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VHC Self-Service Guide

A how-to guide for completing
a Change of Circumstance or
Renewal Form through
self-service

Department of Vermont Health Access

Updated August 2023

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Purpose

This document is to be used as a guide when completing a Change of Circumstance and/or Renewal Form using the self-service tool in the VHC Portal.

Please note that this is subject to change.

How to Use

This guide is designed to walk you through examples of self-service Changes of Circumstance and Renewal Forms by highlighting the basic steps. Use the links in the [Table of Contents](#) to skip to the desired section. Click [BACK TO TOP](#) at the bottom of any page to return to the top of the document.

Each section in this guide features screenshots of a fake case. The order of screenshots is dependent on answers to previous questions and the selected scenario. This document is intended as a guide and may not apply to every scenario.

Section 1: Change of Circumstance

To complete a Change of Circumstance (CoC) through self-service, log into the VHC Portal and navigate to the home screen. Under **My Applications**, follow the hyperlink to begin the change.

My Applications

Has your information changed? [Click here](#)

MY APPLICATIONS | **MY RENEWALS**

DATE	APPLICANT	APPLICATION NAME	BENEFITS APPLYING FOR	STATUS	ACTIONS
07/26/2023	Joe Vermonter	Joe Vermonter - Medicaid	Medicaid	Active	Download View
07/26/2023	Joe Vermonter	Joe Vermonter - Health Insurance	Health Insurance	Active	Download View

On the next screen, select the **type of change** you would like to submit. If the change type is not listed in the drop-down, you will need to call the customer support center to complete the change.

Submit a Change of Circumstance

Step 1: What Kind of Change?

Please select the appropriate change type from the drop-down list.

Change Type:

[Which change type should I select?](#)

[Which changes require me to call the Customer Support Center?](#)

Comments (Optional)

Feel free to tell us more about why you're reporting this change. For example, "We have a new income in the household."

Next >

Change Type options:

- [Addition of a Household Member](#)
- [Address](#)
- [Citizenship/Immigration Status](#)
- [Contact Preferences](#)
- [Disability Status](#)

- [Health Coverage Information](#)
- [Help Paying for Coverage](#)
- [Incarceration Status](#)
- [Income](#)

- [Tax Filing Status](#)
- [Name](#)
- [Social Security Number](#)
- [Date of Birth](#)

[BACK TO TOP](#)

Note: Once the Change Type has been selected, you will be given the option to enter the date that the change occurred. The **Effective Date** should never be changed; please leave the default (today's) date.

Submit a Change of Circumstance

Step 1: What Kind of Change?

Please select the appropriate change type from the drop-down list.

Change Type:

[Which change type should I select?](#)

[Which changes require me to call the Customer Support Center?](#)

Step 2: When Did the Change Occur?

Please enter the date this change occurred, in the format MM/DD/YYYY. For example, if you are reporting a change that happened on January 2, 2014, you should enter 01/02/2014.

Effective Date:

Comments (Optional)

Feel free to tell us more about why you're reporting this change. For example, "We have a new income in the household."

To discard the change and select a different change type, select **Restart** at any time. To save the change and return to it later, select **Save And Exit**. Saved changes can be resumed from the My Applications page under the My Changes tab.

Contact Person

The **External Verification** screen appears during every change. The customer must agree and select "Yes" to continue. Selecting "No" will result in an error message stating the change cannot be completed.

External Verification

(*) Required

By choosing "Yes," I'm indicating that I understand my information will be checked with state and federal agencies like the Internal Revenue Service (IRS), Social Security, and the Department of Homeland Security. I also understand my information will be kept secure and will only be used to help verify my household information.

I understand the above information and wish to continue with the application process. * Yes No

Before submitting the change, review the **Confirmation** page to ensure the information is correct. Fields that have been changed/updated will be indicated with the below icon:

Confirmation

Restart Save And Exit

(*) Required

Please confirm the information below is correct.

Contact Person

Contact person: Joe

Contact Details

Home Phone (XXX-XXX-XXXX): 802-888-0202

Work Phone (XXX-XXX-XXXX)

Cell Phone (XXX-XXX-XXXX)

Email Address: joe.vermonter@gmail.com

Once the information has been reviewed, select “Yes” for each acknowledgement and click **Confirm**.

1 If anyone on this application enrolls in Medicaid, I am giving Vermont Health Connect * Yes No
rights to pursue and get any money from other health insurance, legal settlements,
or other third parties. I am also giving to Vermont Health Connect rights to pursue
and get medical support from a spouse or parent.

1 I know that I must tell Vermont Health Connect if information I listed on this * Yes No
application changes. I know I can make changes by visiting
VermontHealthConnect.gov and clicking on "My Account" or calling 1-855-899-9600.
I understand that a change in my information could change my eligibility and the
eligibility for other members of my household.

1 As a Navigator or Broker, I have conferred with the applicant to assure to the best of * Yes No
my ability that the information provided is accurate. I am signing this application
under penalty of perjury, which means I have provided true answers to all of the
questions to the best of my knowledge. I know that I may be subject to penalties
under federal law if I intentionally provide false or untrue information.

Confirm

Addition of a Household Member

Adding someone to the application, even if this person is not enrolling in health coverage. Examples include adding someone because of marriage, moving into the same home, becoming a tax dependent, or other reasons.

Note: This change type may not be used to report a birth. Call the customer service center to report a birth in the household.

When adding a member to the household, you can select from the below options:

- a. Adoption
- b. Birth (*do not select this change type*)
- c. Foster care change
- d. Loss of eligibility for health coverage
- e. Marriage
- f. Domestic Partnership
- g. Civil Union
- h. Gained dependent by court order
- i. Other

Restart
Save And Exit

Adding an Individual to the Application

* Required

Please tell us about why you're adding someone to your application.

Did any of these events happen in your family? *

Next >

Select the reason for the addition of the household member.

Household Member 5
✕

1 First Name: *

1 Middle Name:

1 Last Name: *

1 Suffix:

1 Other Name (Maiden or Former Name):

1 Birth Date (MM/DD/YYYY): *

1 Sex: * Male Female

1 Marital Status: *

Note: If you are a victim of domestic violence and applying separately from your spouse, you may indicate that you are "never married" on the application to get help paying for coverage.

+ Add Another Household Member

Back
Next >

Enter the new household member's name, date of birth, sex, and marital status.

People Applying for Health Insurance

[Restart](#) [Save And Exit](#)

(*) Required

Please select all of the people who need health insurance through Vermont Health Connect.

[Check all that apply]

To check or uncheck a name, click in the box next to the name.

- Joe
- Debbie
- Thomas
- Linda
- Mark

[Back](#) [Next >](#)

Indicate whether the new household member would like to apply for coverage through VHC.

If the new household member is applying for coverage, you will be required to answer follow-up questions regarding [citizenship/immigration](#), [income](#), [health coverage](#), etc. Refer to the appropriate section for additional details.

Home Address

[Restart](#) [Save And Exit](#)

(*) Required

Please check the name of the newly added person (or people) beneath the address at which he or she lives. If the person lives at an address not listed on the application, you can add the person's address by clicking Add Another Address. If the person spends time living at more than one address, please select only the one address at which he or she spends the greatest number of nights. If the person does not have a home address, you can indicate that below.

Address 1

-
-
-
-
-
-

Please select the household members who live at this address:

- Joe
- Debbie
- Thomas
- Linda
- Mark

Please select all of the household members that do not have a home address:

- Joe
- Debbie
- Thomas
- Linda
- Mark

[+ Add Another Address](#)

[Back](#) [Next >](#)

If the new household member lives at the same address, check the member's name.

Joe's Relationships: Children

[Restart](#) [Save And Exit](#)

(*) Required

Please tell us how people are related in your home. If these people are not related in this way, please skip the question by clicking "Next".

Please choose whom Joe is a parent or step-parent of:

- Debbie
- Thomas
- Mark

[Back](#) [Next >](#)

Indicate the new household member's relationship(s) with other household member(s).

People Who Expect to File Federal Taxes for 2023

[Restart](#) [Save And Exit](#)

(*) Required

Please select the household member(s) who plan to file a federal income tax return for 2023.

Tax filers for 2023:

- Joe
- Debbie
- Thomas
- Linda
- Mark

[Back](#) [Next >](#)

Indicate whether the new household member plans to file a federal income tax return for the current year.

Joe's Dependents on his Federal Income Tax Return for 2023

[Restart](#) [Save And Exit](#)

(*) Required

Who does Joe plan to claim as a dependent on his federal income tax return for 2023?

Joe's dependents:

- Debbie
- Thomas
- Linda
- Mark

[Back](#) [Next >](#)

Indicate whether the new household member will be claimed as a dependent by another tax filer in the household.

Mark's Social Security Number

[Restart](#) [Save And Exit](#)

(*) Required

Providing Mark's Social Security number is helpful even if he or she doesn't want health insurance because it speeds up the process. We use Social Security numbers to check income and other information so we know who's eligible for help in paying for health insurance

If you do not want to share Mark's Social Security Number, click "Next" to skip this question.

If someone wants help getting a Social Security Number, call 1-800-772-1213 or visit [socialsecurity.gov](https://www.socialsecurity.gov). TTY users call 1-800-325-0778.

i What is Mark's Social Security number? (no dashes or spaces; e.g., 987654321)

[Back](#) [Next >](#)

Enter the new household member's Social Security Number.

Address

A change to address information. Examples include moving to a new address, changing which household members live at which address, or whether the primary contact’s mailing address is the same as their home address.

Home Address Restart Save And Exit

(Required)

These are the addresses we have on file for this application. Beneath each address we have check marks next to the household members that live there. Please make any changes on this screen. You can make changes to an existing address, add a new address by clicking Add Another Address, or remove an address by clicking the X. If someone spends time living at two or more addresses, please only list him or her once, at the address where he or she spends the greatest number of nights. If someone on your application does not have a home address, you can also indicate that below.

Address 1 X

Street Address (Line 1): *

Apartment or suite number (Line 2):

City: *

State: *

County: *

ZIP code (XXXXX): *

Please select the household members who live at this address:

- Joe
- Debbie
- Thomas
- Linda

Please select all of the household members that do not have a home address:

- Joe
- Debbie
- Thomas
- Linda

[+ Add Another Address](#)

[Next >](#)

Indicate the household’s residential address, which household members live at this address, and any household members who do not have a home address.

If there is more than one home address for the household, click **Add Another Address**.

If the customer does not have a home address, enter “Homeless” as the street address. Use the same city/town as the mailing address.

Reaching Joe via Mail Restart Save And Exit

(Required)

What is Joe's mailing address?

Is Joe's mailing address 123 Main St, Burlington? * Yes No

[Back](#) [Next >](#)

Select **Yes** if the primary contact’s home address is the same as their mailing address.

Select **No** if the primary contact has a different mailing address. The next screen will allow you to enter the mailing address.

Citizenship/Immigration Status

Gain or loss of citizenship and/or immigration status. Examples include changes to whether someone is a US citizen, details about immigration documentation, or information about qualified immigration status. This change may occur for a variety of reasons and it is important that information is reported accurately. Before starting the change, ensure all necessary documents are available.

Change in Citizenship Status Restart Save And Exit

(*) Required

Please select the person or people who have had a change in citizenship status.

People with a change in citizenship status:

- Joe
- Debbie
- Thomas
- Linda

Next >

Select the household member(s) whose citizenship/immigration status has changed.

Debbie's Citizenship Status Restart Save And Exit

(*) Required

Please tell us about Debbie's citizenship status.

Is Debbie a US Citizen or a US National? * Yes No

If you are not sure please [click here](#) for more information.

Back **Next >**

Indicate whether the household member is a US Citizen or US National.

More About Debbie's Citizenship Status Restart Save And Exit

(*) Required

Please tell us more about Debbie's citizenship status.

Is Debbie either a Naturalized or Derived Citizen? * Yes No

Back **Next >**

If the answer to the previous question was **Yes**, indicate whether the household member is a Naturalized or Derived Citizen.

Is Debbie Lawfully Present?

[Restart](#) [Save And Exit](#)

(*) Required

As a non-US Citizen, Debbie may be able to qualify for help paying for coverage if she is lawfully present.

People who are "lawfully present" are immigrants or non-US citizens who have been legally admitted into the United States. They must not have stayed longer than the period for which they were admitted or they may have current permission from the U.S. Citizenship and Immigrant Services (CIS) to stay or live in the U.S.

Is Debbie lawfully present in the US? Yes

This person understands that if they don't answer this question, they won't be eligible for full Medicaid or Qualified Health Plan coverage and will be considered for only coverage of emergency services.

If you need more information about lawful presence, please [click here](#).

[Back](#)

[Next >](#)

If the answer to the citizenship question was **No**, indicate whether the household member is lawfully present.

Does Debbie Have Eligible Immigration Status?

[Restart](#) [Save And Exit](#)

(*) Required

Another way that non-US Citizens can qualify for help paying for coverage is by having eligible immigration status.

These are some of the groups who have eligible immigration status:

- Lawful Permanent Resident (LPR/Green Card holder)
- Asylee defined in § 208 of INA
- Refugee
- Cuban/Haitian Entrant
- Individual admitted to US under § 207 of INA
- Amerasian
- Battered spouse, child, parent
- Victim of Trafficking and his/her Spouse, Child, Sibling or Parent
- Paroled into US
- Conditional Entrant Granted before 1980
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Lawful Temporary Resident
- Member of a federally-recognized Indian tribe or American Indian Born in Canada
- Honorably discharged veterans, their spouse or unmarried surviving spouse or unmarried dependent children
- Active duty US military, their spouse and unmarried dependent child

If you need more information about your immigration status, please [click here](#) or you can call 1-855-899-9600 for help.

Does Debbie have eligible immigration status? * Yes No

[Back](#)

[Next >](#)

If the answer to the lawfully present question was **Yes**, indicate whether the household member has eligible immigration status.

Debbie's Immigration Document Restart Save And Exit

(*) Required

What immigration documents does Debbie have?

Document type:

Back Next >

If immigration documentation is available, select the document type from the drop-down.

If documentation is not available, click **Next**.

Select the type of immigration document from the list:

- a. Permanent Resident Card ("Green Card," I-551)
- b. Temporary I-551 Stamp (on passport or I-94, I-94A)
- c. Machine Readable Immigrant Visa (with temporary I-551 language)
- d. Employment Authorization Card (EAD, I-766)
- e. Arrival/Departure Record (I-94, I-94A)
- f. Arrival/Departure Record in foreign passport (I-94)
- g. Foreign passport
- h. Reentry Permit (I-327)
- i. Refugee Travel Document (I-571)
- j. Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- k. Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- l. Notice of Action (I-797)
- m. Other documents or status types

Debbie's Immigration Document Details Restart Save And Exit

(*) Required

Alien number (XXXXXXXX):

Card Number:

Please click [here](#) for guidance on locating Alien number and Card number

Document expiration date (MM/DD/YYYY):

Category code:

Back Next >

Enter as many details from the immigration document as possible.

Contact Preferences

A change to the household’s communication preferences. Examples include preferred contact person, language of contact, phone numbers, email addresses, and whether the contact person’s mailing address is the same as their home address. If the change is related to a household member’s home address, select the [Address](#) change type instead.

It is important to keep contact preferences up to date to ensure notices and other communications are received in a timely manner. Without the most current contact information, there may be delays in communication.

Contact Person

Restart Save And Exit

Required

Who's the main contact in your household?

Contact person:

Joe
▼

Next >

Indicate which household member is the main contact for the household.

Contact Details

Restart Save And Exit

Required

How can we contact Joe?

You must provide at least one way to reach Joe, which can be a home phone, cell phone, work phone, or email.

If you do not have a phone number or email address, please enter 999-999-9999 in the phone number field.

1 Home Phone (XXX-XXX-XXXX):

1 Work Phone (XXX-XXX-XXXX):

1 Cell Phone (XXX-XXX-XXXX):

1 Email Address:

1 Preferred spoken language:

1 Preferred written language:

1 What is the best way to get in touch with Joe? *

(If you choose home phone, work phone or cell phone, you will receive all notices, invoices and other information through postal mail.)

Back
Next >

Add or update phone numbers, email address, preferred language, and the best method for reaching the primary contact.

Reaching Joe via Mail

Restart Save And Exit

Required

What is Joe's mailing address?

1 Is Joe's mailing address 123 Main St, Burlington? * Yes No

Back
Next >

Select **Yes** if the primary contact’s home address is the same as their mailing address.

Select **No** if the primary contact has a different mailing address. The next screen will allow you to enter the mailing address.

Disability Status

Gain or loss of disability for selected household member.

Change in Disability Status Restart Save And Exit

(*) Required

Please select the person or people that have had a change in disability status.

People with a change in disability status:

- Joe
- Debbie
- Thomas
- Linda

[Next >](#)

Indicate which household member has had a change in disability status.

Joe's Disability Status Restart Save And Exit

(*) Required

Please tell us if Joe's disability information has changed.

Does Joe have a physical disability or mental health condition that limits their ability to work, attend school, or take care of their daily needs? * Yes No

[Back](#) [Next >](#)

Answer the follow-up question for the household member whose disability status has changed.

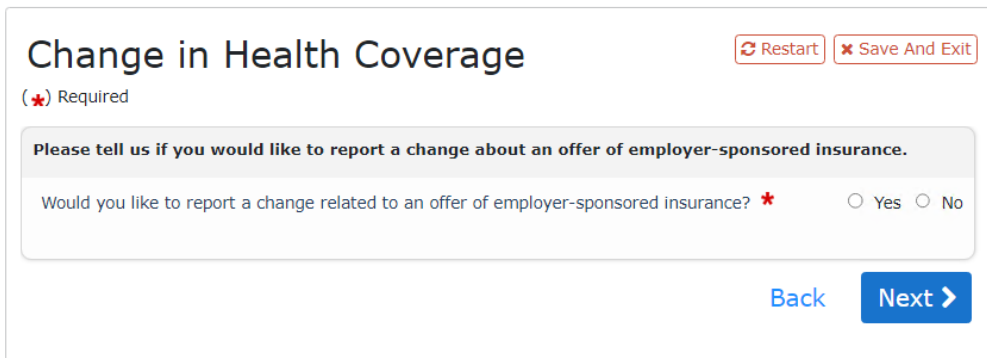
Health Coverage Information

A change to health coverage or access to health coverage from other sources. Examples include changes to eligibility for or enrollment in employer-sponsored insurance, TRICARE, or Medicare.

When changing/updating health coverage information for the household, you can select from the below options:

- a. Employer-sponsored insurance
- b. Medicaid/Dr. Dynasaur
- c. Medicare
- d. TRICARE
- e. VA Health
- f. Peace Corps
- g. Individual Health Insurance
- h. Other limited benefit coverage

Depending on the type of coverage selected, additional information may be required, such as a policy ID.

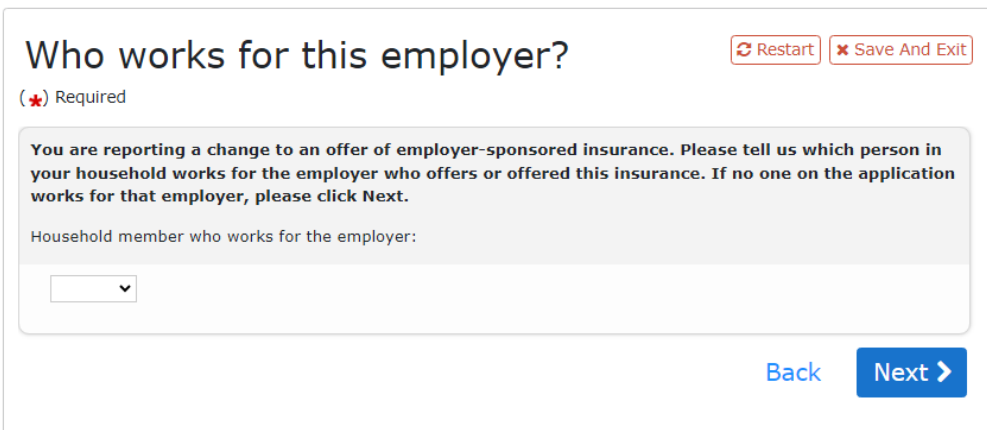


The screenshot shows a web form titled "Change in Health Coverage". At the top right, there are two buttons: "Restart" (with a refresh icon) and "Save And Exit" (with a close icon). Below the title, it says "(*) Required". The main instruction reads: "Please tell us if you would like to report a change about an offer of employer-sponsored insurance." Below this is a question: "Would you like to report a change related to an offer of employer-sponsored insurance? (*)" with radio buttons for "Yes" and "No". At the bottom right, there are "Back" and "Next >" buttons.

Indicate whether the change is related to an offer of employer-sponsored insurance for any/all household member(s).

Employer-Sponsored Insurance

If the coverage change is related to insurance offered by an employer, answer the below follow-up questions.



The screenshot shows a web form titled "Who works for this employer?". At the top right, there are two buttons: "Restart" (with a refresh icon) and "Save And Exit" (with a close icon). Below the title, it says "(*) Required". The main instruction reads: "You are reporting a change to an offer of employer-sponsored insurance. Please tell us which person in your household works for the employer who offers or offered this insurance. If no one on the application works for that employer, please click Next." Below this is a label: "Household member who works for the employer:" followed by a dropdown menu. At the bottom right, there are "Back" and "Next >" buttons.

Select the household member who works for the employer offering insurance.

Does Burlington School District Offer Health Coverage?

[Restart](#) [Save And Exit](#)

(*) Required

Please tell us if Burlington School District offers health insurance to the employee or the employee's family members in 2023. Please answer Yes to this question if Burlington School District offers insurance, even if the employee or the employee's family members are not enrolled.

Is anyone in the household eligible for health insurance offered by Burlington School District? Yes No

[Back](#)

[Next >](#)

Indicate whether any household member is offered health insurance through the employer.

People Eligible for Health Coverage from Burlington School District

[Restart](#) [Save And Exit](#)

(*) Required

Please tell us which household members are eligible to enroll in health insurance from Burlington School District. Please select the person's name even if they are not enrolled.

People eligible for Burlington School District's health insurance:

- Joe
- Debbie
- Thomas
- Linda

[Back](#)

[Next >](#)

Choose the household member(s) who is **eligible** to enroll in the employer-sponsored insurance.

People Enrolled in Health Coverage from Burlington School District

[Restart](#) [Save And Exit](#)

(*) Required

Who is currently enrolled in this health insurance from Burlington School District.

People enrolled in Burlington School District's health insurance:

- Joe
- Debbie
- Thomas
- Linda

[Back](#)

[Next >](#)

Choose the household member(s) who is **enrolled** in the employer-sponsored insurance.

Burlington School District's Health Coverage Details

[Restart](#) [Save And Exit](#)

(*) Required

Tell us about Burlington School District's health coverage for 2023.

If you need help with this question, you can print out and complete the Employer Coverage Tool. Give it to Burlington School District to get the information you need for this section. [Click here to download the Employer coverage tool.](#)

The Employer Coverage Tool provides step-by-step instructions to answer the questions in this section.

1 Does Burlington School District offer health insurance that meets the minimum value * Yes No
standard? A health plan meets this standard if it's designed to pay at least 60% of the total cost of medical services for a standard population. If you are unsure, contact your employer or insurance carrier for help.

[Back](#)

[Next >](#)

Indicate whether the employer-sponsored insurance meets the minimum value standard.

Burlington School District's Health Coverage Details

[Restart](#) [Save And Exit](#)

(*) Required

Tell us about Burlington School District's health coverage for 2023.

If you need help with this question, you can print out and complete the Employer Coverage Tool. Give it to Burlington School District to get the information you need for this section. [Click here to download the Employer coverage tool.](#)

The Employer Coverage Tool provides step-by-step instructions to answer the questions in this section.

1 Does Burlington School District offer health insurance that meets the minimum value * Yes No
standard? A health plan meets this standard if it's designed to pay at least 60% of the total cost of medical services for a standard population. If you are unsure, contact your employer or insurance carrier for help.

Next, we'll ask a question about the plans available from Burlington School District. Please answer this based on the lowest-cost individual plan available. This means the lowest cost plan for just the employee alone. This plan must also meet the minimum value standard.

1 How much would Linda have to pay in premiums for this plan? * \$

1 How often would Linda pay this? *

Please answer the following questions based on the lowest-cost family plan. This means the lowest cost plan for everyone in the household who is eligible to enroll. This plan must also meet the minimum value standard.

1 How much would Linda have to pay in premiums for this plan? * \$

1 How often would Linda pay this? *

[Back](#)

[Next >](#)

Once the previous question is answered, indicate the cost of both the individual-only and family premiums.

Other Insurance

If the coverage change is not related to insurance offered by an employer (e.g., Medicare, TRICARE, Medicaid, etc.), answer the below follow-up questions.

Who has the change in health coverage information?

[Restart](#) [Save And Exit](#)

(*) Required

Please select the person or people who have had a change in health coverage information:

People with a change in health coverage information:

- Joe
- Debbie
- Thomas
- Linda

[Back](#) [Next >](#)

Indicate which household member(s) has had a change in health coverage information.

Household Health Coverage

[Restart](#) [Save And Exit](#)

(*) Required

Please think about the time period you are applying for coverage. We need to know if Thomas will be covered by other insurance during this time.

If Thomas's insurance under one of these programs is ending and Thomas is applying for new insurance (including Medicaid or Dr. Dynasaur coverage) please answer "No."

Please tell us if Thomas receives Medicaid/Dr.Dynasaur benefits. (*) Yes No

Please tell us if Thomas is eligible for or enrolled in either Medicare Part A or Part B. (*) Yes No

TRICARE? (*) Yes No
(Don't check this if you have Direct Care or Line of Duty)

VA health care program? (*) Yes No

Peace Corps? (*) Yes No

Is Thomas enrolled in individual health insurance? Answer "No" if Thomas receives insurance through an employer, a spouse's employer, or a parent's employer. (*) Yes No

Other limited benefit coverage (like a school accident policy)? (*) Yes No

[Back](#) [Next >](#)

Indicate the type of health coverage that is changing for the household member.

Help Paying for Coverage

This change reflects if the household would like to change its decision to be screened for financial assistance (APTC, VPA, CSR, and Medicaid).

Would you like help paying for coverage? Restart Save And Exit

(*) Required

You may qualify to pay less for health insurance through Vermont Health Connect. In fact, even working families may qualify for a free or low-cost plan.

Vermont Health Connect will use information about your income to see if you qualify for Medicaid/Dr. Dynasaur or help lowering your monthly premiums for a private health plan.

To find out if you qualify, you must tell us about your family, your income, and if you or your family have other health insurance available, like insurance you might get through an employer.

To apply for help with paying for your health insurance, click: "YES, I want help paying for coverage." (At the end of this application, you can see what you qualify for.)

To skip this section and pay the full cost each month, click "No, I don't want help paying for coverage."

Do you want to find out if you and your family could get help paying for health insurance? * Yes No

YES, I want help paying for coverage

NO, I don't want help paying for coverage

Next >

Indicate whether the household would like to be screened for financial assistance.

If any member of the household would like to be screened for MCA/financial assistance, the answer to this question must be **Yes**.

People Applying for Health Insurance Restart Save And Exit

(*) Required

Please select all of the people who need health insurance through Vermont Health Connect.

[Check all that apply]

To check or uncheck a name, click in the box next to the name.

Joe

Debbie

Thomas

Linda

Back **Next >**

Indicate which household member(s) would like to apply for coverage through VHC.

Incarceration Status

A change to whether someone is incarcerated or in prison, including whether someone is incarcerated pending disposition of charges. You may indicate whether this change will occur within 60 days.

Change in Incarceration Status Restart Save And Exit

(*) Required

Please select the person or people who have had a change in incarceration status.

People with a change in incarceration status:

- Joe
- Debbie
- Thomas
- Linda

Next >

Indicate which household member(s) has had a change in incarceration status.

Joe's Incarceration Status Restart Save And Exit

(*) Required

Please tell us about Joe's incarceration status.

Is Joe incarcerated? * Yes No

Back **Next >**

Indicate whether the household member is currently incarcerated.

Joe's Incarceration Status Restart Save And Exit

(*) Required

Please tell us about Joe's incarceration status.

Is Joe incarcerated? * Yes No

Is Joe pending disposition? * Yes No

Back **Next >**

Answer the follow-up question for the household member whose incarceration status has changed.

If the household member is incarcerated, review their income and deduction information and make updates as needed. Refer to the [Income](#) section for additional details.

Joe's Income Sources Restart Save And Exit

Required

As a result of Joe's change in incarceration status, please review the information on this screen and make any necessary updates to their income.

NOTE: Any changes made may affect eligibility for your current coverage.

You can edit Joe's income information here. Below are a few common scenarios for income changes:

- If Joe has had a change in income amount (e.g. a raise) from the same employer, then:
 1. On this screen, click Add Another Income Source and
 2. On the next screen you will need to end date the old income amount and
 3. On later screen(s) you will need to enter the details of the new income including the new income, income frequency, start date, etc.

We ask for this information in order to track the changes to Joe's income by date.

- If Joe is reporting a one-time income (e.g. bonus or severance) from the same employer then click Next to make that update on the next screen.
- If Joe was going to receive a job income but never did, then remove the income source by clicking on the X at the top right of that income source.

Income Source 1 X

What type of income does Joe have? Self-employmen

+ Add Another Income Source

Back Next >

Income

A change in income or in income-related deductions. Examples include getting a new source of income, losing a source of income, or changing the amount of income or the dates that income is received.

Note: Please do not enter income changes with start/end dates in the future. Income changes should not be entered until the change occurs.

Change in Income Restart Save And Exit

(*) Required

Please select the person or people who have had a change in income.

Household member with a change in income:

Joe

Debbie

Thomas

Linda

Next >

Indicate which household member(s) has had a change in income.

Linda's Income Sources Restart Save And Exit

(*) Required

NOTE: Any changes made may affect eligibility for your current coverage.

You can edit Linda's income information here. Below are a few common scenarios for income changes:

If Linda has had a change in income amount (e.g. a raise) from the same employer, then:

1. On this screen, click Add Another Income Source and
2. On the next screen you will need to end date the old income amount and
3. On later screen(s) you will need to enter the details of the new income including the new income, income frequency, start date, etc.

We ask for this information in order to track the changes to Linda's income by date.

If Linda is reporting a one-time income (e.g. bonus or severance) from the same employer then click Next to make that update on the next screen.

If Linda was going to receive a job income but never did, then remove the income source by clicking on the X at the top right of that income source.

✕

Income Source 1

What type of income does Linda have? Job

+ Add Another Income Source

Back
Next >

Follow the instructions to add another income source. **DO NOT** click the red X to delete previous income information.

Linda's Job

[Restart](#) [Save And Exit](#)

(*) Required

If you are reporting an income change from the same employer (e.g. a raise), please make sure that you include the end date on the income source with the previous income amount.

1 Who is Linda's employer? *

1 How much does Linda get from this employer before taxes are taken out? * \$

1 How often does Linda earn this amount? *

1 When did Linda start earning this income? (MM/DD/YYYY) (If this income started before the date shown at the right, leave the date as it is.) *

1 If this income stopped, when did Linda get the last payment? (MM/DD/YYYY) (Leave this blank if the income will continue and currently has no end date)

How much does Linda usually work per week for this employer?

1 How many hours per week does Linda usually work for this employer? *

1 Will Linda get any one-time income from this employer? This includes bonuses and severance payments. * Yes No

[Back](#) [Next >](#)

Review previous income information. If there is no change, click **Next**.
 If an income source has ended, follow the instructions to **add an end-date**.
 If a new income source was added, click **Next** until you are given the option to enter the relevant information.

Linda's Deduction Sources

[Restart](#) [Save And Exit](#)

(*) Required

Please think about all of the sources of deductions that Linda expects to get throughout 2023. For each deduction source, select the deduction type. To add another deduction source click "Add Another Deduction Source." To take one away click the X.

List any of the deductions you're able to claim from the 'Adjustments to Income' section of schedule 1 of your 1040 federal income tax return. Please do not include any itemized deductions from schedule A. Only include alimony paid from agreements finalized before 2019.

[+ Add A Deduction Source](#)

[Back](#) [Next >](#)

Add new deduction source(s) or edit existing sources. If none, click **Next**.

Linda's Income this Year

[Restart](#) [Save And Exit](#)

(*) Required

Based on what you told us, if Linda's income is steady each month, then it is about \$47,971.43 per year.

Please note that you must report changes to your application, including income, to Vermont Health Connect in a timely manner. When you report income changes the amount of financial help you receive may also change.

1 Is this how much you think Linda will get in 2023? * Yes No

[Back](#) [Next >](#)

Based on answers to previous questions, the system will calculate the household member's expected yearly income. Eligibility for programs is based on this yearly amount.
 If this number is not representative of the household member's income, select **No** and indicate how much they expect to receive in the applicable year.

Tax Filing Status

A change to tax filing information. Examples include who is filing taxes, who is claimed as a dependent by other household members or by people outside the application, or whether a person plans to file jointly with their spouse. If you need to report a change to income-related deductions, choose the [Income](#) change type instead.

Household Tax Filing Status for 2023 [Restart](#) [Save And Exit](#)

(*) Required

In this section we will ask questions about federal income tax returns.

You do not need to file taxes to be able to apply for health insurance.

*** People who get help lowering their monthly premiums do have to file taxes.**

*** People who qualify for Medicaid/Dr. Dynasaur do not have to file taxes.**

Does anyone on this application plan to file a federal income tax return for 2023? * Yes No

[Next >](#)

Indicate whether anyone in the household plans to file a federal income tax return for the current year.

People Who Expect to File Federal Taxes for 2023 [Restart](#) [Save And Exit](#)

(*) Required

Please select the household member(s) who plan to file a federal income tax return for 2023.

Tax filers for 2023:

- Joe
- Debbie
- Thomas
- Linda

[Back](#) [Next >](#)

Indicate which household member(s) plan to file a federal income tax return for the current year.

Joe's Federal Income Tax Return for 2023 [Restart](#) [Save And Exit](#)

(*) Required

Who does Joe plan to include on his federal income tax return for 2023?

Does Joe plan to file a joint federal income tax return with his spouse for 2023? ***** Yes No

If you are married, you must file jointly to be eligible for help lowering the cost of your monthly premiums. There are exceptions, and you can call 1 (855) 899-9600 for more information.

If you don't file jointly, you may still be eligible for Medicaid/Dr. Dynasaur.

Will Joe claim any household members as dependents on his income tax return for 2023? ***** Yes No

[Back](#) [Next >](#)

For each household member who plans to file taxes, answer the follow-up questions. Tax filing questions must be answered for all household members.

Indicate whether the household member plans to file taxes jointly with a spouse and whether they will claim any household members as tax dependents.

Joe's Dependents on his Federal Income Tax Return for 2023

[Restart](#) [Save And Exit](#)

(*) Required

Who does Joe plan to claim as a dependent on his federal income tax return for 2023?

Joe's dependents:

- Debbie
- Thomas
- Linda

[Back](#)

[Next >](#)

Indicate which household member(s) the tax filer plans to claim as a dependent, if applicable.

People Who Will Claim Joe as a Tax Dependent for 2023

[Restart](#) [Save And Exit](#)

(*) Required

Is there another person who will claim Joe as a dependent on their federal income tax return for 2023?
(For example: If parents are divorced or not living together, the child might be claimed as a tax dependent by the parent they are not living with.)

Will another tax filer who is not part of this application claim Joe as a tax dependent? * Yes No

[Back](#)

[Next >](#)

Indicate whether another person outside of the household will claim the tax filer as a dependent for the current year.

Name

Change a household member's first, middle, and last name.

Identifying Information Restart Save And Exit

(*) Required

Please correct the name(s) of the individuals below.

Household Member 1

First Name: *

Middle Name:

Last Name: *

Suffix:

Other Name (Maiden or Former Name):

Birth Date (MM/DD/YYYY):

Sex: Male Female

Marital Status:

Note: If you are a victim of domestic violence and applying separately from your spouse, you may indicate that you are "never married" on the application to get help paying for coverage.

Household Member 2

First Name: *

Middle Name:

Last Name: *

Suffix:

Other Name (Maiden or Former Name):

Birth Date (MM/DD/YYYY):

Sex: Male Female

Marital Status:

Note: If you are a victim of domestic violence and applying separately from your spouse, you may indicate that you are "never married" on the application to get help paying for coverage.

Household Member 3

First Name: *

Middle Name:

Last Name: *

Suffix:

Other Name (Maiden or Former Name):

Birth Date (MM/DD/YYYY):

Sex: Male Female

Marital Status:

Note: If you are a victim of domestic violence and applying separately from your spouse, you may indicate that you are "never married" on the application to get help paying for coverage.

This screen will list all household members. Make applicable updates to the appropriate household member.

Do not change any member's date of birth, sex, or marital status on this screen.

Social Security Number

Change or update a household member’s Social Security Number (SSN). This may occur as a result of gaining a permanent Social Security Number or a change in current SSN as a result of marriage.

Social Security Number Update or Correction Restart Save And Exit

(*) Required

Please select the household member(s) who need to update or correct their Social Security Number (SSN).

Household Members who need to correct or update their Social Security Number:

- Joe
- Debbie
- Thomas
- Linda

Next >

Indicate which household member(s) has had a change/update to their SSN.

Joe's Social Security Number Restart Save And Exit

(*) Required

Please enter Joe's corrected or updated Social Security Number below.

We need Joe's Social Security number (SSN) if Joe wants health coverage and has an SSN or can get one.

If Joe doesn't have a SSN, leave the answer to this question blank and click Next to continue with the application.

If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users call 1-800-325-0778.

i What is Joe's Social Security number? (no dashes or spaces; e.g., 987654321)

Back **Next >**

Enter the household member’s new/updated SSN.

Date of Birth

Change or update a household member's date of birth (i.e., due to a typo when originally entering the data)

Date of Birth Update or Correction Restart Save And Exit

(*) Required

Please select the household member(s) who need to update or correct their Birth Date.

Household Members who need to correct or update their Birth Date:

- Joe
- Debbie
- Thomas
- Linda

Next >

Indicate which household member(s) has had a change in their date of birth.

Linda's Date of Birth Restart Save And Exit

(*) Required

Please correct Linda's birth date.

Birth Date (MM/DD/YYYY): *

Back **Next >**

Enter the household member's updated date of birth.

Change APTC Amount

If the household is eligible for tax credits, changes to the amount accepted on a monthly basis can be made by navigating to **My Health Plans** and clicking on the **Change your Tax Credit Amount** hyperlink.

Welcome sov009 acting on behalf of Joe Vermonter [\[Exit Sharing\]](#)

- My Applications
- My Verifications
- My Eligibility
- My Health Plans
- My Requests
- My Messages
- My Profile
- My Payment Center

My Health Plans

+ Add Another Household Member

♥ Current Plans

Debbie Vermonter State of Vermont Medicaid / Dr. Dynasaur	Start Date 07/01/2023	End Date 06/30/2024	\$30.00	
Plan Details				
Linda Vermonter We'll see you through. Blue Cross Blue Shield of Vermont BCBSVT Gold Plan 2023	Start Date 07/01/2023	End Date 12/31/2023	\$941.63	
Plan Details				
Thomas Vermonter State of Vermont Medicaid / Dr. Dynasaur	Start Date 07/01/2023	End Date 06/30/2024	\$30.00	
Plan Details				
Joe Vermonter We'll see you through. Blue Cross Blue Shield of Vermont BCBSVT Gold Plan 2023	Start Date 07/01/2023	End Date 12/31/2023	\$941.63	
Plan Details				

Projected Monthly Medicaid Subtotal:	\$60.00
Projected Monthly Subtotal:	\$1,943.26
Federal Advance Tax Credit Applied:	-\$1,404.54
State Premium Assistance Applied:	-\$91.47
i Projected Total Monthly Cost: \$447.25	

[Change your Tax Credit Amount](#)

On the following screen, make applicable updates to the household's APTC amount. Take note of the date on which the change will be applied. If the household would like to apply only some of their total APTC amount (e.g., they are self-employed, their income fluctuates, they are unsure of their expected income, etc.), indicate the amount they would like to apply each month. Once the selection has been made, type the primary tax filer's name in the signature field and click **Confirm**.

Advance Premium Tax Credit

This is a federal tax credit that can help you afford coverage bought through the Marketplace. This is known as APTC, "Advance Payments of the Premium Tax Credit," or premium tax credit. You can get an "advance payment" of this tax credit right away to lower your monthly premium costs.

When it is time to file your federal income tax return, the Internal Revenue Service (IRS) will compare the income and household size on your tax return.

- If your household income is less than what you told us, you may get the extra amount you qualified for as a tax refund.
- If your household income is more than what you told us, you may have to pay back some or all of your APTC.

How much APTC you can get is based on your household size and how much income you think will have for the year. If your income or household size changes during the year, we adjust the amount of APTC you will get each month. We do this to help you avoid receiving too much APTC, which you would have to pay back when you file your taxes.

Example: You report a change in June that qualifies you to get an APTC of \$50 per month (\$600 per year). You received \$100 per month in APTC for the first six months of the year (\$600). You will not get any APTC for the rest of the calendar year.

If your employer helps you pay for health coverage through the Marketplace, you should use the amount you get from your employer to help pay for your monthly premium and select less of the advanced premium tax credit that is available to you.

Joe Vermonter's Tax Household

Joe Vermonter's tax household includes the following household members:

- Thomas Vermonter
- Debbie Vermonter
- Linda Vermonter
- Joe Vermonter

Joe Vermonter can apply up to \$1404.54/month of APTC. **(Please note that the amount applied to your plan selection will change depending on enrolled household members. Final cost will be displayed on plan confirmation page.)**

How much APTC would Joe like to apply?

i This APTC amount will be applied to Joe's monthly premium from 07/01/2023 to 12/31/2023

<input type="radio"/> All Your monthly bill will be reduced by \$1404.54.	<input checked="" type="radio"/> Some \$1,404.54 /month Take some of the advance payment and wait to get the rest of the tax credit when you file your tax return. Your monthly bill will be reduced by \$1,404.54	<input type="radio"/> None Everyone in the tax household will pay the full amount for their monthly health insurance premium. You can claim the premium tax credit when you file your tax return.
------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

[Show me how this could affect Joe's monthly health insurance costs...](#)

APTC Terms and Conditions

If I choose to accept advance payments of the premium tax credit (APTC) to reduce the cost of health coverage for myself and/or my dependents, I understand:

- I must file a federal income tax return in 2024 for the tax year 2023.
- If I am married at the end of 2023, I must file a joint income tax return with my spouse.
- I must expect that:
 - No one else will be able to claim me as a dependent on their 2023 federal income tax return.

By entering Joe's name, Joe is attesting to the fact that they have read and confirmed to the APTC Terms and Conditions:


Joe's Signature

Confirm >

Disenroll from Plan

Disenroll some or all household members from a plan (Medicaid, QHP, and/or Dental) by navigating to **My Health Plans** and following the hyperlink to begin the disenrollment.

Joe Vermonter



Blue Cross Blue Shield of Vermont | BCBSVT Gold Plan 2023

[Plan Details](#)

Start Date **End Date**

07/01/2023 12/31/2023

\$941.63

Projected Monthly Medicaid Subtotal: **\$60.00**

Projected Monthly Subtotal: **\$1,943.26**

Federal Advance Tax Credit Applied: **-\$1,404.54** [Change your Tax Credit Amount](#)

State Premium Assistance Applied: **-\$91.47**

Projected Total Monthly Cost: \$447.25

[Interested in adding another plan? Click here.](#)

[Interested in disenrolling from plans? Click here.](#)

[Future Plans](#)


[Previous Plans](#)

On the next screen, indicate the household member(s) who would like to disenroll from the applicable plan.

Plan Disenrollment

Medicaid

State of Vermont | Medicaid / Dr. Dynasaur



Enrollee(s)


Thomas Vermonter

Debbie Vermonter

\$60.00 /mo

Health Insurance

Blue Cross Blue Shield of Vermont | BCBSVT Gold Plan



Enrollee(s)

Joe Vermonter

Linda Vermonter

\$387.25 /mo

[Back](#)

Disenroll Selected >

Enter any date in the current month to drive the appropriate coverage end date. If the date is on or before the 15th of the month, coverage will end on the last day of the current month. If the date is on or after the 16th of the month, coverage will end for the last day of the next month.

Example: Today is July 20. The household would like coverage to terminate on July 31. Entering any date on or before July 15 will drive a termination date of July 31.

Coverage End Date

(*) Required

Before we disenroll you from that plan, please answer the following questions.

When choosing to disenroll the date that is entered will determine the disenrollment date. If the date you enter is on or before the 15th of the month, the coverage will end for the last day of the current month. However if the date entered is on or after the 16th of the month, the coverage will end for the last day of the next month.

[Back](#) [Next >](#)

Review the confirmation page to ensure the information is correct. Type the customer's name in the signature field and click **Confirm** to complete the disenrollment.

Plan Disenrollment Confirmation

The information you provided is listed below. Please review your answers. You can go back and make changes by clicking the "Edit" link. If everything looks okay, click on the "Confirm" button.

(*) Required

Household Members to Disenroll [Edit](#)

Blue Cross Blue Shield of Vermont | BCBSVT Gold Plan 2023 \$387.25 /mo

Enrollee(s): Joe Vermonter
Linda Vermonter

Disenrollment Questions [Edit](#)

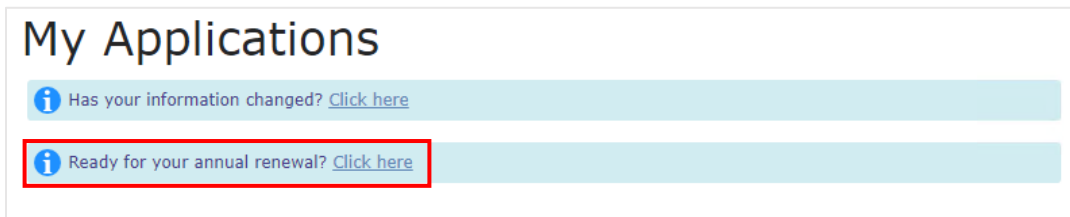
Select the end date for your coverage. 07/27/2023

i By typing my name in the box and submitting the application, I agree that I have carefully checked this information, and it is correct to the best of my knowledge. *

Section 2: Renewal Form

The Renewal Form becomes available when members of the household are due for their annual renewal. Households with QHP enrollment must renew during Open Enrollment, which occurs between November and January each year. Households with Medicaid enrollment may renew up to 2 months prior to the end of their current coverage.

To complete the Renewal Form through self-service, log into the VHC Portal and navigate to the home screen. Under **My Applications**, follow the hyperlink to begin the change.




Completing the Renewal Form

Click **Next** to begin the renewal.


Renew Your Plans

You are about to view your Renewal Form, which has been prepopulated with some of the information you reported in your original application and any updates you have reported to us since then. Please review all of your information and make updates for anything that is no longer accurate before submitting this form.


Review Your Current Information




Household Members




Address



Contact Information



Income, Assets, and Expenses




Other Health Coverage

Report a Change


If you need to make any changes to your current information, you will be asked to report those changes. After those changes are completed, you will continue the renewals process.

Possible Additional Steps




Review Your Results

If you have significantly changed your circumstances, your eligibility for health plans may have changed.



Submit Verification Documents

You may need to submit verification documents like proof of citizenship or income.



Select a Plan

If your eligibility has changed significantly, you may want to select a new health plan.

Next >

The customer must agree to the **privacy statement** to continue. Selecting “No” will result in an error message and you will be unable to move to the next screen.

Privacy & Use of Your Information

[Print](#) [Restart](#) [Save And Exit](#)

Required Fields*

Your answers are private. They're used only to qualify you for health coverage, including Medicaid/Dr. Dynasaur, and to see if you qualify for lower monthly payments.

You must answer basic questions about things like your family size, your citizenship, and your income. We won't ask any questions about your medical history. Household members who don't want coverage won't be asked questions about citizenship or immigration status.

IMPORTANT: We may need to check your answers with state and federal agencies like the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If your status changed recently, your answers might not match information in our or in other agencies' records. Sometimes this happens if you recently got married, got divorced, moved, or changed jobs. If answers don't match, you might need to provide some type of additional proof.

We may also check your information at a later time to make sure your information is up to date. We'll notify you if we find something has changed.

Vermont Health Connect can use my answers to see if I qualify for health insurance and lower payments. Yes No

They can also ask other agencies for information about me or anyone else listed in my application.

*

[Next >](#)

The **External Verification** screen appears during every change. The customer must agree and select “Yes” to continue. Selecting “No” will result in an error message stating the change cannot be completed.

External Verification

[Print](#) [Restart](#) [Save And Exit](#)

Required Fields*

By choosing "Yes," I'm indicating that I understand my information will be checked with state and federal agencies like the Internal Revenue Service (IRS), Social Security, and the Department of Homeland Security. I also understand my information will be kept secure and will only be used to help verify my household information.

I understand the above information and wish to continue with the application process. Yes No

*

[Back](#) [Next >](#)

Select “Yes” if the customer agrees to a renewal period of 5 years. Selecting “No” will allow you to choose the number of years for autorenewal from 0 (do not auto renew) to 5.

Permission to Use Electronic Data Sources at Renewal

[Print](#) [Restart](#) [Save And Exit](#)

Required Fields*

Eligibility must be renewed every year. Vermont Health Connect (VHC) is required to verify household information at renewal using electronic data sources. VHC must have your permission to do so.

What if you say Yes?

VHC may be able to renew your eligibility without you having to do anything.

This includes eligibility for Medicaid/Dr. Dynasaur and for Advance Payments of Premium Tax Credits (APTC).

You can choose to say Yes for 1 to 5 years.

What if I say No?

- If you get APTC now, you will not get APTC when your coverage is renewed. You will have to pay the full price of your Qualified Health Plan (QHP).
- If you are on Medicaid/Dr. Dynasaur, we may not be able to renew you without you giving us more information.

IMPORTANT: You can change your mind at any time about how many years you give VHC permission to use electronic data sources by calling VHC customer support at 1-855-899-9600.

You can also cancel your coverage or make changes to your household information at any time by calling VHC customer support.

Do you agree to a renewal period of 5 years? * Yes No

[Back](#) [Next >](#)

This is an optional question regarding customers who may qualify for Medicaid for the Aged, Blind, and Disabled. Selecting “Yes” will result in a healthcare application (205SUPP) being sent to the customer.

Other Medicaid Programs

[Print](#) [Restart](#) [Save And Exit](#)

Required Fields*

There are other Medicaid programs available through the State of Vermont, including for people who are age 65 or older, blind or disabled. They provide health care coverage and help pay for health care costs. These programs have different requirements to qualify.

Yes

Would you or anyone in your household like to apply for these other Medicaid programs?

(If you check yes, we will send you an application to apply. If you qualify for more than one Medicaid program, we can help you choose which one best meets your needs.)

[Back](#) [Next >](#)

If any household member has a [Hardship Exemption](#) from the Federal government, select “Yes”. If the customer is unsure or does not provide an answer, select “No”.

Hardship Exemption

Print Restart Save And Exit

Required Fields*

If you are age 30 or older and want to enroll in a "Catastrophic" plan for 2024 through Vermont Health Connect, you must have a hardship exemption to qualify. To apply for a Hardship Exemption go to Healthcare.gov for information and detailed instructions.

If you have an approved hardship exemption, you may return to Vermont Health Connect to continue with your Catastrophic plan application.

Does anyone on this application have an exemption from the Federal Government? * Yes No

Back Next >

This screen may be followed by additional questions, such as whether any household member was in foster care at age 18. These are questions that may not have been asked/answered on initial application and must be completed to continue with the renewal.

Making Changes and Confirming Information on the Renewal Form

The Renewal Form will populate the most recent information on file for the household. Review each section to ensure the information is still accurate. Changes can be submitted by selecting **Make Changes to this Information**. This will direct you to the appropriate application questions to update the existing information.

Renewal Form sections:

- a. Household Composition
- b. Address
- c. Contact Information
- d. Income
- e. Health Coverage

Address

▼ Home Address

Street Address (Line 1):	123 Main St
Apartment or suite number (Line 2):	
City:	Burlington
State:	Vermont
County:	Chittenden
ZIP code (XXXXX):	05401

▼ People Who Live At 123 Main St

Please select all the people who live at 123 Main St, Burlington

Joe
 Debbie
 Thomas
 Linda

✎ Make Changes to this Information

Address information is correct*

Review Your Information

[Print](#) [Restart](#) [Save And Exit](#)

Required Fields*

Information marked with a (i) has been updated.

Please review the information below. If any information has changed, please click "Make Changes to Information" under the appropriate section. If all information in a section is up to date, please check the box to confirm the information is correct.

Household Composition

Identifying Information

[Make Changes to this Information](#)

Household Composition information is correct*

Address

Home Address

People Who Live At 123 Main St

[Make Changes to this Information](#)

Address information is correct*

Contact Information

Contact Person

Contact Details

[Make Changes to this Information](#)

Contact Information information is correct*

Income

Joe's Income Sources

Linda's Income Sources

Joe's Self-employment

Linda's Job

Joe's Deduction Sources

Linda's Deduction Sources

Based on your previous income information above, this is what we think your income information will be for the following year. Is this information correct?

- i** If yes, then please check the "Income information is correct" checkbox.
- If not, and you need to update your expected income for the following year, please click on the "Make Changes to this Information" button.

Note that all the income information without an end date will continue to the following year.

[Make Changes to this Information](#)

Income information is correct*

Health Coverage

Household Health Coverage

Does Burlington School District Offer Health Coverage?

Burlington School District Contact Information

Coverage from Other Employers

[Make Changes to this Information](#)

Health Coverage information is correct*

If anyone on this application enrolls in Medicaid, I am giving Vermont Health Connect rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to Vermont Health Connect rights to pursue and get medical support from a spouse or parent. *

Yes No

I know that I must tell Vermont Health Connect if information I listed on this application changes. I know I can make changes by visiting VermontHealthConnect.gov and clicking on "My Account" or calling 1-855-899-9600. I understand that a change in my information could change my eligibility and the eligibility for other members of my household. *

Yes No

As a Navigator or Broker, I have conferred with the applicant to assure to the best of my ability that the information provided is accurate. I am signing this application under penalty of perjury, which means I have provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information. *

Yes No

[Confirm](#)

Once the information in each section is reviewed and updated as needed, select the checkbox to indicate that the section is complete and information is correct.

All sections must be checked off in order to complete the renewal.

Once the information has been reviewed, select "Yes" for each acknowledgement and click **Confirm**.

Changing Plans for Renewal Year

After completing the annual renewal, the household may choose to change plans for the next calendar year. To change plans for the renewal year, navigate to **My Eligibility**, then select **Prospective Eligibility**. Accept the benefits determination and click **Select a Plan for Next Year** to be directed to the [APTC](#) and plan selection pages.

- My Applications
- My Verifications
- My Eligibility
- My Health Plans
- My Requests
- My Messages
- My Profile
- My Payment Center

My Eligibility

i Please note during the Public Health Emergency your Medicaid Eligibility may not match your current Medicaid Enrollment. If you have any questions on your Medicaid Enrollment status, please call 855-899-9600.

CURRENT ELIGIBILITY
PROSPECTIVE ELIGIBILITY

Your eligibility will change for the upcoming coverage year, and you should select new plans. Please click the Select a Plan for Next Year button below to start the plan selection process.

Prospective Eligibility

Temporarily Approved

<u>Dr. Dynasaur Prem. (Uninsured)</u>
Thomas Vermonter
Debbie Vermonter
<u>Advance Premium Tax Credit Amount : \$1,451.69</u>
Tax Filer: Joe Vermonter
<u>Advance Premium Tax Credit Eligibility</u>
Joe Vermonter
Linda Vermonter
<u>CSR Eligibility : Level III</u>
Joe Vermonter
Linda Vermonter
<u>Catastrophic Plan</u>
Thomas Vermonter
Debbie Vermonter
<u>Qualified Health Plan Enrollment</u>
Joe Vermonter
Linda Vermonter
Thomas Vermonter
Debbie Vermonter
<u>Vermont Cost Sharing Assistance Eligibility</u>
Joe Vermonter
Linda Vermonter
<u>Vermont Premium Assistance Amount : \$91.63</u>
Tax Filer: Joe Vermonter

Next Steps

Step 1 :
Accept Benefits Determination

Please review the eligibility determination for each status to the left. Once you have reviewed and agreed with the eligibility determination, please accept using the button below.

✔ Accept

Step 2 :
Select a Plan for Next Year

At least one eligible household member does not yet have a Medicaid or Health Insurance plan for the upcoming benefit year. Please click here to start the Renewal Plan Selection Process.

➔ Select a Plan for Next Year