

APPLICATION/DOCUMENT PROCESSING CTR
280 STATE DRIVE
WATERBURY VT 05671-1500

Questions? Call Green
Mountain Care Member
Services at **800-250-8427**

202MED
BRE

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]

Please complete, sign and return the enclosed form if you wish to have their 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 August 1, 2024, 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 August 31, 2024. 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.

IT'S TIME FOR YOU TO RENEW YOUR HEALTH CARE

202MED Review

Revised 06/2024

<p>Ways you can renew your health care:</p>	<ul style="list-style-type: none"> • Online: There is a form you can fill out online. Visit https://my.vermont.gov 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.
<p>Do NOT use this renewal form IF:</p>	<ul style="list-style-type: none"> • 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.
<p>What you need to do if you are using this form:</p>	<ul style="list-style-type: none"> • Answer all the questions on this form as best you can. • You <u>must</u> sign and date this form. Unsigned forms will be sent back to you. • Return this form to us. If you <u>don't</u> return a signed form, you may lose your health care.
<p>What happens after you return this form:</p>	<ul style="list-style-type: none"> • We will read your information. Then we will send you a letter telling you about your health care. If you <u>don't</u> 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.
<p>Contact us if you have questions:</p>	<p><u>By phone:</u> Call us at 1-800-250-8427</p> <p><u>In person:</u> 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.</p> <p><u>TTY/RELAY:</u> If you are deaf, hard of hearing, or have a speech disability, dial 711.</p> <p><u>By mail:</u> DVHA – HEALTH ACCESS ELIGIBILITY & ENROLLMENT UNIT Application and Document Processing Center 280 State Drive, NOB 1 South Waterbury, VT 05676-9955</p>

Interpretation Services Are Available:

إذا كنت تتحدث لغة أخرى غير اللغة الإنجليزية ، نستوفر 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 số 1-855-899-9600 (Tiếng Việt)



Step 1 – Your Contact Information

<p>1. Name (first, middle, last name & suffix - Jr., Sr., III, etc.)</p>		<p>2. Social Security Number (SSN). Optional, if you are not renewing health care for yourself, you do not need to give us your SSN.</p> <p style="text-align: center;">_____ - _____ - _____</p>	
<p>3. Home Address</p>		<p>4. Apartment or Suite #</p>	
<p>5. City/Town</p>		<p>6. State</p>	<p>7. Zip Code</p>
<p>8. Mailing Address (if different from home address)</p>		<p>9. Apartment or Suite #</p>	
<p>10. City/Town</p>		<p>11. State</p>	<p>12. Zip Code</p>
<p>13. Best phone number to reach you: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell</p> <p>Phone Number: ()</p>			
<p>14. Other phone number, if you have one: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell</p> <p>Phone Number: ()</p>			
<p>15. Do you want an Authorized Representative? Or make a change to the Authorized Representative you now have? <i>For more information about naming an Authorized Representative, see Attachment A</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>16. Do you want an Alternate Reporter? Or to make a change to the Alternate Reporter you now have? <i>For more information about naming an Alternate Reporter, see Attachment A</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			

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.