Section 2: Eligibility& Application

Eligibility & Application

Non-Financial Requirements

Financial Requirements

Application Procedures

Application Procedures *(continued)*

Non-Financial Requirements

In addition to financial requirements that must be met to qualify for Virginia's state-sponsored health insurance programs, several non-financial requirements must also be met.

An asterisk (*****) indicates a rule that **differs between the programs** in the following list of non-financial eligibility requirements.

A. Age

FAMIS and FAMIS Plus are for children from birth up to their 19th birthday.

Medicaid for Pregnant Women and FAMIS MOMS are for pregnant women of any age. *(Note: a pregnant woman under age 19 will be screened for FAMIS/FAMIS Plus eligibility first.)*

Low Income Families With Children (LIFC) is for parents, or a caretaker relative of any age, who have the care of a dependent child under age 18 in their household. If they do have an 18 year old, they may still be eligible if that child is in a secondary school or equivalent level of vocational or technical training or GED program and is reasonably expected to complete the schooling/training before or in the month he/she attains age 19.

Plan First is primarily for men and women of child bearing age (19-64), but any age person is eligible.

A person applying for Medicaid for Former Foster Care (FFC) Youth must be between the ages of 19 and 26. They have to have aged out of state-sponsored foster care and Medicaid in Virginia or another state.

The New Health Coverage for Adults is for people ages 19 to 64.

B. Virginia Residence

Applicants must be residents of Virginia. This means that they must live in, and intend to remain living in, Virginia. Self-declaration of residency is all that is required. (*"Regardless of the individual's immigration status, accept declaration of Virginia residency on the application as verification of residency." Medicaid Policy Manual Sections M0230.001-C and M0220.500-A1)*

C. Assignment of Third Party Payment Rights

The state-sponsored health insurance programs require the applicant to assign any rights to third party payments to the state. This means, for example, that a personal injury settlement received for an enrolled individual would be assigned to Virginia to reimburse the state for any medical bills it paid for the injury. This assignment is listed in the Rights & Responsibilities

section (Step 5) of the Application and the family/individual agrees to it when they sign the application. (A copy of Step 5 is on page 2.30)

D. Social Security Number

Social Security Numbers (SSNs) are required for **all applicants** seeking enrollment in Virginia's state-sponsored health insurance programs. *(An* Application for a Social Security Number *is included in* Section 5: Other Helpful Information.*)*

The application does ask for SSNs for non-applicants on a voluntary basis. Providing SSNs for **non-applicants is not required** and not listing them will not impact the eligibility of anyone else on the application. Including the SSN of a non-applicant may be helpful to the LDSS, Cover Virginia Central Processing Unit (CPU), or Marketplace in verifying income information.

Individuals who are not eligible for a SSN or do not have one and are eligible only for a non-work SSN **do not need to provide or apply for a SSN**. He/she can be given a Medicaid identification number in lieu of a SSN.

E. US Citizenship or Alien Status* Requirements

FAMIS, FAMIS Plus, Medicaid for Pregnant Women, and FAMIS MOMS are for US citizens or lawfully residing non-citizens. Resident Alien children under age 19, who are otherwise eligible (meaning they meet all other financial and non-financial rules) may receive FAMIS and FAMIS Plus. Resident Alien pregnant women, if otherwise eligible, may receive Medicaid for Pregnant Women or FAMIS MOMS.

LIFC, Plan First, Medicaid for Former Foster Care Youth (FFC), and the New Health Coverage for Adults are for US citizens or lawfully residing non-citizens as well. Lawful permanent residents (LPRs) may be eligible for coverage after the first five years of residence in the US if they have worked 40 qualifying work quarters. Most LPRs and conditional entrants who entered the US before August 22, 1996 are eligible.

Certain immigrant categories considered "Mandatory Coverage Categories" are eligible for coverage. These are Refugees and Asylees from certain countries. They may be eligible for coverage for the first 5-7 years they are in the country. Veterans or Active Military (including spouses/dependent children) may be eligible regardless of when they entered the US. The "Alien Code Chart" from the *Medicaid Eligibility Manual* is on pages 2.47-2.49 and shows which categories of immigrants are eligible for full benefits and which are eligible for "emergency services only".

Applicants for all programs will have their citizenship status or alien status and their identity verified electronically (with the Social Security Administration or the US Citizenship & Immigration Services) based on the information they provide on their application. There may be cases where the information can not be verified. In these cases, if the application is eligible for coverage in all other respects, he/she will be enrolled in coverage and

will have 90 days to provide documentation verifying his/her citizenship, identity and/or immigration status. (For examples of acceptable forms of documentation for citizenship, identity and immigration status, see the *Medicaid Eligibility Manual* on line at: *http://www.dmas.virginia.gov/#/assistance* and refer to sections M02, M21, and M22.)

It is very important to note that the **citizenship status of a child's parent is not relevant** and does not affect the child's eligibility for FAMIS or FAMIS Plus.

Individuals who do not qualify for FAMIS Plus or Medicaid due to citizenship or immigration status (including illegal/undocumented aliens) may be eligible for **Medicaid payment for emergency services**. Labor and delivery is considered an emergency service. Eligibility for this coverage can be determined by the local DSS, provided the woman meets all the other program requirements. Other emergency services can be covered when approved by DMAS and the individual meets all other program requirements.

Individuals who do not qualify for Medicaid due to the 5 year/40 quarter work requirement, may still be eligible to receive tax credits and subsidies toward the purchase of private insurance in the Federal Health Insurance Marketplace, even if they are under 100% of FPL.

The federal government has stated that receipt of Title XXI health insurance (including FAMIS/FAMIS MOMS) or Title XIX (FAMIS Plus/Medicaid/LIFC/FFC and New Health Coverage for Adults) will not affect **"Public Charge"** determinations or otherwise affect a non-citizen's immigration status unless FAMIS Plus or Medicaid is used for long-term care services. *(The current* "Public Charge Fact Sheet" *is provided on pages 2.35-2.36. Additional guidance from US Immigration and Customs Enforcement regarding use of information supplied by individuals when applying for premium tax credits and cost sharing subsidies is also included on pages 2.37-2.38)*

Important Note: *Public Charge rules may change in the future. Receipt of Medicaid by the person applying, or his/her family members, may indeed affect his/her ability to immigrate to the US or become a legal permanent resident. Proposed changes to the rule were posted in the Federal Register on October 10, 2018. The general public can submit comments on proposed changes to the law until December 10, 2018. Then there are other formal rulemaking procedures that must be completed before the law is officially changed. The process will take many months. It is not possible to predict what the law may ultimately say.*

F. Other Insurance*

Medicaid (LIFC, FFC, Medicaid for Pregnant Women, and the New Health Coverage for Adults) are available to people **who already have other health insurance**. These Medicaid programs can supplement their existing insurance - paying for care that is not covered under the private insurance. The state-sponsored coverage is the "payer of last resort".

In some cases, if it is cost effective to do so, FAMIS Plus/Medicaid may provide premium assistance to pay the cost of the existing health insurance

policy premiums. This is called the Health Insurance Premium Payment or HIPP Program. More information about this program is in Section 3.

FAMIS and FAMIS MOMS are **not available** to children or pregnant women **who currently have other "creditable" health insurance**. "Creditable" health insurance includes most group and individual insurance plans. It does not include very limited policies such as accident on school grounds or dental-only plans.

G. Residents of Institutions*

Children, pregnant women, parents/caretaker relative, and individuals who are **inmates** in a public institution (i.e. prison, jail, or juvenile detention center) can be eligible for Medicaid provided they meet all the eligibility requirements. **While they are incarcerated**, however, they can **only receive inpatient hospitalization services**.

Children under age 21 who are **inpatients** in an institution for the treatment of mental disease (IMD) **are not eligible for FAMIS,** but may be eligible for FAMIS Plus. Inpatients of an IMD aged 21-65 are not eligible for Medicaid, even if they are pregnant.

H. Cooperation with Child Support Enforcement*

If a parent or caretaker is applying for **Medicaid (including LIFC, FFC and the New Health Coverage for Adults) for him/herself AND for FAMIS Plus for a child with an absent parent,** he/she is required to cooperate with the Division of Child Support Enforcement (DCSE) to establish paternity and obtain medical support (health insurance) for the FAMIS Plus eligible child. If the parent/caretaker fails to cooperate (and does not establish "good cause for failure to cooperate") the parent/caretaker will be ineligible for Medicaid. The **parent/caretaker's refusal or failure to cooperate with DCSE will not affect the child's FAMIS Plus eligibility.** Cooperation is considered to be met when the parent signs the medical assistance application. If the parent later sets up a case with DCSE, all other DCSE requirements will need to be met.

There is no cooperation requirement in FAMIS.

I. Living with a Dependent Child (LIFC Only)

A person applying for LIFC must be a parent or caretaker-relative living in the home with a child under the age of 18. They could also live with a child who is under the age of 19 and is a full-time student in a secondary school or equivalent level of vocational/technical school or in a GED program AND it is expected that the child will graduate from the school/program before or in the month he/she turns 19. The child **does not** have to have state coverage for the parent/caretaker to be eligible.

A "caretaker-relative" is a person who is not the parent and is any of the following: a blood relation (including half-blood) - first cousin, nephew/niece, and people of preceding generations - grand or great grand relations); a step relation (mother, father, brother, sister); related by formal adoption; and spouses of any of the relatives listed above, even after marriage is ended by death or divorce. The relationship is self-declared on the *Application.*

Financial Requirements

Virginia's health insurance programs for children, pregnant women and adults use Modified Adjusted Gross Income (MAGI) methodology to determine household size and income. Once a person's income has been determined using MAGI, this information is compared to the Federal Poverty Level (FPL). This indicator of poverty in America is established by the federal government each year (usually in January or February) and is the same figure for all 48 contiguous states. It is slightly higher in Alaska and Hawaii. If the individual's household size and income fall within a program's FPL limits, he/she is likely financially eligible for the program.

When evaluating eligibility for these programs, it is important to figure out each household member's eligibility separately. Follow these three steps when screening for eligibility.

Step 1: Figure out the household size for each family member
Step 2: Figure the income for each family member based on his/her household size
Step 3: Compare the income for the household size to the income limits for the various programs

Additional information on each step is provided below.

STEP 1: DETERMINING HOUSEHOLD SIZE

When evaluating eligibility for these programs, you must first determine the "household size." Members of a family can each have different household sizes. It is important to figure out each individual's household size when thinking about their eligibility.

First, you must figure out what type of member of the household each person will be. For the purposes of household size, individuals will fit into one of **three categories**:

- Tax filer (person files taxes and is not claimed as a tax dependent on anyone else's taxes);
- Tax dependent; or
- Nonfiler **and** not claimed as a tax dependent.

For the Tax Filer:

Household size = the tax filer + any joint filers (if they exist) + all claimed dependents (*Note: Joint filers can only be spouses. Married couples living together who file separately are considered to be in the same household for the FAMIS and Medicaid programs*)

For Tax Dependents:

Household size = the same as the tax filer who claimed them as a dependent, with three exceptions...

A. If the individual is a tax dependent who is not a child or spouse of the tax filer, then...
   Household size = individual + his/her spouse (if they are living with them) + his/her biological, adoptive, or stepchildren under age 19 (if they are living with them)

B. If the individual is a child living with both parents who are not married, then...
   Household size = the child + any siblings (biological, adoptive, or step) + his/her parents

C. If the individual is a child claimed as a tax dependent by a non-custodial parent, then...
   Household size = the child + any siblings (biological, adoptive, or step) + his/her biological, adoptive, or step-parent(s) (with whom he/she is living)

For People who do not file taxes (nonfilers) and who are not claimed as dependents on anyone else's taxes:

For an Adult:
Household size = individual + his/her spouse (if they are living with them) + his/her biological, adoptive, or stepchildren (if they are living with them)

For a Child:
Household size = child + any siblings (biological, adoptive, or step) + his/her biological, adoptive, or step-parent(s) (with whom they are living)

For the purposes of the three exceptions and the two nonfiler rules, **a child is considered to be anyone under age 19**.

When trying to figure out household size in a family that includes a pregnant woman, the same rules are used. Keep in mind **for the pregnant woman's household size ONLY - she will count as at least 2 people**, or more if multiple children are expected (twins, triplets, etc.)

Note: A pregnant teen will be evaluated for eligibility in the children's programs (FAMIS/FAMIS Plus) first. She will only count as one person in the household size for everyone, including herself. If she is ineligible for the children's programs, then she will be evaluated as an adult and only then will her unborn child(ren) count in her household size.

Following are some examples to help to illustrate these rules. They are from the Center for Budget and Policy Priorities "Beyond the Basics" webinar series which can be viewed at http://www.healthreformbeyondthebasics.org/category/library/webinar-videos/. *Note: These examples are for household size for Medicaid/FAMIS only, household size for Premium Tax Credits and Subsidies via the Federal Health Insurance Marketplace may differ.*

Example 1: Single Person

John is a single adult with no dependents of his own. He lives on his own and is not claimed as a dependent on anyone else's taxes.

John's household size = 1 (just himself).

Example 2: Married Couple with Two Children

Bob and Jane are married and have two children. They file a joint tax return and claim both of their children as dependents.

Bob's household size = Bob + Jane (joint filer) + 2 children (dependents) = 4.
Jane's household size = Jane + Bob + 2 children = 4
Each child's household size = same as tax filer claiming that as a dependent = 4

Example 3: Multiple Generation Household

Rose lives with and supports her 60 year-old mother, Maria. Rose also has a 5 year-old daughter, Natalie. Rose is the tax filer and claims her mother and daughter as dependents.

Rose's household size = herself + her two dependents (her mother and daughter) = 3
Maria's household size = herself = 1 *(exception A for tax dependents)*
Natalie's household size = same as the tax filer claiming her (her mother) = 3

Example 4: Child Claimed by a Non-Custodial Parent

Lisa lives with her son, Alex, and files her taxes as an individual. Alex is claimed as a dependent by his father, her ex-husband, who lives elsewhere.

Lisa's household size = herself = 1
Alex's household size = himself + any parents/siblings **living with him** (his mom) = 2 *(exception C for tax dependents)*

We would not calculate the dad's household as part of doing the determination for Lisa and her son. Since dad does not live in the home, if he needed coverage he would have to file his own application. If he did file one, his household size would be 2 (himself and his claimed tax dependent, Alex.)

Example 5: Non-married Parents

Dan and Jen live together with their two children. They both have income and are not married. They file taxes separately and Dan claims the children as dependents on his taxes.

Dan's household size = himself + claimed dependents = 3
Jen's household size = herself = 1
Each child's household size = child + sibling + parents = 4 *(exception B for tax dependents)*

STEP 2: DETERMINING HOUSEHOLD INCOME

What is MAGI?

MAGI is a methodology for counting income and determining household size, based on federal tax filing rules.

Virginia programs that use MAGI:

- Medicaid Families and Children Groups
- Parent/caretaker relatives (Low Income Families with Children, LIFC)
- Children under age 19 (FAMIS and FAMIS Plus)
- Pregnant women (Medicaid for Pregnant Women and FAMIS MOMS)
- New Health Coverage for Adults
- Reasonable classifications of children under age 21
- Non IV-E foster care/adoption assistance children
- Children in juvenile detention
- Plan First

Income is based on household size. Different members of the family can have different household sizes and, thus, different household incomes.

Eligibility for state-sponsored health insurance programs is based on **gross monthly income** for the month prior to application. This is the income prior to taking any deductions. When calculating a household income for screening purposes, calculate current monthly income.

It is important to note that a family member's countable income must be converted to a monthly amount to evaluate eligibility. To calculate monthly income, use the following conversion factors:

- From **weekly** income – multiply by **4.3**
- From **biweekly** income (paid every two weeks) – multiply by **2.15**

- From **twice monthly** income - multiply by **2**
- For monthly income - just use the gross figure reported.
- From irregular income – determine average weekly income over a 3-month period and multiply by **4.3**

The following chart lists what should and should not be included when you are calculating an individual's current gross monthly income.

Include	Do Not Include
Taxable income: gross earnings from jobs, including cash, wages, salaries, commissions, and tips	*Supplemental Security Income (SSI) and Temporary Assistance For Needy Families (TANF) payments*
Self-employment income allowing for deductions for depreciation and capital losses to determine profit	*Educational grants, loans, scholarship and fellowship income*
*Social Security income (Retirement, Disability, and Survivor's Benefits)****	*Social Security income of a child not required to file taxes****
Alimony received into the home pursuant to a divorce decree filed prior to **December 31, 2018**	*Child support received into the home or alimony received into the home pursuant to a divorce decree filed* **after January 1, 2019**
Unemployment	*Workers Compensation*
Pensions and annuities	*Certain Veterans Administration Benefits*
Rents and royalties received	*Certain Native American and Alaska Native payments*
Foreign earned income	*Gifts and inheritances*
Non-taxable interest	*Income of a dependent (unless they are required to file a tax return, filing threshold - earnings $12,000/year)*
Count lump sum income only in the month it was received	

*** *Here are the Social Security Income Counting Rules for Groups subject to MAGI methodology rules***:

1. Social Security received **by the parent** is income for **both** the parent and the child's eligibility.
2. If **no parent** is in the child's MAGI household when determining the child's eligibility, all of the **child's Social Security is counted.**
3. When determining the child's eligibility, if a **parent is included** in the child's MAGI household, the **child's Social Security is not countable** unless the child is required to file taxes based on his other <u>earned</u> income (filing threshold $12,000).
4. The income of a child who is also the parent (whether or not he/she files taxes), is counted for his/her child's eligibility determination.

The key to counting child's social security income, for the child himself or his parents, is whether or not the **child is <u>required</u>** to file taxes.

Alimony paid out **pursuant to a divorce decree filed prior to December 1, 2018** is **deducted** from gross monthly income. **Alimony** paid out **pursuant to a divorce decree filed after January 1, 2019** is **not deducted** from income.

Student loan interest is deducted from income.

To figure out the household income for each individual, count the MAGI of all the people who were included in that individual's household size. Every person is also allowed an additional 5% FPL "standard disregard" deduction from household income, if they are over income. To account for this, the income guidelines written in this Tool Kit all include the extra 5% FPL amount in the figures listed.

STEP 3: COMPARE HOUSEHOLD SIZE AND INCOME TO PROGRAM GUIDELINES

Once you have figured out the household size and income for each family member, compare it to the charts below to see if each person falls within the income ranges of the state-sponsored health insurance programs.

Applicants for **New Health Coverage for Adults** must have MAGI income **less than or equal to 138% FPL**.

Applicants are financially eligible for **FAMIS Plus or Medicaid for Pregnant Women** if the family has a MAGI income **less than or equal to 148% FPL**.

Children and pregnant women are financially eligible for **FAMIS/FAMIS MOMS** if their MAGI income is **above 148% FPL and less than or equal to 205% FPL.**

Men and women must make **over 138% and less than or equal to 205% FPL** to be eligible for the **Plan First program**.

Note: The FPL changes each year in January or February and the income guidelines for the state-sponsored health insurance programs change accordingly. The income figures listed here became **effective on January 11, 2019** and **all include the additional 5% FPL Standard Disregard.**

New Health Coverage for Adults - 138% FPL

Household Size	Monthly Income	Annual Income
1	$1,438	$17,237
2	$1,946	$23,337
3	$2,454	$29,436
4	$2,962	$35,536
5	$3,470	$41,636
6	$3,979	$47,735
7	$4,487	$53,835
8	$4,995	$59,934
Additional Person Add	$509	$6,100

FAMIS Plus & Medicaid for Pregnant Women - 148% FPL

Household Size	Monthly Income	Annual Income
1	$1,542	$18,486
2	$2,087	$25,028
3	$2,631	$31,569
4	$3,177	$38,111
5	$3,722	$44,653
6	$4,267	$51,194
7	$4,812	$57,736
8	$5,357	$64,277
Additional Person Add	$546	$6,542

FAMIS & FAMIS MOMS & Plan First - 205 % FPL

Household Size	Monthly Income	Annual Income
1	$2,135	$25,605
2	$2,890	$34,666
3	$3,644	$43,727
4	$4,400	$52,788
5	$5,155	$61,849
6	$5,910	$70,910
7	$6,665	$79,971
8	$7,420	$89,032
Additional Person Add	$756	$9,061

The LIFC income guidelines are not based on the Federal Poverty Level. Instead, they are based on the Consumer Price Index and they change every July. Also, income can be higher depending on where the person lives in the Commonwealth. Virginia is broken into three locality groupings with Group III allowing for the highest income and Group I the lowest. Virginia's localities are divided amongst the groups. The income limits listed for LIFC include the 5% FPL standard disregard allowed to all applicants.

A parent/caretaker-relative must make at or below the monthly incomes listed on the next page to be eligible for LIFC. The maximum income depends upon where the person lives in Virginia.

For example, parents in a family of three living in Alexandria making $700 per month would be financially eligible for LIFC, but parents in a family of three living in Washington County making that amount per month would be over income for LIFC.

2019 LIFC Monthly Income Guidelines

Effective on July 1, 2019

Household Size	Group I	Group II	Group III
1	$310	$390	$560
2	$463	$554	$749
3	$587	$695	$919
4	$712	$832	$1,082
5	$838	$978	$1,277
6	$947	$1,105	$1,425
7	$1,068	$1,238	$1,588
8	$1,194	$1,380	$1,756
Additional Person Add	$126	$140	$165

Locality Group I

Accomack, Alleghany, Amelia, Amherst, Appomattox, Bath, Bedford City/ County, Bland, Botetourt, Bristol, Brunswick, Buchanan, Buckingham, Buena Vista, Campbell, Caroline, Carroll, Charles City, Charlotte, Clarke, Craig, Culpeper, Cumberland, Danville, Dickenson, Dinwiddie, Emporia, Essex, Fauquier, Floyd, Fluvanna, Franklin, Franklin County, Frederick, Galax, Giles, Gloucester, Goochland, Grayson, Greene, Greensville, Halifax, Hanover, Henry, Highland, Isle of Wight, James City, King and Queen, King George, King William, Lancaster, Lee, Louisa, Lunenburg, Madison, Mathews, Mecklenburg, Middlesex, Nelson, New Kent, Northampton, Northumberland, Norton, Nottoway, Orange, Page, Patrick, Pittsylvania, Poquoson, Powhatan, Prince Edward, Prince George, Pulaski, Rappahannock, Richmond County, Rockbridge, Russell, Scott, Shenandoah, Smyth, Southampton, Spotsylvania, Stafford, Suffolk, Surry, Sussex, Tazewell, Washington, Westmoreland, Wise, Wythe, York

Locality Group II
Albemarle, Augusta, Chesapeake, Chesterfield, Covington, Harrisonburg, Henrico, Hopewell, Lexington, Loudoun, Lynchburg, Martinsville, Newport News, Norfolk, Petersburg, Portsmouth, Radford, Richmond City, Roanoke City, Roanoke County, Rockingham, Salem, Staunton, Virginia Beach, Warren, Williamsburg, Winchester

Locality Group III
Alexandria, Arlington, Charlottesville, Colonial Heights, Fairfax City, Fairfax County, Falls Church, Fredericksburg, Hampton, Manassas, Manassas Park, Montgomery, Prince William, Waynesboro

Application Procedures

There are many ways to apply for the state-sponsored coverage programs. The single streamlined "Application for Health Coverage & Help Paying Costs" can be filled out in **hard copy and submitted in-person or mailed** to the applicant's local DSS office. The information may also be submitted **over the phone** via the Cover Virginia Call Center and **online** via the CommonHelp website. Additionally, people may apply via Healthcare.gov and the Federal Health Insurance Marketplace Call Center.

A PDF version of the Application may be downloaded from the Cover Virginia website at ***www.coverva.org***. Under the "Partner" link at the top of the page under the Facebook logo, choose "Materials." From the resulting page, you can order multiple printed copies of the Application and other printed outreach materials. Outreach workers should familiarize themselves with the layout of the Application form and its instructions. *Note: the Cover Virginia website is currently undergoing a redesign and the location of the materials may move.*

WHO CAN APPLY

A parent of any age, even if he/she is under 18, can apply for his/her child(ren).

For a child or pregnant teen (under age 18), the parent, legal guardian, adult relative with whom the child lives*, or any person authorized in writing by the parent, may complete the *Application*. (*During application processing, copies of court papers will be requested in the case of legal custody/guardianship. Signed proof of authorization will be required when someone authorized by a parent is applying on behalf of the child.*)

An **adult relative with whom the child lives is any person related by blood or marriage with whom the child is living. Any degree of relationship is acceptable. Documentation of this relationship is **not** required.*

Children age 18 and over, or children under age 18 emancipated by a court, may apply for themselves. (*Copies of court papers will be required in the case of a legally emancipated minor.*)

An adult married to a minor may apply for his/her spouse.

For a pregnant woman over 18: An adult pregnant woman may apply for herself. The adult husband of a pregnant woman, guardian, conservator, attorney-in-fact, designated authorized representative, or and adult relative may apply on the pregnant woman's behalf if she cannot sign for herself.

HOW TO APPLY

<u>By Telephone</u> - Cover Virginia Call Center (CVCC) at (855) 242- 8282
A family/individual may call the **CVCC** toll-free and complete the Application over the telephone with a Customer Service Representative (CSR). The

CVCC is open from 8AM to 7PM, Monday through Friday and 9AM to Noon on Saturdays, except on state holidays. A TTY line is also available: (888) 221-1590. The CVCC has several Spanish-speaking CSRs on staff and also has access to a **language line**. Anybody that is not comfortable conversing in English may state the language they wish to speak, and the CSR will establish a three-way conversation with the applicant and an interpreter on the line.

The call is recorded and all of the information on the paper *Application for Health Coverage & Help Paying Costs* is asked of the applicant and collected by the CSR. The individual "signs" the Application when he/she agrees with and understands the Rights & Responsibilities (Step 5) which have been read by the CSR. Upon completion of the call, the CVCC will issue a Tracking or **"T Number"** as proof that the Application has been submitted. **The date of application is the date of the phone call.**

The application will be processed by the co-located Cover Virginia Central Processing Unit (CPU), **unless the family/individual has an open/ active SNAP, TANF or Child Care case at their Local Department of Social Services (LDSS)**. If there is an open/active case, the case will be **transferred to the LDSS for processing**. If it is a case of a new family member applying where the family/individual only has an existing Medicaid/ FAMIS case locally, then the CPU will process the case. If there are any verification documents needed, a follow-up letter will be sent from CPU. The applicant may mail or fax the requested documents to the CPU to complete the process. The CPU will make a final decision on the case and send the family/individual a *Notice of Action on Benefits* with the result.

People can also apply over the phone with **DSS's Enterprise Customer Service Center (ECSC)** at **(855)635-4370**. The ECSC is open from 7AM to 6PM, Monday through Friday. If a person wishes to apply for multiple benefits at once, it will take his/her telephonic application. If a person calls to apply for just Medical Assistance, the call will be rerouted to the Cover Virginia Call Center.

On line via CommonHelp – www.commonhelp.virginia.gov

Through CommonHelp, Virginia's online application for social service benefits, people can screen themselves for multiple benefit programs [*child care subsidies, SNAP/Food Stamps, Health Coverage (including Medicaid and FAMIS), TANF and Energy Assistance*] and apply for them online. Using CommonHelp they can check the status of applications; report changes; and complete benefit renewals. CommonHelp is available 24 hours a day, 7 days a week.

If a person wishes to apply for Medicaid, Plan First, the New Health Coverage for Adults, or the FAMIS programs, they would click on the "**Get Started**" button on the **"Health Care Only"** side of the home page to start an application for health coverage. If the individual wishes to apply for other benefits at the same time, he/she would choose "All Benefit Programs" option.

The first step is to **set up a CommonHelp account by creating a User Name and Password.** It is important for an applicant to keep this information as **it**

will be his/her ID and password during the application process and if approved, for ongoing case maintenance and annual renewal of benefits. In addition to the ID and password, the person is asked the answers to a series of security questions which are used to verify identity during future log ins.

The online application takes about **60 minutes to complete**. It will take longer if the family has many people in it. If, during the process, a family/individual needs to stop, they can **save** their information and **exit** the application and come back and complete it later. The applicant has up to **60 days to come back** and complete the application process. If more than 60 days pass, he/she must start the application process over.

The family/individual should have the following information at the ready to make the application process go smoothly:

- Household income from jobs and other income sources
- Social Security Numbers (or document numbers for legal immigrants who need coverage), full names, and dates of birth of all applicants
- Current or recent health insurance information (if applicable)

All the information collected on the paper *Application for Health Coverage & Help Paying Costs* will be asked in the online application. It uses dynamic technology, so based on the way some questions are answered, certain other questions can be skipped to help speed the process along. For example if the applicant indicates his gender is male, it will not ask him questions related to pregnancy. Like the paper Application, CommonHelp collects all the information it needs about each household member at one time and then moves on to the next one.

At each step, CommonHelp will ask the applicant to review the information entered for errors and allow for any needed corrections. Once the applicant is satisfied with what has been entered, CommonHelp will indicate which program has been applied for and **where the application will be processed - LDSS or the CPU**.

The verification step explains the applicant's options to submit the application electronically, via mail, fax, or in person drop off. **If the person chooses to continue and submit the application electronically, CommonHelp will take them through the electronic signature process**. Once "signed" and submitted, the applicant **will receive a tracking or "T" number** as confirmation that the application was successfully submitted. **The person should keep the T number as it is needed to check with the local DSS or CPU on the status of the submitted application.** If you are helping the family/individual and have their permission to follow up on the Application, you should keep the T number as well. **The date the application is complete and submitted online is application date.** (*Phone numbers for all the local DSS offices are listed in Section 5: Other Helpful Information*)

If any of the information on the Application cannot be verified using available electronic data sources, the agency processing the case (LDSS or CPU) will

contact the family/individual requesting verification documents and giving instructions on how to return the information for processing. The notice will include a due date. All efforts will be made by LDSS and the CPU to verify the information electronically prior to contacting the applicant for additional documentation.

MMIS check and **Identity (ID) Proofing** allow for "real time" eligibility determination. Once all the household members have been entered, MMIS check allows the system to check the Virginia Department of Medical Assistance services' MMIS system (using name, social security number, and date of birth) to see if any family member is already enrolled in partial or full state health coverage. If a household member is already enrolled, the applicant will see a warning message telling them the person already receives health coverage and there is no need to reapply for that individual. This should prevent duplicate applications. The ID Proofing question is asked in the "Get Started" section of the CommonHelp online application. If the applicant consents to ID Proofing, he/she will be asked a series of personal questions about themselves and his/her answers will be matched against external data sources (Federal Data Hub, Experian, etc.) By consenting to these extra questions, it is possible that by the end of the online application process, "near real time" eligibility results on the application could be given.

If real time results are not possible, approval via a ***Notice of Action on Benefits*** will be sent from the local DSS or CPU. The the family/individual will have the opportunity to link their FAMIS/Medicaid case to their CommonHelp online account with the User Name and Password they used when they applied for coverage. They will login to CommonHelp and look for the "Manage My Account" page. After answering a few questions to verify their identity, they will be able to link their case. One of the items needed to link the case is the enrollee's case number from the *Notice of Action*.

Once the case has been linked, the individual can check benefits (see what programs they have been approved for and their case number); report changes in household size, address, and income; and at annual renewal, renew benefits through CommonHelp. Clicking on the magnifying glass icon next to one of the benefits programs will bring up more detailed page on that benefit.

To report changes, families/individuals will login and choose "Report My Changes" and click the box next to the case they want to update and then report changes to the household information in the resulting form. At the end of the questionnaire, the family/individual will be prompted to submit their changes. These will be reported to their local DSS.

Alternative Online/Telephone/Mail Application Submission Site -
A family/individual may also apply for coverage online with **Healthcare.gov or via telephone (800)-318-2596**. This is the Federal Health Insurance Marketplace. If an application is started here, Healthcare.gov will screen it for eligibility for Virginia's coverage programs first **and if determined eligible, enroll the person in coverage.** If the Healthcare.gov determines the person looks to be eligible for a Virginia program, but the Marketplace can't

verify all the information, they will send the application to Virginia to complete the application process. The Cover Virginia CPU, or the loca DSS, will handle disposition of those cases.

If it is during annual Open Enrollment, or if an applicant is eligible for a "Special Enrollment Period," and the applicant is determined to not likely to be eligible for Virginia coverage, Healthcare.gov will process his/her application for eligibility for premium tax credits and cost sharing subsidies to help make purchasing private insurance on the Marketplace more affordable.

By Paper - *Application for Health Coverage & Help Paying Costs*
The completed paper Application (including a signature) can be submitted **via mail** or delivered **in person** to the local Department of Services (DSS) that serves the locality in which the applicant lives. A listing of the addresses for the 120 local DSS offices in Virginia is located in *Section 5: Other Helpful Information*.

The date the Application **is received by the DSS, not the date it is signed by the applicant**, is considered to be the date of application. *Note: A single stamp may not cover the cost of mailing of an Application, so the family should take care to affix the correct amount of postage or it will be delayed in reaching its destination.*

The paper Application is a booklet consisting of a page of instructions, 7 pages of application information, and 4 pages of included Appendices (A-C). It allows a family to provide information on up to two family members. If there are **more than 2** people in the family, an "**Additional Person Single Page Supplement" must be completed** for each additional person.

Front Cover
The front cover of the Application is "Things to Know." It tells the applicant that he/she can use the form to apply for Medicaid, FAMIS or Plan First and for coverage choices and tax credits. It urges people to apply faster by using ***commonhelp.virginia.gov*** to apply.

It also tells them what information will be needed to complete the Application:

- Social Security Numbers (or document numbers for legal immigrants who need coverage) and dates of birth for applicants
- Employer and income information for all family members
- Policy numbers for current health insurance policies, and
- Information about any job-related health insurance available to the family.

The form indicates that the state is asking for information to determine what coverage the household members qualify for and if they can get help paying for it and assures the family that the information will be kept private and secure.

Once the complete, signed Application is sent to the applicant's local DSS, that agency may follow up with the family for additional needed information.

It states that the Application should be processed within 45 days from the date it was received by the local DSS.

It also provides information on where the applicant can get help completing the application, including the phone number and web address of the Cover Virginia Call Center.

Page One
Page one consists of two steps. ***Step 1*** asks for contact information for the adult in the family that will be the contact person for the Application. It asks for full name (including middle initial and suffix, if applicable), home and mailing addresses, phone numbers, whether the family wants to receive information about the application online at CommonHelp and what their preferred language is (if it is other than English).

The bottom of the page lists the instructions on how to complete ***Step 2,*** which asks for information about everyone in the household. It goes over who to include and not include on the Application and advises the applicant to complete ***Step 2*** for each person in the family starting with the person who completed ***Step 1***.

Page Two
Page two includes more questions for ***Step 2: Person 1***. Questions 1-5 are identifying information - full name, relationship to person 1 (in this case "self"), date of birth, sex, and Social Security number.

Question 6 asks if the person files federal taxes, yes or no. If "Yes," it asks if he/she files jointly with a spouse, claims any dependents, or is claimed as a dependent on anyone else's tax return. [*This question is key for calculating MAGI household size and income.*]

Question 7 asks if the person is **pregnant.** If "Yes," how many babies are expected and what the expected due date is. [*This question flags the application for 10 day expedited processing.*]

Question 8 asks if the person needs health coverage. If "No," the person can skip to Page 3 "Current Job & Income Information". If "Yes," it advises them to continue answering questions 9-17 below. It also has two questions about being evaluated for the Plan First program. Check "Yes" if under age 19 or over age 64 if they don't want to be evaluated for **Plan First** (Opt In). Check "No" if age 19-64 and **do not** want to be evaluated for Plan First (Opt Out)

Question 9 asks if the person needs help with everyday things to live safety in the home or if he/she has a physical disability or long term disease, a mental or emotional health condition, or addiction problem. [*This question explores whether the person might be eligible under the Aged, Blind, & Disabled (ABD) Medicaid coverage category or if he/she is "Medically Complex" which has an effect on the way a person receives their care in the program via a Medallion 4.0 Managed Care Organization (MCO) or a CCC Plus MCO.*]

If age 65 or older and receiving Medicare, it also asks the person to complete Appendix D, which is not included in the Application booklet. Copies can be downloaded from the Cover Virginia Website. Appendix D needs to be completed if someone has disabilities; is age 65 or older; or is in need of Long Term Care Services (nursing facility or community based care).

Question 10 asks if the person is a US citizen or US national. If the answer is no, the person will stop answering questions on this page, and proceed to the income questions (18 to 31).

Question 11 asks if the person is not a US citizen/national, if they have a eligible immigration status. If "Yes," it then asks for an immigration document type, document ID number, if the person has **lived in the US since 1996** and if the person, person's spouse, or parent is a Veteran or active-duty US military member. [*The 1996 question is flagging the person for an evaluation of the 5 years/40 quarter work requirement for LIFC, FFC, New Health Coverage for Adults, and Plan First.*]

Question 12 asks if the **person lives with at least one child under age 19**, a**nd if they are the main person taking care of this child**. [*This question is exploring the possibility LIFC coverage for Person 1.*]

Question 13 asks if the person is incarcerated. If "Yes," it requests more information on where and his/her expected release date.

Question 14 asks if the person is a full-time student.

Question 15 asks if the person was in **foster care at age 18 or older** and if "Yes," in which state. [*This is flagging the person for evaluation for Medicaid coverage as a former foster care youth. If the child was in public foster care at age 18 in any state, he/she is now eligible for Medicaid coverage, regardless of income, until age 26.*]

Question 16 asks if the person is of Hispanic/Latino ethnicity to check all the options that apply to them and Question 17 asks his/her race. Both of these questions are optional. Answering them helps the state collect good demographic information on applicants and enrollees.

Page Three

The next set of questions on page three is regarding the person's current job and income information. At the top it asks if the person is **Employed** - if "Yes" they start with Question 18. If **Not Employed** - the person starts with Question 28. If **Self-Employed**, he/she skips to Question 27.

Current Job 1: Questions 18 through 21 asks for information on their current job - the employer name, address, and phone number, the amount of wages/tips **before taxes have been taken out**, how frequently the person is paid, and the average number of hours worked each week.

Current Job 2: Questions 22 through 25 ask the same questions as for

current Job 1, but for any second employer the person may have. **It also advises applicants that if they have more than 2 jobs, that he/she should answer these same questions for those jobs on a separate sheet of paper.**

Question 26 asks if the person changed jobs, stopped working, started working fewer hours, or none of the above in the past year.

Question 27 should be answered if Person 1 is Self-Employed. It asks for the type of work and how much net income (amount left over once business expenses are taken out) he/she will get from self-employment this month.

Question 28 explores if the person has other income coming into the home, things like unemployment, pensions, Social Security (Retirement, Survivor Benefits or Disability), retirement accounts, alimony received, etc. It asks for the amount of money coming in and how often it is received.

Question 29 asks if the person needs help paying for medical bills from the last 3 months. [**By answering "Yes" to this question, the person is applying for retroactive coverage to help pay those medical bills.** *Retroactive coverage is available for FAMIS Plus, Medicaid for Pregnant Women, LIFC, FFC, Plan First, New Health Coverage for Adults, and for a newborn applying for FAMIS.*] If "Yes", the person must list a total of his/her gross monthly income from all sources for the previous 3 months.

Question 30 asks for any deductions that can be taken from income for things like student loan interest. It asks for the amount paid and the frequency it is paid. These are things claimed on the front page of a 1040 tax return. This also includes any pre-tax deductions for things like a Health Savings Account (HSA), retirement accounts (401K or 403B), or child care.

Question 31 is required only if the person's income changes from month to month. If it does, it asks for the person's total gross income this year, and what the person thinks their total income will be next year. If it does not, the person can skip this question.

Pages Four and Five
These pages are for ***Step 2: Person 2***. Though reordered slightly, all the same questions as those asked for ***Step 2: Person 1*** are asked on these pages with the addition of one question - whether or not they live in the home with Person 1. If the family has more than two family members, they must complete both sides of the "***Additional Person Single Page Supplement***" for each one. Again the questions are the same as for ***Step 2: Person 2***. At the top of the page, they must also include the name of the person from ***Step 1***. [*This is to ensure that these additional pages are associated with the correct Application.*]

Page Six
Step 3 on page six must be completed only for American Indian or Alaska Native family members. If the person is of this decent, he/she should go to and complete ***Appendix B***. If he/she is not, continue to ***Step 4***.

Step 4 must be answered about anyone applying for health coverage. Question 1 asks if anyone is applying is already enrolled in health coverage. If "yes", it asks the person to check next to the type of coverage each person in the family has and write that family member's name next to the type. If anyone has employer coverage, it also asks for the name of the health insurance, the policy number and if it is a COBRA policy or retiree health plan. It also asks if there is any other insurance, the name of that insurer and the policy number and if it is a limited-benefit plan (like a school accident policy).

Question 2 asks if anyone listed on the Application is offered health insurance from a job. He/she is advised to check "Yes" even if this coverage is from someone else's job (i.e. parent's or spouse's). If "Yes", he/she must complete ***Appendix A*** and must answer the question if it is a state employee benefit plan. If "No," continue on to ***Step 5***.

Page Seven

Step 5 is the where the family will read about their rights and responsibilities and will sign and date the application. It is important that the applicant read and understand the information in this step. It warns of the penalties for lying on the application and failing to report any changes to the answers to the Application questions. *(A copy of this page of the Application is on page 2.30)*

Additionally, there is a section about **"renewal of coverage in future years"** that can be completed allowing the local DSS and the Federal Health Insurance Marketplace to use tax return information in future years as income verification to renew coverage. **If checked, the LDSS has permission to attempt to verify income electronically at annual renewal**. If LDSS can verify income this way, it may be able to process an "Ex Parte" renewal without requiring any action on the part of the enrollee.

It also talks about allowing Medicaid to receive Third Party Payments (mentioned on pages 2.1-2.2) and gives information on the right to appeal if the application is denied. After that, there is a place for the Person who completed Step 1 to sign and date the application. The *Application* is not considered to be complete without a signature from the person who completed Step One.

Step 6 at the bottom of the page tells the person to mail the *Application* to the local DSS in the locality in which they live.

Page Eight

Page 8 gives a statement about DMAS's compliance with applicable Federal civil rights laws and nondiscrimination and repeats it in 16 languages.

APPENDIX A

The information on this page is collected for eligibility for Premium Tax Credits toward purchasing private health insurance through the Federal Marketplace. The Applicant does not have to complete this page if no one from the household is eligible for health insurance through a job. If health coverage is offered, this form must be completed for each job that offers it. There is no penalty for

not completing this Appendix, if the family members are only eligible for state coverage programs.

To complete ***Appendix A***, the applicant will need to get some specific information from his/her employer. To facilitate the collection of this information, the reverse side of the sheet with Appendix A on it, includes an "Employer Coverage Tool." The applicant can fill out his/her name and SSN and give it to the employer to complete the rest of the questions. The form asks if the employee is eligible for job-based coverage, if they can get it for other family members (if "Yes," list who), if the coverage meets the "minimum value standard", what the cost of the premium would be, and if the employer will make any changes in coverage in the next year. The applicant can then use this information to answer Questions 13-16 on ***Appendix A***.

Appendix B
This ***Appendix*** must be completed only if the applicant indicates that there were any American Indian or Alaska Native family members in ***Step 3***.

Appendix C
This page allows an applicant to give a trusted person permission to talk about this application with local DSS or the Federal Marketplace. If the applicant wants to designate someone as an "**Authorized Representative**," meaning the person would be signing the application on someone else's behalf, they would fill out the **top part**.

If you work for a **"helper" agency** and are **assisting with the application** do not complete the top of this form, but rather complete **the middle part**. This is a release of information that will allow DSS, the Cover Virginia Call Center, and the Marketplace to talk with you about the application, but does not mean you are acting on the applicant's behalf.

If you are a **Certified Application Counselor, a Navigator, or an Agent or Broker** fill out the **bottom section**. These people are all application assisters registered with the Federal Health Insurance Marketplace.

The last page of the Application booklet gives the applicant the opportunity to register to vote.

Outside of the Application booklet there are other Appendices that may be required by the state for the applicant to be evaluated for proper coverage.

Appendix D is currently required if someone is disabled, over 65 or in need of long term care services. [*This collects the information for someone to be considered for ABD Medicaid - which is coverage for the Aged, Blind, or disabled*]. *Note: This appendix is being re-purposed and soon will only be for those people on Medicare or over age 65 or disabled people with incomes over 138% FPL who have a need for long term care services.*

Appendix E is used to evaluate individuals for Medically Needy Spenddown. This is when an individual is over income for a coverage program, but is incurring medical bills and would like to be evaluated based on income, resources and medical expenses. If their bills get high enough, they may qualify for coverage. *Note: Applicants cannot spenddown for coverage in FAMIS, LIFC, or the New Health Coverage for Adults.*

Appendix F is currently being developed and will be used to gather more information from recipients of the New Health Coverage for Adults who need long term care services.

HOSPITAL PRESUMPTIVE ELIGIBILITY

There is one more pathway to **begin the application process for coverage** in the **Medicaid** programs. It is called Hospital Presumptive Eligibility (HPE). **Participating hospitals** in Virginia are able to enroll eligible individuals in **short-term Medicaid coverage** through this program. The temporary coverage is based on both financial and non-financial eligibility for the following coverage groups:

- A parent or caretaker relative of a child or children in the home under age 18 (or 19 if the child remains in school) [LIFC]
- A pregnant woman [Medicaid for Pregnant Women]
- A child under age 19 [FAMIS Plus]
- An individual under 26 who was a former foster care child [FFC]
- A person eligible for limited Medicaid benefits for family planning coverage only [Plan First]
- A person who has been diagnosed with breast or cervical cancer
- An adult age 19 to 64 [New Health Coverage for Adults].

Hospital employees will screen the patient for eligibility by asking several questions. The person will answer them and self-declare his/her income. If it is within the guidelines, the hospital will provide a **HPE Approval Notice and enter the person into the HPE Online Enrollment Form.** (*A sample of this notice is on page 2.50*) If the person is not within the guidelines, they will be issued a HPE Denial Notice.

The **coverage period** for the presumptive eligibility **begins the day the HPE is determined by the hospital and ends the last day of the following month**. If the HPE recipient files an application for Medicaid before the end of his/her presumptive eligibility coverage, the eligibility continues while the full Medicaid application is being processed.

If the application is filed and the person is found eligible for Medicaid, coverage will continue. If the application is filed and the person is found to be ineligible, the person will receive a denial notice and coverage will end. Any services paid for by Medicaid during the HPE period, do not have to be reimbursed. There are no appeal rights for HPE.

The coverage received during the HPE period is different for pregnant women than for every one else. **Pregnant woman can receive everything but inpatient hospital services**. Other participants receive all services. Pregnant women can only get HPE coverage one period per pregnancy. Non-pregnant individuals can only receive one HPE period per calendar year.

VERIFICATION DOCUMENTS THAT MAY BE REQUESTED DURING THE APPLICATION PROCESS

There are no documents that are required to be "attached" to the Application at the time of submission. If citizenship, immigration status or income cannot be verified through available data sources, the applicant will be contacted to provide more information and documentation. The following is a listing of possible verifications that an applicant may have to send when contacted by the local DSS or the Cover Virginia CPU for more information:

- **Proof of income** for the month prior to application (*for example – if you apply in September, provide proof of income for August*). If income is irregular, three months of income (*or more*) will be requested to determine the applicant's average monthly earnings. If requesting retroactive coverage (available in all programs, except FAMIS MOMS and FAMIS, with the exception of FAMIS for a baby under 3 months) to pay any medical bills incurred during the prior three months, the applicant will be asked to supply proof of income for those three months.

- **Proof of application for a Social Security Number (SSN),** only if the person applying does not have one. Proof is the receipt from the Social Security Office showing the date of application. Once the number is received, it must be reported to the to the local DSS. *(It is not necessary to provide a copy of the social security card.)*

- **Proof of citizenship status/identity** if the applicant's citizenship status and or identity cannot be electronically verified by the state using the information provided on the Application, he/she will be contacted to document proof. Copies of a passport or driver's license and a birth certificate are the usual documents needed. Copies of these documents are acceptable.

- **Proof of immigration status** if the child/adult is not a US citizen and his/her immigration status cannot be verified using the information provided on the Application. A copy of the front and back of the Resident Alien Card or other USCIS document giving the Alien ID# and legal immigration status for the applicant is required.

- **Proof of legal guardianship or authorization from the parent** if a legal guardian or non-relative (godparent, neighbor) is applying for the child. A copy of the legal document naming the person as guardian or a signed statement from the parent stating the person is authorized to apply for health insurance for this child will be necessary.

APPLICATION PROCESSING TIMEFRAMES

Regardless of where the Application was filed (online via CommonHelp, over the phone at the Cover Virginia Call Center or mailed/delivered to the local DSS), Federal Regulation requires that a decision for **FAMIS Plus/Medicaid eligibility** must be made **within 45 calendar days**, unless an extension is requested by the applicant. The state follows this guideline for **FAMIS** as well. The clock starts ticking the day the signed application is received via **any of the above**. During application processing, the caseworker may contact the applicant (and possibly the person listed on the Application as helping with the application) to answer any remaining questions or secure any missing verification documents.*(Sample of "Requests for Verifications" sent by the Cover Virginia CPU and LDSS are located on pages 2.31-2.32 and 2.33-2.34)*

Regardless of where the Application was filed, policy requires that an application for **Medicaid for Pregnant Women/FAMIS MOMS** be processed as soon as possible, but **no later than 10 business days** from the date the signed Application was filed. If all necessary verifications are not received, the application continues to pend until the 45 day processing time limit is met. During this time, the applicant will receive notification of the missing information with a request to provide it within 10 days.

Follow-Up
At any time during the process, the applicant (or person designated as assisting the family) can call the Cover Virginia Call Center, or local DSS where the application was sent, for information on the status of the application. If the person applied online or via the Call Center, the **T number** is an added piece of information that is crucial in locating the application.

DISPOSITION OF THE CASE

The DSS/CPU will complete a full eligibility determination and, if **found eligible**, **will enroll the applicant in the appropriate state-sponsored health insurance** program. The applicant will receive a *Notice of Action on Benefits* stating the person's "application for Medical Assistance has been approved." The second page gives information on who is approved, for which program, their ID numbers, benefit periods, and Copay Statuses (0, 1, or 2), if applicable. It also provides information on things the enrollee(s) will receive and things they will still need to do. The bottom explains the copay status (what the 1 or 2 means) and advises families to keep copies of copayment receipts, so that when they reach their yearly out of pocket maximum they can complete the Copayment Tracking form and submit it to the Cover Virginia Call Center for verification and relief from copayments for the rest of the enrollment year. *(See pages 2.39-2.41 for a sample approval notice and Section 3 for a copy of the FAMIS Copayment Tracking Form.)*

If the eligibility worker finds that the applicant is **not eligible**, the applicant will be sent a *Notice of Action on Benefits* stating that coverage has been **denied**, giving the reason it was denied, and information about the right to appeal. *(See pages 2.43-2.44 for a sample denial notice and page 2.42 for a copy of the Marketplace referral letter.)*

WHAT HAPPENS IF THE APPLICATION IS DENIED

By the Local DSS or Cover Virginia Central Processing Unit:
If the application is denied for coverage by the local DSS or the Cover Virginia CPU, the Application will be referred to the Federal Marketplace for an evaluation of eligibility for Premium Tax Credits and Cost Sharing Subsidies. The applicant will also receive a *Notice of Action* stating the reason for denial of coverage and advising him/her of their right to appeal "any adverse action" such as a denial or termination of eligibility.

Individuals receiving a denial/termination by a Virginia entity may request a meeting or "agency conference" with the local DSS or Cover Virginia CPU (whichever agency processed the case). This must usually be held within 10 working days of the denial/termination. This is an informal opportunity to discuss the reasons for denial/termination. During the "conference", the family/individual can share additional information with the eligibility worker or supervisor who will then review all the information and either uphold the decision, ask for more information, or revise the decision. Having an agency conference does not affect the applicant's right to an appeal.

The applicant has the right to formally appeal the denial/termination decision to the Virginia Department of Medical Assistance Services (DMAS). An appeal must be requested by the parent, legal caretaker, or adult applicant within 30 days after the date of the *Notice of Action* (denial) *or Advance Notice of Proposed Action* (termination/cancellation of benefits). This can be done by writing to DMAS at the following address:

Appeals Division
Virginia Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

The family may also **fax in the written appeal request to (804) 452-5454**. They may call the Appeals Division of DMAS at (804) 371-8488 for more information.*(A sample* Medicaid/FAMIS Appeal Request Form *is on pages 2.45-2.46)*

The individual will be notified of the scheduled hearing, which will be held at a convenient location, usually the local DSS office. During the hearing, the applicant/recipient has the opportunity to tell the Hearing Officer why they believe the agency's action was wrong. The Hearing Officer also receives evidence from the agency or individual who denied the application.

An outreach worker, friend, or family member may represent the applicant. Individuals may seek assistance with their appeals from their local Legal Services office. (*See the listing of Virginia Legal Services Programs in Section 5: Other Helpful Information.*)

A decision will be made within 90 days of the appeal request, unless the applicant/recipient or their representative requests or causes a delay. Decisions made by Medical Assistance Hearing Officers are the final decisions of DMAS.

If the applicant disagrees with the hearing decision, further review may be available through the Circuit Court in the city or county where the family lives.

In termination cases, if the request for an appeal is filed prior to the effective date of the termination, health insurance coverage will continue until a decision is made. However, in the event that the appeal decision is in the agency's favor, the family may have to pay back benefits received while the review was pending.

By the Federal Health Insurance Marketplace/Healthcare.gov:
If a person applies for state-sponsored health insurance through Healthcare.gov and is denied, he/she has the choice of requesting an appeal of eligibility either through the Marketplace or through the Virginia Department of Medical Assistance Services.

If he/she chooses to appeal through the Marketplace, the Eligibility Determination Notice from the Marketplace explains how to appeal. In general, if the person chooses to appeal through the Marketplace, he/she can:

- Write a letter to:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061

- Print out the Appeal Form available online at https://www.healthcare.gov/marketplace-appeals/appeal-forms/ and mail (to address above) or fax it in (secure fax line: 1-877-369-0130).

- Fill out the online Appeal Form and submit it electronically.

After an appeal is filed, the applicant will get a letter stating whether the request was received, and whether it has been "accepted" or is "invalid."

"Invalid" means the Marketplace Appeals Center isn't able to act on the appeal and the applicant must follow the steps outlined in the letter by the stated deadline. If nothing is done, the appeal will be dismissed.

"Accepted" means the Marketplace Appeals Center will review the appeal. The letter provides a description of the appeals process and includes instructions for submitting additional materials, if necessary. In general, the Marketplace Appeals Center must provide a decision and mail the response within 90 days of when it received the appeal request. The Appeals Center reviews the appeal, including the information the Marketplace used to determine eligibility. The applicant may get a letter asking for more information or documentation, like a copy of a passport. If this information is provided in a timely manner, the Appeals Center may be able to informally resolve the case fairly quickly and they'll send a "Notice of Informal Resolution."

The notice gives instructions on how to request a hearing if the applicant isn't satisfied with the informal resolution. Most hearings are conducted over the phone. It's a good idea to save copies of all forms and notices related to the appeal. If needed, the applicant can also request a copy of his/her appeal record (PDF).

When the appeal is resolved, the applicant will get a notice with the Marketplace Appeals Center's final decision about eligibility that explains how they reached their decision and any next steps.

Marketplace eligibility may change, depending on the decision. For example: If eligibility for coverage was appealed, the letter will tell the applicant if he/she qualify to buy a Marketplace plan. If eligibility for financial assistance was appealed, the letter will say if the applicant qualifies to use a different amount of premium tax credit each month, for savings on out-of-pocket costs, or for coverage through Medicaid or CHIP programs.

If he/she chooses to appeal through DMAS, starting November 1, 2018, the Marketplace will send the appeal request to the Eligibility and Enrollment Division at DMAS along with information about the case and the actions taken by the Marketplace during processing.

An Eligibility and Enrollment staff person will review the Marketplace decision. If the decision of the Marketplace was correct, he/she will write the appeal summary and represent the Marketplace at the Appeal hearing.

If the Marketplace decision was not correct, the staff person will work with Cover Virginia to enter the person in the VaCMS system, determine the correct state coverage program, and enroll the person effective back to the date of application.

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**.

ENV

Cover Virginia

Checklist of Needed Verification

Mailing Date: 8/15/2018
Case Number: XXXXXX

Response Required By: 8/25/2018
Date of Application: 7/23/2018

Please mail or fax the requested information in the form to the following office:

Cover Virginia
P.O. Box 1820
Richmond, VA 23218-1820
Hours: 8:00 am to 7:00 pm Monday - Friday / 9:00 am to 12:00 noon Saturdays
Phone: 1-855-242-8282 *Fax: 1-888-221-9402*

We are reviewing individuals listed on the application for healthcare coverage under the Medicaid or FAMIS programs. In order for us to complete this process, you must provide the information checked below.

Fax or use the enclosed envelope to mail the requested information to Cover Virginia.
Documents must be received by due date: **8/25/2018**

The requested information is for Months: June 2018 Through July 2018

Income (Earned and Unearned):

- [✓] Pay stubs
- [✓] Self-employment records
- [ ] Social Security/SSI benefits
- [ ] VA benefits
- [ ] Retirement income
- [ ] Alimony payments (Received/Paid
- [ ] Unemployment benefits
- [✓] Other (*See Note section below*)

Documents:

- [ ] Social Security Number
- [ ] Application for a SSN Card
- [ ] Declaration of Citizenship/Identity
- [ ] Immigrant/Alien documentation
- [ ] Health insurance policies / cards
- [ ] Authorized Representative
- [ ] Birth Verification
- [ ] Other (*See Note section below*)

Identity:

- [ ] Driver's license
- [ ] Clinic, medical card
- [ ] Work ID, school ID, library card
- [ ] Other (*See Note section below*)

See reverse for more information on the items checked above.

Notes:

Please provide consecutive pay verification for xxxxx received from xxxxxxxxxxxxxx from June 1st, 2018 through July 31st 2018. If you are paid weekly, please provide at least 4 consecutive paystubs. If you are paid bi-weekly or semi-monthly, please provide at least 2 consecutive paystubs. If you are paid monthly, please provide at least 1 paystub. If HH member does not have the required amount of paystubs, please provide a signed and dated employer statement verifying gross wages for the missing paystubs.

Additional Notes on Information Being Requested:

1. PROOF OF ALL GROSS INCOME: (Other than Social Security or SSI Income) pertaining to: You, your spouse, Father or Mother of the children applying for Medicaid who are tax dependents living in the home. Your parents' income if you are age 21 and older and are claimed as tax dependent. Received in the month stated above.

2. EARNED INCOME: Pay Stubs: ALL paystubs received in the full month stated above and previous month, (1 pay stub will NOT be sufficient to evaluate your case) Self-Employment (Current taxes: 1040, Schedule C, etc., extension letters) Proof of pay for Odd Jobs, Miscellaneous work.

REV1116

Cover Virginia Call Center
Toll Free: 1-855-242-8282 • TDD: 1-888-221-1590
Toll Free Fax: 1-888-221-9402
8:00 am to 7:00 pm Monday – Friday / 9:00 am to 12:00 noon Saturday
www.coverva.org

Sample Request for Verification from Local DSS
[This document shows information needed for many DSS programs, not just for Medical Assistance Programs]

County/City: Henry County (890)

20 PROGRESSIVE DR
PO BOX 4946
MARTINSVILLE VA 24115
Phone: (276) 656-4300

Commonwealth of Virginia
Department of Social Services

Date: 3/19/2018
Case Number: 113078768
Client ID: 2103570446
Correspondence #: 710301257

Barbara Thompson
100 Randolph ST
Collinsville VA 24078

This is the name and address of the head of household

Checklist of Needed Verifications

In order for us to see if you are eligible for assistance, you must provide the information below. We will help you obtain the information. If you cannot provide the information, or if you need help in providing the information, contact your worker. Call collect, if necessary. If you do not provide this information or contact the agency by the following dates, your application may be denied.
PLEASE RETURN THIS DOCUMENT WITH YOUR VERIFICATIONS.

Medical Assistance: Verifications for the period 01-01-2018 to 02-28-2018

Verifications for the items indicated below are due by 03-29-2018

	TANF	SNAP	Medical Assistance	Energy Assistance		TANF	SNAP	Medical Assistance	Energy Assistance
1. Income (Earned and Unearned)									
Pay stubs, statement from employer					Social Security/SSI Benefits				
Self-employment records			x		Retirement Income				
Child support, alimony payments					Unemployment Benefits				
Worker's Compensation benefits					Loans				
VA Benefits					Scholarships/Grants				
Statement of contribution					Other				
2. Work Expenses									
Day care expenses for child or adult					Other				
3. Resources									
Pension plans, retirement accounts, IRAs					Burial plots funds, contracts				
Checking, savings, credit union, Christmas Club account statements					Title, registration, or personal property, tax receipts for motor vehicles, motor boats, motor homes.				

	TANF	SNAP	Medical Assistance	Energy Assistance		TANF	SNAP	Medical Assistance	Energy Assistance
Real estate property					Stocks, bonds or CDs				
Life Insurance Policies					Other				
4. Shelter Expenses									
Rent or mortgage receipts					Real estate taxes				
Homeowner's insurance					Electric bill				
Gas/kerosene/oil/wood/ coal bill					Water/sewage bill				
Garbage bill					Phone bill				
Initial installation charge					Other				
5. Child Support Paid									
Child support paid					Copy of support order				
Other									
6. Identity									
Proof of identity such as driver's license, state issued ID, voter registration card, medical card, work ID, school ID, library card, etc.					Other				
7. Residency, Living Arrangements, School Enrollment									
Verification of residence					School enrollment				
Separate arrangement to buy and prepare food					Proof that children live in the home				
Other									
8. Documents									
SSN cards/numbers					Application for SSN card				
Citizenship					Immigration/alien documentation				
Birth verification					Verification of paternity				
Marriage certificate					Divorce decree				
Death certificate					Other				
9. Medical Information									
Medical bills, Prescription drug bills					Medical form, statements				
Health insurance policies, cards					Health insurance premiums				
Immunization records					Other				

Other information or verification needed: *[If additional information was needed not in the table above, it would be detailed here]*

U.S. Citizenship and Immigration Services

Public Charge Fact Sheet

Released April 29, 2011

Introduction

Public charge has been part of U.S. immigration law for more than 100 years as a ground of inadmissibility and deportation. An individual who is likely at any time to become a public charge is inadmissible to the United States and ineligible to become a legal permanent resident. However, receiving public benefits does not automatically make an individual a public charge. This fact sheet provides information about public charge determinations to help noncitizens make informed choices about whether to apply for certain public benefits.

Background

Under Section 212(a)(4) of the Immigration and Nationality Act (INA), an individual seeking admission to the United States or seeking to adjust status to permanent resident (obtaining a green card) is inadmissible if the individual "at the time of application for admission or adjustment of status, is likely at any time to become a public charge." If an individual is inadmissible, admission to the United States or adjustment of status will not be granted.

Immigration and welfare laws have generated some concern about whether a noncitizen may face adverse immigration consequences for having received federal, state, or local public benefits. Some noncitizens and their families are eligible for public benefits – including disaster relief, treatment of communicable diseases, immunizations, and children's nutrition and health care programs – without being found to be a public charge.

Definition of Public Charge

In determining inadmissibility, USCIS defines "public charge" as an individual who is likely to become "primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance, or institutionalization for long-term care at government expense." See "Field Guidance on Deportability and Inadmissibility on Public Charge Grounds," 64 FR 28689 (May 26, 1999). In determining whether an alien meets this definition for public charge inadmissibility, a number of factors are considered, including age, health, family status, assets, resources, financial status, education, and skills. No single factor, other than the lack of an affidavit of support, if required, will determine whether an individual is a public charge.

Benefits Subject to Public Charge Consideration

USCIS guidance specifies that cash assistance for income maintenance includes Supplemental Security Income (SSI), cash assistance from the Temporary Assistance for Needy Families (TANF) program and state or local cash assistance programs for income maintenance, often called "general assistance" programs. Acceptance of these forms of public cash assistance could make a noncitizen inadmissible as a public charge if all other criteria are met. However, the mere receipt of these benefits does not automatically make an individual inadmissible, ineligible to adjust status to lawful permanent resident, or deportable on public charge grounds.

See “Field Guidance on Deportability and Inadmissibility on Public Charge Grounds,” 64 FR 28689 (May 26, 1999). Each determination is made on a case-by-case basis in the context of the totality of the circumstances.

In addition, public assistance, including Medicaid, that is used to support aliens who reside in an institution for long-term care – such as a nursing home or mental health institution – may also be considered as an adverse factor in the totality of the circumstances for purposes of public charge determinations. Short-term institutionalization for rehabilitation is not subject to public charge consideration.

Benefits Not Subject to Public Charge Consideration

Under the agency guidance, non-cash benefits and special-purpose cash benefits that are not intended for income maintenance are not subject to public charge consideration. Such benefits include:

- Medicaid and other health insurance and health services (including public assistance for immunizations and for testing and treatment of symptoms of communicable diseases, use of health clinics, short-term rehabilitation services, prenatal care and emergency medical services) other than support for long-term institutional care
- Children's Health Insurance Program (CHIP)
- Nutrition programs, including the Supplemental Nutrition Assistance Program (SNAP)-commonly referred to as Food Stamps, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the National School Lunch and School Breakfast Program, and other supplementary and emergency food assistance programs
- Housing benefits
- Child care services
- Energy assistance, such as the Low Income Home Energy Assistance Program (LIHEAP)
- Emergency disaster relief
- Foster care and adoption assistance
- Educational assistance (such as attending public school), including benefits under the Head Start Act and aid for elementary, secondary or higher education
- Job training programs
- In-kind, community-based programs, services or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter)
- Non-cash benefits under TANF such as subsidized child care or transit subsidies
- Cash payments that have been earned, such as Title II Social Security benefits, government pensions, and veterans' benefits, and other forms of earned benefits
- Unemployment compensation

Some of the above programs may provide cash benefits, such as energy assistance, transportation or child care benefits provided under TANF or the Child Care Development Block Grant (CCDBG), and one-time emergency payments under TANF. Since the purpose of such benefits is not for income maintenance, but rather to avoid the need for ongoing cash assistance for income maintenance, they are not subject to public charge consideration.

Note: In general, lawful permanent residents who currently possess a "green card" cannot be denied U.S. citizenship for lawfully receiving any public benefits for which they are eligible.

Last Reviewed/Updated: 11/15/2013

Link to this page on USCIS website: http://www.uscis.gov/news/fact-sheets/public-charge-fact-sheet

Office of the Director
U.S. Department of Homeland Security
500 12th Street SW
Washington, DC 20536

U.S. Immigration and Customs Enforcement

Oct. 25, 2013

Clarification of Existing Practices Related to Certain Health Care Information

Purpose

The Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 224, and the Social Security Act (SSA) require that individuals[1] seeking coverage under a qualified health plan offered on a Health Insurance Marketplace or through an insurance affordability program (i.e., premium tax credits, cost sharing reductions, Medicaid, Children's Health Insurance Program, or Basic Health Program) provide information regarding their immigration status and certain information about their household members to determine eligibility for such coverage. This memorandum sets forth U.S. Immigration and Customs Enforcement (ICE) civil immigration enforcement policy regarding information concerning such individuals and their household members obtained during the eligibility determination process for such coverage.

Background

The ACA, the SSA, and implementing regulations outline procedures for determining eligibility for coverage under a qualified health plan offered on a Marketplace or through an insurance affordability program. Under the laws and implementing regulations, information provided by individuals for such coverage may not be used for purposes other than ensuring the efficient operation of the Marketplace or administering the program, or making or verifying certain eligibility determinations, including verifying the immigration status of such individuals.

Agency Policy

Consistent with the ACA's, the SSA's, and implementing regulations' limitations on the use of information provided by individuals for such coverage, and in line with ICE's operational focus, ICE does not use information about such individuals or members of their household that is obtained for purposes of determining eligibility for such coverage as the basis for pursuing a civil immigration enforcement action against such individuals or members of their household, whether that information is provided by a federal agency to the Department of Homeland Security for purposes of verifying immigration status information or whether the information is provided to ICE by another source.

[1] For purposes of this statement, "individuals" means certain applicants for, beneficiaries of, and enrollees in coverage under a qualified health plan offered on a Health Insurance Marketplace or through an insurance affordability program.

No Private Right of Action

This document, which is intended only as internal ICE policy, is not intended to, does not, and may not be relied upon to create any rights or benefits, substantive or procedural, enforceable at law by any party in any administrative, civil, or criminal matter.

Commonwealth of Virginia

Department of Social Services

County/City: **Charlottesville City (540)**
120 Seventh St., N.E.
Charlottesville VA 22902
Phone: **(434) 970-3400**

Date: **07/26/2018**
Case Number/ Client ID: **113094733/2103606987**
Correspondence #: **710302260**

Polly Anderson
1100 King ST
Charlottesville VA 22901

This is the name and address of the head of household.

Notice of Action on Benefits

This letter tells you about your benefits. If you have a question, please contact your agency listed above.

Which benefit?	**Status of the benefit?**
Medical Assistance	A decision has been made on your Medical Assistance application dated 07/01/2018. Please red this entire notice for information about this decision.

Comments:

Call Cover Virginia toll free for application assistance, questions and translation services 1-855-242-8282
TDD: 1-888-221-1590 8:00 am to 7:00 pm Monday - Friday 9:00 am to 12 noon Saturday

Your Medical Assistance Benefits

Approved:

Ongoing coverage was approved for the following people. Your next renewal is due 05/31/2018

Who is included?	Benefit Period	Coverage	Enrollee ID	Copay Status
Polly Anderson	04/01/2018- *	MA-PG	350022415019	0
Who is included?	**Benefit Period**	**Coverage**	**Enrollee ID**	**Copay Status**
Bobby Thompson	04/01/2018-*	MA-FAMIS	350022415027	2

Here is what you will receive:

- **Member Card(s):** You will receive a permanent Commonwealth of Virginia Medical Assistance card for each person covered.
    - Show this card to a participating Medicaid or FAMIS provider when you receive services. To locate participating providers in your area, please contact customer service at **1-855-242-8282** or go to **http://coverva.org**
    - If the person has had Medical Assistance in the past, you may continue to use the card you have for this coverage.
- **Medical Assistance Handbook:** Enclosed is a Medical Assistance Handbook. http://dmasva.dmas.virginia.gov/Content_pgs/rcp-home.aspx

Here is what you need to do:

- **Changes:** Report all changes within 10 days of the day you know about it, for example:
    - Address Changes: Let us know if your address changes as soon as you move.
    - Income Changes: Read the handbook for income changes that you must report.
    - Change in household individuals (including newborns)
- **Renewal:** Remember your benefits need to be renewed at least every 12 months.

Here is your copay status information:

- **FAMIS Co-payments:** Some doctor visits and services require a fee called a co-payment. Please refer to the FAMIS handbook which explains co-pay status and amounts you will pay. Native Americans and Alaskan Natives do not have to pay co-payments.
    - Copay status 1: Range from $2 to $15 based on the type of service. The annual maximum copayment per family is $180.
    - Copay status 2: Range from $5 to $25 based on the type of service. The annual maximum copayment per family is $350.

Save Receipts: Keep receipts for co-payments you pay. If you think you have met your annual maximum, fill out a Co-pay Tracking Form found in your FAMIS handbook and send it with a copy of your receipts to **Cover Virginia, PO Box 1820, Richmond, VA 23218-1820**.

2.40 ***Sample Approval Notice***

Medical Assistance Appeals and Fair Hearings

If you do not agree with your worker's decision, you may ask someone else to look at your request for help. This is called an appeal. You must send a letter within 30 days of getting this notice saying you want someone else to let you know if you can get the help you requested. A friend, relative or other person can send the letter for you. If the letter is sent in less than 10 days, and you were already getting help, you will continue getting help while the appeal is going on, but you might have to pay the Medicaid program back if you lose your appeal.

You may write a letter or complete a form. Forms for appeals are available on the Internet at www.dmas.virginia.gov, at your local department of social services, or by calling (804) 371-8488.

Please send a copy of this notice with the appeal request and mail them to the:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, VA 23219
Appeals requests may also be faxed to:
(804) 452-5454

County/City: Central Office (999)
801 East Main Street
Richmond VA 23219
Phone: (999) 999-9999

Commonwealth of Virginia
Department of Social Services

Date: **08/29/2018**
Case Number: 113041135
Client ID: **2103483793**
Correspondence #: **710299195**

Leonard CRYPTIC
600 Grove AVE
Charlottesville VA 22902

address of the head of household.

Federal Health Insurance Marketplace Referral Notice

You applied for Medical Assistance and the following people were determined not eligible for full coverage Medicaid and FAMIS.

Leonard CRYPTIC

We have referred your application to the Federal Health Insurance Marketplace to find out if you qualify for a free or low-cost private health insurance plan, or a new kind of tax credit that lowers your monthly premium. The Marketplace is designed to help you find and compare health insurance options based on price, benefits, quality, and other features that may be important to you.

If you have questions about your application or need additional information, you may go online at www.healthcare.gov or contact the Federal Health Insurance Marketplace at the following toll-free number, 1-800-318-2596.

Commonwealth of Virginia
Department of Social Services

County/City: **Central Office (999)**
801 East Main Street
Richmond VA 23219
Phone: **(999) 999-9999**

Date: **03/19/2018**
Case Number/ Client ID: **113087680/ 2103591044**
Correspondence #: **710292699**

Susan Harp
100 Main ST
Charlottesville VA 22901

This is the name and address of the head of household.

Notice of Action on Benefits

This letter tells you about your benefits. If you have a question, please contact your agency listed above.

Which benefit?	**Status of the benefit?**
Medical Assistance	You applied for Medical Assistance on 04/22/2018, your application was denied. For more information about your benefits, please read this entire notice.

Comments:

Call Cover Virginia toll free for application assistance, questions and translation services 1-855-242-8282
TDD: 1-888-221-1590 8:00 am to 7:00 pm Monday - Friday 9:00 am to 12 noon Saturday

Denied:

Coverage was denied for the following people.

Who is included?	Benefit Period	Why Denied?	Manual Reference
Chloe Harp	As of 06/01/2018	Duplicate Case	(M0130.400D)
Christy Harp	As of 06/01/2018	Duplicate Case	(M0130.400D)
Daniel Harp	As of 06/01/2018	Duplicate Case	(M0130.400D)
Henry Harp	As of 06/01/2018	Duplicate Case	(M0130.400D)
Philip Harp	As of 06/01/2018	Duplicate Case	(M0130.400D)
Susan Harp	As of 06/01/2018	Duplicate Case	(M0130.400D)

(Note: Third page has been omitted for space, this page has the same wording regarding Appeals and Fair Hearings as in the Approval notice)

2.44 *Sample Denial Notice*

VIRGINIA MEDICAID/FAMIS CLIENT APPEAL REQUEST FORM

Online fillable form available at www.dmas.virginia.gov

Complete this Appeal Request Form as fully as possible or write a letter with the same information. Please clearly explain why you are appealing. If more space is needed, additional sheets may be included. For your convenience, the form can be completed online and mailed or faxed to the Appeals Division.

For a deceased appellant, you must submit evidence from a court that you qualified as the Executor or the Administrator of the appellant's Estate. A Power of Attorney or Last Will and Testament is not acceptable proof of representation for a deceased appellant.

Signing Guidelines:

- If the appeal is **for a minor child**, the parent must sign this form. If the parent wishes to appoint a representative, include the Authorized Representative Form on page 3 of this Appeal Request. If you are appealing as a child's legal guardian, proof of guardianship is needed.
- In cases where a **spouse or family member** is representing the adult appellant, include the Authorized Representative Form on page 3 of this Appeal Request. The adult appellant must sign the form or include a Power of Attorney authorizing that person to act on their behalf during the appeal.
- If the appellant is **physically unable** to sign the Authorized Representative Form, the person acting on their behalf must fill out the Authorized Representative Form on page 3 of this Appeal Request, and describe the physical reason why the appellant cannot sign the form.
- If the appellant is **mentally unable** to sign the Authorized Representative Form, the person acting on their behalf must submit legal proof of guardianship with the appeal.

Time Limit for Filing an Appeal:

The appeal must be **postmarked or faxed** within **thirty (30) days** of receiving the agency's decision or the date the applicant was supposed to get a decision, but did not.

Send the Appeal Request Form or an appeal letter as soon as possible to protect appeal rights.

Send the completed Appeal Request Form or appeal request letter and related documents including the Denial/Termination Notice regarding the decision to:

Appeals Division
Dept. of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

or

Fax (804) 452-5454

Are you filing this appeal within 30 days of receipt of the agency's decision or by the date the agency should have made a decision? If no, answer the Good Cause Questionnaire below. ☐ **Yes** ☐ **No**

Good Cause Questionnaire

1. **Did you get a denial or termination notice?** ☐ **Yes** ☐ **No**
2. **What was the postmark date on the envelope?** **When did you receive the notice?**
3. **If you did not receive a notice, how did you learn of the denial or termination?**
4. **Have you had any problems getting mail?** ☐ **Yes** ☐ **No** **What kind of problems?**

   Were problems reported to the post office? ☐ **Yes** ☐ **No**
5. **Has your address changed?** ☐ **Yes** ☐ **No** **If so, when?**
6. **If your address changed, did you notify the agency?** ☐ **Yes** ☐ **No** **If yes, what date did you tell the agency that your address changed?**
7. **Why didn't you file an appeal within 30 days of the date you received notice of the decision, or within 30 days of learning of the agency's decision?**

VIRGINIA MEDICAID/FAMIS CLIENT APPEAL REQUEST FORM

Last Name of Medicaid/FAMIS Appellant:		First Name:	Middle Initial:	Suffix: (Sr., Jr., II, III)
Mailing Address - Street or PO Box		City State	Zip	Date of Birth
Medicaid/FAMIS Case #	Client ID #	Gender ☐ Male ☐ Female	Primary Telephone # with area code	
Preferred spoken language	Preferred written language	Do you need an interpreter? ☐ Yes ☐ No	Alternate Telephone # with area code	
Social Security Number		Have you already filed an appeal for the same issue (e.g. faxed and mailed) ☐ Yes ☐ No Date	Email	

Are you a community spouse appealing the income or resource determination for your spouse? ☐ **Yes** ☐ **No**

Did you receive a denial or termination notice from an Agency? ☐ **Yes** ☐ **No**

Agency Name **Telephone**

Notice Dated **Case Worker**

Include a copy of the Denial / Termination Notice regarding the decision you are appealing.

The agency (check all that apply)

- ☐ Denied my application or terminated my coverage for: ☐ Medicaid ☐ FAMIS
- ☐ Refused to take my application for: ☐ Medicaid ☐ FAMIS
- ☐ Failed to determine my eligibility within the time limit for: ☐ Medicaid ☐ FAMIS
- ☐ Requested repayment of benefits paid for medical services previously received.
- ☐ Declared me not disabled.
- ☐ Denied medical services or authorization for medical services. Name of service:
- ☐ Denied or terminated waiver services. Name the waiver and service:
- ☐ Transferred or discharged from a nursing facility. Name the facility:
- ☐ Took other action which affected my receipt of Medicaid, FAMIS or other medical services.

Write a brief statement about why you are requesting an appeal. Attach an additional page if you need more space.

Important Information if requesting Continued Coverage

The Department of Medical Assistance Services may recover expenses paid on behalf of clients when Medicaid or FAMIS coverage is continued during the appeal process and the hearing officer upholds the agency's action. Payments made for medical services (including MCO fees) from the original proposed date of termination or reduction in services, through the actual date of termination or reduction will be subject to recovery.

Continued Coverage

If you had Medicaid coverage before your benefits were canceled, do you want Continued Coverage through the appeal process if you qualify?

☐ Yes ☐ No

Authorized Representative

Will the appellant be represented by another individual during the appeal process?

If yes, fill out and return the Authorized Representative Form on page 3 of this Appeal Request or submit a Power of Attorney. For a deceased appellant, submit evidence from a court that you qualified as the Executor or Administrator of the appellant's Estate. A Power of Attorney, Last Will and Testament, or the Authorized Representative Form is not acceptable proof of representation for a deceased appellant.

Signature of Appellant **Date**

This form must be signed by the adult appellant or a parent of the minor child named at the top of this form. If the authorized representative who is not an attorney signs this form, fill out and return the Authorized Representative Form on page 3 of this Appeal Request.

For an online fillable form go to www.dmas.virginia.gov

Line Item	MEDICAID ALIEN CODE CHART QUALIFIED ALIEN GROUPS	Arrived Before August 22, 1996	Arrived On or After August 22, 1996	
			1st 5 years	After 5 years
A	Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians [Form DD 214-veteran]	Full Benefit A1	Full Benefit A2	Full Benefit A3
B	Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have worked 40 qtrs., except Amerasians [I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)]	Full Benefit B1	Emergency Only B2	Full Benefit B3
C	Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have NOT worked 40 qtrs., except Amerasians [I-327; I-151; AR-3a; I-551; I688B-274 a.12(a)(1)]	Full Benefit C1	Emergency Only C2	Emergency Only C3
			1st 7 years	After 7 years
D	Conditional entrants-aliens admitted pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA [I-94]	Full Benefit D1	Emergency Only D2	Emergency Only D3
E	Aliens, other than Cuban or Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5) section 212(d)(5) of INA [I-94; I-688B – 274a(12)(c)(11)]	Full Benefit E1	Emergency Only E2	Emergency Only E3
F	Aliens granted asylum pursuant to section 208 of the INA [I-94; I-688B – 274a.12(a)(5)]	Full Benefit F1	Full Benefit F2	Emergency Only F3
G	Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of Refugee Education Assistance Act of 1980 {including those under section 212(d)(5)}, or Amerasians [I-551; I-94; I-688B]	Full Benefit G1	Full Benefit G2	Emergency Only G3
H	Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA [I-688B – 274a.12(a)(10); Immigration Judge's Order]	Full Benefit H1	Full Benefit H2	Emergency Only H3
I	Battered aliens, alien parents of battered children, alien children of battered parents [U.S. Attorney General]	Full Benefit I1	Emergency Only I2	Emergency Only I3
J	Victims of a Severe Form of Trafficking pursuant to the Trafficking Victims Protection Act of 2000, P.L. 106-386 [ORR Certification/eligibility Letter]	N/A J1	Full Benefit J2	Emergency Only J3

	UNQUALIFIED ALIEN GROUPS	Arrived Before 8-22-96	Arrived On or After 8-22-96	
K	Aliens residing in the US pursuant to an indefinite stay of deportation [I-94; Immigration Letter]	Emergency Only K1	Emergency Only K2	Emergency Only K3
L	Aliens residing in the US pursuant to an indefinite voluntary departure [I-94; Immigration Letter]	Emergency Only L1	Emergency Only L2	Emergency Only L3
M	Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure under 8 CFR 242.5(a)(2)(vi) and whose departure the INS does not contemplate enforcing [I-94; I-210]	Emergency Only M1	Emergency Only M2	Emergency Only M3
N	Aliens who have filed an application for adjustment of status pursuant to §245 INA that the INS has accepted as properly filed and whose departure the INS does not contemplate enforcing [I-181; Endorsed Passport]	Emergency Only N1	Emergency Only N2	Emergency Only N3
O	Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the INS whose departure the agency does not contemplate enforcing [I-94; Court Order; INS Letter]	Emergency Only O1	Emergency Only O2	Emergency Only O3
P	Aliens granted voluntary departure pursuant to section 242(b) of the INA whose departure the INS does not contemplate enforcing [I-94; I-210; I-688B – 247a.12(a)(11) or (13)]	Emergency Only P1	Emergency Only P2	Emergency Only P3
Q	Aliens granted deferred action status pursuant to INS Operations Instruction 103.1(a)(ii) prior to 6/15/84 or 242.1a22 issued 6/15/84 and later [I-210; INS Letter]	Emergency Only Q1	Emergency Only Q2	Emergency Only Q3
R	Aliens residing in the U.S. under orders of supervision [I-220B]	Emergency Only R1	Emergency Only R2	Emergency Only R3
S	Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 [Case Record]	Emergency Only S1	Emergency Only S2	Emergency Only S3

	UNQUALIFIED ALIEN GROUPS **(cont.)**	**Arrived Before 8-22-96**	**Arrived On or After 8-22-96**	
T	Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the USCIS does not contemplate enforcing [Immigration Judge Court Order]	Emergency Only T1	Emergency Only T2	Emergency Only T3
U	Any other aliens living in the US with the knowledge and permission of the USCIS whose departure the agency does not contemplate enforcing [USCIS Contact]	Emergency Only U1	Emergency Only U2	Emergency Only U3
V	Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired	Emergency Only V1	Emergency Only V2	Emergency Only V3
W	Visitors (non-immigrants): tourists, diplomas, foreign students, temp. workers, etc. [I-688B – 274a.12(b)(1)-(20); I-94; I-185: I-I186; SW-434; I-95A]	Emergency Only W1	Emergency Only W2	Emergency Only W3

	LAWFULLY RESIDING NON-CITIZENS	**Effective 1/1/10**	**Effective 7/1/12**
Y	Non-citizen (alien) children under the age of 19 and pregnant women lawfully residing in the U.S. who meet the requirements in M0220.314.	Full Benefits for Medicaid children under age 19 (FAMIS Plus)	Full Benefits for Medicaid (FAMIS Plus), Medicaid pregnant women, FAMIS and FAMIS MOMS

	AFGHAN AND IRAQI SPECIAL IMMIGRANTS	**First 7 Years after Entry into U.S.**	**After 7 Years**
Z	Afghan and Iraqi Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder. [I-551 or passport/ I-94 indicating categories SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]	Full Benefits Z1	Emergency Only Z2

APPROVAL NOTICE FOR HOSPITAL PRESUMPTIVE ELIGIBILITY FOR TEMPORARY MEDICAID COVERAGE IN VIRGINIA

Patient Name: _____

Patient SSN*: _____ Date of Birth: _____

Date of notice: _____

Begin date of coverage: _____ **End date of coverage:** _____

Issued by: _____

*Social Security Number is not required for determination.

WHY YOU ARE RECEIVING THIS NOTICE

You qualify for temporary health coverage through the Virginia Hospital Presumptive Medicaid Eligibility program. This form will be your *proof of coverage* until you receive your Commonwealth of Virginia (blue & white) ID card.

TEMPORARY ELIGIBLITY GROUP (check one)

- ☐ Parent/Caretaker-Relative of dependent children under age 18
- ☐ Child under age 19
- ☐ Pregnant Women (Prenatal services only)
- ☐ Former Foster Care Child under age 26
- ☐ Breast and Cervical Cancer Treatment Program (BCCTP)
- ☐ Plan First (Coverage of family planning services only)

WHAT HAPPENS NEXT

The Virginia Department of Medical Assistance Services (DMAS) will mail you a Commonwealth of Virginia Medical Assistance ID card and letter about your health coverage. Please keep this card and coverage letter for the entire time you have coverage.

Your temporary eligibility will cover all services for which you are eligible under the Virginia Hospital Presumptive Medicaid Eligibility program, only while you are eligible. Please review the covered services fact sheet the hospital has provided you to see what services are covered for you.

HOSPITAL PRESUMPTIVE ELIGIBLITY DETERMINATIONS ARE FINAL. There is no right to appeal a hospital presumptive eligibility decision.

If you have filed a Medicaid application, your temporary eligibility will end the day on which the decision is made on that application. Your health coverage may be extended if an application for Medicaid is filed prior to the end date of coverage listed above and additional time is needed for the eligibility determination. If you do not file a Medicaid application, your temporary eligibility will end on the last day of the month following the month in which the determination of presumptive eligibility was made.

There are four easy ways to apply for Medicaid.

1. Online at www.coverva.org;**or**
2. Call the Cover Virginia at **1-855-242-8282** to apply by phone; **or**
3. Print out and complete a paper application from www.coverva.org and mail it or drop it off at your local Department of Social Services; **or**
4. Visit your local Department of Social Services in the city or county in which you live for assistance in applying.

Hospital Name: _____

Hospital Authorized Signature _____ Date: _____

Hospital Representative Name and Title: _____
Print

Hospital Representative Telephone Number: _____

rvsd03202015