VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
ECONOMIC SERVICES DIVISION
DEPARTMENT OF DISABILITIES, AGING, AND INDEPENDENT LIVING
DIVISION OF DISABILITY AND AGING SERVICES

GreenMountainCare
A HEALTHIER STATE OF LIVING

202LTC

Application for Choices for Care Long-Term Care Medicaid

The Choices for Care Long-Term Care Medicaid (CFC LTC) program helps pay for care and support for older Vermonters and people with physical disabilities. To be eligible you must meet financial and clinical criteria. The Economic Services Division (ESD) will determine your financial eligibility. A nurse from the Department of Disabilities, Aging and Independent Living (DAIL) will contact you to complete a clinical assessment. The date the **signed** application is received by ESD or DAIL is the application date.

Applicant Information

First Name | MI | Last Name | Mod. (e.g., Jr, Sr, III)

Social Security Number: ___ - ___ - ____ Date of Birth (format MM/DD/YYYY): __ / __ / ____

Mailing Address:

Street 1:

Street 2:

City: State: ZIP: Town in which you live:

Phone Number Where You Can Be Reached: ( ) -

If you need interpretation services…

(Arabic) 1-855-247-3092 إذا كنت ترغب خدمات الترجمة الفورية اتصل برقم

Ako su Vam potrebne usluge tumačenja, pozovite 1-855-247-3092. (Bosnian)

စကားပြန် ဝန်ဆောင်မှုလုပ်ငန်းကိုအလိုရှိပါက 1-855-247-3092 သို့ဖုန်းဆက်ခေါ်ပါ။ (Burmese)

Si vous avez besoin de services d'interprétation, appelez le 1-855-247-3092. (French)

Mugihe woba ushaka impfashanyo yo gusigurirwa, hamagara uyu murongo 1-855-247-3092. (Kirundi)

यदि तपाईंलाई दोभाषे सेवाको जरुरत परेमा, 1-855-247-3092 मा कल गर्नुहोस्। (Nepali)

Haddii aad u baahan tahay adeegyo turjumaan, wac 1-855-247-3092. (Somali)

Si usted necesita servicios de interpretación, llame al 1-855-247-3092. (Spanish)

Ikiwa unahitaji huduma za ukalimani, piga simu 1-855-247-3092. (Swahili)

Nếu quý vị cần dịch vụ thông ngôn, hãy gọi 1-855-247-3092. (Vietnamese)

The Americans with Disabilities Act gives people with disabilities certain rights. We will make reasonable changes and accommodations in our requirements to help you take part in our programs. If you think you might have a physical or mental condition that considerably limits a major life activity like moving, seeing, or thinking, contact us for help.

IMPORTANT: Be sure to read pages 12-14 before you sign and date the application.

If you need more room for any answers, use page 16 on the back of this application or a separate sheet of paper.

People who are deaf or hard of hearing can call the statewide relay service at 711.

Do you have an Authorized Representative, Power of Attorney, Legal Guardian, Alternate Reporter, or Enrollment Assistor? ☐ Yes ☐ No

If you answered yes, check one: ☐ Authorized Representative ☐ Power of Attorney ☐ Legal Guardian ☐ Alternate Reporter ☐ Enrollment Assistor

☐ I give permission to ESD/DAIL and the person or agency listed below to share information

Full name	Phone No. ( )	Home Cell Work ☐ ☐ ☐
Address		
For legal guardian only: Name of court _____	Date appointed_____	

We can send letters (notices) to someone else. If you have questions or would like one of the options below, please call the Benefits Service Center at 1-800-479-6151:

- **Legal guardian:** If you have a legal guardian, your notices will only be mailed to them.
- **In care of:** We can mail your notices in care of someone you choose. This means your notices will only be mailed to them.
- **Alternate Reporter:** We can mail most notices to you and to someone else. We call this person an "alternate reporter." However, some notices will only go to you or your alternate reporter, not both of you.

Racial and Ethnic Heritage

If you are willing, please answer the following regarding the racial and ethnic heritage of your head of household. You do not have to give this information. It is not required to determine eligibility for any program or the amount of assistance you get. This information is collected only to be sure everyone gets benefits on a fair basis.

Ethnicity (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (check all that apply)
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

Items Needed for a New Application

➔ **If you already receive Long-Term Care Medicaid, and this is your review, see the next page.**

If you do not already receive Long-Term Care Medicaid, we need the items listed below to process your application. Please send as many items as you can with this application. The more items we have the faster we can process your application. Please send copies. **Do not send originals**. We will contact you for a phone interview.

Do not wait to apply!

If you do not have copies of all the documents listed, send in the copies you do have when you apply. *It is important to apply as soon as possible.* We will give you more time to send any missing information.

To find out if you are eligible for Long-Term Care Medicaid, we need the following items that apply to you, your spouse or civil union partner. Please note if more information is needed, your worker will let you know.

- ☐ Power of attorney or legal guardianship documents
- ☐ Private health insurance cards (copy of both sides)
- ☐ Health insurance premium amounts
- ☐ Long-term care insurance policies
- ☐ Federal tax returns, including all forms and schedules, filed in the last 60 months
- ☐ Current bank and credit union statements for all accounts owned or co-owned (your worker will let you know if more statements are needed)
- ☐ Current balance for your nursing home account
- ☐ Current retirement account statements
- ☐ Current burial account statements
- ☐ Current stock, bond, and mutual fund statements
- ☐ Current annuity statements
- ☐ Most recent annual statement for each life insurance policy
- ☐ Gross monthly income from all sources including VA, Railroad Retirement, pensions, annuities, etc.
- ☐ Property tax bills and property transfer tax returns for any property that was sold, traded, given away, or had names added to the deed within the last 60 months
- ☐ Current deeds for all property owned or co-owned by you, your spouse or civil union partner
- ☐ Trusts (including all attachments, amendments and annual accountings for the last 60 months)
- ☐ Promissory notes, mortgage notes and mortgage deeds

If you want to know if your spouse or civil union partner can keep some of your monthly income (this is called a spousal allocation), please provide the following:

- ☐ Spouse or civil union partner's gross monthly income
- ☐ Mortgage
- ☐ Property tax bill
- ☐ Condo fees
- ☐ Lot Rent
- ☐ Rent
- ☐ Room and/or board

Go to Page 5 and answer all questions.

Items Needed for Your Review

If you are completing your review for Long-Term Care Medicaid, we need the items listed below to find out if you continue to be eligible. Please send copies. **Do not send originals.**

- ☐ Health insurance premium amounts
- ☐ Federal tax return, including all forms and schedules, filed in the last 12 months
- ☐ Current bank and credit union account statements of all accounts owned and co-owned
- ☐ Current balance for your nursing home account
- ☐ Current retirement account statements
- ☐ Current burial account statements
- ☐ Current stock, bond, and mutual fund statements
- ☐ Current annuity statements
- ☐ Most recent annual statement for each life insurance policy
- ☐ Gross monthly income from all sources including VA, Railroad Retirement, pension, annuities, etc.
- ☐ All deeds signed by you, your spouse, or civil union partner within the last 12 months (including the corresponding property tax bills and property transfer tax returns)
- ☐ Trusts created in the last 12 months (including all attachments and amendments)
- ☐ Annual accounting for all trusts, signed and dated by the trustee
- ☐ List of all assets (bank accounts, vehicles, stocks, bonds, etc.) you, your spouse, or your civil union partner sold, traded, gave away, or added other names to the ownership in the last 12 months
- ☐ Promissory notes, mortgage notes and mortgage deeds

If your spouse or civil union partner receives spousal allocation, please provide current information about:

- ☐ Spouse or civil union partner's gross monthly income
- ☐ Mortgage
- ☐ Property tax bill
- ☐ Condo fees
- ☐ Lot Rent
- ☐ Rent
- ☐ Room and/or board

Go to Page 5 and answer all questions.

ATTENTION

- You must provide financial information to ESD and personal and health information to DAIL.
- If you are found eligible, your financial and clinical eligibility will be reviewed periodically.
- If you are found eligible, you may be required to pay part of the cost of the Choices for Care services you receive. The amount you pay is called your "patient share".
- If you are found ineligible, you will be responsible to pay for the cost of the services you received while your application was pending if not covered by Medicaid, Medicare or other health insurance.
- If you are found clinically eligible, but funding is not available, DAIL will notify you that you have been placed on a waiting list. ESD will deny Long-Term Care Medicaid and notify you if you qualify for other healthcare programs.

Household Information

1. Please list yourself, your spouse or civil union partner, and anyone you claim as a dependent on your income tax form. **Spouse or civil union partner of LTC applicant must provide a social security number. Other members of your household who are not applying do not have to give their social security number or citizenship information.**

MEMB

First name / Initial / Last name	Assistance applying for	Gender	Citizenship status
	☐ Long-term care Medicaid	☐ Female ☐ Male	☐ U.S. citizen ☐ Asylee ☐ Refugee ☐ Legal alien ☐ Other Country of birth _____
Applicant	**Marital status** ☐ Never married/Single ☐ Civil union ☐ Married ☐ Divorced/dissolved ☐ Separated ☐ Widowed	**Birthdate**	**Social Security number**

First name / Initial / Last name	Assistance applying for	Gender	Citizenship status
	☐ Long-term care Medicaid ☐ None	☐ Female ☐ Male	☐ U.S. citizen ☐ Asylee ☐ Refugee ☐ Legal alien ☐ Other Country of birth _____
Relationship to you ☐ Spouse ☐ Civil union partner	**Marital status** ☐ Never married/Single ☐ Civil union ☐ Married ☐ Divorced/dissolved ☐ Separated ☐ Widowed	**Birthdate**	**Social Security number**

Complete for dependents:

First name / Initial / Last name	Relationship to you	Birthdate

First name / Initial / Last name	Relationship to you	Birthdate

2. Where are you currently living?

Applicant	Applicant's spouse or civil union partner (complete only if spouse or civil union partner is also applying for LTC Medicaid)
☐ Home ☐ Hospital ☐ Nursing Facility ☐ Residential Care/Assisted Living Facility	☐ Home ☐ Hospital ☐ Nursing Facility ☐ Residential Care/Assisted Living Facility
Name of facility _____	Name of facility _____
Admission date _____	Admission date _____
For Nursing Facility or Hospital Swing Bed, is the stay planned to be less than 30 days? ☐ Yes ☐ No	For Nursing Facility or Hospital Swing Bed, is the stay planned to be less than 30 days? ☐ Yes ☐ No

Household Information (continued)

2a. Where do you want to receive your long-term care services?

Applicant	Applicant's spouse or civil union partner (complete only if spouse or civil union partner is also applying for LTC Medicaid)
☐ Own home/apartment ☐ Home of another (family/friend) ☐ Enhanced Residential Care ☐ Nursing Facility ☐ Program for All-Inclusive Care for Elderly (PACE)	☐ Own home/apartment ☐ Home of another (family/friend) ☐ Enhanced Residential Care ☐ Nursing Facility ☐ Program for All-Inclusive Care for Elderly (PACE)

3. If you reside in a nursing or enhanced residential care facility, would you return home if you were able to even if returning home is unlikely?

Applicant ☐ Yes ☐ No Applicant's spouse or civil union partner (if also applying) ☐ Yes ☐ No

3a. Are you expected to return home within 6 months?

Applicant ☐ Yes ☐ No Applicant's spouse or civil union partner (if also applying) ☐ Yes ☐ No

Health Insurance Information

4. Are you covered by Medicare? ☐ Yes ☐ No

MEDI

First name Initial	Medicare claim number		
Part A: Start date _____ Premium $_____	**Part B:** Start date _____ Premium $_____	**Part C:** Start date _____ Premium $_____	**Part D:** Start date _____ Premium $_____

If also applying, is your spouse or civil union partner covered by Medicare? ☐ Yes ☐ No

First name Initial	Medicare claim number		
Part A: Start date _____ Premium $_____	**Part B:** Start date _____ Premium $_____	**Part C:** Start date _____ Premium $_____	**Part D:** Start date _____ Premium $_____

5. Are you enrolled in a Medicare prescription drug plan? ☐ Yes ☐ No

Contract and Plan ID numbers are found in the bottom right-hand corner of your Medicare drug plan card.

First name Initial	Plan name	CMS number	Plan start date
		CMS- __ __ __ __ __ - __ __ __	

If also applying, is your spouse or civil union partner enrolled in a Medicare prescription drug plan? ☐ Yes ☐ No

First name Initial	Plan name	CMS number	Plan start date
		CMS- __ __ __ __ __ - __ __ __	

6. Have you applied for "Extra Help" for Part D through Social Security? ☐ Yes ☐ No

First name Initial	If yes, date applied	If granted, begin date	If denied, what reason did Social Security give you?
			☐ Over income ☐ Over resources ☐ Failed to cooperate ☐ Other: Explain:

If also applying, has your spouse or civil union partner applied for "Extra Help" for Part D through Social Security? ☐ Yes ☐ No

First name Initial	If yes, date applied	If granted, begin date	If denied, what reason did Social Security give you?
			☐ Over income ☐ Over resources ☐ Failed to cooperate ☐ Other: Explain:

Health Insurance Information (continued)

7. Do you have health, dental, Medicare supplemental or long-term care insurance, such as group insurance, veteran or military benefits? (Include information for your spouse or civil union partner if also applying.) ☐ Yes ☐ No

- Do not include any Medicare information listed in question 4.
- Do not include Green Mountain Care programs (Medicaid, VHAP, Premium Assistance and Pharmacy programs).
- List prescription plans separately.
- Send copies of any long-term care insurance policies.
- **Send copies of both sides of all insurance cards.** If you don't, it will cause application processing delays.

INSU

Name of policy holder	Policy number	Group number	Premium amount	Date coverage began	Type of coverage (check all that apply)	Names of people covered	Name, address, and phone number of insurance company
1.			$ per		☐ Doctor ☐ Prescription ☐ Hospital ☐ Major Medical ☐ Dental ☐ Outpatient ☐ Vision ☐ Long-term care ☐ Other _____		
2.			$ per		☐ Doctor ☐ Prescription ☐ Hospital ☐ Major Medical ☐ Dental ☐ Outpatient ☐ Vision ☐ Long-term care ☐ Other _____		
3.			$ per		☐ Doctor ☐ Prescription ☐ Hospital ☐ Major Medical ☐ Dental ☐ Outpatient ☐ Vision ☐ Long-term care ☐ Other _____		
4.			$ per		☐ Doctor ☐ Prescription ☐ Hospital ☐ Major Medical ☐ Dental ☐ Outpatient ☐ Vision ☐ Long-term care ☐ Other _____		

8. Do you, your spouse or civil union partner have unpaid medical or dental bills? The bills may help you become eligible for Medicaid. If the services were received in the last 3 months, we may be able to help you pay them. ☐ Yes ☐ No

Who has the unpaid medical bills?	Provide an estimate of charges incurred within the last 3 months	Provide an estimate of charges incurred more than 3 months ago
	$	$
	$	$
	$	$
	$	$

Resource Information

9. Do you, your spouse or civil union partner have cash that is not in a bank, such as at home, on hand or held by others? ☐ Yes ☐ No

CASH

First name	Initial	Amount	First name	Initial	Amount
		$			$

Resource Information (continued)

10. Do you, your spouse or civil union partner have money in a bank, credit union or other financial institution? Include accounts that are co-owned. ☐ Yes ☐ No BANK

Type	Name of owner and co-owner	Name of bank, credit union, or other institution	Account/Policy number	Balance or value
Savings account				$
Savings account				$
Checking account				$
Checking account				$
Christmas club				$
IRA , Keogh Plan, 401K				$
Savings bonds				$
Certificate of deposit (CD)				$
Certificate of deposit (CD)				$
Pension or Retirement Account				$
Nursing home account				$
Other _____				$

11. Do you, your spouse, or civil union partner own any vehicles? ☐ Yes ☐ No CARS

Type of vehicle	Name of owner and co-owner	Year, make, and model	Leased?	Amount owed	For ESD use only Value
Car, truck, or van			☐ Yes ☐ No	$	$
Car, truck, or van			☐ Yes ☐ No	$	$
Camper or RV				$	$
Snow machine or jet ski				$	$
Trailer or boat				$	$
Motorcycle or ATV				$	$
Other_____				$	$

12. Do you, your spouse or civil union partner own or co-own land, mobile homes, timeshares, buildings, other real estate, or a life estate interest in any property? ☐ Yes ☐ No PROP

Type of property	Name of owner and co-owner	Location	Assessed value	Amount owed
Primary residence			$	$
Camp, vacation, or other real estate			$	$
Rental property			$	$
Business property			$	$
Land			$	$
Other (describe)			$	$

Resource Information (continued)

13. Do you, your spouse or civil union partner own any other resources? ☐ Yes ☐ No STOK

Type of Resource	Name of owner and co-owner	Value
Life insurance ☐ term ☐ whole		Face value $ Cash value $
Life insurance ☐ term ☐ whole		Face value $ Cash value $
Life insurance ☐ term ☐ whole		Face value $ Cash value $
Account set up for burial expenses Is this irrevocable? ☐ Yes ☐ No		$
Burial plot, space, urn, crypt, headstone		$
Stocks, bonds, or mutual funds		$
Annuities		$
Trust funds		$
Promissory or mortgage notes		$
Account set up for medical expenses		$
Other _____		$

Transfer Information

14. Have you, your spouse or civil union partner given away, sold, or traded anything in the last 60 months? Your worker will let you know if more information is needed. ☐ Yes ☐ No TRAN

First name	Initial	What was it?	When was it?

15. Have you, your spouse or civil union partner added another person's name to any assets such as financial accounts or property in the last 60 months? ☐ Yes ☐ No TRAN

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

16. Have you, your spouse or civil union partner placed any assets in a trust in the last 60 months? Send copy of trust document including all schedules, amendments and a trust accounting signed and dated by the trustee telling us what was added or removed from the trust in the last 60 months. ☐ Yes ☐ No TRAN

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

Income Information

17. Do you, your spouse or civil union partner have income from a job, internship or training program? ☐ Yes ☐ No

- List income from the past 30 days before any deductions such as taxes, insurance, child support, or union dues.
- Include income of children (under age 21 and living with you) from a job or training program.
- If income has ended or you expect it to change in the next 30 days, attach a note explaining the change.

JINC

Full Name	Date paid	Hours worked	Income before deductions	Tips and commissions
Paychecks are issued ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Day of week _____			$	$
Employer's name and phone number				

Full Name	Date paid	Hours worked	Income before deductions	Tips and commissions
Paychecks are issued ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly Day of week _____			$	$
Employer's name and phone number				

Please attach copies of your pay stubs for the past 30 days.

18. Do you, your spouse or civil union partner have income from self-employment, such as farming, home party sales, logging, or property rental? ☐ Yes ☐ No

- Send a copy of your most recent federal tax return, including all forms and schedules.
- If you have not filed taxes or it is a new business, send income and expense records to date.
- If income has ended or you expect it to change in the next 30 days, attach a note explaining the change.

BUSI

First name	Initial	Type of business	Date business began

19. Do you, your spouse or civil union partner have any other income? ☐ Yes ☐ No

Some examples are:

social security	pensions or retirement	veteran's compensation	unemployment compensation
SSI/AABD	dividends or interest	veteran's pension	child support
trusts	money from others	insurance settlement	other _____
annuities	promissory or mortgage note	worker's compensation	please describe and list below

List gross income before any deductions, such as Medicare premiums, taxes, insurance, child support, or union dues.

UNEA

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

Income Information (continued)

19a. Do you, your spouse, or your civil union partner have income that you are entitled to and do not receive such as pensions or retirement? ☐ Yes ☐ No

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

Expense Information

20. Do you pay for medical expenses not covered by insurance (include spouse or civil union partner if also applying)? ☐ Yes ☐ No

Some examples are:

pain relievers, antacids, insurance premiums, personal alert system
eyeglasses, dental care, copayments, personal care services
vitamins, hearing aid batteries, over-the counter items prescribed by a doctor

FMED

First name	Initial	Product or service needed	How often	Average monthly cost
				$
				$

21. Does your spouse or civil union partner pay any of the following expenses for your apartment, house, or trailer? ☐ Yes ☐ No

Answer only if your spouse or civil union partner wants (or receives) some of your monthly income. This is called a spousal allocation.

☐ Mortgage $ _____ per _____
☐ Home equity loan $ _____ per _____
☐ Homeowners insurance $ _____ per _____
☐ Property tax $ _____ per _____
☐ Condo fees $ _____ per _____
☐ Fuel and utilities $ _____ per _____
☐ Lot rent $ _____ per _____
☐ Rent $ _____ per _____
☐ Room and/or board $ _____ per _____
☐ None

22. Does your spouse or civil union partner share any housing expenses with other people? **Answer only if your spouse or civil union partner wants (or receives) some of your monthly income.** ☐ Yes ☐ No

Names of people who share the expense	Who pays for what?

You must report changes within 10 days

Some examples of what you must report are:

- Any changes in income (such as social security, veteran's benefits, railroad retirement, pension plans, annuities, and rental income).
- If all your combined resources exceed the allowed $2,000 limit.
- Receipt of lump sum payments (such as trust or retirement fund distributions, inheritances, insurance settlements, or lottery winnings).
- Changes in health insurance cost, company or coverage.
- Changes in ownership (such as adding or removing a name, or sale or transfer of real or personal property).
- If you, 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, bonds, etc.

You may report changes by calling the ESD Benefits Service Center at 1-800-479-6151 or by writing, or sending a Change Report form (ESD 200) to:

DCF – Economic Services Division
Application and Document Processing Center
280 State Drive
Waterbury, VT 05671-1500

If you have any questions about what changes you must report, call the ESD Benefits Service Center at 1-800-479-6151.

ESD Contact Information www.mybenefits.vt.gov

We now have an automated information system you can call 24 hours a day, 7 days a week. Call the ESD Benefits Service Center at 1-800-479-6151 toll free to:

- Get general information about programs;
- Request an application form;
- Get specific information about your case, including the status of your application and benefit details; and
- Speak to a Benefits Service Center Agent – weekdays between 8:00 a.m. and 4:30 p.m.

Rights and Responsibilities

You may request a copy of these Rights and Responsibilities in larger print.

True and complete information. I understand the information I provide to apply for assistance will be subject to verification by federal and state officials to determine if it is correct. This means that sources other than members of my household may be contacted to verify my eligibility for assistance. I understand if any information is not true, ESD may deny assistance to me.

Reporting changes. I understand when I get assistance I must report changes in my situation. The changes I must report may be different depending on the benefits I get. If I am not sure which changes I must report, I will ask my worker. I understand changes may affect the amount of benefits I get. I also understand I must report changes within 10 days from when they happen.

Confidentiality. ESD will not share any information from this application except for purposes directly connected with program administration unless I clearly allow release of this information or a court orders it.

Social security number. I understand that, when I apply for Long-Term Care Medicaid assistance from ESD, I must give my social security number and that of my spouse or civil union partner, if I have one. Federal law requires this as a condition of eligibility. This requirement may be waived for some programs for members of religious organizations that object to furnishing social security numbers. (42 U.S.C. §1320b-7)

ESD uses the social security number: 1) for computer processing of program benefits, support enforcement, fraud investigation, audits, and Lifeline identification; 2) to verify social security and supplemental security income; 3) to prevent individuals from receiving duplicate benefits; 4) to identify groups of cases that must have benefits changed; 5) to exchange information with agencies such as the Social Security Administration, Department of Labor, Internal Revenue Service, or private claims collection agencies to verify income, determine eligibility and benefit amounts, and collect claims; 6) to determine the accuracy and reliability of information given to ESD; and 7) to make medical assistance payments.

No discrimination. Federal and state law, U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, prohibit discriminating based on race, color, national origin, sex, age, disability, religion or political beliefs.

To file a discrimination complaint, write to the HHS Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619- 3257 (TDD). HHS is an equal opportunity provider and employer. Under Vermont law and rules, ESD may not discriminate based on marital status, sexual orientation, religion, political beliefs, or place of birth. To file a discrimination complaint, write: ESD Deputy Commissioner, Department for Children and Families, HC 1 South, 280 State Drive, Waterbury, VT, 05671-1020.

Decision on application. ESD must make a decision on my application within 30 days (90 days if my Medicaid application is based on disability) unless delay is caused by examining physicians, an administrative emergency, or me. If I do not get a decision within 30 (or 90) days, I may call the ESD Benefits Service Center at 1-800-479-6151 for more information or to request a fair hearing.

Fair hearing. I may ask for a fair hearing when my claim for assistance or services is denied in whole or in part, or not responded to with reasonable promptness. Call the ESD Benefits Service Center at 1-800-479-6151 or write to the ESD Deputy Commissioner for financial determinations and DAIL Commissioner's office for clinical determinations. (3 V.S.A. §3091) For health care program actions that, for example, deny, limit, reduce, or end a service or deny a request to go outside the provider network, I may also request an appeal in addition to or in place of a fair hearing. If I have a complaint, for example, about the quality of the health care service or the behavior of staff for matters not related to a health care program action, I may be able to file a grievance. For more information on any of these choices, call the ESD Benefits Service Center at 1-800-479-6151.

Quality control review. ESD may select my application for a quality control review. If so, I agree to give proof of required information. If I am not able to give the proof needed, I authorize ESD to get it.

Release of tax records. I give permission to the Vermont Commissioner of Taxes to disclose information from my state income tax returns to the Deputy Commissioner of ESD. (33 V.S.A. §112))

Release of medical records. I agree that my health care providers may release my medical records when necessary for the purpose of administering ESD health care or Reach Up programs.

Assignment of medical support. As a condition of eligibility for health care assistance, I agree to assign to the state all rights to medical support and to third party payments (such as insurance) for medical care. I agree to enroll in a group health plan if the state requires me to, and I understand the state may pay the premiums. I also agree to cooperate in pursuing any actual or potential source of support or payments, including establishing paternity for my dependent children, if necessary. I understand that if I do not cooperate, my health care benefits will end although my children's health care benefits will continue.

Recovery of Medicaid payments. ESD must file a claim against my estate when I die to recover Medicaid payments made for me for services I received at age 55 or older while in a nursing facility or a home-based waiver program, and for related hospital and prescription drug services. ESD will not seek adjustment or recovery against my estate if, at the time of death, my spouse is still alive, I have surviving children who are blind, disabled, or under age 21, or ESD determines that adjustment or recovery would cause undue hardship. I understand I may find out more about recovery from my worker. (42 U.S.C. §1396p)

Medicare Part B payments. If I get Medicare Part B benefits while getting Medicaid, I want ESD 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.

Consent to bill Medicaid if child receives Special Education Services. I give permission to my child's school district to bill Medicaid for the specified services listed in his/her Individual Education Plan (IEP). I understand that if I refuse consent, my refusal only affects Medicaid billing of IEP services; my refusal does not relieve the school district of its responsibility to provide IEP services at no cost to me. I understand that I may revoke this consent to bill Medicaid for IEP services at any time; if I revoke this consent it will apply to billing for services from that date forward.

Not fleeing prosecution. I certify that neither I nor any member of my household is fleeing prosecution or confinement for a felony or an attempt to commit a felony, or is violating a condition of probation or parole under a federal or state law. I understand ESD must disclose information to law enforcement agencies to apprehend fleeing felons.

No benefits from another state. If any member of my household gets duplicate 3SquaresVT benefits, Medicaid, or cash assistance from another state or has been convicted in the past ten years of fraudulently misrepresenting residency to get benefits from two or more states, I must tell ESD immediately.

Fraud penalties. I or any member of my household will be subject to prosecution for fraud or some other criminal offense for knowingly giving false, incorrect, incomplete, or misleading information in order to get, try to get, or help someone else get Reach Up, 3SquaresVT, or health care benefits. 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 benefits wrongfully received. Federal and other state penalties may also apply. (42 U.S.C. §1320a-7b; 33 V.S.A. §§141, 143)

Signature

You must sign here. If your spouse or civil union partner is also applying for CFC LTC Medicaid, they must also sign. Unsigned applications will not be processed and will be returned for signature. You may lose some benefits.

I give my word, under penalty of perjury, that the information I give in this application is true and complete to the best of my knowledge and belief. I have read and I understand the Rights and Responsibilities included in this application and I agree to them.

Signature of applicant
or authorized representative_____ Date _____
(Required)

Signature of spouse/civil union partner
or authorized representative _____ Date _____
(Required if also applying)

Signature of person helping
you fill out this form _____ Date _____

Print Name _____ Agency Name_____
Phone number _____

Return this application to: DCF – Economic Services Division
Application and Document Processing Center
280 State Drive
Waterbury, VT 05671-1500

We will let you know if we need more information. You will hear from us within 30 days.

The applicant is responsible for the accuracy of all of the information given on this application including information about the applicant's spouse or civil union partner.

Other Programs

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.

Lifeline may provide a discount on your phone bill. If you are not receiving a discount now, would you like to? ☐ Yes ☐ No
If yes, include a copy of your phone bill with this application. *To learn more about this program, call toll free 1-800-479-6151.*

Link Up may pay for part of the installation cost of a new phone. You can get this benefit if you are 18 or older and on a Green Mountain Care program. The phone must be listed in your name or you must pay part of the bill. *Call your telephone company to learn more.*

Weatherization helps with insulation, caulking, or weather-stripping your home or apartment to lower your heating costs.
Would you like us to refer you to this program? ☐ Yes ☐ No
To learn more about this program, call toll free 1-877-919-2299.

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 five. Would you like someone from the WIC program to contact you?
To learn more about this program, call toll free 1-800-464-4343. ☐ Yes ☐ No

Fuel Assistance helps to pay heating bills. *To learn more about this program or to request an application, call toll free 1-800-479-6151.*

3SquaresVT helps to pay for food. If you have little or no money for food, you may also be able to get emergency help. *For information or an application, call toll-free 1-800-479-6151.*

If you need more room for any answers, use this page or a separate sheet of paper.