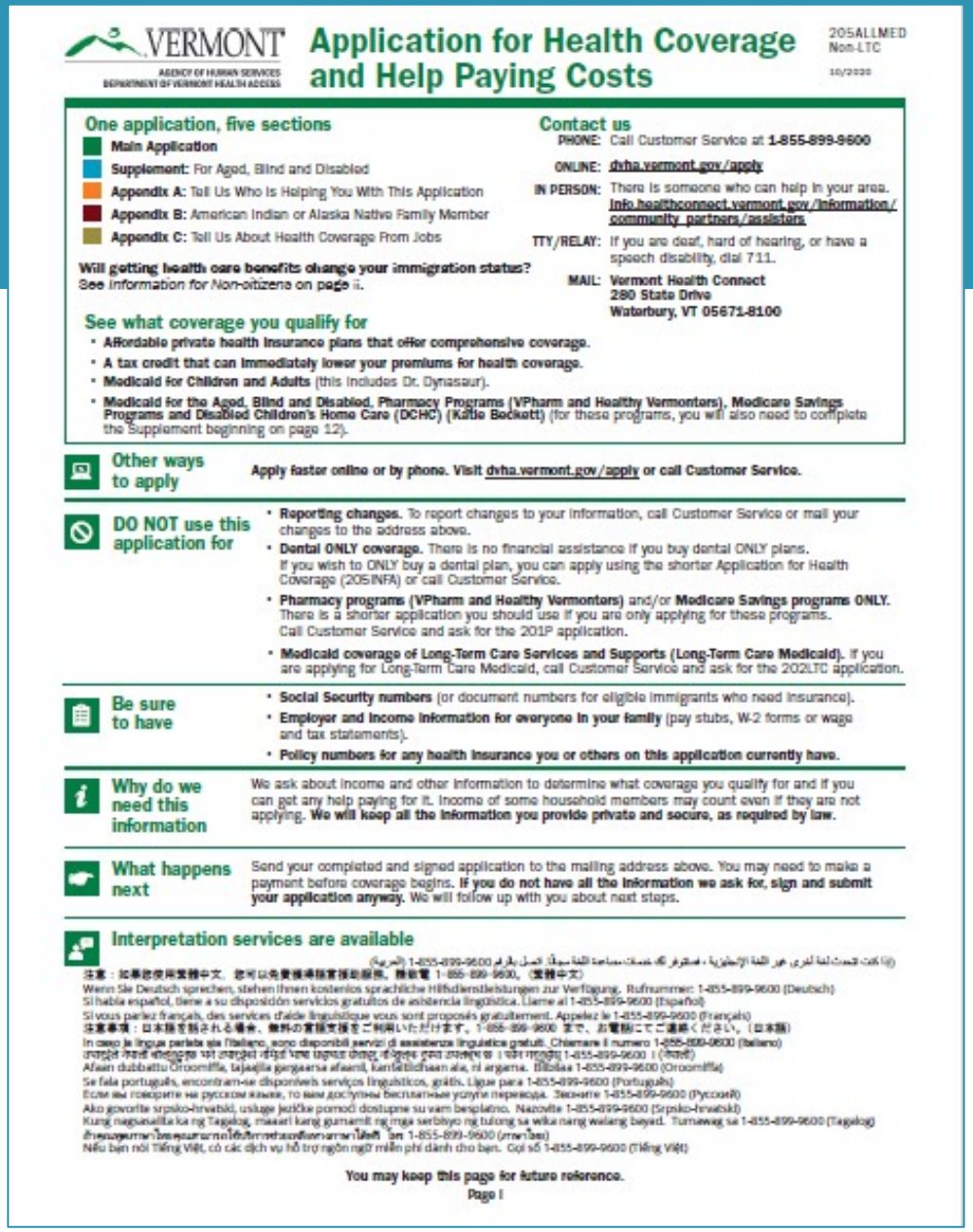
- Birth Certificate
- Social Security Card
- Passport
- Parent Picture Driver's License
- Copy of mail showing name and address
- Green card/Permanent Residence Card
- Certificate of Indian Blood, or other U.S. American Indian/Alaska Native tribal document.
- Copies of Immigration paperwork

Application Page i

Application for Health Coverage and Help Paying Costs

205ALLMED Non-LTC

(As of this date: Updated 10/2020)



VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Application for Health Coverage and Help Paying Costs

205ALLMED
Non-LTC
10/2020

One application, five sections

- **Main Application**
- **Supplement:** For Aged, Blind and Disabled
- **Appendix A:** Tell Us Who Is Helping You With This Application
- **Appendix B:** American Indian or Alaska Native Family Member
- **Appendix C:** Tell Us About Health Coverage From Jobs

Will getting health care benefits change your immigration status?
See *Information for Non-citizens* on page ii.

Contact us

PHONE: Call Customer Service at **1-855-899-9600**

ONLINE: dvha.vermont.gov/apply

IN PERSON: There is someone who can help in your area. info.healthconnect.vermont.gov/information/community_partners/assisters

TTY/RELAY: If you are deaf, hard of hearing, or have a speech disability, dial 711.

MAIL: **Vermont Health Connect**
280 State Drive
Waterbury, VT 05671-8100

See what coverage you qualify for

- **Affordable private health insurance plans that offer comprehensive coverage.**
- **A tax credit that can immediately lower your premiums for health coverage.**
- **Medicaid for Children and Adults** (this includes Dr. Dynasaur).
- **Medicaid for the Aged, Blind and Disabled, Pharmacy Programs (VPharm and Healthy Vermonters), Medicare Savings Programs and Disabled Children's Home Care (DCHC) (Katie Beckett)** (for these programs, you will also need to complete the Supplement beginning on page 12).

Other ways to apply

Apply faster online or by phone. Visit dvha.vermont.gov/apply or call Customer Service.

DO NOT use this application for

- **Reporting changes.** To report changes to your information, call Customer Service or mail your changes to the address above.
- **Dental ONLY coverage.** There is no financial assistance if you buy dental ONLY plans. If you wish to ONLY buy a dental plan, you can apply using the shorter Application for Health Coverage (205INFA) or call Customer Service.
- **Pharmacy programs (VPharm and Healthy Vermonters)** and/or **Medicare Savings programs ONLY.** There is a shorter application you should use if you are only applying for these programs. Call Customer Service and ask for the 201P application.
- **Medicaid coverage of Long-Term Care Services and Supports (Long-Term Care Medicaid).** If you are applying for Long-Term Care Medicaid, call Customer Service and ask for the 202LTC application.

Be sure to have

- **Social Security numbers** (or document numbers for eligible immigrants who need insurance).
- **Employer and income information for everyone in your family** (pay stubs, W-2 forms or wage and tax statements).
- **Policy numbers for any health insurance you or others on this application currently have.**

Why do we need this information

We ask about income and other information to determine what coverage you qualify for and if you can get any help paying for it. Income of some household members may count even if they are not applying. **We will keep all the information you provide private and secure, as required by law.**

What happens next

Send your completed and signed application to the mailing address above. You may need to make a payment before coverage begins. **If you do not have all the information we ask for, sign and submit your application anyway.** We will follow up with you about next steps.

Interpretation services are available

(إذا كنت تحتاج لغة أخرى غير اللغة الإنجليزية ، فستوفر لك خدمات مساعدة اللغة مجانًا. اتصل برقم 1-855-899-9600 (العربية)
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 1-855-899-9600。(繁體中文)
Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-899-9600 (Deutsch)
Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-899-9600 (Español)
Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-899-9600 (Français)
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。1-855-899-9600 まで、お電話にてご連絡ください。(日本語)
In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-899-9600 (Italiano)
(हिन्दी) 1-855-899-9600 पर कॉल करें।
Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-899-9600 (Oroomiffa)
Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-899-9600 (Português)
Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-899-9600 (Русский)
Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-899-9600 (Srpsko-hrvatski)
Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-899-9600 (Tagalog)
(ภาษาไทย) 1-855-899-9600
Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-899-9600 (Tiếng Việt)

You may keep this page for future reference.

Page i

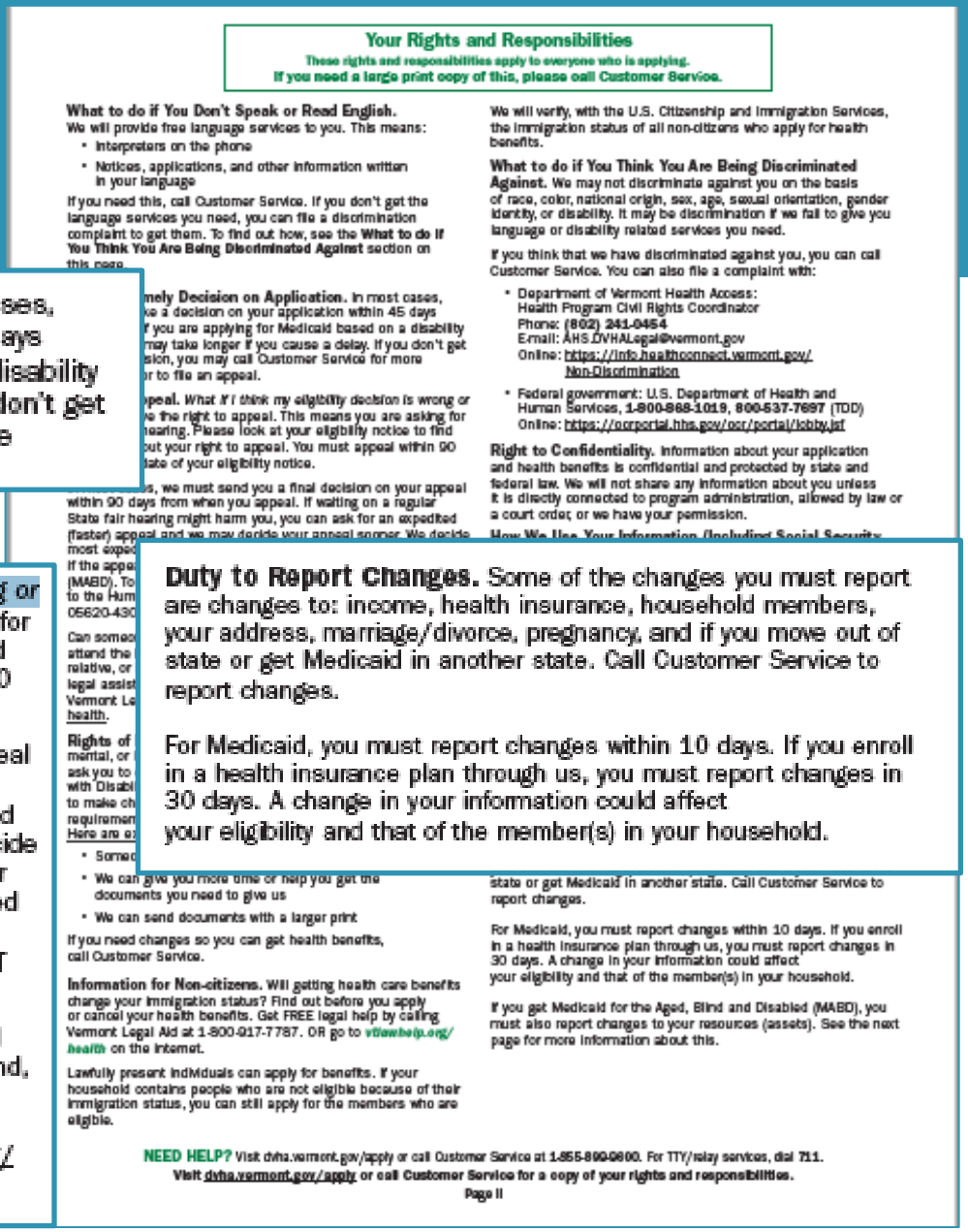
Page ii

Right to Timely Decision on Application. In most cases, we must make a decision on your application within 45 days (or 90 days if you are applying for Medicaid based on a disability decision). It may take longer if you cause a delay. If you don't get a timely decision, you may call Customer Service for more information or to file an appeal.

Right to Appeal. *What if I think my eligibility decision is wrong or late?* You have the right to appeal. This means you are asking for a State fair hearing. Please look at your eligibility notice to find out more about your right to appeal. You must appeal within 90 days of the date of your eligibility notice.

In most cases, we must send you a final decision on your appeal within 90 days from when you appeal. If waiting on a regular State fair hearing might harm you, you can ask for an expedited (faster) appeal and we may decide your appeal sooner. We decide most expedited appeals in 7 working days. We may take longer if the appeal is about Medicaid for the Aged, Blind and Disabled (MABD). To appeal, call Customer Service. You may also write to the Human Services Board, 120 State Street, Montpelier, VT 05620-4301.

Can someone speak for me at my fair hearing? Yes. You should attend the hearing but you may have someone else, like a friend, relative, or lawyer, speak for you. You may be able to get free legal assistance by contacting the Health Care Advocate at Vermont Legal Aid at **1-800-917-7787** or https://vtlawhelp.org/health.



Your Rights and Responsibilities

These rights and responsibilities apply to everyone who is applying.
If you need a large print copy of this, please call Customer Service.

What to do if You Don't Speak or Read English.
We will provide free language services to you. This means:

- Interpreters on the phone
- Notices, applications, and other information written in your language

If you need this, call Customer Service. If you don't get the language services you need, you can file a discrimination complaint to get them. To find out how, see the **What to do if You Think You Are Being Discriminated Against** section on this page.

…mely Decision on Application. In most cases, …e a decision on your application within 45 days …f you are applying for Medicaid based on a disability …may take longer if you cause a delay. If you don't get …sion, you may call Customer Service for more …r to file an appeal.

…peal. *What if I think my eligibility decision is wrong or …e the right to appeal.* This means you are asking for …earing. Please look at your eligibility notice to find …ut your right to appeal. You must appeal within 90 …ate of your eligibility notice.

…s, we must send you a final decision on your appeal within 90 days from when you appeal. If waiting on a regular State fair hearing might harm you, you can ask for an expedited (faster) appeal and we may decide your appeal sooner. We decide most expe… If the appe… (MABD). To… to the Hum… 05620-430…

Can someo… attend the … relative, or … legal assist… Vermont Le… health.

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- Someo…
- We can give you more time or help you get the documents you need to give us
- We can send documents with a larger print

If you need changes so you can get health benefits, call Customer Service.

Information for Non-citizens. Will getting health care benefits change your immigration status? Find out before you apply or cancel your health benefits. Get FREE legal help by calling Vermont Legal Aid at 1-800-917-7787. OR go to *vtlawhelp.org/health* on the internet.

Lawfully present individuals can apply for benefits. If your household contains people who are not eligible because of their immigration status, you can still apply for the members who are eligible.

We will verify, with the U.S. Citizenship and Immigration Services, the immigration status of all non-citizens who apply for health benefits.

What to do if You Think You Are Being Discriminated Against. We may not discriminate against you on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. It may be discrimination if we fail to give you language or disability related services you need.

If you think that we have discriminated against you, you can call Customer Service. You can also file a complaint with:

- Department of Vermont Health Access:
  Health Program Civil Rights Coordinator
  Phone: **(802) 241-0454**
  E-mail: AHS.DVHALegal@vermont.gov
  Online: https://info.healthconnect.vermont.gov/Non-Discrimination
- Federal government: U.S. Department of Health and Human Services, **1-800-868-1019, 800-537-7697** (TDD)
  Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Right to Confidentiality. Information about your application and health benefits is confidential and protected by state and federal law. We will not share any information about you unless it is directly connected to program administration, allowed by law or a court order, or we have your permission.

How We Use Your Information (Including Social Security …

Duty to Report Changes. Some of the changes you must report are changes to: income, health insurance, household members, your address, marriage/divorce, pregnancy, and if you move out of state or get Medicaid in another state. Call Customer Service to report changes.

For Medicaid, you must report changes within 10 days. If you enroll in a health insurance plan through us, you must report changes in 30 days. A change in your information could affect your eligibility and that of the member(s) in your household.

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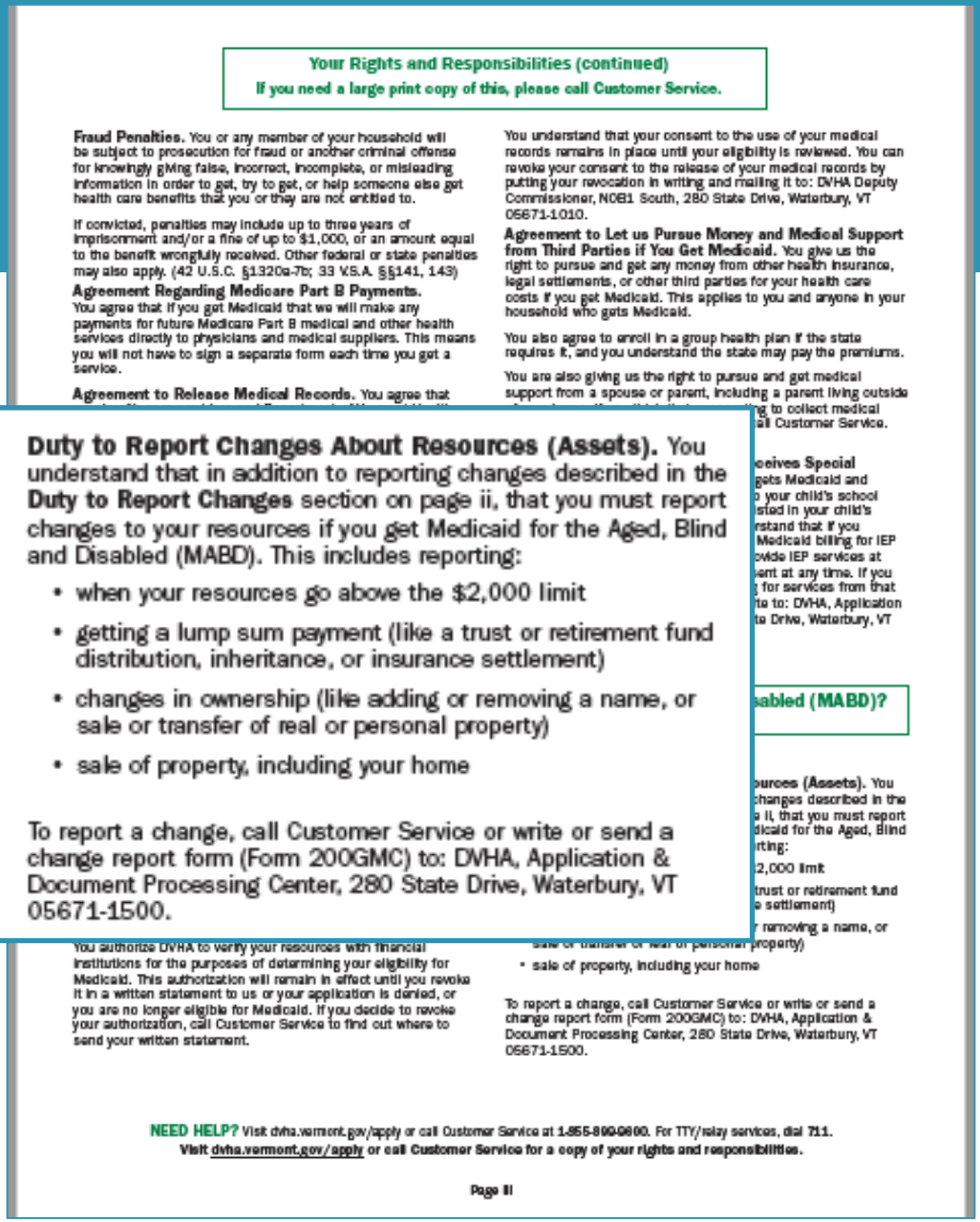
For Medicaid, you must report changes within 10 days. If you enroll in a health insurance plan through us, you must report changes in 30 days. A change in your information could affect your eligibility and that of the member(s) in your household.

If you get Medicaid for the Aged, Blind and Disabled (MABD), you must also report changes to your resources (assets). See the next page for more information about this.

NEED HELP? Visit dvha.vermont.gov/apply or call Customer Service at 1-855-899-0800. For TTY/relay services, dial 711.
Visit dvha.vermont.gov/apply or call Customer Service for a copy of your rights and responsibilities.
Page II

Page iii



Your Rights and Responsibilities (continued)

If you need a large print copy of this, please call Customer Service.

Fraud Penalties. You or any member of your household will be subject to prosecution for fraud or another 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 that you or they are not entitled to.

If convicted, penalties may include up to three years of imprisonment and/or a fine of up to $1,000, 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)

Agreement Regarding Medicare Part B Payments. You agree that if you get Medicaid that we will make any payments for future Medicare Part B medical and other health services directly to physicians and medical suppliers. This means you will not have to sign a separate form each time you get a service.

Agreement to Release Medical Records. You agree that

You understand that your consent to the use of your medical records remains in place until your eligibility is reviewed. You can revoke your consent to the release of your medical records by putting your revocation in writing and mailing it to: DVHA Deputy Commissioner, NOB1 South, 280 State Drive, Waterbury, VT 05671-1010.

Agreement to Let us Pursue Money and Medical Support from Third Parties if You Get Medicaid. You give us the right to pursue and get any money from other health insurance, legal settlements, or other third parties for your health care costs if you get Medicaid. This applies to you and anyone in your household who gets Medicaid.

You also agree to enroll in a group health plan if the state requires it, and you understand the state may pay the premiums.

You are also giving us the right to pursue and get medical support from a spouse or parent, including a parent living outside

to collect medical
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te Drive, Waterbury, VT

abled (MABD)?

ources (Assets). You
changes described in the
e ii, that you must report
dicaid for the Aged, Blind
rting:
2,000 limit
trust or retirement fund
e settlement)
removing a name, or
sale or transfer of real or personal property)
- sale of property, including your home

To report a change, call Customer Service or write or send a change report form (Form 200GMC) to: DVHA, Application & Document Processing Center, 280 State Drive, Waterbury, VT 05671-1500.

Authorization to Verify Resources for Medicaid for the Aged, Blind and Disabled (MABD). You understand that Medicaid for the Aged, Blind and Disabled (MABD) has income and resource eligibility limits. You understand that to meet requirements of federal law (42 U.S.C. 1396w), that the Department of Vermont Health Access (DVHA) uses an electronic asset verification system (eAVS) to assist in verifying eligibility for this program. eAVS requests information from financial institutions on both open and closed accounts for the purpose of determining Medicaid eligibility.

You authorize DVHA to verify your resources with financial institutions for the purposes of determining your eligibility for Medicaid. This authorization will remain in effect until you revoke it in a written statement to us or your application is denied, or you are no longer eligible for Medicaid. If you decide to revoke your authorization, call Customer Service to find out where to send your written statement.

You authorize DVHA to verify your resources with financial institutions for the purposes of determining your eligibility for Medicaid. This authorization will remain in effect until you revoke it in a written statement to us or your application is denied, or you are no longer eligible for Medicaid. If you decide to revoke your authorization, call Customer Service to find out where to send your written statement.

Duty to Report Changes About Resources (Assets). You understand that in addition to reporting changes described in the **Duty to Report Changes** section on page ii, that you must report changes to your resources if you get Medicaid for the Aged, Blind and Disabled (MABD). This includes reporting:

- when your resources go above the $2,000 limit
- getting a lump sum payment (like a trust or retirement fund distribution, inheritance, or insurance settlement)
- changes in ownership (like adding or removing a name, or sale or transfer of real or personal property)
- sale of property, including your home

To report a change, call Customer Service or write or send a change report form (Form 200GMC) to: DVHA, Application & Document Processing Center, 280 State Drive, Waterbury, VT 05671-1500.

NEED HELP? Visit dvha.vermont.gov/apply or call Customer Service at 1-855-8999800. For TTY/relay services, dial 711.
Visit dvha.vermont.gov/apply or call Customer Service for a copy of your rights and responsibilities.

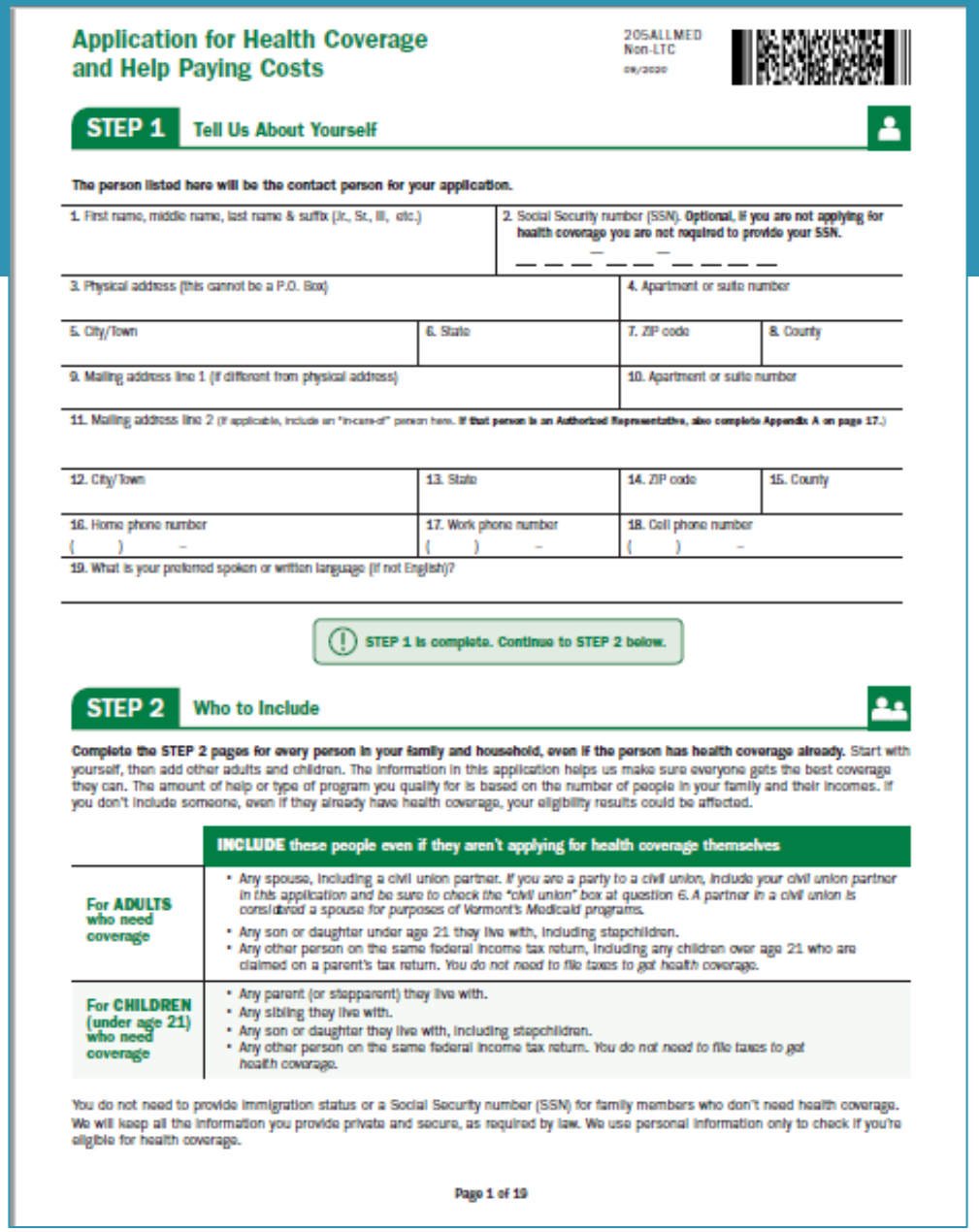
Page ii

Form 200 GMC
https://www.greenmountaincare.org/mabd

Page 1

Step 1:
Tell Us About Yourself

- Yourself is Parent/Guardian NOT the child
- Social Security Number
- Fill in all your address information



Application for Health Coverage and Help Paying Costs

20SALLMED
Non-LTC
09/2020

STEP 1 Tell Us About Yourself

The person listed here will be the contact person for your application.

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.)
2. Social Security number (SSN). **Optional. If you are not applying for health coverage you are not required to provide your SSN.**
3. Physical address (this cannot be a P.O. Box)
4. Apartment or suite number
5. City/Town
6. State
7. ZIP code
8. County
9. Mailing address line 1 (if different from physical address)
10. Apartment or suite number
11. Mailing address line 2 (if applicable, include an "in-care-of" person here. **If that person is an Authorized Representative, also complete Appendix A on page 17.**)
12. City/Town
13. State
14. ZIP code
15. County
16. Home phone number
17. Work phone number
18. Cell phone number
19. What is your preferred spoken or written language (if not English)?

STEP 1 is complete. Continue to STEP 2 below.

STEP 2 Who to Include

Complete the STEP 2 pages for every person in your family and household, even if the person has health coverage already. Start with yourself, then add other adults and children. The information in this application helps us make sure everyone gets the best coverage they can. The amount of help or type of program you qualify for is based on the number of people in your family and their incomes. If you don't include someone, even if they already have health coverage, your eligibility results could be affected.

	INCLUDE these people even if they aren't applying for health coverage themselves
For **ADULTS** who need coverage	• Any spouse, including a civil union partner. *If you are a party to a civil union, include your civil union partner in this application and be sure to check the "civil union" box at question 6. A partner in a civil union is considered a spouse for purposes of Vermont's Medicaid programs.* • Any son or daughter under age 21 they live with, including stepchildren. • Any other person on the same federal income tax return, including any children over age 21 who are claimed on a parent's tax return. *You do not need to file taxes to get health coverage.*
For **CHILDREN** (under age 21) who need coverage	• Any parent (or stepparent) they live with. • Any sibling they live with. • Any son or daughter they live with, including stepchildren. • Any other person on the same federal income tax return. *You do not need to file taxes to get health coverage.*

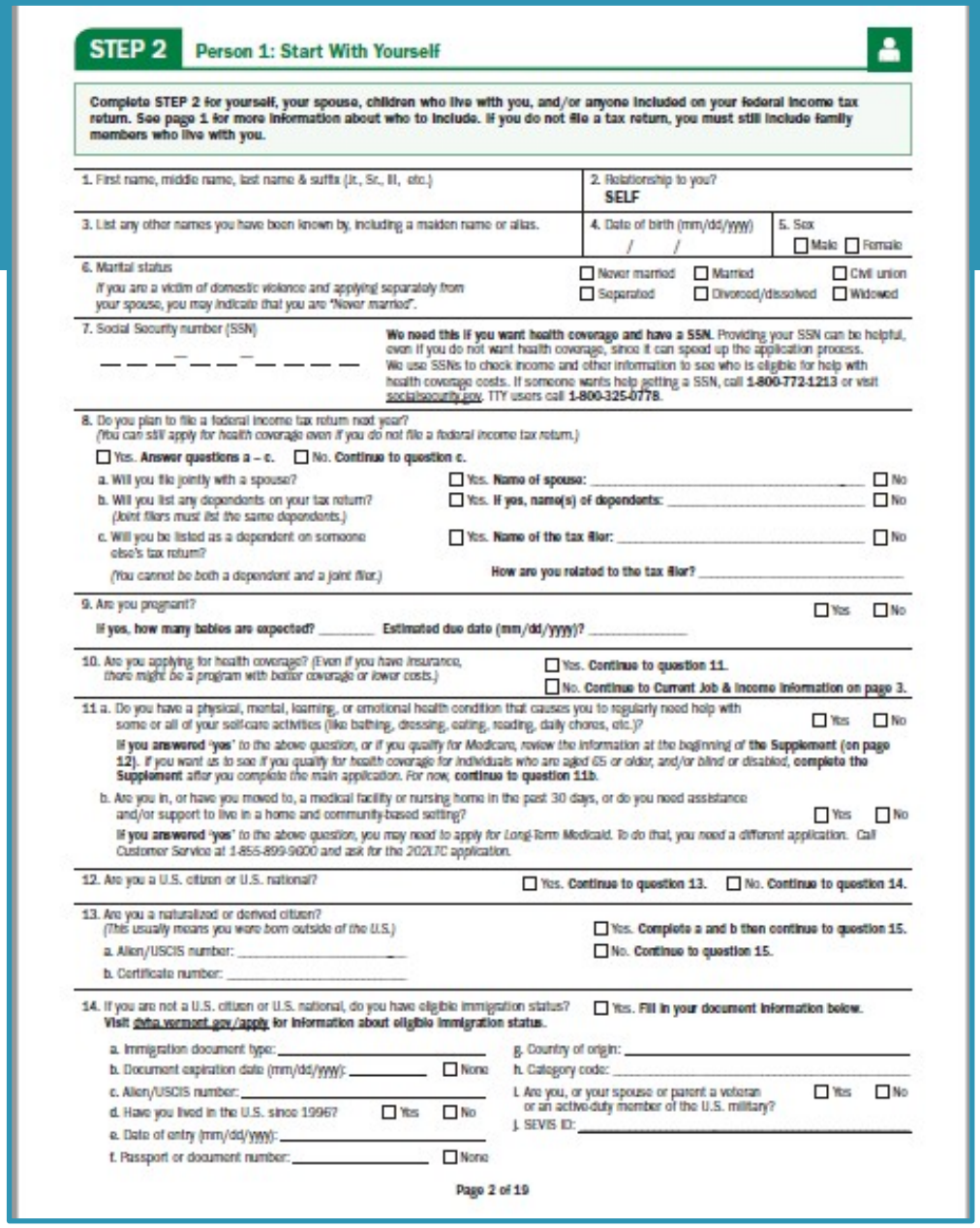
You do not need to provide immigration status or a Social Security number (SSN) for family members who don't need health coverage. We will keep all the information you provide private and secure, as required by law. We use personal information only to check if you're eligible for health coverage.

Page 1 of 19

Page 2

Step 2: Person 1:
Start With Yourself

- Parent/Guardian - (Same person as listed on page 1)
- **Question 10:** Are you applying for health coverage? If no, skip to page 3 – Current Job & Information



STEP 2 Person 1: Start With Yourself

Complete STEP 2 for yourself, your spouse, children who live with you, and/or anyone included on your federal income tax return. See page 1 for more information about who to include. If you do not file a tax return, you must still include family members who live with you.

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.)
2. Relationship to you? **SELF**
3. List any other names you have been known by, including a maiden name or alias.
4. Date of birth (mm/dd/yyyy) / /
5. Sex ☐ Male ☐ Female
6. Marital status — *If you are a victim of domestic violence and applying separately from your spouse, you may indicate that you are "Never married".* ☐ Never married ☐ Married ☐ Civil union ☐ Separated ☐ Divorced/dissolved ☐ Widowed
7. Social Security number (SSN) ___-__-____ — **We need this if you want health coverage and have a SSN.** Providing your SSN can be helpful, even if you do not want health coverage, since it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone wants help getting a SSN, call **1-800-772-1213** or visit socialsecurity.gov. TTY users call **1-800-325-0778**.
8. Do you plan to file a federal income tax return next year? *(You can still apply for health coverage even if you do not file a federal income tax return.)* ☐ Yes. **Answer questions a – c.** ☐ No. **Continue to question c.**
   a. Will you file jointly with a spouse? ☐ Yes. **Name of spouse:** ☐ No
   b. Will you list any dependents on your tax return? *(Joint filers must list the same dependents.)* ☐ Yes. **If yes, name(s) of dependents:** ☐ No
   c. Will you be listed as a dependent on someone else's tax return? *(You cannot be both a dependent and a joint filer.)* ☐ Yes. **Name of the tax filer:** ☐ No — **How are you related to the tax filer?**
9. Are you pregnant? ☐ Yes ☐ No — **If yes, how many babies are expected?** _____ **Estimated due date (mm/dd/yyyy)?**
10. Are you applying for health coverage? (Even if you have insurance, there might be a program with better coverage or lower costs.) ☐ Yes. **Continue to question 11.** ☐ No. **Continue to Current Job & Income Information on page 3.**
11. a. Do you have a physical, mental, learning, or emotional health condition that causes you to regularly need help with some or all of your self-care activities (like bathing, dressing, eating, reading, daily chores, etc.)? ☐ Yes ☐ No — **If you answered 'yes'** *to the above question, or if you qualify for Medicare, review the information at the beginning of* **the Supplement (on page 12).** *If you want us to see if you qualify for health coverage for individuals who are aged 65 or older, and/or blind or disabled,* **complete the Supplement** *after you complete the main application. For now,* **continue to question 11b.**
    b. Are you in, or have you moved to, a medical facility or nursing home in the past 30 days, or do you need assistance and/or support to live in a home and community-based setting? ☐ Yes ☐ No — **If you answered 'yes'** *to the above question, you may need to apply for Long-Term Medicaid. To do that, you need a different application. Call Customer Service at 1-855-899-9600 and ask for the 2021C application.*
12. Are you a U.S. citizen or U.S. national? ☐ Yes. **Continue to question 13.** ☐ No. **Continue to question 14.**
13. Are you a naturalized or derived citizen? *(This usually means you were born outside of the U.S.)* ☐ Yes. **Complete a and b then continue to question 15.** ☐ No. **Continue to question 15.**
    a. Alien/USCIS number:
    b. Certificate number:
14. If you are not a U.S. citizen or U.S. national, do you have eligible immigration status? ☐ Yes. **Fill in your document information below.** **Visit dvha.vermont.gov/apply for information about eligible immigration status.**
    a. Immigration document type:
    b. Document expiration date (mm/dd/yyyy): ☐ None
    c. Alien/USCIS number:
    d. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
    e. Date of entry (mm/dd/yyyy):
    f. Passport or document number: ☐ None
    g. Country of origin:
    h. Category code:
    i. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
    j. SEVIS ID:

Page 2 of 19

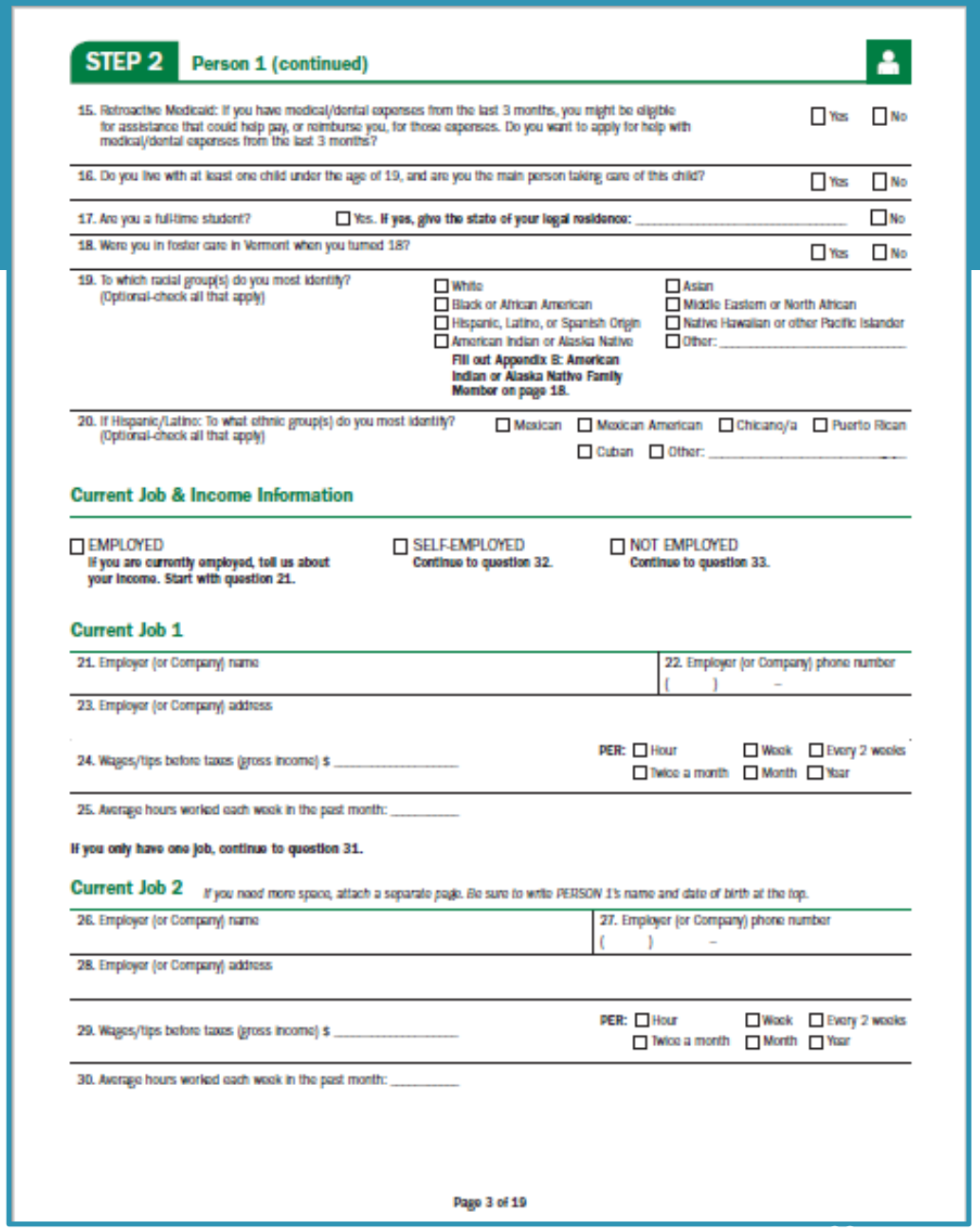
Page 3

Step 2 Person 1 (continued)

- Complete questions 15 - 20 **if you are asking for health care for yourself**.

Current Job & Income Information

- √ the box that marks your state of employment
- Answer questions 21 - 30 about your current job(s)



STEP 2 Person 1 (continued)

15. Retroactive Medicaid: If you have medical/dental expenses from the last 3 months, you might be eligible for assistance that could help pay, or reimburse you, for those expenses. Do you want to apply for help with medical/dental expenses from the last 3 months? ☐ Yes ☐ No

16. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

17. Are you a full-time student? ☐ Yes. **If yes, give the state of your legal residence:** _____ ☐ No

18. Were you in foster care in Vermont when you turned 18? ☐ Yes ☐ No

19. To which racial group(s) do you most identify? (Optional-check all that apply)
☐ White ☐ Asian
☐ Black or African American ☐ Middle Eastern or North African
☐ Hispanic, Latino, or Spanish Origin ☐ Native Hawaiian or other Pacific Islander
☐ American Indian or Alaska Native ☐ Other: _____
Fill out Appendix B: American Indian or Alaska Native Family Member on page 18.

20. If Hispanic/Latino: To what ethnic group(s) do you most identify? (Optional-check all that apply) ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other: _____

Current Job & Income Information

☐ EMPLOYED **If you are currently employed, tell us about your income. Start with question 21.**
☐ SELF-EMPLOYED **Continue to question 32.**
☐ NOT EMPLOYED **Continue to question 33.**

Current Job 1

21. Employer (or Company) name
22. Employer (or Company) phone number ( ) –
23. Employer (or Company) address
24. Wages/tips before taxes (gross income) $ _____ PER: ☐ Hour ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year
25. Average hours worked each week in the past month: _____

If you only have one job, continue to question 31.

Current Job 2 *If you need more space, attach a separate page. Be sure to write PERSON 1's name and date of birth at the top.*

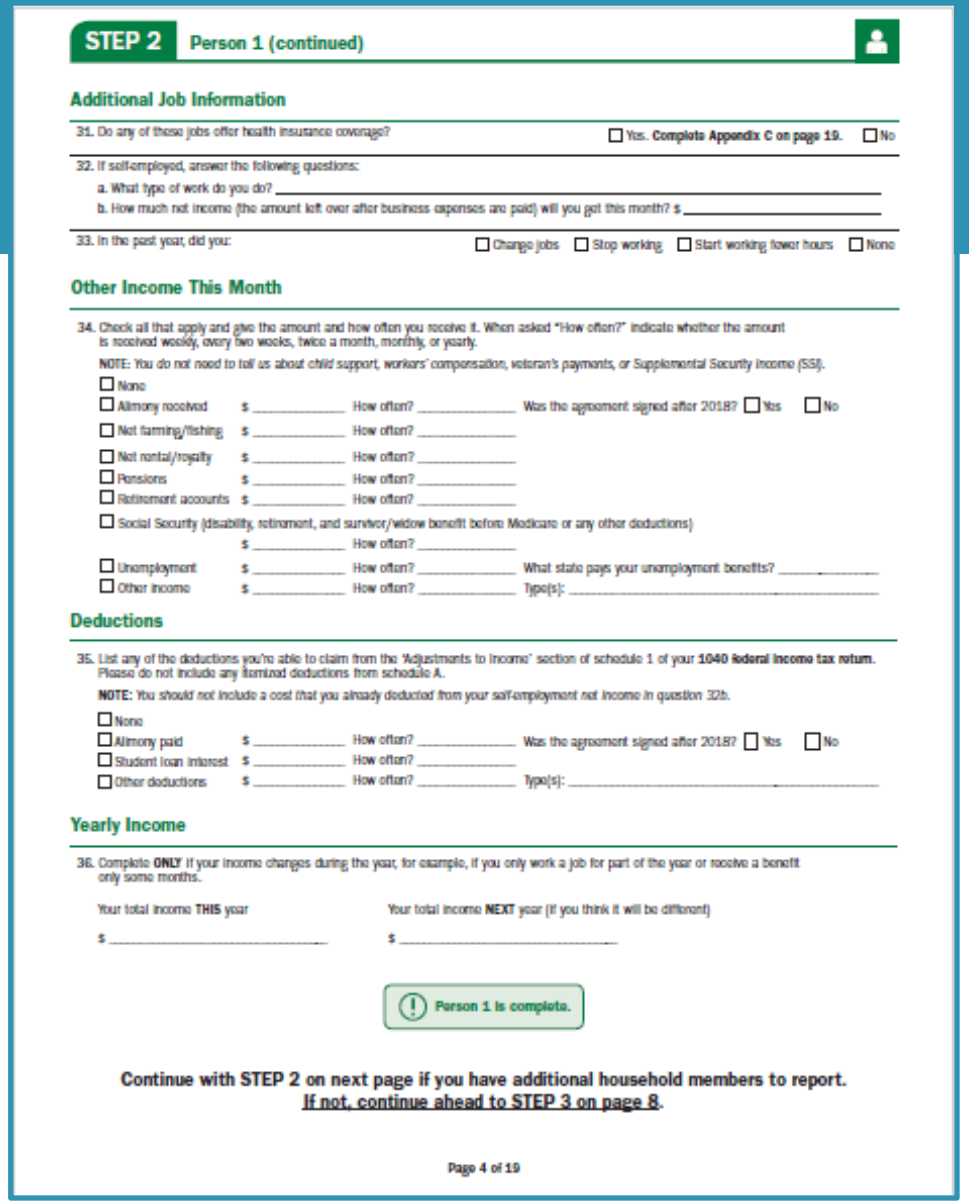
26. Employer (or Company) name
27. Employer (or Company) phone number ( ) –
28. Employer (or Company) address
29. Wages/tips before taxes (gross income) $ _____ PER: ☐ Hour ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year
30. Average hours worked each week in the past month: _____

Page 3 of 19

Page 4

Step 2 Person 1 (continued)

- Additional job information
- Other Income This Month?
- Deductions?
- #36: Yearly Income – Only complete if your income changes during the year.



STEP 2 Person 1 (continued)

Additional Job Information

31. Do any of these jobs offer health insurance coverage? ☐ Yes. **Complete Appendix C on page 19.** ☐ No

32. If self-employed, answer the following questions:
a. What type of work do you do? _____
b. How much net income (the amount left over after business expenses are paid) will you get this month? $ _____

33. In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None

Other Income This Month

34. Check all that apply and give the amount and how often you receive it. When asked "How often?" indicate whether the amount is received weekly, every two weeks, twice a month, monthly, or yearly.

NOTE: You do not need to tell us about child support, workers' compensation, veteran's payments, or Supplemental Security Income (SSI).

☐ None
☐ Alimony received $ _____ How often? _____ Was the agreement signed after 2018? ☐ Yes ☐ No
☐ Net farming/fishing $ _____ How often? _____
☐ Net rental/royalty $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Retirement accounts $ _____ How often? _____
☐ Social Security (disability, retirement, and survivor/widow benefit before Medicare or any other deductions)
$ _____ How often? _____
☐ Unemployment $ _____ How often? _____ What state pays your unemployment benefits? _____
☐ Other income $ _____ How often? _____ Type(s): _____

Deductions

35. List any of the deductions you're able to claim from the 'Adjustments to Income' section of schedule 1 of your **1040 federal income tax return.** Please do not include any itemized deductions from schedule A.

NOTE: You should not include a cost that you already deducted from your self-employment net income in question 32b.

☐ None
☐ Alimony paid $ _____ How often? _____ Was the agreement signed after 2018? ☐ Yes ☐ No
☐ Student loan interest $ _____ How often? _____
☐ Other deductions $ _____ How often? _____ Type(s): _____

Yearly Income

36. Complete **ONLY** if your income changes during the year, for example, if you only work a job for part of the year or receive a benefit only some months.

Your total income **THIS** year: $ _____

Your total income **NEXT** year (if you think it will be different): $ _____

ⓘ Person 1 is complete.

Continue with STEP 2 on next page if you have additional household members to report.
If not, continue ahead to STEP 3 on page 8.

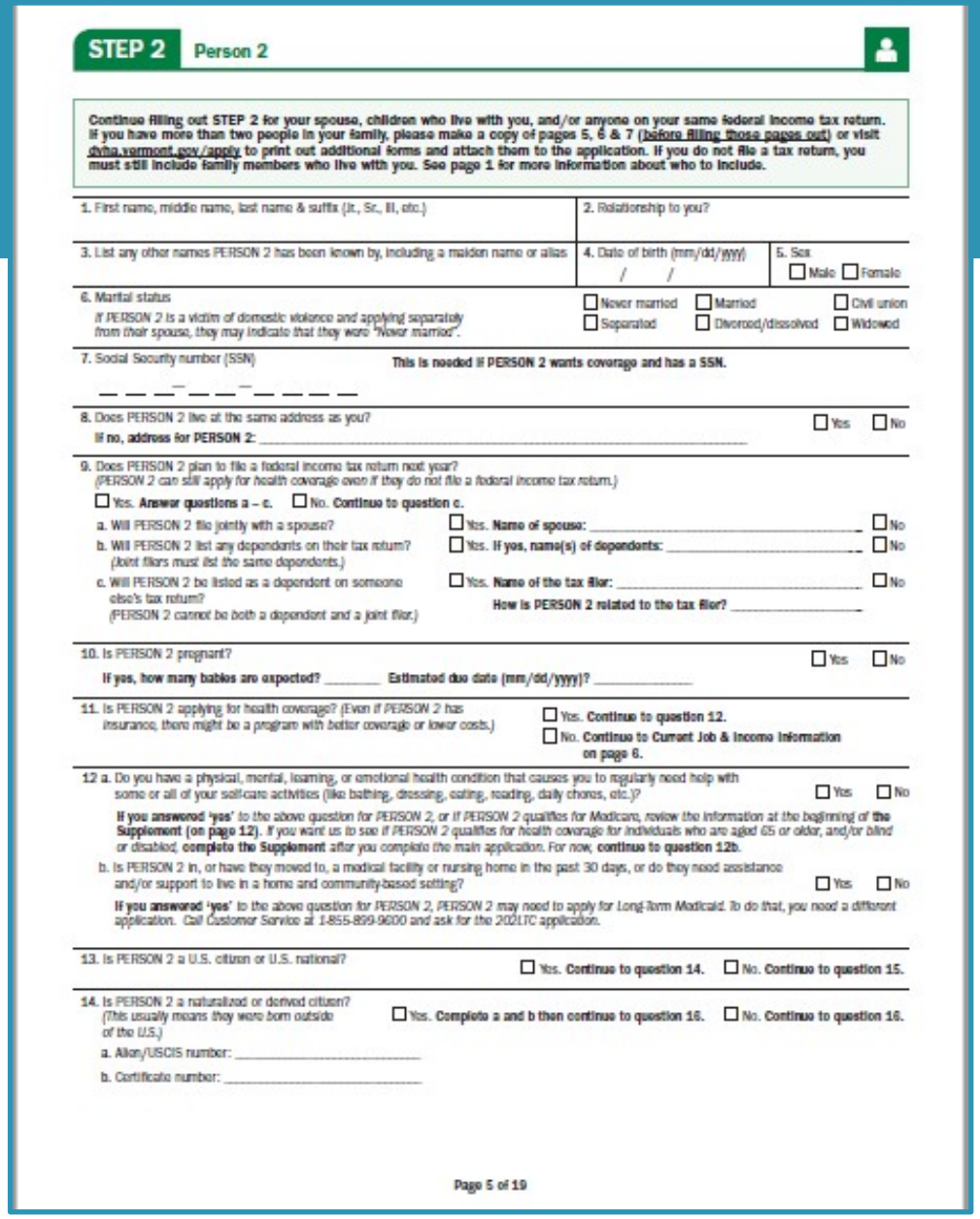
Page 4 of 19

Page 5

Step 2 Person 2

Fill out Step 2 for everyone who lives with you.

- Start with other parent of child
- Then do step 2 for every child
- Extra person pages: https://dvha.vermont.gov/apply



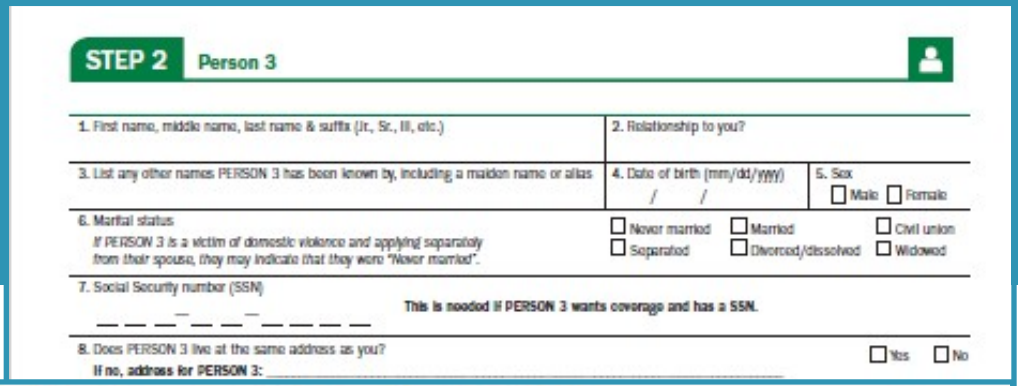
STEP 2 Person 2

Continue filling out STEP 2 for your spouse, children who live with you, and/or anyone on your same federal income tax return. If you have more than two people in your family, please make a copy of pages 5, 6 & 7 (before filling those pages out) or visit dvha.vermont.gov/apply to print out additional forms and attach them to the application. If you do not file a tax return, you must still include family members who live with you. See page 1 for more information about who to include.

1. First name, middle name, last name & suffix (Jr., Sr., II, etc.)
2. Relationship to you?
3. List any other names PERSON 2 has been known by, including a maiden name or alias
4. Date of birth (mm/dd/yyyy) / /
5. Sex ☐ Male ☐ Female
6. Marital status
   If PERSON 2 is a victim of domestic violence and applying separately from their spouse, they may indicate that they were "Never married".
   ☐ Never married ☐ Married ☐ Civil union ☐ Separated ☐ Divorced/dissolved ☐ Widowed
7. Social Security number (SSN) **This is needed if PERSON 2 wants coverage and has a SSN.**
   ___ ___ ___ - ___ ___ - ___ ___ ___ ___
8. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
   If no, address for PERSON 2: _____
9. Does PERSON 2 plan to file a federal income tax return next year?
   (PERSON 2 can still apply for health coverage even if they do not file a federal income tax return.)
   ☐ Yes. **Answer questions a – c.** ☐ No. **Continue to question c.**
   a. Will PERSON 2 file jointly with a spouse? ☐ Yes. **Name of spouse:** _____ ☐ No
   b. Will PERSON 2 list any dependents on their tax return? *(Joint filers must list the same dependents.)* ☐ Yes. **If yes, name(s) of dependents:** _____ ☐ No
   c. Will PERSON 2 be listed as a dependent on someone else's tax return? *(PERSON 2 cannot be both a dependent and a joint filer.)* ☐ Yes. **Name of the tax filer:** _____ ☐ No
   How is PERSON 2 related to the tax filer? _____
10. Is PERSON 2 pregnant? ☐ Yes ☐ No
    If yes, how many babies are expected? _____ **Estimated due date (mm/dd/yyyy)?** _____
11. Is PERSON 2 applying for health coverage? *(Even if PERSON 2 has insurance, there might be a program with better coverage or lower costs.)*
    ☐ Yes. **Continue to question 12.**
    ☐ No. **Continue to Current Job & Income Information on page 6.**
12. a. Do you have a physical, mental, learning, or emotional health condition that causes you to regularly need help with some or all of your self-care activities (like bathing, dressing, eating, reading, daily chores, etc.)? ☐ Yes ☐ No
    If you answered 'yes' *to the above question for PERSON 2, or if PERSON 2 qualifies for Medicare, review the information at the beginning of* **the Supplement (on page 12).** *If you want us to see if PERSON 2 qualifies for health coverage for individuals who are aged 65 or older, and/or blind or disabled,* **complete the Supplement** *after you complete the main application. For now,* **continue to question 12b.**
    b. Is PERSON 2 in, or have they moved to, a medical facility or nursing home in the past 30 days, or do they need assistance and/or support to live in a home and community-based setting? ☐ Yes ☐ No
    If you answered 'yes' *to the above question for PERSON 2, PERSON 2 may need to apply for Long-Term Medicaid. To do that, you need a different application. Call Customer Service at 1-855-899-9600 and ask for the 2021LTC application.*
13. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes. **Continue to question 14.** ☐ No. **Continue to question 15.**
14. Is PERSON 2 a naturalized or derived citizen? *(This usually means they were born outside of the U.S.)* ☐ Yes. **Complete a and b then continue to question 16.** ☐ No. **Continue to question 16.**
    a. Alien/USCIS number: _____
    b. Certificate number: _____

Page 5 of 19

Step 2: Child applying for DCHC



STEP 2 Person 3

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.) | 2. Relationship to you?

3. List any other names PERSON 3 has been known by, including a maiden name or alias | 4. Date of birth (mm/dd/yyyy) / / | 5. Sex ☐ Male ☐ Female

6. Marital status
If PERSON 3 is a victim of domestic violence and applying separately from their spouse, they may indicate that they were "Never married".
☐ Never married ☐ Married ☐ Civil union ☐ Separated ☐ Divorced/dissolved ☐ Widowed

7. Social Security number (SSN) ___ ___ ___ ___ ___ ___ ___ ___ ___
This is needed if PERSON 3 wants coverage and has a SSN.

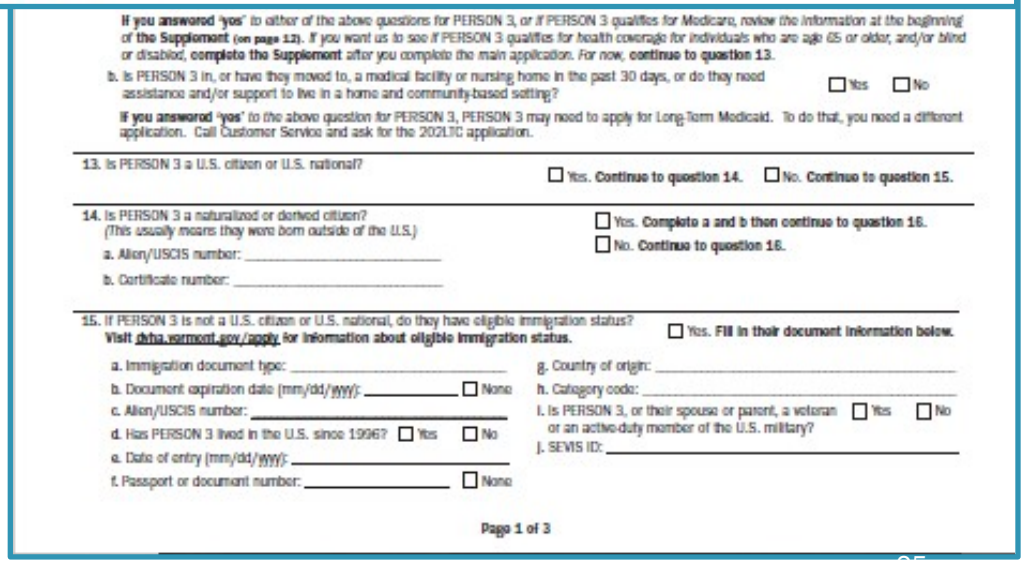
8. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No
If no, address for PERSON 3: _____

12. a. Does PERSON 3 have a physical, mental, learning, or emotional health condition that causes them to regularly need help with some or all of their self-care activities (like bathing, dressing, eating, reading, daily chores, etc.)? ☐ Yes ☐ No

If you answered 'yes' *to either of the above questions for* PERSON 3, *or if* PERSON 3 *qualifies for Medicare, review the information at the beginning of* **the Supplement (on page 12)**. *If you want us to see if* PERSON 3 *qualifies for health coverage for individuals who are age 65 or older, and/or blind or disabled,* **complete the Supplement** *after you complete the main application. For now,* **continue to question 13**.

b. Is PERSON 3 in, or have they moved to, a medical facility or nursing home in the past 30 days, or do they need assistance and/or support to live in a home and community-based setting? ☐ Yes ☐ No

If you answered 'yes' *to the above question for* PERSON 3, PERSON 3 may need to apply for Long-Term Medicaid. To do that, you need a different application. Call Customer Service and ask for the 202LTC application.



If you answered 'yes' *to either of the above questions for* PERSON 3, *or if* PERSON 3 *qualifies for Medicare, review the information at the beginning of* **the Supplement (on page 12)**. *If you want us to see if* PERSON 3 *qualifies for health coverage for individuals who are age 65 or older, and/or blind or disabled,* **complete the Supplement** *after you complete the main application. For now,* **continue to question 13**.

b. Is PERSON 3 in, or have they moved to, a medical facility or nursing home in the past 30 days, or do they need assistance and/or support to live in a home and community-based setting? ☐ Yes ☐ No

If you answered 'yes' *to the above question for* PERSON 3, PERSON 3 may need to apply for Long-Term Medicaid. To do that, you need a different application. Call Customer Service and ask for the 202LTC application.

13. Is PERSON 3 a U.S. citizen or U.S. national? ☐ Yes. **Continue to question 14.** ☐ No. **Continue to question 15.**

14. Is PERSON 3 a naturalized or derived citizen? *(This usually means they were born outside of the U.S.)* ☐ Yes. **Complete a and b then continue to question 16.** ☐ No. **Continue to question 16.**
a. Alien/USCIS number: _____
b. Certificate number: _____

15. If PERSON 3 is not a U.S. citizen or U.S. national, do they have eligible immigration status? ☐ Yes. **Fill in their document information below.**
Visit dvha.vermont.gov/apply for information about eligible immigration status.
a. Immigration document type: _____
b. Document expiration date (mm/dd/yyyy): _____ ☐ None
c. Alien/USCIS number: _____
d. Has PERSON 3 lived in the U.S. since 1996? ☐ Yes ☐ No
e. Date of entry (mm/dd/yyyy): _____
f. Passport or document number: _____ ☐ None
g. Country of origin: _____
h. Category code: _____
i. Is PERSON 3, or their spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
j. SEVIS ID: _____

Page 1 of 3

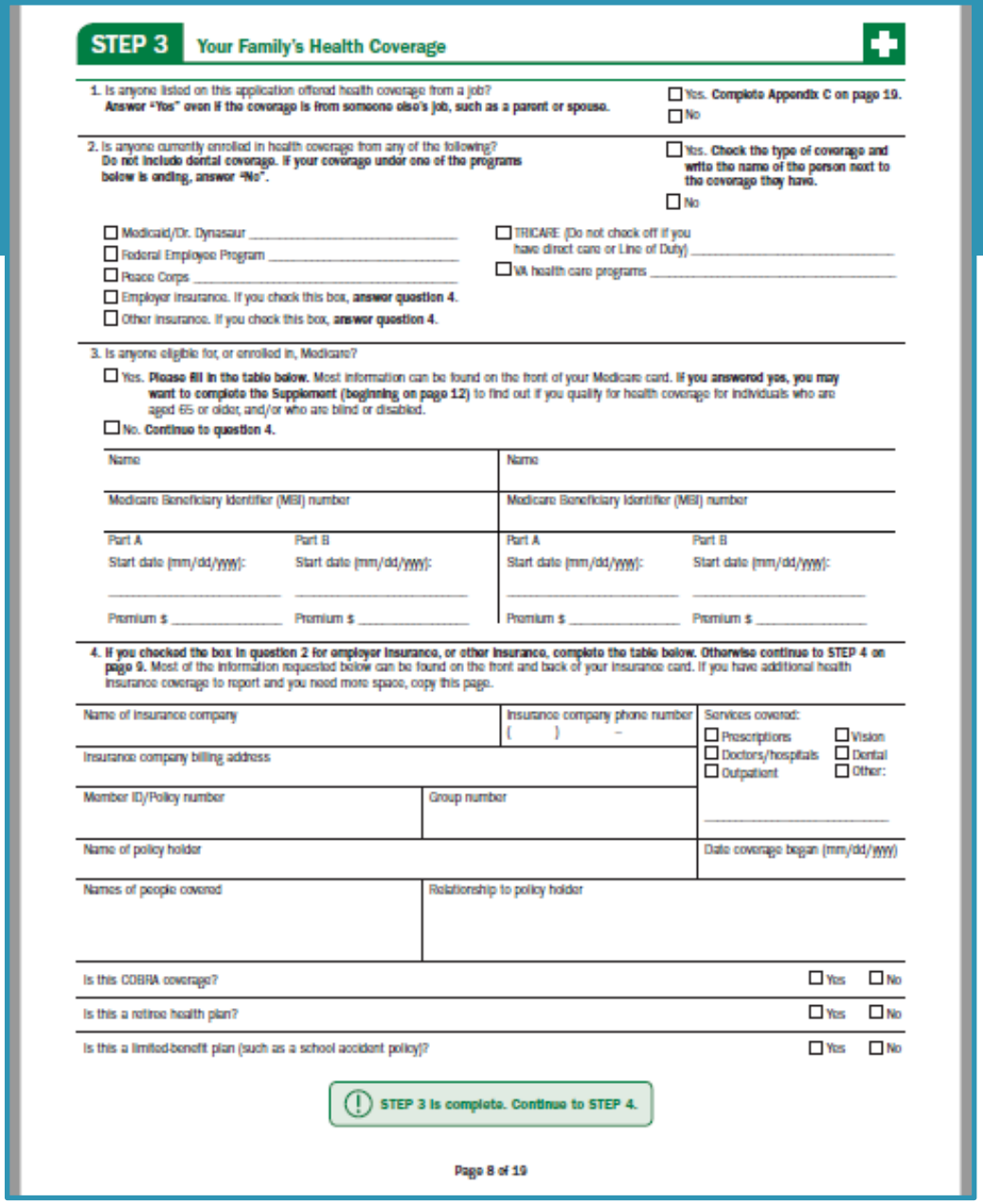
12a: Answer is yes

- Continue to question 13

Page 8

Step 3: Your Family's Health Coverage

- #1: If yes, fill out Appendix C.
- #2: Currently enrolled in these? Medicaid, TRICARE, etc.
- #4: Your insurance coverage information



STEP 3 Your Family's Health Coverage

1. Is anyone listed on this application offered health coverage from a job? **Answer "Yes" even if the coverage is from someone else's job, such as a parent or spouse.**
☐ Yes. **Complete Appendix C on page 19.**
☐ No

2. Is anyone currently enrolled in health coverage from any of the following? **Do not include dental coverage. If your coverage under one of the programs below is ending, answer "No".**
☐ Yes. **Check the type of coverage and write the name of the person next to the coverage they have.**
☐ No

☐ Medicaid/Dr. Dynasaur _____
☐ Federal Employee Program _____
☐ Peace Corps _____
☐ Employer insurance. If you check this box, **answer question 4.**
☐ Other insurance. If you check this box, **answer question 4.**
☐ TRICARE (Do not check off if you have direct care or Line of Duty) _____
☐ VA health care programs _____

3. Is anyone eligible for, or enrolled in, Medicare?
☐ Yes. **Please fill in the table below.** Most information can be found on the front of your Medicare card. **If you answered yes, you may want to complete the Supplement (beginning on page 12)** to find out if you qualify for health coverage for individuals who are aged 65 or older, and/or who are blind or disabled.
☐ No. **Continue to question 4.**

Name		Name	
Medicare Beneficiary Identifier (MBI) number		Medicare Beneficiary Identifier (MBI) number	
Part A Start date (mm/dd/yyyy):	Part B Start date (mm/dd/yyyy):	Part A Start date (mm/dd/yyyy):	Part B Start date (mm/dd/yyyy):
Premium $	Premium $	Premium $	Premium $

4. **If you checked the box in question 2 for employer insurance, or other insurance, complete the table below. Otherwise continue to STEP 4 on page 9.** Most of the information requested below can be found on the front and back of your insurance card. If you have additional health insurance coverage to report and you need more space, copy this page.

Name of insurance company	Insurance company phone number ( ) –	Services covered: ☐ Prescriptions ☐ Vision ☐ Doctors/hospitals ☐ Dental ☐ Outpatient ☐ Other:
Insurance company billing address		
Member ID/Policy number	Group number	
Name of policy holder		Date coverage began (mm/dd/yyyy)
Names of people covered	Relationship to policy holder	

Is this COBRA coverage? ☐ Yes ☐ No
Is this a retiree health plan? ☐ Yes ☐ No
Is this a limited-benefit plan (such as a school accident policy)? ☐ Yes ☐ No

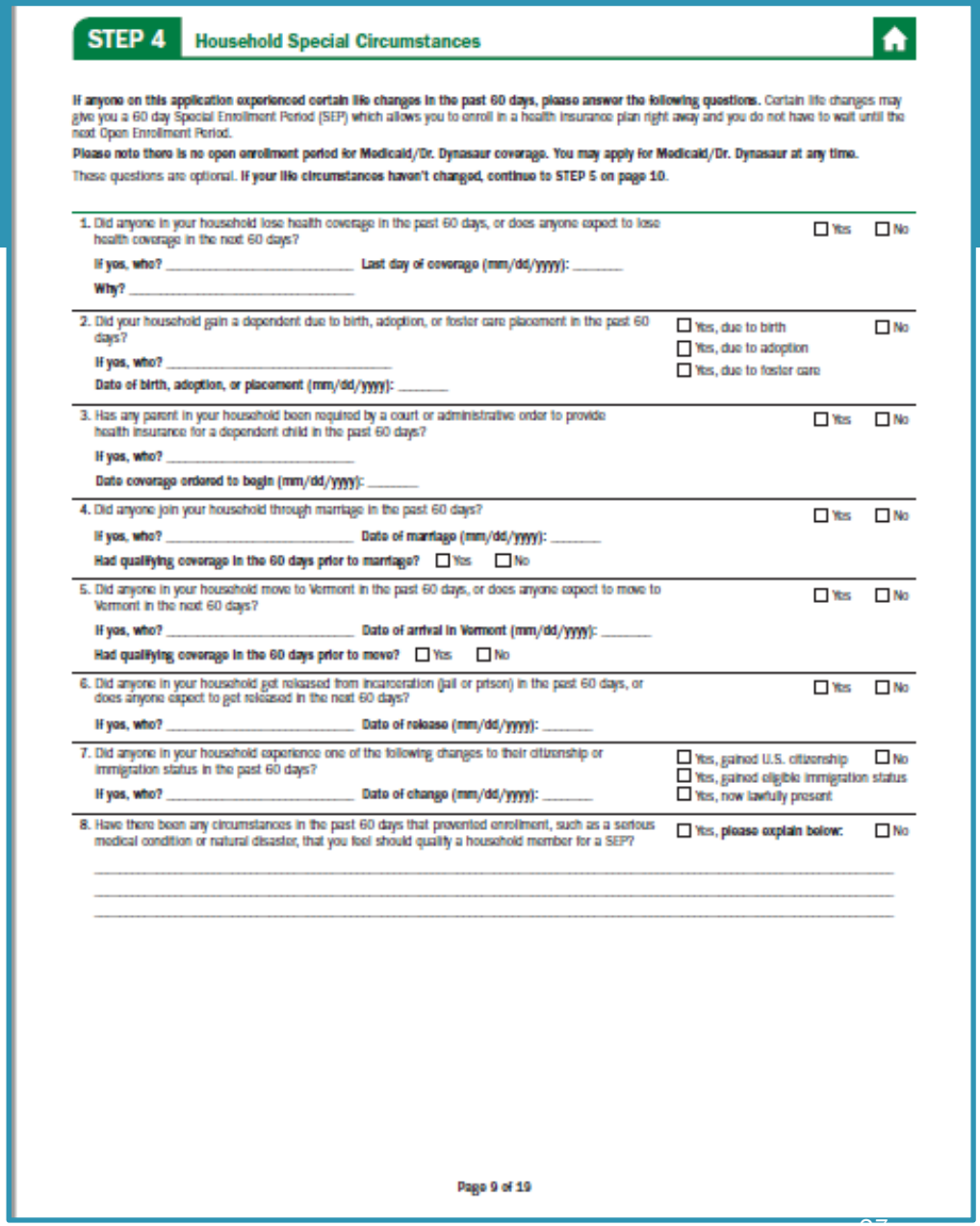
STEP 3 is complete. Continue to STEP 4.

Page 8 of 19

Page 9

Step 4: Household Special Circumstances

- #5: New to Vermont?
- #7: Changes to citizenship or immigration status?



STEP 4 Household Special Circumstances

If anyone on this application experienced certain life changes in the past 60 days, please answer the following questions. Certain life changes may give you a 60 day Special Enrollment Period (SEP) which allows you to enroll in a health insurance plan right away and you do not have to wait until the next Open Enrollment Period.

Please note there is no open enrollment period for Medicaid/Dr. Dynasaur coverage. You may apply for Medicaid/Dr. Dynasaur at any time.

These questions are optional. **If your life circumstances haven't changed, continue to STEP 5 on page 10.**

1. Did anyone in your household lose health coverage in the past 60 days, or does anyone expect to lose health coverage in the next 60 days? ☐ Yes ☐ No
   If yes, who? _____ **Last day of coverage (mm/dd/yyyy):** _____
   Why? _____
2. Did your household gain a dependent due to birth, adoption, or foster care placement in the past 60 days? ☐ Yes, due to birth ☐ Yes, due to adoption ☐ Yes, due to foster care ☐ No
   If yes, who? _____
   Date of birth, adoption, or placement (mm/dd/yyyy): _____
3. Has any parent in your household been required by a court or administrative order to provide health insurance for a dependent child in the past 60 days? ☐ Yes ☐ No
   If yes, who? _____
   Date coverage ordered to begin (mm/dd/yyyy): _____
4. Did anyone join your household through marriage in the past 60 days? ☐ Yes ☐ No
   If yes, who? _____ **Date of marriage (mm/dd/yyyy):** _____
   Had qualifying coverage in the 60 days prior to marriage? ☐ Yes ☐ No
5. Did anyone in your household move to Vermont in the past 60 days, or does anyone expect to move to Vermont in the next 60 days? ☐ Yes ☐ No
   If yes, who? _____ **Date of arrival in Vermont (mm/dd/yyyy):** _____
   Had qualifying coverage in the 60 days prior to move? ☐ Yes ☐ No
6. Did anyone in your household get released from incarceration (jail or prison) in the past 60 days, or does anyone expect to get released in the next 60 days? ☐ Yes ☐ No
   If yes, who? _____ **Date of release (mm/dd/yyyy):** _____
7. Did anyone in your household experience one of the following changes to their citizenship or immigration status in the past 60 days? ☐ Yes, gained U.S. citizenship ☐ Yes, gained eligible immigration status ☐ Yes, now lawfully present ☐ No
   If yes, who? _____ **Date of change (mm/dd/yyyy):** _____
8. Have there been any circumstances in the past 60 days that prevented enrollment, such as a serious medical condition or natural disaster, that you feel should qualify a household member for a SEP? ☐ Yes, **please explain below:** ☐ No
   _____
   _____
   _____

Page 9 of 19

Page 10

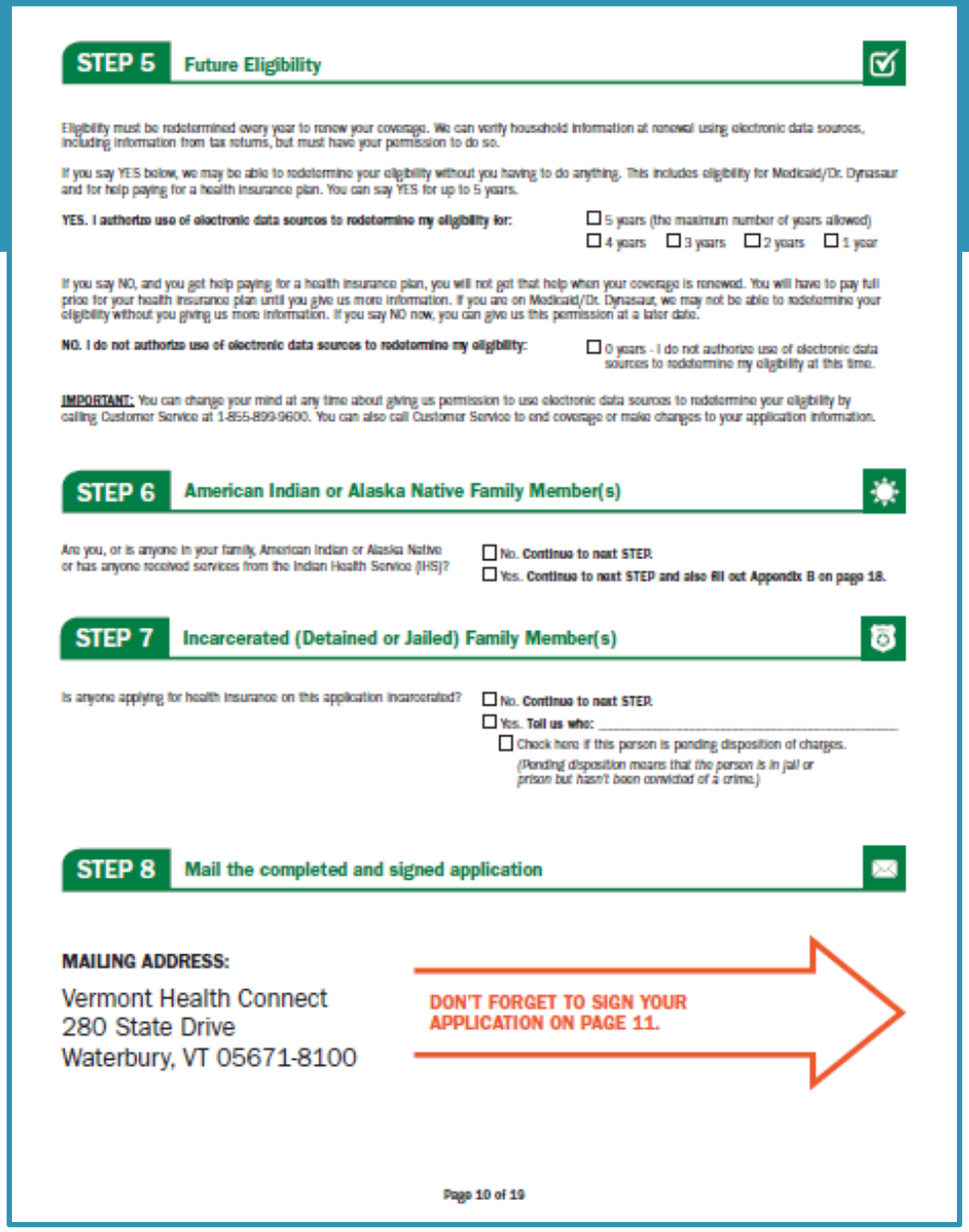
Step 5: Future Eligibility

- Authorization for use of electronic data sources to redetermine yearly financial renewals.

Step 6: Indigenous Peoples? Complete Appendix B

Step 7: Incarcerated?

Step 8: Dr Dynasaur mailing address and reminder to sign and date



STEP 5 Future Eligibility

Eligibility must be redetermined every year to renew your coverage. We can verify household information at renewal using electronic data sources, including information from tax returns, but must have your permission to do so.

If you say YES below, we may be able to redetermine your eligibility without you having to do anything. This includes eligibility for Medicaid/Dr. Dynasaur and for help paying for a health insurance plan. You can say YES for up to 5 years.

YES. I authorize use of electronic data sources to redetermine my eligibility for:
☐ 5 years (the maximum number of years allowed)
☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

If you say NO, and you get help paying for a health insurance plan, you will not get that help when your coverage is renewed. You will have to pay full price for your health insurance plan until you give us more information. If you are on Medicaid/Dr. Dynasaur, we may not be able to redetermine your eligibility without you giving us more information. If you say NO now, you can give us this permission at a later date.

NO. I do not authorize use of electronic data sources to redetermine my eligibility:
☐ 0 years - I do not authorize use of electronic data sources to redetermine my eligibility at this time.

IMPORTANT: You can change your mind at any time about giving us permission to use electronic data sources to redetermine your eligibility by calling Customer Service at 1-855-899-9600. You can also call Customer Service to end coverage or make changes to your application information.

STEP 6 American Indian or Alaska Native Family Member(s)

Are you, or is anyone in your family, American Indian or Alaska Native or has anyone received services from the Indian Health Service (IHS)?
☐ No. **Continue to next STEP.**
☐ Yes. **Continue to next STEP and also fill out Appendix B on page 18.**

STEP 7 Incarcerated (Detained or Jailed) Family Member(s)

Is anyone applying for health insurance on this application incarcerated?
☐ No. **Continue to next STEP.**
☐ Yes. **Tell us who:** _____
☐ Check here if this person is pending disposition of charges.
(Pending disposition means that the person is in jail or prison but hasn't been convicted of a crime.)

STEP 8 Mail the completed and signed application

MAILING ADDRESS:
Vermont Health Connect
280 State Drive
Waterbury, VT 05671-8100

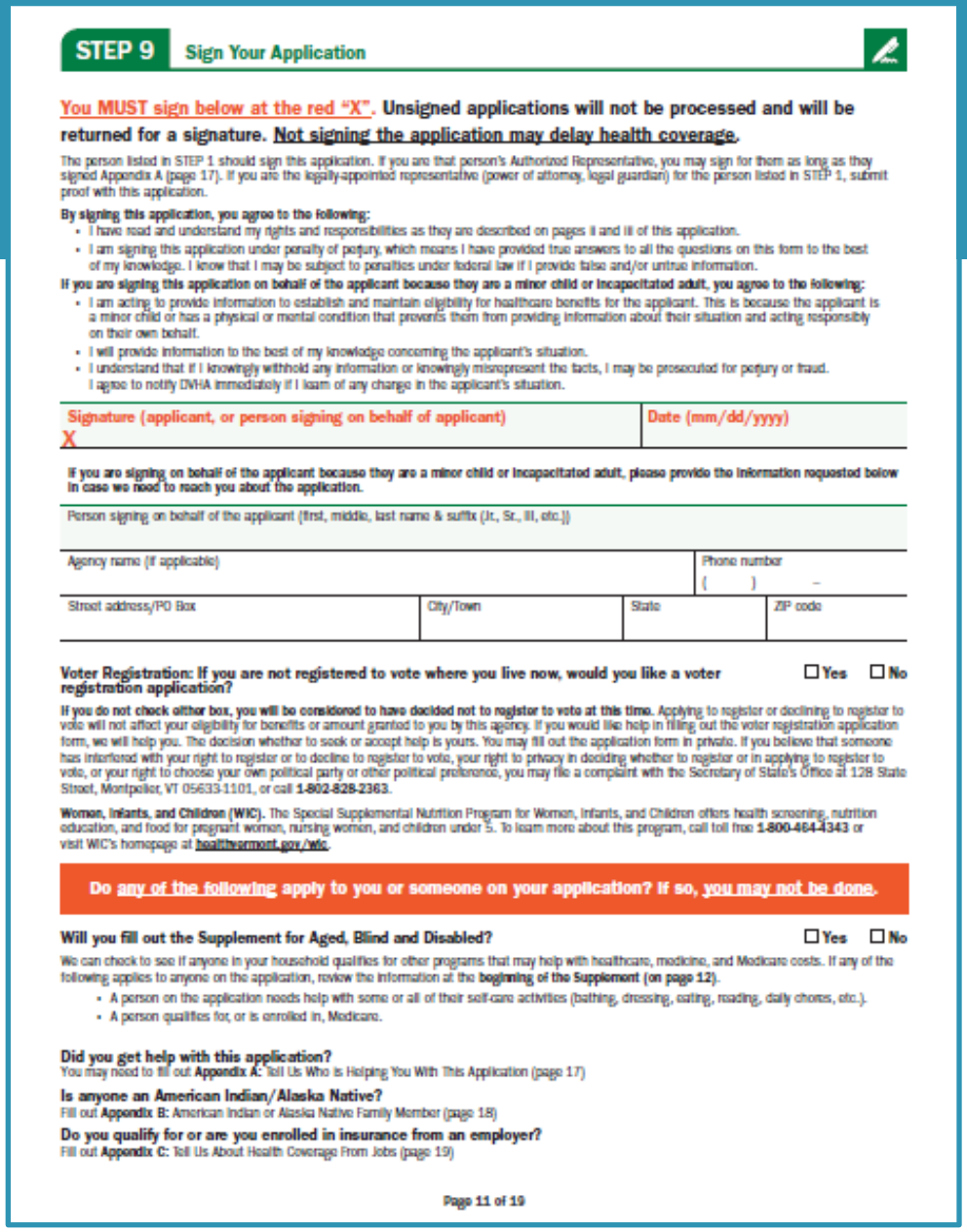
DON'T FORGET TO SIGN YOUR APPLICATION ON PAGE 11.

Page 10 of 19

Page 11

Step 9: Sign Your Application

- Sign by the red X
- Date
- Put your name and contact information in the next spaces, If you are signing for a minor child, or adult that cannot sign because of incapacitation.
- Check the box yes for the supplement for Aged, Blind, and Disabled.



STEP 9 Sign Your Application

You MUST sign below at the red "X". Unsigned applications will not be processed and will be returned for a signature. Not signing the application may delay health coverage.

The person listed in STEP 1 should sign this application. If you are that person's Authorized Representative, you may sign for them as long as they signed Appendix A (page 17). If you are the legally-appointed representative (power of attorney, legal guardian) for the person listed in STEP 1, submit proof with this application.

By signing this application, you agree to the following:

- I have read and understand my rights and responsibilities as they are described on pages ii and iii of this application.
- I am signing this application under penalty of perjury, which means I have provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.

If you are signing this application on behalf of the applicant because they are a minor child or incapacitated adult, you agree to the following:

- I am acting to provide information to establish and maintain eligibility for healthcare benefits for the applicant. This is because the applicant is a minor child or has a physical or mental condition that prevents them from providing information about their situation and acting responsibly on their own behalf.
- I will provide information to the best of my knowledge concerning the applicant's situation.
- I understand that if I knowingly withhold any information or knowingly misrepresent the facts, I may be prosecuted for perjury or fraud. I agree to notify DVHA immediately if I learn of any change in the applicant's situation.

Signature (applicant, or person signing on behalf of applicant)	Date (mm/dd/yyyy)
X	

If you are signing on behalf of the applicant because they are a minor child or incapacitated adult, please provide the information requested below in case we need to reach you about the application.

Person signing on behalf of the applicant (first, middle, last name & suffix (Jr., Sr., III, etc.))

Agency name (if applicable) | Phone number ( ) –

Street address/PO Box | City/Town | State | ZIP code

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**.

Women, Infants, and Children (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 5. To learn more about this program, call toll free **1-800-464-4343** or visit WIC's homepage at **healthvermont.gov/wic**.

Do any of the following apply to you or someone on your application? If so, you may not be done.

Will you fill out the Supplement for Aged, Blind and Disabled? ☐ Yes ☐ No

We can check to see if anyone in your household qualifies for other programs that may help with healthcare, medicine, and Medicare costs. If any of the following applies to anyone on the application, review the information at the **beginning of the Supplement (on page 12)**.

- A person on the application needs help with some or all of their self-care activities (bathing, dressing, eating, reading, daily chores, etc.).
- A person qualifies for, or is enrolled in, Medicare.

Did you get help with this application?
You may need to fill out **Appendix A:** Tell Us Who is Helping You With This Application (page 17)

Is anyone an American Indian/Alaska Native?
Fill out **Appendix B:** American Indian or Alaska Native Family Member (page 18)

Do you qualify for or are you enrolled in insurance from an employer?
Fill out **Appendix C:** Tell Us About Health Coverage From Jobs (page 19)

Page 11 of 19

Coded Blue

Supplement for Aged, Blind and Disabled

Vermont Department of Health

Page 12: Gives instructions for completing the supplement.

If you have more than one child applying for DCHC, you will need to do this supplement for each of them.

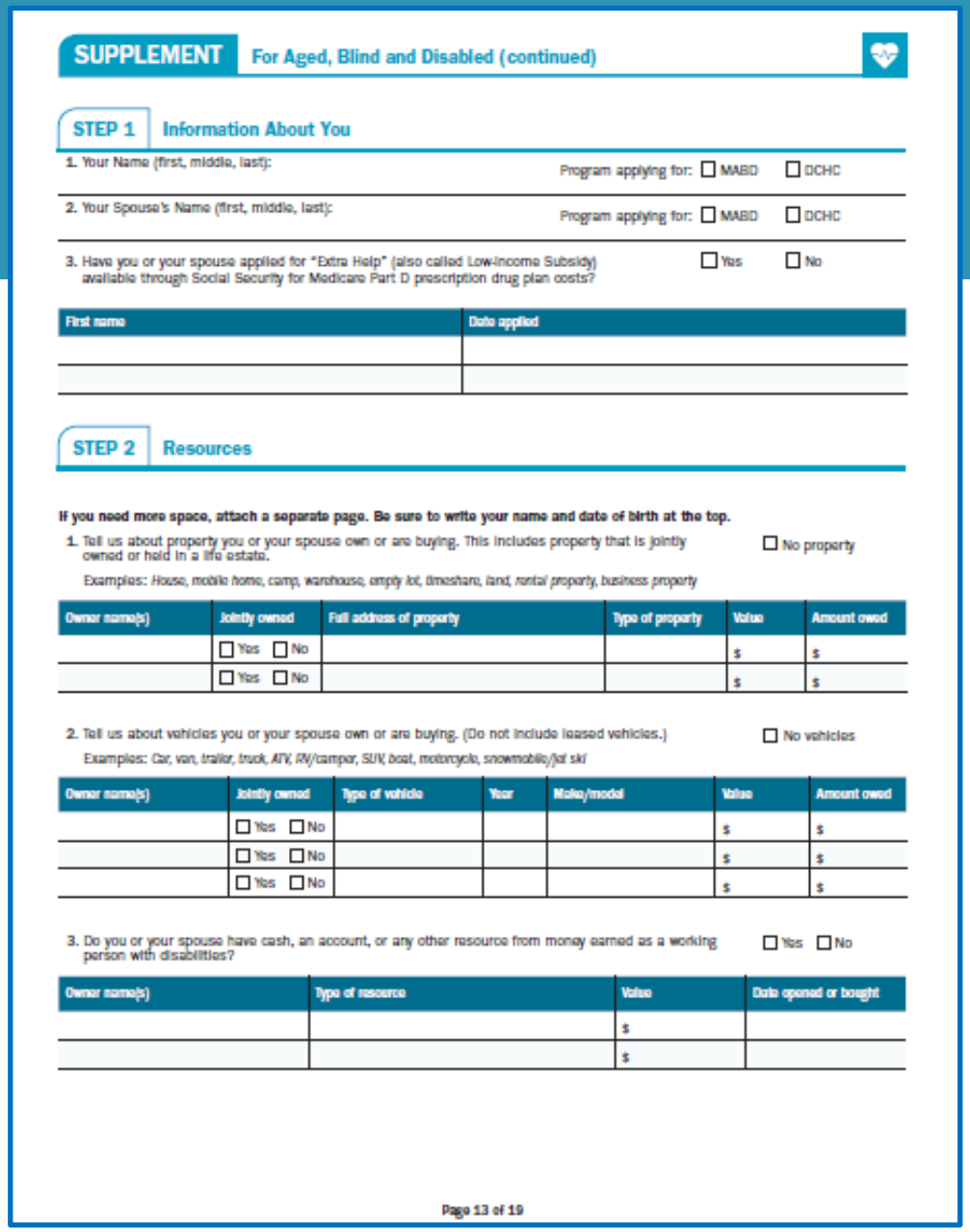
Page 13

Step 1: Information About You (child)

- Your **child's** name and information goes here
- Check the DCHC box

Step 2: Child's Resources

- Property?
- Vehicles?
- $ earned from Working Person with Disabilities?



SUPPLEMENT For Aged, Blind and Disabled (continued)

STEP 1 Information About You

1. Your Name (first, middle, last): Program applying for: ☐ MABD ☐ DCHC

2. Your Spouse's Name (first, middle, last): Program applying for: ☐ MABD ☐ DCHC

3. Have you or your spouse applied for "Extra Help" (also called Low-Income Subsidy) available through Social Security for Medicare Part D prescription drug plan costs? ☐ Yes ☐ No

First name	Date applied

STEP 2 Resources

If you need more space, attach a separate page. Be sure to write your name and date of birth at the top.

1. Tell us about property you or your spouse own or are buying. This includes property that is jointly owned or held in a life estate. ☐ No property

Examples: *House, mobile home, camp, warehouse, empty lot, timeshare, land, rental property, business property*

Owner name(s)	Jointly owned	Full address of property	Type of property	Value	Amount owed
	☐ Yes ☐ No			$	$
	☐ Yes ☐ No			$	$

2. Tell us about vehicles you or your spouse own or are buying. (Do not include leased vehicles.) ☐ No vehicles

Examples: *Car, van, trailer, truck, ATV, RV/camper, SUV, boat, motorcycle, snowmobile/jet ski*

Owner name(s)	Jointly owned	Type of vehicle	Year	Make/model	Value	Amount owed
	☐ Yes ☐ No				$	$
	☐ Yes ☐ No				$	$
	☐ Yes ☐ No				$	$

3. Do you or your spouse have cash, an account, or any other resource from money earned as a working person with disabilities? ☐ Yes ☐ No

Owner name(s)	Type of resource	Value	Date opened or bought
		$	
		$	

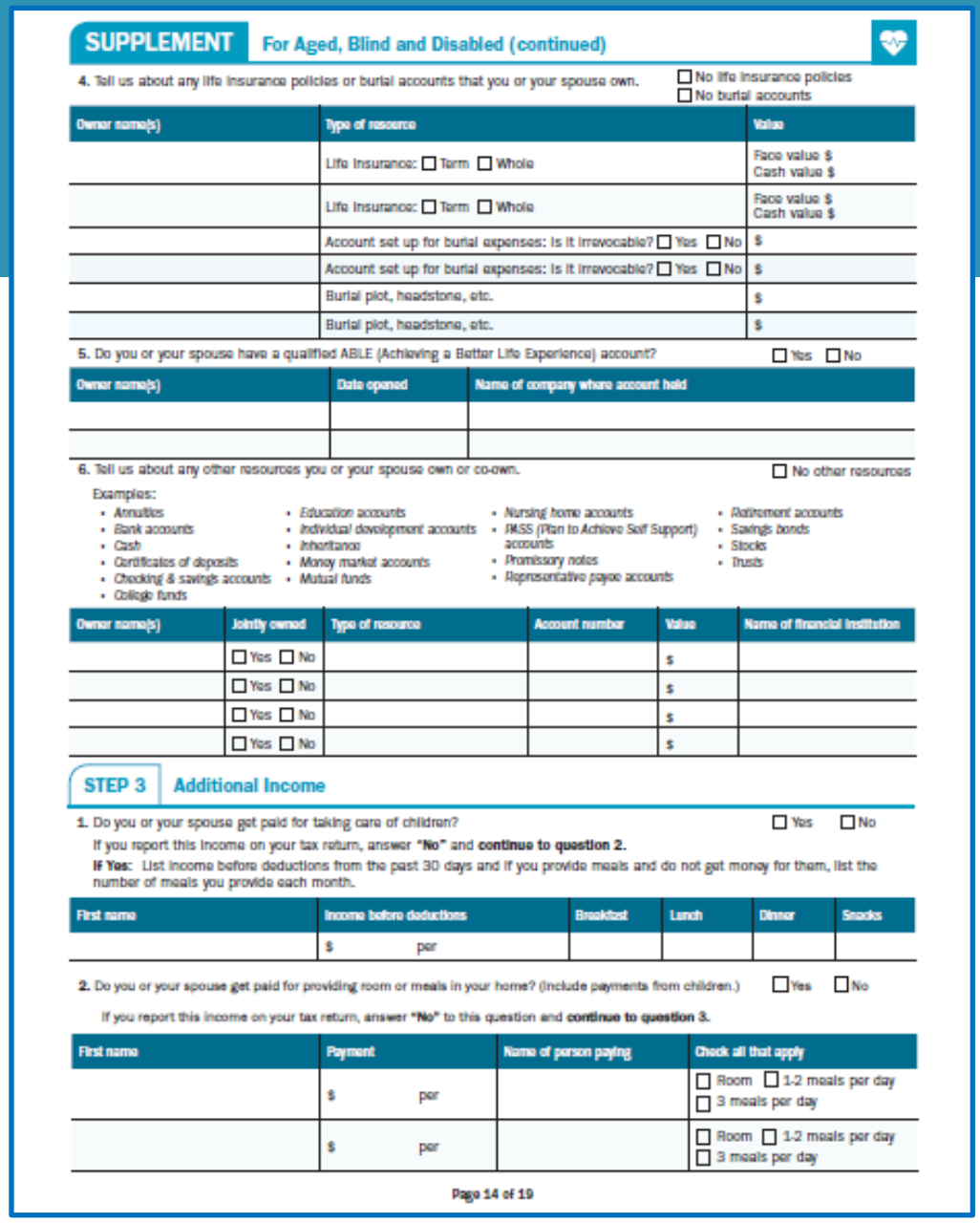
Page 13 of 19

Page 14

- Life Insurance?
- VT ABLE Account?
- Resources like savings account, education accounts, college funds, stocks & saving bonds

Step 3 Additional Income

- Did your child get paid for taking care of children or providing room or meals? If no, check the boxes no.



SUPPLEMENT For Aged, Blind and Disabled (continued)

4. Tell us about any life insurance policies or burial accounts that you or your spouse own. ☐ No life insurance policies ☐ No burial accounts

Owner name(s)	Type of resource	Value
	Life insurance: ☐ Term ☐ Whole	Face value $ Cash value $
	Life insurance: ☐ Term ☐ Whole	Face value $ Cash value $
	Account set up for burial expenses: Is it irrevocable? ☐ Yes ☐ No	$
	Account set up for burial expenses: Is it irrevocable? ☐ Yes ☐ No	$
	Burial plot, headstone, etc.	$
	Burial plot, headstone, etc.	$

5. Do you or your spouse have a qualified ABLE (Achieving a Better Life Experience) account? ☐ Yes ☐ No

Owner name(s)	Date opened	Name of company where account held

6. Tell us about any other resources you or your spouse own or co-own. ☐ No other resources

Examples:
- Annuities
- Bank accounts
- Cash
- Certificates of deposits
- Checking & savings accounts
- College funds
- Education accounts
- Individual development accounts
- Inheritance
- Money market accounts
- Mutual funds
- Nursing home accounts
- PASS (Plan to Achieve Self Support) accounts
- Promissory notes
- Representative payee accounts
- Retirement accounts
- Savings bonds
- Stocks
- Trusts

Owner name(s)	Jointly owned	Type of resource	Account number	Value	Name of financial institution
	☐ Yes ☐ No			$	
	☐ Yes ☐ No			$	
	☐ Yes ☐ No			$	
	☐ Yes ☐ No			$	

STEP 3 Additional Income

1. Do you or your spouse get paid for taking care of children? ☐ Yes ☐ No

If you report this income on your tax return, answer **"No"** and **continue to question 2.**

If Yes: List income before deductions from the past 30 days and if you provide meals and do not get money for them, list the number of meals you provide each month.

First name	Income before deductions	Breakfast	Lunch	Dinner	Snacks
	$ per				

2. Do you or your spouse get paid for providing room or meals in your home? (Include payments from children.) ☐ Yes ☐ No

If you report this income on your tax return, answer **"No"** to this question and **continue to question 3.**

First name	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

Page 14 of 19

Page 15

#3. Additional Income: Cash received (SSI would go here)

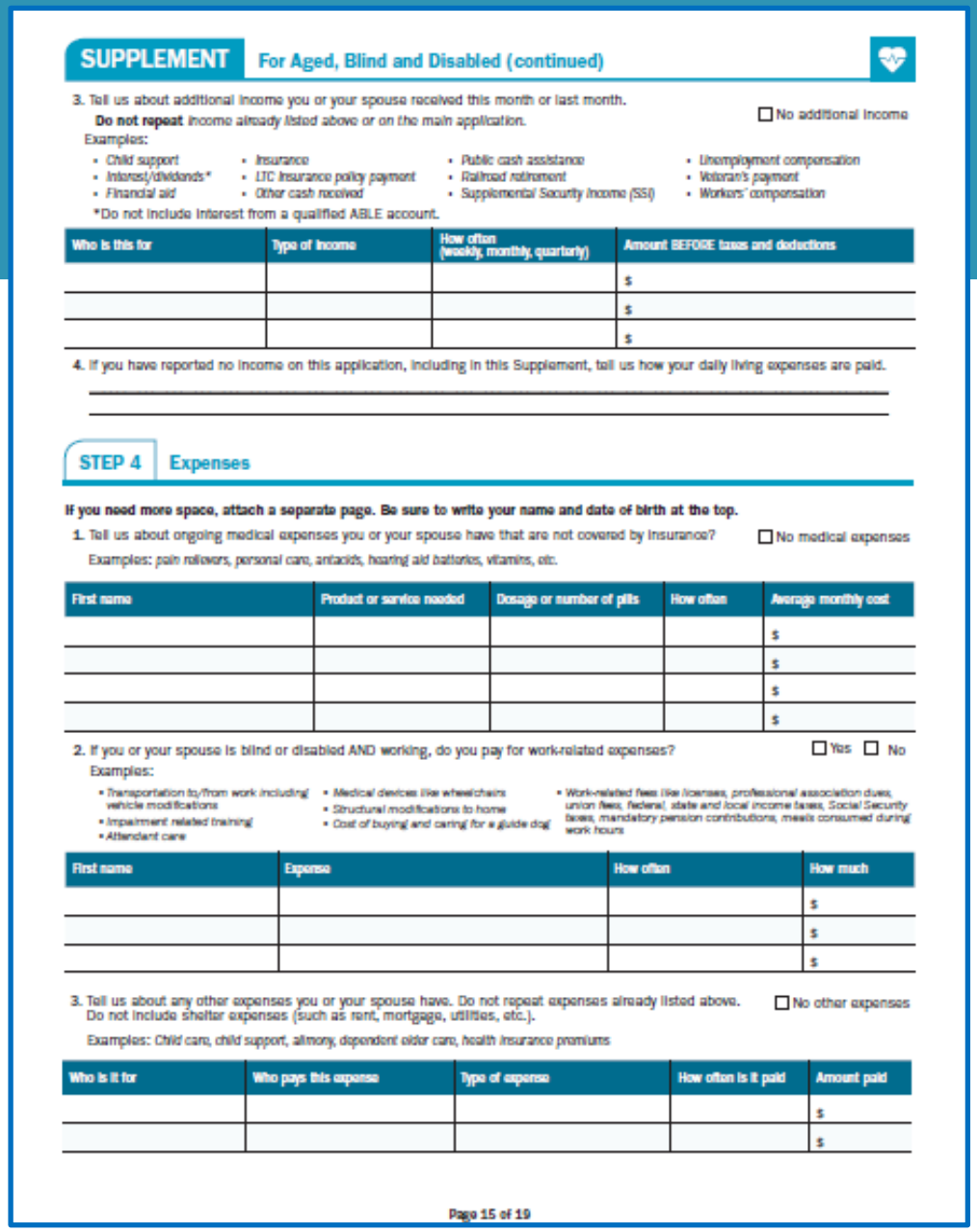
#4 "I am_years old. My parents pay my daily living expenses".

Step 4: Expenses

#1: Medical expenses?

#2: Older and working – any work-related expenses?

#3: Other expenses?



SUPPLEMENT For Aged, Blind and Disabled (continued)

3. Tell us about additional income you or your spouse received this month or last month.
Do not repeat income already listed above or on the main application. ☐ No additional income

Examples:

- Child support
- Interest/dividends*
- Financial aid
- Insurance
- LTC insurance policy payment
- Other cash received
- Public cash assistance
- Railroad retirement
- Supplemental Security Income (SSI)
- Unemployment compensation
- Veteran's payment
- Workers' compensation

*Do not include interest from a qualified ABLE account.

Who is this for	Type of income	How often (weekly, monthly, quarterly)	Amount BEFORE taxes and deductions
			$
			$
			$

4. If you have reported no income on this application, including in this Supplement, tell us how your daily living expenses are paid.

STEP 4 Expenses

If you need more space, attach a separate page. Be sure to write your name and date of birth at the top.

1. Tell us about ongoing medical expenses you or your spouse have that are not covered by insurance? ☐ No medical expenses

Examples: *pain relievers, personal care, antacids, hearing aid batteries, vitamins, etc.*

First name	Product or service needed	Dosage or number of pills	How often	Average monthly cost
				$
				$
				$
				$

2. If you or your spouse is blind or disabled AND working, do you pay for work-related expenses? ☐ Yes ☐ No

Examples:

- Transportation to/from work including vehicle modifications
- Impairment related training
- Attendant care
- Medical devices like wheelchairs
- Structural modifications to home
- Cost of buying and caring for a guide dog
- Work-related fees like licenses, professional association dues, union fees, federal, state and local income taxes, Social Security taxes, mandatory pension contributions, meals consumed during work hours

First name	Expense	How often	How much
			$
			$
			$

3. Tell us about any other expenses you or your spouse have. Do not repeat expenses already listed above. Do not include shelter expenses (such as rent, mortgage, utilities, etc.). ☐ No other expenses

Examples: *Child care, child support, alimony, dependent elder care, health insurance premiums*

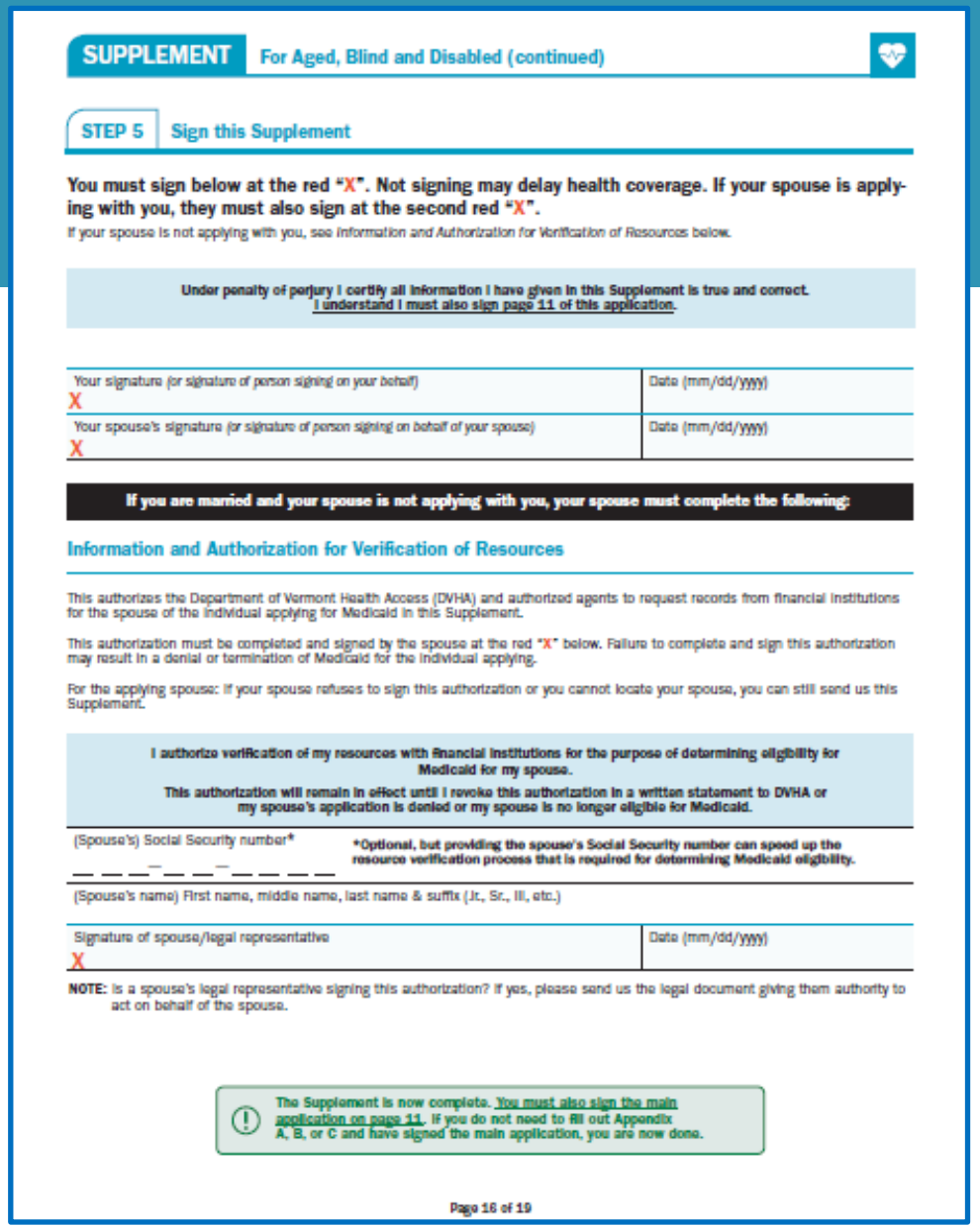
Who is it for	Who pays this expense	Type of expense	How often is it paid	Amount paid
				$
				$

Page 15 of 19

Page 16

Step 5: Sign this supplement:

- Parent/Guardian sign & date by first red X



SUPPLEMENT For Aged, Blind and Disabled (continued)

STEP 5 Sign this Supplement

You must sign below at the red "X". Not signing may delay health coverage. If your spouse is applying with you, they must also sign at the second red "X".

If your spouse is not applying with you, see *Information and Authorization for Verification of Resources* below.

Under penalty of perjury I certify all information I have given in this Supplement is true and correct. I understand I must also sign page 11 of this application.

Your signature (or signature of person signing on your behalf)	Date (mm/dd/yyyy)
X	
Your spouse's signature (or signature of person signing on behalf of your spouse)	Date (mm/dd/yyyy)
X	

If you are married and your spouse is not applying with you, your spouse must complete the following:

Information and Authorization for Verification of Resources

This authorizes the Department of Vermont Health Access (DVHA) and authorized agents to request records from financial institutions for the spouse of the individual applying for Medicaid in this Supplement.

This authorization must be completed and signed by the spouse at the red "X" below. Failure to complete and sign this authorization may result in a denial or termination of Medicaid for the individual applying.

For the applying spouse: If your spouse refuses to sign this authorization or you cannot locate your spouse, you can still send us this Supplement.

I authorize verification of my resources with financial institutions for the purpose of determining eligibility for Medicaid for my spouse.

This authorization will remain in effect until I revoke this authorization in a written statement to DVHA or my spouse's application is denied or my spouse is no longer eligible for Medicaid.

(Spouse's) Social Security number*

_ _ _ – _ _ – _ _ _ _

***Optional, but providing the spouse's Social Security number can speed up the resource verification process that is required for determining Medicaid eligibility.**

(Spouse's name) First name, middle name, last name & suffix (Jr., Sr., III, etc.)

Signature of spouse/legal representative	Date (mm/dd/yyyy)
X	

NOTE: Is a spouse's legal representative signing this authorization? If yes, please send us the legal document giving them authority to act on behalf of the spouse.

The Supplement is now complete. You must also sign the main application on page 11. If you do not need to fill out Appendix A, B, or C and have signed the main application, you are now done.

Page 16 of 19

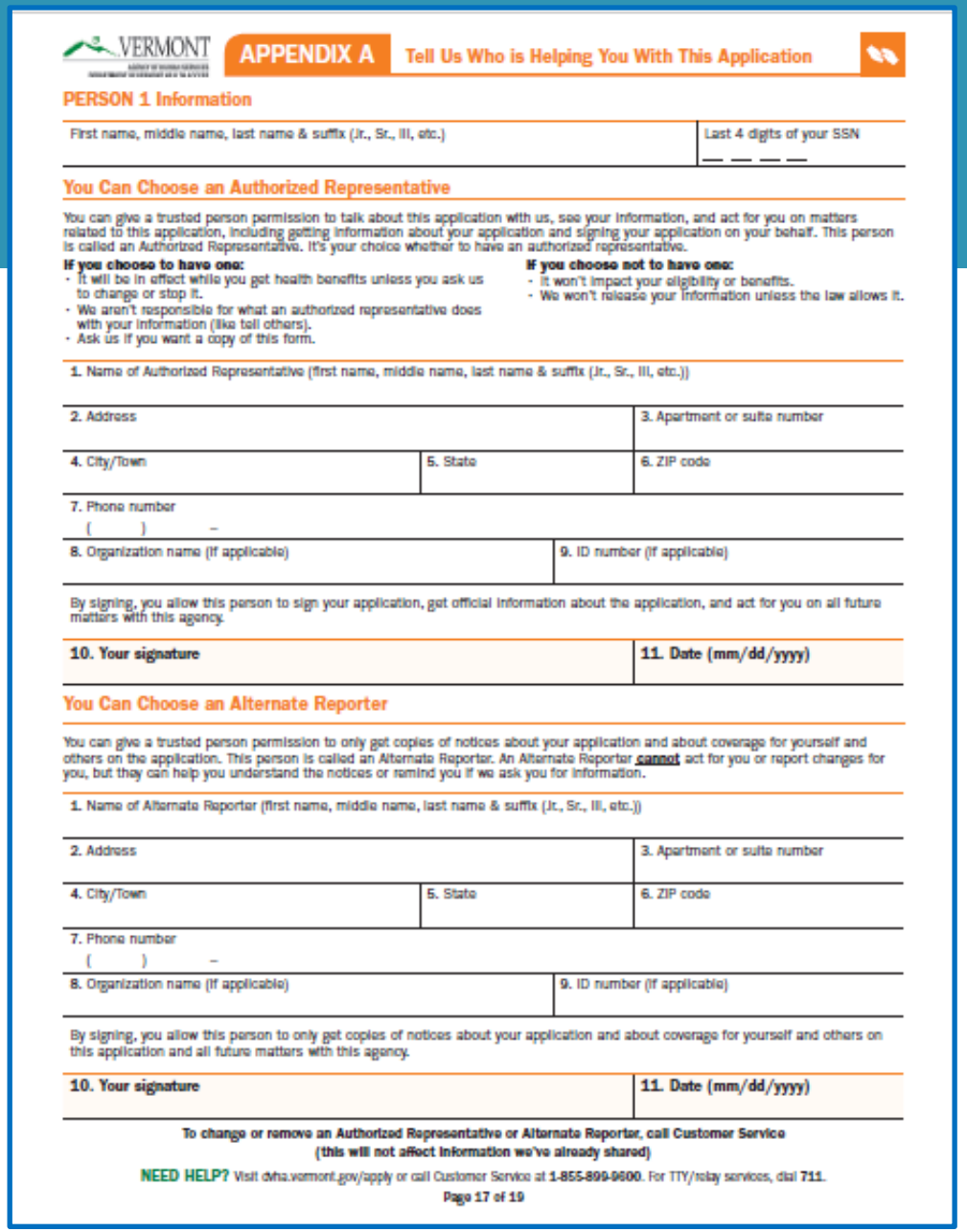
Page 17

Coded Orange: Appendix A

- Put Person 1's (Parent or Guardian) information at the top

Authorized Representative:

- Someone who has helped you fill out the application.
- Someone you give Medicaid permission to speak to about the application and future Medicaid conversations.
- #10 Sign and date!



VERMONT

APPENDIX A Tell Us Who is Helping You With This Application

PERSON 1 Information

First name, middle name, last name & suffix (Jr., Sr., III, etc.) | Last 4 digits of your SSN ____

You Can Choose an Authorized Representative

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an Authorized Representative. It's your choice whether to have an authorized representative.

If you choose to have one:
- It will be in effect while you get health benefits unless you ask us to change or stop it.
- We aren't responsible for what an authorized representative does with your information (like tell others).
- Ask us if you want a copy of this form.

If you choose not to have one:
- It won't impact your eligibility or benefits.
- We won't release your information unless the law allows it.

1. Name of Authorized Representative (first name, middle name, last name & suffix (Jr., Sr., III, etc.))

2. Address | 3. Apartment or suite number

4. City/Town | 5. State | 6. ZIP code

7. Phone number ( ) –

8. Organization name (if applicable) | 9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about the application, and act for you on all future matters with this agency.

10. Your signature | **11. Date (mm/dd/yyyy)**

You Can Choose an Alternate Reporter

You can give a trusted person permission to only get copies of notices about your application and about coverage for yourself and others on the application. This person is called an Alternate Reporter. An Alternate Reporter ***cannot*** act for you or report changes for you, but they can help you understand the notices or remind you if we ask you for information.

1. Name of Alternate Reporter (first name, middle name, last name & suffix (Jr., Sr., III, etc.))

2. Address | 3. Apartment or suite number

4. City/Town | 5. State | 6. ZIP code

7. Phone number ( ) –

8. Organization name (if applicable) | 9. ID number (if applicable)

By signing, you allow this person to only get copies of notices about your application and about coverage for yourself and others on this application and all future matters with this agency.

10. Your signature | **11. Date (mm/dd/yyyy)**

To change or remove an Authorized Representative or Alternate Reporter, call Customer Service (this will not affect information we've already shared)

NEED HELP? Visit dvha.vermont.gov/apply or call Customer Service at **1-855-899-9600**. For TTY/relay services, dial **711**.

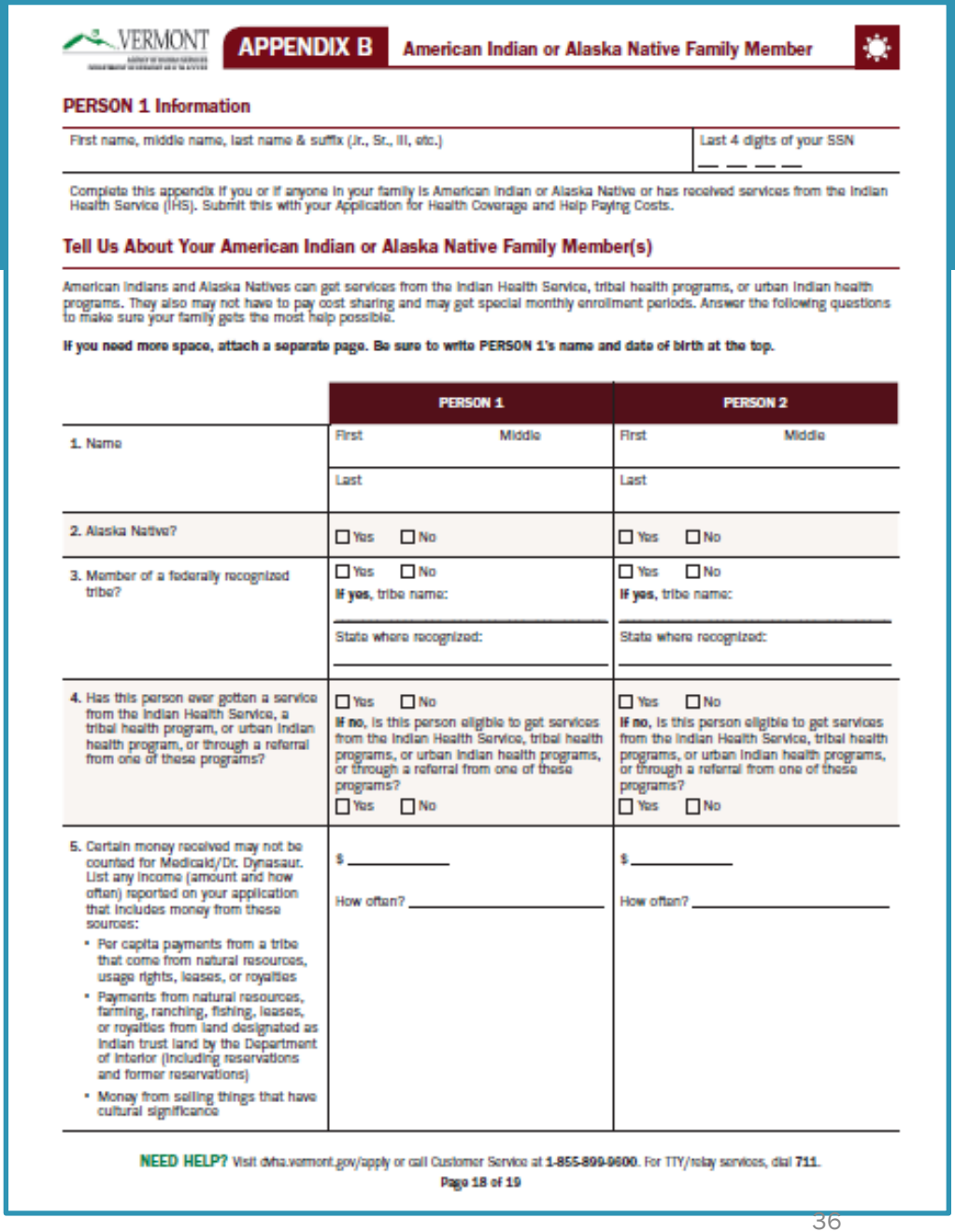
Page 17 of 19

Page 18

Coded Brown: Appendix B

Complete this information only if you, or someone in your household:

- Is an American Indian or Alaskan Native Family Member
- Has received services from the Indian Health Service (HIS)



VERMONT

APPENDIX B American Indian or Alaska Native Family Member

PERSON 1 Information

First name, middle name, last name & suffix (Jr., Sr., III, etc.) | Last 4 digits of your SSN — — — —

Complete this appendix if you or if anyone in your family is American Indian or Alaska Native or has received services from the Indian Health Service (IHS). Submit this with your Application for Health Coverage and Help Paying Costs.

Tell Us About Your American Indian or Alaska Native Family Member(s)

American Indians and Alaska Natives can get services from the Indian Health Service, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

If you need more space, attach a separate page. Be sure to write PERSON 1's name and date of birth at the top.

	PERSON 1	PERSON 2
1. Name	First Middle Last	First Middle Last
2. Alaska Native?	☐ Yes ☐ No	☐ Yes ☐ No
3. Member of a federally recognized tribe?	☐ Yes ☐ No **If yes**, tribe name: State where recognized:	☐ Yes ☐ No **If yes**, tribe name: State where recognized:
4. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
5. Certain money received may not be counted for Medicaid/Dr. Dynasaur. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How often? _____	$ _____ How often? _____

NEED HELP? Visit dvha.vermont.gov/apply or call Customer Service at **1-855-899-9600**. For TTY/relay services, dial **711**.

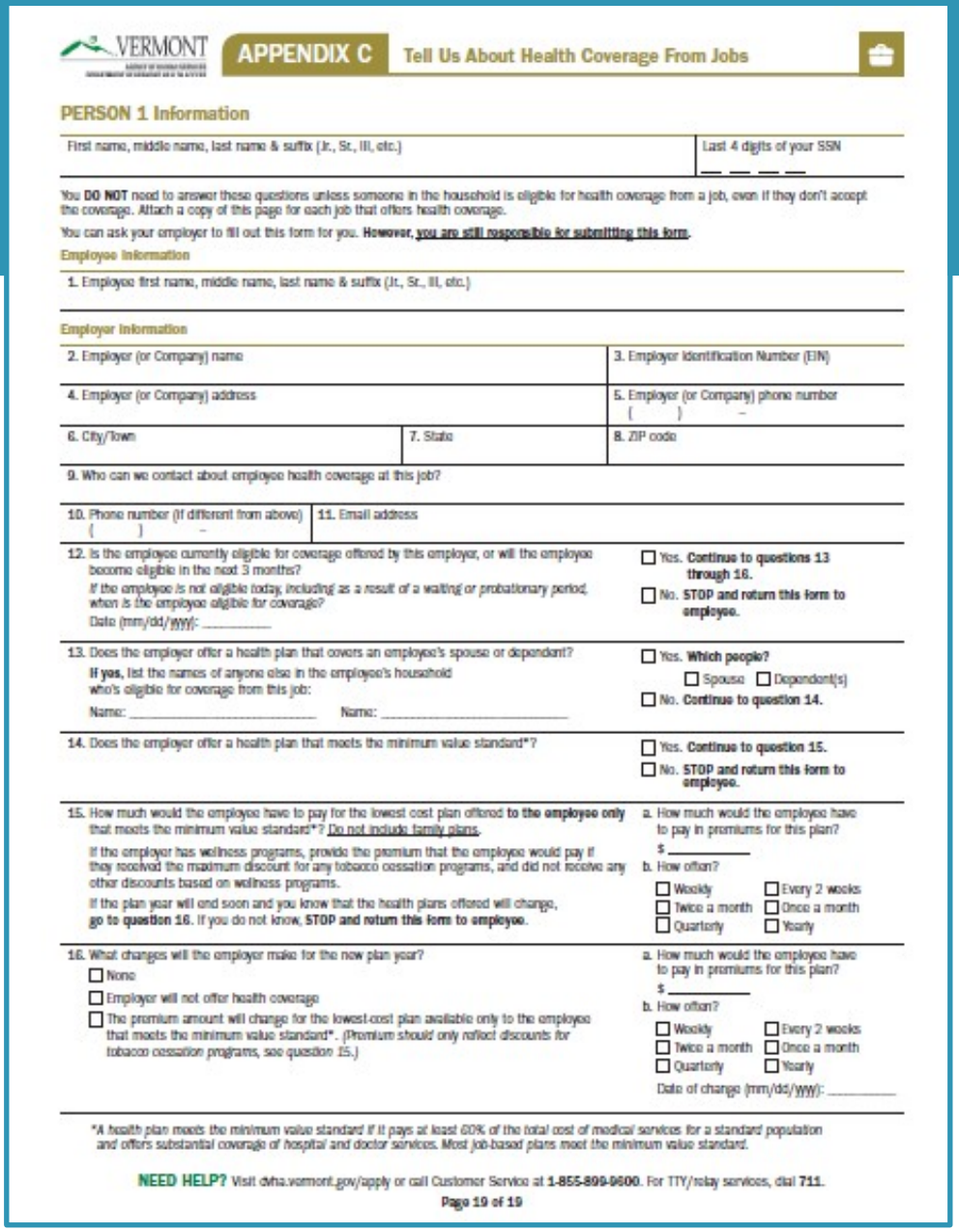
Page 18 of 19

Page 19

Coded Olive: Appendix C

Answer these questions if someone is eligible for health coverage from a job.

- You can ask the HR person from your work to help complete this.
- Minimum value standard is explained at the bottom.



VERMONT

APPENDIX C Tell Us About Health Coverage From Jobs

PERSON 1 Information

First name, middle name, last name & suffix (Jr., Sr., III, etc.) | Last 4 digits of your SSN ___ ___ ___ ___

You **DO NOT** need to answer these questions unless someone in the household is eligible for health coverage from a job, even if they don't accept the coverage. Attach a copy of this page for each job that offers health coverage.

You can ask your employer to fill out this form for you. **However, you are still responsible for submitting this form.**

Employee Information

1. Employee first name, middle name, last name & suffix (Jr., Sr., III, etc.)

Employer Information

2. Employer (or Company) name
3. Employer Identification Number (EIN)
4. Employer (or Company) address
5. Employer (or Company) phone number ( ) -
6. City/Town
7. State
8. ZIP code
9. Who can we contact about employee health coverage at this job?
10. Phone number (if different from above) ( ) -
11. Email address
12. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?
    If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?
    Date (mm/dd/yyyy): _____
    ☐ Yes. **Continue to questions 13 through 16.**
    ☐ No. **STOP and return this form to employee.**
13. Does the employer offer a health plan that covers an employee's spouse or dependant?
    If yes, list the names of anyone else in the employee's household who's eligible for coverage from this job:
    Name: _____ Name: _____
    ☐ Yes. **Which people?** ☐ Spouse ☐ Dependent(s)
    ☐ No. **Continue to question 14.**
14. Does the employer offer a health plan that meets the minimum value standard*?
    ☐ Yes. **Continue to question 15.**
    ☐ No. **STOP and return this form to employee.**
15. How much would the employee have to pay for the lowest cost plan offered **to the employee only** that meets the minimum value standard*? Do not include family plans.
    If the employer has wellness programs, provide the premium that the employee would pay if they received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
    If the plan year will end soon and you know that the health plans offered will change, **go to question 16.** If you do not know, **STOP and return this form to employee.**
    a. How much would the employee have to pay in premiums for this plan?
    $ _____
    b. How often?
    ☐ Weekly ☐ Every 2 weeks
    ☐ Twice a month ☐ Once a month
    ☐ Quarterly ☐ Yearly
16. What changes will the employer make for the new plan year?
    ☐ None
    ☐ Employer will not offer health coverage
    ☐ The premium amount will change for the lowest-cost plan available only to the employee that meets the minimum value standard*. *(Premium should only reflect discounts for tobacco cessation programs, see question 15.)*
    a. How much would the employee have to pay in premiums for this plan?
    $ _____
    b. How often?
    ☐ Weekly ☐ Every 2 weeks
    ☐ Twice a month ☐ Once a month
    ☐ Quarterly ☐ Yearly
    Date of change (mm/dd/yyyy): _____

**A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.*

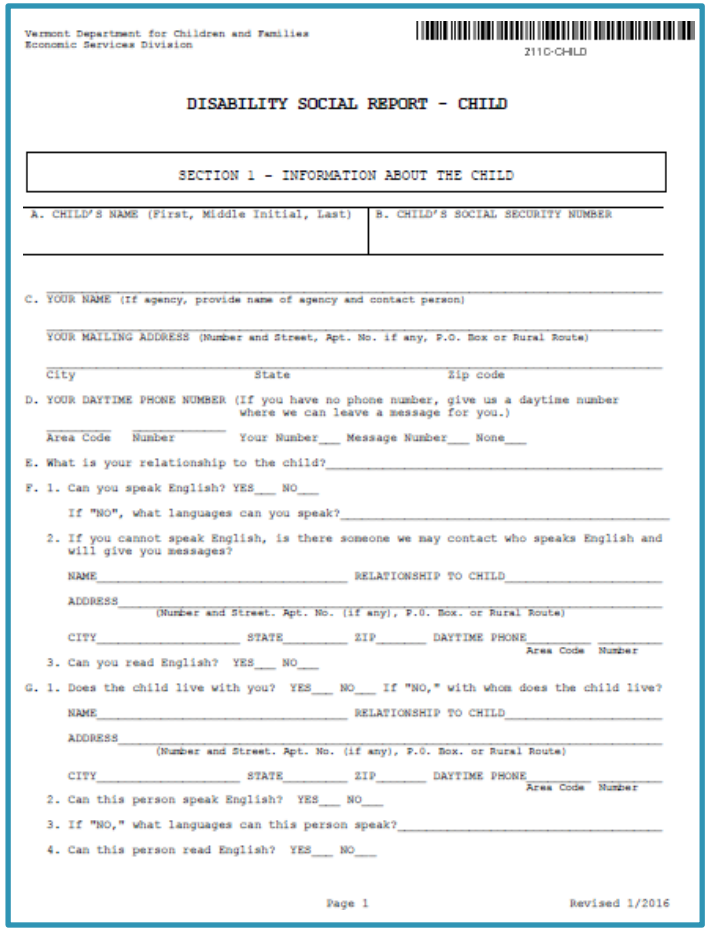
NEED HELP? Visit dvha.vermont.gov/apply or call Customer Service at **1-855-899-9600**. For TTY/relay services, dial **711**.

Page 19 of 19

Disability Social Report 211C- Child

- Revised 1/2016

- Parent is reporting and <u>answering for their child.</u>
- Child's name (A.) and the parent's name (C.).
- Be concise, detailed and complete in answering the questions. You can always attach extra pages, documents or evaluations, as appropriate.
- Page 11: Parent will need to sign and date.
- Section 11 was meant to be filled out by an Economic Services Division worker.



Vermont Department for Children and Families
Economic Services Division

211C-CHILD

DISABILITY SOCIAL REPORT - CHILD

SECTION 1 - INFORMATION ABOUT THE CHILD

A. CHILD'S NAME (First, Middle Initial, Last) | B. CHILD'S SOCIAL SECURITY NUMBER

C. YOUR NAME (If agency, provide name of agency and contact person)

YOUR MAILING ADDRESS (Number and Street, Apt. No. if any, P.O. Box or Rural Route)

City State Zip code

D. YOUR DAYTIME PHONE NUMBER (If you have no phone number, give us a daytime number where we can leave a message for you.)

Area Code Number Your Number___ Message Number___ None___

E. What is your relationship to the child?

F. 1. Can you speak English? YES___ NO___

If "NO", what languages can you speak?

2. If you cannot speak English, is there someone we may contact who speaks English and will give you messages?

NAME RELATIONSHIP TO CHILD

ADDRESS (Number and Street. Apt. No. (if any), P.O. Box. or Rural Route)

CITY STATE ZIP DAYTIME PHONE Area Code Number

3. Can you read English? YES___ NO___

G. 1. Does the child live with you? YES___ NO___ If "NO," with whom does the child live?

NAME RELATIONSHIP TO CHILD

ADDRESS (Number and Street. Apt. No. (if any), P.O. Box. or Rural Route)

CITY STATE ZIP DAYTIME PHONE Area Code Number

2. Can this person speak English? YES___ NO___

3. If "NO," what languages can this person speak?

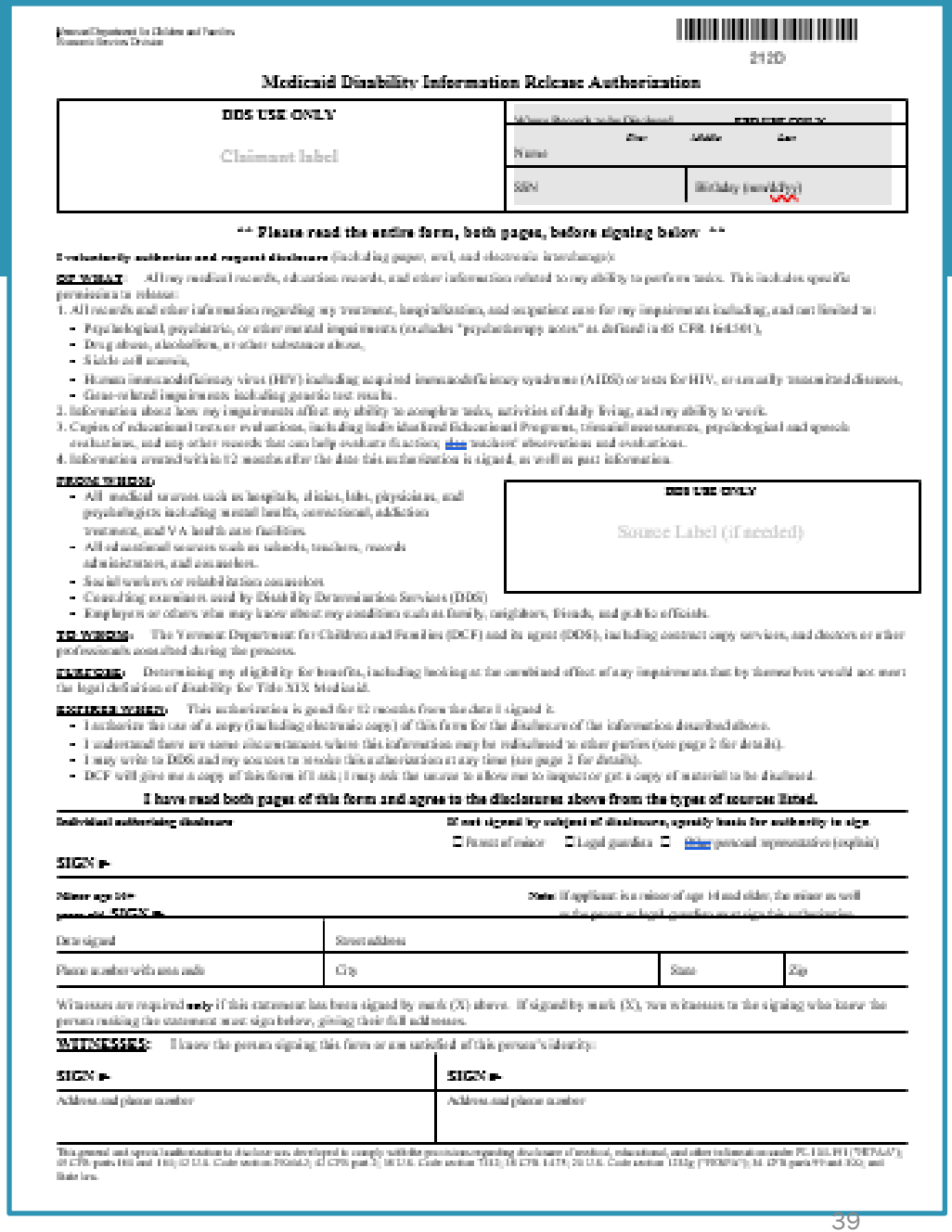
4. Can this person read English? YES___ NO___

Page 1 Revised 1/2016

Medicaid Disability Information Release Authorization

Form 212D

- Review form
- Fill out, sign & date bottom part
- Check box of parent of minor or legal guardian
- ***If child is 14 or over, child must sign also***
- Used by Disability Determination Services to access medical records



212D

Medicaid Disability Information Release Authorization

DDS USE ONLY	
Claimant label	Name: First Middle Last
	SSN / Birthday (mm/dd/yy)

**** Please read the entire form, both pages, before signing below ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT: All my medical records, education records, and other information related to my ability to perform tasks. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairments including, and not limited to:
   - Psychological, psychiatric, or other mental impairments (excludes "psychotherapy notes" as defined in 45 CFR 164.501),
   - Drug abuse, alcoholism, or other substance abuse,
   - Suicide call records,
   - Human immunodeficiency virus (HIV) including acquired immunodeficiency syndrome (AIDS) or tests for HIV, or sexually transmitted diseases,
   - Gene-related impairments including genetic test results.
2. Information about how my impairments affect my ability to complete tasks, activities of daily living, and my ability to work.
3. Copies of educational records or evaluations, including Individualized Educational Programs, transition assessments, psychological and speech evaluations, and any other records that can help evaluate functions, teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM:
- All medical sources such as hospitals, clinics, labs, physicians, and psychologists including mental health, correctional, addiction treatment, and VA health care facilities.
- All educational sources such as schools, teachers, records administrators, and counselors.
- Social workers or rehabilitation counselors.
- Consulting examiners used by Disability Determination Services (DDS).
- Employers or others who may know about my conditions such as family, neighbors, friends, and public officials.

DDS USE ONLY
Source Label (if needed)

TO WHOM: The Vermont Department for Children and Families (DCF) and its agent (DDS), including contract copy services, and doctors or other professionals consulted during the process.

PURPOSE: Determining my eligibility for benefits, including looking at the combined effect of my impairments that by themselves would not meet the legal definition of disability for Title XIX Medicaid.

EXPIRES WHEN: This authorization is good for 12 months from the date I signed it.

- I authorize the use of a copy (including electronic copy) of this form for the disclosures of the information described above.
- I understand there are some circumstances where this information may be redisclosed to other parties (see page 2 for details).
- I may write to DDS and my access to revoke (take back) authorization at any time (see page 2 for details).
- DCF will give me a copy of this form if I ask; I may ask the caseworker to allow me to inspect or get a copy of material to be disclosed.

I have read both pages of this form and agree to the disclosures above from the types of sources listed.

Individual authorizing disclosure — **If not signed by subject of disclosure, specify basis for authority to sign:** ☐ Parent of minor ☐ Legal guardian ☐ Other personal representative (explain)

SIGN ▸

Minor age 14+ must also SIGN ▸ — **Note:** If applicant is a minor of age 14 and older, the minor as well as the parent or legal guardian must sign this authorization.

Date signed	Street address		
Phone number with area code	City	State	Zip

Witnesses are required **only** if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

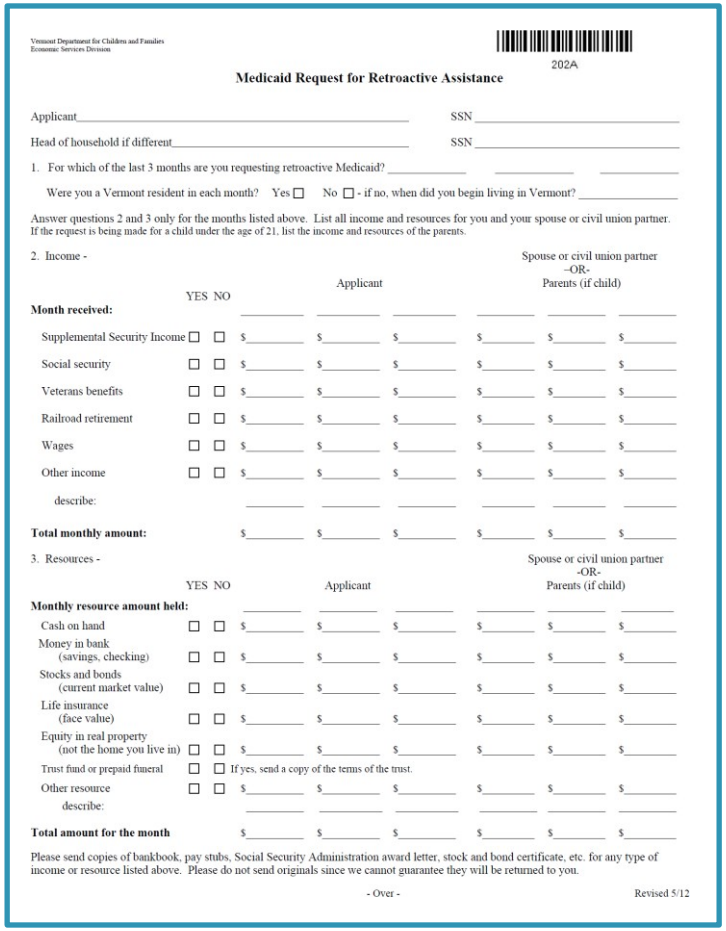
WITNESSES: I know the person signing this form or am satisfied of this person's identity.

SIGN ▸	**SIGN ▸**
Address and phone number	Address and phone number

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under PL 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Medicaid Request for Retroactive Assistance – Form 202A

- Request 3 months coverage prior to date of application submission
- Child is applicant -Fill out as your child
- Only the child's income and resources are listed
- Write across top that it goes with the DCHC application
- Include with DCHC application



Vermont Department for Children and Families
Economic Services Division

202A

Medicaid Request for Retroactive Assistance

Applicant _____ SSN _____

Head of household if different _____ SSN _____

1. For which of the last 3 months are you requesting retroactive Medicaid? _____ _____ _____

Were you a Vermont resident in each month? Yes ☐ No ☐ - if no, when did you begin living in Vermont? _____

Answer questions 2 and 3 only for the months listed above. List all income and resources for you and your spouse or civil union partner. If the request is being made for a child under the age of 21, list the income and resources of the parents.

2. Income -

	YES	NO	Applicant			Spouse or civil union partner -OR- Parents (if child)		
Month received:								
Supplemental Security Income	☐	☐	$	$	$	$	$	$
Social security	☐	☐	$	$	$	$	$	$
Veterans benefits	☐	☐	$	$	$	$	$	$
Railroad retirement	☐	☐	$	$	$	$	$	$
Wages	☐	☐	$	$	$	$	$	$
Other income	☐	☐	$	$	$	$	$	$
describe:								
Total monthly amount:			$	$	$	$	$	$

3. Resources -

	YES	NO	Applicant			Spouse or civil union partner -OR- Parents (if child)		
Monthly resource amount held:								
Cash on hand	☐	☐	$	$	$	$	$	$
Money in bank (savings, checking)	☐	☐	$	$	$	$	$	$
Stocks and bonds (current market value)	☐	☐	$	$	$	$	$	$
Life insurance (face value)	☐	☐	$	$	$	$	$	$
Equity in real property (not the home you live in)	☐	☐	$	$	$	$	$	$
Trust fund or prepaid funeral	☐	☐	If yes, send a copy of the terms of the trust.					
Other resource	☐	☐	$	$	$	$	$	$
describe:								
Total amount for the month			$	$	$	$	$	$

Please send copies of bankbook, pay stubs, Social Security Administration award letter, stock and bond certificate, etc. for any type of income or resource listed above. Please do not send originals since we cannot guarantee they will be returned to you.

- Over -

Revised 5/12

Additional Documents

- Medical records that document your child's disability
- Parent view of a “day in the life” of the child letter
- SSA Child Function Report *https://secure.ssa.gov/poms.nsf/lnx/0425205025*
- IEP, One Plan or 504 Plan
- Primary care doctor (Medical Home) letter describing clinical status with prognosis and function- could attach clinical notes

Before you mail make yourself a COPY!

Disabled Children's Home Care Application

Mail to:

Green Mountain Care
Application and Document
Processing Center
280 State Drive
Waterbury, VT 05671-1500

- 205 ALLMED Non-LTC
- **REMEMBER:** Blue Supplement for Aged, Blind & Disabled
- 212-D (Disability Determination Services Release)
- 211-C Disability Social Report – Child
- 202A Request for Retroactive Medicaid – if needed
- Any attachments

Remember

- Screened for Dr. Dynasaur Medicaid first (30 days)
- DCHC can take up to 90 days for the eligibility process – maybe longer
- You can apply for DCHC at any time of the year.

Need Help?

Green Mountain Care Health Access Member Services
1-800-250-8427
https://www.greenmountaincare.org

In-Person Assisters
In-Person Assisters are trained and certified by the Department of Vermont Health Access to help Vermonters enroll through Vermont Health Connect or Green Mountain Care.
https://info.healthconnect.vermont.gov/information/community_partners/assisters

Your Regional Children with Special Health Needs Medical Social Worker.
CSHN is a free public health program for families,
1-800-660-4427
https://www.healthvermont.gov/family/special-health-needs

Vermont Family Network (VFN)
VFN's mission is to empower and support all Vermont families of children with special needs.
1-800-800-4005
https://www.vermontfamilynetwork.org/

Yearly DCHC Program Financial Review

- Yearly - About six weeks before renewal date
- Receive 202MED Review form
- Complete as if child was filling it out – child is applicant
- Time-line for completion – noted in letter
- Reviewed by the Health Access Eligibility & Enrollment Unit for financial eligibility
- Notification letter sent to family
- Renewal entered in MMIS (Medicaid Monitoring & Information System)

Program Medical Review

A review of the current medical status of children receiving DCHC is required to ensure they continue to meet the medical criteria of the program.

Frequency of reviews

- How often your child's medical condition is reviewed depends on severity and if there could be condition improvement. The initial Medicaid approval letter tells you when the first medical review can be expected.
- Generally approval is for 1 to 5 years

Review by Disability Determination Services (DDS)

- You will receive the Disability Social Report, 211C-Child form
  - Time-line for completing and returning
- New information about your child's medical condition
  - Doctors, hospitals, and other medical, developmental, mental health, educational sources
- If more information is needed, they may ask you to take your child for a special examination/assessment for which they will pay.
- You will receive a letter outlining their determination.
- https://dcf.vermont.gov/dds/contact-us

If you receive a denial letter

Read the letter carefully as it will give you information on how to make an appeal and/or ask for a fair hearing.

- The Health Care Advocate at Vermont Legal Aid may be able to advise and provide representation about your appeal. 1-800-917-7787 https://vtlawhelp.org/health

- Vermont Family Network can assist you with interpreting the denial and understanding the appeal process. 1-800-800-4005 http://www.vermontfamilynetwork.org/

- http://www.greenmountaincare.org/member-information/appeals-and-fair-hearings
- https://humanservices.vermont.gov/human-services-board
- https://vtlawhelp.org/fair-hearing-how-prepare-what-expect#

Early and Periodic Screening, Diagnostic and Treatment

- The EPSDT benefit provides comprehensive and preventive health care services for children who are enrolled in Medicaid.

- EPSDT is key to ensuring that children and adolescents receive appropriate preventative, dental, mental health, and specialty services.

EPSDT

EPSDT

- **Early:** Assessing and identifying problems early
- **Periodic:** Checking children's health at periodic, age-appropriate intervals
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- **Diagnostic:** Performing diagnostic tests to follow up when a risk is identified, and
- **Treatment:** Control, correct or reduce health problems found

https://www.medicaid.gov/medicaid/benefits/epsdt/index.html

Questions?

Thank you!

Betty Morse
Technical Assistance Specialist
Children with Special Health Needs (CSHN)
Vermont Department of Health
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FAX: 1-802-863-6344
Healthvermont.gov

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