

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 _____	
Does the applicant have an authorized representative or legal guardian?	
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.

**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

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

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

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

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

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

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

Current name:	Other name:				
First name	Initial	Last name	First name	Initial	Last name
Current name:	Other name:				
First name	Initial	Last name	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

First name	Initial	Name of facility	Date of admission

3. Is anyone in high school, college, vocational school, or a training program? Yes No

SCHL

First name	Initial	Name of school	Expected completion date	Is health insurance offered here?	Status
				Yes	full-time half-time
				No	less than half-time
				Yes	full-time half-time
				No	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 DISA

First name	Initial	Caused by an accident?		Disability determination		
		Yes	No	Has SSA determined you disabled?	Yes	No
				Have you applied for SSA disability?	Yes	No
		Yes	No	Has SSA determined you disabled?	Yes	No
				Have you applied for SSA disability?	Yes	No

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

Yes No PARE

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 PREG

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 ABSP

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

8. Is anyone who is applying covered by Medicare?

Yes No MEDI

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
			Over income Over resources Other:	Over income Over resources Other:
			Over income Over resources Other:	Over income Over resources 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) Doctors Prescriptions Hospitals Major Medical Dental Outpatient 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) Doctors Prescriptions Hospitals Major Medical Dental Outpatient 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?
They may help you be eligible for Medicaid or Dr. Dynasaur.

Yes No

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
			Yes	No		
Car, truck, or van			Yes	No	\$	\$
Car, truck, or van			Yes	No	\$	\$
Car, truck, or van			Yes	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 term whole		Face value \$ Cash value \$
Life insurance term whole		Face value \$ Cash value \$
Life insurance term whole		Face value \$ Cash value \$
Account set up for burial expenses Is this irrevocable? Yes 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	DCIN
						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		RBIN
				room	meals per day	
		\$ per		1-2	3	
		\$ per		1-2	3	

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	BUSI

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.

UNEA

First name	Initial	Income before deductions	Type of income	Due to disability?	
				Yes	No
		\$ per			
		\$ per			
		\$ per			

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

DCEX

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		working looking for work going to school
		\$ per		working looking for work 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 _____ Date _____
or authorized representative

Signature of person helping _____ Date _____
fill out this form

Return this application to: Department for Children and Families
Health Access Eligibility Unit
3 North, 103 South Main Street
Waterbury, VT 05671-130

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 my local ESD district office 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 contacting an ESD office or writing to the ESD Deputy Commissioner (3 V.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)