

**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 YesTelephone # (HOME): (____) _____ Can a message be left at this number? No YesTelephone # (WORK): (____) _____ Can a message be left at this number? No YesDate of Birth: ____/____/____ Gender: Male Female Transgender
Gender at Birth: Male FemaleWhat is your marital status? Single Married Civil Union*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 HispanicWhat is your race? American Indian or Alaska Native Black or African American
 Asian Native Hawaiian or Other Pacific Islander
 Asian Indian Native Hawaiian
 Chinese Guamanian
 Filipino Samoan
 Japanese Other Pacific Islander
 Korean
 Vietnamese
 Other Asian
 White

What is your primary language? _____

Are you a US Citizen? Yes No If No, what is your immigration status? _____
Legal status is NOT a requirement for the VT Medication Assistance Program.Were you ever in the military? Yes NoIf yes, are you receiving VA health insurance? Yes No
If no, are you eligible to apply? Yes No

PHARMACY: 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: _____

CONTACTS: Please list the following contacts:

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

MEDICATIONS

Please list the prescription medications that you are taking now.

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

HEALTH INSURANCE

****A copy of the FRONT and BACK of your health insurance card(s) is required in order for this application to be processed.**

****Everyone who is eligible for health insurance must have it in order to be eligible for VMAP. If you do not have health insurance you may also be subject to fines from the federal government.**

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 did you apply for health insurance? _____

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: _____

Is it a hardship for you to pay this premium? Yes No

If YES, please contact the VMAP Coordinator at (802) 951-4005.

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

Supplemental Medicare

VPharm Is it a hardship for you to pay your VPharm premium? Yes No

If YES, please contact the VMAP Coordinator (802-951-4005)

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

Other (inc. VA) _____

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

Do you anticipate any changes in income in the next year? Explain: _____

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 signed Zero Income Statement verifying that I do not have an income right now.

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 signed Zero Income Statement verifying that I do not have an income right now.

OR

A letter verifying my income (Social Security, Unemployment, etc.)

Other _____

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 _____