MEDICAID APPLICATION INFORMATION CHECKLIST

	Information Needed for Application:	
1.	U.S. Passport or a copy of the Applicant's birth certificate.	☐
2.	Copy of Applicant's state issued driver's license or identification.	☐
3.	Copy of Applicant's Social Security card.	☐
4.	Copy of the Applicant's Medicare card.	☐
5.	Copy of the Applicant's supplemental health insurance card.	☐
6.	Verification of supplemental health insurance premium. i.e., copy of check stub showing deduction or copy of bank statement showing deduction, etc.	☐
7.	Verification of monthly income (Social Security, pension or any other income). We need the most recent payor statement showing the current gross monthly/annual income. The monthly bank statement is not sufficient; it only reports net income. (To request a copy of the Social Security statement, please use the Social Security Administration's automated system at 800-772-1213.)	☐
8.	Statements for all accounts and investments, including bank accounts, certificates of deposit, savings bonds, annuities, insurance policies, brokerage accounts, nursing home patient fund, etc. held jointly or in the name of the Applicant covering the date(s) of _____ through the application date (to be determined).**	☐
9.	Verification/documentation of all liquidations of accounts and investments, including bank accounts, certificates of deposit, savings bonds, annuities, insurance policies, brokerage accounts, etc. As accounts are closed, we need verification that these accounts have been fully liquidated, as well as verification of where the proceeds have been deposited.	☐
10.	Verification/documentation of any transfers or gifts made within the last 5 years.	☐
11.	Copy of the title and registration for the Applicant's vehicle(s).	☐
12.	Copy of the deed to all real property held jointly or individually by the Applicant, including life estates, vacant land, buildings, timeshares, and mobile homes.	☐
13.	Copy of the current real estate tax assessment for all real property.	☐
14.	Copy of the current homeowner's insurance policy or premium notice for all real property.	☐

15.	Copy of the deed or other documentation for the burial plot(s), pre-paid funeral arrangements or pre-paid burial trusts. **Pre-paid funeral arrangements must be irrevocable - please provide verification of this.**	☐
16.	Does the Applicant have any personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies or livestock? **Yes / No (please circle)**	☐
17.	Education: Confirm the last grade that the Applicant completed ____ High School or GED Graduate? **Yes / No (please circle)**	☐
18.	Marital Status (please check one): ___ Never Married ___ Divorced ___ Widowed ___ Separated	☐
19.	Please verify the address of the Applicant prior to entering a nursing home facility.	☐
20.	Please verify the date the Applicant most recently entered the nursing home facility and verification of the dates of admittance and sequence of the facilities they were placed prior to their current nursing home stay.	☐
21.	Please provide copies of any outstanding medical bills that will not be covered by Medicare or the Applicant's supplemental health insurance.	☐
22.	Please provide a copy of the prior Medicaid Application.	☐
23.	Please provide copy of any and all correspondence with Medicaid.	☐
24.	Please provide copy of all notices sent by DDS including Notice of Denial.	☐

We will need to submit account statements that cover the entire time period from the snapshot date through the actual application date and account for all transactions during that time period. Please provide us with the statements from the snapshot date through the current date, and then continue to provide us with updated account statements through the time the application is actually filed. **We need complete statements with all pages, even if there does not appear to be any relevant information on a particular page. As we review the statements, we may need to ask you for additional clarification or documentation regarding the transactions. For checking accounts, please provide any canceled check copies that you have. If you are not already having copies of your checks included with your statements, please request this service. You may also consider establishing online access for any open accounts.

The Medicaid Agency has 90 days (from the date of receipt) in which to approve an Application. Therefore, it is essential that you provide all requested documentation promptly.

County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

LTC Medicaid/Auxiliary Grant Intake Checklist	Client Name: John Smith
	Application Received: 09/10/17
Mailed/Given To: John Smith Elder Law Attorney xxxxxxxxDrive Town, VA xxx	Retro Active Period: Yes
	Date Mailed/Given to Client: 9/28/17
	Case no: Pending

We need proof of **ALL** items marked to determine if you are eligible. Your application will be denied if all of the requested items are not received by: ***08/21/17***

Non-Financial Verifications:

__ Social Security Number- Copy of card
__ Proof of Alien Status- Copy of front & back of Alien ID card or I-94 documents
__ Proof of US Citizenship- Original documents must be viewed by DFS Staff
__ Proof of Identity- Original documents must be viewed by DFS staff
__ Proof of Age
__ Power of Attorney/Guardianship papers
__ Health Insurance coverage dates, policy numbers and due dates of premiums (copy of front and back of all health insurance cards.
__ Voter Registration Certification Form enclosed.
__ Divorce Decree/settlement

__ Income Verifications: Proof of all monthly gross income (before any deductions) for the month in which you applied and the three retro months before (if income fluctuates). The provider of the income can supply you with proof. You can call Social Security at 1-800-772-1213 for proof of SSA income. Please verify income from the following additional sources:

Other Miscellaneous Items

__ Pre-screening for Medicaid/AG Long Term Care Services- Please call (703) 222-0880 to arrange for a LTC screening.
__ Medical Bills/Nursing Home bills for ____
__ Interview-not mandatory; however strongly encouraged to explain LTC policies & procedures.

__ Patient Pay: Applicants/Recipients of Medicaid LTC (both facility and community based waivers) will have a patient pay responsibility based on gross monthly income. While eligibility is being determined for facility applicants you may want to pay your monthly income to the nursing facility. For questions about how much to pay, please contact your eligibility worker.

☒ **Assets:** Eligibility will not exist for any month when countable assets are over $2000.00. Married couples please see page two. If ownership or value of an asset changes from the date you applied, **it is your responsibility** to report the change within **10 days** and provide updated information. Money is an asset until it is spent or encumbered by a written check. **Auxiliary Grant Applicants-** eligibility exists only on the 1st of the month.

☒ All documents of trusts (entire document) ☒ Title to all vehicles and lien amounts

☒ Deeds for all real estate ☒ Taxed assessed value for all real estate

☒ Deeds of Trust/Promissory Notes owned by applicant ☒ Lien/Mortgage amount owed

☒ Proof of any real estate exemption claimed: See Fact Sheet attached. **(OVER)**

Department of Family Services
Self Sufficiency Division
Pennino Building
12011 Government Center Parkway
Fairfax, VA 22035
Phone 703-324-7500 Fax 703-324-8242
www.fairfaxcounty.gov

County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

☒ **Resources:** Statements of **ALL** resources for the month of application and three months prior for the following resources:

Checking, savings or investment account, credit union account, Christmas Club Account, CDs or money market accounts, individual development account, patient fund account for people in nursing facility of Assisted Living Facility, or special welfare account, stocks or bonds, retirement accounts, IRAs, or annuities. We cannot accept internet bank statements because some statements do not reflect daily account balances required in determining initial eligibility.

We can not accept internet bank statement during the application process. You must explain all large unidentified transfer, withdrawals and deposits on the bank statement.

☒ **Burial:** All papers for all pre-need arrangements including itemized contracts. Burial funds must be in separate accounts to be considered for exemption.
Notes:

☒ **Life Insurance:** Policy type (whole, universal, term, etc.), Face Value, Cash value and all dividends accumulated or added. For all life insurance policies for the month you apply and three months prior. A copy of the policy is **NOT** sufficient. Updated information must come from the insurance company.
Notes:

☒ **Property Transfers:** Proof of all property transfers within the past 60 months (for Auxiliary Grant recipients 36 months). We need proof of what was transferred, proof of date of transfer, and value of the resource/property at time of transfer. We need to know what compensation, if any was received by the individual who transferred the property. Please read enclosed Asset Transfer Fact Sheets.
Notes:

☐ **If YOU ARE MARRIED:** We need proof of your spouse's current gross monthly income from all sources. Proof of spouse's shelter expenses (rent/mortgage, taxes, insurance and utilities.) Proof of husband and wife's combined assets as of he first day of the first month of institutionalization on. The "Intent to Transfer Assets to Community Spouse" form is enclosed and must be returned within 10 days.
Notes: ***Please complete enclosed Medicaid Resource Assessment Request & Intend to transfer Assets to community Spouse.***

☐ **IF YOUR APPLICATION IS PENDING DISABILITY:** All verifications to process eligibility must be received by agency by 45th day to process extend the application deadline beyond the 45th day. If verifications are not received application will be denied on .

☒ **Other: Please provide followings:**

1. Please provide signed authorization form.

You may fax the verifications to 703-653-1350 or email to mycase@fairfaxcounty.gov.

If you are in need of legal advice please contact Legal Services at (703) 778-6800.
If you would like a list of Nursing Homes/Assisted Living Facilities or community based Waiver providers or to report a problem with a provider, please contact the Long Term Care Ombudsman Office at (703) 324-5411.
If additional information is needed we will contact you in writing. Please contact me if you have any questions about what is needed or if you need help in obtaining any of the requested verifications.

Department of Family Services
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12011 Government Center Parkway
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Phone 703-324-7500 Fax 703-324-8242
www.fairfaxcounty.gov

County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

Any changes to your situation must be reported within ten days. If you are unsure of how something could affect your eligibility for Medicaid and/or Auxiliary Grant, please contact your worker.

_____ _____ _____

Eligibility Worker Phone Number

Department of Family Services
Self Sufficiency Division
Pennino Building
12011 Government Center Parkway
Fairfax, VA 22035
Phone 703-324-7500 Fax 703-324-8242
www.fairfaxcounty.gov

THIS IS YOUR MEDICARE CARD. IT SHOWS IF YOU HAVE HOSPITAL INSURANCE, MEDICAL INSURANCE, OR BOTH. IT IS FOR YOUR USE ONLY. SHOW YOUR CARD WHEN YOU RECEIVE HEALTH SERVICES. ON ANY CLAIMS, BILLS OR CORRESPONDENCE BE SURE TO USE YOUR NAME AND CLAIM NUMBER EXACTLY AS SHOWN ON THIS CARD. CUT OUT YOUR HEALTH INSURANCE CARD AND DESTROY THE REST OF THIS FORM.

********AUTO**ALL FOR AADC 220

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
Paul Annapolos

MEDICARE CLAIM NUMBER
XXX-XX-XXXX

SEX
MALE

IS ENTITLED TO

EFFECTIVE DATE

HOSPITAL (PART A) 05-01-2013
MEDICAL (PART B) 05-01-2013

SIGN HERE ➡ _____

Social Security Annual Letter

Your New Benefit Amount

BENEFICIARY'S NAME: Paul Annapolos

Your Social Security benefits will increase by 1.7 percent in 2015 because of a rise in the cost of living. **You can use this letter when you need proof of your benefit amount to receive food, rent, or energy assistance; bank loans; or for other business.** Keep this letter with your important financial records.

How Much Will I Get And When?

• Your monthly amount (before deductions) is	$493.90
• The amount we deduct for Medicare medical insurance is (If you did not have Medicare as of Nov. 20, 2014, or if someone else pays your premium, we show $0.00.)	$104.90
• The amount we deduct for your Medicare prescription drug plan is (If you did not elect withholding as of Nov. 1, 2014, we show $0.00.)	$0.00
• The amount we deduct for voluntary Federal tax withholding is (If you did not elect voluntary tax withholding as of Nov. 20, 2014, we show $0.00.)	$0.00
• After we take any other deductions, you will receive on or about Jan. 14, 2015.	$389.00

If you disagree with any of these amounts, you must write to us within 60 days from the date you receive this letter. We would be happy to review the amounts.

You may receive your benefits through direct deposit, a Direct Express® card, or an Electronic Transfer Account. If you still receive a paper check and want to switch to an electronic payment, please visit the Department of the Treasury's Go Direct website at *www.godirect.org*.

What If I Have Questions?

Please visit our website at *www.socialsecurity.gov* for more information and a variety of online services. You also can call **1-800-772-1213** and speak to a representative from 7 a.m. until 7 p.m., Monday through Friday. Recorded information and services are available 24 hours a day. Our lines are busiest early in the week, early in the month, as well as during the week between Christmas and New Year's Day; it is best to call at other times. If you are deaf or hard of hearing, call our TTY number, 1-800-325-0778. If you are outside the United States, you can contact any U.S. embassy or consulate office. Please have your Social Security claim number available when you call or visit and include it on any letter you send to Social Security. If you are inside the United States and need assistance of any kind, you can visit your local office.

PLAZA 500 SUITE 190
6295 EDSALL ROAD
ALEXANDRIA VA

BNC#: 14B1208J41482

Over ▶

SOCIAL SECURITY ADMINISTRATION
MID-AMERICA PROGRAM SERVICE CENTER
601 E 12TH ST
KANSAS CITY MO 64106-2859

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE, $300

FIRST-CLASS MAIL
PRESORTED
POSTAGE AND FEES PAID
SOCIAL SECURITY
ADMINISTRATION
PERMIT NO. G-11

Open a *my Social Security* account
SocialSecurity.gov

IMPORTANT SOCIAL SECURITY INFORMATION

LIFT TO OPEN

MEDICAID APPLICATION

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Application for Health Coverage & Help Paying Costs

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Free or low-cost insurance from Medicaid, FAMIS or Plan First
- If you are not eligible for Medicaid or FAMIS you will be referred to the Federal Health Insurance Marketplace for affordable private health insurance plans that offer comprehensive coverage to help you stay well and may include a new tax credit that can immediately help pay your premiums for health coverage.

You may qualify for a low-cost program even if you earn as much as $97,200 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.
- If you are applying for someone other than a spouse or family member under age 21, an authorized representative form (Appendix C) must be completed.
- If you are age 65 or older or disabled or any age and need assistance with nursing facility or community based care, you need to complete Appendix D.

Apply faster online

Apply faster online at commonhelp.virginia.gov.
For more information about Medicaid, FAMIS and Plan First visit coverva.org.

What you may need to apply

- Social Security numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

If you use this paper application, send your complete, signed application to the local Department of Social Services in the city or county where you live. They will follow up with you to obtain additional information. Your application should be processed within 45 days from the date it was received.

Get help with this application

- **Phone:** Call Cover Virginia at **1-855-242-8282**
- **In person:** There will be application assisters in your area who can help. Visit our website at coverva.org or call **1-855-242-8282** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-855-242-8282**

NEED HELP WITH YOUR APPLICATION? Visit the Cover Virginia website at coverva.org or call us at **1-855-242-8282**. Para obtener una copia de este formulario en Español, llame **1-855-242-8282**. If you need help in a language other than English, call **1-855-242-8282** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-888-221-1590.**

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name	Middle name	Last name	Suffix

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number

4. City	5. State	6. ZIP code	7. County
	☐☐	☐☐☐☐☐	

8. Mailing address (if different from home address)	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County
	☐☐	☐☐☐☐☐	

14. Phone number	15. Other phone number
(☐☐☐) ☐☐☐ – ☐☐☐☐	(☐☐☐) ☐☐☐ – ☐☐☐☐

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

_____

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Married or unmarried parents (of a child under 21) living in the home
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner if you don't have children together in the home
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to include copies of the Additional Person single page supplement form and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse and children who live with you and/or anyone on your same federal income tax return if you file one. Include both parents living in the home (for a child under 21). See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name | Middle name | Last name | Suffix

3. Date of birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

4. Sex ☐ Male ☐ Female

2. Relationship to you? **SELF**

5. Social Security number (SSN) ☐☐☐-☐☐-☐☐☐☐

We need this if you want health coverage and have an SSN. Even if you don't want health coverage for yourself, providing your SSN can be helpful since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. For help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov.** TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ YES. **If yes,** please answer questions a–c. ☐ NO. **If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? ☐ Expected due date: _____

8. **Do you need health coverage?** *(Even if you have Medicare or other insurance, there might be a program with better coverage or lower costs.)* **If NO, skip to the income questions on page 3 and leave the rest of this page blank.**

☐ YES. **If yes,** answer all the questions below.

8a.

☐ YES. If under 19 or over 64 and not eligible for full coverage, do you wish to be evaluated for Plan First (family planning coverage only)?

or

☐ NO. If you are age 19 to 64 and are not eligible for full coverage, you will be evaluated for Plan First (family planning coverage only) unless you check NO.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? If Yes, please complete Appendix D. ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____

b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

12. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

13. Are you incarcerated (detained or jailed)? ☐ Yes ☐ No **If Yes** ☐ Federal ☐ State (DOC or DJJ) ☐ Local/Regional

☐ Check here if pending disposition of charges Expected release date ☐☐/☐☐/☐☐☐☐

14. Are you a full-time student? ☐ Yes ☐ No 15. Were you in foster care at age 18 or older? ☐ Yes ☐ No **If yes,** in which state _____

16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

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STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

CURRENT JOB 1:

18. Employer name	a. Employer address		
b. City	c. State	d. Zip code	19. Employer phone number ( ) –
20. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly			21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name	a. Employer Address		
b. City	c. State	d. Zip code	23. Employer phone number ( ) –
24. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly			25. Average hours worked each WEEK

26. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. **If self-employed, answer the following questions:**

a. Type of work _____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? $

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it. Check here if none ☐

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment $ How often? _____
☐ Pensions $ How often? _____
☐ Social Security $ How often? _____
☐ Retirement accounts $ How often? _____
☐ Alimony received $ How often? _____
☐ Net farming/fishing $ How often? _____
☐ Net rental/royalty $ How often? _____
☐ Other income $ How often? _____
Type _____

29. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No If yes, provide monthly income for previous 3 months.
Month 1: $ Month 2: $ Month 3: $

30. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid $ How often? _____
☐ Student loan interest $ How often? _____
☐ Other deductions $ How often? _____
Type: _____

31. **YEARLY INCOME: Complete only if your income changes from month to month.**
If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

THANKS! This is all we need to know about you.

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STEP 2: PERSON 2

If you have more than two people to include, complete as many Additional Person single page supplement forms as you need.

Complete Step 2 for your spouse and children who live with you and/or anyone on your same federal income tax return if you file one. Include both parents living in the home (for a child under 21). See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name | Middle name | Last name | Suffix

3. Date of birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

4. Sex ☐ Male ☐ Female

2. Relationship to you?

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐
We need this if you want health coverage for PERSON 2 and PERSON 2 has an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if PERSON 2 doesn't file a federal income tax return.)

☐ YES. **If yes,** please answer questions a–c. ☐ NO. **If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? ☐ Expected due date: _____

9. **Does PERSON 2 need health coverage?** *(Even if Person 2 has Medicare or other insurance, there might be a program with better coverage or lower costs.)* **If NO, skip to the income questions on page 5 and leave the rest of this page blank.**

☐ YES. **If yes,** answer all the questions below.

9a.
☐ YES. If under 19 or over 64 and not eligible for full coverage, does PERSON 2 wish to be evaluated for Plan First (family planning coverage only)?

or

☐ NO. If PERSON 2 is age 19 to 64 and is not eligible for full coverage, PERSON 2 will be evaluated for Plan First (family planning coverage only) unless you check NO.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? If Yes, please complete Appendix D. ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐ Yes. Fill in their document type and ID number below.
a. Document type _____
b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No
d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Is Person 2 living with at least one child under age 19 and the main person taking care of this child? ☐

14. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No
If yes, in which state _____

15. Is PERSON 2 incarcerated (detained or jailed)? ☐ Yes ☐ No
☐ Check here if pending disposition of charges
If Yes ☐ Federal ☐ State (DOC or DJJ) ☐ Local/Regional
Expected release date ☐☐ / ☐☐ / ☐☐☐☐

16. Is PERSON 2 a full-time student? ☐ Yes ☐ No

17. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

Now, tell us about any income from PERSON 2 on the next page.

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STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If PERSON 2 is currently employed, tell us about their income. Start with question 19.

☐ **Not employed**
Skip to question 29.

☐ **Self-employed**
Skip to question 28.

CURRENT JOB 1:

19. Employer name	a. Employer address		
b. City	c. State	d. Zip code	20. Employer phone number
			( ) –

21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$

22. Average hours worked each WEEK

CURRENT JOB 2: (If PERSON 2 has more jobs and needs more space, attach another sheet of paper.)

23. Employer name	a. Employer Address		
b. City	c. State	d. Zip code	24. Employer phone number
			( ) –

25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
$

26. Average hours worked each WEEK

27. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

28. **If PERSON 2 is self-employed, answer the following questions:**

a. Type of work _____

b. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month? $

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it. Check here if none ☐
NOTE: You don't need to tell us about PERSON 2's child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment	$	How often?	☐ Alimony received	$	How often?
☐ Pensions	$	How often?	☐ Net farming/fishing	$	How often?
☐ Social Security	$	How often?	☐ Net rental/royalty	$	How often?
☐ Retirement accounts	$	How often?	☐ Other income Type	$	How often?

30. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No If yes, provide monthly income for last 3 months.
Month 1: $ Month 2: $ Month 3: $

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 2 gets it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

☐ Alimony paid	$	How often?	☐ Other deductions	$	How often?
☐ Student loan interest	$	How often?	Type:		

32. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.**
If you don't expect changes to PERSON 2's monthly income, skip to the next person.

PERSON 2's total income **this year**	PERSON 2's total income **next** year (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

If you have more than two people to include, complete the Additional Person single page supplement form.

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STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. **Are you or is anyone in your family American Indian or Alaska Native?**

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** go to Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ YES. **If yes,** check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ NO.

- ☐ Medicaid _____
- ☐ FAMIS _____
- ☐ Plan First _____
- ☐ Medicare _____
- ☐ TRICARE (Don't check if you have direct care or Line of Duty) _____
- ☐ Veterans Administration health care programs _____
- ☐ Peace Corps _____
- ☐ Federal Health Insurance Marketplace _____
- ☐ Employer insurance _____
  - Name of health insurance: _____
  - Policy number: _____
  - Is this COBRA coverage? ☐ Yes ☐ No
  - Is this a retiree health plan? ☐ Yes ☐ No
- ☐ Other
  - Name of health insurance: _____
  - Policy number: _____
  - Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?**

Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ YES. **If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ NO. **If no, continue to Step 5.**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this application to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I understand that I am authorizing the local Department of Social Service (LDSS) and the Department of Medical Assistance Services (DMAS) to obtain verification/information necessary to determine my eligibility for Medicaid or FAMIS.
- I understand that Medicaid and DMAS contractors may exchange information relating to my coverage with LDSS to assist with application, enrollment, administration and billing services.
- I understand that for individuals enrolled in managed care, a premium is paid each month to the MCO for the person's coverage. If the child or pregnant woman is not eligible for FAMIS, FAMIS Plus, FAMIS MOMS, or Medicaid because I did not report truthful information or failed to report required changes in my family size or income, I may have to repay the monthly premiums paid to the MCO. I may have to repay these premiums even if no medical services were received during those months.
- I know that I must tell the local Department of Social Services within 10 calendar days if anything changes and is different than what I wrote on this application. I can visit **www.commonhelp** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Medicaid or FAMIS programs or the Marketplace to use income data, including information from tax returns. I understand that I will receive notification of the outcome of my renewal. I understand that I can opt out at any time.

Yes, I consent to the use of electronic income data including information from tax returns to annually renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think Medicaid, FAMIS or Plan First has made a mistake I can contact them at **www.coverva.org** or call **1-855-242-8282**. Instructions for filing an appeal will be included on my notice and are also available on the coverva.org website.

If I think the Health Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at **1-800-318-2596**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

STEP 6 Mail completed application.

Mail your signed application to:

The local Department of Social Services in the city or county in which you live

NEED HELP WITH YOUR APPLICATION? Visit the Cover Virginia website at **coverva.org** or call us at **1-855-242-8282**. Para obtener una copia de este formulario en Español, llame **1-855-242-8282**. If you need help in a language other than English, call **1-855-242-8282** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-888-221-1590.**

APPENDIX A

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number ☐☐☐ - ☐☐ - ☐☐☐☐

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) ☐☐ - ☐☐☐☐☐☐☐
5. Employer address		6. Employer phone number (☐☐☐) ☐☐☐ – ☐☐☐☐
7. City	8. State ☐☐	9. ZIP code ☐☐☐☐☐
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) (☐☐☐) ☐☐☐ – ☐☐☐☐	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. * (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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EMPLOYER COVERAGE TOOL

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage that you're eligible for.

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

EMPLOYER Information

Ask the employer for this information.

3. Employer name	4. Employer Identification Number (EIN) ☐☐ - ☐☐☐☐☐☐☐
5. Employer address	6. Employer phone number (☐☐☐) ☐☐☐ - ☐☐☐☐
7. City	8. State ☐☐ / 9. ZIP code ☐☐☐☐☐
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above) (☐☐☐) ☐☐☐ - ☐☐☐☐	12. Email address

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly (Go to next question)

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.

* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name _____ ☐ No	☐ Yes **If yes**, tribe name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid, FAMIS or Plan First. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ ☐☐☐☐☐☐ How often?_____	$ ☐☐☐☐☐☐ How often?_____

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APPENDIX C

COVER VIRGINIA

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the local Department of Social Services. If you are applying for someone other than a spouse or family member, an authorized representative form (Appendix C) must be completed. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address | 3. Apartment or suite number

4. City | 5. State ☐☐ | 6. ZIP code ☐☐☐☐☐

7. Phone number
(☐☐☐) ☐☐☐ – ☐☐☐☐

8. Organization name | 9. ID number (if applicable) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature | 11. Date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

OR

Is there anyone else that you would like us to share your information with about your application?

1. I give permission for (name) and/or (organization name)

2. Address City State Zip

3. Phone number
(☐☐☐) ☐☐☐ – ☐☐☐☐ | 4. ID number (if applicable) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

to receive eligibility and enrollment information relating to my application/case. I also give the Department of Social Services and/or the Department of Medical Assistance Services permission to release information about this application to this person/organization.

5. Your signature | 6. Date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ | 5. Agents/Brokers only: NPN Number ☐☐☐☐☐☐☐☐☐☐

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Commonwealth of Virginia Voter Registration Agency Certification

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Please check only one)

☐ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.

☐ Yes, I would like to apply to register to vote. (please fill out the voter registration application form)

☐ No, I do not want to register to vote.

If you do not check any box, you will be considered to have decided not to register to vote at this time.

Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency. If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219-3497, phone (804) 864-8901.

Applicant Name	Signature	Date

(for agency use only)

Voter Registration form completed: ☐ Yes ☐ No

Voter Registration form given to applicant for later mailing (at applicant's request): ☐

Agency Staff Signature	Date

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01/31/17

APPENDIX "D"

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Name of Applicant_____

Application for Health Coverage and Help Paying Costs
APPENDIX D

Complete Appendix D if you are applying for Health Care Coverage for:

- **someone who has disabilities**
- **someone age 65 years or over**
- **all people, including children, in need of Long-term Care Services** (nursing facility or community based care)
- **someone who is medically needy** (has income greater than Medicaid limit and would like to be evaluated based on their income, resources and medical expenses) - Spenddown

What is Appendix D Used For?

Appendix D gathers additional information needed to determine your eligibility for Health Care Coverage.

Appendix D is not a stand-alone application. You must also complete the Application for Health Coverage and Help Paying Costs and submit Appendix D with the application.

If completing Appendix D for someone else, please answer the questions for that person.

SECTION 1 Household Information

1. Are You? ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

2. Has anyone in your household ever applied for or received any Health Care Coverage from a social service agency in another state or Virginia city or county?

☐ **Yes** ☐ **No**

— If **yes**, please indicate which state or Virginia city or county below:

State or Virginia city or county

3. Is anyone in your household temporarily away from home? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

Name	Date Left
Reason for Leaving	
Where is the person currently staying?	Expected Return Date

Answer questions 4-11 if any applicants are under age 65 years.

4. Are you or is anyone for whom you are applying disabled? ☐ **Yes** ☐ **No**

— If **yes**, please provide the name of the persons:

Name of Person	Name of Person

5. Have you or anyone for whom you are applying ever applied for Social Security, Supplemental Security Income (SSI) or Railroad Retirement benefits as a disabled person?

☐ **Yes** ☐ **No**

— If **yes**, please provide the name of the persons and date of application:

Name of Person and Date of Application	Name of Person and Date of Application

6. Have you or anyone in your household for whom you are applying been approved for disability for Social Security, SSI, Railroad Retirement or Medicaid purposes? ☐ **Yes** ☐ **No**

— If **yes**, please provide the name of the individual:

Name	Name

7. If the application for Social Security, SSI or Railroad Retirement benefits was denied, did you file an appeal of the denial? ☐ **Yes** ☐ **No**

— If **yes**, please tell us the outcome of the appeal:

Outcome

8. Has it been less than 12 months since the most recent application for Social Security, SSI or Railroad Retirement benefits was denied?

☐ **Yes** ☐ **No**

9. Has the condition changed or worsened since the most recent application for disability was denied?

☐ **Yes** ☐ **No**

10. Do you or anyone for whom you are applying have a new medical condition since the most recent application for disability was denied? ☐ **Yes** ☐ **No**

11. Have you or anyone for whom you are applying ever received SSI, disability benefits from the Social Security Administration or Auxiliary Grant payments?

☐ **Yes** ☐ **No**

Has the payment stopped? ☐ **Yes** ☐ **No**

— If **yes**, explain whose payment stopped, when it stopped, and why it stopped.

Explain

SECTION 2 Long-term Care

Answer questions 12-14 if you are applying for anyone who is in a nursing facility or assisted living facility, or who requires nursing home care or assistance to remain in the home

12. Do you or anyone for whom you are applying need nursing facility care or help such as bathing, dressing, toileting, etc., so that you can remain in your own home? ☐ **Yes** ☐ **No**

— If **yes**, and there is a spouse who lives somewhere else, what is the name and address of the spouse?

(Note: Under Virginia law persons are considered married and legally responsible for each other until they divorce)

Name
Address

13. Do you or anyone for whom you are applying live in one of the following?

☐ Assisted Living Facility (ALF) ☐ Nursing Facility ☐ Group Home ☐ Hospital or other Medical Facility

— If you checked one of the above, please provide the following information:

Name	Date of Entry	In what County was the prior address?
Person's address prior to entering the facility		
Facility Name	Facility Address	
Was Placement made by a State agency? ☐ **Yes** ☐ **No**		

14. Does the individual in the nursing facility or requiring assistance in the home have long-term care insurance? ☐ **Yes** ☐ **No** — If **yes**, please provide the following information:

Name of Insurance Company	Address	City, State, ZIP
Policy Number	Person(s) Insured	Is this a Partnership Policy? ☐ **Yes** ☐ **No**

15. Have you or your spouse sold, transferred, placed in a trust/annuity, or given away any resources, such as your home or other real property, cash, bank accounts, or cars in the last sixty (60) months (5 years)? ☐ **Yes** ☐ **No** — If **yes**, please provide the following information:

Type of Property Transferred	Value at Transfer **$**	Amount Received **$**	Date of Transfer
From Whom		To Whom	
Explain the Reason for Transfer			

Note: If more than one transfer has occured, please attach documentation of each transfer.

SECTION 3 Resources and Assets

16. Do you or your spouse have any money/cash on hand that is not in the bank? ☐ **Yes** ☐ **No**
— If **yes**, please provide the following information:

Name	Amount **$**
Name	Amount **$**

17. Do you or your spouse have any of the following resources? ☐ **Yes** ☐ **No**
— If **yes**, please check the boxes that apply and provide the information requested below:

☐ Checking, Savings ☐ Deferred Compensation Plan ☐ Christmas Club
☐ Credit Union ☐ Certificate of Deposit (CD) ☐ Money Market Funds

1. Owner Name		Co-Owner Name	
Name of Bank	Account Type	Account Number	Balance/Value **$**
2. Owner Name		Co-Owner Name	
Name of Bank	Account Type	Account Number	Balance/Value **$**
3. Owner Name		Co-Owner Name	
Name of Bank	Account Type	Account Number	Balance/Value **$**

Is your income (Social Security or SSI benefits, retirement pension, wages, etc.) deposited directly into any of the accounts? ☐ Yes ☐ No If yes, which account? _____

18. You must report ownership of all annuities you and your spouse have. You and your spouse may have to name the Commonwealth of Virginia as the beneficiary of any annuity you or your spouse own.

Do you or your spouse have any stocks or bonds, trust funds, pension plans, retirement accounts, trusts, annuities, promissory notes, or deeds of trust? ☐ Yes ☐ No

— If **yes**, please provide the following information:

1. Owner Name		Co-Owner Name	
Where is the Account Held?	Account Type	Account Number	Balance/Value $
2. Owner Name		Co-Owner Name	
Where is the Account Held?	Account Type	Account Number	Balance/Value $
3. Owner Name		Co-Owner Name	
Where is the Account Held?	Account Type	Account Number	Balance/Value $

19. Do you or your spouse have any life insurance? ☐ Yes ☐ No

— If **yes**, please provide the following information:

1. Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	Policy Number	Face Value $	Cash Value $
2. Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	Policy Number	Face Value $	Cash Value $
3. Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	Policy Number	Face Value $	Cash Value $

20. Do you or your spouse have burial plots, burial arrangements, or trust funds for burial? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

Owner(s)	Item/Type	Value/Amount Owned
		$
Owner(s)	Item/Type	Value/Amount Owned
		$
Owner(s)	Item/Type	Value/Amount Owned
		$

21. Do you or your spouse have real property, including home property, life rights/estates, shares in undivided heir property, land, buildings, or mobile homes? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

Owner(s)	Type of Property/Number of Acres	Value/Amount Owned
		$
Do you live on this property? ☐ **Yes** ☐ **No**		Is this property currently for sale? ☐ **Yes** ☐ **No**
Is this property rented? ☐ **Yes** ☐ **No**		Do you received money from this property ☐ **Yes** ☐ **No**

22. Do you or your spouse have any licensed or unlicensed cars, trucks, vans, boats, motors homes, recreational vehicles, utility trailers, motorcycles, or mopeds? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

Owner(s)	Year-Make-Model	Value/Amount Owned
		$
Owner(s)	Year-Make-Model	Value/Amount Owned
		$
Owner(s)	Year-Make MOdel	Value/Amount Owned
		$

23. Do you or your spouse have any property that is used in the operation of a business, such as farm equipment, tools, or livestock? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

Owner(s)	Type	Value	Amount Owned
		$	**$**
Owner(s)	Type	Value	Amount Owned
		$	**$**

24. Do you or your spouse expect a change in resources this month or next month? ☐ **Yes** ☐ **No**

— If **yes**, please explain below and give the date the change is expected:

Explain
Date Change Expected

SECTION 4 Other Income

25. Do you receive child support? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

Amount	How Often?	Is the payment for past-due child support payments?
$		☐ **Yes** ☐ **No**

26. Do you receive Veteran's Administration benefits? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

Amount	How Often?	Type
$		

27. Does anyone help you pay, or lend you money to pay rent, utilities, medical bills, or any other bills? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

Person Receiving Money	Person Providing Help
Type of Help Received	Amount **$**
Does the money come directly to you?	☐ **Yes** ☐ **No**
Is this a loan?	☐ **Yes** ☐ **No**
Is repayment expected?	☐ **Yes** ☐ **No**

Person Receiving Money	Person Providing Help
Type of Help Received	Amount **$**
Does the money come directly to you?	☐ **Yes** ☐ **No**
Is this a loan?	☐ **Yes** ☐ **No**
Is repayment expected?	☐ **Yes** ☐ **No**

Sign the application

I am signing this application under penalty of perjury which means I've provided true answers to all the questions on this application to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false or untrue information.

Signature	Relationship to Applicant	Date

RECEIPT

County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

September 28, 2017

John Smith
c/c Elder Law Attorney
XX DRIVE
TOWN, VA

RE: Long Term Care (LTC) Medicaid/Auxiliary Grant (AG) Application - VaCMS Case Number: *T*

The Fairfax County Long Term Care Unit has received your application for LTC Medicaid.
Applicant: John Smith Application Date: 9/10/2017

The decision due date for this application is 11/12/2017. (45 days)
If your case requires a disability determination, a decision should be made by the 90th day,

Your LTC case worker is _____. You will be receiving a Checklist with a more detailed list of verifications needed to process your application. If you have any questions you may contact your worker at

If you would like to email verifications to your worker, please send verifications to:
If you would like to fax verifications, please send them to

You may want to begin to gather these documents to determine eligibility:

- Verification of gross income/money received from all sources.
- Verification of all resource values for the month of application & three previous months. Resources are: cash, bank accounts, CD's, money market accounts, retirement accounts, stocks, bonds, burial resources, property-both real estate and/or personal property such as vehicles, boats, etc. All pages of the account statements must be provided.
- Current verification of the Face, Cash and/or Dividend value of all life insurance policies. Current verification must be obtained from the insurance company.
- Deeds of Trust/Trust funds-entire document establishing trust & listing of assets held in the trust & verification of disbursements to/from the trust account(s).
- Annuities-copy of the entire annuity contact showing terms, purchased date, annuity amount, monthly payments and the beneficiary.
- Verification of all transfer of assets within the past 60 months (for Auxiliary Grant recipients 36 months).
- Married or separated couples must complete a Long Term Care Spousal Resource Assessment. You will need to provide verification of all assets both you and your spouse own on the 1st of the month you left the home.

Long Term Care (LTC) Medicaid Applicants:

- If you reside in your home or in an assisted living facility and need Long Term Care Medicaid services either in a nursing facility or at home with in a Medicaid Community Based Waiver or PACE services, please call Coordinated Services at (703) 222-0880 to request a pre-admission screening for Long Term Care Medicaid or Auxiliary Grant.
- Eligibility does not exist for any month when the countable assets are in excess of ***$2000.00***. Married couples for LTC Medicaid has different resource limit and your worker can explain the Spousal Resource Assessment regulations to you. If ownership or value of an asset changes from the date you applied, it is ***your responsibility*** to report the change and provide the updated information. Money is an asset until it is spent or encumbered by a written check.
- Bank account statements must contain the entire account number, all owner(s) of the account and account type (checking, savings, etc.). Statements must not be altered. Internet bank statements must contain the entire account number, owner(s), and type.
- Married couples must also provide the spouse's gross monthly income from all sources, shelter expenses (rent, mortgage, taxes, insurances and utilities) if the Non-LTC Spouse wants a Spousal Allowance Calculation. If the LTC Spouse has more than $2000.00 in his or her name at time of application, he/she may be eligible for LTC Medicaid for 90 days as long as we

Department of Family Services, Self Sufficiency
Long Term Care Unit
12011 Government Center Parkway, suite 232
Fairfax, VA 22035
Phone: 703-324-7622, Fax: 703-653-1350
www.fairfaxcounty.gov

Fairfax County Department of
Family Services

receive the signed "Intent to Transfer to Community Spouse Form." A special review will be done in 90 days to verify the LTC spouse's resources are within the $2000.00 resource limit.

- Applicants under 65 years old must provide resource verification prior to the 45th day of application for your application to remain pending until the disability is determined. Cases requiring a disability determination can take 90 days or longer to process.
- Income limits are higher once an individual passes a screening for LTC Medicaid or is institutionalized for 30 days.
- All applicants/Recipients will have a Patient Pay responsibility based on gross monthly income minus any allowable deductions. A Patient Pay is like a co-pay for LTC Medicaid Services. Patient pay is collected by your provider or facility for LTC Services received. If you do not pay your patient pay, the provider or facility may discontinue services which could affect Medicaid eligibility.
- Medical bills and health insurance premiums must be verified to allow a deduction from patient pay. If you are already in a nursing facility a copy of your most recent statement is needed.
- Newly approved recipients that have not started waiver services or been placed in a nursing facility have 30 days from the approval notice to start services or be placed in a nursing facility.

If you would like legal advice about your application, please contact Legal Services at (703) 778-6800.

If you would like a list of Nursing Homes/Assisted Living Providers or Medicaid Community Based Waiver providers, or to report a problem with a provider/facility, please contact the Long Term Care Ombudsman Office at (703) 324-5411.

Once you have provided verifications, it may result in additional information that is needed. If that occurs you may receive an additional checklist of verifications that you must provide before the application deadline.

Auxiliary Grant (AG) Applicants:

- Auxiliary Grant applicants must be pre-screened for even if you are in a licensed assisted living facility (ALF) to receive an AG payment. If the applicant resides in a Fairfax County ALF, please call Coordinated Services at (703) 222-0880 to request a screening. Applicants residing in an ALF outside of Fairfax County must contact the Social Services Department of the locality where the ALF is to request the Auxiliary Grant screening.
- Auxiliary Grant applicants must be a resident of Virginia for at least 90 days and sign the "Intent to Remain in Virginia" form. There are some exceptions to the 90 day policy. Please contact your worker to inquire about the exceptions.
- Resource eligibility exists only on the 1st of the month. The resource limit for single individuals is $2000.00 and $3000.00 for married couples.
- The Auxiliary Grant program has a minimum income requirement of being a Supplemental Social Security Income (SSI) recipient. If your income is less than the current SSI income limit, you may need to apply for a SSI benefit at the Social Security Administration. Your application will remain pending until your application for SSI is approved. If SSI denies the application for any reason, the Auxiliary Grant application is denied. If the applicant's gross income exceeds the SSI limit, he/she does not need to apply for SSI. The applicant's gross income cannot exceed the current ALF rate plus the personal needs allowance to be eligible for AG. The AG rate and personal needs allowance is established by the Virginia Dept. of Aging and Rehabilitative Services (DARS).
- Auxiliary Grant applicant/recipients have a 36 month Asset Transfer look back period. If any transfers occurred, you will be asked to provide verification of what was transferred, to whom it was transferred to, value at time of transfer and if any compensation was received.
- You must be residing in the Assisted Living Facility (ALF) by the 45th day of the application for eligibility to exist.
- The Auxiliary Grant is prorated based on the date of admission to the ALF. If you have any expenses such as rent, utilities, etc. in the month of admission to the ALF, verification of the expense is required to determine grant amount.
- Recipients of an Auxiliary Grant receive community based Medicaid (not Long Term Care Medicaid). If the recipient enters a nursing facility, the recipient may have a patient pay responsibility (see LTC Medicaid information above).
- If the AG recipient leaves the ALF for more than 14 days and receives a grant, the case may close and the recipient will need to reapply for an Auxiliary Grant if they return to the ALF. A new AG screening will be required before readmission to the ALF.

Sincerely,
Fairfax County LTC Benefits

Department of Family Services, Self Sufficiency
Long Term Care Unit
12011 Government Center Parkway, suite 232
Fairfax, VA 22035
Phone: 703-324-7622, Fax: 703-653-1350
www.fairfaxcounty.gov

Fairfax County Department of
Family Services

Temporary Assistance for Needy Families (TANF)
TANF provides temporary financial assistance to eligible families with children. To be eligible, a family must be financially needy and must meet certain other requirements. An eligible child must be under age 18, or if 18, expected to graduate from high school before age 19; going to school regularly if he is between the ages of 5 and 18; living with a parent or other relative; and a citizen of the U. S. or an eligible immigrant.

An applicant must cooperate in naming the parents of all eligible children and must help establish paternity for each child.

The amount of the TANF benefit is based on the size of the family. A family may still be eligible to receive TANF while receiving money from other sources.

TANF debit cards may not be used to buy lottery tickets, alcoholic beverages, tobacco products, or sexually explicit materials. In addition, TANF debit cards may not be used in ABC stores, tattoo or body-piercing businesses, businesses that provide adult-oriented entertainment, or places where gaming is conducted.

If you receive TANF, you may be required to participate in the Virginia Initiative for Employment not Welfare (VIEW) program. Families in the VIEW program may earn income and receive a TANF check. However, the total income cannot be more than the federal poverty level for the family size.

A family with someone in VIEW may receive TANF for no longer than 24 months followed by a period of 24 months ineligibility. A family may receive TANF no more than a total of 60 months in a lifetime.

Additional information regarding the TANF program, application, forms and manual is available at www.dss.virginia.gov.

Medical Assistance Programs—Medicaid, FAMIS Plus, and FAMIS (Family Access to Medical Insurance Security Plan)
Medicaid and the Family Access to Medical Insurance Security Plan (FAMIS) are Medical Assistance programs that make direct payments to health care service providers for eligible individuals and families who are unable to pay for needed medical services. Medicaid for children is called FAMIS Plus.

To be eligible for Medicaid, you must have income and resources (assets) within specified limits and must be in one of the groups covered by Medicaid. Medicaid covered groups include children under age 19 years, pregnant women, parents with dependent children under age 18 years living in the home, adults age 65 years and older, blind individuals, and individuals who are disabled according to the standards adopted by the Social Security Administration. Plan First is a limited-coverage group that covers family planning services and is available to those who do not meet other full-coverage Medical Assistance groups.

FAMIS, and its program for pregnant women, FAMIS MOMS, covers uninsured children under age 19 years and pregnant women with income that is too high for FAMIS Plus/Medicaid but is under the income limit for FAMIS/FAMIS MOMS.

Medicaid/FAMIS Plus and FAMIS have different income limits and nonfinancial requirements. When someone applies for Medical Assistance, the eligibility worker will determine if the person is eligible for either program. Medicaid and FAMIS pay for a variety of medical services, including prescription drugs, doctor visits, nursing facility care and hospital care.

Information about Medicaid/ FAMIS Plus is available online from the Virginia Department of Social Services at www.dss.virginia.gov and from Cover Virginia at www.coverva.org.

For more information about FAMIS, please contact the local department of social services or call 1-855-242-8282. Information about FAMIS is also available online at www.coverva.org.

Supplemental Nutrition Assistance Program (SNAP)—formerly the Food Stamp Program
SNAP benefits will help you buy nutritious food for your household. You may also buy seeds or plants to grow your own food.

You may not use SNAP benefits to:
- Buy alcoholic beverages, tobacco, soap, paper products, or other nonfood items;
- Buy hot food ready to be eaten on the store premises.

SNAP benefits are issued electronically to eligible households. You will get a card that is similar to a credit or debit card to use at the authorized retailers to buy food. You must select a Personal Identification Number (PIN) and use that PIN when you swipe the card at the store. SNAP benefits will be added to your account at the beginning of each month you are approved for benefits.

Additional information about SNAP benefits is available at www.dss.virginia.gov.

Energy Assistance Program (EAP) - EAP consists of three components: Fuel Assistance, Crisis Assistance, and Cooling Assistance.
Fuel Assistance assists low-income, eligible households by supplementing home energy costs. Applications are accepted the second Tuesday in October through the second Friday in November. Crisis Assistance assists low-income households with energy related emergencies. Applications are accepted November 1st through March 15th. Cooling Assistance assists households in acquiring or repairing cooling equipment and/or payment of electric bills to operate cooling equipment. Applications are accepted June 15th through August 15th.

Additional information about the EAP is available at www.dss.virginia.gov.

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VIRGINIA DEPARTMENT OF SOCIAL SERVICES

Benefit Programs

General Information

This pamphlet contains information about some of the benefits offered through the VDSS, along with information about your rights and responsibilities. This pamphlet addresses the Temporary Assistance for Needy Families (TANF) Program, Supplemental Nutrition Assistance Program (SNAP), Medical Assistance Programs and Energy Assistance Program.

How to Apply for Assistance

- Complete an application
  - Apply online for benefits at https://commonhelp.virginia.gov/access/;
  - Apply for Medical Assistance over the phone by calling the Cover Virginia Call Center at 1-855-242-8282.
  - Pick up an application any time during office hours at your local department of social services (LDSS);
  - Ask the LDSS to mail an application to you; or
  - Print a copy of the application off the internet at http://www.dss.virginia.gov/ under each program under Assistance
- File the application
  - Leave the printed application at the LDSS; or
  - Mail or fax the application to your LDSS.
- Depending on the type of assistance you are requesting, you may need to be interviewed.

Time Standards

Action must generally be taken on applications:

- within 10 work days for Medical Assistance for a pregnant woman;
- within 45 days of application for Medical Assistance (may take up to 90 days if a disability determination is needed);
- within 30 days of application for TANF;
- within 30 days of application for SNAP benefits (7 days if you qualify for emergency service);
- as soon as possible but no later than the last day designated for processing for Fuel Assistance;
- within three working days of all information being received for Crisis Assistance;
- by the close of the application period for Cooling Assistance.

General Eligibility Requirements

- To be eligible for most programs, you must:
  - Live in Virginia;
  - Be a U.S. citizen or meet certain requirements if you are an immigrant;
  - Apply at the agency that serves the city or county where you live;
  - Meet specific requirements of each program for which you are applying;
  - Apply for other benefits that you may be entitled to receive, such as Social Security, Worker's or Unemployment Compensation.
- Before we can determine if you are eligible, some of the information you give must be verified. See the VERIFICATION section of this pamphlet for more information
- Depending on the program, eligibility and the amount of benefits may be based on:
  - Your income;
  - The number of people in the family;
  - Resources; and
  - Certain household expenses.
- As soon as a decision about your application is made, we will send you a written notice. This notice will tell you if you are eligible and the amount of benefits you may receive.

Confidentiality

Information you provide is confidential. We will only give information to someone directly connected with administering or enforcing provisions of the programs for which you applied, other federal assistance programs, or programs that assist low income individuals. Information may also be disclosed to:

- Law enforcement officials who are investigating program violations or, in some instances, law enforcement officials who are investigating persons fleeing prosecution or punishment for a felony.
- The Child Support Enforcement Program to help locate absent parents.
- Persons connected with verifying status of immigrants.
- Agencies that provide employment-related services for TANF recipients or to local school divisions for school age children who get TANF benefits.

Verification

Each program has its own verification requirements. You must provide any information requested to establish your eligibility. Your worker will tell you what you need to provide and the deadline to provide it. Please ask for assistance if you need help. Examples of items the agency may need to verify and some suggested ways you may verify the items include:

Identity, Residence

- Driver's license, alien registration card, voter registration card, work or school ID, library card, and birth certificates;
- Social Security Numbers for everyone for whom you are requesting assistance.

Expenses

- Lease or mortgage agreement, rent receipts;
- Most recent utility and phone bills;
- Bills for the care of children, or elderly or disabled adults;
- Bills for medical expenses;
- Child support paid by a member of the household.

Resources

- Most recent statements for bank accounts such as checking and savings accounts;
- Proof of stocks and bonds;
- Information about burial trusts, burial arrangements, and burial plots;
- Registration or title for all motor vehicles;
- Medical insurance policies or medical cards;
- Life insurance policies that may be cashed.

Income

- Pay stubs for this month and last month for everyone working;
- Records of tips, bonuses, or commissions;
- Divorce decrees or support orders;
- Award letters or notices.

Rights and Responsibilities

- You must give correct information.
- You must cooperate.
- You must report changes that occur in your situation. Your worker will explain which changes need to be reported.
- You may appeal decisions or actions if you are dissatisfied.
- You may review your case record during the agency's business hours.
- You may review program regulations and manuals during the agency's normal business hours. Manuals are also available online at www.dss.virginia.gov.

Authorized Representative

If you would like someone else to act on your behalf, you may select a trusted friend, relative or neighbor to be your representative. The representative may:

- Apply for benefits for you.
- Receive your notices and correspondence.
- Use benefits on your behalf.

You may name a representative on the application form. If you want to name an authorized representative at any time after you have submitted your application, write a note for that person to take to the local social services department. In the note:

- List the name, address and phone number of the person you are naming;
- List the duties you want that person to perform;
- Sign and date the note.

Nondiscrimination

DSS will provide benefits and services without regard to race, color, national origin, disability, sex, age, political beliefs, religion, sexual orientation, marital or family status. If you believe you have been discriminated against, you may file a written complaint with state or federal agencies.

If you have a disability or if you have difficulty with English, you may get extra help to make sure you get the assistance or services you need.

Case Name _____
Case Number _____

Rights and Responsibilities

☐ I declare that I reviewed a listing of my rights and responsibilities in writing about applying for or receiving public assistance benefits such as Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) benefits.

☐ I declare that a representative of the _____ agency discussed rights and responsibilities with me.

_____	_____	_____
Printed Name	Signature	Date

Agency Use

☐ I declare that I discussed applicant and recipient rights and responsibilities with _____ on _____ during a telephone interview or other contact.

_____	_____	_____
Printed Name	Signature	Date

County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

Recipient Name:_____

Case Number:_____

Medicaid Policy Regarding Applicants/Recipients

Due to client confidentiality, Medicaid policy for Adults limits the information that can be released to anyone other than the applicant/recipient. Medicaid policy M0110.100 allows individuals to choose an "Authorized Representative" if the applicant/recipient would like to have someone assist them with the application and/or renewal process. Authorized Representatives are valid for the life of the application/case.

Please check one:

☐ ***I would like to authorize*** _____ ***to act on my behalf.***

I would like for him/her to be given:

- ☐ Receive letters regarding actions taken on my case
- ☐ Receive requests for information needed to determine/re-determine eligibility
- ☐ Apply for and/or renew Medical Assistance
- ☐ Discuss case information via telephone, in person or e-mail
- ☐ Other:_____

Contact Information for Authorized Representative:

Name_____

Address_____

City_____ State_____ Zip_____

Home_____ Work_____ Cell_____

Email:_____

The Authorized Representative must report their address change if recipient's mail goes to this address.

☐ ***I do not want to appoint an authorized representative.***

_____ _____

Signature of Medicaid Applicant/Recipient Date

_____ _____

Witness if signature above made by mark of "X" Date

Department of Family Services
Self Sufficiency Division
Pennino Building
12011 Government Center Parkway
Suite 232
Fairfax, VA 22035
Phone 703-324-7622 Fax 703-324-8242

EXAMPLE OF A COMPLETED APPLICATION

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Application for Health Coverage & Help Paying Costs

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Free or low-cost insurance from Medicaid, FAMIS or Plan First
- If you are not eligible for Medicaid or FAMIS you will be referred to the Federal Health Insurance Marketplace for affordable private health insurance plans that offer comprehensive coverage to help you stay well and may include a new tax credit that can immediately help pay your premiums for health coverage.

You may qualify for a low-cost program even if you earn as much as $97,200 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.
- If you are applying for someone other than a spouse or family member under age 21, an authorized representative form (Appendix C) must be completed.
- If you are age 65 or older or disabled or any age and need assistance with nursing facility or community based care, you need to complete Appendix D.

Apply faster online

Apply faster online at commonhelp.virginia.gov.
For more information about Medicaid, FAMIS and Plan First visit coverva.org.

What you may need to apply

- Social Security numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

If you use this paper application, send your complete, signed application to the local Department of Social Services in the city or county where you live. They will follow up with you to obtain additional information. Your application should be processed within 45 days from the date it was received.

Get help with this application

- **Phone:** Call Cover Virginia at **1-855-242-8282**
- **In person:** There will be application assisters in your area who can help. Visit our website at coverva.org or call **1-855-242-8282** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-855-242-8282**

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EXAMPLE OF A COMPLETED
APPLICATION

COVER VIRGINIA
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STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name	Middle name	Last name	Suffix
Paul		Annapolos	

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number

4. City	5. State	6. ZIP code	7. County
	☐☐	☐☐☐☐☐	

8. Mailing address (if different from home address)	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County
	☐☐	☐☐☐☐☐	

14. Phone number	15. Other phone number
(☐☐☐) ☐☐☐ – ☐☐☐☐	(☐☐☐) ☐☐☐ – ☐☐☐☐

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

_____

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Married or unmarried parents (of a child under 21) living in the home
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner if you don't have children together in the home
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to include copies of the Additional Person single page supplement form and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse and children who live with you and/or anyone on your same federal income tax return if you file one. Include both parents living in the home (for a child under 21). See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name: Paul | Middle name | Last name: Anagnostos | Suffix

3. Date of birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐

4. Sex ☐ Male ☐ Female

2. Relationship to you? **SELF**

5. Social Security number (SSN) ☐☐☐-☐☐-☐☐☐☐

We need this if you want health coverage and have an SSN. Even if you don't want health coverage for yourself, providing your SSN can be helpful since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. For help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ YES. **If yes,** please answer questions a–c. ☐ NO. **If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? ☐ Expected due date: _____

8. **Do you need health coverage?** *(Even if you have Medicare or other insurance, there might be a program with better coverage or lower costs.)* **If NO, skip to the income questions on page 3 and leave the rest of this page blank.**

☐ YES. **If yes**, answer all the questions below.

8a.
☐ YES. If under 19 or over 64 and not eligible for full coverage, do you wish to be evaluated for Plan First (family planning coverage only)?

or

☐ NO. If you are age 19 to 64 and are not eligible for full coverage, you will be evaluated for Plan First (family planning coverage only) unless you check NO.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? If Yes, please complete Appendix D. ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?
☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____

b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

12. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

13. Are you incarcerated (detained or jailed)? ☐ Yes ☐ No **If Yes** ☐ Federal ☐ State (DOC or DJJ) ☐ Local/Regional
☐ Check here if pending disposition of charges Expected release date ☐☐/☐☐/☐☐☐☐

14. Are you a full-time student? ☐ Yes ☐ No | 15. Were you in foster care at age 18 or older? ☐ Yes ☐ No **If yes**, in which state _____

16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

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STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

CURRENT JOB 1:

18. Employer name	a. Employer address		
b. City	c. State	d. Zip code	19. Employer phone number ( ) –
20. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly			21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name	a. Employer Address		
b. City	c. State	d. Zip code	23. Employer phone number ( ) –
24. Wages/tips (before taxes) $ ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly			25. Average hours worked each WEEK

26. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. **If self-employed, answer the following questions:**
a. Type of work Photoshop: will be sold, actively marked for sale - No income
b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? $

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it. Check here if none ☐
NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment	$	How often?	☐ Alimony received	$	How often?
☐ Pensions	$	How often?	☐ Net farming/fishing	$	How often?
☒ Social Security	$ 3000	How often? monthly	☐ Net rental/royalty	$	How often?
☐ Retirement accounts	$	How often?	☐ Other income Type	$	How often?

29. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No If yes, provide monthly income for previous 3 months.
Month 1: $ Month 2: $ Month 3: $

30. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid	$	How often?	☐ Other deductions	$	How often?
☐ Student loan interest	$	How often?	Type:		

31. **YEARLY INCOME: Complete only if your income changes from month to month.**
If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

THANKS! This is all we need to know about you.

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STEP 2: PERSON 2

If you have more than two people to include, complete as many Additional Person single page supplement forms as you need.

Complete Step 2 for your spouse and children who live with you and/or anyone on your same federal income tax return if you file one. Include both parents living in the home (for a child under 21). See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name | Middle name | Last name | Suffix

3. Date of birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

4. Sex ☐ Male ☐ Female

2. Relationship to you?

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐
We need this if you want health coverage for PERSON 2 and PERSON 2 has an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if PERSON 2 doesn't file a federal income tax return.)

☐ YES. **If yes,** please answer questions a–c. ☐ NO. **If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? ☐ Expected due date: _____

9. **Does PERSON 2 need health coverage?** *(Even if Person 2 has Medicare or other insurance, there might be a program with better coverage or lower costs.)* **If NO, skip to the income questions on page 5 and leave the rest of this page blank.**

☐ YES. **If yes,** answer all the questions below.

9a.

☐ YES. If under 19 or over 64 and not eligible for full coverage, does PERSON 2 wish to be evaluated for Plan First (family planning coverage only)?

or

☐ NO. If PERSON 2 is age 19 to 64 and is not eligible for full coverage, PERSON 2 will be evaluated for Plan First (family planning coverage only) unless you check NO.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? If Yes, please complete Appendix D. ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?
☐ Yes. Fill in their document type and ID number below.
a. Document type _____
b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No
d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Is Person 2 living with at least one child under age 19 and the main person taking care of this child? ☐

14. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No
If yes, in which state _____

15. Is PERSON 2 incarcerated (detained or jailed)? ☐ Yes ☐ No
☐ Check here if pending disposition of charges
If Yes ☐ Federal ☐ State (DOC or DJJ) ☐ Local/Regional
Expected release date ☐☐ / ☐☐ / ☐☐☐☐

16. Is PERSON 2 a full-time student? ☐ Yes ☐ No

17. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. **Race (OPTIONAL—check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

Now, tell us about any income from PERSON 2 on the next page.

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STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If PERSON 2 is currently employed, tell us about their income. Start with question 19.

☐ **Not employed**
Skip to question 29.

☐ **Self-employed**
Skip to question 28.

CURRENT JOB 1:

19. Employer name		a. Employer address	
b. City	c. State	d. Zip code	20. Employer phone number
			( ) –
21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly $			22. Average hours worked each WEEK

CURRENT JOB 2: (If PERSON 2 has more jobs and needs more space, attach another sheet of paper.)

23. Employer name		a. Employer Address	
b. City	c. State	d. Zip code	24. Employer phone number
			( ) –
25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly $			26. Average hours worked each WEEK

27. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

28. **If PERSON 2 is self-employed, answer the following questions:**

a. Type of work _____

b. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month? $

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it. Check here if none ☐
NOTE: You don't need to tell us about PERSON 2's child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment	$	How often?	☐ Alimony received	$	How often?
☐ Pensions	$	How often?	☐ Net farming/fishing	$	How often?
☐ Social Security	$	How often?	☐ Net rental/royalty	$	How often?
☐ Retirement accounts	$	How often?	☐ Other income Type	$	How often?

30. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No If yes, provide monthly income for last 3 months.
Month 1: $ Month 2: $ Month 3: $

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 2 gets it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

☐ Alimony paid	$	How often?	☐ Other deductions	$	How often?
☐ Student loan interest	$	How often?	Type:		

32. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.**
If you don't expect changes to PERSON 2's monthly income, skip to the next person.

PERSON 2's total income **this year**	PERSON 2's total income **next** year (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

If you have more than two people to include, complete the Additional Person single page supplement form.

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STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** go to Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ YES. **If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ NO.

- ☐ Medicaid _____
- ☐ FAMIS _____
- ☐ Plan First _____
- ☐ Medicare _____
- ☐ TRICARE (Don't check if you have direct care or Line of Duty)
  _____
- ☐ Veterans Administration health care programs
  _____
- ☐ Peace Corps _____
- ☐ Federal Health Insurance Marketplace
  _____

- ☐ Employer insurance _____
  Name of health insurance: _____
  Policy number: _____
  Is this COBRA coverage? ☐ Yes ☐ No
  Is this a retiree health plan? ☐ Yes ☐ No
- ☐ Other
  Name of health insurance: _____
  Policy number: _____
  Is this a limited-benefit plan (like a school accident policy)?
  ☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?**

Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ YES. **If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ NO. **If no, continue to Step 5.**

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STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this application to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I understand that I am authorizing the local Department of Social Service (LDSS) and the Department of Medical Assistance Services (DMAS) to obtain verification/information necessary to determine my eligibility for Medicaid or FAMIS.
- I understand that Medicaid and DMAS contractors may exchange information relating to my coverage with LDSS to assist with application, enrollment, administration and billing services.
- I understand that for individuals enrolled in managed care, a premium is paid each month to the MCO for the person's coverage. If the child or pregnant woman is not eligible for FAMIS, FAMIS Plus, FAMIS MOMS, or Medicaid because I did not report truthful information or failed to report required changes in my family size or income, I may have to repay the monthly premiums paid to the MCO. I may have to repay these premiums even if no medical services were received during those months.
- I know that I must tell the local Department of Social Services within 10 calendar days if anything changes and is different than what I wrote on this application. I can visit **www.commonhelp** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Medicaid or FAMIS programs or the Marketplace to use income data, including information from tax returns. I understand that I will receive notification of the outcome of my renewal. I understand that I can opt out at any time.

Yes, I consent to the use of electronic income data including information from tax returns to annually renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think Medicaid, FAMIS or Plan First has made a mistake I can contact them at **www.coverva.org** or call **1-855-242-8282**. Instructions for filing an appeal will be included on my notice and are also available on the coverva.org website.

If I think the Health Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at **1-800-318-2596**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)
	☐☐ / ☐☐ / ☐☐☐☐

STEP 6 Mail completed application.

Mail your signed application to:

The local Department of Social Services in the city or county in which you live

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APPENDIX A

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number ☐☐☐ - ☐☐ - ☐☐☐☐

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) ☐☐ - ☐☐☐☐☐☐☐
5. Employer address		6. Employer phone number (☐☐☐) ☐☐☐ – ☐☐☐☐
7. City	8. State ☐☐	9. ZIP code ☐☐☐☐☐
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) (☐☐☐) ☐☐☐ – ☐☐☐☐	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. * (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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EMPLOYER COVERAGE TOOL

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage that you're eligible for.

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number
	☐☐☐ - ☐☐ - ☐☐☐☐

EMPLOYER Information

Ask the employer for this information.

3. Employer name	4. Employer Identification Number (EIN)
	☐☐ - ☐☐☐☐☐☐☐
5. Employer address	6. Employer phone number
	(☐☐☐) ☐☐☐ - ☐☐☐☐
7. City	8. State / 9. ZIP code
	☐☐ / ☐☐☐☐☐
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above) (☐☐☐) ☐☐☐ - ☐☐☐☐	12. Email address

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly (Go to next question)

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.

* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name _____ ☐ No	☐ Yes **If yes**, tribe name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid, FAMIS or Plan First. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ ☐☐☐☐☐☐ How often?_____	$ ☐☐☐☐☐☐ How often?_____

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APPENDIX C

COVER VIRGINIA

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the local Department of Social Services. If you are applying for someone other than a spouse or family member, an authorized representative form (Appendix C) must be completed. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address | 3. Apartment or suite number

4. City | 5. State ☐☐ | 6. ZIP code ☐☐☐☐☐

7. Phone number
(☐☐☐) ☐☐☐ – ☐☐☐☐

8. Organization name | 9. ID number (if applicable) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature | 11. Date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

OR

Is there anyone else that you would like us to share your information with about your application?

1. I give permission for (name) and/or (organization name)

2. Address City State Zip

3. Phone number
(☐☐☐) ☐☐☐ – ☐☐☐☐ | 4. ID number (if applicable) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

to receive eligibility and enrollment information relating to my application/case. I also give the Department of Social Services and/or the Department of Medical Assistance Services permission to release information about this application to this person/organization.

5. Your signature | 6. Date (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)
☐☐ / ☐☐ / ☐☐☐☐

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ | 5. Agents/Brokers only: NPN Number ☐☐☐☐☐☐☐☐☐☐

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Commonwealth of Virginia Voter Registration Agency Certification

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Please check only one)

☐ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.

☐ Yes, I would like to apply to register to vote. (please fill out the voter registration application form)

☐ No, I do not want to register to vote.

If you do not check any box, you will be considered to have decided not to register to vote at this time.

Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency. If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219-3497, phone (804) 864-8901.

Applicant Name	Signature	Date

(for agency use only)

Voter Registration form completed: ☐ Yes ☐ No

Voter Registration form given to applicant for later mailing (at applicant's request): ☐

Agency Staff Signature	Date

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01/31/17

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Name of Applicant_____

Application for Health Coverage and Help Paying Costs
APPENDIX D

Complete Appendix D if you are applying for Health Care Coverage for:

- **someone who has disabilities**
- **someone age 65 years or over**
- **all people, including children, in need of Long-term Care Services** (nursing facility or community based care)
- **someone who is medically needy** (has income greater than Medicaid limit and would like to be evaluated based on their income, resources and medical expenses) - Spenddown

What is Appendix D Used For?

Appendix D gathers additional information needed to determine your eligibility for Health Care Coverage.

Appendix D is not a stand-alone application. You must also complete the Application for Health Coverage and Help Paying Costs and submit Appendix D with the application.

If completing Appendix D for someone else, please answer the questions for that person.

SECTION 1 Household Information

1. Are You? ☐ Married ☐ Never married ☒ Divorced ☐ Widowed ☐ Separated

2. Has anyone in your household ever applied for or received any Health Care Coverage from a social service agency in another state or Virginia city or county?

☐ **Yes** ☒ **No**

— If **yes**, please indicate which state or Virginia city or county below:

NB: Peter could be receiving some social security benefits

State or Virginia city or county

3. Is anyone in your household temporarily away from home? ☐ **Yes** ☒ **No**

— If **yes**, please provide the following information:

Name	Date Left
Reason for Leaving	
Where is the person currently staying?	Expected Return Date

Answer questions 4-11 if any applicants are under age 65 years.

4. Are you or is anyone for whom you are applying disabled? ☐ **Yes** ☐ **No**

— If **yes**, please provide the name of the persons:

Name of Person	Name of Person

5. Have you or anyone for whom you are applying ever applied for Social Security, Supplemental Security Income (SSI) or Railroad Retirement benefits as a disabled person?

☐ **Yes** ☒ **No**

— If **yes**, please provide the name of the persons and date of application:

Name of Person and Date of Application	Name of Person and Date of Application

6. Have you or anyone in your household for whom you are applying been approved for disability for Social Security, SSI, Railroad Retirement or Medicaid purposes? ☐ **Yes** ☒ **No**

— If **yes**, please provide the name of the individual:

Name	Name

7. If the application for Social Security, SSI or Railroad Retirement benefits was denied, did you file an appeal of the denial? ☐ **Yes** ☒ **No**

— If **yes**, please tell us the outcome of the appeal:

Outcome

8. Has it been less than 12 months since the most recent application for Social Security, SSI or Railroad Retirement benefits was denied?

☐ **Yes** ☐ **No**

9. Has the condition changed or worsened since the most recent application for disability was denied?

☐ **Yes** ☐ **No**

10. Do you or anyone for whom you are applying have a new medical condition since the most recent application for disability was denied? ☐ **Yes** ☐ **No**

11. Have you or anyone for whom you are applying ever received SSI, disability benefits from the Social Security Administration or Auxiliary Grant payments?

☐ **Yes** ☐ **No**

Has the payment stopped? ☐ **Yes** ☐ **No**

— If **yes**, explain whose payment stopped, when it stopped, and why it stopped.

Explain

SECTION 2 Long-term Care

Answer questions 12-14 if you are applying for anyone who is in a nursing facility or assisted living facility, or who requires nursing home care or assistance to remain in the home

12. Do you or anyone for whom you are applying need nursing facility care or help such as bathing, dressing, toileting, etc., so that you can remain in your own home? ☒ **Yes** ☐ **No**

— If **yes**, and there is a spouse who lives somewhere else, what is the name and address of the spouse?

(Note: Under Virginia law persons are considered married and legally responsible for each other until they divorce)

Name Paul
Address

13. Do you or anyone for whom you are applying live in one of the following?

☐ Assisted Living Facility (ALF) ☒ Nursing Facility ☐ Group Home ☐ Hospital or other Medical Facility

— If you checked one of the above, please provide the following information:

Name	Date of Entry	In what County was the prior address?
Person's address prior to entering the facility		
Facility Name	Facility Address	
Was Placement made by a State agency? ☐ **Yes** ☐ **No**		

14. Does the individual in the nursing facility or requiring assistance in the home have long-term care insurance? ☐ **Yes** ☒ **No** — If **yes**, please provide the following information:

Name of Insurance Company	Address	City, State, ZIP
Policy Number	Person(s) Insured	Is this a Partnership Policy? ☐ **Yes** ☐ **No**

15. Have you or your spouse sold, transferred, placed in a trust/annuity, or given away any resources, such as your home or other real property, cash, bank accounts, or cars in the last sixty (60) months (5 years)? ☒ **Yes** ☒ **No** — If **yes**, please provide the following information:

Type of Property Transferred	Value at Transfer	Amount Received	Date of Transfer
I	$	$	
From Whom		To Whom	
To Peter			
Explain the Reason for Transfer			
disabled son			

Note: If more than one transfer has occured, please attach documentation of each transfer.

SECTION 3 Resources and Assets

16. Do you or your spouse have any money/cash on hand that is not in the bank? ☒ **Yes** ☐ **No**
— If **yes**, please provide the following information:

Name	Amount $
	3000
Name	Amount $

17. Do you or your spouse have any of the following resources? ☐ **Yes** ☒ **No**
— If **yes**, please check the boxes that apply and provide the information requested below:

☐ Checking, Savings ☐ Deferred Compensation Plan ☐ Christmas Club
☐ Credit Union ☐ Certificate of Deposit (CD) ☐ Money Market Funds

1. Owner Name		Co-Owner Name	
Name of Bank	Account Type	Account Number	Balance/Value $
2. Owner Name		Co-Owner Name	
Name of Bank	Account Type	Account Number	Balance/Value $
3. Owner Name		Co-Owner Name	
Name of Bank	Account Type	Account Number	Balance/Value $

Is your income (Social Security or SSI benefits, retirement pension, wages, etc.) deposited directly into any of the accounts? ☐ Yes ☐ No If yes, which account? _____

18. You must report ownership of all annuities you and your spouse have. You and your spouse may have to name the Commonwealth of Virginia as the beneficiary of any annuity you or your spouse own.

Do you or your spouse have any stocks or bonds, trust funds, pension plans, retirement accounts, trusts, annuities, promissory notes, or deeds of trust? ☐ Yes ☐ No

— If **yes**, please provide the following information:

1. Owner Name Paul		Co-Owner Name	
Where is the Account Held?	Account Type	Account Number	Balance/Value $
2. Owner Name		Co-Owner Name	
Where is the Account Held?	Account Type	Account Number	Balance/Value $
3. Owner Name		Co-Owner Name	
Where is the Account Held?	Account Type	Account Number	Balance/Value $

19. Do you or your spouse have any life insurance? ☐ Yes ☒ No

— If **yes**, please provide the following information:

1. Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	Policy Number	Face Value $	Cash Value $
2. Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	Policy Number	Face Value $	Cash Value $
3. Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	Policy Number	Face Value $	Cash Value $

20. Do you or your spouse have burial plots, burial arrangements, or trust funds for burial?
☒ **Yes** ☐ **No**
— If **yes**, please provide the following information:

Owner(s)	Item/Type	Value/Amount Owned
		$ 30,000
Owner(s)	Item/Type	Value/Amount Owned
		$
Owner(s)	Item/Type	Value/Amount Owned
		$

21. Do you or your spouse have real property, including home property, life rights/estates, shares in undivided heir property, land, buildings, or mobile homes? ☐ **Yes** ☐ **No**
— If **yes**, please provide the following information:

Owner(s)	Type of Property/Number of Acres	Value/Amount Owned
Home		$ 560,000
Do you live on this property? ☐ **Yes** ☐ **No**		Is this property currently for sale? ☐ **Yes** ☐ **No**
Is this property rented? ☐ **Yes** ☒ **No**		Do you received money from this property ☐ **Yes** ☐ **No**

+ Appartment

22. Do you or your spouse have any licensed or unlicensed cars, trucks, vans, boats, motors homes, recreational vehicles, utility trailers, motorcycles, or mopeds? ☒ **Yes** ☐ **No**
— If **yes**, please provide the following information:

Owner(s)	Year-Make-Model	Value/Amount Owned
	BMW	$ 60,000
Owner(s)	Year-Make-Model	Value/Amount Owned
		$
Owner(s)	Year-Make MOdel	Value/Amount Owned
		$

23. Do you or your spouse have any property that is used in the operation of a business, such as farm equipment, tools, or livestock? ☒ **Yes** ☐ **No**
— If **yes**, please provide the following information:

Owner(s)	Type	Value	Amount Owned
		$	$
Owner(s)	Type	Value	Amount Owned
		$	$

24. Do you or your spouse expect a change in resources this month or next month? ☒ **Yes** ☐ **No**

— If **yes**, please explain below and give the date the change is expected:

Explain Photoshop is for sale
Date Change Expected

SECTION 4 Other Income

25. Do you receive child support? ☐ **Yes** ☑ **No**

— If **yes**, please provide the following information:

Amount $	How Often?	Is the payment for past-due child support payments? ☐ Yes ☐ No

26. Do you receive Veteran's Administration benefits? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

Amount $	How Often?	Type

27. Does anyone help you pay, or lend you money to pay rent, utilities, medical bills, or any other bills? ☐ **Yes** ☒ **No**

— If **yes**, please provide the following information:

Person Receiving Money	Person Providing Help
Type of Help Received	Amount $
Does the money come directly to you?	☐ Yes ☐ No
Is this a loan?	☐ Yes ☐ No
Is repayment expected?	☐ Yes ☐ No

Person Receiving Money	Person Providing Help
Type of Help Received	Amount $
Does the money come directly to you?	☐ Yes ☐ No
Is this a loan?	☐ Yes ☐ No
Is repayment expected?	☐ Yes ☐ No

Sign the application

I am signing this application under penalty of perjury which means I've provided true answers to all the questions on this application to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false or untrue information.

Signature	Relationship to Applicant	Date

ASSET TRANSFER UNDUE HARDSHIP CLAIM FORM

Return To: Agency:_____ Address:_____ _____	Case Name:_____ Case #:_____ Worker Name:_____ Worker Telephone #:_____

The opportunity to claim an Undue Hardship must be *offered* when the imposition of a penalty period for the uncompensated transfer of assets affects Medicaid payment for long-term care services including nursing facility, PACE, hospice, or community-based care (CBC). An undue hardship may be granted when documentation is provided that shows the assets transferred cannot be recovered and the immediate adverse impact of the denial or cancellation of Medicaid coverage would result in the individual being removed (discharged) from the nursing facility, PACE, hospice or CBC, or becoming unable to receive life-sustaining medical care, food, clothing or shelter.

The request for an Undue Hardship and all documentation must be submitted to the eligibility worker at the local department of social services.

The Department of Medical Assistance Services will review the documentation provided with the undue hardship request to determine if an undue hardship may be granted and send written notification to your eligibility worker. Your eligibility worker will notify you in writing of the decision that is made.

I want to claim an Undue Hardship. I affirm that the information provided about my claim for an Undue Hardship is true and correct to the best of my knowledge and belief.

_____ _____

Signature of Applicant/Recipient or Authorized Representative Date

---

In order to evaluate your Undue Hardship, *written evidence of* the following information must be provided:

- the reason(s) for the transfer;
- all attempts made to recover the asset or receive full compensation, including legal actions and the results of the attempts;
- notice of discharge from the facility, PACE, hospice, or CBC services due to denial or cancellation of Medicaid payment for these services;
- physician's statement that inability to receive long-term care services would result in the applicant/recipient's inability to obtain life-sustaining medical care;
- documentation that individual would not be able to obtain, food, clothing or shelter;
- list of all assets owned and verification of their value at the time of the transfer if the individual claims he did not transfer resources to become Medicaid eligible; and
- documents such as deeds or wills if ownership of real property is an issue.

Section §20-88.02 of the Virginia Code allows the Department of Medical Assistance Services(DMAS) to seek recovery from the transferee or recipient of the transfer, when a Medicaid enrollee transfers assets with an uncompensated value of $25,000 or more within 30 months of receiving or becoming eligible for Medicaid long-term care services. The DMAS Recipient Audit Unit will notify the Medicaid recipient of the results of the evaluation for recovery.

VIRGINIA MEDICAID/FAMIS APPEAL REQUEST FORM

(For Client Appeals Only)

Last Name of Medicaid/FAMIS Applicant/Recipient:	First Name:	Middle Initial:	Suffix: (e.g., Sr., Jr., II, III)
Mailing Address (Street or Post Office Box)	City	State	Zip Code – 9-Digit
Date of Birth:	Gender: ___ Male ___Female	Medicaid/FAMIS Case #:	Health Care #:
Social Security #: ___-___-____	Primary Telephone #: (area code and number)	Email Address:	
	Alternate Telephone #: (area code and number)	Fax #: (area code and number)	

PLEASE SEND A COPY OF THE DENIAL LETTER OR NOTICE REGARDING THE ACTION YOU ARE APPEALING

I am appealing the action of (agency name) _____

The date on the letter or date I was told about the Medicaid/FAMIS decision is: _____

The name of the person who wrote to me or spoke to me about the decision I am appealing is:

Name: _____ Title: _____ Telephone Number: _____

The agency (*check the appropriate space*):

( ) Denied my application or terminated my coverage for ( ) Medicaid or ( ) FAMIS.
( ) Refused to take my application for ( ) Medicaid or ( ) FAMIS.
( ) Failed to determine my eligibility within the time limit for ( ) Medicaid ( ) FAMIS
( ) Declared me not disabled.
( ) Requested repayment of benefits paid for medical services previously received.
( ) Denied or terminated waiver services. Name the waiver: _____ Service _____
( ) Denied me medical services or authorization for medical services. Name of service: _____
( ) Transferred or discharged me from a nursing facility. Name of facility: _____
( ) Took other action that which affected my receipt of Medicaid, FAMIS or medical services.

Are you a community spouse appealing the income or resource determination for your spouse? ___Yes ___No

Write a brief statement about why you are requesting an appeal. _____

_____

_____

Preferred spoken language: _____ *Preferred written language: _____

DO YOU NEED AN INTERPRETER? ( ) YES ( ) NO

How do you prefer to be contacted about your appeal request?

( ) Email (provided above) ( ) Fax (provided above) ( ) Regular postal mail at the mailing address provided.

If you choose to get information by any method other than mail, do you also want to get paper copies in the mail? ( ) Yes ( ) No

IMPORTANT NOTIFICATION

The Department of Medical Assistance Services shall recover expenses paid on behalf of clients when Medicaid or FAMIS coverage is continued during the appeal process and the hearing officer upholds the agency's action. Expenditures made for medical services (including MCO capitation fees) from the original effective date of the proposed closure or reduction through the actual date of closure or reduction will be subject to recovery.

*DO YOU WISH TO RECEIVE CONTINUED COVERAGE DURING THE APPEAL PROCESS IF YOU QUALIFY? __YES __ NO

This section must be completed only if the client will be represented by another individual during the appeal process.

Representative's Name: _____ Firm or Organization: _____

Address: _____

Area Code and Telephone number: _____

Signature of Client: _____ Date: _____

This form must be signed by the adult client. If a representative who is not an attorney signs this form, the adult client m provide a signed statement or form authorizing that individual to act on his/her behalf during the appeal.

See other side for additional instructions.

INSTRUCTIONS (PLEASE PRINT)

1. **Complete this form as fully as possible or write a letter with the same information. If more space is needed, additional sheets may be included.**

2. **The ADULT Medicaid/FAMIS applicant or recipient MUST sign the form. If the adult applicant or recipient cannot sign the form, the individual who signs the form must explain why he/she is the appropriate person to represent the applicant/recipient. If the representative holds Power of Attorney (POA), a copy of the POA document must be provided. A signed statement from the adult applicant/recipient is acceptable.**

3. **Mail or fax this form or an appeal letter along with the notice from the agency to the address shown below.**

   - **The appeal form or letter must be *postmarked* within *thirty (30) days* of the agency's decision or the date the applicant/recipient was supposed to get a decision, but did not.**
   - **If neither of the above applies, mail in the appeal request form or appeal letter as soon as possible to protect the individual's appeal rights.**

SEND THE COMPLETED FORM OR APPEAL REQUEST LETTER AND RELATED DOCUMENTS TO THE:

Appeals Division
Virginia Dept. of Medical Assistance Services
600 East Broad Street, 11th Floor
Richmond Virginia 23219
Fax (804) 612-0036

IF MORE THAN 30 DAYS HAVE PASSED SINCE THE AGENCY'S ACTION, OR SINCE THE DATE THE AGENCY SHOULD HAVE TAKEN ACTION, PLEASE ANSWER THE QUESTIONS BELOW:

1. **Did you get a denial or termination notice? ___ Yes ___ No What was the postmark date on the envelope? _____ When did you get the notice?_____**

2. **If you did not get a notice, how did you learn of the denial or cancellation? _____**
   _____
   _____

3. **Have you had any problems getting mail? _____ What kind of problems?_____**
   _____ Were problems reported to the post office? ___ Yes ___ No

4. **Has your address changed? ___ Yes ___ No If so, when?_____**

5. **If your address changed, did you tell the agency? ___ Yes ___ No If yes, what date did you tell the agency that your address changed? _____**

6. **Why didn't you file an appeal within 30 days of the date of the agency decision? _____**
   _____
   _____
   _____
   _____
   _____