Appendix D: ABD and/ or Long-Term Services and Supports

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

APPENDIX D

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

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

What is Appendix D Used For?

Appendix D gathers additional information needed to determine your eligibility for Health Care Coverage.

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

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

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Appendix D – Section 1: Household Information

SECTION 1 Household Information

1. Are You?	Married	Never married	Divorced	Widowed	Separated

2. Has anyone in your household ever applied for or received any Health Care Coverage from a social service agency in another state or Virginia city or county? Yes No

— If **yes**, please indicate which state or Virginia city or county below:

State or Virginia city or county

3. Is anyone in your household temporarily away from home? Yes No

Name	Date Left mm/dd/yyyy
Reason for Leaving	
Where is the person currently staying?	Expected Return Date mm/dd/yyyy

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Appendix D – Section 1: Questions 4 – 11

Answer questions 4-11 if any applicants are under age 65 years.

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

Name of Person	Name of Person

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

Name of Person and Date of Application	Name of Person and Date of Application

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

Name	Name

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

Outcome

8. Has it been less than 12 months since the most recent application for Social Security, SSI or Railroad Retirement benefits was denied?
   ☐ Yes ☐ No
   — If yes, please tell us the outcome of the appeal:

Outcome

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Appendix D – Section 1: Household Information

9. Has the condition changed or worsened since the most recent application for disability was denied?
   ☐ Yes ☐ No
   — If yes, please tell us the outcome of the appeal:

Outcome

10. Do you or anyone for whom you are applying have a new medical condition since the most recent application for disability was denied?
    ☐ Yes ☐ No
    — If yes, please tell us the outcome of the appeal:

Outcome

11. Have you or anyone for whom you are applying ever received SSI, disability benefits from the Social Security Administration or Auxiliary Grant payments?
    ☐ Yes ☐ No
    Has the payment stopped? ☐ Yes ☐ No

Explain

- Question 11 screens for eligibility under the "protected cases" categories

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Appendix D – Section 2

SECTION 2 Long-term Care

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

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

Name

Address

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

Name	Date of Entry	County of the prior address
Person's address prior to entering the facility		
Facility Name	Facility Address	
Was Placement made by a State agency?		

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

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

Name of Insurance Company	Address	City, State, ZIP
Policy Number	Person(s) Insured	Is this a Partnership Policy? ☐ Yes ☐ No

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

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

Note: If more than one transfer has occured, please attach documentation of each transfer.

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Appendix D – Section 3: Assets and Resources

SECTION 3 Resources and Assets

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

Name	Amount $

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

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

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

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

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

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Appendix D – Section 3: Assets and Resources

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

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

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

Owner(s)	Item/Type	Value/Amount Owned $

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Appendix D – Section 3: Assets and Resources

21. Do you or your spouse have real property, including home property, life rights/estates, shares in undivided heir property, land, buildings, or mobile homes? ☐ Yes ☐ No

— If **yes**, please provide the following information:

Owner(s)	Type of Property/Number of Acres	Value/Amount Owned
		$
Do you live on this property? ☐ Yes ☐ No		Is this property currently for sale? ☐ Yes ☐ No
Is this property rented? ☐ Yes ☐ No		Do you received money from this property ☐ Yes ☐ No

22. Do you or your spouse have any licensed or unlicensed cars, trucks, vans, boats, motors homes, recreational vehicles, utility trailers, motorcycles, or mopeds? ☐ Yes ☐ No

— If **yes**, please provide the following information:

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

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Appendix D – Section 4: Other Income

25. Do you receive child support? ☐ Yes ☐ No

— If **yes**, please provide the following information:

Amount	How Often?	Is the payment for past-due child support payments?
$		☐ Yes ☐ No

26. Do you receive Veteran's Administration benefits? ☐ Yes ☐ No

— If **yes**, please provide the following information:

Amount	How Often?	Type
$		

27. Does anyone help you pay, or lend you money to pay rent, utilities, medical bills, or any other bills? ☐ Yes ☐ No

— If **yes**, please provide the following information:

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Double-Check Application Information!

- A person's **name**, **date of birth**, and other information provided on the application must be accurate and must match any documentation that person provides to verify identity, citizenship, or immigration status.
  - *Example: The birthdate for an applicant born on January 7, 1956, should be written 01/07/56, rather than 07/01/56.*
- If a person has a hyphenated last name, it is important to make certain **both last names** are included on an application and written the same as on the person's documents verifying identity or immigration status.

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How Long Does it Take to Process an Application?

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

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What if the Case is DENIED?

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

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