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State/Territory Name: Vermont

State Plan Amendment (SPA) #: 15-0006

This file contains the following documents in the order listed:

1) Approval Letter

2) Additional Companion Letter

3) CMS 179 Form/Summary Form (with 179-like data)

4) Approved SPA Pages

5) Additional Supporting Documentation

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
John F. Kennedy Federal Building
Boston, Massachusetts 02203

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Boston Regional Operations Group

August 8, 2019

VIA E-MAIL
Cory Gustafson, Commissioner
Department of Vermont Health Access
280 State Drive
Waterbury, VT 05671

Dear Mr. Gustafson:

We are pleased to enclose via email a copy of approved State plan amendment (SPA) No. 15-0006 submitted to my office on December 30, 2015 and approved on August 8, 2019. This SPA is effective November 1, 2015 as requested by the state.

This SPA transmitted a proposed amendment to Vermont's approved Title XIX State plan to incorporate the alternative single streamlined paper and online applications developed by the state. Enclosed is a companion letter being sent as a companion to our approval of this SPA.

If you have questions concerning this letter, please contact Robert Cruz. He can be reached at (781) 335-3455 or at robert.cruz@cms.hhs.gov.

Sincerely,

/s/

Francis T. McCullough, Director
Division of Medicaid Field Operations East (Boston)

cc: Dylan Frazer, VT Medicaid Policy Unit

DEPARTMENT OF HEALTH & HUMAN SERVICES
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August 8, 2019

VIA E-MAIL
Cory Gustafson, Commissioner
Department of Vermont Health Access
280 State Drive
Waterbury, VT 05671

RE: Vermont Application SPA 15-0006

Dear Mr. Gustafson:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) VT 15-0006, which was submitted to CMS on December 30, 2015. Approval of SPA 15-0006 included approval of the alternative single streamlined paper and online applications developed by the state.

Vermont's approved alternative single streamlined paper application includes a supplement to allow individuals to apply for coverage of long term services and supports (LTSS) that the state will not implement until December 31, 2020. Until December 31, 2021, Vermont will use an interim alternative single streamlined online application. The state will revise the alternative single streamlined online application as described below.

Alternative Single Streamlined Online Application	
Necessary changes:	**Date by which changes will be completed:**
Only applicants who do not appear eligible for Medicaid and CHIP based on income attestation will be asked information about access to employer–sponsored coverage.	December 31, 2021
All applicants will be able to complete and submit the online application for health only without entering information into the citizenship and immigration document detail fields. By June 30, 2020, the state will implement as a mitigation instructional text to direct applicants who do not have necessary information from immigration-related documents to complete the mandatory fields to enter details from available documentation in the "Other document type" fields.	December 31, 2021

The following question will not appear on the online application for health only: • "Is NAME lawfully present in the United States?" This question is not necessary to determine eligibility, as the state collects the necessary information in the question "Do you have eligible immigration status?" on the application. By June 30, 2020, the state will implement as a mitigation updates to the application to remove the "No" response option and allow applicants to continue the application without responding "Yes."	December 31, 2021
The state will remove the "No" response option and allow all applicants to complete and submit the online application without responding "Yes" to the following question: • "Do you have eligible immigration status?"	December 31, 2021
The following question will not appear on the online application for health only: • "When did NAME get legal status in the United States?" The state will utilize system logic to determine immigration status grant date.	December 31, 2021

Please submit the revised alternative single streamlined paper application to CMS for review no later than December 1, 2020 to ensure approval by December 31, 2020. Please submit the revised alternative single streamlined online application to CMS for review no later than December 1, 2021 to ensure approval by December 31, 2021. We continue to be available to provide technical assistance. If you have any questions about this letter, please contact Robert Cruz. He can be reached at (781) 335-3455 or at robert.cruz@cms.hhs.gov.

Sincerely,

/s/

Francis T. McCullough, Director
Division of Medicaid Field Operations East (Boston)

cc: Dylan Frazer, VT Medicaid Policy Unit

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Vermont**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

VT-15-0006

Proposed Effective Date

11/01/2015 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR Sec 430.12(c)(1)(ii)

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$0.00
Second Year	2017	$0.00

Subject of Amendment

VT Eligibility Process; Online and paper application updates; SPA 15-0006

Governor's Office Review

- (●) **Governor's office reported no comment**
- ( ) **Comments of Governor's office received**
  Describe:
- ( ) **No reply received within 45 days of submittal**
- ( ) **Other, as specified**
  Describe:

Signature of State Agency Official

Submitted By: **Dylan Frazer**

Last Revision Date: **Aug 6, 2019**

Submit Date: **Dec 30, 2015**

Plan Approved - One Copy Attached

Date Received: 12/30/15

Date Approved: 8/8/19

Effective date of Approved Material: 11/1/15

Signature of Regional Official

/s/

Typed Name: Frances T. McCullough

Title: Director, Division of Medicaid Field Operations East (Boston)

Medicaid Eligibility

State Name: Vermont

OMB Control Number: 0938-1148

Transmittal Number: VT - 15 - 0006

Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process	S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

○ Yes ◉ No

Medicaid Eligibility

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

V.20140415

VERMONT HEALTH CONNECT
Find the plan that's right for you.

Application for Health Coverage and Help Paying Costs

205IFA
12/2017

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.

Coverages you may qualify for

- 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)

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.

Who can use this application?

- 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.

DO NOT use this application for...

- **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**.

What you may need to apply

- 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

Why do we ask for this information?

We ask about income and other information to determine what coverage you qualify for and if you can get any help paying for it.

We will keep all the information you provide private and secure, as required by law.

What happens next?

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**.

Get help with this application

- **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**.

Interpretation services are available

إذا آنت ترغب خدمات الترجمة الفورية اتصل برقم 1-855-899-9600 (Arabic)
Ako su Vam potrebne usluge tumačenja, pozovite 1-855-899-9600. (Bosnian)
စကားပြန် ဝန်ဆောင်မှုလုပ်ငန်းကိုအလိုရှိပါက 1-855-899-9600 သို့ဖုန်းဆက်ခေါ်ပါ။ (Burmese)
Si vous avez besoin de services d'interprétation, appelez le 1-855-899-9600. (French)
Mugihe woba ushaka impfashanyo yo gusigurirwa, hamagara uyu murongo 1-855-899-9600. (Kirundi)
यदि तपाईलाई दोभाषे सेवाको जरुरत परेमा, 1-855-899-9600 मा कल गनुर्होस्। (Nepali)
Haddii aad u baahan tahay adeegyo turjumaan, wac 1-855-899-9600. (Somali)
Si usted necesita servicios de interpretación, llame al 1-855-899-9600. (Spanish)
Ikiwa unahitaji huduma za ukalimani, piga simu 1-855-899-9600. (Swahili)
Nếu quý vị cần dịch vụ thông ngôn, hãy gọi 1-855-899-9600. (Vietnamese)

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

205IFA - 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**. 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 _____
b. Document expiration date _____ ☐ None
c. Alien number _____
d. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
e. Date of entry _____
f. Passport or document number _____ ☐ None
g Country of origin _____
h. Category code _____
i. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

14. **Retroactive Medicaid:** If you have medical/dental expenses from the last 3 months and your income is within the guidelines, you might be eligible for assistance that could help pay for those expenses.
Do you want help paying for medical/dental expenses from the last 3 months? ☐ Yes ☐ No
IF Yes, was your income in the last 3 months different than what you reported on this application? ☐ 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 _____

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).

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

34. **DEDUCTIONS:** List the deductions that you are able to claim from the front page of your **1040 federal income tax return.**
Check all that apply, and give the amount and how often you pay it. Telling us about them could lower the cost of health coverage.
NOTE: You should not include a cost that you already deducted from your answer to the self-employment net income in question (32.b.).

☐ Alimony paid **$** _____ How often? _____
☐ Student loan **interest** **$** _____ How often? _____
☐ 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.

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 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 ☐ Male ☐ Female

6. Marital status: ☐ Never married ☐ Married ☐ Civil union ☐ Separated ☐ Divorced/dissolved ☐ 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? ☐ Yes ☐ 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.)*

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ 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.) ☐ Yes ☐ 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.) ☐ Yes ☐ No

If yes, name of the tax filer: _____ How is PERSON 2 related to the tax filer? _____

10. Is PERSON 2 pregnant? ☐ Yes ☐ 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?**

☐ **YES. If yes,** answer all the questions below.

☐ **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.)? ☐ Yes ☐ No

b. Does PERSON 2 live in a medical facility or nursing home? ☐ Yes ☐ No

13. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

14. **If PERSON 2 is not a U.S. citizen or U.S. national,** do they have eligible immigration status?

☐ **YES**. Fill in their document information below.

a. Immigration document type _____

b. Document expiration date _____ ☐ None

c. Alien number _____

d. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No

e. Date of entry _____

f. Passport or document number _____ ☐ None

g. Country of origin _____

h. Category code _____

i. Is PERSON 2, or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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? ☐ Yes ☐ 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? ☐ Yes ☐ No

17. Is PERSON 2 a full-time student? ☐ Yes ☐ No a. **If yes,** give the state of their legal residence: _____

18. Was PERSON 2 in foster care in Vermont when they turned 18? ☐ Yes ☐ No

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

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

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

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

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

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) **$** _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ 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) **$** _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ 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).

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

35. **DEDUCTIONS:** List the deductions that PERSON 2 is able to claim from the front page of their **1040 federal income tax return.**
Check all that apply, and give the amount and how often PERSON 2 pays it. Telling us about them could lower the cost of health coverage.
NOTE: You should not include a cost that you already deducted from PERSON 2's self-employment net income in question (33.b.).

☐ Alimony paid **$** _____ How often? _____
☐ Student loan **interest** **$** _____ How often? _____
☐ 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.

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 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 ☐ Male ☐ Female

6. Marital status: ☐ Never married ☐ Married ☐ Civil union ☐ Separated ☐ Divorced/dissolved ☐ 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? ☐ Yes ☐ 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.)*

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will PERSON 3 file jointly with a spouse? ☐ Yes ☐ 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.) ☐ Yes ☐ 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.) ☐ Yes ☐ No

If yes, name of the tax filer: _____ How is PERSON 3 related to the tax filer? _____

10. Is PERSON 3 pregnant? ☐ Yes ☐ 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?

☐ **YES. If yes,** answer all the questions below. ☐ **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.)? ☐ Yes ☐ No

b. Does PERSON 3 live in a medical facility or nursing home? ☐ Yes ☐ No

13. Is PERSON 3 a U.S. citizen or U.S. national? ☐ Yes ☐ No

14. **If PERSON 3 is not a U.S. citizen or U.S. national,** do they have eligible immigration status?

☐ **YES**. Fill in their document information below.

a. Immigration document type _____

b. Document expiration date _____ ☐ None

c. Alien number _____

d. Has PERSON 3 lived in the U.S. since 1996? ☐ Yes ☐ No

e. Date of entry _____

f. Passport or document number _____ ☐ None

g Country of origin _____

h. Category code _____

i. Is PERSON 3, or their spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

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? ☐ Yes ☐ 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? ☐ Yes ☐ No

17. Is PERSON 3 a full-time student? ☐ Yes ☐ No a. **If yes,** give the state of their legal residence: _____

18. Was PERSON 3 in foster care in Vermont when they turned 18? ☐ Yes ☐ No

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

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

20. Race (OPTIONAL—check all that apply.)

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

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

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) **$** _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ 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) **$** _____ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ 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).

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

35. **DEDUCTIONS:** List the deductions that PERSON 3 is able to claim from the front page of their **1040 federal income tax return.**
Check all that apply, and give the amount and how often PERSON 3 pays it. Telling us about them could lower the cost of health coverage.
NOTE: You should not include a cost that you already deducted from PERSON 3's self-employment net income in question (33.b.).

☐ Alimony paid **$** _____ How often? _____
☐ Student loan **interest** **$** _____ How often? _____
☐ 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.**

- ☐ Medicaid/Dr. Dynasaur _____
- ☐ Federal Employee Program _____
- ☐ Peace Corps _____
- ☐ Employee insurance. If you have employee insurance, answer question 4.
- ☐ TRICARE (Do not check off if you have direct care or Line of Duty) _____
- ☐ VA health care programs _____
- ☐ Other insurance. If you have an insurance type not listed here, or in question 2, 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 Start date: _____ Premium $ _____	Part B Start date: _____ Premium $ _____	Part A Start date: _____ Premium $ _____	Part B Start date: _____ 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: ☐ Prescriptions ☐ Dental ☐ Outpatient ☐ Vision ☐ Doctors/hospitals ☐ 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 eligiblity 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 Other Medicaid Programs

There are other Medicaid programs available through the State of Vermont, including for people who are age 65 or older, blind or disabled. They provide health care coverage and help pay for health care costs. These programs have different requirements to qualify.

Would you or anyone in your household like to apply for these other Medicaid programs? ☐ Yes

(If you check YES, we will send you an application to apply. If you qualify for more than one Medicaid program, we can help you choose which one best meets your needs.)

STEP 9 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** 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)

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 Redstone Building, 26*

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.

VERMONT HEALTH CONNECT
Find the plan that's right for you.

APPENDIX A

Assistance Completing the Application

APPLICANT Information

Applicant first name, middle name, last name & suffix (Jr., Sr., III, etc.)	Applicant Social Security number __ __ __ - __ __ - __ __ __ __

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.

VERMONT HEALTH CONNECT
Find the plan that's right for you.

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
	__ __ __ - __ __ - __ __ __ __

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 Last	First Middle Last
2. Alaska Native?	☐ Yes ☐ No	☐ Yes ☐ No
3. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name: _____ State where recognized: _____ ☐ No	☐ Yes **If yes**, tribe name: _____ State where recognized: _____ ☐ 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?	☐ Yes ☐ 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? ☐ Yes ☐ No	☐ Yes ☐ 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? ☐ Yes ☐ 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: • 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?_____

VERMONT HEALTH CONNECT
Find the plan that's right for you.

APPENDIX C
Employer Coverage Tool

APPLICANT Information

Applicant first name, middle name, last name & suffix (Jr., Sr., III, etc.)	Applicant Social Security number __ __ __ - __ __ - __ __ __ __

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).

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Application for Health Coverage and Help Paying Costs

205ALLMED
05/2019

One application, five sections

- **Main Application**
- **Supplement:** For Aged, Blind, Disabled, & Long-Term Care
- **Appendix A:** Tell Us Who is Helping You With This Application
- **Appendix B:** American Indian or Alaska Native Family Member
- **Appendix C:** Tell Us About Health Coverage From Jobs

Contact us

ONLINE: dvha.vermont.gov/apply

PHONE: Call Customer Service at **1-855-899-9600**

IN PERSON: There is someone who can help in your area. info.healthconnect.vermont.gov/information/community_partners/assisters

TTY/RELAY: If you are deaf, hard of hearing, or have a speech disability, dial 711.

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

See what coverage you qualify for

- **Affordable private health insurance plans that offer comprehensive coverage**.
- **A tax credit that can immediately lower your premiums for health coverage**.
- **Medicaid for Children and Adults** (this includes Dr. Dynasaur).
- **Medicaid for the Aged, Blind and Disabled, Pharmacy Programs (VPharm and Healthy Vermonters), Medicare Savings Programs, Disabled Children's Home Care (Katie Beckett),** and **Medicaid coverage of Long-Term Care Services and Support** (for these programs, you will also need to complete the Supplement beginning on page 12).

Other ways to apply

Apply faster online or by phone. Visit dvha.vermont.gov/apply or call Customer Service.

DO NOT use this application for

- **Reporting changes.** To report changes to your information, call Customer Service or mail your changes to the address above.
- **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 Customer Service.
- **Pharmacy programs (VPharm and Healthy Vermonters)** and/or **Medicare Savings programs ONLY.** There is a shorter application you should use if you are only applying for these programs. Call Customer Service and ask for the 201P application.

Be sure to have

- **Social Security numbers** (or document numbers for eligible immigrants who need insurance).
- **Employer and income information for everyone in your family** (pay stubs, W-2 forms or wage and tax statements).
- **Policy numbers for any health insurance you or others on this application currently have**.

Why do we need this information

We ask about income and other information to determine what coverage you qualify for and if you can get any help paying for it. Income of some household members may count even if they are not applying. **We will keep all the information you provide private and secure, as required by law**.

What happens next

Send your completed and signed application to the mailing address above. You may need to make a payment before coverage begins. **If you do not have all the information we ask for, sign and submit your application anyway.** We will follow up with you about next steps.

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)

You may keep this page for future reference.

Your Rights and Responsibilities

These rights and responsibilities apply to everyone who is applying.
If you need a large print copy of this, please call Customer Service.

What to do if You Don't Speak or Read English.
We will provide free language services to you. This means:

- Interpreters on the phone
- Notices, applications, and other information written in your language

If you need this, call Customer Service. If you don't get the language services you need, you can file a discrimination complaint to get them. To find out how, see the **What to do if You Think You Are Being Discriminated Against** section on this page.

Right to Timely Decision on Application. In most cases, we must make a decision on your application within 45 days (or 90 days if you are applying for Medicaid based on a disability decision). It may take longer if you cause a delay. If you don't get a timely decision, you may call Customer Service for more information or to file an appeal.

Right to Appeal. *What if I think my eligibility decision is wrong or late?* You have the right to appeal. This means you are asking for a State fair hearing. Please look at your eligibility notice to find out more about your right to appeal. You must appeal within 90 days of the date of your eligibility notice.

In most cases, we must send you a final decision on your appeal within 90 days from when you appeal. If waiting on a regular State fair hearing might harm you, you can ask for an expedited (faster) appeal and we may decide your appeal sooner. We decide most expedited appeals in 7 working days. We may take longer if the appeal is about (1) Medicaid for the Aged, Blind and Disabled (MABD), or (2) Long-Term Care Medicaid. To appeal, call Customer Service. You may also write to the Human Services Board, 120 State Street, Montpelier, VT 05620-4301.

Can someone speak for me at my fair hearing? Yes. You should attend the hearing but you may have someone else, like a friend, relative, or lawyer, speak for you. You may be able to get free legal assistance by contacting the Health Care Advocate at Vermont Legal Aid at **1-800-917-7787** or https://vtlawhelp.org/health.

Rights of People with Disabilities. If you have a physical, mental, or learning condition that makes it hard to do things we ask you to do, we can make changes to help you. The Americans with Disabilities Act (ADA) and Vermont law say that we may have to make changes (called reasonable accommodations) to our requirements so people with disabilities can get health benefits. Here are examples of changes we can make:

- Someone can write down your answers if you can't
- We can give you more time or help you get the documents you need to give us
- We can send documents with a larger print

If you need changes so you can get health benefits, call Customer Service.

Information About Non-citizens. Lawfully present individuals can apply for benefits. If your household contains people who are not eligible because of their immigration status, you can still apply for the members who are eligible. You do not have to provide immigration information for people who are not applying for health benefits, but you do need to include other information, such as their income and resources, if they are in your household.

We will verify, with the U.S. Citizenship and Immigration Services, the immigration status of all non-citizens who apply for health benefits.

If you have concerns about how getting health benefits may impact your immigration status, you can contact Vermont Legal Aid at **1-800-917-7787** or https://vtlawhelp.org/health before you apply.

What to do if You Think You Are Being Discriminated Against. We may not discriminate against you on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. It may be discrimination if we fail to give you language or disability related services you need.

If you think that we have discriminated against you, you can call Customer Service. You can also file a complaint with:

- Department of Vermont Health Access:
  Health Program Civil Rights Coordinator
  Phone: **(802) 241-0454**
  E-mail: AHS.DVHALegal@vermont.gov
  Online: https://info.healthconnect.vermont.gov/Non-Discrimination
- Federal government: U.S. Department of Health and Human Services, **1-800-868-1019**, **800-537-7697** (TDD)
  Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Right to Confidentiality. Information about your application and health benefits is confidential and protected by state and federal law. We will not share any information about you unless it is directly connected to program administration, allowed by law or a court order, or we have your permission.

How We Use Your Information (Including Social Security Numbers). We will use your information to determine eligibility, help pay for care, and for other lawful purposes. This may include: to verify income and other eligibility information, determine benefits, collect claims, conduct audits, investigate fraud, pay medical assistance, to assess accuracy of information you give us, and to conduct medical support enforcement. We may contact public and private agencies, including the Social Security Administration, financial institutions (Asset Verification), consumer reporting agencies, Department of Labor, Department of Homeland Security, and the Internal Revenue Service (IRS). If the information does not match, we may ask you to send proof to us.

Everyone applying who has a Social Security Number (SSN) must provide it to qualify for health benefits. If someone does not want health care coverage, they do not have to give us their SSN. Some people who don't have an SSN, including people with a religious objection to having one, don't have to get one to apply for health benefits. Call Customer Service to find out more.

Duty to Report Changes. Some of the changes you must report are changes to: income, health insurance, household members, your address, marriage/divorce, pregnancy, and if you move out of state or get Medicaid in another state. Call Customer Service to report changes.

For Medicaid, you must report changes within 10 days. If you enroll in a health insurance plan through us, you must report changes in 30 days. A change in your information could affect your eligibility and that of the member(s) in your household.

If you get Medicaid for the Aged, Blind and Disabled (MABD) or Long-Term Care Medicaid on the basis of MABD, you must also report changes to your resources (assets). See the next page for more information about this.

Fraud Penalties. You or any member of your household will be subject to prosecution for fraud or another criminal offense for knowingly giving false, incorrect, incomplete, or misleading information in order to get, try to get, or help someone else get health care benefits that you or they are not entitled to.

If convicted, penalties may include up to three years of imprisonment and/or a fine of up to $1,000, or an amount equal to the benefit wrongfully received. Other federal or state penalties may also apply. (42 U.S.C. §1320a-7b; 33 V.S.A. §§141, 143)

Agreement Regarding Medicare Part B Payments. You agree that if you get Medicaid that we will make any payments for future Medicare Part B medical and other health services directly to physicians and medical suppliers. This means you will not have to sign a separate form each time you get a service.

Agreement to Release Medical Records. You agree that your health care providers and Department of Vermont Health Access (DVHA) and its contractors and grantees may access, use, and disclose your medical records to: (1) manage state health care programs, or (2) when a hospital, health care provider, mental health provider, or pharmacy needs your medical records. This includes provider and prescription information for your treatment, for payment of your treatment, and for health care operations.

You agree that your consent includes the re-disclosure of prescription medication information received from a drug or alcohol treatment program when such information is needed for purposes of treatment.

You understand that your consent to the use of your medical records remains in place until your eligibility is reviewed. You can revoke your consent to the release of your medical records by putting your revocation in writing and mailing it to: DVHA Deputy Commissioner, NOB1 South, 280 State Drive, Waterbury, VT 05671-1010.

Agreement to Let us Pursue Money and Medical Support from Third Parties if You Get Medicaid. You give us the right to pursue and get any money from other health insurance, legal settlements, or other third parties for your health care costs if you get Medicaid. This applies to you and anyone in your household who gets Medicaid.

You also agree to enroll in a group health plan if the state requires it, and you understand the state may pay the premiums.

You are also giving us the right to pursue and get medical support from a spouse or parent, including a parent living outside of your home. If you think that cooperating to collect medical support may harm you or your children, call Customer Service. You may not have to cooperate.

Consent to Bill Medicaid if Child Receives Special Education. If a child in your household gets Medicaid and Special Education, you give permission to your child's school district to bill Medicaid for the services listed in his/her Individual Education Plan (IEP). You understand that if you refuse consent, your refusal only affects Medicaid billing for IEP services; the school district must still provide IEP services at no cost to you. You may revoke this consent at any time. If you revoke this consent, it will apply to billing for services from that date forward. To revoke your consent, write to: DVHA, Application & Document Processing Center, 280 State Drive, Waterbury, VT 05671-8100.

Are You Using the Supplement to Apply for Medicaid for the Aged, Blind and Disabled (MABD) or Long-Term Care Medicaid? If Yes, You Have These Additional Rights and Responsibilities.

Authorization to Verify Resources for Medicaid for the Aged, Blind and Disabled (MABD) and Long-Term Care under MABD. You understand that Medicaid for the Aged, Blind and Disabled (MABD) and Medicaid coverage of Long-Term Care Services and Supports under MABD have 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 these programs. 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.

Explanation of Recovery of Medicaid Payments for Long-Term Care Services and Supports. You understand that Department of Vermont Health Access (DVHA) must file a claim against your estate when you die to recover the following: 1) Medicaid payments for Long-Term Care Services and Supports you received at age 55 or older while in a nursing facility or a home and community based program; and 2) for related hospital and prescription drug services. You understand that you may find out more about recovery by calling your Long-Term Care worker.

Duty to Report Changes About Resources (Assets). You understand that in addition to reporting changes described in the **Duty to Report Changes** section on page ii, that you must report changes to your resources if you get Medicaid for the Aged, Blind and Disabled (MABD) or Long-Term Care Medicaid on the basis of 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
- if you or your spouse or civil union partner sells, trades, gives away, or adds other names to the ownership of real property or other assets such as bank accounts, stocks, and bonds.

To report a change, call Customer Service or write or send a change report form (Form 200) to: DVHA, Application & Document Processing Center, 280 State Drive, Waterbury, VT 05671-1500.

Application for Health Coverage and Help Paying Costs

205ALLMED
05/2019

STEP 1 Tell Us About Yourself

The person listed here will be the contact person for your application.

1. First name, middle name, last name & suffix (Jr., Sr., III, etc.)	**2.** Social Security number (SSN). **Optional, if you are not applying for health coverage you are not required to provide your SSN.** ___ ___ ___ – ___ ___ – ___ ___ ___ ___

3. Physical address (this cannot be a P.O. Box)		**4.** Apartment or suite number	
5. City/Town	**6.** State	**7.** ZIP code	**8.** County
9. Mailing address line 1 (if different from physical address)		**10.** Apartment or suite number	

11. Mailing address line 2 (If applicable, include an "in-care-of" person here. **If that person is an Authorized Representative, also complete Appendix A on page 19.**)

12. City/Town	**13.** State	**14.** ZIP code	**15.** County
16. Home phone number ( ) –	**17.** Work phone number ( ) –	**18.** Cell phone number ( ) –	

19. What is your preferred spoken or written language (if not English)?

STEP 1 is complete. Continue to STEP 2 below.

STEP 2 Who to Include

Complete the STEP 2 pages for every person in your family and household, even if the person has health coverage already. Start with yourself, then add other adults and children. The information in this application helps us make sure everyone gets the best coverage they can. The amount of help or type of program you qualify for is based on the number of people in your family and their incomes. If you don't include someone, even if they already have health coverage, your eligibility results could be affected.

	INCLUDE these people even if they aren't applying for health coverage themselves
For ADULTS who need coverage	• Any spouse, including a civil union partner. *If you are a party to a civil union, include your civil union partner in this application and be sure to check the "civil union" box at question 6. A partner in a civil union is considered a spouse for purposes of Vermont's Medicaid programs.* • Any son or daughter under age 21 they live with, including stepchildren. • Any other person on the same federal income tax return, including any children over age 21 who are claimed on a parent's tax return. *You do not need to file taxes to get health coverage.*
For CHILDREN (under age 21) who need coverage	• Any parent (or stepparent) they live with. • Any sibling they live with. • Any son or daughter they live with, including stepchildren. • Any other person on the same federal income tax return. *You do not need to file taxes to get health coverage.*

You do not need to provide immigration status or a Social Security number (SSN) for family members who don't need health coverage. We will keep all the information you provide private and secure, as required by law. We use personal information only to check if you're eligible for health coverage.

STEP 2 Person 1: Start With Yourself

Complete STEP 2 for yourself, your spouse, children who live with you, and/or anyone included on your federal income tax return. See page 1 for more information about who to include. If you do not file a tax return, you must still include 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
If you are a victim of domestic violence and applying separately from your spouse, you may indicate that you are "Never married".
☐ Never married ☐ Married ☐ Civil union
☐ Separated ☐ Divorced/dissolved ☐ Widowed

7. Social Security number (SSN)
___ ___ ___ — ___ ___ — ___ ___ ___ ___

We need this if you want health coverage and have a 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 a SSN, call **1-800-772-1213** or visit socialsecurity.gov. TTY users call **1-800-325-0778**.

8. Do you plan to file a federal income tax return next year? *(You can still apply for health coverage even if you do not file a federal income tax return.)*
☐ Yes. **Answer questions a – c.** ☐ No. **Continue to question c.**

a. Will you file jointly with a spouse? ☐ Yes. **Name of spouse:** _____ ☐ No

b. Will you list any dependents on your tax return? *(Joint filers must list the same dependents.)* ☐ Yes. **If yes, name(s) of dependents:** _____ ☐ No

c. Will you be listed as a dependent on someone else's tax return? *(You cannot be both a dependent and a joint filer.)* ☐ Yes. **Name of the tax filer:** _____ ☐ No

How are you related to the tax filer? _____

9. Are you pregnant? ☐ Yes ☐ No

If yes, how many babies are expected? _____ **Estimated due date (mm/dd/yyyy)?** _____

10. Are you applying for health coverage? *(Even if you have insurance, there might be a program with better coverage or lower costs.)*
☐ Yes. **Continue to question 11.**
☐ No. **Continue to Current Job & Income Information on page 3.**

11. a. Do you have a physical, mental, learning, or emotional health condition that causes you to regularly need help with some or all of your self-care activities (like bathing, dressing, eating, reading, daily chores, etc.)? ☐ Yes ☐ No

b. Are you in, or have you moved to, a medical facility or nursing home in the past 30 days, or do you need assistance and/or support to live in a home and community-based setting? ☐ Yes ☐ No

If you answered 'yes' *to either of the above questions, or if you qualify for Medicare, review the information at the beginning of* **the Supplement (on page 12)**. *If you want us to see if you qualify for health coverage for individuals who are aged 65 or older, and/or blind or disabled, or for Medicaid coverage of Long-Term Care Services and Supports,* **complete the Supplement** *after you complete the main application. For now,* **continue to question 12**.

12. Are you a U.S. citizen or U.S. national?
☐ Yes. **Continue to question 13.** ☐ No. **Continue to question 14.**

13. Are you a naturalized or derived citizen? *(This usually means you were born outside of the U.S.)*
☐ Yes. **Complete a and b then continue to question 15.**
☐ No. **Continue to question 15.**

a. Alien/USCIS number: _____

b. Certificate number: _____

14. 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.**
Visit dvha.vermont.gov/apply for information about eligible immigration status.

a. Immigration document type: _____

b. Document expiration date (mm/dd/yyyy): _____ ☐ None

c. Alien/USCIS number: _____

d. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

e. Date of entry (mm/dd/yyyy): _____

f. Passport or document number: _____ ☐ None

g. Country of origin: _____

h. Category code: _____

i. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

j. SEVIS ID: _____

15. Retroactive Medicaid: If you have medical/dental expenses from the last 3 months, 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

16. 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

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

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

19. To which racial group(s) do you most identify? (Optional–check all that apply)

☐ White
☐ Black or African American
☐ Hispanic, Latino, or Spanish Origin
☐ American Indian or Alaska Native
Fill out Appendix B: American Indian or Alaska Native Family Member on page 20.
☐ Asian
☐ Middle Eastern or North African
☐ Native Hawaiian or other Pacific Islander
☐ Other: _____

20. If Hispanic/Latino: To what ethnic group(s) do you most identify? (Optional–check all that apply) ☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other: _____

Current Job & Income Information

☐ EMPLOYED
If you are currently employed, tell us about your income. Start with question 21.

☐ SELF-EMPLOYED
Continue to question 32.

☐ NOT EMPLOYED
Continue to question 33.

Current Job 1

21. Employer (or Company) name

22. Employer (or Company) phone number
( ) –

23. Employer (or Company) address

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

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

If you only have one job, continue to question 31.

Current Job 2

If you need more space, attach a separate page. Be sure to write PERSON 1's name and date of birth at the top.

26. Employer (or Company) name

27. Employer (or Company) phone number
( ) –

28. Employer (or Company) address

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

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

Additional Job Information

31. Do any of these jobs offer health insurance coverage? ☐ Yes. **Complete Appendix C on page 21.** ☐ No

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

a. What type of work do you do? _____

b. How much net income (the amount left over after business expenses are paid) will you get this month? $ _____

33. In the past year, did you: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None

Other Income This Month

34. 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, workers' compensation, veteran's payments, or Supplemental Security Income (SSI).*

☐ None

☐ Alimony received $ _____ How often? _____ Was the agreement signed after 2018? ☐ Yes ☐ No

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Social Security (disability, retirement, and survivor/widow benefit before Medicare or any other deductions)

$ _____ How often? _____

☐ Unemployment $ _____ How often? _____ What state pays your unemployment benefits? _____

☐ Other income $ _____ How often? _____ Type(s): _____

Deductions

35. List any of the deductions you're able to claim from the 'Adjustments to Income' section of schedule 1 of your **1040 federal income tax return**. Please do not include any itemized deductions from schedule A.

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

☐ None

☐ Alimony paid $ _____ How often? _____ Was the agreement signed after 2018? ☐ Yes ☐ No

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____ Type(s): _____

Yearly Income

36. Complete **ONLY** if your income changes during the year, for example, if you only work a job for part of the year or receive a benefit only some months.

Your total income **THIS** year

$ _____

Your total income **NEXT** year (if you think it will be different)

$ _____

Person 1 is complete.

Continue with STEP 2 on next page if you have additional household members to report.
If not, continue ahead to STEP 3 on page 8.

STEP 2 Person 2

Continue filling out STEP 2 for your spouse, children who live with you, and/or anyone on your same federal income tax return. If you have more than two people in your family, please make a copy of pages 5, 6 & 7 (before filling those pages out) or visit dvha.vermont.gov/apply to print out additional forms and attach them to the application. If you do not file a tax return, you must still include family members who live with you. See page 1 for more information about who to include.

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, including a maiden name or alias

4. Date of birth (mm/dd/yyyy) / /

5. Sex ☐ Male ☐ Female

6. Marital status

If PERSON 2 is a victim of domestic violence and applying separately from their spouse, they may indicate that they were "Never married".

☐ Never married ☐ Married ☐ Civil union
☐ Separated ☐ Divorced/dissolved ☐ Widowed

7. Social Security number (SSN)

__ __ __ — __ __ — __ __ __ __

This is needed if PERSON 2 wants coverage and has a SSN.

8. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

If no, address for PERSON 2: _____

9. Does PERSON 2 plan to file a federal income tax return next year? *(PERSON 2 can still apply for health coverage even if they do not file a federal income tax return.)*

☐ Yes. **Answer questions a – c.** ☐ No. **Continue to question c.**

a. Will PERSON 2 file jointly with a spouse? ☐ Yes. **Name of spouse:** _____ ☐ No

b. Will PERSON 2 list any dependents on their tax return? *(Joint filers must list the same dependents.)* ☐ Yes. **If yes, name(s) of dependents:** _____ ☐ No

c. Will PERSON 2 be listed as a dependent on someone else's tax return? *(PERSON 2 cannot be both a dependent and a joint filer.)* ☐ Yes. **Name of the tax filer:** _____ ☐ No

How is PERSON 2 related to the tax filer? _____

10. Is PERSON 2 pregnant? ☐ Yes ☐ No

If yes, how many babies are expected? _____ **Estimated due date (mm/dd/yyyy)?** _____

11. Is PERSON 2 applying for health coverage? *(Even if PERSON 2 has insurance, there might be a program with better coverage or lower costs.)*

☐ Yes. **Continue to question 12.**
☐ No. **Continue to Current Job & Income Information on page 6.**

12. a. Does PERSON 2 have a physical, mental, learning, or emotional health condition that causes them to regularly need help with some or all of their self-care activities (like bathing, dressing, eating, reading, daily chores, etc.)? ☐ Yes ☐ No

b. Is PERSON 2 in, or have they moved to, a medical facility or nursing home in the past 30 days, or do they need assistance and/or support to live in a home and community-based setting? ☐ Yes ☐ No

If you answered 'yes' *to either of the above questions for* PERSON 2, *or if* PERSON 2 *qualifies for Medicare, review the information at the beginning of* **the Supplement (on page 12)**. *If you want us to see if* PERSON 2 *qualifies for health coverage for individuals who are aged 65 or older, and/or blind or disabled, or for Medicaid coverage of Long-Term Care Services and Supports,* **complete the Supplement** *after you complete the main application. For now,* **continue to question 13**.

13. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes. **Continue to question 14.** ☐ No. **Continue to question 15.**

14. Is PERSON 2 a naturalized or derived citizen? *(This usually means they were born outside of the U.S.)* ☐ Yes. **Complete a and b then continue to question 16.** ☐ No. **Continue to question 16.**

a. Alien/USCIS number: _____

b. Certificate number: _____

15. If PERSON 2 is not a U.S. citizen or U.S. national, do they have eligible immigration status? ☐ Yes. **Fill in their document information below.**
Visit dvha.vermont.gov/apply for information about eligible immigration status.

a. Immigration document type: _____
b. Document expiration date (mm/dd/yyyy): _____ ☐ None
c. Alien/USCIS number: _____
d. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No
e. Date of entry (mm/dd/yyyy): _____
f. Passport or document number: _____ ☐ None
g. Country of origin: _____
h. Category code: _____
i. Is PERSON 2, or their spouse or parent, a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No
j. SEVIS ID: _____

16. Retroactive Medicaid: If PERSON 2 has medical/dental expenses from the last 3 months, 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? ☐ Yes ☐ No

17. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

18. Is PERSON 2 a full-time student? ☐ Yes. **If yes, give the state of their legal residence:** _____ ☐ No

19. Was PERSON 2 in foster care in Vermont when they turned 18? ☐ Yes ☐ No

20. To which racial group(s) does PERSON 2 most identify? (Optional–check all that apply)

☐ White
☐ Black or African American
☐ Hispanic, Latino, or Spanish Origin
☐ American Indian or Alaska Native
Fill out Appendix B: American Indian or Alaska Native Family Member on page 20.
☐ Asian
☐ Middle Eastern or North African
☐ Native Hawaiian or other Pacific Islander
☐ Other: _____

21. If Hispanic/Latino: To what ethnic group does PERSON 2 most identify? (Optional–check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican
☐ Cuban ☐ Other: _____

Current Job & Income Information

☐ EMPLOYED
If PERSON 2 is currently employed, tell us about their income. Start with question 22.

☐ SELF-EMPLOYED
Continue to question 33.

☐ NOT EMPLOYED
Continue to question 34.

Current Job 1

22. Employer (or Company) name

23. Employer (or Company) phone number
( ) –

24. Employer (or Company) address

25. Wages/tips before taxes (gross income) $ _____

PER: ☐ Hour ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year

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

If PERSON 2 only has one job, continue to question 32.

Current Job 2

If you need more space, attach a separate page. Be sure to write PERSON 1's name and date of birth at the top.

27. Employer (or Company) name

28. Employer (or Company) phone number
( ) –

29. Employer (or Company) address

30. Wages/tips before taxes (gross income) $ _____

PER: ☐ Hour ☐ Week ☐ Every 2 weeks ☐ Twice a month ☐ Month ☐ Year

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

Additional Job Information

32. Do any of these jobs offer health insurance coverage? ☐ Yes. **Complete Appendix C on page 21.** ☐ No

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

a. What type of work does PERSON 2 do? _____

b. How much net income (the amount left over after business expenses are paid) will PERSON 2 get this month? $ _____

34. In the past year, did PERSON 2**:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None

Other Income This Month

35. 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, workers' compensation, veteran's payments, or Supplemental Security Income (SSI).*

☐ None

☐ Alimony received $ _____ How often? _____ Was the agreement signed after 2018? ☐ Yes ☐ No

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Social Security (disability, retirement, and survivor/widow benefit before Medicare or any other deductions)
$ _____ How often? _____

☐ Unemployment $ _____ How often? _____ What state pays your unemployment benefits? _____

☐ Other income $ _____ How often? _____ Type(s): _____

Deductions

36. List any of the deductions PERSON 2 is able to claim from the 'Adjustments to Income' section of schedule 1 of their **1040 federal income tax return**. Please do not include any itemized deductions from schedule A.

NOTE: *You should not include a cost that* PERSON 2 *already deducted from their self-employment net income in question 33b.*

☐ None

☐ Alimony paid $ _____ How often? _____ Was the agreement signed after 2018? ☐ Yes ☐ No

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____ Type(s): _____

Yearly Income

37. Complete ONLY if PERSON 2's income changes during the year, for example, if they only work a job for part of the year or receive a benefit only some months.

PERSON 2's total income **THIS** year

$ _____

PERSON 2's total income **NEXT** year (if they think it will be different)

$ _____

STEP 2 is complete. Continue to STEP 3.

If you have more than two people in your family, please make a copy of pages 5, 6 & 7 (before filling those pages out) or visit dvha.vermont.gov/apply to print out additional forms and attach them to the application.

STEP 3 Your Family's Health Coverage

1. Is anyone listed on this application offered health coverage from a job?
Answer "Yes" even if the coverage is from someone else's job, such as a parent or spouse.

☐ Yes. **Complete Appendix C on page 21.**
☐ No

2. 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, answer "No".

☐ Yes. **Check the type of coverage and write the name of the person next to the coverage they have.**
☐ No

☐ Medicaid/Dr. Dynasaur _____
☐ Federal Employee Program _____
☐ Peace Corps _____
☐ Employer insurance. If you check this box, **answer question 4**.
☐ Other insurance. If you check this box, **answer question 4**.

☐ TRICARE (Do not check off if you have direct care or Line of Duty) _____
☐ VA health care programs _____

3. Is anyone eligible for, or enrolled in, Medicare?

☐ Yes. **Please fill in the table below.** Most information can be found on the front of your Medicare card. **If you answered yes, you may want to complete the Supplement (beginning on page 12)** to find out if you qualify for health coverage for individuals who are aged 65 or older, and/or who are blind or disabled.

☐ No. **Continue to question 4.**

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

4. If you checked the box in question 2 for employer insurance, or other insurance, complete the table below. Otherwise continue to STEP 4 on page 9. Most of the information requested below can be found on the front and back of your insurance card. If you have additional health insurance coverage to report and you need more space, copy this page.

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

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

STEP 3 is complete. Continue to STEP 4.

STEP 4 Household Special Circumstances

If anyone on this application experienced certain life changes in the past 60 days, please answer the following questions. Certain life changes may give you a 60 day Special Enrollment Period (SEP) which allows you to enroll in a health insurance plan right away and you do not have to wait until the next Open Enrollment Period.

Please note there is no open enrollment period for Medicaid/Dr. Dynasaur coverage. You may apply for Medicaid/Dr. Dynasaur at any time.

These questions are optional. **If your life circumstances haven't changed, continue to STEP 5 on page 10**.

1. Did anyone in your household lose health coverage in the past 60 days, or does anyone expect to lose health coverage in the next 60 days? ☐ Yes ☐ No

   If yes, who? _____ **Last day of coverage (mm/dd/yyyy):** _____

   Why? _____

2. Did your household gain a dependent due to birth, adoption, or foster care placement in the past 60 days? ☐ Yes, due to birth ☐ Yes, due to adoption ☐ Yes, due to foster care ☐ No

   If yes, who? _____

   Date of birth, adoption, or placement (mm/dd/yyyy): _____

3. 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? _____

   Date coverage ordered to begin (mm/dd/yyyy): _____

4. Did anyone join your household through marriage in the past 60 days? ☐ Yes ☐ No

   If yes, who? _____ **Date of marriage (mm/dd/yyyy):** _____

   Had qualifying coverage in the 60 days prior to marriage? ☐ Yes ☐ No

5. Did anyone in your household move to Vermont in the past 60 days, or does anyone expect to move to Vermont in the next 60 days? ☐ Yes ☐ No

   If yes, who? _____ **Date of arrival in Vermont (mm/dd/yyyy):** _____

   Had qualifying coverage in the 60 days prior to move? ☐ Yes ☐ No

6. Did anyone in your household get released from incarceration (jail or prison) in the past 60 days, or does anyone expect to get released in the next 60 days? ☐ Yes ☐ No

   If yes, who? _____ **Date of release (mm/dd/yyyy):** _____

7. Did anyone in your household 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 (mm/dd/yyyy):** _____

8. Have there been any circumstances in the past 60 days that prevented enrollment, such as a serious medical condition or natural disaster, that you feel should qualify a household member for a SEP? ☐ Yes, **please explain below:** ☐ No

   _____

   _____

   _____

STEP 5 Future Eligibility

Eligibility must be redetermined every year to renew your coverage. We can verify household information at renewal using electronic data sources, including information from tax returns, but must have your permission to do so.

If you say YES below, we may be able to redetermine your eligibility without you having to do anything. This includes eligibility for Medicaid/Dr. Dynasaur and for help paying for a health insurance plan. You can say YES for up to 5 years.

YES. I authorize use of electronic data sources to redetermine 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 help paying for a health insurance plan, you will not get that help when your coverage is renewed. You will have to pay full price for your health insurance plan until you give us more information. If you are on Medicaid/Dr. Dynasaur, we may not be able to redetermine your eligibility without you giving us more information. If you say NO now, you can give us this permission at a later date.

NO. I do not authorize use of electronic data sources to redetermine my eligibility:

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

IMPORTANT: You can change your mind at any time about giving us permission to use electronic data sources to redetermine your eligibility by calling Customer Service. You can also call Customer Service to end coverage or make changes to your application information.

STEP 6 American Indian or Alaska Native Family Member(s)

Are you, or is anyone in your family, American Indian or Alaska Native or has anyone received services from the Indian Health Service (IHS)?

- ☐ No. **Continue to next STEP.**
- ☐ Yes. **Continue to next STEP and also fill out Appendix B on page 20.**

STEP 7 Incarcerated (Detained or Jailed) Family Member(s)

Is anyone applying for health insurance on this application incarcerated?

- ☐ No. **Continue to next STEP.**
- ☐ Yes. **Tell us who:** _____
  - ☐ Check here if this person is pending disposition of charges.
    (Pending disposition means that the person is in jail or prison but hasn't been convicted of a crime.)

STEP 8 Mail the completed and signed application

MAILING ADDRESS:

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

DON'T FORGET TO SIGN YOUR APPLICATION ON PAGE 11.

STEP 9 Sign Your Application

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

The person listed in STEP 1 should sign this application. If you are that person's Authorized Representative, you may sign for them as long as they signed Appendix A (page 19). If you are the legally-appointed representative (power of attorney, legal guardian) for the person listed in STEP 1, submit proof with this application.

By signing this application, you agree to the following:

- I have read and understand my rights and responsibilities as they are described on pages ii and iii 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.

If you are signing this application on behalf of the applicant because they are a minor child or incapacitated adult, you agree 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 them from providing information about their situation and acting responsibly on their 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 DVHA immediately if I learn of any change in the applicant's situation.

Signature (applicant, or person signing on behalf of applicant)	Date (mm/dd/yyyy)

If you are signing on behalf of the applicant because they are a minor child or incapacitated adult, please provide the information requested below in case we need to reach you about the application.

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/Town	State	ZIP code

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**.

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**.

Do any of the following apply to you or someone on your application? If so, you may not be done.

Will you fill out the Supplement for Aged, Blind, Disabled and Long-Term Care? ☐ Yes ☐ No

We can check to see if anyone in your household qualifies for other programs that may help with healthcare, medicine, and Medicare costs. If any of the following applies to anyone on the application, review the information at the **beginning of the Supplement (on page 12)**.

- A person on the application needs help with some or all of their self-care activities (bathing, dressing, eating, daily chores, etc.).
- A person on the application is in, or has moved to, a medical facility or nursing home in the past 30 days, or needs assistance and/or support to live in a home and community-based setting.
- A person qualifies for, or is enrolled in, Medicare.

Did you get help with this application?
You may need to fill out **Appendix A:** Tell Us Who is Helping You With This Application (page 19)

Is anyone an American Indian/Alaska Native?
Fill out **Appendix B:** American Indian or Alaska Native Family Member (page 20)

Do you qualify for or are you enrolled in insurance from an employer?
Fill out **Appendix C:** Tell Us About Health Coverage From Jobs (page 21)

The information in this Supplement is needed in order for us to find out if you qualify for health coverage for individuals who are aged 65 or older, and/or who are blind or disabled. This coverage includes Medicaid, pharmacy programs, and help to pay Medicare premiums and cost-sharing. This information is also needed for individuals that are looking for Medicaid coverage of Long-Term Care Services and Supports because they are in, or have been in, a medical facility or nursing home, or need help with self-care activities in the home or community. We will use the information in this Supplement, along with the information you provided in the main application, to see what you qualify for. If you are not sure if you need to complete this supplement, please call Customer Service.

If you complete STEPS 1-4 in the Supplement, you will be screened for the following programs:

Medicaid (MABD)
for individuals who are aged 65 or older, and/or who are blind or disabled.

Disabled Children's Home Care (Katie Beckett) (DCHC)
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.

VPharm (Pharmacy Program)
for all Vermonters age 65 and older or disabled. Coverage ranges from full pharmacy coverage to supplemental coverage for those on Medicare.

Healthy Vermonters Program (HVP)
for all Vermonters without pharmacy coverage. This program provides a discount on some prescriptions.

Medicare Savings Programs (MSP)
for individuals with Medicare to help pay for Medicare premiums, deductibles, and copays.

If you only want to apply for VPharm, HVP and/or MSP, you can fill out a 201P. Call Customer Service for more information.

The following programs are specifically for individuals looking for Medicaid coverage of Long-Term Care Services and Supports (Long-Term Care Medicaid). To apply for Long-Term Care Medicaid, you must complete the entire Supplement (STEPS 1-5). Each Long-Term Care Medicaid program has financial and clinical eligibility criteria. The department that administers the program will assess or verify your clinical eligibility.

The Long-Term Care Medicaid programs are as follows:

Choices for Care (CFC)
provides a package of Long-Term Care Services and Supports to Vermonters who are age 18 and over and need nursing home level of care. Eligible people choose where to receive their services: in their home, their family's home, an adult family care home, enhanced residential care or nursing home. The Department of Disabilities, Aging and Independent Living (DAIL) will contact you to complete a clinical assessment to determine your clinical eligibility.

Developmental Disabilities Home and Community Based Services (DD HCBS)
provides support to people with a developmental disability (DD) to live in their local communities. People complete a program application for DD services at their local designated agency (DA). The DA arranges for or performs the clinical assessment for eligibility. DAIL makes the final clinical eligibility determination.

Traumatic Brain Injury (TBI)
program diverts or returns people with moderate to severe traumatic brain injuries from hospitals and facilities to community-based settings. To be eligible you must be age 16 or older. DAIL will contact you to complete a clinical assessment to determine your clinical eligibility.

Enhanced Family Treatment (formerly known as the Children's Mental Health Waiver)
provides community-based services to children with emotional illness under the age of 21 who have been institutionalized or are at risk of being institutionalized. The Department of Mental Health will determine clinical eligibility.

PLEASE READ THIS BEFORE YOU FILL OUT THE SUPPLEMENT.

Spouses CAN be screened together on one Supplement. Information about your spouse must be provided in this Supplement even if your spouse is not applying for any of the above programs.

Anyone else (other than your spouse) applying needs to fill out a SEPARATE Supplement.
Please be sure to make copies of pages 13-18 prior to filling them out.

STEP 1 Information About You

1. Your Name (first, middle, last): Program applying for: ☐ LTC ☐ MABD

2. Your Spouse's Name (first, middle, last): Program applying for: ☐ LTC ☐ MABD ☐ None

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

First name	Date applied

STEP 2 Resources

If you need more space, attach a separate page. Be sure to write PERSON 1's 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				
	☐ 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					
	☐ 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

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.	$

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 Additional Income

1. Do you or your spouse get paid for taking care of children? ☐ Yes ☐ No

If you get paid for taking care of children **AND** you have already listed this income under the "Additional Job Information" section on the main application, answer "**No**" and **continue to question 2.**

If Yes:

- List income from the past 30 days before deductions.

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.) ☐ 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

3. Tell us about additional income you or your spouse received this month or last month. **Do not repeat** income already listed above or on the main application. ☐ No additional income

*Do not include interest from a qualified ABLE account.

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*

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 this application, including in 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 PERSON 1's 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 medical expenses

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

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

If you or your spouse need Long-Term Care (LTC) Services and Supports answer all questions in STEP 5. Otherwise, continue to STEP 6.

STEP 5 Long-Term Care

1. Check the box for the LTC Medicaid program you would like to apply for **(see page 12 for program descriptions)**:

YOU	YOUR SPOUSE (complete only if spouse is also applying for LTC Medicaid)
☐ Choices for Care (CFC)	☐ Choices for Care (CFC)
☐ Developmental Disabilities Home and Community Based Services (DD HCBS)	☐ Developmental Disabilities Home and Community Based Services (DD HCBS)
☐ Traumatic Brain Injury (TBI)	☐ Traumatic Brain Injury (TBI)
☐ Enhanced Family Treatment (formerly known as the Children's Mental Health Waiver)	☐ Enhanced Family Treatment (formerly known as the Children's Mental Health Waiver)

2. An interview is required as part of the Long-Term Care Medicaid eligibility process. Please list the person who will do the interview below.

Name	Phone number	Relationship to you
	( ) –	

3. Tell us where you are currently living.

YOU	YOUR SPOUSE (complete only if spouse is also applying for LTC Medicaid)
☐ Home ☐ Hospital ☐ Nursing facility ☐ Residential care/assisted living facility Name of facility: _____ Admission date (mm/dd/yyyy): _____ Location of facility: _____ For nursing facility or hospital swing bed, is the stay planned to be less than 30 days? ☐ Yes ☐ No	☐ Home ☐ Hospital ☐ Nursing facility ☐ Residential care/assisted living facility Name of facility: _____ Admission date (mm/dd/yyyy): _____ Location of facility: _____ For nursing facility or hospital swing bed, is the stay planned to be less than 30 days? ☐ Yes ☐ No

4. Tell us where you want to receive your Long-Term Care Services and Supports. **(Fill out for Choices for Care only.)**

YOU	YOUR SPOUSE (complete only if spouse is also applying for LTC Medicaid)
☐ Own home/apartment ☐ Enhanced residential care ☐ Adult family care home ☐ Home of another (family/friend) ☐ Nursing facility	☐ Own home/apartment ☐ Enhanced residential care ☐ Adult family care home ☐ Home of another (family/friend) ☐ Nursing facility

5. If you reside in a nursing or enhanced residential care facility, would you return home if you were able, even if returning home is unlikely? **(Fill out for Choices for Care only.)**

You: ☐ Yes ☐ No
Your spouse (if also applying): ☐ Yes ☐ No

6. Are you expected to return home within 6 months? **(Fill out for Choices for Care only.)**

You: ☐ Yes ☐ No
Your Spouse (if also applying): ☐ Yes ☐ No

7. List any income that you or your spouse are entitled to but do not receive (such as pensions or retirement).

First name	Income before deductions	Type of income
	$ per	
	$ per	

8. List the following expenses for your apartment, house, or trailer. Check all that apply and give the amount and how often you pay it.

☐ Condo fees $ _____ per _____
☐ Fuel and utilities $ _____ per _____
☐ Homeowners insurance $ _____ per _____
☐ Home equity loan $ _____ per _____
☐ Lot rent $ _____ per _____
☐ Mortgage $ _____ per _____
☐ Property tax $ _____ per _____
☐ Rent $ _____ per _____
☐ Room and/or board $ _____ per _____

9. Tell us if you, your spouse, or anyone acting on your, or your spouse's behalf, has given away, sold, gifted, or traded anything within the last 60 months. (We need to know about transfers by your spouse even if your spouse has passed away.)

Examples: *home, financial accounts, land, cash, vehicles*

☐ Nothing has been given away, sold, gifted, or traded within the last 60 months.

Owner of asset	Item	Date transferred	Value of item

10. Tell us if you or your spouse, or anyone acting on your, or your spouse's behalf, has had another person's name added to any assets within the last 60 months (such as financial accounts or property).

☐ No one has been added to any assets within the last 60 months.

First name	What was it	Whose name was added	When was name added

11. Tell us if you or your spouse, or anyone acting on your, or your spouse's behalf, has placed anything in a trust within the last 60 months.

Please include a copy of the trust document with your application.

☐ Nothing has been placed in a trust within the last 60 months.

First name	What was placed in the trust	Date it was placed in the trust

STEP 6 Signature and Certification

You must sign here. Not signing this Supplement may delay health coverage. If your spouse is applying with you, they must also sign here.

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

Under penalty of perjury I certify all information I have given in this Supplement is true and correct. I understand I must also sign page 11 of this application.

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

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 DVHA and authorized agents to request records from financial institutions for the spouse of the individual applying for Medicaid in this Supplement.

This authorization must be completed and signed by the spouse. 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 submit 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)

NOTE: If a spouse's legal representative is signing this authorization, also include the legal document giving them authority to act on behalf of the spouse.

The Supplement is now complete. You must also sign the main application on page 11. If you do not need to fill out Appendix A, B, or C and have signed the main application, you are now done.

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

APPENDIX A Tell Us Who is Helping You With This Application

PERSON 1 Information

First name, middle name, last name & suffix (Jr., Sr., III, etc.)	Last 4 digits of your SSN __ __ __ __

You Can Choose an Authorized Representative

You can give a trusted person permission to talk about this 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. It's your choice whether to have an authorized representative.

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

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

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/Town	**5.** State	**6.** ZIP code

7. Phone number
( ) –

8. Organization name (if applicable)	**9.** ID number (if applicable)

By signing, you allow this person to sign your 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 coverage 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.

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/Town	**5.** State	**6.** ZIP code

7. Phone number
( ) –

8. Organization name (if applicable)	**9.** ID number (if applicable)

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

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

To change or remove an Authorized Representative or Alternate Reporter, call Customer Service (this will not affect information we've already shared)

NEED HELP? Visit dvha.vermont.gov/apply or call Customer Service at **1-855-899-9600**. For TTY/relay services, dial **711**.

APPENDIX B American Indian or Alaska Native Family Member

PERSON 1 Information

First name, middle name, last name & suffix (Jr., Sr., III, etc.)	Last 4 digits of your SSN
	__ __ __ __

Complete this appendix if you or if anyone in your family is American Indian or Alaska Native or has received services from the Indian Health Service (IHS). 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 Service, 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.

If you need more space, attach a separate page. Be sure to write PERSON 1's name and date of birth at the top.

	PERSON 1	PERSON 2
1. Name	First Middle Last	First Middle Last
2. Alaska Native?	☐ Yes ☐ No	☐ Yes ☐ No
3. Member of a federally recognized tribe?	☐ Yes ☐ No **If yes**, tribe name: State where recognized:	☐ Yes ☐ No **If yes**, tribe name: State where recognized:
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?	☐ Yes ☐ 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? ☐ Yes ☐ No	☐ Yes ☐ 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? ☐ Yes ☐ 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: • 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? _____

PERSON 1 Information

First name, middle name, last name & suffix (Jr., Sr., III, etc.)	Last 4 digits of your SSN __ __ __ __

You **DO NOT** need to answer these questions unless someone in the household is eligible for health coverage from a job, even if they don't accept the coverage. Attach a copy of this page for each job that offers health coverage.

You can ask your employer to fill out this form for you. **However, you are still responsible for submitting this form.**

Employee Information

1. Employee first name, middle name, last name & suffix (Jr., Sr., III, etc.)

Employer Information

2. Employer (or Company) name		**3.** Employer Identification Number (EIN)
4. Employer (or Company) address		**5.** Employer (or Company) phone number ( ) –
6. City/Town	**7.** State	**8.** ZIP code

9. Who can we contact about employee health coverage at this job?

10. Phone number (if different from above) ( ) –	**11.** Email address

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

If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?

Date (mm/dd/yyyy): _____

☐ Yes. **Continue to questions 13 through 16.**

☐ No. **STOP and return this form to employee.**

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

If yes, list the names of anyone else in the employee's household who's eligible for coverage from this job:

Name: _____ Name: _____

☐ Yes. **Which people?**

☐ Spouse ☐ Dependent(s)

☐ No. **Continue to question 14.**

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes. **Continue to question 15.**

☐ No. **STOP and return this form to employee.**

15. How much would the employee have to pay for the lowest cost plan offered **to the employee only** that meets the minimum value standard*? Do not include family plans.

If the employer has wellness programs, provide the premium that the employee would pay if they received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

If the plan year will end soon and you know that the health plans offered will change, **go to question 16**. If you do not know, **STOP and return this form to employee**.

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

16. What changes will the employer make for the new plan year?

☐ None

☐ Employer will not offer health coverage

☐ The premium amount will change for the lowest-cost plan available only to the employee that meets the minimum value standard*. *(Premium should only reflect discounts for tobacco cessation programs, see question 15.)*

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

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

**A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.*

Online Portal Questions

Screen	Question #	Original Questions	Current Questions
Privacy & use of your information	Heading	**We'll keep your information private as required by law. Your answers on this form will only be used to determine eligibility for health coverage or help paying for coverage. We'll check your answers using the information in our electronic databases and the databases of other federal agencies. If the information doesn't match, we may ask you to send us proof.** **We won't ask any questions about your medical history. Household members who don't want coverage won't be asked questions about citizenship or immigration status.** **IMPORTANT: As part of the application process, we may need to retrieve your information from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. We need this information to check your eligibility for coverage and help paying for coverage if you want it and to give you the best service possible. We may also check your information at a later time to make sure your information is up to date. We'll notify you if we find something has changed.**	**Your answers are private. They're used only to qualify you for health coverage, including Medicaid/Dr. Dynasaur, and to see if you qualify for lower monthly payments.** **You must answer basic questions about things like your family size, your citizenship, and your income. We won't ask any questions about your medical history. Household members who don't want coverage won't be asked questions about citizenship or immigration status.** **IMPORTANT: We may need to check your answers with state and federal agencies like the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If your status changed recently, your answers might not match information in our or in other agencies' records. Sometimes this happens if you recently got married, got divorced, moved, or changed jobs. If answers don't match, you might need to provide some type of additional proof.** **We may also check your information at a later time to make sure your information is up to date. We'll notify you if we find something has changed.**
Privacy & use of your information	Heading		**We will keep your information private as required by law. Your answers on this form will only be used to see if you qualify for health coverage in Vermont Health Connect, and to help you enroll.**
Privacy & use of your information	1	I agree to have my information used and retrieved from data sources for this application. I have consent from all people I'll list on the application for their information to be retrieved and used from data sources.	Vermont Health Connect can use my answers to see if I qualify for health insurance and lower payments. They can also ask other agencies for information about me or anyone else listed in my application.
Privacy & use of your information	2		I have consent from all people I'll list on the application to include their personally identifiable information, such as dates of birth, Social Security numbers, addresses, and phone numbers.
Choosing a Coverage Year	Heading		**Open Enrollment for Qualified Health Plans for coverage year %Open Enrollment Benefit Start Date year% [begins/began] on %Open Enrollment Start Date%. You have the option to fill out this application for health coverage beginning on %Open Enrollment benefit start date%.** **However, if you are interested in a health plan that starts today, you can answer a few extra questions to see if you are eligible for a Special Enrollment Period to enroll now.** **Please note that if you apply for insurance affordability programs and are found eligible for Medicaid, your Medicaid coverage could begin this month regardless of which option you choose here.**
Choosing a Coverage Year	1		Would you like to apply for coverage that will start before %Open Enrollment Benefit Start Date year%?

Would you like help paying for coverage?	Heading	**Even working families can pay less for health coverage. You may be eligible for a free or low-cost plan, or a new kind of advance premium tax credit (APTC) that can be used to lower your monthly premiums right away even if you earn as much as $94,000 a year (for a family of 4).** **If you choose to apply for help paying for coverage, we will ask you questions to see if you can get Medicaid/Dr. Dynasaur or Advance Premium Tax Credit. Here are some of the questions we may ask you about yourself and your family members:** **How much money each family member gets each year or each month** **How family members are related to each other** **Whether family members have certain benefits right now** **Whether family members have any health coverage right now, including employer sponsored insurance** **If you choose to not apply for help to pay for coverage, we will not ask you these questions. You may shop for health insurance after answering a few short questions. If you enroll in a plan this way, you will pay the full costs each month. You will not be able to get any Advance Premium Tax Credit.** **Not sure if you want to apply for help to pay for coverage? Our Health Program Eligibility Screener can quickly help you find out if you and your family are eligible to get help paying for coverage.**	**Even working families can pay less for health insurance. In fact, you may qualify for a free or low-cost plan even if you're a family of four earning up to $94,000 a year.** **Vermont Health Connect will use information about your income to see if you qualify for Medicaid/Dr. Dynasaur or help lowering your monthly premiums for a private health plan.** **To find out if you qualify, you must tell us about your family, your income, and if you or your family have other health insurance available, like insurance you might get through an employer.** **Not sure if you want help paying for health insurance? Visit our Subsidy Calculator to see if you and your family might be eligible to get help paying for coverage.** **To apply for help with paying for your health insurance, click: "YES, I want help paying for coverage." (At the end of this application, you can see what you qualify for.)** **To skip this section and pay the full cost each month, click "No, I don't want help paying for coverage."**
Would you like help paying for coverage?	1	Do you want to find out if you and your family can get help paying for health coverage? If you select YES, you will answer questions about your income to see what help you and your family qualify for. If you select NO, you will answer fewer questions, but you will not get help paying for coverage.	Do you want to find out if you and your family could get help paying for health insurance? YES, I want help paying for coverage NO, I don't want help paying for coverage
Voter Registration	Heading	**If you are not registered to vote where you live now, would you like a voter registration application?**	**If you are not registered to vote where you live now, would you like a voter registration application?** **If you're already registered to vote or do not want to register to vote at this time, please click 'Next.'**
Voter Registration	1	Do you want a voter registration application sent to you?	Would you like us to mail you a voter registration application? If you do, click 'YES.' If you don't, click 'NEXT.'

Identifying Information	Heading	**Please tell us about yourself and all the people who live at your home, even if someone does not want to apply for health insurance today. Be sure to include yourself, spouse, parents, step-parents, and if applicable, your unmarried partner who needs health coverage. Include children under 21 who live with you, or anyone under 21 who you take care of and lives with you. Also include any children, age 21 through 26, that you want on your Qualified Health Plan, even if they do not 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.)** **Please enter everyone's name exactly as it appears on his or her Social Security card, if they have one, or other documentation.** **At the bottom, you can add someone with %Add%. You can take someone away with %Remove%.**	**Please tell us about yourself, all the people who live in your household, and all the people included in your tax return. (You do not need to file taxes to get health coverage.) Be sure to include:** **• Yourself** **• Your spouse** **• Parents** **• Step-parents** **• Your unmarried partner who needs health coverage** **• Children under 21 who live with you** **• Anyone under 21 who you take care of and lives with you** **• Any children up to age 26 that you want on your Health Plan, even if they do not live with you.** **Please enter everyone's name exactly as it appears on his or her Social Security card, if he or she has one, or as it appears on other documentation.** **Victims of domestic violence may apply separately from a spouse to be able to receive help paying for coverage.** **At the bottom of this page, you can add someone with the %Add Another Household Member% button. You can take someone off of the application by clicking the X.**
Identifying Information	Heading		**Please tell us about yourself and the family members you wish to add to your insurance policy. Please enter everyone's name exactly as it appears on his or her Social Security card, if he or she has one, or as it appears on other documentation.** **At the bottom, you can add someone with %Add Another Household Member.% You can take someone away by clicking the X.**
Identifying Information	Heading		**Unless you are applying for the affordability exemption, please tell us about yourself and everyone in your family who is applying for a waiver to be exempt from the individual mandate.** **If you are applying for the affordability exemption, please tell us about yourself and all the people who live at your home, even if someone does not want to apply for an exemption today. Be sure to include yourself, spouse, parents, and step-parents. Include children under 21 who live with you, or anyone under 21 who you take care of and lives with you.** **At the bottom, you can add someone with %Add Another Household Member.% You can take someone away by clicking the X.**
Identifying Information	1	First name:	First name:
Identifying Information	2	Middle name: (optional)	Middle name: *(optional)*
Identifying Information	3	Last name:	Last name:
Identifying Information	4	Suffix: (optional)	Suffix: *(optional)*
Identifying Information	5	Other name (maiden or former name): (optional)	Other name (maiden or former name): *(optional)*
Identifying Information	6	Birth date (MM/DD/YYYY):	Birth date (MM/DD/YYYY):
Identifying Information	7	Sex:	Sex:

Identifying Information	8	Marital status:	Marital Status: Note: If you are a victim of domestic violence and applying separately from your spouse, you may indicate that you are “never married” on the application to get help paying for coverage.
Identifying Information	9	Is this person the household member who is filling out the application?	Is this the person filling out the application?
%Name%'s catastrophic plan coverage	Heading		**If you get an exemption because coverage is unaffordable based on your expected income, you may also qualify to buy catastrophic coverage through the Marketplace. This may be more affordable than your other options.**
%Name%'s catastrophic plan coverage	1		Is %Name% applying for catastrophic coverage?
People applying for health insurance	Heading	**Please select the people who would like help paying for health coverage. (Check all that apply.)**	**Please select all of the people who need health insurance through Vermont Health Connect.** **[Check all that apply]**
People applying for health insurance	1	People applying for coverage: %Name%	To check or uncheck a name, click in the box next to the name.
Contact person	Heading	**Please tell us which person in your household is the main contact for the household.**	**Who's the main contact in your household?**
Contact person	1	Contact person:	Contact person:
Contact details	Heading	**Please tell us how we can get in touch with %main contact%.**	**How can we contact %main contact%?** **You must provide at least one way to reach %main contact%, which can be a home phone, cell phone, work phone, or email.** **If you do not have a phone number or email address, please enter 999-999-9999 in the phone number field.**
Contact details	1	Home phone (XXX-XXX-XXXX):	Home phone (XXX-XXX-XXXX):
Contact details	2	Work phone (XXX-XXX-XXXX):	Work phone (XXX-XXX-XXXX):
Contact details	3	Cell phone (XXX-XXX-XXXX):	Cell phone (XXX-XXX-XXXX):
Contact details	4	Email address:	Email address:
Contact details	5	Preferred spoken language: (optional)	Preferred spoken language: *(optional)*
Contact details	6	Preferred written language: (optional)	Preferred written language: *(optional)*
	7	Other spoken or written language:	
Contact details	8	What is the best way to get in touch with %Contact name%?	What is the best way to get in touch with %Contact name%? (If you choose home phone, work phone or cell phone, you will receive all notices, invoices and other information through postal mail.)

Home Address	Heading	**We would like to know where everyone on this application lives, and who lives with who. Please think about where everyone on this application lives and enter all of the addresses that belong to these people. On the next screen we will ask you who lives at each address.** **Click %Remove% if no one on the application has a home address, then click %Next%.** **You can add an address with %Add%. You can take one away with %Remove%.**	**We would like to know where everyone on this application lives, and who lives with who. Please think about where everyone on this application lives and enter all of the addresses that belong to these people. On the next screen we will ask you who lives at each address.** **Click "Remove" if no one on the application has a home address, then click "Next."** **You can add an address with "Add." You can take one away with "Remove."**
Home Address	Heading		**Please tell us where %name% lives. Click the X if %name% does not have a home address, then click Next. If %name% lives at two or more places, please add the address where %he/she% spends the greatest number of nights.**
Home Address	1	Street address (Line 1):	Street address (Line 1):
Home Address	2	Apartment or suite number (Line 2): (optional)	Apartment or suite number (Line 2): *(optional)*
Home Address	3	City:	City:
Home Address	4	State:	State:
Home Address	5	County:	County:
Home Address	6	ZIP code (XXXXX):	ZIP code (XXXXX):
People who live at %Street Address (Line 1)%	Heading	**Please select all the household members who live at %Address line 1%, %City%.** **You must select at least one person for each address and no one may have more than 1 main home address. If someone lives at two or more places, please add them to the address where they spend the greatest number of nights. If you need to delete an address you may do so by clicking %Back%.**	**You must select at least one person for each address. No one may have more than one main home address. If someone lives at two or more places, please add them to the address where they spend the greatest number of nights. Click the %Back% button to delete an address.**
People who live at %Street Address (Line 1)%	1	People living at %street address%: %Name%	Please select all the people who live at %Address line 1%, %City%
People who do not have a home address	Heading	**Please select all the household members who do not have a home address.**	**Please select all the people who do not have a home address.**
People who do not have a home address	1	People who do not have a home address: %Name%	People who do not have a home address: %Name%
Will %name% return to %state of the exchange%?	Heading	**Please tell us if %Name% plans to return to %state of the exchange% to live.**	**Does %Name% plan to return to %state of the exchange% to live?**
Will %name% return to %state of the exchange%?	1	Is %Name% living outside of the %state of the Exchange% temporarily?	Is %Name% living outside of the %state of the Exchange% temporarily?

Will %name% return to %state of the exchange%?	Heading	**Please tell us where %name% will live in the %state of the Exchange%. If %Name% does not know where %he/she% will live when they return to the %state of the Exchange%, you can skip these question by clicking %Next%.**	**Where does %name% plan to live in the %state of the Exchange%. If %Name% doesn't know where %he/she% will live when they return to the %state of the Exchange%, you can skip this question by clicking %Next%.**
Will %name% return to %state of the exchange%?	2	City:	City:
Will %name% return to %state of the exchange%?	3	ZIP code (XXXXX):	ZIP code (XXXXX):
Will %name% return to %state of the exchange%?	4	County:	County:
Reaching %Name% via mail	Heading	**Please tell us about %main contact%'s mailing address.**	**What is %main contact%'s mailing address?**
Reaching %Name% via mail	1	Is %main contact%'s mailing address the same as %home address for main contact%?	Is %main contact%'s mailing address %home address for main contact%?
%Name%'s mailing address	Heading	**Please tell us %Contact person%'s mailing address.**	**What's %Contact person%'s mailing address?**
%Name%'s mailing address	1	Street Address (Line 1): Street Address or P.O. Box	Street Address (Line 1):
%Name%'s mailing address	2	Apartment or suite number (Line 2): (optional)	Apartment or suite number (Line 2): *(optional)*
%Name%'s mailing address	3	City:	City:
%Name%'s mailing address	4	State:	State:
%Name%'s mailing address	5	County:	County:
%Name%'s mailing address	6	ZIP Code (XXXXX):	ZIP Code (XXXXX):
Relationships	Heading	**Please tell us about how people in your home are related. If these people are not related in this way, please skip the question by clicking %Next%.**	**Please tell us how people are related in your home. If these people are not related in this way, please skip the question by clicking %Next%.**
Relationships	1	Please choose who %relationship%:	Please choose who %relationship%:

Household tax filing status for %coverage year%	Heading	**Please %tell us% who in your household plans to file a federal income tax return for %coverage year%. You do not have to file taxes to apply for coverage.**	**In this section we will ask questions about federal income tax returns.** **You do not need to file taxes to be able to apply for health insurance.** *** People who get help lowering their monthly premiums do have to file taxes.** *** People who qualify for Medicaid/Dr. Dynasaur do not have to file taxes.**
Household tax filing status for %coverage year%	Heading	**Please tell us if %Name% plans to file a federal income tax return for %Coverage Year%. No one is required to file taxes to apply for coverage.**	**Please tell us if %name% plans to file a federal income tax return for %coverage year%. No one is required to file taxes to apply for coverage.**
Household tax filing status for %coverage year%	1	Does anyone on this application plan to file a federal income tax return for %coverage year%?	Does anyone on this application plan to file a federal income tax return for %coverage year%?
Household tax filing status for %coverage year%	2	Does %Name% plan to file a federal income tax return for %coverage year%?	Does %name% plan to file a federal income tax return for %coverage year%?
People who expect to file federal taxes for %coverage year%	Heading	**Please select the household member(s) who plan to file a federal income tax return for %coverage year%.**	**Please select the household member(s) who plan to file a federal income tax return for %coverage year%.**
People who expect to file federal taxes for %coverage year%	1	Tax filers for %coverage year%: %Name%	Tax filers for %coverage year%: %Name%
%Name%'s federal income tax return for %coverage year%	Heading	**Please %tell us% the people %Name% plans to include on %his/her% federal income tax return for %coverage year%.**	**Who does %Name% plan to include on %his/her% federal income tax return for %coverage year%?**
%Name%'s federal income tax return for %coverage year%	1	*Does %name% plan to file a joint federal income tax return with %his/her% spouse for %coverage year%?	Does %name% plan to file a joint federal income tax return with %his/her% spouse for %coverage year%? If you are married, you must file jointly to be eligible for help lowering the cost of your monthly premiums. There are exceptions, and you can call 1 (855) 899-9600 for more information. If you don't file jointly, you may still be eligible for Medicaid/Dr. Dynasaur.

%Name%'s federal income tax return for %coverage year%	2	Will %name% claim any household members as a dependent on %his/her% income tax return for %coverage year%?	Will %name% claim any household members as dependents on %his/her% income tax return for %coverage year%? (Household means anyone you include on your tax return. A dependent is someone you are financially responsible for and is claimed on your tax return. You may get personal exemptions on your tax return by claiming someone as a dependent.)
%Name%'s dependents on %his/her% federal income tax return for %coverage year%	Heading	**Please tell us the people %Name% plans to include on %his/her% federal income tax return for %coverage year%.**	**Who does %Name% plan to claim as a dependent on %his/her% federal income tax return for %coverage year%?**
%Name%'s dependents on %his/her% federal income tax return for %coverage year%	1	%Name%'s dependents: %Name%	%Name%'s dependents: %Name%
People who will claim %Name% as a tax dependent for %coverage year%	Heading	**Please %tell us% if there is another person who will claim %Name% as a dependent on his or her federal income tax return for %coverage year%.**	**Is there another person who will claim %Name% as a dependent on their federal income tax return for %coverage year%? (For example: If parents are divorced or not living together, the child might be claimed as a tax dependent by the parent they are not living with.)**
People who will claim %Name% as a tax dependent for %coverage year%	Heading	**Please %tell us% if there is another person who will claim %Name% as a dependent on his or her federal income tax return for %coverage year%.**	**Please %tell us% if there is another person who will claim %Name% as a dependent on his or her federal income tax return for %coverage year%.**
People who will claim %Name% as a tax dependent for %coverage year%	1	Will %Name% be claimed as a tax dependent by a taxpayer who is not a part of this application?	Will another tax filer who is not part of this application claim %Name% as a tax dependent?
People who will claim %Name% as a tax dependent for %coverage year%	2	Is the person claiming %Name% the parent of %Name%?	Is the tax filer who claims %Name% as a tax dependent, %his/her% parent?

People who will claim %Name% as a tax dependent for %coverage year%	3	Does %Name% live with the parent who will claim %him/her% as a tax dependent at %Name%'s main home address?	Does %Name% live with the parent who will claim %him/her% as a tax dependent at %Name%'s main home address?
People who live with %Name%	Heading		Please tell us the people that live with %Name% at %Name's address line 1%, %Name%'s city%.
People who live with %Name%	Heading		Please think about the people that live with %Name%.
People who live with %Name%	1		Have all the people who live with %Name% at %Name%'s main home address been added to this application?
%Name% Will Need a Separate Application for Benefits	Heading		In order to be assessed for benefits, %Name% will need to fill out an application that includes the tax payer claiming %Name%, all of people who are tax dependents of that tax payer, as well as all of the people who live in the same household as %Name%. We do not have enough information to determine if %Name% is eligible for benefits based on the people entered on this application.
%Name% Will Need a Separate Application for Benefits	1		I understand that %Name% will need to file a different application to see if [he/she] is eligible for help paying for coverage.
%Name% may need a separate application for Medicaid	Heading	In order for us to see if %Name% can get %name of state Medicaid program%, %Name% must be on an application that includes the taxpayer claiming %Name%. To do this, %Name%'s taxpayer may create a Marketplace account and fill out a separate application that includes %Name%, the taxpayer claiming %Name%, and any other dependents. You can continue with the application now to enroll %Name% in a Qualified Health Plan (QHP) or see if %Name% is eligible for tax credits.	We are not able to determine %Name%'s eligibility for Medicaid/Dr. Dynasaur. %Name% must apply on a separate application. To do this, the person that %Name% lives with may create a Vermont Health Connect account and fill out a separate application that must include the following people if they live with %Name%: • Their spouse • Their children under 19 (or 21 if a full time student) • If they're under 19 (or 21 and a full time student), their parents and step parents •Their siblings if under 19 (or 21 if a full time student) You can continue with the application and enroll %Name% in your Qualifed Health Plan or to see if %he/she% is eligible for help lowering monthly premiums.
%Name% may need a separate application for Medicaid	1	I understand that %Name% will need to file a different application in order to apply for %name of state Medicaid program%. This application will have to include all of the people %Name% lives with. %Name% will still be considered for health coverage and %name of state tax credit program% to help pay for health coverage on this application.	I understand that %Name% will need to file a different application in order to apply for %name of state Medicaid program%. This application will have to include all of the people %Name% lives with. %Name% will still be considered for health coverage and %name of state tax credit program% to help pay for health coverage on this application.

%Name% will need a separate application for tax credits	Heading	In order for us to see if %Name% can get help paying for health coverage through tax credits, %Name% must fill out a separate application with the taxpayer claiming %Name% as the application filer. To do this, %Name%'s taxpayer may create a Marketplace account and fill out a separate application that includes %Name%, the taxpayer claiming %Name%, and any other dependents. You can continue with the application now to see if %Name% can get Medicaid/Dr. Dynasaur or to enroll %Name% in a Qualified Health Plan (QHP).	We are not able to determine %Name%'s eligibility for tax credits that may help lower the monthly cost of premiums. %Name% must apply with the tax filer who claims %Name% as a tax dependent. To do this, the tax filer who claims %Name% as a tax dependent may apply through Vermont Health Connect. You may continue with your application to see if this person can get Medicaid/Dr. Dynasaur or enroll %Name% in a Qualified Health Plan if you wish to do so. However %Name% will not be included when we determine whether or not you qualify for tax credits.
%Name% will need a separate application for tax credits	1	I understand that %Name% will need to file a different application in order to get help pay for coverage through tax credits. %Name% will still be considered for Medicaid/Dr. Dynasaur and Qualified Health Plan enrollment on this application.	I understand that %Name% will need to file a different application to see if %he/she% is eligible for help to lower the monthly cost of health insurance premiums. %Name% will still be considered for Medicaid/Dr. Dynasaur and private health insurance on this application.
%Name%'s primary caregiver	Heading	**Please select the primary caregiver of %Name%. This should be the main person taking care of %Name%. If %Name% does not have a primary caregiver, please click %Next%. If %Name%'s primary caregivers are married, please select one person.**	**Who is %Name%'s primary caregiver? A primary caregiver is the main person taking care of %Name%. If %Name% does not have a primary caregiver, please click %Next%. If %Name%'s primary caregivers are married, please select one person.**
%Name%'s primary caregiver	1	%Name%'s caregiver: [relationship DDL box]	%Name%'s caregiver: [relationship DDL box]
Authorized Representative	Heading	**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 ever need to change your authorized representative, contact Vermont Health Connect. Your authorized representative should not be someone in your household who is also applying for health coverage as a part of this application.**	**You can let a trusted person talk about this application with us, read your answers, and make decisions for you on matters related to this health insurance application. For example, this person could respond to letters we send to you or sign forms for you.** **When you let someone else take care of these matters, this person is called an 'Authorized Representative.'** **This shouldn't be someone in your household who is also applying for health insurance as a part of this application. But it can be a relative or friend who lives outside of your home.** **You do not have to have an Authorized Representative. You can remove or change your Authorized Representative at any time by contacting Vermont Health Connect.**
Authorized Representative	1	Do you want to name someone as your authorized representative?	Do you want to name someone as your authorized representative?
Consent	Heading	**Please %tell us% if the applicant is able to give his or her consent.**	**Can the applicant give his or her consent?**
Consent	1	Is the applicant able to sign a consent form giving the Authorized Representative permission to complete this application?	If you're the applicant, can you sign a form that will let a trusted person help you with this application? If you're not the applicant, can he or she sign a form that will let you help with this application?

Consent	Heading	**If someone is representing the applicant because he or she has a power of attorney or court order, please upload the document in the My Verifications tab after submitting the application. If this person does not have either of these or another document that proves authorized representative status, this person may fill out an authorized representative consent form. Please print out this document, fill it out, and upload the document in the My Verifications tab after submitting the application.**	**Some applicants already have a trusted person by using a power of attorney or court order. If you have done this, finish and submit the application and then send in a copy of your documents.** **If you do not have any documents that let a trusted person help you, you can still fill out a form for this assistance. 'Appendix A--Assistance Completing the Application' can be filled out and sent in after you finish and submit this application.** **Click here for a copy of Appendix A - Assistance Completing the Application.** **Mail your power of attorney, court order, or Appendix A to:** **Vermont Health Connect** **103 South Main Street** **Waterbury VT 05671-8100**
Consent	1b	I understand I must upload a document that proves authorized representation in order to complete the application.	I understand I must send in a document that proves authorized representation in order to complete the application.
Authorized Representative Information	Heading	Please tell us about the authorized representative.	**Please tell us about the authorized representative.**
Authorized Representative Information	1	First name:	First name:
Authorized Representative Information	2	Middle name: (optional)	Middle name: *(optional)*
Authorized Representative Information	3	Last name:	Last name:
Authorized Representative Information	4	Suffix: (optional)	Suffix: *(optional)*
Authorized Representative Information	Heading		**Please enter a mailing address for the authorized representative.**
Authorized Representative Information	7	Street address (Line 1):	Street address (Line 1):
Authorized Representative Information	8	Street address (Line 2): (optional)	Street address (Line 2): *(optional)*
Authorized Representative Information	9	City:	City:
Authorized Representative Information	10	State:	State:

Authorized Representative Information	11	ZIP code (XXXXX):	ZIP code (XXXXX):
Authorized Representative Information	Heading		**Please enter contact information for the authorized representative.**
Authorized Representative Information	12	Work phone number (XXX-XXX-XXXX):	Work phone number (XXX-XXX-XXXX):
Authorized Representative Information	13	Home phone number (XXX-XXX-XXXX):	Home phone number (XXX-XXX-XXXX):
Authorized Representative Information	14	Cell phone number (XXX-XXX-XXXX):	Cell phone number (XXX-XXX-XXXX):
Authorized Representative Information	15	Email address:	Email address:
%Name%'s Social Security Number	Heading	**We need %Name%'s Social Security number (SSN) if %Name% wants health coverage and has an SSN or can get one. We use SSNs to check income and other information to see who is eligible for help paying for health coverage.** **If %name% doesn't have a SSN, leave the answer to this question blank and click %Next% to continue with the application.** **If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users call 1-800-325-0778.**	**If %Name% has a Social Security number (SSN) and you give that number to us, you can speed up the application process. We use SSNs to check income and other information to see who's eligible for help paying for health coverage.** **If %Name% doesn't have a SSN, leave the answer to this question blank and click %Next% to continue with the application.** **If you want help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users call 1-800-325-0778.**
%Name%'s Social Security Number	Heading	**Providing %name%'s Social Security number (SSN) can be helpful even if %name% doesn't want health coverage because it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help paying for health coverage.** **If you do not want to enter %Name%'s SSN, please skip this question by clicking %Next%.** **If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users call 1-800-325-0778.**	**Providing %name%'s Social Security number is helpful even if he or she doesn't want health insurance because it speeds up the process. We use Social Security numbers to check income and other information so we know who's eligible for help in paying for health insurance** **If you don't want to share %Name%'s Social Security Number, click %Next% to skip this question.** **If someone wants help getting a Social Security Number, call 1-800-772-1213 or visit socialsecurity.gov. TTY users call 1-800-325-0778.**
%Name%'s Social Security Number	1	What is %Name%'s Social Security Number? (no dashes or spaces; e.g., 987654321)	What is %Name%'s Social Security Number? (no dashes or spaces; e.g., 987654321)
%name%'s Basic Information	Heading		**Please tell us more about %name%.**
%name%'s Basic Information	2	Is %name% a full-time student?	Is %name% a full-time student?
%name%'s Basic Information	3	*Is %name% an American Indian or Alaska Native?	Is %name% an American Indian or Alaska Native?

%name%'s Basic Information	4	Is %name% incarcerated (detained or jailed)?	Is %name% incarcerated (detained or jailed)?
%name%'s Basic Information	4a	Is this person pending disposition?	Is %Name% still waiting for a final decision from the court about the charges against %him/her%?
%name%'s Basic Information	5	Is %name% pregnant? (optional)	Is %name% pregnant? *(optional)*
%name%'s Basic Information	6	*Does %Name% have a physical disability or mental health condition that limits %his/her% ability to work, attend school, or take care of their daily needs?	Does %name% have a physical disability or mental health condition that limits %his/her% ability to work, attend school, or take care of %his/her% daily needs?
%name%'s Basic Information	9	Is %Name% eligible for or enrolled in federal Medicare coverage?	Is %Name% eligible for or enrolled in federal Medicare coverage?
%name%'s Basic Information	9a	Was %Name% ever in foster care?	Was %Name% ever in foster care in Vermont?
%name%'s Basic Information	10	Was %Name% in foster care in Vermont when %Name% turned 18?	Was %Name% in foster care in Vermont when he or she turned 18?
%name%'s Basic Information	13		Was %name% mother enrolled in %name of state Medicaid program% at the time of %name%'s birth?
%name%'s Basic Information	Heading	**%Name% can tell us about %name%'s ethnicity and race below, but %Name% can still apply if %he/she% would rather not tell us. The information %Name% does (or does not) provide about race and ethnicity will not affect whether %Name%'s application is accepted. If %Name% does not want to tell us about %Name%'s race or ethnicity, you may skip this question by clicking "Next".**	**Please tell us about %Name%'s ethnicity and race. You do not have to answer these questions. If you don't want to tell us about %Name%'s ethnicity or race, you may skip this section by clicking "Next."**
%name%'s Basic Information	14	%name%'s ethnicity? (optional)	%name%'s ethnicity? *(optional)*
%name%'s Basic Information	15	%name%'s race? (optional)	%name%'s race? *(optional)*
%Name%'s Pregnancy Follow-Up	Heading	**Please tell us about %Name%'s pregnancy.**	**Please tell us about %Name%'s pregnancy.**
%Name%'s Pregnancy Follow-Up	1a	How many babies is %name% expecting during this pregnancy? If you do not know how many babies %name% is expecting, please enter 1.	How many babies does %name% expect during this pregnancy? If you don't know, enter 1.
%Name%'s Pregnancy Follow-Up	1b	What is the expected due date of this pregnancy (MM/DD/YYYY)?	What is the expected due date of this pregnancy (MM/DD/YYYY)?
%Name%'s Medicare Part A Information	Heading		**Medicare Part A pays for hosptial services. Please tell us about %Name%'s Medicare Part A information.**
%Name%'s Medicare Part A Information	1	Is %Name% enrolled in Medicare Part A?	Is %Name% enrolled in Medicare Part A?
%Name%'s Medicare Part A Enrollment Follow-Up	Heading		**Please tell us about %Name%'s Medicare Part A information.**

%Name%'s Medicare Part A Enrollment Follow-Up	1	Could %Name% receive Medicare Part A without paying a premium?	Could %Name% receive Medicare Part A without paying a premium?
%Name%'s Medicare Part A Enrollment Follow-Up	2	Does %Name% pay a premium for Medicare Part A?	Does %Name% pay a premium for Medicare Part A?
%Name%'s Medicare Part B Information	Heading		**Medicare B pays for physician services. Please tell us about %Name%'s Medicare Part B information.**
%Name%'s Medicare Part B Information	1	Is %Name% enrolled in Medicare Part B?	Is %Name% enrolled in Medicare Part B?
%Name%'s Health Plan Eligibility	Heading	**Due to %NAme%'s current enrollment in Medicare, %NAme% is ineligible to enroll in a health insurance plan. However, because %NAme% currently pays a premium for Medicare, %NAme% may become eligible to enroll in a health insurance plan.** **Please contact the Vermont Office of Health Care Advocate at 800-917-7787**	**Due to %NAme%'s current enrollment in Medicare, %NAme% is ineligible to enroll in a health insurance plan. However, because %NAme% currently pays a premium for Medicare, %NAme% may become eligible to enroll in a health insurance plan.** **Please contact the Vermont Office of Health Care Advocate at 800-917-7787**
%Name%'s Health Plan Eligibility	1	I have read and understand the above statement.	I've read and understand the statement above.
%Name%'s Native American status details	Heading	**Please tell us about %name%'s Native American status details.**	**Please tell us about %name%'s Native American status details.**
%Name%'s Native American status details	1	*Is %name% a member of a federally recognized tribe?	Is %name% a member of a federally recognized tribe?
%Name%'s Native American status details	1a	State of federally recognized tribe:	State of federally recognized tribe:
%Name%'s Native American status details	1b	Tribe name:	Tribe name:
%Name%'s citizenship status	Heading	**Please tell us about %name%'s citizenship status.**	**Please tell us more about %Name's% citizenship status.** **A Naturalized Citizen is a person who wasn't born in the U.S., but has lawfully become a citizen. A person who becomes a U.S. citizen through naturalization should have a "Certificate of Naturalization."** **A Derived Citizen is a person who receives U.S. citizenship through his or her relationship to a U.S. citizen. A person who becomes a U.S. citizen this way may have a "Certificate of Citizenship."**

%Name%'s citizenship status	1	Is %Name% a Naturalized or Derived Citizen?	Is %Name% either a Naturalized or Derived Citizen?
More about %Name%'s citizenship status	Heading	**Please tell us about %name%'s citizenship status.**	**Please tell us about %name%'s citizenship status.**
More about %Name%'s citizenship status	1	Is %Name% a US Citizen or a US National?	Is %Name% a Naturalized or Derived Citizen?
%Name%'s national identification information	Heading	**If you indicated that %Name% is a Naturalized or Derived Citizen, you can speed up the verification process by entering in %Name%'s citizenship document information below. Entering this information is optional. You may continue with the application by clicking "Next" without answering the question.**	**If %Name% is a Naturalized or Derived Citizen, you can help us verify this by sharing information from official documents such as a Certificate of Naturalization or a Certificate of Citizenship.** **Sharing this information from these documents is optional. If you would like to skip this step, you can click "Next" without answering the question.**
%Name%'s national identification information	1	Document type:	Document type:
%Name%'s national identification information	1a	Alien number (XXXXXXXXX):	Alien number (XXXXXXXXX):
%Name%'s national identification information	1b	Naturalization certificate number:	Naturalization certificate number:
%Name%'s national identification information	1c	Citizenship certificate number:	Citizenship certificate number:
Is %Name% lawfully present?	Heading	**As a non-US Citizen, %Name% may qualify for benefits if %Name% is lawfully present or has eligible immigration status.**	**As a non-US Citizen, %Name% may be able to qualify for help paying for coverage if %he/she% is lawfully present.** **People who are "lawfully present" are immigrants or non-US citizens who have been legally admitted into the United States. They must not have stayed longer than the period for which they were admitted or they may have current permission from the U.S. Citizenship and Immigrant Services (CIS) to stay or live in the U.S.**
Is %Name% lawfully present?	1	Is %Name% lawfully present in the US?	Is %Name% lawfully present in the US?

Does %Name% have eligible immigration status?	Heading	**As a non-US Citizen, %Name% qualify for benefits if %Name% is has eligible immigration status. These are some of the groups who have eligible immigration status:** **• Refugees** **• Asylees** **• Cuban and Haitian Entrants** **• Victims of severe forms of trafficking** **• Noncitizens whose deportation is being withheld** **• Noncitizens admitted as Amerasian immigrants** **• Legal permanent residents who first entered under another exempt category and who later converted to LPR status** **• Haitians granted Humanitarian Parole status** **• Citizens and nationals of Iraq and Afghanistan with Special Immigrant status** **• American Indians born in Canada to whom §289 of the INA applies**	**Another way that non-US Citizens can qualify for help paying for coverage is by having eligibile immigration status. These are some of the groups who have eligible immigration status:** • Lawful Permanent Resident (LPR/Green Card Holder) • Asylee defined in § 208 of INA • Refugee • Cuban/Haitian Entrant • Individual admitted to US under § 207 of INA • Amerasian • Battered Spouse, child, parent • Victim of Trafficking and his/her Spouse, Child, Sibling or Parent • Paroled into US • Conditional Entrant Granted before 1980 • Granted Withholding of Deportation of Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) • Lawful Temporary Resident • Member of a federally-recognized Indian tribe or American Indian Born in Canada • Honorably discharged veterans, their spouse or unmarried surviving spouse or unmarried dependent children • Active duty US military, their spouse and unmarried dependent child **If you need more information about your immigration status, please click here or you can call 1-855-899-9600 for help.**
Does %Name% have eligible immigration status?	Heading	Does %Name% have eligible immigration status?	Does %Name% have eligible immigration status?
%Name%'s immigration document	Heading	**Please enter in %Name%'s immigration document information.**	**What immigration documents does %Name% have?**
%Name%'s immigration document	1	Document type:	Document type:
%var_hhm_name%'s Immigration Document Information	Heading		**Please fill out the following information regarding %var_hhm_name%'s immigration document.**
%var_hhm_name%'s Immigration Document Information	1a	Alien number:	Alien number:
%var_hhm_name%'s Immigration Document Information	1b	I-94 number:	I-94 number:
%var_hhm_name%'s Immigration Document Information	1c	Passport or document number:	Passport or document number:

%var_hhm_name%'s Immigration Document Information	1e	Country of issuance:	Issuing country:
%var_hhm_name%'s Immigration Document Information	1f	Passport expiration date (MM/DD/YYYY):	Passport expiration date (MM/DD/YYYY):
%var_hhm_name%'s Immigration Document Information	1g	SEVIS ID number (XXXXXXXXXX):	SEVIS ID number (XXXXXXXXXX):
%var_hhm_name%'s Immigration Document Information	1h	Document expiration date (MM/DD/YYYY):	Document expiration date (MM/DD/YYYY):
%var_hhm_name%'s Immigration Document Information	1i	Category code:	Category code:
%Name%'s additional immigration documents	Heading	**Please tell us about any other supporting documentation related to %Name%'s immigration status that %he/she% may have.**	**Please tell us about any other supporting documents related to %Name%'s immigration status that %he/she% may have.**
%Name%'s additional immigration documents	1a	Description:	Description:
%Name%'s additional immigration documents	1b	Alien Number, I-94 Number, or document ID:	Alien Number, I-94 Number, or document ID:
%Name%'s entry into the US	Heading	**Please tell us about when %Name% entered the US.**	**Please tell us about when %Name% entered the US.**
%Name%'s entry into the US	1	Has %name% lived in the US since 1996?	Was %Name% lawfully residing in the U.S. before August 22, 1996?
More about %Name%'s legal status in the US	Heading	**Please tell us about when %name%'s gained legal status in the US.**	**Please tell us about when %name%'s gained legal status in the US.**
More about %Name%'s legal status in the US	1	When did %name% get legal status in the US (MM/DD/YYYY)?	When did %name% get legal status in the US (MM/DD/YYYY)?

%Name%'s military service	Heading	**%Name% may be eligible for services if %Name% or %name%'s family member has served in the military.**	**%Name% may be eligible for help paying for coverage if %Name% or %name%'s family member has served in the military.** **Military service includes active duty service, which means the person is in the military now. It also includes veterans who were honorably discharged. A veteran who was honorably discharged had a favorable record when he or she left the military.**
%Name%'s military service	1	Is %Name%, or %Name%'s parents, or %Name%'s spouse an honorably discharged veteran or active-duty member of the military?	Is %Name%, or %Name%'s parents, or %Name%'s spouse an honorably discharged veteran or active-duty member of the military?
External Verification	Heading		**By choosing "Yes," I'm indicating that I understand my information will be checked with state and federal agencies like the Internal Revenue Service (IRS), Social Security, and the Department of Homeland Security. I also understand my information will be kept secure and will only be used to help verify my household information.**
External Verification	1		I understand the above information and wish to continue with the application process.
Expedited Income	Heading		**Please %tell us% the income you claimed on your most recent federal income tax return.**
Expedited Income	1a		Do you expect %name%'s yearly household income for %coverage year% to be the same as what was reported on %his/her% last federal income tax return?
Expedited Income	1b		Is the income reported on %Name%'s %previous year% federal income tax return a good estimate ("accurate projection") of %his/her% yearly income for %coverage year%?
Expedited Income	Heading		**What do you expect %Name%'s yearly income will be in %coverage year%? If you don't know, leave this question blank and click %Next%.**
Expedited Income	2a		What do you expect %Name%'s yearly income will be in %coverage year%? *(optional)*
Expedited Income	2b		What do you expect %Name%'s and %Name%'s spouse's yearly income will be in %coverage year%? *(optional)*
%Name%'s income this month	Heading		**%Tell us% about how much income %Name% expects to get this month.**
%Name%'s income this month	1		Is the household's gross income (before taxes) this month more than [monthly FPL threshold amount for the highest category of applicable Medicaid]?
Does %Name% have a job?	heading		**Please tell us if %Name%'s income comes from a job.**
Does %Name% have a job?	1		Does %Name% have any income that comes from a job?

%Name%'s income sources	Heading	**Please think about all of the sources of income that %Name% expects to get for the rest of this year and throughout %coverage year%. For each income source, select the income type. Many people will need to add more than one income source. For example, if %Name% has two jobs, select "Job" below, then click "Add" and select "Job" again. Once you have added all of %Name%'s income sources click "Next". We will ask you questions about each income source on the next few screens. To add another income source click "Add". To take one away click "Remove".** **You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI).**	**The next section will ask you about the kinds of income that %Name% makes now and expects to make throughout %coverage year%. You must tell us about each kind of income and select the income type from the drop down menu below.** **Many people will need to add more than one kind of income. For example, if %Name% has two jobs, select "Job" below, then click "Add Another Income Source" and select "Job" again. Once you have added all of %Name%'s income sources click "Next."** **We will ask you questions about each kind of income on the next few screens. To add another kind of income click "Add Another Income Source." To take one away click the X.** **You don't need to tell us about child support, Workers' Compensation, veteran's payments, or Supplemental Security Income (SSI). You DO need to tell us about Social Security Benefit payments (SSA) and Social Security Disability Payments (SSDI).**
%Name%'s income sources	Heading	**Please think about all of the sources of income that %Name% expects to get throughout %coverage year%. For each income source, select the income type. Many people will need to add more than one income source. For example, if %Name% has two jobs, select "Job" below, then click "Add" and select "Job" again. Once you have added all of %Name%'s income sources click "Next". We will ask you questions about each income source on the next few screens. To add another income source click "Add". To take one away click "Remove".** **You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI).**	**Please think about all of the sources of income that %Name% expects to get throughout %coverage year%. For each income source, select the income type. Many people will need to add more than one income source. For example, if %Name% has two jobs, select "Job" below, then click "Add Another Income Source" and select "Job" again. Once you have added all of %Name%'s income sources click "Next." We will ask you questions about each income source on the next few screens. To add another income source click "Add Another Income Source." To take one away click the X.** **You don't need to tell us about child support, veteran's payments, or Supplemental Security Income (SSI).**
%Name%'s income sources	Heading		**If %Name% has income that comes from a job, please click Add Another Income Source and then click Next. If %Name% does not have income that comes from a job, please go Back to change your answer.**
%Name%'s income sources	1	*What type of income does %Name% have?	What type of income does %Name% have?
(heading for income details)	Heading	**Please think about the income that %Name% will get from this income source for this month, and throughout %coverage year%.**	**In the next section, you'll provide information about %Name%'s income now and for %coverage year%.**
(heading for income details)	Heading	**Please think about the income that %name% will get from this income source for %coverage year%.**	**In the next section, you'll provide information about %Name%'s income for %coverage year%**
%Name%'s job	Heading	**Please tell us about %Name%'s job.**	**Please tell us about %Name%'s employer.**
%Name%'s job	1	Name of employer:	Who is %Name%'s employer?
%Name%'s job	2	How much does %Name% get (before taxes are taken out)?	How much does %Name% get from this employer before taxes are taken out?
%Name%'s job	3	How often does %Name% get this amount?	How often does %Name% earn this amount?
%Name%'s job	4	*Start date (MM/DD/YYYY):	When did %Name% start earning this income? (MM/DD/YYYY) (If this income started before the date shown at the right, leave the date as it is.)

%Name%'s job	5	*End date (MM/DD/YYYY):	If this income stopped, when did %Name% get the last payment? (MM/DD/YYYY) (If this income will continue after the date shown at the right, leave the date as it is.)
%Name%'s job	Heading	**How much does %Name% usually work per week at this job?**	**How much does %Name% usually work per week for this employer?**
%Name%'s job	3a	Hours per week:	How many hours per week does %Name% usually work for this employer?
%Name%'s job	3b	Days per week:	How many days per week does %Name% usually work for this employer?
%Name%'s job	4	Will %Name% get any one-time amounts from this job, like a bonus or a severance payment?	Will %Name% get any one-time income from this employer? This includes bonuses and severance payments.
%Name%'s job	4a	Amount:	What is the total of all one-time income %Name% is expecting during %coverage year% from this employer?
%Name%'s job	Heading	**Is any of this income from these sources?**	**If you're American Indian or Alaska Native, we need to know about any of your income that comes from these sources:** **·Per capita payments from your tribe that come from natural resources, usage rights, leases or royalties: These are payments from certain legal settlements. Enter any per capita payments that you get from certain settlements of tribal trust cases between the U.S. and those Indian tribes.** **·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): Payments from land held in trust by the Interior Department for a member of an Indian tribe. If you receive this, enter payments from natural resources, farming, and ranching on allotted land held in trust for you by the Interior Department.** **·Money from selling things that have cultural significance: These are payments from selling tangible items that have cultural significance, like documents, art work, or clothing.** **Your answers won't be counted when we decide whether or not your family is eligible for Medicaid and Dr. Dynasaur. This income will still be included when your yearly income is calculated for purposes of your eligibility for lowering monthly premiums if you enroll in a private health plan. You may need to send us proof of income.**
%Name%'s job	6	Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties?	Did %Name% receive per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties?
%Name%'s job	7	Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations or former reservations)?	Did %Name% receive per capita payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior?
%Name%'s job	8	Money from selling things that have cultural significance?	Did %Name% receive money from selling things that have cultural significance?
%Name%'s self-employment	Heading	**Please tell us about %Name%'s self-employment income.**	**Please tell us about %Name%'s self-employment income.**

%Name%'s self-employment	1	*How much net income (profits once business expenses are paid) will %Name% get from this self-employment this month? If the costs of self-employment are more than the amount %Name% expects to earn, you should list amount as a loss instead of a profit.	Self-employment net income is the money that is left after business expenses are paid. If there is money left after business expenses, this is called a profit. If your expenses are more than your income, this is called a loss. Not all losses can be deducted from your income. Please consult with a tax advisor if you have questions about which losses can be counted. How much self-employment net income will %Name% receive this month?
%Name%'s self-employment	2	Is this amount a profit or a loss?	Is this amount a profit or a loss?
%Name%'s self-employment	3	Type of work:	As a self-employed worker, what type of work does %Name% do?
%Name%'s self-employment	Heading	**Is any of this income from these sources?**	**If you're American Indian or Alaska Native, we need to know about any of your income that comes from these sources:** **·Per capita payments from your tribe that come from natural resources, usage rights, leases or royalties: These are payments from certain legal settlements. Enter any per capita payments that you get from certain settlements of tribal trust cases between the U.S. and those Indian tribes.** **·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): Payments from land held in trust by the Interior Department for a member of an Indian tribe. If you receive this, enter payments from natural resources, farming, and ranching on allotted land held in trust for you by the Interior Department.** **·Money from selling things that have cultural significance: These are payments from selling tangible items that have cultural significance, like documents, art work, or clothing.** **Your answers won't be counted when we decide whether or not your family is eligible for Medicaid and Dr. Dynasaur. This income will still be included when your yearly income is calculated for purposes of your eligibility for lowering monthly premiums if you enroll in a private health plan. You may need to send us proof of income.**
%Name%'s self-employment	4	Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties?	Did %Name% receive per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties?
%Name%'s self-employment	5	Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations or former reservations)?	Did %Name% receive per capita payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior?
%Name%'s self-employment	6	Money from selling things that have cultural significance?	Did %Name% receive money from selling things that have cultural significance?

%Name%'s Social Security benefits	Heading	**Please tell us about %Name%'s Social Security benefits.**	**Social Security benefits refers to money people get from Social Security Disability (SSDI), Social Security retirement (SSA) including Railroad retirement, or Survivor's Benefits each month.** **This does not include Supplemental Security Income (SSI).** **Please tell us about %Name%'s Social Security benefits.**
%Name%'s Social Security benefits	1	How much does %Name% get from Social Security? Don't include Supplemental Security Income (SSI).	How much does %Name% get from Social Security? Don't include Supplemental Security Income (SSI).
%Name%'s Social Security benefits	2	How often does %name% get this amount?	How often does %name% get this amount?
%Name%'s Social Security benefits	3	Start date (MM/DD/YYYY):	When did %Name% start receiving these Social Security benefits? (MM/DD/YYYY) (If you started receiving these Social Security Benefits before the date shown at the right, please do not change the date.)
%Name%'s Social Security benefits	4	End date (MM/DD/YYYY):	When will %Name% stop receiving these Social Security benefits? (MM/DD/YYYY) (If you expect to continue receiving these Social Security Benefits after the date shown at the right, please do not change the date.)
%Name%'s unemployment benefits	Heading	**Please tell us about %Name%'s unemployment benefits.**	**Unemployment benefits refers to money provided by a state government or former employer to some people who have lost their job. Please tell us about %Name%'s unemployment benefits.**
%Name%'s unemployment benefits	1	From what state government or former employer does %Name% get unemployment benefits?	Who provides unemployment benefits to %Name%?
%Name%'s unemployment benefits	2	How much does %Name% get?	How much does %Name% get?
%Name%'s unemployment benefits	3	How often does %Name% get this amount?	How often does %Name% get this amount?
%Name%'s unemployment benefits	4	Start date (MM/DD/YYYY):	When did %Name% start receiving unemployment benefits? (MM/DD/YYYY) (If you started receiving unemployment benefits before the date shown at the right, please do not change the date.)
%Name%'s unemployment benefits	5	End date (MM/DD/YYYY):	When will %Name% stop receiving unemployment benefits? (MM/DD/YYYY) (If you expect to continue receiving unemployment benefits after the date shown at the right, please do not change the date.)
%Name%'s untaxable foreign earned income	Heading		**Please tell us about %Name%'s foreign earned income.**
%Name%'s untaxable foreign earned income	1		How much does %Name% get from untaxable foreign earned income?
%Name%'s untaxable foreign earned income	2		How often does %Name% get this amount?

%Name%'s untaxable foreign earned income	3		Start date (MM/DD/YYYY):
%Name%'s untaxable foreign earned income	4		End date (MM/DD/YYYY):
%Name%'s interest income	Heading		**Please tell us about the income %Name% has received from this interest income.**
%Name%'s interest income	1		How much does %Name% get from this interest income?
%Name%'s interest income	2		How often does %Name% get this amount?
%Name%'s interest income	3		Start date (MM/DD/YYYY):
%Name%'s interest income	4		End date (MM/DD/YYYY):
%Name%'s interest received or accrued	Heading		**Please tell us about %Name%'s interest received or accrued during the taxable year which is exempt from tax.**
%Name%'s interest received or accrued	1		How much does %Name% get from interest received or accrued?
%Name%'s interest received or accrued	2		How often does %Name% get this amount?
%Name%'s interest received or accrued	3		Start date (MM/DD/YYYY):
%Name%'s interest received or accrued	4		End date (MM/DD/YYYY):
%Name%'s retirement account	Heading	**Please tell us about %Name%'s retirement account.**	**Some people have savings and investments in a retirement account that provides them with money after they stop working. Please tell us about %Name%'s retirement account payments.**
%Name%'s retirement account	1	How much does %Name% get from this retirement account? Include amounts received as a distribution from a retirement investment even if %Name% isn't retired.	How much does %Name% get from this retirement account? This includes retirement money that is paid out even if %Name% hasn't retired yet.
%Name%'s retirement account	2	How often does %Name% get this amount?	How often does %Name% get this amount?
%Name%'s retirement account	3	Start date (MM/DD/YYYY):	When did %Name% start receiving this retirement amount? (MM/DD/YYYY) (If you started receiving this retirement amount before the date shown at the right, please do not change the date.)

%Name%'s retirement account	4	End date (MM/DD/YYYY):	When will %Name% stop receiving this retirement amount? (MM/DD/YYYY) (If you expect to continue receiving this retirement amount after the date shown at the right, please do not change the date.)
%Name%'s retirement account	Heading	Is any of this income from these sources?	**If you're American Indian or Alaska Native, we need to know about any of your income that comes from these sources:** **·Per capita payments from your tribe that come from natural resources, usage rights, leases or royalties: These are payments from certain legal settlements. Enter any per capita payments that you get from certain settlements of tribal trust cases between the U.S. and those Indian tribes.** **·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): Payments from land held in trust by the Interior Department for a member of an Indian tribe. If you receive this, enter payments from natural resources, farming, and ranching on allotted land held in trust for you by the Interior Department.** **·Money from selling things that have cultural significance: These are payments from selling tangible items that have cultural significance, like documents, art work, or clothing.** **Your answers won't be counted when we decide whether or not your family is eligible for Medicaid and Dr. Dynasaur. This income will still be included when your yearly income is calculated for purposes of your eligibility for lowering monthly premiums if you enroll in a private health plan. You may need to send us proof of income.**
%Name%'s retirement account	5	Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties?	Did %Name% receive per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties?
%Name%'s retirement account	6	Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations or former reservations)?	Did %Name% receive per capita payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior?
%Name%'s retirement account	7	Money from selling things that have cultural significance?	Did %Name% receive money from selling things that have cultural significance?
%Name%'s retirement account	Heading	**Please tell us about %Name%'s pension account.**	**A pension refers to money paid out to someone by their former employer after they retire from their job. Please tell us about %Name%'s pension account.**
%Name%'s retirement account	1	How much does %Name% get from this pension account? Include amounts received as a distribution from a retirement investment even if %Name% isn't retired.	How much does %Name% get from this pension account? This includes retirement money that is paid out even if %Name% hasn't retired yet.
%Name%'s retirement account	2	How often does %Name% get this amount?	How often does %Name% get this amount?
%Name%'s retirement account	3	Start date (MM/DD/YYYY):	When did %Name% start receiving this pension amount? (MM/DD/YYYY) (If you started receiving this pension amount before the date shown at the right, please do not change the date.)
%Name%'s retirement account	4	End date (MM/DD/YYYY):	When will %Name% stop receiving this pension amount? (MM/DD/YYYY) (If you expect to continue receiving this pension amount after the date shown at the right, please do not change the date.)

%Name%'s retirement account	Heading	**Is any of this income from these sources?**	**If you're American Indian or Alaska Native, we need to know about any of your income that comes from these sources:** **·Per capita payments from your tribe that come from natural resources, usage rights, leases or royalties: These are payments from certain legal settlements. Enter any per capita payments that you get from certain settlements of tribal trust cases between the U.S. and those Indian tribes.** **·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): Payments from land held in trust by the Interior Department for a member of an Indian tribe. If you receive this, enter payments from natural resources, farming, and ranching on allotted land held in trust for you by the Interior Department.** **·Money from selling things that have cultural significance: These are payments from selling tangible items that have cultural significance, like documents, art work, or clothing.** **Your answers won't be counted when we decide whether or not your family is eligible for Medicaid and Dr. Dynasaur. This income will still be included when your yearly income is calculated for purposes of your eligibility for lowering monthly premiums if you enroll in a private health plan. You may need to send us proof of income.**
%Name%'s retirement account	5	Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties?	Did %Name% receive per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties?
%Name%'s retirement account	6	Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations or former reservations)?	Did %Name% receive per capita payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior?
%Name%'s retirement account	7	Money from selling things that have cultural significance?	Did %Name% receive money from selling things that have cultural significance?
%Name%'s capital gains	Heading	**Please tell us about %Name%'s capital gains.**	**A capital gain is a profit that comes from selling something such as stocks, bonds or real estate for a higher amount than it cost to buy it. Please tell us about %Name's% capital gains.**
%Name%'s capital gains	1	How much does %Name% expect to get from net capital gains (the profit after subtracting capital losses) this month?	How much capital gains net income will %Name% receive this month?
%Name%'s capital gains	2	Is this amount a profit or a loss?	Is this amount a profit or a loss? Not all losses can be deducted from your income. Please consult with a tax advisor if you have questions about which losses can be counted.
%Name%'s capital gains	3	How much does %Name% expect to get from net capital gains (the profit after subtracting capital losses) this year?	How much capital gains net income will %Name% receive this year?
%Name%'s capital gains	4	Is this amount a profit or a loss?	Is this amount a profit or a loss?

%Name%'s capital gains	Heading	Is any of this income from these sources?	**If you're American Indian or Alaska Native, we need to know about any of your income that comes from these sources:** **·Per capita payments from your tribe that come from natural resources, usage rights, leases or royalties: These are payments from certain legal settlements. Enter any per capita payments that you get from certain settlements of tribal trust cases between the U.S. and those Indian tribes.** **·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): Payments from land held in trust by the Interior Department for a member of an Indian tribe. If you receive this, enter payments from natural resources, farming, and ranching on allotted land held in trust for you by the Interior Department.** **·Money from selling things that have cultural significance: These are payments from selling tangible items that have cultural significance, like documents, art work, or clothing.** **Your answers won't be counted when we decide whether or not your family is eligible for Medicaid and Dr. Dynasaur. This income will still be included when your yearly income is calculated for purposes of your eligibility for lowering monthly premiums if you enroll in a private health plan. You may need to send us proof of income.**
%Name%'s capital gains	5	Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties?	Did %Name% receive per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties?
%Name%'s capital gains	6	Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations or former reservations)?	Did %Name% receive per capita payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior?
%Name%'s capital gains	7	Money from selling things that have cultural significance?	Did %Name% receive money from selling things that have cultural significance?
%Name%'s commission income	Heading	**Please tell us about %Name%'s commission income.**	**Commission income is payment made to someone based on services or items they have provided or sold. Please tell us about %Name%'s commission income.**
%Name%'s commission income	1	How much does %Name% expect to get from net commission income (the profit after subtracting capital losses) this month?	Commission net income is the money that is left after expenses are paid. If there is money left, this is called a profit. If there is no money left, this is called a loss. How much commission net income will %Name% receive this month?
%Name%'s commission income	2	Is this amount a profit or a loss?	Is this amount a profit or a loss?
%Name%'s commission income	3	How much does %Name% expect to get from net capital gains (the profit after subtracting capital losses) this year?	Commission net income is the money that is left after expenses are paid. If there is money left, this is called a profit. If your expenses are more than your income, this is called a loss. Not all losses can be deducted from your income. Please consult with a tax advisor if you have questions about which losses can be counted. How much commission net income will %Name% receive this year?

%Name%'s commission income	4	Is this amount a profit or a loss?	Is this amount a profit or a loss?
%Name%'s commission income	Heading	**Is any of this income from these sources?**	**If you're American Indian or Alaska Native, we need to know about any of your income that comes from these sources:** **·Per capita payments from your tribe that come from natural resources, usage rights, leases or royalties: These are payments from certain legal settlements. Enter any per capita payments that you get from certain settlements of tribal trust cases between the U.S. and those Indian tribes.** **·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): Payments from land held in trust by the Interior Department for a member of an Indian tribe. If you receive this, enter payments from natural resources, farming, and ranching on allotted land held in trust for you by the Interior Department.** **·Money from selling things that have cultural significance: These are payments from selling tangible items that have cultural significance, like documents, art work, or clothing.** **Your answers won't be counted when we decide whether or not your family is eligible for Medicaid and Dr. Dynasaur. This income will still be included when your yearly income is calculated for purposes of your eligibility for lowering monthly premiums if you enroll in a private health plan. You may need to send us proof of income.**
%Name%'s commission income	5	Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties?	Did %Name% receive per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties?
%Name%'s commission income	6	Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations or former reservations)?	Did %Name% receive per capita payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior?
%Name%'s commission income	7	Money from selling things that have cultural significance?	Did %Name% receive money from selling things that have cultural significance?
%Name%'s investment income	Heading	**Please tell us about %Name%'s investment income.**	**Investment income refers to taxable dividends or interest that comes from money invested in stocks, bonds, bank accounts, and other funds. Please tell us about %Name's% investment income.**
%Name%'s investment income	1	How much does %Name% get from investment income, like interest and dividends?	How much does %Name% usually get from investment income payments?
%Name%'s investment income	2	How often does %Name% get this amount?	How often does %Name% get this amount?
%Name%'s investment income	3	Start date (MM/DD/YYYY):	When did %Name% start receiving this investment income? (MM/DD/YYYY) (If you started receiving this investment income before the date shown at the right, please do not change the date.)
%Name%'s investment income	4	End date (MM/DD/YYYY):	When will %Name% stop receiving this investment income? (MM/DD/YYYY) (If you expect to continue receiving this investment income after the date shown at the right, please do not change the date.)

%Name%'s investment income	Heading	Is any of this income from these sources?	**If you're American Indian or Alaska Native, we need to know about any of your income that comes from these sources:** **·Per capita payments from your tribe that come from natural resources, usage rights, leases or royalties: These are payments from certain legal settlements. Enter any per capita payments that you get from certain settlements of tribal trust cases between the U.S. and those Indian tribes.** **·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): Payments from land held in trust by the Interior Department for a member of an Indian tribe. If you receive this, enter payments from natural resources, farming, and ranching on allotted land held in trust for you by the Interior Department.** **·Money from selling things that have cultural significance: These are payments from selling tangible items that have cultural significance, like documents, art work, or clothing.** **Your answers won't be counted when we decide whether or not your family is eligible for Medicaid and Dr. Dynasaur. This income will still be included when your yearly income is calculated for purposes of your eligibility for lowering monthly premiums if you enroll in a private health plan. You may need to send us proof of income.**
%Name%'s investment income	5	Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties?	Did %Name% receive per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties?
%Name%'s investment income	6	Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations or former reservations)?	Did %Name% receive per capita payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior?
%Name%'s investment income	7	Money from selling things that have cultural significance?	Did %Name% receive money from selling things that have cultural significance?
%Name%'s rental or royalty income	Heading	**Please tell us about %Name%'s rental or royalty income.**	**Please tell us about %Name%'s rental or royalty income.**
%Name%'s rental or royalty income	1	How much does %Name% get from net rental or royalty income (the profit after subtracting costs)?	Rental or royalty net income is the money that is left after expenses are paid. If there is money left, this is called a profit. If your expenses are greater than your income, this is called a loss. Not all losses can be deducted from your income. Please consult with a tax advisor if you have questions about which losses can be counted. How much rental or royalty net income will %Name% receive this month?
%Name%'s rental or royalty income	2	Is this amount a profit or a loss?	Is this amount a profit or a loss?
%Name%'s rental or royalty income	3	How often does %Name% get this amount?	How often does %Name% get this amount?

%Name%'s rental or royalty income	4	Start date (MM/DD/YYYY):	When did %Name% start receiving this rental/royalty income? (MM/DD/YYYY) (If you started receiving this rental/royalty income before the date shown at the right, please do not change the date.)
%Name%'s rental or royalty income	5	End date (MM/DD/YYYY):	When will you stop receiving this rental/royalty income? (MM/DD/YYYY) (If you expect to continue receiving this rental/royalty income after the date shown at the right, please do not change the date.)
%Name%'s rental or royalty income	Heading	Is any of this income from these sources?	**If you're American Indian or Alaska Native, we need to know about any of your income that comes from these sources:** **·Per capita payments from your tribe that come from natural resources, usage rights, leases or royalties: These are payments from certain legal settlements. Enter any per capita payments that you get from certain settlements of tribal trust cases between the U.S. and those Indian tribes.** **·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): Payments from land held in trust by the Interior Department for a member of an Indian tribe. If you receive this, enter payments from natural resources, farming, and ranching on allotted land held in trust for you by the Interior Department.** **·Money from selling things that have cultural significance: These are payments from selling tangible items that have cultural significance, like documents, art work, or clothing.** **Your answers won't be counted when we decide whether or not your family is eligible for Medicaid and Dr. Dynasaur. This income will still be included when your yearly income is calculated for purposes of your eligibility for lowering monthly premiums if you enroll in a private health plan. You may need to send us proof of income.**
%Name%'s rental or royalty income	6	Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties?	Did %Name% receive per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties?
%Name%'s rental or royalty income	7	Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations or former reservations)?	Did %Name% receive per capita payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior?
%Name%'s rental or royalty income	8	Money from selling things that have cultural significance?	Did %Name% receive money from selling things that have cultural significance?
%Name%'s farming or fishing income	Heading	**Please tell us about %Name%'s farming or fishing income.**	**Please tell us about %Name%'s farming or fishing income.**
%Name%'s farming or fishing income	1	How much does %Name% get from net farming or fishing income (the profit after subtracting costs)?	Farming or fishing net income is the money that is left after expenses are paid. If there is money left, this is called a profit. If expenses are greater than income, this is called a loss. How much farming or fishing net income will %Name% receive this month?

%Name%'s farming or fishing income	2	Is this amount a profit or a loss?	Is this amount a profit or a loss?
%Name%'s farming or fishing income	3	How often does %Name% get this amount?	How often does %Name% get this amount?
%Name%'s farming or fishing income	4	Start date (MM/DD/YYYY):	When did %Name% start receiving this farming or fishing income? (MM/DD/YYYY) (If you started receiving this farming or fishing income before the date shown at the right, please do not change the date.)
%Name%'s farming or fishing income	5	End date (MM/DD/YYYY):	When will %Name% stop receiving this farming or fishing income? (MM/DD/YYYY) (If you expect to continue receiving this farming or fishing income after the date shown at the right, please do not change the date.)
%Name%'s farming or fishing income	Heading	Is any of this income from these sources?	**If you're American Indian or Alaska Native, we need to know about any of your income that comes from these sources:** **·Per capita payments from your tribe that come from natural resources, usage rights, leases or royalties: These are payments from certain legal settlements. Enter any per capita payments that you get from certain settlements of tribal trust cases between the U.S. and those Indian tribes.** **·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): Payments from land held in trust by the Interior Department for a member of an Indian tribe. If you receive this, enter payments from natural resources, farming, and ranching on allotted land held in trust for you by the Interior Department.** **·Money from selling things that have cultural significance: These are payments from selling tangible items that have cultural significance, like documents, art work, or clothing.** **Your answers won't be counted when we decide whether or not your family is eligible for Medicaid and Dr. Dynasaur. This income will still be included when your yearly income is calculated for purposes of your eligibility for lowering monthly premiums if you enroll in a private health plan. You may need to send us proof of income.**
%Name%'s farming or fishing income	6	Per capita payments from the tribe that come from natural resources, usage rights, leases or royalties?	Did %Name% receive per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties?
%Name%'s farming or fishing income	7	Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations or former reservations)?	Did %Name% receive per capita payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior?
%Name%'s farming or fishing income	8	Money from selling things that have cultural significance?	Did %Name% receive money from selling things that have cultural significance?
%Name%'s alimony received	Heading	Please tell us about the alimony payments that %name% receives.	**Alimony is financial support a person receives from his or her spouse before or after a separation or divorce. Please tell us about the alimony payments that %Name% receives.**

%Name%'s alimony received	1	How much does %name% get from alimony?	How much does %name% get from alimony?
%Name%'s alimony received	2	How often does %Name% get this amount?	How often does %Name% get this amount?
%Name%'s alimony received	3	Start date (MM/DD/YYYY):	When did %Name% start receiving these alimony payments? (MM/DD/YYYY) (If you started receiving these alimony payments before the date shown at the right, please do not change the date.)
%Name%'s alimony received	4	End date (MM/DD/YYYY):	When will %Name% stop receiving these alimony payment? (MM/DD/YYYY) (If you expect to continue receiving these alimony payments after the date shown at the right, please do not change the date.)
%Name%'s canceled debts	Heading		**When a lender no longer requires a person to pay off a debt, this is called cancelled debt. That person is required to count the cancelled debt as income for tax purposes. Please tell us about %name%'s canceled debts.**
%Name%'s canceled debts	1		How much does %name% get from canceled debts?
%Name%'s canceled debts	2		How often does %Name% get this amount?
%Name%'s canceled debts	3		When did %name% start receiving this canceled debt income? (MM/DD/YYYY) (If you started receiving this canceled debt income before the date shown at the right, please do not change the date.)
%Name%'s canceled debts	4		When will %Name% stop receiving this canceled debts? (MM/DD/YYYY) (If you expect to continue receiving this canceled debts after the date shown at the right, please do not change the date.)
%Name%'s canceled debts	Heading		**If you're American Indian or Alaska Native, we need to know about any of your income that comes from these sources:** **·Per capita payments from your tribe that come from natural resources, usage rights, leases or royalties: These are payments from certain legal settlements. Enter any per capita payments that you get from certain settlements of tribal trust cases between the U.S. and those Indian tribes.** **·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): Payments from land held in trust by the Interior Department for a member of an Indian tribe. If you receive this, enter payments from natural resources, farming, and ranching on allotted land held in trust for you by the Interior Department.** **·Money from selling things that have cultural significance: These are payments from selling tangible items that have cultural significance, like documents, art work, or clothing.** **Your answers won't be counted when we decide whether or not your family is eligible for Medicaid and Dr. Dynasaur. This income will still be included when your yearly income is calculated for purposes of your eligibility for lowering monthly premiums if you enroll in a private health plan. You may need to send us proof of income.**

%Name%'s canceled debts	5		Did %Name% receive per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties?
%Name%'s canceled debts	6		Did %Name% receive per capita payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior?
%Name%'s canceled debts	7		Did %Name% receive money from selling things that have cultural significance?
%Name%'s court awards	Heading		**Court awards refers to money that is given to someone as the result of a lawsuit. Please tell us about %Name%'s court awards.**
%Name%'s court awards	1		How much does %name% get from court awards?
%Name%'s court awards	2		How often does %Name% get this amount?
%Name%'s court awards	3		When did %Name% start receiving court award payment? (MM/DD/YYYY) (If you started receiving court awards before the date shown at the right, please do not change the date.)
%Name%'s court awards	4		When will %Name% stop receiving court award payment? (MM/DD/YYYY) (If you expect to continue receiving court awards after the date shown at the right, please do not change the date.)
%Name%'s court awards	Heading		**If you're American Indian or Alaska Native, we need to know about any of your income that comes from these sources:** **·Per capita payments from your tribe that come from natural resources, usage rights, leases or royalties: These are payments from certain legal settlements. Enter any per capita payments that you get from certain settlements of tribal trust cases between the U.S. and those Indian tribes.** **·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): Payments from land held in trust by the Interior Department for a member of an Indian tribe. If you receive this, enter payments from natural resources, farming, and ranching on allotted land held in trust for you by the Interior Department.** **·Money from selling things that have cultural significance: These are payments from selling tangible items that have cultural significance, like documents, art work, or clothing.** **Your answers won't be counted when we decide whether or not your family is eligible for Medicaid and Dr. Dynasaur. This income will still be included when your yearly income is calculated for purposes of your eligibility for lowering monthly premiums if you enroll in a private health plan. You may need to send us proof of income.**
%Name%'s court awards	5		Did %Name% receive per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties?
%Name%'s court awards	6		Did %Name% receive per capita payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior?

%Name%'s court awards	7		Did %Name% receive money from selling things that have cultural significance?
%Name%'s jury duty pay	Heading		**Money that people receive for spending time serving on a jury is called jury pay. Please tell us about %Name%'s jury pay income.**
%Name%'s jury duty pay	1		How much does %name% get from jury pay?
%Name%'s jury duty pay	2		How often does %Name% get this amount?
%Name%'s jury duty pay	3		When did %Name% start receiving this jury pay? (MM/DD/YYYY) (If you started receiving this jury pay before the date shown at the right, please do not change the date.)
%Name%'s jury duty pay	4		When will %Name% stop receiving this jury pay? (MM/DD/YYYY) (If you expect to continue receiving this jury pay after the date shown at the right, please do not change the date.)
%Name%'s jury duty pay	5		Was the Jury Duty Pay remitted to the employer?
%Name%'s gambling, prizes, or awards	Heading		**Please tell us about the income %Name% has received from gambling, prizes, or awards.**
%Name%'s gambling, prizes, or awards	1		How much does %name% get from gambling, prizes, or awards?
%Name%'s gambling, prizes, or awards	2		How often does %Name% get this amount?
%Name%'s gambling, prizes, or awards	3		When did %Name% start receiving this income from gambling, prizes, or awards? (MM/DD/YYYY) (If you started receiving this income from gambling, prizes, or awards before the date shown at the right, please do not change the date.)
%Name%'s gambling, prizes, or awards	4		When will %Name% stop receiving this income from gambling, prizes, or awards? (MM/DD/YYYY) (If you expect to continue receiving this income from gambling, prizes, or awards after the date shown at the right, please do not change the date.)

%Name%'s gambling, prizes, or awards	Heading		**If you're American Indian or Alaska Native, we need to know about any of your income that comes from these sources:** **·Per capita payments from your tribe that come from natural resources, usage rights, leases or royalties: These are payments from certain legal settlements. Enter any per capita payments that you get from certain settlements of tribal trust cases between the U.S. and those Indian tribes.** **·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): Payments from land held in trust by the Interior Department for a member of an Indian tribe. If you receive this, enter payments from natural resources, farming, and ranching on allotted land held in trust for you by the Interior Department.** **·Money from selling things that have cultural significance: These are payments from selling tangible items that have cultural significance, like documents, art work, or clothing.** **Your answers won't be counted when we decide whether or not your family is eligible for Medicaid and Dr. Dynasaur. This income will still be included when your yearly income is calculated for purposes of your eligibility for lowering monthly premiums if you enroll in a private health plan. You may need to send us proof of income.**
%Name%'s gambling, prizes, or awards	5		Did %Name% receive per capita payments from a tribe that comes from natural resources, usage rights, leases, or royalties?
%Name%'s gambling, prizes, or awards	6		Did %Name% receive per capita payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior?
%Name%'s gambling, prizes, or awards	7		Did %Name% receive money from selling things that have cultural significance?
%Name%'s educational scholarship	Heading		**A scholarship or grant is an amount of money that is given by a school or an organization to a student to help pay for the student's education. Please tell us about %Name%'s scholarship or grant to pay for educational expenses.**
%Name%'s educational scholarship	1a		How much does %Name% get from a scholarship or grant that is used to pay for educational expenses?
%Name%'s educational scholarship	1b		How often does %Name% get this amount?
%Name%'s educational scholarship	2		When did %Name% start receiving this grant or scholarship? (MM/DD/YYYY) (If you started receiving this grant or scholarship before the date shown at the right, please do not change the date.)
%Name%'s educational scholarship	3		When will %Name% stop receiving this grant or scholorship? (MM/DD/YYYY) (If you expect to continue receiving this grant or scholorship after the date shown at the right, please do not change the date.)

%Name%'s one-time payment	Heading		**Please tell us the date that %name% received or will receive the one-time payment from %income source type%.**
%Name%'s one-time payment	1		When did or will %Name% receive the one time payment?
%Name%'s Deduction Sources	Heading		**Please think about all of the sources of deductions that %name% expects to get throughout %coverage year%. For each deduction source, select the deduction type. To add another deduction source click "Add Another Deduction Source." To take one away click the X.**
%Name%'s Deduction Sources	1		Deduction type:
%Name%'s Deduction Details	Heading		**Please tell us more about %Name%'s %deduction source type% deduction.**
%Name%'s Deduction Details	1		What is %Name%'s deduction amount?
%Name%'s Deduction Details	2		What is %Name%'s deduction frequency?
%Name%'s Deduction Details	3		What is %Name%'s deduction start date?
%Name%'s Deduction Details	4		What is %Name%'s deduction end date?
%Name%'s One-Time Deduction	Heading		**Please tell us the date that %name%'s deduction from %deduction source type% occurred or will occur.**
%Name%'s One-Time Deduction	1		Date %Name%'s one-time deduction occurred or will occur:
%Name%'s Income this year	Heading		**Based on what you told us, if %Name%'s income is steady each month, then it is about %the household member's calculated annual tax MAGI% per year.** **Please note that you must report changes to your application, including income, to Vermont Health Connect in a timely manner. When you report income changes the amount of financial help you receive may also change.**
%Name%'s Income this year	1		Is this how much you think %name% will get in %coverage year%?
%Name%'s Income this year	2		Based on what you know today, how much do you think %name% will make in %coverage year%?
Household Health Coverage	Heading		**Please think about the time period you are applying for coverage. We need to know if any household members are also enrolled in other health coverage.** **If your insurance under one of these programs is ending and you are applying for new insurance (including Medicaid or Dr. Dynasaur coverage) please answer "No."**
Household Health Coverage	Heading		**During the period for which %name% is applying for coverage, is %name% enrolled in, one of the forms of health insurance programs listed below?**
Household Health Coverage	1		Please tell us if someone in the household receives Medicaid/Dr.Dynasaur benefits.

Household Health Coverage	3		Please tell us if someone is eligible for or enrolled in either Medicare Part A or Part B.
Household Health Coverage	4		TRICARE? (Don't check this if you have *Direct Care* or *Line of Duty)*
Household Health Coverage	5		VA health care program?
Household Health Coverage	6		Peace Corps?
Household Health Coverage	Household Health Coverage		Is anyone enrolled in individual health insurance? Answer "No" if someone receives insurance through an employer, a spouse's employer, or a parent's employer.
Household Health Coverage	8		Employer-sponsored insurance?
Household Health Coverage	9		Other limited benefit coverage (like a school accident policy)?
People enrolled in %name of state Medicaid program%	Heading		**Who's enrolled in or able to get %name of state medicaid program%. ?**
People enrolled in %name of state Medicaid program%	1		People enrolled in Medicaid/Dr. Dynasaur: %Name%
People enrolled in Medicare	Heading		**Medicare is a government program of hospital insurance and voluntary medical insurance for people who are 65 or older or who have certain disabilities. Please select all of the people who have Medicare coverage or who are eligible for insurance from Medicare.**
People enrolled in Medicare	1		People enrolled in Medicare: %Name%
%Name%'s Medicare Part A information	Heading		**Medicare Part A pays for hosptial services. Please tell us about %Name%'s Medicare Part A information.**
%Name%'s Medicare Part A information	1		Is %Name% enrolled in Medicare Part A?
%Name%'s Medicare Part A enrollment follow up	Heading		**Please tell us about %Name%'s Medicare Part A information.**
%Name%'s Medicare Part A enrollment follow up	1		Could %Name% receive Medicare Part A without paying a premium?

%Name%'s Medicare Part A enrollment follow up	2		Does %Name% pay a premium for Medicare Part A?
%Name%'s Medicare Part B information	Heading		**Medicare B pays for physician services. Please tell us about %Name%'s Medicare Part B information.**
%Name%'s Medicare Part B information	1		Is %Name% enrolled in Medicare Part B?
%Name% health plan eligibility	Heading		**Due to %NAme%'s current enrollment in Medicare, %NAme% is ineligible to enroll in a health insurance plan. However, because %NAme% currently pays a premium for Medicare, %NAme% may become eligible to enroll in a health insurance plan.** **Please contact the Vermont Office of Health Care Advocate at 800-917-7787**
%Name% health plan eligibility	1		I've read and understand the statement above.
%Name%'s Medicare policy	Heading		**Please tell us about %Name%'s Medicare policy.**
%Name%'s Medicare policy	1		What is the name of %Name%'s health insurance company?
%Name%'s Medicare policy	2		What is the policy number or member ID?
People enrolled in TRICARE	Heading		**Please select everyone who has TRICARE insurance.**
People enrolled in TRICARE	1		People enrolled in TRICARE: %Name%
%Name%'s TRICARE policy	Heading		**Please tell us about %Name%'s TRICARE policy.**
%Name%'s TRICARE policy	1		What is the name of %Name%'s health insurance company?
%Name%'s TRICARE policy	2		What is the policy number or member ID?
People enrolled in a VA health care program	Heading		**Please select all of the people who are already covered by the VA health care program.**
People enrolled in a VA health care program	1		People enrolled in VA health care: %Name%

%Name%'s VA health care program policy	Heading		**Please tell us about %Name%'s VA health care program policy.**
%Name%'s VA health care program policy	1		What is the name of %Name%'s health insurance company?
%Name%'s VA health care program policy	2		What is the policy number or member ID?
People enrolled in Peace Corps	Heading		**Please select everyone enrolled in insurance from the Peace Corps.**
People enrolled in Peace Corps	1		Who has insurance through the Peace Corps?
%Name%'s Peace Corps Policy	Heading		**Please tell us about %Name%'s Peace Corps policy.**
%Name%'s Peace Corps Policy	1		What is the name of %Name%'s health insurance company?
%Name%'s Peace Corps Policy	2		What is the policy number or member ID?
People enrolled in individual insurance	Heading		**Please select everyone who already has have some type of individual insurance. Answer NO if the person's insurance is from an employer, a spouse's employer , or a parent's employer.**
People enrolled in individual insurance	1		People enrolled in individual insurance: %Name%
%Name%'s individual insurance policy	Heading		**Please tell us about %Name%'s individual insurance policy.**
%Name%'s individual insurance policy	1		What is the name of %Name%'s health insurance company?
%Name%'s individual insurance policy	2		What is the policy number or member ID?
People enrolled in employer-sponsored insurance	Heading		**Please select everyone who has insurance from an employer.**
People enrolled in employer-sponsored insurance	1		People enrolled in employer-sponsored insurance: %Name%

%Name%'s employer-sponsored insurance policy	Heading		**Please tell us about %Name%'s employer-sponsored insurance policy.**
%Name%'s employer-sponsored insurance policy	1		What is the name of %Name%'s health insurance company?
%Name%'s employer-sponsored insurance policy	2		What is the policy number or member ID?
People enrolled in other limited benefits	Heading		**Who has limited-benefit health insurance? (For example, for a student)**
People enrolled in other limited benefits	1		Who has limited-benefit health insurance?
%Name%'s other limited benefit coverage	Heading		**Please tell us about %Name%'s limited benefit health insurance.**
%Name%'s other limited benefit coverage	1		What is the name of %Name%'s health insurance company?
%Name%'s other limited benefit coverage	2		What is the policy number or member ID?
Does %Employer% offer health coverage?	Heading		**Please tell us if %employer% offers health insurance to the employee or the employee's family members in %coverage year%. Please answer Yes to this question if %employer% offers insurance, even if the employee or the employee's family members are not enrolled.**
Does %Employer% offer health coverage?	1		Is anyone in the household eligible for health insurance offered by %employer%?
Does %Employer% offer health coverage?	2		Is %Name% eligible for health coverage offered by %employer%?
People eligible for health coverage from %employer%	Heading		**Please tell us which household members are eligible to enroll in health insurance from %employer%. Please select the person's name even if they are not enrolled.**

People eligible for health coverage from %employer%	1		People eligible for %employer% health insurance: %Name%
People enrolled in health coverage from %employer%	Heading		**Who is currently enrolled in this health insurance from %employer%.**
People enrolled in health coverage from %employer%	1		People enrolled in %employer% health insurance: %Name%
People enrolled in health coverage from %employer%	Heading		**Please tell us if %Name% is enrolled in this coverage from %employer%.**
People enrolled in health coverage from %employer%	1		Is %Name% enrolled in health coverage from %employer%?
%Employer%'s health coverage policy	Heading		Please tell us about the health insurance policy from %employer%.
%Employer%'s health coverage policy	1		What is the name of %Name%'s health insurance company?
%Employer%'s health coverage policy	2		What is the policy number or member ID?
%Employer%'s health coverage details	Heading		**Tell us about %Employer%'s health coverage for %coverage year%.** **If you need help with this question, you can print out and complete the Employer Coverage Tool. Give it to %Employer% to get the information you need for this section. #HTTPLINKClick here to download the Employer Coverage Tool.#HTTPLINK** **The Employer Coverage Tool provides step-by-step instructions to answer the questions in this section.**

%Employer%'s health coverage details	1		Does %Employer% offer health insurance that meets the minimum value standard? A health plan meets this standard if it's designed to pay at least 60% of the total cost of medical services for a standard population. If you are unsure, contact your employer or insurance carrier for help.
%Employer%'s health coverage details	Heading		**Next, we'll ask a question about the plans available from %employer%. Please answer this based on the lowest-cost individual plan available. This plan must also meet the minimum value standard. Please do not tell us about the cost of a family plan.**
%Employer%'s health coverage details	1a		How much would %Employee of employer% have to pay in premiums for this plan?
%Employer%'s health coverage details	1b		How often would %Name% pay this?
%Employer%'s health coverage details	Heading		**For the lowest-cost plan that meets the minimum value standard offered to the employee and family members requesting an exemption (only include family plans for family members that do not already have an exemption): If the employer has wellness programs, provide the premium that the employee would pay if they don't get a discount for wellness programs, including smoking cessation programs.**
%Employer%'s health coverage details	1		*How much would the employee have to pay in premiums for this insurance?
%Employer%'s health coverage details	2		How often would the employee pay this amount?
%Employer% contact information	Heading		**Tell us about %Employer%.**
%Employer% contact information	1		Business Street Address (Line 1):
%Employer% contact information	2		Business Street address (Line 2): (optional)
%Employer% contact information	3		Business City:
%Employer% contact information	4		Business State:
%Employer% contact information	5		Business ZIP Code (XXXXX):
%Employer% contact information	6		Business Phone Number (XXX-XXX-XXXX): (optional)
%Employer% contact information	7		Employer Identification Number (EIN) (XXXXXXXXX): (optional)

Coverage from other employers	Heading		**Please %tell us% if any additional employers offer health insurance to anyone in your household in %coverage year%.**
Coverage from other employers	1		Is anyone in the household eligible for health insurance offered by an employer not entered on this application?
Coverage from other employers	2		Is %Name% enrolled in health coverage offered by an employer not entered on this application?
Other employers that offer coverage	Heading		**Please enter all employers who offer health insurance to a household member on this application.** **Add an employer by clicking "Add". To take an employer off the list click "Remove".**
Other employers that offer coverage	1		Employer:
Other employers that offer coverage	2		COBRA insurance is an extension of an employer's insurance after a job loss. Retiree insurance is insurance that is provided by an employer after the employee retires. Is this COBRA health insurance or retiree health insurance?
People enrolled in coverage from other employers	Heading		**Now we would like to know which household members are enrolled in "%employer%'s" health insurance plan. Please select the household members who are currently enrolled in %employer%'s health insurance plan.**
People enrolled in coverage from other employers	1		People enrolled in %employer% health coverage: %Name%
%Employer%'s health coverage policy	Heading		**Please tell us about %employer%'s health insurance policy.**
%Employer%'s health coverage policy	1		What is the name of %Name%'s health insurance company?
%Employer%'s health coverage policy	2		What is the policy number or member ID?
%Name%'s Indian health services	Heading		**Please tell us if %Name% has gotten any of these services.**
%Name%'s Indian health services	1		Has %Name% ever received a health service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs? (If you are unsure click "NO.")
%Name%'s Indian health services	1a		Is %Name% eligible to receive health services from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of these programs? (If you are unsure click "NO.")

Household Special circumstances	Heading	**These next questions ask about events that may have happened in your household in the past [60/30] days. Please think about what has happened in your household since [date of 60 days ago/date of 30 days ago] until today.** **Your responses to the following questions do not affect medical assistance Medicaid/Dr.Dynasaur eligibility.**	**These next questions ask about events that may have happened in your household during the past 60 days. Please think about what has happened in your household between [date 60 days ago] and today.** **Your responses to the following questions do not affect your Medicaid/Dr. Dynasaur eligibility. If you are currently on Medicaid/Dr.Dynasaur and have received a notice telling you to go to Vermont Health Connect to apply for continued healthcare coverage, please check "yes" to the first question below.**
Household Special circumstances	1	*Did anyone in the household lose health coverage in the past 60 days?	Did anyone on this application lose health insurance in the past 60 days?
Household Special circumstances	2	Did anyone in the household get married in the past 60 days?	Did anyone in the household get married in the past 60 days?
Household Special circumstances	3	Has anyone in the household been adopted or placed up for adoption in the past 60 days?	Has anyone joined your household through an adoption in the past 60 days?
Household Special circumstances	4	Has anyone been added to the household through the foster care program?	Has anyone been added to the household through the foster care program in the past 60 days?
Household Special circumstances	5	Did anyone in the household gain US citizenship, eligible immigration status, or become lawfully present in the past 60 days?	Did anyone in the household gain US citizenship, eligible immigration status, or become lawfully present in the past 60 days?
Household Special circumstances	6	Did anyone in the household move to %state of the exchange% in the past 60 days?	Did anyone in the household move to %state of the exchange% in the past 60 days?
Household Special circumstances	7	Did anyone in the household get released from incarceration (jail or prison) in the last 60 days?	Was anyone on this application released from prison in the past 60 days?
%Name%'s Special circumstances	Heading	**These next questions ask about events that may have happened to %Name% in the past [60/30] days. Please think about what has happened to %Name% since [date of 60/30 days ago] until today.** **Your responses to the following questions do not affect medical assistance Medicaid/Dr. Dynasaur eligibility.**	**The following questions ask about events that may have happened to %Name% during the past 60 days.** **Your answers help us decide if anyone in your household can buy or change a qualified health plan outside of the open enrollment period.** **Your responses to the following questions do not affect Medicaid/Dr.Dynasaur eligibility.**
%Name%'s Special circumstances	1	Did %Name% lose health coverage in the past 60 days?	Did %Name% lose health insurance in the past 60 days?
%Name%'s Special circumstances	2	Has %Name% been adopted or placed up for adoption in the past 60 days?	Has %Name% been adopted or placed up for adoption in the past 60 days?
%Name%'s Special circumstances	3	Has %Name% been added to a household through the foster care program?	Has %Name% been added to a household through the foster care program in the pat 60 days?

%Name%'s Special circumstances	4	Did %Name% gain US citizenship, eligible immigration status, or become lawfully present in the past 60 days?	Did %Name% gain US citizenship, eligible immigration status, or become lawfully present in the past 60 days?
%Name%'s Special circumstances	5	Did %Name% move to %state of the exchange% in the past 60 days?	Did %Name% move to %state of the exchange% in the past 60 days?
%Name%'s Special circumstances	6	Did %Name% get released from incarceration (jail or prison) in the last 60 days?	Was %name% released from prison in the past 60 days?
People Who Have Lost Health Coverage	Heading	**Please tell us who in the household has recently lost health insurance. This could be from someone switching jobs, working less hours, divorce, aging off a parents policy, etc.**	**Please tell us who in the household recently lost health insurance. This could be from someone switching jobs, working fewer hours, getting divorced, or becoming too old to be on their parent's policy.**
People Who Have Lost Health Coverage	1	People who have lost health coverage: %Name%	People who have lost health insurance or got a Medicaid/Dr.Dynasaur renewal notice: %Name%
%Name%'s Loss of Health Coverage	Heading	**Please tell us when %Name% lost health coverage.**	**Please tell us when %Name% lost health insurance.**
%Name%'s Loss of Health Coverage	1	When did %name% lose health coverage? (MM/DD/YYYY)	When did %name% lose health insurance? (MM/DD/YYYY)
%Name%'s Loss of Health Coverage	2	Did %name% lose health coverage because %he/she% did not pay premiums?	Did %name% lose health insurance because %he/she% did not pay premiums?
%Name%'s Loss of Health Coverage	3		Did %name% lose health insurance due to voluntary disenrollment?
%Name%'s Marriage Date	Heading	**Please tell us when %Name% got married.**	**Please tell us when %Name% got married.**
%Name%'s Marriage Date	1	When did %name% get married? (MM/DD/YYYY)	When did %name% get married? (MM/DD/YYYY)
People Who Have Been Adopted or Placed Up for Adoption	Heading	**Please select all the people in who have been added to or removed from your household due to adoption in the past 60 days.**	**Please select the people added to your household through adoption during the past 60 days.**
People Who Have Been Adopted or Placed Up for Adoption	1	People adopted or placed up for adoption: %Name%	People adopted in the last 60 days: %Name%
%Name%'s Adoption Date	Heading	**Please tell us when %Name% was adopted or placed up for adoption.**	**Please tell us when %Name% was adopted.**
%Name%'s Adoption Date	1	When was %name% adopted or placed for adoption? (MM/DD/YYYY)	When was %name% adopted? (MM/DD/YYYY)

People Who Have Been Added to the Household through Foster Care	Heading	**Please select all the people in who have been added to your household through the foster care program in the past 60 days.**	**Please select the people added to your household through the foster care program in the past 60 days.**
People Who Have Been Added to the Household through Foster Care	1	People added to the household through the foster care program: %Name%	People added to the household through the foster care program: %Name%
%Name%'s Foster Care Date	Heading	**Please tell us when %Name% was added to the household through the foster care program.**	**Please tell us when %Name% was added to the household through the foster care program.**
%Name%'s Foster Care Date	1	When was %name% added to the household through the foster care program? (MM/DD/YYYY)	When was %name% added to the household through the foster care program? (MM/DD/YYYY)
People Who Have Gained Citizenship or Immigration Status	Heading	**Please select all of the people in your household who have gained US citizenship, eligible immigration status, or have become lawfully present in the past 60 days.**	**Please select everyone in your household who gained U.S. citizenship, became eligible for immigration, or became lawfully present during the past 60 days.**
People Who Have Gained Citizenship or Immigration Status	1	People who have gained citizenship or immigration status: %Name%	Please provide the name(s)of the people who gained U.S. citizenship or immigration status: %Name%
%Name%'s Citizenship or Immigration Status Date	Heading	**Please tell us when %Name% gained citizenship or immigration status.**	**Please tell us when %Name% gained citizenship or immigration status.**
%Name%'s Citizenship or Immigration Status Date	1	When did %name% gain US citizenship or immigration status? (MM/DD/YYYY)	When did %name% gain US citizenship or legal immigration status? (MM/DD/YYYY)
People Who Have Moved	Heading	**Please select who has moved to %state of the exchange% in the past 60 days.**	**Please select who has moved to %state of the exchange% in the past 60 days.**
People Who Have Moved	1	People who have moved to %state of the exchange%: %Name%	Members of your household who have moved to %state of the exchange%: %Name%
The Household's Moving Details	Heading	**Please tell us about the move to %state of the exchange%.**	**Please tell us about the move to %state of the exchange%.**
The Household's Moving Details	1	Did everyone move to %state of the exchange% on the same day?	Did each of these household members move to %state of the exchange% on the same day?

The Household's Moving Details	2	When did everyone move to %state of the exchange%? (MM/DD/YYYY)	When did these household members move to %state of the exchange%? (MM/DD/YYYY)
%Name%'s moving date	Heading	**Please tell us when %Name% moved to %state of the exchange%.**	**Please tell us when %Name% moved to %state of the exchange%.**
%Name%'s moving date	1	When did %name% move to %state of the exchange%? (MM/DD/YYYY)	When did %name% move to %state of the exchange%? (MM/DD/YYYY)
People Who Have Been Released from Jail	Heading	**Please select all of the people who have been released from incarceration (jailed, prisoned or detained) in the past 60 days.**	**Please select any household members released from incarceration (jail, prison, or detainment) in the past 60 days.**
People Who Have Been Released from Jail	1	People who have been released from incarceration: %Name%	Household members who have been released from incarceration: %Name%
%Name%'s Release Date	Heading	**Please tell us when %Name% was released from incarceration.**	**Please tell us when %Name% was released from incarceration.**
%Name%'s Release Date	1	When was %name% released from incarceration (jail or prison)? (MM/DD/YYYY)	When was %name% released from incarceration? (MM/DD/YYYY)
How did you hear about us?	Heading	**Please tell us how you heard about Vermont Health Connect.**	**Please tell us how you heard about Vermont Health Connect.**
How did you hear about us?	1	Please select an option to the right:	Please select an option to the right:

Future Eligibility Renewal	Heading	**I understand that if I'm eligible for help paying for health insurance, I may also be able to renew the coverage.** **During the renewal process, the Marketplace will use income data including information from the tax returns of household members. This will determine yearly eligibility for help paying for health insurance for the next 5 years. The Marketplace will send me a notice and let me make changes. If I don't respond, the Marketplace will continue my eligibility at the level indicated by the data.** **I understand this renewal process will occur each year for the next 5 years unless I tell the Marketplace that I don't want to renew, or if I leave the Marketplace. I also understand that I can change my answer later.**	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. What if you say Yes? VHC may be able to renew your eligibility without you having to do anything. This includes eligiblity for Medicaid/Dr. Dynasaur and for Advance Payments of Premium Tax Credits (APTC). You can choose to say Yes for 1 to 5 years. What if you say No? If you get 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. IMPORTANT: You can change your mind at any time about how many years you give VHC permission to use electronic data sources by calling VHC customer support at 1-855-899-9600. You can also cancel your coverage or make changes to your household information at any time by calling VHC customer support. You can also cancel your coverage or make changes to your household information at any time by calling VHC customer support.
Future Eligibility Renewal	1	*Do you agree to a renewal period of 5 years?	Do you agree to a renewal period of 5 years?
Future Eligibility Renewal	2	I give my permission for my eligibility for help paying for health insurance to be renewed for a period of:	I give my permission for my eligibility for help paying for health insurance to be renewed for a period of:
Future Eligibility Renewal	3		The current coverage year for Qualified Health Plans ends on December 31, %current year%. Do you give consent for your program eligibility to continue through the end of %current year + 1%?
Confirmation	1	*If anyone on this application enrolls in Medicaid, I am giving the Medicaid agency our rights 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.	If anyone on this application enrolls in Medicaid, I am giving Vermont Health Connect the right to pursue and get money from other health insurance, legal settlements, or other third parties. I am also giving to Vermont Health Connect the right to pursue and get medical support from a spouse or parent.
Confirmation	2	I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate.	I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Vermont Health Connect and I may not have to cooperate.
Confirmation	3	I know that I must tell the program I will be enrolled in if information I listed on this application changes. I know I can make changes in "My account" by visiting HealthConnect.Vermont.gov or calling 1-855-899-9600. I understand that a change in my information could affect my eligibility for member(s) of my household.	I know that I must tell Vermont Health Connect if information I listed on this application changes. I know I can make changes by visiting VermontHealthConnect.gov and clicking on "My Account" or calling 1-855-899-9600. I understand that a change in my information could change my eligibility and the eligibility for other members of my household.

Confirmation	4	I am signing this application under penalty of perjury, which means I have provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.	I am signing this application under penalty of perjury, which means I have provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
Confirmation	4	As a Navigator or Broker, I have conferred with the applicant to assure to the best of my ability that the information provided is accurate. I am signing this application under penalty of perjury, which means I have provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.	As a Navigator or Broker, I have conferred with the applicant to assure to the best of my ability that the information provided is accurate. I am signing this application under penalty of perjury, which means I have provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
Confirmation	5	By entering my name in the box and submitting the application, I agree that I have carefully checked the information in this application and confirm it is correct.	By entering my name in the box and submitting the application, I agree that I have carefully checked the information in this application and confirm it is correct.
Full Medicaid Screening	Header		**Other Medicaid Programs** **There are other Medicaid programs availabe through the State of Vermont, including for people who are age 65 or older, blind or disabled. They provide health coverage and help pay for health care costs. These programs have different requirements to qualify.**
Full Medicaid Screening	1		Would you or anyone in your household like to apply for these other Medicaid programs? (If you check yes, we will send you an application to apply. If you qualify for more than one Medicaid program, we can help you choose which one best meets your needs.)