After Enrollment

Part I: Full Benefit ABD Covered Groups

Part II: Medicare Savings Plans

Part III: Spenddown

Part IV: Long Term Services and Supports (LTSS)

Part V: MEDICAID WORKS

Part VI: Sample Forms

PART I: Full Benefit ABD Covered Groups

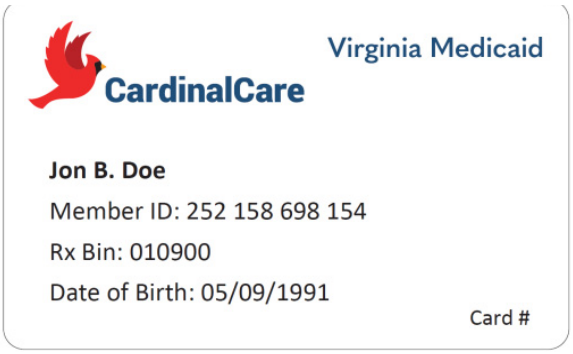
Once Approved

An individual approved for a Full Benefit covered group (e.g., ABD ≤80% FPL; 300% of SSI; SSI recipient; Auxiliary Grant) will receive a *Notice of Action on Benefits* stating that s/he 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 Cardinal Care 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/

Cardinal Care ID Card Front



Back

Selecting a Provider

In Virginia, full benefit ABD Medicaid 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 was formerly called the Commonwealth Coordinated Care Plus (CCC+) program. This name has been phased out with the onset of the Cardinal Care program. Five MCOs deliver the services covered under Cardinal Care:

- Aetna Better Health of Virginia
  1-800-279-1878
- Anthem HealthKeepers Plus
  1-800-901-0020
- Humana Healthy Horizons (start 7/1/25)
  1-844-881-4482
- Sentara Health Plans
  1-800-881-2166
  Northern VA Kaiser Permanente
  Members: 1-855-249-5025
- UnitedHealthcare Community Plan
  1-844-752-9434

The member will receive a letter from DMAS about the managed care enrollment process. S/he will be directed to www.virginiamanagedcare.com to review the Health Plan added benefits which vary by MCO (see Page 4.8 for a sample of these benefits). Depending on a member's situation or health needs, one plan may suit him/her better than another. On the website there is also a "consumer decision support tool" to help with the choice.

The letter directs the person **to call the Enrollment HelpLine** at **(800) 643-2273** [TTY: (800) 817-6608] Monday through Friday between 8:30AM and 6PM to choose a MCO **by the due date indicated or s/he will be assigned to the MCO listed in the letter.** The member can also go online to make the selection or do it through an app downloaded to his/her phone. *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 regional MCO "Open Enrollment Period" in his/her area or with special approval from DMAS ("good cause"). Regional open enrollment dates can be found here: www.virginiamanagedcare.com/learn/open-enrollment.

Cardinal Care allows 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 a Cardinal Care MCO.** 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 his/her MCO's network. Care coordination is available upon the member's request. 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, including if additional time is needed to ensure a safe and effective transition to a provider in the Cardinal Care MCO network.

Using the DMAS/Cardinal Care ID Card and the MCO Health Insurance Card

Upon receipt of the Cardinal Care 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 his/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.

If a member's **DMAS/Cardinal Care ID card is lost or stolen, s/he should report the loss or theft 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 Cardinal Care Medicaid 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.

Those enrolling in Medicaid as ABD have access to a **care coordinator**, who can help make sure the enrollee receives needed health services. To access additional care coordination, the member may be asked to complete 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.

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, including dentures
- And more!

(For a more detailed listing of covered benefits refer to the Medical Assistance Handbook *pages 16-32 available at https://coverva.dmas.virginia.gov/members/member-handbooks/ and/or the information received from the member's MCO about covered benefits.)*

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 applicant 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 LDSS 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 4.35-4.56*)

Eligibility for this coverage must be renewed every 12 months. Approximately **45 days prior to the enrollee's renewal month**, s/he will be **sent a 20+ page renewal form pre-populated with his/her case information**. If a person has indicated another language as his/her primary language, the pre-populated form should be sent in his/her preferred language, if 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 complete the renewal over the phone or if they have associated their Medicaid case with their CommonHelp login information, they can click on the link in CommonHelp to "Renew My Benefits" and complete the renewal online. Instructions on how to associate/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 member 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 retroactive to the date the coverage was terminated**. 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 4.33-4.34*)

Managed Care Enrollment - Full Benefit ABD Categories

A letter is sent from DMAS giving approximately **30 days** for the individual to choose a MCO. In it s/he is advised to review the health plan added benefits and consumer descision support tool on www.virginiamanagedcare.com. S/he is told that if they do not call the Enrollment HelpLine, or go to the website to choose a MCO, the MCO listed in the letter will be assigned to them.

Did the enrollee contact the Enrollment 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 Enrollment HelpLine and **change to a different MCO**. After that they can only change during the regional annual "Managed Care Open Enrollment" in their region or by contacting DMAS and providing "good cause" to change.

179-STAFFORD DSS
P.O. BOX 7
STAFFORD, VA 22555

<Date>

<CASE NAME>
<ADDRESS>
<CITY><STATE><ZIP>

MCF412A_
Case ID: xxx-xxxxxx-xxx

Dear Member,

Welcome to Cardinal Care, Virginia's Medicaid Program.
This letter tells how you will get your medical care in the Medicaid program. You and/or your family members will get health care coverage through a health plan starting <Date>.

A health plan is a group of doctors, hospitals, and specialists. They work together to give you the care you need. We chose a health plan for the members below.

You have the right to choose a different health plan
If you want to keep the health plan we chose, you do not need to do anything. Or you can choose a new health plan. You do not have to choose the same health plan for all family members.

Make health plan changes by <Date>.
Or you will have to wait until the next open enrollment period to change your health plan.

How to choose a health plan
1. Review the health plan added benefits at **www.virginiamanagedcare.com.**
2. Make a list of all your health care providers and places you get care. Include hospitals, doctors, specialists, pharmacies, and therapists.
3. To find out which health plans work with your providers, or to change your health plan:
   - Go to **www.virginiamanagedcare.com**.
   - Or call the Managed Care Helpline at **1-800-643-2273** (TTY: 1-800-817-6608). We are open Monday through Friday, 8:30 a.m. to 6:00 p.m. Interpreter services are free.
   - Or download the free **Virginia Managed Care App** on your Android or iPhone to compare health plans, find a provider and change your health plan. Search **Virginia Managed Care** on Google Play or the App Store.

Your new health plan will send you a welcome packet and member ID card
They will also call you. Be sure to show your member ID card **and** your Medicaid ID card each time you get care.

Get Healthy! The quickest way to help Virginia get back to normal is to make sure you and your family get vaccinated. Please contact your managed care organization for information on how and where to get you and your family vaccinated against COVID-19.

Name	**Recipient ID**	**Health plan**
<Recipient Name>	<12-Digit Recipient ID #>	<MCO Plan>

Sample MCO Added Benefits

CardinalCare
Virginia's Medicaid Program

Compare health plans

Read the **added benefits** that each health plan offers. Members should call the health plan to learn more.
For questions, call us toll free at **1-800-643-2273** (TTY: 1-800-817-6608).

aetna

Aetna Better Health® of Virginia

1-800-279-1878 | TTY: 711
AetnaBetterHealth.com/Virginia

Adult vision and hearing
- 1 eye exam, $125 for glasses or contacts per year
- 1 hearing exam, $1,500 for hearing aids, 60 batteries per year

Healthy moms and kids
- 300 free diapers, virtual baby showers, portable cribs, $25 monthly for mom and baby
- Free swim lessons, sports physicals
- 24/7 lactation and doula support
- $20 monthly for period products
- $200 for youth activities and sports

Phone and online tools
- Free smartphone, with unlimited minutes, text, and 5 GB data

Wellness programs
- Weight management program
- $50 monthly for groceries for members who qualify ($600 per year)

Other benefits
- 15 free round-trip rides per year
- 14 meals after hospital stay
- GED certificate incentive, plus extra $500 for higher ed, trade, or military
- Free mattress cover, pillowcase and $150-$400 per year for carpet cleaning for asthma
- $250 for ESL classes
- $300 for legal supports

Anthem HealthKeepers

1-800-901-0020 | TTY: 711
anthem.com/vamedicaid

Adult vision and hearing
- 1 eye exam, up to $200 for glasses or contacts per year
- Adult hearing exam, $2,000 for hearing aids, 60 batteries per year

Healthy moms and kids
- Up to $300 gift card for baby items (diapers, car seat, and more)
- $100 gift card for youth club membership
- $35 Barnes & Noble card for books
- $400 for period products

Phone and online tools
- Free smartphone, with unlimited minutes, text, and data

Wellness programs
- $120 for Weight Watchers (WW)®
- 24/7 doctor video visits
- $400 healthy grocery gift card
- Mental health programs

Other benefits
- 24 round-trip non-medical rides
- 56 meals after hospital stay
- $120 in GED testing vouchers
- 2 items from Healthy Lifestyle Aids catalog (BP cuff, scale, reacher, etc.)
- 1 item from Asthma/COPD Catalog
- $400 for over-the-counter supplies
- $100 for employment support

Humana

Healthy Horizons in Virginia

1-844-881-4482 | TTY: 711
humana.com/HealthyVirginia

Adult vision and hearing
- 1 eye exam, up to $150 for glasses or contacts per year
- 1 hearing exam per year, hearing aids every 3 years, 60 batteries per year

Healthy moms and kids
- Up to $125 in maternal care rewards
- Convertible car seat or portable crib
- 4 boxes of produce for pregnant moms
- $160 per year for childcare
- $250 for youth activities
- Free yearly sports physicals
- $40 for haircuts for kids, ages 5-20

Phone and online tools
- Free smartphone with unlimited minutes, text, 10 GB data monthly
- 24/7 doctor video visits
- Echo Dot® for dementia support

Wellness programs
- Weight management and financial coaching

Other benefits
- Up to $95 for health plan onboarding activities
- $65 per quarter for OTC supplies
- 30 free round-trip rides per year
- Up to 56 meals delivered to home after hospital stay
- Virtual GED test prep assistance
- Fall prevention kit

Sentara

1-800-881-2166 | TTY: 711
Northern VA Kaiser Permanente members: **1-855-249-5025**
SentaraHealthPlans.com/members/medicaid

Adult vision and hearing
- 1 eye exam, $100 for frames per year
- 1 hearing exam, fitting, and up to $2,000 for hearing aids per year

Healthy moms and kids
- 400 free diapers
- Grocery card for pregnant moms
- Free yearly sports physicals
- $20 quarterly for period products
- Free baby monitor, sleep sack, or pack-n-play (restrictions apply)

Phone and online tools
- Up to $25 for iPad or tablet cover (restrictions apply)

Wellness programs
- Up to $50 wellness rewards
- Weight management

Other benefits
- 24 free round-trip non-medical rides
- 56 meals after hospital stay
- Up to $275 for GED prep, test
- Up to $75 for college application help (restrictions apply)
- Free mattress cover, pillowcase for asthma and COPD
- $30 quarterly for adult incontinence products
- 24 free round-trip rides for LTSS caregivers (restrictions apply)

UnitedHealthcare

1-844-752-9434 | TTY: 711
uhccp.com/virginia

Adult vision and hearing
- 1 eye exam per year, glasses 2 years

Healthy moms and kids
- Up to $100 in maternal health rewards
- Up to 500 free diapers for new moms
- Meals sent home after delivery
- Free period underwear
- Up to $100 vaccine incentives at Footlocker® or Walmart® up to age 18
- Free Boys & Girls Club membership
- Free yearly sports physicals

Phone and online tools
- Low-cost smartphone with 3000 mins, unlimited texts, 4.5 GB data monthly
- Self Care® app for mental health
- 24/7 doctor video visits

Wellness programs
- Free gym membership to 300+ gyms & YMCAs; free virtual fitness options
- 13 Weight Watchers (WW)® vouchers
- Up to $50 healthy rewards

Other benefits
- 12 free round-trip rides to places of worship, grocery, DMV, DSS, library
- 14 meals after hospital stay
- Unlimited support to get GED, ages 18+
- Housing application reimbursement
- Mattress cover & pillowcase for asthma

VA CARD CARE COMP CHART ENG 0525

Virginia Medicaid Dental Coverage

CardinalCare Smiles
Improving Dental Care in Virginia for Children and Adults

WHAT IS CARDINAL CARE SMILES?

Cardinal Care Smiles (CCS) is Virginia's Medicaid and FAMIS dental program for adults and children. The Cardinal Care Smiles 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 MY CARDINAL CARE SMILES INSURANCE?

There are no costs or co-payments for dental care services in the CCS 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.

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

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 for [NAME]" 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)**, **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 for generics and higher prices for brand names, 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 all 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 all 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 Cardinal Care cards since they receive their health care services through Medicare providers.

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 4.13-4.16.

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 the Qualified Medicare Beneficiary (QMB) group. **Coverage under QMB always starts the month after** the approval action. (*For example, if the QMB application is submitted in January, but not approved until February, coverage will start in March.*)

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?" on the Application.

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 LDSS 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 4.35-4.56*)

Eligibility for the MSPs must be **renewed every 12 months**. Approximately **45 days prior to the renewal month**, the enrollee will be **sent a 20+ page renewal form pre-populated with his/her case information**. If a person has indicated another language as his/her primary language, the pre-populated form should be in his/her preferred language, if available. Virginia has translated the renewal form into Spanish, Amharic, Arabic, Urdu, and Vietnamese.

Enrollees have until the due date listed on the form **(the date is located in the big blue circle on the first page)** 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 prepaid envelope provided) or hand-deliver it to the local DSS. Once the preprinted form is received, enrollees can also complete it by calling Cover Virginia to complete the renewal over the phone with a Customer Service Representative there or if they have associated their Medicaid case with their CommonHelp login information, they can click on the link in CommonHelp to "Renew My Benefits" and complete the renewal online. Instructions on how to associate/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 verification 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 renewal form with any needed verification documents and, if found eligible, coverage can be reinstated retroactive to the date the coverage was terminated**. 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 4.33-4.34 for a sample cancellation notice.)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, MD 21244-1850

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

<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 <Coverage Year>. **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.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Product No. 11166 – PURPLE
December 2024

***"Extra Help" Notice* 4.13**

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.
- 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.
- 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).

العربية (Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برق1-800-MEDICARE (رقم هاتف الصم والبكم: 877-486-2048-1).

հայերեն (Armenian) ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-MEDICARE (TTY (հեռատիպ)՝ 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).

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 an applicant is ineligible for full benefit ABD Medicaid due to his/her income, but meets the countable resource limit and all nonfinancial requirements for a full benefit covered group, s/he should receive a *Notice of Action* that **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, sometimes called a "spenddown liability") 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 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 pages 2.31 and 2.34-2.35.)

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. A sample of the Medicaid Spenddown Record can be found on page 2.35)*

Once the individual **incurs or owes an amount equal to or greater than the amount of the Spenddown and reports it to the local DSS, 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: Group III has the highest income limits and Group I the lowest. Virginia's localities are divided amongst these groups.

ABD Medically Needy Income Limits (MNIL)
Effective July 1, 2025

Assistance Unit Size	Group I		Group II		Group III	
	Monthly	6-Month	Monthly	6-Month	Monthly	6-Months
1	$410.05	$2,460.34	$473.14	$2,838.87	$615.08	$3,690.53
2	$522.01	$3,132.06	$582.55	$3,495.33	$741.53	$4,449.18

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 5.35 for how spenddown is calculated.

Once Approved

Once the person meets his/her spenddown, s/he is enrolled in Medicaid, and will receive a Cardinal Care 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 Cardinal Care ID Card

Upon receipt of the Cardinal Care 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 a member's Cardinal Care/DMAS ID Card **is lost or stolen**, s/he should **report its loss or theft 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 Cardinal Care/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 Cardinal Care/DMAS ID card. If s/he qualifies for Medicaid in the future, this card may 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, including dentures
- And more!

(For a more detailed listing of covered benefits refer to the Medical Assistance Handbook *pages 16-32 available at https://coverva.dmas.virginia.gov/members/member-handbooks/)*

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 screening to confirm that s/he has needs that meet a level of care required for Medicaid to pay for LTSS.** The LTSS 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 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 screening. A Community Services Board (CSB) may also complete someone's 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, getting on/off the toilet, cleaning oneself, managing clothes and flushing.
- **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 2025 is $40/month**. **For Community-Based Care, the PMA in 2025 is $1,596/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 (60 months).** 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 trigger this transfer of asset penalty depending on the circumstances or if the Medicaid program determines a disqualification from payment for LTSS would cause an undue hardship. Inappropriate transfers occurring after enrollment in Medicaid may also result in a disqualification period from receiving payment for 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 initially.

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 64 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 $1,801/month ($2,434 for a couple)
- 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 4.27)

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 $75,000 per year and can have resources in their WIN account of up to $59,755 (effective January 1, 2025).

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 eligibility for 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 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 without an additional medical screening. 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.*** 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 $59,755 (effective January 1, 2025).

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.

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

Medicaid Works is a program of the Commonwealth of Virginia
MedWorks Flyer 0125 EN

MEDICAID WORKS

VIRGINIA'S MEDICAID WORK INCENTIVE PROGRAM FOR DISABLED INDIVIDUALS

MEDICAID WORKS is a work incentive opportunity offered by the Virginia Medicaid program for individuals with disabilities who are employed or who want to go to work. ***MEDICAID WORKS*** is a Medicaid plan option that will enable workers with disabilities to earn higher income and retain more in savings, or resources, while ensuring continued Medicaid coverage. This voluntary plan option will allow enrollees to earn up to $75,000 and save up to $59,755 (effective January 1, 2025) of their earnings.

MEDICAID WORKS is available to current and new Medicaid enrollees who are blind or disabled, have total countable income of no more than $1,801 per month for an individual or $2,434 for a couple and resources of no more than $2,000 if single ($3,000 if a couple).

Individuals with disabilities who meet the eligibility requirements for this work incentive plan may choose to enroll in ***MEDICAID WORKS*** if they:

- ✓ Complete the ***MEDICAID WORKS*** **Agreement**;
- ✓ Are employed or have documentation from an employer establishing the date when employment will begin;
- ✓ Are at least 16 years of age and less than 65 years of age;
- ✓ Establish a "Work Incentive" (WIN) account (a regular checking or savings account) at a bank or other financial institution to deposit earned income, which can be used as needed, and to keep financial resources in order to remain eligible for Medicaid;

To apply for ***MEDICAID WORKS***, contact the local Department of Social Services in the city or county where you live.

Medicaid Works is a program of the Commonwealth of Virginia *MedWorks Flyer 0125 EN*

CardinalCare Virginia's Medicaid Program

VIRGINIA'S MEDICAID PROGRAM DMAS

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

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

Letter Date: February 15, 2023
Case Number: 114483443

Secret Service
564561 Protection PL
Lynchburg, VA 24515

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)
Secret Service	Eligible	FULL	July 01, 2022 - Ongoing
Lip Service	Eligible	LIMITED	March 01, 2023 - Ongoing
Lip Service	Closed	FULL	February 28, 2023

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

Note: *Several pages of this notice have been omitted because they can be viewed in Section 2.*
Page 5 included the case worker name and phone number and any additional information on the case, an example can be seen on Page 2.32.
Page 6 was the "If You Think We Made a Mistake" section shown on Page 2.33.
Page 7 was the "It is important we treat you fairly" section that can be seen on Page 2.25.
Page 8 was blank.
Page 9 was the "What is Medicaid Spenddown" and Page 10 was the Medicaid Spenddown Record that are on Pages 2.34-2.35.
Pages 11-12 contained information on how to get help in other languages that can be seen on Pages 2.27-2.28.

How we made our Medicaid decision(s)

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

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

Approvals

Update for Secret Service — Client ID: 2106565828

You qualify for health coverage from Virginia Medicaid.

Medicaid ID Number	Coverage	Effective Date
351265671010	**FULL**	**July 01, 2022 - Ongoing**

Secret Service qualifies for full coverage Medicaid. This covers services like doctor visits, hospital care, prescriptions, dental coverage and more.

Health Coverage must be renewed every year. The next renewal is due **February 29, 2024.** If you are receiving health coverage at that time, we will send more information about your renewal.

Update for Lip Service — Client ID: 2106565829

You qualify for health coverage from Virginia Medicaid.

Medicaid ID Number	Coverage	Effective Date
351264209011	**LIMITED**	**March 01, 2023 - Ongoing**

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

Health Coverage must be renewed every year. The next renewal is due **February 29, 2024.** If you are receiving health coverage at that time, we will send more information about your renewal.

Additional information on how we made our decisions:

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

Using Your Health Coverage

Medicaid Card

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

Finding Services

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

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

Closures

Update for Lip Service — Client ID: 2106565829
February 28, 2023

There is a change in your health coverage from Virginia Medicaid.

There is a change to your health coverage from Virginia Medicaid because rules for the current coverage are not met. We made our decisions based on these rules: Virginia Medical Assistance Manual Reference M0310.001; M1520.300.

Spenddown

Medicaid Spenddown Summary

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

Household Member Name	Spenddown Period	Spenddown Amount
Lip Service	March 01, 2023 - August 31, 2023	$6412.92

Your household must report changes

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

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

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

Your CommonHelp Account

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

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

Case Number: 114483443
Client ID: 2106565828

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)**.

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.** 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."

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.**

Worker Name:	Telephone Number:	For Free Legal Advice Call:
Jane Smith	(555) 555-5555	1-866-534-5243

Additional Information from Your Case Worker:

Note: *The rest of the pages of this notice have been omitted because they can be viewed in Section 2. Page 3 was the "If You Think We Made a Mistake" section shown on Page 2.33.*
Page 4 was the "It is important we treat you fairly" section that can be seen on Page 2.25.
Page 5 was the "What is the Health Insurance Marketplace?" information that is on Page 2.39.
Page 6 was blank and Pages 7-8 contained information on how to get help in other languages that can be seen on Pages 2.27-2.28.

PLEASE DO NOT REMOVE THIS PAGE; IT MUST BE USED IN THE RETURN ENVELOPE TO MAIL THE COMPLETED FORM BACK TO YOUR LOCAL AGENCY.

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

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

Amherst County (009)
PO Box 414
213 Street 2
Amherst, VA 24521-4251

Letter Date: February 13, 2023
Response Due: March 15, 2023
Case Number: 114491089
Case Worker Name: R. JAIN
Worker User ID: xxx009

Sent Mail
4515 Postal PASS
Lynchburg, VA 24515

Please complete your renewal by: March 15, 2023

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

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

Renew your Medicaid in any one of these ways

❶ **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: 114491089
Client ID: 2106584409

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

❸ **By mail or fax:**
Amherst County (009)
PO BOX 1391
23 STREET 2
AMHERST, VA 24521-5321
Fax: (804) 561-6040

❹ **In Person:**
Bring the completed form to:
Amherst County (009)
PO BOX 1390
12 STREET 2
AMHERST, VA 24521-1235

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)**.

*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.*

How to complete this renewal form

1. Answer all the questions on the form.
2. Review the information about you and each member in your household and/or on your tax return. Cross out wrong information. Write in new information and add anything that is missing. 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 return
- Section 3: Your household members
- Section 4: Other health insurance coverage
- Section 5: Information about income
- Section 6: Information about resources and nursing facility care
- Next, fill out all appendices, if any, that apply to your household or individuals listed on your tax return:
  - Appendix A: Complete ONLY if someone in your household is eligible for new health coverage from a job
  - Appendix B: Complete ONLY if someone in your household is an American Indian or Alaska Native
  - Appendix C: Complete ONLY if you are choosing someone to help with your application
  - Appendix D: Complete ONLY for someone who is now applying for health coverage from Virginia Medicaid or whose circumstances may have changed
  - 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.

1 Information about how we can contact you

▼ Review the contact information we have on file for you below.	▼ Cross out wrong information. Write in new information and add anything that is missing.		
Sent Mail	Name		
Home address *4515 Postal PASS* *Lynchburg* *VA 24515*	Home address		Apartment #
	City	State	Zip code
Mailing address	Mailing address		Apartment #
	City	State	Zip code

Phone number:
Cell: **Home:** **Work:**

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 you and each member in your household and/or on your tax return.
- 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:	**Tax dependents** (if anyone is missing, write their name below):
If this person is filling a joint return, write the name of the spouse: **Name** *(first, middle, last & suffix)*	

- If anyone who lives with you will be claimed as a dependent on someones 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)*	

3 Your household members

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

Person 1: *Sent Mail* 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:

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

New Household Member(s) 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 or was pregnant within the last 12 months?

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

Name *(first, middle, last & suffix)*	How many babies are/were expected?	What is/was the expected due date/pregnancy end 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.

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

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

☐ Yes ☐ No ***If yes,*** fill out **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 **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.
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**:

4 Other health insurance coverage

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

- Review the information and 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 ☐ Premium Assistance (HIPP or FAMIS Select) ☐ Other insurance (write below)

☐ **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

- Provide the information below for anyone in your household or on your federal tax return who has income, whether or not they are renewing or applying for health coverage.
- If someone has more than one type of income, tell us about **all of their income**.
- If you need more space, make a copy of this page or call your local office for copies.
- 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:

Address: City: State: Zip code: Phone number:

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: _____

- 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):* *Sent Mail*

Income Type: *Supplemental Security Income (SSI)* **How much? $***752.00*

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):* *Sent Mail*

Income Type: *Social Security (SSA)* **How much? $***100.00*

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? $**_____

6 Information about resources and nursing facility care

- 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.
- If this section does not apply to anyone in your home, continue to section 7.
- 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

Sent Mail	*Real Property*	$
		$

If this person or their spouse who lives with them are working, do either of them have expenses related to work? ☐ **No** ☐ **Yes** ***If yes, attach proof.***

Does this person or their 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 (Trust, Stocks, Annuities, Dividends, Interest, etc.): $ _____

7 STOP 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 within 10 days. 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)** 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.

To confirm or change your authorized representative or 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.

STOP

Signature of Household Contact or Authorized Representative **Date**

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

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*.

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, fill 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 if no less than 60 percent of such costs (Section 36B (c)(2)(C)(ii) of the Internal Revenue Code of 1986).

Appendix B - Renewal	Complete ONLY if someone in your household is an American Indian or Alaska Native

- Tell us about your American Indian or Alaska Native family members(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.

Person One 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:	How much income? $
· Payments from a tribe for natural resources, usage rights, leases, or royalties. · Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations). · Money from selling things that have cultural significance.	How often? ☐ Weekly ☐ Twice a month ☐ Every two weeks ☐ Monthly ☐ Yearly ☐ Not regular (for example, if this person works under a contract) ☐ Other_____

Person Two 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:	How much income? $
· Payments from a tribe for natural resources, usage rights, leases, or royalties. · Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations). · Money from selling things that have cultural significance.	How often? ☐ Weekly ☐ Twice a month ☐ Every two weeks ☐ Monthly ☐ Yearly ☐ Not regular (for example, if this person works under a contract) ☐ Other_____

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. Review the information. Write in any changes to the information.
- If you want to name an authorized representative, complete below. Make a copy of this page if you need additional space or if you need to add an additional authorized representative.

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

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 the you would like to authorize for this person.
☐ Apply for benefits ☐ Receive benefits ☐ Receive letters regarding actions taken on your case
☐ Receive request 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 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 representative? ☐ Yes ☐ No
If yes, has any information changed? ☐ Yes ☐ No
Write in any new information below:

Appendix D - Renewal

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

- 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 Additional Information. ***If no,*** answer all of the questions below.

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

Visit 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.

Additional Information

☐ 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.*

☐ Chicano/a
☐ Cuban
☐ Mexican
☐ Mexican American
☐ Puerto Rican
☐ Non-Hispanic/Unknown

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 ONLY if someone in your household is 65 or older, blind, or disabled.

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

Person's Name

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 ONLY if someone in your home is receiving care in a nursing facility or in the home by a medical professional.

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 transfered 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)**.

Additional Information

Voter Registration & Non-discrimination Information

Voter Registration

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.)

Please check one box only:

☐ Yes, I would like to apply to register to vote.
☐ No, I would not like to apply to register to vote.
☐ I am already register to vote.

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

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 believe that someone has interfered with your right to register or to decline to register to vote, or your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with the **Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219-3497, 804-864-8901.**

WARNING: INTENTIONALLY MAKING A MATERIALLY FALSE STATEMENT ON THIS FORM CONSTITUTES THE CRIME OF ELECTION FRAUD, WHICH IS PUNISHABLE UNDER VIRGINIA LAW AS A FELONY. VIOLATORS MAY BE SENTENCED TO UP TO 10 YEARS IN PRISON, OR UP TO 12 MONTHS IN JAIL AND/OR FINED UP TO $2,500.

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.

(for agency use only)

Voter Registration form completed: ☐ Yes ☐ No
Voter Registration form given to applicant for later mailling (at applicant's request): ☐

_____ _____
Agency Staff Signature Date

Non-discrimination Information

It is important we treat you fairly. We will keep your information secure and private.

This agency complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This agency does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This agency provides free aids and services to people with disabilities to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). If you need these services, call us at **(804) 786- 7933 (TTY: 1-800-343-0634).** This agency also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call us at **1-855-242-8282 (TTY: 1-888-221-1590).**

If you believe that this agency has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, or by phone at: Civil Rights Coordinator, -DMAS, 600 E. Broad St., Richmond, VA 23219, Telephone: **(804) 786-7933 (TTY: 1-800-343-0634).**

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

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)**.

4.54 ***Sample Renewal Notice***

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

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

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

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

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

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

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

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

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

Bengali: আপনার নজিরে ভাষায় সাহায্য পান
Virginia Medicaid এর স্বাস্থ্য বমিা বষিয়ক আপনার সুযোগ-সুবধিা অথবা আবদেন সম্পর্কতি গুরুত্বপূর্ণ তথ্য এই নোটশিে আছে। গুরুত্বপূর্ণ তারখিগুলরি অনুসন্ধান করুন। আপনার প্রাপ্য সুযোগ-সুবধিা চালু রাখতে হলে আপনাকে নর্দিষ্টি তারখিরে মধ্যে পদক্ষপে গ্রহণ করতে হতে পারে। আপনার অধকিার আছে নজিরে ভাষায়, বড় অক্ষরে ছাপা অথবা আপনার পক্ষে সর্বশ্রষ্ঠে এমন যে কোনও উপায়ে এই চঠিটি বনিামূল্যে পাওয়ার। আমাদরে টলেফিোন করুন এই নম্বরে: 1-855-242-8282 (TTY: 1-888-221-1590)।

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

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

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

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

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

Bassa: M̀ bɛ́ìn gbo-kpá-kpá dyéɛ dɛ́ wudu m̀ poɛɛ mú
Céè-dɛ̀ nìà kɛ bɛ́dɛ́ bɔ̃ kpa dɛ bě bó wé bě kɔ̃ ɓaɖa m̀ bɛ́ìn gbo-kpá-kpá bě dyéɛ ɔ jŭ ké m̀ dyi gbo-kpá-kpá zɔ̀ bó nì kpódó-dyùàɔ̀ dyi káná jè sɔ̀ìn dɛ́ nyɔ Kũùn jè gbo-kpáìn-naín nìà dɛ́ Vɔ̀jínìà kɛɛ ní. Dè wé kpa dɛ bě kɔ̃ mú m̀ bɛ́ìn gbo-kpá-kpá bě nìà kɛ dyéɛ kɛɛ jè dyéɖé gbo. M̀ kɔ̃ bɛ́ m̀ ké gbo-kpá-kpá nìà kɛ zɔ̀ bó wé jɛ́ɛ́ bě ɓaɖa, bɛ́ m̀ ké nì gbo-kpá-kpá bě̀ɔ̀ dyé. M̀ bɛ́ìn céè-dɛ̀ nìà kɛ dyéɛ pídyi dɛ́ wudu m̀ poɛɛ mú dɛ́ céè-dɛ̀-dyèdè boo-boo mú, mɔɔ dɛ́ hwìè kà kò dɔ̀ kɔ̃ mú m̀ mó bɛ́ wa ké nì céè-dɛ̀ɔ̀ céè kɛɛ mú. Ɖá à nììn dɛ́ nɔ̀ɓà nìà kɛ kɔ̃ 1-855-242-8282 (TTY: 1-888-221-1590).

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

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