VERMONT

State of Vermont
Department of Health
Vermont Medication Assistance Program
108 Cherry Street–PO Box 70
Burlington, VT 05402-0070
HealthVermont.gov

[phone] 802-951-4005
[fax] 802-863-7314

Agency of Human Services

VT MEDICATION ASSISTANCE PROGRAM (VMAP)

VT DENTAL CARE ASSISTANCE PROGRAM (DCAP)

APPLICATION INSTRUCTIONS

This application covers both the VMAP and DCAP. If you are found eligible for VMAP, you will automatically be enrolled in DCAP.

Please make sure that the application is filled out completely and you have included all the required verifications. **Incomplete applications will not be processed.**

You must have your prescriptions filled out by a physician who is a Vermont Medicaid Provider. Almost every physician in Vermont is a Vermont Medicaid Provider, as are many physicians in nearby communities in bordering states.

WHAT IS NEEDED FOR A COMPLETE APPLICATION

____ **The application is filled out completely, signed and dated**.

____**Verification of your Vermont residence**. This needs to be verification of your physical (street address) that matches the address on your application and not just a Post Office Box. It can be a copy of your driver's license with your current street address, or a utility bill, or social security letter or tax form or rental agreement - anything that verifies that you are living at that address. If you are staying with someone and there are no bills in your name, please fill out Residential Statement section.

_____ **Copy of the front and back of your health insurance card(s).**

_____**Signed Reimbursement Statement.** This section is stating that if you receive any refund for money that VMAP has spent on your behalf, such as co-pays or health insurance premiums, you agree to sign over the check to VMAP at the Vermont Department of Health.

_____ **Verification of income as you stated on page 3 of this application.** If you do not have any income now, complete the Zero Income Statement.

_____ **Signed Release of Information Form** with the names of individuals you would like us to be able to communicate with such as spouse, partner, friend.

_____ **Physician Verification Status Form** filled out by your physician. Your physician can fax it directly to the Vermont Medication Assistance Program office at the Vermont Department of Health (802) 863-7314.

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Department of Health

VERMONT MEDICATION ASSISTANCE PROGRAMS (VMAP & DCAP) APPLICATION

Last Name:_____First:_____MI:._____ SSN:_____-_____-_____

Mailing Address: _____City:_____State:____Zip:_____

Street Address:_____City:_____ State:____ Zip:_____

Date residency in Vermont began: _____/_____ Month/ Year

Telephone # (CELL): (_____)_____ Can a message be left at this number? ❒ No ❒ Yes

Telephone # (HOME): (_____)_____ Can a message be left at this number? ❒ No ❒ Yes

Date of Birth:____/_____/_____ Gender: ❒ Male ❒ Female ❒ Transgender
Gender at Birth: ❒ Male ❒ Female

What is your marital status? ❒ Single ❒ Married ❒ Civil Union

RESIDENTIAL STATEMENT

(Complete this **section** only if you are staying with someone and have no other verification of physical residence)

I, _____ (print name of homeowner or lessee), am allowing

_____ (print name of applicant), to live at my home or apartment until other arrangements can be made.

Length of stay anticipated? _____(days/months/years)(please circle one).

Address of homeowner or Lessee: _____

_____

_____

Please enclose a copy of a utility bill with the homeowners or Lessee name and address that are listed above, with this form.

*It is the responsibility of the applicant to notify the Vermont Department of Health any changes in residency within 15 days of the change.

_____ _____
Signature of Homeowner/Lessee Signature of Applicant

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The following questions are for reporting purposes only and does not affect eligibility. You may check more than one.

Are you Hispanic or Latino? ❒ **Yes** ❒ **No**

- ❒Mexican
- ❒Puerto Rican
- ❒Cuban
- ❒Other Hispanic

What is your race?

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

What is your primary language?_____

Are you a US Citizen? ❒ Yes ❒ No If No, what is your immigration status?_____
Legal status is <u>NOT</u> a requirement for the VT Medication Assistance Program.

Were you ever in the military? ❒ Yes ❒ No

If yes, are you receiving VA health insurance? ❒ Yes ❒ No
If no, are you eligible to apply? ❒ Yes ❒ No

<u>PHARMACY:</u> Prescriptions need to be written by a doctor with a VT Medicaid Provider # and filled at a pharmacy in or near Vermont. Please indicate which pharmacy you want to use:

Name of Pharmacy: _____ Telephone:_____

Address: _____

<u>CONTACTS:</u> Please list the following contacts:

	Name	**Organization/Practice**	**Telephone**
Case Manager			
Social Worker/ Nurse			
Specialist Physician			

<u>MEDICATIONS</u>

Please list the prescription medications that you are taking now.

_____

_____

If you are not currently taking any medications, when do you expect to begin?_____

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HEALTH INSURANCE

****Everyone who is eligible for health insurance must have it in order to be eligible for VMAP.**

Do you have health insurance now? ❒ Yes ❒ No

If NO, what is the reason you do not have health insurance? _____
Have you applied for health insurance through Vermont Health Connect? ❒ Yes ❒ No What date? _____

If YES, what health insurance do you have? Please check all that apply:

❒ Vermont Medicaid

❒ Insurance through Vermont Health Connect

Name of Plan:_____ Amount of monthly premium: _____

❒ Medicare: ❒ Part A (Hosp) ❒ Part B (Medical) ❒ Part D (Drugs) ❒ Part C (Combined Hosp, Med)
❒ Supplemental Medicare
❒ VPharm

❒ Private insurance through your employer ❒ Private insurance through ❒ Spouse or ❒ Parent or ❒ School

❒ Other (inc. VA) _____

Is it a hardship for you to pay your premium? ❒ Yes ❒ No If **YES**, please contact VMAP Coordinator at (802) 951-4005.

VERMONT MEDICATION ASSISTANCE PROGRAM (VMAP)
AGREEMENT REGARDING REIMBURSEMENT

I, _____, agree to immediately endorse (sign over) any payment made to me by my insurance company or Internal Revenue Service (IRS) via premium tax credits for Vermont Medication Assistance Program (VMAP) purchased medications or services.

This payment is the sole property of VMAP.VMAP expects to receive the payment within 10 days of you having received the refund. The check, along with a copy of the explanation of benefits (EOB), should be mailed to:

Vermont Medication Assistance Program
Vermont Department of Health
P.O. Box 70
Burlington, VT 05402

I understand that failure to remit these payments for expenses which VMAP paid on my behalf can result in being terminated from the program. By signing below, I agree to these terms and conditions.

Signature:_____ Date:_____

INCOME INFORMATION

My individual income is: $_____per YEAR.

My income has changed in the past year because I:
❒ Stopped working ❒ Changed jobs ❒ Started working ❒ Worked more hours ❒ Worked less hours

❒ Other_____

❒ There has been no change in my income

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VERIFICATION OF INCOME

****You are required to enclose a copy of your Federal Income Tax Return Form 1040 (Page 1 of what you send in to the IRS), even if your 1040 form also includes other family members. Only your income will be counted.****

❒ I **DO** file federal income taxes and am enclosing a copy of my most recent Form 1040 to verify my income. My current income has not changed or is not expected to change from the Adjusted Gross Income that is reported on this form.

❒ I **DO** file federal income taxes and am enclosing a copy of my most recent Form 1040, **but** my current income is not the same as what is on the Form 1040 so I am also enclosing copies of:

❒ Two recent paystubs
OR
❒ A letter verifying my income (Social Security, Unemployment, etc.)

❒ Other _____

❒ I **DO NOT** file taxes and **DO NOT** have a copy of Form 1040. I am enclosing copies of the following to verify my income:

❒ Two recent paystubs
OR
❒ A letter verifying my income (Social Security, Unemployment, etc.)

❒ Other _____

If you currently have no income, please complete the following Zero Income Statement:

During this verification process, I state that I have no income **of any kind** at this time. I have not received income since _____. I do not expect to receive any income until _____.
I applied for _____ (other financial assistance) on _____ (date).

I understand that any misrepresentation of information or failure to disclose information requested on this form may disqualify me from participation in this program and may be grounds for termination of assistance.

I certify that the above information is true and correct. I also understand that it is my responsibility to report all changes to my household composition or income in writing to within ten (10) business days of such change.

Signature: _____ Date: _____

Case Manager Signature: _____ Date: _____

Case Manager's Notes:

I solemnly swear that the information written on this form is correct and complete to the best of my knowledge. I understand that the information I have provided may be subject to verification in order to determine my eligibility for this program and that it is my responsibility to update the Vermont Medication Assistance Program with any changes to the information I have provided on this application. I also understand that the information I have provided will be kept confidential and will only be used for the administration of this program.

Signature_____Date_____

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Department of Health

VERMONT MEDICATION ASSISTANCE PROGRAM (VMAP)

RELEASE OF INFORMATION

I, _____, authorize the Vermont Department of Health
(Print Name)
Medication Assistance Program staff to receive and disclose medical, dental, insurance, and eligibility information pertaining to my immune-compromised related condition to and from the service providers listed below. I understand that information will be disclosed only to determine eligibility for the Medication Assistance Program or to arrange for payments (insurance premiums, co-pays, deductibles and dental services), on my behalf for these programs. I also understand that information will be disclosed only on an as needed basis and only to the necessary providers and programs.

X Agency of Human Services (AHS) Departments or Divisions
X Medical facility Staff (*Name of provider/office* _____)
X Community Service Organization Staff (*Name of organization*_____)
X Dental Provider Staff (*Name of provider/office*_____)
X Pharmacy Staff (*Name of Pharmacy* _____)
X Change, COPS, PDP team, DXE Staff (*to assist with claims and eligibility issues*)
X Insurance Company Staff (*Name of company* _____)
X State Health Insurance Assistance Program _____)
X Other (*specify name and relationship to you*_____)

By signing this form, I understand:

- ✓ The reason(s) I am being asked to release information.
- ✓ I do not have to agree to the release of information. However, by not giving authorization, I will not be able to obtain all of the assistance I may need with my medication, insurance and dental needs.
- ✓ If I choose not to sign this form any benefits for which I am entitled to will not be affected.
- ✓ While the AHS takes every precaution to protect my health information once it is disclosed pursuant to this authorization, it may be subject to re-disclosure.
- ✓ If I am authorizing AHS to share information about immune-compromised treatment, the recipient may not share my information with others unless permitted to do so by law.
- ✓ My file may be audited by the Health Resources and Services Administration, who provides the funding for this program.
- ✓ I may revoke this authorization at any time by contacting the Medication Assistance Coordinator at 802-951-4005, except to the extent that it has been acted upon.
- ✓ If I do not revoke or update this authorization, it will be in effect as long as I am receiving Medication Assistance Program services.
- ✓ I will be provided a copy of this form.
- ✓ All items on this form and my questions about this form have been answered.

Client's Signature_____**Date**_____

Please return this form to:

VT Medication Assistance Program Coordinator
VT Dept of Health
P.O. Box 70, Drawer 41 IDEPI
Burlington, VT 05402
(802)-951-4005 or 1-800-464-4343 ext 4005

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VERMONT MEDICATION ASSISTANCE PROGRAM (VMAP)

PHYSICIAN VERIFICATION FORM

This form is to be completed and signed by a medical provider for individuals applying for the Vermont Medication Assistance Program through the Vermont Department of Health

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Patient Name: _____

Last 4 digits of Patient's SSN: XXX-XX-__ - __ - __ - __

Patient's DOB (mm/dd/yyyy): _ _ / _ _ / _ _ _ _

Name of Medical Provider: _____

Telephone Number of Medical Provider: (_ _ _) - _ _ _ - _ _ _ _

Patient's Medical Status: _Positive _Negative

CD4 Count: _____ Draw Date: _ _ / _ _ / _ _ _ _

Viral Load: _____ Draw Date: _ _ / _ _ / _ _ _ _

_____ _ _ / _ _ / _ _ _ _

Signature of Medical Provider Date

Please return this form with the completed application to:

VMAP Coordinator
Vermont Department of Health
PO Box 70- Drawer 41 IDEPI
Burlington, VT. 05402
P: (802) 951-4005
F: (802) 863-7314