

Application for Health Coverage and Help Paying Costs

	Apply faster online or by phone. Visit VermontHealthConnect.gov or call 1-855-899-9600.
Applying for health coverage through Vermont Health Connect does not mean you have to buy a health plan.	
	Use this application to find out what coverages you qualify for
<ul style="list-style-type: none"> Affordable private health insurance plans that offer comprehensive coverage to help you stay well A new tax credit that can immediately lower your premiums for health coverage Free or low-cost insurance from Medicaid/Dr. Dynasaur <p>You may qualify for a free or low-cost program even if you earn as much as \$94,000 a year (for a family of 4).</p>	
	Who can use this application?
<ul style="list-style-type: none"> Use this application to apply for yourself. Use this application to apply for anyone in your family. See Step 2 on page 1. Apply even if you or your child already has health coverage. You could still be eligible for lower-cost or free coverage. Families that include immigrants can apply. You can apply for your child even if you are not eligible for coverage. Applying will not affect your immigration status or chances of becoming a permanent resident or citizen. 	
	DO NOT use this form if...
<ul style="list-style-type: none"> You are looking for dental coverage ONLY; there is no financial assistance for dental plans. You have already applied and simply need to REPORT CHANGES. Instead, call 1-855-899-9600. 	
	What you may need to apply
<ul style="list-style-type: none"> Social Security numbers (or document numbers for any legal immigrants who need insurance) Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements) Policy numbers for any health insurance you or others on this application now have If someone is helping you fill out this application, you may need to complete Appendix A. A completed Appendix C for each family member whose employer offers health insurance 	
	Why do we ask for this information?
<p>We ask about income and other information to determine what coverage you qualify for and if you can get any help paying for it.</p> <p>We will keep all the information you provide private and secure, as required by law.</p>	
	What happens next?
<p>Send your completed and signed application to the address in Step 9 on page 11. If you do not have all the information we ask for, sign and submit your application anyway. We will follow-up with you within 1-2 weeks with instructions on the next steps to complete your application. You may need to make a payment before coverage begins. If you do not hear from us, visit VermontHealthConnect.gov or call 1-855-899-9600.</p>	
	Get help with this application
<ul style="list-style-type: none"> Online: VermontHealthConnect.gov Phone: Call our Customer Support Center at 1-855-899-9600. Relay services for the deaf: Dial 711 (TTY and voice) In person: There is someone who can help in your area. Call 1-855-899-9600. 	
	If you need interpretation services...
<p>إذا أنت ترغب خدمات الترجمة الفورية اتصل برقم 1-855-899-9600 (Arabic)</p> <p>Ako su Vam potrebne usluge tumačenja, pozovite 1-855-899-9600. (Bosnian)</p> <p>စကားပြန် ဝန်ဆောင်မှုလုပ်ငန်းကိုအလိုရှိပါက 1-855-899-9600 သို့ ဖုန်းဆက်ခေါ်ပါ။ (Burmese)</p> <p>Si vous avez besoin de services d'interprétation, appelez le 1-855-899-9600. (French)</p> <p>Mugihe woba ushaka impfashanyo yo gusigurirwa, hamagara uyu murungo 1-855-899-9600. (Kirundi)</p> <p>यदि तपाईंलाई दोभाषे सेवाको जरुरत परेमा, 1-855-899-9600 मा कल गर्नुहोस्। (Nepali)</p> <p>Haddii aad u baahan tahay adeegyo turjumaan, wac 1-855-899-9600. (Somali)</p> <p>Si usted necesita servicios de interpretación, llame al 1-855-899-9600. (Spanish)</p> <p>Ikiwa unahitaji huduma za ukalimani, piga simu 1-855-899-9600. (Swahili)</p> <p>Nếu quý vị cần dịch vụ thông ngôn, hãy gọi 1-855-899-9600. (Vietnamese)</p>	

You may keep this page for future reference. Your Rights and Responsibilities are on the back of this page. Be sure to read through them. If you need help understanding something, contact Vermont Health Connect at 1-855-899-9600.

Your Rights and Responsibilities

We need the information we asked for to decide if you qualify for Medicaid/Dr. Dynasaur, or help to pay for health coverage if you choose to apply. We will check your answers using information from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information does not match, we may ask you to send us proof.

Social Security Numbers. All individuals applying for health benefits who have a Social Security number (SSN) must provide them. A person who is not seeking coverage does not need to provide a Social Security number. If you are a member of a religious organization that objects to furnishing an SSN, the Agency of Human Services may disregard this requirement. This requirement does not apply to an individual who: Is not eligible to receive an SSN or does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104. The state will assign an identification number to these individuals. Vermont Health Connect uses SSN for computer processing, child support enforcement, fraud investigation, audits, and Lifeline identification; to verify Social Security and Supplemental Security Income (SSI); to prevent individuals from receiving duplicate benefits; to exchange information with agencies such as the Social Security Administration, Department of Labor, Internal Revenue Service (IRS), or private agencies to verify income, determine eligibility and benefits amounts, and collect claims; to determine the accuracy and reliability of information given to Vermont Health Connect; and to make medical assistance payments.

Quality Control. Vermont Health Connect may select your application for a quality control review. By signing your application, you agree to give proof of required information. If you are not able to give the proof needed, you are authorizing Vermont Health Connect to get it.

Confidentiality. Your confidential information is protected as required by federal and state laws and regulations. The use and disclosure of information concerning applicants, enrollees, and legally-liable third parties is restricted to purposes directly connected with the administration of programs, or as otherwise required by law.

Information Sharing. By signing your application you give Vermont Health Connect permission to share information about you to assist you with program enrollment. Your permission covers the following kinds of information:

- Information or proofs needed to complete your application.
- The status of your application including the program(s) you are enrolled in and the effective date of enrollment.
- The reason you are not eligible for a benefit, if your application is denied or your benefits end.
- The effective date(s) of your renewal(s) for benefits and any outstanding information or verifications needed to assist your renewal.

Release of Medical Records. By signing your application, you agree that your health care providers and Vermont Health Connect and its contractors and grantees may access, use and disclose your medical records to manage state health care programs or when a hospital, health care provider, mental health provider, or pharmacy needs your medical records, including provider and prescription medication information, for your treatment, for payment of your treatment, and for health care operations.

Timely Eligibility Determination. Vermont Health Connect must make a decision on your application no later than 30 days after your application date (or 90 days if your Medicaid application is based on disability) unless delay is caused by physicians, an unexpected emergency or administrative problem beyond the Department's control, or yours. **If you do not get a decision within 30 days (or 90 days),** you may call Vermont Health Connect at **1-855-899-9600** for more information or to request a fair hearing.

Renewal of Eligibility in Future Years. To make it easier to decide if you qualify for help paying for health coverage in future years, you can agree to allow Vermont Health Connect to use income data, including information from tax returns. Vermont Health Connect will send you a notice and let you make any changes. You can tell us not to use your information at any time. Your options are available to you in Step 6 on page 10 of this application.

Medicaid. If anyone on this application is determined eligible for Medicaid, by signing this application you are giving to the Medicaid agency the right to pursue and get any money from other health insurance, legal settlements, or other third parties. You are also giving to the Medicaid agency the right to pursue and get medical support from a spouse or parent.

If any child on this application has a parent living outside of the home, you may be asked to cooperate with the agency that collects medical support from an absent parent. If you think that cooperating to collect medical support may harm yourself or your children, you can tell Medicaid and you may not have to cooperate.

Your Right to Appeal. If you think Vermont Health Connect has made a mistake, you can appeal its decision. To appeal means to tell someone at Vermont Health Connect that you think the action is wrong, and ask for a fair review of the action. Contact Vermont Health Connect at **1-855-899-9600**, or Health Care Advocate at Vermont Legal Aid at **1-800-917-7787** to find out how to appeal. You can be represented in the process by someone other than yourself. Eligibility and other important information will be explained to you when you call Vermont Health Connect.

Complaints, Grievances, Appeals & Fair Hearings. The Agency of Human Services offers several ways to address dissatisfaction with our programs and resulting eligibility decisions. A **"complaint"** is about a general process or program or personnel; there is no formal response back to the individual. A **"grievance"** is usually about an issue or incident within the last 60 days that is not about covered services, authorized services or eligibility. A response is usually provided within 90 days. An **"appeal"** is usually a request to review a recent decision that denied, terminated, or reduced services. An appeal can also be expedited if the individual feels waiting would cause them harm, and a fair hearing can also be requested at the same time. A **"fair hearing"** is a legal process where the Vermont Human Services Board reviews a recent decision that denied, terminated, or reduced services. A fair hearing is scheduled within 30 days of the request but there is no time limit on when a decision will be made. You may attend the review by phone or in person and bring someone who can help you explain why the decision was unfair. It is also possible to appeal a fair hearing decision with the Vermont Supreme Court. Contact Vermont Health Connect at **1-855-899-9600** or write to the Human Services Board, 120 State Street, Montpelier, VT 05620-4301 (3 V.S.A. §3091).

Please be aware there is no right to a fair hearing when either state or federal law requires automatic case adjustments for classes of enrollees, unless the reason for an individual fair hearing is incorrect eligibility determination. These case adjustments are called **"mass changes."**



STEP 1 PERSON 1: Tell us about yourself

The adult listed here will be considered the “applicant” and primary contact for this household’s application.

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.)			
2. Home address (leave blank if you do not have one)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address line 1 (if different from home address)			9. Apartment or suite number
10. Mailing address line 2 (If applicable, include an “in-care-of” person here. For an Authorized Representative, complete Appendix A.)			
11. City	12. State	13. ZIP code	14. County
15. HOME phone number () -	16. WORK phone number () -	17. CELL phone number () -	
18. What is your preferred spoken or written language (if not English)?			

STEP 2 Tell us about your family

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. You do not need to file taxes to get health coverage.

DO Include:

- Yourself
- Your parents/step parents who live with you, (if you are under 21)
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they do not live with you
- Anyone else under 21 who you take care of and lives with you
- Any children, ages 21 through 26, that you want to include on your Qualified Health Plan, even if they do not live with you

You DO NOT have to include:

- Your unmarried partner who does not need health coverage, unless you have a child together
- Your unmarried partner’s children, unless you have a child together
- Your parents/step parents who live with you, but file their own tax return (if you are over 21)
- Other adult relatives who file their own tax return
- Anyone who is incarcerated or detained
- Roommates

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage that they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 3 people in your family, you will need to make a copy of pages 6 and 7 for each additional person and attach the additional pages to your application. You should always include your own name and Social Security number (SSN) on any additional pages you attach. You do not need to provide immigration status or a Social Security number for family members who do not need health coverage. We will keep all the information you provide private and secure as required by law. We will use personal information only to check if you are eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself)

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

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.) _____	2. Relationship to you? SELF
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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: <input type="checkbox"/> Male <input type="checkbox"/> Female
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6. Marital status: Never married Married Civil Union Separated Divorced/dissolved Widowed
If you are a victim of domestic violence and applying separately from your spouse, you may indicate that you are "Never married".

7. Social Security number (SSN) _____ - _____ - _____

We need this if you want health coverage and have an 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 an SSN, call **1-800-772-1213** or visit **socialsecurity.gov**. TTY users call **1-800-325-0778**.

8. **Do you or your spouse plan to file a federal income tax return, or be included in a federal income tax return, NEXT YEAR?**
(You can still apply for health insurance even if you do not file a federal income tax return.)

YES. If yes, please answer questions a-c. **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? Yes No **If yes,** name of spouse: _____

b. Will you claim any dependents on your tax return? (Joint filers must claim the same dependents.) Yes No
If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone else's tax return? (You cannot be both a dependent and a joint filer.) Yes No
If yes, name of tax filer: _____ How are you related to the tax filer? _____

9. Are you pregnant? Yes No a. **If yes,** how many babies are expected during this pregnancy? _____
b. What is the estimated due date? _____

10. **Are you applying for health coverage?** (Even if you have insurance, there might be a program with better coverage or lower costs.)

YES. If yes, answer all the questions below. **NO. If no,** SKIP ahead to page 3 and leave the rest of this page blank.

11. a. Do you have a physical, mental, or emotional health condition that causes limitations in daily activities (like bathing, dressing, daily chores, etc.)? Yes No
b. Do you live in a medical facility or nursing home? Yes No

12. Are you a U.S. citizen or U.S. national? Yes No

13. **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.

a. Immigration document type _____	e. Passport or document number _____ <input type="checkbox"/> None
b. Document expiration date _____ <input type="checkbox"/> None	f. Country of origin _____
c. Alien number _____	g. Category code _____
d. Have you lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No	h. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No

14. **Retroactive Medicaid:** If you have medical/dental expenses from the last 3 months and your income is within the guideline, 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

15. 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

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

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

18. **Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
 Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

19. **Race (OPTIONAL—check all that apply.)**

<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
			<input type="checkbox"/> Other _____	

Now, tell us about your income on the next page.

STEP 2: PERSON 1 (Continue with your income)

Current Job & Income Information

Employed

If you are currently employed, tell us about your income. Start with question 20.

Self-employed

Skip to question 32.

Not employed

Skip to question 33.

CURRENT JOB 1:

20. Employer name	21. Employer phone number () -
22. Employer address	
23. Gross wages/tips (before taxes) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
24. Average hours worked each week in the past month: _____	

CURRENT JOB 2: To list additional jobs, attach another sheet of paper. Be sure to include your name and SSN on any additional sheets.

25. Employer name	26. Employer phone number () -
27. Employer address	
28. Gross wages/tips (before taxes) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
29. Average hours worked each week in the past month: _____	
30. Do any of these jobs offer health insurance coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes , be sure to complete Appendix C at the end of this application.	
31. In the past year, did you: <input type="checkbox"/> Change jobs <input type="checkbox"/> Stop working <input type="checkbox"/> Start working fewer hours <input type="checkbox"/> None of these	

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

- a. Type of work? _____
- b. How much net income will you get from self-employment this month? (profit once business expenses are paid) \$ _____

33. OTHER INCOME THIS MONTH: 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, worker compensation, veteran's payments, or Supplemental Security Income (SSI).

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Net farming/fishing \$ _____ How often? _____ |
| <input type="checkbox"/> Alimony received \$ _____ How often? _____ | <input type="checkbox"/> Net rental/royalty \$ _____ How often? _____ |
| <input type="checkbox"/> Canceled debt \$ _____ How often? _____ | <input type="checkbox"/> Non-taxable SSA \$ _____ How often? _____ |
| <input type="checkbox"/> Commissions \$ _____ How often? _____ | <input type="checkbox"/> Pensions \$ _____ How often? _____ |
| <input type="checkbox"/> Court awards \$ _____ How often? _____ | <input type="checkbox"/> Retirement accounts \$ _____ How often? _____ |
| <input type="checkbox"/> Foreign-earned income \$ _____ How often? _____ | <input type="checkbox"/> Scholarships and grants \$ _____ How often? _____ |
| <input type="checkbox"/> Gambling/prizes/awards \$ _____ How often? _____ | <input type="checkbox"/> Social Security (disability, retirement, and survivor/widow benefit before Medicare deduction) \$ _____ How often? _____ |
| <input type="checkbox"/> Investment income \$ _____ How often? _____ | <input type="checkbox"/> Tax-exempt interest/dividends \$ _____ How often? _____ |
| <input type="checkbox"/> Jury pay \$ _____ How often? _____ | |
| <input type="checkbox"/> Unemployment \$ _____ What state pays your unemployment benefit? _____ How often? _____ | |

34. DEDUCTIONS: Check all that apply, and give the amount and how often you pay it.

If you pay for certain things that can be **deducted on a federal income tax return**, telling us about them could lower your healthcare costs.

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

- | | |
|---|---|
| <input type="checkbox"/> Alimony paid \$ _____ How often? _____ | <input type="checkbox"/> Student loan interest \$ _____ How often? _____ |
| <input type="checkbox"/> Other deductions \$ _____ Type(s)? _____ | How often? _____ |

35. YEARLY INCOME: Complete **ONLY** if your income changes from month to month.

Your total income this calendar year	Your total income next calendar year (if you think it will be different)
\$ _____	\$ _____

Continue with Step 2 if you have additional household members to report. If not, skip ahead to Step 3.

STEP 2: PERSON 2

Continue filling out Step 2 for your spouse/partner, children who live with you, and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you do not file a tax return, you must still add family members who live with you.

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 (e.g., maiden name or alias). _____		4. Date of birth (mm/dd/yyyy) _____ / _____ / _____	5. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
6. Marital status: <input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Widowed			
7. Social Security number (SSN) _____ - _____ - _____ We need this if you want health coverage and have an SSN.			
8. Does PERSON 2 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no , list address: _____			
9. Does PERSON 2 or their spouse plan to file a federal income tax return, or be included in a federal income tax return, NEXT YEAR? (You can still apply for health insurance even if you do not file a federal income tax return.)			
<input type="checkbox"/> YES. If yes , please answer questions a-c.		<input type="checkbox"/> NO. If no , skip to question c.	
a. Will PERSON 2 file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes , name of spouse: _____	
b. Will PERSON 2 claim any dependents on his or her tax return? (Joint filers must claim the same dependents.) <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes , list name(s) of dependents: _____	
c. Will PERSON 2 be claimed as a dependent on someone else's tax return? (Cannot be both a dependent and a joint filer) <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes , name of tax filer: _____ How is PERSON 2 related to the tax filer? _____	
10. Is PERSON 2 pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		a. If yes , how many babies are expected during this pregnancy? _____	
		b. What is the estimated due date? _____	
11. Is PERSON 2 applying for health coverage?			
<input type="checkbox"/> YES. If yes , answer all the questions below. 		<input type="checkbox"/> NO. If no , SKIP ahead to page 5 and leave the rest of this page blank. 	
12. a. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in daily activities (like bathing, dressing, daily chores, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
b. Does PERSON 2 live in a medical facility or nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Is PERSON 2 a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No			
14. If PERSON 2 is not a U.S. citizen or U.S. national , do they have eligible immigration status?			
<input type="checkbox"/> YES . Fill in their document information below.			
a. Immigration document type _____		e. Passport or document number _____ <input type="checkbox"/> None	
b. Document expiration date _____ <input type="checkbox"/> None		f. Country of origin _____	
c. Alien number _____		g. Category code _____	
d. Has PERSON 2 lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No		h. Is PERSON 2, or their spouse or parent a veteran or an active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Retroactive Medicaid: If PERSON 2 has medical/dental expenses from the last 3 months and their income is within the guideline, they might be eligible for assistance that could help pay, or reimburse you for, those expenses. Does PERSON 2 want to apply for help with medical/dental expenses from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
16. Does PERSON 2 live with at least one child under the age of 19, and is PERSON 2 the main person taking care of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
17. Is PERSON 2 a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		a. If yes , give the state of their legal residence: _____	
18. Was PERSON 2 in foster care in Vermont when they turned 18? <input type="checkbox"/> Yes <input type="checkbox"/> No			
19. Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)			
<input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other _____			
20. Race (OPTIONAL—check all that apply.)			
<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian
			<input type="checkbox"/> Guamanian or Chamorro
			<input type="checkbox"/> Samoan
			<input type="checkbox"/> Other Pacific Islander
			<input type="checkbox"/> Other _____

Now, tell us about any income from PERSON 2 on the next page. 

STEP 2: PERSON 2 (Continue with income for PERSON 2)

Current Job & Income Information

Employed

If PERSON 2 is currently employed, tell us about their income. Start with question 21.

Self-employed

Skip to question 33.

Not employed

Skip to question 34.

CURRENT JOB 1:

21. Employer name _____ 22. Employer phone number () -

23. Employer address _____

24. Gross wages/tips (before taxes) \$ _____ Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

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

CURRENT JOB 2: To list additional jobs, attach another sheet of paper. Be sure to include your name and SSN on any additional sheets.

26. Employer name _____ 27. Employer phone number () -

28. Employer address _____

29. Gross wages/tips (before taxes) \$ _____ Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

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

31. Do any of these jobs offer health insurance coverage? No Yes. **If yes**, be sure to complete **Appendix C** at the end of this application.

32. **In the past year, did PERSON 2:** Change jobs Stop working Start working fewer hours None of these

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

- a. Type of work? _____
- b. How much net income will PERSON 2 get from self-employment this month? (profit once business expenses are paid) \$ _____

34. OTHER INCOME THIS MONTH: 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, worker compensation, veteran's payments, or Supplemental Security Income (SSI).

- | | | | | |
|---|----------|---|----------|------------------|
| <input type="checkbox"/> None | | <input type="checkbox"/> Net farming/fishing | \$ _____ | How often? _____ |
| <input type="checkbox"/> Alimony received | \$ _____ | <input type="checkbox"/> Net rental/royalty | \$ _____ | How often? _____ |
| <input type="checkbox"/> Canceled debt | \$ _____ | <input type="checkbox"/> Non-taxable SSA | \$ _____ | How often? _____ |
| <input type="checkbox"/> Commissions | \$ _____ | <input type="checkbox"/> Pensions | \$ _____ | How often? _____ |
| <input type="checkbox"/> Court awards | \$ _____ | <input type="checkbox"/> Retirement accounts | \$ _____ | How often? _____ |
| <input type="checkbox"/> Foreign-earned income | \$ _____ | <input type="checkbox"/> Scholarships and grants | \$ _____ | How often? _____ |
| <input type="checkbox"/> Gambling/prizes/awards | \$ _____ | <input type="checkbox"/> Social Security (disability, retirement, and survivor/widow benefit before Medicare deduction) | \$ _____ | How often? _____ |
| <input type="checkbox"/> Investment income | \$ _____ | <input type="checkbox"/> Tax-exempt interest/dividends | \$ _____ | How often? _____ |
| <input type="checkbox"/> Jury pay | \$ _____ | | | |
| <input type="checkbox"/> Unemployment | \$ _____ | What state pays your unemployment benefit? _____ | | How often? _____ |

35. DEDUCTIONS: Check all that apply, and give the amount and how often PERSON 2 pays it.

If PERSON 2 pays for things that can be **deducted on a federal income tax return**, telling us about them could lower your healthcare costs.

NOTE: You should not include a cost that you already deducted from PERSON 2's self-employment net income in question (33.b.).

- | | | | | | |
|---|----------|------------------|--|----------|------------------|
| <input type="checkbox"/> Alimony paid | \$ _____ | How often? _____ | <input type="checkbox"/> Student loan interest | \$ _____ | How often? _____ |
| <input type="checkbox"/> Other deductions | \$ _____ | Type(s)? _____ | | | How often? _____ |

36. YEARLY INCOME: Complete **ONLY** if income for PERSON 2 changes from month to month.

PERSON 2's total income **this** calendar year \$ _____

PERSON 2's total income **next** calendar year (if you think it will be different) \$ _____

Continue with Step 2 if you have additional household members to report. If not, skip ahead to Step 3. 

STEP 2: PERSON 3

Continue filling out Step 2 for your spouse/partner, children who live with you, and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you do not file a tax return, you must still add family members who live with you. **If you have more than 3 household members, you will want to copy the next two pages before filling them out and use them for additional members. You must also include your own name and SSN at the top of each additional page.**

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.) _____		2. Relationship to you? _____		
3. List any other names PERSON 3 has been known by (e.g., maiden name or alias). _____		4. Date of birth (mm/dd/yyyy) __ / __ / ____	5. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
6. Marital status: <input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Widowed				
7. Social Security number (SSN) ____ - ____ - ____ We need this if you want health coverage and have an SSN.				
8. Does PERSON 3 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no , list address: _____				
9. Does PERSON 3 or their spouse plan to file a federal income tax return, or be included in a federal income tax return, NEXT YEAR? (You can still apply for health insurance even if you do not file a federal income tax return.) <input type="checkbox"/> YES. If yes , please answer questions a–c. <input type="checkbox"/> NO. If no , skip to question c.				
a. Will PERSON 3 file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , name of spouse: _____				
b. Will PERSON 3 claim any dependents on his or her tax return? (Joint filers must claim the same dependents.) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , list name(s) of dependents: _____				
c. Will PERSON 3 be claimed as a dependent on someone else's tax return? (Cannot be both a dependent and a joint filer) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , name of tax filer: _____ How is PERSON 3 related to the tax filer? _____				
10. Is PERSON 3 pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes , how many babies are expected during this pregnancy? _____ b. What is the estimated due date? _____				
11. Is PERSON 3 applying for health coverage? <input type="checkbox"/> YES. If yes , answer all the questions below.  <input type="checkbox"/> NO. If no , SKIP ahead to page 7 and leave the rest of this page blank. 				
12. a. Does PERSON 3 have a physical, mental, or emotional health condition that causes limitations in daily activities (like bathing, dressing, daily chores, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Does PERSON 3 live in a medical facility or nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No				
13. Is PERSON 3 a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No				
14. If PERSON 3 is not a U.S. citizen or U.S. national , do they have eligible immigration status? <input type="checkbox"/> YES . Fill in their document information below.				
a. Immigration document type _____		e. Passport or document number _____ <input type="checkbox"/> None		
b. Document expiration date _____ <input type="checkbox"/> None		f. Country of origin _____		
c. Alien number _____		g. Category code _____		
d. Has PERSON 3 lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No		h. Is PERSON 3, or their spouse or parent a veteran or an active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No		
15. Retroactive Medicaid: If PERSON 3 has medical/dental expenses from the last 3 months and their income is within the guideline, they might be eligible for assistance that could help pay, or reimburse you for, those expenses. Does PERSON 3 want to apply for help with medical/dental expenses from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No				
16. Does PERSON 3 live with at least one child under the age of 19, and is PERSON 3 the main person taking care of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No				
17. Is PERSON 3 a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes , give the state of their legal residence: _____				
18. Was PERSON 3 in foster care in Vermont when they turned 18? <input type="checkbox"/> Yes <input type="checkbox"/> No				
19. Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.) <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other _____				
20. Race (OPTIONAL—check all that apply.)				
<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
			<input type="checkbox"/> Other _____	

Now, tell us about any income from PERSON 3 on the next page. 

STEP 2: PERSON 3 (Continue with income for PERSON 3)

Current Job & Income Information

Employed

If PERSON 3 is currently employed, tell us about their income. Start with question 21.

Self-employed

Skip to question 33.

Not employed

Skip to question 34.

CURRENT JOB 1:

21. Employer name	22. Employer phone number () -
23. Employer address	
24. Gross wages/tips (before taxes) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
25. Average hours worked each week in the past month: _____	

CURRENT JOB 2: To list additional jobs, attach another sheet of paper. Be sure to include your name and SSN on any additional sheets.

26. Employer name	27. Employer phone number () -
28. Employer address	
29. Gross wages/tips (before taxes) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
30. Average hours worked each week in the past month: _____	
31. Do any of these jobs offer health insurance coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes , be sure to complete Appendix C at the end of this application.	
32. In the past year, did PERSON 3: <input type="checkbox"/> Change jobs <input type="checkbox"/> Stop working <input type="checkbox"/> Start working fewer hours <input type="checkbox"/> None of these	

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

- a. Type of work? _____
- b. How much net income will PERSON 3 get from self-employment this month? (profit once business expenses are paid) \$ _____

34. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often PERSON 3 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, worker compensation, veteran's payments, or Supplemental Security Income (SSI).

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Net farming/fishing \$ _____ How often? _____ |
| <input type="checkbox"/> Alimony received \$ _____ How often? _____ | <input type="checkbox"/> Net rental/royalty \$ _____ How often? _____ |
| <input type="checkbox"/> Canceled debt \$ _____ How often? _____ | <input type="checkbox"/> Non-taxable SSA \$ _____ How often? _____ |
| <input type="checkbox"/> Commissions \$ _____ How often? _____ | <input type="checkbox"/> Pensions \$ _____ How often? _____ |
| <input type="checkbox"/> Court awards \$ _____ How often? _____ | <input type="checkbox"/> Retirement accounts \$ _____ How often? _____ |
| <input type="checkbox"/> Foreign-earned income \$ _____ How often? _____ | <input type="checkbox"/> Scholarships and grants \$ _____ How often? _____ |
| <input type="checkbox"/> Gambling/prizes/awards \$ _____ How often? _____ | <input type="checkbox"/> Social Security (disability, retirement, and survivor/widow benefit before Medicare deduction) \$ _____ How often? _____ |
| <input type="checkbox"/> Investment income \$ _____ How often? _____ | <input type="checkbox"/> Tax-exempt interest/dividends \$ _____ How often? _____ |
| <input type="checkbox"/> Jury pay \$ _____ How often? _____ | |
| <input type="checkbox"/> Unemployment \$ _____ What state pays your unemployment benefit? _____ How often? _____ | |

35. DEDUCTIONS: Check all that apply, and give the amount and how often PERSON 3 pays it.

If PERSON 3 pays for things that can be **deducted on a federal income tax return**, telling us about them could lower your healthcare costs.

NOTE: You should not include a cost that you already deducted from PERSON 3's self-employment net income in question (33.b.).

- | | |
|---|--|
| <input type="checkbox"/> Alimony paid \$ _____ How often? _____ | <input type="checkbox"/> Student loan interest \$ _____ How often? _____ |
| <input type="checkbox"/> Other deductions \$ _____ Type(s)? _____ | How often? _____ |

36. YEARLY INCOME: Complete **ONLY** if income for PERSON 3 changes from month to month.

PERSON 3's total income this calendar year	PERSON 3's total income next calendar year (if you think it will be different)
\$ _____	\$ _____

STEP 3

American Indian or Alaska Native family member(s)

1. Are you, or anyone in your family, an American Indian with a federally recognized tribe or an Alaska Native?

- NO.** If no, skip to Step 4.
- YES.** If yes, you must also fill out **Appendix B.**

STEP 4

Your family's health coverage

Answer these questions for anyone applying for health coverage.

1. 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 and you are applying for new/continued coverage, including Medicaid/Dr. Dynasaur, please answer 'NO.'

- YES.** If yes, check the type of coverage and write the person(s) name(s) next to the coverage they have. **NO.**
- Medicaid/Dr. Dynasaur _____
 - TRICARE (Do not check off if you have direct care or Line of Duty) _____
 - Federal Employee Program _____
 - VA health care programs _____
 - Peace Corps _____
 - Other insurance. If you have an insurance type not listed here, or in question 2, answer question 3.
 - Employee insurance. If you have employee insurance, answer question 3.

2. Is anyone currently enrolled in or eligible for Medicare?

- YES.** Who? _____ **NO.**

3. Provide information about employee or other insurance below. Most of the information requested can be found on the front and back of your insurance card. If you have additional health insurance coverages to report and you need more space, copy this page.

Name of insurance company		Company phone number () -	Services covered: <input type="checkbox"/> Prescriptions <input type="checkbox"/> Dental <input type="checkbox"/> Outpatient <input type="checkbox"/> Vision <input type="checkbox"/> Doctors/hospitals <input type="checkbox"/> Other _____
Insurance company billing address			
Member ID/Policy number	Group number		
Name of policy holder	Social Security number		Date coverage began
Name of person covered	Social Security number		Relationship to policy holder
Name of person covered	Social Security number		Relationship to policy holder
Name of person covered	Social Security number		Relationship to policy holder
Name of person covered	Social Security number		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

4. Is anyone listed on this application offered health coverage from a job?

Check **Yes** even if the coverage is from someone else's job, such as a parent or spouse.

- YES.** If yes, you will need to complete and include **Appendix C.**
- NO.** If no, continue to Step 5.



STEP 5

Household Special Circumstances

The questions below are about life events that may have happened in your household in the past 60 days. Your answers will help us determine if you, or other household members, who are NOT eligible for Medicaid/Dr. Dynasaur, can enroll in a private health plan, outside of an open enrollment period. A representative may contact you for additional information about your situation to determine if you or other household members qualify for a Special Enrollment Period (SEP). **Please note there is no open enrollment period for Medicaid/Dr. Dynasaur coverage. You may apply for Medicaid/Dr. Dynasaur at any time.**

1. Did anyone on this application lose health coverage in the past 60 days (including employer-sponsored coverage or Medicaid/Dr. Dynasaur)? Yes No
Who? _____ Date coverage ended: _____
2. Has anyone joined your household through an adoption in the past 60 days? Yes No
Who? _____ Date adoption was finalized: _____
3. Has anyone joined your household through the foster care program in the past 60 days? Yes No
Who? _____ Date child joined your household: _____
4. Did anyone on this application gain U.S. citizenship, eligible immigration status, or become lawfully present in the past 60 days? Yes No
Who? _____ Date of change to status: _____
5. Did anyone on this application move to Vermont in the past 60 days? Yes No
Who? _____ Date arrived in Vermont: _____
6. Did anyone on this application get released from incarceration (jail or prison) in the past 60 days? Yes No
Who? _____ Date of release: _____
7. Has anyone gained a dependent through marriage or birth in the past 60 days? Yes No
Who? _____ Date of marriage and/or birth: _____
8. Has anyone in the household become newly eligible or newly ineligible for an Individual Exemption to purchase a Catastrophic Plan in the past 60 days? Yes No
Who? _____ Date of eligibility or *ineligibility*: _____
9. Has any household member's employer-sponsored insurance become unaffordable due to a decrease in their job income or had their work hours decreased in the past 60 days? Yes No
Who? _____ Date of income decrease: _____
10. In the past 60 days, has anyone in your household become eligible for employer-sponsored health coverage but is in a waiting period before they can enroll? Yes No
Who? _____ Date waiting period ends: _____
11. 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
Who? _____
12. Have there been any other changes in your household or circumstances in the past 60 days that you feel should be considered when making a decision about any household member's eligibility for a Special Enrollment Period? If so, please explain: Yes No

STEP 6

Renewal of eligibility in future years

To make it easier to determine your eligibility for Medicaid or for help paying for health coverage in future years, Vermont Health Connect (VHC) can use electronic data sources for income information, including information from tax returns, for 0 to 5 years. Please choose how many years you give VHC permission to use electronic data sources. You may change your mind about how many years you give VHC permission to use electronic data sources to verify your income at any time by calling the VHC Customer Support Center at **1-855-899-9600**.

YES, I authorize use of electronic data sources to renew my eligibility for:

5 years (the maximum number of years allowed), 4 years, 3 years, 2 years, 1 year

NO, I do not authorize use of electronic data sources to renew my eligibility at this time:

0 years - I do not authorize use of electronic data sources to renew my coverage at this time.

(Note: If you do not allow VHC to use electronic data sources for income data from federal tax returns, you will not receive the Advance Payment of Premium Tax Credits (APTC) that help you pay your premiums when your coverage is renewed, and you will have to pay full price for your qualified health plan. Also, Medicaid/Dr. Dynasaur coverage will not be renewed without this permission. However, you can give this permission at a later date or you can reapply when your renewal is due.)

STEP 7

Read your rights and responsibilities

- I know that I must tell Vermont Health Connect if anything changes or is different than what I wrote on this application. I can visit **VermontHealthConnect.gov** or call **1-855-899-9600** to report any changes. I understand that a change in my information could affect the eligibility for myself and the member(s) of my household.
- I am signing this application with the understanding that information obtained in this application will be used to help with my enrollment and continued eligibility in the programs I have applied for. I know that Vermont Health Connect will check my answers for all members listed in this application using information in their electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. I understand that if the information does not match, I may be asked to send proof. I also certify that:
- I understand why I am being asked to release this information.
- I know I do not have to give permission to release this information.
- I know signing this permission is voluntary.
- I know if I do not give my permission, the information will not be released unless the law otherwise allows it.
- I know I may stop this permission to share information at any time with a written notice to Vermont Health Connect. I know this written notice will not affect information the agencies have already released.
- I know the person or agency that receives my information might pass it on to others. If so, it may no longer be protected by this permission form.
- I know if I do not stop this permission, it will be in effect as long as I am receiving benefits applied for in this application.
- I know I can be provided with a copy of this form.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- By signing, I am stating that all of my questions about this permission have been answered.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, I now indicate _____ is incarcerated.
(name of incarcerated person)

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency the right to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? Yes No
- If yes, I know I may be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support may harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think Vermont Health Connect has made a mistake, I can appeal its decision. To appeal means to tell someone at Vermont Health Connect that I think the action is wrong, and ask for a fair review of the action. I understand that I can find out how to appeal by contacting Vermont Health Connect at **1-855-899-9600**, or Health Care Advocate at Vermont Legal Aid at **1-800-917-7787**. My eligibility and other important information will be explained to me. I know that I can be represented in the process by someone other than myself.

STEP 8

Sign this application

You MUST sign below. Unsigned applications will not be processed and will be returned for a signature.

The person listed in Step 1 (the applicant) should sign this application. If they cannot, and you are their Authorized Representative, you may sign for them, as long as you have provided the information required in **Appendix A**. If signing on behalf of a minor child or an incapacitated adult, you may do so as long as you provide your personal information below as well.

Not signing the application may delay health coverage.

By signing this application, the applicant agrees to the following:

- I have read and understand my rights and responsibilities as they are described on pages ii and 10 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.

By signing this application on behalf of the applicant, a person other than the applicant agrees 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 him or her from providing information about his or her situation and acting responsibly in his or her 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 Vermont Health Connect immediately if I learn of any change in the applicant's situation.

If you are signing on behalf of the applicant because they are a minor child or incapacitated adult, please also provide the information requested below, in case we need to reach you about the application. If you are signing as an Authorized Representative, you must fill out Appendix A.

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	State	ZIP code

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

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, we will assume you have decided not to register to vote at this time. Answering Yes or No here will not affect your eligibility for health coverage.

STEP 9

Mail the completed and signed application to:

**Vermont Health Connect
103 South Main Street
Waterbury, VT 05671-8100**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average 45 minutes per application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

 **NEED HELP WITH YOUR APPLICATION?** Visit VermontHealthConnect.gov or call toll-free **1-855-899-9600**. Relay services for the deaf **711**.

APPENDIX A

Assistance Completing the Application

APPLICANT Information

Applicant first name, middle name, last name & suffix (Jr., Sr., III, etc.)	Applicant Social Security number _ _ - _ - _ _ _
---	---

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. If you are a legally appointed representative for someone on the application (power of attorney, legal guardian) submit proof with this form.

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	5. State	6. ZIP code
7. Phone number () - - - -		
8. Organization name	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 coverages 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. An Alternate Reporter can also be an Authorized Representative.

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	5. State	6. ZIP code
7. Phone number () - - - -		
8. Organization name	9. ID number (if applicable)	
By signing, you allow this person to only receive copies of notices about your coverage and the coverage for others on the application and all future matters with this agency.		
10. Your signature	11. Date (mm/dd/yyyy)	

If you want to change your Authorized Representative or Alternate Reporter, contact Vermont Health Connect at 1-855-899-9600.

For certified application counselors, navigators, and brokers only.

Complete this section if you are a certified application counselor, navigator, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, middle name, last name & suffix (Jr., Sr., III, etc.)	
3. Organization name	4. ID number (if applicable)

APPENDIX B

American Indian or Alaska Native Family Member

APPLICANT Information

Applicant first name, middle name, last name & suffix (Jr., Sr., III, etc.)	Applicant Social Security number _ _ _ - _ _ - _ _ _
---	---

Complete this appendix if you or if anyone in your family is American Indian with a **federally recognized tribe** or an Alaska Native. 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 Services, 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.

NOTE: If you have more people to include, make a copy of this page before you fill it out and attach.

	PERSON 1	PERSON 2
1. First, middle, last name & suffix (Jr., Sr., III, etc.)	First Middle	First Middle
	Last	Last
2. Alaska Native?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name: _____ State where recognized: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tribe name: _____ State where recognized: _____ <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <ul style="list-style-type: none"> • 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? _____

APPLICANT Information

Applicant first name, middle name, last name & suffix (Jr., Sr., III, etc.)	Applicant Social Security number _ _ - _ - _ - _
---	---

Health Coverage from Jobs

You **DO NOT** need to answer these questions unless someone in the household is eligible for health coverage from a job. Use this tool to help answer questions about any employer health coverage that you are eligible for (even if it is from another person's job, like a parent or spouse). Complete one tool for each employer that offers health coverage. Two copies of this form are provided. You can ask your employer to fill out this form. Remember, if you have your employer fill out this form, **you are still responsible for getting the information in with the application.**

EMPLOYEE Information

1. Employee first name, middle name, last name & suffix (Jr., Sr., III, etc.)	2. Employee Social Security number _ _ - _ - _ - _
---	---

EMPLOYER Information

3. Business name		4. Employer Identification Number (EIN) _ - _ - _ - _ - _ - _	
5. Business address		6. Business phone number () -	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above) () -		12. Email address	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

Yes (Continue to questions 14 through 17 below.)
If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?
_____ (mm/dd/yyyy)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that covers an employee's spouse or dependent?

Yes. Which people? Spouse Dependent(s)
 No

15. Does the employer offer a health plan that meets the minimum value standard*? Yes No

16. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (do not include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

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

If the plan year will end soon and you know that the health plans offered will change, go to question 17. If you do not know, STOP and return this form to employee.

17. What change will the employer make for the new plan year (if known)?

Employer will not offer health coverage
 Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 16.)

a. How much will the employee have to pay in premiums for that plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

APPLICANT Information

Applicant first name, middle name, last name & suffix (Jr., Sr., III, etc.)	Applicant Social Security number _ _ - _ - _ _ _
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Health Coverage from Jobs

You **DO NOT** need to answer these questions unless someone in the household is eligible for health coverage from a job. Use this tool to help answer questions about any employer health coverage that you are eligible for (even if it is from another person's job, like a parent or spouse). Complete one tool for each employer that offers health coverage. Two copies of this form are provided. You can ask your employer to fill out this form. Remember, if you have your employer fill out this form, **you are still responsible for getting the information in with the application.**

EMPLOYEE Information

1. Employee first name, middle name, last name & suffix (Jr., Sr., III, etc.)	2. Employee Social Security number _ _ - _ - _ _ _
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EMPLOYER Information

3. Business name		4. Employer Identification Number (EIN) _ _ - _ _ _ _ _	
5. Business address		6. Business phone number () -	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above) () -		12. Email address	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

Yes (Continue to questions 14 through 17 below.)
If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?
_____ (mm/dd/yyyy)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that covers an employee's spouse or dependent?

Yes. Which people? Spouse Dependent(s)
 No

15. Does the employer offer a health plan that meets the minimum value standard*? Yes No

16. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (do not include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

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

If the plan year will end soon and you know that the health plans offered will change, go to question 17. If you do not know, STOP and return this form to employee.

17. What change will the employer make for the new plan year (if known)?

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a. How much will the employee have to pay in premiums for that plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

