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 that application.

STEP 2: ADDITIONAL PERSON

Name from STEP 1

Complete Step 2 for yourself, your spouse and children (including step-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 ı	name	Suffix
1a. Is this PERSON? Single	e Married			
2. Date of birth (mm/dd/yyyy)	3. Sex		4. Relationship to you?
		Male	Female	
5. Social Security number (SS	N) We need	this if you want h	ealth coverage for this PER	SON and they have a SSN.
6. Does this PERSON live at the lift no, list address:	he same address as you? Yes	No		
	o file a federal income tax retur Ith insurance even if this PERSON		l income tax return.)	
YES. If yes, please ans	wer questions a-c.	D. If no, skip to que	stion c.	
a. Will this PERSON file joi	ntly with a spouse? Yes 1	No If yes, name o	of spouse:	
If yes, list name(s) of o	any dependents on your tax return dependents: imed as a dependent on someone			
If yes, please list the na	ame of the tax filer:	How	is this PERSON related to the	e tax filer?
8. Is this PERSON pregnant o	r were they pregnant in the last 12	2 months? Yes	No	
a. If yes, how many babies	are/were expected during pregna	ncy? Expecte	ed/actual due date :	
	realth coverage? (Even if PERSON IO, skip to the income questions			· · · · · · · · · · · · · · · · · · ·
YES. If yes, answer all	the questions below.			
9a. If aged 19 to 64 and not 6	eligible for full coverage, does this	PERSON wish to be	evaluated for Plan First (fam	nily planning coverage only)?
=	ON will NOT be evaluated for Plar			
Has a doctor or nurse tole problem? Yes No 10a. If this PERSON answered supports, please complete 11. Is this PERSON a U.S. citiz 12. Is this PERSON a naturaliz	d yes to question 9 and is betweer e Appendix F. en or U.S. national? Yes N red or derived citizen? (This usually	or has Medicare, pointhe ages of 19-64, who were bounded to the ages of 19-64, which were bounded to the ages of 19-64, which were bounded to the ages of 19-64, and the ages of 19-64,	m disease, mental or emotion blease complete Appendix D. and does not have Medicare orn outside the U.S.)	nal illness, or addiction
Yes. If yes, complete a a. Alien number:	and b below. Then SKIP to questic	on 14. No. lf r b. Certificate numbe	no, continue to question 13.	
a. Immigration document c. Has this PERSON lived in		b. Document	: ID number	II in document type and ID below
14. Is this PERSON living with	at least one child under the age o	of 19 and the main p	person taking care of this chil	d? Yes No
15. Is this PERSON incarcerated	d (detained or jailed)? (Response option	nal) Yes No	If Yes Federal Sta	ate (DOC / DJJ) Local/Regional
Check here if pending of	disposition of charges Incarcera	tion date	Expected rele	ease date
16. Is this PERSON a full-time	student? Yes No			 -
17. Was this PERSON in foster	r care at age 18 or older? Yes	No If yes , in wl	nich state	
18. If Hispanic/Latino, ethn	icity (OPTIONAL—check all that	apply.)		
Mexican Mexican Am		Rican Cuban	Other	
19. Race (OPTIONAL—check			Oth an Asian	Camaran
White Black or African America		Japanese Koroan	Other Asian	Samoan Other Pacific Islander
American Indian or Alask		Korean	Native Hawaiian Guamanian or Chamorro	Other Pacific Islander
American mulan of Alask	a Native Filipino	Vietnamese	Guainanian of Chamorfo	Other:

NEED HELP WITH YOUR APPLICATION? Visit <u>coverva.dmas.virginia.gov</u> 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**.

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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 20.

Not employed Skip to question 30.

Self-employed Skip to question 29.

CURRENT JOB 1:					
20. Employer name	a. Employer address	a. Employer address			
b. City c. State	d. Zip code	21. Employer phone number			
22. Wages/tips (before taxes) Hourly Weekly \$ Twice a month Monthly	Every 2 weeks Yearly	23. Average hours worked each WEEK			
CURRENT JOB 2: (If this person has more jobs and need more space, attach another sheet of paper.)					
24. Employer name	a. Employer Address				
b. City c. State	d. Zip code	25. Employer phone number			
26. Wages/tips (before taxes) Hourly Weekly \$	Every 2 weeks Yearly	27. Average hours worked each WEEK			
28. In the past year, did this PERSON: Change jobs Stop working Start working fewer hours None of these					
27. 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? \$					
30. OTHER INCOME THIS MONTH: Check all that apply, a NOTE: You don't need to tell us about this child support, veteran' Unemployment	s payment, or Supplemental Alimony receive Net farming/fis Net rental/roya	Security Income (SSI). ed \$			
31. 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: \$					
32. 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 29b). Alimony paid Student loan interest How often? Type: Type:					
33. 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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