



## Application for Health Care Assistance

Name _____	Social security number _____
Mailing address _____	Home phone (_____) _____
Town, state, and zip _____	Daytime phone (_____) _____
Town where you live _____	
Directions to your home _____	
<b>Does the applicant have an authorized representative or legal guardian?</b>	
If yes, check one:    Authorized representative    Legal guardian	Yes, please include proof    No
Name _____	Telephone (_____) _____
Mailing address _____	Town, state, and zip _____
If legal guardian, name of probate court _____	Date appointed _____

**Medicaid** pays for medical expenses for children under 21, people with children, and people who are blind, have a disability, or who are age 65 or older.

**Dr. Dynasaur** helps pay for medical services for children under age 18 and pregnant women.

**Vermont Health Access Plan (VHAP)** helps pay medical expenses for people age 18 and older who do not have insurance for both doctors and hospitals.

**Premium Assistance** helps people who are uninsured get health insurance. The state may pay a portion of the premium for Catamount Health or for some plans offered by employers.

**Pharmacy Assistance** helps pay prescription costs. **VHAP-Pharmacy, VScript, and VPharm** help those who are blind, have a disability, or are age 65 or older. **Healthy Vermonters** helps people of any age. *If this is the only assistance your household is applying for, you only need to answer questions 1-2, 4-5, 8-9 and 17-24.*

**Medicare Savings Programs** help pay Medicare expenses. **Qualified Medicare Beneficiary (QMB)** pays Medicare premiums, deductibles and coinsurance. **Specified Low-Income Medicare Beneficiary (SLMB)** and **Qualified Individuals (QI-1)** pay Part B premiums. **Qualified Disabled Working Individual (QDWI)** pays Part A premiums. *If these are the only assistance your household is applying for, you only need to answer questions 1-2, 4-5, 8-9 and 17- 24.*

**Disabled Children's Home Care (DCHC ~ Katie Beckett)** pays for medical services for children with disabilities who are living at home and would be eligible for Medicaid if living in an institution. Parents' income is not counted when determining eligibility. *If this is the only program your household is applying for, you only need to answer questions 1-2, 4, 8-11, 18, 20-21 and 24.*

All health care programs have income limits; some also have resource limits. Some programs may have premiums or copayments. Children who are members of federally designated American Indian or Alaska Native tribes may not have to pay a Dr. Dynasaur premium.

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**If you do not speak English, we can provide free translation for our services.  
 Please tell us if you need an interpreter for any language.**

Nếu quý vị có thắc mắc hoặc cần các dịch vụ phiên dịch, xin gọi: (Vietnamese)

Если у Вас есть вопросы или Вы нуждаетесь в услугах переводчика, позвоните по номеру: (Russian)

Si vous avez des questions ou avez besoin de services de traduction, appelez le: (French)

Ukoliko imate dodatnih pitanja ili Vam je potreban prevodilac, javite se na: (SerboCroatian)

**People with a hearing impairment can call the statewide relay service at  
 1-800-253-0191 (TDD) or 1-800-253-0195 (voice)**

**1. List anyone living in your home including people not asking for assistance.** If any noncitizens are applying, attach proof of immigration or citizenship status such as a copy of your permanent resident card or visa. People in your household who are not applying do not have to give their social security number or citizenship information but must provide all other information.

MEMB

<b>1.</b>	<b>First name</b> Initial Last name	<b>Assistance applying for</b> <input type="checkbox"/> Medicaid/Dr. Dynasaur <input type="checkbox"/> Pharmacy <input type="checkbox"/> Medicare Savings Programs	<input type="checkbox"/> VHAP <input type="checkbox"/> DCHC <input type="checkbox"/> None	<b>Sex</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Citizenship status</b> <input type="checkbox"/> U.S. citizen <input type="checkbox"/> Refugee <input type="checkbox"/> Other	<input type="checkbox"/> Asylee <input type="checkbox"/> Legal alien
	<b>Relationship to you</b>  Self	<b>Marital status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Widowed		<b>Birthdate</b>	<b>Social security number</b>	

  

<b>2.</b>	<b>First name</b> Initial Last name	<b>Assistance applying for</b> <input type="checkbox"/> Medicaid/Dr. Dynasaur <input type="checkbox"/> Pharmacy <input type="checkbox"/> Medicare Savings Programs	<input type="checkbox"/> VHAP <input type="checkbox"/> DCHC <input type="checkbox"/> None	<b>Sex</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Citizenship status</b> <input type="checkbox"/> U.S. citizen <input type="checkbox"/> Refugee <input type="checkbox"/> Other	<input type="checkbox"/> Asylee <input type="checkbox"/> Legal alien
	<b>Relationship to you</b>	<b>Marital status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Widowed		<b>Birthdate</b>	<b>Social security number</b>	

  

<b>3.</b>	<b>First name</b> Initial Last name	<b>Assistance applying for</b> <input type="checkbox"/> Medicaid/Dr. Dynasaur <input type="checkbox"/> Pharmacy <input type="checkbox"/> Medicare Savings Programs	<input type="checkbox"/> VHAP <input type="checkbox"/> DCHC <input type="checkbox"/> None	<b>Sex</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Citizenship status</b> <input type="checkbox"/> U.S. citizen <input type="checkbox"/> Refugee <input type="checkbox"/> Other	<input type="checkbox"/> Asylee <input type="checkbox"/> Legal alien
	<b>Relationship to you</b>	<b>Marital status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Widowed		<b>Birthdate</b>	<b>Social security number</b>	

  

<b>4.</b>	<b>First name</b> Initial Last name	<b>Assistance applying for</b> <input type="checkbox"/> Medicaid/Dr. Dynasaur <input type="checkbox"/> Pharmacy <input type="checkbox"/> Medicare Savings Programs	<input type="checkbox"/> VHAP <input type="checkbox"/> DCHC <input type="checkbox"/> None	<b>Sex</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Citizenship status</b> <input type="checkbox"/> U.S. citizen <input type="checkbox"/> Refugee <input type="checkbox"/> Other	<input type="checkbox"/> Asylee <input type="checkbox"/> Legal alien
	<b>Relationship to you</b>	<b>Marital status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Widowed		<b>Birthdate</b>	<b>Social security number</b>	

  

<b>5.</b>	<b>First name</b> Initial Last name	<b>Assistance applying for</b> <input type="checkbox"/> Medicaid/Dr. Dynasaur <input type="checkbox"/> Pharmacy <input type="checkbox"/> Medicare Savings Programs	<input type="checkbox"/> VHAP <input type="checkbox"/> DCHC <input type="checkbox"/> None	<b>Sex</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Citizenship status</b> <input type="checkbox"/> U.S. citizen <input type="checkbox"/> Refugee <input type="checkbox"/> Other	<input type="checkbox"/> Asylee <input type="checkbox"/> Legal alien
	<b>Relationship to you</b>	<b>Marital status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Widowed		<b>Birthdate</b>	<b>Social security number</b>	

Please answer the following questions about all the people listed above. If you need more room, attach another sheet of paper.

**1b. Has anyone ever been known by any other name, such as a maiden name or alias?**  Yes  No

ALIA

<b>Current name:</b> First name Initial Last name	<b>Other name:</b> First name Initial Last name
<b>Current name:</b> First name Initial Last name	<b>Other name:</b> First name Initial Last name

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

Some examples are: hospital, correctional facility, residential care home, nursing home, treatment facility, group home

INST

<b>First name</b> Initial	<b>Name of facility</b>	<b>Date of admission</b>
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**3. Is anyone in high school, college, vocational school, or a training program?**  Yes  No

SCHL

<b>First name</b> Initial	<b>Name of school</b>	<b>Expected completion date</b>	<b>Is health insurance offered here?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Status</b> <input type="checkbox"/> full-time <input type="checkbox"/> half-time <input type="checkbox"/> less than half-time
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> full-time <input type="checkbox"/> half-time <input type="checkbox"/> less than half-time

Does any child listed above have an Individualized Education Program (IEP) or a disability preventing graduation before age 19?  Yes  No

**4. Does anyone have a physical, mental, or emotional disability that limits activities such as working, going to school, or taking care of the children?**

Yes  No

First name	Initial	Caused by an accident?	Disability determination
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Has SSA determined you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you applied for SSA disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	Has SSA determined you disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you applied for SSA disability? <input type="checkbox"/> Yes <input type="checkbox"/> No

**5. Is anyone living with you who is a parent to your minor child?**

Yes  No

Do not list your husband, wife, or civil union partner.

First name	Initial	Name of child	Name of child

**6. Is anyone pregnant?** Please attach proof of pregnancy and due date from your medical provider.

Yes  No

First name	Initial	Expected due date	Are you expecting a multiple birth?
			If yes, how many babies? _____

**7. Are there children in your home who do not have both parents living with them?**

Yes  No

Absent parent's full name and address	Social security number (optional)	Date of birth	Children of absent parent
1.			1. 2. 3. 4.
Your relationship to absent parent <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Dissolved civil union <input type="checkbox"/> Never married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed date _____		Absent parent's current marital status <input type="checkbox"/> Married <input type="checkbox"/> Civil union <input type="checkbox"/> Divorced <input type="checkbox"/> Never married <input type="checkbox"/> Dissolved civil union <input type="checkbox"/> Widowed	
2.			1. 2. 3. 4.
Your relationship to absent parent <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Dissolved civil union <input type="checkbox"/> Never married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed date _____		Absent parent's current marital status <input type="checkbox"/> Married <input type="checkbox"/> Civil union <input type="checkbox"/> Divorced <input type="checkbox"/> Never married <input type="checkbox"/> Dissolved civil union <input type="checkbox"/> Widowed	

**8. Is anyone who is applying covered by Medicare?**

Yes  No

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

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

**8a. Is anyone enrolled in a Medicare Part D prescription drug plan?**

Yes  No

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

First name	Initial	Plan name	Contract ID	Plan start date
			CMS- _____ - ____	
			CMS- _____ - ____	

**8b. Has anyone applied for the low income subsidy for Part D (prescription coverage) through Social Security?**

Yes  No

First name	Initial	Start date	Denial reason	I did not apply because
			<input type="checkbox"/> Over income <input type="checkbox"/> Over resources <input type="checkbox"/> Other:	<input type="checkbox"/> Over income <input type="checkbox"/> Over resources <input type="checkbox"/> Other:
			<input type="checkbox"/> Over income <input type="checkbox"/> Over resources <input type="checkbox"/> Other:	<input type="checkbox"/> Over income <input type="checkbox"/> Over resources <input type="checkbox"/> Other:

**9. Is anyone covered by a health or dental insurance plan, such as group insurance, veteran's or military benefits?** Include insurance for any child in your home even if covered by a parent not in your home. Do not include Medicare or state health care programs. Please send copies of both sides of all insurance cards.

Yes  No

INSU

1. Name of policy holder		Type of coverage (check all that apply) <input type="checkbox"/> Doctors <input type="checkbox"/> Prescriptions <input type="checkbox"/> Hospitals <input type="checkbox"/> Major Medical <input type="checkbox"/> Dental <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____	Names of people covered	Name, address, and phone number of insurance company
Policy number	Group number			
Premium amount \$ per	Date coverage began			

2. Name of policy holder		Type of coverage (check all that apply) <input type="checkbox"/> Doctors <input type="checkbox"/> Prescriptions <input type="checkbox"/> Hospitals <input type="checkbox"/> Major Medical <input type="checkbox"/> Dental <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____	Names of people covered	Name, address, and phone number of insurance company
Policy number	Group number			
Premium amount \$ per	Date coverage began			

**10. Has health insurance ended for anyone in the past 12 months?** Do not include state health care programs.

Yes  No

First name	Initial	Date ended	Reason

**11. Does anyone have unpaid medical or dental bills?**

Yes  No

They may help you be eligible for Medicaid or Dr. Dynasaur.

First name	Initial	Estimate of amount owed	First name	Initial	Estimate of amount owed

**12. Does anyone have cash that is not in a bank, such as at home, on hand, or held by others?** Include cash that is owned by children.

Yes  No

CASH

First name	Initial	Amount	First name	Initial	Amount
		\$			\$

**13. Does anyone have money in a bank, credit union, or other institution?**

Include accounts that are co-owned or owned by children.

Yes  No

BANK

Type	Name of owner and co-owner	Name of bank, credit union, or other institution	Identifying number	Balance or value
Savings account				\$
Savings account				\$
Checking account				\$
Checking account				\$
Christmas club				\$
IRA, Keogh Plan, 401K				\$
Savings bond or trusts				\$
Certificate of deposit (CD)				\$
Pension or retirement				\$
Other _____				\$

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

**14. Does anyone own any vehicles?**

Yes  No **CARS**

Type of vehicle	Name of owner and co-owner	Year, make, and model	Leased?	Amount owed	For ESD use only Value
Car, truck, or van			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Car, truck, or van			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Car, truck, or van			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Motorcycle or ATV				\$	\$
Snow machine or jet ski				\$	\$
Trailer or boat				\$	\$
Camper or RV				\$	\$
Other _____				\$	\$

**15. Does anyone own or jointly own land, mobile homes, buildings, or other real estate?**

Yes  No

Do not list the home you live in.

**PROP**

Name of owner and co-owner, if any	Type of property	Location	Assessed value	Amount owed
			\$	\$
			\$	\$

**16. Does anyone own any other resources?**

Yes  No **STOK**

Type of Resource	Name of owner and co-owner, if any	Value
Life insurance <input type="checkbox"/> term <input type="checkbox"/> whole		Face value \$ Cash value \$
Life insurance <input type="checkbox"/> term <input type="checkbox"/> whole		Face value \$ Cash value \$
Life insurance <input type="checkbox"/> term <input type="checkbox"/> whole		Face value \$ Cash value \$
Account set up for burial expenses Is this irrevocable? <input type="checkbox"/> Yes <input type="checkbox"/> No		\$
Burial plot		
Stocks, bonds, or mutual funds		\$
Trust funds or collections		\$
Promissory notes		\$
Other _____		\$

**17. Does anyone have income from a job?** Include income of children. Include income from a training program. List income from the past 30 days before any deductions such as taxes, insurance, child support, or union dues. If income has ended or you expect it to change in the next 30 days, attach a note explaining the change.

Yes  No

**JINC**

First name	Initial	Date paid	Hours worked	Income before deductions	Tips and commissions
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
Employer's name and phone number:				\$	\$

  

First name	Initial	Date paid	Hours worked	Income before deductions	Tips and commissions
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
Employer's name and phone number:				\$	\$

**18. Does anyone get paid for taking care of children?** List income from the past 30 days, before deductions, and list the number of meals you provide each month that you are not paid for.  Yes  No

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

**19. Does anyone get paid for providing room or meals?** Include payments from children.  Yes  No

First name	Initial	Payment	Name of person paying	Check all that apply
		\$ per		<input type="checkbox"/> room <input type="checkbox"/> 1-2 meals per day <input type="checkbox"/> 3 meals per day
		\$ per		<input type="checkbox"/> room <input type="checkbox"/> 1-2 meals per day <input type="checkbox"/> 3 meals per day

**20. Does anyone have income from self-employment, such as farming, home party sales, logging, or property rental?** Send copies of your most recent federal tax return, including all forms and schedules. If you have not filed taxes, send a statement of income and expenses for the past three months.  Yes  No

First name	Initial	Type of business	Date business began

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

Social Security    unemployment compensation    veteran's compensation    dividends or interest  
 SSI/AABD    worker's compensation    veteran's pension    trusts or annuities  
 child support    pensions or retirement    money from others    insurance settlement

List income before any deductions such as Medicare premiums, taxes, insurance, child support, or union dues.

First name	Initial	Income before deductions	Type of income	Due to disability?
		\$ per		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$ per		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$ per		<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have no income, please tell us how your daily living expenses are paid. \_\_\_\_\_

**22. Does anyone pay child support or alimony?**  Yes  No

First name	Initial	Alimony paid	Child support paid	Names of children for whom support is paid
		\$ per	\$ per	
		\$ per	\$ per	

**23. Does anyone pay for day care?** List each child or adult separately.  Yes  No

First name	Initial	Amount	Names of children or adults in day care	Reason
		\$ per		<input type="checkbox"/> working <input type="checkbox"/> looking for work <input type="checkbox"/> going to school
		\$ per		<input type="checkbox"/> working <input type="checkbox"/> looking for work <input type="checkbox"/> going to school

**24. Does anyone pay for medical expenses not covered by insurance?**

Yes  No

Some examples are: pain relievers      eyeglasses      hearing aid batteries  
 antacids                      dental care      vitamins

FMED

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

**Other information and referrals**

**Lifeline** is a monthly credit on your home or Unicef wireless phone bill. **Link Up** is a payment for part of the installation cost of a phone. The phone must be listed in your name or you must pay part of the bill. You can get these credits if you are an adult recipient of ESD benefits. Call your telephone company for more information.

If you are not receiving a Lifeline credit now, would you like to?  Yes  No If yes, please send a copy of your bill.

**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 at this time. Applying to register or declining to register to vote will not affect your eligibility for benefits or the amount of assistance that ESD will provide you. If you want help filling out the voter registration application, we will help you. The decision 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 decline to register to vote, you may file a complaint with the Secretary of State's Office at Redstone Building, 26 Terrace Street, Drawer 09, Montpelier, VT 05609-1101 (telephone 1-802-828-2363).

**Sending notices or premium bills to someone else**

**Alternate Reporter:** If you want us to, each time we send you a notice, we can send a copy of the notice to a person you choose. We call this person an "alternate reporter."

**In care of:** If you want us to send all your notices and bills in care of a friend or relative instead of you, we can do that. This means that you will not get these notices or bills.

If you would like one of these options, please let us know.

**Americans with Disabilities Act**

If you think you might have a physical or mental condition that considerably limits a major life activity, like moving, seeing, hearing, or thinking, let us know. The Americans with Disabilities Act gives people with disabilities certain rights. We will make reasonable changes and accommodations in our requirements to help you take part in our programs. Tell your worker if you think there is anything you need.

**If your household includes a woman who is pregnant or nursing, or a child under five, you may contact your local Department of Health to apply for WIC benefits.**

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

Signature of applicant  
 or authorized representative \_\_\_\_\_ Date \_\_\_\_\_

Signature of person helping  
 fill out this form \_\_\_\_\_ Date \_\_\_\_\_

**Return this application to:** DCF/Economic Services Division  
 Application and Document Processing Center  
 103 South Main Street  
 Waterbury, VT 05671-1500

For questions call 1-800-250-8427, (TTY/TDD 1-888-834-7898) or your local Department of Health office.

## Rights and Responsibilities

You may request a copy of this page in larger print.

**True and Complete information.** I understand the information I provide to ESD to apply for assistance will be subject to verification by federal and state officials to determine if it is correct. This means that sources other than members of my household may be contacted to verify my eligibility for assistance. I understand that if any information is not true, ESD may deny assistance to me.

**Confidentiality.** ESD will not share any information from this application except for purposes directly connected with program administration unless you clearly allow release of this information or a court orders it. ESD takes strict precautions to safeguard social security numbers and other confidential information transmitted via the internet or fax machine.

**Reporting changes.** I understand when I get assistance, I must report changes in my situation. The changes I must report may be different depending on the benefits I get. If I am not sure which changes I must report, I will ask my worker. I understand changes may affect the amount of benefits I get. I also understand I must report changes within 10 days from when they happen.

**Social security number.** I understand that, when I apply for assistance from ESD, I must give the social security number of everyone in my household who wants assistance. Federal law requires this as a condition of eligibility. This requirement may be waived for some programs for members of religious organizations that object to furnishing social security numbers. (42 U.S.C. §1320b-7)

ESD uses the social security number: 1) for computer processing of program benefits, support enforcement, fraud investigation, audits, and Lifeline identification; 2) to verify social security and supplemental security income; 3) to prevent individuals from receiving duplicate benefits; 4) to identify groups of cases that must have benefits changed; 5) to exchange information with agencies such as the Social Security Administration, Department of Labor, Internal Revenue Service, or private claims collection agencies to verify income, determine eligibility and benefit amounts, and collect claims; 6) to determine the accuracy and reliability of information given to ESD; and 7) to make medical assistance payments.

**No Discrimination.** Federal and state law and U.S. Department of Health and Human Services (HHS) policy, prohibit ESD from discriminating based on race, color, national origin, sex, age, or disability.

To file a discrimination complaint, write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619- 3257 (TTY). HHS is an equal opportunity provider and employer. Under Vermont law and rules, DCF may not discriminate based on marital status, sexual orientation or place of birth. To file a discrimination complaint, write: Deputy Commissioner, Department for Children and Families, Economic Services Division, 103 S. Main St., Waterbury, VT, 05671-1201.

**Decision on application.** ESD must make a decision on my application within 30 days (or 90 days if my Medicaid application is based on disability) unless delay is caused by examining physicians, an administrative emergency, or me. If I do not get a decision within 30 (or 90) days, I may call the ESD Benefits Service Center at 1-800-479-6151 for more information or to request a fair hearing.

**Fair hearing.** I may ask for a fair hearing when my claim for assistance, benefits, or services is denied in whole or in part, or not responded to with reasonable promptness by calling the ESD Benefits Service Center or writing to the ESD Deputy Commissioner (3V.S.A. §3091). For health care actions that, for example, deny, limit, reduce, or end a service or deny a request to go outside the provider network, I may also request an appeal in addition to or in place of a fair hearing. If I have a complaint, for example, about the quality of the health care service or the behavior of staff for matters not related to a health care program action, I may be able to file a grievance. For more information on any of these choices, call Member Services at 1-800-250-8427.

For the WIC Program, I may appeal any decision made by the Health Department regarding eligibility by contacting a Department of Health District Office or by calling 1-800-464-4343, ext. 7333.

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

**Release of medical records.** I understand my health care providers may release my medical records when necessary for the purpose of administering state health care programs.

**Assignment of medical support.** As a condition of eligibility for health care assistance, I agree to assign to the state all rights to medical support and to third party payments (such as insurance) for medical care. I agree to enroll in a group health plan if the state requires me to, and I understand the state may pay the premiums. I also agree to cooperate in pursuing any actual or potential source of support or payments, including establishing paternity for my dependent children, if necessary. I understand that if I do not cooperate, my health care benefits will end although my children's health care benefits will continue.

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

**Not fleeing prosecution.** I certify that neither I nor any member of my household is fleeing prosecution or confinement for a felony or an attempt to commit a felony, or is violating a condition of probation or parole under a federal or state law. I understand ESD must disclose information to law enforcement agencies to apprehend fleeing felons.

**No benefits from another state.** If any member of my household gets duplicate Medicaid from another state or has been convicted in the past ten years of fraudulently misrepresenting residence to get benefits from two or more states, I must tell ESD immediately.

**Fraud penalties.** I or any member of my household will be subject to prosecution for fraud or some other criminal offense for knowingly giving false, incorrect, incomplete, or misleading information in order to get, try to get, or help someone else get health care benefits. If convicted, penalties may include up to three years of imprisonment and/or a fine of up to \$1,000, or an amount equal to the benefits wrongfully received. Federal and other state penalties may also apply. (42 U.S.C. § 1320a-7b; 33 V.S.A. §§141, 143)