GreenMountainCare
A HEALTHIER STATE OF LIVING

201P REVIEW

Pharmacy Programs Application

VPharm and Healthy Vermonters Programs

Revised 09/2016

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

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...

إذا آنت ترغب خدمات الترجمة الفورية اتصل برقم 1-855-247-3092 (Arabic)
Ako su Vam potrebne usluge tumačenja, pozovite 1-855-247-3092. (Bosnian)
စကားပြန် ဝန်ဆောင်မှုလုပ်ငန်းကိုအလိုရှိပါက 1-855-247-3092 သို့ဖုန်းဆက်ခေါ်ပါ။ (Burmese)
Si vous avez besoin de services d'interprétation, appelez le 1-855-247-3092. (French)
Mugihe woba ushaka impfashanyo yo gusigurirwa, hamagara uyu murongo 1-855-247-3092. (Kirundi)
यदि तपाईलाई दोभाषे सेवाको जरुरत परेमा 1-855-247-3092 मा कल गनुर्होस्। (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. (Spanish)
Ikiwa unahitaji huduma za ukalimani, piga simu 1-855-247-3092. (Swahili)
Nếu quý vị cần dịch vụ thông ngôn, hãy gọi 1-855-247-3092. (Vietnamese)

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.** _____
First M.I. Last

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

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

HEALTH INSURANCE INFORMATION

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

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.

	Applicant Amount *(before deductions)*	Spouse or CU Partner Amount *(before deductions)*
8. Social Security Retirement (SSA)	$ per mo. ☐ None	$ per mo. ☐ None
9. Social Security Disability (SSDI)	$ per mo. ☐ None	$ per mo. ☐ None
10. Supplemental Security Income (SSI)	$ per mo. ☐ None	$ per mo. ☐ None
11. Railroad Retirement	$ per mo. ☐ None	$ per mo. ☐ None
12. Veteran's Benefits	$ per mo. ☐ None	$ per mo. ☐ None
13. Pensions or Annuities	$ _____ ☐ None Income is received: ☐ Monthly ☐ Bi-monthly ☐ Annually ☐ Quarterly Date last received:	$ _____ ☐ None Income is received: ☐ Monthly ☐ Bi-monthly ☐ Annually ☐ Quarterly Date last received:
14. Interest or Dividends	$ per mo. ☐ None	$ per mo. ☐ None

15. Does anyone have income from a job, internship or training program?
If yes, please provide gross wages and pay dates for the past 30 days below. ☐ Yes ☐ No

Applicant				Spouse or CU Partner			
Full name				Full name			
Date paid	Hours worked	Income before deductions	Tips and commissions	Date paid	Hours worked	Income before deductions	Tips and commissions
		$	$			$	$
		$	$			$	$
		$	$			$	$
		$	$			$	$
Paychecks are issued: ☐ Weekly ☐ Monthly ☐ Every two weeks ☐ Twice a month				Paychecks are issued: ☐ Weekly ☐ Monthly ☐ Every two weeks ☐ Twice a month			
Employer's name:				Employer's name:			
Employer's phone number:				Employer's phone number:			

	Applicant	Spouse or CU Partner
16. Does anyone get paid for taking care of children? 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.	☐ Yes ☐ No	☐ Yes ☐ No
16. a. Income before deductions	$ per	$ per
16. b. Breakfasts	per mo.	per mo.
16. c. Lunches	per mo.	per mo.
16. d. Dinners	per mo.	per mo.
16. e. Snacks	per mo.	per mo.

INCOME INFORMATION (CONTINUED)

	Applicant	Spouse or CU Partner
17. Does anyone get paid for providing room or meals in your home? Include payments from children.	☐ Yes ☐ No	☐ Yes ☐ No
17a. Payment received	$ per	$ per
17b. Name of person paying		
17c. What is provided? Check all that apply.	☐ Room ☐ 1-2 meals per day ☐ 3 meals per day	☐ Room ☐ 1-2 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
18a. Type of business		
18b. 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
19a. Type of income		
19b. Amount	$	$
19c. Occurrence	☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month	☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month

EXPENSE INFORMATION

	Applicant	Spouse or CU Partner
20. Do you pay for daycare for a child or an incapacitated adult?	☐ Yes ☐ No	☐ Yes ☐ No
20a. Payment	$ per month	$ per month
20b. Name of child or incapacitated adult		
21. Do you pay court-ordered child support or alimony?	☐ Yes ☐ No	☐ Yes ☐ No
21a. Payment	$ per month	$ per month

IMPORTANT: After reading the following Rights and Responsibilities and the Authorizations and Releases, be

RIGHTS AND RESPONSIBILITIES

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.

RIGHTS AND RESPONSIBILITIES (CONTINUED)

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)

AUTHORIZATIONS AND RELEASES

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

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

SIGNATURE

<u>You must sign here</u>. 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.

Name (agency name, if applicable)		Phone number	
Street address/PO Box	City	State	ZIP code

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 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.	☐ Yes ☐ No
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. Would you like us to refer you to this program?	☐ Yes ☐ No
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?	☐ Yes ☐ No
Lifeline	For assistance with the federal Lifeline program, please call the USAC Lifeline consumer support phone number at 1-800-234-9473 or visit https://www.lifelinesupport.org.	
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.	