CardinalCare
Virginia's Medicaid Program

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Application for Health Coverage & Help Paying Costs

Use this application to see what coverage choices you qualify for

- Free or low-cost insurance from Medicaid, FAMIS or Plan First
- If you are not eligible for Medicaid or FAMIS you will be referred to Virginia's Insurance Marketplace for affordable private health insurance plans that offer comprehensive coverage to help you stay well and may include a new tax credit that can immediately help pay your premiums for health coverage.

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, or you are applying for someone other than a spouse or family member under age 21, an authorized representative form (Appendix C) must be completed
- Complete Appendix F if you are applying for health coverage for someone in need of nursing facility or community-based care, who is between the ages of 19 and 64 and who is not eligible for or enrolled in Medicaid.
- If you are age 65 or older or disabled or any age and need assistance with nursing facility or community based care, you need to complete Appendix D.

Apply faster online

Apply faster online at **commonhelp.virginia.gov.** For more information about Medicaid, FAMIS and Plan First visit **coverva.dmas.virginia.gov.**

What you may need to apply

- Social Security numbers (or document numbers for any eligible immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

If you use this paper application, send your complete, signed application to the local Department of Social Services in the city or county where you live. They will follow up with you to obtain additional information. Your application should be processed within 45 days from the date it was received.

Get help with this application

- **Phone:** Call Cover Virginia at **1-855-242-8282**
- **In person:** There will be application assisters in your area who can help. Visit our website at **coverva.dmas.virginia.gov** or call **1-855-242-8282** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-855-242-8282**

If you are visually impaired and need large print or other assistance to access this document, please contact us at 1-855-242-8282 (TTY: 1-888-221-1590).

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**.

It is important we treat you fairly.

We will keep your information secure and private.

This agency complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This agency does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

This agency provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). This agency also provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call us at 1-855-242-8282 (TTY: 1-888-221-1590).

If you believe that this agency has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, or by phone at Civil Rights Coordinator, DMAS, 600 E. Broad Street, Richmond, VA 23219, Telephone: (804)-786-7933 (TTY: 1-800-343-0634). If you need help filing a grievance, the DMAS Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019 (TTY 800-537-7697). Complaint forms are available at **https://hhs.gov/ocr/office/file/index.html.**

This notice is available at **https://coverva.dmas.virginia.gov/non-discrimination/**

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STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name	Middle name	Last name	Suffix

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number

4. City	5. State	6. ZIP code	7. County

8. Mailing address (if different from home address)	9. Apartment or suite number

10. City	11. State	12. ZIP code	13. County

14. Phone number	15. Other phone number

16a. We need to know the best way to contact you about this application and your health coverage if you're eligible. Do you want to read your notices about your application electronically?

☐ Yes. I want to read the notices online. (If selected, continue to question 16b)

☐ No. I want to get paper notices sent to me in the mail. (If selected, skip to question 17)

b. You'll be contacted when a notice is ready for you. How can we contact you?

(Choose one)

☐ Cell phone number: _____

☐ Email address: _____

You can change your notices and communication preferences at any time.

17. What is your preferred spoken or written language (if not English)? _____

STEP 2 Tell us about your family.

Who do you need to include on this application?

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 don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children (including stepchildren) under 21 who live with you
- Married or unmarried parents (of an applicant under 21) living in the home
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner if you don't have children together in the home
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

For children under age 21 who need coverage:

- Include these people even if they aren't applying for health coverage themselves: Any parent (or stepparent), sibling, son or daughter (including stepchildren) they live with, and any other person on the same federal income 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. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to include copies of the Additional Person single page supplement form and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself)

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. Are you?	2. Date of birth (mm/dd/yyyy)	3. Sex	4. Relationship to you?
☐ Single ☐ Married		☐ Male ☐ Female	**SELF**

5. Social Security number (SSN) _____

We need this if you want health coverage and have an SSN. Even if you don't want health coverage for yourself, providing your SSN can be helpful since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. For help getting an SSN, call 1-800-772-1213 or visit **socialsecurity.gov.** TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No **If yes,** name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____ How are you related to the tax filer? _____

7. Are you pregnant or were you pregnant in the last 12 months? ☐ Yes ☐ No

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

8. **Do you need health coverage?** *(Even if you have Medicare or other insurance, there might be a program with better coverage or lower costs.)* **If NO, skip to the income questions on page 3 and leave the rest of this page blank.**

☐ **YES. If yes**, answer all the questions below.

8a. If aged 19 to 64 and not eligible for full coverage, do you wish to be evaluated for Plan First (family planning coverage only)?

☐ Yes ☐ No You will **NOT** be evaluated for Plan First unless you check YES.

9. Do you need help with everyday things like bathing, dressing, walking or using the bathroom to live safely in your home? **or**
Has a doctor or nurse told you that you have a physical disability or long term disease, mental or emotional illness, or addiction problem?
☐ Yes ☐ No If you are 65 or older **or** have Medicare, please complete Appendix D.

9a. If you answered yes to question 9 and are between the ages of 19-64, and do not have Medicare, but need long term services and supports, please complete Appendix F.

10. Are you a **U.S. citizen** or **U.S. national** ☐ Yes ☐ No

11. Are you a naturalized or derived citizen? *(This usually means you were born outside the U.S.)*

Yes. If yes, complete a and b below. Then SKIP to question 13. ☐ **No. If no,** continue to question 12.

a. Alien number: ☐☐☐☐☐☐☐☐☐☐☐ b. Certificate number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

12. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ☐ **Yes.** Fill in your document type and ID below

a. Immigration document type: _____ b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you, your spouse or parent(s) serving in the U.S. military currently or in the past? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

14. Are you incarcerated (detained or jailed)? *(Response optional)* ☐ Yes ☐ No **If Yes** ☐ Federal ☐ State (DOC or DJJ) ☐ Local/Regional

☐ Check here if pending disposition of charges Incarceration date _____ Expected release date _____

15. Are you a full-time student? ☐ Yes ☐ No

16. Were you in foster care at age 18 or older? ☐ Yes ☐ No **If yes**, in which state _____

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	☐ 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: _____

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STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

CURRENT JOB 1:

18. Employer name	a. Employer address		
b. City	c. State	d. Zip code	19. Employer phone number
20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly $			21. Average hours worked each WEEK

CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name	a. Employer Address		
b. City	c. State	d. Zip code	23. Employer phone number
24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly $			25. Average hours worked each WEEK

26. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. **If self-employed, answer the following questions:**

a. Type of work _____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?
$

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it. Check here if none ☐
NOTE: You don't need to tell us about 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 _____

29. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No If yes, provide monthly income for previous 3 months.
Month 1: $ Month 2: $ Month 3: $

30. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay 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 27b).

☐ Alimony paid $ How often? _____
☐ Student loan interest $ How often? _____
☐ Other deductions $ How often? _____
Type: _____

31. **YEARLY INCOME: Complete only if your income changes from month to month.**
If you don't expect changes to your monthly income, skip to the next person.

Your total income **this year**	Your total income **next** year (if you think it will be different)
$	$

THANKS! This is all we need to know about you.

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STEP 2: PERSON 2

If you have more than two people to include, complete as many Additional Person single page supplement forms as you need.

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 PERSON 2? ☐ 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 PERSON 2 and PERSON 2 has an SSN.**

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address:

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if PERSON 2 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 PERSON 2 file jointly with a spouse? ☐ Yes ☐ No **If yes,** name of spouse: _____

b. Will PERSON 2 claim any dependents on your tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____ How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 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 PERSON 2 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 PERSON 2 wish to be evaluated for Plan First (family planning coverage only)?
☐ Yes ☐ No PERSON 2 will **NOT** be evaluated for Plan First unless you check YES.

10. Does PERSON 2 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 PERSON 2 is 65 or older **or** has Medicare, please complete Appendix D.

10a. If PERSON 2 answered yes to question 9 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 PERSON 2 a **U.S. citizen** or **U.S. national?** ☐ Yes ☐ No

12. Is PERSON 2 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: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

12. **If PERSON 2 is not a U.S. citizen or U.S. national,** do they have eligible immigration status? ☐ **Yes.** Fill in the document type and ID below
a. Immigration document type: _____ b. Document ID number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐
c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No
d. Is PERSON 2, their spouse or their parent(s) serving in the U.S. military currently or in the past? ☐ Yes ☐ No

14. Is PERSON 2 living with at least one child under the age of 19 and the main person taking care of this child? ☐ Yes ☐ No

15. Is PERSON 2 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 PERSON 2 a full-time student? ☐ Yes ☐ No

17. Was PERSON 2 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: _____

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STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If PERSON 2 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 you have 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 PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. **If PERSON 2 is self-employed, answer the following questions:**

a. Type of work _____

b. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month?
$

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it. ☐ Check here if none

NOTE: You don't need to tell us about 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 PERSON 2 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 PERSON 2 gets it.

If PERSON 2 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 PERSON 2's income changes from month to month.**

If you don't expect changes to PERSON 2's monthly income, skip to the next person.

PERSON 2's total income **this year**	PERSON 2's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

If you have more than two people to include, complete the Additional Person single page supplement form.

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STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

☐ **No.** If **no,** skip to Step 4.

☐ **Yes.** If **yes,** go to Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **YES. If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.** If **no,** skip to Question 2.

☐ Medicaid _____

☐ FAMIS _____

☐ Plan First _____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ Veterans Administration health care programs

_____

☐ Peace Corps _____

☐ Virginia's Insurance Marketplace

_____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?**

Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ **NO. If no, continue to Step 5.**

Health (Managed Care) Plan Selection (FAMIS only)

The section will not be used if the applicant is determined eligible for Medicaid or for coverage through Virginia's Insurance Marketplace. If that occurs you will need to enter a new plan selection process.

Most Medicaid and FAMIS members get care through a health plan, also known as Managed Care. Each health plan has a network (group) of primary care providers (PCPs), specialists, hospitals, and other health care providers. If you are approved you will be "pre-assigned" to a health plan and will receive a letter explaining assignment.

Members have 90 days from the date on the letter to change the health plan. All family members do not need to have the same health plan. To research or change your health plan, search for doctors, check your enrollment and more, go to the Medicaid Managed Care website **www.virginiamanagedcare.com.**

If anyone is determined eligible for FAMIS and you want to select your health plan in advance, please check one of the following and list their name(s) below:

☐ Aetna Better Health of Virginia: _____

☐ Anthem HealthKeepers Plus: _____

☐ Molina Healthcare: _____

☐ Sentara Healthplans: _____

☐ United Healthcare Community Plan: _____

STEP 5 Read & sign this application.

Your rights and responsibilities: Review the information below and sign the application.

- I understand that I am authorizing the local Department of Social Service (LDSS) and the Department of Medical Assistance Services (DMAS) to obtain verification/information necessary to determine my eligibility for Medicaid or FAMIS. [We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.]

- I understand that Medicaid and DMAS contractors may exchange information relating to my coverage with LDSS to assist with application, enrollment, administration, and billing services.

- I have permission from everyone whose information is on this form to submit their information to Virginia Medicaid and to receive any communications about their eligibility and enrollment.

- I understand that guidance and procedures used to determine eligibility can be found within the Medical Assistance Eligibility Manual, which can be located at **https://www.dmas.virginia.gov/for-applicants/eligibility-guidance/eligibility-manual/.**

- I understand that if I do not qualify for health coverage, my local Department of Social Services may send my information to Virginia's Insurance Marketplace at **www.marketplace.virginia.gov** to see if I qualify.

If anyone on this application is eligible for Medicaid

- I know that I must tell my local Department of Social Services if anything changes and is different from whatI wrote on this form within 10 days. I can call 1-855-242-8282 (TTY: 1-888-221-1590), contact or visit my local agency, or visit CommonHelp.Virginia.gov to report any changes. A change in my information might affect whether someone in my household qualifies for coverage.

- I understand that for individuals enrolled in managed care, a premium is paid each month to the MCO forthe person's coverage. If the child or pregnant woman is not eligible for FAMIS, FAMIS Plus, FAMIS MOMS,or Medicaid because I did not report truthful information or failed to report required changes in my familysize 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.

- The information provided on this application, including your phone number(s), will be shared with Local Departments of Social Services (LDSS) and the Managed Care Organization (MCO), otherwise known as health plan, to which you are assigned. You consent to being called or texted by the MCO at any phone number(s) you provide in relation to your application, now or in the future, including in regard to your health care needs and treatment, wellness services, plan benefits, eligibility, renewal and/or redetermination, and for any other communications relating to your relationship with the MCO or concerning your health care coverage. These calls/texts may be made using automated technology, such as with an automatic telephone dialing system or artificial or prerecorded voice message. You acknowledge that text messages are not encrypted and can be read by unauthorized persons. Standard message and data rates may apply.

- I understand that DMAS has the responsibility to recover money from the estate of a Medicaid member age 55 and over. Recovery may take place only after the death of the surviving spouse and only if there are no children who are blind, disabled, or under the age of 21. The dependents or heirs of an estate can also claim an undue hardship (an action requiring significant difficulty or expense) during the recovery process. If a hardship is granted, DMAS may waive part of all of the recovery, and if denied, the individual is granted an opportunity to appeal the decision.

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.

- **Does any child on this application have a parent living outside of the home? ☐Yes ☐No**

  If any child on this application has a parent living outside of the home, I know I may be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal:

If I think Medicaid, FAMIS or Plan First has made a mistake I can contact them at coverva.dmas.virginia.gov or call **1-855-242-8282**. Instructions for filing an appeal will be included on my notice and are also available on the coverva.org website.

If I think Virginia's Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at Virginia's Insurance Marketplace that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at **1-888-687-1501**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Renewal of Coverage in Future Years:

Your benefits may be automatically renewed depending on your circumstances using electronic sources. If your benefits cannot be automatically renewed, we will send you a renewal form to complete. While your signature on this application is an agreement to the rights and responsibilities listed above, we need special permission to use your tax return information to automatically renew your coverage. You may change your mind at any time about using tax return information by contacting your local Department of Social Services.

I understand that my benefits may be renewed automatically using other data sources. I give Virginia Medicaid permission to use updated income information from my tax returns for the next (check one):

☐5 years ☐4 years ☐3 years ☐2 years ☐1 year ☐Do not use my tax information to renew coverage.

I am signing this application form under penalty of perjury. I have provided true answers to all questions on this form and I know that I may be subject to penalties under federal law if I provide false or untrue information.

Signature of Applicant or Authorized Representative	Date (mm/dd/yyyy)

ALL individuals in the home 21 or older (or 18 or older in a home without a parent) who are renewing or applying for health coverage MUST sign below. A spouse can sign for their spouse.

Print Name	Signature	Date (mm/dd/yyyy)
Print Name	Signature	Date (mm/dd/yyyy)

STEP 6 Submit your completed application.

Mail, fax or drop off your signed application to:

To the local Department of Social Services in the city or county in which you live. For the names, addresses and fax numbers of all Virginia local Departments of Social Services, visit www.dss.virginia.gov/localagency/index.cgi.

Help in Any Language

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-855-242-8282 (TTY:1-888-221-1590).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-242-8282 (TTY: 1-888-221-1590).

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-242-8282 (TTY:1-888-221-1590) 번으로 전화해 주십시오.

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-242-8282 (TTY:1-888-221-1590).

繁體中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-242-8282（TTY:1-888-221-1590）

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-242-8282 (رقم هاتف الصم والبكم: 1-888-221-1590-).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-242-8282 (መስማት ለተሳናቸው: 1-888-221-1590).

Urdu اردو

توجہ: اگر آپ اردو نہیں بولتے ہیں، تو آپ کے لیے لینگویج اسسٹنس سروسز مفت میں دستیاب ہیں۔ کال کریں 1-855-242-8282 (TTY:1-888-221-1590)۔

Tagalog (Tagalog – Filipino) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-242-8282 (TTY:1-888-221-1590)

فارسی (Farsi).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-242-8282 (TTY:1-888-221-1590) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-242-8282 (TTY:1-888-221-1590).

বাংলা (Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-855-242-8282 (TTY:1-888-221-1590)।

తెలుగు (Telugu) గమనించండి: మీకు ఇంగ్లీషు రాకపోతే, భాషా సహాయ సేవలు మీకు ఉచితంగా అందుబాటులో ఉంటాయి. 1-855-242-8282 (TTY:1-888-221-1590)కి కాల్ చేయండి.

हिंदी (Hindi) नोट: यदि आप हिंदी बोलते हैं, तो भाषा समर्थन सेवाएं आपको मुफ्त में उपलब्ध हैं। कॉल 1-855-242-8282 (TTY:1-888-221-1590)।

नेपाली (Nepali) ध्यान दिनहोस्: तपाईंले नेपाली बोल्नुहुन्न भने, तपाईंलाई निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। 1-855-242-8282 (TTY:1-888-221-1590) मा कल गर्नुहोस्।

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-242-8282 (телетайп:1-888-221-1590).

APPENDIX A

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)	12. Email address

13. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?**

☐ **Yes** (Continue to 13a)

☐ **No** (Stop here and and go to Step 4 in the application)

13a. Does your employer offer a health plan that will cover your spouse and dependents? ☐ Yes ☐ No (if yes, complete 13b; if no go to #14)

13b. If you're in a waiting or probationary period, when can you enroll in coverage? (mm/dd/yyyy) _____

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage as of (mm/dd/yyyy): _____

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. * (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change (mm/dd/yyyy): _____

☐ I don't know if the employer will make changes

☐ Employer won't make any of these changes

*An employer-sponsored health plan meets the "minimum value standard" if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the value standard.

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EMPLOYER COVERAGE TOOL

CardinalCare Virginia's Medicaid Program

COVER VIRGINIA Connecting Virginians to Affordable Health Insurance

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage that you're eligible for.

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number

EMPLOYER Information

Ask the employer for this information.

3. Employer name	4. Employer Identification Number (EIN)
5. Employer address	**6. Employer phone number**

7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)	12. Email address

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) _____

☐ **No** (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No (Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly (Go to next question)

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.

* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ ☐☐☐☐☐☐

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

c. Date of change (mm/dd/yyyy): _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

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 also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

AI/AN PERSON 1

1. Name (First name, Middle name, Last name)

2. Member of a federally recognized tribe? ☐ Yes ☐ No **If yes**, tribe name _____

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No

If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No

4. Certain money received may not be counted for Medicaid, FAMIS or Plan First. List any income (amount and how often) reported on your application that includes money from these sources:
   - Per capita payments from a tribe that come from 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 often? _____

AI/AN PERSON 2

1. Name (First name, Middle name, Last name)

2. Member of a federally recognized tribe? ☐ Yes ☐ No **If yes**, tribe name _____

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No

If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No

4. Certain money received may not be counted for Medicaid, FAMIS or Plan First. List any income (amount and how often) reported on your application that includes money from these sources:
   - Per capita payments from a tribe that come from 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 often? _____

APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the local Department of Social Services. If you are applying for someone other than a spouse or family member, an authorized representative form (Appendix C) must be completed. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number		
8. Organization name		9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature (Person 1- Application filer)	11. Date (mm/dd/yyyy)

OR

Is there anyone else that you would like us to share your information with about your application?

1. I give permission for (name)	and/or (organization name)		
2. Address	City	State	Zip code
3. Phone number		4. ID number (if applicable)	

By signing, you allow this person/organization to receive eligibility and enrollment information relating to my application/case. I also give the Department of Social Services and/or the Department of Medical Assistance Services permission to release information about this application to this person/ organization.

5. Your signature	6. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	
4. ID number (if applicable)	5. Agents/Brokers only: NPN Number

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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?

☐ Yes, I would like to apply to register to vote.

☐ No, I do not want to register to vote.

IF YOU DO NOT CHECK EITHER 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

(for agency use only)

Voter Registration form completed: ☐ Yes ☐ No

Voter Registration form given to applicant for later mailing (at applicant's request): ☐

_____ _____

Agency Staff Signature Date (mm/dd/yyyy)