VERMONT

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

Department for Children and Families
Economic Service Division
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Agency of Human Services

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Extension of GA Housing Eligibility for the Most Medically Vulnerable

On March 28th, Governor Scott signed an Executive Order that lets some people with certain medical needs stay longer in General Assistance (GA) emergency housing.

If you have one or more of the medical needs listed in Part 1 below, complete Part 1 of this form and sign the last page of this form to authorize the sharing of your information. Then, give this form to your health care provider to complete Part 2 of this form.

Staff at the Agency of Human Services (AHS) will look at your records and decide if you qualify for more time in GA emergency housing.

To be approved, your records must clearly show that you have one or more of the medical needs listed below. A simple note from your health care provider is not enough.

The Executive Order does not allow GA emergency housing extensions for any medical reasons other than those listed below. AHS knows that being homeless can make people's health worse, and they are working hard to find ways to help people in Vermont get housing.

Applicant Name:_____ DOB:_____ Last 4 SSN:_____

PART 1 – To Be Completed By the Applicant. Please answer each question related to your medical need as thoroughly as possible so your health care provider can share the appropriate medical records with AHS.

Please check all that currently apply:

☐ I require a lifesaving medical device that requires electricity, such as an oxygen concentrator.
- List the device or devices you need:_____
- How often do you use these devices:_____
- List the medical conditions these devices are used to treat:_____

☐ I am homebound and rely on the medically necessary assistance of another person or medical equipment such as a wheelchair for mobility and other essential functions
- The medical condition causing my limited mobility is:_____
- The types of assistance I need and/or the equipment I need are:_____
- Without this I equipment I am unable to:_____

☐ I am in active treatment for cancer and/or have severe liver, heart, or kidney disease.
- I am diagnosed with:_____
- The treatment I receive is:_____
- The type of treatment I receive is: _____
- I have been admitted to the hospital or visited the emergency department because of these conditions in the last 6 months ☐ Yes ☐ No
- If yes, list type of treatment, location and approximate dates:_____

Part 1 – continued

☐ I am actively receiving home-based nursing services (like VNA visits, or hospice).

- The home-based nursing services are for :_____
- The name of the organization providing the services is:_____
- List the types of services you receive:_____
- How often do you receive these services:_____

PART 2 - For the Medical Office:

Is your office currently providing care coordination services to the individual named on this form? ☐ Yes ☐ No

Please send medical records to support the above medical condition(s) 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.

I, or my authorized representative, authorize: (1) the provider listed above to provide the information requested in this form to the Department of Vermont Health Access (DVHA) and the Department for Children and Families(DCF); (2) DVHA to share my Medicaid claims data, including information related to substance use treatment, with DCF; and (3) DCF and DVHA to access medical records from my health care providers through the Vermont Health Information Exchange for the purpose of verifying my eligibility for emergency housing assistance. DCF may also release my information to the Vermont Chronic Care Initiative for consultation on eligibility and for Medicaid case management purposes.

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.
- If any of my drug and alcohol treatment records are protected by Federal confidentiality rules (42 CFR Part 2), they cannot be disclosed or re-disclosed without my express written consent or as allowed by the regulation. I may need to sign a separate form to release those records.
- I may revoke this authorization at any time by contacting the provider named above or the Department for Children and Families 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:

_____