

Application



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. The Americans with Disabilities Act gives people with disabilities certain rights. We will make reasonable changes and accommodations in our requirements to help you take part in our programs. Tell your worker if you think there is something 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)

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)

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)

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.

Information for Applicants

Social Security Numbers. Everyone applying for benefits must provide a social security number. If you don't have one, ESD will help you apply for one. People not applying for benefits do not have to give a social security number; however, they will have to provide all other information such as income and resources.

Important Information for Immigrants. Only U.S. citizens and certain legal aliens can get benefits. If your household includes people who are not eligible because of immigration status, you can still apply for and get benefits for other eligible members. ESD will verify with the Immigration and Naturalization Service the immigration status of noncitizens who apply for benefits. People not applying for benefits do not have to give immigration information.

If you get assistance from us, it may affect your sponsor or your immigration status. Before you apply, you may want to talk with Vermont Legal Aid at 1-800-889-2047 or an agency that helps immigrants with legal questions.

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. The Americans with Disabilities Act gives people with disabilities certain rights. We will make reasonable changes and accommodations in our requirements to help you take part in our programs. Tell your worker if you think there is something that you need.

Rights and Responsibilities. When you sign this form, it means you have read and understand your rights and responsibilities on the back of this form. You will get a copy of these to keep. You may ask for a copy in larger print if you would like. If you do not understand your Rights and Responsibilities, ask your worker to explain them to you.

Confidentiality. ESD will not share any information from this application except for purposes directly connected with program administration unless you clearly allow release of this information or a court orders it. ESD takes strict precautions to safeguard social security numbers and other confidential information transmitted via the internet or fax machine.

The Application Process

Answer each question as completely as you can. Sign the application and give it to the receptionist or mail it to your local office. Please print. If you have questions or need help with this form, your local office can help you. See the back of this form for the addresses and telephone numbers. If you need more room for your answers, please attach another piece of paper.

If you only want food stamps, you just need to answer the questions with the apple (🍏) symbol.

If you are applying for food stamps or Reach Up, an interview will be scheduled for you. In certain situations, your food stamp interview can be by phone. At your appointment, your worker will go over this form with you. It is your responsibility to give your worker all the information needed. If you are not able to get this information, ask your worker for help.

Application

This page is your application. You may tear it off and give it to your local office now without the rest of the form. It must have your name, address, and signature. You may mail the rest of the form or bring it to your interview. Please complete the entire form when possible. This information helps us determine if you qualify for emergency benefits. We must have the completed form and all required verification to see if you are eligible.

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 _____

Directions to your home _____

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

If yes, check one: Authorized representative
 Legal guardian – name of court _____ Date appointed _____

Name _____ Telephone number (_____) _____

Address _____

Someone in my household is applying for the following programs (check one or more boxes):

- Food Stamps** – Help to buy more and better food. If you are eligible, you get benefits from the date ESD gets this application. If you have little or no money for food, you may be able to get emergency help.
- Reach Up** – Services and cash to help families with children become more independent. If eligible, benefits begin 30 days from the date ESD gets this application or the date it is approved, whichever is earlier.
- Medicaid/Dr. Dynasaur** – Help to pay medical expenses for children under 21, people 65 or older, people who are blind or have a disability, pregnant women, and people with children. Medicaid may also help pay Medicare premiums, deductibles, and coinsurance.
Ask for an “Application for Health Care Assistance, ESD 202MED” if you want help only with medical expenses.
- VHAP or Pharmacy Assistance – VHAP** (Vermont Health Access Plan) helps pay medical expenses for people 18 and older who do not have insurance for both doctors and hospitals. **VHAP-Pharmacy, VScript, and VPharm** help pay prescription costs for people who are blind, have a disability, or are 65 or older. **Healthy Vermonters** helps people of any age. Your worker will enroll you in the best program that you qualify for.
Ask for a “Pharmacy Programs Application, HC 201P” if you want help only with prescription costs.
- Essential Person** – For people who are blind, have a disability, or are 65 or older, to help meet expenses for someone who lives with and provides care for them so they can live at home.

I have read and I understand the Rights and Responsibilities on the back of this application. I was given a copy of these statements and I agree to them.

Signature of applicant
 or authorized representative _____ Date _____

Signature of person helping
 fill out this form _____ Date _____

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 ESD 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 that 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.

Social security number. I understand that, when I apply for assistance from ESD, I must give the social security number of everyone in my household who wants assistance. Federal law requires this as a condition of eligibility. If I am a member of a religious organization that objects to furnishing a social security number, ESD may disregard this requirement. (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 ESD from discriminating based on race, color, national origin, sex, age, disability, religion or political beliefs.

To file a discrimination complaint, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write 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 (TTY). USDA and HHS are equal opportunity providers and employers. Under Vermont law and rules, ESD may not discriminate based on marital status, sexual orientation 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, 05671-1201.

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

Fair hearing. I may ask for a fair hearing when my claim for assistance, benefits, or services is denied in whole or in part, or not responded to with reasonable promptness by contacting an ESD office or writing to the ESD Deputy Commissioner. (3 V.S.A. §3091)

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 (c))

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.

Assignment of support rights. As a condition of eligibility for public assistance, I agree to assign all my rights to support to ESD. I understand this includes all current support owed to me while I get public assistance, all arrears owed to me that are collected during this assignment, and all arrears collected through federal tax offset during or after this assignment, up to the amount I get or have ever gotten. The noncustodial parent(NCP) will owe me amounts over the total amount of public assistance. Arrears include, but are not limited to, unpaid support obligations, debts, and court-ordered and administrative judgments. While I am on assistance, I understand the NCP will pay all support directly to the Office of Child Support (OCS). While I am waiting for ESD to grant me assistance, I will tell ESD of any support the NCP pays directly to me. After I have been granted assistance, I will immediately turn over to OCS any support the NCP pays me directly.

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.

Take part in Reach Up activities. I understand that I and members of my household may have to participate in certain Reach Up activities and that my worker will tell us what we have to do and what the penalty is if we do not.

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 Food Stamp benefits, Medicaid, or cash assistance from another state or has been convicted in the past ten years of fraudulently misrepresenting residence 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, Food Stamp, 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)

Food Stamp fraud penalties. I or any household member cannot trade or sell Food Stamp benefits, use them to buy ineligible items such as alcohol or tobacco, or use someone else's food stamps. If convicted, the member may be barred from the Food Stamp program for one year for the first offense, two years for the second offense, or permanently for the third offense, and be fined up to \$250,000, imprisoned up to 20 years, or both. If convicted of buying or selling illegal drugs in exchange for food stamps, a member may be barred for two years or barred permanently for a second offense. If convicted of purchasing firearms, explosives, or ammunition with food stamps or of trafficking in Food Stamp benefits of \$500 or more, a member may be barred permanently. If convicted of falsely representing identity or residence, a member may be barred for 10 years and may be prosecuted under other federal and state laws. (7 C.F.R. §273.16(b).)

Emergency Needs

If you have little or no money for food, you may be able to get food stamp benefits within 7 days. Answer the questions in the box below to see if you can get expedited service.

Expedited Food Stamps for New Applicants

Have you received food stamps this month in any state?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Is anyone in your household a migrant or seasonal farm worker?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
What is your household's total income for this calendar month?			\$	_____
How much money does your household have in cash, checking, and savings accounts? Give your best guess if you're not sure.			\$	_____
What is your monthly rent or mortgage?			\$	_____
How much are your monthly utilities?			\$	_____

General Assistance

You may also be able to get general assistance to help meet your emergency needs. Ask your worker for a general assistance application if you need emergency help.

Head of Household for Food Stamp Benefits

If your household has adult parents with children or adults with parental control of children, you may choose the head of household for food stamp benefits.

- ESD sends notices, forms, and benefits to the head of household.
- If you leave this line blank, ESD will make the selection.
- You may change the head of household when your case is reviewed or when the people in your household change.

Head of household _____

 Have you visited the Food Stamp website at www.vermontfoodhelp.com? Yes No

For ESD use only

Interview date	<input type="checkbox"/> Applicator	<input type="checkbox"/> Reach Up	<input type="checkbox"/> Food Stamps	Worker
	<input type="checkbox"/> Review	<input type="checkbox"/> Health care	<input type="checkbox"/> Essential person	



1. List anyone living in your home including people not asking for assistance. People in your household who are not applying do not have to give their social security number or citizenship information but must provide all other information. If you are applying for food stamps only, answer just the questions with the apple (🍏).

MEMB

1.	First name Initial Last name	Assistance applying for: <input type="checkbox"/> Reach Up <input type="checkbox"/> Medicaid/Dr. Dynasaur <input type="checkbox"/> Food Stamps <input type="checkbox"/> VHAP or pharmacy <input type="checkbox"/> Essential Person <input type="checkbox"/> None	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Social security number	Citizenship status <input type="checkbox"/> U.S. citizen <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Legal alien <input type="checkbox"/> Other
	Relationship to you Self	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Civil union <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Birth date	Last grade completed	

2.	First name Initial Last name	Assistance applying for: <input type="checkbox"/> Reach Up <input type="checkbox"/> Medicaid/Dr. Dynasaur <input type="checkbox"/> Food Stamps <input type="checkbox"/> VHAP or pharmacy <input type="checkbox"/> Essential Person <input type="checkbox"/> None	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Social security number	Citizenship status <input type="checkbox"/> U.S. citizen <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Legal alien <input type="checkbox"/> Other
	Relationship to you	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Civil union <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Birth date	Last grade completed	

3.	First name Initial Last name	Assistance applying for: <input type="checkbox"/> Reach Up <input type="checkbox"/> Medicaid/Dr. Dynasaur <input type="checkbox"/> Food Stamps <input type="checkbox"/> VHAP or pharmacy <input type="checkbox"/> Essential Person <input type="checkbox"/> None	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Social security number	Citizenship status <input type="checkbox"/> U.S. citizen <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Legal alien <input type="checkbox"/> Other
	Relationship to you	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Civil union <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Birth date	Last grade completed	

4.	First name Initial Last name	Assistance applying for: <input type="checkbox"/> Reach Up <input type="checkbox"/> Medicaid/Dr. Dynasaur <input type="checkbox"/> Food Stamps <input type="checkbox"/> VHAP or pharmacy <input type="checkbox"/> Essential Person <input type="checkbox"/> None	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Social security number	Citizenship status <input type="checkbox"/> U.S. citizen <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Legal alien <input type="checkbox"/> Other
	Relationship to you	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Civil union <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Birth date	Last grade completed	

5.	First name Initial Last name	Assistance applying for: <input type="checkbox"/> Reach Up <input type="checkbox"/> Medicaid/Dr. Dynasaur <input type="checkbox"/> Food Stamps <input type="checkbox"/> VHAP or pharmacy <input type="checkbox"/> Essential Person <input type="checkbox"/> None	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Social security number	Citizenship status <input type="checkbox"/> U.S. citizen <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Legal alien <input type="checkbox"/> Other
	Relationship to you	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Civil union <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Birth date	Last grade completed	

6.	First name Initial Last name	Assistance applying for: <input type="checkbox"/> Reach Up <input type="checkbox"/> Medicaid/Dr. Dynasaur <input type="checkbox"/> Food Stamps <input type="checkbox"/> VHAP or pharmacy <input type="checkbox"/> Essential Person <input type="checkbox"/> None	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Social security number	Citizenship status <input type="checkbox"/> U.S. citizen <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Legal alien <input type="checkbox"/> Other
	Relationship to you	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Civil union <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Birth date	Last grade completed	

7.	First name Initial Last name	Assistance applying for: <input type="checkbox"/> Reach Up <input type="checkbox"/> Medicaid/Dr. Dynasaur <input type="checkbox"/> Food Stamps <input type="checkbox"/> VHAP or pharmacy <input type="checkbox"/> Essential Person <input type="checkbox"/> None	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Social security number	Citizenship status <input type="checkbox"/> U.S. citizen <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee <input type="checkbox"/> Legal alien <input type="checkbox"/> Other
	Relationship to you	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Civil union <input type="checkbox"/> Divorced/dissolved <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Birth date	Last grade completed	

Please answer the following questions about all the people listed on the previous page.
If you need more room, attach another sheet of paper.

1a. Has anyone moved to Vermont in the past 12 months?

Yes No

First name	Initial	Date arrived in Vermont	State or country moved from

 1b. Has anyone received food stamp or cash assistance from another state since 1996?


Yes No

First name	Initial	State or country	Date started	Date ended

 1c. Did anyone receive a Vermont earned income tax credit (EITC) in the past 12 months?

Yes No

First name	Initial	Date received


 2. Is anyone living outside your home in a facility that is not a school or college?

Yes No

Some examples are:

hospital correctional facility residential care home
nursing home treatment facility group home

First name	Initial	Name of facility	Date of admission	INST

 3. Is anyone in high school, college, vocational school, or a training program?

Yes No

SCHL

First name	Initial	Name of school	Expected completion date	Is health insurance offered here?	Status
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> full-time <input type="checkbox"/> half-time <input type="checkbox"/> less than half-time
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> full-time <input type="checkbox"/> half-time <input type="checkbox"/> less than half-time
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> full-time <input type="checkbox"/> half-time <input type="checkbox"/> less than half-time

Does any child listed above have an Individualized Education Program (IEP) or a disability preventing graduation before age 19? Yes No

4. Is anyone known by any other name, such as a maiden name or alias?

Yes No

ALIA

Current name			Other name		
First name	Initial	Last name	First name	Initial	Last

5. Does anyone have a physical, mental, or emotional condition that limits activities such as working, going to school, or taking care of the children?

Yes No

DISA

First name	Initial	Caused by an accident?	Applied for SSI/AABD?	Condition
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

6. Is there anyone living with you who is a parent to your minor child?

Yes No

Do not list your husband, wife, or civil union partner.

PARE

First name	Initial	Name of child	Name of child

7. Did anyone leave a job in the last 60 days or go on strike?

Yes No

QUIT

First name	Initial	Reason for leaving	Date left

8. Does anyone live with you who does not share your food?

Yes No

EATS

First name	Initial	Last	First name	Initial	Last	First name	Initial	Last

Answer question 9 only if you are applying for the Essential Person program.

9. Does anyone live with you to provide care so you can live at home?

Yes No

Do not list your husband, wife, or civil union partner.

			ESSP	
First name	Initial	Last name	Kind of care	Is this paid for by another agency?
				<input type="checkbox"/> Yes <input type="checkbox"/> No

 **10. Is anyone pregnant?**

Yes No

		PREG	
First name	Initial	Expected due date	Does this prevent her from working?
			<input type="checkbox"/> Yes <input type="checkbox"/> No

11. Are there children in your home who do not have both parents living with them?

Yes No

			ABSP		
Absent parent's full name and address		Social security number (optional)	Date of birth	Children of absent parent	
1.				1	
Your relationship to absent parent <input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Never married <input type="checkbox"/> Dissolved civil union <input type="checkbox"/> Civil Union <input type="checkbox"/> Widowed - date _____		Absent parent's current marital status <input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Never married <input type="checkbox"/> Dissolved civil union <input type="checkbox"/> Civil Union <input type="checkbox"/> Widowed		2	
				3	
				4	
Absent parent's full name and address		Social security number (optional)	Date of birth	Children of absent parent	
2.				1	
Your relationship to absent parent <input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Never married <input type="checkbox"/> Dissolved civil union <input type="checkbox"/> Civil Union <input type="checkbox"/> Widowed - date _____		Absent parent's current marital status <input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Never married <input type="checkbox"/> Dissolved civil union <input type="checkbox"/> Civil Union <input type="checkbox"/> Widowed		2	
				3	
				4	
Absent parent's full name and address		Social security number (optional)	Date of birth	Children of absent parent	
3.				1	
Your relationship to absent parent <input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Never married <input type="checkbox"/> Dissolved civil union <input type="checkbox"/> Civil Union <input type="checkbox"/> Widowed - date _____		Absent parent's current marital status <input type="checkbox"/> Married <input type="checkbox"/> Divorce <input type="checkbox"/> Never married <input type="checkbox"/> Dissolved civil union <input type="checkbox"/> Civil Union <input type="checkbox"/> Widowed		2	
				3	
				4	

12. If there are two parents in your home who are able to work, please list the parent who is most likely to meet a work requirement? _____

 **13. Is anyone who is applying 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 \$ _____

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 \$ _____

13a. Is anyone 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	Contract ID	Plan ID	Plan start date
			CMS- -		
			CMS- -		

13b. Has anyone 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
			<input type="checkbox"/> Over income <input type="checkbox"/> Over resources <input type="checkbox"/> Other: _____	<input type="checkbox"/> Over income <input type="checkbox"/> Over resources <input type="checkbox"/> Other: _____
			<input type="checkbox"/> Over income <input type="checkbox"/> Over resources <input type="checkbox"/> Other: _____	<input type="checkbox"/> Over income <input type="checkbox"/> Over resources <input type="checkbox"/> Other: _____

14. Is anyone covered by a health or dental insurance plan, such as group insurance, veteran's or military benefits?

Yes No

Include insurance for any child in your home even if covered by a parent not in your home. Do not include Medicare or state health care programs.

Please send copies of both sides of all insurance cards.

INSU

Name of policy holder		Type of coverage (check all that apply)	Names of people covered	Name, address, and phone number of insurance company
1.		<input type="checkbox"/> Doctors <input type="checkbox"/> Prescriptions <input type="checkbox"/> Hospitals <input type="checkbox"/> Major Medical <input type="checkbox"/> Dental <input type="checkbox"/> Outpatient <input type="checkbox"/> Other _____		
Policy number	Group number			
Premium amount \$ _____ per	Date coverage began			

Name of policy holder		Type of coverage (check all that apply)	Names of people covered	Name, address, and phone number of insurance company
2.		<input type="checkbox"/> Doctors <input type="checkbox"/> Prescriptions <input type="checkbox"/> Hospitals <input type="checkbox"/> Major Medical <input type="checkbox"/> Dental <input type="checkbox"/> Outpatient <input type="checkbox"/> Other _____		
Policy number	Group number			
Premium amount \$ _____ per	Date coverage began			

14a. Could anyone else in your family be covered under the above plan?

Yes No

First name	Initial	First name	Initial

14b. Has health insurance ended for anyone in the past 12 months?

Yes No

Do not include state health care programs.

LOSS

First name	Initial	Date ended	Reason

14c. Does anyone have unpaid medical or dental bills for services received in the past 3 months? If yes, Medicaid may be able to help you pay them.

Yes No


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

14c. Does anyone have unpaid medical bills older than 3 months?

Yes No

If yes, they may help you qualify for Medicaid or Dr. Dynasaur.


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

 **15. Does anyone have cash that is not in a bank, such as at home, on hand, or held by others?** Include cash owned by children.

Yes No

CASH

First name	Initial	Amount	First name	Initial	Amount
		\$			\$

 **16. Does anyone have money in a bank, credit union, or other institution?**

Include accounts that are owned or co-owned by children.

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 bond or trusts				\$
Certificate of deposit (CD)				\$
Pension or retirement				\$
Other _____				\$

Does any portion of these savings come from money earned as a "Working Person with Disabilities?" Yes No

 17. Does anyone 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			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Car, truck, or van			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Car, truck, or van			<input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Motorcycle or ATV				\$	\$
Snow machine or jet ski				\$	\$
Trailer or boat				\$	\$
Camper or RV				\$	\$
Other _____				\$	\$

 18. Does anyone own or jointly own land, mobile homes, buildings, or other real estate?

Yes No

Do not list the home you live in.

PROP

Name of owner and co-owner, if any	Type of property	Location	Assessed value	Amount owed
			\$	\$
			\$	\$

 19. Does anyone own any other resources? Include resources owned by children.

Yes No

STOK


Type of Resource	Name of owner and co-owner, if any	Value
Life insurance: <input type="checkbox"/> term <input type="checkbox"/> whole		Face value \$ Cash value \$
Life insurance: <input type="checkbox"/> term <input type="checkbox"/> whole		Face value \$ Cash value \$
Life insurance: <input type="checkbox"/> term <input type="checkbox"/> whole		Face value \$ Cash value \$
Account set up for burial expenses Is this irrevocable? <input type="checkbox"/> Yes <input type="checkbox"/> No		\$
Burial plot		
Stocks, bonds, or mutual funds		\$
Trust funds or collections		\$
Promissory notes		\$
Other _____		\$

 **20. Has anyone sold, traded, or given away anything of value in the last two years?** Yes No

If you are applying only for food stamps, list only those in the last three months.

TRAN

First name	Initial	Type of resource	Date transferred	Sale price or value
				\$

 **21. Does anyone have income from a job?** Yes No

Include income of children. Include income from a training program. 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.

JINC


First name	Initial	Date paid	Hours worked	Income before deductions	Tips and commissions
How often paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____ Employer's name and phone number:				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$

First name	Initial	Date paid	Hours worked	Income before deductions	Tips and commissions
How often paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____ Employer's name and phone number:				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$
				\$	\$

22. Does anyone get food, housing, clothing, or anything else instead of, or in addition to, being paid for work? Yes No

INKD

First name	Initial	Item received	Value
			\$ per

 **23. Does anyone get paid for taking care of children?** Yes No

List income from the past 30 days before deductions and list the number of meals you provide each month that you are not paid for.

DCIN


First name	Initial	Income before deductions	Breakfast	Lunch	Dinner	Snacks
		\$ per				

 **24. Does anyone get paid for providing room or meals?** Yes No

Include payments from children.

RBIN

First name	Initial	Payment	Names of people paying	Check all that apply
		\$ per		<input type="checkbox"/> room <input type="checkbox"/> 1-2 meals per day <input type="checkbox"/> 3 meals per day
		\$ per		<input type="checkbox"/> room <input type="checkbox"/> 1-2 meals per day <input type="checkbox"/> 3 meals per day

 **25. Does anyone have income from self-employment, such as farming, home party sales, logging, or property rental?** Send copies of your most recent federal tax return, including all forms and schedules. If you have not filed taxes, send a statement of business income and expense from January 1st to now.

Yes No

First name	Initial	Type of business	Date business began

BUSI

 **26. Does anyone have income from work study, a student grant, or loan?**

Yes No

First name	Initial	Grant or loan amount	Tuition and fees amount	Period covered month/year to month/year
		\$	\$	

STIN

 **27. Does anyone have unearned income?** Some examples are:

Yes No

Social Security unemployment compensation veteran's compensation dividends or interest
 SSI/AABD worker's compensation veteran's pension trusts or annuities
 child support pensions or retirement money from others insurance settlement

List 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		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$ per		<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$ per		<input type="checkbox"/> Yes <input type="checkbox"/> No

UNEA

 **28. Does anyone pay child support or alimony?**

Yes No


First name	Initial	Alimony paid	Child support paid	Names of children for whom support is paid
		\$ per	\$ per	
		\$ per	\$ per	

DCEX

 **28a. Does anyone pay for day care?** List each child or adult separately.

Yes No

First name	Initial	Amount	Names of children or adults in day care	Reason
		\$ per		<input type="checkbox"/> working <input type="checkbox"/> looking for work <input type="checkbox"/> going to school
		\$ per		<input type="checkbox"/> working <input type="checkbox"/> looking for work <input type="checkbox"/> going to school


 29. Does anyone 60 or older or with a disability pay for medical expenses not covered by insurance? Some examples are:

Yes No

pain relievers antacids insurance premiums hearing aid batteries vitamins
 eyeglasses dental care copayments lifeline bracelet/necklace

FMED

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

 29a. Does anyone 60 or older or with a disability pay for trips to medical services?

Yes No

drug stores doctor's office hospital

First name	Initial	Type and location of provider	How often do you make these trips?

If you rent only a room, answer "No" to questions 30-32a

 30. Does anyone (including yourself) pay rent for the home you live in?

Yes No

RENT

First name	Initial	Amount you pay	What's included?	Type of housing
		\$ per	<input type="checkbox"/> heat <input type="checkbox"/> utilities	Public housing? <input type="checkbox"/> Yes <input type="checkbox"/> No Subsidized housing? <input type="checkbox"/> Yes <input type="checkbox"/> No


 31. Does anyone pay a mortgage payment, property taxes, lot rent, home equity loan, condo fees, or other costs for the home you live in?

Yes No


List each separately.

HOME


First name	Initial	Type of payment	Amount and how often	Date due
		Mortgage	\$ per This amount includes: <input type="checkbox"/> taxes <input type="checkbox"/> insurance	
			\$ per	
			\$ per	
			\$ per	

 **32. Does anyone pay for fuel or utilities?** Yes No UTIL


First name	Initial	Check all that apply
		<input type="checkbox"/> heat <input type="checkbox"/> air conditioning <input type="checkbox"/> hot water <input type="checkbox"/> cooking <input type="checkbox"/> lights

 **32a. Do you share any housing expenses?** Yes No

Names of people who share expenses with you	Shared expenses

 **33. Does anyone pay phone or homeowners insurance expenses?** Yes No PHON

First name	Initial	Check all that apply
		<input type="checkbox"/> phone <input type="checkbox"/> homeowner's insurance \$ _____ per _____

 **34. Does anyone pay for room or meals?** Yes No RBEX

First name	Initial	Amount and how often	Check all that apply
		\$ _____ per _____	<input type="checkbox"/> room <input type="checkbox"/> 1-2 meals <input type="checkbox"/> 3 or more meals

To get the most food stamp benefits, report all expenses asked for in this application. Deductions for these expenses are only applied after they are reported. Expenses can be reported any time to get these deductions for future benefits.

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

I give my word, under penalty of perjury, the information I give in this application is true and complete to the best of my knowledge and belief.

Signature of applicant
or authorized representative _____ Date _____

Signature of person helping
fill out this form _____ Date _____

Other Information and Referrals

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

Children who are members of federally designated American Indian or Alaska Native tribes may not have to pay a Dr. Dynasaur premium. Call 1-800-250-8427 for more information.

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 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).

Referrals to other programs

Lifeline is a monthly credit on your home or Unicef wireless phone bill. **Link Up** is 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. *Call your telephone company for more information.*

If you are not receiving a Lifeline credit now, would you like to?

Yes **No**

If yes, you must send us a copy of your bill.

Fuel Assistance – Help paying heating bills. Applications are accepted July 15 through the last day of February. Your local office can give you an application during this time; otherwise you can ask the *Office of Home Heating Fuel Assistance (OHHFA)* to mail you an application in June. *Call OHHFA at 1-800-479-6151 for more information or an application.*

Would you like a brochure about fuel assistance?

Yes **No**

Weatherization – Help with insulating, caulking, or weatherstripping your home or apartment to lower your heating costs. *Call toll free 1-877- 919-2299 for more information about weatherization.*

Would you like a brochure about weatherization services?

Yes **No**

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – Health screening, nutrition education, and food for pregnant women, nursing women, and children under five. *Call your local Department of Health office for more information about WIC.*

If you are not already receiving WIC, would you like to?

Yes **No**

To enroll in WIC, you must make an appointment with your local Health Department office.

Individual Development Account (IDA) - Learn about finances and save money for education, purchasing a home, or developing a small business. Your money in an IDA is matched by state money dollar for dollar up to an annual and lifetime limit. *Call your local Community Action Agency for more information.*

Would you like a brochure about IDAs?

Yes **No**

**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



Reporting requirements for food stamps

If the only benefit I get is food stamps, I must report:

- my household expenses when I am determined eligible for food stamps and when my case is reviewed. If I don't, I lose the right to a deduction of these expenses during this period.
- when my household income in a calendar month reaches 130% of the federal poverty level for my household size. Your worker can tell you this amount. I must report this no later than 10 days after the end of the month it happens.
- when the status of an able-bodied adult without dependents (ABAWD) in my household changes. Some examples are:
 - loses a job
 - reduces hours of work
 - becomes exempt

Reporting requirements for other programs

If I get health care, Reach Up, or PSE benefits, I must report when someone in my household:

- has an increase or decrease in the number of regularly scheduled hours of work;
- gets a job or stops working;
- has a change in the amount of money coming into the household, including winnings;
- moves in, moves out, gets married, becomes pregnant, or has a baby;
- is given money, land, a car, or other property; or
- gets or changes private health insurance, including prescription coverage.

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

Contact information

1-800-287-0589
www.dcf.state.vt.us

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

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

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 ESD 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 that 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.

Social security number. I understand that, when I apply for assistance from ESD, I must give the social security number of everyone in my household who wants assistance. Federal law requires this as a condition of eligibility. If I am a member of a religious organization that objects to furnishing a social security number, ESD may disregard this requirement. (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 ESD from discriminating based on race, color, national origin, sex, age, disability, religion or political beliefs.

To file a discrimination complaint, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). Write 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 (TTY). USDA and HHS are equal opportunity providers and employers. Under Vermont law and rules, ESD may not discriminate based on marital status, sexual orientation 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, 05671-1201.

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

Fair hearing. I may ask for a fair hearing when my claim for assistance, benefits, or services is denied in whole or in part, or not responded to with reasonable promptness by contacting an ESD office or writing to the ESD Deputy Commissioner. (3 V.S.A. §3091)

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 (e))

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.

Assignment of support rights. As a condition of eligibility for public assistance, I agree to assign all my rights to support to ESD. I understand this includes all current support owed to me while I get public assistance, all arrears owed to me that are collected during this assignment, and all arrears collected through federal tax offset during or after this assignment, up to the amount I get or have ever gotten. The noncustodial parent(NCP) will owe me amounts over the total amount of public assistance. Arrears include, but are not limited to, unpaid support obligations, debts, and court-ordered and administrative judgments. While I am on assistance, I understand the NCP will pay all support directly to the Office of Child Support (OCS). While I am waiting for ESD to grant me assistance, I will tell ESD of any support the NCP pays directly to me. After I have been granted assistance, I will immediately turn over to OCS any support the NCP pays me directly.

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.

Take part in Reach Up activities. I understand that I and members of my household may have to participate in certain Reach Up activities and that my worker will tell us what we have to do and what the penalty is if we do not.

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 Food Stamp benefits, Medicaid, or cash assistance from another state or has been convicted in the past ten years of fraudulently misrepresenting residence 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, Food Stamp, 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)

Food Stamp fraud penalties. I or any household member cannot trade or sell Food Stamp benefits, use them to buy ineligible items such as alcohol or tobacco, or use someone else's food stamps. If convicted, the member may be barred from the Food Stamp program for one year for the first offense, two years for the second offense, or permanently for the third offense, and be fined up to \$250,000, imprisoned up to 20 years, or both. If convicted of buying or selling illegal drugs in exchange for food stamps, a member may be barred for two years or barred permanently for a second offense. If convicted of purchasing firearms, explosives, or ammunition with food stamps or of trafficking in Food Stamp benefits of \$500 or more, a member may be barred permanently. If convicted of falsely representing identity or residence, a member may be barred for 10 years and may be prosecuted under other federal and state laws. (7 C.F.R. §273.16(b).)