COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

1-855-242-8282

How to Apply

If, after using the Screening Tool, you think you may qualify for health care coverage under Medicaid, FAMIS, or Plan First, there are four easy ways to apply.

1. Call Cover Virginia at **1-855-242-8282** to apply on the phone Mon - Fri: 8:00 am to 7:00 pm and Sat: 9:00 am to 12:00 pm or
2. Apply online at www.commonhelp.virginia.gov or
3. Print out and complete a paper application (Spanish version available here) and mail it to your local Department of Social Services (* Additional forms or applications may be required) or
4. Visit your local Department of Social Services in the city or county in which you live

You should have the following information ready when you apply:

- Full legal name, Date of Birth, Social Security Number, Citizenship or Immigration Status for you and anyone in your household who is applying for health care coverage.
- Most recent federal tax filing information (if available).
- Job and income information for members of your household for the month prior or the current month. Having recent pay stubs or W-2s to reference may be helpful.
- Information about other taxable income for members of your household such as unemployment benefits, Social Security benefits, pensions, retirement income, rental income, alimony received, etc.
- Policy numbers for any current health insurance

When you apply, you will be asked if you wish to give your permission (Consent to Share) allowing us to use the information you gave us on the application to create a User Profile for you. Your answer does not affect your eligibility for health care coverage. You can read and download the Consent to Share document here.

*You may need to print out additional single page supplement forms if applying for Medicaid, FAMIS or Plan First for more than two people in your household. The Additional Person Single Page Supplement is not a stand-alone application. You must also complete the Application for Health Coverage and Help Paying Costs and submit the Additional Person Single Page Supplement with the application.

Additional Person Single Page Supplement
Additional Person Single Page Supplement (Spanish)

When applying for Medicaid for adults over age 19 with disabilities, adults aged 65 or over, and for all people who need long term care services, you will need to fill out an ABD-LTC - Appendix D application as well as the Application for Health Coverage and Help Paying Costs.

ABD-LTC Application - Appendix D
ABD-LTC Application - Appendix D (Spanish)

Complete Appendix E if you applied for Health care Coverage for someone who is medically needy (has income greater than the Medicaid limit) and would like to be evaluated for a spenddown based on income, resources and medical expenses. Spenddown works like an insurance policy deductible. The amount of the "deductible" is called the "spenddown liability." Once medical bills are incurred equal to or greater than the spenddown liability, the application is re-evaluated for Medicaid eligibility.

APPENDIX E (Medically Needy Spenddown) to the Application for Health Coverage and Help Paying Costs
APPENDIX E (Medically Needy Spenddown) to the Application for Health Coverage and Help Paying Costs (Spanish)

For information about how to appeal a decision, visit the Appeals page.

Not Sure If You Qualify?

To find out if you may qualify for Medicaid, FAMIS or Plan First, answer the questions on the Screening Tool on the Am I Eligible? page.

Application Assisters

If you need help with filling out your application, please click on the link to find an Application Assister in your area.

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event — like getting married, having or adopting a baby, losing your current health coverage — in order to be eligible. If you have a qualifying event, you may be eligible to enroll during the 2017 Special Enrollment Period (SEP). For more information go to the Marketplace page. If you think you may be eligible for Special Enrollment and would like to apply for health insurance now through the Marketplace, go to www.healthcare.gov.

Governor's Access Plan (GAP)

For information about how to apply for the Governor's Access Plan, please go to the GAP page.

Veteran's Benefits

Click here for information about Veteran's benefits and how to apply.

Low or No-Cost Providers of Care

For a list of free clinics in your area, visit The Virginia Association of Free Clinics website. To find a community health center in your area, visit the Virginia Community Healthcare Association's website.

Select Language ▼ Powered by Google **Translate**

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Toll Free: 1-855-242-8282 • TDD: 1-888-221-1590
Cover Virginia is sponsored by the Commonwealth of Virginia

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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COVER VIRGINIA

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? _____
☐ 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 _____

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? _____
☐ Student loan interest $ How often? _____
☐ Other deductions $ 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

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

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

COVER VIRGINIA

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

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.**

STEP 2: ADDITIONAL PERSON

Name from STEP 1 _____

COVER VIRGINIA

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 this PERSON and they have an SSN.

6. Does this PERSON live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **Does this PERSON plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if this PERSON 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 this PERSON file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will this PERSON claim any dependents on his or her tax return? ☐ Yes ☐ No

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

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

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

How is this PERSON related to the tax filer? _____

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

9. **Does this PERSON need health coverage?** (Even if this PERSON has Medicare or other insurance, there might be a program with better coverage or lower costs.) **If NO, skip to the income questions on the next page 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 this PERSON wish to be evaluated for Plan First (family planning coverage only)?

or

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

10. Does this PERSON 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 this PERSON a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If this PERSON 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 this PERSON lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is this PERSON, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

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

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

15. Is this PERSON 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 this PERSON 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 _____

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STEP 2: ADDITIONAL PERSON

Current Job & Income Information

☐ **Employed**
If this PERSON 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 this PERSON 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 this PERSON is self-employed, answer the following questions:**

a. Type of work _____

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

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often this PERSON gets it. Check here if none ☐
NOTE: You don't need to tell us about this PERSON's 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 _____

30. Does this PERSON 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 this PERSON gets it.
If this PERSON 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? _____
☐ Student loan interest $ How often? _____
☐ Other deductions $ How often? _____
Type: _____

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

This PERSON's total income **this year** $

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

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

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

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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

Appendix E is not a stand-alone application. Submit at LDSS request after filing The Application for Health Coverage and Help Paying Costs.

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Name of Applicant_____
Case Number_____
Date Received_____

Application for Health Coverage and Help Paying Costs APPENDIX E (Medically Needy Spenddown)

Complete Appendix E if you have applied for Health care Coverage for someone who is medically needy (has income greater than the Medicaid limit and would like to be evaluated based on income, resources and medical expenses). LIFC (low income families with children) applicants cannot be evaluated as medically needy.

SECTION 1 Resources and Assets

Answer for the applicant and his or her husband, wife and/or parents and siblings (if applicant is a child). Include any resources anyone owns, or that are jointly owned with someone else, even if that person does not live with you. List the names of all joint owners.

Do you or anyone who lives with you have any of the following resources or assets?

Yes	No		Yes	No		Yes	No	
☐	☐	Cash $_____	☐	☐	Motor Vehicles	☐	☐	Stocks or Bonds
☐	☐	Checking, Savings	☐	☐	Real Property	☐	☐	Annuities
☐	☐	Credit Union	☐	☐	Life Insurance	☐	☐	Deeds of Trust
☐	☐	Money Market Funds	☐	☐	Burial Arrangements	☐	☐	Trust Funds
☐	☐	Certificate of Deposit (CD)	☐	☐	Retirement Accounts	☐	☐	Other
☐	☐	Self Sufficiency Account	☐	☐	Pension Plan			

IMPORTANT: If you have **any of the above** resources, please provide the following information and return documents, such as bank statements, life insurance policies, or a letter from the bank or company documenting the **cash value of the resource.** Verify any liens which reduce cash value. Use additional pages to list additional resources.

Complete the following section for any **"Yes"** answers

Owner Name (last, first, middle initial) **a.**		Co-owner Name (last, first, middle initial)	
Name of Bank, Institution or Company	Resource Type	Identifying Number	Balance or Value $
Address of Bank, Institution or Company (if applicable)			
Owner Name (last, first, middle initial) **b.**		Co-owner Name (last, first, middle initial)	
Name of Bank, Institution or Company	Resource Type	Identifying Number	Balance or Value $
Address of Bank, Institution or Company (if applicable)			
Owner Name (last, first, middle initial) **c.**		Co-owner Name (last, first, middle initial)	
Name of Bank, Institution or Company	Resource Type	Identifying Number	Balance or Value $
Address of Bank, Institution or Company (if applicable)			

Owner Name (last, first, middle initial) **d.**		Co-owner Name (last, first, middle initial)	
Name of Bank, Institution or Company	Resource Type	Identifying Number	Balance or Value
Address of Bank, Institution or Company (if applicable)			

SECTION 2 Additional Income

Do you or anyone who lives with you (including children) receive or expect to receive any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Worker's Compensation	☐	☐	VA Benefits	☐	☐	Other (including Gifts, Life Insurance Proceeds, Inheritances)
☐	☐	Child Support	☐	☐	Lump Sums			

IMPORTANT: If you answered "yes" above, please provide the following information and return documents, such as a letter from the source documenting the **monthly gross amount of income.** Use additional pages if needed to list additional income sources.

Complete the following section for any **"Yes"** answers

Name of Person **a.**	Amount **$**	Type of Money or Help	How Often Received?
Name of Person **b.**	Amount **$**	Type of Money or Help	How Often Received?
Name of Person **c.**	Amount **$**	Type of Money or Help	How Often Received?
Name of Person **d.**	Amount **$**	Type of Money or Help	How Often Received?

Does anyone have a day care expense for a child, an elderly person, or an adult with a disability?

☐ **Yes** ☐ **No**

— If **yes**, give name of person being cared for, name of person providing care, monthly cost and attach verification.

Name of Person Being Cared For	Name of Person Providing Care	Monthly Cost **$**

Sign the Form

I am signing this appendix under penalty of perjury which means I've provided true answers to all the questions on this form 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

Return:

- Signed Appendix E
- Bank statements, life insurance policies, or a letter from the bank or company documenting the **cash value of the resource** and verification of any liens which reduce cash value.
- Pay stubs or a letter from the source documenting the **monthly gross amount of income.**