VERMONT Department of Vermont Health Access
Department of Disabilities, Aging & Independent Living
Division of Disability & Aging Services

GreenMountainCare
A HEALTHIER STATE OF LIVING

202LTC REV

Application for Long-Term Care Medicaid

Revised 2/2018

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.

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 *(including area code)*		For interviews call
Gender	Language Preferred	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
☐ *Physical address is same as mailing address*	*Send mail to:* ☐ *Mailing address*	☐ *Physical address*
Physical Address line 1		Apartment or suite number
Physical Address line 2 *(If applicable, include an "in-care-of" person here)*		
City	State	ZIP Code

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-247-3092. (Arabic)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-247-3092. (French)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-247-3092. (Spanish)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-247-3092. (Vietnamese)
ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-247-3092। (Nepali)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-247-3092. (German)
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-247-3092. (Cushite)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-247-3092. (Russian)
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-247-3092. (Portuguese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-247-3092 まで、お電話にてご連絡ください。(Japanese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-247-3092。(Chinese)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-247-3092. (Italian)
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-247-3092. (Serbo-Croatian/Bosnian)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-247-3092. (Tagalog)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-247-3092. (Thai)

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

Full name	Phone No. ( )	Home ☐ Cell ☐ Work ☐
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.**

MEMB

First name / Initial / Last name	Assistance applying for	Gender	Citizenship status
Applicant	☐ Choices for Care ☐ Developmental Disability Services Waiver ☐ Traumatic Brain Injury ☐ Enhanced Family Treatment	☐ Female ☐ Male	☐ U.S. citizen ☐ Asylee ☐ Refugee ☐ Legal alien ☐ Other Country of birth _____
	Marital status ☐ Never married/Single ☐ Civil union ☐ Married ☐ Divorced/dissolved ☐ Separated ☐ Widowed	**Birthdate**	**Social Security Number** ___ - ___ - ___
	Date Widowed or Divorced: ___/___/___ mm/dd/yyyy		

First name / Initial / Last name	Assistance applying for	Gender	Citizenship status
	☐ ***None*** ☐ Choices for Care ☐ Developmental Disability Services Waiver ☐ Traumatic Brain Injury ☐ Enhanced Family Treatment	☐ Female ☐ Male	☐ U.S. citizen ☐ Asylee ☐ Refugee ☐ Legal alien ☐ Other Country of birth _____
Relationship to you ☐ Spouse ☐ Civil union partner	**Marital status** ☐ Never married/Single ☐ Civil union ☐ Married ☐ Divorced/dissolved ☐ Separated ☐ Widowed	**Birthdate**	**Social Security Number** ___ - ___ - ___

Complete for dependents:

First name / Initial / Last name	Relationship to you	Birthdate

First name / Initial / Last name	Relationship to you	Birthdate

2. Where are you currently living?

Applicant	Applicant's spouse or civil union partner (Complete only if spouse or civil union partner is also applying for LTC Medicaid)
☐ Home ☐ Hospital ☐ Nursing Facility ☐ Residential Care/Assisted Living Facility 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	☐ Home ☐ Hospital ☐ Nursing Facility ☐ Residential Care/Assisted Living Facility 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.)

Applicant	Applicant's spouse or civil union partner (complete only if spouse or civil union partner is also applying for LTC Medicaid)
☐ Own home/apartment ☐ Home of another (family/friend) ☐ Enhanced Residential Care ☐ Nursing Facility ☐ Adult Family Care Home	☐ Own home/apartment ☐ Home of another (family/friend) ☐ Enhanced Residential Care ☐ Nursing Facility ☐ Adult Family Care Home

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

MEDI

First name Initial		Medicare claim number	
Part A:	**Part B:**	**Part C:**	**Part D:**
Start Date:_____	Start Date:_____	Start Date:_____	Start Date:_____
Premium $:_____	Premium $:_____	Premium $:_____	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.

First name Initial	Plan name	CMS number	Plan start date
		CMS- __ __ __ __ __ - __ __ __	

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

First name Initial	Plan name	CMS number	Plan start date
		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***

INSU

Name of policy holder	Policy number	Group number	Premium amount	Date coverage began	Type of coverage (check all that apply)	Names of people covered	Name, address, and phone number of insurance company
1.			$ per		☐ Doctor ☐ Prescription ☐ Hospital ☐ Major Medical ☐ Dental ☐ Outpatient ☐ Vision ☐ Long-term care ☐ Other:_____		
2.			$ per		☐ Doctor ☐ Prescription ☐ Hospital ☐ Major Medical ☐ Dental ☐ Outpatient ☐ Vision ☐ Long-term care ☐ Other:_____		
3.			$ per		☐ 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)

CASH

First name	Initial	Amount	First name	Initial	Amount
		$			$

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).

BANK

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

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

CARS

Type of vehicle	Name of owner and co-owner	Year, make, and model	Leased?	Amount Owed
Car, truck, or van			☐ Yes ☐ No	$
Car, truck, or van			☐ Yes ☐ No	$
Camper or RV			☐ Yes ☐ No	$
Snow mobile or jet ski			☐ Yes ☐ No	$
Trailer or boat			☐ Yes ☐ No	$
Motorcycle or ATV			☐ Yes ☐ No	$
Other_____			☐ Yes ☐ No	$

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)

PROP

Type of property	Name of owner and co-owner	Location	Assessed value	Amount owed
Primary residence (your home)			$	$
Vacation home			$	$
Camp			$	$
Rental property			$	$
Business property			$	$
Land			$	$
Time share			$	$
Other (describe)			$	$

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

STOK

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

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

Street or Road	City	State	Zip Code

Transfer Information

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.

TRAN

First name	Initial	What was it?	When was it?

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)

TRAN

First name	Initial	What was it?	Whose name was added?	When was name added?

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.

TRAN

First name	Initial	What was placed in the trust?	Date it was placed in the trust

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.

JINC

Full Name	Date paid	Hours worked	Income before deductions	Tips and commissions
Paychecks are issued ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Day of week:_____			$	$
Employer's name and phone number				

Full Name	Date paid	Hours worked	Income before deductions	Tips and commissions
Paychecks are issued ☐ 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.

BUSI

First name	Initial	Type of business	Date business began

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. UNEA

First name	Initial	Income before deductions	Type of income
		$ per	
		$ per	
		$ per	
		$ per	

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)

First name	Initial	Income before deductions	Type of income
		$ per	
		$ per	

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)

☐ Yes ☐ No

Some examples are:

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

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

21. List the following expenses for your apartment, house, or trailer.

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

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

Names of people who share the expense	Who pays for what?

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, 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 must read your rights and responsibilities. If you need help understanding them call 1-800-479-6151. You can also review them online at any time by visiting my Benefits.vt.gov.

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

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
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

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)

Signature

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?
To learn more about this program, call toll free 1-800-464-4343. ☐ Yes ☐ No

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.