



Health Care Programs Application

Applying for these programs is a multi-step process. Start by filling out this form.

Applicant Information			
First Name	MI	Last Name	Mod. (e.g., Jr, Sr, III)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security Number:		Date of Birth (format MM/DD/YYYY):	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mailing Address:			
Street 1: <input type="text"/>			
Street 2: <input type="text"/>			
City:	State:	ZIP:	Town in which you live:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone Number Where You Can Be Reached: (<input type="text"/>) <input type="text"/> - <input type="text"/>			

- If you have questions or need interpretation services, call 1-800-250-8427: (English)
- Si vous avez des questions ou besoin de services d'interprétation, composez le 1-800-250-8427: (French)
- Ukoliko imate dodatnih pitanja ili Vam je potreban prevodilac, javite se na 1-800-250-8427: (SerboCroatian)
- Si usted tiene preguntas o necesita servicios de interpretación, llame al 1-800-250-8427: (Spanish)
- Haddii aad su'aalo qabto ama aad u baahan tahay adeeg tarjumaan, wac lambarka hoos ku qoran 1-800-250-8427: (Somali)
- Kama una maswali au unahitaji huduma za tafsiri, piga 1-800-250-8427: (Swahili)
- यदि तपाईंसित प्रश्नहरू छन् वा दोभाषे सेवाहरूको खाँचो छ भने, बसस 1.800.250.8427: (Nepali)
- သင့်တွင် မေးခွန်းများရှိလျှင်၊ သို့မဟုတ် ဘာသာပြန်ဆိုရန်လိုအပ်လျှင်၊ အောက်ဖော်ပြပါ ဖုန်းနံပါတ်ကို ဆက်သွယ်ပါ။ ၁-၈၀၀-၂၅၀-၈၄၂၇ (Burmese)

Green Mountain Care is the name of our health care programs for Vermonters. We will screen you for the health care program for which you are eligible. In order to do so, we may ask you for more information. If you are eligible, you may have to pay a premium based on your income. Health Care programs include:

- **Dr. Dynasaur** – for children under age 18 and pregnant women.
- **Vermont Health Access Plan (VHAP)** – for uninsured Vermonters age 18 and older.
- **Premium Assistance** – for uninsured Vermonters age 18 and older to help pay for health insurance at your job or Catamount Health premiums.
- **Pharmacy Programs** – for Vermonters age 65 and older or disabled. Coverage ranges from full pharmacy coverage to supplemental coverage for those on Medicare.
- **Medicare Savings Programs** – for individuals with Medicare to help pay for Medicare premiums, deductibles and co-pays.
- **Healthy Vermonters Program** – for all Vermonters without pharmacy coverage. This program provides a discount on some prescriptions.

IMPORTANT: Be sure to read pages 9-11 before you sign and date the application.

We may ask you to provide proof of your citizenship and/or identity if we are not able to find you in the state's records, like Department of Motor Vehicles or birth records. *Do not send anything at this time. We will tell you more about this after we get your application.*

The Americans with Disabilities Act gives people with disabilities certain rights. We will make reasonable changes and accommodations in our requirements to help you take part in our programs. If you think you might have a physical or mental condition that considerably limits a major life activity like moving, seeing, or thinking, contact us for help.

Children who are members of federally designated American Indian or Alaska Native tribes may not have to pay a premium.

Applicant Information

1. Are you applying for benefits for yourself?

YES NO

Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Citizenship Status: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Other Country of Birth _____	Marital Status: <input type="checkbox"/> Never Married/Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Dissolved <input type="checkbox"/> Civil Union
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2. Do you have an Authorized Representative, Power of Attorney, Legal Guardian, Alternate Reporter, or Enrollment Assistor?

YES NO

If you answered yes, check one: Authorized Representative Power of Attorney Legal Guardian
 Alternate Reporter Enrollment Assistor

I give permission to the Economic Services Division and the person or agency listed below to share information about me as stated in the Rights and Responsibilities confidentiality section (p. 9) of this application.

Full name	Phone No. ()	Home Cell Work <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Address		
For legal guardian only: Name of court _____	Date appointed _____	

Sending letters (notices) or premium bills to someone else:

- **Legal guardian:** If you have a legal guardian, your notices and premium bills will only be mailed to them.
- **In care of:** We can mail your notices and bills in care of someone else. This means you will not get notices or bills.
- **Alternate Reporter:** We can mail most notices to you and to someone else. We call this person an "alternate reporter." However, some notices will only go to you or your alternate reporter, not both of you. For example, the premium bills will only go to you.

If you have questions or would like one of these options, please call 1-800-250-8427.

Household Information

MEMB

If you live alone, skip to question 4.

3. We need information about the people living in your household even if they are not asking for assistance. Please answer questions 3 to 22 for any people in the following groups:

- Yourself.
- Your spouse or civil union partner.
- Your parents and siblings, if you are under age 21. If you are under age 21 a parent must sign this application.
- Your children under age 21 who are living with you.
- The parent of your child (even if you are not married) if you are living in the same household.

You do not have to give information about anyone else living with you who is not listed in one of the groups above.

Send proof of immigration status for anyone applying who is not a U.S. citizen.

People who are not applying do not have to give their social security number, citizenship, or immigration status.

Household Information (continued)

3. Continued from page 3

First Name	M.I.	Last Name
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male Birthdate _____ Social Security No. _____ Relationship to you _____ Check here if this person is not applying <input type="checkbox"/>	Citizenship Status: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Other Country of birth _____	Marital Status: <input type="checkbox"/> Never Married/Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Dissolved <input type="checkbox"/> Civil Union

First Name	M.I.	Last Name
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male Birthdate _____ Social Security No. _____ Relationship to you _____ Check here if this person is not applying <input type="checkbox"/>	Citizenship Status: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Other Country of birth _____	Marital Status: <input type="checkbox"/> Never Married/Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Dissolved <input type="checkbox"/> Civil Union

First Name	M.I.	Last Name
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male Birthdate _____ Social Security No. _____ Relationship to you _____ Check here if this person is not applying <input type="checkbox"/>	Citizenship Status: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Other Country of birth _____	Marital Status: <input type="checkbox"/> Never Married/Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Dissolved <input type="checkbox"/> Civil Union

First Name	M.I.	Last Name
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male Birthdate _____ Social Security No. _____ Relationship to you _____ Check here if this person is not applying <input type="checkbox"/>	Citizenship Status: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Other Country of birth _____	Marital Status: <input type="checkbox"/> Never Married/Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Dissolved <input type="checkbox"/> Civil Union

First Name	M.I.	Last Name
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male Birthdate _____ Social Security No. _____ Relationship to you _____ Check here if this person is not applying <input type="checkbox"/>	Citizenship Status: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Legal Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Other Country of birth _____	Marital Status: <input type="checkbox"/> Never Married/Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Dissolved <input type="checkbox"/> Civil Union

If you need to list more people, add an extra sheet of paper. Be sure to answer all of the above questions for each additional person.

Household Information (continued)

ALIA

4. Has anyone been known by another name, such as a maiden name or alias? YES NO

Current Name First Name M.I. Last Name	Other Name First Name M.I. Last Name
Current Name First Name M.I. Last Name	Other Name First Name M.I. Last Name

SCHL

5. Is anyone in high school, college, vocational school, or a training program? YES NO

First Name	M.I.	Name of School	Type of school	Is health insurance offered?	Attendance status
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full time <input type="checkbox"/> Half-time <input type="checkbox"/> Less than half-time
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full time <input type="checkbox"/> Half-time <input type="checkbox"/> Less than half-time

6. Does any child listed above have an Individualized Education Program (IEP) or a disability preventing graduation before age 19? YES NO

7. Could anyone listed in question 5 be covered under a parent's insurance policy? YES NO

First name Initial	First name Initial

8. Is anyone in your household a parent to your minor child (under age 21)? Do not include your spouse or civil union partner. YES NO

PARE

9. Is anyone pregnant? YES NO

PREG

First Name M.I.	Expected due date	How many babies are expected? _____
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10. Are there children in your home who do not have both parents living with them? YES NO

ABSP

a. Absent parent's full name and address Your relationship to absent parent <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Never Married Absent parent's current marital status <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Never Married	Social Security # Date of birth 1) Has the absent parent been in jail? <input type="checkbox"/> Yes <input type="checkbox"/> No 2) Is the absent parent unemployed? <input type="checkbox"/> Yes <input type="checkbox"/> No 3) Is the absent parent unable to work due to physical or mental health issues? <input type="checkbox"/> Yes <input type="checkbox"/> No	Children of absent parent 1. 2. 3. 4. <input type="checkbox"/> Check here if this absent parent is deceased
b. Absent parent's full name and address Your relationship to absent parent <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Never Married Absent parent's current marital status <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Never Married	Social Security # Date of birth 1) Has the absent parent been in jail? <input type="checkbox"/> Yes <input type="checkbox"/> No 2) Is the absent parent unemployed? <input type="checkbox"/> Yes <input type="checkbox"/> No 3) Is the absent parent unable to work due to physical or mental health issues? <input type="checkbox"/> Yes <input type="checkbox"/> No	Children of absent parent 1. 2. 3. 4. <input type="checkbox"/> Check here if this absent parent is deceased

Health Insurance Information

MEDI

11. Is anyone who is applying covered by Medicare?

YES NO

First name	Initial	Medicare claim number	
Start date _____ Premium \$ _____	Part A:	Start date _____ Premium \$ _____	Part B:
Start date _____ Premium \$ _____	Part C:	Start date _____ Premium \$ _____	Part D:

First name	Initial	Medicare claim number	
Start date _____ Premium \$ _____	Part A:	Start date _____ Premium \$ _____	Part B:
Start date _____ Premium \$ _____	Part C:	Start date _____ Premium \$ _____	Part D:

11a. Is anyone enrolled in a Medicare Part D prescription drug plan?

YES NO

First name	Initial	Date applied

11b. Has anyone applied for the Low-Income Subsidy or "Extra Help" available through Social Security for Medicare Part D prescription drug plan costs?

YES NO

Contract and Plan ID numbers are found in the bottom right-hand corner of your Medicare drug plan card.

First name	Initial	Plan name	Contract ID	Plan start date
			CMS- _____ - _____	
			CMS- _____ - _____	

12. Does anyone have health insurance, including veterans, military or Medicare supplement policies?

YES NO

Include insurance for any child in your home even if they are covered by a parent not in your home.

- Do not include any Medicare information listed in #9 above.
- Do not include Green Mountain Care programs (Medicaid, Dr. Dynasaur, VHAP, Premium Assistance and Pharmacy programs).
- List prescription plans separately.
- **Send copies of both sides of all insurance cards.** If you don't, it will cause application processing delays.

Name of policy holder		Services covered (check all that apply) <input type="checkbox"/> Doctors/Hospitals <input type="checkbox"/> Outpatient <input type="checkbox"/> Prescriptions <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Names of people covered	Name, address and phone number of insurance company
Policy Number	Group Number			
Premium amount \$ per	Date coverage began			
Name of policy holder		Services covered (check all that apply) <input type="checkbox"/> Doctors/Hospitals <input type="checkbox"/> Outpatient <input type="checkbox"/> Prescriptions <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Names of people covered	Name, address and phone number of insurance company
Policy Number	Group Number			
Premium amount \$ per	Date coverage began			

Health Insurance Information (continued)

LOSS

13. Has health insurance ended for anyone in the past 12 months or will health insurance end in the next 60 days? Do not include Green Mountain Care programs (Medicaid, Dr. Dynasaur, VHAP, Premium Assistance or Pharmacy Programs).

YES NO

First name	M.I.	Date ended or date will end	Reason

If you need to list more people, add an extra sheet of paper. Be sure to answer the above question for each individual person.

If you lost your health insurance due to domestic violence, check here. Yes

14. Does anyone have unpaid medical or dental bills? The bills may help you become eligible for Medicaid. If the services were received in the last 3 months, we may be able to help you pay them.

YES NO

Who has the unpaid medical bills?	Provide an estimate of charges incurred within the last 3 months	Provide an estimate of charges incurred more than 3 months ago
	\$	\$
	\$	\$

Income Information

JINC

15. Does anyone have income from a job, internship or training program?

YES NO

- List income from the past 30 days before any deductions such as taxes, insurance, child support, or union dues.
- Include income of children (under age 21 and living with you) from a job or training program.
- If income has ended or you expect it to change in the next 30 days, attach a note explaining the change.

Full Name	Date paid	Hours worked	Income before deductions	Tips and commissions
Paychecks are issued <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly Day of week _____			\$	\$
Employer's name and phone number				

Full Name	Date paid	Hours worked	Income before deductions	Tips and commissions
Paychecks are issued <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly Day of week _____			\$	\$
Employer's name and phone number				

Income Information (continued)

DCIN

16. Does anyone get paid for taking care of children?

YES NO

If you claim income for providing daycare on your taxes, answer question 18 below instead of this question.

List income from the past 30 days before deductions. List the number of meals you provide each month for which you are not paid/reimbursed.

First name	M.I.	Income before deductions	Breakfast	Lunch	Dinner	Snack
		\$ _____				
		per _____				

RBIN

17. Does anyone get paid for providing room or meals in your home? Include payments from children.

YES NO

First name	M.I.	Payment	Name of people paying	Check all that apply
		\$ _____		<input type="checkbox"/> Room <input type="checkbox"/> 1-2 meal/day <input type="checkbox"/> 3 meals/day
		\$ _____		<input type="checkbox"/> Room <input type="checkbox"/> 1-2 meal/day <input type="checkbox"/> 3 meals/day

BUSI

18. Does anyone have income from self-employment, such as farming, home party sales, logging or property rental?

YES NO

- Send a copy of your most recent federal tax return, including all forms and schedules.
- If you have not filed taxes and it is a new business, send income and expense records to date.
- If income has ended or you expect it to change in the next 30 days, attach a note explaining the change.

First name	M.I.	Type of business	Date business began

UNEA

19. Does anyone have unearned income? Some examples are:

YES NO

Social Security	Unemployment	Veteran's compensation	Insurance settlement
Dividends or interest	SSI/AABD	Worker's compensation	Veteran's pension
Trusts or annuities	Child support	Pensions or retirement	Money from others

List **gross** income (before any deductions such as Medicare premiums, taxes, insurance, child support, or union dues).

First name	M.I.	Income before deductions	Type of income	Due to disability?
		\$ _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$ _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$ _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$ _____		<input type="checkbox"/> Yes <input type="checkbox"/> No

20. If you have no income, tell us how your daily living expenses are paid. (If you don't, it may delay the processing of your application.)

Expense Information

DCEX

21. Does anyone pay court ordered child support or alimony?

YES NO

Name of person paying	Child support paid	Alimony paid	Names of children for whom support is paid
	\$ per	\$ per	
	\$ per	\$ per	

22. Does anyone pay for daycare?

YES NO

Name of person paying	Amount paid	Name of child or adult in daycare	Reason for daycare
	\$ per		<input type="checkbox"/> working <input type="checkbox"/> looking for work <input type="checkbox"/> going to school
	\$ per		<input type="checkbox"/> working <input type="checkbox"/> looking for work <input type="checkbox"/> going to school

Rights and Responsibilities

IMPORTANT: After reading the following Rights and Responsibilities and the Authorizations and Releases, be sure to sign and date the application. Unsigned applications cannot be processed and will be returned to you for your signature. You may lose some benefits.

True and Complete Information.

I understand information I provide to the Department for Children and Families (DCF) will be subject to verification by federal and state officials to determine if it is correct. This means that sources other than members of my household may be contacted to verify my eligibility. I understand that if any information is not true I may be denied assistance.

Reporting Changes.

I understand that I must report changes in information reported in this application within 10 days from when they happen by calling Member Services at 1-800-250-8427.

Confidentiality.

Information in this application is confidential. DCF will not share any information from this application except when needed for program administration. For more information see Release of Medical Records below.

If, in Question 2 on this application, I give permission to share information about me to assist me with program enrollment, that permission covers the following kinds of information:

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

This information will be used to help with my enrollment and continued eligibility in the programs I have applied for. I know that state federal privacy laws protect my records, I know:

- Why I am being asked to release this information.
- I do not have to give permission to release this information.
- Signing this permission is voluntary. If I choose not to sign, my enrollment in or eligibility for benefits will not be affected.
- If I do not give my permission, the information will not be released unless the law otherwise allows it.

Rights and Responsibilities (continued)

- I may stop this permission to share information at any time with a written notice to the Economic Services Division and the person or agency listed in Question 2 on the application. However, this written notice will not affect information the agencies have already released.
- The person or agency that gets my information might pass it on to others. If so, it may no longer be protected by this permission form.
- If I do not stop this permission, it will be in effect as long as I am receiving the benefits that I have applied for in this application.
- I will be provided with a copy of this form.
- All of my questions about this permission have been answered.

Social Security Number.

I understand that I must give the social security number of everyone in my household who is applying for assistance. Federal law requires this as a condition of eligibility. If I am a member of a religious organization that objects to furnishing a social security number, the Agency of Human Services may disregard this requirement (42 U.S.C. §1320b-7).

DCF uses social security numbers for computer processing, child support enforcement, fraud investigation, audits, and Lifeline identification; to verify social security and supplemental security income; to prevent individuals from receiving duplicate benefits; to exchange information with agencies such as the Social Security Administration, Department of Labor, Internal Revenue Service, or private agencies to verify income, determine eligibility and benefits amounts, and collect claims; to determine the accuracy and reliability of information given to DCF; and to make medical assistance payments.

Discrimination.

DCF does not discriminate based on race, color, national origin, sex, age, disability, marital status, sexual orientation or place of birth. To file a discrimination complaint, write Health and Human Services, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201; call (202) 619-0403 or (202) 619-3257 (TDD); or write to DCF, ESD Deputy Commissioner, 103 S. Main Street, Waterbury, VT 05671-1201.

Decision on Application.

DCF must make a decision on my application no later than 30 days after my application date (or 90 days if my Medicaid application is based on disability) unless delay is caused by physicians, an unexpected emergency or administrative problem beyond the Department's control, or me. If I do not get a decision within 30 days (or 90 days), I may call Member Services at 1-800-250-8427 for more information or to request a fair hearing.

Grievance Appeals & Complaints.

I may ask for a fair hearing if benefits or services are denied, or I am not responded to with reasonable promptness by calling the ESD Benefits Service Center at 1-800-479-6151, by calling Member Services at 1-800-250-8427 or by writing to the Human Services Board, 120 State Street, Montpelier, VT 05620-4301 (3 V.S.A. §3091).

For health care program actions that, for example, deny, limit, reduce, or end a service or deny a request to go outside the provider network, I may also request an appeal in addition to or in place of a fair hearing. If I have a complaint, for example, about the quality of the health care service or the behavior of staff for matters not related to health care program action, I may be able to file a grievance. For more information on any of these choices, call Member Services at 1-800-250-8427.

Quality Control Review.

DCF may select my application for a quality control review. I agree to cooperate and give proof of required information. If I am not able to give the proof needed, I authorize DCF to get it.

Rights and Responsibilities (continued)

Fleeing Prosecution.

I certify that neither I nor any member of my household is fleeing prosecution or confinement for a felony or an attempt to commit a felony, or is violating a condition of probation or parole under a federal or state law. I understand DCF must disclose information to law enforcement agencies to apprehend fleeing felons.

Benefits from Another State.

If any member of my household gets health care benefits from another state or has been convicted in the past ten years of fraudulently misrepresenting residence in order to get benefits from two or more states, I must notify DCF immediately by calling Member Services at 1-800-250-8427.

Fraud Penalties.

I or any member of my household will be subject to prosecution for fraud or some other criminal offense for knowingly giving false, incorrect, incomplete, or misleading information in order to get, try to get, or help someone else get health care benefits. If convicted, penalties may include up to three years of imprisonment and/or a fine of up to \$1000, or an amount equal to the benefit, wrongfully received. Other Federal or state penalties may also apply. (42 U.S.C. §1320a-7b; 33 V.S.A. §§141, 143)

Authorizations and Releases

Release of Medical Records.

I agree that my health care providers and the Department of Vermont Health Access and its contractors and grantees may access, use and disclose my medical records when necessary for the purpose of administering state health care programs or when a hospital, health care provider, mental health provider, or pharmacy needs my medical records, including provider and prescription medication information, for my treatment, for payment of my treatment, and for health care operations.

I agree that my consent includes the re-disclosure of prescription medication information received from a drug or alcohol treatment program when such information is needed for purposes of treatment. I understand that my consent to the use of my medical records remains in place until my eligibility is reviewed. I also understand that I can revoke my consent to the release of my medical records by putting my revocation in writing and mailing it to DCF, ESD Deputy Commissioner, 103 S. Main Street, Waterbury, VT 05671-1201.

Assignment of Medical Support and Third Party Payments.

As a condition of eligibility for health care assistance, I agree to assign to DCF all rights to medical support and to third party payments (such as insurance) for medical care. I agree to enroll in a group health plan if the state requires me to, and I understand the state may pay all or part of the premiums.

I also agree to cooperate in pursuing any actual or potential source of support or payments, including establishing paternity for my dependent children, if necessary. I understand that if I do not cooperate, my health care benefits will end although my children's health care will continue.

Consent to bill Medicaid if Child Receives Special Education Services.

I give permission to my child's school district to bill Medicaid for the specified services listed in his/her Individual Education Plan (IEP). I understand that if I refuse consent, my refusal only affects Medicaid billing of IEP services; my refusal does not relieve the school district of its responsibility to provide IEP services at no cost to me. I understand that I may revoke this consent to bill Medicaid for IEP services at any time. If I revoke this consent it will apply to billing for services from that date forward. I can revoke my consent by writing to the DCF-Economic Services Division address on the following page.

Signature

You must sign here. Unsigned applications will not be processed and will be returned for signature. You may lose some benefits.

I give my word, under penalty of perjury, that the information I give in this application is true and complete to the best of my knowledge and belief. I have read and I understand the Rights and Responsibilities and Authorizations and Releases included in this application and I agree to them.

Signature of applicant _____ Date _____

Signature of person helping
you fill out this form _____ Date _____

Return this application to: DCF – Economic Services Division
Application and Document Processing Center
103 South Main Street
Waterbury, VT 05671-1500

We will let you know if we need more information. You will hear from us within 30 days. For questions call 1-800-250-8427 or TDD 1-888-834-7898.

The applicant is responsible for the accuracy of all of the information given on this application including information about the applicant's husband, wife, or civil union partner.

Other Programs

Voter Registration: If you are not registered to vote where you live now, would you like a voter registration application? Yes No
If you do not check either box, you will be considered to have decided not to register at this time. Applying or declining to register will not affect your eligibility for benefits or the amount of benefits. If you believe that someone has interfered with your right to register or decline to register to vote, you may file a complaint with the Secretary of State's Office at Redstone Building, 26 Terrace Street, Drawer 09, Montpelier, VT 05609-1101 (telephone (802) 828-2363).

Lifeline may provide a discount on your phone bill. If you are not receiving a discount now, would you like to? Yes No
If yes, include a copy of your phone bill with this application. To learn more about this program, call toll free at 1-800-479-6151.

Link Up may pay for part of the installation cost of a new phone. You can get these benefits if you are 18 or older and on a Green Mountain Care program. The phone must be listed in your name or you must pay part of the bill. *Call your telephone company to learn more.*

Weatherization: This program helps with insulation, caulking, or weather-stripping your home or apartment to lower your heating costs. Would you like us to refer you to this program? Yes No
To learn more about this program, call toll free 1-877-919-2299.

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 five. Would you like someone from the WIC program to contact you? Yes No
To learn more about this program, call toll free 1-800-464-4343.

Fuel Assistance: This program helps to pay heating bills. *To learn more about this program or to request an application, call toll free 1-800-479-6151.*

3SquaresVT: This program helps to pay for food. If you have little or no money for food, you may be able to get emergency help. *For information or an application, call 1-800-479-6151.*