VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

SUPPLEMENTAL Information for Medicaid for the Aged, Blind and Disabled

205SUPP Non-LTC *(202MED in OnBase)* *12/2019*

Important! We need more information to find out if you qualify for health coverage programs that are only available to people who are 65 or older, blind, or disabled. We will use this information, along with the information you gave in the application you already gave us, to see what you qualify for. See the list of programs below.

If you want any of these programs below, complete steps 1-4 starting on page 1.

- **Medicaid for Aged, Blind and Disabled (MABD)** for people who are aged 65 or older, blind or disabled.
- **VPharm (Pharmacy Program)** for people on Medicare to help pay for prescription drugs.
- **Medicare Savings Programs (MSP)** for people on Medicare to help pay for Medicare premiums, deductibles, and copays.
- **Disabled Children's Home Care (DCHC)(Katie Beckett)** for children with disabilities who are living at home and would be eligible for Medicaid if living in an institution. Parent's income and resources are not counted when determining eligibility. However, we do need to know the child's income and resources.
- **Healthy Vermonters Program (HVP)** for all Vermonters without pharmacy coverage. This program provides a discount on some prescriptions.

PLEASE READ THIS BEFORE YOU FILL OUT THE SUPPLEMENT

If you are married, you and your spouse CAN be screened together on one Supplement. Even if only one of you wants to be screened, we still need information about both of you.

Is your child applying for DCHC (Katie Beckett)? If so, complete Step 1 with your child's name. All other steps must include information about you, your spouse and your child.

Is anyone else also applying? If yes, you must fill out a SEPARATE Supplement for them. Make copies of pages 1-6 prior to filling them out or call Customer Service and we will send you one.

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 नमि्ति भाषा सहायता सेवाहरू नःशुल्क 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)

NEED HELP? Visit ***dvha.vermont.gov/apply*** or call Customer Service at **1-855-899-9600**. For TTY/relay services, dial **711**. There is someone who can help in your area. Call Customer Service or go to: ***info.healthconnect.vermont.gov/information/community_partners/assisters***

Understand Your Rights and Responsibilities
These apply to everyone who is using this Supplement. These are in addition to the Rights and Responsibilities on the application you already gave us. If you need a larger print copy of this, please call Customer Service at 1-855-899-9600.

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.

Duty to Report Changes About Resources (Assets).

You understand that you must report changes to your resources if you get Medicaid for the Aged, Blind and Disabled (MABD). This includes reporting:

- *when your resources go above the $2,000 limit*
- *getting a lump sum payment (like a trust or retirement fund distribution, inheritance, or insurance settlement)*
- *changes in ownership (like adding or removing a name, or sale or transfer of real or personal property)*
- *sale of property, including your home*

Women, Infants, and Children (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 5. To learn more about this program, call toll free **1-800-464-4343** or visit WIC's homepage at **healthvermont.gov/wic**.

TO REPORT A CHANGE:

- call Customer Service at *1-855-899-9600*
- go online to fill out a change report form (Form *200GMC*) at: *https://www.greenmountaincare.org/mabd*
- write to us and send it to:
  DVHA - Application & Document Processing Center
  280 State Drive, Waterbury, VT 05671-1500.

NEED HELP? Visit ***dvha.vermont.gov/apply*** or call Customer Service at **1-855-899-9600**. For TTY/relay services, dial **711**. There is someone who can help in your area. Call Customer Service or go to: ***info.healthconnect.vermont.gov/information/community_partners/assisters***

SUPPLEMENTAL Information for Medicaid for the Aged, Blind and Disabled

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12/2019

CONTACT INFO The person listed here will be the contact person for this supplement.

First name, middle name, last name & suffix (Jr., Sr., III, etc.)	Date of Birth	Social Security number (SSN).	
Mailing address		Apartment or suite number	
City/Town	State	ZIP code	County

STEP 1 Information About You

1. Your Name (first, middle, last):	Date of Birth	Your Social Security number (SSN)	Program applying for
			☐ MABD ☐ DCHC

2. Your Spouse's Name (first, middle, last):	Spouse Date of Birth	Spouse Social Security number (SSN) *(Optional if not applying)*	Program applying for
			☐ MABD ☐ DCHC

3. Have you or your spouse applied for "Extra Help" (also called Low-Income Subsidy) available through the Social Security office for Medicare Part D prescription drug plan costs? ☐ Yes ☐ No

First name	Date applied

STEP 2 Resources

Resources are things you own. They are also called "assets". If you need more space, attach a separate page. Be sure to write your name and date of birth at the top.

1. Tell us about property you or your spouse own or are buying. This includes property that is jointly owned or held in a life estate. ☐ No property

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

Owner name(s)	Jointly owned	Full address of property	Type of property	Value	Amount owed
	☐ Yes ☐ No			$	$
	☐ Yes ☐ No			$	$

2. Tell us about vehicles you or your spouse own or are buying. (Do not include leased vehicles.) ☐ No vehicles

Examples: *Car, van, trailer, truck, ATV, RV/camper, SUV, boat, motorcycle, snowmobile/jet ski*

Owner name(s)	Jointly owned	Type of vehicle	Year	Make/model	Value	Amount owed
	☐ Yes ☐ No				$	$
	☐ Yes ☐ No				$	$
	☐ Yes ☐ No				$	$

3. Do you or your spouse have cash, an account, or any other resource from money earned as a working person with disabilities? ☐ Yes ☐ No

Owner name(s)	Type of resource	Value	Date opened or bought
		$	
		$	

SUPPLEMENT For Aged, Blind and Disabled (continued)

4. Tell us about any life insurance policies or burial accounts that you or your spouse own.

☐ No life insurance policies
☐ No burial accounts

Owner name(s)	Type of resource	Value
	Life Insurance: ☐ Term ☐ Whole	*Face value* $ *Cash value* $
	Life Insurance: ☐ Term ☐ Whole	*Face value* $ *Cash value* $
	Account set up for burial expenses: Is it irrevocable? ☐ Yes ☐ No	$
	Account set up for burial expenses: Is it irrevocable? ☐ Yes ☐ No	$
	Burial plot, headstone, etc.	$
	Burial plot, headstone, etc.	$

5. Do you or your spouse have a qualified ABLE (Achieving a Better Life Experience) account? ☐ Yes ☐ No

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

6. Tell us about any other resources you or your spouse own or co-own.

☐ No other resources

Examples:

- *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*

Owner name(s)	Jointly owned	Type of resource	Account number	Value	Name of financial institution
	☐ Yes ☐ No			$	
	☐ Yes ☐ No			$	
	☐ Yes ☐ No			$	
	☐ Yes ☐ No			$	

STEP 3 Income

1. Do you or your spouse get paid for taking care of children?

If you report this income on your tax return, answer "No" to this question and continue to question 2. ☐ Yes ☐ No

If Yes:

- List income before deductions from the past 30 days.

First name	Income before deductions	Breakfast	Lunch	Dinner	Snacks
	$ per				

2. Do you or your spouse get paid for providing room or meals in your home? (Include payments from children.)

If you report this income on your tax return, answer "No" to this question and continue to question 3. ☐ Yes ☐ No

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

SUPPLEMENT For Aged, Blind and Disabled (continued)

3. Tell us about additional income you or your spouse received this month or last month.

If you report this income on your tax return, answer "No" to this question and continue to question 4. ☐ No additional income

Examples:

- *Child support*
- *Interest/dividends**
- *Financial aid*
- *Insurance*
- *LTC Insurance policy payment*
- *Other cash received*
- *Public cash assistance*
- *Railroad retirement*
- *Supplemental Security Income (SSI)*
- *Unemployment compensation*
- *Veteran's payment*
- *Workers' compensation*

*Do not include interest from a qualified ABLE account.

Who is this for	Type of Income	How often (weekly, monthly, quarterly)	Amount BEFORE taxes and deductions
			$
			$
			$

4. If you have reported no income on the application you already gave us, or on this Supplement, tell us how your daily living expenses are paid.

_____

_____

STEP 4 Expenses

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

1. Tell us about ongoing medical expenses you or your spouse have that are not covered by insurance? ☐ No expenses

Examples: *pain relievers, personal care, antacids, hearing aid batteries, vitamins.*

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

2. If you or your spouse is blind or disabled AND working, do you pay for work-related expenses? ☐ Yes ☐ No

Examples:

- *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	Expense	How often	How much
			$
			$
			$

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

Examples: *Child care, child support, alimony, dependent elder care, health insurance premiums*

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

STEP 5 Sign this Supplement

You must sign below at the red "X" . Not signing may delay health coverage. If your spouse is applying with you, they must also sign at the second red "X".

If your spouse is not applying with you, see *Information and Authorization for Verification of Resources* below.

I give my word under penalty of perjury that all information I have given in this Supplement is true and correct. By signing this Supplement, I am agreeing to the following:

- **I have read the Rights and Responsibilities in this Supplement on page ii, in addition to the Rights and Responsibilities in the application I already gave you.**
- **I understand that I can ask for a copy of my Rights and Responsibilities by calling Customer Service at 1-855-899-9600.**

Your signature *(or signature of person signing on your behalf)*	Date *(mm/dd/yyyy)*
X	
Your spouse's signature *(or signature of person signing on behalf of your spouse)*	Date *(mm/dd/yyyy)*
X	

If you are married and your spouse is NOT applying with you, your spouse must complete the following:

Information and Authorization for Verification of Resources

This authorizes the Department of Vermont Health Access (DVHA) and authorized agents to request records from financial institutions for the spouse of the person applying for Medicaid in this Supplement.

This authorization must be completed and signed by the spouse at the red "X" below. Failure to complete and sign this authorization may result in a denial or termination of Medicaid for the individual applying.

For the applying spouse: If your spouse refuses to sign this authorization or you cannot locate your spouse, you can still send us this Supplement.

I authorize verification of my resources with financial institutions for the purpose of determining eligibility for Medicaid for my spouse.

This authorization will remain in effect until I revoke this authorization in a written statement to DVHA or my spouse's application is denied or my spouse is no longer eligible for Medicaid.

(Spouse's) Social Security number* ***Optional, but providing the spouse's Social Security number can speed up the resource verification process that is required for determining Medicaid 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.

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**.

STEP 6 Send us the completed and signed Supplement.

You can send us your Supplement two ways:

1. By mail to: *Green Mountain Care*
   Application & Document Processing Center
   280 State Drive
   Waterbury, VT 05671-1500
2. Online through our uploader, visit: *www.greenmountaincare.org/mabd* for instructions on how to send us the Supplement electronically.

You have now completed the Supplement.

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