

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. Economic Services Division (ESD) will determine your financial eligibility. A nurse from the Department of 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 _____ Social security no. _____ Birth date _____

Home address _____

Mailing address, if different _____ Town _____ Zip _____

Phone number where you can be reached (____) _____ Town where you live _____

Do you have an authorized representative or legal guardian? Yes No

If yes, please include documents giving your representative authority to act on your behalf.

If yes, check one: Authorized representative (person helping you)

Legal guardian – name of court _____ Date appointed _____

Power of Attorney

Name _____ Phone number (____) _____ Home Cell Work

Address _____

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

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

Signature of applicant
or authorized representative _____ Date _____
(Required)

Signature of person helping
fill out this form _____ Date _____

Agency name _____

Rights and Responsibilities

You may request a copy of this page 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: Deputy Commissioner, Department for Children and Families, Economic Services Division, 103 S. Main St., Waterbury, VT, 05671.

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 an ESD district office 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. Contact an ESD office 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, contact your local district office listed on Page 11 of this application.

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)

Items Needed for Your 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. 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 for you and your spouse:

- Power of attorney or legal guardianship documents
- Private health insurance cards (copy of both sides)
- Health insurance premium amounts
- Federal tax returns from 2006 forward (please include all forms and schedules)
- Current bank and credit union statements of all accounts owned and co-owned
- Current balance for your nursing home account
- Current retirement accounts statements
- Current burial accounts statements
- Current stocks, bonds, mutual funds statements
- Face and cash value of life insurance policies (current annual statement)
- 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 since February 2006
- Life estate deeds
- Trusts (including appendices, schedules, annual accountings, and amendments for the last 5 years)
- Promissory notes
- Mortgage notes and mortgage deeds
- Current annuities statements (Federal law requires the State to become a remainder beneficiary under an annuity or similar financial instrument when the State provides long-term care medical assistance.)

If you want to find out if your spouse can keep some of your monthly income (allocation), please provide:

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

Please continue by completely answering every question on this application.

(If you need more room for any answers, use a separate sheet of paper.)

Items Needed for Your Annual Review

➔ **If you do not already receive long-term care Medicaid, see the previous page for items needed.**

If you are completing your annual review for long-term care Medicaid, we need the items listed below to find out if you continue to be eligible. Please do not send originals.

- Health insurance premium amounts
- Gross monthly income from all sources including VA, Railroad Retirement, pension, annuities, etc.
- Current bank and credit union statements of all accounts owned and co-owned
- Current value of stocks, bonds, mutual funds
- All deeds executed by you, your spouse, or civil union partner within the last 12 months including life estate deeds
- Trusts created by you, your spouse, or civil union partner within the last 12 months
- Most recent federal tax return for you, your spouse, or civil union partner
- List of all property you, your spouse, or your civil union partner sold, traded, or gave away within the last 12 months
- 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 12 months

If your spouse is receiving an allocation, I will also need the following items:

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

Please continue by completely answering every question on this annual review form.

(If you need more room for any answers, use a separate sheet of paper.)

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 Choices for Care services. This is called your “patient share”.
- If you are found ineligible, you will be required to pay for the cost of the services received while your application was pending.
- If you are found eligible, but funding is not available, DAIL may place your name on a waiting list. ESD will determine if you qualify for other healthcare programs. You will be notified if this is the case.

1. Please list yourself, your spouse or civil union partner, and anyone you claim as a dependent on your income tax form. **Spouse 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		
1.	First name	Initial	Last name	Assistance applying for <input type="checkbox"/> Long-term care Medicaid	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Social security number	Citizenship status U.S. citizen Refugee Asylee Legal alien Other	
	Relationship to you <p style="text-align: center;">Applicant</p>			Marital status Single Civil union Divorced/dissolved Married Separated Widowed		Birth date		
2.	First name	Initial	Last name	Assistance applying for <input type="checkbox"/> Long-term care Medicaid <input type="checkbox"/> None	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Social security number	Citizenship status U.S. citizen Refugee Asylee Legal alien Other	
	Relationship to you			Marital status Single Civil union Divorced/dissolved Married Separated Widowed		Birth date		
3.	First name	Initial	Last name	Relationship to you		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Social security number	Birth date
4.	First name	Initial	Last name	Relationship to you		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Social security number	Birth date

2a. You are currently at:

- Home
 Hospital
 Residential Care/Assisted Living Facility
 Nursing Facility
 Program for All-Inclusive Care for the Elderly (PACE)

Name of facility _____ Admission date _____

For Nursing Facility or Hospital Swing Bed, is the stay planned to be **less than 30 days**? Yes No

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

- Own home/apartment
 Home of another (family, friend)
 Program for All-Inclusive Care for the Elderly (PACE)
 Enhanced Residential Care
 Nursing Facility
 No preference

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? Yes No

3a. Are you expected to return home within 6 months? Yes No

If yes, please submit a doctor's statement that you are expected to be discharged within 6 months and will return home immediately afterwards.

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 \$ _____

4a. 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- _____ - _____	

4b. Have you applied for the low income subsidy for Part D (prescription coverage) through social security?

Yes No

First name Initial	Start date	Denial reason	I did not apply because
		Over income Over resources Other: _____	Over income Over resources Other: _____

5. Do you have health, dental, or long-term care insurance, such as group insurance, veteran or military benefits?

Yes No

Do not include Medicare or state health care programs.

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

6. Do you, your spouse or civil union partner have unpaid medical or dental bills?

Yes No

If yes, please send current copies of unpaid bills.

First name Initial	Estimate of amount owed	First name Initial	Estimate of amount owed

7. 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
	\$ _____		\$ _____

8. Do you, your spouse or civil union partner have money in a bank, credit union or other 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	Identifying 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				\$
Nursing home account				\$
Other _____				\$

9. 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 _____				\$	\$

10. Do you, your spouse or civil union partner own or jointly own land, mobile homes, time-shares, buildings, other real estate, or a life estate interest in any property?

Yes No PROP

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

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

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

12. Have you, your spouse or civil union partner given away, sold, or traded anything of value since February 8, 2006? Yes No TRAN

First name	Initial	Resource type	Date transferred	Value	Sale price
				\$	\$
				\$	\$

12a. Have you, your spouse or civil union partner added another person's name as co-owner to any assets such as financial accounts or property since February 8, 2006? Yes No

First name	Initial	Resource Type	Name added	Date of Action	Amount
					\$
					\$
					\$

13. 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 and amendments. Yes No TRAN

First name	Initial	Asset Type	Date of Action	Amount
				\$
				\$

14. Do you, your spouse or civil union partner have income from a job? List income from the past 30 days before any deductions, such as taxes, insurance, child support, or union dues. If income has ended or you expect it to change in the next 30 days, attach a note explaining the change. Yes No JINC

First name	Initial	Date paid	Hours worked	Income before deductions	Tips and commissions
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$

How often paid?
 Weekly Twice a month
 Every two weeks Monthly Other _____

Name and phone number of employer _____

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

15. 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 copies of your most recent federal tax return, including all forms and schedules. If you have not filed taxes, send a statement of income and expenses for the past three months.

First name	Initial	Type of business	Date business began

BUSI

16. Do you, your spouse or civil union partner have unearned 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 | promissory note |
| annuities | mortgage note | worker's compensation | |

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

First name	Initial	Income before deductions	Type of income	Due to disability?	
		\$ _____ per _____		Yes	No
		\$ _____ per _____		Yes	No
		\$ _____ per _____		Yes	No
		\$ _____ per _____		Yes	No

UNEA

16a. 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 _____	

17. Do you pay for medical expenses not covered by insurance? 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 |

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

FMED

18. Do you, your spouse or civil union partner pay any of the following for your apartment, house, or trailer? (Check all that apply and state amount.)

Answer only if your spouse wants or receives a monthly allocation.

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

19. Do you, your spouse, or civil union partner share any housing expenses with other people? Yes No

Answer only if your spouse wants or receives a monthly allocation.

Names of people who share expenses with you	Shared expenses

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

Voter Registration

If you are not registered to vote where you live now, would you like to apply to register to vote here today? **Yes** **No**

If you do not check either box, you will be considered to have decided not to register at this time.

Applying to register or declining to register to vote will not affect your eligibility for benefits or the amount of assistance that ESD will provide you.

If you want help filling out the voter registration application, we will help you. The decision 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 decline to register to vote, you may file a complaint with the Secretary of State's Office at Redstone Building, 26 Terrace Street, Drawer 09, Montpelier, VT 05609-1101 (telephone 1-802-828-2363).

Lifeline is a monthly credit on your home or Unicef wireless phone bill. **Link Up** is a payment for part of the installation cost of a new phone. You can get these credits if you are an adult recipient of ESD benefits. The phone must be listed in your name or you must pay part of the bill. We need a copy of your bill. *Call your telephone company for more information.*

If you are not receiving a Lifeline credit now, would you like to? **Yes** **No** If yes, send a copy of your bill.

Americans with Disabilities Act - If you think you might have a physical or mental condition that considerably limits a major life activity, like moving, seeing, hearing, or thinking, let us know. We will make reasonable changes and accommodations in our requirements to help you take part in our programs. Tell your worker if you think there is something that you need.

**If you do not speak English, we can provide free translation for our services.
Please tell us if you need an interpreter for any language.**

Si usted no habla inglés, podemos proveer traducción gratis para nuestros servicios. Favor de dejarnos saber si necesita un intérprete. (Spanish)

Si vous ne parlez pas anglais, nous pouvons vous fournir un traducteur gratuitement pour nos services. Veuillez nous signaler si vous avez besoin d'un interprète. (French)

Ako ne govorite engleski, mi vam mozemo za nase usluge obezbjediti besplatnu pomoc prevodioca. Molimo vas da nas obavijestite ako vam je potrebna ova pomoc. (Serbo-Croatian)

Nếu bạn không biết nói Tiếng Anh, chúng tôi có thể cung cấp sự thông dịch miễn phí cho những dịch vụ của chúng tôi. Xin vui lòng nói cho chúng tôi biết nếu bạn cần thông dịch viên. (Vietnamese)

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

Take this page with you.
It has information that may be helpful;
and it is your copy of your Rights and Responsibilities.

You must report changes

I must report:

- Any changes in income (such as social security, veteran's benefits, railroad retirement, pension plans, annuities, and rental income).
- If my resources exceed the allowed \$2,000 limit.
- Receipt of lump sum payments (such as 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 me, my spouse, or my civil union partner sells, trades or gives away property or other assets such as bank accounts, stocks, bonds, etc.

You may report changes to your local ESD district office in person, by telephone, by writing, or by sending a Change Report form, ESD 200. See the Agreement to Report Change, ESD 201A LTC, for exactly what you must report. If you have any questions about what changes you must report, ask your worker.

**ESD District Office
Contact Information**
www.dcf.state.vt.us

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If you do not speak English, we can provide free translation for our services.
Please tell us if you need an interpreter for any language.

Barre
5 Perry Street, Suite 150
Barre, VT 05641-4270
Tel: (802) 479-1041
Tel: 1-800-499-0113

Burlington
101 Cherry Street, Suite 101
Burlington, VT 05401-4405
Tel: (802) 863-7365
Tel: 1-800-775-0506

Newport
100 Main Street, Suite 240
Newport, VT 05855-4898
Tel: (802) 334-6504
Tel: 1-800-775-0526

St. Albans
20 Houghton Street
Suite 313
St. Albans, VT 05478-9922
Tel: (802) 524-7900
Tel: 1-800-660-4513

Bennington
150 Veterans Memorial
Drive, Suite 6
Bennington, VT 05201-1918
Tel: (802) 442-8541
Tel: 1-800-775-0527

Middlebury
700 Exchange Street,
Suite 103
Middlebury, VT 05753-9943
Tel: (802) 388-3146
Tel: 1-800-244-2035

Rutland
320 Asa Bloomer Building State
Office Building
Rutland, VT 05701-9400
Tel: (802) 786-5800
Tel: 1-800-775-0516

St. Johnsbury
67 Eastern Avenue, Suite 7
St. Johnsbury VT 05819-9950
Tel: (802) 748-5193
Tel: 1-800-775-0514

Brattleboro
232 Main Street
P.O. Box 70
Brattleboro, VT 05302-0070
Tel: (802) 257-2820
Tel: 1-800-775-0515

Morrisville
63 Professional Drive, Suite 4
Morrisville, VT 05661-8522
Tel: (802) 888-4291
Tel: 1-800-775-0525

Springfield
100 Mineral Street, Suite 201
Springfield, VT 05156-9900
Tel: (802) 885-8856
Tel: 1-800-589-5775

White River Junction
224 Holiday Dr., Suite A
White River Jct., VT 05001-2097
Tel: (802) 295-8855
Tel: (802) 1-800-775-0507

For further assistance contact the **Waterbury Central Office** at 1-800-287-0589

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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: Deputy Commissioner, Department for Children and Families, Economic Services Division, 103 S. Main St., Waterbury, VT, 05671.

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 an ESD district office 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. Contact an ESD office 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, contact your local district office listed on Page 11 of this application.

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)