



Breast and Cervical Cancer Treatment Program (BCCT) Application and Referral Form

Revised 10/2017

Part I: To be filled out by Applicant

Name (First, Middle, Last – as it appears on your SS card): _____

Social security number: _____ Date of Birth (mm/dd/yyyy): _____

Home phone: () _____ Work Phone: () _____ Cell Phone: () _____

Street Address* (Required): _____

Mailing Address* (If different than above): _____

Please provide your FULL address(es) (including City, State & Zip Code)

Have you been determined blind or disabled by the Social Security Administration? Yes No

By signing below:

- I understand that a final decision on my eligibility for coverage may require that I provide additional information.
- I hereby acknowledge that I have completed the application and have read and understand my rights and responsibilities on page 2.

Are you a U.S. Citizen or U.S. National? Yes No

If you are not a U.S. citizen or U.S. national, do you have eligible immigration status?

YES. Fill in your document information below.

- | | |
|--|--|
| a. Immigration document type _____ | f. Passport or document number _____ <input type="checkbox"/> None |
| b. Document expiration date _____ <input type="checkbox"/> None | g. Country of origin _____ |
| c. Alien number _____ | h. Category code _____ |
| d. Have you lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No | i. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Date of entry: _____ | |

You MUST sign here. Unsigned applications will not be processed and will be returned for a signature. Not signing the application may delay treatment coverage.

Signature _____ Date (mm/dd/yyyy): _____

Signature of person witnessing and/or helping to fill out this form:

Signature (witness/helper): _____ Date (mm/dd/yyyy): _____

Part II: **ONLY** to be filled out by You First

Treatment Provider Name: _____

Specialty: _____ Affiliation: _____

Address (including City, State, Zip): _____

Telephone number: _____

Date of diagnosis _____ Would you like retroactive coverage back to the date of diagnosis? Yes No

Applicant Rights and Responsibilities

I certify, under penalty of perjury, that the information I give to the Department of Vermont Health Access (DVHA) to process my application for assistance is true and correct to the best of my knowledge and belief.

I understand that if any information is incorrect, the department may deny assistance to me. I also understand that I must pay back any benefits I receive that I should not have received.

I understand that when I receive assistance, I must report to DVHA within 10 days any change in income, resources, expenses, insurance coverage, or people living with me. I understand these changes may affect the amount of assistance I get.

(continued on back)

I also understand that:

1. The information I have given is private and cannot be seen by the public. I understand that I am required by federal law (Deficit Reduction Act of 1984, § 2651) and regulation (42 CFR 435.910) to provide my social security number if I want health care programs and that it will be used to check my statements with other resources such as the Social Security Administration, the Internal Revenue Service, and Unemployment Compensation. If I am a member of a religious organization that objects to furnishing a social security number, this requirement may be waived.
2. The department is required to make a decision on my application within 30 days (90 days if my application is based on disability) unless I, examining physicians, or an administrative emergency cause delay. If I do not receive a decision within 30 days (90) days, I may call the department or request a fair hearing.
3. I may ask for a fair hearing on this decision or any action with which I disagree by contacting the department.
4. The department may select my application for a quality control review. If so, I agree to give proof of required information to the department. If I am unable to give the proof needed, I hereby authorize the department to get required information.
5. If I am an otherwise qualified individual with a disability in the United States I shall not be excluded from the participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving federal assistance solely because of my disability.
6. If I believe that I have been discriminated against because of race, color, religious creed, age sex, disability, national origin or political beliefs, I have the right to contact:

Health Access Eligibility Unit Chief
HC 1 South
280 State Drive
Waterbury, VT 05671-1020

Office of Civil Rights
Health and Human Services
Room 1875, JFK Federal Building
Boston, MA 02203

ADA Coordinator
Agency of Human Services
280 State Drive, HC 1 South
Waterbury, VT 05671-1020

7. I agree that my health care providers may release my medical records when necessary for administering the program.
8. As a condition of eligibility for health care programs, I agree to assign to the state all rights to medical support and to third party payments (such as insurance) for medical care. I also agree to enroll in a group health plan if the state requires me to do so and I understand the state may pay the premiums. I also agree to cooperate in the pursuit of any such actual or potential source of medical support or payments, including establishing paternity for my dependent children, if necessary. I understand that if I do not cooperate, my benefits will end.
9. Federal regulations require DVHA to file a claim against my estate for recovery of Medicaid payments made on my behalf while I am 55 years of age or older and living in a nursing facility or enrolled in a home and community-based waiver program. DVHA will not seek adjustment or recovery against my estate if, at the time of my death, my husband or wife is still alive or I have any surviving children who are blind, disabled, or under age 21, or the department determines that adjustment or recovery would cause undue hardship. I understand that my worker has additional information about recovery.
10. If I receive benefits under Medicare, Part B, while receiving health care program benefits, I request that payments of future medical and other health services under Medicare, Part B, be made directly to physicians and medical suppliers, as long as I am receiving health care program benefits. This means that it will not be necessary to sign a separate form each time I receive service.
11. Under Vermont law if I knowingly give false information or hold back needed information when I apply for or receive any assistance, I can be taken to court for fraud. If convicted, I may be fined not more than the amount of wrongfully received benefits AND/OR I may be imprisoned up to one year if I wrongfully received \$1000 or less in benefits or up to three years if I wrongfully received more than \$1000 in benefits.
12. Section 1909 of the Social Security Act provides federal penalties for fraudulent acts and false reporting in connection with my application for or receipt of health care program benefits. I may be prosecuted in federal court for deliberate statements that I know to be false and that affect my eligibility for any benefit or payment under health care programs. I may also be prosecuted for concealing or failing to disclose any event of which I have knowledge that affects my right to any benefit or payment, or its conversion to the use of someone else. In addition, the law provides a penalty for kickback, bribe, or rebate in connection with the furnishing of health care benefits. Penalties could result in loss of health care program benefits for a period not to exceed one year.

Application for Health Coverage and Help Paying Costs

 <p>Apply faster online or by phone. Visit VermontHealthConnect.gov or call 1-855-899-9600. Applying for health coverage through Vermont Health Connect does not mean you have to buy a health plan.</p>	
 <p>Coverages you may qualify for</p>	<ul style="list-style-type: none"> Affordable private health insurance plans that offer comprehensive coverage to help you stay well A new tax credit that can immediately lower your premiums for health coverage Free or low-cost insurance from Medicaid/Dr. Dynasaur (includes some dental coverage) <p>You may qualify for a free or low-cost program even if you earn as much as \$95,400* a year (for a family of 4). *This number changes every January.</p>
 <p>Who can use this application?</p>	<ul style="list-style-type: none"> Use this application to apply for yourself. Use this application to apply for anyone in your family. See Step 2 on page 1. Apply even if you or your child already has health coverage. You could still be eligible for lower-cost or free coverage. Families that include immigrants can apply. You can apply for your child even if you are not eligible for coverage. Applying will not affect your immigration status or chances of becoming a permanent resident or citizen.
 <p>DO NOT use this application for...</p>	<ul style="list-style-type: none"> Dental ONLY coverage. There is no financial assistance if you buy dental ONLY plans. If you wish to ONLY buy a dental plan, you can apply using the shorter Application for Health Coverage (205INFA) or call 1-855-899-9600. Reporting changes. To report changes to your household information, call 1-855-899-9600.
 <p>What you may need to apply</p>	<ul style="list-style-type: none"> Social Security numbers (or document numbers for any legal immigrants who need insurance) Employer and income information for everyone in your family (for example, from pay stubs, W-2 forms, or wage and tax statements) Policy numbers for any health insurance you or others on this application now have If someone is helping you fill out this application, you may need to complete Appendix A. A completed Appendix C for each family member whose employer offers health insurance
 <p>Why do we ask for this information?</p>	<p>We ask about income and other information to determine what coverage you qualify for and if you can get any help paying for it.</p> <p>We will keep all the information you provide private and secure, as required by law.</p>
 <p>What happens next?</p>	<p>Send your completed and signed application to the address in Step 10 on page 12. If you do not have all the information we ask for, sign and submit your application anyway. We will follow-up with you within 1–2 weeks with instructions on the next steps to complete your application. You may need to make a payment before coverage begins. If you do not hear from us, visit VermontHealthConnect.gov or call 1-855-899-9600.</p>
 <p>Get help with this application</p>	<ul style="list-style-type: none"> Online: VermontHealthConnect.gov Phone: Call our Customer Support Center at 1-855-899-9600. TTY/Relay: If you are deaf, hard of hearing, or have a speech disability, dial 711. In person: There is someone who can help in your area. Call 1-855-899-9600.
 <p>Interpretation services are available</p>	<p>إذا أنت ترغب خدمات الترجمة الفورية اتصل برقم 1-855-899-9600 (Arabic)</p> <p>Ako su Vam potrebne usluge tumačenja, pozovite 1-855-899-9600. (Bosnian)</p> <p>စကားပြန် ဝန်ဆောင်မှုလိုအပ်ပါက 1-855-899-9600 သို့ ဖုန်းဆက်ခေါ်ပါ။ (Burmese)</p> <p>Si vous avez besoin de services d'interprétation, appelez le 1-855-899-9600. (French)</p> <p>Mugihe woba ushaka impfashanyo yo gusigurirwa, hamagara uyu murongo 1-855-899-9600. (Kirundi)</p> <p>यदि तपाईंलाई दोभाषे सेवाको जरुरत परेमा, 1-855-899-9600 मा कल गर्नुहोस्। (Nepali)</p> <p>Haddii aad u baahan tahay adeegyo turjumaan, wac 1-855-899-9600. (Somali)</p> <p>Si usted necesita servicios de interpretación, llame al 1-855-899-9600. (Spanish)</p> <p>Ikiwa unahitaji huduma za ukalimani, piga simu 1-855-899-9600. (Swahili)</p> <p>Nếu quý vị cần dịch vụ thông ngôn, hãy gọi 1-855-899-9600. (Vietnamese)</p>

You may keep this page for future reference. Your Rights and Responsibilities are on the back of this page and page 11. If you need help understanding something, contact Vermont Health Connect at 1-855-899-9600.

Your Rights and Responsibilities within Vermont Health Connect

Additional rights and responsibilities can be found on page 11.

How We Use Your Information. We need the information we asked for to decide if you qualify for Medicaid/Dr. Dynasaur, or for help paying for health coverage if you choose to apply. We will check your answers using information from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or a consumer reporting agency. If the information does not match, we may ask you to send us proof.

Americans with Disabilities Act. If you think you might have a physical or mental condition that substantially limits a major life activity (for example, walking, seeing, hearing, or learning), let us know. The Americans with Disabilities Act and Vermont law give people with disabilities certain rights. We will make reasonable changes (called an “accommodation”) in our requirements to help you take part in our programs. Call **1-855-899-9600** to let Vermont Health Connect know if you need an accommodation.

Discrimination. Under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. You can file a complaint of discrimination online by visiting www.hhs.gov/ocr/office/file; by writing to Health and Human Services, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201; or by calling **1-800-368-1019** or **1-800-537-7697** (TDD).

Social Security Numbers. All individuals applying for health benefits who have a Social Security number (SSN) must provide it. A person who is not seeking coverage does not need to provide a Social Security number. If you are a member of a religious organization that objects to furnishing an SSN, Vermont Health Connect may disregard this requirement. This requirement does not apply to an individual who: is not eligible to receive an SSN or does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104. The state will assign an identification number to these individuals. Vermont Health Connect uses an SSN for computer processing, child support enforcement, fraud investigation, audits, and Lifeline identification; to verify Social Security and Supplemental Security income (SSI); to prevent individuals from receiving duplicate benefits; to exchange information with agencies such as the Social Security Administration, Department of Labor, Internal Revenue Service (IRS), or private agencies to verify income, determine eligibility and benefits amounts, and collect claims; to determine the accuracy and reliability of information given to Vermont Health Connect; and to make medical assistance payments.

Confidentiality. Your confidential information is protected as required by federal and state laws and regulations. The use and disclosure of information concerning applicants, enrollees, and legally-liable third parties is restricted to purposes directly connected with the administration of programs, or as otherwise required by law.

Release of Medical Records. By signing your application, you agree that your health care providers and Vermont Health Connect and its contractors and grantees may access, use and disclose your medical records to manage state health care programs or when a hospital, health care provider, mental health provider, or pharmacy needs your medical records. This includes provider and prescription medication information for your treatment, for payment of your treatment, and for health care operations.

Renewal of Eligibility in Future Years. To make it easier to decide if you qualify for help paying for health coverage in future years, you can agree to allow Vermont Health Connect to use income data, including information from tax returns. You can tell us not to use your information at any time. Your options are available to you in Step 5 on page 10 of this application. Vermont Health Connect may send you a notice and let you make any changes. You can also call us at **1-855-899-9600**.

Medicaid. If you or anyone in your household enrolls in Medicaid, you give the Medicaid agency the right to pursue and get any money from other health insurance, legal settlements, or other third parties. You also give the agency the right to pursue and get medical support from a spouse or parent. If a child on Medicaid has a parent living outside of the home, we may ask you to cooperate with us to collect medical support from an absent parent. If you think that cooperating to collect medical support may harm you or your children, tell Medicaid. You may not have to cooperate.

Reporting changes. You must tell Vermont Health Connect if anything changes or is different than what you wrote on this application. If enrolled in Medicaid, you must report changes within 10 days. If enrolled in a Qualified Health Plan with financial assistance, you must report changes within 30 days. Visit VermontHealthConnect.gov or call **1-855-899-9600** to report any changes. A change in your information could affect the eligibility for yourself and the member(s) of your household.

Timely Decision on Application. Vermont Health Connect must make a decision on your application no later than 30 days after your application date (or 90 days if your Medicaid application is based on disability) unless delay is caused by physicians, an unexpected emergency or administrative problem beyond the Department’s control, or you. **If you do not get a decision within 30 days (or 90 days),** you may call Vermont Health Connect at **1-855-899-9600** for more information or to file an appeal.

Your Right to Appeal. If you think Vermont Health Connect has made a mistake, you can appeal its decision. You can also appeal if we are late making a decision. To appeal means to ask for a fair hearing. A fair hearing is a chance to tell a hearing officer at the Human Services Board why you think the decision is wrong. The hearing officer will make a new decision after looking at all the facts.

If waiting on a regular appeal might harm you, you can file an expedited (faster) appeal. When you appeal, tell us if you need an “expedited” appeal. You must appeal within 90 days of a Vermont Health Connect decision. We will send you a notice (decision) on your application. It will tell you more about how to appeal and any deadlines. To appeal call Vermont Health Connect 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 advice by calling the Health Care Advocate at Vermont Legal Aid at **1-800-917-7787**.

Please be aware that there is no right to a fair hearing when either state or federal law requires automatic case adjustments for classes of enrollees, unless the reason for an individual fair hearing is incorrect eligibility determination. These case adjustments are called “mass changes.”

Other Kinds of Complaints. If you want to complain about something other than an eligibility decision, like how Vermont Health Connect has treated you, call Vermont Health Connect at **1-855-899-9600**. Call within 60 days if you want a written response.

Application for Health Coverage and Help Paying Costs



2051FA - Revised 8/2016

STEP 1 PERSON 1: Tell us about yourself

The adult listed here will be considered the “applicant” and primary contact for this household’s application.

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.)			
2. Home address (leave blank if you do not have one)			3. Apartment or suite number
4. City	5. State	6. ZIP code	7. County
8. Mailing address line 1 (if different from home address)			9. Apartment or suite number
10. Mailing address line 2 (If applicable, include an “in-care-of” person here. For an Authorized Representative, complete Appendix A.)			
11. City	12. State	13. ZIP code	14. County
15. HOME phone number () -	16. WORK phone number () -	17. CELL phone number () -	
18. What is your preferred spoken or written language (if not English)?			

STEP 2 Tell us about your family

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. You do not need to file taxes to get health coverage.

DO Include:

- Yourself
- Your parents/step parents who live with you, (if you are under 21)
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they do not live with you
- Anyone else under 21 who you take care of and lives with you
- Any children, ages 21 through 26, that you want to include on your Qualified Health Plan, even if they do not live with you

You DO NOT have to include:

- Your unmarried partner who does not need health coverage, unless you have a child together
- Your unmarried partner’s children, unless you have a child together
- Your parents/step parents who live with you, but file their own tax return (if you are over 21)
- Other adult relatives who file their own tax return
- Anyone who is incarcerated or detained
- Roommates

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage that they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 3 people in your family, you will need to make copies of pages 6 and 7 for each additional person and attach the additional pages to your application. You should always include your own name and date of birth on any additional pages you attach. You do not need to provide immigration status or a Social Security number for family members who do not need health coverage. We will keep all the information you provide private and secure as required by law. We will use personal information only to check if you are eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner, children who live with you, and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you do not file a tax return, you must still add family members who live with you.

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.) _____ 2. Relationship to you?
SELF

3. List any other names you have been known by, including a maiden name or alias. _____ 4. Date of birth (mm/dd/yyyy) _____ 5. Sex
 Male Female

6. Marital status: Never married Married Civil union Separated Divorced/dissolved Widowed
If you are a victim of domestic violence and applying separately from your spouse, you may indicate that you are "Never married".

7. Social Security number (SSN) _____ - _____ - _____

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful, even if you do not want health coverage, since it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health coverage costs. If someone wants help getting an SSN, call **1-800-772-1213** or visit [socialsecurity.gov](https://www.socialsecurity.gov). TTY users call **1-800-325-0778**.

8. **Do you or your spouse plan to file a federal income tax return, or be included in a federal income tax return, NEXT YEAR?**
(You can still apply for health insurance even if you do not file a federal income tax return.)

- YES. If yes,** please answer questions a-c. **NO. If no,** skip to question c.
- a. Will you file jointly with a spouse? Yes No **If yes,** name of spouse: _____
- b. Will you claim any dependents on your tax return? (Joint filers must claim the same dependents.) Yes No
If yes, list name(s) of dependents: _____
- c. Will you be claimed as a dependent on someone else's tax return? (You cannot be both a dependent and a joint filer.) Yes No
If yes, name of the tax filer: _____ How are you related to the tax filer? _____

9. Are you pregnant? Yes No a. **If yes,** how many babies are expected during this pregnancy? _____
b. What is the estimated due date? _____

10. **Are you applying for health coverage?** (Even if you have insurance, there might be a program with better coverage or lower costs.)

- YES. If yes,** answer all the questions below.  **NO. If no,** SKIP ahead to page 3 and leave the rest of this page blank. 

11. a. Do you have a physical, mental, or emotional health condition that causes limitations in daily activities (like bathing, dressing, daily chores, etc.)? Yes No

b. Do you live in a medical facility or nursing home? Yes No

12. Are you a U.S. citizen or U.S. national? Yes No

13. **If you are not a U.S. citizen or U.S. national,** do you have eligible immigration status?

- YES.** Fill in your document information below.
- a. Immigration document type _____ f. Passport or document number _____ None
- b. Document expiration date _____ None g. Country of origin _____
- c. Alien number _____ h. Category code _____
- d. Have you lived in the U.S. since 1996? Yes No i. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? Yes No
- e. Date of entry _____

14. **Retroactive Medicaid:** If you have unpaid medical/dental expenses from the last 3 months and your income is within the guideline, you might be eligible for assistance that could help pay, or reimburse you for those expenses.

Do you want to apply for help with medical/dental expenses from the last 3 months? Yes No

15. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? Yes No

16. Are you a full-time student? Yes No a. **If yes,** give the state of your legal residence: _____

17. Were you in foster care in Vermont when you turned 18? Yes No

18. **Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

Mexican Mexican American Chicano/a Puerto Rican Cuban Other _____

19. **Race (OPTIONAL—check all that apply.)**

- White American Indian or Alaska Native Filipino Vietnamese Guamanian or Chamorro
- Black or African American Asian Indian Japanese Other Asian Samoan
- Chinese Korean Native Hawaiian Other Pacific Islander
- Other _____

Now, tell us about your income on the next page. 

STEP 2: PERSON 1 (Continue with your income)

Current Job & Income Information

Employed

If you are currently employed, tell us about your income. Start with question 20.

Self-employed

Skip to question 32.

Not employed

Skip to question 33.

CURRENT JOB 1:

20. Employer name	21. Employer phone number () -
22. Employer address	

23. Gross wages/tips (before taxes) \$ _____ Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

24. Average hours worked each week in the past month: _____

CURRENT JOB 2: To list additional jobs, attach another sheet of paper. Include your name and date of birth on any additional sheets.

25. Employer name	26. Employer phone number () -
27. Employer address	

28. Gross wages/tips (before taxes) \$ _____ Hourly Weekly Every 2 weeks Twice a month Monthly Yearly

29. Average hours worked each week in the past month: _____

30. Do any of these jobs offer health insurance coverage? No Yes. **If yes**, be sure to complete **Appendix C** at the end of this application.

31. **In the past year, did you:** Change jobs Stop working Start working fewer hours None of these

32. **If self-employed, answer the following questions:**

- a. What type of work do you do? _____
- b. How much net income (profit after business expenses are paid) will you get this month? \$ _____

33. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you receive it.

When asked "How often?", indicate whether the amount is received weekly, every two weeks, twice a month, monthly, or yearly.

NOTE: You do not need to tell us about child support, worker compensation, veteran's payments, or Supplemental Security Income (SSI).

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Net farming/fishing \$ _____ How often? _____ |
| <input type="checkbox"/> Alimony received \$ _____ How often? _____ | <input type="checkbox"/> Net rental/royalty \$ _____ How often? _____ |
| <input type="checkbox"/> Canceled debt \$ _____ How often? _____ | <input type="checkbox"/> Non-taxable SSA \$ _____ How often? _____ |
| <input type="checkbox"/> Commissions \$ _____ How often? _____ | <input type="checkbox"/> Pensions \$ _____ How often? _____ |
| <input type="checkbox"/> Court awards \$ _____ How often? _____ | <input type="checkbox"/> Retirement accounts \$ _____ How often? _____ |
| <input type="checkbox"/> Foreign earned income \$ _____ How often? _____ | <input type="checkbox"/> Scholarships & grants \$ _____ How often? _____ |
| <input type="checkbox"/> Gambling/prizes/awards \$ _____ How often? _____ | <input type="checkbox"/> Social Security (disability, retirement, and survivor/widow benefit before Medicare deduction) \$ _____ How often? _____ |
| <input type="checkbox"/> Investment income \$ _____ How often? _____ | <input type="checkbox"/> Tax exempt interest/dividends \$ _____ How often? _____ |
| <input type="checkbox"/> Jury pay \$ _____ How often? _____ | <input type="checkbox"/> Unemployment \$ _____ What state pays your unemployment benefit? _____ How often? _____ |

34. **DEDUCTIONS:** Check all that apply, and give the amount and how often you pay it.

If you pay for certain things that can be **deducted on a federal income tax return**, telling us about them could lower your healthcare costs

NOTE: You should not include a cost that you already deducted from your answer to the self-employment net income in question (32.b).

- | | |
|---|--|
| <input type="checkbox"/> Alimony paid \$ _____ How often? _____ | <input type="checkbox"/> Student loan interest \$ _____ How often? _____ |
| <input type="checkbox"/> Other deductions \$ _____ Type(s) _____ How often? _____ | |

35. **YEARLY INCOME:** Complete **ONLY** if your income changes from month to month.

Your total income this calendar year	Your total income next calendar year (if you think it will be different)
\$ _____	\$ _____

Continue with Step 2 if you have additional household members to report. If not, skip ahead to Step 3.

STEP 2: PERSON 2

Continue filling out Step 2 for your spouse/partner, children who live with you, and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you do not file a tax return, you must still add family members who live with you.

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.) _____		2. Relationship to you? _____
3. List any other names PERSON 2 has been known by (e.g., maiden name or alias) _____	4. Date of birth (mm/dd/yyyy) ____/____/____	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
6. Marital status: <input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Civil union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Widowed		
7. Social Security number (SSN) ____ - ____ - ____ We need this if PERSON 2 wants coverage and has an SSN.		
8. Does PERSON 2 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no , list address: _____		
9. Does PERSON 2 or their spouse plan to file a federal income tax return, or be included in a federal income tax return, NEXT YEAR? (PERSON 2 can still apply for health insurance even if they do not file a federal income tax return.) <input type="checkbox"/> YES. If yes , please answer questions a-c. <input type="checkbox"/> NO. If no , skip to question c. a. Will PERSON 2 file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , name of spouse: _____ b. Will PERSON 2 claim any dependents on his or her tax return? (Joint filers must claim the same dependents.) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , list name(s) of dependents: _____ c. Will PERSON 2 be claimed as a dependent on someone else's tax return? (Cannot be both a dependent and a joint filer.) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , name of the tax filer: _____ How is PERSON 2 related to the tax filer? _____		
10. Is PERSON 2 pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes , how many babies are expected during this pregnancy? _____ b. What is the estimated due date? _____		
11. Is PERSON 2 applying for health coverage? <input type="checkbox"/> YES. If yes , answer all the questions below.  <input type="checkbox"/> NO. If no , SKIP ahead to page 5 and leave the rest of this page blank. 		
12. a. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in daily activities (like bathing, dressing, daily chores, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Does PERSON 2 live in a medical facility or nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Is PERSON 2 a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No		
14. If PERSON 2 is not a U.S. citizen or U.S. national , do they have eligible immigration status? <input type="checkbox"/> YES . Fill in their document information below. a. Immigration document type _____ f. Passport or document number _____ <input type="checkbox"/> None b. Document expiration date _____ <input type="checkbox"/> None g. Country of origin _____ c. Alien number _____ h. Category code _____ d. Has PERSON 2 lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No i. Is PERSON 2, or their spouse or parent a veteran or an active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No e. Date of entry _____		
15. Retroactive Medicaid: If PERSON 2 has medical/dental expenses from the last 3 months and their income is within the guideline, they might be eligible for assistance that could help pay, or reimburse them for those expenses. Does PERSON 2 want to apply for help with medical/dental expenses from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
16. Does PERSON 2 live with at least one child under the age of 19, and is PERSON 2 the main person taking care of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No		
17. Is PERSON 2 a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes , give the state of their legal residence: _____		
18. Was PERSON 2 in foster care in Vermont when they turned 18? <input type="checkbox"/> Yes <input type="checkbox"/> No		
19. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.) <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other _____		
20. Race (OPTIONAL—check all that apply.) <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Other Asian <input type="checkbox"/> Samoan <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other _____		

Now, tell us about any income from PERSON 2 on the next page. 

 **NEED HELP WITH YOUR APPLICATION?** Visit VermontHealthConnect.gov or call toll-free 1-855-899-9600. For TTY/relay services, dial 711.

STEP 2: PERSON 2 (Continue with income for PERSON 2)

Current Job & Income Information

Employed

If PERSON 2 is currently employed, tell us about their income. Start with question 21.

Self-employed

Skip to question 33.

Not employed

Skip to question 34.

CURRENT JOB 1:

21. Employer name	22. Employer phone number () -
23. Employer address	
24. Gross wages/tips (before taxes) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
25. Average hours worked each week in the past month: _____	

CURRENT JOB 2: To list additional jobs, attach another sheet of paper. Include your name and date of birth on any additional sheets.

26. Employer name	27. Employer phone number () -
28. Employer address	
29. Gross wages/tips (before taxes) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
30. Average hours worked each week in the past month: _____	

31. Do any of these jobs offer health insurance coverage? No Yes. **If yes**, be sure to complete **Appendix C** at the end of this application.

32. **In the past year, did PERSON 2:** Change jobs Stop working Start working fewer hours None of these

33. If self-employed, answer the following questions:

- a. What type of work does PERSON 2 do? _____
- b. How much net income (profit after business expenses are paid) will PERSON 2 get this month? \$ _____

34. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often PERSON 2 receives it.

When asked "How often?", indicate whether the amount is received weekly, every two weeks, twice a month, monthly, or yearly.

NOTE: You do not need to tell us about child support, worker compensation, veteran's payments, or Supplemental Security Income (SSI).

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Net farming/fishing \$ _____ How often? _____ |
| <input type="checkbox"/> Alimony received \$ _____ How often? _____ | <input type="checkbox"/> Net rental/royalty \$ _____ How often? _____ |
| <input type="checkbox"/> Canceled debt \$ _____ How often? _____ | <input type="checkbox"/> Non-taxable SSA \$ _____ How often? _____ |
| <input type="checkbox"/> Commissions \$ _____ How often? _____ | <input type="checkbox"/> Pensions \$ _____ How often? _____ |
| <input type="checkbox"/> Court awards \$ _____ How often? _____ | <input type="checkbox"/> Retirement accounts \$ _____ How often? _____ |
| <input type="checkbox"/> Foreign earned income \$ _____ How often? _____ | <input type="checkbox"/> Scholarships & grants \$ _____ How often? _____ |
| <input type="checkbox"/> Gambling/prizes/awards \$ _____ How often? _____ | <input type="checkbox"/> Social Security (disability, retirement, and survivor/widow benefit before Medicare deduction) \$ _____ How often? _____ |
| <input type="checkbox"/> Investment income \$ _____ How often? _____ | <input type="checkbox"/> Tax exempt interest/dividends \$ _____ How often? _____ |
| <input type="checkbox"/> Jury pay \$ _____ How often? _____ | <input type="checkbox"/> Unemployment \$ _____ What state pays your unemployment benefit? _____ How often? _____ |

35. DEDUCTIONS: Check all that apply, and give the amount and how often PERSON 2 pays it.

If PERSON 2 pays for things that can be **deducted on a federal income tax return**, telling us about them could lower their healthcare costs.

NOTE: You should not include a cost that you already deducted from PERSON 2's self-employment net income in question (33.b.).

- | | |
|--|--|
| <input type="checkbox"/> Alimony paid \$ _____ How often? _____ | <input type="checkbox"/> Student loan interest \$ _____ How often? _____ |
| <input type="checkbox"/> Other deductions \$ _____ Type(s) _____ | How often? _____ |

36. YEARLY INCOME: Complete **ONLY** if income for PERSON 2 changes from month to month.

PERSON 2's total income this calendar year	PERSON 2's total income next calendar year (if you think it will be different)
\$ _____	\$ _____

Continue with Step 2 if you have additional household members to report. If not, skip ahead to Step 3. 

STEP 2: PERSON 3

Continue filling out Step 2 for your spouse/partner, children who live with you, and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you do not file a tax return, you must still add family members who live with you. **If you have more than 3 household members, you will want to copy the next two pages before filling them out and use them for additional members. You must also include your own name and date of birth at the top of each additional page.**

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.) _____		2. Relationship to you? _____	
3. List any other names PERSON 3 has been known by (e.g., maiden name or alias) _____		4. Date of birth (mm/dd/yyyy) _____/_____/_____	
5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			
6. Marital status: <input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Civil union <input type="checkbox"/> Separated <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Widowed			
7. Social Security number (SSN) ____ - ____ - ____ We need this if PERSON 3 wants coverage and has an SSN.			
8. Does PERSON 3 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no , list address: _____			
9. Does PERSON 3 or their spouse plan to file a federal income tax return, or be included in a federal income tax return, NEXT YEAR? (PERSON 3 can still apply for health insurance even if you do not file a federal income tax return.) <input type="checkbox"/> YES. If yes , please answer questions a-c. <input type="checkbox"/> NO. If no , skip to question c.			
a. Will PERSON 3 file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , name of spouse: _____			
b. Will PERSON 3 claim any dependents on his or her tax return? (Joint filers must claim the same dependents.) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , list name(s) of dependents: _____			
c. Will PERSON 3 be claimed as a dependent on someone else's tax return? (Cannot be both a dependent and a joint filer.) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , name of the tax filer: _____ How is PERSON 3 related to the tax filer? _____			
10. Is PERSON 3 pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No			
a. If yes , how many babies are expected during this pregnancy? _____			
b. What is the estimated due date? _____			
11. Is PERSON 3 applying for health coverage? <input type="checkbox"/> YES. If yes , answer all the questions below. <input type="checkbox"/> NO. If no , SKIP ahead to page 7 and leave the rest of this page blank.			
12. a. Does PERSON 3 have a physical, mental, or emotional health condition that causes limitations in daily activities (like bathing, dressing, daily chores, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
b. Does PERSON 3 live in a medical facility or nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Is PERSON 3 a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No			
14. If PERSON 3 is not a U.S. citizen or U.S. national , do they have eligible immigration status? <input type="checkbox"/> YES . Fill in their document information below.			
a. Immigration document type _____		f. Passport or document number _____ <input type="checkbox"/> None	
b. Document expiration date _____ <input type="checkbox"/> None		g. Country of origin _____	
c. Alien number _____		h. Category code _____	
d. Has PERSON 3 lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No		i. Is PERSON 3, or their spouse or parent a veteran or an active-duty member of the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Date of entry _____			
15. Retroactive Medicaid: If PERSON 3 has medical/dental expenses from the last 3 months and their income is within the guideline, they might be eligible for assistance that could help pay, or reimburse them for those expenses. Does PERSON 3 want to apply for help with medical/dental expenses from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
16. Does PERSON 3 live with at least one child under the age of 19, and is PERSON 3 the main person taking care of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
17. Is PERSON 3 a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes , give the state of their legal residence: _____			
18. Was PERSON 3 in foster care in Vermont when they turned 18? <input type="checkbox"/> Yes <input type="checkbox"/> No			
19. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.) <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other _____			
20. Race (OPTIONAL—check all that apply.)			
<input type="checkbox"/> White		<input type="checkbox"/> American Indian or Alaska Native	
<input type="checkbox"/> Black or African American		<input type="checkbox"/> Filipino	
<input type="checkbox"/> Asian Indian		<input type="checkbox"/> Japanese	
<input type="checkbox"/> Chinese		<input type="checkbox"/> Korean	
<input type="checkbox"/> Vietnamese		<input type="checkbox"/> Guamanian or Chamorro	
<input type="checkbox"/> Other Asian		<input type="checkbox"/> Samoan	
<input type="checkbox"/> Native Hawaiian		<input type="checkbox"/> Other Pacific Islander	
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	

Now, tell us about any income from PERSON 3 on the next page.

NEED HELP WITH YOUR APPLICATION? Visit VermontHealthConnect.gov or call toll-free 1-855-899-9600. For TTY/relay services, dial 711.

STEP 2: PERSON 3 (Continue with income for PERSON 3)

Current Job & Income Information

Employed

If PERSON 3 is currently employed, tell us about their income. Start with question 21.

Self-employed

Skip to question 33.

Not employed

Skip to question 34.

CURRENT JOB 1:

21. Employer name	22. Employer phone number () -
23. Employer address	
24. Gross wages/tips (before taxes) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
25. Average hours worked each week in the past month: _____	

CURRENT JOB 2: To list additional jobs, attach another sheet of paper. Include your name and date of birth on any additional sheets.

26. Employer name	27. Employer phone number () -
28. Employer address	
29. Gross wages/tips (before taxes) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
30. Average hours worked each week in the past month: _____	

31. Do any of these jobs offer health insurance coverage? No Yes. **If yes**, be sure to complete **Appendix C** at the end of this application.

32. **In the past year, did PERSON 3:** Change jobs Stop working Start working fewer hours None of these

33. If self-employed, answer the following questions:

- a. What type of work does PERSON 3 do? _____
- b. How much net income (profit after business expenses are paid) will PERSON 3 get this month? \$ _____

34. OTHER INCOME THIS MONTH: Check all that apply, and give the amount and how often PERSON 3 receives it.

When asked "How often?", indicate whether the amount is received weekly, every two weeks, twice a month, monthly, or yearly.

NOTE: You do not need to tell us about child support, worker compensation, veteran's payments, or Supplemental Security Income (SSI).

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Net farming/fishing \$ _____ How often? _____ |
| <input type="checkbox"/> Alimony received \$ _____ How often? _____ | <input type="checkbox"/> Net rental/royalty \$ _____ How often? _____ |
| <input type="checkbox"/> Canceled debt \$ _____ How often? _____ | <input type="checkbox"/> Non-taxable SSA \$ _____ How often? _____ |
| <input type="checkbox"/> Commissions \$ _____ How often? _____ | <input type="checkbox"/> Pensions \$ _____ How often? _____ |
| <input type="checkbox"/> Court awards \$ _____ How often? _____ | <input type="checkbox"/> Retirement accounts \$ _____ How often? _____ |
| <input type="checkbox"/> Foreign earned income \$ _____ How often? _____ | <input type="checkbox"/> Scholarships & grants \$ _____ How often? _____ |
| <input type="checkbox"/> Gambling/prizes/awards \$ _____ How often? _____ | <input type="checkbox"/> Social Security (disability, retirement, and survivor/widow benefit before Medicare deduction) \$ _____ How often? _____ |
| <input type="checkbox"/> Investment income \$ _____ How often? _____ | <input type="checkbox"/> Tax exempt interest/dividends \$ _____ How often? _____ |
| <input type="checkbox"/> Jury pay \$ _____ How often? _____ | |
| <input type="checkbox"/> Unemployment \$ _____ What state pays your unemployment benefit? _____ How often? _____ | |

35. DEDUCTIONS: Check all that apply, and give the amount and how often PERSON 3 pays it.

If PERSON 3 pays for things that can be **deducted on a federal income tax return**, telling us about them could lower their healthcare costs.

NOTE: You should not include a cost that you already deducted from PERSON 3's self-employment net income in question (33.b.).

- | | |
|---|---|
| <input type="checkbox"/> Alimony paid \$ _____ How often? _____ | <input type="checkbox"/> Student loan interest \$ _____ How often? _____ |
| <input type="checkbox"/> Other deductions \$ _____ Type(s) _____ How often? _____ | |

36. YEARLY INCOME: Complete **ONLY** if income for PERSON 3 changes from month to month.

PERSON 3's total income this calendar year	PERSON 3's total income next calendar year (if you think it will be different)
\$ _____	\$ _____

Continue with Step 2 if you have additional household members to report. If not, skip ahead to Step 3.

STEP 3 Your family's health coverage

Answer these questions for anyone applying for health coverage.

1. Is anyone currently enrolled in health coverage from any of the following? (Do not include dental coverage. If your coverage under one of the programs below is ending and you are applying for new/continued coverage, including Medicaid/Dr. Dynasaur, answer NO.)

- YES. If yes,** check the type of coverage and write the name of the person next to the coverage they have. **NO.**
- | | |
|---|---|
| <input type="checkbox"/> Medicaid/Dr. Dynasaur _____ | <input type="checkbox"/> TRICARE (Do not check off if you have direct care or Line of Duty) _____ |
| <input type="checkbox"/> Federal Employee Program _____ | <input type="checkbox"/> VA health care programs _____ |
| <input type="checkbox"/> Peace Corps _____ | <input type="checkbox"/> Other insurance. If you have an insurance type not listed here, or in question 2, answer question 4. |
| <input type="checkbox"/> Employee insurance. If you have employee insurance, answer question 4. | |

2. Is anyone eligible for or enrolled in Medicare because they are age 65 or older, or because of a permanent disability?

- YES.** Please fill in the table below. **NO.**

Name: _____		Name: _____	
Medicare claim number: _____		Medicare claim number: _____	
Part A	Part B	Part A	Part B
Start date: _____	Start date: _____	Start date: _____	Start date: _____
Premium \$ _____	Premium \$ _____	Premium \$ _____	Premium \$ _____

3. Provide information about employee or other insurance below. Most of the information requested can be found on the front and back of your insurance card. If you have additional health insurance coverages to report and you need more space, copy this page.

Name of insurance company		Company phone number () -	Services covered: <input type="checkbox"/> Prescriptions <input type="checkbox"/> Dental <input type="checkbox"/> Outpatient <input type="checkbox"/> Vision <input type="checkbox"/> Doctors/hospitals <input type="checkbox"/> Other _____
Insurance company billing address			
Member ID/Policy number	Group number		
Name of policy holder	Social Security number		Date coverage began
Name of person covered	Social Security number		Relationship to policy holder
Name of person covered	Social Security number		Relationship to policy holder
Name of person covered	Social Security number		Relationship to policy holder
Name of person covered	Social Security number		Relationship to policy holder

- Is this COBRA coverage? Yes No
 Is this a retiree health plan? Yes No
 Is this a limited-benefit plan (such as a school accident policy)? Yes No

4. Is anyone listed on this application offered health coverage from a job?
 Check **yes** even if the coverage is from someone else's job, such as a parent or spouse.

- YES. If yes,** you will need to complete and include **Appendix C.**
 NO. If no, continue to Step 4.

STEP 4

Household Special Circumstances

The questions below are about life events that may have happened in your household in the past 60 days. Your answers will help us determine if you, or other household members, who are NOT eligible for Medicaid/Dr. Dynasaur, can enroll in a Qualified Health Plan outside of an open enrollment period. A representative may contact you for additional information about your situation to determine if you or other household members qualify for a Special Enrollment Period (SEP). **Please note there is no open enrollment period for Medicaid/Dr. Dynasaur coverage. You may apply for Medicaid/Dr. Dynasaur at any time.**

1. Did anyone in your household lose health insurance in the past 60 days? Yes No
If yes, who? _____ Date coverage ended: _____
Why? _____
2. Was anyone in your household removed from a Vermont Health Connect Qualified Health Plan in the past 60 days, due to death or divorce?
 Yes, due to death Yes, due to divorce No
If yes, who? _____ Date coverage ended: _____
3. Has anyone joined your household through the foster care program in the past 60 days? Yes No
If yes, who? _____ Date child joined household: _____
4. Did a household member experience one of the following changes to their citizenship status in the past 60 days?
 Yes, gained U.S. citizenship Yes, gained eligible immigration status Yes, now lawfully present No
If yes, who? _____ Date of change: _____
5. Did anyone in your household move to Vermont in the past 60 days? Yes No
If yes, who? _____ Date arrived in Vermont: _____
6. Did anyone in your household get released from incarceration (jail or prison) in the past 60 days? Yes No
If yes, who? _____ Date of release: _____
7. Did your household gain a dependent due to marriage, birth, or adoption in the past 60 days?
 Yes, due to marriage Yes, due to birth Yes, due to adoption No
If yes, who? _____ Date of marriage, birth, or adoption: _____
8. A. Has anyone in the household received approval of an Individual Hardship Exemption to purchase a Catastrophic Plan in the past 60 days? Yes No
If yes, who? _____ Date exemption granted: _____
B. Did any household member's Individual Hardship Exemption end in the past 60 days? Yes No
If yes, who? _____ Date exemption ended: _____
9. Has any household member's employer-sponsored insurance become unaffordable due to a decrease in their job income or a decrease in their work hours in the past 60 days? Yes No
If yes, who? _____ Date of income decrease: _____
10. Has any parent in your household been required by a court or administrative order to provide health insurance for a dependent child in the past 60 days? Yes No
If yes, who? _____
11. Have there been any other changes or circumstances in the past 60 days that you feel should be considered for deciding any household member's eligibility for an SEP? If so, please explain: Yes No

NOTE: The following question alone does NOT qualify you for a Special Enrollment Period but will tell us if/when you may qualify for help to pay QHP premiums. You must have at least one other qualifying event from the questions above in order to qualify for a Special Enrollment Period.

12. In the past 60 days, has anyone in your household become eligible for employer-sponsored health coverage but is in a waiting period before they can enroll? Yes No
If yes, who? _____ Date waiting period ends: _____



STEP 5 Future Eligibility Renewal

Eligibility must be renewed every year. Vermont Health Connect (VHC) is required to verify household information at renewal using electronic data sources. VHC must have your permission to do so.

If you say YES below, VHC may be able to renew your eligibility without you having to do anything. This includes eligibility for Medicaid/Dr. Dynasaur and for Advance Payment of Premium Tax Credits (APTC) for a Qualified Health Plan. You can say YES to a renewal of up to 5 years.

YES. I authorize use of electronic data sources to renew my eligibility for:

5 years (the maximum number of years allowed), 4 years, 3 years, 2 years, 1 year

If you say NO, and you get Advance Payment of Premium Tax Credits (APTC) now, you will not get APTC when your coverage is renewed. You will have to pay full price of your Qualified Health Plan (QHP). If you are on Medicaid/Dr. Dynasaur, we may not be able to renew you without you giving us more information. You can also give this permission at a later date if you say no now.

NO. I do not authorize use of electronic data sources to renew my eligibility at this time:

0 years - I do not authorize use of electronic data sources to renew my eligibility at this time.

IMPORTANT: You can change your mind at any time about how many years you give VHC permission to use electronic data sources to renew your eligibility by calling VHC customer support at **1-855-899-9600**. You can also call this number at any time to cancel your coverage or make changes to your household information.

STEP 6 American Indian or Alaska Native family member(s)

1. Are you, or is anyone in your family, an American Indian with a federally recognized tribe, or an Alaska Native?

NO. If no, skip to Step 7

YES. If yes, you must also fill out **Appendix B**.

STEP 7 Incarcerated (detained or jailed) family member(s)

1. Is anyone applying for health insurance on this application incarcerated?

NO. If no, skip to Step 8.

YES. If yes, tell us who: _____ Check here if this person is pending disposition of charges

**Pending disposition means that you are in jail or prison but haven't been convicted of a crime.

STEP 8

Read your rights and responsibilities before signing

How my information will be used. I understand that information obtained in this application will be used to help with my enrollment and continued eligibility in the programs I have applied for. I know that Vermont Health Connect will check my answers for all members listed in this application using information in their electronic databases and databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or a consumer reporting agency. I understand that if the information does not match, I may be asked to send proof.

Reporting changes. I know that I must tell Vermont Health Connect if anything changes or is different than what I wrote on this application. If enrolled in Medicaid, I must report changes within 10 days. If enrolled in a Qualified Health Plan with financial assistance, I must report changes within 30 days. I can visit [VermontHealthConnect.gov](https://www.vermonthealthconnect.gov) or call **1-855-899-9600** to report any changes. I understand that a change in my information could affect the eligibility for myself and the member(s) of my household.

My right to appeal. If I think Vermont Health Connect has made a mistake, I understand I can appeal its decision. I understand I can also appeal if Vermont Health Connect is late in making a decision. To appeal means to ask for a fair hearing. A fair hearing is a chance for me to tell a hearing officer at the Human Services Board why I think the decision is wrong. The hearing officer will make a new decision after looking at all the facts.

If waiting on a regular appeal might harm me, or another member of my household applying for health coverage, I can file an expedited (faster) appeal. To do so, I must tell Vermont Health Connect I need an "expedited" appeal.

I understand I must appeal within 90 days of a Vermont Health Connect decision. The notice (decision) I receive after submitting my application will tell me more about how to appeal and any deadlines. To appeal, I must call Vermont Health Connect at **1-855-899-9600**. I may also write to the Human Services Board, 120 State Street, Montpelier, VT 05620-4301.

I may be able to get free legal advice by calling the Health Care Advocate at Vermont Legal Aid at **1-800-917-7787**.

Discrimination. I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination online by visiting www.hhs.gov/ocr/office/file; by writing to Health and Human Services, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201; or by calling **1-800-368-1019** or **1-800-537-7697** (TDD).

Eligibility for Medicaid. I am giving to the Medicaid agency the right to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.

Does any child on this application have a parent living outside of the home? Yes No

If yes, I know I may be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support may harm me or my children, I can tell Medicaid and I may not have to cooperate.

Quality Control. Vermont Health Connect may select my application for a quality control review. I agree to give proof of required information. If I am not able to give the proof needed, I am authorizing Vermont Health Connect to get it.

Medicare Part B payments. If I get Medicare Part B benefits while getting Medicaid, I want Vermont Health Connect to make any payments for future Medicare Part B medical and other health services directly to physicians and medical suppliers. This means I will not have to sign a separate form each time I get a service.

Confidentiality. Information in this application is confidential and won't be shared except as needed for program administration. However, if in Appendix A, I give permission to share information about me to assist me with program enrollment, that permission covers the following kinds of information:

- Information or proofs needed to complete your application.
- The status of your application including the program(s) you are enrolled in and the effective date of enrollment.
- The reason you are not eligible for a benefit, if your application is denied or your benefits end.
- The effective date(s) of your renewal(s) and any outstanding information or verifications needed to assist your renewal.

This information will be used to help with my enrollment and continued eligibility in the programs I have applied for. I know that state and federal privacy laws protect my records. I also know:

- Why I am being asked to release this information.
- I do not have to give permission to release this information.
- Signing this permission is voluntary.
- If I do not give my permission, the information will not be released unless the law otherwise allows it.
- I may stop this permission to share information at any time with a written notice to Vermont Health Connect. I know this written notice will not affect information the agencies have already released.
- The person or agency that receives my information might pass it on to others. If so, it may no longer be protected by this permission form.
- If I do not stop this permission, it will be in effect as long as I am receiving benefits applied for in this application.
- I can be provided with a copy of this form.
- All of my questions about this permission have been answered.

STEP 9 Sign this application

You MUST sign below. Unsigned applications will not be processed and will be returned for a signature.

The person listed in Step 1 (the applicant) should sign this application. If they cannot, and you are their Authorized Representative, you may sign for them, as long as you have provided the information required in Appendix A. If signing on behalf of a minor child or an incapacitated adult, you may do so as long as you provide your personal information below as well.

Not signing the application may delay health coverage.

By signing this application, the applicant agrees to the following:

- I have read and understand my rights and responsibilities as they are described on pages ii and 11 of this application.
- I am signing this application under penalty of perjury, which means I have provided true answers to all the 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.

By signing this application on behalf of the applicant, a person other than the applicant agrees 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 him or her from providing information about his or her situation and acting responsibly in his or her 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 Vermont Health Connect 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 also provide the information requested below in case we need to reach you about the application. If you are signing as an Authorized Representative, you must fill out Appendix A.

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

Signature (applicant, or person signing on behalf of applicant)	Date (mm/dd/yyyy)
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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 woman, nursing women, and children under five. To learn more about this program, call toll free **1-800-464-4343** or visit WIC's homepage at healthvermont.gov/wic.

STEP 10 Mail the completed and signed application to:

**Vermont Health Connect
280 State Drive
Waterbury, VT 05671-8100**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average 45 minutes per application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

? **NEED HELP WITH YOUR APPLICATION?** Visit VermontHealthConnect.gov or call toll-free **1-855-899-9600**. For TTY/relay services, dial **711**.

APPENDIX A

Assistance Completing the Application

APPLICANT Information

Applicant first name, middle name, last name & suffix (Jr., Sr., III, etc.)	Applicant Social Security number _ _ _ - _ _ - _ _ _
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You can choose an AUTHORIZED REPRESENTATIVE.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an Authorized Representative. If you are a legally appointed representative for someone on the application (power of attorney, legal guardian) submit proof with this form.

1. Name of Authorized Representative (first name, middle name, last name & suffix (Jr., Sr., III, etc.))		
2. Address		3. Apartment or suite number
4. City	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 application, get official information about the application, and act for you on all future matters with this agency.		
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 application and about coverages for yourself and others on the application. 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. An Alternate Reporter can also be an Authorized Representative.

1. Name of Alternate Reporter (first name, middle name, last name & suffix (Jr., Sr., III, etc.))		
2. Address		3. Apartment or suite number
4. City	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 receive copies of notices about your coverage and the coverage for others on the application and all future matters with this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

If you want to change your Authorized Representative or Alternate Reporter, contact Vermont Health Connect at 1-855-899-9600.

APPENDIX B

American Indian or Alaska Native Family Member

APPLICANT Information

Applicant first name, middle name, last name & suffix (Jr., Sr., III, etc.)	Applicant Social Security number _ _ - _ - _
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Complete this appendix if you or if anyone in your family is American Indian with a **federally recognized tribe** or an Alaska Native. Submit this with your Application for Health Coverage and Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page before you fill it out and attach.

	PERSON 1	PERSON 2
1. First, middle, last name & suffix (Jr., Sr., III, etc.)	First Middle	First Middle
	Last	Last
2. Alaska Native?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name: _____ State where recognized: _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tribe name: _____ State where recognized: _____ <input type="checkbox"/> No
4. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Certain money received may not be counted for Medicaid/Dr. Dynasaur. List any income (amount and how often) reported on your application that includes money from these sources: <ul style="list-style-type: none"> • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance 	\$ _____ How often? _____	\$ _____ How often? _____

APPLICANT Information

Applicant first name, middle name, last name & suffix (Jr., Sr., III, etc.)	Applicant Social Security number _ _ - _ - _ _ _
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Health Coverage from Jobs

You **DO NOT** need to answer these questions unless someone in the household is eligible for health coverage from a job. Use this tool to help answer questions about any employer health coverage that you are eligible for (even if it is from another person's job, like a parent or spouse). Complete one tool for each employer that offers health coverage. Two copies of this form are provided. You can ask your employer to fill out this form. Remember, if you have your employer fill out this form, **you are still responsible for getting the information in with the application.**

EMPLOYEE Information

1. Employee first name, middle name, last name & suffix (Jr., Sr., III, etc.)	2. Employee Social Security number _ _ - _ - _ _ _
---	---

EMPLOYER Information

3. Business name		4. Employer Identification Number (EIN) _ _ - _ _ _ _ _	
5. Business address		6. Business phone number () -	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above) () -		12. Email address	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

Yes (Continue to questions 14 through 17 below.)
If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?
_____ (mm/dd/yyyy)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that covers an employee's spouse or dependent?

Yes. Which people? Spouse Dependent(s)
 No

15. Does the employer offer a health plan that meets the minimum value standard*? Yes No

16. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (do not include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 17. If you do not know, STOP and return this form to employee.

17. What change will the employer make for the new plan year (if known)?

Employer will not offer health coverage
 Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 16.)

a. How much will the employee have to pay in premiums for that plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).