

From: [Frazer, Dylan](#)
To: "[Michelle Rupp](#)"
Subject: RE: Response to Public Records Request
Date: Monday, September 22, 2014 1:32:00 PM

Hello Michelle,

Regarding your request for training materials for VHC Assisters that specifically address voter registration, there are no such training materials. The only role that Assisters play in the voter registration process would be to help an individual through the question regarding voter registration as the VHC application is being filled out.

Please let me know if you have any further questions.

Thanks,
-Dylan

Dylan Frazer

Program Consultant – Policy Unit
Dept. of Vermont Health Access
289 Hurricane Lane
Williston, VT 05495
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From: Michelle Rupp [mailto:mrupp@projectvote.org]
Sent: Thursday, September 18, 2014 4:12 PM
To: Frazer, Dylan
Subject: Re: Response to Public Records Request

Thanks. Please do reach out next week to the person who has the training materials, that would be great.

Michelle Rupp
Election Counsel & Assistant General Counsel
Project Vote
202-546-4173 x305

*Authorized to practice only in Virginia. Practice in DC limited to cases in federal court.

From: "Frazer, Dylan" <Dylan.Frazer@state.vt.us>
Date: Thursday, September 18, 2014 4:07 PM
To: Michelle Rupp <mrupp@projectvote.org>
Subject: RE: Response to Public Records Request

Hi Michelle,

I apologize for not getting back to you sooner, but I've been out of the office. I will try to address your questions as best I can.

The following link contains grants awarded to Navigator Organizations: <http://dvha.vermont.gov/administration/grants>.

The following link contains MOUs regarding Vermont Health connect (VHC), including on with the Department for Children and Families for their role in the VHC eligibility and enrollment process:

<http://dvha.vermont.gov/administration/memorandums-of-understanding>.

The following link contains most of the contracts that the Department of Vermont Health Access (DVHA) has executed, which includes the contract and subsequent amendments with Maximus, the VHC Call Center contractor:

<http://dvha.vermont.gov/administration/contracts>.

Here is some supplemental info that also came up when I was looking around:

There are the two Notices of Application for Navigator Organization Grants for the 2014 and 2015 open enrollment periods:

- 2014: <http://www.vermontbusinessregistry.com/bidAttachments/9802/VT%20Navigator%20Organization%20Application.pdf>
- 2015: <http://dvha.vermont.gov/administration/1navigator-organization-application-2014-final.pdf>.

At first glance, the 2015 notice mentions voter registration, while the 2014 notice does not.

Here is the link to the Navigator program website: <http://info.healthconnect.vermont.gov/node/586>.

There are also these paper applications which include a box to check in order to register to vote:

<http://info.healthconnect.vermont.gov/sites/hcexchange/files/205INFA.pdf> and
<http://info.healthconnect.vermont.gov/sites/hcexchange/files/205IFA.pdf>.

Here is a press release announcing the designation of Vermont Health Connect as a 'Voter Registration Agency':

https://www.aclu.org/files/assets/pr_-_designates_hce_voter_reg_agency_07.29.2013.pdf.

I do not have immediate access to training materials for Assisters, and the individual who would have such documents is out until next week. If you would like, I can reach out to her then and see what there may be in terms of voter registration. I'm thinking it may just be a brief mention of it in the training materials.

I hope this helps! Let me know if you have any other questions,

-Dylan

From: Michelle Rupp [<mailto:mrupp@projectvote.org>]

Sent: Friday, September 05, 2014 3:53 PM

To: Frazer, Dylan

Subject: Re: Response to Public Records Request

Thanks, Dylan.

For question 1, I'm most interested in the relationship between the Department of Vermont Health Access and any other entities, in terms of who is actually determining whether Exchange applicants are eligible for the various assistance programs (tax credits, cost share reductions, Medicaid, CHIP, etc). Do you have any documents that would reflect who has that responsibility? I don't need a whole slew of documents, just something that shows what agencies (or agency sub-units) play a part in making that determination, and what their roles are.

It would also be very helpful to get more information about how voter registration is offered, beyond the screenshot you sent me. Can you provide the following, or give me an estimate as to cost?

A. Training materials prepared or distributed by the Department of Vermont Health Access or its sub-units for "assisters" (navigators, brokers, and certified application counselors) and for personnel at the enrollment support unit and the Vermont-based call center, for the 2014 Open Enrollment period for health benefits. If the training materials are voluminous, it may make sense to narrow this to only those materials that somewhere reference voter registration.

B. The same for the 2015 Open Enrollment period.

C. Any contracts, MOUs/MOAs, Joint Effort Agreements, etc. — excluding confidential financial information — that set forth the responsibilities of "assistants." If available, a template should be sufficient, rather than the individual contracts signed by each assister or assister organization.

D. If not included in the above, any other communications with "assistants," as well as with the enrollment support unit and/or the Vermont-based call center, regarding voter registration.

Thanks,

Michelle Rupp
Election Counsel & Assistant General Counsel
Project Vote
202-546-4173 x305

*Authorized to practice only in Virginia. Practice in DC limited to cases in federal court.

From: "Frazer, Dylan" <Dylan.Frazer@state.vt.us>
Date: Friday, September 5, 2014 8:09 AM
To: Michelle Rupp <mrupp@projectvote.org>
Subject: RE: Response to Public Records Request

Dear Ms. Rupp:

It has come to my attention that there is an additional MOU to the ones I sent you yesterday. Apologies for not having sent this initially.

Thanks,
-Dylan

From: Frazer, Dylan
Sent: Thursday, September 04, 2014 3:10 PM
To: 'mrupp@projectvote.org'
Subject: Response to Public Records Request

Dear Ms. Rupp:

The Department of Vermont Health Access has conducted a search in response to your public records request dated August 26th, 2014. The following information was requested:

1. Documents showing or describing (including, but not limited to, screenshots) an electronic eligibility system that will determine eligibility for:
 - a. Advance premium tax credits and cost share reductions, which are applied towards the purchase of individual policies under the Affordable Care Act, and partially offset premium costs; and
 - b. Medicaid and CHIP under the Affordable Care Act.
- Please find attached a compilation of screenshots for the online Vermont Health Connect application.
- There may be additional documents developed by consultants reviewing or developing the Vermont Health Connect system. These documents are voluminous and the relevant eligibility elements are not easily separable or searchable. Compiling these records would likely exceed the \$200 limit you requested. We did release documents to Vermont Public Radio which may contain information you are seeking. These are publically available here: <http://www.documentcloud.org/public/search/projectid:11803-gartner-qa-reports> Please contact us if this does not satisfy your request.
2. Any Memorandum of Understanding (MOU), contract, or other agreement between the Department of Vermont Health Access and the Vermont Agency of Administration.

➤ Please find attached MOUs between the Department of Vermont Health Access and the Agency of Administration.

Feel free to contact me if you have any questions.

Sincerely,

Dylan Frazer

Program Consultant – Policy Unit
Dept. of Vermont Health Access
289 Hurricane Lane
Williston, VT 05495
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F: 802-879-8224

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Application Screenshots – July 29, 2014

One Stop Shop

Welcome to Vermont Health Connect, where you can choose from a variety of health plans to find one that best fits your needs. Depending on your income, you may qualify to have the government help you make your premium payments.

Secure

You can rest assured all of your personal information will be secure. Information stored in our system can only be accessed by the people who need it in order to help you with your insurance and other benefits, and we always transmit information using secure channels.

Privacy

We will not share your information with marketing companies or any other entities that do not need access to your information to help you with your insurance and other benefits. Please read our Privacy Policy for more information.

Additional Help

If you need any additional help, please feel free to contact us.

Your Rights and Responsibilities

We need the information we asked for to decide if you qualify for health coverage if you choose to apply. We may check your answers using information from the Internal Revenue Service (IRS), Social Security, 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.

Social Security Numbers. All individuals applying for health benefits who have a Social Security number (SSN) must provide them. Vermont Health Connect uses 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.

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.

Quality Control. Vermont Health Connect may select your application for a quality control

[Next](#)

Privacy & Use of Your Information

Print  Restart  Exit  Save And Exit 

 Required

We'll keep your information private as required by law. Your answers on this form will only be used to determine eligibility for health coverage or help paying for coverage. We'll check your answers using the information in our electronic databases and the databases of other federal agencies. If the information doesn't match, we may ask you to send us proof.

We won't ask any questions about your medical history. Household members who don't want coverage won't be asked questions about citizenship or immigration status.

IMPORTANT: As part of the application process, we may need to retrieve your information from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. We need this information to check your eligibility for coverage and help paying for coverage if you want it and to give you the best service possible. We may also check your information at a later time to make sure your information is up to date. We'll notify you if we find something has changed.

 I agree to have my information used and retrieved from data sources for this application. I have consent from all people I'll list on the application for their information to be retrieved and used from data sources.  Yes No

Next 

START

People

Getting Started With The Application 

Privacy & Use of Your Information

Contact Details

Home And Mailing Addresses

Household Tax Filing Information

Caregiver Information

Authorized Representative

Citizenship Information

Income Information

Household Health Coverage Information

Employer Sponsored Insurance Information

Household Special Circumstances

Renewal Information

FINISH

Help Paying For Coverage

Print  Restart

(*) Required

Even working families can pay less for health coverage. You may be eligible for a free or low-cost plan, or a new kind of advance premium tax credit (APTC) that can be used to lower your monthly premiums right away even if you earn as much as \$94,000 a year (for a family of 4).

If you choose to apply for help paying for coverage, we will ask you questions to see if you can get Medicaid/Dr. Dynasaur or Advance Premium Tax Credit. Here are some of the questions we may ask you about yourself and your family members:

- How much money each family member gets each year or each month
- How family members are related to each other
- Whether family members have certain benefits right now
- Whether family members have any health coverage right now, including employer sponsored insurance

If you choose to not apply for help to pay for coverage, we will not ask you these questions. You may shop for health insurance after answering a few short questions. If you enroll in a plan this way, you will pay the full costs each month. You will not be able to get any Advance Premium Tax Credit.

Not sure if you want to apply for help to pay for coverage? Our [Health Program Eligibility Screener](#) can quickly help you find out if you and your family are eligible to get help paying for coverage.

Do you want to find out if you and your family can get help paying for health coverage? If you select YES, you will answer questions about your income to see what help you and your family qualify for. If you select NO, you will answer fewer questions, but you will not get help paying for coverage. Yes No

Voter Registration

Print  Restart

(*) Required

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

 Do you want a voter registration application sent to you?

Yes

[Back](#)

[Next](#) 

Identification

(*) Required

Please tell us about yourself and all the people who live at your home, even if someone does not want to apply for health insurance today. Be sure to include yourself, spouse, parents, step-parents, and if applicable, include children under 21 who live with you, or anyone under 21 who you take care of and lives with you. Also include any children, age 21 through 26, that you want on your Qualified Health Plan, even if they do not 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.)

Please enter everyone's name exactly as it appears on his or her Social Security card, if they have one, or other documentation.

At the bottom, you can add someone with "Add". You can take someone away with "Remove".

i First Name: *	<input type="text" value="Hope"/>
i Middle Name:	<input type="text"/>
i Last Name: *	<input type="text" value="Falls"/>
i Suffix:	<input type="text"/>
i Other Name (Maiden or Former Name):	<input type="text"/>
i Birth Date (MM/DD/YYYY): *	<input type="text" value="1/2/1986"/>
i Sex: *	<input type="radio"/> Male <input checked="" type="radio"/> Female
i Marital Status: *	<input type="text" value="Married"/>
i Is this person the household member who is filling out the application? *	<input checked="" type="radio"/> Yes <input type="radio"/> No

Remove 

Add 

Drop down menu from the marital status field.



Husband

i First Name: *	<input type="text" value="Micky"/>
i Middle Name:	<input type="text"/>
i Last Name: *	<input type="text" value="Falls"/>
i Suffix:	<input type="text"/> <input type="button" value="v"/>
i Other Name (Maiden or Former Name):	<input type="text"/>
i Birth Date (MM/DD/YYYY): *	<input type="text" value="1/1/1983"/> <input type="button" value="v"/>
i Sex: *	<input checked="" type="radio"/> Male <input type="radio"/> Female
i Marital Status: *	<input type="text" value="Married"/> <input type="button" value="v"/>
i Is this person the household member who is filling out the application? *	<input type="radio"/> Yes <input checked="" type="radio"/> No

Child

i First Name: *	<input type="text" value="Minnie"/>
i Middle Name:	<input type="text"/>
i Last Name: *	<input type="text" value="Falls"/>
i Suffix:	<input type="text" value=""/>
i Other Name (Maiden or Former Name):	<input type="text"/>
i Birth Date (MM/DD/YYYY): *	<input type="text" value="2/1/2009"/>
i Sex: *	<input type="radio"/> Male <input checked="" type="radio"/> Female
i Marital Status: *	<input type="text" value="Never Married"/>
i Is this person the household member who is filling out the application? *	<input type="radio"/> Yes <input checked="" type="radio"/> No

Remove 

People Applying for Health Insurance

Print  **Rest**

(*) Required

Please select the people who would like help paying for health coverage. (Check all that apply).

People applying for coverage:

- Hope
- Micky
- Minnie

Contact Person

(*) Required

Please tell us which person in your household is the main contact for the household.

Contact person:

Hope
Micky
Minnie

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

Contact Details

(*) Required

Please tell us how we can get in touch with Hope.

In addition to telling us the best way to contact you, please provide at least one of the following methods of contact: home phone, cell phone, or email address.

i Home Phone (XXX-XXX-XXXX):

i Work Phone (XXX-XXX-XXXX):

i Cell Phone (XXX-XXX-XXXX):

i Email Address:

i Preferred spoken language:

i Preferred written language:

i What is the best way to get in touch with Hope? (*)

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

Drop down Menus for Contact details.

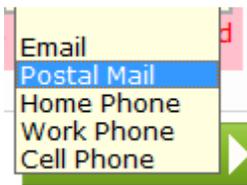
Preferred Spoken Language



Preferred Written Language



What is the best way to get in touch with Hope?



Home Address

Print  Rest

(*) Required

We would like to know where everyone on this application lives, and who lives with who. Please think about where everyone on this application lives and enter all of the addresses that belong to these people. On the next screen we will ask you who lives at each address.

Click "Remove" if no one on the application has a home address, then click "Next".

You can add an address with "Add". You can take one away with "Remove".

i Street Address (Line 1): *	<input type="text" value="7 Elm St"/>
i Apartment or suite number (Line 2):	<input type="text"/>
i City: *	<input type="text" value="Burlington"/>
i State: *	<input type="text" value="Vermont"/>
i County: *	<input type="text" value="Chittenden"/>
i ZIP code (XXXXX): *	<input type="text" value="05401"/>





People Who Live At 7 Elm St

Print  Resta

(*) Required

Please select all the household members who live at 7 Elm St, Burlington.

You must select at least one person for each address and no one may have more than 1 main home address. If someone lives at two or more places, please add them to the address where they spend the greatest number of nights. If you need to delete an address you may do so by clicking Back.

People living at 7 Elm St:

Hope

Micky

Minnie

[Back](#)

Next 

Reaching Hope via Mail

Print  Restart

(*) Required

Please tell us about Hope's mailing address.

 Is Hope's mailing address the same as 7 Elm St, Burlington? *

Yes No

[Back](#)

Next 

Hope's Relationships: Spouse

(*) Required

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

Please choose whom Hope is married to:

Micky

[Back](#) **Next** 

Hope's Relationships: Children

(*) Required

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

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

Micky

Minnie

Micky's Relationships: Children

Print  Resta

(*) Required

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

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

Hope

Minnie

Household Tax Filing Status for 2014

Print  Resta

(*) Required

Please tell us who in your household plans to file a federal income tax return for 2014. You do not have to file taxes to apply for coverage.

i Does anyone on this application plan to file a federal income tax return for 2014? (*) Yes No

[Back](#)

Next 

People Filing Taxes

Print  Restart

(*) Required

Please select the household member(s) who plan to file a federal income tax return for 2014.

Tax filers for 2014:

Hope

Micky

Minnie

[Back](#)

Next 

Hope's Federal Income Tax Return for 2014

Print  Restart

(*) Required

Please tell us the people Hope plans to include on her federal income tax return for 2014.

i Does Hope plan to file a joint federal income tax return with her spouse for 2014? * Yes No

i Will Hope claim any household member as a dependent on her income tax return for 2014? * Yes No

[Back](#)

Next 

Hope's Dependents

Print  Restart

(*) Required

Please tell us the people Hope plans to include on her federal income tax return for 2014.

Hope's dependents:

Micky

Minnie

[Back](#)

Next 

People Who Will Claim Hope as a Tax Dependent for 2014

Print  Restart

(*) Required

Please tell us if there is another person who will claim Hope as a dependent on his or her federal income tax return for 2014.

 Will Hope be claimed as a tax dependent by a taxpayer who is not a part of this application? * Yes No

[Back](#)

Next 

People Who Will Claim Micky as a Tax Dependent for 2014

Print  Restart

(*) Required

Please tell us if there is another person who will claim Micky as a dependent on his or her federal income tax return for 2014.

i Will Micky be claimed as a tax dependent by a taxpayer who is not a part of this application? * Yes No

[Back](#) **Next** 

Authorized Representative

Print  Restart

(*) Required

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 ever need to change your authorized representative, contact Vermont Health Connect. Your authorized representative should not be someone in your household who is also applying for health coverage as a part of this application.

i Do you want to name someone as your authorized representative? * Yes No

[Back](#) **Next** 

The question below is asked for all household members.

Hope's Social Security Number

Print  Restart

(*) Required

We need Hope's Social Security number (SSN) if Hope wants health coverage and has an SSN or can get one. We use SSNs to check income and other information to see who is eligible for help paying for health coverage.

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

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

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

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Next



Same questions below are asked for all household members. The pregnancy question is only asked of females.

Hope's Basic Information

Print  Restart 

(*) Required

Please tell us more about Hope.

Is Hope an American Indian or Alaska Native? * Yes No

Is Hope incarcerated (detained or jailed)? * Yes No

Is Hope pregnant? *

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

You can tell us about Hope's ethnicity and race below, but you can still apply if you would rather not tell us. The information you do (or don't) provide about race and ethnicity will not affect whether your application is accepted. If you do not want to tell us about Hope's race or ethnicity, you may skip this question by clicking "Next".

Hope's ethnicity? (optional)

Hope's race? (optional)

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Same question on Citizenship is asked for all household members.

Hope's Citizenship Status

Print  Restart

(*) Required

Please tell us about Hope's citizenship status.

 Is Hope a US Citizen or a US National? *

Yes No

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More About Hope's Citizenship Status

Print  Restart

(*) Required

Please tell us about Hope's citizenship status.

 Is Hope a Naturalized or Derived Citizen? *

Yes No

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External Verification

Print  Restart

(*) Required

By choosing "Yes," I indicate that I understand that my identifying information will be sent to government systems to try to verify information about my household for this application and for future processing. I also understand that my information will be kept secure and will only be used to help verify my household information.

 I understand the above information and wish to continue with the application process. *

Yes No

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The two following questions are asked of each household member on income.

Hope's Income Sources

Print  Restate

(*) Required

Please think about all of the sources of income that Hope expects to get throughout 2014. For each income source, select the income type. Many people will need to add more than one income source. For example, if Hope has two jobs, select "Job" below, then click "Add" and select "Job" again. Once you have added all of Hope's income sources click "Next". We will ask you questions about each income source on the next few screens. To add another income source click "Add". To take one away click "Remove".

You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI).

 What type of income does Hope have? *



- Job
- Self-employment
- Social Security benefits
- Unemployment benefits
- Retirement account
- Capital Gains
- Investment income
- Rental or Royalty income
- Farming or fishing income
- Alimony received
- Canceled debts
- Court awards
- Jury duty pay
- Gambling, prizes, or awards
- Pension
- Educational scholarship
- Commission





Hope's Income Sources

Print  Restate

(*) Required

Please think about all of the sources of income that Hope expects to get throughout 2014. For each income source, select the income type. Many people will need to add more than one income source. For example, if Hope has two jobs, select "Job" below, then click "Add" and select "Job" again. Once you have added all of Hope's income sources click "Next". We will ask you questions about each income source on the next few screens. To add another income source click "Add". To take one away click "Remove".

You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI).



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Questions on income:

Hope's Income Details

Print  Restart

(*) Required

Please think about the income that Hope will get from this income source for 2014.

Please tell us about Hope's job.

i Name of employer: *	<input type="text" value="Burger King"/>
i How much does Hope get (before taxes are taken out)? *	\$ <input type="text" value="600.00"/>
i How often does Hope get this amount? *	<input type="text" value=""/>
i Start date (MM/DD/YYYY): *	<input type="text" value="1/1/2014"/>
i End date (MM/DD/YYYY): *	<input type="text" value="12/31/2014"/>
i Will Hope get any one-time amounts from this job this month, like a bonus or a severance payment? *	<input type="radio"/> Yes <input type="radio"/> No

Drop down menu on how often Individual gets this income.

<input type="text" value=""/>
Hourly
Daily
Weekly
Every 2 Weeks
Twice a month
Monthly
Yearly
<input type="radio"/> Yes <input type="radio"/> No

Screen on Self-Employment

Please think about the income that Micky will get from this income source for 2014.

Please tell us about Micky's self-employment income.

i How much net income (profits once business expenses are paid) will Micky get from this self-employment this month? If the costs of self-employment are more than the amount Micky expects to earn, you should list amount as a loss instead of a profit. *

\$

i Is this amount a profit or a loss? *

i Type of work: *

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Deduction Questions: this is asked of all members applying.

Hope's Deductions

[Print](#)  [Restart](#)

(*) Required

Does Hope get any of these deductions reported on the front page of a federal income tax return? Do not include costs that you already used to indicate your self-employed income.

This could make the cost of coverage a little lower.

i Alimony paid? *

Yes No

i Student loan interest? *

Yes No

i Other deductions? *

Yes No

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Hope's Income this Year

Print  Restart

(*) Required

Based on what you told us, if Hope's income is steady each month, then it is about \$7,200.00 per year.

 Is this how much you think Hope will get in 2014? *

Yes No

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Micky's Income this Year

Print  Restart

(*) Required

Based on what you told us, if Micky's income is steady each month, then it is about \$14,400.00 per year.

 Is this how much you think Micky will get in 2014? *

Yes No

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Minnie's Income this Year

Print  Restart

(*) Required

Based on what you told us, if Minnie's income is steady each month, then it is about \$0.00 per year.

 Is this how much you think Minnie will get in 2014? *

Yes No

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Household Health Coverage

Print  Restart

(*) Required

During the period for which the household is applying for coverage, is anyone eligible for, or enrolled in, one of the forms of health insurance programs listed below?

- Yes No

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Does Burger King Offer Health Coverage?

Print  Restart

(*) Required

Please tell us if Burger King offers employer-sponsored health insurance to the employee or the employee's family members for coverage in 2014. Please answer Yes to this question if Burger King offers insurance, even if the employee or the employee's family members are not enrolled.

- Yes No

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Burger King Contact Information

Print  Restart

(*) Required

Tell us about Burger King.

 Business Street Address (Line 1): *	<input type="text" value="7 Main St"/>
 Business Street address (Line 2):	<input type="text"/>
 Business City: *	<input type="text" value="Winooski"/>
 Business State: *	<input type="text" value="Vermont"/>
 Business ZIP Code (XXXXX): *	<input type="text" value="05452"/>
 Business Phone Number (XXX-XXX-XXXX): *	<input type="text" value="802-363-9889"/>
 Employer Identification Number (EIN) (XXXXXXXXXX):	<input type="text"/>

Coverage from Other Employers

Print  Restart

(*) Required

Please tell us if any employers not yet entered on this application offer employer-sponsored health insurance to anyone in this household for coverage in 2014.

 Is anyone in the household eligible for health insurance offered by an employer not entered on this application? *

Yes No

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Household Special Circumstances

Print  Resto

(*) Required

These next questions ask about events that may have happened in your household in the past 60 days. Please think about what has happened in your household since 5/29/14 until today.

Your responses to the following questions do not affect medical assistance eligibility.

If you are currently on Medicaid and have received a notice about your annual review telling you to go to Vermont Health Connect to apply for continued healthcare coverage, please check "yes" to the first question below. Enter today's date when asked for the date of loss of coverage.

- Yes No
1 Did anyone on this application lose health coverage in the past 60 days? *
- Yes No
1 Did anyone on this application get married in the past 60 days? *
- Yes No
1 Has anyone on this application been adopted or placed up for adoption in the past 60 days? *
- Yes No
1 Has anyone been added to the household through the foster care program? *
- Yes No
1 Did anyone on this application gain US citizenship, eligible immigration status, or become lawfully present in the past 60 days? *
- Yes No
1 Did anyone on this application move to Vermont in the past 60 days? *
- Yes No
1 Did anyone on this application get released from incarceration (jail or prison) in the last 60 days? *

How Did You Hear About Us?

Print  Resto

(*) Required

Please tell us how you heard about Vermont Health Connect.

1 Please select an option to the right:

- Friends/Family
- Employer
- Internet
- Mail
- Email
- News
- Other

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Automatic Renewal

(*) Required

I understand that if I'm eligible for help paying for health insurance, I may also be able to renew the coverage.

During the renewal process, the Marketplace will use income data including information from the tax returns of household members. This will determine yearly eligibility for help paying for health insurance for the next 5 years. The Marketplace will send me a notice and let me make changes. If I don't respond, the Marketplace will continue my eligibility at the level indicated by the data.

I understand this renewal process will occur each year for the next 5 years unless I tell the Marketplace that I don't want to renew, or if I leave the Marketplace. I also understand that I can change my answer later.

 Do you agree to a renewal period of 5 years? *

Yes No

**MEMORANDUM OF UNDERSTANDING
BETWEEN THE DEPARTMENT OF VERMONT HEALTH ACCESS AND THE
AGENCY OF ADMINISTRATION**

This MOU replaces MOU Number 03410-06-14 in its entirety. The Department of Vermont Health Access (DVHA) and the Agency of Administration (AOA) will enter in to an agreement to outline the process necessary for billing DVHA for work completed by AOA staff specific to the State Innovation Models (SIM) grant.

Purpose

The DVHA agrees to transfer to the AOA up to the amount as specified in the project budget as mutually agreed to by both parties for the term that this MOU will be in effect. The funds will be for the purpose of both staffing and contract expenditures pursuant to the SIM grant.

MOU Terms

This MOU will be in effect upon October 1, 2013 and will end on September 30, 2015. This MOU may be amended as necessary. The project budget may be amended per mutual written consent of both parties.

Terms of Agreement

AOA and DVHA agree to the following process for documenting the billing and payment cycle:

1. AOA staff whose positions will be funded by the SIM grant will document time worked using the appropriate program code as defined by DVHA.
2. AOA agrees to use the appropriate program code as defined by DVHA when paying contract expenditures pursuant to the SIM grant.
3. AOA will invoice DVHA on a monthly basis for expenditures related to the SIM grant per the Payment Terms outlined below.
4. The annual amount of this agreement will not exceed the amount as specified in the project budget as mutually agreed to by both parties.
5. DVHA reviews and approves the invoices from AOA.
6. AOA has the responsibility to only pay for time allowed per the Federal Award to DVHA.
7. AOA has the responsibility to comply with terms of the Federal Award for any expenditure approved in the project budget outlined below.
8. AOA will be financially responsible for any Federal disallowance due to failure to maintain adequate documentation supporting the expenses per this agreement.
9. AOA will submit all contracts and related material 35 days prior to contract execution to robert.pierce@state.vt.us for final review and approval by federal partners.

Contacts

AOA

Name:	Georgia Maheras	Title:	Project Director, AOA
Phone:	(802) 828-2919	E-mail:	georgia.maheras@state.vt.us

DVHA

Name:	Kara Suter	Title:	Reimbursement Director
Phone:	(802) 879-5900	Email:	kara.suter@state.vt.us

Payment Terms

- For expenses directly incurred by AOA, AOA agrees to submit monthly invoices to DVHA with appropriate detail to meet the AHS Federal reporting requirements. AOA will maintain sufficient supporting documentation (e.g., time reports, and expense reports, detailed expenditures, etc) to comply with federal audit requirements.) AOA will submit a report by the 15th days following month end. All invoices shall be submitted to Robert Pierce in the DVHA BO at robert.piercevt@state.vt.us.
- By June 14, 2014, DVHA and AOA will work together to arrive at an agreed upon estimate of fourth quarter expenditures for the purpose of closing SFY 2014. DVHA and AOA will agree on a reconciled accounting of actual fourth quarter expenditures by July 15, 2014.
- By June 16, 2015, DVHA and AOA will work together to arrive at an agreed upon estimate of fourth quarter expenditures for the purpose of closing SFY 2015. DVHA and AOA will agree on a reconciled accounting of actual fourth quarter expenditures by July 15, 2015.
- By June 15, 2016, DVHA and AOA will work together to arrive at an agreed upon estimate of fourth quarter expenditures for the purpose of closing SFY 2016. DVHA and AOA will agree on a reconciled accounting of actual fourth quarter expenditures by July 15, 2016.
- Based on the monthly expenditure reports, DVHA will initiate an interdepartmental transfer to reimburse AOA for expenditures by the 30th day of the month in which the invoice is received by DVHA. Notification of the transfer will be sent via email to jason.pinard@state.vt.us.
- DVHA considers AOA a sub-recipient per OMB A-133 for these funds. AOA agrees to follow all applicable federal and state regulations in association with all activities tied to this MOU.

Project Budget

State Innovation Models: Funding for Model Design		
Year 1, 10/01/2013 – 09/30/2015		
Personnel Cost: Salary + Fringe	Program Code	
FY14 Project Director	37991	\$234,720.00
Workforce staff - TBA	37991	\$114,000.00
Contracts: Workforce (see below)	37990	\$743,000.00
Contracts: Project Manager	37990	\$930,681.95
Expenses	37991	\$18,000.00
Equipment	37991	\$10,000.00
Total		\$2,050,401.95

Funding

Source of Funds: 100% Federal
CFDA Title: ACA - State Innovation Models: Funding for Model Design or Model Testing Assistance
CFDA Number: 93.624
Award Number: 1G1CMS331181-01-00
Award Year: FFY2013

Federal Granting Agency: HHS, CMS/CMS Innovation Center

The provisions of this Memorandum of Understanding are hereby entered into and agreed to by virtue of the authorized signatures below:

<hr/> <p>Mark Larson, Commissioner Department of Vermont Health Access</p>	<hr/> <p>Michael Clasen Project Director Agency of Administration</p>
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MEMORANDUM OF UNDERSTANDING
BETWEEN THE DEPARTMENT OF VERMONT HEALTH ACCESS AND THE
AGENCY OF ADMINISTRATION

The Department of Vermont Health Access (DVHA) and the Agency of Administration (AoA) will collaborate to complete the work associated with the Level 1 Establishment Grant # HBEIE120080-01-00 (Exchange Grant) awarded to DVHA for the period of November 29, 2011 through November 28, 2012. Through this agreement, DVHA will be responsible for the administration and reporting related to the federal award, while AoA will assist in functions tied to the administration of Exchange Grant.

Purpose

DVHA agrees to transfer up to \$251,970 to the AoA for functions relating to AoA's role in Establishment of the Health Insurance Exchange (HIX) as approved in the federal award. It is expected that select AoA staff will assist DVHA and DVHA's contracted HIX implementation agents in the following efforts:

- Ensuring that the exchange implementation and all health care reforms are a coordinated effort within state government;
- Assist in implementing Vermont's HIX platform;
- Researching legal and health policy issues related to the exchange in Vermont and prepare policy briefs and reports, public hearing testimony, meetings and conference presentations;
- Manage the federal government and state government relationship for all of Vermont's health care reform efforts.

Term of Agreement

This MOU will be in effect upon signature by the Commissioner of DVHA and will end on November 28, 2012. This MOU shall be amended as necessary.

Contacts

DVHA

Name: Kate Jones **Title:** Financial Manager
Phone: (802) 879-8256 **E-mail:** kate.jones@ahs.state.vt.us

AOA

Name: Jason Pinard **Title:** Financial Director
Phone: (802) 828-3547 **E-mail:** jason.pinard@state.vt.us

Payment Terms

- AoA agrees to submit quarterly invoices to DVHA detailing a report of expenditure by the 25th day of the month following each fiscal quarter for expenses relating to the included budget. Expenses incurred by AoA from September 30, 2010 through November 28, 2012 directly relating to the Exchange Grant and as outlined in the included budget are herein noted as eligible for reimbursement by DVHA.
- Based on the quarterly expenditure reports, DVHA will initiate an interdepartmental transfer to reimburse AoA for these expenditures by the 30th day after receipt of the report. Notification of the transfer will be sent via email to Jason Pinard in the AoA business office @ jason.pinard@state.vt.us.

Funds transfer to AoA by DVHA will be for the following expenses:

Budgeted costs for AoA Exchange Grant Administration			
Position Title	Average Hourly Rate	Hours to Project	Salary Expense
Attorney/Policy Analyst	38.47	1,387	53,354.00
Admin for AoA	19.54	1,733	33,861.00
Director, Health Care Reform (Robin Lunge)	43.58	867	37,782.00
	FTEs:	2.5	
Personnel (listed above)		Subtotal	\$124,997
Fringe Benefits	46%		\$57,499
Equipment/Supply/Other			\$17,476
Travel			\$2,000
Indirect	40%		\$49,999
GRAND TOTAL		Total	\$251,970

Funding

\$251,970

Source of Funds: 100% Federal

CFDA Title: Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges

CFDA Number: 93.525

Award Name: Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges

Award Number: 1-HBEIE120080-01-00

Award Year: 2011

Federal Granting Agency: HHS, OCIO

Research and Development Grant? Yes No

The provisions of this Memorandum of Understanding are hereby entered into and agreed to by virtue of the authorized signatures below:

<p>_____</p> <p>Lindsey Tucker, Deputy Commissioner Department of Vermont Health Access</p> <p>_____</p> <p>Date</p>	<p style="text-align: center;"></p> <p>Michael Clasen, Deputy Secretary Agency of Administration</p> <p style="text-align: center;">05/02/12</p> <p>_____</p> <p>Date</p>
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- Based on the monthly expenditure reports, DVHA will initiate an interdepartmental transfer to reimburse AoA for these expenditures by the 30th day after receipt of the report. Notification of the transfer will be sent via email to Jason Pinard in the AoA business office @ jason.pinard@state.vt.us.
- AoA agrees to use the appropriate program codes as identified in the Budget Detail found below in reporting their actual VISION expenses for contracts and staff in order to properly report all AoA reimbursable expenses for this project.
- All Requests for Proposals (RFPs), contracts, and grants to be charged to these funds must be pre-approved through the existing PMO structure which supports the AHS Health Services Enterprise. Furthermore, all such agreements must also be approved by CMS prior to issuance. All such documents must be submitted to Joe Liscinsky (joseph.liscinsky@state.vt.us) and Kate Jones to route through the HSE PMO structure and CMS for approval prior to release or execution. DVHA will not reimburse for any claimed expenses that have not been preapproved through this process.

Funds transfer to AoA by DVHA will be for the following expenses:

Exchange Level II - AoA Costs			
Budget Detail			
Program Code		Budget Period	9/10/2010 -12/31/2014
Personnel (Salary & Fringe)	41696	Level 1:100%	\$ 182,496.00
	41704	Level 2: 100%	\$ 493,799.88
		Subtotal	\$ 676,295.88
Equipment/Supplies/Other	41696	Level 1: 100%	\$ 17,476.00
	41704	Level 2: 100%	\$ 21,750.00
		Subtotal	\$ 39,226.00
Travel	41696	Level 1: 100%	\$ 2,000.00
	41704	Level 2: 100%	\$ 18,784.00
		Subtotal	\$ 20,784.00
Contractual	41632	Mintz SI Level 2: 74.05%/ Medicaid 25.95%	\$ 300,000.00
	41609	Mintz IE Level 2: 74.05%/ Medicaid 25.95%	\$ 300,000.00
	41704/41470	Financing Plan Level 2: 82.89% DFR GF 17.1%	\$ 175,000.00
		Subtotal	\$ 775,000.00
	41696	Subtotal Level 1: 100%	\$ 201,972.00
	41704	Subtotal Level 2: 100%	\$ 534,333.88
	41632/41609	Subtotal Level 2: 74.05%/ Medicaid 25.95%	\$ 600,000.00
	41704/41470	Subtotal Level 2: 82.89% DFR GF 17.1%	\$ 175,000.00
GRAND TOTAL			\$ 1,511,305.88

Funding

Source of Funds: Federal, \$201,972.00

CFDA Title: Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges

CFDA Number: 93.525

Award Name: Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges

Award Number: 1-HBEIE120080-01-00

Award Year: 2011

Federal Granting Agency: HHS, OCIIO

Research and Development Grant? Yes No

**MEMORANDUM OF UNDERSTANDING
AFFORDABLE CARE ACT'S EXCHANGE**

**MOU # 03410-1002-13
PAGE 3 OF 3**

Source of Funds: Federal, \$1,086,061.92

CFDA Title: Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges

CFDA Number: 93.525

Award Name: Cooperative Agreements to Support Establishment of State-Operated Health Insurance Exchanges

Award Number: 1-HBEIE120130-01-00

Award Year: 2012

Federal Granting Agency: HHS, OCIIO

Research and Development Grant? Yes No

Source of Funds: Enhanced Medicaid, \$193,346.96

Source of Funds: General Funds from Department of Financial Regulation, \$29,925.00

The provisions of this Memorandum of Understanding are hereby entered into and agreed to by virtue of the authorized signatures below:

<p> E-SIGNED by Lindsey Tucker on 2013-Mar-01</p> <hr/> <p>Lindsey Tucker, Deputy Commissioner Department of Vermont Health Access</p> <hr/> <p>Date _____</p>	<p> E-SIGNED by Michael Clasen on 2013-Mar-01</p> <hr/> <p>Michael Clasen, Deputy Secretary Agency of Administration</p> <hr/> <p>Date _____</p>
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