Name of Applicant: _____

CardinalCare
Virginia's Medicaid Program

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

Application for Health Coverage and Help Paying Costs APPENDIX E (Medically Needy Spenddown)

Complete Appendix E if you have applied for Health care Coverage for someone who is medically needy (has income greater than the Medicaid limit and would like to be evaluated based on income, resources and medical expenses). LIFC (low income families with children) applicants cannot be evaluated as medically needy.

Appendix E is not a full application for benefits. Submit at LDSS request after filing The Application for Health Coverage and Help Paying Costs.

SECTION 1 Resources and Assets

Answer for the applicant and his or her husband, wife and/or parents and siblings (if applicant is a child). Include any resources anyone owns, or that are jointly owned with someone else, even if that person does not live with you. List the names of all joint owners.

Do you or anyone who lives with you have any of the following resources or assets?

Yes	No		Yes	No		Yes	No	
☐	☐	Cash $_____	☐	☐	Motor Vehicles	☐	☐	Stocks or Bonds
☐	☐	Checking, Savings	☐	☐	Real Property	☐	☐	Annuities
☐	☐	Credit Union	☐	☐	Life Insurance	☐	☐	Deeds of Trust
☐	☐	Money Market Funds	☐	☐	Burial Arrangements	☐	☐	Trust Funds
☐	☐	Certificate of Deposit (CD)	☐	☐	Retirement Accounts	☐	☐	Other
☐	☐	Self Sufficiency Account	☐	☐	Pension Plan			

IMPORTANT: If you have **any of the above** resources, please provide the following information and return documents, such as bank statements, life insurance policies, or a letter from the bank or company documenting the **cash value of the resource**. Verify any liens which reduce cash value. Use additional pages to list additional resources. Complete the following section for any **"Yes"** answers

a. Owner Name (first, middle initial, last)		Co-owner Name (first, middle initial, last)	
Name of Bank, Institution or Company	Resource Type	Identifying Number	Balance or Value **$**
Address of Bank, Institution or Company (if applicable)			
b. Owner Name (first, middle initial, last)		Co-owner Name (first, middle initial, last)	
Name of Bank, Institution or Company	Resource Type	Identifying Number	Balance or Value **$**
Address of Bank, Institution or Company (if applicable)			

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).

c. Owner Name (last, first, middle initial)		Co-owner Name (last, first, middle initial)	
Name of Bank, Institution or Company	Resource Type	Identifying Number	Balance or Value **$**
Address of Bank, Institution or Company (if applicable)			
d. Owner Name (last, first, middle initial)		Co-owner Name (last, first, middle initial)	
Name of Bank, Institution or Company	Resource Type	Identifying Number	Balance or Value **$**
Address of Bank, Institution or Company (if applicable)			

SECTION 2 Additional Income

Do you or anyone who lives with you (including children) receive or expect to receive any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Worker's Compensation	☐	☐	VA Benefits	☐	☐	Other (including Gifts, Life Insurance Proceeds, Inheritances)
☐	☐	Child Support	☐	☐	Lump Sums	☐	☐	

IMPORTANT: If you answered "yes" above, please provide the following information and return documents, such as a letter from the source documenting the **monthly gross amount of income**. Use additional pages if needed to list additional income sources.

Complete the following section for any **"Yes"** answers

Name of Person **a.**	Amount **$**	Type of Money or Help	How Often Received?
Name of Person **b.**	Amount **$**	Type of Money or Help	How Often Received?
Name of Person **c.**	Amount **$**	Type of Money or Help	How Often Received?
Name of Person **d.**	Amount **$**	Type of Money or Help	How Often Received?

Does anyone have a day care expense for a child, an elderly person, or an adult with a disability?

☐ **Yes** ☐ **No**

— If **yes**, give name of person being cared for, name of person providing care, monthly cost and attach verification.

Name of Person Being Cared For	Name of Person Providing Care	Monthly Cost **$**

Sign the Form

I am signing this appendix under penalty of perjury which means I've provided true answers to all the questions on this form 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 (mm/dd/yyyy)