Application

Application Procedures

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There are many ways an individual who is Aged, Blind, or Disabled (ABD) can apply for Medicaid. The single streamlined ***Application for Health Coverage & Help Paying Costs***, along with **a completed *Appendix D*** can be filled out in **hard copy and submitted in-person or mailed to the applicant's local Department of Social Services (DSS) office**. Application information may also be submitted **over the phone** via the Cover Virginia Call Center (a completed Appendix D is still required) and **online** via the CommonHelp website (as an application for "All Benefit Programs," or using the "Apply for Health Care Benefits" option and completing *Appendix D* later).

Individuals can also begin an ABD Medicaid application at the Health Insurance Marketplace, online at www.healthcare.gov or via its call center at (800) 318-2596. The Marketplace will then transfer the application to the applicable LDSS for processing. Individuals who begin an application via the Marketplace should be prepared to submit a completed *Appendix D* after completing the initial application.

PDF versions of the ***Application*** and ***Appendix D*** may be **downloaded** from the Cover Virginia website at **www.coverva.org**. Under "Partners" on the top menu, choose "Materials" in the drop down menu. From the resulting page, you can order multiple printed copies of the *Application* and *Appendix D* (among other printed outreach materials) and download the PDF versions.

HOW TO APPLY

By Telephone - **Cover Virginia Call Center (CVCC) at (855) 242- 8282**
An applicant or his/her authorized representative may **call the CVCC toll-free** and apply 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. It is closed 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**. An applicant who is most comfortable applying in a language other than 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. If the CVCC gleans that an applicant may be eligible for Medicaid as ABD, the CSR will also ask the applicant the questions on *Appendix D*.

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 **transferred to the LDSS for processing**. If there are any verification documents needed, a follow-up letter will be sent from the LDSS. The applicant may mail or fax the requested documents to the LDSS to complete the process. The LDSS will make a final decision on the case and send the applicant a ***Notice of Action on Benefits*** with the result.

People who wish to **apply for multiple benefits at once** 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. Like the CVCC, ECSC 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.

Online Via CommonHelp – **www.commonhelp.virginia.gov**
Through CommonHelp, Virginia's online application for social service benefits, people can self-screen and apply for multiple benefit programs, including child care subsidies, the Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps), Health Coverage (including Medicaid and FAMIS), the Temporary Assistance for Needy Families (TANF) program, and Energy Assistance. They can check the status of an application; report changes; and complete benefit renewals. CommonHelp is available 24 hours a day, 7 days a week.

If a person wishes to apply for coverage under the ABD Medicaid covered groups, they would need to click on the **"Apply for All Benefit Programs" button (the red box) in the middle of the home page** to start an application for health coverage. This option will take them through all the questions on the *Application for Health Coverage & Help Paying Costs*, and all the questions on *Appendix D*.

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 can take a minimum of around **60 minutes to complete**. If, during the process, the applicant needs to stop, s/he can **save the application** 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, s/he must start the application process over.

The applicant should have the following information at the ready to make the application process go smoothly:

- Household income from all sources
- Information on resources, including bank account balances

- 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* and *Appendix D* will be asked in the online application. It uses dynamic technology, so based on the way some questions are answered, certain other questions may be triggered. Others may be skipped to help speed the process along. 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 covered group or program has been applied for.

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 on the status of the submitted application**.* If you are helping the applicant 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 LDSS worker processing the case will contact the applicant 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 the LDSS worker to verify the information electronically prior to contacting the applicant for additional documentation.

Medicaid Enterprise System (MES) check and Identity (ID) Proofing allow for a smoother application process, and eligibility determination. Once all the household members have been entered, this check allows the system to check the Virginia Department of Medical Assistance Services' MES 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, s/he 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.).

Approval via a ***Notice of Action on Benefits*** will be sent from the LDSS. Applicants will have the opportunity to link their 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 **"Associate"** (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 a 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 applicant will be prompted to submit their changes. These will be reported to their local DSS.

Alternative Online/Telephone/Mail Application Submission Site

An applicant may also begin an application for coverage online with **Healthcare.gov** or **via telephone at (800) 318-2596**. This is the Health Insurance Marketplace. If an application is started here, Healthcare.gov will screen it for eligibility for Virginia's coverage programs and will send the application to Virginia to complete the application process. If an applicant looks to be eligible for one of the ABD Medicaid covered groups, the local DSS in the locality where an applicant lives will then handle disposition of these cases.

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 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 applicant 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 household 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 s/he can use the form to apply for Virginia's state-sponsored health insurance programs, and/or for coverage through the Health Insurance Marketplace. 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 applicant(s).

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 (including a completed *Appendix D*, if one was not submitted with the regular *Application*). It states that the Application should be processed within 45 days from the date it was received by the local DSS. (*Note: this timeline extends to 90 days if the person also needs a disability determination at the same time.*) 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, marital status, 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 s/he 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 for the Medicaid covered groups for children, families and non-elderly adults.*]

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 7 calendar 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 safely 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 "Medically Complex" and potentially require care coordination services through his/her Medicaid health plan.*]

Question 9 also directs an applicant who is age 65 or older OR receiving Medicare, to complete *Appendix D*, which is not included in the Application booklet. Copies can be downloaded from the Cover Virginia Website. Appendix D is described in detail starting on Page 2.9.

Appendix D needs to be completed if the applicant:

- Has a disability;
- Is age 65 or older; or
- Is in need of Long Term Services and Supports (LTSS, including in a nursing facility or community based care). This includes children in need of these services.

If an applicant is between the ages of 19 and 64 and needs LTSS (including nursing home care or community based care) it instructs the person to complete ***Appendix F***, which is not included with the application booklet. Copies of *Appendices* can also be downloaded from the Cover Virginia Website.

Question 10 asks if the person is a US citizen or US national.

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 year US residency requirement for non-pregnant adults, including the ABD Medicaid covered groups.*]

Question 12 asks if the **person lives with at least one child under age 19**, **and if they are the main person taking care of this child**. [*This question is assesses whether Person 1 may be eligible for the Low Income Families with Children, or LIFC, covered group.*]

Question 13 asks if the person is incarcerated. If "Yes," it requests more information on where and his/her expected release date. *Note: applications for incarcerated individuals are processed by a special unit called the Cover Virginia Incarcerated Unit (CVIU), not at local DSS.*

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, s/he 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**, s/he skips to Question 27.

Current Job 1: Questions 18 through 21 asks for information on a 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 s/he 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) s/he 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 the following ABD covered groups: ABD ≤80% FPL; Protected Cases; SSI and AG recipients, and all of the MSPs with the exception of QMB. It is also 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. 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 his/her 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 s/he 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, even if s/he did not enroll in it. The applicant is advised to check "Yes" even if this coverage is from someone else's job (i.e. parent's or spouse's). If "Yes", s/he must complete ***Appendix A*** and must answer the question if it is a state employee benefit plan. If "No," continue on to ***Step 5***. [*This question does not factor in to Medicaid eligibility, but it may factor in to someone's eligibility for tax credits and subsidies toward purchasing private insurance through the Health Insurance Marketplace.*]

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.

Additionally, there is a section about **"renewal of coverage in future years"** that can be completed allowing the local DSS 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**.

It also talks about allowing Medicaid to receive Third Party Payments (mentioned in Section 3 in the part about Non-financial Eligibility) 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 s/he lives.

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 Health Insurance 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. 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 section**. This is a release of information that will allow LDSS, the Cover Virginia Call Center, and the Health Insurance 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 Health Insurance Marketplace.

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

Appendix D

Appendix D is a separate document. Paper copies can be ordered from the state (an 8 page saddle-stitched booklet) or printed from PDF, both provided on the "Materials" page of the Cover Virginia Website.

PAGE 1
Appendix D is required to be **completed for someone who is 65 years or older, and/or eligible for Medicare**. This also includes children in need of Long-Term Services and Supports. These individuals would need to be evaluated for eligibility under the Aged, Blind, or Disabled (ABD) Medicaid covered groups. *Appendix D* is also required to evaluate someone's eligibility for the Medicare Savings Programs (MSPs). *Note: An applicant must also complete the FULL* Application for Health Coverage & Help Paying Costs *(either on paper, by phone at Cover Virginia, or online via CommonHelp), in addition to completing* Appendix D*, to be fully evaluated.*

If someone is **between the ages of 19 and 65 and is not eligible for Medicare, but needs Medicaid to pay for Long-Term Services and**

Supports (LTSS), that person would complete ***Appendix F*** instead of *Appendix D*, since that individual may be able to access LTSS in a different, non-ABD Medicaid covered group.

Section 1: Household Information

Questions 1 – 2 ask about the household, including **marital status and whether someone has applied for Medicaid in another Virginia locality, or in another state.** This is both so that the locality receiving the application knows whether the applicant has a case open somewhere else within Virginia (so the case can be transferred to the appropriate new locality, rather than the applicant requesting to open a new one), and so that the state can ensure that an applicant does not have Medicaid in multiple states at the same time.

Question 3 Asks whether **anyone in the household is temporarily absent**, including their name, the date they left their home, their reason for leaving, where they are currently staying, and their anticipated date of return. Temporary absence of a household member may impact whether the state "deems" someone's income and/or resources as available to the applicant.

PAGE 2

Questions 4 – 11 need to be completed if the individual applying is under 65, but still needs to complete *Appendix D* due to having a disability or being enrolled in Medicare.

Question 4 asks whether anyone on the **application is disabled**, yes or no. The subsequent questions ask that person to elaborate about his/her disability.

Question 5 asks whether anyone on the application **has applied for Social Security Disability, or for Supplemental Security Income (SSI), or Railroad Retirement benefits due to having a disability, through the US Social Security Administration (SSA)**. If they have, the state needs to know more about the outcome of the SSA's decision, asked in Questions 6 – 8.

Question 6 asks if the **application for** Social Security, SSI, Railroad Retirement, or a state **disability** determination **was approved**, through Virginia's Department of Aging and Rehabilitative Services (DARS) Disability Determination Services (DDS). If it was, the person would meet the definition of being disabled for the purposes of an ABD Medicaid covered group.

Question 7 asks whether, if the **application** for Social Security, SSI, or Railroad Retirement **was denied**, the applicant **has appealed the decision**. Sometimes, a lengthy appeal process is required for an applicant to receive a favorable disability determination. Legal representation is often necessary for success.

Question 8 asks whether it has been **less than one year since the applicant's most recent denial** for Social Security, SSI, or Railroad

Retirement. This is because typically, DARS DDS **cannot issue a favorable disability determination for a person who has been denied by the SSA within the last 12 months**, since the federal denial is binding unless the individual's condition has changed or worsened (Question 9), or the individual has developed a new condition since the most recent disability denial (Question 10).

PAGE 3

Question 11 asks whether the **applicant previously received SSI, Social Security Disability Income (SSDI), Railroad Retirements for reason of disability, or an Auxiliary Grant.** This question serves several purposes: first, it assesses whether the individual may be eligible for Medicaid as ABD under the "Protected Cases" categories. There are lots of potential scenarios where someone may be eligible for Medicaid as ABD if s/he has received SSI and/or an Auxiliary Grant in the past (including certain former SSI recipients, those eligible under the Pickle Amendment, disabled widow/er, former disabled child or adult, Qualified Severely Impaired Individuals, former Auxiliary Grant recipients, and Conversion Cases). See page 3.5 for details on these special "Protected Cases."

It also asks **whether the SSI, SSDI, Railroad Retirement, or Auxiliary Grant have stopped**, and if so, **the reasons the payments have stopped.** If someone has received SSI, SSDI, or Railroad Retirement for at least one month in the year prior to applying for Medicaid, and s/he **lost those benefits for a reason other than no longer being disabled or blind**, s/he **may still meet the definition of being disabled** for the purposes of an ABD covered group.

Section 2: Long-Term Care

The questions in Section 2 need to be **answered if anyone on the application is in a nursing or Assisted Living Facility (ALF), or who needs a similar level of care** to that provided in a nursing home or ALF to remain safely in his/her home (this is sometimes called Community-Based Care, or CBC). This screens an individual for **"institutionalization," which is one of the key components of eligibility under one of the 300% of SSI ABD eligibility groups.** An individual can be eligible to receive Medicaid payment for LTSS under any of the full-benefit programs, though.

Question 12 asks whether **anyone requires nursing home or CBC, and whether that person has a spouse** (either living in the home with them or living elsewhere). This is to help assess whether the person is receiving Long-Term Services and Supports (LTSS, sometimes called Long-Term Care, or LTC). If the spouse lives outside the home, the spouse's address is also needed. *Note: Virginia does not recognize legal separation. Per Virginia law, spouses are considered to be married and legally responsible for one another unless divorced.*

Question 13 asks about the **applicant's living arrangement, and whether s/he resides in an ALF, nursing facility, group home, or hospital or other medical facility.** If so, the state needs to know whom on the application lives in a facility, and when s/he entered that facility. The state

also needs to know the person's former address and county of residence prior to entering the facility. This is to help ensure that the appropriate LDSS processes the individual's application. It also asks if the individual was placed in this facility by a state agency.

Question 14 asks whether the person has **long-term care insurance, and questions about his/her policy**, if s/he does. This is because if someone has long-term care insurance, that long-term care insurance should pick up the tab for the individual's long-term care costs before Medicaid, since Medicaid always acts as the "payer of last resort."

This question also asks **whether the long-term care insurance the applicant has is part of a Partnership Policy**, which is a joint federal-state policy initiative to promote the purchase of private long term care insurance. Partnership Policies use a "dollar-for-dollar" asset disregard. Individuals who purchase a Partnership Policy have a dollar of their assets disregarded for every dollar of insurance coverage paid on their behalf by the Partnership Policy.

> *For example: Eunice buys a Partnership Policy, and needs care for one day. Her policy pays out $15,000. This allows Eunice to maintain $15,000 in countable resources over the countable resource limit she would otherwise have to meet in order to be eligible for Medicaid.*

PAGE 4

Question 15 is **very important for an applicant who is receiving LTSS, and/or seeking for Medicaid to pay for LTSS**. This question is asking **about transfer of assets within the last 5 years.** Depending on the way a person has transferred his/her assets, Medicaid may assess a transfer of asset (TOA) penalty period for which that person may be disqualified from Medicaid payment for LTSS services.

If an individual needing services reduces resources in an unapproved way, s/he may be temporarily disqualified from Medicaid payment for LTSS. ***Note: The TOA penalty applies only to LTSS services, and impacts only those who are seeking for Medicaid to pay for LTSS. It does NOT impact whether the person is eligible for Medicaid.*** It may impact what Medicaid will pay for after the person becomes enrolled.

Certain transfers will not trigger a penalty, including certain trusts (e.g. those to the transferor's child who is under 21, or for a disabled person under 65), and/or certain transfers that directly benefit an applicant's spouse or dependent child. This can sometimes include even transfers of the home.

An applicant is encouraged to consult a health attorney or a local Long-Term Care Ombudsman office (listing in Section 5) for any questions about TOA and other LTSS issues.

Question 15 asks about the **details behind the transfer of someone's assets**:

- The type of property that was transferred, and its value at the time of transfer
- The date the property was transferred, and the amount received in exchange for it
- The person from whom and to whom the asset was transferred
- The reason for the transfer

If more than one transfer of assets has occurred, the individual will need to attach documentation answering the questions above about all asset transfers within the last 60 months (5 years).

Section 3: Resources and Assets

These questions assess whether an individual (and, if applicable, his/her spouse) has **countable resources** that meet the countable resource limits for an ABD covered group.

Question 16 asks whether the applicant or his/her spouse has any **cash on hand that is not in the bank**. Even cash that is not in a bank account somewhere **is a countable resource**. This includes money hidden under a mattress, or buried in the yard!

Question 17 asks about some **specific bank account types**, and whether the applicant or his/her spouse has one or more of them. The applicant is asked to give information about all accounts of which s/he is an owner or co-owner. The requested account types include:

- **Checking and savings accounts**
- **Credit Union**
- **Certificate of Deposit (CD)**
- **Money Market Funds**
- **Deferred Compensation Plan** (Plan through which an employer may defer a portion of an employee's compensation until a specified date.)
- **Christmas Club** (This is a savings account in which people make routine deposits throughout the year, and withdraw the accumulated savings before the holidays.)

It also asks whether an applicant's SSI benefits, retirement, wages, or other frequent deposits are received via direct deposit into any of the accounts and if "yes," which one(s). This is to help the eligibility worker assess the true countable resource value of an account in a given month, and parse out what portion of funds in the account may be part of countable income for that month rather than the countable resource value of the account for that month.

Question 18 asks whether the applicant **owns any of the following**, and if so, where the account is held:

- **Annuities**
- **Stocks or bonds**
- **Trusts, deeds of trust, or trust funds**
- **Pension plans**
- **Retirement accounts**
- **Promissory notes**

These are requested because like other account types, they may be part of an applicant's countable resources if s/he owns them, can convert them to cash, and is not legally restricted from using them. The applicant must also note the balance or value of all accounts of any of these types on which s/he is an owner or co-owner, so the state can accurately assess the value of that resource.

This question also notes, that applicants may have to name the Commonwealth of Virginia as a beneficiary of any annuity they or their spouse owns.

Question 19 asks about **life insurance policies**, including the face value and cash value of all policies insuring the applicant and/or his/her spouse. This is to enable the state to see whether the collective face value of all policies insuring the applicant (and separately, the collective value of the policies insuring his/her spouse) is **>$1,500**.

If so, **the cash-surrender value** of the applicant's (and/or his/her spouse's) life insurance, which is the value of the life insurance during the insured person's lifetime (minus any applicable fees) **is a countable resource**. ***Note: term life insurance has no cash-surrender value and thus would not be considered a countable resource.***

Question 20 asks whether an applicant or his/her spouse has **any burial plots, burial arrangements, or burial trust funds, and the value or amount of each.** Burial spaces or plots held for an applicant or his/her family members **are typically excluded from countable resources**, **with one exception**: an applicant being evaluated under the Qualified Disabled Working Individual (**QDWI**) Medicare Savings Program, who owns a burial space **in excess of one per person, would have the additional burial space(s) counted as a resource.**

If **a portion of the cash-surrender value of a life insurance policy is set aside as a burial trust or burial fund, $3,500 of that portion is excluded** from an applicant's (or his/her spouse's) countable resources.

Question 21 asks whether the applicant or his/her spouse have **any real property, including home property, life rights or estates, shares in undivided heir property, land, buildings, or mobile homes.** It also asks

whether the applicant lives on the property, whether it is currently for sale, and whether it is being rented or generating income in some way. This is assessing whether the applicant lives on the home property (even if s/he is absent temporarily), **in an effort to see whether the applicant's home may be a countable resource.** It would not be counted so long as either the applicant intends to return home (i.e., is absent temporarily), or his/her spouse or dependent relative is still residing there. The question also asks whether the property is currently for sale, in an attempt to assess whether the applicant is making a reasonable effort to sell the property, as that may also make it an excluded resource.

For applicants being evaluated for the ABD ≤80% FPL covered group and the Medicare Savings Programs, contiguous property that is adjacent to the home is excluded from countable resources. For those being evaluated **for the other ABD covered groups, $5,000-worth of contiguous property adjacent to the home is excluded** from countable resources.

Question 22 asks whether the applicant or his/her spouse own **one or more motor vehicles, including cars, trucks, vans, motor homes, RVs, trailers, motorcycles, or mopeds.** This can even include an animal, if it is used primarily for transportation rather than recreation!

This question asks about each vehicle, including the year, make, and model, and its value. **One vehicle per household is excluded from being counted as a resource for ABD covered groups, with one exception: QDWI excludes one vehicle only if the applicant uses it for medical or work-related transportation. All other vehicles' countable resource value is the equity value** of the vehicle (**current market value, per the National Automobile Dealers Association trade-in value, minus amount owed**). If an applicant or his/her spouse owns multiple vehicles, the highest-value vehicle is the one whose value is excluded from countable resources.

Question 23 asks whether the applicant or his/her spouse **have income-producing property**, since some income-producing property may be excluded from countable resources, if it generates income above a certain amount and has a value below a certain threshold, or is needed for an individual's work (e.g., farming equipment).

Question 24 asks whether an applicant or his/her spouse **expects a change in resources during the current month or the following month.** If so, s/he is asked to describe any expected changes, and when they are expected to occur. This is requested in an effort to assess an individual's ongoing eligibility up-front.

Section 4: Other Income

These questions assess whether an individual has countable income beyond what was already reported on the *Application for Health Coverage & Help Paying Costs*.

Question 25 asks whether the applicant **receives child support**, and the amount and frequency. Child support payments are unearned income to the child. **One-third of the amount of a payment made to or for an eligible child by an absent parent is excluded from countable income.**

This question also asks whether the applicant is due any child support payments that are in arrears. For details about arrearage payments on child support, consult the *Medicaid Eligibility Manual* (M0830.420).

Question 26 asks about **benefits through the Veterans Administration (VA)**, as some VA benefits may be counted as unearned income for the ABD covered groups. Others are excluded.

Virginia's *Medicaid Eligibility Manual* dedicates an entire Subchapter (S0830.300) to VA payments. For details about the countable income calculations for different types of VA payments, consult the appropriate subsection below:

- Pensions (S0830.302)
- Compensations (S0830.304)
- Educational Assistance (S0830.306)
- Aid and Attendance Allowance (S0830.308)
- Housebound Allowance (S0830.308)
- Clothing Allowance (S0830.310)
- Payment Adjustment for Unusual Medical Expenses (S0830.312)
- Insurance Payments (S0830.160 for disability insurance; S0830.545 for life insurance)

Question 27 asks whether **an individual receives third-party payments for bills, and/or** if s/he is **being loaned any money**. A loan is not considered to be income if repayment is expected, and **so long as a bill is paid directly by a third-party** (e.g., an electric bill that is paid by the applicant's family member directly to the local electricity Cooperative), **this would not count as income.**

VERIFICATION DOCUMENTS THAT MAY BE REQUESTED DURING THE APPLICATION PROCESS

If citizenship, immigration status or income cannot be verified through available data sources, the applicant will be contacted to provide more information and documentation. Resource documentation may also need to be provided, if an applicant's attestation of resources needs to be verified. The following is a listing of possible verifications that an applicant may have to send when contacted by the local DSS 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, documentation of three months of income (*or more*) will be requested to determine the applicant's average monthly income. If requesting retroactive coverage (available in most ABD Medicaid covered groups and the MSPs, except QMB) 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, but requires 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*, s/he 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 a 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.

- **Verification of resources** if the eligibility worker processing the application has reason to believe that the applicant's attestation of his/her countable resources is inaccurate, the worker may request a verification.

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 **Medicaid eligibility** must be made **within 45 calendar days**, unless an extension is requested by the applicant **or a disability determination is also needed.**

If a disability determination is needed from the Virginia Department of Aging and Rehabilitative Services' **Disability Determination Services**, **the processing period is 90 days**. An applicant **can request expedited processing if s/he is hospitalized, or is in need of/receiving nursing home care.**

The clock starts ticking the day the signed application is received. 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 "Request for Verifications" sent by LDSS is on pages 2.23-2.28)*

Follow-Up
At any time during the process, the applicant (or person designated as assisting the individual or 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 LDSS will complete a full eligibility determination and, if **found eligible**, **will enroll the applicant in the appropriate Medicaid covered group (including the MSPs)**. The applicant will receive a *Notice of Action on Benefits* stating the person's "application for Medical Assistance has been approved." The second page of the *Notice* 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. *(See pages 2.29-2.36 for a sample approval notice)*

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 2.37-2.39 for a sample denial notice.)*

WHAT HAPPENS IF THE APPLICATION IS DENIED

If the application is denied for coverage by the local DSS, the applicant will 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 may request **a meeting or "agency conference" with the local DSS**. 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 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 applicant or his/her Authorized Representative **within 30 days after receipt** of the written *Notice of Action* (denial) or *Advance Notice of Proposed Action* (termination/cancellation of benefits). If appealing an unreasonable delay in processing of an application, an appeal may be filed at any time until the agency has acted upon the application.

If the person misses this 30 day window, there is the possibility to **claim good cause for filing an untimely appeal**. Complete the good cause questionnaire that is part of the Appeal Form.

The preferred method of filing an Appeal is via the new Appeals Information Management System (AIMS). To register go to ***https://appeals-registration.dmas.virginia.gov/client***. Once registered, the address to log in to the system is ***https://login.vamedicaid.dmas.virginia.gov/.***

While DMAS is encouraging the use of the AIMS portal for appeals, it will continue to accept appeals by telephone (804) 371-8488, fax (804) 452-5454, email (appeals@dmas.virginia.gov), and mail:

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

If appealing via email, fax, or mail complete the "Client Appeal Request Form" and submit it via one of the above methods. (*See pages 2.41-2.44*)

Appeals Overview and Frequently Asked Questions documents are available on the DMAS website at https://www.dmas.virginia.gov/appeals/applicant-member-appeals/

The individual will be notified of the scheduled hearing, which can be in person or via telephone. Before the hearing, the person will receive an

"Appeal Summary" from the agency that took the action being appealed. It provides documentation and explains the reasons the agency took the action it did. 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, family member, or legal counsel 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 his/her 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.

SAMPLE LDSS REQUEST FOR VERIFICATIONS

Lynchburg City (680)
99 9th St., PO Box 6798
Lynchburg, VA 24504

Commonwealth of Virginia
Department of Social Services
Questions? Call: (999) 999-9999

Letter Date: April 05, 2022
Case Number: 114322288

Slava Ukraini
454561 Freedom FLDS
Lynchburg, VA 24515

Why Slava Ukraini is getting this letter

We need more information to finish our review for the following program(s): Medical Assistance.

Please give us the information requested by the date(s) listed on the following page

A checklist of the documents you can give us for proof is included. **Keep your original documents and give us copies along with the checklist**. If you need help, call **(999) 999-9999**.

Ways to give us a copy of your documents:

1. **Online.** Go to **CommonHelp.Virginia.gov** and follow the website directions to upload a copy.
2. **By fax.** Fax a copy to us at **(434) 847-1785**.
3. **By mail.** Send a copy to us at **101 S. Main St., PO Box 176 Madison, VA 22727**.
4. **In person.** Bring us a copy to **99 9th St., PO Box 6798 Lynchburg, VA 24504**.

Your CommonHelp Account

CommonHelp.Virginia.gov keeps all important information about your family's applications. You can choose to get letters like this online. Your CommonHelp account is secure.

To create an account, go to **CommonHelp.Virginia.gov** and click "Check My Benefits." To link your case to your CommonHelp account using the information below, log in and select "Manage My Account."

Case Number: 114322288
Client ID: 2106148129

Worker Name:	Telephone Number:	For Free Legal Advice Call:
J. WATKINS	(555) 555-5555	1-866-534-5243

Additional Information from your Case Worker:

Things to remember when submitting proof:

- ✓ **Keep your original document(s) and give us a copy.**
- ✓ **Write first and last name, date of birth, and Case Number 114322288 on the copy of your documents you give to us.**
- ✓ **Call us if there has been a change in your situation since you applied, if you don't have the documents requested below, or if you need help obtaining the information.**

Remember, if you do not give us proof of your information, we cannot finish reviewing your eligibility and your application may be denied or your case may close.

Give us a copy of one of these documents as proof for each verification type. We have listed common documents people use to provide their verification(s) below:

Program: Medical Assistance While we are requesting that you return your verifications within ten days of the receipt of this letter, you may return your verifications within 45 days from the date of your Medicaid application, or within 30 days from the date of your Medicaid change or renewal.

Due Date: April 15, 2022

Who?	What information is needed?	What is accepted as proof?
Slava Ukraini	Identity	Federal, State or Local Government Issued ID , School photo ID, U.S. passport, Valid US driver's license
Slava Ukraini	Financial Account - CD/money market	Current statement from bank or financial institution, Note/Contract/Loan Agreement
Slava Ukraini	Unearned Income Payment Verification - Black Lung	Attorney records, Award letter, Court records or other legal document, Statement from payer

If you indicated when applying for benefits (Medicaid, SNAP, TANF, Energy Assistance, or Child Care) that you wanted to receive an email or a text message telling you that you have electronic mail about your benefits, you must first go to CommonHelp, **www.CommonHelp.virginia.gov** before you can access that mail. In CommonHelp, you will need to set up a secure mailbox. Have your client ID and case number available.

Instructions are provided in CommonHelp.

If you are acting on behalf of an individual as an authorized representative, you will continue to receive all correspondence for that individual through the mail.

For health coverage from Virginia Medicaid:

It is important we treat you fairly. We will keep your information secure and private. This agency complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This agency does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This agency provides free aids and services to people with disabilities to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). If you need these services, call us at **(804) 786-7933 (TTY: 1-800-343-0634)**. This agency also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call us at **1-855-242-8282 (TTY: 1-888-221-1590)**. If you believe that this agency has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, or by phone at: Civil Rights Coordinator, DMAS, 600 E. Broad St., Richmond, VA 23219, Telephone: **(804) 786-7933 (TTY: 1-800-343-0634)**.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; **1-800-368-1019 (TTY 800-537-7697)**. Complaint forms are available at **https://hhs.gov/ocr/office/file/index.html**.

Slava Ukraini
454561 Freedom FLDS
Lynchburg, VA 24515

Commonwealth of Virginia
Department of Social Services
Questions? Call (999) 999-9999

Lynchburg City (680)
99 9th St., PO Box 6798
Lynchburg, VA 24504

Make sure both addresses above show in the return envelope.
FOLD 2

Fold the paper at FOLD 1, and then FOLD 2 so that the top portion
of the page shows in the windows of the return envelope.

The return envelope is postage paid, so there is no reason to use your own stamps!

If you would like to return your verifications in person, online, or by fax,
please see the steps on the previous page for instructions.

FOLD 1

Letter Date: April 05, 2022
Case Number: 114322288
Worker Name: J. WATKINS

English: Get help in your language
This Notice has important information about your benefits or application for health coverage from Virginia Medicaid. Look for important dates. You might need to take action by certain dates to keep your benefits. You have the right to get this letter for free in your language, in large print, or in another way that is best for you. Call us at 1-855-242-8282 (TTY: 1-888-221-1590).

Spanish: Obtenga ayuda en su idioma
Este aviso tiene información importante de Virginia Medicaid sobre sus beneficios o solicitud de cobertura de salud. Busque fechas importantes. Puede que necesite hacer algo antes de ciertas fechas para conservar sus beneficios. Tiene derecho a obtener esta carta en su idioma, con letra grande, o de cualquier otra manera que sea mejor para usted, de manera gratuita. Llámenos al 1-855-242-8282 (telefonía de texto [TTY]: 1-888-221-1590).

Korean: 본인의 언어로 도움을 받으세요.
이 통지서에는 버지니아 메디케이드의 의료 보험 혜택 또는 의료 보험 신청에 대한 중요한 정보가 들어 있습니다. 이에 대한 중요한 마감일도 공지하고 있습니다. 혜택을 받으려면 마감일까지 조치를 취하셔야 합니다. 이 통지서는 본인이 사용하는 언어로 또는 큰 글자로 인쇄된 서신으로 또는 본인에게 최선이 될 수 있는 방법으로 무료로 받을 수 있는 권리가 있습니다. 저희에게 문의해 주십시오. 문의처 1-855-242-8282 (TTY: 1-888-221-1590)로 전화하십시오.

Vietnamese: Nhận giúp đỡ bằng ngôn ngữ của quý vị
Thông báo này có thông tin quan trọng về cách quý vị nhận phúc lợi hoặc cách nạp đơn nhận bảo hiểm y tế thuộc chương trình Medicaid của tiểu bang Virginia. Hãy chú ý đến những ngày quan trọng. Quý vị có thể phải hành động trước một số ngày trong Thông báo này để tiếp tục nhận phúc lợi. Quý vị có quyền nhận thư này miễn phí bằng tiếng Việt, bằng chữ khổ lớn hoặc theo cách nào phù hợp nhất với quý vị. Xin gọi cho chúng tôi theo số 1-855-242-8282 (máy TTY: 1-888-221-1590).

Chinese (Traditional): 用您使用的語言獲得幫助
本通知包含有關您的Virginia Medicaid福利或醫療承保申請的重要資訊。請查看重要的日期。您可能需要在某些日期之前採取行動，才能保持您的福利。您有權免費用您使用的語言、大印刷體或其他最適合您的方式收到本信函。請電洽 1-855-242-8282（TTY: 1-888-221-1590）。

Arabic: احصل على المساعدة بلغتك
يتضمن هذا الإخطار معلومات مهمة عن المزايا التي سوف تحصل عليها -أو عند التقدم للحصول عليها- من التأمين الصحي المقدم من فيرجينيا ميديكيد Virginia Medicaid. ابحث عن التواريخ المهمة. قد يتعين عليك القيام بإجراءات بحلول تواريخ محددة للاحتفاظ بمزاياك. يحق لك الحصول على هذا الخطاب مجانًا بلغتك، مطبوعًا طباعة كبيرة، أو بأفضل طريقة تراها. اتصل بنا على رقم 1-855-242-8282 (TTY: 1-888-221-1590).

Urdu: اپنی زبان میں مدد حاصل کریں
اس نوٹس میں آپ کے بینیفٹس یا Virginia Medicaid سے صحت کے کوریج کے لیے درخواست کے بارے میں اہم معلومات ہیں۔ اہم تاریخوں پر نظر رکھیں۔ آپ کو اپنے بینفٹس برقرار رکھنے کے لیے مخصوص تاریخوں تک کارروائی کرنے کی ضرورت ہوسکتی ہے۔ آپ کو یہ خط اپنی زبان میں، بڑے حروف میں، یا کسی دوسرے طریقے سے جو آپ کے لیے بہترین ہو، مفت حاصل کرنے کا حق ہے۔ ہمیں 1-855-242-8282 (ٹی ٹی وائی: 1-888-221-1590) پر کال کریں۔

Hindi: अपनी भाषा में मदद लें
इस नोटिस में Virginia Medicaid से प्राप्त होने वाले आपके लाभों या हेल्थ कवरेज हेतु आवेदन के बारे में महत्वपूर्ण जानकारी दी गयी है। महत्वपूर्ण तारीखें देखें। आपको अपने लाभों को बनाये रखने के लिए निश्चित तारीखों तक कार्यवाही करने की आवश्यकता हो सकती है। आपको इस पत्र को अपनी भाषा में, बड़े प्रिंट में, या ऐसे किसी अन्य ढंग में जो आपके लिए सबसे अच्छा हो, नि:शुल्क प्राप्त करने का अधिकार है। हमें 1-855-242-8282 (TTY: 1-888-221-1590) पर फोन करें।

Farsi: دریافت کمک به زبان خود
این اطلاعیه حاوی اطلاعات و مطالب مهمی درباره مزایا یا درخواست شما برای پوشش بهداشتی و درمانی از Virginia Medicaid می باشد. به تاریخهای مهم توجه داشته باشید. شاید لازم باشد برای حفظ مزایا در تاریخهای مشخصی اقداماتی بعمل آورید. شما حق دارید این نامه را به رایگان به زبان خود، با حروف چاپی درشت یا هر روش دیگری که برایتان مناسب است دریافت کنید. لطفاً با ما در شماره 1-855-242-8282 (TTY: 1-888-221-1590) تماس بگیرید.

Bengali: আপনার নজিরে ভাষায় সাহায্য পান
Virginia Medicaid এর স্বাস্থ্য বমিা বষিয়ক আপনার সুযে·াগ-সুবধিা অথবা আবদেন সম্পর্কতি গুরুত্বপূর্ণ তথ্য এই নে·াটশিে আছে। গুরুত্বপূর্ণ তারখিগুলরি অনুসন্ধান করুন। আপনার প্রাপ্য সুযে·াগ-সুবধিা চালু রাখতে হলে আপনাকে নর্দিষ্টি তারখিরে মধ্যে পদক্ষপে গ্রহণ করতে হতে পারে। আপনার অধকিার আছে নজিরে ভাষায়, বড় অক্ষরে ছাপা অথবা আপনার পক্ষে সর্বশ্রষ্ঠে এমন যে কে·ানও উপায়ে এই চঠিটি বনিামূল্যে পাওয়ার। আমাদরে টলেফি·োন করন এই নমবর: 1-855-242-8282 (TTY: 1-888-221-1590)।

Tagalog: Tumanggap ng tulong sa inyong wika
May mahalagang impormasyon ang patalastas na ito tungkol sa inyong mga benefit [kapakanan] o paghiling na masakop ng segurong pangkalusugan ng Virginia Medicaid. Tignan ang mga mahahalagang petsa. Maaaring dapat kumilos kayo sa ilan mga petsa upang mapanatili ang inyong mga benefit. May karapatan kayong matanggap ang sulat na ito sa iyong wika. malaking mga letra, o sa anumang paraan na pinakamahusay sa inyo. Tawagan kami sa 1-855-242-8282 (TTY: 1-888-221-1590).

Amharic: በቋንቋዎ እርዳታ ያግኙ
ይህ ማስታወቅያ ከቨርጂንያ ሜዲኬይድ የሚያገኙትን ጥቅሞችዎን ወይም የጤና ሽፋን ማመልከቻን አስመልክቶ አስፈላጊ መረጃ ያዘለ ነው። አስፈላጊ ቀኖችን ይመልከቱ። ጥቅሞችዎ እንዳይቋረጥብዎ፣ በተወሰኑ ቀኖች ውስጥ እርምጃዎችን መውሰድ ሊያስፈልግዎ ይችል ይሆናል። ይህን ደብዳቤ፣ በነጻ፣ በቋንቋዎ፣ ተለቅ ባሉ ፊደሎች ታትሞ፣ ወይም ለእርስዎ በሚያመቹ በሌላ መንገዶች የማግኘት መብት አልዎት። ወደኛ በ 1-855-242-8282 (TTY: 1-888-221-1590) መደወል ይችላሉ።

French: Obtenez de l'aide dans votre langue
Cet avis contient des informations importantes sur vos prestations ou votre demande d'assurance-maladie auprès de Virginia Medicaid. Recherchez les dates importantes. Vous devrez peut-être prendre des mesures avant certaines dates pour conserver vos prestations. Vous avez le droit d'obtenir cette lettre gratuitement dans votre langue, en gros caractères ou de la manière qui vous convient le mieux. Appelez-nous au 1-855-242-8282 (ATS: 1-888-221-1590).

Russian: Получите помощь на вашем языке
В этом уведомлении содержится важная информация о ваших льготах или заявке на медицинское страховое покрытие Medicaid штата Вирджиния. Обратите внимание на важные даты. От вас может требоваться выполнение тех или иных действий в определенные сроки для сохранения ваших льгот. Вы имеете право на бесплатное получение этого письма на вашем языке, крупным шрифтом или в другом удобном для вас формате. Позвоните нам по номеру 1-855-242-8282 (TTY: 1-888-221-1590).

German: Holen Sie sich Hilfe in Ihrer Sprache
Diese Mitteilung enthält wichtige Informationen zu Ihren Krankenversicherungsleistungen oder zu Ihrem Antrag auf Krankenversicherung von Virginia Medicaid. Achten Sie auf wichtige Daten. Sie müssen möglicherweise zu bestimmten Terminen Maßnahmen ergreifen, um Ihre Leistungen weiterhin zu erhalten. Sie haben das Recht, diesen Brief kostenlos in Ihrer Sprache, in Großdruck oder auf eine andere Weise zu erhalten, die für Sie am besten ist. Rufen Sie uns bitte an unter 1-855-242-8282 (TTY: 1-888-221-1590).

Bassa: Ṁ ɓɛ́ìn gbo-kpá-kpá dyéɛ ɖɛ́ wuɖu ṁ poɛɛ mú
Céè-ɖɛ̀ nìà kɛ ɓéɖɛ́ bɔ̃ kpa ɖɛ ɓě ɓó wé ɓě kɔ̃ ɓaɖa ṁ ɓɛ́ìn gbo-kpá-kpá ɓě dyéɛ ɔ jǔ ké ṁ dyi gbo-kpá-kpá zɔ̀ ɓó nì kpóɖó-dyùàɔ̀ dyi káná jè sɔ̀ìn ɖé nyɔ Kũùn jè gbo-kpáìn-naín nìà ɖé Vɔ̀jínìà kɛɛ ní. Dè wé kpa ɖɛ ɓě kɔ̃ mú ṁ ɓɛ́ìn gbo-kpá-kpá ɓě nìà kɛ dyéɛ kɛɛ jè dyéɖé gbo. Ṁ kɔ̃ ɓé ṁ ké gbo-kpá-kpá nìà kɛ zɔ̀ ɓó wé jɛ́ɛ́ ɓě baɖa, ɓé ṁ ké nì gbo-kpá-kpá ɓěɔ̀ dyé. Ṁ ɓɛ́ìn céè-ɖɛ̀ nìà kɛ dyéɛ pídyi ɖé wuɖu ṁ poɛɛ mú ɖé céè-ɖɛ̀-dyèɖè boo-boo mú, mɔɔ ɖé hwìè kà kò ɖò kɔ̃ mú ṁ mɔ́ ɓɛ́ wa ké nì céè-ɖɛ̀ɔ̀ céè kɛɛ mú. Ɖá à nììn ɖé nɔ̀ɓà nìà kɛ kɔ̃ 1-855-242-8282 (TTY: 1-888-221-1590).

Ibo: Nweta enyemaka n'asusu gị
Nkwupụta nke a nwere ozi dị mkpa banyere uru ndị gị maọbụ arịrịọ gị maka mkpuchi ahụike site na Virginia Medicaid. Chọọ maka deeti dị mkpa. Aga-achọrọ ka ịme ufọdu ihe n'ufọdu ubọchị iji dowe uru gị gasị. Ị nwere ikike ịnweta akwukwọ ozi nke a n'efu n'asụsụ gị, ebiputara n'iji nnukwu mkpụrụedemede, maọbu n'uzọ ọzọ kacha mma maka gị. Kpọọ anyị na 1-855-242 8282 (TTY: 1-888-221-1590).

Yoruba: Gba iranlowo ni ede rẹ
Akiyesi yi ni iwifun-ni pataki nipa awon anfaani tabi iwe ìbẹwẹ fun agbegbe ilera lati Virginia Medicaid. Wa awọn ọjọ pataki. Ó se é se lati gbe igbésẹ ni awọn ọjọ kan lati fi awọn anfaani rẹ pamọ. Ó ni ẹtọ lati gba lẹtà yi ni ọfẹ ni ede rẹ, ni kikọsilẹ gàdàgbà tabi ni ọnà miran ti ó dara fun ọ. Pè wá ni 1-855-242-8282 (TTY: 1-888-221-1590).

Lynchburg City (680)
99 9th St., PO Box 6798
Lynchburg, VA 24504

Sample
Notice of Action

Commonwealth of Virginia
Department of Social Services
Questions? Call: (999) 999-9999

Letter Date: April 05, 2022
Case Number: 114322288

Slava Ukraini
454561 Freedom FLDS
Lynchburg, VA 24515

News for your household

Our records show that you applied for health coverage from Virginia Medicaid on **April 05, 2022**. This letter tells you more about the determination and how it was made. It has information about the household's health coverage choices and what to do next. It also explains what to do if you think we made a mistake.

Medicaid Decision Summary for Your Household

Household Member Name	Decision	Coverage	Effective Date(s)
Slava Ukraini	Eligible	LIMITED	April 01, 2022 - Ongoing

To learn more about how we made our decision for each person, read the rest of this letter.

How we made our Medicaid decision(s)

Virginia has rules and income limits for how people can qualify for health coverage depending on things like age, pregnancy and parenting status, and disability. We counted the household size and income and reviewed the information given to us on the application or available in other data sources. To learn more about health care coverage rules and income limits, go to **www.coverva.org.** If your information has changed since you applied or you think we made a mistake call us. You can also file an appeal. For more information on how to file an appeal see the page titled "If you think we made a mistake."

Medicaid may pay past bills, even if you already paid them yourself. If you were not evaluated for health coverage for the three months prior to your application month and you had medical expenses, contact us at **(999) 999-9999.**

Approvals

Update for Slava Ukraini — Client ID: 2106148129

You qualify for health coverage from Virginia Medicaid.

Medicaid ID Number	Coverage	Effective Date
351203960015	**LIMITED**	**April 01, 2022 - Ongoing**

Slava Ukraini qualifies for limited coverage Medicaid. This coverage pays for your Medicare Part B premiums. Your household has been approved for limited benefit coverage, but could be eligible for full coverage if something has changed in your household. If something has changed, like your income or household size, or if you think we used the wrong information to determine your eligibility, please call your local agency.

Health Coverage must be renewed every year. The next renewal is due **March 31, 2023.** If you are receiving health coverage at that time, we will send more information about your renewal.

Additional information on how we made our decisions:

Since the household's monthly income is below the income limit, the above individual(s) qualify for health coverage. We made our decisions based on these rules: Virginia Medical Assistance Manual Reference M0130.300.

Using Your Health Coverage

Medicaid Card

Most enrollees receive a Medicaid card. If you do not already have a card with the Medicaid ID above, and do not receive a card in the mail in 10 business days, please call 1-855-242-8282. Some people in limited coverage Medicaid do not receive a card. Your health coverage can be used right away by giving your provider the Medicaid ID number listed above.

Finding Services

Your health coverage can be used right away. Services can be received from any doctor, clinic, or other health care provider who accepts FAMIS or Medicaid. To find a provider, call **1-855-242-8282** or visit **www.virginiamedicaid.dmas.virginia.gov** and select "Search for Providers" under the "Provider Resources" menu. Most people get their health coverage through a health plan. If the above individual(s) need to join a plan, we will send information about choosing a health plan. If you had any medical services since your coverage started, make sure to give the provider(s) your Medicaid ID number.

There is no premium (a monthly cost) for FAMIS or Medicaid health coverage. There **may** be co-payments for some services. To learn more, see the Member Handbook at **https://www.coverva.org/en/member-handbooks.** To get a paper copy of the Handbook, call us at **(999) 999-9999.**

Spenddown

Medicaid Spenddown Summary

While you are not eligible for full Medicaid coverage at this time, see the enclosed information sheet about spenddowns and to learn how you may become eligible for full Medicaid health care coverage by spending down income towards certain medical expenses. We made our decision based on these rules: Virginia Medical Assistance Manual Reference M1330.

Household Member Name	Spenddown Period	Spenddown Amount
Slava Ukraini	April 01, 2022 - September 30, 2022	$5530.38

Your household must report changes

You must report any changes that might affect health coverage for anyone in your household who was approved health coverage from Virginia Medicaid. Please report changes for both you and other people in your household within ten days of the change, such as:

» If someone moves
» If someone's income changes
» If your household changes. For example, if someone in your household marries or divorces, becomes pregnant, or has or adopts a child.
» If you are in FAMIS, FAMIS MOMS, FAMIS Prenatal or Medicaid, and you recently gave birth, you can report the birth of your child in one of these ways:
  - Call the Cover Virginia Call Center at 1-855-242-8282 (TDD: 1-888-221-1590).
  - Call your local department of social services (DSS).
  - You can also ask the hospital to submit the enrollment information for your newborn.

To report changes: go to **CommonHelp.Virginia.gov** and click on "Report Changes," call **1-855-242-8282 (TTY: 1-888-221-1590)**, or call us at **(999) 999-9999 .**

Your CommonHelp Account

CommonHelp.Virginia.gov keeps all important information about your family's application and health coverage. You can choose to get letters like this online. Your CommonHelp account is secure.

To create an account, go to **CommonHelp.Virginia.gov** and click "Check Benefits."
To link your case to your CommonHelp account using the information below, log in and select "Manage My Account."

Case Number: 114322288
Client ID: 2106148129

Information about other programs

You and others in your household may qualify for other assistance, like help buying food or paying heating and cooling bills. If you already applied for other assistance, information about those programs may come in a separate letter.

To learn more, go to **CommonHelp.Virginia.gov** or call **1-855-635-4370 (TTY: 1-800-828-1120)**.

Worker Name:	Telephone Number:	For Free Legal Advice Call:
J. WATKINS	(555) 555-5555	1-866-534-5243

Additional Information from Your Case Worker:

If You Think We Made a Mistake

You can appeal this decision about Medicaid health coverage. Appeals are handled by the Department of Medical Assistance Services (DMAS).

If you have an urgent health care need, you can ask DMAS for an expedited (faster) appeal to get a decision on your appeal sooner. An urgent health care need means that it could result in serious harm to your health if it's not treated soon. You may need to give proof of your urgent health care need.

If your benefits are being stopped or reduced in this notice, you may ask to have your coverage continued during your appeal. In order to continue your coverage, you must file your appeal before the date that your coverage ends or within 10 days of the date on this letter. Not every case qualifies for continued coverage. You may have to pay back Medicaid for the coverage you received if you lose your appeal.

Ways to ask for an appeal:

1. **Electronically.** Online at **https://www.dmas.virginia.gov/appeals/** or email to **appeals@dmas.virginia.gov**
2. **By fax.** Fax your appeal request to DMAS at **(804) 452-5454**
3. **By mail or in person.** Send or bring your appeal request to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219
4. **By phone.** Call DMAS at (**804) 371-8488 (TTY: 1-800-828-1120)**

To help you, an appeal request form is available from DMAS at **https://www.dmas.virginia.gov/appeals/**. You can also write your own letter. Include a full copy of this notice when you file your appeal. Also include any documents you would like DMAS to review during your appeal. **Your deadline to ask for an appeal with DMAS is May 10, 2022**.

Once you ask for an appeal, DMAS will schedule a hearing if you qualify for one. A hearing is a meeting between you, someone from the Medicaid program, and a DMAS hearing officer. Before the hearing, we will send you a copy of the information that will be used at the hearing. This is called the appeal summary. You also have the right to ask us for a full copy of your file from your local Department of Social Services. You can ask someone to represent you at any point during the appeal process, as long as you let DMAS know about your decision in writing. At the hearing, you can explain why you think we made a mistake. DMAS decides non-expedited appeals within 90 days or sooner of your request.

To get ready for your hearing, you can:

- Review the appeal summary before the hearing.
- Bring someone with you to the hearing, like a friend, relative, lawyer, or come alone.
- Bring information or witnesses to show where you think we made a mistake.

If you have any questions, call the Appeals Division of DMAS at **(804) 371-8488 (TTY: 1-800-828-1120)**. Call the free Legal Aid Helpline at **1-866-534-5243** or visit **www.valegalaid.org** to learn more about getting free legal advice or to ask someone to represent you in your appeal case.

[Page 6 of 12 was omitted for space, it is the same as page 2.25 in this section]

HOUSEHOLD MEMBER NAME: **Slava Ukraini** CASE NUMBER: **114322288**

What is a Medicaid Spenddown?

A spenddown is for individuals or families whose current income is too high to qualify for Medicaid, but all other requirements are met. The amount of income a person or household reports (earned or received) is compared to the Medicaid income limit. The amount over the income limit is called the "spenddown liability." A person will qualify for Medicaid if they spend or owe the amount over the Medicaid income limit on medical bills. Reporting changes, such as a decrease or loss of income or resources, can also result in eligibility. This is called a "spenddown" since the person is "spending down" to the Medicaid limit.

If a person is eligible for a spenddown they are mailed a letter telling them the amount of their spenddown liability. The letter also explains the period of time that is covered by the spenddown. This is called a spenddown period. If a person owes or has paid medical bills that equal the amount of the spenddown liability, they will be eligible for Medicaid until the end of the spenddown period.

The types of medical bills that can be counted towards a spenddown liability are:

- Doctor or hospital bills
- Dentist bills
- Cost of prescription drugs and certain medical supplies
- Health insurance premiums

Medical expenses incurred before the spenddown period cannot be counted unless they have not been paid. Medical expenses for services DURING the spenddown period can be counted whether paid or still owed. Any bills incurred prior to the date you meet your spenddown are still your responsibility to pay.

Use the Medicaid Spenddown Record form (on the back of this page) to track any old or current medical expenses. Track these expenses for yourself, your spouse, or your children under age 18 who live in your home. Write down the date of service, the name of the provider, and the amount of money owed after any insurance payments or the amount of money paid. **Copies** of the proof of the expenses should be given to the local Department of Social Services (DSS). Below is a list of items that can be submitted as proof of the expenses:

- Copies of medical bills
- Copies of payment receipts for prescription drugs, medical supplies or medical services
- Proof of payments of health insurance premiums

Note: Any changes in the household should be reported. These changes include things like income, resources (like money in bank accounts, cars, or life insurance policies), or household members. The local DSS will review the proof of medical expenses and any changes reported. A new letter will be sent to let the person know if they are now eligible for Medicaid. If the person is now eligible for Medicaid, the letter will also tell them when the Medicaid coverage will end.

HOUSEHOLD MEMBER NAME: **Slava Ukraini** CASE NUMBER: **114322288**

MEDICAID SPENDDOWN RECORD

Spenddown Dates: April 01, 2022 - September 30, 2022 Spenddown Amount: $5530.38

Keep a record of all medical expenses and payments for yourself and/or others for whom you have requested Medicaid. This will help you to know when you have medical expenses totaling the spenddown liability amount. Send **copies** of your medical bills with this tracking sheet to your local department of social services for evaluation. **When the spenddown is over, a new application may be needed if the person wants to apply for Medicaid again.** An example of how to complete the Medicaid Spenddown Record has been provided on the first line.

DATE OF SERVICE	WHO GAVE MEDICAL CARE	WHO RECEIVED THE CARE	BILL AMOUNT
4/14/2019	*Dr. Example*	*Example Smith*	*$1,230.00*

Information on Advance Health Care Directive

All adults have a right to prepare a document called an "Advance Health Care Directive." An Advance Health Care Directive lets other people know the types of medical care you do and do not want in the event you cannot express your wishes on your own.

An Advance Health Care Directive can authorize another person, such as a spouse, child, or friend, to be your "agent" or "proxy." That person can make decisions for you if you become unable to make informed decisions about your health care. You can tell that person exactly what kind of health care you do and do not want. In legal terms this is often called a "Power of Attorney for Health Care."

Many people have an Advance Health Care Directive as a part of their medical record. It can have information like:

- What type of health care a person authorizes
- What type of health care a person does not authorize
- Who a person would like to make health care decisions on their behalf
- If the person would like to be an organ donor

An adult who can make a decision for themselves and who has been told by a doctor that they are terminally ill, can make an oral (spoken) advance health care directive which can give information like:

- What type of health care a person authorizes
- Why type of health care a person does not authorize
- Who a person would like to make health care decisions on their behalf

The Commonwealth of Virginia has a statewide Advance Health Care Directive Registry that provides a free and safe place to store this kind of document. The documents you can store here can protect your legal rights and make sure your medical wishes are honored if you cannot speak for yourself. You should share this information with each of your health care providers. If you would like to learn more visit the: **https://www.connectvirginia.org/adr/.**

[Pages 10 - 12 of 12 were omitted from this sample to save space. Page 10 was blank and pages 11-12 contains the same content as pages 2.27-2.28 of this Section re: getting help in your language]

Sample
Denial Notice

[Location Name (FIPS)
Location Mailing Address
Location Mailing Address
Location Mailing Address]

Commonwealth of Virginia
[Processing Agency]
Questions? Call: [Phone Number]

[Case Name
Case Mailing Address
Case Mailing Address
Case Mailing Address]

Letter Date: [Letter Date]
Case Number: [Case Number]

News for your household

[Our records show that you applied for health coverage from Virginia Medicaid on **[Date]**. This letter tells you more about the decision and how it was made. It has information about the household's health coverage choices and what to do next. It also explains what to do if you think we made a mistake.

Medicaid Decision Summary for Your Household

Household Member Name	Decision	Coverage	Effective Date(s)
[Case Name]	Not Eligible	--	March 01, 2020 - Ongoing

To learn more about how we made our decision for each person, read the rest of this letter.

Update for [Case Name]
March 01, 2020 - Ongoing

Client ID: ##########

You do not qualify for health coverage from Virginia Medicaid. To learn more, read the "How we made our Medicaid decision" section below.

How we made our Medicaid decision

Medicaid has rules and income limits for how people can qualify for health coverage depending on things like age, pregnancy and parenting status, and disability. We counted the household size and income and reviewed the information given to us on the application or available in other data sources. To learn more about Medicaid rules and income limits, go to **www.coverva.org.** If your information has changed since you applied or you think we made a mistake call us. You can also file an appeal. For more information on how to file an appeal see the page titled "If you think we made a mistake."

Application #: [Variable Data]

Correspondence #: [Variable Data]

This individual does not qualify for Medicaid health coverage because the countable household income is over the income limit; rules for the current coverage are not met. We made our decisions based on these rules: Virginia Medical Assistance Manual Reference M0440.100; M0710.700; M0810.002, M0310.001; M1520.300.

You might still be able to get full health coverage — and help paying for it — through the Health Insurance Marketplace. We sent your information to them. The Marketplace will send you a letter. **To learn more, read the "How to Complete the Marketplace Application" insert with this letter.**

Information about other programs

You and others in your household may qualify for other assistance, like help buying food or paying heating and cooling bills. If you already applied for other assistance, information about those programs may come in a separate letter.

To learn more, go to **CommonHelp.Virginia.gov** or call **1-855 635-4370 (TTY: 1-800-828-1120)**.

Worker Name:	Telephone Number:	For Free Legal Advice Call:
[CASEWORKER NAME]	(804) 726-7130	1-866-534-5243

Additional Information from Your Case Worker:

Note: The above pages would be followed by the "It is important we treat you fairly" language supplied in the Sample Request for Verifications on Page 2.25 and the "If You Think We Made a Mistake" language from the Sample Notice of Action on page 2.33. Additional pages with information on getting help in other languages (provided in Spanish, Korean, Vietnamese, Chinese (Traditional), Arabic, Urdu, Hindi, Farsi, Bengali, Tagalog, Amharic, French, Russian, German, Bassa, Ibo, and Yoruba) were omitted from this sample to save space.

What is the Health Insurance Marketplace?

Use the Marketplace to shop for and buy affordable private health insurance online, over the phone, or with in-person help. There is financial help available for people who qualify.

You or someone in your household was found not eligible for Medicaid. You may still be able to get help paying for health coverage through the Health Insurance Marketplace. Your information has been sent to the Marketplace to start an application, but you must take action to see if you qualify!

How to Complete the Marketplace Application:

You must complete the Marketplace application within 60 days of your Medicaid denial. The sooner you apply for coverage; the sooner new coverage can begin. You should complete the Marketplace application as soon as you can to see if you can get coverage now. To complete your application, you can:

1. **Wait for the letter from the Marketplace.** The letter will tell you how to complete your application with them. The Marketplace is starting a health insurance application for the following individual(s): **Valerie Hope**

   Or

2. **Start a new application.** You can go to **HealthCare.gov** or contact the Call Center at **1-800-318-2596 (TTY: 1-855-889-4325)**. You will need to:
   - » Create a Marketplace user account online or by phone with a Call Center Representative.
   - » Have this letter with you to help answer questions.
   - » Provide the information you gave us already.
   - » Answer "yes" when asked if anyone has been found not eligible for Medicaid or the Children's Health Insurance Program (CHIP) in the past 90 days, if this applies.

If you have questions or need help completing your application, call the Marketplace Call Center at **1-800-318-2596 (TTY: 1-855-889-4325)** or go online to **HealthCare.gov/help/statetransfer**.

After you complete your application, the Marketplace will tell you if you qualify to enroll in Marketplace insurance, if you can enroll right away, or have to wait to enroll. The Marketplace will tell you if you qualify for help paying for your coverage. **If you qualify for coverage right away, select and enroll in a plan!**

If the Marketplace tells you that you have to wait, you can reapply during Open Enrollment (November 1st –December 15th). Some individuals who experience a life event will qualify for a Special Enrollment Period and can enroll outside of Open Enrollment. Examples of life events that may qualify you for a Special Enrollment Period include losing Medicaid or other health insurance, having a baby or getting married. You usually only have 60 days after the date of the life change to apply for Marketplace coverage. However, if you are losing coverage, you can apply up to 60 days before the loss, which can help to prevent a gap in health coverage.

VIRGINIA MEDICAID / FAMIS CLIENT APPEAL REQUEST FORM

To file your appeal online via the Appeals Information Management System (AIMS) portal visit https://www.dmas.virginia.gov/appeals

To file via email, fax, or mail, fill out this form completely including why you are appealing or write a letter with the same information. Include a copy of the written notice you are appealing.

Signing guidelines:

If the appeal request is for **someone who is physically or mentally unable** to sign a document, clearly explain to us why he or she is physically or mentally unable to sign. Also let us know, to the best of your knowledge, if there is any known guardian.

If the appeal request is for **someone who has died**, provide written proof that you can represent them. If you do not have written proof, clearly explain your relationship to the deceased and why you are appealing on their behalf. Also let us know, to the best of your knowledge, if there is any known executor or administrator of the estate.

A parent or legal guardian must file appeal requests for a **minor child**. If filing an appeal as a child's legal guardian, include proof of guardianship.

Organizations need to have written documentation from the appellant authorizing them to appeal on their behalf. If the appellant is deceased, provide authorization by an administrator or executor of the estate.

In some cases, we may require a power of attorney, a written statement from the appellant, or other additional information.

Time limit for filing an appeal:

The time limit for filing an appeal is on the written notice from the agency. In most cases it is 30 days.

If you are filing your appeal late, the DMAS Appeals Division may grant an extension of the time limit if the reason is due to a good cause (as defined by regulation). There is a Good Cause Questionnaire on page 4 where you can provide information about why you filed your appeal late. A DMAS Hearing Officer will evaluate your response and make a determination whether filing your appeal late was due to a good cause.

Note: For Managed Care Organization (MCO) appeals there are three major differences:

1) You have to first appeal to the MCO
2) You have 120 days to file an appeal with DMAS once you have received a final decision from the MCO
3) By regulation, there is no good cause for filing a late appeal

Ways to ask for an appeal:

1) **Electronically.** Online at **https://www.dmas.virginia.gov/appeals** or email to **appeals@dmas.virginia.gov**
2) **By fax.** Fax your appeal request to DMAS at **(804) 452-5454**
3) **By mail or in person.** Send or bring your appeal request to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219
4) **By phone.** Call DMAS at **(804) 371-8488 (TTY: 1-800-828-1120)**

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IMPORTANT: Please attach all documents that you would like the Appeals Division to consider. Any supporting documents you submit with your appeal request will be considered in rendering a decision.

VIRGINIA MEDICAID / FAMIS CLIENT APPEAL REQUEST FORM

You may file your appeal online via the Appeals Information Management System (AIMS) portal by visiting https://www.dmas.virginia.gov/appeals

Last Name of Medicaid/FAMIS Appellant	First Name	Middle Initial	Suffix (Sr., Jr., II, III)

Mailing Address - Street or PO Box Apt.	City	State and Zip	Date of Birth

Medicaid Member ID #	Client ID #	Primary Phone # with Area Code	Alternate Phone # with Area Code

Preferred Spoken Language	Preferred Written Language	Do you need an interpreter? Yes No	Email

Do you need a reasonable ADA accommodation? Explain	What way would you like us to communicate with you? Email Mail	Have you already filed an appeal for the same issue (e.g. faxed and mailed)? Yes No

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

Did you receive a written notice from an agency? **Yes** **No**

Agency Name **Telephone**

Notice Dated **Case Worker**

Include a copy of the written notice you are appealing.

Managed Care Organization (MCO)

Are you appealing a decision by an MCO? Yes No

If yes, you must first appeal to the MCO. If you disagree with the MCO's final decision, you can appeal that decision to DMAS.

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.

Took other action which affected my receipt of Medicaid, FAMIS or other medical services.

Denied medical services or authorization for medical services. Name the service:

Denied or terminated waiver services. Waiver name and service:

Transferred or discharged from a nursing facility. Facility name and phone #:

Important: Attach any documents you believe support your position in the appeal

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

If the final appeal decision supports the agency's action, you may be expected to repay DMAS for all services received during the appeal process. For this reason, you may choose not to receive continued coverage.

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 or an organization during the appeal process? If yes, fill out and return the Authorized Representative Form on page 3 of this Appeal Request. Yes No

Signature of Appellant* **Date**

* See signing guidelines on Page 1

VIRGINIA MEDICAID / FAMIS APPEAL
AUTHORIZED REPRESENTATIVE FORM

You can use this form to appoint an individual or organization to act as your authorized representative.
I understand:

- I can represent myself
- This authorization is voluntary and I have the right to refuse to sign or cancel it at any time
- This authorization will expire automatically when my Medical Assistance appeal is closed
- My signature does not waive my financial obligation if the appeal is decided in the agency's favor
- My authorized representative has access to all protected health information regarding my appeal and I agree that this information may be disclosed to other persons in connection with this appeal

Appellant Information (tell us about you)

Appellant Name:_____ Date of Birth: _____ Social Security #:_____

Medicaid Member ID #:_____ Phone: (_____)_____

Authorized Representative Information (tell us about who you would like to represent you)

Authorized Rep Name or Organization _____ Phone Number (_____)_____

Authorized Representative's Relationship to the Appellant: _____

Preferred written language (letters will be sent in this language) English Spanish

Authorized Representative's Address: _____

Signature of Appellant / Parent or Guardian of Minor Child: _____ Date: _____

For Organizations: The appellant must give written authorization to act on their behalf. For deceased appellants, provide documentation from the executor or administrator of the estate naming you as the Authorized Representative, this is needed to file an appeal.

If you are filing an appeal on behalf of an appellant who is unable to sign

To the best of my knowledge does the appellant have a legal guardian? Yes No

If the appellant is physically or mentally unable to sign tell us why _____

_____

Is the appellant deceased? ____ Yes ____ No Your relationship the deceased_____
To the best of my knowledge, the appellant does not have executor or administrator of their estate. Initial _____

Signature of Authorized Representative: _____ Date: _____

DMAS Appeals Division				
Email	**Fax**	**Phone**	**Mail**	**AIMS Portal**
appeals@dmas.virginia.gov	(804) 452-5454	804-371-8488	DMAS Appeals Division 600 E. Broad Street Richmond, VA 23219	https://www.dmas.virginia.gov/appeals

Print

VIRGINIA MEDICAID / FAMIS APPEAL
GOOD CAUSE QUESTIONNAIRE FOR NON MCO APPEALS

Only required for late appeals. Complete this form if you are filing an appeal request more than 30 days after receipt of the agency's written notice. By regulation, there is no good cause for late MCO appeals which have a longer deadline to file of 120 days.

Appellant Information

Name:_____ Date of Birth:_____ Social Security #:_____

Medicaid Member ID #: _____ Phone with Area Code: (____)_____

1. Did you receive a written notice from the Agency? ☐ Yes ☐ No
2. What date did you receive the written notice? _____
3. If you did not receive a written notice, how did you find out about the denial or termination?
   _____
4. What date did you find out about the denial or termination of coverage? _____
5. Have you had problems receiving mail? ☐ Yes ☐ No If yes, explain: _____
   _____
6. Has your address changed? ☐ Yes ☐ No Date of change: _____
7. Did you tell the agency about your address change? ☐ Yes ☐ No Date notified: _____
8. Why are you appealing now? _____
9. Did you contact the agency regarding the denial or termination? ☐ Yes ☐ No Date contacted: _____
10. Were you prevented from filing an appeal? ☐ Yes ☐ No How were you prevented:_____
    _____
11. Did you file an appeal with another agency or with your managed care organization (MCO) regarding the denial or termination? ☐ Yes ☐ No Date appeal was filed: _____
12. Enter the name of the agency you filed an appeal with: _____

_____ _____
Printed Name Date

_____
Signature

DMAS Appeals Division				
Email	**Fax**	**Phone**	**Mail**	**AIMS Portal**
appeals@dmas.virginia.gov	(804) 452-5454	804-371-8488	DMAS Appeals Division 600 E. Broad Street Richmond, VA 23219	https://www.dmas.virginia.gov/appeals