

# After Enrollment

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# PART I: Full Benefit ABD Covered Groups

## Once Approved

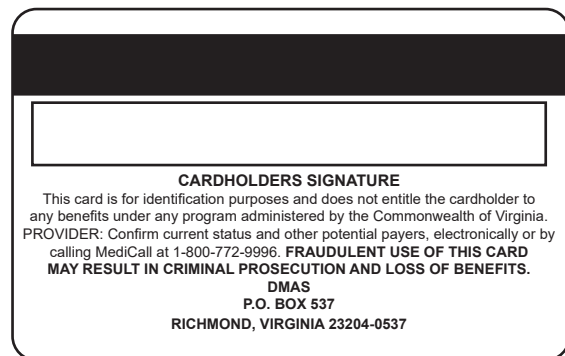
An individual approved for a Full Benefit covered group (e.g., ABD ≤80% FPL; 300% of SSI, Auxiliary Grant) will receive a *Notice of Action on Benefits* stating that he/she has been approved. (A sample of this form is in [Section 2 on Page 2.29-2.36](#))

In a separate mailing, the member will receive a permanent plastic ID card from DMAS. This card enables the individual to receive services from any Medicaid provider while his/her permanent benefits delivery method is determined. This is known as “Fee-for-Service”. Enrollment into managed care usually takes less than 30 days.

Members do not have to wait for the receipt of this card to get services. Their Medicaid number (Enrollee ID) is on the *Notice of Action* and the provider can verify enrollment with it. There is a Member HelpLine that can help with finding a provider at (804) 786-6145, as well as a provider search engine on the DMAS website via the page: <https://www.dmas.virginia.gov/for-members/find-a-provider/>



**FRONT**



**BACK**

## Selecting a Provider

In Virginia, ABD Medicaid care services are ultimately delivered through managed care organizations (MCOs). Members will access all care through a primary care provider (PCP) that they will select from the network of primary care providers within the health plan. This PCP will coordinate all of their care within the MCO’s network of providers, specialists and hospitals.

The managed care program for ABD members is called the Commonwealth Coordinated Care Plus (CCC Plus) program. Six MCOs deliver the services covered under CCC Plus:

- Aetna Better Health of Virginia 1-855-652-8249
- Anthem Healthkeepers Plus 1-855-323-4687
- Molina Complete Care 1-800-424-4524
- Optima Family Care 1-800-512-3717 or  
1-757-552-8360
- UnitedHealthcare Community Plan 1-866-622-7982
- Virginia Premier 1-877-719-7358

The member will receive a letter from DMAS about the CCC Plus enrollment process. A comparison chart listing the six CCC Plus MCOs and any “added benefits” (e.g., hearing and vision benefits and things like free cellphones or meal delivery after a hospital stay) they provide will be sent along with this letter. These “added benefits” vary by MCO, depending on a member’s situation or health needs, one plan may suit him/her better than another. (See [Page 4.10](#) for the *CCC Plus MCO Comparison Chart*)

The letter directs the person **to call the CCC Plus Enrollment HelpLine at (844) 374-9159** [TTY: (800) 817-6608] Monday through Friday between 8:30AM and 6PM to choose a MCO **by the due date indicated or he/she will be assigned to the MCO listed in the letter.** The member can also go online to [www.cccplusva.com](http://www.cccplusva.com) to make the selection. *Note: The HelpLine has access to **interpreter services**, if English is not the Member’s primary or preferred language. Information in large print or audio format can also be requested from the HelpLine.*

If the member does not respond to the letter by the due date, the MCO listed will be assigned to them. Once a health plan has been chosen, either actively by calling/going online, or assigned by DMAS because the enrollee failed to choose one, **a welcome packet and card will be sent from the MCO.**

**After receiving this information, a member still has about 60 days to change to one of the other MCOs.** After this period, the member can only change MCO during the annual CCC Plus MCO “Open Enrollment Period” in the fall (October 1 to December 31) or with special approval from DMAS.

CCC Plus does allow for a **continuity of care period.** If a MCO is new to a member, s/he can keep **seeing other health providers during the first 30 days s/he is enrolled in CCC Plus.** The member can also keep receiving authorized services for the duration of the authorization or 30 days after first enrolling, whichever is sooner. After this 30-day period, s/he will need to see doctors and other providers in the CCC Plus MCO’s network. **The member’s care coordinator can help him/her find new network providers.**

If the member **is in a nursing facility at the start of her/his ABD enrollment,** s/he may choose to:

- Remain in the facility as long as s/he meets DMAS’s criteria for nursing facility care,

- Move to a different nursing facility, or
- Receive services in his/her home or other community-based setting.

The continuity of care period may last longer than 30 days in some cases, such as until the health risk assessment is completed, or until the member can have a safe and effective transition to a provider in the CCC Plus MCO network.

**Note:** Beginning in July 2022, **DMAS will be rolling out Cardinal Care**, the unification of the Medallion and CCC Plus managed care programs. Cardinal Care will connect members to the care they need when they need it and reduce transitions between programs as their health care needs evolve. All managed care and fee-for-service Medicaid members will be part of the Cardinal Care program and the care members receive through it will not be reduced or changed from existing coverage. Phase 1 is the merging of the two programs that will begin in July 2022. New ID cards with the Cardinal Care logo will be phased in starting in 2023. Both the old (blue and white) and new cards will be accepted by Medicaid providers.



### Using the DMAS ID Card and the MCO Health Insurance Card

Upon receipt of the DMAS ID card, the member should check the information on it to be sure it is correct. If it is not correct, s/he must inform her local DSS or the Cover Virginia Call Center of any needed change/corrections. A listing of all 120 local DSSs, including addresses and phone numbers, is in [Section 5](#) of this *Tool Kit*. If the problem is with the MCO card, the member will need to contact the MCO.

The member should **report the loss or theft of his/her DMAS ID card to the local DSS or Cover Virginia Call Center** immediately. If the MCO card is lost or stolen, s/he should report this to the MCO. The cards should never be lent to anyone.

It is the enrollee's responsibility to show the MCO ID card and the DMAS ID card to providers each time medical services are received and to make sure the provider participates in the Medicaid program. The provider uses the information on the card(s) to verify enrollment prior to delivering services. Failure to present the card(s), or the Medicaid ID number, at the time of service may result in the enrollee being charged for services.

As a CCC Plus member, an enrollee will be assigned **a care coordinator** who will help make sure s/he is getting needed health services and care. **Within the first four months** of CCC Plus enrollment, the MCO will call the member for **a health screening**. Following the screening, his/her care coordinator may create a personalized care plan based on needs and preferences.

The care coordinator is available to help answer questions about covered health care and can also:

- Help a member find a new provider or specialist;
- Help a member access needed community resources and social services;
- Improve communication between a member's providers through care team meetings; and
- Monitor a member's progress toward meeting goals.

For assistance or more information, the member can call his/her care coordinator at the appropriate number below depending on the MCO:

- Aetna Better Health of Virginia 1-855-652-8249; press #1; ask for CC
- Anthem HealthKeepers Plus 1-855-323-4687; press #4; TTY: 711
- Molina Complete Care 1-800-424-4524
- Optima Health 1-866-546-7924; or 1-757-552-8398
- UnitedHealthcare 1-866-622-7982
- Virginia Premier 1-877-719-7358

## Covered Services Overview

Medicaid provides a comprehensive package of benefits. Including:

- Doctor, hospital, and emergency services
- Prescription drugs
- Laboratory and X-ray services
- Long-term care and support services, including community-based care
- Home health services
- Behavioral health services and counseling
- Addition and recovery treatment services (ARTS)
- Rehabilitative services including physical, occupational, and speech therapies
- Transportation to Medicaid-covered services when no alternatives are available
- Medical equipment and supplies
- Smoking cessation services
- Dental care (effective 7/1/21)
- And more!

*(For a more detailed listing of covered benefits refer to the Medical Assistance Handbook pages 19-24 available at <https://www.coverva.org/en/member-handbooks> and/or the information received from the member's MCO about covered benefits.)*

## Cost Sharing

There are **small copayments** for services rendered **during the initial fee-for-service period**, see the chart below. **Once enrolled in a Managed Care Organization, there are no copayments for any services.**

Service	Copayment Amount
Inpatient hospital	\$75 per admission
Outpatient hospital clinic	\$3 per visit
Clinic or physician office visit	\$1 per visit
Specialist visit	\$3 per visit
Eye exam	\$1 per visit
Prescription	\$1 for generic; \$3 for brand-name
Home health visit	\$3 per visit
Rehabilitation service	\$3 per visit

Individuals receiving institutional or community-based long-term care services and individuals in hospice care do not pay a copayment for services covered by Medicaid. There are also no copayments for emergency services (including dialysis treatments) or Emergency Room services.

*Note: a Medicaid enrolled medical provider cannot refuse to treat an individual or provide medical care if the patient is not able to pay the copayment, but the individual is still responsible for paying the copayment, if any.*

## Period of Coverage and Reporting Requirements

When a person is determined to be eligible, coverage may **retroactively pay outstanding medical bills for the three months prior to his/her application date**. The applicant would need to request retroactive coverage at time of application by answering "Yes" to the question "Does this PERSON want help paying for medical bills from the last 3 months?" If no retroactive coverage was requested, coverage begins the first day of the month in which the Application was received.

*Example: if a signed application is received in May and ultimately results in an enrollment, the outstanding medical bills may be covered for February, March, and April, if it is determined that the recipient would have been eligible for coverage during that time and retroactive coverage was requested.*

An individual must report any "changes in circumstances" that might affect ongoing eligibility for this coverage to his/her local DSS or the CVCC **within 10 days**. For example, changes in income or resources must be reported. When a change is reported, the LDSS caseworker will reevaluate ongoing eligibility and notify the enrollee of any adjustment to coverage.

**Note:** Reporting a **change of address** is especially important because DSS/DMAS/CPU mail is not forwarded, even if the individual has a forwarding order on record with the post office. If any mail is returned to the agency, the case may be closed and coverage

may be terminated! LDSS also needs a correct address to be able to deliver any renewal information in a timely manner.

### **Annual Renewal** (A sample Renewal Form is on pages 4.39-4.54)

Eligibility for this coverage must be renewed every 12 months. Approximately **45 days prior to the enrollee's renewal month**, the person will be **sent a 16+ page renewal form pre-populated with the his/her case information**. If a person has indicated another language as his/her primary language, a pre-populated form in that language may be sent instead (if that language is available). Virginia has translated the renewal form into Spanish, Amharic, Arabic, Urdu, and Vietnamese.

Enrollees have **30 days from the receipt of the form** to look it over, correct any errors, add any missing information, sign it, and **return it for processing**. It can be returned via mail (in the envelope provided) or hand-delivered to the local DSS. Once the preprinted form is received, enrollees can also complete it by calling the CVCC to report any changes in information or, if they have linked their case in CommonHelp, they can complete it online. Instructions on how to link a case in CommonHelp are in [Section 5](#).

Once the information is supplied via any of the above methods, the local DSS will use it to redetermine eligibility. If additional information is needed, the eligibility worker will contact the person in writing to ask for it. If found to be still eligible, the member will get a *Notice of Action* stating that coverage has been renewed and giving new dates of coverage.

**If the individual fails to return the form by the due date**, a cancellation notice will be sent, and coverage will be cancelled effective the end of the renewal month. It is important to note, however, that **the person still has an additional 90 days to return the form with any needed verification documents and coverage can be reinstated**. If he/she returns the form after that additional 90-day period, s/he will have to file a new application. (A sample cancellation notice is on pages 4.36-4.38)



## Managed Care Enrollment - Full Benefit ABD Categories

A letter is sent from DMAS giving approximately **30 days** for the individual to choose a MCO. A comparison chart with the six MCO choices is provided. They are told that if they do not call the CCC Plus HelpLine, or go to its website to choose, the MCO listed in the letter will be assigned to them.

**Did the enrollee contact the CCC Plus HelpLine?**

**YES**

Gets MCO of choice and is asked to pick their PCP.

MCO welcome packet sent (ID Card, provider directory, and handbook).

**NO**

Gets assigned an MCO and the MCO assigns a PCP.

MCO welcome packet sent (ID Card, provider directory, and handbook).

**Does the person want to change to a different MCO?**

Enrollees still have **about 60 days left** to contact the HelpLine and **change to a different MCO**. After that they can only change during CCC Plus "Open Enrollment" or by contacting DMAS and providing "good cause" to change.

# Sample CCC Plus MCO Selection Letter

MCF603I

163-ROCKBRIDGE-BUENA VISTA-LEXINGTON DSS  
20 E PRESTON ST  
LEXINGTON, VA 24450



## COMMONWEALTH of VIRGINIA *Department of Medical Assistance Services*

Date

John Q Sample  
1234 Any Street  
Any City, US 12345-6789

Dear John Q Sample:

### Welcome to Commonwealth Coordinated Care Plus (CCC Plus)!

You will soon be enrolled in the CCC Plus Medicaid managed care program. Medicaid is working with health plans to provide health coverage to CCC Plus members across Virginia. Below is your health plan and the date your coverage starts:

Name	Coverage Begin Date	CCC Plus Medicaid Health Plan	Medicaid ID
John Q Sample	Date	SAMPLE MEDICAID HEALTH PLAN	009999999999

The health plan listed above will send you a welcome packet in the mail that has information about the health plan, the services offered, as well as your **Health Plan ID card**. Please take your **Health Plan ID card** and your **Medicaid ID card** with you when you get health care.

You can stay with this health plan, or you can choose a different health plan, if you want. Each of the health plans has different doctors and health care providers in their networks.

### How to Choose a Health Plan

1. Make a list of your health care providers and places you get care including hospitals, doctors, specialists, pharmacies, therapists and other health care providers.
2. Use the **Enrollment website [cccplusva.com](http://cccplusva.com)** or call the Enrollment Helpline at **1-844-374-9159** (TTY: 1-800-817-6608) weekdays 8:30AM to 6:00PM to see which health plans participate with your health care providers or to change your health plan.
3. Review the health plan added benefits in the "CCC Plus Comparison Chart."



You can change health plans:

- In the first 90 days after you become a CCC Plus member
- Once a year during open enrollment
- At other times if approved by the Department of Medical Assistance Services

### **Your CCC Plus Medicaid Health Plan**

Your health plan will assign a Care Coordinator to you. This is a person you can call for help to get the care you need. Your enrollment is consent for the health plan to call you. You have the right to tell your health plan not to call you.

Your health plan will call you for a health screening to ask questions about your medical conditions and your ability to do everyday things. It is very important that you complete the screening. Please keep your phone number and address up to date with your Medicaid Eligibility Worker.

For individuals enrolled in one of the Developmental Disabilities Waivers, the CCC Plus health plan will only provide coverage for your non-waiver services. Medicaid will continue to provide coverage for your waiver services.

### **Program of All-inclusive Care for the Elderly (PACE)**

If you are age 55 or older and need a higher level of assistance to stay at home, you may qualify for PACE. PACE provides all Medicare and Medicaid benefits, plus some extra services to help eligible seniors who have chronic conditions to live at home. To learn more or see if there is a PACE site near you, go to: [www.pace4you.org/](http://www.pace4you.org/). If you qualify for and enroll in PACE, PACE will replace your current health plan. All services will be provided by PACE.

### **Help From an Independent Advocate**

If you would like to speak to an Advocate that can help you with questions, concerns or problems, please call 1-800-552-5019 or TTY toll-free 1-800-464-9950, Office of the State Long-Term Care Ombudsman, Department for Aging & Rehabilitative Services.

You can share this letter with someone you trust who knows your healthcare needs.

You can also get this information for free in other formats such as large print, audio or online at [cccplusva.com](http://cccplusva.com).

**Note:** If we find that you do **not** qualify for Medicaid for past coverage months because you did not report truthful information or changes in your circumstances to your Medicaid eligibility worker, you may have to repay monthly premiums, even if you did not get services during those months.

# CCC Plus Comparison Chart

<p><b>aetna</b> Aetna Better Health of Virginia 1-855-652-8249 TTY 711 AetnaBetterHealth.com/Virginia</p>	<p><b>Anthem. HealthKeepers Plus</b> Offered by HealthKeepers, Inc. 1-855-323-4687 TTY 711 anthem.com/vamedicaid</p>	<p><b>MOLINA HEALTHCARE</b> Molina Complete Care 1-800-424-4524 TTY 711 MCCofVA.com</p>	<p><b>OptimaHealth &amp;</b> 1-888-512-3171 or 1-757-552-8360 TTY 711 optimahealth.com/communitycare</p>	<p><b>UnitedHealthcare</b> Community Plan 1-866-622-7982 TTY 711 uhccp.com/Virginia</p>	<p><b>VirginiaPremier</b> 1-877-719-7358 TTY 711 virginiapremier.com</p>
<p><b>Added benefits:</b> <b>Adult vision</b></p> <ul style="list-style-type: none"> <li>1 eye exam and \$250 for glasses or contacts per year</li> </ul> <p><b>Adult hearing</b></p> <ul style="list-style-type: none"> <li>Exam and \$1,500 for hearing aids plus 60 batteries per year</li> </ul> <p><b>Phone services</b></p> <ul style="list-style-type: none"> <li>Free smartphone with unlimited minutes, data, and texts monthly</li> </ul> <p><b>Wellness programs</b></p> <ul style="list-style-type: none"> <li>Wellness rewards card</li> <li>Virtual wellness center</li> <li>Personalized weight management with registered dietitian</li> </ul> <p><b>Other benefits</b></p> <ul style="list-style-type: none"> <li>Free rides to grocery store, farmers market, food pantry, place of worship, DSS, DMV, WIC, Social Security Office and more (30 round trips each year)</li> <li>Meals delivered to your home after discharge, 2 meals each day for 7 days</li> <li>Memory alarms and devices</li> <li>Community health worker</li> <li>Diabetic shoes or inserts</li> </ul>	<p><b>Added benefits:</b> <b>Adult vision</b></p> <ul style="list-style-type: none"> <li>1 eye exam and \$100 for lenses and frames per year</li> </ul> <p><b>Adult hearing</b></p> <ul style="list-style-type: none"> <li>1 exam, \$1,000 for hearing aids and 60 batteries per year</li> </ul> <p><b>Phone services</b></p> <ul style="list-style-type: none"> <li>Free smartphone with 350 minutes, 4.5 GB of data and unlimited texts monthly</li> </ul> <p><b>Wellness programs</b></p> <ul style="list-style-type: none"> <li>Online search tool to find food, jobs and more</li> <li>Healthy Rewards gift card (up to \$50 per goal)</li> <li>Personalized / interactive app</li> </ul> <p><b>Other benefits</b></p> <ul style="list-style-type: none"> <li>Up to 12 rides a year to community events, grocery stores and more</li> <li>Meal delivery after hospital or nursing facility discharge</li> <li>Coupons with over \$1,000 in savings to local stores</li> <li>\$100 for assistive devices and wheelchair accessories</li> <li>Air purifier (with approval)</li> </ul>	<p><b>Added benefits:</b> <b>Adult vision</b></p> <ul style="list-style-type: none"> <li>1 eye exam every other year and up to \$100 for glasses (frames and lenses) or contacts every year</li> </ul> <p><b>Phone services</b></p> <ul style="list-style-type: none"> <li>Free smartphone with 350 minutes, 4.5 GB of data and unlimited texts monthly</li> </ul> <p><b>Wellness programs</b></p> <ul style="list-style-type: none"> <li>Healthy Rewards gift cards (up to \$50 each year)</li> <li>Annual physicals for all adults</li> </ul> <p><b>Other benefits</b></p> <ul style="list-style-type: none"> <li>Fresh meals delivered to your home after discharge</li> <li>Environmental, home and vehicle modifications for all members when needed</li> <li>Additional personal care attendant support</li> <li>Online directory of community services and organizations</li> <li>Bicycle helmets for children</li> <li>SaveAround retail coupon book</li> </ul>	<p><b>Added benefits:</b> <b>Adult vision</b></p> <ul style="list-style-type: none"> <li>1 eye exam and \$100 for frames per year</li> </ul> <p><b>Phone services</b></p> <ul style="list-style-type: none"> <li>Free smartphone with 350 minutes, 1 GB of data and unlimited texts monthly</li> </ul> <p><b>Wellness programs</b></p> <ul style="list-style-type: none"> <li>Weight management</li> <li>Online tool to find food, housing, jobs and more</li> </ul> <p><b>Other benefits</b></p> <ul style="list-style-type: none"> <li>Free rides to grocery stores, community events and more (24 round trips each year)</li> <li>Meals delivered to your home after hospital stay, including OB, 2 meals each day for 7 days</li> <li>Memory alarms and devices</li> <li>24-hour doctor access for non-life threatening health questions</li> <li>Up to \$275 for GED prep &amp; testing vouchers plus prep coaching</li> <li>Up to \$75 college applications help (restrictions apply)</li> </ul>	<p><b>Added benefits:</b> <b>Adult vision</b></p> <ul style="list-style-type: none"> <li>1 eye exam per year, lenses and frames every 2 years</li> </ul> <p><b>Phone services</b></p> <ul style="list-style-type: none"> <li>Free smartphone with 350 minutes, 3 GB of data and unlimited texts monthly</li> </ul> <p><b>Wellness programs</b></p> <ul style="list-style-type: none"> <li>Vaccine incentives up to \$100 at Footlocker® for ages 5-18</li> <li>13 Weight Watchers vouchers per year</li> <li>Wellness rewards for healthy behavior, up to \$25 per goal</li> </ul> <p><b>Other benefits</b></p> <ul style="list-style-type: none"> <li>12 free round trip rides to places of worship, grocery, DMV, health fairs, &amp; library</li> <li>14 meals delivered to home after discharge</li> <li>Stress, anxiety, and depression support by Sanvello app</li> <li>Environmental and home modifications for all members when needed</li> <li>Prenatal and postpartum incentives</li> </ul>	<p><b>Added benefits:</b> <b>Adult vision</b></p> <ul style="list-style-type: none"> <li>1 eye exam, up to \$100 for frames or contacts every 24 months</li> </ul> <p><b>Adult hearing</b></p> <ul style="list-style-type: none"> <li>1 hearing aid, exam, fitting (up to \$1,250 every 36 months)</li> </ul> <p><b>Phone services</b></p> <ul style="list-style-type: none"> <li>Free smartphone with 350 minutes, 4.5 GB of data, unlimited texts monthly</li> </ul> <p><b>Wellness programs</b></p> <ul style="list-style-type: none"> <li>Healthy Heartbeats prenatal, postpartum wellness program with incentives</li> <li>Nutritional education and personal fitness program</li> <li>Wellness reward gift cards</li> <li>Registered nurse and text-based programs to help manage chronic conditions</li> <li>Free sports physicals</li> </ul> <p><b>Other benefits</b></p> <ul style="list-style-type: none"> <li>3 free non-medical round trips every 3 months</li> <li>Up to 14 days meal delivery after hospital or nursing facility discharge</li> <li>Online access to health plan services and resources</li> </ul>

► These benefits start **January 1, 2022**. Call the plan or visit their website to learn about doctors, hospitals and limits that apply.

► For the **basic benefits** that **all plans** offer, see the brochure in this packet.

## Part II: Medicare Savings Programs (MSPs)

### Once Approved

Once approved, the member will receive a *Notice of Action on Benefits* stating that they have been **approved for LIMITED coverage**. In the “Update” section, it will describe the type of coverage the person has been approved for, in this case it would be Medicaid payments for his/her Medicare premiums. (For an example of this form see [Section 2 Pages 2.29-2.36](#))

For **Qualified Medicaid Beneficiaries (QMB)** members, **Medicaid will pay for Medicare Part A and B premiums and the coinsurance and deductibles Medicare does not pay**. They should not have to pay copays, except for outpatient drugs, which can be up to \$4, so long as the drug is covered by Medicare Part D.

For **Special Low-Income Medicare Beneficiaries (SLMB) and Qualified Individual (QI) members**, **Medicaid will pay their Medicare Part B premiums** (any outpatient care). SLMB and QI members are subject to Medicare copayments, coinsurance, and deductibles for Medicare-covered services.

For **Qualified Disabled and Working Individuals (QDWI)**, **Medicaid will pay for their Medicare Part A Premiums (Hospital Services)**. QDWI members are subject to Medicare copayments, coinsurance, and deductibles for Medicare-covered services.

The member will also receive a notice from the Department of Health and Human Services, Centers for Medicare & Medicaid Services that Medicare premium payments are being paid on his/her behalf.

Members enrolled in the MSPs will not receive Medicaid cards.

### Medicare Part D Enrollment

All MSP enrollees also **automatically qualify for “Extra Help” paying for Medicare Part D prescription drug coverage premiums, deductibles and copays** (also known as the Low-Income Subsidy or LIS). They will receive a letter printed on purple or yellow paper from the Department of Health and Human Services, Centers for Medicare & Medicaid Services regarding being enrolled in a Medicare Part D drug plan. A sample of this notice can be found on [pages 4.14-4.17](#).

### Period of Coverage and Reporting Requirements

Medicaid premium payments will **begin on the first day of the month of application** for the MSP programs, with the exception of QMB. **Coverage**

**under the Qualified Medicare Beneficiary (QMB) group always starts the month after** the approval action.

**Retroactive coverage for up to three months prior to application is also available for all MSP categories except QMB**, which does not retroact. For example, if a signed application is received in March and ultimately results in an enrollment, the premium payments may be covered for December, January, and February, if it is determined that the member would have been eligible for the program during that time and retroactive coverage was requested. The person would need to request retroactive coverage at time of application by answering "yes" to the question "Does this PERSON want help paying for medical bills from the last 3 months?"

Enrollees must **report any "changes in circumstances"** that might affect ongoing eligibility to their local DSS, the CVCC, or via CommonHelp **within 10 days**. For example, changes in income or resources must be reported. When a change is reported, the caseworker will reevaluate ongoing eligibility and notify the enrollee of any adjustment to coverage. Types of changes to be reported are:

- Change of address
- Change in marital status
- Person in home no longer disabled
- Change in amount of income (earned and unearned)
- Change in resources (e.g. change in motor vehicles owned)
- Change in dependent care expenses
- Change in source of income (job, benefits, etc.)

If a member continues to receive coverage because s/he failed to report changes on time, his/her case may be referred to the DMAS Recipient Audit Unit (RAU) for an evaluation of possible Medical Assistance overpayment. That evaluation could result in a request for repayment of charges for medical services received or for premiums paid to a Managed Care Organization to cover his/her medical services.

Reporting **a change of address is especially important** because DSS/DMAS mail is not forwarded, even if the person has a forwarding order on record with the post office. If correspondence is returned to the agency, the case may be closed and coverage may be terminated! DSS also needs a correct address to be able to deliver any renewal information in a timely manner.

**Annual Renewal** (*A sample Renewal Form is located on pages 4.39-4.54*)

Eligibility for the MSPs must be **renewed every 12 months**. Approximately **45 days prior to the renewal month**, the enrollee will be **sent a 16+ page renewal form pre-populated with the case information**. If a person has indicated another language as his/her primary language, a pre-populated form in that language may be sent instead (if that language is available). Virginia

has translated the renewal form into Spanish, Amharic, Arabic, Urdu, and Vietnamese.

Enrollees will have **30 days from the receipt of the form** to look it over, correct any errors, add any missing information, sign it, and **return it to LDSS for processing**. They can return it via mail (in the envelope provided), hand-deliver it to the local DSS, contact the CVCC to report any changes in information via the telephone, or go online to CommonHelp and complete the renewal there, if after approval for the program they linked their case. Instructions on how to link a case in CommonHelp are in [Section 5](#).

Once the information is provided (via paper, phone or online), the local DSS will use it to redetermine eligibility. If the LDSS worker still needs additional information, a written request will be sent asking for it. **If the person is still eligible, a Notice of Action will be sent stating that coverage has been renewed and giving new dates of coverage.**

If the information is **not provided by the due date, the case may be closed and the person may experience a break in the state paying his/her Medicare premium**. Coverage will be cancelled effective the end of the renewal month. It is important to note, however, that the enrollee **still has three months from the date the case was closed to return the form with any needed verification documents and coverage can be reinstated**. If the form is returned after the additional three months, coverage cannot be reinstated, and a new application for coverage will be required. (See [pages 4.36-4.38](#) for a sample cancellation notice.)







## Medicare Part D Extra Help Notice

<BENEFICIARY FULL NAME>  
<ADDRESS>  
<CITY STATE ZIP>

7500 Security Boulevard  
Baltimore, MD 21244-1850

<file creation date>

You're getting this notice because you automatically qualify for Extra Help paying Medicare Part D drug coverage costs. **Please keep this notice for your records.**

What does it mean to automatically qualify for Extra Help?  
Getting Extra Help means you'll pay no more than <gen\_amt> for a generic drug and no more than <brd\_amt> for a brand-name drug in a Medicare Part D drug plan in 2022. **You automatically qualify for this help starting <effective date> at least until December 31, <year>.**

**Note:** You can only get Extra Help if you live in one of the 50 states or Washington D.C.

Medicare will enroll you in a Part D drug plan  
Medicare will enroll you in a plan to make sure you get help paying for drug coverage. You'll get a yellow or green notice from Medicare telling you what plan you'll be enrolled in.

If you need drug coverage after <effective date> but before your new Medicare drug plan starts, your pharmacist can bill Medicare's Limited Income Newly Eligible Transition (NET) Program.

Also, if you paid for any prescriptions before you got this notice, and you were eligible for Medicare and Medicaid, you may be able to get back part of what you paid. Call Medicare's Limited Income NET Program for more information at 1-800-783-1307. TTY users can call 711.

What if I don't want a Medicare Part D drug plan?

If you don't want to be in any Medicare drug plan, you can opt out of this drug coverage. Call 1-800-MEDICARE (1-800-633-4227) and tell them you want to "opt out." TTY users can call 1-877-486-2048. **Caution:** If you opt out, you won't get Medicare drug coverage or Extra Help paying your drug costs.

What if I'm already in a Medicare Part D drug plan?

If you've had any prescriptions filled since <effective date>, you may be able to get back part of what those prescriptions cost. Call your plan for more information.

Get help & more information

For help understanding this notice, call your State Health Insurance Assistance Program at <SHIP Phone Number> for free, personalized health insurance counseling. Or, call 1-800-MEDICARE (1-800-633-4227) for help. TTY users can call 1-877-486-2048.



**Nondiscrimination Notice** - The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you've been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by:

- Calling 1-800-368-1019. TTY users can call 1-800-537-7697.
- Visiting [hhs.gov/ocr/civilrights/complaints](https://hhs.gov/ocr/civilrights/complaints).
- Writing: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201

**Notice of Availability of Auxiliary Aids & Services** - We're committed to making our programs, benefits, services, facilities, information, and technology accessible in accordance with Sections 504 and 508 of the Rehabilitation Act of 1973. We'll take appropriate steps to make sure that people with disabilities, including people who are deaf, hard of hearing or blind, or who have low vision or other sensory limitations, have an equal opportunity to participate in our services, activities, programs, and other benefits. We provide various auxiliary aids and services to communicate with people with disabilities, including:

- Relay service — TTY users can call 1-877-486-2048.
- Alternate formats — This notice is available in alternate formats, including large print, Braille, data CD and audio CD. To request your notice in an alternate format, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

**Aviso sobre la discriminación** - Los Centros de Servicios de Medicare y Medicaid (CMS) no excluye, niega beneficios o discrimina contra ninguna persona por motivos de raza, color, origen nacional, incapacidad, género o edad. Si cree que ha sido discriminado o tratado injustamente por cualquiera de estos motivos, puede presentar una queja ante el Departamento de Salud y Servicios Humanos, Oficina de Derechos Civiles:

- Llamando al 1-800-368-1019. Los usuarios de TTY pueden llamar al 1-800-537-7697.
- Visitando [hhs.gov/ocr/civilrights/complaints](https://hhs.gov/ocr/civilrights/complaints).
- Escribiendo a la: Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

**Ayuda y servicios auxiliares para personas con incapacidades** - Medicare está dedicado a ofrecerles a todos sus beneficiarios los programas, beneficios, servicios, dependencias, información y su tecnología, en cumplimiento con las Secciones 504 y 508 de la Ley de Rehabilitación del 1973. Medicare tomará las medidas necesarias para asegurarse de que las personas incapacitadas, entre los que se incluyen los que tiene problemas auditivos, son sordos, ciegos, tienen problemas visuales u otro tipo de limitaciones, tengan las mismas oportunidades de participar y aprovechar los programas y beneficios disponibles. Medicare ofrece varios servicios y ayuda para facilitar la comunicación con las personas incapacitadas incluyendo:

- Servicios de retransmisión de mensajes — Los usuarios de TTY pueden llamar al 1-877-486-2048.



- Formatos alternativos — Los productos de Medicare, incluyendo este documento, están disponible en letra grande, versión digital, Braille y audio. Para ordenar su aviso en un formato alternativo, llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY pueden llamar al 1-877-486-2048.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-MEDICARE (TTY: 1-877-486-2048).

عربي (Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برق 1-800-MEDICARE (رقم هاتف الصم والبكم: 1-877-486-2048).

**հայերեն (Armenian)** ՈՒՇԱԳՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, սպա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք 1-800-MEDICARE (TTY (հեռախոյ)՝ 1-877-486-2048)

**繁體中文 (Chinese)** 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-800-MEDICARE (TTY : 1-877-486-2048) 。

**فارسی (Farsi) توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-MEDICARE (TTY: 1-877-486-2048) تماس بگیرید.

**Français (French)** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-MEDICARE (ATS : 1-877-486-2048).

**Kreyòl Ayisyen (French Creole)** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-MEDICARE (TTY: 1-877-486-2048).

**Deutsch (German)** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-MEDICARE (TTY: 1-877-486-2048).

**Italiano (Italian)** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-MEDICARE (TTY: 1-877-486-2048).

**日本語 (Japanese)** 注意事項 : 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-MEDICARE (TTY:1-877-486-2048) まで、お電話にてご連絡ください。

**한국어(Korean)** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-MEDICARE (TTY: 1-877-486-2048) 번으로 전화해 주십시오.

**Polski (Polish)** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-MEDICARE (TTY: 1-877-486-2048).

**Português (Portuguese)** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-MEDICARE (TTY: 1-877-486-2048).



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PURPLE December 2021

**Русский (Russian)** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-MEDICARE (телетайп: 1-877-486-2048).

**Español (Spanish)** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-MEDICARE (TTY: 1-877-486-2048).

**Tagalog (Tagalog)** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-MEDICARE (TTY: 1-877-486-2048).

**Tiếng Việt (Vietnamese)** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-MEDICARE (TTY: 1-877-486-2048).



# Part III: Spenddown

## Spending Down to Medicaid

If the *Notice of Action* an individual receives **includes information about Spenddown**, the Spenddown Summary will include a **“Spenddown Amount”** (amount of expenses a person must incur prior to qualifying for full coverage) and a **“Spenddown Period”** (period of time covered by the spenddown. The spenddown period **for an institutionalized person is typically 1 month; for a non-institutionalized person/family it is usually 6 months.**

A **“Medicaid Spenddown Record” will be included** in the *Notice of Action*. This form will be used by the applicant to document any old (unpaid) or current medical expenses. (See [Section 2 pages 2.29-2.36](#) for a sample *Notice of Action* including Spenddown, specifically [page 2.31.](#))

The types of bills that count toward a spenddown liability are:

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

The applicant will **submit the “Medicaid Spenddown Record”** (filled out with the date of service, medical provider and amount owed), **copies of the medical bills/verification of insurance payments** to the local DSS **for the case to be evaluated for full coverage**. Medical expenses incurred before the spenddown period do not count, unless they have not yet been paid. Medical expenses incurred for services during the spenddown period do count, whether paid or still owed. Any bills incurred prior to the date the person meets his/her spenddown are still his/her responsibility to pay. The medical expenses may be for the enrollee him/herself, a spouse, or children under age 18 who live in the home. *Note: Medical expenses already paid by Medicare, Medicaid or other insurance do not count toward the spenddown liability.*

Once the individual **incurs or owes an amount equal to or greater than the amount of the Spenddown, Medicaid eligibility can be established** for the remainder of the spenddown period (dates listed on the *Notice of Action*).

## ABD Medically Needy “Spenddown” Income Limits

The ABD Medically Needy Income Limits (MNIL) are given in one month and six month amounts and for Assistance Units 1 and 2. The income a person has can be higher depending upon where the person lives in the Commonwealth. Virginia is broken into three locality groupings with Group III allowing for the highest income and Group I the lowest and Virginia’s localities are divided amongst these groups.

## ABD Medically Needy Income Limits (MNIL)

Effective July 1, 2022

Assistance Unit Size	Group I		Group II		Group III	
	Monthly	6-Month	Monthly	6-Month	Monthly	6-Months
<b>1</b>	\$356.35	\$2,138.14	\$411.18	\$2,467.09	\$534.54	\$3,207.24
<b>2</b>	\$453.65	\$2,721.95	\$506.31	\$3,037.88	\$644.42	\$3,866.55

### Locality Group I

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

### Locality Group II

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

### Locality Group III

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

See **Case Example #1** on [page 5.39](#) for how spenddown is calculated.

### Once Approved

Once the person meets his/her spenddown, s/he is enrolled in Medicaid, and will receive a plastic ID card from DMAS (pictured on [page 4.1](#)). This card enables the individual to receive services from any Medicaid provider in Virginia. This Medicaid coverage is called "Fee-for-Service".

Members do not have to wait for the receipt of this card to get services, their Medicaid number (Enrollee ID) is on the *Notice of Action* and the provider can verify enrollment with it. There is a **Member HelpLine** that can help with **finding a provider at (804) 786-6145** as well as a provider search engine accessed via the DMAS website at: <https://www.dmas.virginia.gov/for-members/find-a-provider/>

## Using the DMAS ID Card

Upon receipt of the DMAS ID card, the member should check the information on it to be sure it is correct. If it is not correct, s/he must inform her local DSS or the Cover Virginia Call Center of any needed change/corrections. A listing of all 120 local DSSs, including addresses and phone numbers, is in [Section 5](#) of this *Tool Kit*.

The member should **report the loss or theft of his/her DMAS ID card to the local DSS or Cover Virginia Call Center** immediately. The card should never be lent to anyone.

It is the enrollee's responsibility to show the DMAS ID card to providers each time medical services are received and to make sure the provider participates in the Medicaid program. The provider uses the information on the card to verify enrollment prior to delivering services. Failure to present the card, or the Medicaid ID number, at the time of service may result in the member being charged for services.

Once the person's period of Medicaid coverage ends, s/he should hold on to the DMAS ID card. If they qualify for Medicaid in the future, this card will be reactivated.

## Covered Services Overview

Once enrolled in Full-Benefit Medicaid, members are entitled to services including:

- Doctor, hospital, and emergency services
- Prescription drugs
- Laboratory and X-ray services
- Long-term care and support services, including community-based care
- Home health services
- Behavioral health services and counseling
- Addition and recovery treatment services (ARTS)
- Rehabilitative services including physical, occupational, and speech therapies
- Transportation to Medicaid-covered services when no alternatives are available
- Medical equipment and supplies
- Smoking cessation services
- Dental care (effective 7/1/21)
- And more!

*(For a more detailed listing of covered benefits refer to the Medical Assistance Handbook pages 19-24 available at <https://www.coverva.org/en/member-handbooks> and/or the information received from the member's MCO about covered benefits.)*

## Cost Sharing

There are **small copayments for services** received through Medicaid **when enrolled in fee-for-service**, including after meeting a spenddown. See the chart below.

Service	Copayment Amount
Inpatient hospital	\$75 per admission
Outpatient hospital clinic	\$3 per visit
Clinic or physician office visit	\$1 per visit
Specialist visit	\$3 per visit
Eye exam	\$1 per visit
Prescription	\$1 for generic; \$3 for brand-name
Home health visit	\$3 per visit
Rehabilitation service	\$3 per visit

Individuals receiving institutional or community-based long-term care services and individuals in hospice care do not pay a copayment for services covered by Medicaid. There are also no copayments for emergency services (including dialysis treatments) or Emergency Room services.

*Note: a Medicaid enrolled medical provider cannot refuse to treat an individual or provide medical care if the patient is not able to pay the copayment, but the individual is still responsible for paying the copayment, if any.*

## Period of Coverage and Reporting Requirements

Once enrolled, the member will be **covered for the remainder of the Spenddown Period**.

During his/her enrollment, the member is **still responsible for reporting all changes in income, resources** (money in bank accounts, cars, or life insurance policies) **and living arrangements** (household members) to the state. The LDSS may require verification of reported changes. Medicaid eligibility will be re-evaluated within 30 days of the reported change (or after receiving verification of the change). A written notice will be sent with the results of the re-evaluation.

## Additional Coverage

When the Medicaid coverage ends, or when the spenddown certification period ends, another Medicaid application must be filed if the applicant wishes to be evaluated again for ongoing Medicaid. If an adult member has an ongoing MSP case (QMB, SLMB, or QI), his/her spenddown can also be re-evaluated at the time of annual program renewal.



# PART IV: Long term Services and Supports (LTSS)

## What is Long Term Services and Supports (LTSS)?

LTSS is not unto itself a Medicaid covered group. Those enrolled in a full-benefit Medicaid covered group may be able to have Medicaid pay for LTSS (sometimes called “Long-Term Care,” or LTC). **If someone wants Medicaid to pay for LTSS, s/he must undergo a Pre-Admission Screening to confirm that s/he has needs that meet a level of care required for Medicaid to pay for LTSS.** The **Pre-Admission Screening** is required for all individuals who are or are becoming institutionalized, as well as individuals who seek for Medicaid to pay for Community-Based Care (CBC, sometimes known as a “waiver”), or those who want to receive LTSS through the Program for All-inclusive Care for the Elderly (PACE).

Since the Pre-Admission Screening involves medical criteria, either a hospital or provider (sometimes a health department) usually completes it, as part of a team. If an individual is being discharged from the hospital into a facility, the hospital will often assist that person by completing the Pre-Admission Screening. A Community Services Board (CSB) may also complete someone’s Pre-Admission Screening.

To **qualify for Medicaid to pay for LTSS, the applicant must be dependent in a number of activities of daily living (ADLs)**, including:

- **Bathing:** Getting in and out of the tub, preparing the bath (e.g., turning on the water), actually washing oneself, and towel drying.
- **Dressing:** Getting clothes from closets and/or drawers, putting them on, fastening, and taking them off.
- **Eating:** Getting food/fluid by any means into the body. This activity includes cutting food, transferring food from a plate or bowl into the individual’s mouth, opening a carton and pouring liquids, and holding a glass to drink.
- **Toileting:** Getting to and from the bathroom, get on/off the toilet, clean oneself, manage clothes and flush.
- **Transferring:** Moving between the bed, chair, and/or wheelchair.
- **Bowel and bladder function:** Continence (ability to control urination and elimination)

The Screening will also assess the individual’s mental state and behavior, mobility, joint motion, and ability to self-administer medications. It will evaluate the person’s medical and nursing needs, including the need for observation or monitoring, and his/her potential for medical instability. The Screening will assign a “score” for an applicant’s ability to perform each ADL. The score will indicate whether the applicant is independent, semi-dependent, dependent, or totally dependent in each category.

## Patient Pay

Patient pay is the **amount of a person's countable income that exceeds his/her Personal Needs Allowance (PNA)**. This is called a Personal Maintenance Allowance (PMA) for waiver recipients. The PNA is calculated by the Local Department of Social Services at the time the individual applies for Medicaid payment of LTSS services. The **PNA for a nursing facility in 2022 is \$40/month. For Community-Based Care, the PNA in 2022 is \$1,388/month.** The individual is expected to **contribute any income above the PNA to his/her care**, minus certain deductions:

- Home maintenance expenses\*
- Dependents
- Non-covered medical or remedial expenses
- Long-Term Care Insurance premiums, in the first month of an individual's admission into a facility or CBC

*\*Home maintenance expenses are not ongoing deductions for patient pay purposes. A member can only deduct them for the first six months of a facility stay if the stay is certified as temporary. This is not an allowed deduction for waiver recipients.*

A significant portion of a person's earned income is disregarded when calculating the Patient Pay.

## Asset Transfer

If an individual needs LTSS, either in a nursing facility or in his/her home, s/he will be **asked to describe all transfers of assets (resources) that have occurred within the past five (5) years.** This can include such actions as transferring the title to a vehicle, removing his/her name from a property deed, setting up a trust, or giving away money. **Medicaid applicants or participants who transfer (sell, give away, or dispose of) assets without receiving adequate compensation may be ineligible for Medicaid payment of long-term care services for a period of time.** Some asset transfers may not affect eligibility depending on the circumstances or if the Medicaid program determines a denial of Medicaid eligibility would cause an undue hardship. Transfers occurring after enrollment in Medicaid may also result in a penalty for payment of his/her long-term care services.

## Special Rules for Married Individuals

Medicaid uses special rules to determine Medicaid eligibility **when one member of a married couple receives long-term care and the other does not.** These rules are referred to as "**spousal impoverishment protections.**" Resources are evaluated to determine how much may be reserved for the spouse who does not need LTSS without affecting the Medicaid eligibility of the other spouse. A review of resources (resource assessment) may be requested without filing a Medicaid application when a

spouse is a patient in a nursing facility. When applying for ABD, a resource assessment must be completed when a married institutionalized individual with a spouse in the community applies for Medicaid, even when the couple is not living together.

**The presence of a “community spouse” (non-institutionalized spouse) impacts both eligibility, and the institutionalized spouse’s Patient Pay amount.** The community spouse can be living:

- In the home with his/her spouse, who receives Community-Based Care (CBC) paid by Medicaid,
- In a residential institution him/herself, such as an Assisted Living Facility (ALF), or
- In the institutionalized spouse’s former home.

### General Note about LTSS

Because the LTSS policy is very complex, it is suggested that individuals contact their local DSS if they have further questions. Local DSS staff will not advise anyone on how to become eligible for Medicaid, but they can provide detailed policy information pertaining to an application.

### Renewals in Long-Term Care

The Medicaid *ex parte* renewal process may be successful for institutionalized individuals who receive SSI and have no countable real property. This means these individuals would not need to complete a manual (contact-based) renewal. For others in an ABD covered group (as well as individuals who are over age 18, in the 300% of SSI covered group), **ongoing eligibility for Medicaid to pay for Long-Term Care requires that they complete a contact-based renewal**, due to the resource requirement. The patient pay must be updated **at least every 12 months**, even if there is no change in patient pay. The provider will be sent a DMAS-225 form when there has been a change in circumstances resulting in a change in eligibility. If there has been no change in circumstances, a DMAS-225 will not be sent to the provider. *(For more information see the Virginia Medical Assistance Eligibility Manual Section M1520.200.)*



# PART V: MEDICAID WORKS

*MEDICAID WORKS* is a program that offers disabled individuals aged 16 to 65 who are employed, or who want to go to work, the ability to earn more income and save more of their earnings than otherwise allowed by Medicaid rules. *MEDICAID WORKS* allows people to keep their health coverage from Virginia Medicaid while they work and gain greater independence.

## How to Qualify for *MEDICAID WORKS*

*MEDICAID WORKS* is available to **new and current Medicaid members**. In order to be eligible, applicants must:

- Live in Virginia and be a US citizen, US national, or a qualified non-citizen
- Be at least 16 years of age and less than 65 years of age
- Be disabled or blind (current participation in SSI or SSDI will satisfy the condition for disability)\*
- Be employed or have a letter from an employer stating when the employment will begin
- Have total countable income that is no more than \$1,563/month
- Have countable resources of no more than \$2,000 if single and \$3,000 for a couple.
- Not be in a Medicaid waiver

*\*A person without Social Security Administration documentation of disability will have to be evaluated by the state's Disability Determination Services program before eligibility for MEDICAID WORKS can be established.*

## How to Enroll in *MEDICAID WORKS*

**Step 1:** The individual contacts his/her local DSS and speaks with his/her Medicaid Eligibility Caseworker

**Step 2:** The LDSS Caseworker determines the individual's eligibility for the *MEDICAID WORKS* program. If approved, the member must complete and sign/date the "*MEDICAID WORKS Agreement*." (See a sample on [Page 4.30](#))

**Step 3:** The individual provides documentation of employment or provides documentation from an employer establishing the date when the employment will begin. The individual must also provide documentation of the salary expected.

**Step 4:** Once approved for *MEDICAID WORKS*, the member must establish a "Work Incentive" (WIN) account (a regular checking or savings account) at a bank or other financial institution to deposit earned income. Only income earned through employment can be deposited into this account. The WIN account is used to deposit all earned income and keep any savings

above \$2,000 in order to remain eligible for Medicaid. There are no restrictions on use of funds in the WIN account(s) so they may be used as needed. In addition to the designated checking or savings WIN account described above, certain IRS-approved accounts (retirement, medical savings accounts, medical reimbursement accounts, education accounts, and independence accounts) can be designated as WIN accounts. Access to these types of accounts is restricted.

**Possible Step 6:** If, in the future, a premium is required for *MEDICAID WORKS*, an enrollee will have to submit payment of the premium before enrollment can occur. ***MEDICAID WORKS* is currently premium-free for all enrollees.** If a premium requirement is established, enrollees will be notified well in advance of its effective date. A premium schedule will be provided illustrating how premiums will be charged on a sliding scale based on individual enrollee income. Monthly premium payments will have to be submitted in a timely manner in order to maintain eligibility and continue to be enrolled in the program.

**In the *MEDICAID WORKS* program, members can earn up to \$75,000 per year and can have resources in their WIN account of up to \$46,340 (effective January 1, 2022).**

The effective date of enrollment in the program is dependent upon receipt of the documentation of the WIN account(s). Coverage will begin the first date of the month following the month in which the documentation was received. In the event an applicant has a future start date for employment, the effective date of enrollment will be no earlier than the first day of employment. However, unless employment begins on the first day of the month, program enrollment will be the first of the following month.

### **How to Continue Enrollment in *MEDICAID WORKS***

In order to remain enrolled in *MEDICAID WORKS*, members must:

- Continue to be disabled or blind and under the age of 65
- Not earn more income or have more savings than allowed by the *MEDICAID WORKS* program
- Not receive unearned income (like Social Security) greater than 138% of the Federal Poverty Level

**Eligibility will be redetermined annually.** Changes that may affect their coverage must be reported to the state (change of address, change in income/employment, loss of employment). Periodic reporting of documentation regarding the enrollee's employer, employment status, earned income, and WIN account(s) will be required.

**Special rules apply for individuals who are unable to keep employment.** These rules are called a "safety net" and allow the member to remain in *MEDICAID WORKS* for up to six months. Safety net components of the program include allowing enrollees who are unable to maintain

employment due to illness or unavoidable job loss to remain in the program as unemployed for up to six months with the continued payment of any required monthly premiums. The amount of unearned income received by the enrollee must continue to remain below 138% of the Federal Poverty Level. Unemployment cash benefits are considered unearned income. However, if an enrollee becomes unemployed and receives income from unemployment insurance payments, the enrollee must deposit all of these payments into a WIN account in order to remain eligible for *MEDICAID WORKS* during the six-month safety net or “grace” period.

Enrollees who are unable to sustain employment and must terminate from the program will be evaluated by the LDSS to determine if they meet the eligibility requirements for any other Medicaid covered groups. This will be completed before an enrollee is terminated from the program. Resources accumulated after enrollment in *MEDICAID WORKS* from enrollee earnings that are held in WIN accounts and are no greater than the WIN limit will not be counted in this eligibility determination. If found **eligible and enrolled in another Medicaid covered group**, the individual **will have up to one year to dispose of these funds before they are counted toward ongoing Medicaid eligibility**

Resources accumulated after enrollment in *MEDICAID WORKS* from enrollee earnings held in IRS-approved retirement, medical savings, education, and independence accounts that have been designated as WIN accounts will not be counted in any future eligibility determinations.

# **MEDICAID WORKS**

## **Agreement**

I, \_\_\_\_\_, want to enroll in **MEDICAID WORKS**, the  
PRINT ENROLLEE NAME  
work incentive plan for individuals with disabilities through the Virginia Medicaid program. I understand that this is a voluntary option and that I may leave the program at any time and return to regular Medicaid coverage if I continue to meet the eligibility requirements for another Medicaid covered group. I further understand that while enrolled in **MEDICAID WORKS**, I will have a different health benefit plan, which includes all standard Medicaid benefits plus personal assistance services, instead of the standard Medicaid benefit plan usually provided to Medicaid enrollees that does not include personal assistance services. I may choose to discontinue the **MEDICAID WORKS** benefit plan at any time and return to the standard Medicaid benefit plan.

I know that I must be employed to be enrolled in **MEDICAID WORKS** and that a monthly premium payment may be required to continue to participate in this program. I understand that I must establish at least one Work Incentive (WIN) account (a regular checking or savings account) at a bank or other financial institution to be eligible for this work incentive plan. I must deposit all of my earned income into a WIN account and I am able to use this income as needed. If I am going to save some of my earnings, I also must keep it in a WIN account, where I can accumulate up to \$46,340 (effective January 1, 2022).

I can have annual earnings of up to \$75,000 if I deposit my earned income into my WIN account. If I receive a monthly SSDI payment and the amount increases due to work and/or a cost-of-living adjustment (COLA), I understand that I must deposit the amount of this increase into my WIN account if the new SSDI payment amount exceeds the unearned income limit of 138% of the federal poverty level. In addition, if I become unemployed and receive income from unemployment insurance payments, I must deposit all of these payments into my WIN account in order to remain eligible for **MEDICAID WORKS** during the six-month safety net or “grace” period.

I agree to the above requirements for **MEDICAID WORKS** and to inform my eligibility worker about changes that may affect my coverage, including but not limited to, change of address, change in income, change in employment or loss of employment. I further agree to provide any required documentation regarding my employer, employment status, earned income and WIN account(s). If I choose to discontinue enrollment in **MEDICAID WORKS** or in the benefit plan provided in this program, I will inform my eligibility worker.

\_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Prepared by the Virginia Department of Medical Assistance Services, revised February 24, 2022



# Virginia Medicaid Dental Coverage



**Smiles For Children**  
Improving Dental Care for Children and Adults

## WHAT IS SMILES FOR CHILDREN?

Smiles For Children (SFC) is Virginia's Medicaid and FAMIS dental program for adults and children. The SFC program is managed by DentaQuest.

## HOW DO I FIND A DENTIST?

Contact DentaQuest at 1-888-912-3456 or [search the DentaQuest website](#) to find a listing of dentists who accept Medicaid in your zip code.

**Already have a dentist?** Call and make sure that your provider accepts Medicaid coverage so you can receive quality services at no cost.

## HOW DO I USE SMILES FOR CHILDREN INSURANCE?

There are no costs or co-payments for dental care services in the SFC program. On the day of the appointment, be sure to bring your Virginia Medicaid card and your managed care organization ID card (if you are enrolled in a health plan).

### CHILDREN

- Regular dental checkups
- X-rays
- Cleaning and fluoride
- Sealants
- Space maintainers
- Braces
- Anesthesia
- Extractions
- Root canal treatment
- Crowns

### PREGNANT MEMBERS

- X-rays
- Exams
- Cleanings
- Fillings
- Root canals
- Gum related treatment
- Crowns
- Partials and Dentures
- Extractions and other oral surgeries

### ADULTS

- X-rays
- Exams
- Cleanings
- Fillings
- Root canals
- Gum related treatment
- Dentures
- Extractions and other oral surgeries

**Need a ride?** Transportation services are available to Medicaid members for their dentist appointments. Visit the [Virginia Medicaid website](#) or [contact your health plan](#) for contact information to make a reservation.





# Sample Renewal Approval

Charlottesville City (540)  
120 Seventh Street, NE  
Charlottesville, VA 22902

[Sample DSS]

Commonwealth of Virginia  
Department of Social Services  
Questions? Call: (434) 970-3400

Letter Date: February 11, 2021  
Case Number: #####

Susan Hope  
801 E Main ST  
Charlottesville, VA 22902

[Sample Client]

## News for your household

A renewal has been completed for health coverage from Virginia Medicaid. 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)
Susan Hope	Eligible	FULL	March 01, 2021 - Ongoing

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

### Update for Susan Hope

Client ID: 2104869120

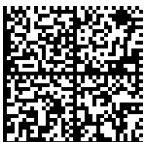
You qualify for health coverage from Virginia Medicaid.

### Health Coverage Information for Susan Hope:

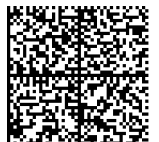
Medicaid ID Number	Coverage	Effective Date
351148810017	FULL	March 01, 2021 - Ongoing

**Medicaid Card:** Most Medicaid 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 Medicaid health coverage can be used right away by giving your provider the Medicaid ID number listed above.

**Health Coverage must be renewed every year.** The next renewal is due **February 28, 2022**. We will send more information when it is time to renew.



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282 (TTY: 1-888-221-1590)**.



Case #: #####

Page 1 of X

Correspondence #: #####

**Sample Renewal Approval 4.33**

## Using your health coverage

Medicaid health coverage can be used right away. Services can be received from any doctor, clinic, or other health care provider who accepts 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 this individual needs 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.

## Health services and costs

Susan Hope qualifies for full coverage Medicaid. This covers services like doctor visits, hospital care, prescriptions and more.

There is no premium (a monthly cost) for Medicaid health coverage. There **may** be co-payments for some services. To learn more, see the Member Handbook at <https://www.coverva.org/handbooks/>. To get a paper copy of the Handbook, call us at **(434) 970-3400**.

## 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. Since the household’s monthly income is below the Medicaid income limit, this individual qualifies for Medicaid health coverage. To learn more about Medicaid rules and income limits, go to **www.coverva.org**. We made our decisions based on these rules: Virginia Medical Assistance Manual Reference M0130.300. 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.”

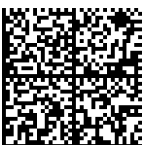
Medicaid may pay past bills, even if you already paid them yourself. If you were not evaluated for health coverage for the three months prior to your application month and you had medical expenses, contact us at **(434) 970-3400**.

## Your household must report changes

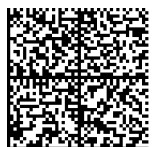
You must report any changes that might affect health coverage for anyone in your household who was approved health coverage from Virginia Medicaid. Please report changes for both you and other people in your household within ten days of the change, such as:

- » 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.

To report changes: go to **CommonHelp.Virginia.gov** and click on “Report My Changes,” call **1-855-242-8282 (TTY: 1-888-221-1590)**, or call us at **(434) 970-3400**.



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282 (TTY: 1-888-221-1590)**.



Case #: #####

Page 2 of X

Correspondence #: #####

## 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 My Benefits."  
To link your case to your CommonHelp account using the information below, log in and select "Manage My Account."

**Case Number: #####**

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

## Information about other programs

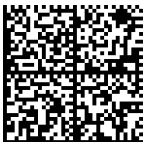
You and others in your household may qualify for other assistance, like help buying food or paying heating and cooling bills. If you already applied for other assistance, information about those programs may come in a separate letter.

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

<b>Worker Name:</b>	<b>Telephone Number:</b>	<b>For Free Legal Advice Call:</b>
JOE WORKER	(804) 555-5555	1-866-534-5243

## Additional Information from Your Case Worker:

*Note: Some pages of this notice have been omitted to save space, but their contents can be seen in sample notices in Section 2. One would be the "If You Think We Made a Mistake" section that can be viewed on Page 2.33. Another is the "It is important we treat you fairly" wording that can be seen on Page 2.25. The final two pages are information about the right to get this information in other languages, which can be seen on Pages 2.27-2.28.*



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282 (TTY: 1-888-221-1590)**.



Case #: #####

Page 3 of X

Correspondence #: #####

**Sample Renewal Approval 4.35**

# Sample Cancellation Notice

Charlottesville City (540)  
120 Seventh Street, NE  
Charlottesville, VA 22902

[Sample DSS]

Commonwealth of Virginia  
Department of Social Services  
Questions? Call: (434) 970-3400

Letter Date: February 11, 2021  
Case Number: #####

Susan Hope  
801 E Main ST  
Charlottesville, VA 22902

[Sample Client]

## News for your household

A renewal has been completed for health coverage from Virginia Medicaid. 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)
Susan Hope	Closed	FULL	February 28, 2021

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

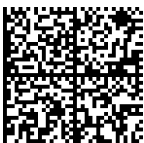
### Update for Susan Hope February 28, 2021

Client ID: #####

You no longer 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](http://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."



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282 (TTY: 1-888-221-1590)**.



Case #: #####

Page 1 of 8

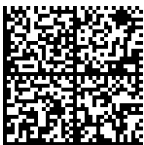
Correspondence #: #####

This individual does not qualify for health coverage from Virginia Medicaid because they moved from the state of Virginia. We made our decisions based on these rules: Virginia Medical Assistance Manual Reference M0230.001.

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.**

<b>Worker Name:</b> Jane Smith	<b>Telephone Number:</b> (555) 555-5555	<b>For Free Legal Advice Call:</b> 1-866-534-5243
<b>Additional Information from Your Case Worker:</b>		

*Note: Some pages this notice have been omitted to save space. One would be the "If You Think We Made a Mistake" section that can be viewed on Page 2.33. Another is the "It is important we treat you fairly" wording that can be seen on Page 2.25.*



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282 (TTY: 1-888-221-1590)**.



Case #: #####

Page 2 of 8

Correspondence #: #####

**Sample Cancellation Notice 4.37**

## 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): **Susan Hope, Jasmine 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.

You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282 (TTY: 1-888-221-1590)**.

Case #: #####

Page 5 of 8

Correspondence #: #####

*Note: Page 6 of 8 was a blank page and pages 7 -8 of 8 contained information on how to get information in other languages. These pages were omitted to save space.*

### 4.38 Sample Cancellation Notice



# Sample Renewal Form

Charlottesville City  
120 Seventh Street, NE  
Charlottesville, VA 22902  
*[Sample LDSS]*

Mary Smith  
300 East Main Street  
Charlottesville, VA 22902  
*[Sample Client]*

Commonwealth of Virginia  
[VARIABLE DATA]

Questions? Call us: [VARIABLE DATA]

Letter Date: [VARIABLE DATA]

Response due: [VARIABLE DATA]

Case Number: [VARIABLE DATA]

Case Worker Name: [VARIABLE DATA]

Worker User ID: [VARIABLE DATA]

## It is Time to Renew Your Health Coverage from Virginia Medicaid.

Completing your renewal online ([www.commonhelp.virginia.gov](http://www.commonhelp.virginia.gov)) or by phone (1-855-242-8282) can be faster and easier! See below for more information.

Please complete your renewal by:  
[DATE]

### If you do not complete your renewal, you will lose your Medicaid health coverage.

Renew your Medicaid in any one of these ways

**1 Online\*:**

Go to **CommonHelp.Virginia.gov**.  
Click on "Renew My Benefits."

To create an account:

- Go to **CommonHelp.Virginia.gov**
- 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: 12345678**

**Client Number: 12345678**

**2 By phone:**

Call 1-855-242-8282/ TTY: 1-888-221-1590; this call is free.

**3 By mail or fax:**

Charlottesville City  
P.O. Box 120  
Charlottesville, VA 22902  
Fax: [variable data]

**4 In person:**

Bring the completed form to:  
Charlottesville City  
120 Seventh Street, NE  
Charlottesville, VA 22902

*This is a renewal of your Medicaid benefits. Information regarding open enrollment to change health plans (such as Anthem or Optima) will be mailed separately. Open enrollment dates depend on where you live. Go to <https://www.virginiamanagedcare.com> for more information.*

*\*Free Internet access may be available at your local Department of Social Services or public library.*



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).



Case #: [Variable Data] Page 1 of 16 Correspondence #: [Variable Data]

**How to complete this renewal form**

1. Answer all the questions on the form.
2. Review the information about you and each member of your household or on your tax return. Cross out wrong information. Write in new information and add anything that is missing information. If you have household members who are new to the home and/or would like to apply, please fill out all applicable sections of the renewal for that person.
3. **Sign and date the form at the end of the renewal.**

**What we need**

**We filled out the form with the information we have in our records. Cross out wrong information. Write in new information and add anything that's missing. This form will ask about:**

- Section 1: Information about how we can contact you
- Section 2: Information about your federal tax returns
- Sections 3: Information about people in your household
- Section 4: Other health insurance coverage
- Sections 5: Household income from jobs or other sources
- Section 6: Information about resources and nursing facility care (you will only get this section in your packet if it applied to your household.)
- Next, fill out all appendices, if any, that apply to your household or individuals listed on your tax return:
  - Appendix A: People in your household who are eligible for new health coverage from a job
  - Appendix B: People in your household who are an American Indian or Alaska Native
  - Appendix C: Choose who can help with your application
  - Appendix D: New people in your home who want to apply for Medicaid
  - Additional Information: Voter registration and non-discrimination information

We need information about each person living in your household or listed on your tax return, including those who:

- Have Medicaid health coverage now,
- Do not get Medicaid health coverage, but want to apply
- Do not have Medicaid health coverage and do not want to apply.

We will check your answers using information available in data sources, like the Internal Revenue Service (IRS), the Social Security Administration (SSA), and the Department of Homeland Security (DHS). If the information does not match our records, we may ask you to send more information.

**What happens next?**

After you return the renewal form, we will review it to see if you and others in your household are eligible for Virginia Medicaid. If we have more questions, we will contact you.



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).

Case #: [Variable Data] Page **2** of **16** Correspondence #: [Variable Data]



# 1

## Information about how we can contact you

▼ Review the contact information we have on file for you below.

*Mary Smith*

▼ Cross out wrong information. Write in new information and add anything that is missing.

**Name**

**Home address**

*300 East Main Street  
Charlottesville, VA 22902*

**Home address**

**Apartment #**

**City**

**State**

**ZIP code**

**Mailing address**

*300 East Main Street  
Charlottesville, VA 22902*

**Mailing address**

**Apartment #**

**City**

**State**

**ZIP code**

**Phone number:**

**Cell:** *805-555-1234*

**Home:** *804-555-1234*

**Work:** *804-555-1234*

**Best phone number** to reach you during the day:  Cell  Home  Work

**Email address**, if you have one:

# 2

## Information about your federal tax return

You can still renew if you do not file a tax return.

- ▶ Review the information about tax filers and dependents in your household.
- ▶ Cross out any information that is wrong. Write in any new information about how you plan to file your next federal tax return.

▼ Review your tax information here.

**Person filing tax return:** *Mary Smith*

If this person is filing a joint return, write the name of the spouse:

Tax dependents (if anyone is missing, write their name below):

*Annie Smith*

- ▶ If anyone who lives with you will be claimed as a dependent on someone else's tax return, write the name of the filer and the dependents below. Include only names that do **not** appear above.

**Name** (*first, middle, last & suffix*)



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).



Case #: [Variable Data] Page **3** of **16** Correspondence #: [Variable Data]

### 3

## Your household members

► Review the information below. Cross out anything that is wrong. Fill in any missing information.

**Person 1:** Mary Smith

This person's Social Security number is  on file  not on file

*If not on file*, write this person's Social Security number here:

This person is no longer living in the household. Date person left the household: \_\_\_\_\_  
(mm/dd/yyyy)

**Person 2:** Annie Smith

This person's Social Security number is  on file  not on file

*If not on file*, write this person's Social Security number here, if they have one:

This person is no longer living in the household. Date person left the household: \_\_\_\_\_  
(mm/dd/yyyy)

► Review people in your household not receiving Medicaid and write in any new people in your household

**Person 1:** John Smith

This person is no longer living in the household. Date person left the household: \_\_\_\_\_  
(mm/dd/yyyy)

**New Household Member Name:** *(first, middle, last & suffix):*

**If anyone in your household is not currently enrolled in Virginia Medicaid and wants to apply, complete Appendix D.**

► Answer these questions for **everyone** in your household or on your tax return.

Is anyone in your household or on your tax return pregnant?

Yes  No *If yes*, fill in the information below.

**Name** *(first, middle, last & suffix)*

How many babies are expected?

What is the due date?

\_\_\_\_\_  
(mm/dd/yyyy)

Is anyone in your household or on your tax return an American Indian or Alaska Native?

Yes  No *If yes*, fill out **Appendix B**.

► Answer these questions for anyone who is **renewing or applying** for health coverage.

► Does anyone need help with every day activities, like bathing, dressing, eating, walking, or using the bathroom in order to live safely in your home? **or** Has a doctor or nurse told anyone in your household that they have a physical disability, a long-term disease, a mental or emotional illness, or an addiction problem?

Yes  No *If yes*, write the name(s) below.



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).



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Name (first, middle, last & suffix)

Has anyone turned age 65 years old or become blind or disabled?

Yes  No **If yes, fill out Section 2 of Appendix D.**

Has anyone entered a nursing home, assisted living facility, or started receiving nursing care in the home?

Yes  No **If yes, fill out Section 3 of Appendix D.**

Is anyone who is renewing or applying for health coverage incarcerated (detained or jailed)?

Yes  No **If yes, write the name(s) below.**

Name (first, middle, last & suffix)

Facility Name (place of incarceration)

**Plan First** is a limited benefits program that covers services like family planning exams, prescription contraceptives, testing, and family planning related lab services. Learn more: [www.coverva.org/planfirst](http://www.coverva.org/planfirst). **Individuals between the ages of 19 and 64 are automatically evaluated for Plan First.**

If you do **not** want household members between the ages of 19 and 64 to be evaluated for Plan First, write their name(s):

**Household Members Younger than 19 and Older than 64:**

If you want us to see if household members younger than 19 and older than 64 qualify for Plan First, write their name(s):

In the past, the following household members chose not to be evaluated for Plan First coverage. If they now want to be evaluated, **circle their name(s) below:**

John Smith, Annie Smith

## 4

### Other health insurance coverage

Does any person who is **renewing or applying for health coverage** have other health insurance?

- ▶ Review the information about tax filers and dependents in your household.
- ▶ Cross out any information that is wrong. Write in any new insurance information for your household.
- ▶ If someone in the household has new insurance through an employer complete **Appendix A**.

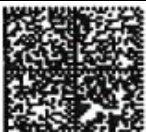
Name(s) of person with other health insurance:

Policy number:

Insurance company name:

Monthly Premium Amount: \$

Type of insurance:  Medicare  Tricare  Veteran's health coverage  Marketplace  
 Other insurance  Premium Assistance (HIPP or FAMIS Select)



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Check here if this other health insurance has ended. Coverage End Date: \_\_\_\_\_  
(mm/dd/yyyy)  
If you have indicated that health insurance has ended for any household member(s), please provide proof of the date of termination of the member's other health insurance.

List everyone renewing or applying for health coverage who has this other insurance policy:

Check here if this other health insurance coverage is offered through a job.

## 5 Information about income from jobs

- ▶ Provide the information below for anyone in your household or on your federal tax return who has income from a job, whether or not they are renewing or applying for health coverage.
- ▶ If someone has more than one job, tell us about **all of their jobs**.
- ▶ If you need more space, make a copy of this page before filling it out.
- ▶ Cross out wrong information. Write in new information and add anything that is missing.

Person who has the job: **Name** (*first, middle, last & suffix*)

Employer name and address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Phone number: \_\_\_\_\_  
ABC Employer 123 Main Street Richmond VA 23224-0001 804-555-1234

**Monthly gross income** currently on file: \$ \_\_\_\_\_

Is this person still employed at this job?  Yes  No **If No**, date they left the job: \_\_\_\_\_  
(mm/dd/yyyy)

How often are wages and tips paid?

- Weekly  Every two weeks  Monthly  Twice a month  Yearly  Other \_\_\_\_\_  
 Not regularly (for example, if this person works under a contract)

How much does this person earn (before taxes are taken out)? \$ \_\_\_\_\_

Average hours worked each week: \_\_\_\_\_

If anyone in the household has **changed or has a new job**, list him or her and answer the questions below.

Name (*first, middle, last & suffix*):

Employer name and address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Phone number: \_\_\_\_\_

Start Date: \_\_\_\_\_

How often are wages and tips paid?

- Weekly  Every two weeks  Monthly  Twice a month  Yearly  Other \_\_\_\_\_  
How much does this person get paid (before taxes)? \_\_\_\_\_

Average hours worked each week: \_\_\_\_\_



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- ▶ If anyone in your household is **self-employed or does odd jobs**, we need to know about their work.
- ▶ Cross out wrong information. Write in new information and add anything that's missing.

Name (first, middle, last & suffix): \_\_\_\_\_

Type of work: \_\_\_\_\_

What do you expect his or her income to be this year? Amount: \$ \_\_\_\_\_

How much **net income** will this person get from self-employment (or odd jobs) this month?

Amount: \$ \_\_\_\_\_

**Net income** means the profits left over after business expenses are paid. For more information about business expenses visit <https://www.coverva.org/>.

▶ **Information about other income.** If anyone in your household has income from sources other than a job, like Social Security income, pensions, Veterans benefits, or annuities.

- ▶ Cross out wrong information. Write in new information and add anything that is missing.

Name (first, middle, last & suffix): \_\_\_\_\_

Income Type: \_\_\_\_\_ How much? \$ \_\_\_\_\_

How often?

Yearly  Every two weeks  Monthly  Weekly  Twice a month  Other \_\_\_\_\_

Not regularly (for example, if this person works under a contract)

Name (first, middle, last & suffix): \_\_\_\_\_

Income Type: \_\_\_\_\_ How much? \$ \_\_\_\_\_

How often?

Yearly  Every two weeks  Monthly  Weekly  Twice a month  Other \_\_\_\_\_

Not regularly (for example, if this person works under a contract)

**Deductions – Only certain individuals are eligible to receive deductions.**

▶ If anyone in your household has pre-tax deductions from pay, tell us what kind. Deductions are amounts, listed on your tax return, that are subtracted from your income for certain expenses.

▶ You should not include expenses that members of your household subtracted from their self-employment gross income. Common deductions include student loan interest paid, contributions to individual retirement arrangements (IRAs), and contributions to health savings accounts (HSAs).

Name (first, middle, last & suffix): \_\_\_\_\_

Deduction Type \_\_\_\_\_ How much monthly? \$ \_\_\_\_\_

Name (first, middle, last & suffix): \_\_\_\_\_

Deduction Type \_\_\_\_\_ How much monthly? \$ \_\_\_\_\_



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## Information about resources and nursing facility care (you will only see information in this section if it currently applies to your household)

- ▶ This section refers to individuals who are 65 or older, blind, or disabled and/or receiving nursing care in a facility or in the home.
- ▶ Cross out wrong information. Write in new information and add anything that's missing.

**Resources include things like checking/savings accounts, stocks, bonds, life insurance, and retirement funds. Resources also include property, vehicles, annuities, and trusts.**

Owner	Resource	Amount
		\$
		\$
		\$

**If you or your spouse who lives with you are working, do either of you have expenses related to work?**

No  Yes *If yes, attach proof.*

Do you or your spouse or child have medical expenses not covered by Medicaid?

No  Yes *If yes, attach proof.*

Name of the nursing facility, state institution, or community-based care provider:

**Has this person or their spouse sold or given away any resources within the last year?**

No  Yes *If yes, fill out below.*

Resource Type	Value	Date Sold or Given Away
	\$	

If married or separated, spouse's name: Name (*first, middle, last & suffix*):

**Does this person's spouse have any home expenses? If yes, tell us below.**

Rent/Mortgage: \$ \_\_\_\_\_ Utilities  Yes  No  
 Homeowner's/Renter's Insurance: \$ \_\_\_\_\_ Real Estate Taxes: \$ \_\_\_\_\_  
 Maintenance Charges for Condominium: \$ \_\_\_\_\_

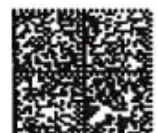
**Does this person's dependent(s) have any income? If yes, tell us below.**

Social Security: \$ \_\_\_\_\_ Social Security Income: \$ \_\_\_\_\_  
 Civil Service: \$ \_\_\_\_\_ Veterans Administration: \$ \_\_\_\_\_  
 Retirement/Pension: \$ \_\_\_\_\_ Disability: \$ \_\_\_\_\_  
 Wages: \$ \_\_\_\_\_ Other (Trusts, Stocks, Annuities, Dividends, Interest, etc.): \$ \_\_\_\_\_



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Case #: [Variable Data] Page 8 of 16 Correspondence #: [Variable Data]







## Sign the application

**Your rights and responsibilities:** Review the information below and sign the application.

- I know that I must tell my local Department of Social Services if anything changes and is different from what I wrote on this form. I can call 1-855-242-8282 (TTY: 1-888-221-1590), contact or visit my local agency, or visit **CommonHelp.Virginia.gov** to report any changes. A change in my information might affect whether someone in my household qualifies for coverage.
- I understand that if I do not qualify for health coverage, my local Department of Social Services may send my information to the Health Insurance Marketplace ([www.healthcare.gov](http://www.healthcare.gov)) to see if I qualify.
- I understand that I am authorizing the local Department of Social Service (LDSS) and the Department of Medical Assistance Services (DMAS) to obtain verification/information necessary to determine my eligibility for Medicaid or FAMIS.
- I have permission from everyone whose information is on this form to submit their information to Virginia Medicaid and to receive any communications about their eligibility and enrollment.

**Renewal of Coverage in Future Years:** Read the statements below and choose.

Giving the Virginia Medicaid program permission to use my federal tax return to confirm my income can make it easier to renew health coverage and may allow renewals to happen automatically. I understand that I can change my mind at any time by contacting my local Department of Social Services.

**I give permission to use updated income information from my tax returns for the next (check one):**

- 5 years  4 years  3 years  2 years  1 year  
 Do not use my tax information to renew coverage.

### Choose or Change Your Authorized Representative

To confirm or change your authorized representative, fill out **Appendix C**.

### Choose or Change Your Outreach Worker/Application Assister/Certified Application Counselor

To confirm or change your Certified Application Counselor/Navigator/Broker, fill out **Appendix C**.

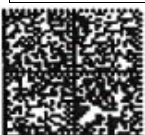


I am signing this renewal form (including any appendices) under penalty of perjury. I have provided true answers to all questions on this form and I know that I may be subject to penalties under federal law if I provide false or untrue information.

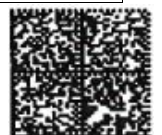
_____	_____
<b>Signature of Household Contact or Authorized Representative</b>	<b>Date</b>

**ALL individuals in the home 21 or older (or 18 or older in a home without a parent) who are renewing or applying for health coverage MUST sign below. A spouse can sign for their spouse.**

Print Name	Signature	Date



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).



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**Appendix A -  
Renewal**

**Complete ONLY if someone in your household is eligible for  
new health coverage from a job**

- ▶ Tell us about the job that offers coverage for your household.
- ▶ Take the Employer Coverage Tool on the back of this page to the employer who offers the coverage to help you answer these questions.
- ▶ If more than one person has coverage offered through a job, make a copy of this page.

**Employee Information**

**Employee name** (*first, middle, last & suffix*)

**Employee Social Security number**

**Employer Information**

**Employer name**

**Employer identification number**

**Employer address**

**Employer phone number**

**City**

**State**

**Zip Code**

Name and title of person who can be contacted about employee health coverage at this job

**Name**

**Title**

**Phone number**

**Email address**

If you are currently eligible for coverage offered by this employer, or will become eligible in the next 3 months fill in the information below:

If in a waiting or probationary period, what date can you enroll in coverage? \_\_\_\_\_  
(mm/dd/yyyy)

List the name of anyone else who is eligible for coverage from this job

**Name** (first, middle, last & suffix)

**Name** (first, middle, last & suffix)

**Tell us about the health plan offered by this employer**

Does the employer offer a health plan that meets the minimum value standard\*?  Yes  No

For the lowest-cost plan that meets the minimum value standard offered only to the employee (don't include family plans) provide the premium that the employee would pay is the maximum discount was received for any tobacco cessation without any other discounts. \$

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

What changes will the employer make for the new plan year (if known)?

Health coverage will not be offered

Employer will offer or change health coverage for the lowest-cost plan available to the employee that meets the minimum value standard\*.



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Employee premium cost \$ \_\_\_\_\_ Date of change \_\_\_\_\_  
(mm/dd/yyyy)

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

## Employer Coverage Tool

This section should be completed by the employer to help answer questions about any employer health coverage that you are eligible for (even if it is from another person's job, like a parent or a spouse).

Is the employee currently eligible for coverage or will the employee be eligible in the next three months?  Yes  No *(If yes, write in information below. If no, stop and return form to employee.)*

If in a waiting or probationary period, when can the employee enroll in coverage? \_\_\_\_\_  
(mm/dd/yyyy)

Does the employer offer a health plan that covers an employee's spouse or dependent?  Yes  No  
If yes, which people?  Spouse  Dependents

### Tell us about the health plan offered by this employer

Does the employer offer a health plan that meets the minimum value standard\*?  Yes  No  
*(If yes, please complete the information below. If no, stop and return form to employee.)*

For the lowest-cost plan that meets the minimum value standard offered only to the employee (don't include family plans) provide the premium that the employee would pay is the maximum discount was received for any tobacco cessation without any other discounts. \$

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

**If the plan year will end soon and you know that the health plans offered will change, write in the information below. If you do not know, stop and return form to the employee.**

Health coverage will not be offered  Employer will offer or change health coverage for the lowest-cost plan available to the employee that meets the minimum value standard\*.

Employee premium cost \$ \_\_\_\_\_ Date of change \_\_\_\_\_  
*(Premium should reflect the discount for the wellness program.)* (mm/dd/yyyy)

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

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



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**Complete ONLY if someone in your household is an  
American Indian or Alaska Native**

- ▶ Tell us about your American Indian or Alaska Native family member(s).
- ▶ American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They may not have to pay co-pays and may get special monthly enrollment periods.
- ▶ If more than two people are American Indian or Alaska Native, make a copy of this page.

**1. Name (first, middle, last & suffix):**

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program?  Yes  No

If no, does this person qualify to get these services?  Yes  No

List any income that includes money from these sources: <ul style="list-style-type: none"> <li>· Payments from a tribe for natural resources, usage rights, leases, or royalties.</li> <li>· Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).</li> <li>· Money from selling things that have cultural significance.</li> </ul>	How much \$ income?
	How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Not regularly (for example, if this person works under a contract) <input type="checkbox"/> Other _____

**2. Name (first, middle, last & suffix):**

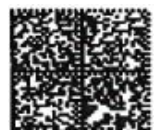
Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program?  Yes  No

If no, does this person qualify to get these services?  Yes  No

List any income that includes money from these sources: <ul style="list-style-type: none"> <li>· Payments from a tribe for natural resources, usage rights, leases, or royalties.</li> <li>· Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).</li> <li>· Money from selling things that have cultural significance.</li> </ul>	How much \$ income?
	How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Twice a month <input type="checkbox"/> Every two weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Not regularly (for example, if this person works under a contract) <input type="checkbox"/> Other _____



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).



**Appendix C -  
Renewal**

**Complete ONLY if you are choosing someone to help with  
your application**

- ▶ An authorized representative is a trusted friend, partner, or lawyer you choose to sign your renewal form, get information about this renewal form, and act for you with this agency.
- ▶ If we have an authorized representative on file for you, their information is shown below in section one. Review the information. Write in any changes to the information.
- ▶ If you want to name an authorized representative, complete section 2 below. Make a copy of this page if you need additional space or if you need to add an additional authorized representative.

1. If you have an authorized representative on file, their name is shown below. Complete this section to confirm this information is still correct.

We show this person is your authorized representative:

Do you still want this person to be your representative?  Yes  No

*If yes*, has any information changed?  Yes  No

2. If your authorized representative's information has changed, or if you would like to name a new or different authorized representative, write in the information below.

Name of authorized representative and/or organization:

Address: City State Zip code

Phone number: Phone Type:  Home  Cell  Work  Other

Relationship to Applicant:

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

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

**Your Signature (person applying or renewing for coverage):**

**Date:**

**You can choose one Outreach Worker/Application Assister/Certified Application Counselor/  
Navigator/Broker**

- ▶ Complete this section to authorize a certified application counselor/navigator/broker to be able to access confidential information related to your health coverage case.
- ▶ If we have a person/organization on file for you, the information name is shown below. If you want to add/change your certified application counselor /navigator/broker, write in the information below.

Outreach Worker/Application Assister/Certified Application Counselor/Navigator/Broker name and name of organization:

ID Number (if applicable):

Do you still want this person to be your Outreach Worker/Application Assister/Certified Application Counselor/Navigator/Broker?  Yes  No If yes, has any information changed?  Yes  No

Write in any new information below:



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).



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**Complete ONLY for someone who is now applying for health coverage from Virginia Medicaid or whose circumstances may have changed.**

**Section 1:**

- ▶ Fill out this page for people who are listed in Section 3 who are **applying for Medicaid or whose circumstances have changed.**
- ▶ Make a copy first if you need space for more people.

**Tell us about this person’s citizenship or immigration status.**

Name *(first, middle, last & suffix)*

Date of Birth:

Social Security Number:

Is this person a U.S. citizen or U.S. national?  Yes  No **If yes,** go to number 2. **If no,** answer all of the questions below.

Document type	Alien or I-94 number	Card or foreign passport number
---------------	----------------------	---------------------------------

Visit [www.coverva.org](http://www.coverva.org) for more information about eligible immigration status and document types.

- Check here if this person has arrived in the U.S. before 1996.
- Check here if this person, their spouse, or parent is a veteran or active duty member in the U.S. military.

**2. Tell us more about this person.**

- Check here if this person lives with and is the main person taking care of a child under the age of 19.
- Check here if this person wants help paying for medical bills from the last three months.
- Check here if this person was in foster care at age 18 or older and had Medicaid health coverage.

If this person is Hispanic/Latino, check all that apply. *You do not have to answer this question to be eligible for Medicaid.*

- Chincano/a
- Cuban
- Mexican
- Mexican American
- Puerto Rican
- Non-Hispanic/Uknown

What is this person’s race? Check all that apply. *You may choose not to answer this question. You do not have to answer this question to be eligible for Medicaid.*

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



**STOP! Continue to Section 2 ONLY if someone in your household who is 65 or older, blind, or disabled.**



You can get this letter in another language, in large print, or in another way that’s best for you. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).



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**Section 2: Complete ONLY if someone in your household who is 65 or older, blind, or disabled.**

**1. Person's Name**

**2. What resources does this person or their spouse have? Resources include things like checking/savings accounts, stocks, bonds, life insurance, and retirement funds.**

Resource	Amount
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____



**STOP! Continue to Section 3 ONLY if someone in your home is receiving care in a nursing facility or in the home by a medical professional.**

**Section 3: Complete ONLY for someone in your household who is in a nursing facility or receiving nursing care in the home.**

Name of the nursing facility, state institution, or community-based care provider: \_\_\_\_\_

If married or separated, spouse's name: Name *(first, middle, last & suffix)*: \_\_\_\_\_

**Does this person's spouse have any home expenses? If yes, tell us below.**

Rent/Mortgage: \$ \_\_\_\_\_ Utilities  Yes  No  
 Homeowner's/Renter's Insurance: \$ \_\_\_\_\_ Real Estate Taxes: \$ \_\_\_\_\_  
 Maintenance Charges for Condominium: \$ \_\_\_\_\_

**Does this person's dependent(s) have any income? If yes, tell us below.**

Social Security: \$ \_\_\_\_\_ Social Security Income: \$ \_\_\_\_\_  
 Civil Service: \$ \_\_\_\_\_ Veterans Administration: \$ \_\_\_\_\_  
 Retirement/Pension: \$ \_\_\_\_\_ Disability: \$ \_\_\_\_\_  
 Wages: \$ \_\_\_\_\_ Other (Trusts, Stocks, Annuities, Dividends, Interest, etc.): \$ \_\_\_\_\_

**Has this person or their spouse transferred any real or personal property within the last year?**

No  Yes *If yes*, fill out below.

Property Transferred	Value of Transfer	Date of Transfer
_____	\$ _____	_____

**Any household members who are 18 or older and not living with a parent or who are 21 and older and are now applying for coverage must also sign Section 7 of this renewal form.**



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).



**Section I: Voter Registration**

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

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

No, I do not want to register to vote.

- IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME. Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency.
- If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes.
- If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

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

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

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To register to vote visit: <https://vote.elections.virginia.gov> or call or go to your local agency to request a paper voter registration form. If you need help completing the form, visit your local agency.

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**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, national origin, age, disability, or sex. 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>.



You can get this letter in another language, in large print, or in another way that's best for you. Call us at **1-855-242-8282** (TTY: 1-888-221-1590).



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