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 _____

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

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

1a. Is this PERSON? ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

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? Or were they pregnant in the last 60 days? ☐ 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. If aged 19 to 64 and not eligible for full coverage, does this PERSON wish to be evaluated for Plan First (family planning coverage only)? Yes ☐ No ☐ This PERSON will be evaluated for Plan First unless you check NO

10. Does this PERSON need help with everyday things like bathing, dressing, walking or using the bathroom to live safely in their home? **or** Has a doctor or nurse told them that they have a physical disability or long term disease, mental or emotional illness, or addiction problem? ☐ Yes ☐ No If this PERSON is 65 or older **or** has Medicare, please complete Appendix D

10a. If this PERSON answered yes to question 9 and is between the ages of 19-64, and does not have Medicare, but needs long term services and supports, please complete Appendix F.

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. Immigration 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 of the U.S. military? ☐ Yes ☐ No

e. Has this PERSON, their spouse or a parent ever served 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? ☐ Yes ☐ No

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 **If Yes** ☐ Federal ☐ State (DOC or DJJ) ☐ Local/Regional
☐ Check here if pending disposition of charges Incarceration date ☐☐ / ☐☐ / ☐☐☐☐ 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 _____

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

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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