GreenMountainCare
A HEALTHIER STATE OF LIVING

IT'S TIME FOR YOU TO RENEW YOUR HEALTH CARE

202MED Review - ELECTRONIC

Revised 04/2024

Ways you can renew your health care:	• **Online:** There is a form you can fill out online. Visit 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**.** • **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 for a change report form. • **You are a NEW applicant.** If you are newly applying for health care, visit 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 **1-855-899-9600**.
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. **TTY/RELAY:** If you are deaf, hard of hearing, or have a speech disability, dial 711. **By mail:** **DVHA – HEALTH ACCESS ELIGIBILITY & ENROLLMENT UNIT** Application and Document Processing Center 280 State Drive, NOB 1 South Waterbury, VT 05676-9955

Interpretation Services Are Available:

إذا كنت تتحدث لغة أخرى غير اللغة الإنجليزية ، فستتوفر لك خدمات مساعدة اللغة مجانًا. اتصل بالرقم 1-855-899-9600) (العربية

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 1-855-899-9600。（繁體中文）

Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-899-9600 (Deutsch)

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-899-9600 (Español)

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-899-9600 (Français)

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。1-855-899-9600 まで、お電話にてご連絡ください。（日本語）

In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-899-9600 (Italiano)

तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-855-899-9600। (नेपाली)

Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-899-9600 (Oroomiffa)

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-899-9600 (Português)

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-899-9600 (Русский)

Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-899-9600 (Srpsko-hrvatski)

Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-899-9600 (Tagalog)

ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-899-9600 (ภาษาไทย)

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi so 1-855-899-9600 (Tiếng Việt)

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Your Rights and Responsibilities

These rights and responsibilities are for everyone who applies. If you need a large print copy of this, please call Customer Service at 1-855-899-9600. When we say "health insurance" below it may include all of our health care programs such as Medicaid, VPharm, Medicare Savings Programs, and Qualified Health Plans.

If You Don't Speak or Read English.

We will give you free language services. This means an interpreter can:

- Translate for you over the phone when you call us.
- Read and explain papers to you over the phone.
- Help you apply and renew over the phone.

Ask if we have papers in your language.

If you need language help, call Customer Service at **1-855-899- 9600**. You can also get an in-person Assister to help you. Call **1-855-899-9600** to find an Assister. If you don't get the language services you need, you can file a complaint. See **What to Do If You Think You Are Being Discriminated Against** on this page.

Right to File New Application and Yearly Renewal Application and Get Decisions on Time. We will give you a decision on a new application within 45 days. (It can take 90 days if we need to decide if you are disabled.) It may take longer if you cause a delay.

For your renewal application, you stay on Medicaid while we see if you still qualify as long as you don't cause delay. We will send you a letter telling you if you still qualify.

What if we take too long? Call Customer Service at **1-855-899-9600** for more information or to file an appeal.

Do You Disagree with a Decision We Made? Or is the Decision Late? You Can Appeal. An appeal means asking for a State fair hearing before the Human Services Board. Look at your notice of decision to find out more about your right to appeal. You must appeal **within 90 days** from the date on your notice.

In most cases, we must send you a final decision on your appeal within 90 days.

Will waiting on a regular State fair hearing harm you? You can ask for a fast (expedited) appeal. If you qualify for this, we will decide your appeal in 7 working days in most cases. We can take longer if you get Medicaid due to disability or age.

Someone else may speak for you at the hearing. This can be a friend, relative, or lawyer. Do you need to go to the hearing? Yes, or your appeal may be dismissed.

To appeal, call Customer Service at **1-855-899-9600**. You may also write to the *Human Services Board, 120 State Street, Montpelier, VT 05620-4301*.

You may be able to get **free legal help** on your appeal**.** Call the Health Care Advocate at Vermont Legal Aid **at 1-800-917-7787. OR** go to **https://vtlawhelp.org/ health** on the internet.

Rights of People with Disabilities. Is it hard for you to do the things we ask you to do? We can make changes to help you. Changes are called "reasonable accommodations" under the ADA (Americans with Disabilities Act).

Here are some changes we can make:

- Someone can write down your answers if you can't.
- We can give you more time.
- We can help you get papers you need to give us.
- You can have a support person with you when you talk to us.
- We can send you papers with a larger print.

Do you need any changes to help you? Tell us by calling **1-855- 899-9600** for free.

Information for Non-citizens. Getting health insurance from us will NOT change your immigration status. The only time it could is if you get long term care Medicaid in an institution. An example is if you are living in a nursing home. If you want to find out more, get FREE legal help by calling Vermont Legal Aid at **1-800-917-7787**. **OR** go to https://vtlawhelp.org/health on the internet.

Immigrants can apply for health insurance. Does your household have people who can't qualify for Medicaid because of their immigration status? You can still apply for the members who meet the rules. Pregnant people and children under age 19 can get health insurance no matter their immigration status.

Whose immigration status do we check on with the U.S. Citizenship and Immigration Services? We will check for anyone who applies for health insurance.

What about people who only apply on the immigration Health Insurance Plan application (*205IHIP*)? We DO NOT contact U.S. Citizenship and Immigration Services about them.

What to do if You Think You Are Being Discriminated Against. We can't treat you differently because of race, color, national origin, sex, or age. We can't treat you differently because of your sexual orientation, gender identity, or disability. What if we don't give you language or disability services you need? It may be discrimination.

Do you think we have discriminated against you? Call Customer Service at **1-855-899-9600**. 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 insurance is private. It is protected by state and federal law. We won't share your information with anyone else unless:

- It is directly connected to running our programs, or
- The law or a court order says we have to, or
- You tell us we can.

How We Use Your Information (Including Social Security Numbers). We use your information to see if you meet the rules to get health insurance. We also use it to help pay for care and for other legal reasons. We check income and other information to see if you meet the rules. We decide what insurance you get. We collect claims, do audits, investigate cheating, and pay for medical help. We check the truth of information you gave us.

We may contact public and private agencies. This includes the Social Security Administration, banks (Asset Verification), and consumer reporting agencies. It includes the 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 us proof.

Do you have a Social Security Number (SSN)? You must give it to us to get health insurance. What if someone does not want health care? They don't have to give us their SSN. Some people who don't have an SSN don't have to get one to apply. This includes people with a religious reason not to have one. Call Customer Service at **1-855-899-9600** to find out more.

Your Rights and Responsibilities

These rights and responsibilities are for everyone who applies. If you need a large print copy of this, please call Customer Service at 1-855-899-9600. When we say "health insurance" below it may include all of our health care programs such as Medicaid, VPharm, Medicare Savings Programs, and Qualified Health Plans.

You must tell us IF:

- Your address, phone, or email changes
- Your income changes
- Who lives with you changes
- You marry or divorce
- You get pregnant
- Your immigration status changes or you become a citizen
- You get other health insurance
- You move out of state
- When your resources go above the $2,000 limit
- You get a lump sum payment like:
  - a trust or retirement fund distribution
  - inheritance or
  - insurance settlement
- You have a change in ownership like:
  - adding or removing a name or
  - sale or transfer of real or personal property
- You have a sale of property, including your home

To report a change, call Customer Service at **1-855-899-9600**. OR write or send a change report form (*Form 200GMC*) to: DVHA, Application & Document Processing Center, 280 State Drive, NOB 1 South, Waterbury, VT 05671-1500

Call Customer Service at **1-855-899-9600** to report changes. For Medicaid, you must report changes within 10 days. Did you or someone in your household enroll in a qualified health plan through us? You must report changes in 30 days.

Don't Lie to Get or Keep Medicaid or Help Someone Else Get or Keep It. You or any member of your household cannot lie on purpose to get or keep health care.

What if you do lie and are found guilty? Penalties may include up to 3 years in prison and/or a fine of up to $1,000. Or you may be fined as much as the health care cost. There may be other federal or state penalties. (42 U.S.C. §1320a-7b; 33 V.S.A. §§141, 143)

Agreement Regarding Medicare Part B Payments. You agree that we will pay doctors and medical suppliers directly for these services. This means you won't have to sign separate papers each time you get a service.

Agreement to Release Medical Records. You agree that your medical records may be read, used and shown to others. This means health care providers, Department of Vermont Health Access and its contractors and grantees. They can share your records to manage state health care programs. Or if a hospital, health care provider, mental health provider, or pharmacy needs your medical records. This includes provider and drug information for your treatment and payment of your treatment. It includes information for health care operations.

Have you been in a drug or alcohol treatment program? You agree to let them tell us what prescription drugs you got in their program. We only ask for this if it is needed to treat you.

You can take back your consent to release your medical records. Just say that in writing and mail it to: *DVHA Deputy Commissioner, 280 State Drive, NOB 1 South, Waterbury, VT 05671-1010.*

Agreement to Let us Pursue Money and Medical Support from Third Parties if You Get Medicaid. Do you get Medicaid? Then you give us the right to try and get money for your health care. This would come from other health insurance, legal settlements, or other third parties. This is true for you and anyone in your household who gets Medicaid.

You agree to sign up for a group health plan if the state requires it. The state may pay the monthly payments.

You give us the right to get medical support from a husband/wife or parent. This includes a parent living outside of your home. Do you think that helping collect medical support may harm you or your children? Call Customer Service at **1-855-899-9600**. You may not have to help us.

Consent to Bill Medicaid if Child Receives Special Education. Does a child in your household get Medicaid and Special Education? Then you agree your child's school district can bill Medicaid. They can bill for the services listed in your child's Individual Education Plan or IEP. What if you don't give permission? You are only saying they can't bill Medicaid for IEP services. The school district must still give your child free IEP services. You may take back consent to bill Medicaid at any time. The school must stop billing Medicaid the day you take back your consent. To take back your consent, write to: *DVHA, Application & Document Processing Center, 280 State Drive, NOB 1 South, Waterbury, VT 05671-8100.*

You Agree We Can Check Resources for Medicaid for the Aged, Blind and Disabled. There are rules for who can get Medicaid for the Aged, Blind and Disabled. There are rules about how much income, money, and property you can have. To meet federal law (42 U.S.C. 1396w), the Department of Vermont Health Access uses an electronic asset verification system. This helps us see if you can get this program. The system asks for information from banks and financial institutions. They check open and closed accounts to see if you meet the rules.

You agree the Department of Vermont Health Access can check with banks and financial institutions. This is to see if you meet the rules to get Medicaid. This agreement lasts until you take it back in writing. It will end if your application is turned down or you stop meeting Medicaid rules. What if you decide to take back your agreement? Call Customer Service at **1-855-899-9600** to find out where to send your written statement.

NEED HELP? Visit dvha.vermont.gov/apply or call Customer Service at **1-855-899-9600**.

For TTY/relay services, dial **711**.

Visit dvha.vermont.gov/apply or call Customer Service for a copy of your rights and responsibilities.

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

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

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.

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.

Step 3 – Tell us about Person 1's spouse

If Person 1 is newly married, tell us about their spouse. If not, continue to Step 4.

1. Name of spouse: **2.** Gender: F **3.** SSN *(optional if not applying)*: **4.** Date of Birth:

5. Home Address *(if different from Person 1)* **6.** Apartment or suite #

7. City/Town **8.** State **9.** Zip Code

10. Mailing Address *(if different from Person 1)* **11.** Apartment or suite #

12. City/Town **13.** State **14.** Zip Code

15. Does Person 1's spouse want to apply for health care? ☐ Yes - We will be in touch with next steps. ☐ No

Answer all questions for Steps 4-7 for everyone you listed in Step 2 as renewing.
If you are married, answer for your spouse, even if they are not renewing.

Step 4 – Resources

1. Has there been a change in property you own? ☐ Yes ☐ No

Examples of property: House, mobile home, camp, warehouse, empty lot, timeshare, land, rental property, business property

If **YES**, explain the change. ☐ New property ☐ No longer have property ☐ Other:

Explain:_____

2. Has there been a change in the vehicles you own? ☐ Yes ☐ No

If **YES**, tell us about the change. ☐ New vehicle ☐ No longer have vehicle

Year:	Make:	Model:	If new, amount owed: $

3. Have you had any change in life insurance policies or burial funds? ☐ Yes ☐ No

Examples: whole or term life insurance, burial accounts, burial plot, headstone

If **YES**, explain the change. ☐ New ☐ No longer have ☐ Other

Explain:_____

4. Do you have cash, an account, or any other resource from money earned as a working person with disabilities that you haven't already told us about? ☐ Yes – Fill out the information below ☐ No

Name of owner	Type of resource	Name of financial institution	Current value
			$
			$

5. Do you have an ABLE (*Achieving a Better Life Experience*) account you haven't already told us about? ☐ Yes - Fill out the information below ☐ No

Owner name(s)	Date opened	Name of company where account is held

6. Has there been any other change to your resources that you haven't already told us about? ☐ Yes-Fill out the information below ☐ No other changes

Examples of other resources:

- *Annuities*
- *Bank accounts*
- *Cash*
- *Certificates of deposits*
- *Checking & savings accounts*
- *College funds*
- *Education accounts*
- *Individual development accounts*
- *Inheritance*
- *Money market accounts*
- *Mutual funds*
- *Nursing home accounts*
- *PASS (Plan to Achieve Self Support)accounts*
- *Promissory notes*
- *Representative payee accounts*
- *Retirement accounts*
- *Savings bonds*
- *Stocks*
- *Trusts*

Name of owner	Type of resource	Tell us what changed	Name of financial institution	Account number	Current value
					$
					$
					$
					$
					$

Step 5 – Income

1. Do you have income from a job? ☐ Yes - Tell us about it below ☐ No

Answer for everyone you listed in Step 2 as renewing. Are you married? If yes, answer for your spouse, even if they are not renewing.

Current Job 1

a. Name of employee

b. Employer (or Company) name

c. Employer (or Company) phone number

d. Wages/tips before taxes (gross income) $_____ PER: ☐ Hour ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year

e. Average hours worked each week in the past month:

Current Job 2

a. Name of employee

b. Employer (or Company) name

c. Employer (or Company) phone number

d. Wages/tips before taxes (gross income) $_____ PER: ☐ Hour ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year

e. Average hours worked each week in the past month:

2. Do you get paid for taking care of children? ☐ Yes – Tell us about it below ☐ No

Do you claim what you get as income on your taxes? ☐ Yes – Go to question 3 ☐ No - Tell us about this income below

- *List income from the past 30 days before anything is taken out.*
- *List the number of meals you provide each month for which you are not paid.*

First name	Income before deductions	Breakfast	Lunch	Dinner	Snacks
	$ per				

3. Do you have income from self-employment? ☐ Yes - Answer the questions below ☐ No

What type of work do you do? *Examples: Farming, home party sales, logging, or property rental:*_____

If this is a new business, on what date did it begin?_____

How much net income will you get this month? Net income is how much is left after business expenses are paid $_____

Please send us the following:

- A copy of your most recent federal tax return, including all forms and schedules. If you do not have this to send us now, we can get it from you later.
- Is this a new business and you have not filed taxes yet? If yes, send income and expense records to date.

Has income ended or do you expect it to change in the next 30 days? If Yes, explain the change below.

Explain:_____

4. Do you get paid for providing room or meals in your home? *(Include payments from children)* ☐ Yes – Tell us about it below ☐ No

Do you claim what you get as income on your taxes? ☐ Yes - Go to question 5 ☐ No – Tell us about this income below.

First name	Payment	Name of person paying	Check all that apply
	$ per		☐ Room ☐ 1-2 meals per day ☐ 3 meals per day
	$ per		☐ Room ☐ 1-2 meals per day ☐ 3 meals per day

5. Do you have any other income? ☐ Yes – Fill out the information below ☐ No other income

We do not need to know about your Social Security income if you reported it last year.

Examples of other income:

- *Child support*
- *Interest/dividends**
- *Annuity*
- *Pension*
- *Insurance*
- *LTC Insurance policy payment*
- *Other cash received*
- *Workers' Compensation*
- *Retirement Fund*
- *Railroad retirement*
- *Veteran's payment*
- Unemployment compensation

* Do not include interest from a qualified ABLE account.

Who is this for	Type of income	Amount BEFORE taxes and deductions	How often do you get it *(Weekly, monthly, quarterly)*
		$	
		$	
		$	
		$	
		$	

6. If you have not listed any income, tell us how your daily living expenses are paid:

Step 6 –Expenses

If you need more space, attach a separate page. Be sure to write your name and date of birth at the top.

1. Do you have ongoing medical expenses that are not covered by insurance?

☐ Yes – Fill out the information below ☐ No medical expenses

Examples of medical expenses: *pain relievers, personal care, antacids, hearing aid batteries, vitamins, health insurance premiums*

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

2. If you are blind or disabled and working, do you pay for work-related expenses?

☐ Yes – Fill out the information below ☐ No work-related expenses

Examples of work-related expenses:

- *Transportation to/from work including vehicle modifications*
- *Impairment related training*
- *Attendant care*
- *Medical devices like wheelchairs*
- *Structural modifications to home*
- *Cost of buying and caring for a guide dog*
- *Work-related fees like licenses, professional association dues, union fees, federal, state and local income taxes, Social Security taxes, mandatory pension contributions, meals consumed during work hours*

First name	Type of expense	How often is it paid	Amount paid
			$
			$
			$
			$

3. Tell us about any other expenses you have. Do not repeat expenses already listed above. ☐ No other expenses
Do not include shelter expenses (*such as rent, mortgage, utilities, etc.*).

Examples of other expenses: *Childcare, child support, alimony, dependent elder care*

Who is it for	Who pays for it?	Type of expense	How often is it paid	Amount paid
				$
				$

Step 7 – Your Health Care Coverage

1. Are you new to Medicare?

☐ Yes – Fill out the information below. Most information can be found on the front of your Medicare card.
☐ No

Name		Name	
Medicare Beneficiary Identifier (MBI) number		Medicare Beneficiary Identifier (MBI) number	
Part A Start date *(mm/dd/yyyy)*: Premium $_____	Part B Start date *(mm/dd/yyyy)*: Premium $_____	Part A Start date *(mm/dd/yyyy)*: Premium $_____	Part B Start date *(mm/dd/yyyy)*: Premium $_____

2. Has there been any change to other health insurance? ☐ Yes – Tell us about the changes ☐ No changes

Examples of other health insurance: *Private health insurance, veterans' insurance, employer sponsored insurance, or Medicare supplemental policies*

a. If you have new insurance, complete the table below:

Name of insurance company:	Insurance company phone number:	Services covered: ☐ Prescriptions ☐ Vision ☐ Doctors/hospitals ☐ Dental ☐ Outpatient ☐ Other:_____
Insurance company billing address:		
Member ID/Policy number:	Group number:	
Name of policy holder:		Date coverage began *(mm/dd/yyyy):*
Names of people covered:	Relationship to policy holder:	

b. If you have had a change to your other health insurance, describe the change:

c. If other health insurance ended, tell us which one ended: Date it ended:

Step 8 – Sign this renewal form

You must sign below at the red "X". Unsigned forms will be returned to you. You may lose your health care.

I am signing this renewal form under penalty of perjury, which means I have provided true answers to all of the questions 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.

To sign this renewal form and send it electronically, you must do these 3 things:

1. **Check this box ☐.**
2. **Type your name after the red "X" on the signature line below and put the date you signed it.**
3. **Follow the instructions in Step 9 below.**

Check this box to electronically sign this application and type your name on the signature line right below.

Your signature *(or signature of person signing for you)*	Date *(mm/dd/yyyy)*
X	

Did you report in Step 2 that you are newly married? If yes,complete the following:

Information and Authorization by Spouse for Verification of Resources

This lets the Department of Vermont Health Access (DVHA), and authorized agents request records. This would be records from financial institutions for the spouse of the person renewing on this renewal form.

This authorization must be completed and signed at the red "X" below by the spouse of the person renewing. What if they don't complete and sign this? It may end health care for the person renewing.

For the person renewing: What if your spouse refuses to sign this authorization, or you cannot locate them? You should still send us this renewal form.

As the spouse of the person renewing, I give permission for my resources with financial institutions to be checked. This is to see if my spouse can renew their health care.

This permission will remain in effect until I end it in a written statement or my spouse is no longer eligible for health care.

(Spouse's) Social Security number*	***Optional, by providing your spouse's Social Security number, it will speed up the resource verification process that is required for determining health care eligibility.**

(Spouse's name) First name, middle name, last name & suffix *(Jr., Sr., III, etc.)*

Signature of spouse/legal representative	Date *(mm/dd/yyyy)*
X	

NOTE: Is a spouse's legal representative signing this authorization? If yes, please send us the legal document giving them authority to act on behalf of the spouse.

Step 9 – Submit this renewal form electronically

Important! You **must** check the box **AND** type your name at Step 8 above **AND** use the Uploader to submit this renewal form. If you don't, we will send it back to you. *We can't take your typed signature on this renewal form unless you do all 3 things.*

Here is what you need to do:

- **Save this renewal form to your computer.**
- **Then click on this link: https://dvha.vermont.gov/members/medicaid/medicaid-aged-blind-or-disabled-mabd**
- **At this link, scroll down to "Uploader Instructions." This will give you step-by-step instructions on how to upload this renewal form.**

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Attachment A – Tell Us Who is Helping You

The information you provide here will replace whatever you gave us before.
If you want to keep what you have, do not fill out this attachment.

PERSON 1 Information

Name *(first, middle, last name & suffix - Jr., Sr., III, etc.)*	Last 4 digits of your SSN

You Can Choose an Authorized Representative

You can give a trusted person permission to talk about this renewal with us. You can give them permission to see your information. You can let them act for you on matters related to this renewal. This includes getting information about your renewal and signing your renewal on your behalf. This person is called an Authorized Representative. It's your choice whether to have an authorized representative.

If you choose to have one:
- It will be in effect while you get health benefits unless you ask us to change or stop it.
- We aren't responsible for what an authorized representative does with your information (like tell others).
- Ask us if you want a copy of this form.

If you choose not to have one:
- It won't change your eligibility or benefits.
- We won't release your information unless the law allows it.

1. Name of Authorized Representative *(first, middle, last name & suffix - Jr., Sr., III, etc.)*		
2. Mailing Address		3. Apartment or suite #
4. City/Town	5. State	6. ZIP code
7. Phone number	8. Organization name *(if applicable)*	9. ID number *(if applicable)*

By signing, you allow this person to sign your renewal form, and get official information about your renewal. You allow them to act for you on all future matters with us.

10. Your signature	**11. Date** *(mm/dd/yyyy)*

You Can Choose an Alternate Reporter

You can give a trusted person permission to only get copies of notices about your renewal and about coverage for yourself and others on the renewal. This person is called an Alternate Reporter. An Alternate Reporter cannot act for you or report changes for you, but they can help you understand the notices or remind you if we ask you for information.

1. Name of Alternate Reporter *(first, middle, last name & suffix - Jr., Sr., III, etc.)*		
2. Mailing Address		3. Apartment or suite #
4. City/Town	5. State	6. ZIP code
7. Phone number	8. Organization name *(if applicable)*	9. ID number *(if applicable)*

By signing, you allow this person to only get copies of notices about your renewal and about coverage for yourself and others on this renewal and all future matters with us.

10. Your signature	**11. Date** *(mm/dd/yyyy)*