Table of Contents

State Name: Virginia

State Plan Amendment (SPA) #: 18-0015

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
801 Market Street - Suite 9400
Philadelphia, Pennsylvania 19107

Region III/Division of Medicaid and Children's Health Operations
SWIFT #081620184048

November 7, 2018

Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Dr. Lee:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Virginia's State Plan Amendment (SPA) 18-0015, Changes to Medicaid Application. This amendment proposes to revise the Virginia Medicaid paper and online application to include the changes resulting from Virginia's Medicaid expansion.

This SPA is acceptable. Therefore, we are approving SPA 18-0015 with an effective date of November 1, 2018. Enclosed are the approved State Plan pages.

Please note that accompanying this approval of SPA 18-0015, there is an enclosed companion letter regarding the need for Virginia to make modifications to the Virginia Common Help Medicaid online application.

We appreciate the cooperation and effort provided by your staff throughout this process. If you have further questions about this SPA, please contact Margaret Kosherzenko of my staff at 215-861-4288.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

VA - Submission Package - VA2018MS0009O - (VA-18-0015) - Eligibility

CMS-10434 OMB 0938-1188

Package Information

Package ID	VA2018MS0009O	**Submission Type**	Official
Program Name	N/A	**State**	VA
SPA ID	VA-18-0015	**Region**	Philadelphia, PA
Version Number	2	**Package Status**	Approved
Submitted By	Emily McClellan	**Submission Date**	8/10/2018
Package Disposition		**Approval Date**	11/7/2018 9:09 AM EST
Priority Code	P2		

Approval Notice

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard, Mail Stop S2-14-26

Baltimore, Maryland 21244-1850

Date: 11/07/2018

Head of Agency: Jennifer Lee, M.D.

Title/Dept : Director

Address 1: 600 E. Broad Street

Address 2:

City : Richmond

State: VA

Zip: 23219

MACPro Package ID: VA2018MS0009O

SPA ID: VA-18-0015

Subject

Approval of Virginia SPA 18-0015

Dear Jennifer Lee, M.D.

This is an informal communication that will be followed with an official communication to the State's Medicaid Director.

The Centers for Medicare and Medicaid Services (CMS) is pleased to inform you that we are recommending approval for your request for

Virginia SPA 18-0015

Reviewable Unit	Effective Date
Application	11/1/2018

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Virginia's State Plan Amendment (SPA) 18-0015, Changes to Medicaid Application. This amendment proposes to revise the Virginia Medicaid paper and online application to include the changes resulting from Virginia's Medicaid expansion.

This SPA is acceptable. Therefore, we are approving SPA 18-0015 with an effective date of November 1, 2018. Attached are the approved State Plan pages.

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We appreciate the cooperation and effort provided by your staff throughout this process. If you have further questions about this SPA, please contact Margaret Kosherzenko at 215-861-4288.

Sincerely,

Sarah Spector

Ms.

Approval Documentation

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0009O | VA-18-0015

Package Header

Package ID VA2018MS0009O

SPA ID VA-18-0015

Submission Type Official

Initial Submission Date 8/10/2018

Approval Date 11/7/2018

Effective Date N/A

Superseded SPA ID N/A

State Information

State/Territory Name: Virginia

Medicaid Agency Name: Department of Medical Assistance Services

Submission Component

◯ State Plan Amendment

◯ Medicaid

◯ CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0009O | VA-18-0015

Package Header

Package ID VA2018MS0009O
SPA ID VA-18-0015
Submission Type Official
Initial Submission Date 8/10/2018
Approval Date 11/7/2018
Effective Date N/A
Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID VA-18-0015

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Application	11/1/2018	VA-13-0010

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0009O | VA-18-0015

Package Header

Package ID VA2018MS0009O

SPA ID VA-18-0015

Submission Type Official

Initial Submission Date 8/10/2018

Approval Date 11/7/2018

Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives The purpose of this SPA is to revise the Virginia Medicaid application to include the changes resulting from Medicaid Expansion.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2019	$0
Second	2020	$0

Federal Statute / Regulation Citation

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

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0009O | VA-18-0015

Package Header

Package ID	VA2018MS0009O	**SPA ID**	VA-18-0015
Submission Type	Official	**Initial Submission Date**	8/10/2018
Approval Date	11/7/2018	**Effective Date**	N/A
Superseded SPA ID	N/A		

Governor's Office Review

- ◯ No comment
- ◯ Comments received
- ◯ No response within 45 days
- ◯ Other

Submission - Public Comment

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0009O | VA-18-0015

Package Header

Package ID	VA2018MS0009O	**SPA ID**	VA-18-0015
Submission Type	Official	**Initial Submission Date**	8/10/2018
Approval Date	11/7/2018	**Effective Date**	N/A
Superseded SPA ID	N/A		

Indicate whether public comment was solicited with respect to this submission.

- ◯ Public notice was not federally required and comment was not solicited
- ◯ Public notice was not federally required, but comment was solicited
- ◯ Public notice was federally required and comment was solicited

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0009O | VA-18-0015

Package Header

Package ID	VA2018MS0009O	**SPA ID**	VA-18-0015
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Approval Date	11/7/2018	**Effective Date**	N/A
Superseded SPA ID	N/A		

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

- ◯ Yes
- ◯ No

Medicaid State Plan Eligibility

General Eligibility Requirements

Application

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0009O | VA-18-0015

Package Header

Package ID	VA2018MS0009O	**SPA ID**	VA-18-0015
Submission Type	Official	**Initial Submission Date**	8/10/2018
Approval Date	11/7/2018	**Effective Date**	11/1/2018
Superseded SPA ID	VA-13-0010		
	System-Derived		

A. MAGI Paper Application

The state uses the following paper application(s) for individuals applying for coverage based on the applicable modified adjusted gross income (MAGI) standard.

○ 1. 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

○ 2. One or more alternative single, streamlined applications 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

Name

Virginia Application for Health Coverage_1.1.2019

The paper application(s) has been uploaded.

Document Name	Date Created	
Medicaid Application_7.10.2018	7/19/2018 8:43 AM EDT	

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

☐ 4. Other alternative applications, provided that the agency makes readily available the single streamlined application used only for insurance affordability programs to individuals seeking assistance only through such programs

Application

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0009O | VA-18-0015

Package Header

Package ID	VA2018MS0009O	**SPA ID**	VA-18-0015
Submission Type	Official	**Initial Submission Date**	8/10/2018
Approval Date	11/7/2018	**Effective Date**	11/1/2018
Superseded SPA ID	VA-13-0010		
	System-Derived		

B. MAGI Online Application

The state uses the following online application(s) for individuals applying for coverage based on the applicable MAGI standard.

- ○ 1. 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
- ○ 2. One or more 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

Name

Online Application Screen Shots

Screenshots or other documentation of the online application(s) has been uploaded.

Document Name	Date Created	
Electronic Application Screenshots	8/10/2018 3:34 PM EDT	

- ☐ 3. One or more alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single application used only for insurance affordability programs to individuals seeking assistance only through such programs
- ☐ 4. Other alternative applications, provided that the agency makes readily available the single streamlined application used only for insurance affordability programs to individuals seeking assistance only through such programs

Application

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0009O | VA-18-0015

Package Header

Package ID	VA2018MS0009O	**SPA ID**	VA-18-0015
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Superseded SPA ID	VA-13-0010		
	System-Derived		

C. Basis Other than MAGI - Paper Application

The state uses the following paper application(s) for individuals applying for coverage on a basis other than the applicable MAGI standard:

- [ ] 1. 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
- [ ] 2. One or more applications designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary
- [ ] 3. One or more applications used to apply for multiple human service programs
- [ ] 4. Other alternative applications

Application

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0009O | VA-18-0015

Package Header

Package ID	VA2018MS0009O	**SPA ID**	VA-18-0015
Submission Type	Official	**Initial Submission Date**	8/10/2018
Approval Date	11/7/2018	**Effective Date**	11/1/2018
Superseded SPA ID	VA-13-0010		
	System-Derived		

D. Other than MAGI - Online Application

The state uses the following online application(s) for individuals applying for coverage who may be eligible on a basis other than the applicable MAGI standard:

- [ ] 1. The single, streamlined application developed by the Secretary or one of the alternate online forms developed by the state and approved by the Secretary, and supplemental online forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary
- [ ] 2. One or more 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
- [ ] 3. One or more application used to apply for multiple human service programs
- [ ] 4. Other alternative applications

Application

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0009O | VA-18-0015

Package Header

Package ID	VA2018MS0009O	**SPA ID**	VA-18-0015
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Superseded SPA ID	VA-13-0010		
	System-Derived		

E. Additional Information (optional)

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 0938-1188. 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.

This view was generated on 11/7/2018 9:56 AM EST

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

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
- If you are not eligible for Medicaid or FAMIS you will be referred to the Federal Health Insurance Marketplace for affordable private health insurance plans that offer comprehensive coverage to help you stay well and may include a new tax credit that can immediately help pay your premiums for health coverage.

  You may qualify for a low-cost program even if you earn as much as $98,400 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 applying for someone other than a spouse or family member under age 21, an authorized representative form (Appendix C) must be completed.
- If you are age 65 or older or disabled or any age and need assistance with nursing facility or community based care, you need to complete Appendix D.

Apply faster online

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

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.**

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

STEP 1 Tell us about yourself.

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

1. First name	Middle name	Last name	Suffix

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

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

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

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

14. Phone number	15. Other phone number
(☐☐☐) ☐☐☐ – ☐☐☐☐	(☐☐☐) ☐☐☐ – ☐☐☐☐

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

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

☐ No. I want to get paper notices sent to me in the mail.

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

(Choose one)

☐ Cell phone number _____

☐ Email address _____

c. You can change your notices and communication preferences at any time. Cell phone or 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
- Married or unmarried parents (of a child under 21) living in the home
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

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

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 and children who live with you and/or anyone on your same federal income tax return if you file one. Include both parents living in the home (for a child under 21). See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name | Middle name | Last name | Suffix

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

4. Sex ☐ Male ☐ Female

2. Relationship to you? **SELF**

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

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

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

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

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

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

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

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

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant or were you pregant in the last 60 days? ☐ Yes ☐ No

a. **If yes,** how many babies are expected during pregnancy ☐ Expected due date : _____

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

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

8a. ☐ **YES.** If under 19 or over 64 and not eligible for full coverage, do you wish to be evaluated for Plan First (family planning coverage only)?

or

☐ **NO.** If you are age 19 to 64 and are not eligible for full coverage, you will be evaluated for Plan First (family planning coverage only) unless you check NO.

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

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

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

☐ Check here if pending disposition of charges Expected release date ☐☐ / ☐☐ / ☐☐☐☐

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

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

16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. **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 _____

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 (Continue with yourself)

Current Job & Income Information

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

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

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

CURRENT JOB 1:

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

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

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

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

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

a. Type of work _____

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

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it. Check here if none ☐

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

☐ Unemployment $ How often? _____
☐ Pensions $ How often? _____
☐ Social Security $ How often? _____
☐ Retirement accounts $ How often? _____
☐ Alimony received $ How often? _____
☐ Net farming/fishing $ How often? _____
☐ Net rental/royalty $ How often? _____
☐ Other income $ How often? _____
Type _____

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

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

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

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

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

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

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

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

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

Complete Step 2 for your spouse and children who live with you and/or anyone on your same federal income tax return if you file one. Include both parents living in the home (for a child under 21). See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name | Middle name | Last name | Suffix

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

4. Sex ☐ Male ☐ Female

2. Relationship to you?

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐
We need this if you want health coverage for PERSON 2 and PERSON 2 has an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if PERSON 2 doesn't file a federal income tax return.)

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

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on 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? Or were they pregnant in the last 60 days? ☐ 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 Person 2 has Medicare or other insurance, there might be a program with better coverage or lower costs.)* **If NO, skip to the income questions on page 5 and leave the rest of this page blank.**

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

9a. ☐ **YES.** If under 19 or over 64 and not eligible for full coverage, does PERSON 2 wish to be evaluated for Plan First (family planning coverage only)?

or

☐ **NO.** If PERSON 2 is age 19 to 64 and is not eligible for full coverage, PERSON 2 will be evaluated for Plan First (family planning coverage only) unless you check NO.

10. Does PERSON 2 need help with everyday things like bathing, dressing, walking or using the bathroom to live safely in their home? **or** Has a doctor or nurse told them that they have a physical disability or long term disease, mental or emotional illness, or addiction problem? Yes ☐ No ☐ If PERSON 2 is 65 or older **or** has Medicare, please complete Appendix D.

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. Is Person 2 living with at least one child under age 19 and the main person taking care of this child? ☐

14. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No **If yes**, in which state _____

15. Is PERSON 2 incarcerated (detained or jailed)? ☐ Yes ☐ No **If Yes** ☐ Federal ☐ State (DOC or DJJ) ☐ Local/Regional

☐ Check here if pending disposition of charges Expected release date ☐☐ / ☐☐ / ☐☐☐☐

16. Is PERSON 2 a full-time student? ☐ 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 _____

Now, tell us about any income from PERSON 2 on the next page.

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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 19.

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

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

CURRENT JOB 1:

19. Employer name

a. Employer address

b. City

c. State

d. Zip code

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

23. Employer name

a. Employer Address

b. City

c. State

d. Zip code

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 PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

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

a. Type of work _____

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

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it. Check here if none ☐
NOTE: You don't need to tell us about PERSON 2's child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment $ How often? _____
☐ Pensions $ How often? _____
☐ Social Security $ How often? _____
☐ Retirement accounts $ How often? _____
☐ Alimony received $ How often? _____
☐ Net farming/fishing $ How often? _____
☐ Net rental/royalty $ How often? _____
☐ Other income $ How often? _____
Type _____

30. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No If yes, provide monthly income for last 3 months.
Month 1: $ Month 2: $ Month 3: $

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 2 gets it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

☐ 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, skip to the next person.

PERSON 2's total income **this year** $

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

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

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

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

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

☐ 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 _____

☐ Federal Health Insurance Marketplace

_____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance: _____

Policy number: _____

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

☐ Yes ☐ No

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

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

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

☐ **NO. If no, continue to Step 5.**

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.

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, I consent to the use of electronic income data including information from tax returns to annually 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.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this application to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I understand that I am authorizing the local Department of Social Service (LDSS) and the Department of Medical Assistance Services (DMAS) to obtain verification/information necessary to determine my eligibility for Medicaid or FAMIS.
- I understand that Medicaid and DMAS contractors may exchange information relating to my coverage with LDSS to assist with application, enrollment, administration and billing services.
- I 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 within 10 calendar days 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**.

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.

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

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**.

The Department of Medical Assistance Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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

KOREAN
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-855-242-8282 (TTY: 1-888-221-1590) 번으로 전화해 주십시오.

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

CHINESE
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-242-8282

（TTY：1-888-221-1590）。

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

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

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

AMHARIC
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው

ቁጥር ይደውሉ 1-855-242-8282 (መስማት ለተሳናቸው: 1-888-221-1590).

URDU
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-242-8282 (TTY: 1-888-221-1590).

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

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

HINDI
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-242-8282 (TTY: 1-888-221-1590) पर कॉल करें।

GERMAN
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-242-8282 (TTY: 1-888-221-1590).

BENGALI
ল য করুন যদি আপনি বাংলা, কথা বলতে পারেন , তাহলে নিি খরচায় ভাষা সহায়তা পরিষেবা

উপল আছে। ফোন করুন ১-855-242-8282 (TTY: ১-888-221-1590)।

IGBO
AKWỤKWỌ: Ọ bụrụ na ị na-asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dị gị. Kpọọ 1-855-242-8282 (TTY: 1-888-221-1590).

YORUBA
AKIYESI: Ti o ba sọrọ Yoruba, awọn iranlọwọ iranlọwọ ni ede, laisi idiyele, wa fun ọ. Pe 1-855-242-8282 (TTY: 1-888-221-1590).

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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

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

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

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EMPLOYER COVERAGE TOOL

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

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

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

EMPLOYEE Information

The employee needs to fill out this section.

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

EMPLOYER Information

Ask the employer for this information.

3. Employer name	4. Employer Identification Number (EIN) ☐☐ - ☐☐☐☐☐☐☐
5. Employer address	6. Employer phone number (☐☐☐) ☐☐☐ – ☐☐☐☐
7. City	8. State ☐☐ / 9. ZIP code ☐☐☐☐☐
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above) (☐☐☐) ☐☐☐ – ☐☐☐☐	12. Email address

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

☐ **Yes** (Continue)

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

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

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

☐ Employer won't offer health coverage

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

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

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

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

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

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

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APPENDIX B

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

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

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

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

	AI/AN PERSON 1	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?_____

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** .

APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

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

1. Name of authorized representative (First name, Middle name, Last name)

2. Address | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code

7. Phone number

( ) –

8. Organization name | 9. ID number (if applicable)

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

10. Your signature | 11. Date (mm/dd/yyyy)

OR

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

1. I give permission for (name) and/or (organization name)

2. Address | City | State | Zip

3. Phone number

( ) –

4. ID number (if applicable)

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

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

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

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

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable) | 5. Agents/Brokers only: NPN Number

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Commonwealth of Virginia Voter Registration Agency Certification

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Please check only one)

☐ 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 fill out the voter registration application 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, phone (804) 864-8901.

Applicant Name _____ Signature _____ Date _____

(for agency use only)

Voter Registration form completed: ☐ Yes ☐ No

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

Agency Staff Signature _____ Date _____

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07/01/18

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

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
- If you are not eligible for Medicaid or FAMIS you will be referred to the Federal Health Insurance Marketplace for affordable private health insurance plans that offer comprehensive coverage to help you stay well and may include a new tax credit that can immediately help pay your premiums for health coverage.

  You may qualify for a low-cost program even if you earn as much as $98,400 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 applying for someone other than a spouse or family member under age 21, an authorized representative form (Appendix C) must be completed.
- If you are age 65 or older or disabled or any age and need assistance with nursing facility or community based care, you need to complete Appendix D.

Apply faster online

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

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.**

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

STEP 1 Tell us about yourself.

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

1. First name	Middle name	Last name	Suffix

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

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

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

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

14. Phone number	15. Other phone number
(☐☐☐) ☐☐☐ – ☐☐☐☐	(☐☐☐) ☐☐☐ – ☐☐☐☐

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

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

☐ No. I want to get paper notices sent to me in the mail.

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

(Choose one)

☐ Cell phone number _____

☐ Email address _____

c. You can change your notices and communication preferences at any time. Cell phone or 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
- Married or unmarried parents (of a child under 21) living in the home
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

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

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.

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STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse and children who live with you and/or anyone on your same federal income tax return if you file one. Include both parents living in the home (for a child under 21). See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name | Middle name | Last name | Suffix

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

4. Sex ☐ Male ☐ Female

2. Relationship to you? **SELF**

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

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

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

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

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

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

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

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

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant or were you pregant in the last 60 days? ☐ Yes ☐ No

a. **If yes,** how many babies are expected during pregnancy ☐ Expected due date : _____

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

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

8a. ☐ **YES.** If under 19 or over 64 and not eligible for full coverage, do you wish to be evaluated for Plan First (family planning coverage only)?

or

☐ **NO.** If you are age 19 to 64 and are not eligible for full coverage, you will be evaluated for Plan First (family planning coverage only) unless you check NO.

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

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

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

☐ Check here if pending disposition of charges Expected release date ☐☐ / ☐☐ / ☐☐☐☐

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

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

16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. **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 18.

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

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

CURRENT JOB 1:

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

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

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

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

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

a. Type of work _____

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

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it. Check here if none ☐

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

☐ Unemployment $ How often? _____
☐ Pensions $ How often? _____
☐ Social Security $ How often? _____
☐ Retirement accounts $ How often? _____
☐ Alimony received $ How often? _____
☐ Net farming/fishing $ How often? _____
☐ Net rental/royalty $ How often? _____
☐ Other income $ How often? _____
Type _____

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

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

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

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

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

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

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

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

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

Complete Step 2 for your spouse and children who live with you and/or anyone on your same federal income tax return if you file one. Include both parents living in the home (for a child under 21). See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name | Middle name | Last name | Suffix

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

4. Sex ☐ Male ☐ Female

2. Relationship to you?

5. Social Security number (SSN) ☐☐☐ - ☐☐ - ☐☐☐☐
We need this if you want health coverage for PERSON 2 and PERSON 2 has an SSN.

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

If no, list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if PERSON 2 doesn't file a federal income tax return.)

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

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on 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? Or were they pregnant in the last 60 days? ☐ 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 Person 2 has Medicare or other insurance, there might be a program with better coverage or lower costs.)* **If NO, skip to the income questions on page 5 and leave the rest of this page blank.**

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

9a. ☐ **YES.** If under 19 or over 64 and not eligible for full coverage, does PERSON 2 wish to be evaluated for Plan First (family planning coverage only)?

or

☐ **NO.** If PERSON 2 is age 19 to 64 and is not eligible for full coverage, PERSON 2 will be evaluated for Plan First (family planning coverage only) unless you check NO.

10. Does PERSON 2 need help with everyday things like bathing, dressing, walking or using the bathroom to live safely in their home? **or** Has a doctor or nurse told them that they have a physical disability or long term disease, mental or emotional illness, or addiction problem? Yes ☐ No ☐ If PERSON 2 is 65 or older **or** has Medicare, please complete Appendix D.

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. Is Person 2 living with at least one child under age 19 and the main person taking care of this child? ☐

14. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No **If yes**, in which state _____

15. Is PERSON 2 incarcerated (detained or jailed)? ☐ Yes ☐ No **If Yes** ☐ Federal ☐ State (DOC or DJJ) ☐ Local/Regional

☐ Check here if pending disposition of charges Expected release date ☐☐ / ☐☐ / ☐☐☐☐

16. Is PERSON 2 a full-time student? ☐ 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 _____

Now, tell us about any income from PERSON 2 on the next page.

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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 19.

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

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

CURRENT JOB 1:

19. Employer name

a. Employer address

b. City

c. State

d. Zip code

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

23. Employer name

a. Employer Address

b. City

c. State

d. Zip code

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 PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

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

a. Type of work _____

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

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often PERSON 2 gets it. Check here if none ☐
NOTE: You don't need to tell us about PERSON 2's child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment $ How often? _____
☐ Pensions $ How often? _____
☐ Social Security $ How often? _____
☐ Retirement accounts $ How often? _____
☐ Alimony received $ How often? _____
☐ Net farming/fishing $ How often? _____
☐ Net rental/royalty $ How often? _____
☐ Other income $ How often? _____
Type _____

30. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No If yes, provide monthly income for last 3 months.
Month 1: $ Month 2: $ Month 3: $

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often PERSON 2 gets it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 28b).

☐ 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, skip to the next person.

PERSON 2's total income **this year** $

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

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

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

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 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 _____

☐ Federal Health Insurance Marketplace

_____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance: _____

Policy number: _____

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

☐ Yes ☐ No

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

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

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

☐ **NO. If no, continue to Step 5.**

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.

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, I consent to the use of electronic income data including information from tax returns to annually 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.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this application to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I understand that I am authorizing the local Department of Social Service (LDSS) and the Department of Medical Assistance Services (DMAS) to obtain verification/information necessary to determine my eligibility for Medicaid or FAMIS.
- I understand that Medicaid and DMAS contractors may exchange information relating to my coverage with LDSS to assist with application, enrollment, administration and billing services.
- I 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 within 10 calendar days 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**.

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.

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

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**.

The Department of Medical Assistance Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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

KOREAN
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-855-242-8282 (TTY: 1-888-221-1590) 번으로 전화해 주십시오.

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

CHINESE
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-242-8282

（TTY：1-888-221-1590）。

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

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

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

AMHARIC
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው

ቁጥር ይደውሉ 1-855-242-8282 (መስማት ለተሳናቸው: 1-888-221-1590).

URDU
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-242-8282 (TTY: 1-888-221-1590).

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

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

HINDI
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-242-8282 (TTY: 1-888-221-1590) पर कॉल करें।

GERMAN
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-242-8282 (TTY: 1-888-221-1590).

BENGALI
ল য করুন যদি আপনি বাংলা, কথা বলতে পারেন , তাহলে নিি খরচায় ভাষা সহায়তা পরিষেবা

উপল আছে। ফোন করুন ১-855-242-8282 (TTY: ১-888-221-1590)।

IGBO
AKWỤKWỌ: Ọ bụrụ na ị na-asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dị gị. Kpọọ 1-855-242-8282 (TTY: 1-888-221-1590).

YORUBA
AKIYESI: Ti o ba sọrọ Yoruba, awọn iranlọwọ iranlọwọ ni ede, laisi idiyele, wa fun ọ. Pe 1-855-242-8282 (TTY: 1-888-221-1590).

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**.

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

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

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

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EMPLOYER COVERAGE TOOL

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

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

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

EMPLOYEE Information

The employee needs to fill out this section.

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

EMPLOYER Information

Ask the employer for this information.

3. Employer name	4. Employer Identification Number (EIN) ☐☐ - ☐☐☐☐☐☐☐
5. Employer address	6. Employer phone number (☐☐☐) ☐☐☐ – ☐☐☐☐
7. City	8. State ☐☐ / 9. ZIP code ☐☐☐☐☐
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above) (☐☐☐) ☐☐☐ – ☐☐☐☐	12. Email address

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

☐ **Yes** (Continue)

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

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

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

☐ Employer won't offer health coverage

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

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

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

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

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

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

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APPENDIX B

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

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

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

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

	AI/AN PERSON 1	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 are applying for someone other than a spouse or family member, an authorized representative form (Appendix C) must be completed. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code

7. Phone number

( ) –

8. Organization name | 9. ID number (if applicable)

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

10. Your signature | 11. Date (mm/dd/yyyy)

OR

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

1. I give permission for (name) and/or (organization name)

2. Address | City | State | Zip

3. Phone number

( ) –

4. ID number (if applicable)

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

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

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

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

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable) | 5. Agents/Brokers only: NPN Number

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Commonwealth of Virginia Voter Registration Agency Certification

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Please check only one)

☐ 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 fill out the voter registration application 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, phone (804) 864-8901.

Applicant Name _____ Signature _____ Date _____

(for agency use only)

Voter Registration form completed: ☐ Yes ☐ No

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

Agency Staff Signature _____ Date _____

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07/01/18

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
801 Market Street - Suite 9400
Philadelphia, Pennsylvania 19107

Region III/Division of Medicaid and Children's Health Operations
SWIFT #081620184048

November 7, 2018

Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Dear Dr. Lee:

This letter is being sent as a companion to our approval of Virginia's State Plan Amendment (SPA) 18-0015, Changes to the Medicaid Application. This amendment proposes to revise the Virginia Medicaid paper and online application to include the changes resulting from Virginia's Medicaid expansion.

Section 1902(a) of the Social Security Act (the Act) requires that States have a State Plan for medical assistance that meets certain Federal requirements that set out a framework for the State program. Implementing regulations at 42 Code of Federal Regulations (CFR) §430.10 require that the State Plan be a comprehensive written statement describing the nature and scope of the State's Medicaid Program and that it contain all information necessary for the Centers for Medicare & Medicaid Services (CMS) to determine whether the plan can be approved to serve as the basis for Federal financial participation (FFP) in the state program. While the SPA is approvable, CMS' analysis determined that additional changes related to the Virginia's Common Help Medicaid online application are needed. Please see the enclosed Exhibit 1 which outlines the requested changes.

Please respond to this letter within 90 days with a corrective action plan providing a plan and timeline for completing the required online application changes described in Exhibit 1. During the 90-day period, we are happy to provide any technical assistance that you need.

If you have any questions regarding this letter, please contact Margaret Kosherzenko at 215- 861-4288. We look forward to working with you on these issues.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosure: Exhibit 1

cc: Sarah O'Connor, CMS
Jessica Stephens, CMS
Jason Berry, CMS

Virginia SPA 18-0015 Changes to Medicaid Application Companion Letter Exhibit 1

	Necessary changes:	**Date by which changes will be completed (state to fill in):**
1	The state will add Agent/Broker back into the list of who is completing the application.	
2	The state will add a marital status question to the "About You" screen with response choice of "yes" or "no".	
3	The state will remove/revise the help text defines "Illegal Alien" at page 10. The definition includes "those who have entered the country by other means, or stayed beyond the time allowed on a visa."	
4	The state will provide guidance in the application or instructions and provide a link to SSA.gov if an applicant needs help getting a SSN.	
5	The state will revise the Citizenship Information question so that applicants are asked if they are a US citizen or national.	
6	The state will add the following immigration statuses to the listing in the Citizenship Information section of the application: Parole less than one year, Individual with non-immigration status, Applicant for Victim of Trafficking.	
7	The state will change the following non-citizen categories to be consistent with terms frequently used to describe certain non-citizen categories: 1) "Native Americans" to "Member of a federally-recognized Indian Tribe or American Indian born in Canada. 2) Recommend changing: "Spouse child sibling of trafficking victim to "Victim of Trafficking and his/her spouse, child, sibling or parent" (better to include these together beginning with "Victim of Trafficking", since it is in alphabetical order), 3) Change "permanent resident Alien" to "Lawful Permanent Resident (LPR/Green Card Holder)"	
8	The state, in order to rectify the incorrect denial of applicants who may other otherwise be eligible if the applicant selects "other" from the dropdown menu will update the language contained in the SSN dropdown menu to mirror the exception to not providing a SSN at 42 CFR §435.910(h), and take the following action:	

	Necessary changes:	Date by which changes will be completed (state to fill in):
	1.) An interim business process will be issued. This process allows DMAS and state DSS to communicate the issue to all local DSS workers and will instruct them: a.) If an applicant makes this selection and would otherwise be eligible for coverage then the worker should override the denial (with supervisor review and approval); b.) If an applicant selects "other" and also requires additional verification (i.e. income), the worker will pend the application to provide information to determine what the "other" reason is as well as the need for other information, and then approve if all other verifications are received and the applicant would otherwise be eligible; override the denial, and approve and enroll (with supervisor approval). 2.) DMAS and DSS will work with the contractor, Deloitte, to implement the rules engine update that this change will require. DMAS has made this issue a priority with Deloitte who has indicated this change will be made within the first quarter of 2019. 3.) DMAS has requested that DSS research and provide data for any applicants that were previously denied for this reason. Once this information is provided, DMAS will formulate a plan moving forward to communicate with the applicants and make any needed corrections.	
9	CMS recommends that the state clarify what "social services" means.	
10	The state will update the former foster care question, since Virginia has elected to cover former foster care youth who aged out in other states, "Virginia" will be removed from question 2 to read: "Was XXX enrolled in Medicaid and Foster Care on his/her 18th birthday?"	
11	In the Voter Registration section, the state will work with DSS to remove the option of "already registered to vote or ineligible to vote". The text which reads "IF YOU DO NOT CHECK EITHER YOU WILL BE CONSIDERED TO HAVE TO DECIDED NOT TO REGISTER TO VOTE AT THIS TIME" will be updated to all caps as indicated in 52 USC section 20506(a)(6)(B)	

	Necessary changes:	Date by which changes will be completed (state to fill in):
12	CMS recommends the state include on its application notice of fair hearing rights when the agency does not determine eligibility with reasonable promptness within the 45/90 day timeframe consistent with 42 CFR section 435.912(c)(3). CMS is considering developing guidance and states may be required to implement these changes in the future.	