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State Name: Virginia

State Plan Amendment (SPA) #: 13-0010-MM2

This file contains the following documents in the order listed:

1) Approval Letter
2) Additional Companion Letter
3) CMS 179 Form/Summary Form (with 179-like data)
4) Superseding Pages Notice
5) Approved SPA Pages
6) Additional Attachments that are part of the State Plan
7) Approval Letter
8) Revised Alternative Single Streamlined Online Application

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Medicaid and Children's Health Operations

SWIFT #102220134027

APR 30 2014

Cynthia B. Jones, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Ms. Jones:

Enclosed is an approved copy of Virginia's State Plan Amendment (SPA) 13-0010-MM2, which was submitted to CMS on October 4, 2013. SPA 13-0010-MM2 incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Virginia's Medicaid State Plan in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of SPA 13-0010-MM2 includes full approval of your State's alternative single streamlined paper application. The State is using an interim alternative single streamlined online application used to apply for multiple human service programs. By December 31, 2014, Virginia will implement a revised alternative online application that addresses CMS concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the Summary Page (CMS-179), the following S94 State Plan pages and attachments to be incorporated within a separate section at the end of Virginia's approved State Plan:

- S94, pages S94-1 and S94-2
- Attachment 1 –Alternative single streamlined paper application
    - Standard Application for web
    - Additional Person Supplemental Application
- Attachment 2 – Statement of use with respect to the alternative single, streamlined online application
- Attachment 3- Statement related to the coordination of eligibility and enrollment

In addition, enclosed is a summary of State Plan pages which are superseded by SPA 13-0010-MM2, which should also be incorporated into a separate section in the front of the State Plan.

- Superseding Pages of State Plan Material, 13-0010-MM2

CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. If you have any questions concerning this SPA, please contact Margaret Kosherzenko at (215) 861- 4288 or Margaret.Kosherzenko@cms.hhs.gov.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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SWIFT #102220134027

APR 30 2014

Cynthia B. Jones, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Ms. Jones:

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of Virginia's (VA) State Plan Amendment (SPA) 13-0010-MM2. CMS is granting approval for Form S94-Eligibility Process VA SPA 13-0010-MM2, which was submitted to CMS on October 4, 2014. Our review of this submission included a review of the alternative single streamlined paper and online applications developed by the State.

Until December 31, 2014, the State is using an interim, alternative single streamlined online application used to apply for multiple human service programs. This interim application needs to be revised to reflect the following changes.

Necessary changes	**Completion Date**
1. The following questions will not appear for household members not seeking any benefits: • Residency questions (other than information needed to determine whether household members live together) • All citizenship and immigration questions • Non-MAGI screening questions related to blindness, disability, and Medicare • MCO Selection • The attestation which states "I understand that my signature on this application certifies, under penalty of perjury, that I am a U.S. Citizen or alien in lawful immigration status (unless applying for emergency services only.)	December 31, 2014
2. The following questions will not appear on application for health coverage only. • Questions regarding roomer/boarder • Questions regarding income not countable under MAGI, such as SSI and	December 31, 2014

child support income (Note: SSI may be asked as a yes/no question of applicants only as a non-MAGI screening question) • Questions regarding dependent care bills • Questions regarding school enrollment status and grade completed, except for 18-22 year-olds as needed.	
3. Questions about the cost of the employer-sponsored coverage premium will be moved to follow the question regarding the name of the lowest cost plan.	December 31, 2014

Please submit the revised alternative online application to CMS for review no later than December 1, 2014 to ensure approval by December 31, 2014. We continue to be available to provide technical assistance. If you have any questions about your application, please contact Dena Greenblum at Dena.Greenblum@cms.hhs.gov or (410) 786-8684. If you have any questions about this letter or need any additional information, please contact Margaret Kosherzenko of my staff at either 215-861-4288 or by email at Margaret.Kosherzenko@cms.hhs.gov.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Virginia**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

VA-13-0010

Proposed Effective Date

10/01/2013 (mm/dd/yyyy)

Federal Statute/Regulation Citation

Section 1902(e)(14) of the Social Security Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

S94 –Eligibility Process: Submission of the alternative single, streamlined Medicaid/CHIP application developed by Virginia, the eligibility redetermination process, and confirmation of coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs

Governor's Office Review

Governor's office reported no comment

Comments of Governor's office received

Describe:

No reply received within 45 days of submittal

Other, as specified

Describe:

Secretary of Health and Human Services

Signature of State Agency Official

Submitted By: **Brian McCormick**

Last Revision Date: **Mar 24, 2014**

Submit Date: **Oct 4, 2013**

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements
Eligibility Process | **S94**

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

○ Yes ◉ No

Medicaid Eligibility

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Application for Health Coverage & Help Paying Costs

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Free or low-cost insurance from Medicaid, FAMIS or Plan First
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage

You may qualify for a low-cost program even if you earn as much as $94,000 a year (for a family of 4).

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, you may need to complete Appendix C.
- If you are disabled and/or need assistance with nursing home or community based care, you may 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.org.

What you may need to apply

- Social Security Numbers (or document numbers for any legal 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 may be application assisters in your area who can help. Visit our website at coverva.org or call **1-855-242-8282** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-855-242-8282.**

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 ( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: ____________________

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 under 21 who live with you
- Your unmarried partner who needs health coverage
- 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 who doesn't need health coverage
- 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

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.

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: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. 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

2. Relationship to you? **SELF**

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

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

We need this if you want health coverage and have an SSN. Providing your SSN can be helpful if you don't want health coverage too 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. If someone wants 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? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? ______ Expected due date: ______

8. **Do you need health coverage?** (Even if you have insurance, there might be a program with better coverage or lower costs.)

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

☐ **YES.** If not eligible for full coverage, do you wish to be evaluated for Plan First (family planning coverage only)?

☐ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

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

11. **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 number below.

a. Immigration document type ______

b. Document ID number ______

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

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last 3 months? ☐ 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

Please answer the following questions if you are 18 or younger:

14. Did you have insurance that ended within the past 4 months? ☐ Yes ☐ No
a. **If yes,** end date: ______ b. Reason the insurance ended: ______

*For a list of reasons, please see page 6.

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

16. Were you in foster care in Virginia at age 18 or older? ☐ 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
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ 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 19.

☐ **Not employed** Skip to question 29.

☐ **Self-employed** Skip to question 28.

CURRENT JOB 1:

19. Employer name and address

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 you have more jobs and need more space, attach another sheet of paper.)

23. Employer name and address

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 you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

28. **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?

$ ____________

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ 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. **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.

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: PERSON 2

Complete Step 2 for your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. 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

2. Relationship to you?

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

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have 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 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 PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: ____________________

b. Will PERSON 2 claim any dependents on his or her 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? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? ______ Expected due date: ______

9. **Does PERSON 2 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

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

☐ **YES.** If not eligible for full coverage, do you wish to be evaluated for Plan First (family planning coverage only)?

☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 2 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. Document type ____________________
b. Document ID number ____________________
c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No
d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 2 in foster care in Virginia at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 18 or younger:

16. Did PERSON 2 have insurance that ended within the past 4 months? ☐ Yes ☐ No
a. **If yes,** end date: ____________ b. Reason the insurance ended: ____________

*For a list of reasons, please see page 6.

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

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

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 PERSON 2 has more jobs and needs more space, attach another sheet of paper.)

24. Employer name and address

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

29. **If 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 they get it.
NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ 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. **DEDUCTIONS:** Check all that apply, and give the amount and how often they get 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 the answer to net self-employment (question 29b).

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

32. **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, add another person or skip to the next section.

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?**

☐ 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.**

- ☐ 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 ______
- ☐ 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.**

*** REASONS CHILD'S HEALTH INSURANCE ENDED: 1** Parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage. **2** Parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage. **3** Insurance company discontinued coverage because child is uninsurable. **4** Cost of insurance exceeded 10% of monthly income (before taxes). **5** Insurance stopped/dropped by someone other than parent or stepparent living with child. **6** Stopped/dropped a COBRA policy. **7** Other.

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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STEP 5 Read & sign this application.

- I'm signing this application 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 and or untrue information.
- I understand that for individuals enrolled in managed care, a premium is paid each month to the MCO for the 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 family size 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.
- I know that I must tell the local Department of Social Services if anything changes and is different than what I wrote on this application. I can visit **www.commonhelp** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, ______________________ is incarcerated.
  (name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. 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.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Medicaid or FAMIS programs or the Marketplace to use income data, including information from tax returns. I understand that I will receive notification of the outcome of my renewal. I understand that I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid

- 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 yes, I know I will 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 **www.coverva.org** 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 the Health Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health 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 **1-800-318-2596**. 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.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 6 Mail completed application.

Mail your signed application to:

The local Department of Social Services in the city or county in which you live

As a citizen of the Commonwealth of Virginia, we are required to provide you with the opportunity to register to vote when applying for benefits. If you are not already registered and you want to register to vote, you can complete a voter registration form at **www.sbe.virginia.gov.**

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STEP 7 Consent to Share User Profile Information

The Virginia Department of Social Services (VDSS) would like to use some of the personal information that you have provided on your application about you and your dependents to create your User Profile. VDSS is asking for permission to share your User Profile electronically with the state agencies listed below. Each agency will be told when you make a change to the information in your User Profile. This will allow you to save time by only providing User Profile information once when visiting these agencies.

Legal notice

The data being shared

Your User Profile will only be created if you agree to share it and you are eligible for assistance. Your User Profile will contain first name, last name, middle initial, suffix (Jr., Sr., etc.), current home address, date of birth, Social Security Number and Medicaid identification number (if applicable), email address, home phone, driver's license ID and cell phone number. However, you can share your User Profile without sharing your Social Security number; this will not affect your eligibility. Your Medicaid identification number will only be shared with VDSS and your local department of social services. Because the User Profile is based on your application for assistance, the agencies named below also will know that you are receiving assistance.

Agencies Included and Allowed Use

Below are the agencies that will get your information. The reasons they have requested your User Profile and what they will be allowed to do with your User Profile are listed.

Sharing your User Profile will allow them to update the information in their computers, saving taxpayer dollars. It may save you a visit to one of these agencies because your information has been changed electronically.

The Department of Motor Vehicles (DMV) would like a copy of your User Profile when it changes. DMV can change your address for cars you own or driver's license/identification card information they have for you. They will send you a card automatically through the mail to complete this update.

The Virginia Information Technologies Agency (VITA) operates an electronic system known as Enterprise Data Management (EDM). EDM contains data that you have already provided to DMV for your driver's license or identification card. If you give permission to share your User Profile, EDM will match the DMV data and your User Profile, and share this information with your local department of social services and DMV. If the data does not match, DMV or your local department of social services may contact you to confirm the information. Email address, home phone number, cell phone number and Medicaid identification number may be reviewed by a local department of social services worker inside EDM to identify possible duplicate User Profiles.

If you choose not to share your User Profile

Your information will remain only with the Department of Social Services. Choosing not to share your User Profile will not affect your eligibilityfor assistance.

Social Security Number

Including your Social Security Number (SSN) in your User Profile is your choice. The SSN is used to match your User Profile with DMV data in EDM easily. Your SSN is kept confidential.

Dependents

This request is for your own User Profile and for the User Profile of any person who is your legal dependent, including your children under age 18, any person for whom you serve as legal guardian, or any other person for whom you have the authority to agree to share information.

To stop sharing of your User Profile

You can stop sharing your User Profile at any time by going to www.commonhelp.virginia.gov and changing your decision to share. You can also change your decision to share your User Profile by visiting your local department of social services.

How long consent to share lasts

Your permission to share your User Profile will remain active for one (1) year from the date you approve, unless you change your decision to share sooner. Your agreement for any minor child who turns 18 will be stopped on the date of the child's 18th birthday. That individual then will be asked to agree to share his information.
You will be asked to share your information every time you make a change to the information that is used in your User Profile.

Giving Consent

I have reviewed the Consent language contained here and hereby authorize the Commonwealth to:

- ☐ Share my User Profile with the specified agencies. Include Social Security Number when creating my User Profile.
- ☐ My User Profile can be shared with the specified agencies, but do not include Social Security Number when creating my User Profile.
- ☐ Do not allow my User Profile to be shared.

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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)

13a. 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: ______________

☐ No (Stop here and go to Step 5 in the application)

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

☐ 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

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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EMPLOYER COVERAGE TOOL

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.

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 (the Marketplace will send notices to this 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) (Continue)

☐ **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

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

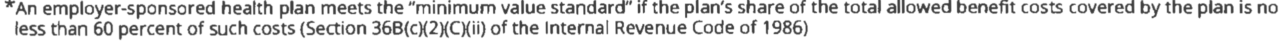
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.

* (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

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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10/1/2013

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	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name ____ ☐ No	☐ Yes **If yes**, tribe name ____ ☐ No
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	☐ 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	**$** ____ How often?____	**$** ____ How often?____

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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'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	11. 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)

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STEP 2: ADDITIONAL PERSON

Name from STEP 1 ____________________

Complete Step 2 for your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. 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
2. Relationship to you?
3. Date of birth (mm/dd/yyyy)
4. Sex ☐ Male ☐ Female
5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
   We need this if you want health coverage and 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 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 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? ☐ 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 they have insurance, there might be a program with better coverage or lower costs.)

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

   ☐ **YES.** If not eligible for full coverage, do you wish to be evaluated for Plan First (family planning coverage only)?

   ☐ **NO. If no,** SKIP to the income questions on next page. Leave the rest of this page blank.
10. Does this PERSON have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No
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. 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 in the U.S. military? ☐ Yes ☐ No
13. Does this PERSON want help paying for medical bills from the last 3 months? ☐ Yes ☐ No
14. Does this PERSON live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No
15. Was this PERSON in foster care in Virginia at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if this PERSON is 18 or younger:

16. Did this PERSON have insurance that ended within the past 4 months? ☐ Yes ☐ No
    a. **If yes,** end date: ____________________ b. Reason the insurance ended: ____________________
    *For a list of reasons, please see page 6.
17. Is this PERSON a full-time student? ☐ Yes ☐ No
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
    ☐ Black or African American
    ☐ American Indian or Alaska Native
    ☐ Asian Indian
    ☐ Chinese
    ☐ Filipino
    ☐ Japanese
    ☐ Korean
    ☐ Vietnamese
    ☐ Other Asian
    ☐ Native Hawaiian
    ☐ Guamanian or Chamorro
    ☐ Samoan
    ☐ Other Pacific Islander
    ☐ Other ____________

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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 and address

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 they have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

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 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 they get it.
NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ 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. **DEDUCTIONS:** Check all that apply, and give the amount and how often they get 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: ____________

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, add another person or skip to the next section.

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.

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.**

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION ☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: 13-0010-MM2	**STATE:** Virginia

Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

COORDINATION OF ELIGIBILITY AND ENROLLMENT	
TRANSMITTAL NUMBER: 13-0010-MM2	**STATE:** Virginia
Notwithstanding the final checked statement on page 2, the single state agency has not entered into an agreement with the Federally-facilitated Marketplace to date. The single state agency will make a good faith effort to enter into a memorandum of agreement with the Federally-facilitated Marketplace as soon as possible. At such time the agreement is signed, it will be incorporated by reference into this attachment.	

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: VA 13-0010 MM2	**STATE:** Virginia
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S94 – Eligibility Process	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Section 2, Page 10, section 2.1(a), TN 93-04 Effective date: 6/16/93, approved: 1/3/94 Section 2, Page 11a, section 2.1(d), TN 93-04 Effective date: 6/16/93, approved: 1/3/94

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

Region III/Division of Medicaid and Children's Health Operations

SWIFT #102220134027

NOV 21 2014

Cynthia B. Jones, Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Ms. Jones:

On April 15, 2014, the Centers for Medicare & Medicaid Services (CMS) approved Virginia's State Plan Amendment (SPA) 13-0010-MM2 with an effective date of October 1, 2013. This SPA included approval for the State to use an interim alternative single streamlined online application until December 31, 2014.

The CMS has reviewed the changes submitted with respect to Virginia's alternative single streamlined online application. The revised application addresses the concerns outlined in the companion letter that was issued with the SPA approval. This letter serves as official approval of Virginia's alternative single streamlined online application with an approval date of November 14, 2014 and an effective date of March 9, 2015.

Enclosed is a copy of the approved alternative single streamlined online application. Please incorporate these pages into the State Plan following the attachment to S94 entitled "Use of the Alternative Single Streamlined Application."

If you have any additional questions or require any further assistance, please contact Margaret Kosherzenko at 215-861-4288 or Margaret.Kosherzenko@cms.hhs.gov.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

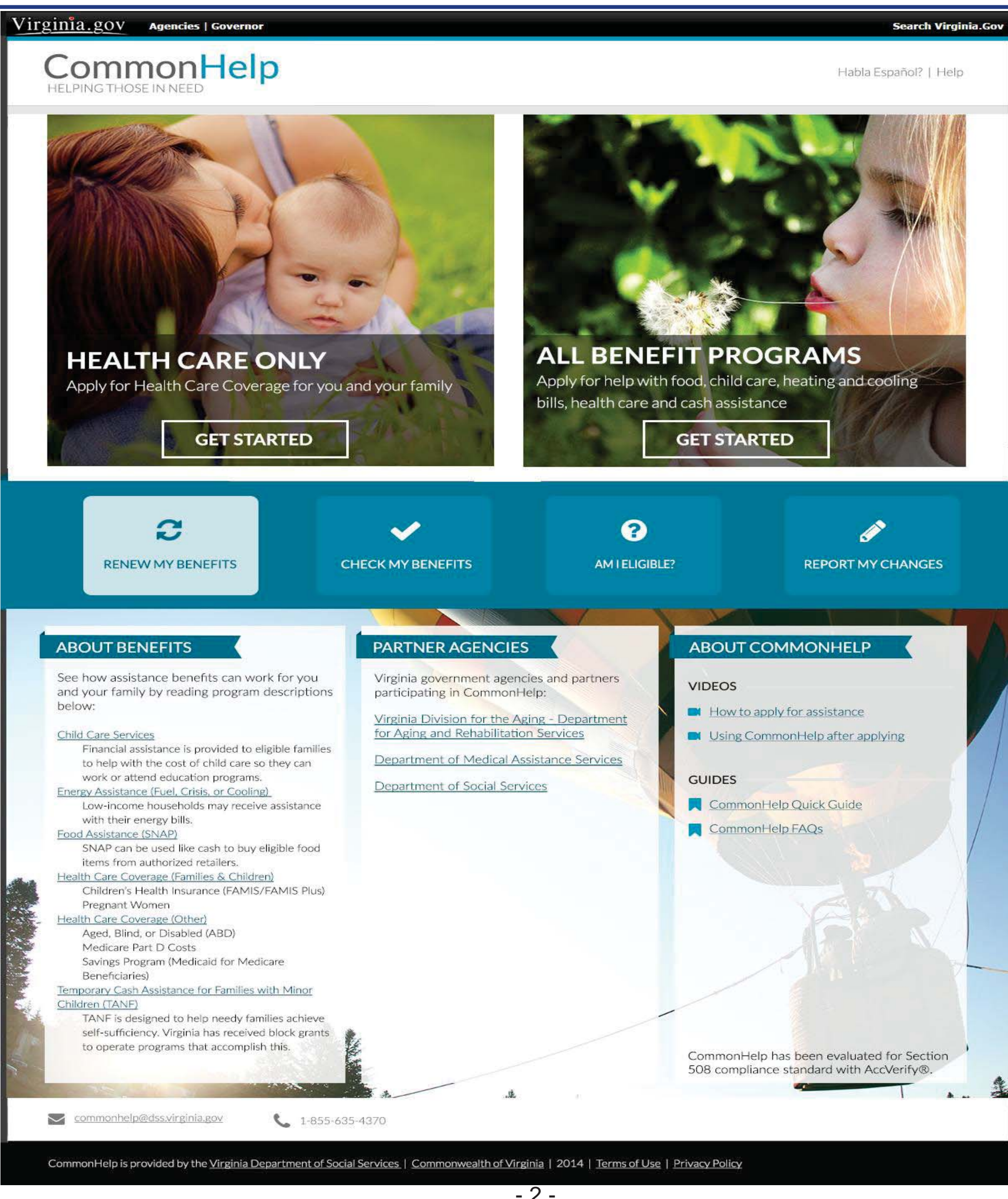
Enclosure

CommonHelp – Health Care Coverage Application Process

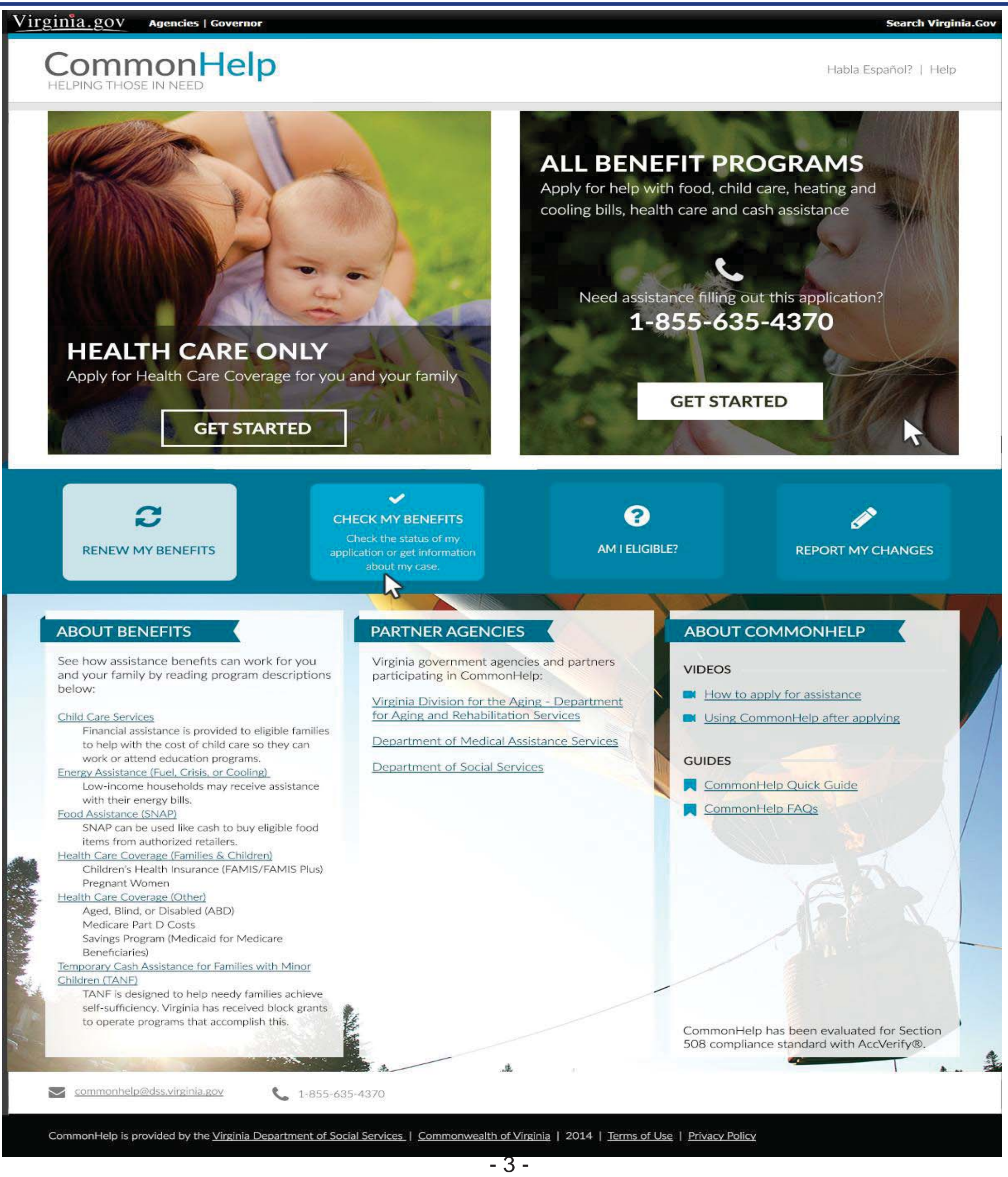
Commonwealth of Virginia

October 15, 2014

Home Page – Mandatory



Home Page – Sample Hover Action on All Benefit Programs Door and Check My Benefits



Screening for Health Care Coverage

Welcome Page – Mandatory

Welcome

CommonHelp

Welcome to CommonHelp! This website is a quick and easy way for people who live in Virginia to find out if they might be able to receive:

- Help with buying food
- Low or no-cost health care
- Help with buying prescription drugs
- Help with paying for child care
- Home energy assistance
- Temporary cash assistance for families with minor children

This website will take you about 15 minutes to use. We will ask you to tell us about the people in your home, the money you receive from a job or other places, your housing costs, medical bills, and child care expenses. What you tell us will stay private and safe.

When you are finished we will tell you if you may be able to receive help through programs like SNAP (Supplemental Nutrition Assistance Program), Health Care Coverage (Medicaid/FAMIS), Child Care, TANF (Temporary Assistance for Needy Families) and Energy Assistance.

This website only provides a check to see if you might be able to get help. You will have to apply for these programs to get a final decision about assistance, but we will let you know how to do that. If you want to apply online for SNAP (Supplemental Nutrition Assistance Program), Health Care Coverage, Child Care, TANF (Temporary Assitance for Needy Families), Energy Assistance and/or Other Medicaid Programs (such as coverage for elderly or disabled individuals, long term care services, etc.), then click here. If you want to apply online for only Health Care Coverage, then click here or call 1-855-242-8282.

Ready to get started? Use the mouse to select the type of programs that you would like to see if you may be eligible for! Please do not use the Forward, Back or Stop buttons on your browser. Instead, use the CommonHelp buttons at the bottom of each page.

Please select the type of programs that you would like to see if you may be eligible to receive.

HEALTH CARE ONLY
Health Care Coverage for you and your family

ALL BENEFIT PROGRAMS
Benefit Programs and Health Care Coverage for you and your household

EXIT

CommonHelp is provided by the Virginia Department of Social Services
Toll-Free Helpline:1-855-635-4370 | Email: mailto:commonhelp@dss.virginia.gov?subject=Virginia%20CommonHelp%20Support
Commonwealth of Virginia - 2014 - Terms of Use - Privacy Policy

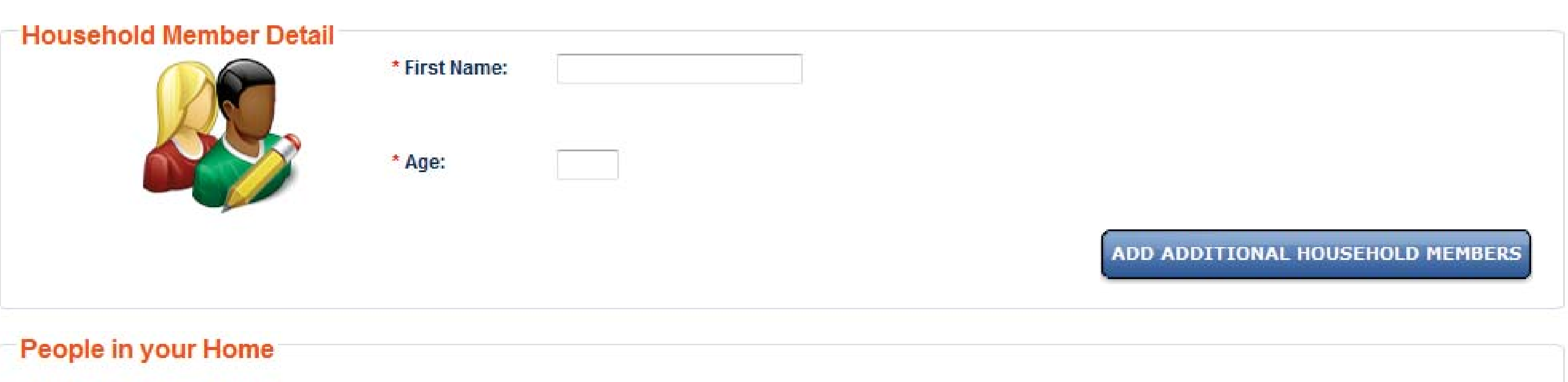
Your Home (1/2) – Mandatory

About You and Your Family

Let us get started! First, please tell us a little bit about you. Feel free to use a nickname or your initials.

You can click the Page Help button if you have a question about what we're asking.

Add additional household members for the people in your family that are included on your federal taxes. If you don't file federal taxes, just add the family members living with you (spouse and children under 21). If there is a child in your home who is younger than 1 year old, please type in 0 for his or her age.



Household Member Detail

* First Name:

* Age:

ADD ADDITIONAL HOUSEHOLD MEMBERS

People in your Home

First Name	Age	Change or Remove
Mary	25	or
Peter	14	or

Additional Information

* Where do you live ? < Click here to choose >
* Is anyone in your home currently pregnant? Yes No
* Is anyone in your home blind or disabled? Yes No
* Was anyone in your home receiving foster care and Medicaid on their 18th birthday? Yes No

Your Home (2/2) – Mandatory

Your Money

Next, tell us the gross monthly income for everyone you have listed above. This includes any income from a job, self employment, or other income (such as social security, unemployment payments, etc)

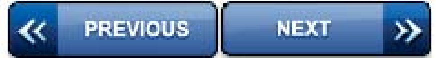
We know that money is a very private manner, but we need to ask about it to see if you might be able to get assistance.

When you type in your answers, ***do not use dollar signs ($) or commas (,)***. For example, type 1234.56, not $1,234.56.

If you do not know how much you receive each month, please enter your best guess or use the calculator.

Gross Monthly Household Income (before taxes and deductions) $ 0.00

EXIT



CommonHelp is provided by the Virginia Department of Social Services
Toll-Free Helpline:1-855-635-4370 | Email: mailto:commonhelp@dss.virginia.gov?subject=Virginia%20CommonHelp%20Support
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Income Calculator – Pop-up window upon clicking Calculator button on previous page

Income Calculator

First, please tell us about each person who earns money from a job or self employment.

When you type in your answers, ***do not use dollar signs ($) or commas (,)***. For example, type 1234.56, not $1,234.56.

John

	Type of Income	How much does John receive before taxes and deductions?	How often does John receive this type of income?
Income 1:		$ 0.00	
Income 2:		$ 0.00	
Income 3:		$ 0.00	

Mary

	Type of Income	How much does Mary receive before taxes and deductions?	How often does Mary receive this type of income?
Income 1:		$ 0.00	
Income 2:		$ 0.00	
Income 3:		$ 0.00	

CALCULATE

Calculated Monthly Household Income

Monthly Household Income: $ 0.00

EXIT

USE THIS AMOUNT

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Toll-Free Helpline:1-855-635-4370 | Email: commonhelp@dss.virginia.gov
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Screening Results for people who may be eligible – Mandatory

100% Complete

Your Results

We looked at what you told us today to see if you may be able to get help with Health Care Coverage.
You will have to apply for this program to get a final decision and we will let you know how to do that. Keep in mind that you always have the right to apply, no matter what this website tells you.

It looks like you may be able to get Health Care Coverage

Learn More

- Based on what you told us, it looks like someone in your household may be able to get low or no-cost health care.
- Health Care Coverage programs may pay for most services you get from State approved health care providers. It may also pay for prescriptions (unless you are also getting Medicare). You may have a small co-payment for some services and prescriptions.
- Medicaid provides limited coverage for Medicare beneficiaries. Medicaid pays for Medicare Part B premiums and may pay for Medicare deductibles and co-payments.
- A special note for immigrants: getting low- or no-cost health care will not hurt your immigration status. Keep in mind that in some cases, immigrants are only able to get health care in emergencies.
- Please note that some adults may only qualify for PlanFirst which provides limited family planning services.

To obtain more information about Health Care Coverage, please click on the "Learn More" button. Clicking on the "Learn More" button and/or below links will take you to a new browser window, please close the new browser window to return to this screen.
Finding Affordable Health Care in Virginia
211 Virginia.

Next Steps

Please click the next button at the bottom of the page to print the summary of results and/or apply for assistance. For more information on Health Care Coverage through Medicaid, FAMIS, or Plan First, visit www.coverva.org. If you have questions or need help applying, contact Cover Virginia at **1-855-242-8282**, Monday through Friday, 8:00 a.m. to 7:00 p.m. or 9:00 a.m. to noon on Saturday. Interpretation services are available. (TDD 1-888-221-1590 *for deaf and hearing impaired*); or click on the "Learn More" button above.

CommonHelp is provided by the Virginia Department of Social Services
Toll-Free Helpline:1-855-635-4370 | Email: mailto:commonhelp@dss.virginia.gov?subject=Virginia%20CommonHelp%20Support
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Screening Results for people who may not be eligible – Mandatory

100% Complete

Your Results

We looked at what you told us today to see if you may be able to get help with Health Care Coverage.
You will have to apply for this program to get a final decision and we will let you know how to do that. Keep in mind that you always have the right to apply, no matter what this website tells you.

It looks like you may not be eligible for Health Care Coverage

Learn More

- Based on what you told us, your household may not be able to get low or no-cost health care. You may still complete an application so that we can make an official decision about your eligibility.
- Health Care Coverage programs will pay for most services you get from State approved health care providers. It will also pay for prescriptions (unless you are also getting Medicare). You may have a small co-payment for some services and prescriptions.
- If you do not qualify for Health Care Coverage then health insurance can be purchased through the federal health benefit exchange. To access the health benefit exchange see the "Healthcare.gov" link below.
- A special note for immigrants: getting low- or no-cost health care will not hurt your immigration status. Keep in mind that in some cases, immigrants are only able to get health care in emergencies.

To obtain more information about Health Care Coverage, please click on the "Learn More" button. Clicking on the "Learn More" button and/or below links will take you to a new browser window, please close the new browser window to return to this screen.
Finding Affordable Health Care in Virginia
211 Virginia.

Based on the information you have provided, someone in your household may be eligible for Other Medicaid programs (such as coverage for elderly or disabled individuals including SSI recipients, or long-term care services, etc.). Click here to be screened for those programs, or click here to apply for them.

Individuals not eligible for Medicaid or FAMIS coverage may qualify for a free or low-cost private health insurance plan through the Federal Health Insurance Marketplace or a new kind of tax credit that lowers your monthly premium. The Marketplace is designed to help you find and compare health insurance options based on price, benefits, quality and other features that may be important to you. For more information or to apply for coverage, go online to www.healthcare.gov or call 1-800-318-2596.

Next Steps

Please click the next button at the bottom of the page to print the summary of results and/or apply for assistance. For more information on Health Care Coverage through Medicaid, FAMIS, or Plan First, visit www.coverva.org. If you have questions or need help applying, contact Cover Virginia at **1-855-242-8282**, Monday through Friday, 8:00 a.m. to 7:00 p.m. or 9:00 a.m. to noon on Saturday. Interpretation services are available. (TDD 1-888-221-1590 *for deaf and hearing impaired*); or click on the "Learn More" button above.

CommonHelp is provided by the Virginia Department of Social Services
Toll-Free Helpline:1-855-635-4370 | Email: mailto:commonhelp@dss.virginia.gov?subject=Virginia%20CommonHelp%20Support
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Thank You & Exit – Mandatory

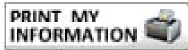
Thank You & Exit

Print Summary

Here are your next steps. If you would like to keep a copy of your results, click the "Print My Information" button to print out a summary of your screening results.

This summary is not an application and cannot be used to apply for assistance.
A final decision about your eligibility will be made after you apply for Health Care Coverage.

Advisory- Please read:
The account and application you just created are secure, but if you are using a computer in a Library, Community Center or other public place, please take these additional steps: If you print anything, remember to get the printed copies of your application. If the printer jams or your application fails to print, contact someone at the location for help. And, after you have completed your application(s), shut down the Internet program and if possible ask the staff to restart the computer.



You'll need a program called Adobe Acrobat Reader to see and print this information. If you don't have this program on your computer, you may install it for free by clicking:

Screens in Health Care Coverage Application

Confidentiality Agreement – Mandatory

Confidentiality Agreement

Confidentiality Agreement

By clicking the "I Accept" button, you are accepting the Confidentiality Agreement and Acceptable Use policies as mandated by the Commonwealth of Virginia. Also, note that it is your responsibility to protect any items that you print from this website. Click the "I Do Not Accept" button to end this session and log out.

I Accept | I Do Not Accept

Apply For Assistance Landing Page – Mandatory

Apply For Assistance

Before you get started, please read this information:

* Apply For Assistance

Please note: This application is for Health Care Coverage for children under 19, pregnant women, low income parents or care-taker relatives and family planning services only. If you or someone in your household wants to apply as an aged (65+), blind or disabled individual or for long-term care coverage, please click here.

For people who are not applying for help, you do not have to give a Social Security number or information that verifies citizenship or immigration status.

Information about the people in your home will be used to help determine if you are eligible to receive assistance with Health Care Coverage (Medicaid or FAMIS). If you do not have this information, or if you do not provide it, your application could be denied. If more information is needed, you will receive a written notice. For questions about Health Care Coverage (Medicaid or FAMIS), you may call Cover Virginia toll free at 1-855-242-8282 (TDD# 1-888-221-1590 for hearing impaired). You may also contact your local department of social services. Their phone number and address will show after you submit your application.

Please click one of the buttons to tell us what you would like to do. Then click the NEXT button at the bottom of the page. Please note: You need to start a new application even if you did the screening labeled "Am I Eligible".

- ○ **Start a new application for Health Care Coverage (Medicaid or FAMIS)**
  (For most people, it will take from 20 to 45 minutes to fill out the application.)

- ○ **Login to keep working on an application you have already started**

This application works best with Internet Explorer 6, 7, or 8. You may experience problems if you use other browsers like Firefox, Safari, or Chrome. If you have questions or need technical assistance, please call the toll free helpline at 1-855-635-4370.

Apply For Assistance Info Page – Mandatory

Apply For Assistance

You are ready to start your application. Here are some helpful hints.

* Apply For Assistance

It is a good idea to have information about:

- Household income (including Social Security benefits and your most recent federal tax filing information if available)
- People in your home
- Health insurance policies

Certain information is required in order to approve an application for assistance. If additional information is needed to process your application, you will be contacted.

✓ You can start and then save your application. You can log back in to continue the application.

✓ Any questions that have an asterisk (*) next to them must be answered.

✓ Once you have answered all the questions, you will be asked to electronically sign the application. You will receive a confirmation number (or T #) when the application has been successfully submitted. Keep this number for reference. You will also be able to print a copy of your submitted application for your records.

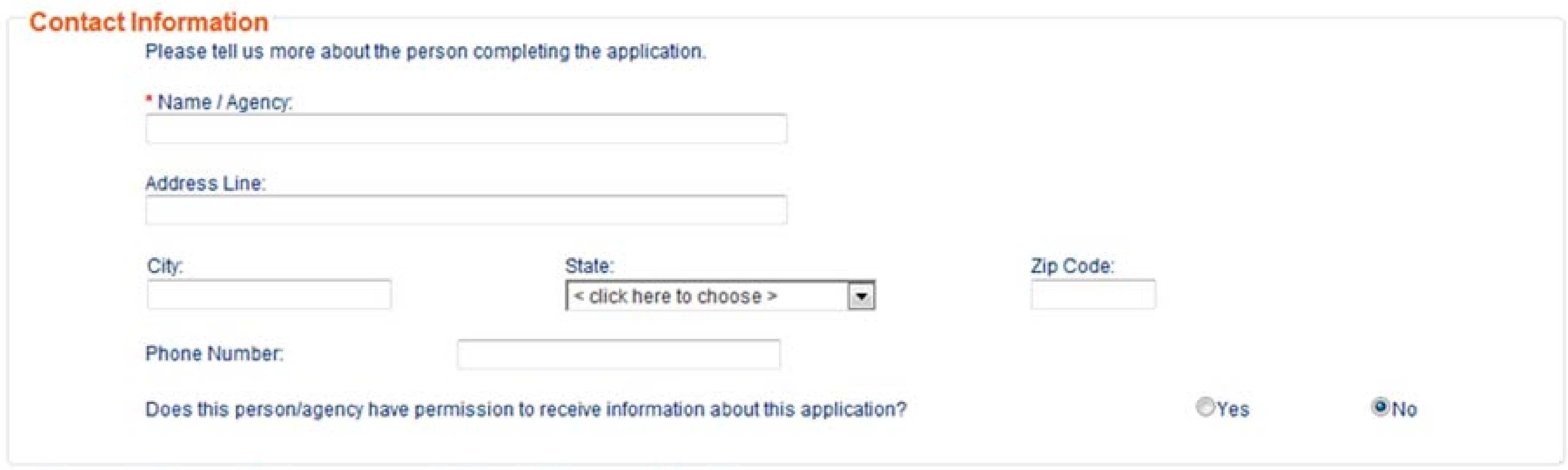
✓ It may take from 30 to 45 days to make a decision on your application.

✓ Before a decision can be made, we may need to get proof for some of your answers.

Click the NEXT button to continue.

Completing this Application – Mandatory

Contact Information – Optional


Contact Information

Please tell us more about the person completing the application.

* Name / Agency:

Address Line:

City:

State:

< click here to choose >

Zip Code:

Phone Number:

Does this person/agency have permission to receive information about this application?

Yes

No

From this point in the application, when we say "you" or "your" we mean the applicant.

More About Assistance – Mandatory

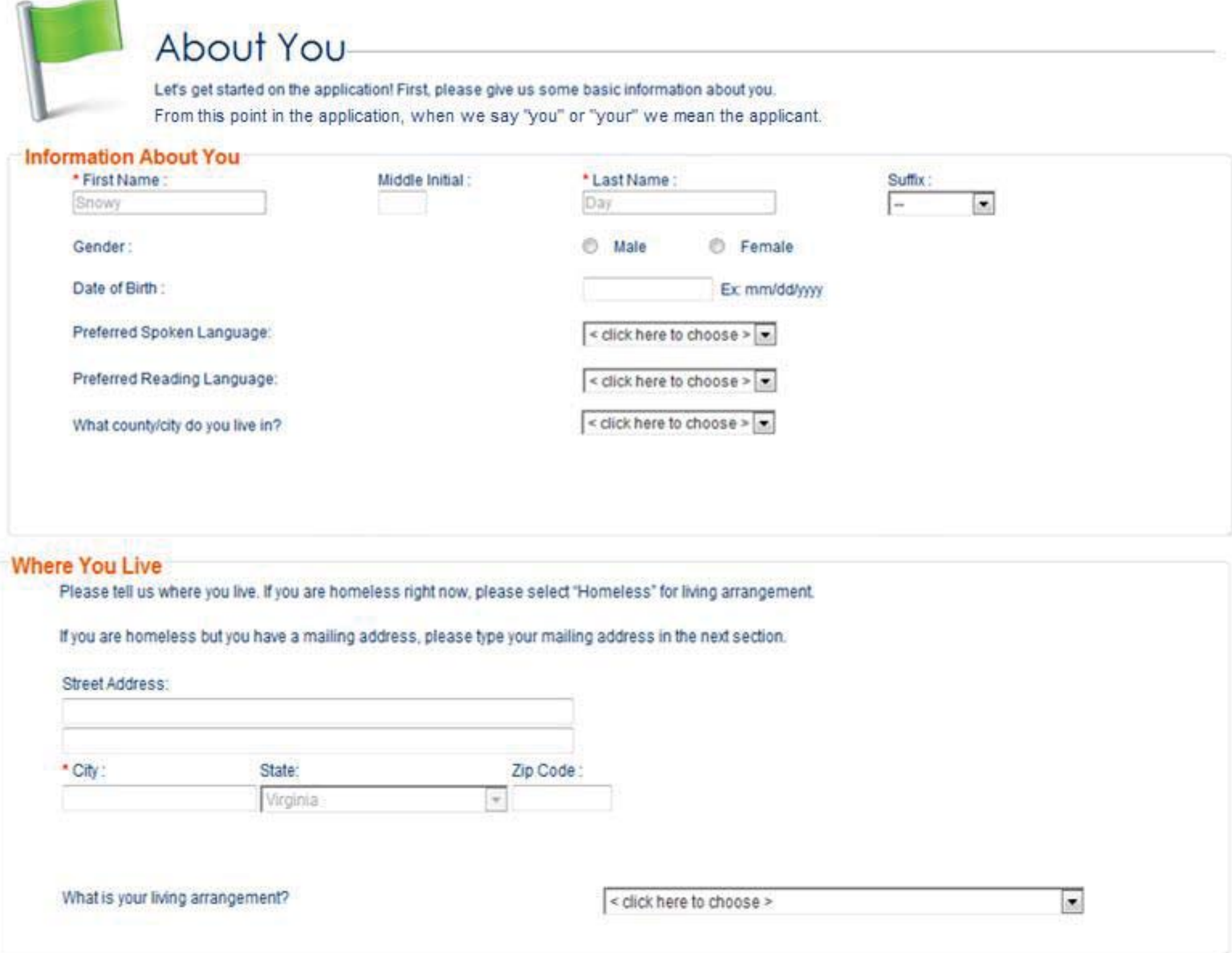
More About Assistance

Here is more information about the programs for which you are applying.

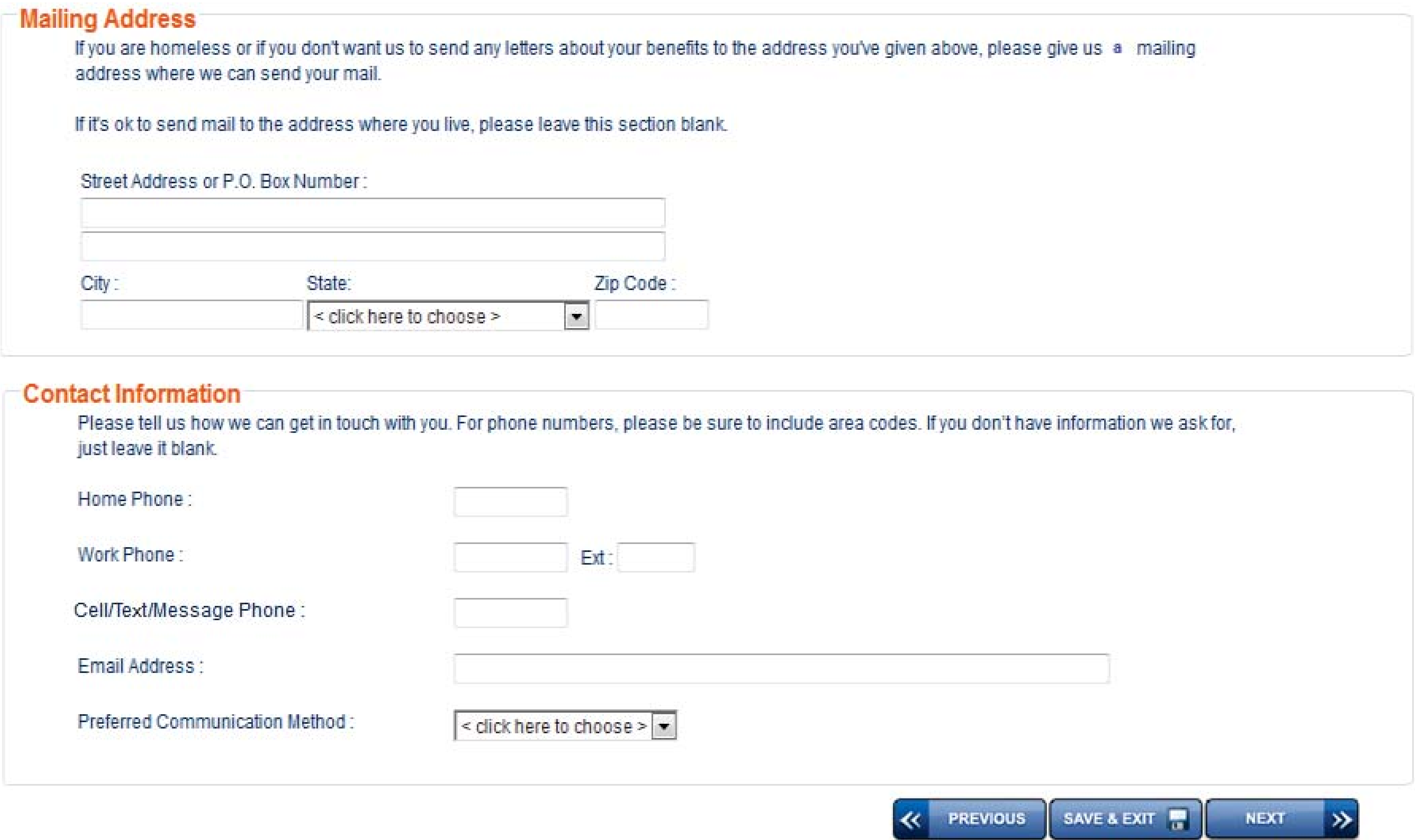
Health Care Coverage (Medicaid or FAMIS)

- ✓ Health Care Coverage programs provide medical coverage for adults, children under 19, pregnant women, low income parents or care-taker relatives and family planning services only.
  Please note: If you or someone in your household wants to apply as an aged (65+), blind or disabled individual or for long-term care coverage, please click here.
- ✓ Health Care Coverage may help pay medical bills, doctor's visits or even Medicare premiums.
- ✓ When you apply for Health Care Coverage, we will screen and evaluate you for all Health Care Coverage programs for which you may be eligible.
- ✓ If you do not qualify for Medicaid or FAMIS, your application will be sent to the Federal Health Insurance Marketplace for further review.

About You (1/2) – Mandatory



About You (2/2) – Mandatory



Applicant Summary – Mandatory

Applicant Summary

Here is a summary of what you've told us. If the Section Complete columns have a checkmark, you have given us all of the information we have asked for. You are not required to give all information before you submit the application.

- If you would like to change your answers or finish a section that doesn't have a check mark, click on "Change".
- Once you've reviewed this summary and all the information is correct, click the Next button at the bottom of the page.

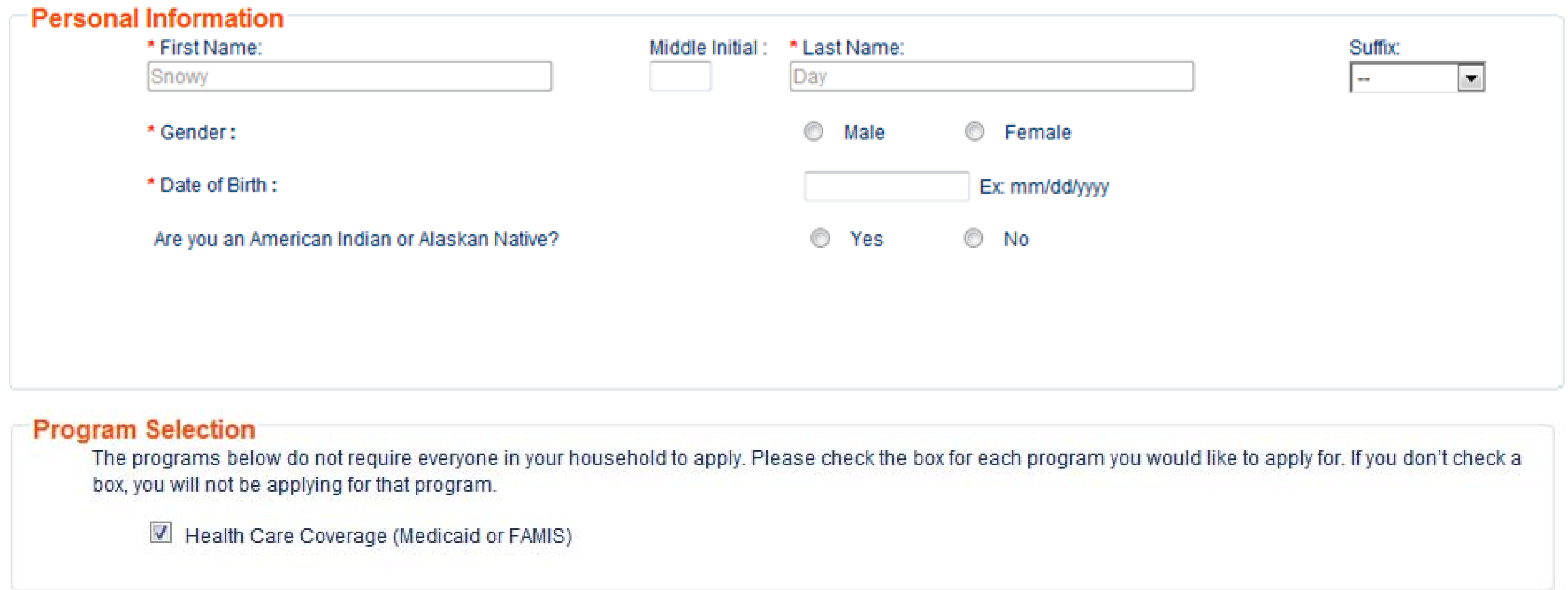
Review Your Answers: Person Completing the Application

Who	Relationship to the Applicant	Contact Phone	Section Complete?	Change
Test Name	Legal Guardian	899-991-1000		

Review Your Answers: Basic Information Summary

Applicant	Physical Address	County / City	Phone Number	Section Complete?	Change
John	891 E Main Street Amherst, VA 23451-2454	Richmond City	899-991-1000		

More About You (1/5) – Mandatory



More About You (2/5) – Mandatory

SSN Information

If you are not applying for assistance, you do not have to answer the next set of questions. However, providing this information can speed up the application process. If you are applying for assistance, the next set of questions must be completed. We use the SSNs to check income and other information to see who is eligible for help.

If you are applying for Health Care Coverage (Medicaid, or FAMIS) for yourself, you will need to provide a SSN so we can see if you can get assistance.

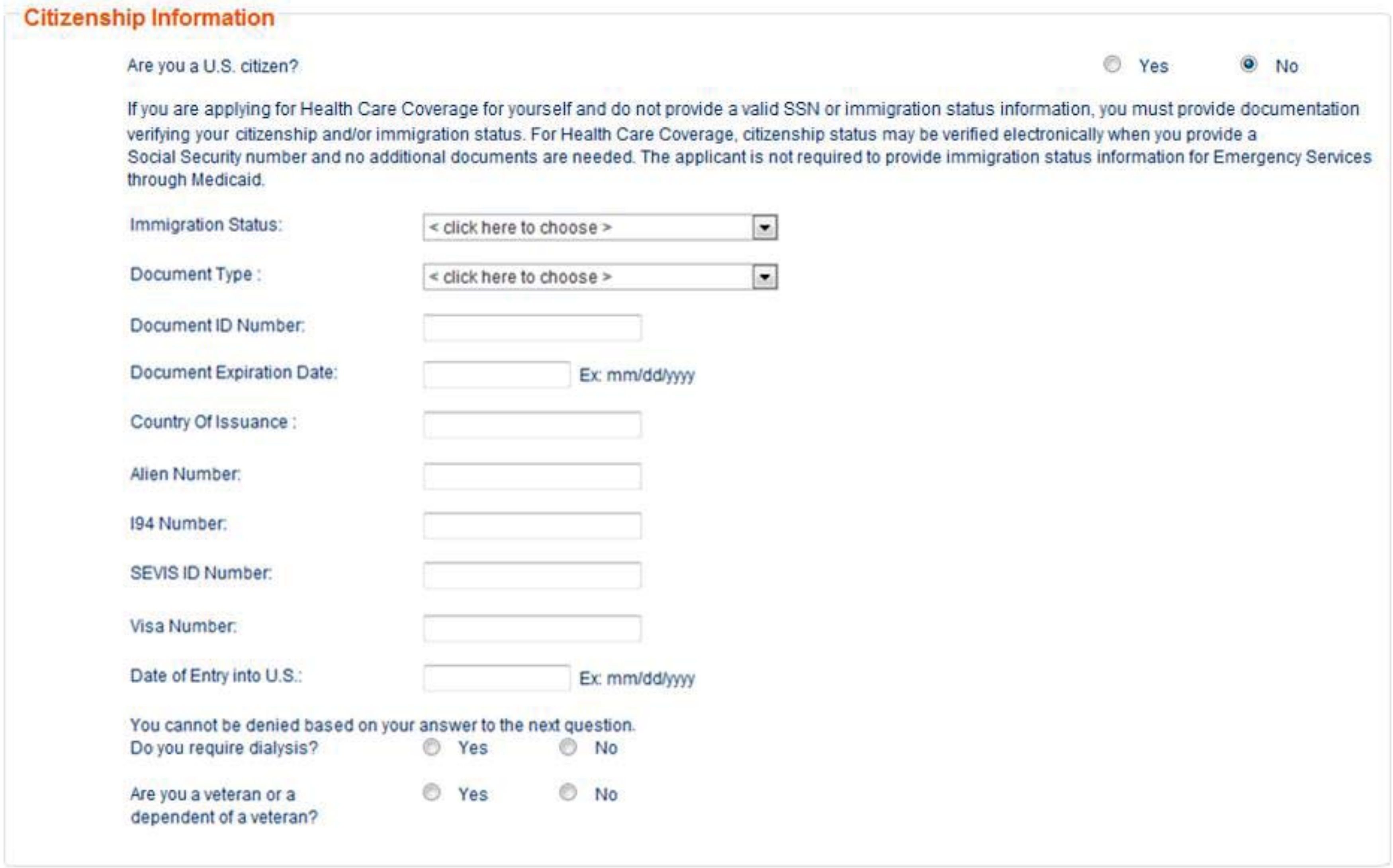
Are you willing to provide your Social Security number? ○ Yes ○ No

Social Security number*: [ ] - [ ] - [ ]

If you do not have a Social Security number, please provide a reason: < click here to choose >

If you do not have a Social Security number* but have applied, please provide the date you submitted your application: [ ] Ex: mm/dd/yyyy

More About You (3/5) – Mandatory


Citizenship Information

Are you a U.S. citizen? ○ Yes ◉ No

If you are applying for Health Care Coverage for yourself and do not provide a valid SSN or immigration status information, you must provide documentation verifying your citizenship and/or immigration status. For Health Care Coverage, citizenship status may be verified electronically when you provide a Social Security number and no additional documents are needed. The applicant is not required to provide immigration status information for Emergency Services through Medicaid.

Immigration Status: < click here to choose >

Document Type : < click here to choose >

Document ID Number:

Document Expiration Date: Ex: mm/dd/yyyy

Country Of Issuance :

Alien Number:

I94 Number:

SEVIS ID Number:

Visa Number:

Date of Entry into U.S.: Ex: mm/dd/yyyy

You cannot be denied based on your answer to the next question.
Do you require dialysis? ○ Yes ○ No

Are you a veteran or a dependent of a veteran? ○ Yes ○ No

More About You (4/5) – Mandatory

Ethnicity

Please select your ethnicity. You don't have to answer this question if you don't want to. This answer will not be used to make a decision about your assistance.

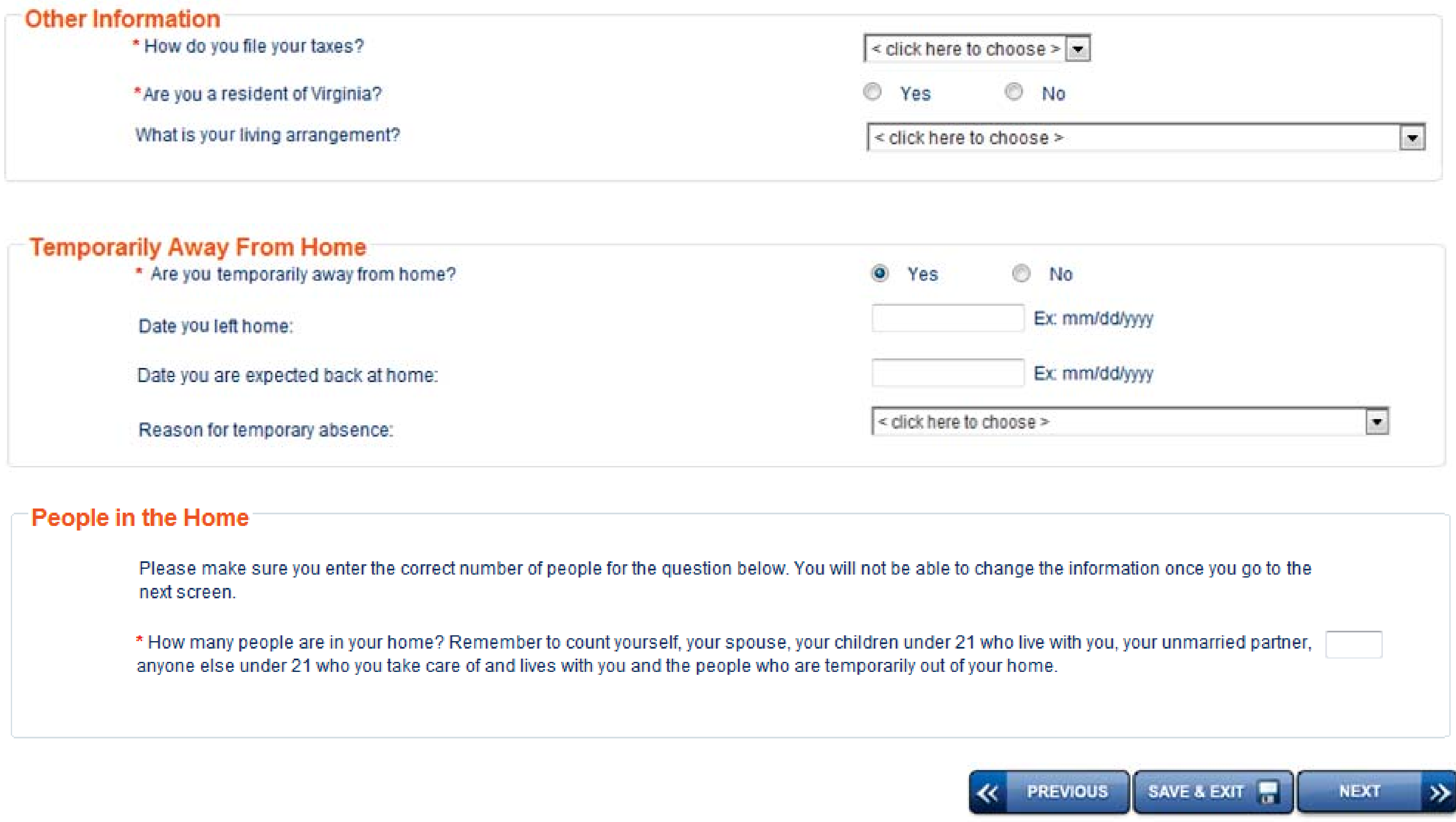
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano/a
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Non-Hispanic / Unknown

Race

Please check the box or boxes to tell us your race. You don't have to answer this question if you don't want to. This answer will not be used to make a decision about your assistance.

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

More About You (5/5) – Mandatory



Other People In Your Home (1/2) for members who are not applying – Optional

Other People In Your Home

We have your information. Now we need to get personal information for other people in your home. Please provide more information about Snowy. If you do not need to add this person, click the "Remove This Person" button. Please note that any information you may have entered for this person will be deleted.

REMOVE THIS PERSON

Personal Information

* First Name: Snowy
Middle Initial :
* Last Name: Day
Suffix: --

* Gender : Male Female

* Date of Birth : Ex: mm/dd/yyyy

Is this person an American Indian or Alaskan Native? Yes No

Program Selection

The programs below do not require everyone in your household to apply. Please check the box for each program this person would like to apply for. If you don't check a box, this person will not be applying for that program.

☐ Health Care Coverage (Medicaid or FAMIS)

Other People In Your Home (2/2) for members who are not applying – Optional

SSN Information

If this person is not applying for assistance, you do not have to answer the next set of questions. However, providing this information can speed up the application process. If this person is applying for assistance, the next set of questions must be completed. We use the SSNs to check income and other information to see who is eligible for help.

If this person is applying for Health Care Coverage (Medicaid or FAMIS), you will need to provide a SSN so that we can see if they can get assistance.

Are you willing to provide this person's Social Security number? ○ Yes ○ No

Social Security number: [ ] - [ ] - [ ]

If this person does not have a Social Security number, please provide a reason: < click here to choose >

If this person does not have a Social Security number but has applied, please provide the date they submitted their application. [ ] Ex: mm/dd/yyyy

Other Information

* How does this person file their taxes? < click here to choose >

What is this person's living arrangement? < click here to choose >

Temporarily Away From Home

* Is this person temporarily away from home? ◉ Yes ○ No

Date person left home: [ ] Ex: mm/dd/yyyy

Date person expected back at home: [ ] Ex: mm/dd/yyyy

Reason for temporary absence: < click here to choose >

PREVIOUS | SAVE & EXIT | NEXT

Relationships – Optional

Tax Return Information (1/2) – Optional

Tax Return Information

Tax Dependents

Please select the tax filer that claims the person as a dependent on their federal income tax return.

Sam

Someone outside of the home

First Name: | Middle Name : | Last Name: | Suffix: --

Relationship to Dependent: < click here to choose >

Tax Dependents Outside the Home

Please indicate if the person claims anyone living outside the home as a tax dependent. These people will not be evaluated for Health Care Coverage.

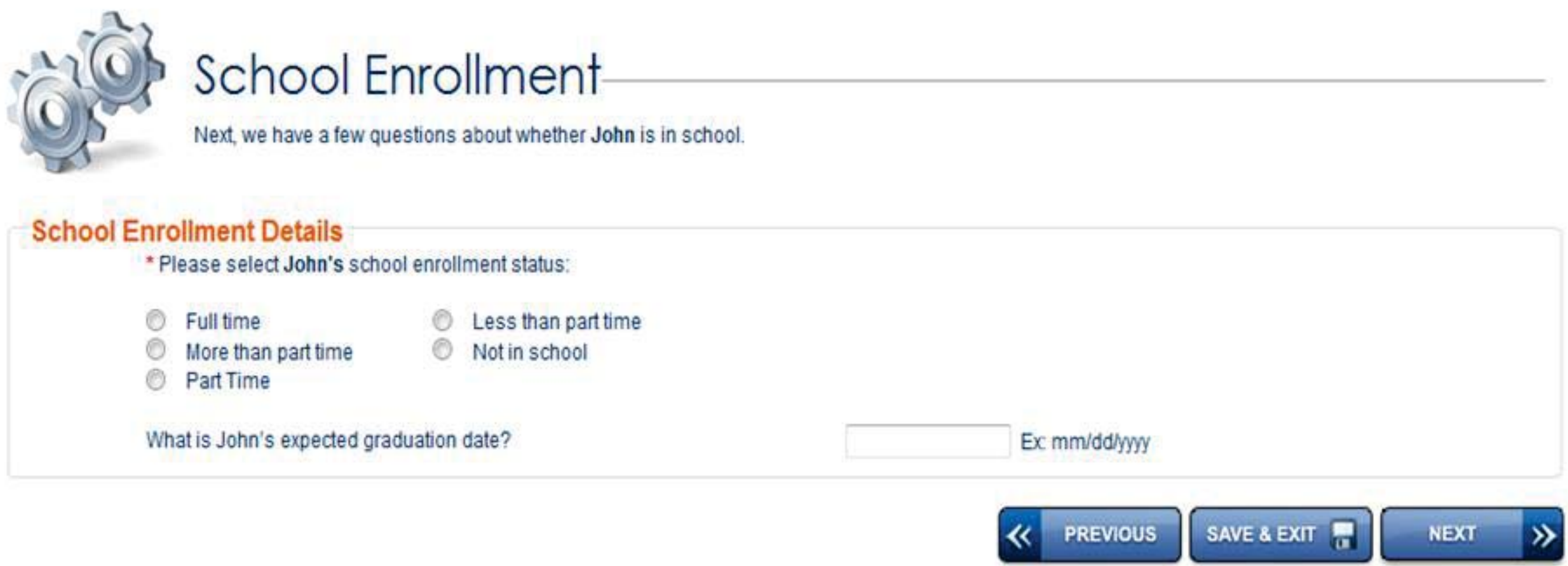
John

Yes No

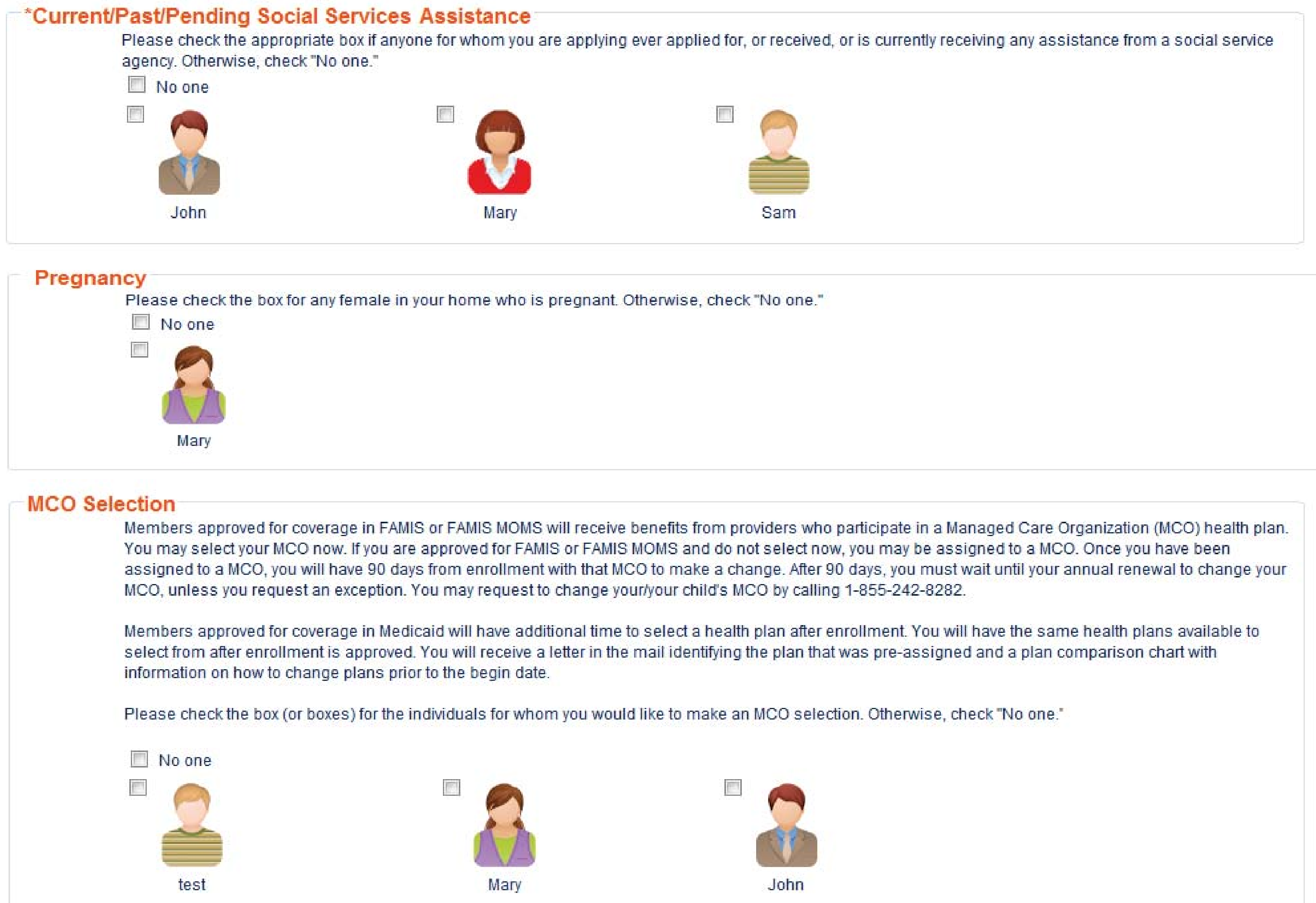
	First Name:	Middle Name :	Last Name:	Suffix:
Tax Dependent 1:				--
Tax Dependent 2 (If applicable):				--
Tax Dependent 3 (If applicable):				--

Tax Return Information (2/2) – Optional

School Enrollment – Optional



Individual Non-Financial Gatepost (1/2) – Mandatory



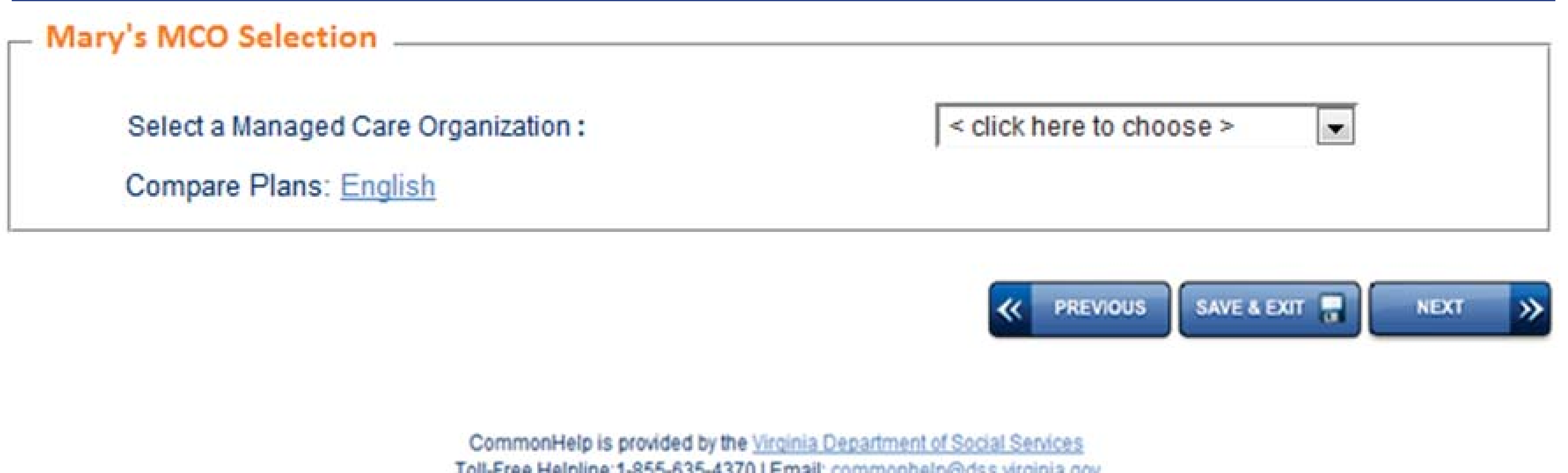
Individual Non-Financial Gatepost (2/2) – Mandatory

CommonHelp is provided by the Virginia Department of Social Services
Toll-Free Helpline:1-855-635-4370 | Email: commonhelp@dss.virginia.gov
Commonwealth of Virginia - 2014 - Terms of Use - Privacy Policy

Current/Past/Pending Assistance – Optional

Pregnancy Details – Optional

MCO Selection – Optional



Individual Non-Financial Summary (1/5) – Mandatory

Household Members Summary

Here is a summary of what you've told us. If a section below has a checkmark, you have given us all of the information we have asked for. You are not required to give all information before you submit the application.

- If you would like to change your answers or finish a section that doesn't have a check mark, click on "Change".
- If you need to add information for an individual, choose the person's name from the dropdown box and then click the Add button.
- If you would like to remove something, click "Remove".

Once you've reviewed this summary and all the information is correct, click the Next button at the bottom of the page.

People in Your Home

Who	Gender	Date of Birth	Section Complete?	Change or Remove
John	Male	12/12/1982		
Mary	Female	12/12/1990		or
Sam	Male	12/12/2010		or
David	Male	12/12/1998		or

Add More People

To add another person in your household who is receiving or has received assistance, please choose the name, and click the Add button.

ADD

Individual Non-Financial Summary (2/5) – Mandatory

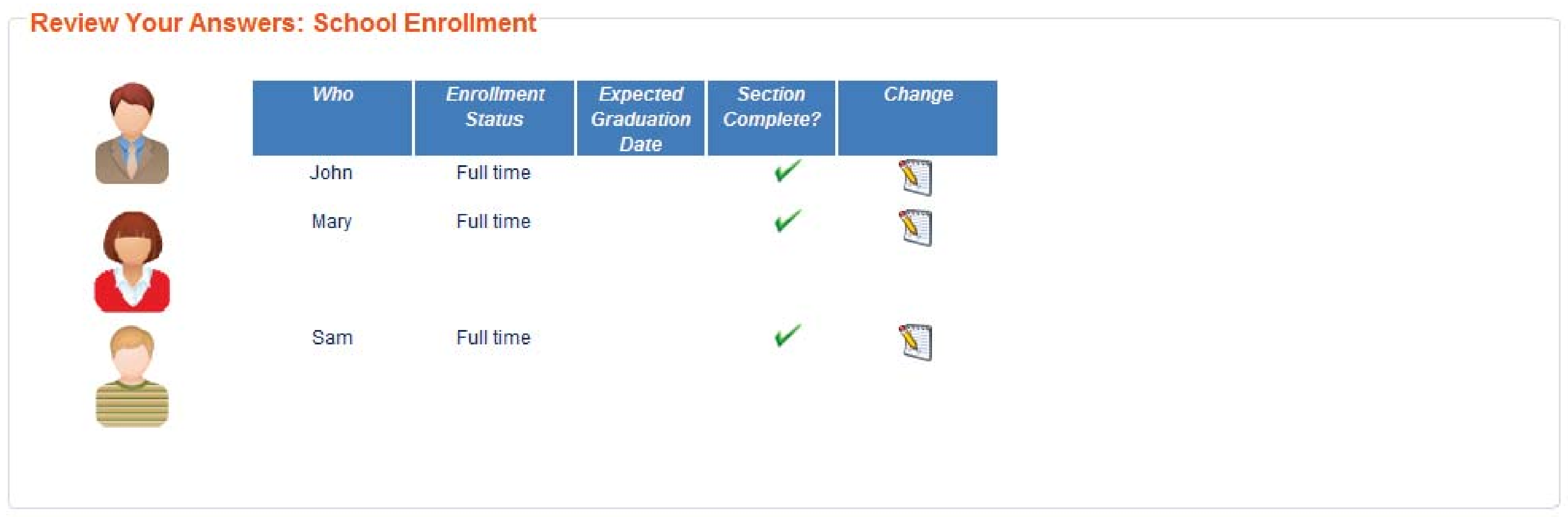
Review Your Answers: Relationships

Who	Relationships	Section Complete?	Change
John	is the Husband of Mary	✔	
John	is the Father of Sam	✔	
John	is the Step Father of David	✔	
Mary	is the Mother of Sam	✔	
Mary	is the Mother of David	✔	
David	is the Half Brother of Sam	✔	

Review Your Answers: Tax Return(s)

Who	Tax Filing Status	Number of Dependents?	Change
John	Taxpayer	1	
Mary	Joint taxpayer	0	
David	Tax dependent	0	

Individual Non-Financial Summary (3/5) – Mandatory



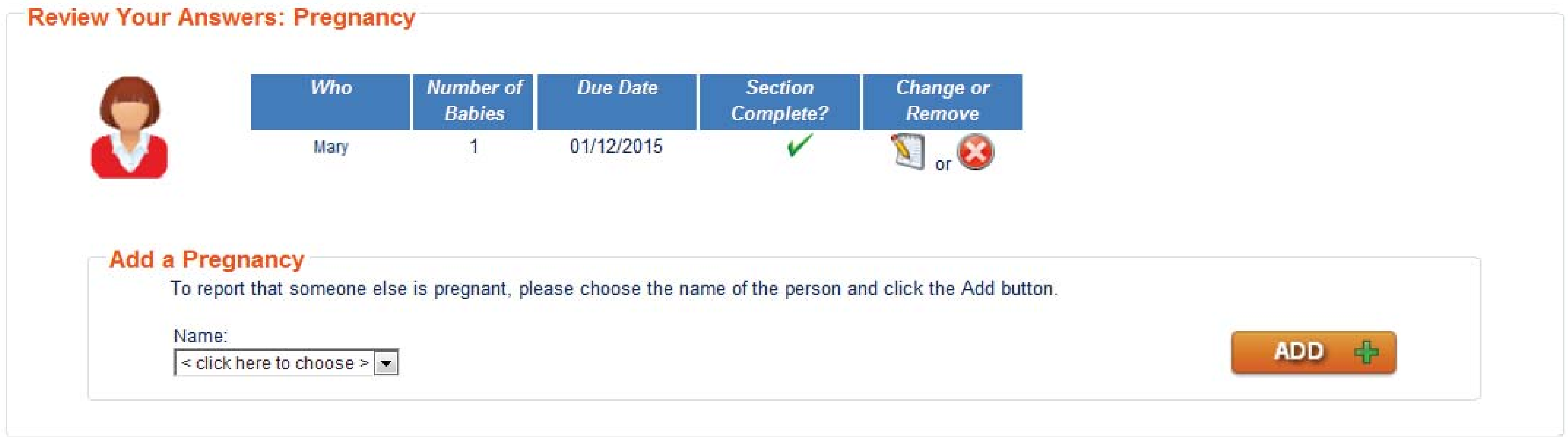
Review Your Answers: School Enrollment

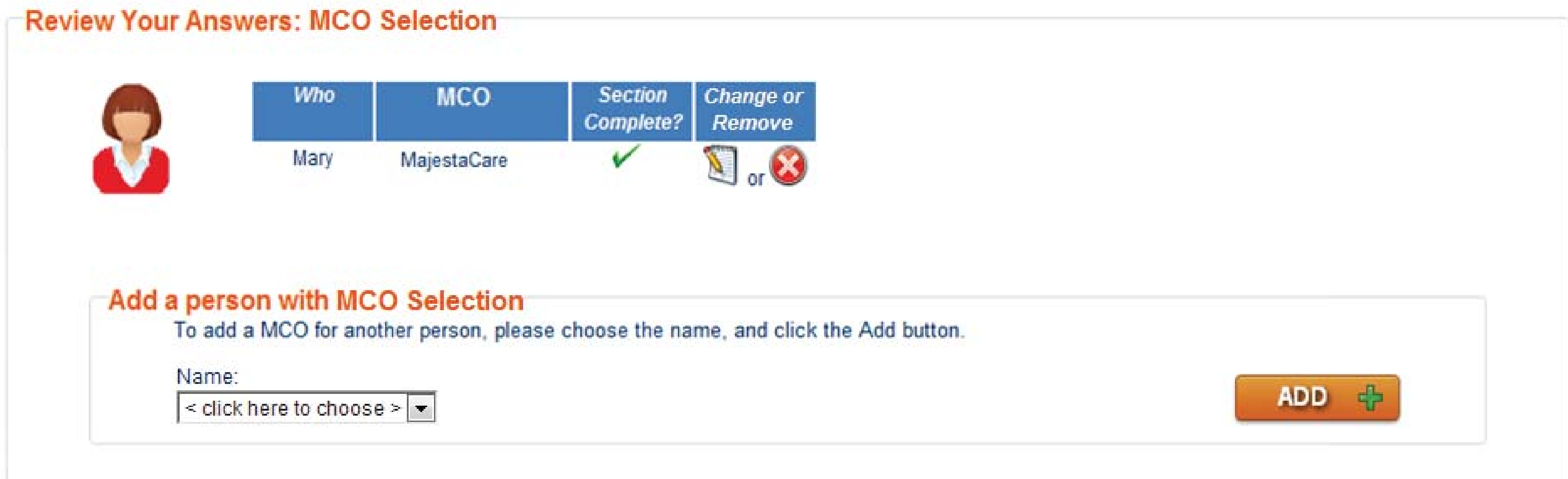
Who	Enrollment Status	Expected Graduation Date	Section Complete?	Change
John	Full time		✔	
Mary	Full time		✔	
Sam	Full time		✔	

Review Your Answers: Current/Past/Pending Social Services Assistance

Who	Assistance Program	End Month	State	Section Complete?	Change
James	TANF	09/2011	Virginia	✔	or

Individual Non-Financial Summary (4/5) – Mandatory





Individual Non-Financial Summary (5/5) – Mandatory

Review Your Answers: Other Questions

Here are your answers to the other questions in this section. Please take a look and make sure your answers are correct. If they aren't correct, you can check or uncheck the boxes to change your answers.

Employment Income Gatepost (1/2) – Mandatory

Employment income information

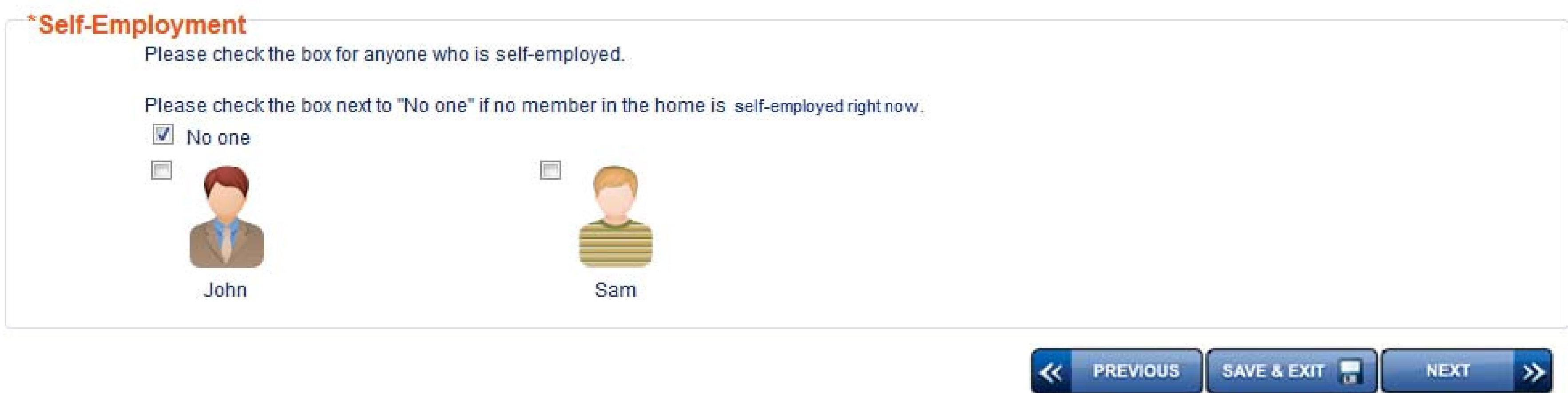
Next, please tell us about the job information of people in your home.
Note: Please be sure to answer the questions for everyone in your home, even if they are not applying for assistance. Depending on your situation, we may need this information in order to approve you for assistance. If we find that your situation does not require us to use this information, then we won't use it to determine your eligibility.

*Current/New Jobs

Please check the box for anyone who is currently employed or is expected to start working or has reduced hours in one or more jobs. Do not check this box if they are paid only with goods and services.
Please check the box next to "No one" if no member in the home has a job right now, no one is expected to start working and no one has any reduced hours in one or more jobs.

- [x] No one
- [ ] John
- [ ] Sam

Employment Income Gatepost (2/2) – Mandatory



Current Job (1/2) – Optional

More About John's Job

You have told us that John has a job or is expected to start a job. Please answer the questions below to tell us more about this job.

Employer

* Name of Employer :

* Employment Type : < click here to choose >

Employer Address : Address Line:

Address Line 2:

City : State : < click here to choose > Zip Code :

Employer Phone :

Have John's hours been reduced in the past 3 months? ○ Yes ○ No

Pay Period

How often does John get paid? < click here to choose >

John's Next Pay Date: Ex: mm/dd/yyyy

Current Job (2/2) – Optional

Hourly Pay

If John gets paid by the hour, please tell us the amount that John gets paid each hour. (Please give us John's regular rate of pay. We'll ask about overtime and other kinds of pay below). If you enter an hourly rate, then you have to enter hours.

$ [ ]

[ ]

Please tell us how many hours John works each week **at this rate.** If John's hours are not regular, try to estimate the number of hours he or she usually works at this hourly rate.

Salary Pay

If John earns a salary instead of being paid by the hour, please tell us the total gross amount that John gets paid each pay period. By gross amount, we mean the amount John earns before taxes or anything else is taken out of the paycheck. By pay period, we mean the time between each paycheck.

$ [ ]

Bonus or Commission Pay

If John gets any other pay, such as bonus or commission pay, please tell us the type of pay John earns, how often it is received and the amount. If the amount is not regular, try to estimate the average amount that John gets.

Type of pay	How often	Amount
< click here to choose >	< click here to choose >	$
< click here to choose >	< click here to choose >	$

Does John have another job? ○ Yes ● No

PREVIOUS | SAVE & EXIT | NEXT

Past Job – Optional

Self-Employment (1/2) – Optional

More About John's Self-Employment

You've told us that John is self-employed. Please answer the questions below to tell us more about this self-employment.

Self-Employment

What type of self-employment does John have? < click here to choose >

What is the start date of John's self-employment ? Ex: mm/dd/yyyy

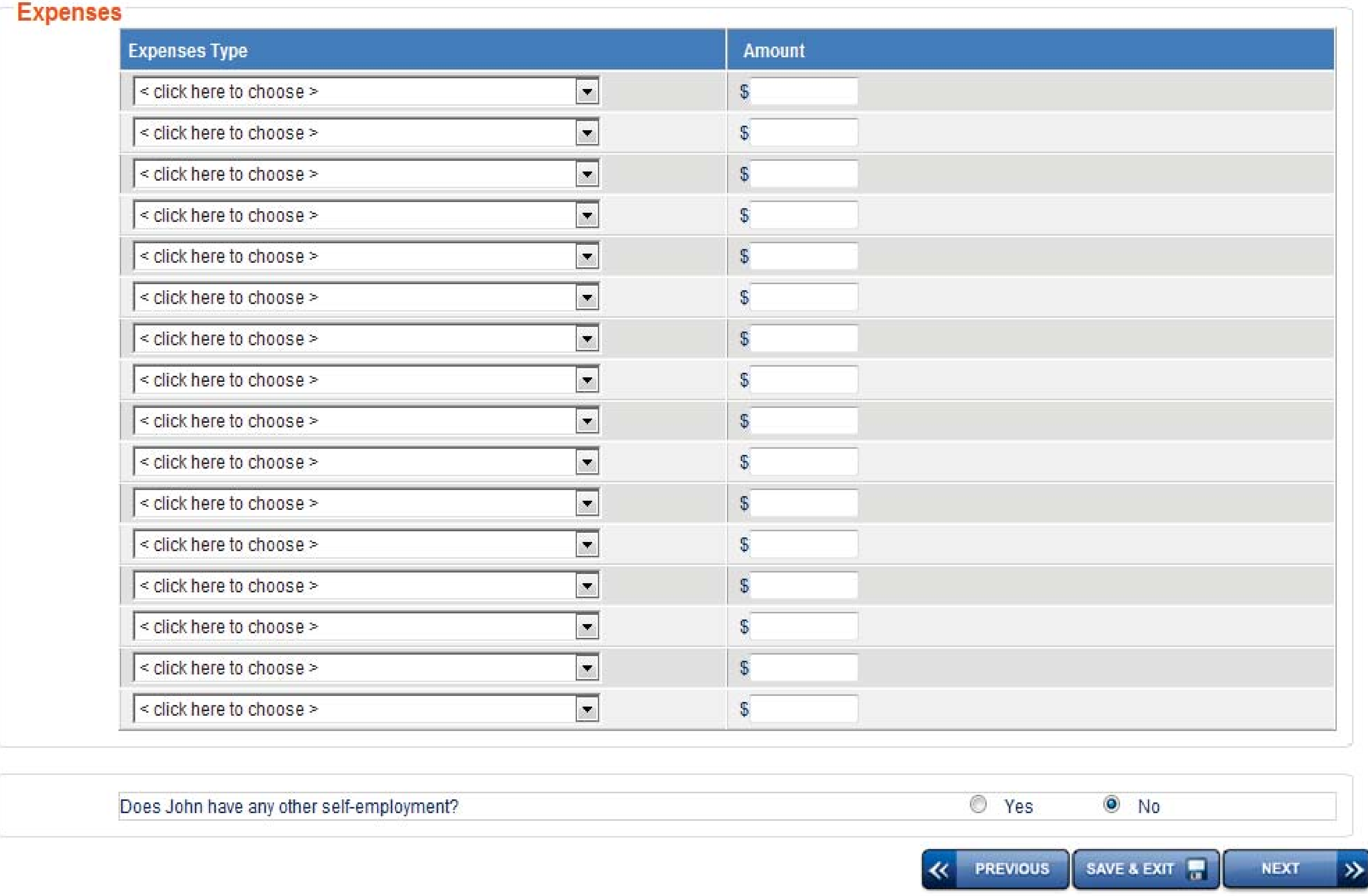
What is the estimated gross monthly income amount from John's self-employment before any expenses ? $

How many hours a month is John self-employed? If John's hours are not regular, please try to estimate the number of hours.

John's Next Pay Date: Ex: mm/dd/yyyy

Do you have any expenses from this self-employment? Yes No

Self-Employment (2/2) – Optional



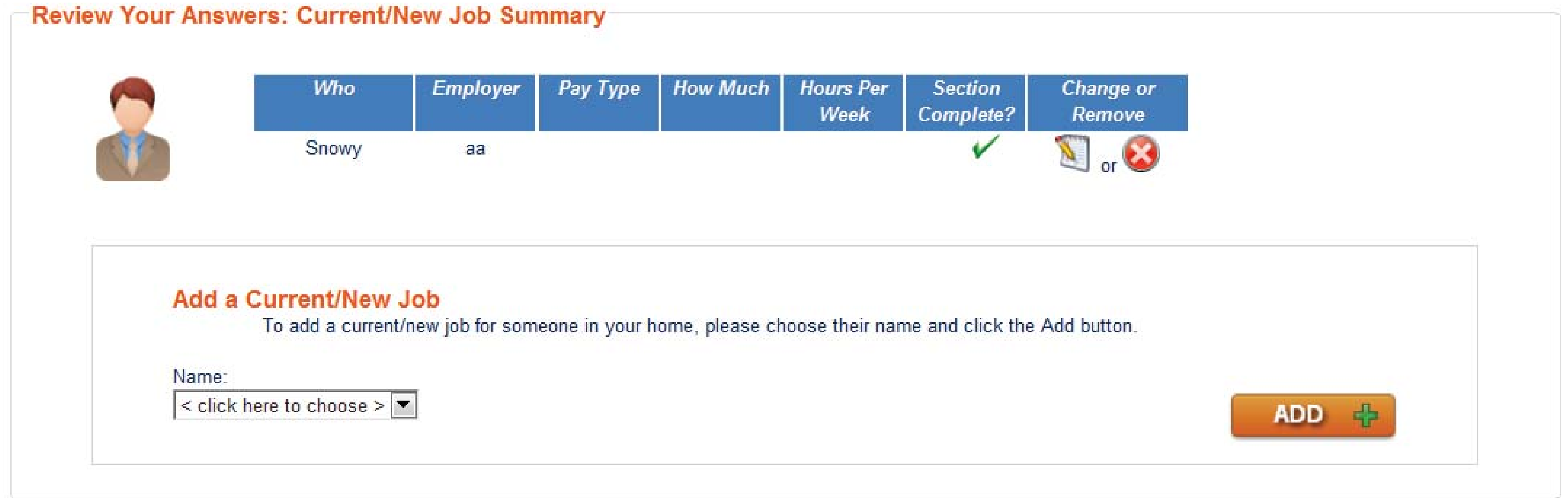
Expenses

Expenses Type	Amount
< click here to choose >	$
< click here to choose >	$
< click here to choose >	$
< click here to choose >	$
< click here to choose >	$
< click here to choose >	$
< click here to choose >	$
< click here to choose >	$
< click here to choose >	$
< click here to choose >	$
< click here to choose >	$
< click here to choose >	$
< click here to choose >	$
< click here to choose >	$
< click here to choose >	$
< click here to choose >	$

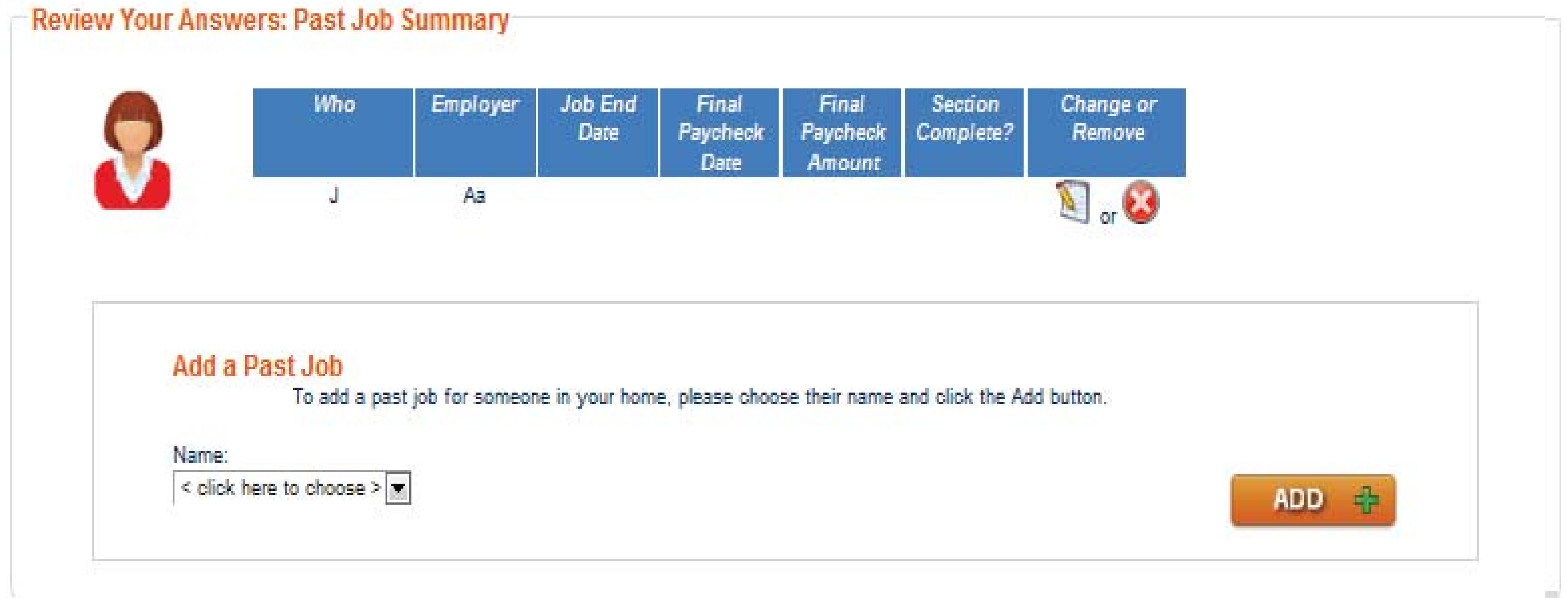
Does John have any other self-employment? ○ Yes ◉ No

PREVIOUS | SAVE & EXIT | NEXT

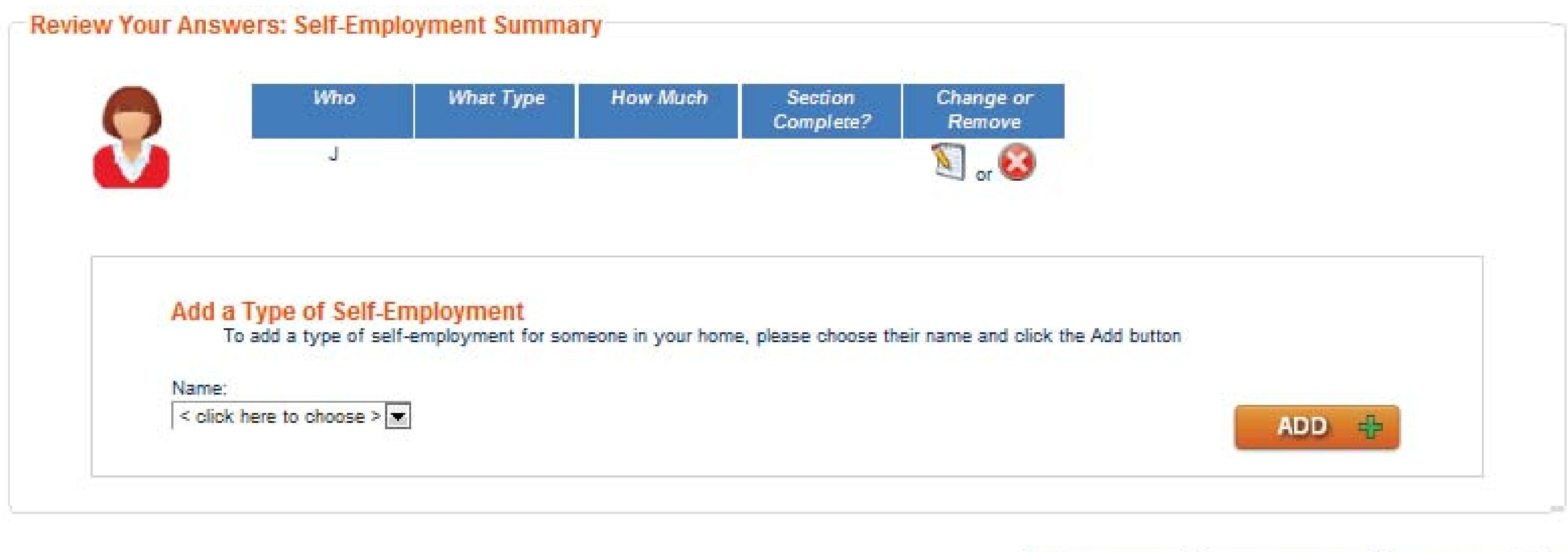
Employment Income Summary (1/3) – Mandatory



Employment Income Summary (2/3) – Mandatory



Employment Income Summary (3/3) – Mandatory



Other Income Gatepost – Mandatory

Money From Other Sources

Next, please tell us about the money that the people in your home receive or are expected to receive from sources other than a job or self-employment. If you're not sure about a source of income, click on Page Help for more information.

Note: Please be sure to answer the questions for everyone in your home, even if they are not applying for assistance. Depending on your situation, we may need this information in order to determine your eligibility. If we find that your situation does not require us to use this information, then we won't use it to determine your eligibility.

Supplemental Security Income (SSI)

Does anyone in your household receive Supplemental Security Income (SSI)? If so, you do not have to report it. This income will not be used to determine your eligibility.

***Social Security Administration (SSA)**

Please check the box for anyone who is receiving or will receive any Social Security payments (example: retirement, disability, survivor's benefits etc). Otherwise, check "No one".

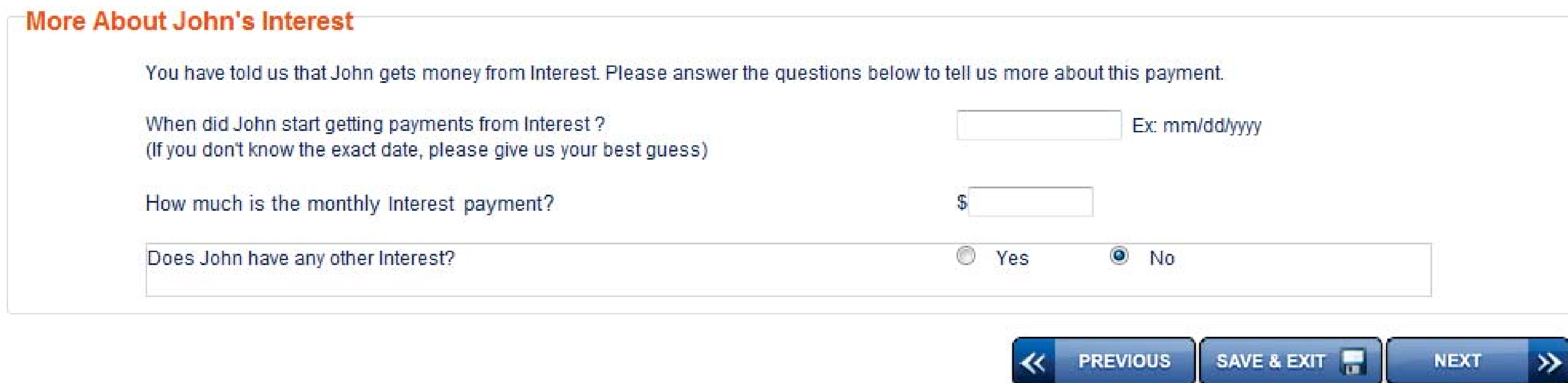
- [x] No one
- [ ] John
- [ ] Mary
- [ ] David
- [ ] Sam

PREVIOUS | SAVE & EXIT | NEXT

Social Security Benefits – Optional

Other Types Of Income – Optional

More About Interest – Optional


More About John's Interest

You have told us that John gets money from Interest. Please answer the questions below to tell us more about this payment.

When did John start getting payments from Interest ?
(If you don't know the exact date, please give us your best guess)

Ex: mm/dd/yyyy

How much is the monthly Interest payment?

$

Does John have any other Interest?

Yes

No

PREVIOUS

SAVE & EXIT

NEXT

Other Income Summary – Mandatory

Other Income Summary

Here is a summary of what you've told us. If a section below has a checkmark, you have given us all of the information we have asked for. You are not required to give all information before you submit the application.

- If you would like to change your answers or finish a section that doesn't have a checkmark, click on "Change."
- If you need to add information for an individual, choose the person's name and the type of income from the dropdown boxes and then click the Add button.
- If you would like to remove something, click "Remove".

Once you've reviewed this summary and all the information is correct, click the Next button at the bottom of the page.

Other Income

Who	Type of Income	How Much	Frequency	Section Complete?	Change or Remove
S	Alimony	$ 10.00	Monthly	✔	or
S	Interest	$ 30.00	Monthly	✔	or
S	Money from Another Person	$ 10.00	Monthly	✔	or
S	Other Income	$ 100.00	Monthly	✔	or

Add Other Income

To add a type of other income, please choose the person and the type of income, then click the Add button.

Name:

< click here to choose >

Type:

< click here to choose >

ADD

Yearly Income – Mandatory

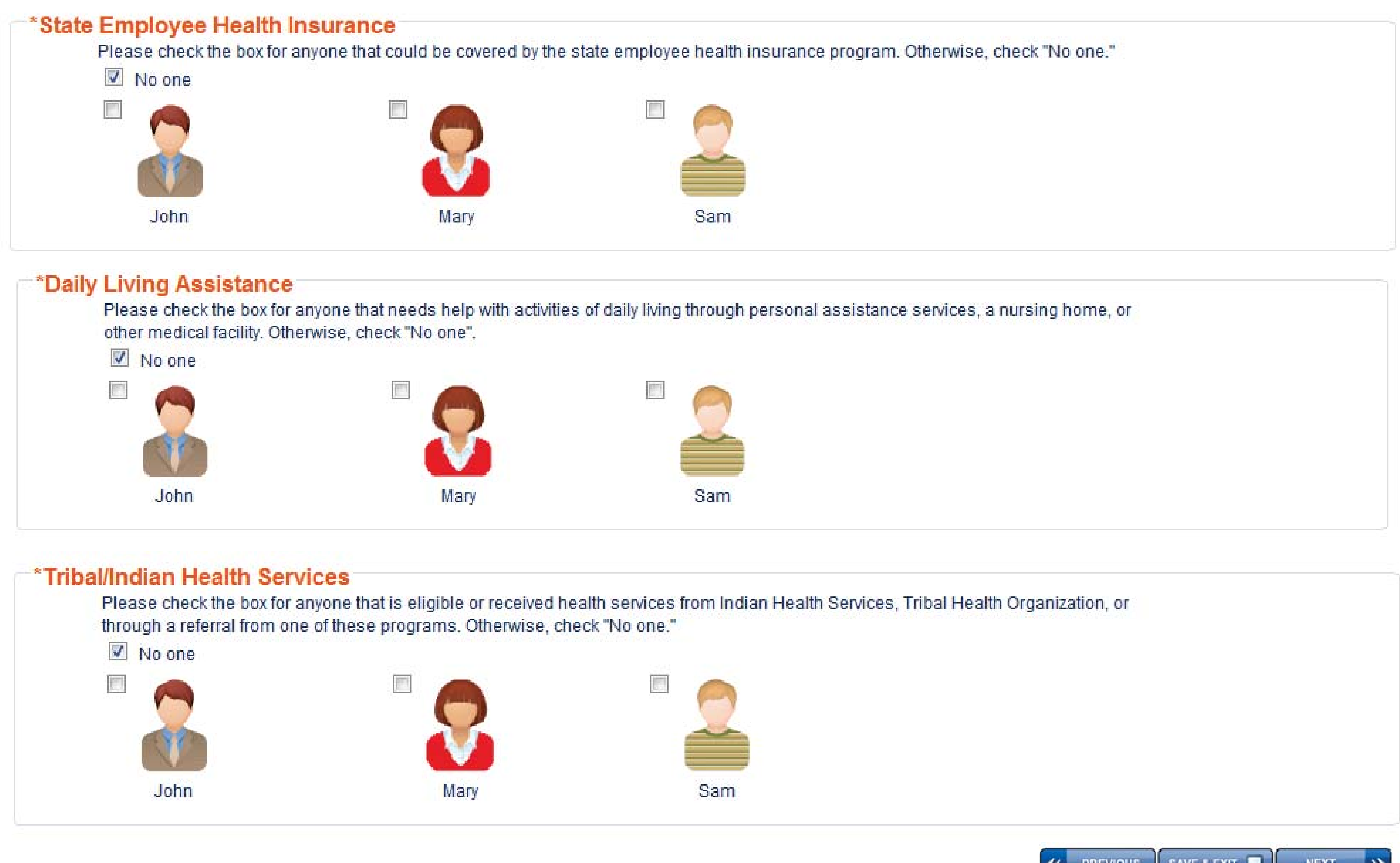
Yearly Gross Income

If the income you provided is not steady from month to month, please tell us what you expect the yearly income to be before taxes and deductions. For example, some people expect their income to change because they only work some months of the year. If you do not expect changes to your monthly income, you do not have to complete this section.

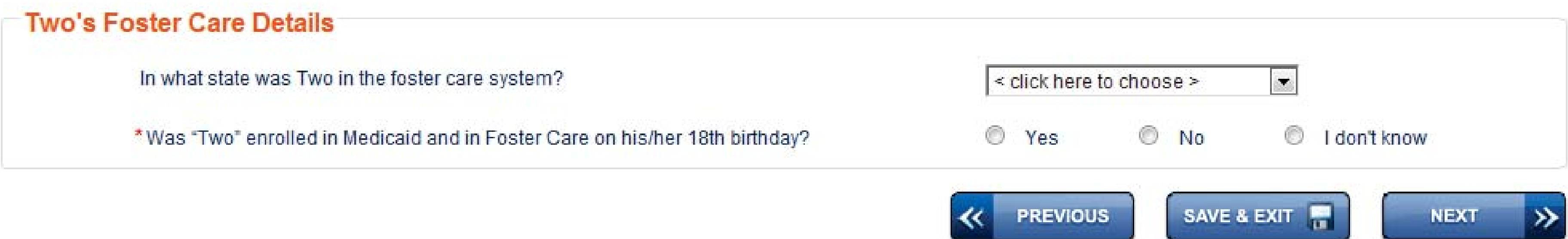
Person Name	Total Gross Annual Income This Year	Total Gross Annual Income Next Year
John	$	$
Mary	$	$
Sam	$	$

Additional Information Gatepost (1/2) – Mandatory

Additional Information Gatepost (2/2) – Mandatory



Foster Care Details – Optional



Employer Health Insurance – Optional

John's Employer Health Insurance

Employer

* Name of the Employer:

Employer's Address:

Address Line 1: | Address Line 2: | City: | State: < click here to choose > | Zip Code:

Employer's Phone Number: | Ext:

Employer Identification Number(EIN):

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

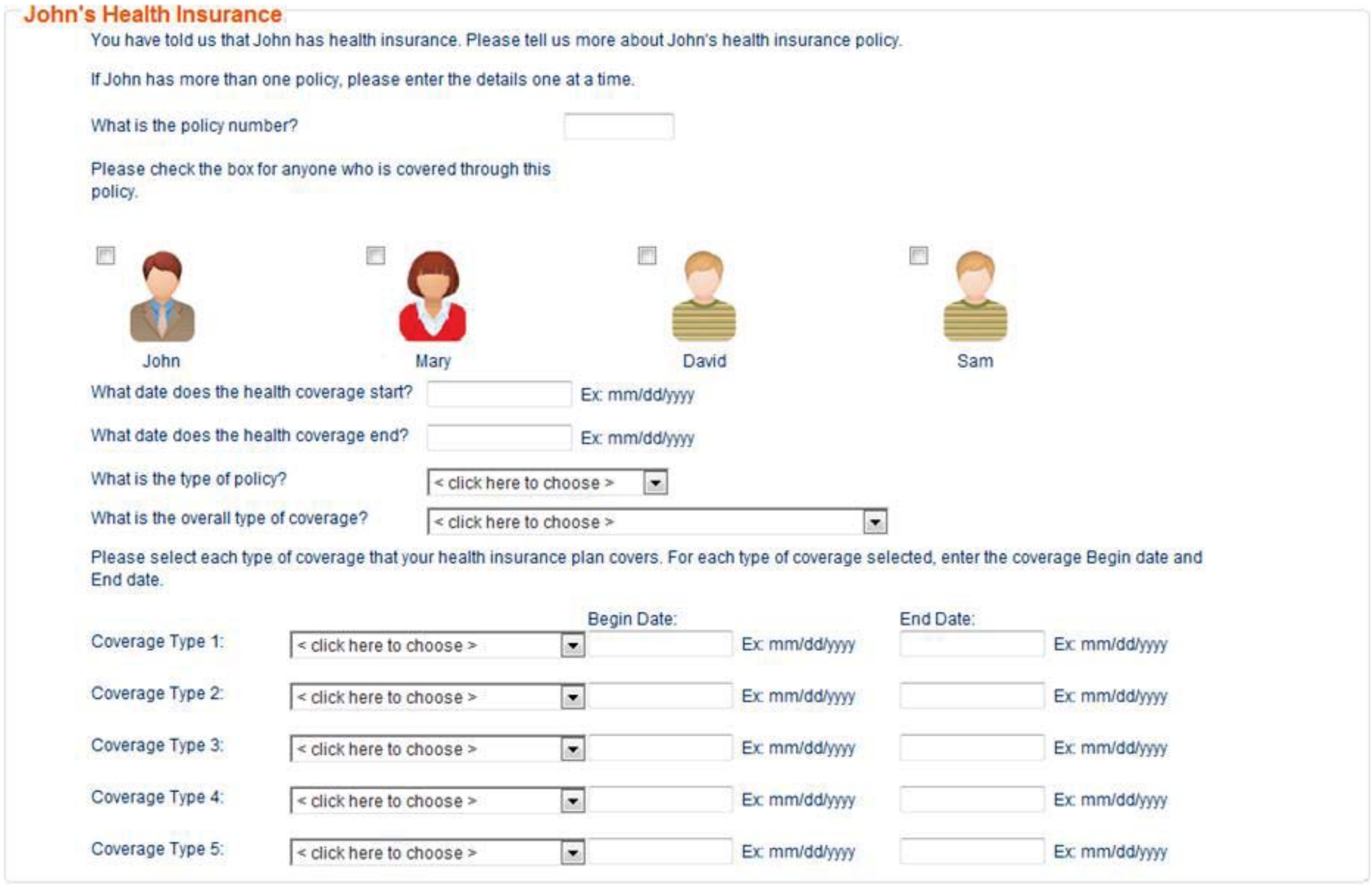
Name: | Phone Number: | Email Address:

Health Insurance

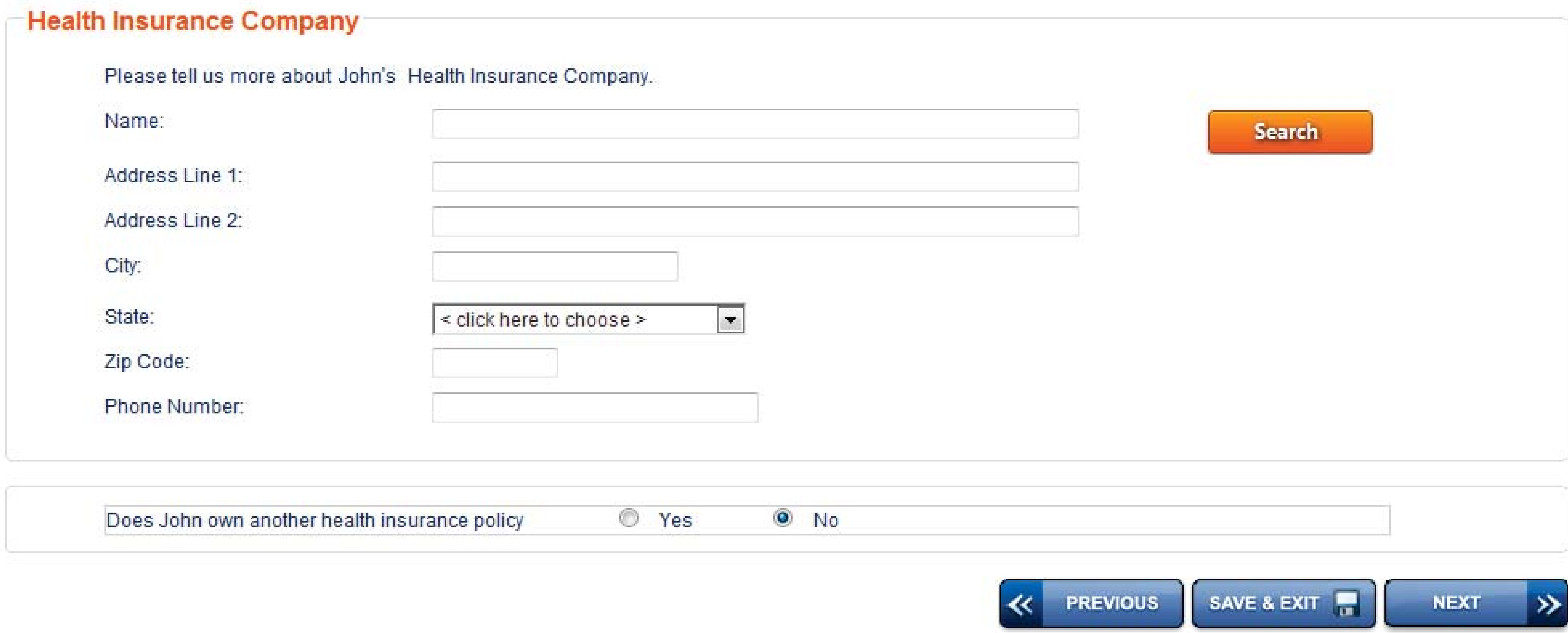
What is the policy number?

Is John offered another health insurance through this job? ○ Yes ◉ No

Other Health Insurance for Household Member (1/2) – Optional



Other Health Insurance for Household Member (2/2) – Optional



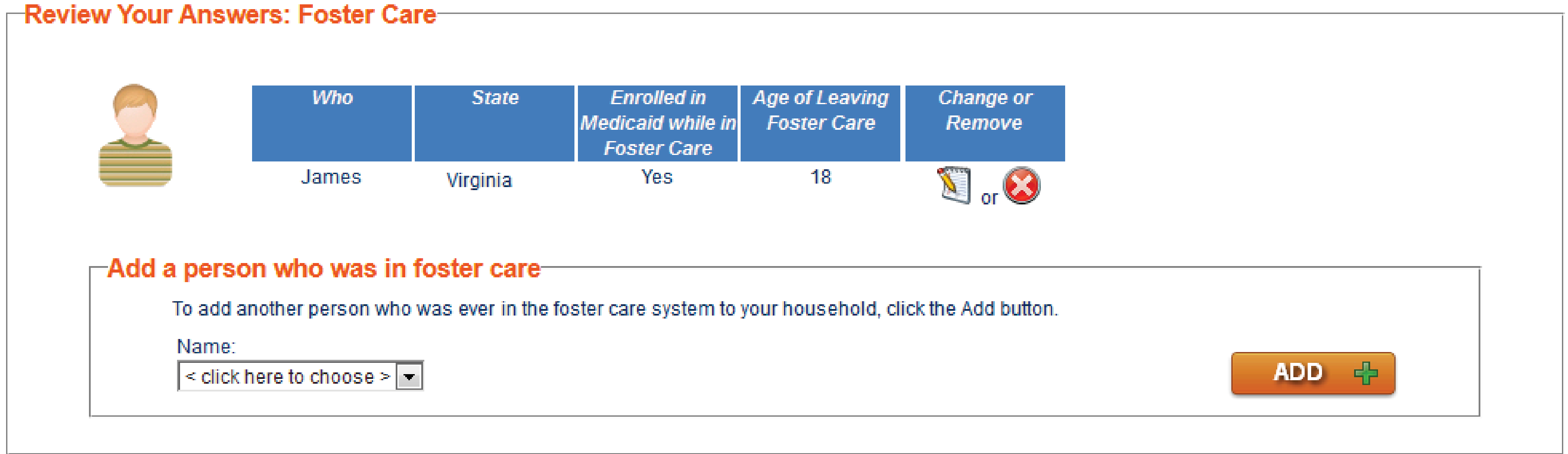
Additional Information Summary (1/4) – Mandatory

Additional Information Summary

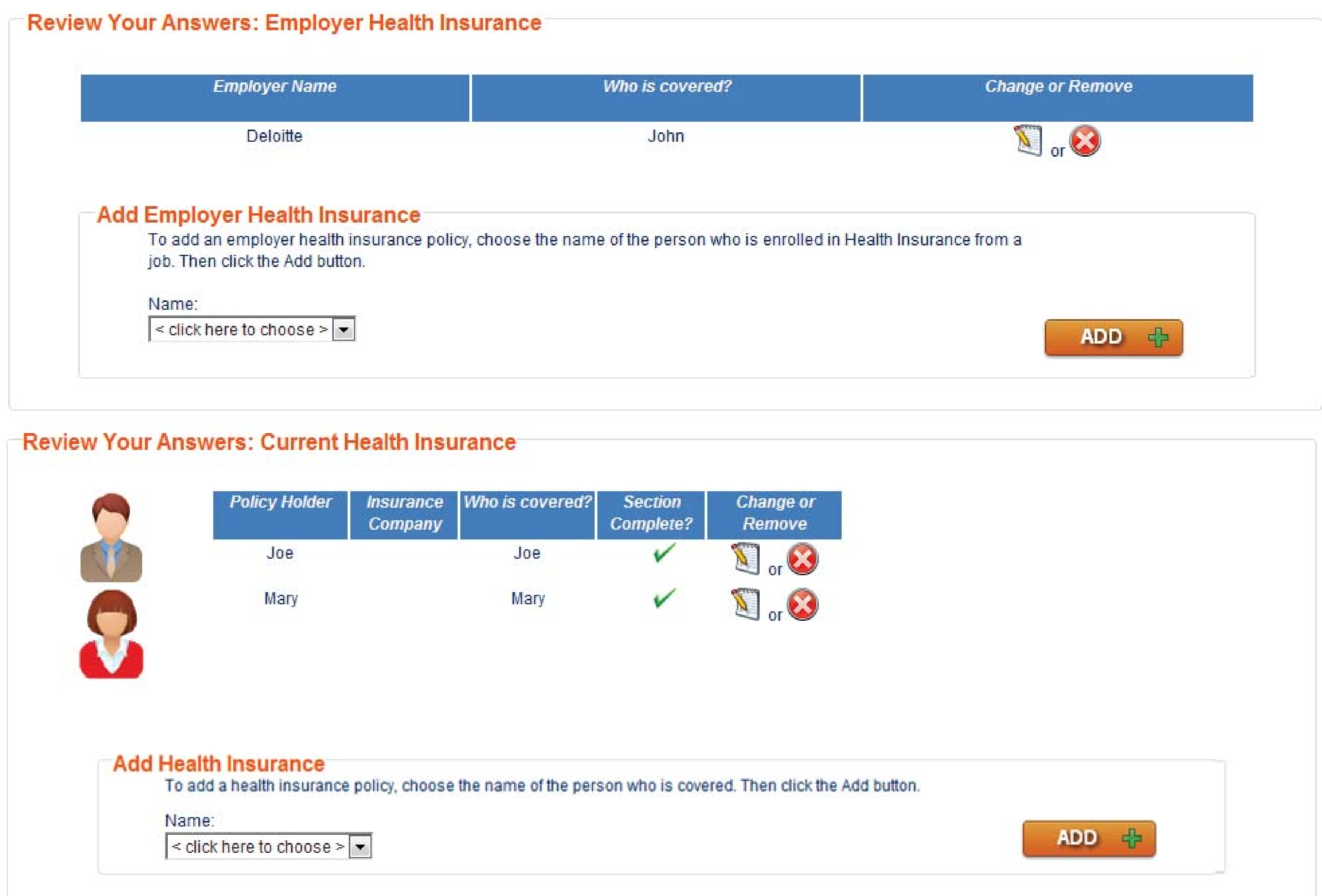
Here is a summary of what you've told us. If a section below has a checkmark, you have given us all of the information we have asked for. You are not required to give all information before you submit the application.

- If you would like to change your answers or finish a section that doesn't have a check mark, Click on "Change".
- If you need to add information for an individual, choose the person's name from the dropdown box and then click the Add button.
- If you would like to remove something, Click "Remove".

Once you've reviewed this summary and all the information is correct, click the Next button at the bottom of the page.



Additional Information Summary (2/4) – Mandatory



Additional Information Summary (3/4) – Mandatory

Review Your Answers: Other Questions

Here are your answers to the other questions in this section. Please take a look and make sure your answers are correct. If they aren't correct, you can check or uncheck the boxes to change your answers.

Review Your Answers: State Employee Health Insurance

Please review your answers for anyone that could be covered by the state employee health insurance program and modify your selection as needed.

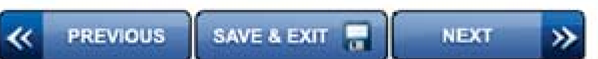
- [x] No one
- [ ] John
- [ ] Mary
- [ ] James

Review Your Answers: Daily Living Assistance

Please review your answers for anyone who needs help with activities of daily living through personal assistance services, a nursing home, or other medical facility and modify your selection as needed.

- [x] No one
- [ ] John
- [ ] Mary
- [ ] Sam

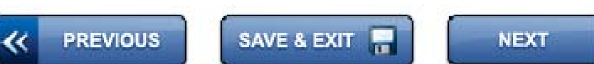
Additional Information Summary (4/4) – Mandatory



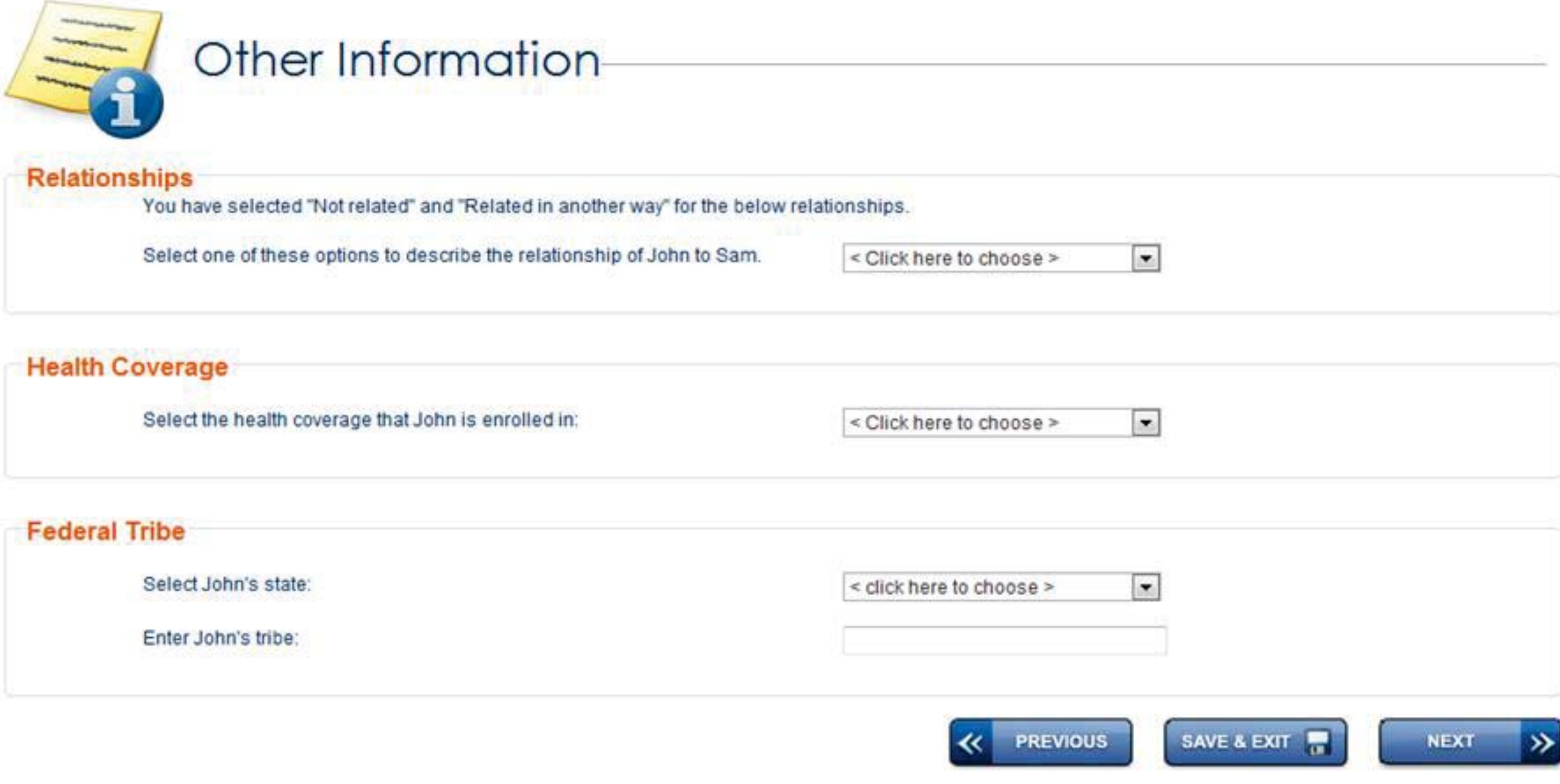
Advanced Premium Tax Credit (APTC) Information Gatepost – Optional

Advance Premium Tax Credits (APTC) Information

Based on the information you have provided so far, it appears that your application may be sent to the Federal Health Insurance Marketplace. They will evaluate you to determine eligibility for assistance with purchase and payment of private health insurance.



Other APTC Information – Optional



APTC Employer Health Insurance (1/2) – Optional

APTC Employer Health Insurance

Employer

Name of Employer: **Deloitte**
Name of Insurance Company:

Health Insurance

Is John currently enrolled in this employer's health coverage? ◯ Yes ◯ No

Which of these people are eligible for coverage from this job?

☐ John ☐ Mary ☐ Sam

What's John's current work status at this employer? < Click here to choose

Is the coverage from employer COBRA coverage? ◯ Yes ◯ No

Is John's coverage from employer a retiree health plan? ◯ Yes ◯ No

APTC Employer Health Insurance (2/2) – Optional

Health Coverage Details

Does the employer offer a health plan that meets the minimum value standard? (An employer-sponsored health plan meets the 'minimum value standard' if the plan's share of the total allowed benefits costs covered by the plan is no less than 60 percent of such costs (Section36(c)(2)(C)(ii) of the Internal Revenue Code of 1986) ○ Yes ○ No

Does John expect this employer to make any of these changes to the coverage offered to John for the next plan year?

○ This employer will no longer offer health coverage

What will be the last day this employer offers coverage? [ ] Ex: mm/dd/yyyy

○ This employer will change the cost of premiums for the lowest-cost plan available to the employee that meets the minimum value.

How much will the employee have to pay in premiums for this plan? [ ]

How often would John pay this amount? [< click here to choose >]

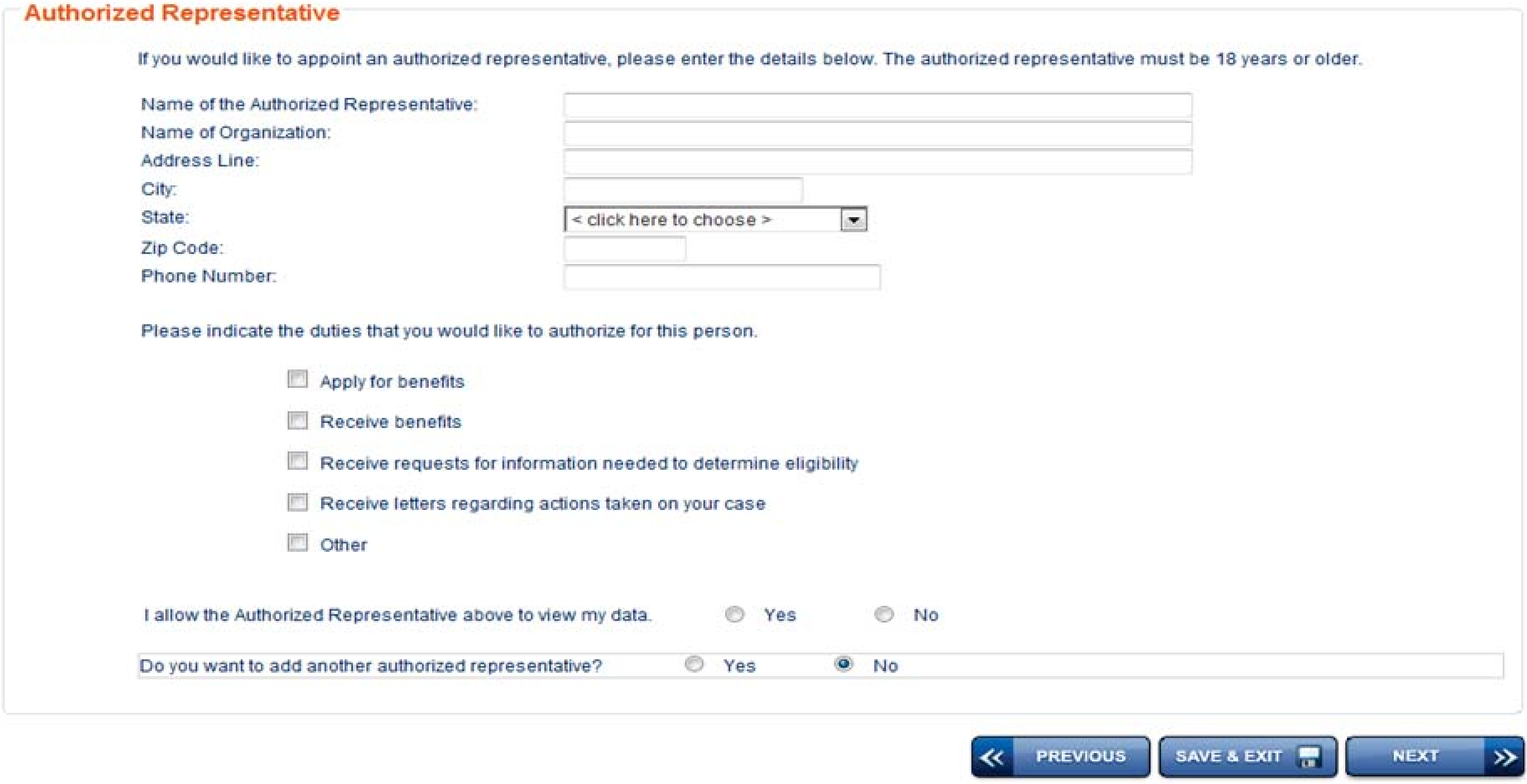
When will this employer make this change? [ ] Ex: mm/dd/yyyy

○ I don't know if this employer will make changes.

○ This employer won't make any of these changes.

PREVIOUS | SAVE & EXIT | NEXT

Authorized Representative – Mandatory


Authorized Representative

If you would like to appoint an authorized representative, please enter the details below. The authorized representative must be 18 years or older.

Name of the Authorized Representative:

Name of Organization:

Address Line:

City:

State: < click here to choose >

Zip Code:

Phone Number:

Please indicate the duties that you would like to authorize for this person.

- Apply for benefits
- Receive benefits
- Receive requests for information needed to determine eligibility
- Receive letters regarding actions taken on your case
- Other

I allow the Authorized Representative above to view my data. Yes No

Do you want to add another authorized representative? Yes No

PREVIOUS SAVE & EXIT NEXT

Certified Application Counselor/Navigator/Broker – Mandatory

Certified Application Counselor/Navigator/Broker

Complete this section if you would like to authorize a Certified Application Counselor or Navigator or Broker to be able to access confidential information related to your Health Care Coverage application or case. If you don't have a Certified Application Counselor/Navigator or Broker, click "Next" to continue.

First Name : | Middle Name : | Last Name : | Suffix : --

Name of Organization

ID Number (if applicable)

PREVIOUS | SAVE & EXIT | NEXT

Finish Summary (1/2) – Mandatory

Finish Summary

Here is a summary of what you've told us. If a section below has a checkmark, you have given us all of the information we have asked for. You are not required to give all information before you submit the application.

- If you would like to change your answers or finish a section that doesn't have a checkmark, click on "Change."
- If you would like to remove something, click "Remove".

Once you've reviewed this summary and all the information is correct, click the Next button at the bottom of the page. Once you have answered all the questions, you will be asked to electronically sign the application. Then click the Next button at the bottom of the page. You will then be asked to sign back into your account. Once you have signed back into your account, it will take you back to the electronic signature page and you will need to click the Submit button at the bottom of the page. You will receive a confirmation number (or T #) when the application has been successfully submitted. Keep this number for reference. You will also be able to print a copy of your submitted application for your records.

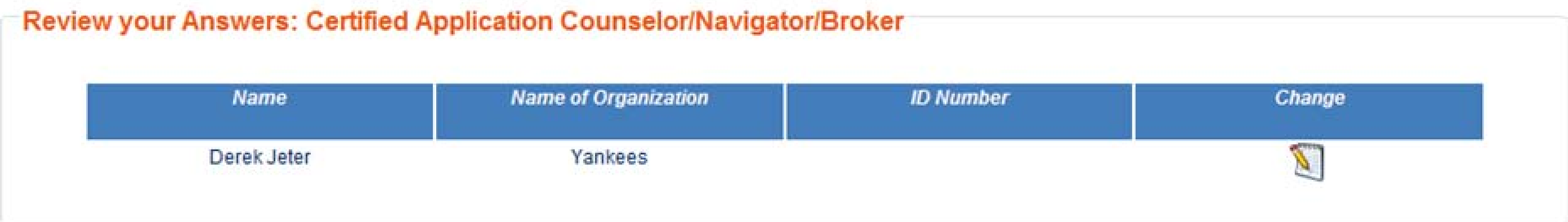
Review Your Answers: Authorized Representative

Name	Address	Authorized For	Section Completed?	Change or Remove
David	3600 Vartan way, Harrisburg, PA, 11111	Apply for benefits, Receive benefits	✔	or

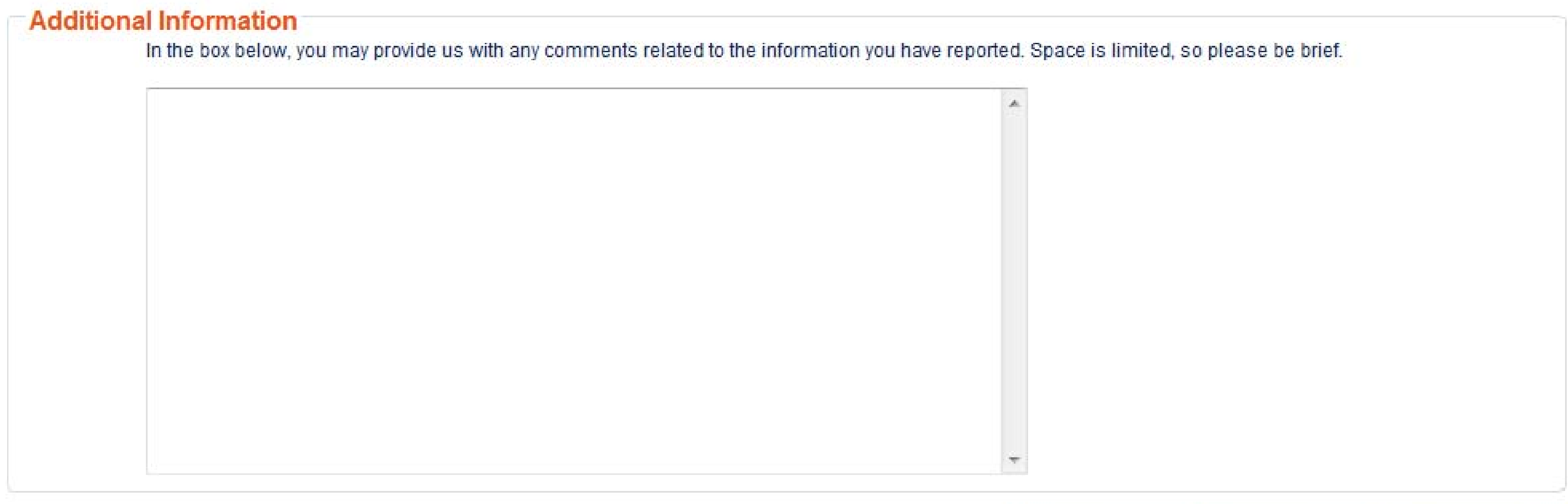
Add an Authorized Representative
To add an Authorized Representative, click the Add button

ADD

Finish Summary (2/2) – Mandatory



Additional Information Comments – Mandatory



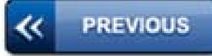
Next Steps – Mandatory

More ways we can help

Thank you for providing information required for the Health Care Coverage application. Your application has not yet been submitted.

If you want to apply for additional Benefit programs (such as SNAP, TANF, Child Care, Energy Assistance) or other Medicaid programs (such as coverage for elderly or disabled individuals including SSI recipients, long-term care services, etc.), click on the 'Apply For Other Benefit And Medicaid Programs' button. If you decide to do this now, additional information may be required but you will not be asked to re-enter information already provided.

If you only want to apply for Health Care Coverage at this time, click on the 'Complete My Health Care Application' button.



COMPLETE MY HEALTH CARE APPLICATION | APPLY FOR OTHER BENEFIT AND MEDICAID PROGRAMS

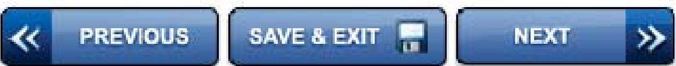
CommonHelp is provided by the Virginia Department of Social Services
Toll-Free Helpline:1-855-635-4370 | Email: mailto:commonhelp@dss.virginia.gov
Commonwealth of Virginia - 2014 - Terms of Use - Privacy Policy

Section Complete – Optional

Before You Submit the Application

We have found that there are a few things missing from your application. You do not have to answer all of the questions before you submit your application, but in most cases, you will have to answer them in order to get benefits.

Section	Section Complete?	Go Back
Start	No	Go Back to Start
People	No	Go Back to People



Sign Application (1/4) – Mandatory

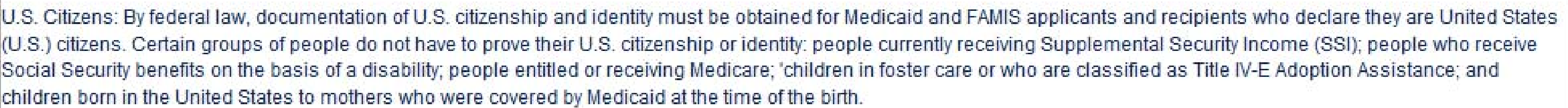
Signing Your Application

You're just a few minutes away from submitting your application. To do so, you'll need to:

- Read the Rights and Responsibilities we've listed below.
- Check the signature box and type your name below to sign your application.
- Save & Exit if you are not ready to submit your application. However, your application will be deleted in 60 days if it is not updated.

Responsibilities, Rights, and Penalties

GENERAL INFORMATION



U.S. Citizens: By federal law, documentation of U.S. citizenship and identity must be obtained for Medicaid and FAMIS applicants and recipients who declare they are United States (U.S.) citizens. Certain groups of people do not have to prove their U.S. citizenship or identity: people currently receiving Supplemental Security Income (SSI); people who receive Social Security benefits on the basis of a disability; people entitled or receiving Medicare; 'children in foster care or who are classified as Title IV-E Adoption Assistance; and children born in the United States to mothers who were covered by Medicaid at the time of the birth.

You will be enrolled in coverage if you meet all other eligibility requirements. A data match will be conducted with the Social Security Administration (SSA) to verify your claim of U.S. citizenship. If the SSA cannot verify your claim of U.S. citizenship, you will receive a written request from your eligibility worker at your local department of social services or from the Cover Virginia central processing unit to provide a document that proves you are a U.S. citizen and a photo identification card or document that identifies you.

Sign Application (2/4) – Mandatory

Consent to Exchange Information

The Virginia Department of Social Services (VDSS) would like to use some of the personal information that you have provided on your application about you and your dependents to create your User Profile. VDSS is asking for permission to share your User Profile electronically with the state agencies listed below. Each agency will be told when you make a change to the information in your User Profile. This will allow you to save time by only providing User Profile information once when visiting these agencies.

Legal Notice

The data being shared

Your User Profile will only be created if you agree to share it and you are eligible for assistance. Your User Profile will contain first name, last name, middle initial, suffix (Jr., Sr., etc.), current home address, date of birth, Social Security Number and Medicaid identification number (if applicable), email address, home phone, driver's license ID and cell phone number. However, you can share your User Profile without sharing your Social Security number; this will not affect your eligibility. Your Medicaid identification number will only be shared with VDSS and your local department of social services. Because the User Profile is based on your application for assistance, the agencies named below also will know that you are receiving assistance.

Agencies Included and Allowed Use

Below are the agencies that will get your information. The reasons they have requested your User Profile and what they will be allowed to do with your User Profile are listed.

Sharing your User Profile will allow them to update the information in their computers, saving taxpayer dollars. It may save you a visit to one of these agencies because your information has been changed electronically.

The Department of Motor Vehicles (DMV) would like a copy of your User Profile when it changes. DMV can change your address for cars you own or driver's

Giving Consent

- ○ My User Profile can be shared with the specified agencies, but do not include Social Security Number when creating my User Profile.
- ○ Share my User Profile with the specified agencies. Include Social Security Number when creating my User Profile.
- ○ Do not allow my User Profile to be shared.

Sign Application (3/4) – Mandatory

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 today?

- I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.
- Yes, I would like to apply to register to vote. (Please click here to apply online or click here to download a voter registration form).
- No, I do not want to register to vote.

If you do not check any 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

Authorization to Use Income Data to Renew Coverage

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Medicaid or FAMIS programs or the Marketplace to use income data, including information from tax returns. I understand that I will receive notification of the outcome of my renewal.

I understand that I can opt out at any time. Please contact your local agency for details.

* Do you want to use information from your tax returns to automatically renew your coverage for future years? Yes No

How many years would you like to have your coverage automatically renewed for?

Sign Application (4/4) – Mandatory

Signature Declaration

BY MY SIGNATURE, I DECLARE:

. I understand and agree to abide by all the information in the Responsibilities, Rights, Penalties, Additional Information, and Signature Declaration sections of this application.

. I understand that if I refuse to cooperate with any review of my eligibility including review by Quality Assurance, my benefits may be denied until I cooperate.

. I understand that I have the right to file a complaint if I believe I have been discriminated against because of race, color, national origin, sex, age, disability, or religious or political beliefs.

. I understand the Department of Social Services or the Department of Medical Assistance Services may use information on this application or that I may be contacted for the purposes of research, evaluation and analysis to the extent allowed by state and federal law.

. I understand that I have the right to appeal and have a fair hearing if I am (1) not notified in writing of the decision regarding my application within specified time frames; (2) denied benefits from the programs for which I applied; or (3) dissatisfied with any other decision that affects my receipt of assistance. For FAMIS/ FAMIS MOMS, there will be no opportunity for review of a negative action if the sole basis for the action is exhaustion of funding.

Electronic Signature

I certify that the above statements are true and correct to the best of my knowledge. If I give false information, withhold information, fail to report changes promptly, or obtain assistance for which I am not eligible, I may be breaking the law and could be prosecuted for perjury, larceny and/or fraud.

If I completed, or assisted in completing this application form and aided and abetted the applicant to obtain assistance for which he/she is not eligible, I may be breaking the law and could be prosecuted.

I agree to submit this application by electronic means. By signing this application electronically, I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

* ☐ By checking this box and typing my name below, I am electronically signing my application.

* First Name: Middle Initial : * Last Name: Suffix : --

If you are ready to submit your application, click the Next button. You will then be asked to sign back into your account. Once you have signed back into your account, click the Submit button at the bottom of the page to complete your application.

PREVIOUS NEXT

Thank You – Mandatory

Congratulations! Your application has been successfully submitted.

Here are a few important things that you should do

Keep Track of Your Application

The tracking number is **T13991857**. Be sure to write this number down or print this page for your records.

You can track your application online by clicking on the "Check My Benefits" button on the home page.

If you haven't heard back about an application you've submitted, please contact the agency before submitting another online application. If you give the agency tracking number, the agency can give you information more quickly.

Contact details for the agency are provided below:

CHESTERFIELD
PO BOX 430
CHESTERFIELD, VA 23832-0430
804-748-1100

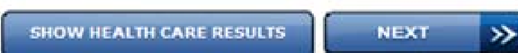
Print Your Application

If you would like to print or save a copy of your application for your files, please click the Print PDF button below. If you decide to print or save, please keep in mind that your application has your private, personal information in it.
Advisory- Please read:
The account and application you just created are secure, but if you are using a computer in a Library, Community Center or other public place, please take these additional steps:
If you print anything, remember to get the printed copies of your application. If the printer jams or your application fails to print, contact someone at the location for help.
And, after you have completed your application(s), shut down the Internet program and if possible ask the staff to restart the computer.

You will need to have a program called Adobe Acrobat Reader to see and print this information. If you don't have this program on your computer, you may install it for free by clicking:

View Your Health Care Results

You may be able to obtain your Health Care results now by clicking on the "Show Health Care Results" button below. If the system is unable to determine eligibility now, you may be contacted for additional information.



Eligibility Results (1/2) – Optional

Eligibility Determination Details

This is information about your eligibility for Health Care Coverage.

Whenever your benefits change, you should get a letter in the mail telling you about the change. This letter will also let you know your rights if you feel the change has been made in error.

Eligibility Determination Results

Adam

As of today, Adam is approved for Health Care Coverage.

Eligibility Determination Results

Mary

As of today, Mary is not approved for Health Care Coverage because of the following reason(s):

- Did not meet Virginia Residency Requirement.

Eligibility Results (2/2) – Optional

Eligibility Determination Results

John

As of today, John has a pending application for Health Care Coverage. The application is being processed and you will be contacted with additional details.

Eligibility Determination Results

Jane

As of today, Jane has a pending application for Health Care Coverage because there are additional documents needed for verification.

What is needed:

- SSN Card or Driver's License
- Pay Stubs

Please click on the "Submit Verification Documents" button to upload the additional documents.

If you have already provided these documents, you do not need to upload these documents again.

PREVIOUS NEXT

Submit Document – Optional

Submit Your Documents

No additional documentation of information is required at this time. However, if you have documents or information that you would like to add to your application at this time, you may upload them here. If you do not upload any documents, this will not impact your eligibility. We will use electronic sources to verify income data, including information from tax returns, if available, to make a decision on your application. If we are unable to use electronic data sources, we may ask you to send documents later. This section is for your convenience only.

If you have already uploaded documents, a list of the documents you have already uploaded will appear in the "Documents You Have Already Uploaded" section.

Upload a New Document

For each document you upload, please select the name of the person for whom you are uploading the document and the type of document. Next, click "Browse.", and then select the file. After you have selected the file, click Upload. Please ensure that the file name describes the content of the file.

If you need more information on the document types to upload, please click on the Page Help for instructions.

Once the document has been uploaded, it will be listed in the Documents You Have Already Uploaded section

Name:	Document Type	File Name
< Click here to choose >	< click here to choose >	Browse... Upload

Files with extensions ".jpg", ".pdf" and ".tif" are supported.

Having trouble uploading? This website may need to be added to your Trusted Sites for upload to work. Please click on the Page Help for instructions.

Documents You Have Already Uploaded

These documents have already been uploaded and will be submitted when you submit your application. If you would like to remove a document, click "Remove".