SEALED BID
REQUEST FOR PROPOSAL
FOR
Health Care Paper Application Usability Consolidation/Enhancement

ISSUE DATE: May 2, 2018
BIDDERS’ CONFERENCE CALL: Thursday, May 10, 2018 2:00pm EDT (Skype Call In below)
NOTICE OF INTENT TO RESPOND: Monday, May 14, 2018 4:00pm EDT
RFP RESPONSES DUE BY: Thursday, May 24, 2018 1:30pm EDT
BID OPENING: Thursday, May 24, 2018 1:30pm EDT
280 State Drive – NOB 1 South
Waterbury, VT 05671-1010

PLEASE BE ADVISED THAT ALL NOTIFICATIONS, RELEASES, AND AMENDMENTS ASSOCIATED WITH THIS RFP WILL BE POSTED AT:

http://vermontbusinessregistry.com/

THE STATE WILL MAKE NO ATTEMPT TO CONTACT INTERESTED PARTIES WITH UPDATED INFORMATION. IT IS THE RESPONSIBILITY OF EACH BIDDER TO PERIODICALLY CHECK THE ABOVE WEBPAGE FOR ANY AND ALL NOTIFICATIONS, RELEASES AND AMENDMENTS ASSOCIATED WITH THIS RFP.

STATE CONTACT: John Kohlmeyer, Manager, Vendor Management
TELEPHONE: (802) 557-5549
E-MAIL: John.Kohlmeyer@Vermont.gov
Skype Call in: Join Skype Meeting - (802) 552-8456 Conference ID 30409960#
BID OPENING LOCATION: 280 State Drive, Waterbury, VT
1. OVERVIEW:

1.1. SCOPE AND BACKGROUND: Through this Request for Proposal (RFP) the Agency of Human Services/Department of Vermont Health Access (hereinafter the “State”) is seeking to establish contracts with one or more companies that can provide Health Care Paper Application Usability Consolidation/Enhancement.

1.2. CONTRACT PERIOD: Contracts arising from this RFP will be for a period of nine (9) months with an option to renew for one (1) additional six-month period. The State anticipates the start date will be July 1, 2018.

1.3. SINGLE POINT OF CONTACT: All communications concerning this RFP are to be addressed in writing to the State Contact listed on the front page of this RFP. Actual or attempted contact with any other individual from the State concerning this RFP is strictly prohibited and may result in disqualification.

1.4. BIDDERS’ CONFERENCE: A non-mandatory bidders’ conference will be held through a Skype meeting (see bottom of cover page for Skype link/call in information) to be held on the date and time indicated on the front page of this RFP. Vendors will be provided an opportunity to submit additional questions after the bidder’s conference.

2. DETAILED ESSENTIAL BID REQUIREMENTS/DESIRABLE OUTCOMES:

This section 2 provides essential bid requirements and details on the State’s desired outcomes. Additional information and requirements are provided in sections below.

The objective for this effort is a newly designed paper application for health care eligibility and enrollment, that will consolidate five (5) paper applications within a 2 to 3-month timeframe. The consolidated single application will result in:

- a single, streamlined, paper application
- branded with Vermont logo and colors
- that uses plain language, usability and readability techniques to make it easy for applicants to understand and complete
- allows option for applicants to self-select health benefits program(s) or request a full health care screening for both Modified Adjusted Gross Income (MAGI) and non-MAGI based eligibility determinations
- collects information needed for efficient and accurate eligibility decisions
- reduces data entry and processing time for staff

3. PURPOSE

This Health Care Paper Application Usability (HCAU) initiative is one of the initial projects of the IE&E Program that will result ultimately in the implementation of a modern IE&E system. Utilizing modular procurements, agile principles, and user-centered design, AHS will migrate current eligibility and enrollment functionality for all in-scope health care and financial benefit programs from current eligibility and enrollment systems, including the State’s legacy ACCESS system and its Health Insurance Exchange, Vermont Health Connect (VHC) to the new IE&E system. Each project should implement a component of IE&E functionality that ensures the State moves closer to meeting its business goals.

Through this Request for Proposal (RFP) the Vermont Agency of Human Services (AHS) (hereinafter the “State”) is seeking to establish contracts with one or more companies that can provide its Health Care Paper Application Usability initiative (the Work) from qualified offerors.
4. BACKGROUND

The Agency of Human Services (AHS) is responsible for health care and human services support across the State of Vermont. AHS is currently engaged in a multi-year, multimillion-dollar modernization effort, known as the Integrated Eligibility & Enrollment (IE&E) Program, to enhance business processes and leverage technology to achieve its goal of serving Vermonters efficiently and effectively, with lower administrative costs, streamlined processes, and ensuring that the cost of system maintenance is sustainable over time.

4.1. EXISTING ENVIRONMENT

The State currently uses and seeks to consolidate the following five separate paper healthcare applications to obtain essential information needed for State staff to process health care benefit eligibility decisions:

- a) 201P Pharmacy Programs Application
- b) 202MED Health Care Programs Application (Under Revision)
- c) 202LTC CFC Long-Term Care Application (Under Revision)
- d) 205IFA Application for Health Coverage and Help Paying Costs (Under Revision)
- e) 205INFA Application for Health Coverage

Information from the paper applications is currently entered into two computer systems that can't share information leading to labor intensive manual processes:

- Vermont Health Connect (VHC) for MAGI-based benefits from forms 205IFA and 205INFA; and
- ACCESS for non-MAGI based benefits from forms 201P, 202MED and 202LTC

Each paper application master is maintained utilizing Adobe InDesign.

4.2. PROJECT MANAGEMENT APPROACH

Describe your internal project management approach for this effort (ex. Scrum, Kanban, or other Agile approaches). The State is not seeking the contractor to provide it with project management services for this work.

**Proposed Services – Work Plan**

- a) Proposed Services: A description of the Contractor’s proposed services to accomplish the specified work requirements, including start date and dates of completion for each phase.
- b) Risk Assessment: An assessment of any risks inherent in the work requirements and actions to mitigate these risks.
- c) Proposed Tools: A description of proposed tools that may be used to facilitate the work, including tools for readability and measurements.
- d) Samples of Similar Work: A sample that is indicative of the work you have done in previous engagements demonstrating your ability to design applications that incorporate Plain Language, Usability and Readability standards in a paper format.
- e) Acceptance: A description of proposed means to verify work meets:
• Centers for Medicare & Medicaid Services (CMS) Alternative Health Care Applications requirements
• Plain Language, Usability and Readability requirements

5. SCOPE OF WORK

This HCAU effort is a newly designed paper application for health care eligibility and enrollment, consolidating the five currently used paper health benefits applications into one single, streamlined paper application, that allows an applicant to apply for specific health benefits program(s) or a “full health benefits screening, branded with Vermont logo and colors that is easy for applicants to complete, allows the option for applicants to self-select health benefits program(s) or request a full health care screening for both MAGI and non-MAGI based eligibility determinations, collects information needed for efficient and accurate eligibility decisions and reduces data entry and processing time for staff.

The successful design of a new, single streamlined paper application will eliminate the need for some applicants to file multiple paper applications and answer similar questions multiple times to ensure full screening for all health benefit programs.

5.1. REQUIREMENTS:

For this request, knowledge requirements include:

• Ability to consolidate and design a single, streamlined paper application from the 5 existing paper applications that enables applicants to self-select health benefits program(s) or request a full health benefits screening
• Plain language practices
• Content and form design
• Centers for Medicare & Medicaid Services (CMS) Alternative Health Care Applications requirements
• Readability consistent with federal requirements and industry best practices
• Ability to design and conduct readability and usability tests
• Ability to design and conduct consumer user focus group

Other requirements include:

Design of a single, streamlined paper application for health care eligibility and enrollment that consolidates all the information currently contained in the following 5 separate paper, applications (Appendices 1 through 5):

1. 201P Pharmacy Programs Application (Appendix 1)
2. 202MED Health Care Programs Application (Under Revision) (Appendix 2)
3. 202LTC CFC Long-Term Care Application (Under Revision) (Appendix 3)
4. 205IFA Application for Health Coverage and Help Paying Costs (Under Revision) (Appendix 4)
5. 205INFA Application for Health Coverage (Appendix 5)

This re-designed single, streamlined paper application form must also meet each of the following requirements:

a) Have a 1st page that clearly indicates:
   • Program(s) the applicant is applying for
   • Space for Bar Codes
   • Applicant information (Name, SSN, DOB, address)
b) Adheres to CMS’s Guidance on State Alternative Applications for Health (see attached letter dated June 18, 2013). (Appendix 6)

c) Consolidates the above listed five (5) health care paper applications into a single, streamlined paper application, including removing duplicate and/or similar questions; and creating common sense groupings of information to minimize the burden for applicants and the State staff in a way that is easy for applicants to understand which questions they have to answer based on the health benefit(s) program they are apply for.

d) Uses visual, content, and intuitive design techniques that allow applicants to choose the health benefit program(s) they want to apply for or request full screening for all health benefit programs.

e) Meets the plain language and readability requirements: Language that the intended audience (Medicaid, Qualified Health Plan/subsidy applicants/enrollees), including persons with limited English proficiency and persons with disabilities, can easily understand and use because the language is concise and well-organized. See the Plain Language - A Handbook for Writers In the U.S. Federal Government found at http://www.lauclhmangroup.com/PDFfiles/PLHandbook.PDF

f) Includes a placeholder for rights and responsibilities language to be provided by State policy/legal.

g) Includes customer service, inclusion and accessibility best practices and information.

h) Uses State approved colors, style and logos. Final style and required State approved logos and colors to be determined in design sessions.

i) Contractor will be expected at a minimum to work onsite at State offices for design sessions, user research and usability and readability testing as requested by the State and should include in its proposal any offsite work schedule.

j) Contractors proposal should include a timetable and phase milestones for completion of this scope of work.

k) Final product will be delivered in electronic format that is maintainable by the State and is printer ready.
6. GENERAL REQUIREMENTS:

6.1. PRICING: Bidders must price the terms of this solicitation at their best pricing. Any and all costs that Bidder wishes the State to consider must be submitted for consideration.

SAMPLE PRICE PROPOSAL FORM

<table>
<thead>
<tr>
<th>Phase</th>
<th>Expected Completion Date:</th>
<th>Hourly Rate (Time and Materials)</th>
<th>Price (aggregate per Phase if deliverable based bid)</th>
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<tr>
<td>Combined Bid</td>
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</tbody>
</table>

Travel and Expenses: Bidder’s hourly rates should be inclusive of all travel costs and expenses.

The Price Proposal form must use the same deliverables as outlined in the Request from the State.

6.1.1. Rates shall remain firm for the initial term of the contract. The pricing policy submitted by Bidder must (i) be clearly structured, accountable, and auditable and (ii) cover the full spectrum of materials and/or services required.

6.1.2. Cooperative Agreements. Bidders that have been awarded similar contracts through a competitive bidding process with another state and/or cooperative are welcome to submit the pricing in response to this solicitation.

6.2. BEST AND FINAL OFFER:

6.2.1. Best and Final Offer (BAFO). At any time after submission of Responses and prior to the final selection of Bidder(s) for Contract negotiation or execution, the State may invite Bidder(s) to provide a BAFO. The state reserves the right to request BAFOs from only those Bidders that meet the minimum qualification requirements and/or have not been eliminated from consideration during the evaluation process.

6.3. WORKER CLASSIFICATION COMPLIANCE REQUIREMENTS: In accordance with Section 32 of The Vermont Recovery and Reinvestment Act of 2009 (Act No. 54), Bidders must comply with the following provisions and requirements.

6.3.1. Self Reporting: For bid amounts exceeding $250,000.00, Bidder shall complete the appropriate section in the attached Certificate of Compliance for purposes of self-reporting information relating to past violations, convictions, suspensions, and any other information related to past performance relative to coding and classification of workers. The State is requiring information on any violations that occurred in the previous 12 months.

6.3.2. Subcontractor Reporting: For bid amounts exceeding $250,000.00, Bidders are hereby notified that upon award of contract, and prior to contract execution, the State shall be provided with a list of all proposed subcontractors and subcontractors’ subcontractors, together with the identity of those subcontractors’ workers compensation insurance providers, and additional required or requested information, as applicable, in accordance with Section 32 of The Vermont Recovery and Reinvestment Act of 2009 (Act No. 54). This requirement does not apply to subcontractors providing supplies only and no labor to the overall contract or project. This list MUST be updated and provided to the State as
additional subcontractors are hired. A sample form is available online at http://bgs.vermont.gov/purchasing-contracting/forms. **The subcontractor reporting form is not required to be submitted with the bid response.**

6.4. **EXECUTIVE ORDER 05-16: CLIMATE CHANGE CONSIDERATIONS IN STATE PROCUREMENTS:**

For bid amounts exceeding $25,000.00 Bidders are requested to complete the Climate Change Considerations in State Procurements Certification, which is included in the Certificate of Compliance for this RFP.

After consideration of all relevant factors, a bidder that demonstrates business practices that promote clean energy and address climate change as identified in the Certification, shall be given favorable consideration in the competitive bidding process. Such favorable consideration shall be consistent with and not supersede any preference given to resident bidders of the State and/or products raised or manufactured in the State, as explained in the Method of Award section. But, such favorable consideration shall not be employed if prohibited by law or other relevant authority or agreement.

6.5. **METHOD OF AWARD:** Awards will be made in the best interest of the State. The State may award one or more contracts and reserves the right to make additional awards to other compliant bidders at any time if such award is deemed to be in the best interest of the State. All other considerations being equal, preference will be given first to resident bidders of the state and/or products raised or manufactured in the state, and then to bidders who have practices that promote clean energy and address climate change, as identified in the applicable Certificate of Compliance.

6.6. **Evaluation Criteria:** Consideration shall be given to the Bidder’s project approach and methodology, qualifications and experience, ability to provide the services within the defined timeline, cost, and/or success in completing similar projects, as applicable, and to the extent specified below. The responses will be evaluated based on the following:

- Quality of proposal content
- Prior Experience with this type of work
- Timeline for completion of work to be performed
- How the design team will approach the project
- What difficulties are expected and how they will be handled
- Proposed Staffing and Resumés
- Examples/Portfolios/Samples of Plain Language and Readability Paper Applications
- Cost

<table>
<thead>
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<th>Scoring Criteria</th>
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<tr>
<td><strong>Project Approach &amp; Methodology</strong></td>
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<tr>
<td>• Timeline for completion of work</td>
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<tr>
<td>to be performed</td>
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<td>• How the design team will</td>
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<td>approach the project</td>
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<td>and how they will be handled</td>
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<td><strong>Qualifications and Experience</strong></td>
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<tr>
<td>• Quality of proposal content</td>
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<td>Prior Experience with this type</td>
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<td>of work</td>
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<td>Plain Language and Readability</td>
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<td>of Paper Applications</td>
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</table>
6.7. **STATEMENT OF RIGHTS:** The State of Vermont reserves the right to obtain clarification or additional information necessary to properly evaluate a proposal. Vendors may be asked to give a verbal presentation of their proposal after submission. Failure of vendor to respond to a request for additional information or clarification could result in rejection of that vendor's proposal. To secure a project that is deemed to be in the best interest of the State, the State reserves the right to accept or reject any and all bids, in whole or in part, with or without cause, and to waive technicalities in submissions. The State also reserves the right to make purchases outside of the awarded contracts where it is deemed in the best interest of the State.

6.8. **CONTRACT TERMS:** The selected bidder(s) will be expected to sign a contract with the State, including the Standard Contract Form and Attachment C as attached to this RFP for reference. The contract will obligate the bidder to provide the services and/or products identified in its bid, at the prices listed.

6.9. **PAYMENT TERMS:** All invoices are to be rendered by the Contractor on the vendor's standard billhead and forwarded directly to the institution or agency ordering materials or services and shall specify the address to which payments will be sent. Payment terms are Net 30 days from receipt of an error-free invoice with all applicable supporting documentation. Percentage discounts may be offered for prompt payments of invoices; however, such discounts must be in effect for a period of 30 days or more in order to be considered in making awards.

7. **CONTENT AND FORMAT OF RESPONSES:** The content and format requirements listed below are the minimum requirements for State evaluation. These requirements are not intended to limit the content of a Bidder’s proposal. Bidders may include additional information or offer alternative solutions for the State’s consideration. However, the State discourages overly lengthy and costly proposals, and Bidders are advised to include only such information in their response as may be relevant to the requirements of this RFP.

7.1. **NUMBER OF COPIES:**

The RFP Responses are to be submitted to the State Contact set forth above via e-mail. The "subject" line in the e-mail submission shall state the "RFP HCAU [vendor name]". The e-mail must have five attachments:

7.1.1. Cover Letter – [vendor name]-RFP HCAU Cover Letter
7.1.2. Technical Response MS Word format – [vendor name]-RFP HCAU Technical
7.1.3. Technical Response pdf format– [vendor name]-RFP HCAU Technical
7.1.4. Financial Response MS Word format – [vendor name]-RFP HCAU Financial
7.1.5. Financial Response pdf format – [vendor name]-RFP HCAU Financial

7.2. **COVER LETTER:**

7.2.1. **Confidentiality.** To the extent your bid contains information you consider to be proprietary and confidential, you must comply with the following requirements concerning the contents of your cover letter and the submission of a redacted copy of your bid (or affected portions thereof).

7.2.2. The successful response will become part of the contract file and will become a matter of public record, as will all other responses received. If the response includes material that is considered by the bidder to be proprietary and confidential under the State’s Public Records Act, 1 V.S.A. § 315 et seq., the bidder shall submit a cover letter that clearly identifies each page or section of the response that it believes is proprietary and confidential. The bidder shall also provide in their cover letter a written explanation for each marked section explaining why such material should be considered exempt from public disclosure in the event of a public records request, pursuant to 1 V.S.A. § 317(c), including the prospective harm to the competitive position of the bidder if the identified material were to be released. Additionally, the bidder must include a redacted copy of its response for portions that are considered proprietary and confidential. Redactions must be limited so that the reviewer may understand the nature of the information being withheld. It is typically inappropriate to redact entire pages, or to redact the titles/captions of tables and figures. Under no circumstances can the entire response be marked confidential, and the State reserves the right to disqualify responses so marked.
7.2.3. Exceptions to Terms and Conditions. If the bidder wishes to propose an exception to any terms and conditions set forth in the Standard Contract Form and its attachments, such exceptions must be included in the cover letter to the RFP response. Failure to note exceptions when responding to the RFP will be deemed to be acceptance of the State contract terms and conditions. If exceptions are not noted in the response to this RFP but raised during contract negotiations, the State reserves the right to cancel the negotiation if deemed to be in the best interests of the State. Note that exceptions to contract terms may cause rejection of the proposal.

7.3. BACKGROUND AND EXPERIENCE. Provide details concerning the form of business organization, company size and resources; describe particular experience relevant to the proposed project and list all current or past State projects.

If a Bidder intends to use subcontractors, the Bidder must identify in the proposal the names of the subcontractors, the portions of the work the subcontractors will perform, and address the background and experience of the subcontractor(s), as above.

7.4. REFERENCES. Provide the names, addresses, and phone numbers of at least three companies with whom you have transacted similar business in the last 12 months. You must include contact names who can talk knowledgeably about performance.

7.5. REPORTING REQUIREMENTS: Provide a sample of any reporting documentation that may be applicable to the Detailed Requirements of this RFP.

7.6. PRICING: Bidders shall submit their pricing information in the Price Schedule attached to the RFP. Bidders are required to submit the pricing information in separately files as defined above. CERTIFICATE OF COMPLIANCE: This form must be completed and submitted as part of the response for the proposal to be considered valid.

8. SUBMISSION INSTRUCTIONS:

8.1. CLOSING DATE: Bids must be received electronically by the due date and time at the email address identified above.

8.2. The bid opening will be held at the address identified above and is open to the public.

8.3. SECURITY PROCEDURES: Please be advised extra time will be needed when visiting State Office identified above. All individuals visiting must present a valid government issued photo ID when entering the facility.

8.4. BID INSTRUCTIONS:

8.4.1. All bidders are hereby notified that electronic bids must be received and time stamped by the Vermont Agency of Human Services by the time of the bid opening. Bids not in possession of the at the time of the bid opening will be returned to the vendor and will not be considered. Any delay deemed caused by Security Procedures will be at the bidder’s own risk.

8.4.2. Vermont Agency of Human Services may, for cause, change the date and/or time of bid openings or issue an addendum. If a change is made, the State will make a reasonable effort to inform all bidders by posting at: http://vermontbusinessregistry.com/.

8.4.3. All bids will be publicly opened. Typically, the Vermont Agency of Human Services will open the bid, read the name and address of the bidder, and read the bid amount. However, the State reserves the right to limit the information disclosed at the bid opening to the name and address of the bidder when, in its sole discretion, the State determines that the nature, type, or size of the bid is such that the State cannot immediately (at the opening) determine that the bids are in compliance with the RFP. As such, there will be cases in which the bid amount will not be read at the bid opening. Bid openings are open to members of the public. Bid results are a public record however, the bid results are exempt from disclosure to the public until the award has been made and the contract is executed.

9. ATTACHMENTS:

9.1. Standard State Contract Form


9.3. Attachment D: Modification of Customary Provisions or Attachment C
9.4. Attachment E: Business Associate Agreement (BAA)
9.6. Certificate of Compliance
9.7. Price Schedule
9.8. Appendixes
   a) Appendix 1: Health Care Application forms (five total):
      • 205IFA - Application for Health Coverage and Help Paying Costs (Under Revision)
      • 202MED - Health Care Programs Application (Under Revision)
      • 202LTC - Choices for Care Long-Term Care Application (Under Revision)
      • 201P - Pharmacy Programs Application
      • 205INFA - Application for Health Coverage
   b) Appendix 2: CMS Alternative Application Guidance dated June 18, 2013
1. **Parties.** This is a contract for services between the State of Vermont, _____________ (hereinafter called “State”), and _____________, with a principal place of business in _____________, (hereinafter called “Contractor”). Contractor’s form of business organization is _____________. It is Contractor’s responsibility to contact the Vermont Department of Taxes to determine if, by law, Contractor is required to have a Vermont Department of Taxes Business Account Number.

2. **Subject Matter.** The subject matter of this contract is services generally on the subject of _____________. Detailed services to be provided by Contractor are described in Attachment A.

3. **Maximum Amount.** In consideration of the services to be performed by Contractor, the State agrees to pay Contractor, in accordance with the payment provisions specified in Attachment B, a sum not to exceed $________.00.

4. **Contract Term.** The period of contractor’s performance shall begin on _____________, 20__ and end on _____________, 20__.

5. **Prior Approvals.** This Contract shall not be binding unless and until all requisite prior approvals have been obtained in accordance with current State law, bulletins, and interpretations.

6. **Amendment.** No changes, modifications, or amendments in the terms and conditions of this contract shall be effective unless reduced to writing, numbered and signed by the duly authorized representative of the State and Contractor.

7. **Cancellation.** This contract may be canceled by either party by giving written notice at least thirty (30) days in advance.

8. **Attachments.** This contract consists of ___ pages including the following attachments which are incorporated herein:

   - Attachment A - Statement of Work
   - Attachment B - Payment Provisions
   - Attachment D - Other Provisions (if any)

   Additional attachments may be lettered as necessary

9. **Order of Precedence.** Any ambiguity, conflict or inconsistency between the documents comprising this contract shall be resolved according to the following order of precedence:

   (1) Standard Contract  
   (2) Attachment D (if applicable)  
   (3) Attachment C (Standard Contract Provisions for Contracts and Grants)  
   (4) Attachment A  
   (5) Attachment B

   List other attachments, if any, in order of precedence
WE THE UNDERSIGNED PARTIES AGREE TO BE BOUND BY THIS CONTRACT

By the State of Vermont:  
Date: ______________________
Signature: ____________________
Name: ________________________
Title: ________________________

By the Contractor:  
Date: ______________________
Signature: ____________________
Name: ________________________
Title: ________________________
ATTACHMENT A – STATEMENT OF WORK

The Contractor shall: ________

DELETE THESE INSTRUCTIONS All State contracts must describe the work to be performed in clear, concise and complete statements. Attachment A of the Standard State Contract should be used to detail the work to be performed or products to be delivered by the contractor. A well written description will include the schedule for performance, identification of project deliverables, deliverable milestones, and standards by which the contractor’s performance will be measured. This description of the work may also be referred to as the Statement of Work, Specifications of Work, or Subject Matter. Please refer to Appendix II for further guidance. The deliverables and milestones should be used to inform the payment terms in Attachment B. Attaching RFPs and RFP responses to contracts is not permitted. RFP responses can be long and complicated and may include both unnecessary information and introduce internally inconsistent terms within the contract.

The level of required contract compliance monitoring, if applicable, should be based on the assessment of the risk for delay or failure to deliver the services. In assessing the risk, agencies should consider factors such as: amount of funds involved; contract duration; contract complexity; history of the Contractor with State government; amount of subcontracting involved; and other relevant issues. Whether or not liquidated damages, service credits and/or retainage are part of the contract, the document should include a section that describes specifically how the Agency will monitor the contract for compliance.

Types of compliance monitoring processes and steps may include: (i) periodic contractor reports; (ii) invoice reviews; (iii) on-site visits; (iv) scheduled meetings; (v) audits; (vi) independent performance reviews; (vii) surveys of users/clients; and (viii) post-contract audit or review. This section may also describe a process for identification, discussion, and resolution of disputes between the Contractor and the State, both during the contract duration and after expiration.

NOTE: Additional guidance for drafting Attachment A is provided in Bulletin 3.5, Appendix II
ATTACHMENT B – PAYMENT PROVISIONS

The maximum dollar amount payable under this contract is not intended as any form of a guaranteed amount. The Contractor will be paid for products or services actually delivered or performed, as specified in Attachment A, up to the maximum allowable amount specified on page 1 of this contract.

1. Prior to commencement of work and release of any payments, Contractor shall submit to the State:
   a. a certificate of insurance consistent with the requirements set forth in Attachment C, Section 8 (Insurance), and with any additional requirements for insurance as may be set forth elsewhere in this contract; and
   b. a current IRS Form W-9 (signed within the last six months).

2. Payment terms are Net 30 days from the date the State receives an error-free invoice with all necessary and complete supporting documentation.

3. Contractor shall submit detailed invoices itemizing all work performed during the invoice period, including the dates of service, rates of pay, hours of work performed, and any other information and/or documentation appropriate and sufficient to substantiate the amount invoiced for payment by the State. All invoices must include the Contract # for this contract.

4. Contractor shall submit invoices to the State in accordance with the schedule set forth in this Attachment B. Unless a more particular schedule is provided herein, invoices shall be submitted not more frequently than monthly.

5. Invoices shall be submitted to the State at the following address: ______________________

6. The payment schedule for delivered products, or rates for services performed, and any additional reimbursements, are as follows: _____________

DELETE THESE INSTRUCTIONS The above language up through section 5 is standard and should be included in all services contracts. Section 6 is merely a prompt for completion of the particular payment terms necessary to the contract, such as the schedule and/or rates of pay. Sample language is provided below, if helpful, but there is no required format.
1. **Definitions:** For purposes of this Attachment, “Party” shall mean the Contractor, Grantee or Subrecipient, with whom the State of Vermont is executing this Agreement and consistent with the form of the Agreement. “Agreement” shall mean the specific contract or grant to which this form is attached.

2. **Entire Agreement:** This Agreement, whether in the form of a contract, State-funded grant, or Federally-funded grant, represents the entire agreement between the parties on the subject matter. All prior agreements, representations, statements, negotiations, and understandings shall have no effect.

3. **Governing Law, Jurisdiction and Venue; No Waiver of Jury Trial:** This Agreement will be governed by the laws of the State of Vermont. Any action or proceeding brought by either the State or the Party in connection with this Agreement shall be brought and enforced in the Superior Court of the State of Vermont, Civil Division, Washington Unit. The Party irrevocably submits to the jurisdiction of this court for any action or proceeding regarding this Agreement. The Party agrees that it must first exhaust any applicable administrative remedies with respect to any cause of action that it may have against the State with regard to its performance under this Agreement. Party agrees that the State shall not be required to submit to binding arbitration or waive its right to a jury trial.

4. **Sovereign Immunity:** The State reserves all immunities, defenses, rights or actions arising out of the State’s sovereign status or under the Eleventh Amendment to the United States Constitution. No waiver of the State’s immunities, defenses, rights or actions shall be implied or otherwise deemed to exist by reason of the State’s entry into this Agreement.

5. **No Employee Benefits For Party:** The Party understands that the State will not provide any individual retirement benefits, group life insurance, group health and dental insurance, vacation or sick leave, workers compensation or other benefits or services available to State employees, nor will the State withhold any state or Federal taxes except as required under applicable tax laws, which shall be determined in advance of execution of the Agreement. The Party understands that all tax returns required by the Internal Revenue Code and the State of Vermont, including but not limited to income, withholding, sales and use, and rooms and meals, must be filed by the Party, and information as to Agreement income will be provided by the State of Vermont to the Internal Revenue Service and the Vermont Department of Taxes.

6. **Independence:** The Party will act in an independent capacity and not as officers or employees of the State.

7. **Defense and Indemnity:** The Party shall defend the State and its officers and employees against all third party claims or suits arising in whole or in part from any act or omission of the Party or of any agent of the Party in connection with the performance of this Agreement. The State shall notify the Party in the event of any such claim or suit, and the Party shall immediately retain counsel and otherwise provide a complete defense against the entire claim or suit. The State retains the right to participate at its own expense in the defense of any claim. The State shall have the right to approve all proposed settlements of such claims or suits.

After a final judgment or settlement, the Party may request recoupment of specific defense costs and may file suit in Washington Superior Court requesting recoupment. The Party shall be entitled to recoup costs only upon a showing that such costs were entirely unrelated to the defense of any claim arising from an act or omission of the Party in connection with the performance of this Agreement.

The Party shall indemnify the State and its officers and employees if the State, its officers or employees become legally obligated to pay any damages or losses arising from any act or omission of the Party or an agent of the Party in connection with the performance of this Agreement.

Notwithstanding any contrary language anywhere, in no event shall the terms of this Agreement or any document furnished by the Party in connection with its performance under this Agreement obligate the State to (1) defend or indemnify the Party or any third party, or (2) otherwise be liable for the expenses or reimbursement, including attorneys’ fees, collection costs or other costs of the Party or any third party.
8. Insurance: Before commencing work on this Agreement the Party must provide certificates of insurance to show that the following minimum coverages are in effect. It is the responsibility of the Party to maintain current certificates of insurance on file with the State through the term of this Agreement. No warranty is made that the coverages and limits listed herein are adequate to cover and protect the interests of the Party for the Party’s operations. These are solely minimums that have been established to protect the interests of the State.

Workers Compensation: With respect to all operations performed, the Party shall carry workers’ compensation insurance in accordance with the laws of the State of Vermont. Vermont will accept an out-of-state employer's workers’ compensation coverage while operating in Vermont provided that the insurance carrier is licensed to write insurance in Vermont and an amendatory endorsement is added to the policy adding Vermont for coverage purposes. Otherwise, the party shall secure a Vermont workers’ compensation policy, if necessary to comply with Vermont law.

General Liability and Property Damage: With respect to all operations performed under this Agreement, the Party shall carry general liability insurance having all major divisions of coverage including, but not limited to:

- Premises - Operations
- Products and Completed Operations
- Personal Injury Liability
- Contractual Liability

The policy shall be on an occurrence form and limits shall not be less than:

- $1,000,000 Each Occurrence
- $2,000,000 General Aggregate
- $1,000,000 Products/Completed Operations Aggregate
- $1,000,000 Personal & Advertising Injury

Automotive Liability: The Party shall carry automotive liability insurance covering all motor vehicles, including hired and non-owned coverage, used in connection with the Agreement. Limits of coverage shall not be less than $500,000 combined single limit. If performance of this Agreement involves construction, or the transport of persons or hazardous materials, limits of coverage shall not be less than $1,000,000 combined single limit.

Additional Insured. The General Liability and Property Damage coverages required for performance of this Agreement shall include the State of Vermont and its agencies, departments, officers and employees as Additional Insureds. If performance of this Agreement involves construction, or the transport of persons or hazardous materials, then the required Automotive Liability coverage shall include the State of Vermont and its agencies, departments, officers and employees as Additional Insureds. Coverage shall be primary and non-contributory with any other insurance and self-insurance.

Notice of Cancellation or Change. There shall be no cancellation, change, potential exhaustion of aggregate limits or non-renewal of insurance coverage(s) without thirty (30) days written prior written notice to the State.

9. Reliance by the State on Representations: All payments by the State under this Agreement will be made in reliance upon the accuracy of all representations made by the Party in accordance with this Agreement, including but not limited to bills, invoices, progress reports and other proofs of work.

10. False Claims Act: The Party acknowledges that it is subject to the Vermont False Claims Act as set forth in 32 V.S.A. § 630 et seq. If the Party violates the Vermont False Claims Act it shall be liable to the State for civil penalties, treble damages and the costs of the investigation and prosecution of such violation, including attorney’s fees, except as the same may be reduced by a court of competent jurisdiction. The Party’s liability to the State under the False Claims Act shall not be limited notwithstanding any agreement of the State to otherwise limit Party’s liability.

11. Whistleblower Protections: The Party shall not discriminate or retaliate against one of its employees or agents for disclosing information concerning a violation of law, fraud, waste, abuse of authority or acts threatening health or safety, including but not limited to allegations concerning the False Claims Act. Further, the Party shall not require such employees or agents to forego monetary awards as a result of such
disclosures, nor should they be required to report misconduct to the Party or its agents prior to reporting to any governmental entity and/or the public.

12. Location of State Data: No State data received, obtained, or generated by the Party in connection with performance under this Agreement shall be processed, transmitted, stored, or transferred by any means outside the continental United States, except with the express written permission of the State.

13. Records Available for Audit: The Party shall maintain all records pertaining to performance under this agreement. “Records” means any written or recorded information, regardless of physical form or characteristics, which is produced or acquired by the Party in the performance of this agreement. Records produced or acquired in a machine readable electronic format shall be maintained in that format. The records described shall be made available at reasonable times during the period of the Agreement and for three years thereafter or for any period required by law for inspection by any authorized representatives of the State or Federal Government. If any litigation, claim, or audit is started before the expiration of the three-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved.

14. Fair Employment Practices and Americans with Disabilities Act: Party agrees to comply with the requirement of 21 V.S.A. Chapter 5, Subchapter 6, relating to fair employment practices, to the full extent applicable. Party shall also ensure, to the full extent required by the Americans with Disabilities Act of 1990, as amended, that qualified individuals with disabilities receive equitable access to the services, programs, and activities provided by the Party under this Agreement.

15. Set Off: The State may set off any sums which the Party owes the State against any sums due the Party under this Agreement; provided, however, that any set off of amounts due the State of Vermont as taxes shall be in accordance with the procedures more specifically provided hereinafter.

16. Taxes Due to the State:
   A. Party understands and acknowledges responsibility, if applicable, for compliance with State tax laws, including income tax withholding for employees performing services within the State, payment of use tax on property used within the State, corporate and/or personal income tax on income earned within the State.
   B. Party certifies under the pains and penalties of perjury that, as of the date this Agreement is signed, the Party is in good standing with respect to, or in full compliance with, a plan to pay any and all taxes due the State of Vermont.
   C. Party understands that final payment under this Agreement may be withheld if the Commissioner of Taxes determines that the Party is not in good standing with respect to or in full compliance with a plan to pay any and all taxes due the State of Vermont.
   D. Party also understands the State may set off taxes (and related penalties, interest and fees) due to the State of Vermont, but only if the Party has failed to make an appeal within the time allowed by law, or an appeal has been taken and finally determined and the Party has no further legal recourse to contest the amounts due.

17. Taxation of Purchases: All State purchases must be invoiced tax free. An exemption certificate will be furnished upon request with respect to otherwise taxable items.

18. Child Support: (Only applicable if the Party is a natural person, not a corporation or partnership.) Party states that, as of the date this Agreement is signed, he/she:
   A. is not under any obligation to pay child support; or
   B. is under such an obligation and is in good standing with respect to that obligation; or
   C. has agreed to a payment plan with the Vermont Office of Child Support Services and is in full compliance with that plan.

Party makes this statement with regard to support owed to any and all children residing in Vermont. In addition, if the Party is a resident of Vermont, Party makes this statement with regard to support owed to any and all children residing in any other state or territory of the United States.
19. **Sub-Agreements:** Party shall not assign, subcontract or subgrant the performance of this Agreement or any portion thereof to any other Party without the prior written approval of the State. Party shall be responsible and liable to the State for all acts or omissions of subcontractors and any other person performing work under this Agreement pursuant to an agreement with Party or any subcontractor.

In the case this Agreement is a contract with a total cost in excess of $250,000, the Party shall provide to the State a list of all proposed subcontractors and subcontractors’ subcontractors, together with the identity of those subcontractors’ workers compensation insurance providers, and additional required or requested information, as applicable, in accordance with Section 32 of The Vermont Recovery and Reinvestment Act of 2009 (Act No. 54).

Party shall include the following provisions of this Attachment C in all subcontracts for work performed solely for the State of Vermont and subcontracts for work performed in the State of Vermont: Section 10 (“False Claims Act”); Section 11 (“Whistleblower Protections”); Section 12 (“Location of State Data”); Section 14 (“Fair Employment Practices and Americans with Disabilities Act”); Section 16 (“Taxes Due the State”); Section 18 (“Child Support”); Section 20 (“No Gifts or Gratuities”); Section 22 (“Certification Regarding Debarment”); Section 30 (“State Facilities”); and Section 32.A (“Certification Regarding Use of State Funds”).

20. **No Gifts or Gratuities:** Party shall not give title or possession of anything of substantial value (including property, currency, travel and/or education programs) to any officer or employee of the State during the term of this Agreement.

21. **Copies:** Party shall use reasonable best efforts to ensure that all written reports prepared under this Agreement are printed using both sides of the paper.

22. **Certification Regarding Debarment:** Party certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, neither Party nor Party’s principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible or excluded from participation in Federal programs, or programs supported in whole or in part by Federal funds.

Party further certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, Party is not presently debarred, suspended, nor named on the State’s debarment list at: http://bgs.vermont.gov/purchasing/debarment

23. **Conflict of Interest:** Party shall fully disclose, in writing, any conflicts of interest or potential conflicts of interest.

24. **Confidentiality:** Party acknowledges and agrees that this Agreement and any and all information obtained by the State from the Party in connection with this Agreement are subject to the State of Vermont Access to Public Records Act, 1 V.S.A. § 315 et seq.

25. **Force Majeure:** Neither the State nor the Party shall be liable to the other for any failure or delay of performance of any obligations under this Agreement to the extent such failure or delay shall have been wholly or principally caused by acts or events beyond its reasonable control rendering performance illegal or impossible (excluding strikes or lock-outs) (“Force Majeure”). Where Force Majeure is asserted, the nonperforming party must prove that it made all reasonable efforts to remove, eliminate or minimize such cause of delay or damages, diligently pursued performance of its obligations under this Agreement, substantially fulfilled all non-excused obligations, and timely notified the other party of the likelihood or actual occurrence of an event described in this paragraph.

26. **Marketing:** Party shall not refer to the State in any publicity materials, information pamphlets, press releases, research reports, advertising, sales promotions, trade shows, or marketing materials or similar communications to third parties except with the prior written consent of the State.

27. **Termination:**
A. Non-Appropriation: If this Agreement extends into more than one fiscal year of the State (July 1 to June 30), and if appropriations are insufficient to support this Agreement, the State may cancel at the end of the fiscal year, or otherwise upon the expiration of existing appropriation authority. In the case that this Agreement is a Grant that is funded in whole or in part by Federal funds, and in the event Federal funds become unavailable or reduced, the State may suspend or cancel this Grant immediately, and the State shall have no obligation to pay Subrecipient from State revenues.

B. Termination for Cause: Either party may terminate this Agreement if a party materially breaches its obligations under this Agreement, and such breach is not cured within thirty (30) days after delivery of the non-breaching party’s notice or such longer time as the non-breaching party may specify in the notice.

C. Termination Assistance: Upon nearing the end of the final term or termination of this Agreement, without respect to cause, the Party shall take all reasonable and prudent measures to facilitate any transition required by the State. All State property, tangible and intangible, shall be returned to the State upon demand at no additional cost to the State in a format acceptable to the State.

28. Continuity of Performance: In the event of a dispute between the Party and the State, each party will continue to perform its obligations under this Agreement during the resolution of the dispute until this Agreement is terminated in accordance with its terms.

29. No Implied Waiver of Remedies: Either party’s delay or failure to exercise any right, power or remedy under this Agreement shall not impair any such right, power or remedy, or be construed as a waiver of any such right, power or remedy. All waivers must be in writing.

30. State Facilities: If the State makes space available to the Party in any State facility during the term of this Agreement for purposes of the Party’s performance under this Agreement, the Party shall only use the space in accordance with all policies and procedures governing access to and use of State facilities which shall be made available upon request. State facilities will be made available to Party on an “AS IS, WHERE IS” basis, with no warranties whatsoever.

31. Requirements Pertaining Only to Federal Grants and Subrecipient Agreements: If this Agreement is a grant that is funded in whole or in part by Federal funds:

A. Requirement to Have a Single Audit: The Subrecipient will complete the Subrecipient Annual Report annually within 45 days after its fiscal year end, informing the State of Vermont whether or not a Single Audit is required for the prior fiscal year. If a Single Audit is required, the Subrecipient will submit a copy of the audit report to the granting Party within 9 months. If a single audit is not required, only the Subrecipient Annual Report is required. For fiscal years ending before December 25, 2015, a Single Audit is required if the subrecipient expends $500,000 or more in Federal assistance during its fiscal year and must be conducted in accordance with OMB Circular A-133. For fiscal years ending on or after December 25, 2015, a Single Audit is required if the subrecipient expends $750,000 or more in Federal assistance during its fiscal year and must be conducted in accordance with 2 CFR Chapter I, Chapter II, Part 200, Subpart F. The Subrecipient Annual Report is required to be submitted within 45 days, whether or not a Single Audit is required.

B. Internal Controls: In accordance with 2 CFR Part II, §200.303, the Party must establish and maintain effective internal control over the Federal award to provide reasonable assurance that the Party is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the award. These internal controls should be in compliance with guidance in “Standards for Internal Control in the Federal Government” issued by the Comptroller General of the United States and the “Internal Control Integrated Framework”, issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

C. Mandatory Disclosures: In accordance with 2 CFR Part II, §200.113, Party must disclose, in a timely manner, in writing to the State, all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Failure to make required disclosures may result in the
imposition of sanctions which may include disallowance of costs incurred, withholding of payments, termination of the Agreement, suspension/debarment, etc.

32. Requirements Pertaining Only to State-Funded Grants:

A. Certification Regarding Use of State Funds: If Party is an employer and this Agreement is a State-funded grant in excess of $1,001, Party certifies that none of these State funds will be used to interfere with or restrain the exercise of Party’s employee’s rights with respect to unionization.

B. Good Standing Certification (Act 154 of 2016): If this Agreement is a State-funded grant, Party hereby represents: (i) that it has signed and provided to the State the form prescribed by the Secretary of Administration for purposes of certifying that it is in good standing (as provided in Section 13(a)(2) of Act 154) with the Agency of Natural Resources and the Agency of Agriculture, Food and Markets, or otherwise explaining the circumstances surrounding the inability to so certify, and (ii) that it will comply with the requirements stated therein.

(End of Standard Provisions)
ATTACHMENT D:
MODIFICATION OF CUSTOMARY PROVISIONS
OF
ATTACHMENT C OR ATTACHMENT F

1. The insurance requirements contained in Attachment C, Section 8 are hereby modified to add the following:

   Professional Liability: Before commencing work on this Agreement and throughout the term of this Agreement, the Party shall procure and maintain professional liability insurance for any and all services performed under this Agreement, with minimum coverage of $1,000,000 per occurrence, and $2,000,000 aggregate.

2. Reasons for Modifications:

   Attachment C is modified to include Professional liability insurance.

APPROVAL:

___________________________________
ASSISTANT ATTORNEY GENERAL

DATE: ______________________

State of Vermont – Attachment D
Revised AHS – 10-30-2010
ATTACHMENT E
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (“Agreement”) is entered into by and between the State of Vermont Agency of Human Services, operating by and through its _______ [Insert Name of AHS Department, Office or Division] (“Covered Entity”) and [Insert Name of Contractor/Grantee] (“Business Associate”) as of _______ (“Effective Date”). This Agreement supplements and is made a part of the contract/grant to which it is attached.

Covered Entity and Business Associate enter into this Agreement to comply with standards promulgated under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), including the Standards for the Privacy of Individually Identifiable Health Information, at 45 CFR Parts 160 and 164 (“Privacy Rule”), and the Security Standards, at 45 CFR Parts 160 and 164 (“Security Rule”), as amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (HITECH), and any associated federal rules and regulations.

The parties agree as follows:

1. Definitions. All capitalized terms used but not otherwise defined in this Agreement have the meanings set forth in 45 CFR Parts 160 and 164 as amended by HITECH and associated federal rules and regulations.

   “Agent” means those person(s) who are agents(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).

   “Breach” means the acquisition, access, use or disclosure of protected health information (PHI) which compromises the security or privacy of the PHI, except as excluded in the definition of Breach in 45 CFR § 164.402.

   “Business Associate shall have the meaning given in 45 CFR § 160.103.

   “Individual” includes a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

   “Protected Health Information” or PHI shall have the meaning given in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Agency.

   “Security Incident” means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.

   “Services” includes all work performed by the Business Associate for or on behalf of Covered Entity that requires the use and/or disclosure of protected health information to perform a business associate function described in 45 CFR § 160.103 under the definition of Business Associate.

   “Subcontractor” means a person or organization to whom a Business Associate delegates a function, activity or service, other than in the capacity of a member of the workforce of the Business Associate. For purposes of this Agreement, the term Subcontractor includes Subgrantees.

2. Identification and Disclosure of Privacy and Security Offices. Business Associate and Subcontractors shall provide, within ten (10) days of the execution of this agreement, written notice to the Covered Entity’s contract/grant manager the names and contact information of both the HIPAA Privacy
Officer and HIPAA Security Officer. This information must be updated any time either of these contacts changes.

3. **Permitted and Required Uses/Disclosures of PHI.**

   3.1 Except as limited in this Agreement, Business Associate may use or disclose PHI to perform Services, as specified in the underlying grant or contract with Covered Entity. The uses and disclosures of Business Associate are limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the underlying agreement. Business Associate shall not use or disclose PHI in any manner that would constitute a violation of the Privacy Rule if used or disclosed by Covered Entity in that manner. Business Associate may not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law.

   3.2 Business Associate may make PHI available to its employees who need access to perform Services provided that Business Associate makes such employees aware of the use and disclosure restrictions in this Agreement and binds them to comply with such restrictions. Business Associate may only disclose PHI for the purposes authorized by this Agreement: (a) to its agents and Subcontractors in accordance with Sections 9 and 18 or, (b) as otherwise permitted by Section 3.

   3.3 Business Associate shall be directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Covered Entity, and for impermissible uses and disclosures, by Business Associate’s Subcontractor(s), of the PHI that Business Associate handles on behalf of Covered Entity and that it passes on to Subcontractors.

4. **Business Activities.** Business Associate may use PHI received in its capacity as a Business Associate to Covered Entity if necessary for Business Associate’s proper management and administration or to carry out its legal responsibilities. Business Associate may disclose PHI received in its capacity as Business Associate to Covered Entity for Business Associate’s proper management and administration or to carry out its legal responsibilities if a disclosure is Required by Law or if Business Associate obtains reasonable written assurances via a written agreement from the person to whom the information is to be disclosed that the PHI shall remain confidential and be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the Agreement requires the person or entity to notify Business Associate, within two (2) business days (who in turn will notify Covered Entity within two (2) business days after receiving notice of a Breach as specified in Section 6.1), in writing of any Breach of Unsecured PHI of which it is aware. Uses and disclosures of PHI for the purposes identified in Section 3 must be of the minimum amount of PHI necessary to accomplish such purposes.

5. **Safeguards.** Business Associate, its Agent(s) and Subcontractor(s) shall implement and use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement. With respect to any PHI that is maintained in or transmitted by electronic media, Business Associate or its Subcontractor(s) shall comply with 45 CFR sections 164.308 (administrative safeguards), 164.310 (physical safeguards), 164.312 (technical safeguards) and 164.316 (policies and procedures and documentation requirements). Business Associate or its Agent(s) and Subcontractor(s) shall identify in writing upon request from Covered Entity all of the safeguards that it uses to prevent impermissible uses or disclosures of PHI.

6. **Documenting and Reporting Breaches.**

   6.1 Business Associate shall report to Covered Entity any Breach of Unsecured PHI, including Breaches reported to it by a Subcontractor, as soon as it (or any of its employees or agents) becomes
aware of any such Breach, and in no case later than two (2) business days after it (or any of its employees or agents) becomes aware of the Breach, except when a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security.

6.2 Business Associate shall provide Covered Entity with the names of the individuals whose Unsecured PHI has been, or is reasonably believed to have been, the subject of the Breach and any other available information that is required to be given to the affected individuals, as set forth in 45 CFR § 164.404(c), and, if requested by Covered Entity, information necessary for Covered Entity to investigate the impermissible use or disclosure. Business Associate shall continue to provide to Covered Entity information concerning the Breach as it becomes available to it. Business Associate shall require its Subcontractor(s) to agree to these same terms and conditions.

6.3 When Business Associate determines that an impermissible acquisition, use or disclosure of PHI by a member of its workforce is not a Breach, as that term is defined in 45 CFR § 164.402, and therefore does not necessitate notice to the impacted individual(s), it shall document its assessment of risk, conducted as set forth in 45 CFR § 402(2). When requested by Covered Entity, Business Associate shall make its risk assessments available to Covered Entity. It shall also provide Covered Entity with 1) the name of the person(s) making the assessment, 2) a brief summary of the facts, and 3) a brief statement of the reasons supporting the determination of low probability that the PHI had been compromised. When a breach is the responsibility of a member of its Subcontractor’s workforce, Business Associate shall either 1) conduct its own risk assessment and draft a summary of the event and assessment or 2) require its Subcontractor to conduct the assessment and draft a summary of the event. In either case, Business Associate shall make these assessments and reports available to Covered Entity.

6.4 Business Associate shall require, by contract, a Subcontractor to report to Business Associate and Covered Entity any Breach of which the Subcontractor becomes aware, no later than two (2) business days after becomes aware of the Breach.

7. Mitigation and Corrective Action. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to it of an impermissible use or disclosure of PHI, even if the impermissible use or disclosure does not constitute a Breach. Business Associate shall draft and carry out a plan of corrective action to address any incident of impermissible use or disclosure of PHI. If requested by Covered Entity, Business Associate shall make its mitigation and corrective action plans available to Covered Entity. Business Associate shall require a Subcontractor to agree to these same terms and conditions.

8. Providing Notice of Breaches.

8.1 If Covered Entity determines that an impermissible acquisition, access, use or disclosure of PHI for which one of Business Associate’s employees or agents was responsible constitutes a Breach as defined in 45 CFR § 164.402, and if requested by Covered Entity, Business Associate shall provide notice to the individual(s) whose PHI has been the subject of the Breach. When requested to provide notice, Business Associate shall consult with Covered Entity about the timeliness, content and method of notice, and shall receive Covered Entity’s approval concerning these elements. The cost of notice and related remedies shall be borne by Business Associate.

8.2 If Covered Entity or Business Associate determines that an impermissible acquisition, access, use or disclosure of PHI by a Subcontractor of Business Associate constitutes a Breach as
defined in 45 CFR § 164.402, and if requested by Covered Entity or Business Associate, Subcontractor shall provide notice to the individual(s) whose PHI has been the subject of the Breach. When Covered Entity requests that Business Associate or its Subcontractor provide notice, Business Associate shall either 1) consult with Covered Entity about the specifics of the notice as set forth in section 8.1, above, or 2) require, by contract, its Subcontractor to consult with Covered Entity about the specifics of the notice as set forth in section 8.1

8.3 The notice to affected individuals shall be provided as soon as reasonably possible and in no case later than 60 calendar days after Business Associate reported the Breach to Covered Entity.

8.4 The notice to affected individuals shall be written in plain language and shall include, to the extent possible, 1) a brief description of what happened, 2) a description of the types of Unsecured PHI that were involved in the Breach, 3) any steps individuals can take to protect themselves from potential harm resulting from the Breach, 4) a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals and to protect against further Breaches, and 5) contact procedures for individuals to ask questions or obtain additional information, as set forth in 45 CFR § 164.404(c).

8.5 Business Associate shall notify individuals of Breaches as specified in 45 CFR § 164.404(d) (methods of individual notice). In addition, when a Breach involves more than 500 residents of Vermont, Business Associate shall, if requested by Covered Entity, notify prominent media outlets serving Vermont, following the requirements set forth in 45 CFR § 164.406.

9. **Agreements with Subcontractors.** Business Associate shall enter into a Business Associate Agreement with any Subcontractor to whom it provides PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity in which the Subcontractor agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such PHI. Business Associate must enter into this Business Associate Agreement before any use by or disclosure of PHI to such agent. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the use or disclosure of PHI. Business Associate shall provide a copy of the Business Associate Agreement it enters into with a subcontractor to Covered Entity upon request. Business associate may not make any disclosure of PHI to any Subcontractor without prior written consent of Covered Entity.

10. **Access to PHI.** Business Associate shall provide access to PHI in a Designated Record Set to Covered Entity or as directed by Covered Entity to an Individual to meet the requirements under 45 CFR § 164.524. Business Associate shall provide such access in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any request for access to PHI that Business Associate directly receives from an Individual.

11. **Amendment of PHI.** Business Associate shall make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526, whether at the request of Covered Entity or an Individual. Business Associate shall make such amendments in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any request for amendment to PHI that Business Associate directly receives from an Individual.

12. **Accounting of Disclosures.** Business Associate shall document disclosures of PHI and all information related to such disclosures as would be required for Covered Entity to respond to a request by
an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. Business Associate shall provide such information to Covered Entity or as directed by Covered Entity to an Individual, to permit Covered Entity to respond to an accounting request. Business Associate shall provide such information in the time and manner reasonably designated by Covered Entity. Within three (3) business days, Business Associate shall forward to Covered Entity for handling any accounting request that Business Associate directly receives from an Individual.

13. Books and Records. Subject to the attorney-client and other applicable legal privileges, Business Associate shall make its internal practices, books, and records (including policies and procedures and PHI) relating to the use and disclosure of PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity available to the Secretary of HHS in the time and manner designated by the Secretary. Business Associate shall make the same information available to Covered Entity, upon Covered Entity’s request, in the time and manner reasonably designated by Covered Entity so that Covered Entity may determine whether Business Associate is in compliance with this Agreement.

14. Termination.

14.1 This Agreement commences on the Effective Date and shall remain in effect until terminated by Covered Entity or until all of the PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity is destroyed or returned to Covered Entity subject to Section 19.8.

14.2 If Business Associate breaches any material term of this Agreement, Covered Entity may either: (a) provide an opportunity for Business Associate to cure the breach and Covered Entity may terminate the contract or grant without liability or penalty if Business Associate does not cure the breach within the time specified by Covered Entity; or (b) immediately terminate the contract or grant without liability or penalty if Covered Entity believes that cure is not reasonably possible; or (c) if neither termination nor cure are feasible, Covered Entity shall report the breach to the Secretary. Covered Entity has the right to seek to cure any breach by Business Associate and this right, regardless of whether Covered Entity cures such breach, does not lessen any right or remedy available to Covered Entity at law, in equity, or under the contract or grant, nor does it lessen Business Associate’s responsibility for such breach or its duty to cure such breach.

15. Return/Destruction of PHI.

15.1 Business Associate in connection with the expiration or termination of the contract or grant shall return or destroy, at the discretion of the Covered Entity, all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity pursuant to this contract or grant that Business Associate still maintains in any form or medium (including electronic) within thirty (30) days after such expiration or termination. Business Associate shall not retain any copies of the PHI. Business Associate shall certify in writing for Covered Entity (1) when all PHI has been returned or destroyed and (2) that Business Associate does not continue to maintain any PHI. Business Associate is to provide this certification during this thirty (30) day period.

15.2 Business Associate shall provide to Covered Entity notification of any conditions that Business Associate believes make the return or destruction of PHI infeasible. If Covered Entity agrees that return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that...
make the return or destruction infeasible for so long as Business Associate maintains such PHI. This shall also apply to all Agents and Subcontractors of Business Associate.

16. **Penalties.** Business Associate understands that: (a) there may be civil or criminal penalties for misuse or misappropriation of PHI and (b) violations of this Agreement may result in notification by Covered Entity to law enforcement officials and regulatory, accreditation, and licensure organizations.

17. **Training.** Business Associate understands that it is its obligation to comply with the law and shall provide appropriate training and education to ensure compliance with this Agreement. If requested by Covered Entity, Business Associate shall participate in AHS training regarding the use, confidentiality, and security of PHI, however, participation in such training shall not supplant nor relieve Business Associate of its obligations under this Agreement to independently assure compliance with the law and this Agreement.

18. **Security Rule Obligations.** The following provisions of this section apply to the extent that Business Associate creates, receives, maintains or transmits Electronic PHI on behalf of Covered Entity.

18.1 Business Associate shall implement and use administrative, physical, and technical safeguards in compliance with 45 CFR sections 164.308, 164.310, and 164.312 with respect to the Electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate shall identify in writing upon request from Covered Entity all of the safeguards that it uses to protect such Electronic PHI.

18.2 Business Associate shall ensure that any Agent and Subcontractor to whom it provides Electronic PHI agrees in a written agreement to implement and use administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI. Business Associate must enter into this written agreement before any use or disclosure of Electronic PHI by such Agent or Subcontractor. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the use or disclosure of Electronic PHI. Business Associate shall provide a copy of the written agreement to Covered Entity upon request. Business Associate may not make any disclosure of Electronic PHI to any Agent or Subcontractor without the prior written consent of Covered Entity.

18.3 Business Associate shall report in writing to Covered Entity any Security Incident pertaining to such Electronic PHI (whether involving Business Associate or an Agent or Subcontractor). Business Associate shall provide this written report as soon as it becomes aware of any such Security Incident, and in no case later than two (2) business days after it becomes aware of the incident. Business Associate shall provide Covered Entity with the information necessary for Covered Entity to investigate any such Security Incident.

18.4 Business Associate shall comply with any reasonable policies and procedures Covered Entity implements to obtain compliance under the Security Rule.

19. **Miscellaneous.**

19.1 In the event of any conflict or inconsistency between the terms of this Agreement and the terms of the contract/grant, the terms of this Agreement shall govern with respect to its subject matter. Otherwise, the terms of the contract/grant continue in effect.
19.2 Business Associate shall cooperate with Covered Entity to amend this Agreement from time to time as is necessary for Covered Entity to comply with the Privacy Rule, the Security Rule, or any other standards promulgated under HIPAA.

19.3 Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule, Security Rule, or any other standards promulgated under HIPAA.

19.4 In addition to applicable Vermont law, the parties shall rely on applicable federal law (e.g., HIPAA, the Privacy Rule and Security Rule, and the HIPAA omnibus final rule) in construing the meaning and effect of this Agreement.

19.5 As between Business Associate and Covered Entity, Covered Entity owns all PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity.

19.6 Business Associate shall abide by the terms and conditions of this Agreement with respect to all PHI it receives from Covered Entity or creates or receives on behalf of Covered Entity even if some of that information relates to specific services for which Business Associate may not be a “Business Associate” of Covered Entity under the Privacy Rule.

19.7 Business Associate is prohibited from directly or indirectly receiving any remuneration in exchange for an individual’s PHI. Business Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Reports or data containing the PHI may not be sold without Agency’s or the affected individual’s written consent.

19.8 The provisions of this Agreement that by their terms encompass continuing rights or responsibilities shall survive the expiration or termination of this Agreement. For example: (a) the provisions of this Agreement shall continue to apply if Covered Entity determines that it would be infeasible for Business Associate to return or destroy PHI as provided in Section 14.2 and (b) the obligation of Business Associate to provide an accounting of disclosures as set forth in Section 12 survives the expiration or termination of this Agreement with respect to accounting requests, if any, made after such expiration or termination.
1. **Definitions:** For purposes of this Attachment F, the term “Agreement” shall mean the form of the contract or grant, with all of its parts, into which this Attachment F is incorporated. The meaning of the term “Party” when used in this Attachment F shall mean any named party to this Agreement other than the State of Vermont, the Agency of Human Services (AHS) and any of the departments, boards, offices and business units named in this Agreement. As such, the term “Party” shall mean, when used in this Attachment F, the Contractor or Grantee with whom the State of Vermont is executing this Agreement. If Party, when permitted to do so under this Agreement, seeks by way of any subcontract, sub-grant or other form of provider agreement to employ any other person or entity to perform any of the obligations of Party under this Agreement, Party shall be obligated to ensure that all terms of this Attachment F are followed. As such, the term “Party” as used herein shall also be construed as applicable to, and describing the obligations of, any subcontractor, sub-recipient or sub-grantee of this Agreement. Any such use or construction of the term “Party” shall not, however, give any subcontractor, sub-recipient or sub-grantee any substantive right in this Agreement without an express written agreement to that effect by the State of Vermont.

2. **Agency of Human Services:** The Agency of Human Services is responsible for overseeing all contracts and grants entered by any of its departments, boards, offices and business units, however denominated. The Agency of Human Services, through the business office of the Office of the Secretary, and through its Field Services Directors, will share with any named AHS-associated party to this Agreement oversight, monitoring and enforcement responsibilities. Party agrees to cooperate with both the named AHS-associated party to this contract and with the Agency of Human Services itself with respect to the resolution of any issues relating to the performance and interpretation of this Agreement, payment matters and legal compliance.

3. **Medicaid Program Parties** (applicable to any Party providing services and supports paid for under Vermont’s Medicaid program and Vermont’s Global Commitment to Health Waiver):

   **Inspection and Retention of Records:** In addition to any other requirement under this Agreement or at law, Party must fulfill all state and federal legal requirements, and will comply with all requests appropriate to enable the Agency of Human Services, the U.S. Department of Health and Human Services (along with its Inspector General and the Centers for Medicare and Medicaid Services), the Comptroller General, the Government Accounting Office, or any of their designees: (i) to evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed under this Agreement; and (ii) to inspect and audit any records, financial data, contracts, computer or other electronic systems of Party relating to the performance of services under Vermont’s Medicaid program and Vermont’s Global Commitment to Health Waiver. Party will retain for ten years all documents required to be retained pursuant to 42 CFR 438.3(u).

   **Subcontracting for Medicaid Services:** Notwithstanding any permitted subcontracting of services to be performed under this Agreement, Party shall remain responsible for ensuring that this Agreement is fully performed according to its terms, that subcontractor remains in compliance with the terms hereof, and that subcontractor complies with all state and federal laws and regulations relating to the Medicaid program in Vermont. Subcontracts, and any
service provider agreements entered into by Party in connection with the performance of this Agreement, must clearly specify in writing the responsibilities of the subcontractor or other service provider and Party must retain the authority to revoke its subcontract or service provider agreement or to impose other sanctions if the performance of the subcontractor or service provider is inadequate or if its performance deviates from any requirement of this Agreement. Party shall make available on request all contracts, subcontracts and service provider agreements between the Party, subcontractors and other service providers to the Agency of Human Services and any of its departments as well as to the Center for Medicare and Medicaid Services.

**Medicaid Notification of Termination Requirements:** Party shall follow the Department of Vermont Health Access Managed-Care-Organization enrollee-notification requirements, to include the requirement that Party provide timely notice of any termination of its practice.

**Encounter Data:** Party shall provide encounter data to the Agency of Human Services and/or its departments and ensure further that the data and services provided can be linked to and supported by enrollee eligibility files maintained by the State.

**Federal Medicaid System Security Requirements Compliance:** Party shall provide a security plan, risk assessment, and security controls review document within three months of the start date of this Agreement (and update it annually thereafter) in order to support audit compliance with 45 CFR 95.621 subpart F, *ADP System Security Requirements and Review Process*.

4. **Workplace Violence Prevention and Crisis Response** *(applicable to any Party and any subcontractors and sub-grantees whose employees or other service providers deliver social or mental health services directly to individual recipients of such services)*:

Party shall establish a written workplace violence prevention and crisis response policy meeting the requirements of Act 109 (2016), 33 VSA §8201(b), for the benefit of employees delivering direct social or mental health services. Party shall, in preparing its policy, consult with the guidelines promulgated by the U.S. Occupational Safety and Health Administration for *Preventing Workplace Violence for Healthcare and Social Services Workers*, as those guidelines may from time to time be amended.

Party, through its violence protection and crisis response committee, shall evaluate the efficacy of its policy, and update the policy as appropriate, at least annually. The policy and any written evaluations thereof shall be provided to employees delivering direct social or mental health services.

Party will ensure that any subcontractor and sub-grantee who hires employees (or contracts with service providers) who deliver social or mental health services directly to individual recipients of such services, complies with all requirements of this Section.

5. **Non-Discrimination:**

Party shall not discriminate, and will prohibit its employees, agents, subcontractors, sub-grantees and other service providers from discrimination, on the basis of age under the Age Discrimination Act of 1975, on the basis of handicap under section 504 of the Rehabilitation
Act of 1973, on the basis of sex under Title IX of the Education Amendments of 1972, and on the basis of race, color or national origin under Title VI of the Civil Rights Act of 1964. Party shall not refuse, withhold from or deny to any person the benefit of services, facilities, goods, privileges, advantages, or benefits of public accommodation on the basis of disability, race, creed, color, national origin, marital status, sex, sexual orientation or gender identity as provided by Title 9 V.S.A. Chapter 139.

No person shall on the grounds of religion or on the grounds of sex (including, on the grounds that a woman is pregnant), be excluded from participation in, be denied the benefits of, or be subjected to discrimination, to include sexual harassment, under any program or activity supported by State of Vermont and/or federal funds.

Party further shall comply with the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, et seq., and with the federal guidelines promulgated pursuant to Executive Order 13166 of 2000, requiring that contractors and subcontractors receiving federal funds assure that persons with limited English proficiency can meaningfully access services. To the extent Party provides assistance to individuals with limited English proficiency through the use of oral or written translation or interpretive services, such individuals cannot be required to pay for such services.

6. **Employees and Independent Contractors:**

   Party agrees that it shall comply with the laws of the State of Vermont with respect to the appropriate classification of its workers and service providers as “employees” and “independent contractors” for all purposes, to include for purposes related to unemployment compensation insurance and workers compensation coverage, and proper payment and reporting of wages. Party agrees to ensure that all of its subcontractors or sub-grantees also remain in legal compliance as to the appropriate classification of “workers” and “independent contractors” relating to unemployment compensation insurance and workers compensation coverage, and proper payment and reporting of wages. Party will on request provide to the Agency of Human Services information pertaining to the classification of its employees to include the basis for the classification. Failure to comply with these obligations may result in termination of this Agreement.

7. **Data Protection and Privacy:**

   **Protected Health Information:** Party shall maintain the privacy and security of all individually identifiable health information acquired by or provided to it as a part of the performance of this Agreement. Party shall follow federal and state law relating to privacy and security of individually identifiable health information as applicable, including the Health Insurance Portability and Accountability Act (HIPAA) and its federal regulations.

   **Substance Abuse Treatment Information:** Substance abuse treatment information shall be maintained in compliance with 42 C.F.R. Part 2 if the Party or subcontractor(s) are Part 2 covered programs, or if substance abuse treatment information is received from a Part 2 covered program by the Party or subcontractor(s).

   **Protection of Personal Information:** Party agrees to comply with all applicable state and federal statutes to assure protection and security of personal information, or of any personally identifiable information (PII), including the Security Breach Notice Act, 9 V.S.A. § 2435, the Social Security Number Protection Act, 9 V.S.A. § 2440, the Document Safe Destruction Act,
9 V.S.A. § 2445 and 45 CFR 155.260. As used here, PII shall include any information, in any medium, including electronic, which can be used to distinguish or trace an individual’s identity, such as his/her name, social security number, biometric records, etc., either alone or when combined with any other personal or identifiable information that is linked or linkable to a specific person, such as date and place or birth, mother’s maiden name, etc.

**Other Confidential Consumer Information:** Party agrees to comply with the requirements of AHS Rule No. 08-048 concerning access to and uses of personal information relating to any beneficiary or recipient of goods, services or other forms of support. Party further agrees to comply with any applicable Vermont State Statute and other regulations respecting the right to individual privacy. Party shall ensure that all of its employees, subcontractors and other service providers performing services under this agreement understand and preserve the sensitive, confidential and non-public nature of information to which they may have access.

**Data Breaches:** Party shall report to AHS, though its Chief Information Officer (CIO), any impermissible use or disclosure that compromises the security, confidentiality or privacy of any form of protected personal information identified above within 24 hours of the discovery of the breach. Party shall in addition comply with any other data breach notification requirements required under federal or state law.

8. **Abuse and Neglect of Children and Vulnerable Adults:**

**Abuse Registry.** Party agrees not to employ any individual, to use any volunteer or other service provider, or to otherwise provide reimbursement to any individual who in the performance of services connected with this agreement provides care, custody, treatment, transportation, or supervision to children or to vulnerable adults if there has been a substantiation of abuse or neglect or exploitation involving that individual. Party is responsible for confirming as to each individual having such contact with children or vulnerable adults the non-existence of a substantiated allegation of abuse, neglect or exploitation by verifying that fact though (a) as to vulnerable adults, the Adult Abuse Registry maintained by the Department of Disabilities, Aging and Independent Living and (b) as to children, the Central Child Protection Registry (unless the Party holds a valid child care license or registration from the Division of Child Development, Department for Children and Families). See 33 V.S.A. §4919(a)(3) and 33 V.S.A. §6911(c)(3).

**Reporting of Abuse, Neglect, or Exploitation.** Consistent with provisions of 33 V.S.A. §4913(a) and §6903, Party and any of its agents or employees who, in the performance of services connected with this agreement, (a) is a caregiver or has any other contact with clients and (b) has reasonable cause to believe that a child or vulnerable adult has been abused or neglected as defined in Chapter 49 or abused, neglected, or exploited as defined in Chapter 69 of Title 33 V.S.A. shall: as to children, make a report containing the information required by 33 V.S.A. §4914 to the Commissioner of the Department for Children and Families within 24 hours; or, as to a vulnerable adult, make a report containing the information required by 33 V.S.A. §6904 to the Division of Licensing and Protection at the Department of Disabilities, Aging, and Independent Living within 48 hours. Party will ensure that its agents or employees receive training on the reporting of abuse or neglect to children and abuse, neglect or exploitation of vulnerable adults.

9. **Information Technology Systems:**
**Computing and Communication:** Party shall select, in consultation with the Agency of Human Services’ Information Technology unit, one of the approved methods for secure access to the State’s systems and data, if required. Approved methods are based on the type of work performed by the Party as part of this agreement. Options include, but are not limited to:

1. Party’s provision of certified computing equipment, peripherals and mobile devices, on a separate Party’s network with separate internet access. The Agency of Human Services’ accounts may or may not be provided.

2. State supplied and managed equipment and accounts to access state applications and data, including State issued active directory accounts and application specific accounts, which follow the National Institutes of Standards and Technology (NIST) security and the Health Insurance Portability & Accountability Act (HIPAA) standards.

**Intellectual Property/Work Product Ownership:** All data, technical information, materials first gathered, originated, developed, prepared, or obtained as a condition of this agreement and used in the performance of this agreement -- including, but not limited to all reports, surveys, plans, charts, literature, brochures, mailings, recordings (video or audio), pictures, drawings, analyses, graphic representations, software computer programs and accompanying documentation and printouts, notes and memoranda, written procedures and documents, which are prepared for or obtained specifically for this agreement, or are a result of the services required under this grant -- shall be considered "work for hire" and remain the property of the State of Vermont, regardless of the state of completion unless otherwise specified in this agreement. Such items shall be delivered to the State of Vermont upon 30-days notice by the State. With respect to software computer programs and / or source codes first developed for the State, all the work shall be considered "work for hire," i.e., the State, not the Party (or subcontractor or sub-grantee), shall have full and complete ownership of all software computer programs, documentation and/or source codes developed.

Party shall not sell or copyright a work product or item produced under this agreement without explicit permission from the State of Vermont.

If Party is operating a system or application on behalf of the State of Vermont, Party shall not make information entered into the system or application available for uses by any other party than the State of Vermont, without prior authorization by the State. Nothing herein shall entitle the State to pre-existing Party’s materials.

Party acknowledges and agrees that should this agreement be in support of the State’s implementation of the Patient Protection and Affordable Care Act of 2010, Party is subject to the certain property rights provisions of the Code of Federal Regulations and a Grant from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. Such agreement will be subject to, and incorporates here by reference, 45 CFR 74.36, 45 CFR 92.34 and 45 CFR 95.617 governing rights to intangible property.

**Security and Data Transfers:** Party shall comply with all applicable State and Agency of Human Services’ policies and standards, especially those related to privacy and security. The State will advise the Party of any new policies, procedures, or protocols developed during the term of this agreement as they are issued and will work with the Party to implement any required.
Party will ensure the physical and data security associated with computer equipment, including desktops, notebooks, and other portable devices, used in connection with this Agreement. Party will also assure that any media or mechanism used to store or transfer data to or from the State includes industry standard security mechanisms such as continually up-to-date malware protection and encryption. Party will make every reasonable effort to ensure media or data files transferred to the State are virus and spyware free. At the conclusion of this agreement and after successful delivery of the data to the State, Party shall securely delete data (including archival backups) from Party’s equipment that contains individually identifiable records, in accordance with standards adopted by the Agency of Human Services.

Party, in the event of a data breach, shall comply with the terms of Section 6 above.

10. Other Provisions:

**Environmental Tobacco Smoke.** Public Law 103-227 (also known as the Pro-Children Act of 1994) and Vermont’s Act 135 (2014) (An act relating to smoking in lodging establishments, hospitals, and child care facilities, and on State lands) restrict the use of tobacco products in certain settings. Party shall ensure that no person is permitted: (i) to use tobacco products or tobacco substitutes as defined in 7 V.S.A. § 1001 on the premises, both indoor and outdoor, of any licensed child care center or after-school program at any time; (ii) to use tobacco products or tobacco substitutes on the premises, both indoor and in any outdoor area designated for child care, health or day care services, kindergarten, pre-kindergarten, elementary, or secondary education or library services; and (iii) to use tobacco products or tobacco substitutes on the premises of a licensed or registered family child care home while children are present and in care. Party will refrain from promoting the use of tobacco products for all clients and from making tobacco products available to minors.

Failure to comply with the provisions of the federal law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. The federal Pro-Children Act of 1994, however, does not apply to portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, & Children (WIC) coupons are redeemed.

**2-1-1 Database:** If Party provides health or human services within Vermont, or if Party provides such services near the Vermont border readily accessible to residents of Vermont, Party shall adhere to the "Inclusion/Exclusion" policy of Vermont's United Way/Vermont 211 (Vermont 211), and will provide to Vermont 211 relevant descriptive information regarding its agency, programs and/or contact information as well as accurate and up to date information to its database as requested. The “Inclusion/Exclusion” policy can be found at [www.vermont211.org](http://www.vermont211.org).

**Voter Registration:** When designated by the Secretary of State, Party agrees to become a voter registration agency as defined by 17 V.S.A. §2103 (41), and to comply with the requirements of state and federal law pertaining to such agencies.

**Drug Free Workplace Act:** Party will assure a drug-free workplace in accordance with 45 CFR Part 76.

**Lobbying:** No federal funds under this agreement may be used to influence or attempt to influence an officer or employee of any agency, a member of Congress, an officer or employee
of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendments other than federal appropriated funds.

*AHS ATT. F 12.31.16*
CERTIFICATE OF COMPLIANCE

For a bid to be considered valid, this form must be completed in its entirety, executed by a duly authorized representative of the bidder, and submitted as part of the response to the proposal.

A. NON COLLUSION: Bidder hereby certifies that the prices quoted have been arrived at without collusion and that no prior information concerning these prices has been received from or given to a competitive company. If there is sufficient evidence to warrant investigation of the bid/contract process by the Office of the Attorney General, bidder understands that this paragraph might be used as a basis for litigation.

B. CONTRACT TERMS: Bidder hereby acknowledges that is has read, understands and agrees to the terms of this RFP, including Attachment C: Standard State Contract Provisions, and any other contract attachments included with this RFP.

C. FORM OF PAYMENT: Does Bidder accept the Visa Purchasing Card as a form of payment?

____ Yes ____ No

D. WORKER CLASSIFICATION COMPLIANCE REQUIREMENT: In accordance with Section 32 of The Vermont Recovery and Reinvestment Act of 2009 (Act No. 54), the following provisions and requirements apply to Bidder when the amount of its bid exceeds $250,000.00.

Self-Reporting. Bidder hereby self-reports the following information relating to past violations, convictions, suspensions, and any other information related to past performance relative to coding and classification of workers, that occurred in the previous 12 months.

<table>
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<tr>
<th>Summary of Detailed Information</th>
<th>Date of Notification</th>
<th>Outcome</th>
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Subcontractor Reporting. Bidder hereby acknowledges and agrees that if it is a successful bidder, prior to execution of any contract resulting from this RFP, Bidder will provide to the State a list of all proposed subcontractors and subcontractors’ subcontractors, together with the identity of those subcontractors’ workers compensation insurance providers, and additional required or requested information, as applicable, in accordance with Section 32 of The Vermont Recovery and Reinvestment Act of 2009 (Act No. 54), and Bidder will provide any update of such list to the State as additional subcontractors are hired. Bidder further acknowledges and agrees that the failure to submit subcontractor reporting in accordance with Section 32 of The Vermont Recovery and Reinvestment Act of 2009 (Act No. 54) will constitute non-compliance and may result in cancellation of contract and/or restriction from bidding on future state contracts.
E. Executive Order 05 – 16: Climate Change Considerations in State Procurements Certification

Bidder certifies to the following (Bidder may attach any desired explanation or substantiation. Please also note that Bidder may be asked to provide documentation for any applicable claims):

1. Bidder owns, leases or utilizes, for business purposes, space that has received:
   - Energy Star® Certification
   - LEED®, Green Globes®, or Living Buildings Challenge℠ Certification
   - Other internationally recognized building certification:

2. Bidder has received incentives or rebates from an Energy Efficiency Utility or Energy Efficiency Program in the last five years for energy efficient improvements made at bidder’s place of business. Please explain:

3. Please Check all that apply:
   - Bidder can claim on-site renewable power or anaerobic-digester power (“cow-power”). Or bidder consumes renewable electricity through voluntary purchase or offset, provided no such claimed power can be double-claimed by another party.
   - Bidder uses renewable biomass or bio-fuel for the purposes of thermal (heat) energy at its place of business.
   - Bidder’s heating system has modern, high-efficiency units (boilers, furnaces, stoves, etc.), having reduced emissions of particulate matter and other air pollutants.
   - Bidder tracks its energy consumption and harmful greenhouse gas emissions. What tool is used to do this?
   - Bidder promotes the use of plug-in electric vehicles by providing electric vehicle charging, electric fleet vehicles, preferred parking, designated parking, purchase or lease incentives, etc.
   - Bidder offers employees an option for a fossil fuel divestment retirement account.
   - Bidder offers products or services that reduce waste, conserve water, or promote energy efficiency and conservation. Please explain:

4. Please list any additional practices that promote clean energy and take action to address climate change:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
F. Acknowledge receipt of the following Addenda:

Addendum No.:  Dated:                  
Addendum No.:  Dated:                  
Addendum No.:  Dated:                  

Bidder Name:  Contact Name:  
Address:  Fax Number:  
                        Telephone:  
                        E-Mail:  
By:  Name:  
Signature of Bidder (or Representative):  (Type or Print)

END OF CERTIFICATE OF COMPLIANCE
PRICE SCHEDULE

A. Hourly Labor Rates:

PRICING: Bidders must price the terms of this solicitation at their best pricing. Any and all costs that Bidder wishes the State to consider must be submitted for consideration.

SAMPLE PRICE PROPOSAL FORM

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<thead>
<tr>
<th>Phase</th>
<th>Expected Completion Date:</th>
<th>Hourly Rate (Time and Materials)</th>
<th>Price (aggregate per Phase if deliverable based bid)</th>
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Travel and Expenses: Bidder’s hourly rates should be inclusive of all travel costs and expenses.

The Price Proposal form must use the same deliverables as outlined in the Request from the State.

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<tr>
<th>Service Category/Title of Positions</th>
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Name of Bidder: ____________________________________________________________

Signature of Bidder: ______________________________________________________

Date: __________________________
Appendix 1 – Health Care Application Forms – the application forms listed below can be found in the email attachments:

- 201P Pharmacy Programs Application
- 202MED Health Care Programs Application (Under Revision)
- 202LTC CFC Long-Term Care Application (Under Revision)
- 205IFA Application for Health Coverage and Help Paying Costs
- 205INFA Application for Health Coverage
Pharmacy Programs Application
VPharm and Healthy Vermonters Programs

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

Social Security number

Date of birth (mm/dd/yyyy)

Phone number where you can be reached
(Town where you live)

Mailing address line 1

Mailing address line 2 (If applicable, include an “in-care-of” person here.)

City

State

ZIP code

This application is for programs that help Vermonters pay for prescription drugs. We will give you the best coverage we can. You may be required to pay a monthly premium of up to $50 per month for each person. Please answer all of the following questions. IMPORTANT: Be sure to read pages 5-7 before you sign and date the application.

If you need interpretation services...

(Arabic) إذا أنت ترغب خدمات الترجمة الفورية اتصل برقم 1-855-247-3092.
(Bosnian) Ako su Vam potrebne usluge tušenja, pozovite 1-855-247-3092.
(Burmese) Mugihe woba ushaka impfashanyo yo gusiguirwa, hamagara uyu murongo 1-855-247-3092.
(French) Si vous avez besoin de services d’interprétation, appelez le 1-855-247-3092.
(Kirundi) Mpya n'apfashantu bugu dwahe sebeke kuburya Mpya ubu muwuho 
(Nepali) Haddii aad u baahan tahay adeegyo turjumaan, wac 1-855-247-3092.
(Somali) Si usted necesita servicios de interpretación, llame al 1-855-247-3092.
(Swahili) Ikiwa unahtaji huduma za ukuimali, piga simu 1-855-247-3092.
(Vietnamese) Nếu quý vị cần dịch vụ thông ngôn, hãy gọi 1-855-247-3092.

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 (pg. 6) of this application.

Full name

Phone number where this person can be reached

Home ☐ Cell ☐ Work ☐

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 your notices to you and to someone else. We call this person an “alternate reporter.”

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

**What is your marital status?**
- Single/Never married
- Married
- Civil Union (CU)
- Separated
- Divorced/Dissolved
- Widowed

**Spouse or CU Partner**

**Social Security No.**

**Is this person also applying?**
- Yes
- No

**Telephone No.**

**Do you have children or stepchildren under age 21 living with you?**
- Yes – ages of children
- No

<table>
<thead>
<tr>
<th></th>
<th>Applicant</th>
<th>Spouse or CU Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>What is your date of birth?</strong></td>
<td>_ _ / _ _ / _ _ _ _</td>
</tr>
<tr>
<td>2.</td>
<td><strong>Are you a U.S. citizen?</strong>&lt;br&gt;<strong>If no, include proof of immigrant status.</strong></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>3.</td>
<td><strong>Do you have Medicare?</strong></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>3. a.</td>
<td><strong>Medicare claim number</strong></td>
<td></td>
</tr>
<tr>
<td>3. b.</td>
<td><strong>Part A (hospital coverage)</strong>&lt;br&gt;<strong>Begin date:</strong> __________&lt;br&gt;<strong>Monthly premium:</strong> $ __________</td>
<td><strong>Begin date:</strong> __________&lt;br&gt;<strong>Monthly premium:</strong> $ __________</td>
</tr>
<tr>
<td>3. c.</td>
<td><strong>Part B (medical coverage)</strong>&lt;br&gt;<strong>Begin date:</strong> __________&lt;br&gt;<strong>Monthly premium:</strong> $ __________</td>
<td><strong>Begin date:</strong> __________&lt;br&gt;<strong>Monthly premium:</strong> $ __________</td>
</tr>
<tr>
<td>3. d.</td>
<td><strong>Part C (managed care)</strong>&lt;br&gt;<strong>Begin date:</strong> __________&lt;br&gt;<strong>Monthly premium:</strong> $ __________</td>
<td><strong>Begin date:</strong> __________&lt;br&gt;<strong>Monthly premium:</strong> $ __________</td>
</tr>
<tr>
<td>4.</td>
<td><strong>Have you chosen a Part D Prescription Drug Plan?</strong></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>4. a.</td>
<td><strong>Plan name</strong></td>
<td></td>
</tr>
<tr>
<td>4. b.</td>
<td><strong>Contract ID # on the bottom right corner of your Medicare drug plan card</strong>&lt;br&gt;(Typically begins with an S or H)</td>
<td>__________</td>
</tr>
<tr>
<td>4. c.</td>
<td><strong>Plan ID # on the bottom of your Medicare drug plan card</strong></td>
<td>__________</td>
</tr>
<tr>
<td>4. d.</td>
<td><strong>Plan start date</strong></td>
<td>_ _ / _ _ / _ _ _ _</td>
</tr>
<tr>
<td>4. e.</td>
<td><strong>Monthly premium amount</strong></td>
<td>$</td>
</tr>
<tr>
<td>5.</td>
<td><strong>Have you applied for “Extra Help” for Part D through Social Security?</strong></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>5. a.</td>
<td><strong>If yes, date applied</strong></td>
<td>_ _ / _ _ / _ _ _ _</td>
</tr>
<tr>
<td>5. b.</td>
<td><strong>If granted, begin date</strong></td>
<td>_ _ / _ _ / _ _ _ _</td>
</tr>
<tr>
<td>5. c.</td>
<td><strong>If denied, what reason did Social Security give you?</strong></td>
<td>☐ Over income&lt;br&gt;☐ Over resources&lt;br&gt;☐ Failed to cooperate&lt;br&gt;☐ Other; Explain:</td>
</tr>
</tbody>
</table>
### HEALTH INSURANCE INFORMATION

<table>
<thead>
<tr>
<th></th>
<th>Applicant</th>
<th>Spouse or CU Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. <strong>Do you have insurance that covers prescription drugs?</strong> Do NOT include prescription discount programs or Medicare information listed in #4.</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>6. a. <strong>Name of insurance company</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. b. <strong>Insurance company address</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. c. <strong>Policy #</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. d. <strong>Date coverage began</strong></td>
<td>__ __ / __ __ / __ __ __ __</td>
<td>__ __ / __ __ / __ __ __ __</td>
</tr>
<tr>
<td>6. e. <strong>Does this drug coverage have an annual limit?</strong></td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>6. f. <strong>Has the annual limit been met?</strong></td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>7. <strong>Do you or your spouse or civil union partner have health insurance other than Medicare?</strong></td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>7. a. <strong>Name of policy holder</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. b. <strong>Policy and group numbers</strong></td>
<td>Policy # _____________</td>
<td>Policy # _____________</td>
</tr>
<tr>
<td></td>
<td>Group # _____________</td>
<td>Group # _____________</td>
</tr>
<tr>
<td>7. c. <strong>Date coverage began</strong></td>
<td>__ __ / __ __ / __ __ __ __</td>
<td>__ __ / __ __ / __ __ __ __</td>
</tr>
<tr>
<td>7. d. <strong>Premium cost</strong></td>
<td>$_______ per _________</td>
<td>$_______ per _________</td>
</tr>
<tr>
<td>7. e. <strong>Services offered</strong></td>
<td>Services (check all that apply)</td>
<td>Services (check all that apply)</td>
</tr>
<tr>
<td></td>
<td>□ Doctors □ Hospitals</td>
<td>□ Doctors □ Hospitals</td>
</tr>
<tr>
<td></td>
<td>□ Outpatient □ Major medical</td>
<td>□ Outpatient □ Major medical</td>
</tr>
<tr>
<td></td>
<td>□ Dental □ Prescriptions</td>
<td>□ Dental □ Prescriptions</td>
</tr>
<tr>
<td></td>
<td>□ Vision □ Other _________</td>
<td>□ Vision □ Other _________</td>
</tr>
<tr>
<td>7. f. <strong>Names of people covered</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. g. <strong>Name of insurance company</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. h. <strong>Insurance company address</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. i. <strong>Insurance company phone number</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. j. <strong>If you have more than one policy, check here and add a separate sheet of paper.</strong></td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>
INCOME INFORMATION

Please list all current gross income (before deductions such as taxes, Medicare premiums or other deductions) for yourself and your spouse or civil union partner, if he or she lives with you. Please answer ALL questions.

<table>
<thead>
<tr>
<th></th>
<th>Applicant Amount (before deductions)</th>
<th>Spouse or CU partner Amount (before deductions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Social Security Retirement (SSA)</td>
<td>$ per mo. □ None</td>
<td>$ per mo. □ None</td>
</tr>
<tr>
<td>9. Social Security Disability (SSDI)</td>
<td>$ per mo. □ None</td>
<td>$ per mo. □ None</td>
</tr>
<tr>
<td>10. Supplemental Security Income (SSI)</td>
<td>$ per mo. □ None</td>
<td>$ per mo. □ None</td>
</tr>
<tr>
<td>11. Railroad Retirement</td>
<td>$ per mo. □ None</td>
<td>$ per mo. □ None</td>
</tr>
<tr>
<td>12. Veteran's Benefits</td>
<td>$ per mo. □ None</td>
<td>$ per mo. □ None</td>
</tr>
<tr>
<td>13. Pensions or Annuities</td>
<td>$ □ None</td>
<td>$ □ None</td>
</tr>
<tr>
<td></td>
<td>Income is received:  □ Monthly □ Bi-monthly □ Annually □ Quarterly</td>
<td>Income is received:  □ Monthly □ Bi-monthly □ Annually □ Quarterly</td>
</tr>
<tr>
<td></td>
<td>Date last received:  ____ / ____ / _____</td>
<td>Date last received:  ____ / ____ / _____</td>
</tr>
<tr>
<td>14. Interest or Dividends</td>
<td>$ per mo. □ None</td>
<td>$ per mo. □ None</td>
</tr>
</tbody>
</table>

15. Does anyone have income from a job, internship or training program?  □ Yes  □ No

If yes, please provide gross wages and pay dates for the past 30 days below.

<table>
<thead>
<tr>
<th></th>
<th>Applicant</th>
<th>Spouse or CU Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full name</td>
<td>Full name</td>
</tr>
<tr>
<td>Date paid</td>
<td>Hours worked</td>
<td>Income before deductions</td>
</tr>
<tr>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

Paychecks are issued:  □ Weekly  □ Monthly  □ Every two weeks  □ Twice a month

Employer's name:

Employer's phone number:

16. Does anyone get paid for taking care of children?  □ Yes  □ No

If you claim income for providing day care on your taxes, answer question 18 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.

<table>
<thead>
<tr>
<th></th>
<th>Applicant</th>
<th>Spouse or CU Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. a. Income before deductions</td>
<td>$ per mo.</td>
<td>$ per mo.</td>
</tr>
<tr>
<td>16. b. Breakfasts</td>
<td>per mo.</td>
<td>per mo.</td>
</tr>
<tr>
<td>16. c. Lunches</td>
<td>per mo.</td>
<td>per mo.</td>
</tr>
<tr>
<td>16. d. Dinners</td>
<td>per mo.</td>
<td>per mo.</td>
</tr>
<tr>
<td>16. e. Snacks</td>
<td>per mo.</td>
<td>per mo.</td>
</tr>
</tbody>
</table>
**INCOME INFORMATION (CONTINUED)**

<table>
<thead>
<tr>
<th>17. Does anyone get paid for providing room or meals in your home? Include payments from children.</th>
<th>Applicant</th>
<th>Spouse or CU Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
</tbody>
</table>

**17. a. Payment received**

| $ | per | $ | per |

| 17. b. Name of person paying |

| ☐ Room | ☐ Room |

**17. c. What is provided? Check all that apply.**

| ☐ Room | ☐ Room |
| ☐ 1-2 meals per day | ☐ 1-2 meals per day |
| ☐ 3 meals per day | ☐ 3 meals per day |

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

If yes, please send a copy of your most recent federal income tax return, including all schedules and forms. 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.

| ☐ Yes ☐ No | ☐ Yes ☐ No |

**18. a. Type of business**

**18. b. Date business began**

| _ _ / _ _ / _ _ _ _ | _ _ / _ _ / _ _ _ _ |

**19. Other income in the last 30 days, such as unemployment, worker’s compensation, child support, or alimony?**

| ☐ Yes ☐ No | ☐ Yes ☐ No |

**19. a. Type of income**

**19. b. Amount**

| $ | $ |

**19. c. Occurrence**

| ☐ Weekly ☐ Every two weeks | ☐ Weekly ☐ Every two weeks |
| ☐ Monthly ☐ Twice a month | ☐ Monthly ☐ Twice a month |

**EXPENSE INFORMATION**

<table>
<thead>
<tr>
<th>20. Do you pay for daycare for a child or an incapacitated adult?</th>
<th>Applicant</th>
<th>Spouse or CU Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
</tbody>
</table>

**20. a. Payment**

| $ | per month | $ | per month |

**20. b. Name of child or incapacitated adult**

**21. Do you pay court-ordered child support or alimony?**

| ☐ Yes ☐ No | ☐ Yes ☐ No |

**21. a. Payment**

| $ | per month | $ | per month |

**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, on page 1, 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.
- 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 on page 1 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 1-800-368-1019 or 1-800-537-7697 (TDD); or write to DCF, ESD Deputy Commissioner, HC 1 South, 280 State Drive, Waterbury, VT 05671-1020.

Decision on Application.
DCF must act on my application no later than 30 days after my application date unless delay is caused by physicians, an unexpected emergency or administrative problem beyond the Department's control, or me. If, ESD has not contacted me regarding my application within 30 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, 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.

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 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 amount equal to the benefit wrongfully received. Federal or state penalties may also apply. (42 U.S.C. § 1320a-7b; 33 V.S.A. §§ 141, 143)

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, HC 1 South, 280 State Drive, Waterbury, VT 05671-1020.

Assignment of Third Party Payments.
As a condition of eligibility for health care assistance, I agree to assign to DCF all rights 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.
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 Authorized Representative or person acting for the applicant (see below) ___________________________ Date ________________

If you are acting for the applicant and you are not the applicant’s Legal Guardian, agent under Power of Attorney, or Authorized Representative, by signing this application (above) you agree to the following:

I am acting to provide information to establish and maintain eligibility for ESD benefits for the applicant. This is because the applicant has a physical or mental condition that prevents him or her from providing information about his or her situation and acting responsibly in his or her own behalf. I will provide information to the best of my knowledge concerning the applicant’s situation. I understand that if I knowingly withhold any information or knowingly misrepresent the facts, I may be prosecuted for perjury or fraud. I agree to notify ESD immediately if I learn of any change in the applicant’s situation.

Please also provide information below about the person acting for the applicant.

<table>
<thead>
<tr>
<th>Name (agency name, if applicable)</th>
<th>Phone number (____-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street address/PO Box</td>
<td>City</td>
</tr>
<tr>
<td></td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>ZIP code</td>
</tr>
</tbody>
</table>

Return this application to:

DCF – Economic Services Division,
Application and Document Processing Center,
280 State Drive, Waterbury, VT 05671-1500

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. 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 TTY/Relay: 711.

OTHER PROGRAMS

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

Weatherization
This program helps with insulation, caulking, or weather-stripping your home or apartment to lower your heating costs. To learn more, 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. To learn more, call toll free 1-800-464-4343. Would you like someone from the WIC program to contact you?

Lifeline
This program may provide a discount on your phone bill. A separate application is needed to determine eligibility for Lifeline. To learn more or to request an application, call toll free 1-800-479-6151.

Fuel Assistance
This program helps to pay heating bills. To learn more 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. To learn more or to request an application, call toll free 1-800-479-6151.
Health Care Programs Application

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

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

Social Security number

Date of birth (mm/dd/yyyy)

Phone number where you can be reached

Town where you live

Mailing address line 1

Apartment or suite number

Mailing address line 2 (If applicable, include an "in-care-of" person here.)

City

State

ZIP code

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

Green Mountain Care is the name of some of our health care programs for Vermonters. These health care programs are not associated with Vermont Health Connect. 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. Green Mountain Health Care programs include:

- Medicaid – for individuals who are blind, have a disability, or are age 65 or older. If applying for Medicaid, answer all questions in this application.

  Medicaid for children or adults who are not blind, disabled, or age 65 or older must be applied for through Vermont Health Connect. Visit VermontHealthConnect.gov or call 1-855-899-9600.

- Disabled Children’s Home Care (DCHC) – for children with disabilities who are living at home and would be eligible for Medicaid if living in an institution. Parents’ income and resources are not counted when determining eligibility. However, we do need to know the child’s income and resources. Please be sure to answer all questions in this application.

- Pharmacy Program (VPharm) – for Vermonters age 65 and older or disabled. Coverage ranges from full pharmacy coverage to supplemental coverage for those on Medicare. If applying for ONLY the Pharmacy Program (VPharm), answer questions 1-3, 5, 7-12, 19-26.

- Healthy Vermonters Program (HVP) – for all Vermonters without pharmacy coverage. This program provides a discount on some prescriptions. If applying for ONLY the Healthy Vermonters Program (HVP), answer questions 1-3, 5, 7-12, 19-26.

- Medicare Savings Programs – for individuals with Medicare to help pay for Medicare premiums, deductibles and copays. If applying for ONLY the Medicare Savings Programs, answer questions 1-3, 5, 7, 9, 19-25.

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 identify 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.*

**Rights of People with Disabilities**

Do you have a physical or mental or learning condition that makes it hard to do things we ask you to do? We can make changes to help you. The Americans with Disabilities Act (ADA) and Vermont law say that we must make changes so people with disabilities can get health and public benefits. These changes are called reasonable accommodations. Here are some examples of changes we can make:

- Someone can write down your answers if you can’t.
- We can give you more time or help you get the documents you need to give us.
- You can have a support person with you when you talk to us.
- We can send documents with a larger print so you can read them.

*If you need us to make changes so you can get the benefits you need, call 1-800-250-8427.*

### Applicant Information

1. **Are you applying for benefits for yourself?**

   - ☐ YES
   - ☐ NO

<table>
<thead>
<tr>
<th>Gender:</th>
<th>Citizenship status:</th>
<th>Marital status:</th>
<th>Program(s) you are applying for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Female</td>
<td>☐ U.S. Citizen</td>
<td>☐ Never Married/Single</td>
<td>☐ Medicaid</td>
</tr>
<tr>
<td>☐ Male</td>
<td>☐ Legal Alien</td>
<td>☐ Married</td>
<td>☐ Disabled Children’s Home Care</td>
</tr>
<tr>
<td></td>
<td>☐ Refugee</td>
<td>☐ Separated</td>
<td>☐ Pharmacy Program</td>
</tr>
<tr>
<td></td>
<td>☐ Asylee</td>
<td>☐ Widowed</td>
<td>☐ Healthy Vermonters Program</td>
</tr>
<tr>
<td></td>
<td>☐ Other</td>
<td>☐ Divorced/Dissolved</td>
<td>☐ Medicare Savings Program</td>
</tr>
<tr>
<td></td>
<td>Country of Birth:</td>
<td>☐ Civil Union</td>
<td>☐ None</td>
</tr>
</tbody>
</table>

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 (pgs. 9-11) of this application.

<table>
<thead>
<tr>
<th>Full name</th>
<th>Phone No.</th>
<th>Home</th>
<th>Cell</th>
<th>Work</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( )</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

   Address

   For legal guardian only:

<table>
<thead>
<tr>
<th>Name of court</th>
<th>Date appointed</th>
</tr>
</thead>
</table>

### 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 notices to you and to someone else. We call this person an “alternate reporter.”

*If you have questions or would like one of these options, please call 1-800-250-8427.*
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 27 for any people in the following groups:
   - 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

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Last name</th>
<th>Assistance applying for</th>
<th>Sex</th>
<th>Citizenship Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>□ Medicaid □ DCHC □ VPharm □ HVP □ Medicare Savings Programs □ None</td>
<td>□ Female □ Male</td>
<td>□ U.S. citizen □ Asylee □ Refugee □ Legal alien □ Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Country of birth</td>
</tr>
</tbody>
</table>
### 4. Has anyone been known by another name, such as a maiden name or alias?

<table>
<thead>
<tr>
<th>Current name:</th>
<th></th>
<th></th>
<th>Other name:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First name</td>
<td>Initial</td>
<td>Last name</td>
<td>First name</td>
<td>Initial</td>
<td>Last name</td>
</tr>
</tbody>
</table>

### 5. Is anyone living outside your home in a facility that is not a school or college?

- Yes
- No

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Name of facility</th>
<th>Date of admission</th>
</tr>
</thead>
</table>

### 6. Is anyone in high school, college, vocational school, or a training program?

- Yes
- No

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Name of school</th>
<th>Type of school</th>
<th>Expected completion date</th>
<th>Is health insurance offered?</th>
<th>Enrollment Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>full-time</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No</td>
<td>half-time</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>less than half-time</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

### 7. Does anyone have a physical, mental, or emotional disability that limits activities such as working, going to school, or taking care of the children?

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Caused by an accident?</th>
<th>Disability determination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### 8. Is anyone pregnant?

- Yes
- No

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Expected due date</th>
<th>How many babies are expected?</th>
</tr>
</thead>
</table>

### Health Insurance Information

### 9. Is anyone who is applying covered by Medicare?

- Yes
- No

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Medicare claim number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Part A:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Start date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Part B:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Start date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Part C:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Start date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Part D:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Start date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Medicare claim number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Part A:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Start date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Part B:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Start date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Part C:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Start date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Part D:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Start date</td>
</tr>
</tbody>
</table>
10a. Is anyone enrolled in a Medicare Part D prescription drug plan?  
☐ Yes  ☐ No

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Plan name</th>
<th>Contract ID</th>
<th>Plan start date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>CMS-__ __ __</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CMS-__ __ __</td>
<td></td>
</tr>
</tbody>
</table>

10b. 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

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Date applied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. 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 question 9.
- Do not include Green Mountain Care programs (Medicaid and Pharmacy programs), or Medicaid/Dr. Dynasaur with Vermont Health Connect.
- List prescription plans separately.
- **Send copies of both sides of all insurance cards.** If you don’t, it will cause application processing delays.

<table>
<thead>
<tr>
<th>Name of policy holder</th>
<th>Services Covered (check all that apply)</th>
<th>Names of people covered</th>
<th>Name, address, and phone number of insurance company</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Doctors/Hospitals ☐ Vision ☐ Prescriptions ☐ Dental ☐ Outpatient ☐ Other: _____________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Policy number</td>
<td>Group number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium amount $</td>
<td>per</td>
<td>Date coverage began</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of policy holder</th>
<th>Services Covered (check all that apply)</th>
<th>Names of people covered</th>
<th>Name, address, and phone number of insurance company</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Doctors/Hospitals ☐ Vision ☐ Prescriptions ☐ Dental ☐ Outpatient ☐ Other: _____________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Policy number</td>
<td>Group number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium amount $</td>
<td>per</td>
<td>Date coverage began</td>
<td></td>
</tr>
</tbody>
</table>

12. 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 and Pharmacy Programs), or Medicaid/Dr. Dynasaur with Vermont Health Connect.  
☐ Yes  ☐ No

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Date ended or date will end</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you lost your health insurance due to domestic violence, check here.  ☐ Yes
13. 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.

<table>
<thead>
<tr>
<th>Who has the unpaid medical bills?</th>
<th>Provide an estimate of charges incurred within the last 3 months</th>
<th>Provide an estimate of charges incurred more than 3 months ago</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

14. Does anyone have cash that is not in a bank, such as at home, on hand, or held by others? Include cash that is owned by children.

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Amount</th>
<th>First name</th>
<th>Initial</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

15. Does anyone have money in a bank, credit union, or other financial institution? Include accounts that are owned or co-owned by children.

<table>
<thead>
<tr>
<th>Type</th>
<th>Name of owner and co-owner</th>
<th>Name of bank, credit union, or other financial institution</th>
<th>Account number</th>
<th>Balance or value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings Account</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Savings Account</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Checking Account</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Checking Account</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Christmas Club</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>IRA, Keogh Plan, 401K</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Savings Bond or Trust</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Certificate of Deposit (CD)</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Pension or Retirement Account</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

Does any portion of these savings come from money earned as a “Working Person with Disabilities”? 

16. Does anyone own any vehicles?

<table>
<thead>
<tr>
<th>Type of vehicle</th>
<th>Name of owner and co-owner</th>
<th>Year, make, and model</th>
<th>Leased?</th>
<th>Amount owed</th>
<th>For DVHA use only Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Car, truck, or van</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Car, truck, or van</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Car, truck, or van</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Motorcycle or ATV</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Snowmobile or jet ski</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Trailer or boat</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Camper or RV</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

17. Does anyone own or jointly own land, mobile homes, buildings, or other real estate? Do NOT list the home you live in.

<table>
<thead>
<tr>
<th>Name of owner and co-owner</th>
<th>Type of property</th>
<th>Location</th>
<th>Assessed value</th>
<th>Amount owed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>
18. Does anyone own, or jointly own, any other resources? □ Yes □ No

<table>
<thead>
<tr>
<th>Type of Resource</th>
<th>Name of owner and co-owner</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Insurance Term □ Whole</td>
<td></td>
<td>Face value $</td>
</tr>
<tr>
<td>Life Insurance Term □ Whole</td>
<td></td>
<td>Cash value $</td>
</tr>
<tr>
<td>Life Insurance Term □ Whole</td>
<td></td>
<td>Face value $</td>
</tr>
<tr>
<td>Account set up for burial expenses</td>
<td></td>
<td>Cash value $</td>
</tr>
<tr>
<td>Is this irrevocable? □ Yes □ No</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Burial Plot</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Stocks, Bonds, or Mutual Funds</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Annuities</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Trust Funds or Collections</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Promissory or Mortgage Notes</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

Income Information

19. 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.

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Date paid</th>
<th>Hours worked</th>
<th>Income before deductions</th>
<th>Tips and commissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paychecks are issued</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Weekly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Every two weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Twice a month</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Monthly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day of week</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer’s name and phone number</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. Does anyone get paid for taking care of children? □ Yes □ No

- If you claim income for providing day care on your taxes, answer question 22 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.

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Income before deductions</th>
<th>Breakfast</th>
<th>Lunch</th>
<th>Dinner</th>
<th>Snacks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$ per</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
21. Does anyone get paid for providing room or meals in your home? ☐ Yes ☐ No

Include payments from children.

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Payment</th>
<th>Name of person paying</th>
<th>Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$</td>
<td></td>
<td>□ Room □ 1-2 meals per day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$</td>
<td></td>
<td>□ Room □ 3 meals per day</td>
</tr>
</tbody>
</table>

22. 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.

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Type of business</th>
<th>Date business began</th>
</tr>
</thead>
</table>

23. Does anyone have unearned income? Some examples are: ☐ Yes ☐ No

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

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

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Income before deductions</th>
<th>Type of income</th>
<th>Due to disability?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$</td>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$</td>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$</td>
<td></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

24. 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).

Expenses Information

25. Does anyone pay court-ordered child support or alimony? ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Name of person paying</th>
<th>Child support paid</th>
<th>Alimony paid</th>
<th>Names of children for whom support is paid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

26. Does anyone pay for daycare? ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Name of person paying</th>
<th>Amount paid</th>
<th>Name of child or adult in daycare</th>
<th>Reason for daycare</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
27. Does anyone pay for medical expenses not covered by insurance? □ Yes □ No

Some examples are: Pain relievers Hearing aid batteries Laxatives
Antacids Vitamins Sleep aids

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Product or service needed</th>
<th>How often</th>
<th>Average monthly cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

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 Department of Vermont Health Access (DVHA) 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. DVHA 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.
- 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).

DVHA 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 DVHA; and to make medical assistance payments.

Discrimination
DVHA does not exclude people from its programs or deny them benefits because of race, color, national origin, age, disability, or sex. DVHA provides free aids and services to people with disabilities so they can work with us more easily. DVHA provides free language services to people who need to speak a language that is not English, such as qualified interpreters and information written in other languages. If you believe that DVHA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with DVHA's Health Programs Civil Rights Coordinator.

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, a DVHA's Health Programs Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone.

Health Program Civil Rights Coordinator
DVHA Legal Department
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
Phone: (802) 241-0454
Fax: (802) 241-0260
E-mail: AHS.DVHALegal@vermont.gov

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Decision on Application
DVHA 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 Member Services at 1-800-250-8427 or by writing to the Human Services Board, 14-16 Baldwin Street, 2nd Floor, Montpelier, VT 05633-4302 (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
DVHA 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 DVHA to get it.

Medicare Part B payments
If I get Medicare Part B benefits while getting Medicaid, I want DVHA to make any payments for future Medicare Part B medical and other health services directly to physicians and medical suppliers. This means I will not have to sign a separate form each time I get a service.

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 DVHA must disclose information to law enforcement agencies to apprehend fleeing felons.
**Authorizations and Releases**

**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 DVHA 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)

**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 DVHA Deputy Commissioner, NOB1 South, 280 State Drive, Waterbury, VT 05671-1010.

**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 DVHA address on the following page.

**Other Programs**

**Lifeline** may provide a discount on your phone bill. A separate application is needed to determine eligibility for Lifeline. *To learn more about this program or to request an application, call toll free 1-800-479-6151. When requesting an application, ask for Lifeline.*

**Weatherization:** This program helps with insulation, caulking, or weather-stripping your home or apartment to lower your heating costs. *To learn more about this program, call (802) 241-0943.*

**Fuel Assistance:** This program helps to pay heating bills. *To learn more about this program or to request an application, call toll free 1-800-464-4343.*

**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. *To learn more about this program or to request an application, call toll free 1-800-479-6151.*
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.

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. To learn more about this program, call toll free 1-800-649-4357.

Would you like someone from the WIC program to contact you? ☐ Yes ☐ No

You must sign here. Unsigned applications will not be processed and will be returned for a 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: DVHA - Department of Vermont Health Access
Application and Document Processing Center
280 State Drive
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 (TTY/Relay Service: dial 711).

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.
Application for Long-Term Care Medicaid

Long-Term Care Medicaid (LTC) helps pay for care and support for older Vermonters and people with disabilities. To be eligible you must meet financial and clinical criteria. The Department of Vermont Health Access (DVHA) will determine your financial eligibility. The date the signed application is received by the State is the application date. Please check which one of the following LTC services you are applying for:

- **Choices for Care (CFC)** provides a package of long-term services and supports to Vermonters who are age 18 years and over and need nursing home level of care. Eligible people choose where to receive their services: in their home, in their family’s home, an Adult Family Care home, Enhanced Residential Care or nursing facility. A nurse from DAIL completes the clinical assessment.
- **Developmental Disabilities Services Home and Community-Based Services (DD HCBS)** provides support to people with developmental disabilities to live in their local communities. The local Designated Agency which arranges the necessary assessments.
- **Traumatic Brain Injury (TBI)** program diverts or returns people with moderate to severe traumatic brain injuries from hospitals and facilities to community-based settings. To be eligible you must be age 16 or older. DAIL staff complete the clinical assessment.
- **Enhanced Family Treatment** (formerly known as the Children’s Mental Health Waiver) provides community-based services to children with emotional illness under the age of 21 who have been institutionalized or are at risk of being institutionalized. Department of Mental Health will determine clinical eligibility.

<table>
<thead>
<tr>
<th>First name, Middle name, Last name &amp; suffix (Jr., Sr., III, etc.)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number</td>
<td>Date of Birth (mm/dd/yyyy)</td>
<td></td>
</tr>
<tr>
<td>Phone number where you can be reached (including area code)</td>
<td>For interviews call</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Language Preferred</td>
<td>Town where you live</td>
</tr>
<tr>
<td>Mailing Address line 1</td>
<td>Apartment or Suite number</td>
<td></td>
</tr>
<tr>
<td>Mailing Address line 2 (If applicable, include an “in-care-of” person here)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>ZIP Code</td>
</tr>
<tr>
<td>Physical address is same as mailing address</td>
<td>Send mail to:</td>
<td>□ Mailing address □ Physical address</td>
</tr>
<tr>
<td>Physical Address line 1</td>
<td>Apartment or suite number</td>
<td></td>
</tr>
<tr>
<td>Physical Address line 2 (If applicable, include an “in-care-of” person here)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>ZIP Code</td>
</tr>
</tbody>
</table>

People who are deaf or hard of hearing can call the statewide relay service at 711.

www.GreenMountainCare.org 1-800-250-8427 (TTY/Relay Service: Dial 711)
Rights of People with Disabilities
Do you have a physical or mental or learning condition that makes it hard to do things we ask you to do? We can make changes to help you. The Americans with Disabilities Act (ADA) and Vermont law say that we must make changes so people with disabilities can get health and public benefits. These changes are called reasonable accommodations. Here are some examples of changes we can make:

- Someone can write down your answers if you can’t.
- We can give you more time or help you get the documents you need to give us.
- You can have a support person with you when you talk to us.
- We can send documents with a larger print so you can read them.

*If you need us to make changes so you can get the benefits you need, call 1-800-250-8427.*

**IMPORTANT:** Be sure to read pages 10-12 before you sign and date the application.

If you need more room for any answers, use page 14 on the back of this application or a separate sheet of paper.

List if you have an Authorized Representative, Power of Attorney, Legal Guardian, Alternate Reporter, or Enrollment Assistor:

Check one: ☐ Authorized Representative ☐ Power of Attorney ☐ Legal Guardian ☐ Alternate Reporter ☐ Enrollment Assistor

<table>
<thead>
<tr>
<th>Full name</th>
<th>Phone No.</th>
<th>Home</th>
<th>Cell</th>
<th>Work</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(        )</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Address

For legal guardian only:

Name of court: __________________________ Date Appointed: __________________

☐ I give permission to DVHA/DAIL and the person or agency listed above to share information

We can send letters (notices) to someone else.

- **Legal guardian:** If you have a legal guardian, your notices will only be mailed to them.
- **In care of:** We can mail your notices in care of someone you choose. Your notices will only be mailed to them.
- **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.

Racial and Ethnic Heritage

If you are willing, please answer the following regarding the racial and ethnic heritage of your head of household. You do not have to give this information. It is not required to determine eligibility for any program or the amount of assistance you get. This information is collected only to be sure everyone gets benefits on a fair basis.

*Ethnicity (check one)*

☐ Hispanic or Latino ☐ Not Hispanic or Latino

*Race (check all that apply)*

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White
Items Needed for a New Application

- Please send as many items as you can with this application.
- The more items we have the faster we can process your application.
- Please send copies - **DO NOT send originals**.
- We will contact you for a phone interview.

**Do not wait to apply!**

- If you do not have copies of all the documents listed, send in the copies you do have when you apply. *It is important to apply as soon as possible.* We will give you more time to send any missing information.

- To find out if you are eligible for Long-Term Care Medicaid, we need the following items that apply to *you, your spouse or civil union partner*. Please Note: if more information is needed, your worker will let you know.

  - [ ] Power of attorney or legal guardianship documents
  - [ ] Private health insurance cards (copy of both sides)
  - [ ] Health insurance premium amounts
  - [ ] Long-term care insurance policies
  - [ ] Federal tax returns, including all forms and schedules, filed in the last 60 months
  - [ ] Current balance for your nursing home account
  - [ ] Current retirement account statements
  - [ ] Current burial account statements
  - [ ] Current stock, bond, and mutual fund statements
  - [ ] Current annuity statements
  - [ ] Most recent annual statement for each life insurance policy
  - [ ] Gross monthly income from all sources including VA, Railroad Retirement, pensions, annuities, etc.
  - [ ] Property tax bills and property transfer tax returns for any property that was sold, traded, given away, or had names added to the deed within the last 60 months
  - [ ] Current deeds for all property owned or co-owned by you, your spouse or civil union partner
  - [ ] Trusts (including all attachments, amendments and annual accountings for the last 60 months)
  - [ ] Promissory notes, mortgage notes and mortgage deeds

If you want to know if your spouse or civil union partner can keep some of your monthly income (this is called a spousal allocation), please provide the following:

  - [ ] Spouse or civil union partner’s gross monthly income
  - [ ] Mortgage
  - [ ] Property tax bill
  - [ ] Condo fees
  - [ ] Lot Rent
  - [ ] Rent
  - [ ] Room and/or board
ATTENTION

- You must provide financial information to DVHA and personal and health information to DAIL.
- If you are found eligible, your financial and clinical eligibility will be reviewed periodically.
- If you are found eligible, you may be required to pay part of the cost of the services you receive. The amount you pay is called your “patient share”.
- If you are found ineligible, you will be responsible to pay for the cost of the services you received while your application was pending if not covered by Medicaid, Medicare or other health insurance.
- If you are found clinically eligible, but funding is not available, DAIL will notify you that you have been placed on a waiting list. DVHA will deny Long-Term Care Medicaid and notify you if you qualify for other healthcare programs.

Household Information

1. Please list yourself, your spouse or civil union partner, and anyone you claim as a dependent on your income tax form. Spouse or civil union partner of LTC applicant must provide a social security number.

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Last name</th>
<th>Assistance applying for</th>
<th>Gender</th>
<th>Citizenship status</th>
<th>Marital status</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Choices for Care</td>
<td>Female</td>
<td>U.S. citizen</td>
<td>Never married</td>
<td>123-45-6789</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Developmental Disability Services Waiver</td>
<td>Male</td>
<td>Asylee</td>
<td>Civil union</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Traumatic Brain Injury</td>
<td></td>
<td>Refugee</td>
<td>Married</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Enhanced Family Treatment</td>
<td></td>
<td>Legal alien</td>
<td>Divorced/dissolved</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Last name</th>
<th>Assistance applying for</th>
<th>Gender</th>
<th>Citizenship status</th>
<th>Marital status</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>None</td>
<td>Female</td>
<td>U.S. citizen</td>
<td>Never married</td>
<td>123-45-6789</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Choices for Care</td>
<td>Male</td>
<td>Asylee</td>
<td>Civil union</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Developmental Disability Services Waiver</td>
<td></td>
<td>Refugee</td>
<td>Married</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Traumatic Brain Injury</td>
<td></td>
<td>Legal alien</td>
<td>Divorced/dissolved</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Enhanced Family Treatment</td>
<td></td>
<td>Other</td>
<td>Separated</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Last name</th>
<th>Marital status</th>
<th>Gender</th>
<th>Citizenship status</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Never married/Single</td>
<td>Female</td>
<td>U.S. citizen</td>
<td>123-45-6789</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Civil union</td>
<td>Male</td>
<td>Asylee</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Married</td>
<td></td>
<td>Refugee</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Divorced/dissolved</td>
<td></td>
<td>Legal alien</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Separated</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Widowed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Last name</th>
<th>Relationship to you</th>
<th>Birthdate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Spouse</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Civil union partner</td>
<td></td>
</tr>
</tbody>
</table>

Complete for dependents:

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Last name</th>
<th>Relationship to you</th>
<th>Birthdate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

www.GreenMountainCare.org  1-800-250-8427 (TTY/Relay Service: Dial 711)
2. Where are you currently living?

<table>
<thead>
<tr>
<th>Applicant</th>
<th>Applicant’s spouse or civil union partner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Home</td>
<td>□ Hospital</td>
</tr>
<tr>
<td>□ Hospital</td>
<td>□ Nursing Facility</td>
</tr>
<tr>
<td>□ Residential Care/Assisted Living Facility</td>
<td>□ Residential Care/Assisted Living Facility</td>
</tr>
</tbody>
</table>

Name of facility: ____________________________
Admission date: ____________________________
Location of facility: ____________________________

For Nursing Facility or Hospital Swing Bed, is the stay planned to be less than 30 days? □ Yes □ No

2a. Where do you want to receive your long-term care services? (Fill out for Choices for Care only.)

<table>
<thead>
<tr>
<th>Applicant</th>
<th>Applicant’s spouse or civil union partner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Own home/apartment</td>
<td>□ Home of another (family/friend)</td>
</tr>
<tr>
<td>□ Enhanced Residential Care</td>
<td>□ Nursing Facility</td>
</tr>
<tr>
<td>□ Adult Family Care Home</td>
<td>□ Adult Family Care Home</td>
</tr>
</tbody>
</table>

Name of facility: ____________________________
Admission date: ____________________________
Location of facility: ____________________________

For Nursing Facility or Hospital Swing Bed, is the stay planned to be less than 30 days? □ Yes □ No

3. If you reside in a nursing or enhanced residential care facility, would you return home if you were able, even if returning home is unlikely? (Fill out for Choices for Care only.)

Applicant: □ Yes □ No
Applicant’s spouse or civil union partner (if also applying): □ Yes □ No

3a. Are you expected to return home within 6 months? (Fill out for Choices for Care only.)

Applicant: □ Yes □ No
Applicant’s spouse or civil union partner (if also applying): □ Yes □ No

Health Insurance Information

4. Are you covered by Medicare? □ Yes □ No

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Medicare claim number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Part A:
Start Date: ____________________________
Premium $: ____________________________

Part B:
Start Date: ____________________________
Premium $: ____________________________

Part C:
Start Date: ____________________________
Premium $: ____________________________

Part D:
Start Date: ____________________________
Premium $: ____________________________

4a. If also applying, is your spouse or civil union partner covered by Medicare? □ Yes □ No

5. Are you enrolled in a Medicare prescription drug plan? □ Yes □ No

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

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Plan name</th>
<th>CMS number</th>
<th>Plan start date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CMS- __ __ __ __ __ __

5a. If also applying, is your spouse or civil union partner enrolled in a Medicare prescription drug plan? □ Yes □ No

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Plan name</th>
<th>CMS number</th>
<th>Plan start date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CMS- __ __ __ __ __ __

6. Do you or your spouse or civil union partner have any unpaid medical bills? □ Yes □ No
7. List all health, dental, Medicare supplemental or long-term care insurance, such as group insurance, veteran or military benefits. *(Include information for your spouse or civil union partner, if also applying).*
   - Do not include any Medicare information listed in question 4.
   - Do not include Green Mountain Care programs (Medicaid, Premium Assistance and Pharmacy programs).
   - List prescription plans separately.

Please send: 1. Copies of any long-term care insurance policies; 2. Verification of all premiums paid; 3. Copies of both sides of all insurance cards. **Failure to provide the requested documentation will cause application processing delays**

<table>
<thead>
<tr>
<th>INSU</th>
<th>Name of policy holder</th>
<th>Type of coverage (check all that apply)</th>
<th>Names of people covered</th>
<th>Name, address, and phone number of insurance company</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>[ ] Doctor [ ] Prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Hospital [ ] Major Medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Dental [ ] Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Vision [ ] Long-term care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>[ ] Other ___________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 2.   |                       | [ ] Doctor [ ] Prescription           |                        |                                                  |
|      |                       | [ ] Hospital [ ] Major Medical        |                        |                                                  |
|      |                       | [ ] Dental [ ] Outpatient             |                        |                                                  |
|      |                       | [ ] Vision [ ] Long-term care         |                        |                                                  |
|      |                       | [ ] Other ___________________________ |                        |                                                  |

| Resource Information |

8. List any cash that you or your spouse or civil union partner have that is not in a bank. *(Such as at home, on hand or held by others)*

<table>
<thead>
<tr>
<th>CASH</th>
<th>First name</th>
<th>Initial</th>
<th>Amount</th>
<th>First name</th>
<th>Initial</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

9. List all banks, credit unions or other financial institutions that you or your spouse or civil union partner have had money in for the last 60 months *(Provide current statements for all accounts).*

<table>
<thead>
<tr>
<th>BANK</th>
<th>Type</th>
<th>Name of owner &amp; co-owner</th>
<th>Name of bank, credit union, or other institution</th>
<th>Account/Policy number</th>
<th>Balance or value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Checking account</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Checking account</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Checking account</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Savings account</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Savings account</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Savings account</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Savings account</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Christmas club</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IRA, Keogh Plan, 401K</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Savings bonds</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Certificate of deposit (CD)</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pension or Retirement Account</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residential account</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Safety deposit box</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Direct Express</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other States &amp; Countries</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

If you need more space use a separate sheet of paper.
10. List any vehicle owned by you or your spouse or civil union partner

<table>
<thead>
<tr>
<th>Type of vehicle</th>
<th>Name of owner and co-owner</th>
<th>Year, make, and model</th>
<th>Leased?</th>
<th>Amount Owed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Car, truck, or van</td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Car, truck, or van</td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Camper or RV</td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Snow mobile or jet ski</td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Trailer or boat</td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Motorcycle or ATV</td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

11. List all land, mobile homes, timeshares, buildings, other real estate, or life estate interests that you or your spouse or civil union partner own or co-own. (All deeds are needed)

<table>
<thead>
<tr>
<th>Type of property</th>
<th>Name of owner and co-owner</th>
<th>Location</th>
<th>Assessed value</th>
<th>Amount owed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary residence</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Vacation home</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Camp</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Rental property</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Business property</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Land</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Time share</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Other (describe)</td>
<td></td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

12. List any other resources owned by you or your spouse or civil union partner (Current statements needed)

<table>
<thead>
<tr>
<th>Type of Resource</th>
<th>Name of owner and co-owner</th>
<th>Company or location</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life insurance</td>
<td></td>
<td></td>
<td>Face value $</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cash value $</td>
</tr>
<tr>
<td>Life insurance</td>
<td></td>
<td></td>
<td>Face value $</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cash value $</td>
</tr>
<tr>
<td>Life insurance</td>
<td></td>
<td></td>
<td>Face value $</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cash value $</td>
</tr>
<tr>
<td>Account set up for burial expenses</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Is this irrevocable? □ Yes □ No</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Burial plot, space, urn, crypt, headstone</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Stocks</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Bonds</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Mutual funds</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Annuities</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Trust funds</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>ABLE accounts</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>401K or Retirement accounts</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Promissory or mortgage notes (money owed to you)</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Account set up for medical expenses</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

13. List all physical addresses where you lived in the last 60 months.

<table>
<thead>
<tr>
<th>Street or Road</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
14. List anything that you or your spouse or civil union partner have given away, sold, gifted or traded in the last 60 months. Your worker will let you know if more information is needed.

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>What was it?</th>
<th>When was it?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. List any assets that you or your spouse or civil union partner have had another person’s name added to in the last 60 months. (Such as financial accounts or property)

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>What was it?</th>
<th>Whose name was added?</th>
<th>When was name added?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. List any assets that you or your spouse or civil union partner have placed in a trust in the last 60 months.

Send copy of trust document including all schedules, amendments and a trust accounting signed and dated by the trustee telling us what was added or removed from the trust in the last 60 months.

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>What was placed in the trust?</th>
<th>Date it was placed in the trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Income Information

17. List any income you or your spouse or civil union partner have had from a job, internship or training program.

- 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.

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Date paid</th>
<th>Hours worked</th>
<th>Income before deductions</th>
<th>Tips and commissions</th>
</tr>
</thead>
</table>
| Paychecks are issued
  □ Weekly  □ Every two weeks  □ Twice a month
  □ Monthly
  Day of week _______________
| Employer's name and phone number |

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Date paid</th>
<th>Hours worked</th>
<th>Income before deductions</th>
<th>Tips and commissions</th>
</tr>
</thead>
</table>
| Paychecks are issued
  □ Weekly  □ Every two weeks  □ Twice a month
  □ Monthly
  Day of week _______________
| Employer's name and phone number |

Please attach copies of your pay stubs for the past 30 days.

18. List any income you or your spouse or civil union partner have had from self-employment.

- Such as farming, home party sales, logging or property rental.
- Send a copy of your most recent federal tax return, including all forms and schedules.
- If you have not filed taxes or 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.

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Type of business</th>
<th>Date business began</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

www.GreenMountainCare.org
1-800-250-8427 (TTY/Relay Service: Dial 711)
19. List any other income that you or your spouse or civil union partner have had.

Some examples are:
- Social Security
- Pensions or retirement
- Veteran’s compensation
- Workers’ Comp
- Trusts
- SSI/AABD
- Veteran’s pension
- Child support
- Unemployment
- Rent
- Money from others
- Insurance settlement
- Annuities
- Promissory or Mortgage note
- LTC Insurance
- Other: (Please describe and list below)

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

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Income before deductions</th>
<th>Type of income</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

19a. List any income that you or your spouse or civil union partner are entitled to but do not receive. (Such as pensions or retirement)

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Income before deductions</th>
<th>Type of income</th>
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<tbody>
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</table>

Expense Information

20. Do you pay for medical expenses not covered by insurance (include spouse or civil union partner if also applying)? (Disregard if nursing home setting)

- Pain relievers
- Antacids
- Insurance premiums
- Personal alert system
- Eyeglasses
- Dental care
- Copayments
- Personal care services
- Hearing aid batteries
- Vitamins
- Over-the-counter items

<table>
<thead>
<tr>
<th>First name</th>
<th>Initial</th>
<th>Product or service needed</th>
<th>How often</th>
<th>Dosage or number of pills</th>
<th>Average monthly cost</th>
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21. List the following expenses for your apartment, house, or trailer.

- Mortgage
- Home equity loan
- Homeowners insurance
- Property tax
- Condo fees
- Fuel and utilities
- Lot rent
- Rent
- Room and/or board

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<tbody>
<tr>
<td>Mortgage</td>
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<tr>
<td>Home equity loan</td>
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<tr>
<td>Homeowners insurance</td>
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<td>Property tax</td>
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<tr>
<td>Condo fees</td>
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</tbody>
</table>

22. List any housing expenses that you or your spouse or civil union partner share with other people.

<table>
<thead>
<tr>
<th>Names of people who share the expense</th>
<th>Who pays for what</th>
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<tbody>
<tr>
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</table>

You must report changes within 10 days

Some examples of what you must report are:

- Any changes in income (such as social security, veteran’s benefits, railroad retirement, pension plans, annuities, and rental income).
- If all your combined resources exceed the allowed $2,000 limit.
- Receipt of lump sum payments (such as trust or retirement fund distributions, inheritances, insurance settlements, or lottery winnings).
- Changes in health insurance cost, company or coverage.
- Changes in ownership (such as adding or removing a name, or sale or transfer of real or personal property).
- If you or your spouse, or civil union partner sells, trades, gives away, or adds other names to the ownership of real property or other assets such as bank accounts, stocks, bonds, etc.
  - **If you sold property, including your home.**
  - If you have any questions about what changes you must report, call Member Services at 1-800-250-8427

You may report changes by:

- Calling Member Services at 1-800-250-8427
- Writing to the address listed below
- Sending a Change Report form (Form 200) to:

  Department of Vermont Health Access  
  Application and Document Processing Center  
  280 State Drive  
  Waterbury, VT 05671-1500

Call Member Services at 1-800-250-8427 to:

- Get general information about programs;
- Request an application form;
- Speak to a Member Services Agent – weekdays between 8:00 a.m. and 4:30 p.m.

We now have an automated information system you can call 24 hours a day, 7 days a week.
## Rights and Responsibilities

You may request a copy of these Rights and Responsibilities in larger print.

**True and complete information.** I understand the information I provide to apply for assistance 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 for assistance. I understand if any information is not true, DVHA may deny assistance to me.

**Reporting changes.** I understand when I get assistance I must report changes in my situation. The changes I must report may be different depending on the benefits I get. If I am not sure which changes I must report, I will ask my worker. I understand changes may affect the amount of benefits I get. I also understand I must report changes within 10 days from when they happen.

**Confidentiality.** DVHA will not share any information from this application except for purposes directly connected with program administration unless I clearly allow release of this information or a court orders it.

**Social security number.** I understand that, when I apply for Long-Term Care Medicaid assistance from DVHA, I must give my social security number and that of my spouse or civil union partner, if I have one. Federal law requires this as a condition of eligibility. This requirement may be waived for some programs for members of religious organizations that object to furnishing social security numbers. (42 U.S.C. §1320b-7)

DVHA uses the social security number: 1) for computer processing of program benefits, support enforcement, fraud investigation, audits, and Lifeline identification; 2) to verify social security and supplemental security income; 3) to prevent individuals from receiving duplicate benefits; 4) to identify groups of cases that must have benefits changed; 5) to exchange information with agencies such as the Social Security Administration, Department of Labor, Internal Revenue Service, or private claims collection agencies to verify income, determine eligibility and benefit amounts, and collect claims; 6) to determine the accuracy and reliability of information given to DVHA; and 7) to make medical assistance payments.

**No discrimination.** DVHA does not exclude people from its programs or deny them benefits because of race, color, national origin, age, disability, or sex. DVHA provides free aids and services to people with disabilities so they can work with us more easily. DVHA provides free language services to people who need to speak a language that is not English, such as qualified interpreters and information written in other languages. If you believe that DVHA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with DVHA’s Health Programs Civil Rights Coordinator.

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, a DVHA’s Health Programs Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone.

**Health Program Civil Rights Coordinator**

<table>
<thead>
<tr>
<th>DVHA Legal Department</th>
<th>U.S. Department of Health and Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>280 State Drive, NOB 1 South</td>
<td>200 Independence Avenue, SW</td>
</tr>
<tr>
<td>Waterbury, VT 05671-1010</td>
<td>Room 509F, HHH Building</td>
</tr>
<tr>
<td>Phone: (802) 241-0454</td>
<td>Washington, D.C. 20201</td>
</tr>
<tr>
<td>Fax: (802) 241-0260</td>
<td>1-800-368-1019, 800-537-7697 (TDD)</td>
</tr>
<tr>
<td>E-mail: <a href="mailto:AHS.DVHALegal@vermont.gov">AHS.DVHALegal@vermont.gov</a></td>
<td>Complaint forms are available at</td>
</tr>
</tbody>
</table>

**Decision on application.** DVHA must make a decision on my application within 30 days (90 days if my Medicaid application is based on disability) unless delay is caused by examining physicians, an administrative emergency, or me. If I do not get a decision within 30 (or 90) days, I may call Member Services at 1-800-250-8427 for more information or to request a fair hearing.
**Fair hearing.** I may ask for a fair hearing when my claim for assistance or services is denied in whole or in part, or not responded to with reasonable promptness. Call Member Services at 1-800-250-8427 or write to the DVHA Deputy Commissioner for financial determinations or the DAIL Commissioner’s office for clinical determinations. (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 a 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. If waiting on a regular fair hearing might harm me, I can ask for an expedited (faster) fair hearing. If I need this, I will call Member Services at 1-800-250-8427.

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

**Release of tax records.** I give permission to the Vermont Commissioner of Taxes to disclose information from my state income tax returns to the Deputy Commissioner of DVHA. (33 V.S.A. §112))

**Release of medical records.** I agree that my health care providers may release my medical records when necessary for the purpose of administering DVHA health care or Reach Up programs.

**Assignment of medical support.** As a condition of eligibility for health care assistance, I agree to assign to the state 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 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 benefits will continue.

**Recovery of Medicaid payments.** DVHA must file a claim against my estate when I die to recover Medicaid payments made for me for services I received at age 55 or older while in a nursing facility or a home-based waiver program, and for related hospital and prescription drug services. DVHA will not seek adjustment or recovery against my estate if, at the time of death, my spouse is still alive, I have surviving children who are blind, disabled, or under age 21, or DVHA determines that adjustment or recovery would cause undue hardship. I understand I may find out more about recovery from my worker. (42 U.S.C. §1396p)

**Medicare Part B payments.** If I get Medicare Part B benefits while getting Medicaid, I want DVHA to make any payments for future Medicare Part B medical and other health services directly to physicians and medical suppliers. This means I will not have to sign a separate form each time I get a service.

**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.

**Not 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 DVHA must disclose information to law enforcement agencies to apprehend fleeing felons.

**No benefits from another state.** If any member of my household gets duplicate 3SquaresVT benefits, Medicaid, or cash assistance from another state or has been convicted in the past ten years of fraudulently misrepresenting residency to get benefits from two or more states, I must tell DVHA immediately.

**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 Reach Up, 3SquaresVT, or health care benefits. If convicted, penalties may include up to three years of imprisonment and/or a fine of up to $1,000, or an amount equal to the benefits wrongfully received. Federal and other state penalties may also apply. (42 U.S.C. §1320a-7b; 33 V.S.A. §§141, 143)
You must sign here. If your spouse or civil union partner is also applying for CFC LTC Medicaid, they must also sign. 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 included in this application and I agree to them.

Signature of applicant or authorized representative: ____________________________ Date: __________

(Required)

Signature of spouse/civil union partner or authorized representative: ____________________________ Date: __________

(Required if also applying)

Signature of person helping you fill out this form: ____________________________ Date: __________

Print Name: ____________________________ Agency Name: ____________________________ Phone number: ____________________________

Return this application to: DVHA
Application and Document Processing Center
280 State Drive
Waterbury, VT 05671-1500

We will let you know if we need more information. You will hear from us within 30 days.

The applicant is responsible for the accuracy of all of the information given on this application including information about the applicant’s spouse 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 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.

Lifeline may provide a discount on your phone bill and is a service offered directly through phone providers. To learn more about this program visit http://publicservice.vermont.gov/publications-resources/consumers/lifeline.

Link Up may pay for part of the installation cost of a new phone. You can get this benefit 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 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 helps to pay heating bills. To learn more about this program or to request an application, call toll free 1-800-479-6151.

3SquaresVT helps to pay for food. If you have little or no money for food, you may also be able to get emergency help. For information or an application, call toll-free 1-800-479-6151.
If you need more room for any answers use this page or a separate sheet of paper.
Affordable
Policy
Free
Families that include immigrants can apply. You can apply for your child even if you are
Social
A

You may keep this page for future reference. Your Rights and Responsibilities are on the back of this page and page 11.

Apply faster online or by phone. Visit VermontHealthConnect.gov or call 1-855-899-9600.
Applying for health coverage through Vermont Health Connect does not mean you have to buy a health plan.

<table>
<thead>
<tr>
<th>Coverages you may qualify for</th>
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</thead>
<tbody>
<tr>
<td>• Affordable private health insurance plans that offer comprehensive coverage to help you stay well</td>
</tr>
<tr>
<td>• A new tax credit that can immediately lower your premiums for health coverage</td>
</tr>
<tr>
<td>• Free or low-cost insurance from Medicaid/Dr. Dynasaur (includes some dental coverage)</td>
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</tbody>
</table>

You may qualify for a free or low-cost program even if you earn as much as $95,400* a year (for a family of 4). *This number changes every January.

<table>
<thead>
<tr>
<th>Who can use this application?</th>
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<tbody>
<tr>
<td>• Use this application to apply for yourself.</td>
</tr>
<tr>
<td>• Use this application to apply for anyone in your family. See Step 2 on page 1.</td>
</tr>
<tr>
<td>• Apply even if you or your child already has health coverage. You could still be eligible for lower-cost or free coverage.</td>
</tr>
<tr>
<td>• Families that include immigrants may apply. You can apply for your child even if you are not eligible for coverage. Applying will not affect your immigration status or chances of becoming a permanent resident or citizen.</td>
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<thead>
<tr>
<th>DO NOT use this application for...</th>
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<tbody>
<tr>
<td>• 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 1-855-899-9600.</td>
</tr>
<tr>
<td>• Reporting changes. To report changes to your household information, call 1-855-899-9600.</td>
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</table>

<table>
<thead>
<tr>
<th>What you may need to apply</th>
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<tbody>
<tr>
<td>• Social Security numbers (or document numbers for any legal immigrants who need insurance)</td>
</tr>
<tr>
<td>• Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements)</td>
</tr>
<tr>
<td>• Policy numbers for any health insurance you or others on this application now have</td>
</tr>
<tr>
<td>• If someone is helping you fill out this application, you may need to complete Appendix A.</td>
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<tr>
<td>• A completed Appendix C for each family member whose employer offers health insurance</td>
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<thead>
<tr>
<th>Why do we ask for this information?</th>
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<tbody>
<tr>
<td>We ask about income and other information to determine what coverage you qualify for and if you can get any help paying for it.</td>
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<tr>
<td>We will keep all the information you provide private and secure, as required by law.</td>
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<th>What happens next?</th>
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<tr>
<td>Send your completed and signed application to the address in Step 10 on page 12. If you do not have all the information we ask for, sign and submit your application anyway. We will follow-up with you within 1–2 weeks with instructions on the next steps to complete your application. You may need to make a payment before coverage begins. If you do not hear from us, visit VermontHealthConnect.gov or call 1-855-899-9600.</td>
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<thead>
<tr>
<th>Get help with this application</th>
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<tr>
<td>• Online: VermontHealthConnect.gov</td>
</tr>
<tr>
<td>• Phone: Call our Customer Support Center at 1-855-899-9600.</td>
</tr>
<tr>
<td>• TTY/Relay: If you are deaf, hard of hearing, or have a speech disability, dial 711.</td>
</tr>
<tr>
<td>• In person: There is someone who can help in your area. Call 1-855-899-9600.</td>
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<tr>
<th>Interpretation services are available</th>
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<tbody>
<tr>
<td>• Arabic 1-855-899-9600</td>
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<tr>
<td>• Bosnian 1-855-899-9600 (Bosnian)</td>
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<tr>
<td>• Burmese 1-855-899-9600 (Burmese)</td>
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<tr>
<td>• French 1-855-899-9600 (French)</td>
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<tr>
<td>• Kirundi 1-855-899-9600 (Kirundi)</td>
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<tr>
<td>• Nepali 1-855-899-9600 (Nepali)</td>
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<tr>
<td>• Somali 1-855-899-9600 (Somali)</td>
</tr>
<tr>
<td>• Spanish 1-855-899-9600 (Spanish)</td>
</tr>
<tr>
<td>• Vietnamese 1-855-899-9600 (Vietnamese)</td>
</tr>
</tbody>
</table>

You may keep this page for future reference. Your Rights and Responsibilities are on the back of this page and page 11.

If you need help understanding something, contact Vermont Health Connect at 1-855-899-9600.
Your Rights and Responsibilities within Vermont Health Connect
Additional rights and responsibilities can be found on page 11.

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

Americans with Disabilities Act. If you think you might have a physical or mental condition that substantially limits a major life activity (for example, walking, seeing, hearing, or learning), let us know. The Americans with Disabilities Act and Vermont law give people with disabilities certain rights. We will make reasonable changes (called an “accommodation”) in our requirements to help you take part in our programs. Call 1-855-899-9600 to let Vermont Health Connect know if you need an accommodation.

Discrimination. Under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. You can file a complaint of discrimination online by visiting www.hhs.gov/ocr/office/file; by writing to Health and Human Services, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201; or by calling 1-800-368-1019 or 1-800-537-7697 (TDD).

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

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

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

Renewal of Eligibility in Future Years. To make it easier to decide if you qualify for help paying for health coverage in future years, you can agree to allow Vermont Health Connect to use income data, including information from tax returns. You can tell us not to use your information at any time. Your options are available to you in Step 5 on page 10 of this application. Vermont Health Connect may send you a notice and let you make any changes. You can also call us at 1-855-899-9600.

Medicaid. If you or anyone in your household enrolls in Medicaid, you give the Medicaid agency the right to pursue and get any money from other health insurance, legal settlements, or other third parties. You also give the agency the right to pursue and get medical support from a spouse or parent. If a child on Medicaid has a parent living outside of the home, we may ask you to cooperate with us to collect medical support from an absent parent. If you think that cooperating to collect medical support may harm you or your children, tell Medicaid. You may not have to cooperate.

Reporting changes. You must tell Vermont Health Connect if anything changes or is different than what you wrote on this application. If enrolled in Medicaid, you must report changes within 10 days. If enrolled in a Qualified Health Plan with financial assistance, you must report changes within 30 days. Visit VermontHealthConnect.gov or call 1-855-899-9600 to report any changes. A change in your information could affect the eligibility for yourself and the member(s) of your household.

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

Your Right to Appeal. If you think Vermont Health Connect has made a mistake, you can appeal its decision. You can also appeal if we are late making a decision. To appeal means to ask for a fair hearing. A fair hearing is a chance to tell a hearing officer at the Human Services Board why you think the decision is wrong. The hearing officer will make a new decision after looking at all the facts. If waiting on a regular appeal might harm you, you can file an expedited (faster) appeal. When you appeal, tell us if you need an “expedited” appeal. You must appeal within 90 days of a Vermont Health Connect decision. We will send you a notice (decision) on your application. It will tell you more about how to appeal and any deadlines. To appeal call Vermont Health Connect at 1-855-899-9600. You may also write to the Human Services Board, 120 State Street, Montpelier, VT 05620-4301.

You may be able to get free legal advice by calling the Health Care Advocate at Vermont Legal Aid at 1-800-917-7787.

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

Other Kinds of Complaints. If you want to complain about something other than an eligibility decision, like how Vermont Health Connect has treated you, call Vermont Health Connect at 1-855-899-9600. Call within 60 days if you want a written response.
Application for Health Coverage and Help Paying Costs

STEP 1 PERSON 1: Tell us about yourself

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

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

2. Home address (leave blank if you do not have one) 3. Apartment or suite number


8. Mailing address line 1 (if different from home address) 9. Apartment or suite number

10. Mailing address line 2 (If applicable, include an “in-care-of” person here. For an Authorized Representative, complete Appendix A.)


15. HOME phone number (  ) – 16. WORK phone number (  ) – 17. CELL phone number (  ) –

18. What is your preferred spoken or written language (if not English)?

STEP 2 Tell us about your family

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

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

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

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

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 3 people in your family, you will need to make copies of pages 6 and 7 for each additional person and attach the additional pages to your application. You should always include your own name and date of birth on any additional pages you attach. You do not need to provide immigration status or a Social Security number for family members who do not need health coverage. We will keep all the information you provide private and secure as required by law. We will use personal information only to check if you are eligible for health coverage.
**STEP 2: PERSON 1** (Start with yourself)

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

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

2. **Relationship to you?**
   - SELF

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:
   - Never married
   - Married
   - Civil union
   - Separated
   - Divorced/dissolved
   - Widowed

   If you are a victim of domestic violence and applying separately from your spouse, you may indicate that you are “Never married”.

7. Social Security number (SSN)

   **We need this if you want health coverage and have an SSN.** Providing your SSN can be helpful, even if you do not want health coverage, since it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users call 1-800-325-0778.

8. **Do you or your spouse plan to file a federal income tax return, or be included in a federal income tax return, NEXT YEAR?** (You can still apply for health insurance even if you do not file a federal income tax return.)
   - YES. If yes, please answer questions a–c.
   - NO. If no, skip to question c.
     a. Will you file jointly with a spouse?  
        - Yes
        - No
        If yes, name of spouse: __________________________
     b. Will you claim any dependents on your tax return? (Joint filers must claim the same dependents.)  
        - Yes
        - No
     c. Will you be claimed as a dependent on someone else’s tax return? (You cannot be both a dependent and a joint filer.)  
        - Yes
        - No
     d. If yes, name of the tax filer: __________________________

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

10. **Are you applying for health coverage?** (Even if you have insurance, there might be a program with better coverage or lower costs.)
    - YES. If yes, answer all the questions below.
    - NO. If no, SKIP ahead to page 3 and leave the rest of this page blank.
    a. Do you have a physical, mental, or emotional health condition that causes limitations in daily activities (like bathing, dressing, daily chores, etc.)?  
       - Yes
       - No
    b. Do you live in a medical facility or nursing home?  
       - Yes
       - No

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

12. **If you are not a U.S. citizen or U.S. national,** do you have eligible immigration status?
    - YES. Fill in your document information below.
    a. Immigration document type __________________________
    b. Document expiration date __________________________  
       - None
    c. Alien number __________________________
    d. Have you lived in the U.S. since 1996?  
       - Yes
       - No
    e. Date of entry __________________________
    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

13. **Retroactive Medicaid:** If you have unpaid medical/dental expenses from the last 3 months and your income is within the guideline, you might be eligible for assistance that could help pay, or reimburse you for those expenses. Do you want to apply for help with medical/dental expenses from the last 3 months?  
    - Yes
    - No

14. 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

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

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

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

18. **Race (OPTIONAL—check all that apply.)**
    - White
    - Black or African American
    - American Indian or Alaska Native
    - Asian Indian
    - Chinese
    - Filipino
    - Japanese
    - Korean
    - Vietnamese
    - Other Asian
    - Native Hawaiian
    - Guamanian or Chamorro
    - Samoan
    - Other Pacific Islander
    - Other __________________________

Now, tell us about your income on the next page.
**STEP 2: PERSON 1**  (Continue with your income)

### Current Job & Income Information

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

- **Self-employed**  
  Skip to question 32.

- **Not employed**  
  Skip to question 33.

#### CURRENT JOB 1:

20. Employer name

21. Employer phone number

22. Employer address

23. Gross wages/tips (before taxes) $ 

24. Average hours worked each week in the past month: 

#### CURRENT JOB 2:  
To list additional jobs, attach another sheet of paper. Include your name and date of birth on any additional sheets.

25. Employer name

26. Employer phone number

27. Employer address

28. Gross wages/tips (before taxes) $ 

29. Average hours worked each week in the past month: 

#### OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often you receive it.

When asked “How often?”, indicate whether the amount is received weekly, every two weeks, twice a month, monthly, or yearly.  

**NOTE:** You do not need to tell us about child support, worker compensation, veteran’s payments, or Supplemental Security Income (SSI).

- None
- Alimony received
- Canceled debt
- Commissions
- Court awards
- Foreign earned income
- Gambling/prizes/awards
- Investment income
- Jury pay
- Unemployment

- Net farming/fishing
- Net rental/royalty
- Non-taxable SSA
- Pensions
- Retirement accounts
- Scholarships & grants
- Social Security (disability, retirement, and survivor/widow benefit before Medicare deduction)
- Tax exempt interest/dividends
- What state pays your unemployment benefit?

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

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

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

- Alimony paid
- Other deductions

- Student loan interest

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

Your total income this calendar year

Your total income next calendar year (if you think it will be different)

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

**NEED HELP WITH YOUR APPLICATION?** Visit VermontHealthConnect.gov or call toll-free 1-855-899-9600. For TTY/relay services, dial 711.
STEP 2: PERSON 2

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

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.)
2. Relationship to you?

3. List any other names PERSON 2 has been known by (e.g., maiden name or alias)
4. Date of birth (mm/dd/yyyy)
5. Sex
   - Male
   - Female

6. Marital status:
   - Never married
   - Married
   - Civil union
   - Separated
   - Divorced/dissolved
   - Widowed

7. Social Security number (SSN)

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

9. Does PERSON 2 or their spouse plan to file a federal income tax return, or be included in a federal income tax return, NEXT YEAR?
   (PERSON 2 can still apply for health insurance even if they do not file a federal income tax return.)
   - YES. If yes, please answer questions a–c.
   - NO. If no, skip to question c.
   a. Will PERSON 2 file jointly with a spouse?  Yes  No
      If yes, name of spouse:
   b. Will PERSON 2 claim any dependents on his or her tax return? (Joint filers must claim the same dependents.)  Yes  No
      If yes, list name(s) of dependents:
   c. Will PERSON 2 be claimed as a dependent on someone else's tax return? (Cannot be both a dependent and a joint filer.)  Yes  No
      If yes, name of the tax filer:  ________________

10. Is PERSON 2 pregnant?  Yes  No
    a. If yes, how many babies are expected during this pregnancy?  ________________
    b. What is the estimated due date?  ________________

11. Is PERSON 2 applying for health coverage?
    - YES. If yes, answer all the questions below.
    - NO. If no, SKIP ahead to page 5 and leave the rest of this page blank.
    a. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in daily activities (like bathing, dressing, daily chores, etc.)?  Yes  No
    b. Does PERSON 2 live in a medical facility or nursing home?  Yes  No

12. Is PERSON 2 a U.S. citizen or U.S. national?  Yes  No

13. 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.
    a. Immigration document type  ________________
    b. Document expiration date  ________________
    c. Alien number  ________________
    d. Has PERSON 2 lived in the U.S. since 1996?  Yes  No
    e. Date of entry  ________________
    f. Passport or document number  ________________
    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

15. Retroactive Medicaid: If PERSON 2 has medical/dental expenses from the last 3 months and their income is within the guideline, they might be eligible for assistance that could help pay, or reimburse them for those expenses.
    Does PERSON 2 want to apply for help with medical/dental expenses from the last 3 months?  Yes  No

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

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

18. Was PERSON 2 in foster care in Vermont when they turned 18?  Yes  No

19. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
    - Mexican
    - Mexican American
    - Chicano/a
    - Puerto Rican
    - Cuban
    - Other

20. Race (OPTIONAL—check all that apply.)
    - White
    - Black or African American
    - American Indian or Alaska Native
    - Asian Indian
    - Chinese
    - Filipino
    - Japanese
    - Korean
    - Vietnamese
    - Other Asian
    - Native Hawaiian
    - Guamanian or Chamorro
    - Samoan
    - Other Pacific Islander
    - Other

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

NEED HELP WITH YOUR APPLICATION? Visit VermontHealthConnect.gov or call toll-free 1-855-899-9600. For TTY/relay services, dial 711.
## Current Job & Income Information

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

### CURRENT JOB 1:

<table>
<thead>
<tr>
<th>21. Employer name</th>
<th>22. Employer phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

23. Employer address

24. Gross wages/tips (before taxes) $ __________

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

### CURRENT JOB 2:

To list additional jobs, attach another sheet of paper. Include your name and date of birth on any additional sheets.

<table>
<thead>
<tr>
<th>26. Employer name</th>
<th>27. Employer phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28. Employer address

29. Gross wages/tips (before taxes) $ __________

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

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

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

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

34. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often PERSON 2 receives it.
   When asked “How often?”, indicate whether the amount is received weekly, every two weeks, twice a month, monthly, or yearly.

   **NOTE:** You do not need to tell us about child support, worker compensation, veteran’s payments, or Supplemental Security Income (SSI).

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

35. DEDUCTIONS: Check all that apply, and give the amount and how often PERSON 2 pays it.
   If PERSON 2 pays for things that can be deducted on a federal income tax return, tell us about them could lower their healthcare costs.
   **NOTE:** You should not include a cost that you already deducted from PERSON 2’s self-employment net income in question (33.b.).

   - Alimony paid $ __________ How often? __________
   - Student loan interest $ __________ How often? __________
   - Other deductions $ __________ Type(s) __________ How often? __________

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

   PERSON 2’s total income **this** calendar year $ __________
   PERSON 2’s total income **next** calendar year (if you think it will be different) $ __________

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

NEED HELP WITH YOUR APPLICATION? Visit VermontHealthConnect.gov or call toll-free 1-855-899-9600. For TTY/relay services, dial 711.
**STEP 2: PERSON 3**

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

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

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

**NEED HELP WITH YOUR APPLICATION?** Visit VermontHealthConnect.gov or call toll-free 1-855-899-9600. For TTY/relay services, dial 711.

Page 6 of 12
## Current Job & Income Information

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Employed</td>
<td>□ Self-employed</td>
</tr>
<tr>
<td>If PERSON 3 is currently employed, tell us about their income. Start with question 21.</td>
<td>Skip to question 33.</td>
</tr>
</tbody>
</table>

**CURRENT JOB 1:**

21. Employer name

22. Employer phone number

23. Employer address

24. Gross wages/tips (before taxes) $__________

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

**CURRENT JOB 2:** To list additional jobs, attach another sheet of paper. Include your name and date of birth on any additional sheets.

26. Employer name

27. Employer phone number

28. Employer address

29. Gross wages/tips (before taxes) $__________

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

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

32. In the past year, did PERSON 3: □ Change jobs □ Stop working □ Start working fewer hours □ None of these

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

   a. What type of work does PERSON 3 do?

   b. How much net income (profit after business expenses are paid) will PERSON 3 get this month? $__________

34. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often PERSON 3 receives it.

**NOTE:** You do not need to tell us about child support, worker compensation, veteran's payments, or Supplemental Security Income (SSI).

<table>
<thead>
<tr>
<th>Type(s)</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Alimony received</td>
<td>$__________</td>
</tr>
<tr>
<td>Canceled debt</td>
<td>$__________</td>
</tr>
<tr>
<td>Commissions</td>
<td>$__________</td>
</tr>
<tr>
<td>Court awards</td>
<td>$__________</td>
</tr>
<tr>
<td>Foreign earned income</td>
<td>$__________</td>
</tr>
<tr>
<td>Gambling/prizes/awards</td>
<td>$__________</td>
</tr>
<tr>
<td>Investment income</td>
<td>$__________</td>
</tr>
<tr>
<td>Jury pay</td>
<td>$__________</td>
</tr>
<tr>
<td>Unemployment</td>
<td>$__________</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>Type(s)</th>
<th>How often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alimony paid</td>
<td>$__________</td>
</tr>
<tr>
<td>Student loan interest</td>
<td>$__________</td>
</tr>
<tr>
<td>Other deductions</td>
<td>$__________</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Person 3’s total income this calendar year</th>
<th>Person 3’s total income next calendar year (if you think it will be different)</th>
</tr>
</thead>
</table>

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

NEED HELP WITH YOUR APPLICATION? Visit VermontHealthConnect.gov or call toll-free 1-855-899-9600. For TTY/relay services, dial 711.
**STEP 3**

Your family’s health coverage

Answer these questions for anyone applying for health coverage.

1. **Is anyone currently enrolled in health coverage from any of the following?** (Do not include dental coverage. If your coverage under one of the programs below is ending and you are applying for new/continued coverage, including Medicaid/Dr. Dynasaur, answer NO.)

   - YES. If **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 ____________________________
   - Employee insurance. If you have employee insurance, answer question 4.
   - TRICARE (Do not check off if you have direct care or Line of Duty)
   - VA health care programs ____________________________
   - Other insurance. If you have an insurance type not listed here, or in question 2, answer question 4.

2. **Is anyone eligible for or enrolled in Medicare because they are age 65 or older, or because of a permanent disability?**

   - YES. Please fill in the table below.  
   - NO.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare claim number:</td>
<td>Medicare claim number:</td>
</tr>
<tr>
<td>Part A</td>
<td>Part B</td>
</tr>
<tr>
<td>Start date: [ ]</td>
<td>Start date: [ ]</td>
</tr>
<tr>
<td>Premium $ [ ]</td>
<td>Premium $ [ ]</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name of insurance company</th>
<th>Company phone number</th>
<th>Services covered:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( ) –</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insurance company billing address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member ID/Policy number</th>
<th>Group number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of policy holder</th>
<th>Social Security number</th>
<th>Date coverage began</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of person covered</th>
<th>Social Security number</th>
<th>Relationship to policy holder</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of person covered</th>
<th>Social Security number</th>
<th>Relationship to policy holder</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of person covered</th>
<th>Social Security number</th>
<th>Relationship to policy holder</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of person covered</th>
<th>Social Security number</th>
<th>Relationship to policy holder</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is this COBRA coverage?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is this a retiree health plan?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is this a limited-benefit plan (such as a school accident policy)?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

4. **Is anyone listed on this application offered health coverage from a job?** Check **yes** even if the coverage is from someone else’s job, such as a parent or spouse.

   - YES. If **yes**, you will need to complete and include Appendix C.
   - NO. If **no**, continue to Step 4.
STEP 4  Household Special Circumstances

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

1. Did anyone in your household lose health insurance in the past 60 days? □ Yes □ No
   If yes, who? ___________________________ Date coverage ended: ________________________
   Why? ___________________________

2. Was anyone in your household removed from a Vermont Health Connect Qualified Health Plan in the past 60 days, due to death or divorce?
   □ Yes, due to death  □ Yes, due to divorce  □ No
   If yes, who? ___________________________ Date coverage ended: ________________________

3. Has anyone joined your household through the foster care program in the past 60 days? □ Yes □ No
   If yes, who? ___________________________ Date child joined household: ________________________

4. Did a household member experience one of the following changes to their citizenship 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: ________________________

5. Did anyone in your household move to Vermont in the past 60 days? □ Yes □ No
   If yes, who? ___________________________ Date arrived in Vermont: ________________________

6. Did anyone in your household get released from incarceration (jail or prison) in the past 60 days? □ Yes □ No
   If yes, who? ___________________________ Date of release: ________________________

7. Did your household gain a dependent due to marriage, birth, or adoption in the past 60 days?
   □ Yes, due to marriage  □ Yes, due to birth  □ Yes, due to adoption  □ No
   If yes, who? ___________________________ Date of marriage, birth, or adoption: ________________________

8. A. Has anyone in the household received approval of an Individual Hardship Exemption to purchase a Catastrophic Plan in the past 60 days? □ Yes □ No
   If yes, who? ___________________________ Date exemption granted: ________________________

   B. Did any household member's Individual Hardship Exemption end in the past 60 days? □ Yes □ No
   If yes, who? ___________________________ Date exemption ended: ________________________

9. Has any household member's employer-sponsored insurance become unaffordable due to a decrease in their job income or a decrease in their work hours in the past 60 days? □ Yes □ No
   If yes, who? ___________________________ Date of income decrease: ________________________

10. 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? ___________________________

11. Have there been any other changes or circumstances in the past 60 days that you feel should be considered for deciding any household member's eligibility for an SEP? If so, please explain: ___________________________

   ___________________________

NOTE: The following question alone does NOT qualify you for a Special Enrollment Period but will tell us if/when you may qualify for help to pay QHP premiums. You must have at least one other qualifying event from the questions above in order to qualify for a Special Enrollment Period.

12. In the past 60 days, has anyone in your household become eligible for employer-sponsored health coverage but is in a waiting period before they can enroll? □ Yes □ No
    If yes, who? ___________________________ Date waiting period ends: ________________________

NEED HELP WITH YOUR APPLICATION? Visit VermontHealthConnect.gov or call toll-free 1-855-899-9600. For TTY/relay services, dial 711.
STEP 5  Future Eligibility Renewal

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

If you say YES below, VHC may be able to renew your eligibility without you having to do anything. This includes eligibility for Medicaid/Dr. Dynasaur and for Advance Payment of Premium Tax Credits (APTC) for a Qualified Health Plan. You can say YES to a renewal of up to 5 years.

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

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

If you say NO, and you get Advance Payment of Premium Tax Credits (APTC) now, you will not get APTC when your coverage is renewed. You will have to pay full price of your Qualified Health Plan (QHP). If you are on Medicaid/Dr. Dynasaur, we may not be able to renew you without you giving us more information. You can also give this permission at a later date if you say no now.

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

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

IMPORTANT: You can change your mind at any time about how many years you give VHC permission to use electronic data sources to renew your eligibility by calling VHC customer support at 1-855-899-9600. You can also call this number at any time to cancel your coverage or make changes to your household information.

STEP 6  American Indian or Alaska Native family member(s)

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

☐ NO. If no, skip to Step 7

☐ YES. If yes, you must also fill out Appendix B.

STEP 7  Incarcerated (detained or jailed) family member(s)

1. Is anyone applying for health insurance on this application incarcerated?

☐ NO. If no, skip to Step 8.

☐ YES. If yes, tell us who: ___________________________ ❑ Check here if this person is pending disposition of charges

**Pending disposition means that you are in jail or prison but haven't been convicted of a crime.**
How my information will be used. I understand that information obtained in this application will be used to help with my enrollment and continued eligibility in the programs I have applied for. I know that Vermont Health Connect will check my answers for all members listed in this application using information in their electronic databases and databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or a consumer reporting agency. I understand that if the information does not match, I may be asked to send proof.

Reporting changes. I know that I must tell Vermont Health Connect if anything changes or is different than what I wrote on this application. If enrolled in Medicaid, I must report changes within 10 days. If enrolled in a Qualified Health Plan with financial assistance, I must report changes within 30 days. I can visit VermontHealthConnect.gov or call 1-855-899-9600 to report any changes. I understand that a change in my information could affect the eligibility for myself and the member(s) of my household.

My right to appeal. If I think Vermont Health Connect has made a mistake, I understand I can appeal its decision. I understand I can also appeal if Vermont Health Connect is late in making a decision. To appeal means to ask for a fair hearing. A fair hearing is a chance for me to tell a hearing officer at the Human Services Board why I think the decision is wrong. The hearing officer will make a new decision after looking at all the facts.

If waiting on a regular appeal might harm me, or another member of my household applying for health coverage, I can file an expedited (faster) appeal. To do so, I must tell Vermont Health Connect I need an “expedited” appeal.

I understand I must appeal within 90 days of a Vermont Health Connect decision. The notice (decision) I receive after submitting my application will tell me more about how to appeal and any deadlines. To appeal, I must call Vermont Health Connect at 1-855-899-9600. I may also write to the Human Services Board, 120 State Street, Montpelier, VT 05620-4301.

I may be able to get free legal advice by calling the Health Care Advocate at Vermont Legal Aid at 1-800-917-7787.

Discrimination. I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination online by visiting www.hhs.gov/ocr/office/file; by writing to Health and Human Services, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201; or by calling 1-800-368-1019 or 1-800-537-7697 (TDD).

Eligibility for Medicaid. I am giving to the Medicaid agency the right to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.

Does any child on this application have a parent living outside of the home? □ Yes □ No

If yes, I know I may be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support may harm me or my children, I can tell Medicaid and I may not have to cooperate.

Quality Control. Vermont Health Connect may select my application for a quality control review. I agree to give proof of required information. If I am not able to give the proof needed, I am authorizing Vermont Health Connect to get it.

Medicare Part B payments. If I get Medicare Part B benefits while getting Medicaid, I want Vermont Health Connect to make any payments for future Medicare Part B medical and other health services directly to physicians and medical suppliers. This means I will not have to sign a separate form each time I get a service.

Confidentiality. Information in this application is confidential and won’t be shared except as needed for program administration. However, if in Appendix A, 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 your application.
• The status of your application including the program(s) you are enrolled in and the effective date of enrollment.
• The reason you are not eligible for a benefit, if your application is denied or your benefits end.
• The effective date(s) of your renewal(s) and any outstanding information or verifications needed to assist your 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 and federal privacy laws protect my records. I also 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 do not give my permission, the information will not be released unless the law otherwise allows it.
• I may stop this permission to share information at any time with a written notice to Vermont Health Connect. I know this written notice will not affect information the agencies have already released.
• The person or agency that receives my information might pass it on to others. If so, it may no longer be protected by this permission form.
• I do not stop this permission, it will be in effect as long as I am receiving benefits applied for in this application.
• I can be provided with a copy of this form.
• All of my questions about this permission have been answered.
**STEP 9**  Sign this application

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

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

**Not signing the application may delay health coverage.**

**By signing this application, the applicant agrees to the following:**
- I have read and understand my rights and responsibilities as they are described on pages ii and 11 of this application.
- I am signing this application under penalty of perjury, which means I have provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.

**By signing this application on behalf of the applicant, a person other than the applicant agrees to the following:**
- I am acting to provide information to establish and maintain eligibility for healthcare benefits for the applicant. This is because the applicant is a minor child or has a physical or mental condition that prevents him or her from providing information about his or her situation and acting responsibly in his or her own behalf.
- I will provide information to the best of my knowledge concerning the applicant’s situation.
- I understand that if I knowingly withhold any information or knowingly misrepresent the facts, I may be prosecuted for perjury or fraud. I agree to notify Vermont Health Connect immediately if I learn of any change in the applicant’s situation.

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

Person signing on behalf of the applicant (first, middle, last name & suffix (Jr., Sr., III, etc.)

<table>
<thead>
<tr>
<th>Agency name (if applicable)</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( ) –</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street address/PO Box</th>
<th>City</th>
<th>State</th>
<th>ZIP code</th>
</tr>
</thead>
</table>

**Signature** (applicant, or person signing on behalf of applicant)  

**Date** (mm/dd/yyyy)

**Voter Registration:** If you are not registered to vote where you live now, would you like a voter registration application? [ ] YES [ ] NO

If you do not check either box, 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.

**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. To learn more about this program, call toll free 1-800-464-4343 or visit WIC’s homepage at [healthvermont.gov/wic](http://healthvermont.gov/wic).

**STEP 10**  Mail the completed and signed application to:

**Vermont Health Connect**  
280 State Drive  
Waterbury, VT 05671-8100

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1911. The time required to complete this information collection is estimated to average 45 minutes per application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**NEED HELP WITH YOUR APPLICATION?** Visit [VermontHealthConnect.gov](http://VermontHealthConnect.gov) or call toll-free 1-855-899-9600. For TTY/relay services, dial 711.
APPENDIX A
Assistance Completing the Application

<table>
<thead>
<tr>
<th>APPLICANT Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant first name, middle name, last name &amp; suffix (Jr., Sr., III, etc.)</td>
<td>Applicant Social Security number</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You can choose an AUTHORIZED REPRESENTATIVE.
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an Authorized Representative. If you are a legally appointed representative for someone on the application (power of attorney, legal guardian) submit proof with this form.

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

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number

8. Organization name (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 coverages for yourself and others on the application. This person is called an Alternate Reporter. An Alternate Reporter cannot act for you or report changes for you, but they can help you understand the notices or remind you if we ask you for information. An Alternate Reporter can also be an Authorized Representative.

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

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number

8. Organization name (if applicable)

9. ID number (if applicable)

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

10. Your signature

11. Date (mm/dd/yyyy)

If you want to change your Authorized Representative or Alternate Reporter, contact Vermont Health Connect at 1-855-899-9600.
APPENDIX B
American Indian or Alaska Native Family Member

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

Complete this appendix if you or if anyone in your family is American Indian with a **federally recognized tribe** or an Alaska Native. Submit this with your Application for Health Coverage and Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

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

<table>
<thead>
<tr>
<th>PERSON 1</th>
<th>PERSON 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. First, middle, last name &amp; suffix (Jr., Sr., III, etc.)</td>
<td>First</td>
</tr>
<tr>
<td>Last</td>
<td>Last</td>
</tr>
<tr>
<td>2. Alaska Native?</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Member of a federally recognized tribe?</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, tribe name:</td>
<td>[state where recognized]</td>
</tr>
<tr>
<td>State where recognized:</td>
<td>[state where recognized]</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, tribe name:</td>
<td>[state where recognized]</td>
</tr>
<tr>
<td>State where recognized:</td>
<td>[state where recognized]</td>
</tr>
<tr>
<td>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?</td>
<td>Yes</td>
</tr>
<tr>
<td>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?</td>
<td>Yes</td>
</tr>
<tr>
<td>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?</td>
<td>Yes</td>
</tr>
<tr>
<td>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:</td>
<td>$</td>
</tr>
<tr>
<td>Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties</td>
<td>How often?</td>
</tr>
<tr>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>Money from selling things that have cultural significance</td>
<td></td>
</tr>
</tbody>
</table>

**NEED HELP WITH YOUR APPLICATION?** Visit VermontHealthConnect.gov or call toll free 1-855-899-9600. For TTY/relay services, dial 711.
## APPENDIX C

### Employer Coverage Tool

**APPLICANT Information**

<table>
<thead>
<tr>
<th>Applicant first name, middle name, last name &amp; suffix (Jr., Sr., III, etc.)</th>
<th>Applicant Social Security number</th>
</tr>
</thead>
</table>

### Health Coverage from Jobs

You **DO NOT** need to answer these questions unless someone in the household is eligible for health coverage from a job.

Use this tool to help answer questions about any employer health coverage that you are eligible for (even if it is from another person’s job, like a parent or spouse). Complete one tool for each employer that offers health coverage. Two copies of this form are provided. You **can ask your employer to fill out this form.** Remember, if you have your employer fill out this form, you are still responsible for getting the information in with the application.

**EMPLOYEE Information**

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

**EMPLOYER Information**

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

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?
   - Yes (Continue to questions 14 through 17 below.)
   - If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?
     
     (mm/dd/yyyy)
   - No (STOP and return this form to employee)

14. Does the employer offer a health plan that covers an employee's spouse or dependent?
   - Yes. Which people? ☐ Spouse  ☐ Dependent(s)
   - No

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

16. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (do not include family plans):
   - If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
     a. How much would the employee have to pay in premiums for this plan? $________
     b. How often? ☐ Weekly  ☐ Every 2 weeks  ☐ Twice a month  ☐ Once a month  ☐ Quarterly  ☐ Yearly

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

17. What change will the employer make for the new plan year (if known)?
   - Employer will not offer health coverage
   - Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 16.)
     a. How much will the employee have to pay in premiums for that plan? $________
     b. How often? ☐ Weekly  ☐ Every 2 weeks  ☐ Twice a month  ☐ Once a month  ☐ Quarterly  ☐ Yearly
     Date of change (mm/dd/yyyy): ____________________________

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

Apply faster and easier online by visiting VermontHealthConnect.gov

Reporting changes
If you have already applied for health coverage and simply need to report a change, DO NOT use this application, instead call 1-855-899-9600.

Get help with costs
You need to use a different application to get help with costs. You could qualify for:
• A new tax credit that can immediately lower your premiums for health coverage
• Free or low-cost coverage from Medicaid/Dr. Dynasaur
You may qualify for a free or low-cost program even if you earn as much as $95,400* a year (for a family of 4). Visit VermontHealthConnect.gov or call 1-855-899-9600 to learn more. *This number changes every January.

Who can use this application?
• If you do not need help to pay for your health coverage, you can use this application. You will be responsible for the full cost.
• If you are seeking dental coverage only, you can use this application.
• If someone is helping you fill out this application, you may need to complete Appendix A.

What happens next?
Send your completed and signed application to the address on page 5. (If you do not have all the information we ask for, sign and submit your application anyway.)
We will follow up with you within 1–2 weeks to let you know how to join a health plan.
Filling out this application does not mean you have to buy health coverage.

Get help with this application
• Online: VermontHealthConnect.gov.
• Phone: Call our Help Center at 1-855-899-9600.
• TTY/Relay: If you are deaf, hard of hearing, or have a speech disability, dial 711.
• In person: There is someone who can help in your area. Call 1-855-899-9600.
• Find a Navigator or Broker: Call 1-855-554-4488 or visit VermontHealthConnect.gov.

Interpretation services are available
(Arabic) إذا أنت ترغب خدمات الترجمة الفورية اتصل برقم 1-855-899-9600
(Arabic) فتحـاء الاتصال 1-855-899-9600
(Bosnian) Ako su Vam potrebne usluge tumačenja, pozovite 1-855-899-9600.
(Burmese) Si vous avez besoin de services d’interprétation, appelez le 1-855-899-9600.
(French) Mugihe woba ushaka impfashanyo yo guisigrina, hamagara uyu murongo 1-855-899-9600.
(Kirundi) Ndira tipaidi toka ombaye muvako burantu pahma, 1-855-899-9600 ma yali maturuhoza.
(Nepali) Haddii aad u baahan tahay adeegyo turjumaan, wac 1-855-899-9600.
(Swahili) Ikiwa unahitaji huduma za ukalimani, piga simu 1-855-899-9600.
(Vietnamese) Nếu quý vị cần dịch vụ thông ngôn, hãy gọi 1-855-899-9600.

You may keep this page for future reference. Your Rights and Responsibilities are on the back of this page and page 4. If you need help understanding something, contact Vermont Health Connect at 1-855-899-9600.
Your Rights and Responsibilities within Vermont Health Connect

How We Use Your Information. We need the information we ask for to decide if you qualify for health coverage if you choose to apply. We will check your answers using information from the Social Security Administration, the Department of Homeland Security, and/or a consumer reporting agency. If the information does not match, we may ask you to send us proof.

Americans with Disabilities Act. If you think you might have a physical or mental condition that substantially limits a major life activity (for example, walking, seeing, hearing, or learning), let us know. The Americans with Disabilities Act and Vermont law give people with disabilities certain rights. We will make reasonable changes (called an “accommodation”) in our requirements to help you take part in our programs. Call 1-855-899-9600 to let Vermont Health Connect know if you need an accommodation.

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

Social Security Numbers. All individuals applying for health benefits who have a Social Security number (SSN) must provide it. A person who is not seeking coverage does not need to provide a Social Security number. If you are a member of a religious organization that objects to furnishing an SSN, the Agency of Human Services may disregard this requirement. This requirement does not apply to an individual who: is not eligible to receive an SSN or does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104. The state will assign an identification number to these individuals.

Vermont Health Connect uses an SSN for computer processing, child support enforcement, fraud investigation, audits, and Lifeline identification; to verify Social Security and Supplemental Security income (SSI); to prevent individuals from receiving duplicate benefits; to exchange information with agencies such as the Social Security Administration, Department of Labor, Internal Revenue Service (IRS), or private agencies to verify income, determine eligibility and benefits amounts, and collect claims; to determine the accuracy and reliability of information given to Vermont Health Connect; and to make medical assistance payments.

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

Reporting changes. If anything changes or is different than what you wrote on this application, you must tell Vermont Health Connect within 30 days. Visit VermontHealthConnect.gov or call 1-855-899-9600 to report any changes.

Timely Decision on Application. Vermont Health Connect has 30 days to give you a decision on your application. If after 30 days you have not received a response, call 1-855-899-9600.

Your Right to Appeal. If you think Vermont Health Connect has made a mistake, you can appeal its decision. You can also appeal if we are late making a decision. To appeal means to ask for a fair hearing. A fair hearing is a chance to tell a hearing officer at the Human Services Board why you think the decision is wrong. The hearing officer will make a new decision after looking at all the facts.

If waiting on a regular appeal might harm you, you can file an expedited (faster) appeal. When you appeal, tell us if you need an “expedited” appeal. You must appeal within 90 days of a Vermont Health Connect decision. We will send you a notice (decision) on your application. It will tell you more about how to appeal and any deadlines. To appeal call Vermont Health Connect at 1-855-899-9600. You may also write to the Human Services Board, 120 State Street, Montpelier, VT 05620-4301.

You may be able to get free legal advice by calling the Health Care Advocate at Vermont Legal Aid at 1-800-917-7787.

Other Kinds of Complaints. If you want to complain about something other than an eligibility decision, like how Vermont Health Connect has treated you, call Vermont Health Connect at 1-855-899-9600. Call within 60 days if you want a written response.
**STEP 1** PERSON 1: Tell us about yourself

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

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

2. List any other names you have been known by, including a maiden name or alias.

3. **Home address** (leave blank if you do not have one)  
4. Apartment or suite number

5. City  
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. For an Authorized Representative, complete Appendix A.)

12. City  
13. State  
14. ZIP code  
15. County

16. HOME phone number ( ) –  
17. WORK phone number ( ) –  
18. CELL phone number ( ) –

19. Marital status: □ Never married □ Married □ Civil union □ Separated □ Divorced/dissolved □ Widowed  
   If you are a victim of domestic violence and applying separately from your spouse, you may indicate that you are “Never married”.

20. What is your preferred spoken or written language (if not English)?

21. Are you applying for health coverage for yourself? □ Yes □ No

22. Social Security number __ __ __ - __ __ __ - __ __ __ __ __

   **We need Social Security Numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship.**  
   If someone does not have an SSN, visit socialsecurity.gov or call 1-800-772-1213. TTY users should call 1-800-325-0778.

23. Sex □ Male □ Female

24. Date of birth (mm/dd/yyyy) ___ ___ / ___ ___/ ___ ___ ___ ___

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

26. **If you are not a U.S. citizen or U.S. national, do you have eligible immigration status?**  
   □ YES. Fill in your document type and ID number below.
   a. Immigration document type ___________________________  
   b. Document expiration date ___________________________ □ None  
   c. Alien number ___________________________  
   d. Passport or document number ___________________________ □ None  
   e. Country of origin ___________________________  
   f. Category code ___________________________  

27. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)
   □ Mexican □ Mexican American □ Chicano/a □ Puerto Rican □ Cuban □ Other ___________________________

28. Race (OPTIONAL—check all that apply.)
   □ White □ Black or African American □ American Indian or Alaska Native □ Asian Indian □ Chinese □ Filipino □ Japanese □ Korean □ Vietnamese □ Other Asian □ Native Hawaiian □ Guamanian or Chamorro □ Samoan □ Other Pacific Islander □ Other ___________________________

Now, tell us who else needs health coverage. ➡️
**STEP 2**

Tell us about anyone who needs health coverage

If you have more than 3 members in your household, copy this page before you fill it out. You should also include your name and date of birth at the top of all copied page(s).

---

### STEP 2: PERSON 2

1. First name, middle name, last name & suffix (jr., Sr., Ill, etc.)

2. Relationship to you?

3. List any other names PERSON 2 has been known by (e.g., maiden name or alias)

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

5. Sex

   □ Male  □ Female

6. Social Security number

7. Marital status:

   □ Married  □ Civil Union  □ Never married

   □ Separated  □ Divorced/dissolved  □ Widowed

8. Does PERSON 2 live at the same address as you?

   □ Yes  □ No  If no, list address:

9. Do you want health coverage for PERSON 2?

   □ Yes  □ No

10. Is PERSON 2 a U.S. citizen or U.S. national?

    □ Yes  □ No

---

11. If PERSON 2 is not a U.S. citizen or U.S. national, do they have eligible immigration status?

    □ YES. Fill in PERSON 2's document information below.

    a. Immigration document type __________________________

    b. Document expiration date __________________________

    c. Alien number __________________________

    d. Passport or document number __________________________

    e. Country of origin __________________________

    f. Category code __________________________

---

12. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

    □ Mexican  □ Mexican American  □ Chicano/a  □ Puerto Rican  □ Cuban  □ Other __________________________

---

13. Race (OPTIONAL—check all that apply.)

    □ White  □ Black or African American  □ American Indian or Alaska Native  □ Asian Indian  □ Chinese  □ Filipino  □ Japanese  □ Korean  □ Vietnamese  □ Other Asian  □ Native Hawaiian  □ Guamanian or Chamorro  □ Samoan  □ Other Pacific Islander  □ Other __________________________

---

### STEP 2: PERSON 3

1. First name, middle name, last name & suffix (jr., Sr., Ill, etc.)

2. Relationship to you?

3. List any other names PERSON 3 has been known by (e.g., maiden name or alias)

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

5. Sex

   □ Male  □ Female

6. Social Security number

7. Marital status:

   □ Married  □ Civil Union  □ Never married

   □ Separated  □ Divorced/dissolved  □ Widowed

8. Does PERSON 3 live at the same address as you?

   □ Yes  □ No  If no, list address:

9. Do you want health coverage for PERSON 3?

   □ Yes  □ No

10. Is PERSON 3 a U.S. citizen or U.S. national?

    □ Yes  □ No

---

11. If PERSON 3 is not a U.S. citizen or U.S. national, do they have eligible immigration status?

    □ YES. Fill in PERSON 3's document information below.

    a. Immigration document type __________________________

    b. Document expiration date __________________________

    c. Alien number __________________________

    d. Passport or document number __________________________

    e. Country of origin __________________________

    f. Category code __________________________

---

12. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)

    □ Mexican  □ Mexican American  □ Chicano/a  □ Puerto Rican  □ Cuban  □ Other __________________________

---

13. Race (OPTIONAL—check all that apply.)

    □ White  □ Black or African American  □ American Indian or Alaska Native  □ Asian Indian  □ Chinese  □ Filipino  □ Japanese  □ Korean  □ Vietnamese  □ Other Asian  □ Native Hawaiian  □ Guamanian or Chamorro  □ Samoan  □ Other Pacific Islander  □ Other __________________________
STEP 3  Household Special Circumstances

The questions below are about life events that may have happened in your household in the past 60 days. Your answers will help us determine if you, or other household members, can enroll in a Qualified Health Plan outside of an open enrollment period. Someone may contact you for more information about your situation to determine if you or other household members qualify for a Special Enrollment Period (SEP). Please note there is no open enrollment period for Medicaid/Dr. Dynasaur coverage. You may apply for Medicaid/Dr. Dynasaur at any time. To apply, you need the application for “Help Paying Costs”.

1. Did anyone in your household lose health insurance in the past 60 days?  □ Yes □ No
   If yes, who? ___________________________ Date coverage ended: ________________
   Why? ___________________________

2. Was anyone in your household removed from a Vermont Health Connect Qualified Health Plan in the past 60 days, due to death or divorce?
   □ Yes, due to death □ Yes, due to divorce □ No
   If yes, who? ___________________________ Date coverage ended: ________________

3. Has anyone joined your household through the foster care program in the past 60 days?  □ Yes □ No
   If yes, who? ___________________________ Date child joined household: ________________

4. Did a household member experience one of the following changes to their citizenship 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: ________________

5. Did anyone in your household move to Vermont in the past 60 days?  □ Yes □ No
   If yes, who? ___________________________ Date arrived in Vermont: ________________

6. Did anyone in your household get released from incarceration (jail or prison) in the past 60 days?  □ Yes □ No
   If yes, who? ___________________________ Date of release: ________________

7. Did your household gain a dependent due to marriage, birth, or adoption in the past 60 days?
   □ Yes, due to marriage □ Yes, due to birth □ Yes, due to adoption □ No
   If yes, who? ___________________________ Date of marriage, birth, or adoption: ________________

8. A. Has anyone in the household received approval of an Individual Hardship Exemption to purchase a Catastrophic Plan in the past 60 days?  □ Yes □ No
    If yes, who? ___________________________ Date exemption granted: ________________

B. Did any household member's Individual Hardship Exemption end in the past 60 days?  □ Yes □ No
   If yes, who? ___________________________ Date exemption ended: ________________

9. Has any household member’s employer-sponsored insurance become unaffordable due to a decrease in their job income or a decrease in their work hours in the past 60 days?  □ Yes □ No
   If yes, who? ___________________________ Date of income decrease: ________________

10. 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? ___________________________

11. Have there been any other changes or circumstances in the past 60 days that you feel should be considered for deciding any household member’s eligibility for an SEP? If so, please explain: ___________________________

NOTE: The following question alone does NOT qualify you for a Special Enrollment Period but will tell us if/when you may qualify for help to pay QHP premiums. You must have at least one other qualifying event from the questions above in order to qualify for a Special Enrollment Period.

12. In the past 60 days, has anyone in your household become eligible for employer-sponsored health coverage but is in a waiting period before they can enroll?  □ Yes □ No
    If yes, who? ___________________________ Date waiting period ends: ________________

NEED HELP WITH YOUR APPLICATION? Visit VermontHealthConnect.gov or call toll-free 1-855-899-9600. For TTY/relay services, dial 711.
### STEP 3 American Indian or Alaska Native family member(s)

1. **Are you, or is anyone in your family, an American Indian with a federally recognized tribe, or an Alaska Native?**
   - ☐ No. If no, skip to Step 4.
   - ☐ Yes. If yes, continue. If you have more people to include, make a copy of this page and attach.

<table>
<thead>
<tr>
<th>PERSON 1</th>
<th>PERSON 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. First name, middle name, last name &amp; suffix (Jr., Sr., III, etc.)</td>
<td>2. First name, middle name, last name &amp; suffix (Jr., Sr., III, etc.)</td>
</tr>
<tr>
<td>3. Alaska Native? ☐ Yes ☐ No</td>
<td>3. Alaska Native? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>4. Member of a federally recognized tribe? ☐ Yes. If Yes, tribe name: __________________________ State where recognized: __________________________</td>
<td>☐ Yes. If Yes, tribe name: __________________________ State where recognized: __________________________</td>
</tr>
<tr>
<td>☐ No</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

### STEP 4 Incarcerated (detained or jailed) family member(s)

1. **Is anyone applying for health insurance on this application incarcerated?**
   - ☐ No. If no, skip to Step 5.
   - ☐ Yes. If yes, tell us who: __________________________ ☐ Check here if this person is pending disposition of charges

**Pending disposition means that you are in jail or prison but haven’t been convicted of a crime.**

### STEP 5 Read your rights and responsibilities before signing

- I know that if anything changes (or is different than) what I wrote on this application, I must tell Vermont Health Connect within 30 days. I can visit VermontHealthConnect.gov or call 1-855-899-9600 to report any changes. I understand that a change in my information could affect the eligibility for the member(s) of my household.

- I know that the information on this application is confidential and will not be shared except as needed for program administration. I know that state and federal privacy laws protect my records.

- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

- If I think Vermont Health Connect has made a mistake, I can appeal its decision. To appeal means to ask for a fair hearing to have the decision looked at again. I can appeal by calling Vermont Health Connect at 1-855-899-9600. I may be able to get free legal advice from the Health Care Advocate at Vermont Legal Aid at 1-800-917-7787.
**STEP 6** Sign this application

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

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

**Not signing the application may delay health coverage.**

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

- I have read and understand my rights and responsibilities as they are described on pages ii and 4 of this application.
- I am signing this application under penalty of perjury, which means I have provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.

By signing this application on behalf of the applicant, a person other than the applicant agrees to the following:

- I am acting to provide information to establish and maintain eligibility for healthcare benefits for the applicant. This is because the applicant is a minor child or has a physical or mental condition that prevents him or her from providing information about his or her situation and acting responsibly in his or her own behalf.
- I will provide information to the best of my knowledge concerning the applicant's situation.
- I understand that if I knowingly withhold any information or knowingly misrepresent the facts, I may be prosecuted for perjury or fraud. I agree to notify Vermont Health Connect immediately if I learn of any change in the applicant's situation.

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

Person signing on behalf of the applicant (first, middle, last name & suffix (Jr., Sr., III, etc.)

<table>
<thead>
<tr>
<th>Agency name (if applicable)</th>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(            ) –</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street address/PO Box</th>
<th>City</th>
<th>State</th>
<th>ZIP code</th>
</tr>
</thead>
</table>

**Signature** (applicant, or person signing on behalf of applicant)

<table>
<thead>
<tr>
<th>Date (mm/dd/yyyy)</th>
</tr>
</thead>
</table>

**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.

**STEP 7** Mail the completed and signed application to:

Vermont Health Connect  
280 State Drive  
Waterbury, VT 05671-8100

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average 20 minutes per application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**NEED HELP WITH YOUR APPLICATION?** Visit VermontHealthConnect.gov or call toll-free 1-855-899-9600. For TTY/relay services, dial 711.
### APPENDIX A
Assistance Completing the Application

#### APPLICANT Information

<table>
<thead>
<tr>
<th>Applicant first name, middle name, last name &amp; suffix (Jr., Sr., III, etc.)</th>
<th>Applicant Social Security number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>_ _ _ _ - _ _ _ - _ _ _ _ _</td>
</tr>
</tbody>
</table>

You can choose an AUTHORIZED REPRESENTATIVE.
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an Authorized Representative. If you are a legally appointed representative for someone on the application (power of attorney, legal guardian) submit proof with this form.

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

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number
   (     )    -

8. Organization name (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)

#### Alternate Reporter

You can choose an ALTERNATE REPORTER.
You can give a trusted person permission to only get copies of notices about your coverage and the coverage for others on the application and all future matters with this agency. This person is called an Alternate Reporter. An Alternate Reporter cannot act for you or report changes for you, but they can help you understand the notices or remind you if we ask you for information. An Alternate Reporter can also be an Authorized Representative.

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

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number
   (     )    -

8. Organization name (if applicable)

9. ID number (if applicable)

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

10. Your signature

11. Date (mm/dd/yyyy)

If you want to change your Authorized Representative or Alternate Reporter, contact Vermont Health Connect at 1-855-899-9600.
Appendix 2 – See the CMS Alternative Application dated June 18, 2013 marked up with State of Vermont requirements in the email attachments.

Asterisks (*) indicate sections that apply to State health care benefit applications requirements.

Footnotes 1 – 7 provide notes with further explanations of the requirement.

Stop at #7 at the top of page 6. The remainder of the letter applies only to the State when submitting new applications to CMS.
Date:       June 18, 2013  
From:  Gary Cohen, CMS Deputy Administrator and Director  
              Center for Consumer Information and Insurance Oversight  
Cindy Mann, CMS Deputy Administrator and Director 
              Center for Medicaid and CHIP Services  
Subject:  Guidance on State Alternative Applications for Health Coverage  

**Purpose and Scope of Guidance**  
Beginning on October 1, 2013, the new Health Insurance Marketplace, also known as the Affordable Insurance Exchanges (Exchanges), and State Medicaid and Children’s Health Insurance Program (CHIP) agencies will use a single, streamlined application to determine eligibility for enrollment in Qualified Health Plans (QHPs) through the Marketplace, and for insurance affordability programs including advance payments of the premium tax credit (APTCs), cost-sharing reductions (CSRs), Medicaid, and CHIP.  

On April 30, 2013, CMS released the model single, streamlined application for coverage through the Marketplace and insurance affordability programs. The model single, streamlined application is available for review at [http://www.cms.gov](http://www.cms.gov). This application, in both its paper and online versions, will be the sole application used by the Federally-facilitated Marketplace to facilitate eligibility determinations and enrollment in health coverage. State-based Marketplaces, as well as Medicaid and CHIP agencies, may choose to use the model single, streamlined application, or may develop an alternative single, streamlined application that is approved by CMS! In States utilizing the Federally-facilitated Marketplace, the Medicaid and/or CHIP agency may develop an alternative application, but the Medicaid and/or CHIP agency must still be able to accept and process the paper version of the model single, streamlined application if an applicant for coverage submits it. This guidance is intended to provide background on the development, review and approval of alternative applications.  

* **Designing an Alternative Application**  
States may submit for approval an alternative application that can be tailored to accommodate state preferences and policies, while also reflecting the general principles of the model application and complying with the applicable provision of law, as described below. This section outlines the parameters for creating an alternative application and also identifies areas where a formal approval of modifications to the model application is not needed.

* Applies to State of Vermont
General Principles
States must adhere to regulations implementing the Affordable Care Act in the area of applications, eligibility standards, verifications, determinations, and coordination in developing alternative applications. States should be guided by the model application and CMS expects State-based Marketplaces, Medicaid and CHIP agencies to collaborate in the development of alternative applications to the maximum extent possible (see specifically, 42 CFR 435.907, 435.911, 435.945-435.956 and 435.1200, 457.330-457.380, and 45 CFR 155.300-155.320 and 155.405). Some examples of the aspects of the application that are minimally required for alternative application approval include:

1. *An alternative application must request information necessary for determining eligibility for coverage in a Qualified Health Plan (QHP) and all insurance affordability programs.* The law requires that one application be used for all programs under the Affordable Care Act to ensure a proper adjudication of eligibility, minimize burden on applicants who may not know which program they are eligible for and allow households with members eligible for different programs to apply using a single application. States must include all questions that will help the relevant entity or entities determine whether an applicant is potentially eligible for coverage through a QHP and any insurance affordability program, even if the agency making available the application will not be the entity processing certain portions of the application. For example, Medicaid and CHIP agencies must include questions about access to employer-sponsored health coverage on their paper applications, though the responses may not affect eligibility for Medicaid or CHIP coverage. On an online application, system logic should trigger these questions to appear only when an applicant does not appear eligible for Medicaid and CHIP based on their attestations. It is important to note, too, that Medicaid and CHIP agencies do not need to ask questions related to QHP enrollment such as Special Enrollment Periods or tobacco use.

Likewise, because an individual cannot be eligible for APTC if he or she is eligible for Medicaid or CHIP, a State-based Marketplace must ask applicants to provide answers to questions relating to Medicaid eligibility. Additionally, states must include non-MAGI screening questions related to disability and long-term care needs, though states may seek to adjust these questions to more specifically fit the non-MAGI standards in that state.

2. *States must only ask questions that are necessary for determining eligibility for coverage in a Qualified Health Plan (QHP) and all insurance affordability programs, or for the administration of these programs.* Questions that are not essential to these purposes or programs cannot be required. For example, in accordance with 42 CFR 435.907, states may not request citizenship and immigration information from “non-applicants,” or individuals who are identified on an application of an individual who is applying for coverage but who are themselves not applying for coverage. Requests for Social Security Numbers of non-applicants must be optional. Please see page 5 for information on multi-benefit applications.

3. *Requests for information from application filers should minimize the burden on the applying household. For State-based Marketplaces, this includes providing two paths in the application such that individuals who opt to not receive financial assistance do not need to answer financial assistance questions.* For example, online applications must be structured in a

* Applies to State of Vermont
dynamic manner, so that questions that are specific to an insurance affordability program are only asked of individuals who appear eligible for that program. These program-specific questions are outlined in sections XII and XIII of the online application questionnaire which can be found at https://calt.cms.gov/sf/go/doc28817?nav=1. Also, a State-based Marketplace must provide an opportunity for individuals to opt to not receive financial assistance and apply for coverage in a QHP without requesting information on income or other criteria related only to insurance affordability programs. In addition, when questions only apply to certain age groups or genders, states should ask them on online applications only when they are relevant. On paper applications, threshold questions which lead to appendices are one approach to streamline forms and minimize burden.

4. **In accordance with the regulations on the use of the Federal Data Services Hub and other electronic data sources, states must first rely on available electronic data sources and should request paper documentation only when electronic data is insufficient or inconsistent.** The state may only request paper documentation when an individual’s attestation conflicts with electronic data, or when there is no electronic data available to verify an individual’s attestation.² (See 42 CFR 435.945-435.956 and 457.330-457.380, and 45 CFR 155.315)

**Customizing the Model Application (No Approval Required)**³

There are a number of ways that a state may adapt the model application without need for formal approval from CMS as an alternative application. These include:

* 1. Adding the state Marketplace, Medicaid, and CHIP agency or program names and contact information to the application. It is important that the state’s application provide the appropriate contact information for applicants to mail the paper application, contact the applicable call center, and access online help tools.

* 2. Changing the colors, logos, icons, and pictures on the model application to reflect branding appropriate for that state. This includes removing CMS logos from the application.

* 3. Eliminating questions that are not relevant to the state’s eligibility rules. The model online application includes some questions that are not relevant to all states. For example, a state that does not take 40 work quarters into consideration for status as a qualified non-citizen does not need to include the associated question from the model application. This same principle applies to the paper application.

* 4. If the state has additional income or other verification data sources outside of those received from the Federal Data Services Hub that can be used to pre-populate the current income section of the online application, those sources may be included as part of the application process without formal approval. States may adjust the income section of the application to account for the data sources and verification criteria to be used by the state. For example, if a state Medicaid or CHIP agency will not be using or storing federal tax information (FTI), then the state would not include the “expedited” income section as it exists in the model online application. However, state Medicaid and CHIP agencies will still need to request attestations of annual income on the application in order to determine potential eligibility for APTC.⁴

* Applies to State of Vermont
5. Adding language to the privacy statement or rights and responsibilities section of the application, if required by state law or regulation.

6. Changing the placement and order of questions regarding contact information for the household, and removal of the question about text messaging if the state does not plan to send text messages to individuals.

Modifications that Minimize Consumer Burden (No Approval Required)

States may add or change the model application questions so that their application reflects the eligibility policies in place in the state. Formal approval from CMS is not required for these changes if they do not add burden on the consumer. Examples of these types of acceptable modifications include:

1. The removal of questions when a state elects to address an issue post-eligibility. States may also tailor questions to make them more state-specific, such as including the state definition of “temporary” in the question regarding residency or the state definition of “full-time student” in the question about student status.

2. Changing the order of questions, as long as the change does not impede the online application’s dynamic nature. For example, a state could change the order of income questions within the income section, but must collect full income and household information early enough in the application so that only questions applicable to the relevant insurance affordability program or programs are asked (see item 3 in the “General Principles” section, above).

3. When needed to complete a MAGI-based eligibility determination, states may add questions relating to a state option that is not supported in the Federally-facilitated Marketplace’s eligibility assessment or determination logic. This may include questions relating to family planning, state-only funded eligibility groups, state premium assistance programs, and exceptions to waiting periods for CHIP coverage.

4. Making the application more dynamic to adapt to the state’s cascade of Medicaid eligibility categories.

Development and Approval of Alternative Applications – Modifications that Require CMS Approval

If your state’s application differs from the model application in ways other than those described in the previous sections (which do not require CMS approval), CMS will review these changes to ensure that the state’s application is consistent with the applicable statute and regulations, and maintains the principle of minimizing burden on the consumer. Some examples of changes that would require approval include:

1. A different implementation of the option to consider reasonably predictable future changes in income.

* Applies to State of Vermont
2. A different mechanism to determine whether dependents and children have federal income tax filing requirements.

3. Different “reasonable explanation” questions for addressing inconsistencies between income or household size information provided on the application and information from with electronic data sources used for verification.

4. A different approach to the timing of checking electronic data sources, e.g., at the end of the application after all questions have been asked, rather than verifying with electronic data sources as questions are asked at earlier points in the application process. In this situation, a state may be considering eliminating questions that CMS has included based on data matching, including the questions soliciting reasonable explanations for discrepancies with income data and the “expedited” income section.

5. The addition of questions related to eligibility for Medicaid on a basis other than MAGI. Please see information further below on the use of a supplemental form for non-MAGI Medicaid questions.

*Special Considerations for Multi-benefit Applications*
Many states have expressed interest in using a multi-benefit human services application as the base for their alternative application. This approach is acceptable if the application collects sufficient information to determine MAGI-based eligibility for all insurance affordability programs. These applications include questions related to other benefit programs. These types of questions may be included on a single streamlined application, as long as the state clearly indicates the additional questions are optional, or not required for submission, and therefore do not serve as a barrier to the MAGI determination. States may not deny or delay eligibility for an insurance affordability program due to missing or unverified information pertaining only to a non-health program. States that elect to make available a multi-benefit application must also ensure the opportunity for an applicant to file a health coverage-only application.

*Non-MAGI Based Medicaid Applications*
For individuals seeking Medicaid eligibility on a basis other than MAGI, states may use a combination of the model single, streamlined application (or a CMS-approved single, streamlined application) and supplemental forms to collect the information needed to determine eligibility, or states may use a completely separate application designed specifically for this population. If a state chooses to ask non-MAGI questions through a separate supplemental form, or through a completely separate application, these materials should be submitted to CMS in accordance with 42 CFR 435.907, but do not require CMS approval prior to use.

Medicaid agencies seeking to incorporate non-MAGI related questions in their alternative application must ensure that these questions do not add burden on the consumer completing the application. In an online application, these questions should only be asked of individuals who are potentially eligible for Medicaid on a basis other than MAGI, such as when the applicant answers affirmatively to one of the non-MAGI screening questions. On a paper application, the

*Applies to State of Vermont*
state must clearly indicate that these questions are optional and are posed to the applicant only if relevant. Under both formats, the MAGI-based eligibility determination must not be delayed while information is collected to make the non-MAGI eligibility determination.

Process for Submission and Approval of Alternative Applications

Starting this year, for State-based Marketplaces, the state’s submission of its Marketplace Blueprint application will indicate the state’s intent to use either the model single, streamlined application or a CMS-approved alternative application. As part of the Blueprint application, the State-based Marketplace should submit the material described below for CMS review and approval. For State-based Marketplace states that develop an alternative application, decisions pertaining to the approval of the state’s application will be conferred by the Center for Consumer Information and Insurance Oversight (CCIIO). CMS is committed to providing states with a coordinated, streamlined review process and CCIIO will conduct its review of State-based Marketplace alternative applications in close consultation with the Center for Medicaid and CHIP Services.

* For Medicaid and CHIP agencies, the review and approval of alternative applications will be through the State Plan Amendment (SPA) process. CMS will soon be releasing SPA pages to assist states in indicating their decision to use the model single, streamlined application or an alternative application. The approval of alternative applications will occur within the timeframes required by the SPA process, but CMS will make every effort to expedite technical assistance and requests for additional information so that states have time to implement changes and reach resolution. For Medicaid/CHIP agencies that develop an alternative application, decisions pertaining to the approval of the state’s application will be conferred by the Center for Medicaid and CHIP Services (CMCS). Likewise, CMCS will conduct its review of Medicaid and/or CHIP-developed alternative applications in close consultation with CCIIO.

For the paper application, states should submit a full copy of the proposed alternative form and any accompanying supplements and instructions which relate to a MAGI-based determination. For the online application, the state may submit 1) a questionnaire document in a format similar to the model application online questionnaire; 2) a packet of screenshots depicting the screens a family completing the alternative application would see, and/or 3) a flow chart demonstrating the logic that takes applicants between sections and questions on the online application. CMS may also request an interactive demonstration of the proposed online application.

States should also provide an analysis document that identifies and describes key differences between the model application and the state’s alternative application, in terms of the modifications that require CMS approval. Differences that do not require CMS approval do not need to be included in this document, but would be helpful to note and may expedite the review process. States using a common IT vendor to develop their core application can submit one analysis document for the vendor-developed core application, along with a state-specific analysis describing only the state-specific modifications made, or proposed, to the core application that represents differences from the model application. Upon receipt of a submission, CMS will contact the state to confirm receipt, and conduct its review.

Approval of Alternative Applications for Coverage Year 2014

* Applies to State of Vermont
CMS recognizes that a unique set of circumstances exist for State-based Marketplaces, as well as Medicaid and CHIP agencies, who are implementing applications for coverage beginning on January 1, 2014. Specifically, we are aware of the challenges posed by the amount of development work that states had completed on their applications and eligibility systems prior to the release of the model application and the release of this guidance. CMS may offer an expedited approval process, as necessary, for states and CMS will allow for conditional approval of an alternative application for 2014.

In order to receive conditional approval of an alternative application, a state must: 1) attest that the application meets, or will meet by a certain date, all applicable regulatory requirements described in the “General Principles” section of this document; 2) attest that the design of the state’s application took into consideration, or aligns with, the proposed model single, streamlined application released on January 29, 2013; and 3) provide the material described in the section above, “Process for Submissions of Alternative Applications,” for CMS review. A state must also submit a proposed timeline towards addressing any recommendations identified through CMS’ review.

In order to receive full approval from CMS, a state must demonstrate that all applicable regulatory requirements are met by doing the following: 1) modifying its application based on recommendations identified by CMS’ review, or modifying its application to align with the model application. This includes modifications to core application functionality that is shared across multiple states, through the use of a common IT vendor. CMS will evaluate the State’s proposed timeline for such modifications and will arrive at an agreed-upon timeline between CMS and the state; 2) subsequently submitting evidence of the modifications, or submitting evidence indicating alignment with the model application, for CMS review. This evidence can be submitted as part of regular or ad-hoc reviews conducted by CMS (e.g., Exchange Life Cycle Reviews, Gate Reviews, Design Reviews, and/or Implementation Reviews).

States intending to implement alternative applications for coverage year 2014 may begin requesting CMS approval upon the release of this guidance, and will need to receive full approval of their applications in 2014. CMS will make every effort to work with states in achieving conditional or full approval to states in as timely a manner as possible.

**Technical Assistance**

CMS is committed to providing states with a coordinated technical assistance process to states in their development of alternative applications. CMS remains available to provide technical assistance to states to facilitate adoption of the model application, in their development of alternative applications. CMS staff is available to review draft materials, participate in discussions and to join interactive demonstrations with states. Questions from Medicaid and CHIP agencies regarding this guidance can be directed to Anne Marie Costello, Director of the Division of Eligibility, Enrollment and Outreach at CMCS at 410-786-5175. Questions from State-based Marketplaces regarding this guidance can be directed to Hilary Dalin, Director of the State Technical Assistance Division, State Exchange Group at CCIIO at 301-492-4343, or Jenny Chen in the State Exchange Group at CCIIO at 301-492-5156.

* Applies to State of Vermont