Commonwealth of Virginia
Department of Social Services

County/City:

Phone:
Date:
Case Number:
Correspondence #:

Medical Assistance (Medicaid & FAMIS) Renewal Form

For Families and Children Medical Assistance:
Contact Cover Virginia at 855-242-8282 (TTY:1-888-221-1590) or your local department of social services at the phone number listed in left corner above

For Aged, Blind, Disabled and Long Term Care Medical Assistance: **Contact your local department of social services at the phone number listed in right corner above.**

It is time to renew your Medical Assistance coverage.

- **By mail:** Complete this form and mail it to your local department of social services at the address at the top of this form.
- **In person:** Visit your local department of social services. Contact your local department of social services for office hours.
- Go to coverva.org or contact your local department of social services for information about obtaining assistance with this form.

How to complete this renewal form

1. Please answer all of the questions on the form.
2. Please read the information about you and each member of your household. Add any missing information. If any information has changed, print the right information.

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 do not need to file taxes to get health coverage).

DO Include:
- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they do not live with you
- Anyone else under 21 who you take care of and lives with you
- Parent of your child(ren) living with you

You DO NOT have to include:
- Your unmarried partner who does not need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you are 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.

3. If you are Aged (65 or older), Blind or Disabled, please be sure to complete Section 11 in addition to the other relevant sections.
4. Please **sign** and date the form at the end of Section 12.
5. **Please return this from by** .If you do not return the form by this deadline, you may lose your Medical Assistance coverage.

What we need

We need information about each person living in your household or listed on your tax return, including:

- those who get Medical Assistance now,
- those who do not get Medical Assistance now but would like to apply, ***and***
- others who live in the household and do not get Medical Assistance

If you have questions about what we might need, contact Cover Virginia (phone listed at bottom of page) or your local department of social services.

We will check your answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration (SSA), and the Department of Homeland Security (DHS). If the information does not match, we may ask you to send more information.

If you do not qualify for Medical Assistance

If you do not qualify for Medical Assistance, we will check to see if you qualify for other kinds of health coverage. We may send your information to the Health Insurance Marketplace so they can see if you qualify for advanced premium tax credits or other coverage.

1 Your contact information

Review your contact information here.	Correct only wrong or missing information here.
Home address:	Name *(first,middle,last & suffix)*
	Home address Apartment#
Mailing address:	City *(home)* State Zip code
Phone: Home: Other:	**Mailing** address Apartment#
	City *(mailing)* State Zip code
	Best phone number to reach you: ☐ Home ☐ Cell ☐ Work
	Phone Number:
	Other phone number, if you have one : ☐ Home ☐ Cell ☐ Work
	Phone Number:

Email address: If you have an email address and would like to provide it to us:

2 We need information about who files tax returns.

Review your tax information here.	Correct any wrong or missing tax information here.
Person filing tax return:	Will anyone in the household file a **federal tax return next year** to report income earned ***this year?***
If this person filed a joint return, name of the spouse:	☐ Yes ***If yes,*** answer all of the questions below. ☐ No ***If no,*** answer the question marked with asterisk (*) below.
If this person had dependents, names of the dependents:	**Person filing tax return:** Name *(first,middle,last & suffix)*
	If this person is filing a joint return, write the name of the spouse:
	If this person will claim dependents, write the names of the dependents:
	Person filing tax return: Name *(first,middle,last & suffix)*
	If this person is filing a joint return, write the name of the spouse:
	If this person will claim dependents, write the names of the dependents:
	* If anyone will be claimed as a dependent on someone else's tax return, write the name of the filer and the dependents. Answer only if different than what you reported above.
	Name of filer:
	Name of dependents:

3 These are the people in your household who get Medical Assistance and need to renew

Person 1

This person's Social Security number is ☐ On file ☒ Not on file

If not on file, write this person's Social Security number here: _ _ _ - _ _ - _ _ _ _

If the person is no longer living in the household, check here. ☐

Date left household: _____

Immigration status on file (if applicable):

☒ You need to provide the information below. ☐ You do not need to provide the information below unless there are any changes.

If this person has eligible immigration status, check here ☐ and provide the document type:_____

and ID number: _____ See Appendix C for more information about eligible immigration status.

Person 2

This person's Social Security number is ☐ On file ☒ Not on file

If not on file, write this person's Social Security number here: _ _ _ - _ _ - _ _ _ _

If the person is no longer living in the household, check here. ☐

Date left household: _____

Immigration status on file (if applicable):

☒ You need to provide the information below. ☐ You do not need to provide the information below unless there are any changes.

If this person has eligible immigration status, check here ☐ and provide the document type:_____

and ID number: _____ See Appendix C for more information about eligible immigration status.

4 Tell us about the *other* people living in your household, and the other people listed on your tax return

List the people who you did not tell us about in Section 3.

Other person:

This person's Social Security number is ☐ On file ☒ Not on file

If not on file, write the Social Security number if this person is applying for health insurance: _ _ _ - _ _ - _ _ _ _

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

If the person is no longer living in the household, check here ☐

Date left household:_____

Date of birth (month/ day / year):

This person is: ☐ Male ☐ Female

If this person wants health insurance, check here ☐ and fill out Section 5.

Other person:

This person's Social Security number is ☐ On file ☒ Not on file

If not on file, write the Social Security number if this person is applying for health insurance: _ _ _ - _ _ - _ _ _ _

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

If the person is no longer living in the household, check here ☐

Date left household:_____

Date of birth (month/ day / year):

This person is: ☐ Male ☐ Female

If this person wants health insurance, check here ☐ and fill out Section 5.

5 Tell us about other people in your household who want to apply for Medical Assistance

Tell us about anyone in your household who wants to apply for Medical Assistance. **Do not answer** these questions for people **who already have Medical Assistance**. *If more than one person is applying make a copy of this page.*

Name of person applying: Name (*first, middle, last & suffix)*

Social Security Number: _ _ _ - _ _ - _ _ _ _
(You may choose not to include)

Relationship to all household members:

Tell us about citizenship

Is this person a U.S. citizen or U.S. national? ☐ Yes ***If yes,*** answer all of the questions below.
☐ No ***If no,*** *go* to "Tell us more information about this person".

If this person **is not** a U.S. citizen or U.S. national, but has eligible immigration status check here. ☐

and write the document type: _____ and ID number: _____

See Appendix C for more information about eligible immigration status.

If this person has lived in the U.S. since 1996, check here. ☐

If this person, his or her spouse, or a parent is a veteran or an active duty member in the U.S. military, check here. ☐

Tell us more information about this person

If this person lives with at least one child who is 18 years or younger, and is the main person taking care of this child, check here. ☐

If this person is 18 years or younger and has a parent living outside of the household, check here. ☐

If this person wants help paying for medical bills from the last three months, check here. ☐
Is this person pregnant? ☐ Yes ☐ No What is the expected due date? _____ How many babies are expected? _____

Tell us about ethnicity and race. *You may choose not to answer these questions.*

What is this person's ethnicity? Check all that apply:

☐ Mexican ☐ Mexican American
☐ Chicano/a ☐ Puerto Rican ☐ Cuban
☐ Hispanic ☐ Unknown

What is this person's race? Check all that apply:

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

6 Tell us about *other* health insurance

If anyone who is renewing or applying for Medical Assistance is enrolled in some other type of health insurance, list him or her below.

Name of insurance company:	**Policy number:**

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Marketplace ☐ Other insurance _____
☐ Premium Assistance (HIPP or FAMIS Select)

List everyone who is on this policy:

Name of insurance company:	**Policy number:**

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Marketplace ☐ Other insurance _____
☐ Premium Assistance (HIPP or FAMIS Select)

List everyone who is on this policy:

If anyone on this form is offered health insurance through a job, check here. ☐
If this is a state employee benefit plan, check here. ☐
Do you want to apply for health insurance? ☐

Managed Care Organization (MCO)

FAMIS Enrollees

For FAMIS enrollees renewing their FAMIS coverage: this is the time each year you are able to change Managed Care Organization (MCO) plans without a special reason. If you wish to change your child's FAMIS MCO now, please check which MCO for each child enrolled in FAMIS. If you do not request a change, your child will remain with the same FAMIS MCO until next year. If you need assistance with changing your child's FAMIS MCO or you need to change to your child's MCO after you complete your renewal, call Cover Virginia at 1-855-242-8282.

Each person with MCO listed below:

Person	**Current MCO**	**Change MCO here (Select from list below)**

To Change MCO in the table above, Enter an MCO from list below:
Valid MCOs for Locality: .

Please complete for any new person for whom you are requesting an MCO.

Person	**MCO (Select from list above)**

Medicaid Enrollees

Medicaid enrollees will receive a separate letter in the mail to notify you about open enrollment and your opportunity to change MCO plans. Different regions of the state have different open enrollment periods when you can change your Medicaid MCO.

7 Tell us more about the people listed on this form

If anyone who is renewing or applying for health insurance has a physical, mental, emotional, or developmental disability, write his or her name here.

Name *(first,middle,last & suffix):*

Name *(first,middle,last & suffix):*

If anyone who is renewing or applying for health insurance lives in a medical facility or nursing home, write his or her name here.

Name *(first,middle,last & suffix):*

Name *(first,middle,last & suffix):*

Name *(first,middle,last & suffix):*

If anyone who is renewing or applying for health insurance is between the ages of 18 and 26 and was on Medicaid and in foster care in Virginia at age 18, write his or her name here.

Name *(first,middle,last & suffix):*

Name *(first,middle,last & suffix):*

Name *(first,middle,last & suffix):*

If anyone listed on this form is pregnant (whether renewing or applying for health insurance or not), write her information below.

Name *(first,middle,last & suffix):*	How many babies are expected ?	What is the expected due date?
Name *(first,middle,last & suffix):*	How many babies are expected ?	What is the expected due date?

If anyone who is renewing or applying is an American Indian or Alaska Native, check here ☐ and fill out Appendix A.

8 Tell us about work

Provide the information below for anyone in your household who is working. If someone has more than one job, tell us about **all jobs.** Make a copy of this page if you need more space. **Cross out any information that is not correct** about members of your household. Write in the new information.

Person who has the job: Name *(first,middle,last & suffix)*

If you are unemployed, check here ☐ | Employer phone number:

Employer name and address: City: State: Zip code:

Is this person still employed at this job? ☐ Yes ☐ No If No, date when they left the job:

How often are wages or tips paid? ☐ Weekly ☐ Bi - Weekly ☐ Semi - monthly ☐ Monthly ☐ Irregular ☐ Annual

☐ Contractual/Single Payment Covering More than One Month

How much does this person get paid (before taxes)? **$** Average hours worked each week:

If anyone in your household has a **new job** or has **changed jobs**, list him or her below.

Name *(first,middle,last & suffix)* Date when job began:

Employer name and address: City: State: Zip code: Employer phone number:

How often are wages or tips paid? ☐ Weekly ☐ Bi - Weekly ☐ Semi - monthly ☐ Monthly ☐ Irregular ☐ Annual

☐ Contractual/Single Payment Covering More than One Month

How much does this person get paid (before taxes)? **$** Average hours worked each week:

If anyone in your household has a **new job** or has **changed jobs**, list him or her below.

Name *(first,middle,last & suffix)* Date when job began:

Employer name and address: City: State: Zip code: Employer phone number:

How often are wages or tips paid? ☐ Weekly ☐ Bi - Weekly ☐ Semi - monthly ☐ Monthly ☐ Irregular ☐ Annual

☐ Contractual/Single Payment Covering More than One Month

How much does this person get paid (before taxes)? **$** Average hours worked each week:

9 Tell us about work (continued)

If any household member's income changes from month to month, tell us this person's name and what you think he or she will be making this year.

Name *(first,middle,last & suffix):*

What do you expect his or her income to be **this** year? Amount: **$**

Name *(first,middle,last & suffix):*

What do you expect his or her income to be **this** year? Amount: **$**

If anyone in your household is **self-employed**, we need to know about their work. See Appendix C for more information about deductions.

Name *(first,middle,last & suffix):*

Type of work:

How much net income will this person get from self-employment this month? Amount: **$**
Net income means the profits left over after business expenses are paid. For more information about business expenses, see Appendix C.

Name *(first,middle,last & suffix):*

Type of work:

How much net income will this person get from self-employment this month? Amount: **$**
Net income means the profits left over after business expenses are paid. For more information about business expenses, see Appendix C.

Provide us with any other work details which may be helpful below.

Name *(first,middle,last & suffix):*

Work Details:

Name *(first,middle,last & suffix):*

Work Details:

10 Tell us about other income

Cross out any information that is not correct about members of your household. Write in the new information.

Income
Income Type:

Name (first,middle,last & suffix):

How much?
$

How often?

☐ Annual ☐ Bi - Weekly ☐ Monthly
☐ Weekly ☐ Semi- Monthly ☐ Irregular
☐ Contractual/Single Payment Covering More than One Month

Income Type:

Name (first,middle,last & suffix):

How much?
$

How often?

☐ Annual ☐ Bi - Weekly ☐ Monthly
☐ Weekly ☐ Semi- Monthly ☐ Irregular
☐ Contractual/Single Payment Covering More than One Month

If anyone in your household has **deductions**, tell us what kind.

Deductions
Deduction Type:

Name (first,middle,last & suffix):

How much monthly?
$

Deduction Type:

Name (first,middle,last & suffix):

How much monthly?
$

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11 Aged, Blind or Disabled General Questions – Answer if you are 65 or over, blind or disabled.

1. Does your spouse or your child(ren) under age 21 live with you? ☐ No ☐ Yes If yes, tell us their names and their relationship to you:

2. List all the money received by you or your spouse during the past month. List Social Security benefits, VA benefits, wages, retirement benefits, disability benefits, unemployment, etc. Attach proof of the amount received. Proof of SSA, SSI, or unemployment is not required.

Who received money?	Source	Amount
		$
		$
		$

3. If you or your spouse who lives with you are working, do either of you have expenses related to work? ☐ Yes ☐ No
   If yes, list what kind of expenses you have and attach proof.

4. List changes in your health insurance, including company name, policy number, coverage, what the change was and the date of change:

5. Do you or your spouse have any of the following resources (check all below that apply and attach proof):

☐ checking/savings accounts	☐ stocks, bonds	☐ vehicles (car, truck, RV, boat)
☐ certificate of deposit (CD)	☐ life insurance	☐ real estate, life rights/estate
☐ annuity or trust fund	☐ burial funds	☐ pension plan, 401K, IRA, other retirement fund

6. Have you or your spouse sold or given away any resources? ☐ Yes ☐ No If yes, attach a statement explaining what you sold/gave away, the date you did this, and what you received in return.

7. Have you or your spouse transferred any real or personal property within the last year? ☐ Yes ☐ No If yes:
   What? _____ Value _____ Date _____

Long Term Care (LTC) Questions – Answer these additional questions if you are receiving LTC services.

1. Name of nursing facility, state institution or community-based care provider: _____
2. If married or separated, spouse's name :Name (*first,middle,last & suffix)* _____
   Spouse's Social Security Number: ___ - ___ - ____
   Spouse's Address, if different: _____
   Spouse's Telephone Number: _____
   Spouse's Shelter Expenses: (Attach Current Verification)
   Rent/Mortgage: $_____ Utilities ☐ Yes ☐ No
   Homeowner's/Renter's Insurance: $_____ Real Estate Taxes: $_____
   Maintenance Charges for Condominium: $_____
3. Dependent's Income: (Attach Current Verification)
   Social Security: $_____ SSI: $_____

Civil Service: $_____ VA: $_____

Retirement/Pension: $_____ Disability: $_____

Wages: $_____ Other (Trusts, Stocks, Annuities, Dividends, Interest, etc.): $_____

4. Medical Expenses: (Attach Premium Notice or Statement)

Does the patient have:

Medicare? Part A: ☐ Yes ☐ No Part B: ☐ Yes ☐ No

Other health insurance? ☐ Yes ☐ No If yes:

Company: _____ Policy #: _____

Coverage Type: _____ Premium Amount: $_____

Company: _____ Policy #: _____

Coverage Type: _____ Premium Amount: $_____

Medical expenses other than insurance premiums? ☐ Yes ☐ No

What? _____ Amount: $_____

12 Read and sign this renewal application

Renewal of coverage in future years

Read the statement below and check **one** box.

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

Yes, 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 ☐ Do not use information from tax returns to renew my coverage

Your rights and responsibilities

Read the statements below.

- I am signing this renewal form under penalty of perjury. That means that I have provided true answers to all the questions on this form to the best of my knowledge, and I know that I may be subject to penalties under federal law if I provide false or untrue information.
- I know that I must tell my local department of social services if anything changes and is different from what I wrote on this form. I can call 1-855-242-8282 or visit coverva.org or CommonHelp at https://commonhelp.virginia.gov to report any changes. I understand that a change in my information might affect whether someone in my household qualifies for coverage.
- I know that under federal law, discrimination is not 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.
- If you think there was a mistake, you can appeal the decision. To appeal means to tell someone at the state that you think the action is wrong, and ask for a fair review of the action. You can find out how to appeal by calling the Department of Medical Assistance Services at 804-371-8488, or you can visit the website at www.dmas.virginia.gov and click on Client Services on the left, and then select Appeals Information or go to coverva.org.
- I understand that if I do not qualify for Medical Assistance my local department of social services will check to see if I qualify for other kinds of health coverage. My local department of social services may send my information to another program so they can see if I qualify.
- 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 Medicaid or FAMIS 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.

Other Request for Information:

1. All Medical Assistance applicants 19-64 years old will be evaluated for Plan First (family planning services only) if they do not qualify for full Medical Assistance benefits unless they tell us not to below. Applicants under 19 years and 65 years or older will be evaluated for Plan First by request below.

   List the names in the space provided.
   DO NOT evaluate these applicants for Plan First coverage: _____
   Evaluate these applicants for Plan First coverage: _____

2. Please answer the following questions IF PERSON(S) is 18 or younger:
   Did person(s) have health insurance that ended in the last 4 months? Yes ☐ No ☐
   If yes,

   Name: _____ End date: _____ Reason the insurance ended :_____(for list of reasons, please see below)

   Name: _____ End date: _____ Reason the insurance ended :_____(for list of reasons, please see below)

   Reasons Child's Health Insurance Ended: **1**.Parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage. **2**. Parent or stepparent's employers stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage. **3**. Insurance companies discontinued coverage because child is uninsurable. **4**. Cost of insurance exceeded 10% of monthly income (before taxes). **5**. Insurance stopped/dropped by someone other than parent or stepparent living with child. **6**. Stopped/dropped a COBRA policy. **7**. Other.

3. I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, (name of person) is incarcerated: _____

Consent to Exchange Information

The Virginia Department of Social Services (VDSS) would like to use some of the personal information that you have provided on your application about you and your dependents to create your User Profile. VDSS is asking for permission to share your User Profile

electronically with the state agencies listed below. Each agency will be told when you make a change to the information in your User Profile. This will allow you to save time by only providing User Profile information once when visiting these agencies.

Legal Notice

The data being shared

Your User Profile will only be created if you agree to share it and you are eligible for assistance. Your User Profile will contain first name, last name, middle initial, suffix (Jr., Sr., etc.), current home address, date of birth, Social Security Number and Medicaid identification number (if applicable), email address, home phone, driver's license ID and cell phone number. However, you can share your User Profile without sharing your Social Security number; this will not affect your eligibility. Your Medicaid identification number will only be shared with VDSS and your local department of social services. Because the User Profile is based on your application for assistance, the agencies named below also will know that you are receiving assistance.

Agencies Included and Allowed Use

Below are the agencies that will get your information. The reasons they have requested your User Profile and what they will be allowed to do with your User Profile are listed.

Sharing your User Profile will allow them to update the information in their computers, saving taxpayer dollars. It may save you a visit to one of these agencies because your information has been changed electronically.

The Department of Motor Vehicles (DMV) would like a copy of your User Profile when it changes. DMV can change your address for cars you own or driver's license/identification card information they have for you. They will send you a card automatically through the mail to complete this update.

The Virginia Information Technologies Agency (VITA) operates an electronic system known as Enterprise Data Management (EDM). EDM contains data that you have already provided to DMV for your driver's license or identification card. If you give permission to share your User Profile, EDM will match the DMV data and your User Profile, and share this information with your local department of social services and DMV. If the data does not match, DMV or your local department of social services may contact you to confirm the information. Email address, home phone number, cell phone number and Medicaid identification number may be reviewed by a local department of social services worker inside EDM to identify possible duplicate User Profiles.

If you choose not to share your User Profile

Your information will remain only with the Department of Social Services. Choosing not to share your User Profile will not affect your eligibility for assistance.

Social Security Number

Including your Social Security Number (SSN) in your User Profile is your choice. The SSN is used to match your User Profile with DMV data in EDM easily. Your SSN is kept confidential.

Dependents

This request is for your own User Profile and for the User Profile of any person who is your legal dependent, including your children under age 18, any person for whom you serve as legal guardian, or any other person for whom you have the authority to agree to share.

To stop sharing of your User Profile

You can stop sharing your User Profile at any time by going to www.commonhelp.virginia.gov and changing your decision to share. You can also change your decision to share your User Profile by visiting your local department of social services.

How long consent to share lasts

Your permission to share your User Profile will remain active for one (1) year from the date you approve, unless you change your decision to share sooner. Your agreement for any minor child who turns 18 will be stopped on the date of the child's 18th birthday. That individual then will be asked to agree to share his information.

You will be asked to share your information every time you make a change to the information that is used in your User Profile.

Giving Consent

☐ My User Profile can be shared with the specified agencies, but do not include Social Security Number when creating my User Profile.
☐ Share my User Profile with the specified agencies. Include Social Security Number when creating my User Profile.
☐ Do not allow my User Profile to be shared.

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?

☐ 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
804-864-8901

Sign and date below. If you want an authorized representative or Certified Application Counselor/ Navigator/Broker or want to change the authorized representative or Certified Application Counselor/ Navigator/Broker you have now, fill out Appendix B.

If you are an authorized representative, check here ☐ , sign below, and fill out Appendix B

Signature of household contact or authorized representative that the Department of Social Services may send you information to:	Date:

Signature of any new individuals applying, that are 18 years old and over

Name	Signature	Date

Appendix A

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 may not have to pay co-pays and may get special monthly enrollment periods.

If more than two people are American Indian or Alaska Native, make a copy of this page.

1. Name (*first, middle, last & suffix):*

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program?

☐ Yes ☐ No

If no, does this person qualify to get these services?

☐ Yes ☐ No

List any income that includes money from these sources:

- Payments from a tribe for 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 much income? **$**

How often?

☐ Weekly ☐ Semi- Monthly ☐ Irregular
☐ Annual ☐ Monthly ☐ Bi- Weekly
☐ Contractual/Single Payment Covering More than One Month

2. Name (*first, middle, last & suffix):*

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program?

☐ Yes ☐ No

If no, does this person qualify to get these services?

☐ Yes ☐ No

List any income that includes money from these sources:

- Payments from a tribe for 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 much income? **$**

How often?

☐ Weekly ☐ Semi- Monthly ☐ Irregular
☐ Annual ☐ Monthly ☐ Bi- Weekly
☐ Contractual/Single Payment Covering More than One Month

Appendix B

You can choose an authorized representative

An authorized representative is a trusted friend, partner, or lawyer you choose to sign your renewal form, get information about this renewal form, and act for you with this agency.

Do you want an authorizedrepresentative? ☐ Yes ☐ No

If yes, you want an authorized representative, answer the questions below.

We show that you chose this person as your authorized representative:	Do you still want this person to be your representative? ☐ Yes ☐ No ***If yes,*** has any of his or her information changed? ☐ Yes ☐ No

If your authorized representative's information has changed, or if you would like a different authorized representative, please write the new information here.:

Name of authorized representative and/or Organization:

Address: Apartment # City State Zip code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other
Number:

Relationship to Applicant:

Please indicate the duties that you would like to authorize for this person.

- ☐ Apply for benefits
- ☐ Receive benefits
- ☐ Receive requests for information needed to determine eligibility
- ☐ Receive letters regarding actions taken on your case
- ☐ Other

I Allow the Authorized Representative above to view my data. ☐ Yes ☐ No

Do you want to add another authorized representative? ☐ Yes ☐ No

If yes, make a copy of this page and complete the information.

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your Signature:	Date:

You can choose one certified application counselor/ navigator/ broker

Complete this section if you would like to authorize a Certified Application Counselor or Navigator or Broker to be able to access confidential information related to your medical assistance case.

Do you want a certified application counselor/navigator/broker? ☐Yes ☐No

If yes, youwant a certified application counselor/ navigator/ broker, answer the questions below.

We show that you chose this person as your certified application counselor/navigator/broker: Name of Organization: ID Number (if applicable):	Do you still want this person to be your certified application counselor/navigator/broker? ☐ Yes ☐ No ***If yes,*** has any of his or her information changed? ☐Yes ☐ No

If your certified application counselor/ navigator/ broker's information has changed, or if you would like a different certified application counselor/Navigator/broker, please write the new information here:

Name:

Name of Organization: ID Number (if applicable):

Appendix C

Eligible immigration status list

If you see the person's status below, go back to the question and check the Yes box.

- Lawful Permanent Resident (LPR or Green Card holder)
- Asylee
- Refugee
- Cuban or Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child and parent
- Victim of Trafficking and his/her spouse, child, sibling or parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws and under the Convention against Torture (CAT)
- Individual with Non-immigrant Status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS) and Applicant for Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Family Unity beneficiary
- Deferred Action Status (Deferred Action for Childhood Arrivals (DACA) is not an eligible immigration status for applying for health insurance
- Lawfully Residing Non-Citizen
- Applicant for Special Immigrant Juvenile Status
- Applicant for Adjustment to LPR Status
- Applicant for Asylum
- Applicant for Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Registry Applicants (with Employment Authorization)
- Order of Supervision (with Employment Authorization)
- Applicant for Cancellation of Removal or Suspension of Deportation (with EAD Employment Authorization)
- Applicant for Legalization under IRCA (with Employment Authorization)
- Legalization under the LIFE Act (with Employment Authorization)
- Lawful Temporary Resident
- Member of a federally-recognized Indian tribe or American Indian
- Born in Canada
- Resident of American Samoa
- Administrative order staying removal issued by the Department of Homeland Security (DHS)

Immigration document types

Eligible non-citizens applying for health coverage also need to list their immigration document.
Below are some common types. If the document you have is not listed, you can still write its name. If you are not sure, or you have an eligible status but no document, call Cover Virginia at 1-855-242-8282 (TTY 1-888-221-1590) or your local department of social services so we can help.

- Permanent Resident Card (I-551, also known as Green Card)
- Temporary I-551 Stamp (on passport or I-94, I-94A)
- Immigrant Visa (with temporary I-551 language)
- Employment Authorization Card (EAD or I-766)
- Arrival/Departure Record (I-94 or I-94A)
- Arrival/Departure Record in foreign passport (I-94)
- Foreign passport
- Reentry Permit (I-327)
- Refugee travel document (I-571)
- Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- Notice of Action (I-797)
- Other document with an Alien Number or I-94 number, or other document showing you have an eligible immigration status listed above

Self-employment expenses

You can subtract the business expenses listed below from your gross income to get an amount for your net self- employment income.

- Car and truck expenses (for travel during the workday, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan