Unemployment Insurance and Wages Division
Program Integrity Unit
PO Box 488, Montpelier, VT 05601-0488
(802) 828-4333 | Fax: (802) 828-4198
labor.UIoverpaymentwaiver@vermont.gov

VERMONT
DEPARTMENT OF LABOR

CARES Act Overpayment Waiver Questionnaire

Part I: Personal Information

First Name: Last Name:
Last 4 Digits of Social Security Number:
Mailing Address:

Physical Address:

Home Phone: Cell Phone:
Email Address:

☐ Check this box if your contact information has changed since you last filed for Unemployment Insurance benefits.

Part II. Financial Hardship

Section A: Complete this section if you believe that repayment of the federal CARES Act overpayment would create a financial hardship. The Department will consider the circumstances surrounding the overpayment and your stated personal financial circumstances.

Are you a recipient of additional federal or state economic assistance? If yes, please check all that apply:

SNAP ☐ TANF ☐ LIHEAP ☐ MEDICARE ☐ MEDICAID ☐ SSI ☐ SSDI ☐

OTHER(S) or if you are not sure, please explain:

**** You must provide proof of receipt of the benefits you indicated you are receiving. ****

If you checked any of the boxes **"Yes"** in section A, please stop, sign, date, and certify your responses.

Signature (type in your full name): **Date:**

☐ I certify that the information I provided is true and correct to the best of my knowledge and belief, and that I understand that the law provides penalties for making false statements or misrepresentations.

**** If you are not receiving additional assistance of any kind, proceed to Section B. ****

Part II., Section B

Complete this section if you wish the Department to consider your gross monthly household income. Your CARES Act overpayment may be waived if your gross monthly income is equal to or less than 185% of the federal poverty level based on household size. These figures are from the State of Vermont, Division of Economic Services. Please refer to the amounts under 185% FPL (SF & VGS).

INCOME GUIDELINES FOR STATE ASSISTANCE
2023-2024

# OF PEOPLE IN HOUSEHOLD	185% FPL
1	2248.00
2	3040.00
3	3833.00
4	4625.00
5	5417.00
6	6210.00
7	7002.00
8	7794.00
9	8586.00
10	9378.00

Part II., Section B. Continued – Affidavit of Current Income and Living Expenses

Include any temporary, permanent, long-term employment, or self-employment, if applicable, regardless of where the work was performed or how long you worked.

Are you currently: Employed ☐ Unemployed ☐ Retired ☐

If employed, do you work: Full Time ☐ Part Time ☐ On Call ☐

How many hours do you work each week:
If unemployed, last date of employment:
If retired, date of retirement:

Do you own or rent your home? Rent ☐ Own ☐
Other (explain):

Please provide the total number of people in your household.

Monthly Gross Income. Include information for you and your spouse (or domestic partner), or other individual(s) who contribute to the household. Enter a response on every line. Enter a zero (0) if there is no figure to enter or if your household does not receive the source of income.

Wages from Employment:
Social Security:
Pension and/or Retirement:
Severance:
Workers Compensation:
Disability:
Unemployment Insurance:
Alimony:
Child Support:
Other Income, please explain:

You must provide proof of your household's income. This includes all members residing in the household that receive income. Examples of proof includes, but is not limited to, paystubs, payroll deposits, monthly invoices for self employment income, income statements or printouts, or income verification letters.

Monthly Expenses. Enter a response on every line. Enter zero (0) if the expense does not apply to your household.

Mortgage/Rent:
Water:
Gas:
Electric:
Cable/Internet:
Medical/Dental:
Telephone:
Transportation (car payment, gas, bus, etc.):
Food:
Child Care:
Student Loan(s):
Home/Renter's Insurance:
Auto Insurance:
Health Insurance:
Life Insurance:
Court Ordered Child Support:
Other Expenses Not Listed:

Part III. Health Conditions of you and/or your Family:

Only complete this section if you believe your prospects of employment are severely limited as a result of physical or mental disability, overall poor health, or any other circumstance that would be detrimental to securing or maintaining employment. If additional space is needed for child/other dependent information, please send attachments.

Family Member	Health Condition	Explanation
Self		
Spouse/Domestic Partner		
Child		
Other Dependent (Must reside in the same household)		

☐ I certify that the information I provided is true and correct, to the best of my knowledge and belief, and that I understand that the law provides penalties for making false statements or misrepresentations.

Signature (type in your full name): **Date:**

Please Note: Your application will not be considered complete if the box above is unchecked, and/or if you do not fill out sections completely. You may email or mail your completed application to the address shown above.