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 $106,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.
- If you are 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**

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Write and Highlight at the top of each page: REQUESTING LONG TERM CARE SCREENING FOR CCC+ WAIVER

COVER VIRGINIA

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
FULL NAME (First, Middle, Last) of the person applying for the Waiver; not the preparer)			(None, Jr., II, III, IV)

2. Home address (Leave blank if you don't have one.)	3. Apartment or suite number
Home Address of the person applying for the Waiver	If Applicable

4. City	5. State	6. ZIP code	7. County
List city in the State of Virginia	VA	5-digit Postal Code	VA County

8. Mailing address (if different from home address)	9. Apartment or suite number
Mailing Address of the person applying for the Waiver	If Applicable

10. City	11. State	12. ZIP code	13. County
List city in the State of Virginia	VA	5-digit Postal Code	VA County

14. Phone number	15. Other phone number
Phone Number of person applying for Waiver or Authorized Represetative	Alternate Number of person applying for Waiver or Authorized Represetative

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?

Choose One Option

☐ 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 Option

☐ Cell phone number If choosing this option, enter phone number here

☐ Email address If choosing this option, enter email address here

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)? State Language Preference Here

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 FULL NAME (First, Middle, Last) of the person applying for the Waiver; not the preparer) Suffix

1a. Are you? ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated Select Applicable Marital Status

3. Date of birth (mm/dd/yyyy) Birthday of person applying for the Waiver

4. Sex Select Applicable Gender

2. Relationship to you? **SELF**

5. Social Security number (SSN) SSN of person applying for the Waiver

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: _____ Leave the rest of this page blank _____

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

☐ Yes ☐ No You will be evaluated for Plan First 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.

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

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

11. **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

e. Have you, your spouse or a parent ever served in 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 Incarceration date ☐☐/☐☐/☐☐☐☐ 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.

Leave the rest of this page blank

CURRENT JOB 1:

18. Employer name

a. Employer address

b. City

c. State

d. Zip code

19. Employer phone number ( ) –

20. Wages/tips (before taxes) $

☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

21. Average hours worked each WEEK

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

22. Employer name

a. Employer Address

b. City

c. State

d. Zip code

23. Employer phone number ( ) –

24. Wages/tips (before taxes) $

☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

25. Average hours worked each WEEK

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

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

a. Type of work _____

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

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

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

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

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

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

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

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

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

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

Your total income **this year** $

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

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

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STEP 2: PERSON 2

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

Complete Step 2 for 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. Leave the rest of this page blank

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

1a. Is PERSON 2? ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Separated

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. If aged 19 to 64 and not eligible for full coverage, does PERSON 2 wish to be evaluated for Plan First (family planning coverage only)?

☐ Yes ☐ No PERSON 2 will be evaluated for Plan First 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.

10a. If PERSON 2 answered yes to question 9 and is between the ages of 19-64, and does not have Medicare, but needs long term services and supports, please complete Appendix F.

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. Immigration 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 of the U.S. military? ☐ Yes ☐ No

e. Has PERSON 2, their spouse or a parent ever served 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? ☐ Yes ☐ No

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 Incarceration date ☐☐/☐☐/☐☐☐☐ 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 _____

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STEP 2: PERSON 2

Leave the rest of this page blank

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?

☐ **No.** If **no,** skip to Step 4.

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

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

Answer this question only for the person applying for the Waiver

Select YES if the waiver applicant is currently enrolled in health coverage from any of the plans listed, check the type of coverage & write the waiver applicants name on the line; Otherwise, select NO.

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) nex

☐ 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?**

Answer this question only for the person applying for the Waiver

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.**

Select YES if the waiver applicant is eligible for health insurance through an employer but chooses not to enroll in the health insurance through the employer; Otherwise, select NO

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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: Select one

☐ 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.virginia.gov** 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)
Signature of person applying for the Waiver and/or signature of the Preparer "on behalf of Waiver applicant"	MM DD YYYY

STEP 6 Mail completed application.

Mail your signed application to: It's best to hand deliver this application to your local Department of Social Services office; get date stamp of their receipt of this application (ask them to make a copy of the application for you and stamp a date on it)

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 ተዘጋጀተዋል፡ 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 করঁন যদি আপি বাংলা, কথা বলতে পারেঁ , তাহলে নি খরচায় ভাষা সহায়তা পরিষেবা

উপল আছে। ফোঁ করঁ 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**.

Write and Highlight at the top of each page: REQUESTING LONG TERM CARE SCREENING FOR CCC+ WAIVER

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
Name of Employee who holds health policy from employer	10 digit Social Security # of Employee/Policy Holder

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN)
Employer Name		Employer ID Number (EIN)
5. Employer address		6. Employer phone number
Employer Address		Employer Phone Number
7. City	8. State	9. ZIP code
City	State	5 digit zip code
10. Who can we contact about employee health coverage at this job?		
Leave Blank		
11. Phone number (if different from above)	12. Email address	
Leave Blank	Leave Blank	

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

☐ Yes (Continue) Leave the rest of this page blank

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

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

Leave the rest of this page blank

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.

Leave the rest of this page blank

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)
Name of Authorized Representative: First, Middle, Last name (preparer)

2. Address
Address of Authorized Representative

3. Apartment or suite number

4. City
City of Authorized Representative

5. State
STATE

6. ZIP code
5-digit postal code

7. Phone number
Phone number of Authorized Representative

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
Waiver Applicant Signature or Preparer/Authorized Representative

11. Date (mm/dd/yyyy)
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)
Moms In Motion/At Home Your Way, Consumer-Direct Service Facilitation Provider

2. Address
P.O. Box 609

City
Front Royal

State
Virginia

Zip
22630

3. Phone number
(**800**) **417** – **0908**

4. ID number (if applicable)
Provider ID: 0158250065

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
Waiver Applicant Signature or Preparer/Authorized Representative

6. Date (mm/dd/yyyy)
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)
Leave blank

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

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN Number

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**.

Commonwealth of Virginia Voter Registration Agency Certification

If you are not registered to vote where you live now, would you like to apply to register to vote here?

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

Leave Blank

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

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

- Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency.
- If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes.
- If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with:

Secretary of the Virginia State Board of Elections
Washington Building
1100 Bank Street
Richmond, VA 23219-3497
804-864-8901

(for agency use only)

Voter Registration form completed: ☐ Yes ☐ No

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

_____ _____

Agency Staff Signature Date

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