VERMONT

201G-MV **(201GE in OnBase)**

Department for Children and Families
*Economic Services Division*280 State Drive
[fax] 802-241-0514
Waterbury, VT 05671-1020

Agency of Human Services

[phone] 800-775-0506

Emergency Housing Verification of Medically Vulnerable

This form must be used to document a qualifying medical condition which makes the individual Medically Vulnerable and necessitates Emergency Housing Assistance. A health care provider who is licensed, certified, or otherwise authorized by law to provide professional health care services in Vermont must complete this form.

Applicant Name:____ DOB:____________ Last 4 SSN:_________

To Be Completed By the Provider:

Please check all that currently apply:

☐ Individual requires a lifesaving medical device that requires electricity, such as an oxygen concentrator.
- If yes, list name of device:____
- If yes, frequency of use:____
- If yes, list diagnosis:____

☐ Individual is homebound and relies on the medically necessary assistance of another person or medical equipment such as a wheelchair for mobility and other essential functions
- If yes, list medical condition causing limited mobility:______________________________

☐ Individual is in treatment for severe liver, heart, or kidney disease.
- If yes, list diagnosis:____
- Has the patient had any emergency department visits related to the condition in the last 3 months? ☐ Yes ☐ No

☐ Individual is actively receiving cancer treatment
- If yes, list diagnosis:____
- If yes, list type of treatment:____

☐ Individual is actively receiving home-based nursing services
- If yes, list diagnosis:____
- If yes, frequency of home-based services:____
- If yes, list type of service:____

Please enter the date the client was last seen for one of the above conditions:_________________________

Please enter the frequency with which the client is seen for this condition:_________________________

☐ Is this a temporary condition? ☐ Yes ☐ No

☐ If yes, Anticipated duration until resolution of condition:______________________________

Please send medical records to support the above medical condition to the AHS Uploader (https://dcf.vermont.gov/esd/applicants/uploader) or they can be delivered in person to a local District Office.

➢District Office locations can be found at https://dcf.vermont.gov/esd/contact/districts.

Please see next page

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☐ *I have assessed the individual referenced above and/or I am treating the person for the conditions listed above.*

Provider Name *(Please print)*:______________________________

Provider Credential:______________________ Credential Number:______________________

Address:______________________________ Phone number:__________________

Provider Signature:______________________________ Date:__________________

I, or my authorized representative, authorize the provider listed above to provide the information requested in this form to the Department of Vermont Health Access for the purpose of verifying my eligibility for emergency housing assistance.

By signing this form, I understand:

- The reason(s) I am being asked to release information.
- Signing this authorization is voluntary. If I choose not to sign, I may be found ineligible for emergency housing assistance.
- While the Vermont Department of Vermont Health Access takes every precaution to protect my health information, once it is disclosed pursuant to this authorization, it may be subject to re-disclosure.
- My drug and alcohol treatment records are protected by Federal confidentiality rules (42 CFR Part 2) and cannot be disclosed or re-disclosed without my express written consent or as allowed by the regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.
- I may revoke this authorization at any time by contacting the provider named above 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 services from the Vermont Department for Children and Families, Economic Services Division.
- I will be given a copy of this form.

I have read this form and all of my questions have been answered. By signing below, I acknowledge that I have read and accepted all of the above.

Signature of Patient or
Authorized Representative:______________________________ Date:__________________

If not the patient, print name and contact information of authorized representative:

____

Description of authority to sign on patient’s behalf:

____

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