

**VERMONT DEPARTMENT OF HEALTH
MEDICATION ASSISTANCE PROGRAMS (VMAP)
Instructions**

Please read required documentation carefully. Incomplete applications will not be processed.

Program Selection

When applying for the **Vermont Medication Assistance Program (VMAP)**, you will be automatically be enrolled in the **Dental Care Assistance Program (DCAP)**.

Vermont Residency/Insurance and Contact Information (Section A)

Verification of Vermont residency is required. Please send a copy of a utility bill, income tax form, VT driver's or non-driver's license or another document that verifies your current Vermont residency. Length of residency in Vermont will not affect your eligibility for this program.

State or Private Insurance

If you are covered under any other insurance coverage, state or private, please include a **copy of your insurance card, front and back**. If you do not currently have any form of insurance you must apply for either Medicaid or the Green Mountain Health Programs and provide a copy of the acceptance or denial letters with your application. Forms for either program can be found at http://www.greenmountaincare.org/sites/gmc/files/GMC_Application_8_Pages.pdf

List of Medications (Section B)

Please list **all** medications which you are taking and the monthly cost to you.

Household Members (Section C)

List all individuals for whom you are financially responsible or who is responsible for you. Include yourself, a married spouse, or civil union partner, and any legal dependents.

Income (Section D)

List all income received by you and/or your legal spouse or civil union partner. Other income includes other unearned income, alimony, pensions, rental income, cash/check from others. **Verification of all income is required with your application and may include: paystubs, W-2's, written employer statements, self-employment business records, and award letters such as Social Security, SSI, or VA award letters.**

Deductions (Section E)

List all amounts deducted in the allowable categories listed for you and/or your legal spouse or civil union partner. These will be deducted from your gross income to determine financial eligibility. (below 200% Federal Poverty Level)

Physician Verification status

Physician verification form is required. Have your physician or other medical provider sign the form and return it with your completed application. Prescribing physician is required to have a VT Medicaid provider number.

Disclosure of Information

Fill out and sign the enclosed Release of Information form. **Only information that is necessary to determine eligibility and billing would be disclosed.** Include anyone with whom you may want us to speak. If their name does not appear on the release, we may not, and will not, speak with them.

Requirement to Report Change

If you are found eligible for the Assistance Programs, you will be responsible for reporting any changes in your residence, income, health insurance coverage, or other circumstances affecting eligibility within 15 days of the change. Failure to do so may result in your becoming ineligible, and required to reapply.

Mail your application to:

VT Department of Health
VMAP Coordinator
PO Box 70-Drawer 41- IDEPI
Burlington, VT 05402

**VERMONT DEPARTMENT OF HEALTH
MEDICATION ASSISTANCE PROGRAMS**

A) Last Name: _____ First: _____ MI.: _____ SSN: _____ - _____ - _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Do you currently live in Vermont? No Yes Date residency in Vermont began: _____ / _____
(Duration of Vermont residency does not affect eligibility for this program) Month/ Year

Telephone # (home): (____) _____ Can a message be left at this number (name & tel. # only)? No Yes

Telephone # (work): (____) _____ Can a message be left at this number (name & tel. # only)? No Yes

Telephone # (cell): (____) _____ Can a message be left at this number (name & tel. # only)? No Yes

Date of Birth: ____ / ____ / ____

Gender: Male Female Transgender

What is your marital status? Single Married civil union

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

Are you Hispanic or Latino? Yes No

What is your race? American Indian or Alaska Native
 Asian
 Black or African American
 Native Hawaiian or Other Pacific Islander
 White

Were you were ever in the military? Yes No

If yes, are you receiving VA benefits? Yes No
If no, are you eligible to apply? Yes No

Pharmacy: You will be asked to have your prescriptions filled at only one pharmacy. Please indicate:

Name of Pharmacy: _____ Telephone: _____

Address: _____

Insurance: Do you currently have *private health insurance*, including Medicare Part D? Yes No
(Please send copy of insurance card front and back)

Insurance Co. Name: _____

Address: _____ Telephone #: _____

Policy #: _____ Group #: _____

Name of policy holder: _____ Start Date of Insurance: ___/___/___

Social Security # of policy holder: : ____-____-_____

Does your health insurance cover *prescriptions*, including Medicare Part D? No Yes

If yes, what is the coverage? _____

Date eligible to receive prescription coverage: _____

Name of Prescription Insurance carrier (if other): _____

Telephone #: _____

State insurance programs: (please include acceptance or denial letter(s) with your application)

Do you currently have any of the following insurance programs?

VHAP VPharm VScript Medicaid Catamount

If no, have you applied for any of these programs in the past 6 months? Yes No

If yes, reason you were denied? Over income Had other insurance in past 12 months

Not a US Citizen Student Did not complete application Other _____

Dental: Do you currently have *Dental Insurance*? Yes No
(Please send copy of insurance card front and back)

Contacts: Please list the following contacts where appropriate:

	Name	Organization/Practice	Telephone
Primary Care Physician			
Specialist Physician			
Dentist/Oral Surgeon			
Case Manager			
Social Worker			

B) MEDICATION INFORMATION

Please list all medications which you are taking (include prescription and non-prescription medications) and their **monthly** cost to you. Please deduct the amount your health insurance company will pay. You may use the total cost to you as a deduction on the Financial Information page.

<u>Name of medication</u>	<u>Cost per month to you</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

TOTAL COST PER MONTH \$ _____

ANNUAL COST (X 12 months) = \$ _____ (Place this amount on Line E(i))

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

FINANCIAL INFORMATION

(Annual)

C) List legal dependents, including your married spouse or civil union partner, if applicable:

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

D) Annual Household Income (List all income received by you and/or married spouse/civil union partner, if applicable. If you do not have any income, you are required to fill out the Zero Income form at the end of the application): Please see Instructions for filling out this section

	<u>Self</u>	<u>married spouse/civil union partner</u>
a) Gross wages/salary	\$ _____	_____
b) Self-employment	\$ _____	_____
c) Dividends/interest	\$ _____	_____
d) Social Security	\$ _____	_____
e) SSDI	\$ _____	_____
f) Veterans Benefits	\$ _____	_____
g) Unemployment	\$ _____	_____
h) Worker's Comp.	\$ _____	_____
i) Child Support	\$ _____	_____
j) Other	\$ _____	_____

E) Deductions from Annual Household Income

	<u>Self</u>	<u>Spouse/CU partner</u>
a) State income taxes	\$ _____	_____
b) Federal income taxes	\$ _____	_____
c) Property taxes or 21% of rent <u>you</u> pay	\$ _____	_____
d) Social Security	\$ _____	_____
e) Medicare Tax	\$ _____	_____
f) Cost of medical insurance (inc. Medigap and Medicare)	\$ _____	_____
g) Cost of medical services (not covered by insurance)	\$ _____	_____
h) Cost of medical supplies (not covered by insurance)	\$ _____	_____
i) Cost of medications (" <i>Annual Cost</i> " from Section B)	\$ _____	_____
j) Child support payments	\$ _____	_____
k) Child care costs	\$ _____	_____

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. 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 _____

Zero Income Statement

Vermont Medication Assistance Program (VMAP)

I, _____, have applied for the Vermont Medication Assistance Program (VMAP) through the Vermont Department of Health. Federal/State regulations require verification of all income from applicants household.

Income includes but is not limited to:

- Gross wages, salaries, overtime pay, commissions, fees, tips and bonuses
- Net income from operation of a business or from rental or real personal property
- Interest, dividends and other net income of any kind for real personal property
- Periodic payments received from Social Security, annuities, insurance policies, retirement funds, pensions, disability or death benefits and other similar types of period receipts
- Payments in lieu of earnings, such as unemployment and disability compensation, worker's compensation, and severance pay
- Public assistance
- Alimony and child support payments (whether through the court system or not)
- Regular pay, special pay and allowances of a head of household or spouse who is a member of the Armed Forces (whether or not living in the dwelling)

I have stated during this verification process that I have no income 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: _____

Medical Case Manager Signature: _____

Date: _____

Medical Case Manager's Notes:

**VERMONT DEPARTMENT OF HEALTH MEDICATION ASSISTANCE PROGRAM
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.

<p><input checked="" type="checkbox"/> Department of Children & Families - Economic Services Division</p> <p><input checked="" type="checkbox"/> Medical facility Staff (<i>Name of provider/office</i> _____)</p> <p><input checked="" type="checkbox"/> Community Service Organization Staff (<i>Name of organization</i> _____)</p> <p><input checked="" type="checkbox"/> Dental Provider Staff (<i>Name of provider/office</i> _____)</p> <p><input checked="" type="checkbox"/> Pharmacy Staff (<i>Name of Pharmacy</i> _____)</p> <p><input checked="" type="checkbox"/> Med Metrics, COPS, PDP team, HP Staff (<i>to assist with claims and eligibility issues</i>)</p> <p><input checked="" type="checkbox"/> Insurance Company Staff (<i>Name of company</i> _____)</p> <p><input type="checkbox"/> Other (<i>specify name and relationship to you</i> _____)</p>

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.
- ✓ 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:

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