VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

APPENDIX A Tell Us Who is Helping You With This Application

PERSON 1 Information

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

You Can Choose an Authorized Representative

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

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

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

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

2. Address		**3.** Apartment or suite number
4. City/Town	**5.** State	**6.** ZIP code
7. Phone number ( ) –		
8. Organization name (if applicable)	**9.** ID number (if applicable)	

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

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

You Can Choose an Alternate Reporter

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

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

2. Address		**3.** Apartment or suite number
4. City/Town	**5.** State	**6.** ZIP code
7. Phone number ( ) –		
8. Organization name (if applicable)	**9.** ID number (if applicable)	

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

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

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

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