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 name | Suffix

1a. Is this PERSON? ☐ Single ☐ Married

2. Date of birth (mm/dd/yyyy)

3. Sex ☐ Male ☐ Female

4. Relationship to you?

5. Social Security number (SSN) **We need this if you want health coverage for this PERSON and they have a 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 your 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 12 months? ☐ Yes ☐ No

a. **If yes,** how many babies are/were expected during pregnancy? ____ Expected/actual due date : _____

9. **Does this PERSON 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. 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 **NOT** be evaluated for Plan First unless you check YES.

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 10 and is between the ages of 19-64, and does not have Medicare, but need long term services and supports, please complete Appendix F.

11. Is this PERSON a **U.S. citizen** or **U.S. national?** ☐ Yes ☐ No

12. Is this PERSON a naturalized or derived citizen? *(This usually means they were born outside the U.S.)*
☐ **Yes. If yes,** complete a and b below. Then SKIP to question 14. ☐ **No. If no,** continue to question 13.
a. Alien number: b. Certificate number:

13. **If this PERSON is not a U.S. citizen or U.S. national,** do they have eligible immigration status? ☐ **Yes.** Fill in document type and ID 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, their spouse or their parent(s) serving in the U.S. military currently or in the past? ☐ Yes ☐ No

14. Is this PERSON living with at least one child under the age of 19 and the main person taking care of this child? ☐ Yes ☐ No

15. Is this PERSON incarcerated (detained or jailed)? *(Response optional)* ☐ Yes ☐ No **If Yes** ☐ Federal ☐ State (DOC / 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. Was this PERSON in foster care at age 18 or older? ☐ Yes ☐ No **If yes**, in which state _____

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

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

NEED HELP WITH YOUR APPLICATION? Visit coverva.dmas.virginia.gov 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 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name		a. Employer address	
b. City	c. State	d. Zip code	21. Employer phone number

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ 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 ☐ Twice a month ☐ Monthly ☐ 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

29. **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, 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 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 _____

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: $ ☐☐☐☐☐ Month 2: $ ☐☐☐☐☐ Month 3: $ ☐☐☐☐☐

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