Review Reminder Notice

You have family members receiving at least one of the following benefits:
♦ Medicaid for the Aged, Blind or Disabled/VPharm/Medicare Savings Program

The following members are due for review:
♦ [Redacted]

Their health care coverage is due for review. Please complete, sign and return the enclosed form if you wish to have your coverage continue. Be sure to answer all questions. If you are self-employed, please send a copy of your most recent Federal tax return; we need the entire return -- all forms and schedules. If we need more information, we will let you know. A face-to-face interview is not required.

Please return your completed form by June 1, 2022, so that we will have enough time to process your review. This is the ONLY reminder you will receive. If you don't return your completed form, your health care coverage will end as of June 30, 2022. If you have questions about this notice, please call the number listed above.

Premium Reminder

Please remember that if you received a premium bill for this health care coverage, to continue your coverage you must pay the premium in addition to completing this review. If you have questions, call Green Mountain Care Member Services at 1-800-250-8427.
**Ways you can renew your health care:**

- **Online:** There is a form you can fill out online. Visit [http://dvha.vermont.gov/apply](http://dvha.vermont.gov/apply) for more information.
- **By phone:** Call us for FREE at **1-800-250-8427** Monday - Friday, 8 a.m. to 4:30 p.m.
- **In person:** You can get in-person help from an Assister. To find one in your area, call us at **1-800-250-8427**. Or go to [https://info.healthconnect.vermont.gov/find-local-help](https://info.healthconnect.vermont.gov/find-local-help).
- **By mail:** Mail your completed, signed form to:
  
  **DVHA HEALTH ACCESS ELIGIBILITY & ENROLLMENT UNIT**
  
  Application and Document Processing Center
  
  280 State Drive, NOB 1 South
  
  Waterbury, VT 05676-9955

  **Bring your completed, signed form to a district office.** Call us at **1-800-250-8427** for help finding the office closest to you.

**Do NOT use this renewal form if:**

- **You are reporting changes.** To report changes to your information, call us at **1-800-250-8427**, or visit [http://dvha.vermont.gov/apply](http://dvha.vermont.gov/apply) for a change report form.
- **You are a NEW applicant.** If you are newly applying for health care, visit [http://dvha.vermont.gov/apply](http://dvha.vermont.gov/apply) for more information.
- **You are renewing your coverage for Medicaid for Children & Adults through Vermont Health Connect.** Call Customer Service at **1-800-899-9600**.

**What you need to do if you are using this form:**

- **Answer** all the questions on this form as best you can.
- **You must** sign and date this form. Unsigned forms will be sent back to you.
- **Return this form to us.** If you don’t return a signed form, you may lose your health care.

**What happens after you return this form:**

- We will read your information. Then we will send you a letter telling you about your health care.
- **If you don’t meet the rules for the program you are renewing**, we will see if you meet the rules for another program.
- **If at any time we need more information from you**, we will send you a letter telling you what we need.

**Contact us if you have questions:**

- **By phone:** Call us at **1-800-250-8427**
- **In person:** You can get in-person help from an Assister. To find one in your area, call us at **1-800-250-8427**. Or go to [https://info.healthconnect.vermont.gov/find-local-help](https://info.healthconnect.vermont.gov/find-local-help).
- **TTY/RELAY:** If you are deaf, hard of hearing, or have a speech disability, dial 711.
- **By mail:** [DVHA – HEALTH ACCESS ELIGIBILITY & ENROLLMENT UNIT](http://dvha.vermont.gov/apply)
  
  Application and Document Processing Center
  
  280 State Drive, NOB 1 South
  
  Waterbury, VT 05676-9955

**Interpretation Services Are Available:**

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**Note:** If you are deaf or hard of hearing, or have a speech disability, dial 711. For help finding an interpreter, call **1-855-899-9600**.
### Step 1 – Your Contact Information

1. Name (first, middle, last name & suffix - Jr., Sr., III, etc.)

2. Social Security Number (SSN). Optional, if you are not renewing health care for yourself, you do not need to give us your SSN.

   _____ _____ – _____ – _____

3. Home Address

4. Apartment or Suite #

5. City/Town

6. State

7. Zip Code

8. Mailing Address (if different from home address)

9. Apartment or Suite #

10. City/Town

11. State

12. Zip Code

13. Best phone number to reach you: □ Home □ Work □ Cell

   Phone Number: (            )

14. Other phone number, if you have one: □ Home □ Work □ Cell

   Phone Number: (            )

15. Do you want an Authorized Representative? Or make a change to the Authorized Representative you now have?

   For more information about naming an Authorized Representative, see Attachment A □ Yes □ No

16. Do you want an Alternate Reporter? Or to make a change to the Alternate Reporter you now have?

   For more information about naming an Alternate Reporter, see Attachment A □ Yes □ No

Did you answer YES to one or both of the questions above? Then complete Attachment A at the end of this renewal form.

Do you have a change in your Power of Attorney or legal Guardian? If yes, please call us. We may need copies of those documents.

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**Please read this before you fill out this renewal form:**

- Are you married? If yes, are you and your spouse both renewing? If yes, then you CAN do the renewal for both of you on one form. Is only one of you renewing? If yes, we still need information for both of you.

  In this form, when we say “spouse,” it means husband, wife and civil union partner.

- Is your child renewing their DCHC (Katie Beckett)? If yes, complete Steps 2 through 7 with only your child’s information. If we need anything more, we will let you know.
Step 2 – Who Is Renewing: – PERSON 1

1. Name (first, middle, last name & suffix - Jr., Sr., III, etc.)
2. Date of Birth (mm/dd/yyyy)
3. Social Security Number

4. Has PERSON 1 had a change in their immigration status? □ Yes - Fill out the information below. □ No
   Visit http://dvha.vermont.gov/apply for more information about eligible immigration status.
   a. Document Type: ____________________________  b. Alien or I-94 Number: ____________________________
   c. Card or Foreign Passport Number: ____________________________  d. Expiration Date (if applicable): __________

5. Has PERSON 1 had a change in their marital status? □ Yes – Tell us about the change below □ No
   □ Married  □ Separated  □ Divorced/dissolved  □ Widowed
   If newly married, complete Step 3 with information about PERSON 1’s spouse.

6. Have there been any changes to PERSON 1’s household members? □ Yes – Tell us about the change below □ No
   Name of household member with change: ____________________________ Date of Birth: __________
   Relationship to PERSON 1: ____________________________  Does this household member want to apply for health care? □ Yes □ No
   Type of Change:  □ Moved In  □ Moved Out  □ Other (explain): ____________________________ Date of change: __________

7. Is PERSON 1 living outside of their home in a facility that is not a school or college?
   Examples: Hospital, correctional facility, residential care home, assisted living facility, nursing home, treatment facility, group home
   □ Yes – Fill out the information below:  □ No
   Name of Facility: ____________________________ Date of Admission: __________

8. Is PERSON 1 pregnant? □ Yes – Fill out the information below □ No
   What is PERSON 1’s due date? __________ How many babies are expected? __________

   PERSON 1 is Complete. Continue with Step 2 if another person is renewing. Otherwise, go to Step 4.
   If PERSON 1 is newly married tell us about their spouse in Step 3.

Step 2 – Who Is Renewing: – PERSON 2

1. Name (first, middle, last name & suffix - Jr., Sr., III, etc.)

2. Has PERSON 2 had a change in their immigration status? □ Yes - Fill out the information below. □ No
   Visit http://dvha.vermont.gov/apply for more information about eligible immigration status.
   a. Document Type: ____________________________  b. Alien or I-94 Number: ____________________________
   c. Card or Foreign Passport Number: ____________________________  d. Expiration Date (if applicable): __________

3. Is PERSON 2 living outside of their home in a facility that is not a school or college?
   Examples: Hospital, correctional facility, residential care home, assisted living facility, nursing home, treatment facility, group home
   □ Yes – Fill out the information below:  □ No
   Name of Facility: ____________________________ Date of Admission: __________

4. Is PERSON 2 pregnant? □ Yes – Fill out the information below □ No
   What is PERSON 2’s due date? __________ How many babies are expected? __________

   You are done with Step 2. Continue to Step 4.