

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 occurred, 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | Is this property currently for sale? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Is this property rented? <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you received money from this property <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is this a loan? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is repayment expected? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | |
|--------------------------------------|--|
| Person Receiving Money | Person Providing Help |
| Type of Help Received | Amount \$ |
| Does the money come directly to you? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is this a loan? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is repayment expected? | <input type="checkbox"/> Yes <input type="checkbox"/> 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