YOU FIRST
Formerly Ladies First

Membership Re-Application

Mail this application to:

Vermont Department of Health, PO Box 70 Drawer 38 (YF), Burlington, VT 05402-0070

Fax this application to:

802-657-4208

For deaf and hard of hearing individuals, please use Vermont Relay Service 711 and give our number: 1-800-508-2222.
If you have questions or need interpretation services, call 1-800-508-2222.
Si vous avez des questions ou besoin de services d'interprétation, composez le 1-800-508-2222.
Ukoliko imate dodatnih pitanja ili Vam je potreban prevodilac, javite se na 1-800-508-2222.
Si usted tiene preguntas o necesita servicios de interpretación, llame al 1-800-508-2222.
Haddii aad su'aalo qabto ama aad u baahan tahay adeeg tarjumaan, wac lambarka hoos ku qoran 1-800-508-2222.
Kama una maswali au unahitaji huduma za tafsiri, piga 1-800-508-2222.
စကားပြန် ဝန်ဆောင်မှုလုပ်ငန်းကိုအလိုရှိပါက 1-800-508-2222 သို့ဖုန်းဆက်ခေါ်ပါ။
यिद तपाईंलाई दोभाषे सेवाको जरुरत परेमा, 1-800-508-2222 मा कल गनुहो

Section 1: About You

If you have questions or need help filling out this form, call 1-800-508-2222.

Name (legal name or as it appears on Social Security card):

Date of birth (mm/dd/yyyy):

Street address (required):

Mailing address (if different than above):

City **State** **Zip Code**

E-mail address:

Best phone number to reach you at: ☐ Home ☐ Work ☐ Cell

(_____) _____ - _____ **Is it ok to leave a message?** ☐ Yes ☐ No

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Section 2: Income

Please fill this out even if you have given us this information in the past. This must be filled out in order for you to receive services. If you have questions about how to answer, please call 1-800-508-2222.

Total household income before taxes (including benefits):	$	per year / per month / per week (circle one)

Total number of people who live on this income:

(Include yourself, spouse/partner, and children who are claimed on tax return.)

Section 3: Health Insurance

Do you have health insurance?

- ☐ I do NOT have health insurance at this time. → **Please go to Section 4**
- ☐ I have health insurance. **Please tell us about your insurance below.** Most of the information is on your insurance card.

Please note, if you have Medicare Part B you are not eligible for You First.

If you have insurance (NOT including Medicare Part B), please fill out below:

Name of insurance company:	Coverage dates or Effective dates: Start Date_____ End Date _____ (leave blank if no end date)	
Policy holder's name or subscriber:	Policy or ID number:	
Group or account number:	How much is your deductible? $	What is your co-pay? $

Section 4: Health History

Do you have any changes in your breasts that you are concerned about?	☐ Yes: _____	☐ No
Have you been told that you need treatment for breast or cervical cancer?	☐ Yes	☐ No
Have you been told you have anything that increases the chance of developing into cancer?	☐ Yes	☐ No