Application for Health Coverage and Help Paying Costs

205ALLMED Non-LTC
01/2023

One application, five sections

- **Main Application**
- **Supplement: For Aged, Blind and Disabled**
- **Appendix A: Tell Us Who is Helping You With This Application**
- **Appendix B: American Indian or Alaska Native Family Member**
- **Appendix C: Tell Us About Health Coverage From Jobs**

Will getting health care benefits change your immigration status?
See *Information for Non-citizens* on page ii.

See what coverage you qualify for

- **Affordable private health insurance plans that offer comprehensive coverage.**
- **A tax credit that can immediately lower your premiums for health coverage.**
- **Medicaid for Children and Adults** (this includes Dr. Dynasaur).
- **Immigrant Health Insurance Plan** (IHIP).
- **Medicaid for the Aged, Blind and Disabled, Pharmacy Programs (VPharm and Healthy Vermonters), Medicare Savings Programs and Disabled Children's Home Care (DCHC) (Katie Beckett)** (for these programs, you will also need to complete the Supplement beginning on page 12).

Contact us

PHONE: Call Customer Service at **1-855-899-9600**

ONLINE: dvha.vermont.gov/apply

IN PERSON: There is someone who can help in your area. Info.healthconnect.vermont.gov/find-local-help

TTY/RELAY: If you are deaf, hard of hearing, or have a speech disability, dial 711.

MAIL: **Vermont Health Connect**
280 State Drive, NOB 1 South
Waterbury, VT 05671-8100

Other ways to apply

Apply faster online or by phone. Visit dvha.vermont.gov/apply or call Customer Service.

DO NOT use this application for

- **Reporting changes.** To report changes to your information, call Customer Service or mail your changes to the address above.
- **Dental ONLY coverage.** There is no financial assistance if you buy dental ONLY plans. If you wish to ONLY buy a dental plan, you can apply using the shorter Application for Health Coverage (205INFA) or call Customer Service.
- **Pharmacy programs (VPharm and Healthy Vermonters)** and/or **Medicare Savings programs ONLY.** There is a shorter application you should use if you are only applying for these programs. Call Customer Service and ask for the 201P application.
- **Medicaid coverage of Long-Term Care Services and Supports (Long-Term Care Medicaid).** If you are applying for Long-Term Care Medicaid, call Customer Service and ask for the 202LTC application.

Be sure to have

- **Social Security numbers** (or document numbers for eligible immigrants who need insurance).
- **Employer and income information for everyone in your family** (pay stubs, W-2 forms or wage and tax statements).

Why do we need this information

We ask about income and other information to determine what coverage you qualify for and if you can get any help paying for it. Income of some household members may count even if they are not applying. **We will keep all the information you provide private and secure, as required by law.**

What happens next

Send your completed and signed application to the mailing address above. You may need to make a payment before coverage begins. **If you do not have all the information we ask for, sign and submit your application anyway.** We will follow up with you about next steps.

Interpretation services are available

(إذا كنت تتحدث لغة أخرى غير اللغة الإنجليزية ، فستتوفر لك خدمات مساعدة اللغة مجانًا. اتصل بالرقم 1-855-899-9600 (العربية)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1–855–899–9600。（繁體中文）
Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-899-9600 (Deutsch)
Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-899-9600 (Español)
Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-899-9600 (Français)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1–855–899–9600 まで、お電話にてご連絡ください。（日本語）
In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-899-9600 (Italiano)
तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-899-9600 । (नेपाली)
Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-899-9600 (Oroomiffa)
Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-899-9600 (Português)
Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-899-9600 (Русский)
Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-899-9600 (Srpsko-hrvatski)
Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-899-9600 (Tagalog)
ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-899-9600 (ภาษาไทย)
Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-899-9600 (Tiếng Việt)

You may keep this page for future reference.

Your Rights and Responsibilities

These rights and responsibilities apply to everyone who is applying.
If you need a large print copy of this, please call Customer Service.

If You Don't Speak or Read English.
We will give you free language services. This means an interpreter can:

- Translate for you over the phone when you call us.
- Read and explain papers to you over the phone.
- Help you apply and renew over the phone.

Ask if we have papers in your language.

If you need language help, call Customer Service at **1-855-899-9600**. You can also get an in-person Assister to help you. Call **1-855-899-9600** to find an Assister. If you don't get the language services you need, you can file a complaint. See **What to Do If You Think You Are Being Discriminated Against** on this page.

Right to Apply and Get a Decision on Time. In most cases, we must make a decision on your application within 45 days. It can take 90 days if you apply for Medicaid based on disability. It may take longer if you cause a delay. What if it takes longer? Call Customer Service at **1-855-899-9600** for more information or to file an appeal.

Do You Disagree with a Decision We Made? Or is the Decision Late? You Can Appeal. This means you are asking for a State fair hearing. Look at your notice of decision to find out more about your right to appeal. You must appeal **within 90 days** from the date on your letter.

In most cases, we must decide your appeal within 90 days. The 90 days start when you appeal. Will waiting that long harm you? You can ask for a fast (expedited) appeal. We decide most fast appeals in 7 working days. Appeals about Medicaid for the Aged, Blind and Disabled may take longer. Appeals about the Immigrant Health Insurance Plan also take longer. To appeal, call Customer Service at **1-855-899-9600**. Or write to the *Human Services Board, 120 State Street, Montpelier, VT 05620-4301*.

You should go to the hearing. But you may have a friend, relative, or lawyer speak for you. You may be able to get free legal help. Call the *Health Care Advocate at Vermont Legal Aid* at **1-800-917-7787**. OR go to https://vtlawhelp.org/health on the internet.

Rights of People with Disabilities. Is it hard for you to do the things we ask you to do? We can make changes to help you. Changes are called "reasonable accommodations" under the ADA (Americans with Disabilities Act).

Here are <u>some</u> changes we can make:

- Someone can write down your answers if you can't.
- We can give you more time.
- We can help you get papers you need to give us.
- You can have a support person with you when you talk to us.
- We can send you papers with a larger print.

Do you need **any** changes to help you? Tell us by calling **1-855-899-9600** for free.

Information for Non-citizens. Getting health insurance from us will **NOT** change your immigration status. The only time it could is if you get long term care Medicaid in an institution. An example is if you are living in a nursing home. If you want to find out more, get FREE legal help by calling Vermont Legal Aid at **1-800-917-7787**. OR go to https://vtlawhelp.org/health on the internet.

Immigrants can apply for health insurance. Does your household have people who can't qualify for Medicaid because of their immigration status? You can still apply for the members who meet the rules. Pregnant people and children under age 19 can get health insurance no matter their immigration status.

Whose immigration status do we check on with the U.S. Citizenship and Immigration Services? We will check for anyone who applies for health insurance.

What about people who only apply on the Immigration Health Insurance Plan application (205IHIP)? We DO NOT contact U.S. Citizenship and Immigration Services about them.

What to do if You Think You Are Being Discriminated Against. We can't treat you differently because of race, color, national origin, sex, or age. We can't treat you differently because of your sexual orientation, gender identity, or disability. What if we don't give you language or disability services you need? It may be discrimination.

Do you think we have discriminated against you? Call Customer Service at **1-855-899-9600**. You can also file a complaint with:

- Department of Vermont Health Access:
  Health Program Civil Rights Coordinator
  Phone: **(802) 241-0454**
  E-mail: AHS.DVHALegal@vermont.gov
  Online: https://info.healthconnect.vermont.gov/non-discrimination
- Federal government: U.S. Department of Health and Human Services, **1-800-868-1019, 800-537-7697** (TDD)
  Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Right to Confidentiality. Information about your application and health insurance is private. It is protected by state and federal law. We won't share your information with anyone else unless:

- It is directly connected to running our programs, or
- The law or a court order says we have to, or
- You tell us we can.

How We Use Your Information (Including Social Security Numbers). We use your information to see if you meet the rules to get health insurance. We also use it to help pay for care and for other legal reasons. We check income and other information to see if you meet the rules. We decide what insurance you get. We collect claims, do audits, investigate cheating, and pay for medical help. We check the truth of information you gave us.

We may contact public and private agencies. This includes the Social Security Administration, banks (Asset Verification), and consumer reporting agencies. It includes the Department of Labor, Department of Homeland Security, and the Internal Revenue Service (IRS). If the information does not match, we may ask you to send us proof.

Do you have a Social Security Number (SSN)? You must give it to us to get health insurance. What if someone does not want health care? They don't have to give us their SSN. Some people who don't have an SSN don't have to get one to apply. This includes people with a religious reason not to have one. Call Customer Service at **1-855-899-9600** to find out more.

You Must Tell Us About Changes. You must tell us if your address, phone, email or income changes. Tell us if who lives with you changes or you marry or divorce. Tell us if you start or end a pregnancy or your immigration status changes. Tell us if you get other health insurance or move out of Vermont. Tell us if you get Medicaid in another state. Call Customer Service at **1-855-899-9600** to report changes.

For Medicaid and the Immigrant Health Insurance Plan, you must report changes within **10 days**. Do you have a health insurance plan (Qualified Health Plan) through us? You must report changes in **30 days**. New information could change if you or household members can get or keep health care.

Your Rights and Responsibilities *(continued)*

These rights and responsibilities apply to everyone who is applying.
If you need a large print copy of this, please call Customer Service.

Don't Lie to Get or Keep Medicaid or Help Someone Else Get or Keep It. You or any member of your household cannot lie on purpose to get or keep health care.

What if you do lie and are found guilty? Penalties may include up to 3 years in prison and/or a fine of up to $1,000. Or you may be fined as much as the health care cost. There may be other federal or state penalties. (42 U.S.C. §1320a-7b; 33 V.S.A. §§141, 143)

Agreement Regarding Medicare Part B Payments. You agree that we will pay doctors and medical suppliers directly for these services. This means you won't have to sign separate papers each time you get a service.

Agreement to Release Medical Records. You agree that your medical records may be read, used and shown to others. This means health care providers, Department of Vermont Health Access and its contractors and grantees. They can share your records to manage state health care programs. Or if a hospital, health care provider, mental health provider, or pharmacy needs your medical records. This includes provider and drug information for your treatment and payment of your treatment. It includes information for health care operations.

Have you been in a drug or alcohol treatment program? You agree to let them tell us what prescription drugs you got in their program. We only ask for this if it is needed to treat you.

You can take back your consent to release your medical records. Just say that in writing and mail it to: *DVHA Deputy Commissioner, 280 State Drive, NOB 1 South, Waterbury, VT 05671-1010.*

Agreement to Let us Pursue Money and Medical Support from Third Parties if You Get Medicaid. Do you get Medicaid? Then you give us the right to try and get money for your health care. This would come from other health insurance, legal settlements, or other third parties. This is true for you and anyone in your household who gets Medicaid.

You agree to sign up for a group health plan if the state requires it. The state may pay the monthly payments.

You give us the right to get medical support from a husband/wife or parent. This includes a parent living outside of your home. Do you think that helping collect medical support may harm you or your children? Call Customer Service at **1-855-899-9600**. You may not have to help us.

Consent to Bill Medicaid if Child Receives Special Education. Does a child in your household get Medicaid and Special Education? Then you agree your child's school district can bill Medicaid. They can bill for the services listed in your child's Individual Education Plan or IEP. What if you don't give permission? You are only saying they can't bill Medicaid for IEP services. The school district must still give your child free IEP services. You may take back consent to bill Medicaid at any time. The school must stop billing Medicaid the day you take back your consent. To take back your consent, write to: *DVHA, Application & Document Processing Center, 280 State Drive, NOB 1 South, Waterbury, VT 05671-8100.*

Are You Using the Supplement to Apply for Medicaid for the Aged, Blind and Disabled (MABD)? If Yes, You Have These Additional Rights and Responsibilities.

You Agree We Can Check Resources for Medicaid for the Aged, Blind and Disabled. There are rules for who can get Medicaid for the Aged, Blind and Disabled. There are rules about how much income, money, and property you can have. To meet federal law (42 U.S.C. 1396w), the Department of Vermont Health Access uses an electronic asset verification system. This helps us see if you can get this program. The system asks for information from banks and financial institutions. They check open and closed accounts to see if you meet the rules.

You agree the Department of Vermont Health Access can check with banks and financial institutions. This is to see if you meet the rules to get Medicaid. This agreement lasts until you take it back in writing. It will end if your application is turned down or you stop meeting Medicaid rules. What if you decide to take back your agreement? Call Customer Service at **1-855-899-9600** to find out where to send your written statement.

Duty to Report Changes About Resources (Assets). You must report the changes listed in the You Must Tell Us About Changes section on page ii. Do you get Medicaid for the Aged, Blind and Disabled? Then you must also report changes in your resources. This means reporting:

- When your resources go above the $2,000 limit.
- If you get a lump sum payment. This can be a trust or retirement fund payment, inheritance, or insurance settlement.
- Changes in ownership. This can be adding or removing a name, or sale or transfer of real or personal property.
- If you sell property, including your home.

To report a change, call Customer Service at **1-855-899-9600**. Or write or send a change report (Form 200GMC) to: *DVHA, Application & Document Processing Center, 280 State Drive, NOB 1 South, Waterbury, VT 05671-1500*.

Application for Health Coverage and Help Paying Costs

205ALLMED Non-LTC
01/2023

STEP 1 Tell Us About Yourself

The person listed here will be the contact person for your application.

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.)		**2.** Social Security number (SSN). **Optional, if you are not applying for health coverage you are not required to provide your SSN.** ___ ___ ___ — ___ ___ — ___ ___ ___ ___	
3. Home address (this cannot be a P.O. Box)		**4.** Apartment or suite number	
5. City/Town	**6.** State	**7.** ZIP code	**8.** County
9. Mailing address line 1 (if different from home address)		**10.** Apartment or suite number	
11. Mailing address line 2 (If applicable, include an "in-care-of" person here. **If that person is an Authorized Representative, also complete Appendix A on page 17.**)			
12. City/Town	**13.** State	**14.** ZIP code	**15.** County
16. Home phone number ( ) –	**17.** Work phone number ( ) –	**18.** Cell phone number ( ) –	
19. What is your preferred spoken or written language (if not English)?			

STEP 1 is complete. Continue to STEP 2 below.

STEP 2 Who to Include

Complete the STEP 2 pages for every person in your family and household, even if the person has health coverage already. Start with yourself, then add other adults and children. The information in this application helps us make sure everyone gets the best coverage they can. The amount of help or type of program you qualify for is based on the number of people in your family and their incomes. If you don't include someone, even if they already have health coverage, your eligibility results could be affected.

	INCLUDE these people even if they aren't applying for health coverage themselves
For ADULTS who need coverage	• Any spouse, including a civil union partner. *If you are a party to a civil union, include your civil union partner in this application and be sure to check the "civil union" box at question 6. A partner in a civil union is considered a spouse for purposes of Vermont's Medicaid programs.* • Any son or daughter under age 21 they live with, including stepchildren. • Any other person on the same federal income tax return, including any children over age 21 who are claimed on a parent's tax return. *You do not need to file taxes to get health coverage.*
For CHILDREN (under age 21) who need coverage	• Any parent (or stepparent) they live with. • Any sibling they live with. • Any son or daughter they live with, including stepchildren. • Any other person on the same federal income tax return. *You do not need to file taxes to get health coverage.*

You do not need to provide immigration status or a Social Security number (SSN) for family members who don't need health coverage. We will keep all the information you provide private and secure, as required by law. We use personal information only to check if you're eligible for health coverage.

Person 1: Start With Yourself

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

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.)

2. Relationship to you? **SELF**

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 ☐ Male ☐ Female

6. Marital status
If you are a victim of domestic violence and applying separately from your spouse, you may indicate that you are "Never married".
☐ Never married ☐ Married ☐ Civil union
☐ Separated ☐ Divorced/dissolved ☐ Widowed

7. Social Security number (SSN)
___ ___ ___ – ___ ___ – ___ ___ ___ ___

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

8. Do you plan to file a federal income tax return next year? *(You can still apply for health coverage even if you do not file a federal income tax return.)*
☐ Yes. **Answer questions a – c.** ☐ No. **Continue to question c.**

a. Will you file jointly with a spouse? ☐ Yes. **Name of spouse:** ______________________ ☐ No

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

c. Will you be listed as a dependent on someone else's tax return? *(You cannot be both a dependent and a joint filer.)* ☐ Yes. **Name of the tax filer:** ______________________ ☐ No
How are you related to the tax filer? ______________________

9. Are you pregnant? ☐ Yes ☐ No
If yes, how many babies are expected? ________ **Estimated due date (mm/dd/yyyy)?** ______________

10. Are you applying for health coverage? *(Even if you have insurance, there might be a program with better coverage or lower costs.)*
☐ Yes. **Continue to question 11.**
☐ No. **Continue to Current Job & Income Information on page 3.**

11 a. Do you have a physical, mental, learning, or emotional health condition that causes you to regularly need help with some or all of your self-care activities (like bathing, dressing, eating, reading, daily chores, etc.)? ☐ Yes ☐ No

If you answered 'yes' *to the above question, or if you qualify for Medicare, review the information at the beginning of* **the Supplement (on page 12)**. *If you want us to see if you qualify for health coverage for individuals who are aged 65 or older, and/or blind or disabled,* **complete the Supplement** *after you complete the main application. For now,* **continue to question 11b**.

b. Are you in, or have you moved to, a medical facility or nursing home in the past 30 days, or do you need assistance and/or support to live in a home and community-based setting? ☐ Yes ☐ No

If you answered 'yes' *to the above question, you may need to apply for Long-Term Medicaid. To do that, you need a different application. Call Customer Service at* **1-855-899-9600** *and ask for the 202LTC application.*

12. Are you a U.S. citizen or U.S. national? ☐ Yes. **Continue to question 13.** ☐ No. **Continue to question 14.**

13. Are you a naturalized or derived citizen? *(This usually means you were born outside of the U.S.)*
☐ Yes. **Complete a and b then continue to question 15.**
☐ No. **Continue to question 15.**
a. Alien/USCIS number: ______________________
b. Certificate number: ______________________

14. 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.**
If you can't answer 'yes', we will see if you can get Emergency Medicaid. It pays for emergencies, labor and delivery.
Visit dvha.vermont.gov/apply for information about eligible immigration status.

a. Immigration document type: ______________________
b. Document expiration date (mm/dd/yyyy): ____________ ☐ None
c. Alien/USCIS number: ______________________
d. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
e. Date of entry (mm/dd/yyyy): ______________________
f. Passport or document number: ________________ ☐ None
g. Country of origin: ______________________
h. Category code: ______________________
i. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
j. SEVIS ID: ______________________

15. Retroactive Medicaid: Do you have medical/dental expenses from the last 3 months? You might be eligible for assistance that could help pay, or reimburse you for those expenses. Were you pregnant during any of those 3 months? Then you may meet the rules for extra Medicaid coverage.

Do you want to apply for help with medical/dental expenses from the last 3 months? ☐ Yes ☐ No

16. 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

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

18. Were you in foster care at age 18 or older? ☐ Yes ☐ No

☐ If YES, check this box if you were in foster care in Vermont when you turned 18.

19. To which racial group(s) do you most identify? (Optional–check all that apply)

- ☐ White
- ☐ Black or African American
- ☐ Hispanic, Latino, or Spanish Origin
- ☐ American Indian or Alaska Native **Fill out Appendix B: American Indian or Alaska Native Family Member on page 18.**
- ☐ Asian
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other: __________________________

20. If Hispanic/Latino: To what ethnic group(s) do you most identify? (Optional–check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other: ____________________________

Current Job & Income Information

☐ EMPLOYED
If you are currently employed, tell us about your income. Start with question 21.

☐ SELF-EMPLOYED
Continue to question 32.

☐ NOT EMPLOYED
Continue to question 33.

Current Job 1

21. Employer (or Company) name

22. Employer (or Company) phone number ( ) –

23. Employer (or Company) address

24. Wages/tips before taxes (gross income) $ _________________

PER: ☐ Hour ☐ Twice a month ☐ Week ☐ Month ☐ Every 2 weeks ☐ Year

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

If you only have one job, continue to question 31.

Current Job 2

If you need more space, attach a separate page. Be sure to write PERSON 1's name and date of birth at the top.

26. Employer (or Company) name

27. Employer (or Company) phone number ( ) –

28. Employer (or Company) address

29. Wages/tips before taxes (gross income) $ _________________

PER: ☐ Hour ☐ Twice a month ☐ Week ☐ Month ☐ Every 2 weeks ☐ Year

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

Additional Job Information

31. Do any of these jobs offer health insurance coverage? ☐ Yes. **Complete Appendix C on page 19.** ☐ No

32. If self-employed, answer the following questions:
a. What type of work do you do? ______________________________
b. How much net income (the amount left over after business expenses are paid) will you get this month? $ ______________

33. In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None

Other Income This Month

34. 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, workers' compensation, veteran's payments, or Supplemental Security Income (SSI).*

☐ None
☐ Alimony received $ ________ How often? ________ Was the agreement signed after 2018? ☐ Yes ☐ No
☐ Net farming/fishing $ ________ How often? ________
☐ Net rental/royalty $ ________ How often? ________
☐ Pensions $ ________ How often? ________
☐ Retirement accounts $ ________ How often? ________
☐ Social Security (disability, retirement, and survivor/widow benefit before Medicare or any other deductions)
$ ________ How often? ________
☐ Unemployment $ ________ How often? ________ What state pays your unemployment benefits? ________
☐ Other income $ ________ How often? ________ Type(s): ________________

Deductions

35. 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.

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

☐ None
☐ Alimony paid $ ________ How often? ________ Was the agreement signed after 2018? ☐ Yes ☐ No
☐ Student loan interest $ ________ How often? ________
☐ Other deductions $ ________ How often? ________ Type(s): ________________

Yearly Income

36. Complete **ONLY** if your income changes during the year, for example, if you only work a job for part of the year or receive a benefit only some months.

Your total income **THIS** year

$ ______________________

Your total income **NEXT** year (if you think it will be different)

$ ______________________

Person 1 is complete.

Continue with STEP 2 on next page if you have additional household members to report.
<u>If not, continue ahead to STEP 3 on page 8</u>.

STEP 2 Person 2

Continue filling out STEP 2 for your spouse, children who live with you, and/or anyone on your same federal income tax return. If you have more than two people in your family, please make a copy of pages 5, 6 & 7 (before filling those pages out) or visit dvha.vermont.gov/apply to print out additional forms and attach them to the application. If you do not file a tax return, you must still include family members who live with you. See page 1 for more information about who to include.

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, including a maiden name or alias

4. Date of birth (mm/dd/yyyy) / /

5. Sex ☐ Male ☐ Female

6. Marital status
If PERSON 2 is a victim of domestic violence and applying separately from their spouse, they may indicate that they were "Never married".
☐ Never married ☐ Married ☐ Civil union
☐ Separated ☐ Divorced/dissolved ☐ Widowed

7. Social Security number (SSN) **This is needed if PERSON 2 wants coverage and has a SSN.**
___ ___ ___ — ___ ___ — ___ ___ ___ ___

8. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, address for PERSON 2: ______________________________

9. Does PERSON 2 plan to file a federal income tax return next year? *(PERSON 2 can still apply for health coverage even if they do not file a federal income tax return.)* ☐ Yes. **Answer questions a – c.** ☐ No. **Continue to question c.**

a. Will PERSON 2 file jointly with a spouse? ☐ Yes. **Name of spouse:** ______________ ☐ No

b. Will PERSON 2 list any dependents on their tax return? *(Joint filers must list the same dependents.)* ☐ Yes. **If yes, name(s) of dependents:** ______________ ☐ No

c. Will PERSON 2 be listed as a dependent on someone else's tax return? *(PERSON 2 cannot be both a dependent and a joint filer.)* ☐ Yes. **Name of the tax filer:** ______________ ☐ No
How is PERSON 2 related to the tax filer?______________

10. Is PERSON 2 pregnant? ☐ Yes ☐ No
If yes, how many babies are expected? ________ **Estimated due date (mm/dd/yyyy)?** ______________

11. Is PERSON 2 applying for health coverage? *(Even if PERSON 2 has insurance, there might be a program with better coverage or lower costs.)*
☐ Yes. **Continue to question 12.**
☐ No. **Continue to Current Job & Income Information on page 6.**

12a. Does PERSON 2 have a physical, mental, learning, or emotional health condition that causes them to regularly need help with some or all of their self-care activities (like bathing, dressing, eating, reading, daily chores, etc.)? ☐ Yes ☐ No

If PERSON 2 answered 'yes' *to the above question, or if PERSON 2 qualifies for Medicare, review the information at the beginning of* **the Supplement (on page 12)***. If they want us to see if PERSON 2 qualifies for health coverage for individuals who are aged 65 or older, and/or blind or disabled,* **complete the Supplement** *after they complete the main application. For now,* **continue to question 12b**.

b. Is PERSON 2 in, or have they moved to, a medical facility or nursing home in the past 30 days, or do they need assistance and/or support to live in a home and community-based setting? ☐ Yes ☐ No

If PERSON 2 answered 'yes' *to the above question, PERSON 2 may need to apply for Long-Term Medicaid. To do that, they need a different application. Call Customer Service at* **1-855-899-9600** *and ask for the 202LTC application.*

13. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes. **Continue to question 14.** ☐ No. **Continue to question 15.**

14. Is PERSON 2 a naturalized or derived citizen? *(This usually means they were born outside of the U.S.)* ☐ Yes. **Complete a and b then continue to question 16.** ☐ No. **Continue to question 16.**
a. Alien/USCIS number: ______________
b. Certificate number: ______________

15. If PERSON 2 is not a U.S. citizen or U.S. national, do they have eligible immigration status? ☐ Yes. **Fill in their document information below.**
If PERSON 2 can't answer 'yes', we will see if they can get Emergency Medicaid. It pays for emergencies, labor and delivery.
Visit dvha.vermont.gov/apply for information about eligible immigration status.

a. Immigration document type: ______
b. Document expiration date (mm/dd/yyyy): ______ ☐ None
c. Alien/USCIS number: ______
d. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No
e. Date of entry (mm/dd/yyyy): ______
f. Passport or document number: ______ ☐ None
g. Country of origin: ______
h. Category code: ______
i. Is PERSON 2, or their spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
j. SEVIS ID: ______

16. Retroactive Medicaid: Does PERSON 2 have medical/dental expenses from the last 3 months? They might be eligible for assistance that could help pay, or reimburse them for those expenses. Was PERSON 2 pregnant during any of those 3 months? Then they may meet the rules for extra Medicaid coverage.

Does PERSON 2 want to apply for help with medical/dental expenses from the last 3 months? ☐ Yes ☐ No

17. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

18. Is PERSON 2 a full-time student? ☐ Yes. **If yes, give the state of their legal residence:** ______ ☐ No

19. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No
☐ If YES, check this box if they were in foster care in Vermont when they turned 18.

20. To which racial group(s) does PERSON 2 most identify? (Optional–check all that apply)
☐ White
☐ Black or African American
☐ Hispanic, Latino, or Spanish Origin
☐ American Indian or Alaska Native
Fill out Appendix B: American Indian or Alaska Native Family Member on page 18.
☐ Asian
☐ Middle Eastern or North African
☐ Native Hawaiian or other Pacific Islander
☐ Other: ______

21. If Hispanic/Latino: To what ethnic group does PERSON 2 most identify? (Optional—check all that apply)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican
☐ Cuban ☐ Other: ______

Current Job & Income Information

☐ EMPLOYED
If PERSON 2 is currently employed, tell us about their income. Start with question 22.

☐ SELF-EMPLOYED
Continue to question 33.

☐ NOT EMPLOYED
Continue to question 34.

Current Job 1

22. Employer (or Company) name

23. Employer (or Company) phone number
(   )   –

24. Employer (or Company) address

25. Wages/tips before taxes (gross income) $ ______
PER: ☐ Hour ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year

26. Average hours worked each week in the past month: ______

If PERSON 2 only has one job, continue to question 32.

Current Job 2

If you need more space, attach a separate page. Be sure to write PERSON 1's name and date of birth at the top.

27. Employer (or Company) name

28. Employer (or Company) phone number
(   )   –

29. Employer (or Company) address

30. Wages/tips before taxes (gross income) $ ___________________

PER: ☐ Hour ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year

31. Average hours worked each week in the past month: __________

Additional Job Information

32. Do any of these jobs offer health insurance coverage? ☐ Yes. **Complete Appendix C on page 19.** ☐ No

33. If self-employed, answer the following questions:
a. What type of work does PERSON 2 do? ______________________________
b. How much net income (the amount left over after business expenses are paid) will PERSON 2 get this month? $ ____________________

34. In the past year, did PERSON 2**:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None

Other Income This Month

35. 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, workers' compensation, veteran's payments, or Supplemental Security Income (SSI).*

☐ None
☐ Alimony received $ ____________ How often? ____________ Was the agreement signed after 2018? ☐ Yes ☐ No
☐ Net farming/fishing $ ____________ How often? ____________
☐ Net rental/royalty $ ____________ How often? ____________
☐ Pensions $ ____________ How often? ____________
☐ Retirement accounts $ ____________ How often? ____________
☐ Social Security (disability, retirement, and survivor/widow benefit before Medicare or any other deductions)
$ ____________ How often? ____________
☐ Unemployment $ ____________ How often? ____________ What state pays your unemployment benefits? ____________
☐ Other income $ ____________ How often? ____________ Type(s): ________________________

Deductions

36. List any of the deductions PERSON 2 is able to claim from the 'Adjustments to Income' section of schedule 1 of their **1040 federal income tax return**. Please do not include any itemized deductions from schedule A.

NOTE: *You should not include a cost that* PERSON 2 *already deducted from their self-employment net income in question 33b.*

☐ None
☐ Alimony paid $ ____________ How often? ____________ Was the agreement signed after 2018? ☐ Yes ☐ No
☐ Student loan interest $ ____________ How often? ____________
☐ Other deductions $ ____________ How often? ____________ Type(s): ________________________

Yearly Income

37. Complete ONLY if PERSON 2's income changes during the year, for example, if they only work a job for part of the year or receive a benefit only some months.

PERSON 2's total income **THIS** year
$ ______________________________

PERSON 2's total income **NEXT** year (if they think it will be different)
$ ______________________________

STEP 2 is complete. Continue to STEP 3.

If you have more than two people in your family, please make a copy of pages 5, 6 & 7 (before filling those pages out) or visit dvha.vermont.gov/apply to print out additional forms and attach them to the application.

STEP 3 Your Family's Health Coverage

1. Is anyone listed on this application offered health coverage from a job?
Answer "Yes" even if the coverage is from someone else's job, such as a parent or spouse.

☐ Yes. **Complete Appendix C on page 19.**
☐ No

2. 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, answer "No".

☐ Yes. **Check the type of coverage and write the name of the person next to the coverage they have.**
☐ No

☐ Medicaid/Dr. Dynasaur ______
☐ Federal Employee Program ______
☐ Peace Corps ______
☐ Employer insurance. If you check this box, **answer question 4**.
☐ Other insurance. If you check this box, **answer question 4**.
☐ TRICARE (Do not check off if you have direct care or Line of Duty) ______
☐ VA health care programs ______

3. Is anyone eligible for, or enrolled in, Medicare?

☐ Yes. **Please fill in the table below.** Most information can be found on the front of your Medicare card. **If you answered yes, you may want to complete the Supplement (beginning on page 12)** to find out if you qualify for health coverage for individuals who are aged 65 or older, and/or who are blind or disabled.

☐ No. **Continue to question 4.**

Name		Name	
Medicare Beneficiary Identifier (MBI) number		Medicare Beneficiary Identifier (MBI) number	
Part A Start date (mm/dd/yyyy): ______	Part B Start date (mm/dd/yyyy): ______	Part A Start date (mm/dd/yyyy): ______	Part B Start date (mm/dd/yyyy): ______
Premium $ ______	Premium $ ______	Premium $ ______	Premium $ ______

4. **If you checked the box in question 2 for employer insurance, or other insurance, complete the table below. Otherwise continue to STEP 4 on page 9.** Most of the information requested below can be found on the front and back of your insurance card. If you have additional health insurance coverage to report and you need more space, copy this page.

Name of insurance company		Insurance company phone number ( ) –	Services covered: ☐ Prescriptions ☐ Vision ☐ Doctors/hospitals ☐ Dental ☐ Outpatient ☐ Other: ______
Insurance company billing address			
Member ID/Policy number	Group number		
Name of policy holder			Date coverage began (mm/dd/yyyy)
Names of people covered	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

STEP 3 is complete. Continue to STEP 4.

STEP 4 Household Special Circumstances

This section asks about life changes that may let you enroll outside Open Enrollment.

If you meet income and other rules, you do not need to complete this section. You can sign up or change health plans any time. To see if you meet income and other rules, go to **http://VermontHealthConnect.gov**. Click on the 'Eligibility Tables' link. It has a picture of measuring scales. Or call customer service for free at **1-855-899-9600**.

What if you do not meet income and other rules? Life changes may let you sign up for a health insurance plan right away. They may get you a 60-day Special Enrollment Period (SEP) to sign up. Some life changes are marriage, divorce, having or adopting a child or losing health coverage. There are many other life changes.

Has anyone on this application had a life change in the past 60 days? If yes, then answer the questions below. If you have no life changes, you can skip these questions and go to STEP 5 on page 10.

---

1. Did anyone in your household lose health coverage in the past 60 days, or does anyone expect to lose health coverage in the next 60 days? ☐ Yes ☐ No

   If yes, who? ____________________ **Last day of coverage (mm/dd/yyyy):** ________

   Why? ____________________

2. Did your household gain a dependent due to birth, adoption, or foster care placement in the past 60 days? ☐ Yes, due to birth ☐ Yes, due to adoption ☐ Yes, due to foster care ☐ No

   If yes, who? ____________________

   Date of birth, adoption, or placement (mm/dd/yyyy): ________

3. 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

   If yes, who? ____________________

   Date coverage ordered to begin (mm/dd/yyyy): ________

4. Did anyone join your household through marriage in the past 60 days? ☐ Yes ☐ No

   If yes, who? ____________________ **Date of marriage (mm/dd/yyyy):** ________

   Had qualifying coverage in the 60 days prior to marriage? ☐ Yes ☐ No

5. Did anyone in your household move to Vermont in the past 60 days, or does anyone expect to move to Vermont in the next 60 days? ☐ Yes ☐ No

   If yes, who? ____________________ **Date of arrival in Vermont (mm/dd/yyyy):** ________

   Had qualifying coverage in the 60 days prior to move? ☐ Yes ☐ No

6. Did anyone in your household get released from incarceration (jail or prison) in the past 60 days, or does anyone expect to get released in the next 60 days? ☐ Yes ☐ No

   If yes, who? ____________________ **Date of release (mm/dd/yyyy):** ________

7. Did anyone in your household experience one of the following changes to their citizenship or immigration status in the past 60 days? ☐ Yes, gained U.S. citizenship ☐ Yes, gained eligible immigration status ☐ Yes, now lawfully present ☐ No

   If yes, who? ____________________ **Date of change (mm/dd/yyyy):** ________

8. Have there been any circumstances in the past 60 days that prevented enrollment, such as a serious medical condition or natural disaster, that you feel should qualify a household member for a SEP? ☐ Yes, **please explain below:** ☐ No

   ____

   ____

   ____

STEP 5 Future Eligibility

Eligibility must be redetermined every year to renew your coverage. We can verify household information at renewal using electronic data sources, including information from tax returns, but must have your permission to do so.

If you say YES below, we may be able to redetermine your eligibility without you having to do anything. This includes eligibility for Medicaid/Dr. Dynasaur and for help paying for a health insurance plan. You can say YES for up to 5 years.

YES. I authorize use of electronic data sources to redetermine my eligibility for:

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

If you say NO, and you get help paying for a health insurance plan, you will not get that help when your coverage is renewed. You will have to pay full price for your health insurance plan until you give us more information. If you are on Medicaid/Dr. Dynasaur, we may not be able to redetermine your eligibility without you giving us more information. If you say NO now, you can give us this permission at a later date.

NO. I do not authorize use of electronic data sources to redetermine my eligibility:

☐ 0 years - I do not authorize use of electronic data sources to redetermine my eligibility at this time.

IMPORTANT: You can change your mind at any time about giving us permission to use electronic data sources to redetermine your eligibility by calling Customer Service at 1-855-899-9600. You can also call Customer Service to end coverage or make changes to your application information.

STEP 6 American Indian or Alaska Native Family Member(s)

Are you, or is anyone in your family, American Indian or Alaska Native or has anyone received services from the Indian Health Service (IHS)?

☐ No. **Continue to next STEP.**
☐ Yes. **Continue to next STEP and also fill out Appendix B on page 18.**

STEP 7 Incarcerated (Detained or Jailed) Family Member(s)

Is anyone applying for health insurance on this application incarcerated?

☐ No. **Continue to next STEP.**
☐ Yes. **Tell us who:** ______________________________
☐ Check here if this person is pending disposition of charges.

(Pending disposition means that the person is in jail or prison but hasn't been convicted of a crime.)

STEP 8 Mail the completed and signed application

MAILING ADDRESS:
Vermont Health Connect
280 State Drive, NOB 1 South
Waterbury, VT 05671-8100

DON'T FORGET TO SIGN YOUR APPLICATION ON PAGE 11.

STEP 9 Sign Your Application

You MUST sign below at the red "X". If you don't sign, we will send the application back. This may delay your health coverage.

The person listed in STEP 1 should sign this application. Are you that person's Authorized Representative? Then you may sign for them **IF** they signed Appendix A on page 17. Are you the legal guardian or have power of attorney for the person listed in STEP 1? Then send proof with this application.

By signing, you agree that:

- You have read and understand your rights and responsibilities. They are listed on pages ii and iii of this application.
- You are signing under penalty of perjury. This means you must give true answers to all the questions. If you lie on purpose, you could be fined or go to prison.
- Everyone who is applying for health coverage on this application is a Vermont resident. A person must be a Vermont resident to get Vermont health coverage.

Is the person applying a minor child or a disabled adult who needs assistance applying? Are you signing for them? Then you agree that:

- The person applying is a minor child or a disabled adult who needs assistance applying (is incapacitated). You are giving information to get or keep health care for them.
- You will tell the truth about what you know about the person applying.
- You understand you cannot keep any information secret or lie on purpose. If you do, you may have to pay a fine or go to prison. You agree to tell DVHA right away if things change for the person applying.

Sign Here *(person applying or person signing for them)* X	**Date** *(mm/dd/yyyy)*

Are you signing because the person applying is a minor child or disabled adult who needs assistance (is incapacitated)? Fill out the part below in case we need to reach you about the application.

Name of person signing for a minor child or disabled adult who needs assistance (first, middle, last name & suffix (Jr., Sr., III, etc.))			
Agency name (if there is one)		Phone number ( ) –	
Street address/PO Box	City/Town	State	ZIP code

Voter Registration: If you are not registered to vote where you live now, would you like a voter registration application?

☐ Yes ☐ No

If you do not check either box, you will be considered to have decided not to register to vote at this time. Applying to register or declining to register to vote will not affect your eligibility for benefits or amount granted to you by this agency. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of State's Office at 128 State Street, Montpelier, VT 05633-1101, or call **1-802-828-2363**.

Women, Infants, and Children (WIC). The Special Supplemental Nutrition Program for Women, Infants, and Children offers health screening, nutrition education, and food for pregnant women, nursing women, and children under 5. To learn more about this program, call toll free **1-800-464-4343** or visit WIC's homepage at **healthvermont.gov/wic**.

Is any of the following true for you or someone on your application? If so, you may not be done.

Will you fill out the Supplement for Aged, Blind and Disabled?

☐ Yes ☐ No

There are other programs that may help with health care, medicine, and Medicare costs. We can check to see if anyone in your household meets the rules to get them. Look at the information below. Is any of it true for anyone on the application? Then read the information at the **beginning of the Supplement (on page 12).**

- A person on the application needs help with some or all of their self-care. This means bathing, dressing, eating, reading, daily chores, etc.
- A person has Medicare or meets the rules to get it.

Did you get help with this application?

You may need to fill out **Appendix A:** Tell Us Who is Helping You With This Application (page 17)

Is anyone an American Indian/Alaska Native?

Fill out **Appendix B:** American Indian or Alaska Native Family Member (page 18)

Do you qualify for or are you enrolled in insurance from an employer?

Fill out **Appendix C:** Tell Us About Health Coverage From Jobs (page 19)

Important! We need more information to find out if you qualify for health coverage programs that are only available to people who are 65 or older, blind, or disabled. We will use the information in this Supplement, along with the information you provided in the main application, to see what you qualify for. If you are not sure if you need to complete this supplement, please call Customer Service. See the list of programs below.

If you want any of the programs below, complete steps 1-5 in the Supplement.

Medicaid for the Aged, Blind & Disabled (MABD)
for people who are aged 65 or older, and/or who are blind or disabled.

VPharm (Pharmacy Program)
for people on Medicare to help pay for prescription drugs.

Medicare Savings Programs (MSP)
for people with Medicare to help pay for Medicare premiums, deductibles, and copays.

Disabled Children's Home Care (DCHC) (Katie Beckett)
for children with disabilities who are living at home and would be eligible for Medicaid if living in an institution. Parent's income and resources are not counted when determining eligibility. However, we do need to know the child's income and resources.

Healthy Vermonters Program (HVP)
for all Vermonters without pharmacy coverage. This program provides a discount on some prescriptions.

If you only want to apply for VPharm, HVP and/or MSP, you can fill out a 201P. Call Customer Service for more information.

PLEASE READ THIS BEFORE YOU FILL OUT THE SUPPLEMENT.

If you are married, you and your spouse CAN be screened together on one Supplement. Even if only one of you wants to be screened, we still need information about both of you.

Is your child applying for DCHC (Katie Beckett)? If so, complete Step 1 with your child's name. Complete Steps 2-4 with only your child's information. We will let you know if we need more information.

Is anyone else also applying? If yes, you must fill out a SEPARATE Supplement for them. Make copies of pages 13-16 prior to filling them out or call Customer Service and we will send you send you a separate supplement.

STEP 1 Information About You

1. Your Name (first, middle, last): Program applying for: ☐ MABD ☐ DCHC

2. Your Spouse's Name (first, middle, last): Program applying for: ☐ MABD ☐ DCHC

3. Have you or your spouse applied for "Extra Help" (also called Low-Income Subsidy) available through Social Security for Medicare Part D prescription drug plan costs? ☐ Yes ☐ No

First name	Date applied

4. Are you or your spouse living outside your home in a residential care home, group home or assisted living facility? ☐ Yes ☐ No

First name	Name of Facility	Date of Admission

STEP 2 Resources

If you need more space, attach a separate page. Be sure to write your name and date of birth at the top.

1. Tell us about property you or your spouse own or are buying. This includes property that is jointly owned or held in a life estate. ☐ No property

   Examples: *House, mobile home, camp, warehouse, empty lot, timeshare, land, rental property, business property*

Owner name(s)	Jointly owned	Full address of property	Type of property	Value	Amount owed
	☐ Yes ☐ No			$	$
	☐ Yes ☐ No			$	$

2. Tell us about vehicles you or your spouse own or are buying. (Do not include leased vehicles.) ☐ No vehicles

   Examples: *Car, van, trailer, truck, ATV, RV/camper, SUV, boat, motorcycle, snowmobile/jet ski*

Owner name(s)	Jointly owned	Type of vehicle	Year	Make/model	Value	Amount owed
	☐ Yes ☐ No				$	$
	☐ Yes ☐ No				$	$
	☐ Yes ☐ No				$	$

3. Do you or your spouse have cash, an account, or any other resource from money earned as a working person with disabilities? ☐ Yes ☐ No

Owner name(s)	Type of resource	Value	Date opened or bought
		$	
		$	

4. Tell us about any life insurance policies or burial accounts that you or your spouse own.

☐ No life insurance policies
☐ No burial accounts

Owner name(s)	Type of resource	Value
	Life Insurance: ☐ Term ☐ Whole	Face value $ Cash value $
	Life Insurance: ☐ Term ☐ Whole	Face value $ Cash value $
	Account set up for burial expenses: Is it irrevocable? ☐ Yes ☐ No	$
	Account set up for burial expenses: Is it irrevocable? ☐ Yes ☐ No	$
	Burial plot, headstone, etc.	$
	Burial plot, headstone, etc.	$

5. Do you or your spouse have a qualified ABLE (Achieving a Better Life Experience) account? ☐ Yes ☐ No

Owner name(s)	Date opened	Name of company where account held

6. Tell us about any other resources you or your spouse own or co-own. ☐ No other resources

Examples:

- *Annuities*
- *Bank accounts*
- *Cash*
- *Certificates of deposits*
- *Checking & savings accounts*
- *College funds*
- *Education accounts*
- *Individual development accounts*
- *Inheritance*
- *Money market accounts*
- *Mutual funds*
- *Nursing home accounts*
- *PASS (Plan to Achieve Self Support) accounts*
- *Promissory notes*
- *Representative payee accounts*
- *Retirement accounts*
- *Savings bonds*
- *Stocks*
- *Trusts*

Owner name(s)	Jointly owned	Type of resource	Account number	Value	Name of financial institution
	☐ Yes ☐ No			$	
	☐ Yes ☐ No			$	
	☐ Yes ☐ No			$	
	☐ Yes ☐ No			$	

STEP 3 Additional Income

1. Do you or your spouse get paid for taking care of children? ☐ Yes ☐ No
If you report this income on your tax return, answer "**No**" and **continue to question 2.**
If Yes: List income before deductions from the past 30 days and if you provide meals and do not get money for them, list the number of meals you provide each month.

.

First name	Income before deductions	Breakfast	Lunch	Dinner	Snacks
	$ per				

2. Do you or your spouse get paid for providing room or meals in your home? (Include payments from children.) ☐ Yes ☐ No

If you report this income on your tax return, answer **"No"** to this question and **continue to question 3.**

First name	Payment	Name of person paying	Check all that apply
	$ per		☐ Room ☐ 1-2 meals per day ☐ 3 meals per day
	$ per		☐ Room ☐ 1-2 meals per day ☐ 3 meals per day

3. Tell us about additional income you or your spouse received this month or last month.

☐ No additional income

Do not repeat *income already listed above or on the main application.*
Examples:

- *Child support*
- *Interest/dividends**
- *Financial aid*
- *Insurance*
- *LTC Insurance policy payment*
- *Other cash received*
- *Public cash assistance*
- *Railroad retirement*
- *Supplemental Security Income (SSI)*
- *Unemployment compensation*
- *Veteran's payment*
- *Workers' compensation*

*Do not include interest from a qualified ABLE account.

Who is this for	Type of Income	How often (weekly, monthly, quarterly)	Amount BEFORE taxes and deductions
			$
			$
			$

4. If you have reported no income on this application, including in this Supplement, tell us how your daily living expenses are paid.

____

____

STEP 4 Expenses

If you need more space, attach a separate page. Be sure to write your name and date of birth at the top.

1. Tell us about ongoing medical expenses you or your spouse have that are not covered by insurance?

☐ No medical expenses

Examples: *pain relievers, personal care, antacids, hearing aid batteries, vitamins, etc.*

First name	Product or service needed	Dosage or number of pills	How often	Average monthly cost
				$
				$
				$
				$

2. If you or your spouse is blind or disabled AND working, do you pay for work-related expenses?

☐ Yes ☐ No

Examples:

- *Transportation to/from work including vehicle modifications*
- *Impairment related training*
- *Attendant care*
- *Medical devices like wheelchairs*
- *Structural modifications to home*
- *Cost of buying and caring for a guide dog*
- *Work-related fees like licenses, professional association dues, union fees, federal, state and local income taxes, Social Security taxes, mandatory pension contributions, meals consumed during work hours*

First name	Expense	How often	How much
			$
			$
			$

3. Tell us about any other expenses you or your spouse have. Do not repeat expenses already listed above. Do not include shelter expenses (such as rent, mortgage, utilities, etc.).

☐ No other expenses

Examples: *Child care, child support, alimony, dependent elder care, health insurance premiums*

Who is it for	Who pays this expense	Type of expense	How often is it paid	Amount paid
				$
				$

STEP 5 Sign this Supplement

You MUST sign below at the red "X". If you don't sign, we will send it back. This may delay your health coverage. Is your spouse is applying with you? They must sign at the second red "X".

Is your spouse not applying with you? See *Information and Authorization for Verification of Resources* below.

You are signing under penalty of perjury. This means you swear you gave true answers to all the questions. If you lie on purpose, you could be fined or go to prison. You understand you must also sign page 11 of this application.

Your signature *(or signature of person signing on your behalf)* X	Date (mm/dd/yyyy)
Your spouse's signature *(or signature of person signing on behalf of your spouse)* X	Date (mm/dd/yyyy)

Are you married but your spouse is not applying with you? Then your spouse must complete the following:

Proof of Resources

Are you the spouse of the person applying for Medicaid in this Supplement? Fill this out and sign at the red "X" below. This lets the Department of Vermont Health Access (DVHA) and authorized agents ask for records. They will be asking for your financial records from banks and other financial places.

What if you do not fill out and sign this? Your spouse may be turned down for or lose their Medicaid.

For the person applying for Medicaid: What if your spouse refuses to sign this? Or what if you cannot find your spouse? You can still send us this Supplement.

I agree to let banks and other financial places give information on my resources. The reason for this is to see if my spouse can get or keep Medicaid.

This agreement will be good until my spouse's application is denied. Or until my spouse no longer meets the rules to get Medicaid. Or until I send a letter to DVHA taking back my agreement.

(Spouse's) Social Security number* ***You do not have to give us this. But it will make it faster for us to see if you can get Medicaid.**

__ __ __–__ __–__ __ __ __

(Spouse's name) First name, middle name, last name & suffix (Jr., Sr., III, etc.)

Signature of spouse/legal representative X	Date (mm/dd/yyyy)

NOTE: Is a spouse's legal representative signing this authorization? If yes, please send us the legal document that says they can sign for the spouse.

The Supplement is now complete. You must also sign the main application on page 11. If you do not need to fill out Appendix A, B, or C and have signed the main application, you are now done.

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)

PERSON 1 Information

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

Complete this appendix if you or if anyone in your family is American Indian or Alaska Native or has received services from the Indian Health Service (IHS). 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 Service, 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.

If you need more space, attach a separate page. Be sure to write PERSON 1's name and date of birth at the top.

	PERSON 1	PERSON 2
1. Name	First Middle Last	First Middle Last
2. Alaska Native?	☐ Yes ☐ No	☐ Yes ☐ No
3. Member of a federally recognized tribe?	☐ Yes ☐ No **If yes**, tribe name: ______ State where recognized: ______	☐ Yes ☐ No **If yes**, tribe name: ______ State where recognized: ______
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?	☐ Yes ☐ 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? ☐ Yes ☐ No	☐ Yes ☐ 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? ☐ Yes ☐ 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: • 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? ______

205APX-C
Revised 08/2022

PERSON 1 Information

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

You **DO NOT** need to answer these questions unless someone in the household is eligible for health coverage from a job, even if they don't accept the coverage. Attach a copy of this page for each job that offers health coverage.

You can ask your employer to fill out this form for you. **However, you are still responsible for submitting this form.**

Employee Information

1. Employee first name, middle name, last name & suffix (Jr., Sr., III, etc.)

Employer Information

2. Employer (or Company) name		**3.** Employer Identification Number (EIN)
4. Employer (or Company) address		**5.** Employer (or Company) phone number ( ) –
6. City/Town	**7.** State	**8.** ZIP code

9. Who can we contact about employee health coverage at this job?

10. Phone number (if different from above) ( ) –	**11.** Email address

12. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?
If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?
Date (mm/dd/yyyy): ___________

☐ Yes. **Continue to questions 13 through 16.**
☐ No. **STOP and return this form to employee.**

13. Does the employer offer a health plan that covers an employee's spouse or dependent?
If yes, list the names of anyone else in the employee's household who's eligible for coverage from this job:
Name: ______________________________ Name: ______________________________

☐ Yes. **Which people?**
☐ Spouse ☐ Dependent(s)
☐ No. **Continue to question 14.**

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes. **Continue to question 15.**
☐ No. **STOP and return this form to employee.**

15. How much would the employee have to pay for the lowest cost plan offered **to the employee only** that meets the minimum value standard*? Do not include family plans.
If the employer has wellness programs, provide the premium that the employee would pay if they received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

If the employer offers a health plan that covers employee's spouse and/or dependents, go to question 16. If it doesn't, go to question 17.

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

16. How much would the employee have to pay for the lowest cost plan offered to the family that meets the minimum value standard?

If the employer has wellness programs, provide the premium that the employee would pay if they 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
Date of change (mm/dd/yyyy): ___________

**A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.*

17. If the plan year will end soon, will the health plans offered change?
If yes, go to question 18. If No or I don't know, STOP and return this form to the employee.

- ☐ Yes.
- ☐ No.
- ☐ I don't know.

18. What changes will the employer make to the employee only plan for the new plan year?

☐ Employer will not offer health coverage.

☐ The premium amount will change for the lowest-cost plan available only to the employee that meets the minimum value standard*. (Premium should only reflect discounts for tobacco cessation programs, see question 15.)

If the employer offers a health plan that covers an employee's spouse and/or dependent go to question 19. If it doesn't, STOP and return this form to employee.

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

19. What changes will the employer make to the family plan for the new plan year?

☐ Employer will not offer health coverage.

☐ The premium amount will change for the lowest-cost plan available to the family that meets the minimum value standard*. (Premium should only reflect discounts for tobacco cessation programs, see question 15.)

Please return this form to the employee.

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

**A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.*