205INFA
8/2016

Application for Health Coverage

Apply faster and easier online by visiting VermontHealthConnect.gov

Reporting changes	If you have already applied for health coverage and simply need to report a change, **DO NOT** use this application, instead call **1-855-899-9600.**
Get help with costs	**You need to use a different application to get help with costs**. You could qualify for: • A new tax credit that can immediately lower your premiums for health coverage • Free or low-cost coverage from Medicaid/Dr. Dynasaur **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). Visit VermontHealthConnect.gov or call 1-855-899-9600 to learn more.** *This number changes every January.
Who can use this application?	• If you do not need help to pay for your health coverage, you can use this application. **You will be responsible for the full cost.** • If you are seeking dental coverage only, you can use this application. • If someone is helping you fill out this application, you may need to complete **Appendix A.**
What happens next?	Send your completed and signed application to the address on page 5. (**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 to let you know how to join a health plan. Filling out this application does not mean you have to buy health coverage.
Get help with this application	• **Online:** VermontHealthConnect.gov. • **Phone:** Call our Help 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**. • **Find a Navigator or Broker:** Call **1-855-554-4488** or visit VermontHealthConnect.gov.
Interpretation services are available	إذا أنت 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 तपाईंलाई दोभाषे सेवाको जरुरत परेमा, 1-855-899-9600 मा कल गर्नुहोस्। (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 4. If you need help understanding something, contact Vermont Health Connect at 1-855-899-9600.

Your Rights and Responsibilities within Vermont Health Connect

How We Use Your Information. We need the information we ask for to decide if you qualify for health coverage if you choose to apply. We will check your answers using information from the 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, the Agency of Human Services 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.

Quality Control. Vermont Health Connect may select your application for a quality control review. By signing your application, you agree to give proof of required information. If you are not able to give the proof needed, you are authorizing Vermont Health Connect to get it.

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.

Reporting changes. If anything changes or is different than what you wrote on this application, you must tell Vermont Health Connect within 30 days. Visit **VermontHealthConnect.gov** or call **1-855-899-9600** to report any changes.

Timely Decision on Application. Vermont Health Connect has 30 days to give you a decision on your application. If after 30 days you have not received a response, call **1-855-899-9600.**

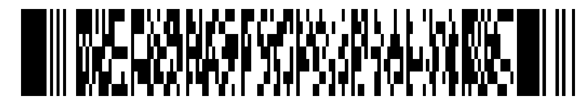
Your Right to Appeal. If you think Vermont Health Connect has made a mistake, you can appeal its decision. You can also appeal if we are late making a decision. To appeal means to ask for a fair hearing. A fair hearing is a chance to tell a hearing officer at the Human Services Board why you think the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

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



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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. List any other names you have been known by, including a maiden name or alias.

3. **Home address** (leave blank if you do not have one)
4. Apartment or suite number

5. City
6. State
7. ZIP code
8. County

9. **Mailing address** line 1 (if different from home address)
10. Apartment or suite number

11. Mailing address line 2 (If applicable, include an "in-care-of" person here. For an Authorized Representative, complete **Appendix A.**)

12. City
13. State
14. ZIP code
15. County

16. HOME phone number ( ) –
17. WORK phone number ( ) –
18. CELL phone number ( ) –

19. 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".

20. What is your preferred spoken or written language (if not English)?
21. Are you applying for health coverage for yourself? ☐ Yes ☐ No

22. Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

We need Social Security Numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship.
If someone does not have an SSN, visit **socialsecurity.gov** or call **1-800-772-1213**. TTY users should call **1-800-325-0778**.

23. Sex ☐ Male ☐ Female
24. Date of birth (mm/dd/yyyy) ___ ___ / ___ ___/ ___ ___ ___ ___

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

26. **If you are not a U.S. citizen or U.S. national,** do you have eligible immigration status?
☐ **YES.** Fill in your document type and ID number below.

a. Immigration document type ____________
b. Document expiration date ____________ ☐ None
c. Alien number ____________
d. Passport or document number ____________ ☐ None
e Country of origin ____________
f. Category code ____________

27. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other ____________

28. **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 who else needs health coverage.

STEP 2 Tell us about anyone who needs health coverage

If you have more than 3 members in your household, copy this page before you fill it out. You should also include your name and date of birth at the top of all copied page(s).

STEP 2: PERSON 2

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. Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

7. Marital status: ☐ Married ☐ Civil Union ☐ Never married ☐ Separated ☐ Divorced/dissolved ☐ Widowed

8. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No **If no**, list address:

9. Do you want health coverage for PERSON 2? ☐ Yes ☐ No

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

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

☐ **YES.** Fill in PERSON 2's document information below.

a. Immigration document type ______________________

b. Document expiration date ________________ ☐ None

c. Alien number ______________________

d. Passport or document number ________________ ☐ None

e Country of origin ______________________

f. Category code ______________________

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

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

13. **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 ____________

STEP 2: PERSON 3

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. Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

7. Marital status: ☐ Married ☐ Civil Union ☐ Never married ☐ Separated ☐ Divorced/dissolved ☐ Widowed

8. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No **If no**, list address:

9. Do you want health coverage for PERSON 3? ☐ Yes ☐ No

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

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

☐ **YES.** Fill in PERSON 3's document information below.

a. Immigration document type ______________________

b. Document expiration date ________________ ☐ None

c. Alien number ______________________

d. Passport or document number ________________ ☐ None

e Country of origin ______________________

f. Category code ______________________

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

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

13. **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 ____________

STEP 3 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, can enroll in a Qualified Health Plan outside of an open enrollment period. Someone may contact you for more 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. To apply, you need the application for "Help Paying Costs".**

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 3 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 4.

☐ **Yes. If yes,** continue. If you have more people to include, make a copy of this page and attach.

PERSON 1	PERSON 2
2. First name, middle name, last name & suffix (Jr., Sr., III, etc.)	2. First name, middle name, last name & suffix (Jr., Sr., III, etc.)
3. Alaska Native? ☐ Yes ☐ No	3. Alaska Native? ☐ Yes ☐ No
4. Member of a federally recognized tribe? ☐ **Yes. If Yes**, tribe name: ____ State where recognized: ____ ☐ **No**	4. Member of a federally recognized tribe? ☐ **Yes. If Yes**, tribe name: ____ State where recognized: ____ ☐ **No**

STEP 4 Incarcerated (detained or jailed) family member(s)

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

☐ **No. If no,** skip to Step 5.

☐ **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 5 Read your rights and responsibilities before signing

- I know that if anything changes (or is different than) what I wrote on this application, I must tell Vermont Health Connect 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 the member(s) of my household.
- I know that the information on this application is confidential and will not be shared except as needed for program administration. I know that state and federal privacy laws protect my records.
- 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 by visiting **www.hhs.gov/ocr/office/file**.
- If I think Vermont Health Connect has made a mistake, I can appeal its decision. To appeal means to ask for a fair hearing to have the decision looked at again. I can appeal by calling Vermont Health Connect at **1-855-899-9600**. I may be able to get free legal advice from the Health Care Advocate at Vermont Legal Aid at **1-800-917-7787**.

STEP 6 Sign this application

<u>You MUST sign below</u>. 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.

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 4 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 Terrace Street, Drawer 09, Montpelier, VT 05609-1101, or call **1-802-828-2363**.

STEP 7 Mail the completed and <u>signed</u> 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 20 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.

205APX-A
8/2016

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.