




Section 2 and Handout

Module 5: Appendix D

68

Appendix D – Required Supplement for Aged, Blind, or Disabled

APPENDIX D

Complete Appendix D if you are applying for Health Care Coverage for:

- someone who has disabilities
- someone age 65 years or over
- all people, including children, in need of Long-term Care Services (nursing facility or community based care)
- someone who is medically needy (has income greater than Medicaid limit and would like to be evaluated based on their income, resources and medical expenses) - Spenddown

What is Appendix D Used For?
Appendix D gathers additional information needed to determine your eligibility for Health Care Coverage.

Appendix D is not a stand-alone application. You must also complete the Application for Health Coverage and Help Paying Costs and submit Appendix D with the application.

If completing Appendix D for someone else, please answer the questions for that person.

Section 2; Handout

69

Appendix D – Section 1: Household Information

SECTION 1 Household Information

1. Are You? Married Never married Divorced Widowed Separated

2. Has anyone in your household ever applied for or received any Health Care Coverage from a social service agency in another state or Virginia city or county?
 Yes No
— If yes, please indicate which state or Virginia city or county below:

3. Is anyone in your household temporarily away from home? Yes No
— If yes, please provide the following information:

4. Are you or is anyone for whom you are applying disabled? Yes No
— If yes, please provide the name of the persons:

Section 2; Handout

70

Appendix D – Section 1: Household Information

5. Have you or anyone for whom you are applying ever applied for Social Security, Supplemental Security Income (SSI) or Railroad Retirement benefits as a disabled person? Yes No
— If yes, please provide the name of the persons and date of application:

6. Have you or anyone in your household for whom you are applying been approved for disability for Social Security, SSI, Railroad Retirement or Medicaid purposes? Yes No
— If yes, please provide the name of the individual:

7. If the application for Social Security, SSI or Railroad Retirement benefits was denied, did you file an appeal of the denial? Yes No
— If yes, please tell us the outcome of the appeal:

8. Has it been less than 12 months since the most recent application for Social Security, SSI or Railroad Retirement benefits was denied? Yes No

9. Has the condition changed or worsened since the most recent application for disability was denied? Yes No

10. Do you or anyone for whom you are applying have a new medical condition since the most recent application for disability was denied? Yes No

Section 2; Handout

71

Appendix D – Section 1: Household Information

11. Have you or anyone for whom you are applying ever received SSI, disability benefits from the Social Security Administration or Auxiliary Grant payments? Yes No
Has the payment stopped? Yes No
— If yes, explain whose payment stopped, when it stopped, and why it stopped.

Explain:

📌 Screening for eligibility under the “protected cases” categories

Section 2; Handout

72

Appendix D – Section 2

SECTION 2 Long-term Care

Answer questions 12-14 if you are applying for anyone who is in a nursing facility or assisted living facility, or who requires nursing home care or assistance to remain in the home

12. Do you or anyone for whom you are applying need nursing facility care or help such as bathing, dressing, toileting, etc., so that you can remain in your own home? Yes No
— If yes, and there is a spouse who lives somewhere else, what is the name and address of the spouse? (Note: Under Virginia law persons are considered married and legally responsible for each other until they divorce)

13. Do you or anyone for whom you are applying live in one of the following?
 Assisted Living Facility (ALF) Nursing Facility Group Home Hospital or other Medical Facility
— If you checked one of the above, please provide the following information:

Name	Date of Entry	In what County was the prior address?
Person's address prior to entering the facility		
Facility Name	Facility Address	
Was Placement made by a State agency? <input type="checkbox"/> Yes <input type="checkbox"/> No		

73

Appendix D – Section 2: Long-Term Services and Supports

14. Does the individual in the nursing facility or requiring assistance in the home have long-term care insurance? Yes No — If yes, please provide the following information:

Name of Insurance Company	Address	City, State, ZIP
Policy Number	Person(s) Insured	Is this a Partnership Policy? <input type="checkbox"/> Yes <input type="checkbox"/> No

15. Have you or your spouse sold, transferred, placed in a trust/annuity, or given away any resources, such as your home or other real property, cash, bank accounts, or cars in the last sixty (60) months (5 years)? Yes No — If yes, please provide the following information:

Type of Property Transferred	Value at Transfer \$	Amount Received \$	Date of Transfer
From Whom	To Whom		
Explain the Reason for Transfer			

Note: If more than one transfer has occurred, please attach documentation of each transfer. **Section 2; Handout**

74

Appendix D – Section 3: Assets and Resources

SECTION 3 Resources and Assets

16. Do you or your spouse have any money/cash on hand that is not in the bank? Yes No — If yes, please provide the following information:

17. Do you or your spouse have any of the following resources? Yes No — If yes, please check the boxes that apply and provide the information requested below:

Checking, Savings Deferred Compensation Plan Christmas Club
 Credit Union Certificate of Deposit (CD) Money Market Funds

1. Owner Name		Co-Owner Name	
Name of Bank	Account Type	Account Number	Balance/Value \$

Is your income (Social Security or SSI benefits, retirement pension, wages, etc.) deposited directly into any of the accounts? Yes No If yes, which account? _____

Section 2; Handout

75

Appendix D – Section 3: Assets and Resources

19. Do you or your spouse have any life insurance? Yes No — If yes, please provide the following information:

1. Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	Policy Number	Face Value \$	Cash Value \$

20. Do you or your spouse have burial plots, burial arrangements, or trust funds for burial? Yes No — If yes, please provide the following information:

Section 2; Handout

76

Appendix D – Section 3: Assets and Resources

21. Do you or your spouse have real property, including home property, life rights/estates, shares in undivided heir property, land, buildings, or mobile homes? Yes No
— If yes, please provide the following information:

Owner(s)	Type of Property/Number of Acres	Value/Amount Owned \$
Do you live on this property? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this property currently for sale? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is this property rented? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you received money from this property <input type="checkbox"/> Yes <input type="checkbox"/> No

22. Do you or your spouse have any licensed or unlicensed cars, trucks, vans, boats, motors homes, recreational vehicles, utility trailers, motorcycles, or mopeds? Yes No
— If yes, please provide the following information:

Owner(s)	Year-Make-Model	Value/Amount Owned \$
Owner(s)	Year-Make-Model	Value/Amount Owned \$
Owner(s)	Year-Make Model	Value/Amount Owned \$

77

Appendix D – Section 4: Other Income

25. Do you receive child support? Yes No
— If yes, please provide the following information:

Amount \$	How Often?	Is the payment for past-due child support payments? <input type="checkbox"/> Yes <input type="checkbox"/> No

26. Do you receive Veteran's Administration benefits? Yes No
— If yes, please provide the following information:

Amount \$	How Often?	Type

27. Does anyone help you pay, or lend you money to pay rent, utilities, medical bills, or any other bills? Yes No
— If yes, please provide the following information:

Section 2; Handout

78

How Long Does it Take to Process an Application?



- Maximum 45-calendar-day processing time for most applicants
- If a state Disability Determination Services (DDS) disability determination is needed, the processing time is extended to 90 calendar days.
 - Local DSS will send applicant a *Notice of Action* letting him/her know that additional processing time is needed.
 - Expedited processing (*as little as 7 days*) is available for a hospitalized individual who needs both Medicaid and a DDS disability determination.

Section 2

79

What if the Case is **DENIED**?

- The applicant will get a *Notice of Action* from the state showing:
 - Reason for the **denial**, with a **code section citation** from the Medicaid manual.
- If someone **meets the resource limit** for a program, but is **over the income limit**, the person will also receive a **notice of his/her Spenddown Amount and Budget Period**.
- If the applicant doesn't **agree/understand** and **if fewer than 10 business days have passed** since the *Notice of Action*, s/he should contact the LDSS and **ask to speak to the worker** who denied the case. If an error is discovered, case **decision** can be **revised on the spot**.
- Applicant has the right to **Appeal** (written form submitted to DMAS) within 30 days of the *Notice of Action*.

Section 2
