VERMONT

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

GreenMountainCare
A HEALTHIER STATE OF LIVING

202LTC REV

Application for Long-Term Care Medicaid

Revised 04/2023

LTC (Long-Term Care Medicaid) helps pay for care and support for older Vermonters and people with disabilities. To be eligible you must meet financial and clinical criteria. DVHA (Department of Vermont Health Access) 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 Medicaid services you are applying for:

☐ CFC (Choices for Care) provides a package of long-term care services and supports to Vermonters who are age 18 years and older 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 facility or nursing facility. A nurse from DAIL (Department of Disabilities, Aging & Independent Living) completes the clinical assessment.

☐ DD HCBS (Developmental Disabilities Home and Community-Based Services) provides support to people with developmental disabilities to live in their local communities. The local Designated Agency arranges the necessary assessments.

☐ BIP (Brain Injury Program) serves individuals in the community who have experienced a moderate to severe acquired (traumatic or non-traumatic) brain injury (excludes congenital and degenerative brain conditions). To be eligible you must be age 16 or older and have medical documentation of your brain injury. DAIL will contact you to determine your clinical eligibility.

☐ IHCBS (Intensive Home and Community-Based Services) (formerly known as Enhanced Family Treatment) 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 Initial	Last Name	Suffix (Sr., Jr., III, etc.)

Social Security Number	Date of Birth (mm/dd/yyyy)	Gender	Language Preferred

Primary Phone Number	Provide name to call for interviews	For interviews call #	Town where you live

Mailing Address line 1	Apartment or Suite number

Mailing Address line 2	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	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: तपार्इंले नेपाली बोल्नुहुन्छ? भने तपार्इंको 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：日口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、お電話にてトご連絡ください。(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)

Will getting health care change your immigration status? See information for Non-Citizens on page 13.

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, 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 11, 13, and 14 before you sign and date the application.

If you need more room for any answers, use page 12 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 Number	Home ☐ Cell ☐ Work ☐
Address		

Some correspondence may be sent to the person listed above. Additional documentation and/or forms may be needed.

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 Your Review

We need proof of the items listed below to find out if you continue to be eligible for LTC Medicaid. Please send copies with your renewal form - DO NOT send originals.

- ☐ Health insurance premium amounts.
- ☐ Current balance for your nursing home or rep payee account.
- ☐ Current retirement account statements.
- ☐ Current stock, bond, and mutual fund statements.
- ☐ Most recent annual statement for each life insurance policy that is not designated for burial.
- ☐ Gross monthly income from all sources including VA, Railroad Retirement, pensions, annuities, etc.
- ☐ All deeds signed by you within the last 12 months (including the corresponding property tax bills and property transfer tax returns)
- ☐ Trusts created in the last 12 months (including all attachments and amendments)
- ☐ List of all assets (bank accounts, vehicles, stocks, bonds, etc.) you sold, traded, gave away, or added other names for ownership in the last 12 months.

If your spouse receives an income allocation, please provide proof of the following items for your spouse:

- ☐ Gross monthly income from all sources including VA, Railroad Retirement, pension, annuities, etc.
- ☐ 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.
- Your financial and clinical eligibility will be reviewed periodically.
- 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 receive after closure if not covered by Community Medicaid, Medicare, or other health insurance.

Household Information

1. Please list yourself, your spouse, and anyone you claim as a dependent on your income tax form.

MEMB

Applicant

First name | M. Initial

Last name

Assistance applying for
- ☐ Choices for Care
- ☐ Developmental Disabilities Home and Community-Based Services
- ☐ Brain Injury Program
- ☐ Enhanced Family Treatment

Gender
- ☐ Female
- ☐ Male

Citizenship status
- ☐ U.S. Citizen ☐ Asylee
- ☐ Refugee ☐ Legal alien
- ☐ Other

Country of birth

Marital status
- ☐ Never married/Single ☐ Civil Union
- ☐ Married ☐ Divorced/dissolved
- ☐ Separated ☐ Widowed

Date of Birth

Social Security Number

Date Widowed or Divorced

mm/dd/yyyy

First name | M. Initial

Last name

Assistance applying for
- ☐ NONE
- ☐ Choices for Care
- ☐ Developmental Disabilities Home and Community-Based Services
- ☐ Brain Injury Program
- ☐ Enhanced Family Treatment

Gender
- ☐ Female
- ☐ Male

Citizenship status
- ☐ U.S. Citizen ☐ Asylee
- ☐ Refugee ☐ Legal alien
- ☐ Other

Country of birth

Date of Birth

Social Security Number

Complete for dependents:

First name	M. Initial	Last name	Relationship to you	Date of Birth

Household Information (Continued)

2. Where are you currently living?

Applicant	Applicant's Spouse (Complete only if spouse is also applying for LTC Medicaid)
☐ Home ☐ Hospital ☐ Nursing Facility ☐ Resident Care/Assisted Living Facility	☐ Home ☐ Hospital ☐ Nursing Facility ☐ Resident Care/Assisted Living Facility
Name of Facility	Name of Facility
Admission Date	Admission Date
Location of facility	Location of facility
For Nursing Facility or Hospital Swing Bed, is the stay planned to be less than 30 days? ☐ Yes ☐ No	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.)

INST

Applicant	Applicant's Spouse (Complete only if spouse 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 (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 (if also applying) ☐ Yes ☐ No

Health Insurance Information

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

MEDI

First name	Initial	Medicare Beneficiary Identifier (MBI) 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 covered by Medicare? ☐ Yes ☐ No

Health Insurance Information (Continued)

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	Last name	Plan name	CMS number	Plan Start Date
			CMS-	

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

First name	Last name	Plan name	CMS number	Plan Start Date
			CMS-	

6. List all health, dental, Medicare supplemental or long-term care insurance, such as group insurance, veteran or military benefits (Include information for your spouse, 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

1. Name of Policy holder			Type of Coverage (check all that apply)	Name of people covered	Insurance company name, address, and phone #
Plan name	Group Number		☐ Doctor ☐ Prescription ☐ Hospital ☐ Major Medical ☐ Dental ☐ Outpatient ☐ Vision ☐ Long-Term Care ☐ Other		
Premium Amount	Per	Effective Date			
2. Name of Policy holder			Type of Coverage (check all that apply)	Name of people covered	Insurance company name, address, and phone #
Plan name	Group Number		☐ Doctor ☐ Prescription ☐ Hospital ☐ Major Medical ☐ Dental ☐ Outpatient ☐ Vision ☐ Long-Term Care ☐ Other		
Premium Amount	Per	Effective Date			

Resource Information

7. Do you or your spouse have any cash that is not in a bank? (Such as at home, on hand, or held by others) ☐ Yes ☐ No

CASH

First name	Last name	Amount	First name	Last name	Amount

Resource Information (Continued)

8. Do you or your spouse have money is a bank, credit union, or other financial institution? If you need more space use a separate sheet of paper. ☐ Yes ☐ No

BANK

Type	Name of owner & co-owner	Name of bank, credit union, or other financial institution	Account number	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:				

9. Do you or your spouse own any vehicles? ☐ Yes ☐ No

CARS

Type of Vehicle	Name of owner & co-owner	Year	Make	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	

Resource Information (Continued)

10. Do you or your spouse own or co-own any land, mobile homes, timeshares, buildings, other real estate, or a life estate interest in any property? (Send a copy of all current deeds) ☐ Yes ☐ No

PROP

Type of Property	Name of owner & co-owner	Location	Assessed Value	Amount Owed
Primary residence (your home)				
Vacation home				
Camp				
Rental Property				
Business Property				
Land				
Time Share				
Other:				

11. Do you or your spouse own any other resources? ☐ Yes ☐ No

STOK

Type of Resource	Name of owner & 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:				

Transfer Information

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

Street or Road	City	State	Zip Code

13. Have you or your spouse given away, sold, gifted or traded anything in the last 60 months? Your worker will let you know if more information is needed. ☐ Yes ☐ No

TRAN

First name	M. Initial	Last name	What was it?	When was it?

14. Have you or your spouse added another person's name to any assets in the last 60 months? (Such as financial accounts or property) ☐ Yes ☐ No

TRAN

First name & Middle Initial	Last name	What was it?	Whose name was added?	When was it added?

15. Have you or your spouse placed any assets 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. ☐ Yes ☐ No

TRAN

First name & Middle Initial	Last name	What was placed in the trust?	Date placed in trust

Income Information

16. Have you or your spouse had any income from a job, internship, or training program? ☐ Yes ☐ No

- List income from the past 30 days before any deductions such as taxes, insurance, child support, or union dues.
- Include income of children (under age 21 and living with you) from a job or training program.
- If income has ended or you expect it to change in the next 30 days, attach a note explaining the change.
- Please attach copies of your pay stubs for the past 30 days.

JINC

Full Name / Paychecks are issued: ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly / Day of Week / Employer's Name / Employer's Phone	Date Paid	Hours Worked	Income before deductions	Tips and Commissions

17. Have you or your spouse had any income from self-employment? ☐ Yes ☐ No

- 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 for the past 12 months.
- If income has ended or you expect it to change in the next 30 days, attach a note explaining the change.

BUSI

First name & Middle Initial	Last name	Type of Business	Date Business Began

18. Do you or your spouse have any other income? ☐ Yes ☐ No

Examples:

Social Security. SSI/AABD. Money from. others. LTC Insurance. Pension or retirement. Veteran's payments. Insurance settlement. Child support. Annuities. Workers' Compensation. Unemployment Compensation. Promissory or Mortgage note. Trust. Rent.

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 & Middle Initial	Last name	Income before deductions	Per	Type of Income

Income Information (Continued)

18a. Do you or your spouse have any income you are entitled to but do not receive? ☐ Yes ☐ No
(Such as pensions or retirement)

First name & Middle Initial	Last name	Income before deductions		Type of Income
			Per	
			Per	

Expense Information

19. Do you or your spouse have medical expenses that are not covered by insurance? ☐ Yes ☐ No
(Disregard if nursing home setting)

Some examples are:

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

20. Do you or your spouse have any unpaid medical bills? ☐ Yes ☐ No

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

☐ Mortgage	Amount	Per		☐ Fuel and utilities	Amount	Per	
☐ Home equity loan	Amount	Per		☐ Lot rent	Amount	Per	
☐ Homeowners insurance	Amount	Per		☐ Rent	Amount	Per	
☐ Property tax	Amount	Per		☐ Room and/or board	Amount	Per	
☐ Condo fees	Amount	Per		☐ None	Amount	Per	

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 in assets (such as adding or removing a name, selling, trading or giving away assets such as bank accounts, stocks, bonds, property, etc.)
- If you sold property, including your home.

You may report changes by:

- Calling Member Services at 1-800-250-8427 (weekdays between 8:00 a.m. and 4:30 p.m.)
- Writing to the address listed below:

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

If you need more room for any answers use this page or a separate sheet of paper.

Rights and Responsibilities

These rights and responsibilities apply to everyone who is applying. If you want a copy for your records, please visit greenmountaincare.org to download a copy or call customer service. If you need a large print copy of this, please call customer service.

What to do if You Don't Speak or Read English.
We will provide free language services to you. This means:

- Interpreters on the phone.
- Notices, applications, and other information written in your language.

If you need this, call Customer Service. If you don't get the language services you need, you can file a discrimination complaint to get them. To find out how, see the **What to do if You Think You Are Being Discriminated Against** section on this page.

Right to Timely Decision on Application. In most cases, we must make a decision on your application within 45 days (or 90 days if you are applying for Medicaid based on a disability decision). It may take longer if you cause a delay. If you don't get a timely decision, you may call Customer Service for more information or to file an appeal.

Right to Appeal. *What if I think my eligibility decision is wrong or late?* You have the right to appeal. This means you are asking for a State fair hearing. Please look at your eligibility notice to find out more about your right to appeal. You must appeal within 90 days of the date of your eligibility notice.

In most cases, we must send you a final decision on your appeal within 90 days from when you appeal. If waiting on a regular State fair hearing might harm you, you can ask for an expedited (faster) appeal and we may decide your appeal sooner. We decide most expedited appeals in 7 working days. We may take longer if the appeal is about Medicaid for the Aged, Blind and Disabled (MABD). To appeal, call Customer Service. You may also write to the Human Services Board, 120 State Street, Montpelier, VT 05620-4301.

Can someone speak for me at my fair hearing? Yes. You should attend the hearing but you may have someone else, like a friend, relative, or lawyer, speak for you. You may be able to get free legal assistance by contacting the Health Care Advocate at Vermont Legal Aid at **1-800-917-7787** or https://vtlawhelp.org/ health.

Rights of People with Disabilities. If you have a physical, 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 may have to make changes (called reasonable accommodations) to our requirements so people with disabilities can get health benefits. Here are 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.
- We can send documents with a larger print.

If you need changes so you can get health benefits, call Customer Service.

Information About Non-citizens. Will getting health care change your immigration status? Find out BEFORE you apply or cancel your health benefits. Get FREE legal help by calling Vermont Legal Aid at 1-800-917-7787 OR go to **vtlawhelp.org/health** on the internet. Lawfully present individuals can apply for benefits. If your household contains people who are not eligible because of their immigration status, you can still apply for the members who are eligible. You do not have to provide immigration information for people who are not applying for health benefits, but you do need to include other information, such as their income and resources, if they are in your household.

We will verify, with the U.S. Citizenship and Immigration Services, the immigration status of all non-citizens who apply for health benefits.

What to do if You Think You Are Being Discriminated Against. We may not discriminate against you on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. It may be discrimination if we fail to give you language or disability related services you need.

If you think that we have discriminated against you, you can call Customer Service. You can also file a complaint with:

- Department of Vermont Health Access:
  - Health Program Civil Rights Coordinator.
  - Phone: **(802) 241-0454.**
  - E-mail: AHS.DVHALegal@vermont.gov.
  - Online: https://info.healthconnect.vermont.gov/ Non-Discrimination.
- Federal government: U.S. Department of Health and Human Services, **1-800-868-1019**, **800-537-7697** (TDD).

  Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Right to Confidentiality. Information about your application and health benefits is confidential and protected by state and federal law. We will not share any information about you unless it is directly connected to program administration, allowed by law or a court order, or we have your permission.

How We Use Your Information (Including Social Security Numbers). We will use your information to determine eligibility, help pay for care, and for other lawful purposes. This may include: to verify income and other eligibility information, determine benefits, collect claims, conduct audits, investigate fraud, pay medical assistance, to assess accuracy of information you give us, and to conduct medical support enforcement. We may contact public and private agencies, including the Social Security Administration, financial institutions (Asset Verification), consumer reporting agencies, Department of Labor, Department of Homeland Security, and the Internal Revenue Service (IRS). If the information does not match, we may ask you to send proof to us.

Everyone applying who has a Social Security Number (SSN) must provide it to qualify for health benefits. If someone does not want health care coverage, they do not have to give us their SSN. Some people who don't have an SSN, including people with a religious objection to having one, don't have to get one to apply for health benefits. Call Customer Service to find out more.

Duty to Report Changes. Some of the changes you must report are changes to: income, resources, health insurance, household members, your address, marriage/divorce, pregnancy, and if you move out of state or get Medicaid in another state. Call your worker or Customer Service to report changes.

For Medicaid, you must report changes within 10 days. A change in your information could affect your eligibility and that of the member(s) in your household.

Rights and Responsibilities (Continued)

These rights and responsibilities apply to everyone who is applying. If you want a copy for your records, please visit greenmountaincare.org to download a copy or call customer service. If you need a large print copy of this, please call customer service.

Fraud Penalties. You or any member of your household will be subject to prosecution for fraud or another 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 that you or they are not entitled to.

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

Agreement Regarding Medicare Part B Payments. You agree that if you get Medicaid that we will make any payments for future Medicare Part B medical and other health services directly to physicians and medical suppliers. This means you will not have to sign a separate form each time you get a service.

Agreement to Release Medical Records. You agree that your health care providers and Department of Vermont Health Access (DVHA) and its contractors and grantees may access, use, and disclose your medical records to: (1) manage state health care programs, or (2) when a hospital, health care provider, mental health provider, or pharmacy needs your medical records. This includes provider and prescription information for your treatment, for payment of your treatment, and for health care operations.

You agree that your 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.

You understand that your consent to the use of your medical records remains in place until your eligibility is reviewed. You can revoke your consent to the release of your medical records by putting your revocation in writing and mailing it to: DVHA Deputy Commissioner, NOB1 South, 280 State Drive, Waterbury, VT 05671-1010.

Agreement to Let us Pursue Money and Medical Support from Third Parties if You Get Medicaid. You give us the right to pursue and get any money from other health insurance, legal settlements, or other third parties for your health care costs if you get Medicaid. This applies to you and anyone in your household who gets Medicaid.

You also agree to enroll in a group health plan if the state requires it, and you understand the state may pay the premiums.

You are also giving us the right to pursue and get medical support from a spouse or parent, including a parent living outside of your home. If you think that cooperating to collect medical support may harm you or your children, call Customer Service. You may not have to cooperate.

Consent to Bill Medicaid if Child Receives Special Education. If a child in your household gets Medicaid and Special Education, you give permission to your child's school district to bill Medicaid for the services listed in his/her Individual Education Plan (IEP). You understand that if you refuse consent, your refusal only affects Medicaid billing for IEP services; the school district must still provide IEP services at no cost to you. You may revoke this consent at any time. If you revoke this consent, it will apply to billing for services from that date forward. To revoke your consent, write to: DVHA, Application & Document Processing Center, 280 State Drive, Waterbury, VT 05671-8100.

Authorization to Verify Resources for Medicaid for the Aged, Blind, and Disabled (MABD). You understand that Medicaid for the Aged, Blind and Disabled (MABD) has income and resource eligibility limits. You understand that to meet requirements of federal law (42 U.S.C. 1396w), that the Department of Vermont Health Access (DVHA) uses an electronic asset verification system (eAVS) to assist in verifying eligibility for this program. eAVS requests information from financial institutions on both open and closed accounts up to the past 5 years for the purpose of determining Medicaid eligibility.

You authorize DVHA to verify your resources with financial institutions for the purposes of determining your eligibility for Medicaid. This authorization will remain in effect until you revoke it in a written statement to us or your application is denied, or you are no longer eligible for Medicaid. If you decide to revoke your authorization, call Customer Service to find out where to send your written statement.

Signatures

You must sign below at the red "x". Unsigned applications will not be processed and will be returned for a signature. You may lose some benefits.

By signing this application, you agree to the following:

- I have read and understand my rights and responsibilities as they are described on pages 13 and 14 of this application.
- I am signing this application under penalty of perjury, which means I have provided true answers to all questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.

X Signature of Applicant | Date

Signature of person helping you fill out this form | Date

☐ If you are signing this application on behalf of the applicant because they are a minor child or incapacitated adult, you agree to the following:

- I am acting to provide information to establish and maintain eligibility for healthcare benefits for the applicant. This is because the applicant is a minor child or has a physical or mental condition that prevents them from providing information about their situation and acting responsibly on their 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 DVHA immediately if I learn of any change in the applicant's situation.

If you are signing on behalf of the applicant because they are a minor child or incapacitated adult, please provide the information requested below in case we need to reach you about the application.

Person Signing on behalf of the applicant (first, middle, last name & Suffix (Jr., Sr., III, etc.)			
Agency Name (if applicable)			Phone number
Street Address/ PO Box	City	State	Zip Code

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.

WIC: The Special Supplemental Nutrition Program for Women, Infants, and Children offers health screening, nutrition education, and food for pregnant women, nursing women, and children under five. To learn more about this program, call toll free 1-800-649-4357.

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

Other Programs (Continued)

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.

Weatherization: This program helps with insulation, caulking, or weather-stripping your home or apartment to lower your heating costs. To learn more about this program, call 1-877-919-2299.

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

3SquaresVT: This program helps to pay for food. If you have little or no money for food, you may be able to get emergency help. To learn more about this program or to request an application, call toll free 1-800-479-6151.

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

We will let you know if we need more information. You will hear from us within 45 days. For questions call 1-800-250-8427 (TTY/Relay Service: dial 711).

The applicant is responsible for the accuracy of all of the information given on this application including information about the applicant's husband, wife, or civil union partner.