The Application Process

Section 2

22

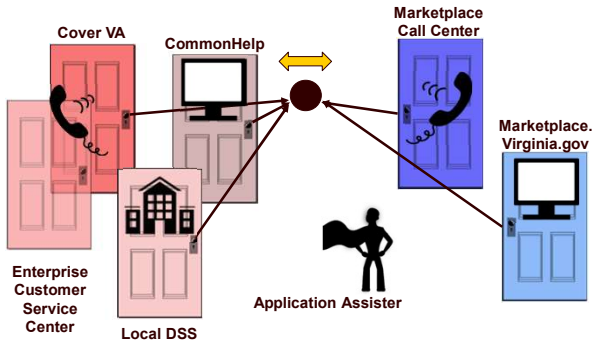
Ways to Apply: "No Wrong Door"

- There is one streamlined application for all of Virginia's Medicaid/FAMIS programs and Marketplace coverage.
- The application can be completed **online, by phone, or on paper.**
- If a person applies at one of Virginia's portals and is **not eligible for Medicaid/FAMIS**, the application will be automatically forwarded to the Health Insurance Marketplace to be evaluated for eligibility.

Sections 2 and 5

23

Ways to Apply: "No Wrong Door"



24

Apply by Phone at the Cover Virginia Call Center

(855) 242-8282

- Open 8am – 7pm weekdays; 9am – 12pm Saturdays.
- English/Spanish Customer Service Representatives (CSRs) and access to language line.
- Applicant completes the application with a CSR, and "signs" it by agreeing to *Rights & Responsibilities* and attesting that all information s/he provided is true.
  - The call is recorded.
  - Applicant gets an application Tracking Number (**"T-Number"**) upon submission.
  - Application date is date of telephonic signature.
  - Follow-up mail (including requests for additional documentation) comes from Cover Virginia unless the applicant has an open/active benefits case at the local DSS.

Section 2

25

Apply by Phone at the Enterprise Customer Service Center

(855) 635-4370

- Open 7am – 6pm weekdays
- Accepts telephonic applications for *multiple benefits*:
  - Supplemental Nutrition Assistance Program (SNAP)
  - Temporary Assistance for Needy Families (TANF)
  - Energy Assistance Program (EAP)
  - Medical Assistance (MA)
- Responds to basic inquiries about case status or benefits
- Also handles calls from custodial and non-custodial parents needing information from the Division of Child Support Enforcement at 1-800-468-8894.

26

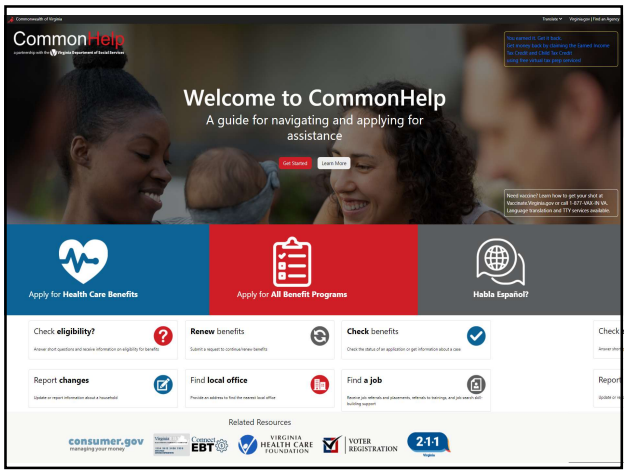
Apply Online with CommonHelp

a partnership with the Virginia Department of Social Services

- https://commonhelp.virginia.gov/
- Available **24/7**
- Offers the option to apply for "**Health Care Benefits**" only, or for **"All Benefit Programs"** simultaneously
  - "Health Care only" includes Medicaid and FAMIS (Medicaid Expansion, FAMIS Plus, FAMIS, FAMIS MOMS, FAMIS Prenatal, Medicaid for Pregnant Women, LIFC, & Plan First).
  - "All Benefit Programs" includes SNAP, TANF, energy assistance, and/or child care subsidies in addition to Medicaid/FAMIS coverage.

Section 2

27



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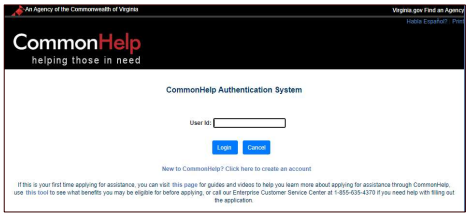


- Create **user name** and **password**.
- Choose and answer **security questions**.
- Application takes **≥1 hr** to complete.
- Applicant **can partially complete, save and come back** to complete and submit it, for up to 60 days.
- Application date is the date on which applicant agrees to *Rights & Responsibilities* (electronically "signs"), and gets a **T-Number**.

T-Number = successfully submitted!

29

Apply Online with CommonHelp

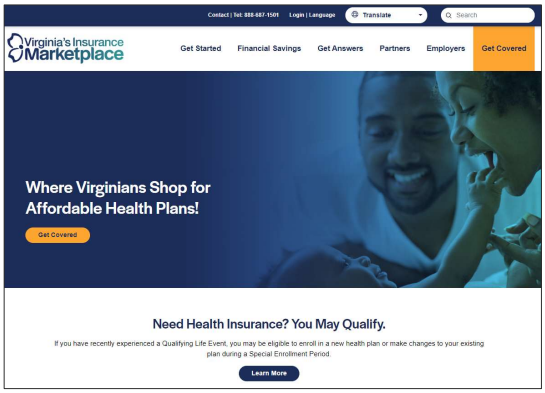
HELPING THOSE IN NEED

- **"Health Care Only" applications submitted via CommonHelp are processed by the Cover Virginia Central Processing Unit, unless applicant has an open SNAP/TANF case.**
- If additional information is needed to process the application, Cover Virginia will send a request for verifications.
- Once a determination is made, Cover Virginia will send a *Notice of Action* (approval or denial).
- An applicant can also **manage** his/her case via CommonHelp
  - ***Associate my Case:*** Links CommonHelp account with existing case *(Note: Very helpful to have Case ID to link).*
  - ***Report My Changes:*** *address, income, person moving in or out of the household, etc.*
  - ***Renew My Coverage:*** Allows applicant to complete annual renewal online.

Section 2 and Section 5

30

Virginia's Insurance Marketplace



31

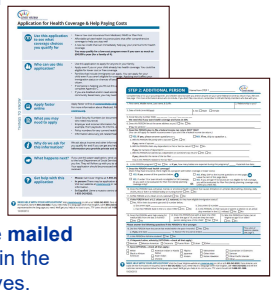
Apply via Virginia's Insurance Marketplace

- Telephonic and online options
  - Via telephone at 888-687-1501 (TTY: 711), Monday – Friday 8AM to 5PM
  - Online at marketplace.virginia.gov
- The Marketplace **may be able to determine** if an applicant is eligible for **Medicaid/FAMIS or Marketplace coverage**.
- An application that requires additional verifications will be forwarded from the Marketplace to the Cover Virginia CPU for follow-up and processing, unless the applicant has an open SNAP/TANF case (then application goes to local DSS).

32

Apply with the Paper Application

- Let's take a look at the **paper application**.
- It has:
  - **6 Steps**,
  - **6 Appendixes**, and a
  - **Supplement** that needs to be completed if there are more than 2 household members.
- The paper application can be **mailed** or **dropped off** at local DSS in the locality where an applicant lives.



Section 2; Handout

33

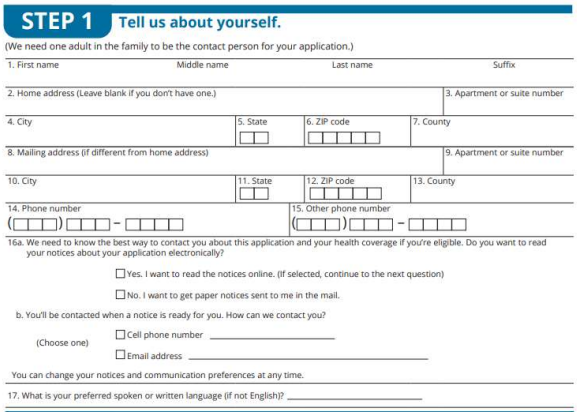
How to Order Paper Applications

1. *Go to* coverva.dmas.virginia.gov/
2. *Hover over* **Apply in the top menu, and select Applications**
3. Under **Application for Health Coverage & Help Paying Costs,** click on **Order Online**
4. An online order form will result.

You can order 100 copies of the *Application* and 200 copies of the *Additional Person Application Supplement* at a time. Copies of Appendixes D, E, and F are also available to order.

Items are shipped to you free of charge in a couple of weeks.

34



STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First name | Middle name | Last name | Suffix

2. Home address (Leave blank if you don't have one.) | 3. Apartment or suite number

4. City | 5. State | 6. ZIP code | 7. County

8. Mailing address (if different from home address) | 9. Apartment or suite number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone number (☐☐☐) ☐☐☐ – ☐☐☐☐ | 15. Other phone number (☐☐☐) ☐☐☐ – ☐☐☐☐

16a. We need to know the best way to contact you about this application and your health coverage if you're eligible. Do you want to read your notices about your application electronically?

☐ Yes. I want to read the notices online. (If selected, continue to the next question)

☐ No. I want to get paper notices sent to me in the mail.

b. You'll be contacted when a notice is ready for you. How can we contact you?

(Choose one) ☐ Cell phone number _____

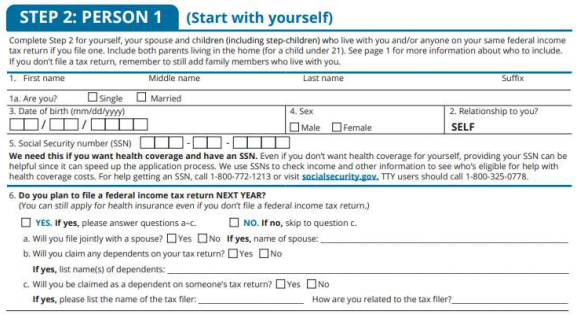
☐ Email address _____

You can change your notices and communication preferences at any time.

17. What is your preferred spoken or written language (if not English)? _____

35

Step 2, Person 1, Questions 1-6



STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse and children (including step-children) who live with you and/or anyone on your same federal income tax return if you file one. Include both parents living in the home (for a child under 21). See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name | Middle name | Last name | Suffix

1a. Are you? ☐ Single ☐ Married

3. Date of birth (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐ | 4. Sex ☐ Male ☐ Female | 2. Relationship to you? **SELF**

5. Social Security number (SSN) ☐☐☐-☐☐-☐☐☐☐

We need this if you want health coverage and have an SSN. Even if you don't want health coverage for yourself, providing your SSN can be helpful since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. For help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ **YES. If yes,** please answer questions a–c. ☐ **NO. If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No **If yes,** name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

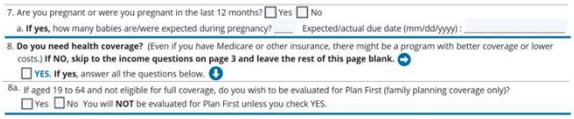
If yes, list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____ How are you related to the tax filer? _____

36

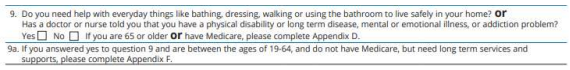
Step 2, Pers. 1, Questions 7-8


7. Are you pregnant or were you pregnant in the last 12 months? ☐ Yes ☐ No
a. **If yes,** how many babies are/were expected during pregnancy? ____ Expected/actual due date (mm/dd/yyyy) : _____
8. **Do you need health coverage?** *(Even if you have Medicare or other insurance, there might be a program with better coverage or lower costs.)* **If NO, skip to the income questions on page 3 and leave the rest of this page blank.**
☐ **YES. If yes,** answer all the questions below.
8a. If aged 19 to 64 and not eligible for full coverage, do you wish to be evaluated for Plan First (family planning coverage only)?
☐ Yes ☐ No You will **NOT** be evaluated for Plan First unless you check YES.

- Question 8a was adjusted effective December 1, 2024. **Plan First is now an opt-in program.** Previously, everyone who met the requirements was evaluated for this program if they did not qualify for full benefit Medicaid or FAMIS coverage. **Now, applicants need to check YES on this question to be evaluated for Plan First.**
- If you are working with someone who may need to access family planning services, be sure to **counsel them on opting in** to this program by checking YES on this question!

37

Step 2, Pers. 1, Question 9

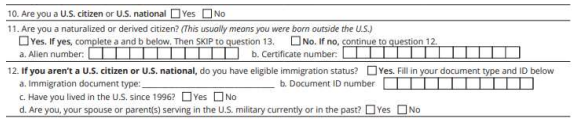

9. Do you need help with everyday things like bathing, dressing, walking or using the bathroom to live safely in your home? **or** Has a doctor or nurse told you that you have a physical disability or long term disease, mental or emotional illness, or addiction problem? Yes ☐ No ☐ If you are 65 or older **or** have Medicare, please complete Appendix D.
9a. If you answered yes to question 9 and are between the ages of 19-64, and do not have Medicare, but need long term services and supports, please complete Appendix F.

- This question was adjusted with the onset of Medicaid Expansion. It is a screening question, not for eligibility into the program, but rather to see if someone is considered medically complex.

38

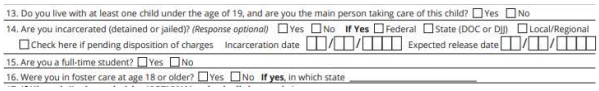
Step 2, Pers. 1, Questions 10-12

- These are the questions regarding if a person is a US Citizen/National or a legal immigrant.


10. Are you a **U.S. citizen** or **U.S. national** ☐ Yes ☐ No
11. Are you a naturalized or derived citizen? *(This usually means you were born outside the U.S.)*
☐ **Yes. If yes,** complete a and b below. Then SKIP to question 13. ☐ **No. If no,** continue to question 12.
a. Alien number: ☐☐☐☐☐☐☐☐☐ b. Certificate number: ☐☐☐☐☐☐☐☐☐☐
12. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status? ☐ **Yes.** Fill in your document type and ID below
a. Immigration document type: _____ b. Document ID number: ☐☐☐☐☐☐☐☐☐☐
c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No
d. Are you, your spouse or parent(s) serving in the U.S. military currently or in the past? ☐ Yes ☐ No

39

Step 2, Pers. 1, Questions 13-16

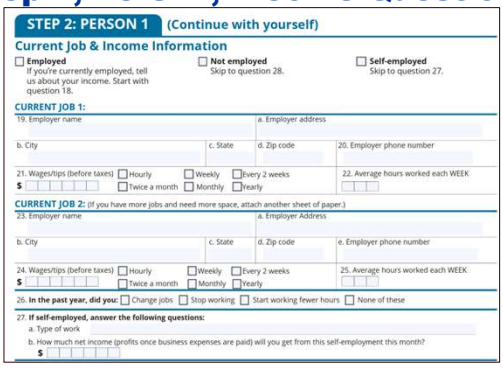

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No
14. Are you incarcerated (detained or jailed)? *(Response optional)* ☐ Yes ☐ No **If Yes** ☐ Federal ☐ State (DOC or DJJ) ☐ Local/Regional
☐ Check here if pending disposition of charges Incarceration date ☐☐/☐☐/☐☐☐☐ Expected release date ☐☐/☐☐/☐☐☐☐
15. Are you a full-time student? ☐ Yes ☐ No
16. Were you in foster care at age 18 or older? ☐ Yes ☐ No **If yes**, in which state _____

- The next questions screen for a series of different programs:
  - 13 and 15 for LIFC
  - 14 for Medicaid, but if currently incarcerated and approved for coverage, only inpatient hospital services can be accessed.
  - 16 for coverage for former foster care youth through age 25

Section 2

40

Step 2, Pers. 1, Income Questions


STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed** If you're currently employed, tell us about your income. Start with question 18.
☐ **Not employed** Skip to question 28.
☐ **Self-employed** Skip to question 27.

CURRENT JOB 1:

19. Employer name | a. Employer address
b. City | c. State | d. Zip code | 20. Employer phone number
21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly $ | 22. Average hours worked each WEEK

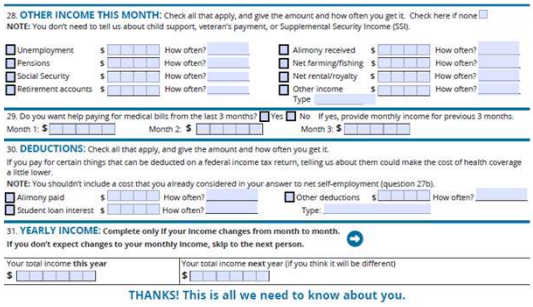
CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

23. Employer name | a. Employer Address
b. City | c. State | d. Zip code | e. Employer phone number
24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly $ | 25. Average hours worked each WEEK
26. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these
27. **If self-employed, answer the following questions:**
a. Type of work
b. How much net income (profits once business expenses are paid) will you get from this self-employment this month? $

Section 2

41

Step 2, Pers. 1, Questions 28-31


28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it. Check here if none ☐
NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ Unemployment $ How often? | ☐ Alimony received $ How often?
☐ Pensions $ How often? | ☐ Net farming/fishing $ How often?
☐ Social Security $ How often? | ☐ Net rental/royalty $ How often?
☐ Retirement accounts $ How often? | ☐ Other income $ How often? Type

29. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No If yes, provide monthly income for previous 3 months.
Month 1: $ Month 2: $ Month 3: $

30. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.
If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).
☐ Alimony paid $ How often? | ☐ Other deductions $ How often?
☐ Student loan interest $ How often? | Type:

31. **YEARLY INCOME: Complete only if your income changes from month to month.**
If you don't expect changes to your monthly income, skip to the next person.

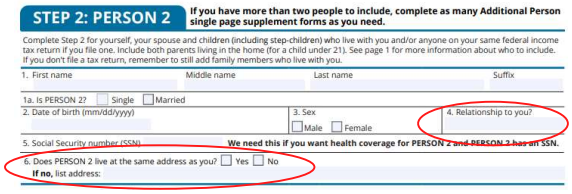
Your total income **this year** $ | Your total income **next** year (if you think it will be different) $

THANKS! This is all we need to know about you.

Section 2

42

Step 2, Person 2


STEP 2: PERSON 2 — If you have more than two people to include, complete as many Additional Person single page supplement forms as you need.

Complete Step 2 for yourself, your spouse and children (including step-children) who live with you and/or anyone on your same federal income tax return if you file one. Include both parents living in the home (for a child under 21). See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name | Middle name | Last name | Suffix

1a. Is PERSON 2? ☐ Single ☐ Married

2. Date of birth (mm/dd/yyyy) | 3. Sex ☐ Male ☐ Female | 4. Relationship to you?

5. Social Security number (SSN) — We need this if you want health coverage for PERSON 2 and PERSON 2 has an SSN.

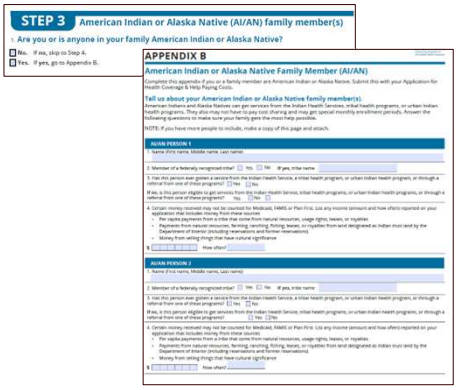
6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
If no, list address:

- All the same questions as Person 1 with 2 additional questions:
  - Question 4: Relationship to you? Person 2 should indicate the relationship to person one.
  - Question 6: Does Person 2 live at the same address as Person 1?
- If more than 2 family members, an Additional Person Single Page Supplement Form should be completed for each family member.

Section 2

43

Step 3 and Appendix B


STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

1. Are you or is anyone in your family American Indian or Alaska Native?

☐ No. If no, skip to Step 4.
☐ Yes. If yes, go to Appendix B.

APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

Tell us about your American Indian or Alaska Native family member(s):

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

AI/AN PERSON 1

1. Name (first name, Middle name, Last name)

2. Member of a federally recognized tribe? ☐ Yes ☐ No If yes, tribe name

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No

If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No

4. Certain money received may not be counted for Medicaid, FAMIS or Plan First. List any income (amount and how often) reported on your application that includes money from these sources:
- Per capita payments from a tribe that come from 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?

AI/AN PERSON 2

1. Name (First name, Middle name, Last name)

2. Member of a federally recognized tribe? ☐ Yes ☐ No If yes, tribe name

3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐ Yes ☐ No

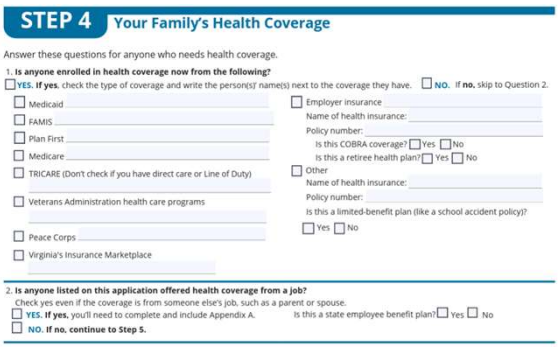
If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No

4. Certain money received may not be counted for Medicaid, FAMIS or Plan First. List any income (amount and how often) reported on your application that includes money from these sources:
- Per capita payments from a tribe that come from 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?

44

Step 4


STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**
☐ **YES. If yes,** check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO. If no,** skip to Question 2.

☐ Medicaid
☐ FAMIS
☐ Plan First
☐ Medicare
☐ TRICARE (Don't check if you have direct care or Line of Duty)
☐ Veterans Administration health care programs
☐ Peace Corps
☐ Virginia's Insurance Marketplace
☐ Employer insurance
Name of health insurance:
Policy number:
Is this COBRA coverage? ☐ Yes ☐ No
Is this a retiree health plan? ☐ Yes ☐ No
☐ Other
Name of health insurance:
Policy number:
Is this a limited-benefit plan (like a school accident policy)?
☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?**
Check yes even if the coverage is from someone else's job, such as a parent or spouse.
☐ **YES. If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No
☐ **NO. If no, continue to Step 5.**

45

Step 5: Read & Sign This Application (Rights & Responsibilities)

STEP 5 Read & sign this application.

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

- 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. [We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.]
- I understand that Medicaid and DMAS contractors may exchange information relating to my coverage with LDSS to assist with application, enrollment, administration, and billing services.
- 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.
- I understand that guidance and procedures used to determine eligibility can be found within the Medical Assistance Eligibility Manual, which can be located at https://www.dmas.virginia.gov/for-applicants/eligibility-guidance/eligibility-manual/.
- I understand that if I do not qualify for health coverage, my local Department of Social Services may send my information to Virginia's Insurance Marketplace at www.marketplace.virginia.gov to see if I qualify.

If anyone on this application is eligible for Medicaid

- I know that I must tell my local Department of Social Services if anything changes and is different from whatI 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 for individuals enrolled in managed care, a premium is paid each month to the MCO forthe person's coverage. If the child or pregnant woman is not eligible for FAMIS, FAMIS Plus, FAMIS MOMS,or Medicaid because I did not report truthful information or failed to report required changes in my familysize or income, I may have to repay the monthly premiums paid to the MCO. I may have to repay these premiums even if no medical services were received during those months.
- The information provided on this application, including your phone number(s), will be shared with Local Departments of Social Services (LDSS) and the Managed Care Organization (MCO), otherwise known as health plan, to which you are assigned. You consent to being called or texted by the MCO at any phone number(s) you provide in relation to your application, now or in the future, including in regard to your health care needs and treatment, wellness services, plan benefits, eligibility, renewal and/or redetermination, and for any other communications relating to your relationship with the MCO or concerning your health care coverage. These calls/texts may be made using automated technology, such as with an automatic telephone dialing system or artificial or prerecorded voice message. You acknowledge that text messages are not encrypted and can be read by unauthorized persons. Standard message and data rates may apply.
- I understand that DMAS has the responsibility to recover money from the estate of a Medicaid member age 55 and over. Recovery may take place only after the death of the surviving spouse and only if there are no children who are blind, disabled, or under the age of 21. The dependents or heirs of an estate can also claim an undue hardship (an action requiring significant difficulty or expense) during the recovery process. If a hardship is granted, DMAS may waive part of all of the recovery, and if denied, the individual is granted an opportunity to appeal the decision.
- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.

NEED HELP WITH YOUR APPLICATION? Visit coverva.dmas.virginia.gov or call us at 1-855-242-8282. Para obtener una copia de este formulario en Español, llame 1-855-242-8282. If you need help in a language other than English, call 1-855-242-8282 and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call 1-888-221-1590.

01/06/25 Page 7 of 8

46

Step 5: Rights & Responsibilities Listing

If anyone on this application is eligible for Medicaid

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47

Step 5: Rights & Responsibilities Listing

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I understand that my benefits may be renewed automatically using other data sources. I give Virginia Medicaid 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.

STOP I am signing this application form 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.

Signature of Applicant or Authorized Representative	Date (mm/dd/yyyy)

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 (mm/dd/yyyy)
Print Name	Signature	Date (mm/dd/yyyy)

48

Appendices

- A* – Health Coverage from Jobs
- B* – American Indian or Alaska Native Family Member
- **C* – Assistance with Completing this Application**
- D – Aged (65+); Blind/Disabled; in need of Long Term Care Services (Children 0-18 and adults 65+)
- E – Medically Needy Spenddown
- F – Nursing Facility or Community-Based Care (age19-64, not eligible for or enrolled in Medicare)

Appendices A, B, and C are part of the Application booklet. Others can ordered/downloaded from the CoverVA website.

49

Appendix C – Assistance with Completing this Application

- The **top section** is for an applicant to designate someone else to act on his/her behalf with regard to this application and ultimate enrollment into Medicaid or FAMIS.
- The **middle section** is the section that most "helper agencies" will complete to get permission to follow up on the application with the entity processing it.
- **Bottom section** is for Certified Application Counselors, Navigators, and insurance brokers who assist with applications

50

Application Assistance

There are several different groups that offer **in-person application assistance**:

- ***Project Connect* Outreach Workers:** Northern Virginia, Richmond, Tidewater, Southside, Roanoke, Far Southwest
- **Navigators & Certified Application Counselors** (CACs): Statewide; specially-trained to help with Marketplace applications, and can also help with Medicaid/FAMIS applications
  - https://coverva.dmas.virginia.gov/apply/find-help-in-your-area/

51

Who Can Sign an Application?

For an Adult

- Applicant him/herself, or applicant's spouse
- Legal guardian, conservator, or attorney-in-fact
- Any adult authorized by the applicant (documentation required)

For a Child

- Parent or legal guardian
- Any related adult with whom the child lives (documentation is not required).
- Court-emancipated minor or 18-year-old can sign own application
- Any adult authorized by the child's parent or legal guardian (documentation required).

Section 2

52

Federal Data "Hub"

- Information supplied on all applications will be **compared to data stored in a Federal Data Hub ("the Hub")** and other **state data sources.**
- If Hub data **does not match** or is not **reasonably compatible with** what is on an application, **LDSS/CPU will ask an applicant to provide documents to verify** what is on the application.

Section 2

53

How Long Does it Take to Process an Application?

- Maximum **45-calendar-day processing time** for **most applicants**
- Maximum **7-day processing time** for **pregnant individuals (*including teens*)**
  - An incomplete application will "pend" for up to 45 days
  - Can request additional time to secure certain documents, like immigration paperwork, that take time to obtain
- "Real-Time" approval is possible via online application methods (marketplace.virginia.gov or CommonHelp) if information on an application matches or is reasonably compatible with data sources.

Section 2

54

Where Are Applications Reviewed?

Application Method	Processed By	Exception(s)
Online via **CommonHelp or** by phone with **Cover Virginia** Call Center	Cover Virginia CPU	If applicant has an existing SNAP or TANF case, or applied for "All Benefit Programs," app goes to local DSS.
Online at **marketplace.virginia.gov, or** by phone with **VIM call center**	Virginia's Insurance Marketplace	If applicant *looks* eligible for Medicaid/FAMIS program, but more information is needed, app goes to Cover Virginia CPU.
Paper	Local DSS	If ineligible, LDSS will send applicant a letter letting him/her know the app has been sent to the Marketplace.
Cover Virginia Incarcerated Unit	Cover Virginia Incarcerated Unit	This unit will also maintain the case if the person is found eligible.

55

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 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/Cover Virginia and ask to speak to the worker who denied the case and/or a supervisor. If an error is discovered, case decision can be revised on the spot.
- Applicant has the right to **Appeal** (form submitted to DMAS – online, telephonic, and paper options) within 35 days of the *Notice of Action*.

Individuals/families can request to *keep* coverage while appeal is pending and can have hearings by phone.

Section 2

56