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 تتحدث لغة أخرى غير اللغة الإنجليزية ، فستتوفر لك خدمات مساعدة اللغة مجانًا. اتصل بالرقم 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)
तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको नमि्ति भाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-899-9600 । (नेपाली)
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)
ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-899-9600 (ภาษาไทย)
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.

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.

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.

Rights of People with Disabilities. If you have a physical, mental, or learning condition that makes it hard to do things we ask you to do, we can make changes to help you. The Americans with Disabilities Act (ADA) and Vermont law say that we may have to make changes (called reasonable accommodations) to our requirements so people with disabilities can get health benefits. Here are examples of changes we can make:

- Someone can write down your answers if you can't
- We can give you more time or help you get the documents you need to give us
- 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 Numbers). We will use your information to determine eligibility, help pay for care, and for other lawful purposes. This may include: to verify income and other eligibility information, determine benefits, collect claims, conduct audits, investigate fraud, pay medical assistance, to assess accuracy of information you give us, and to conduct medical support enforcement. We may contact public and private agencies, including the Social Security Administration, financial institutions (Asset Verification), consumer reporting agencies, Department of Labor, Department of Homeland Security, and the Internal Revenue Service (IRS). If the information does not match, we may ask you to send proof to us.

Everyone applying who has a Social Security Number (SSN) must provide it to qualify for health benefits. If someone does not want health care coverage, they do not have to give us their SSN. Some people who don't have an SSN, including people with a religious objection to having one, don't have to get one to apply for health benefits. Call Customer Service to find out more.

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.

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.

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 your health care providers and Department of Vermont Health Access (DVHA) and its contractors and grantees may access, use, and disclose your medical records to: (1) manage state health care programs, or (2) when a hospital, health care provider, mental health provider, or pharmacy needs your medical records. This includes provider and prescription information for your treatment, for payment of your treatment, and for health care operations.

You agree that your consent includes the re-disclosure of prescription medication information received from a drug or alcohol treatment program when such information is needed for purposes of treatment.

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 of your home. If you think that cooperating to collect medical support may harm you or your children, call Customer Service. You may not have to cooperate.

Consent to Bill Medicaid if Child Receives Special Education. If a child in your household gets Medicaid and Special Education, you give permission to your child's school district to bill Medicaid for the services listed in your child's Individual Education Plan (IEP). You understand that if you refuse consent, your refusal only affects Medicaid billing for IEP services; the school district must still provide IEP services at no cost to you. You may revoke this consent at any time. If you revoke this consent, it will apply to billing for services from that date forward. To revoke your consent, write to: DVHA, Application & Document Processing Center, 280 State Drive, Waterbury, VT 05671-8100.

Are You Using the Supplement to Apply for Medicaid for the Aged, Blind and Disabled (MABD)? If Yes, You Have These Additional Rights and Responsibilities.

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.

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.

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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.

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? ☐ Yes. **Name of the tax filer:** _____ ☐ No
(You cannot be both a dependent and a joint filer.)
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 202LTC 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: _____

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
☐ Black or African American
☐ Hispanic, Latino, or Spanish Origin
☐ American Indian or Alaska Native
Fill out Appendix B: American Indian or Alaska Native Family Member on page 18.
☐ Asian
☐ Middle Eastern or North African
☐ Native Hawaiian or other Pacific Islander
☐ Other: _____

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: _____

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.

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., III, 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 202LTC 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: _____

STEP 2 Person 2 (continued)

15. If PERSON 2 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 2 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 2, or their spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
j. SEVIS ID: _____

16. Retroactive Medicaid: If PERSON 2 has medical/dental expenses from the last 3 months, they might be eligible for assistance that could help pay, or reimburse, them for those expenses. Does PERSON 2 want to apply for help with medical/dental expenses from the last 3 months? ☐ Yes ☐ No

17. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

18. Is PERSON 2 a full-time student? ☐ Yes. **If yes, give the state of their legal residence:** _____ ☐ No

19. Was PERSON 2 in foster care in Vermont when they turned 18? ☐ Yes ☐ No

20. To which racial group(s) does PERSON 2 most identify? (Optional–check all that apply)

☐ White
☐ Black or African American
☐ Hispanic, Latino, or Spanish Origin
☐ American Indian or Alaska Native
Fill out Appendix B: American Indian or Alaska Native Family Member on page 18.
☐ Asian
☐ Middle Eastern or North African
☐ Native Hawaiian or other Pacific Islander
☐ Other: _____

21. If Hispanic/Latino: To what ethnic group does PERSON 2 most identify? (Optional–check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican
☐ Cuban ☐ Other: _____

Current Job & Income Information

☐ EMPLOYED
If PERSON 2 is currently employed, tell us about their income. Start with question 22.

☐ SELF-EMPLOYED
Continue to question 33.

☐ NOT EMPLOYED
Continue to question 34.

Current Job 1

22. Employer (or Company) name

23. Employer (or Company) phone number
( ) –

24. Employer (or Company) address

25. Wages/tips before taxes (gross income) $ _____
PER: ☐ Hour ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year

26. Average hours worked each week in the past month: _____

If PERSON 2 only has one job, continue to question 32.

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.

27. Employer (or Company) name

28. Employer (or Company) phone number
( ) –

29. Employer (or Company) address

STEP 2 Person 2 (continued)

30. Wages/tips before taxes (gross income) $ _____

PER: ☐ Hour ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year

31. Average hours worked each week in the past month: _____

Additional Job Information

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

33. If self-employed, answer the following questions:

a. What type of work does PERSON 2 do? _____

b. How much net income (the amount left over after business expenses are paid) will PERSON 2 get this month? $ _____

34. In the past year, did PERSON 2**:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None

Other Income This Month

35. Check all that apply and give the amount and how often PERSON 2 receives 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

36. List any of the deductions PERSON 2 is able to claim from the 'Adjustments to Income' section of schedule 1 of their **1040 federal income tax return**. Please do not include any itemized deductions from schedule A.

NOTE: *You should not include a cost that* PERSON 2 *already deducted from their self-employment net income in question 33b.*

☐ 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

37. Complete ONLY if PERSON 2's income changes during the year, for example, if they only work a job for part of the year or receive a benefit only some months.

PERSON 2's total income **THIS** year

$ _____

PERSON 2's total income **NEXT** year (if they think it will be different)

$ _____

STEP 2 is complete. Continue to STEP 3.

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.

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): Premium $	Part B Start date (mm/dd/yyyy): Premium $	Part A Start date (mm/dd/yyyy): Premium $	Part B Start date (mm/dd/yyyy): 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.

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

   _____

   _____

   _____

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.

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)

Important! We need more information to find out if you qualify for health coverage programs that are only available to people who are 65 or older, blind, or disabled. We will use the information in this Supplement, along with the information you provided in the main application, to see what you qualify for. If you are not sure if you need to complete this supplement, please call Customer Service. See the list of programs below.

If you want any of the programs below, complete steps 1-5 in the Supplement.

Medicaid for the Aged, Blind & Disabled (MABD)
for people who are aged 65 or older, and/or who are blind or disabled.

VPharm (Pharmacy Program)
for people on Medicare to help pay for prescription drugs.

Medicare Savings Programs (MSP)
for people with Medicare to help pay for Medicare premiums, deductibles, and copays.

Disabled Children's Home Care (DCHC) (Katie Beckett)
for children with disabilities who are living at home and would be eligible for Medicaid if living in an institution. Parent's income and resources are not counted when determining eligibility. However, we do need to know the child's income and resources.

Healthy Vermonters Program (HVP)
for all Vermonters without pharmacy coverage. This program provides a discount on some prescriptions.

If you only want to apply for VPharm, HVP and/or MSP, you can fill out a 201P. Call Customer Service for more information.

PLEASE READ THIS BEFORE YOU FILL OUT THE SUPPLEMENT.

If you are married, you and your spouse CAN be screened together on one Supplement. Even if only one of you wants to be screened, we still need information about both of you.

Is your child applying for DCHC (Katie Beckett)? If so, complete Step 1 with your child's name. Complete Steps 2-4 with only your child's information. We will let you know if we need more information.

Is anyone else also applying? If yes, you must fill out a SEPARATE Supplement for them. Make copies of pages 13-16 prior to filling them out or call Customer Service and we will send you send you a separate supplement.

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
		$	
		$	

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

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
				$
				$

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.

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**.

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? _____

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DEPARTMENT OF VERMONT HEALTH ACCESS

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 dependent?

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.*