202A

Medicaid Request for Retroactive Assistance

Applicant	SSN				
Head of household if different	SSN				
. For which of the last 3 months are you requesting retroactive Medicaid?					
Were you a Vermont resident in each month? Yes 🗌 No 🗌 - if no, v	when did you begin living in Vermont?				

Answer questions 2 and 3 only for the months listed above. List all income and resources for you and your spouse or civil union partner. If the request is being made for a child under the age of 21, list the income and resources of the parents.

2. Income -				Applicant		S	pouse or civil –OR- Parents (if	union partner
	YES	NO		Applicali	L		Parents (II	ciiiid)
Month received:								
Supplemental Security Income	e□		\$	\$	\$	\$	\$	
Social security			\$	\$	\$	\$	\$	\$
Veterans benefits			\$	\$	\$	\$	\$	\$
Railroad retirement			\$	\$	\$	\$	\$	\$
Wages			\$	\$	\$	\$	\$	\$
Other income			\$	\$	\$	\$	\$	\$
describe:								
Total monthly amount:			\$	\$	\$	\$	\$	\$
3. Resources -						:		il union partner
	YES	NO		Applicant			-OI Parents (it	
Monthly resource amount held	l :							
Cash on hand			\$	\$	\$	\$	\$	\$
Money in bank (savings, checking)			\$	\$	\$	\$	\$	\$
Stocks and bonds (current market value)			\$	\$	\$	\$	\$	\$
Life insurance (face value)			\$	\$	\$	\$	\$	\$
Equity in real property (not the home you live in)			\$	\$	\$	\$	\$	\$
Trust fund or prepaid funeral		🗌 I	f yes, send a copy	y of the terms of th	ne trust.			
Other resource			\$	\$	\$	\$	\$	\$
describe:					. <u></u>			
Total amount for the month			\$	\$	\$	\$	\$	\$

Please send copies of bankbook, pay stubs, Social Security Administration award letter, stock and bond certificate, etc. for any type of income or resource listed above. Please do not send originals since we cannot guarantee they will be returned to you.

Does anyone own any vehicles? No Yes			Leased? Yes No	\$
Does anyone own any vehicles? No Yes	Name	Year, make, and model		Amount owed
			Leased? 🗌 Yes 🗌 No	
	Name	Year, make, and model		Amount owed
If there are more than 2 veh	icles, please provide v	vehicle information in the Additi	onal space area below.	
4. If you have a disability, is your disability the res	sult of an accident?	□ No □ Yes		
5. During any of the months for which you are req	uesting retroactive	medical coverage:		
a. Did you have health insurance other th	an Medicare? 🗌 N	• Ves - which months?		
Insurance company (name and address))			
Gro	oup number	Policy	number	
b. Were you living in an institution? \Box	No 🗌 Yes – wh	ich months?		
Name of institution				
Answer all of the questions on this	s form and read	l the following stateme	nt before you sign	your name.
I have provided and reviewed the information on the complete to the best of my knowledge and belief.	nis application. I gi	ve my word, under penalty o	f perjury, that it is corre	et and

I have read and I understand the Rights and Responsibilities on my application for assistance. I was given a copy of these statements and I agree to them.

Signature of applicant	Signature of spouse or civil union partner	Signature of person helping fill out this form
Date:	Date:	Date:

Additional space if needed: