

# After Enrollment

This section is divided into five parts. The first three address how recipients in the Medicaid and the FAMIS programs access their benefits. The fourth section addresses certain situations where the state might pay for an individual's coverage in a private insurance plan (FAMIS *Select* and HIPP). The last section is sample forms.

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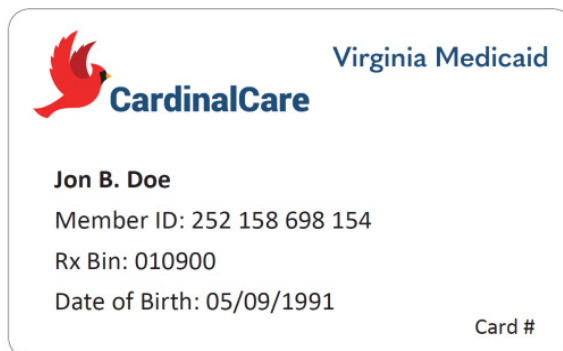
# PART I: Medicaid Expansion, LIFC, Former Foster Care Youth, FAMIS Plus & FAMIS

## Once Approved

An adult approved for Medicaid (MedEx, LIFC, Former Foster Care Youth) or a child approved for FAMIS/FAMIS Plus will receive a *Notice of Action on Benefits* stating that s/he has been approved for full-benefits either through Medicaid or the FAMIS programs. (*A Sample Notice of Action is on page 2.35.*)

In a separate mailing, the enrollee will receive a permanent plastic CardinalCare 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. Enrollment into managed care takes about 30 days. This is the period referred to as "Fee-for-Service". Enrollees do not have to wait for the receipt of this card to get services, their Medicaid (Enrollee ID) number is on the *Notice of Action* and the provider can verify enrollment with it.

### CARDINAL CARE ID CARD FRONT



### BACK

**Member Services** - 1-833-522-5582 or TDD: 1-888-221-1590;  
web: [www.coverva.org](http://www.coverva.org) / [www.dmas.virginia.gov/for-members](http://www.dmas.virginia.gov/for-members)  
Dental - 1-888-912-3456 or TTY/TDD 1-800-466-7566  
Transportation - 1-866-246-9979 TTY 711

**Provider Services**  
Eligibility Verification - 1-800-884-9730 or 1-800-772-9996 or  
<https://vamedicaid.dmas.virginia.gov/provider>  
Provider Helpline - 1-800-552-8627  
Service Authorization - 1-888-827-2884  
Pharmacy - [www.virginiamedicaidpharmacyservices.com](http://www.virginiamedicaidpharmacyservices.com)

*Fraudulent use of this card may result in criminal prosecution, loss of benefits, and cost reimbursement to Virginia Medicaid. This card does not entitle the cardholder to any benefits; providers must verify membership eligibility at the time of service.*

Return lost ID cards to:  
DMAS, PO BOX 537, Richmond, VA 23204-0537

## Selecting a Provider

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

Five MCOs deliver services in the Cardinal Care program\*:

- Aetna Better Health of Virginia (800) 279-1878
- Anthem Healthkeepers Plus (800) 901-0020
- Humana Healthy Horizons (844) 881-4482
- Sentara Community Plan (800) 881-2166
- UnitedHealthcare Community Plan (844) 752-9434

*\*Molina Healthcare stopped being a Medicaid MCO on June 30, 2025.*

The enrollee will receive a letter from DMAS about the managed care enrollment process. The letter directs the person to call the **Enrollment HelpLine** at **(800) 643-2273** Monday through Friday between 8:30AM and 6PM to choose an MCO by the date indicated or s/he will be assigned to the MCO listed in the letter. The enrollee can also go online to [www.viriniamanagedcare.com](http://www.viriniamanagedcare.com) to make the selection or download an app to a cellphone to do so. *(See sample enrollment letter on page 3.9)*

On the website there is a comparison tool where enrollees can compare the MCOs and the “added benefits” each MCO offers in addition to the core package of Medicaid benefits. They can also check to see if any current providers they might have participate in one of the MCOs with the “Find a Provider” tool. **Note:** *The HelpLine has access to **interpreter services**, if English is not the recipient’s primary or preferred language. (A sample of the types of added benefits offered by the MCOs can be seen on page 3.10)*

*Note: A family may choose the same MCO for all the enrolled children in the family, or different MCO’s for each, depending on their circumstance, such as a doctor’s or provider’s participation in an MCO.*

If the enrollee does not respond to the letter by the due date, the MCO listed in the letter 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 ID card will be sent by the MCO.

After receiving this information, an enrollee **still has about 60 days to change to another MCO**. After this period, the enrollee can only change MCOs during the annual Medicaid MCO “Open Enrollment Period” in his/her region or if s/he requests a change and demonstrate good cause as to why s/he should be allowed to switch MCOs. *Note: At any time, a enrollee may switch to a different PCP within their MCO. (For clarification of the enrollment process see the chart on page 3.8)*

## Using the Cardinal Care and the MCO Health Insurance Cards

Upon receipt of the Cardinal Care ID Card, the enrollee 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 changes/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 enrollee will need to call the MCO.

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

It is the enrollee’s responsibility to show the MCO ID card and the DMAS/ Cardinal Care 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.

## Covered Services Overview

**Medicaid coverage for adults** provides a comprehensive package of benefits. Including:

- Doctor, hospital, and emergency services
- Prescription drugs
- Laboratory and X-ray services
- Maternity and newborn care\*
- Long-term care and support services
- Home health services
- Behavioral health services including addition/recovery treatment services
- Rehabilitative services including physical, occupational, and speech therapies
- Transportation to Medicaid-covered services when no alternatives are available
- Family planning services
- Medical equipment and supplies
- Preventive and wellness services, chronic disease management services
- Dental care (see [page 3.17](#)), and
- Enhanced preventive services (annual adult wellness exams; individual and group smoking cessation counseling; nutritional counseling for individuals with obesity or chronic medical diseases; and recommended adult immunizations).

For a full listing of benefits for the Medicaid programs, including FAMIS Plus, see the Medicaid Handbook ([coverva.dmas.virginia.gov/media/qy4mthbc/medical-assistance-handbook-en-final-06-03-25.pdf](http://coverva.dmas.virginia.gov/media/qy4mthbc/medical-assistance-handbook-en-final-06-03-25.pdf)).

*\*If an existing Medicaid enrollee gets pregnant, the pregnancy should be reported to the state. Coverage will be transferred to Medicaid for Pregnant Women, which ensures access to 12 months of postpartum coverage.*

**FAMIS Plus** provides a comprehensive package of benefits uniquely designed to meet the needs of lower income children. In addition to covering traditional health care services such as hospitalizations, doctor visits and prescriptions, FAMIS Plus also covers services such as non-emergency transportation to medical appointments, case management and health education for babies with potential health risks, behavioral health and substance abuse treatment services, eye exams and glasses, dental care including medically necessary orthodontia, services in a school based setting (audiology, occupational therapy, etc.), and other services not often covered by private health insurance plans.

Of special note, children covered by FAMIS Plus are entitled to the **EPSDT** (Early Periodic Screening, Diagnosis and Treatment) benefit. This valuable

component of Virginia's FAMIS Plus program provides comprehensive health screenings for children **up to age 21**. Any medical condition diagnosed through an EPSDT screening must be treated at no cost to the family, even if it is a service not normally covered by FAMIS Plus.

The **FAMIS** benefit package is modeled after the state employee health insurance plan. While many medical services are covered, some have annual "caps" or limits on the amount of service. Unlike FAMIS Plus, non-emergency transportation is not covered as an ongoing benefit. Although "well-child" examinations are covered up to age 19, the services provided are slightly less extensive than the FAMIS Plus/Medicaid EPSDT program. Non-emergency transportation and EPSDT are only available to FAMIS children during the initial 30-day fee-for-service period. For a full listing of benefits for FAMIS see the FAMIS Handbook ([coverva.dmas.virginia.gov/media/sn5hmb10/famis-handbook-en-final-06-03-25.pdf](http://coverva.dmas.virginia.gov/media/sn5hmb10/famis-handbook-en-final-06-03-25.pdf)).

**Note:** Families should be made aware that some services may not be fully paid by FAMIS (i.e. FAMIS pays \$25 for eyeglass frames, any cost over this amount is the family's responsibility).

For **all Medicaid and FAMIS members**, MCOs may provide additional enhanced services such as health education, 24 hour nurse advice line access, disease management programs, etc. The "added benefits" differ by MCO. (*A sample of the types of added benefits offered by the MCOs can be seen on page 3.10*)

### Period of Coverage and Reporting Requirements

When an applicant is determined to be eligible, **MedEx/LIFC/FFC/FAMIS Plus** coverage may **retroactively pay outstanding medical bills for the three months prior to their 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 enrollee 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 household size must be reported. When a change is reported, the caseworker will reevaluate ongoing eligibility and notify the enrollee of any adjustment to coverage.

If a woman becomes pregnant while enrolled in MedEx/LIFC/FFC, she should call and report it. Her coverage will be changed to Medicaid for Pregnant Women for the duration of the pregnancy and the 12 month postpartum period.

**Note:** Reporting a **change of address** is especially important because the LDSS needs a correct address to be able to deliver any renewal information in a timely manner.

When a **FAMIS** application is approved for a child, health coverage is **retroactive to the 1<sup>st</sup> day of the month of application**. For example, if the signed and completed application is received on June 14<sup>th</sup> and the child is approved and enrolled, the coverage is effective June 1<sup>st</sup>. In the case of a family applying for FAMIS for a **newborn**, coverage would begin **on the date of birth if the application is filed in the birth month (or within 3 months of the date of birth provided the question on the Application about help paying for medical bills on the application is completed)**.

**FAMIS Plus and FAMIS children** are guaranteed **12 months of continuous coverage unless the child moves out of state, turns 19, or the parent/caretaker requests a termination of coverage**. If no changes occur, eligibility will be reevaluated after 12 months.

**When a child turns 19 his/her coverage will be automatically cancelled at the end of the birth month**. At that time, s/he will be reevaluated for ongoing coverage in any other available state-sponsored health coverage category.

The **pregnancy** of a teen on FAMIS Plus or FAMIS must be reported **so that coverage can be switched to appropriate pregnancy program** to ensure the 12 months postpartum coverage. FAMIS Plus teens are switched to Medicaid for Pregnant Women and FAMIS teens to FAMIS MOMS.

If a Medicaid/FAMIS member is **moving out of state**, this must be **reported so the coverage can be cancelled**. The individual/family does this by contacting local DSS in writing, or by calling the Cover Virginia Call Center at (855) 242-8282, or online via the CommonHelp Customer Portal.

### **Annual Renewal** *(An example of this form is located on pages 3.33-3.54)*

Eligibility for MedEx/LIFC/FFC/FAMIS Plus/FAMIS coverage must be renewed every 12 months. LDSS will initiate an "Ex Parte" renewal. If current income information can be electronically verified as "reasonably compatible" with the prior year's income and the income is still within program guidelines, the individual will be sent a *Notice of Action* indicating that coverage has been renewed for an additional year. *(A sample renewal approval is on pages 3.25-3.28)*

If the electronic income data is not "reasonably compatible" with the information in the recipient's file, a paper renewal application will be issued. Approximately **45 days prior to the enrollee's renewal month**, the person will be sent a 16+ page renewal form pre-populated with the his/her household and income information. If a person has indicated Spanish as his/her primary language, a pre-populated form in Spanish will be sent.

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 postage-paid envelope provided) or hand-delivered to the local DSS. S/he can also complete the renewal form by calling the CVCC to report any changes in information. If s/he linked his/her case in CommonHelp after approval, s/he can log in to CommonHelp and access the renewal online and complete and submit it there. Instructions on how to link a case in CommonHelp are in [Section 5](#).

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

**If the individual fails to return the form by the due date, a cancellation notice will be sent**, and coverage will be cancelled effective the end of the renewal month. It is important to note, however that the person **still has an additional 90 days to return the form with any needed verification documents and coverage can be reinstated**. If s/he returns the form after that additional 90-day period, coverage cannot be reinstated, and s/he will have to file a new application. ([A sample cancellation notice is on pages 3.29-3.32](#))

If it is found that an adult is no longer eligible for MedEx/FFC, coverage will be cancelled. The LDSS will send the information to the Virginia Insurance Marketplace (VIM) so the person may be evaluated for financial assistance toward purchasing private health insurance on the Marketplace. Losing Medicaid coverage at annual renewal opens a "Special Enrollment Period" allowing the individual to shop on the Marketplace. If over the age of 18, the person will also be evaluated for Plan First coverage, if his/her income is under 205% FPL.

### ***Special note about Children's Coverage***

Many children are terminated from FAMIS Plus/FAMIS at renewal time because of the family's failure to complete the process. A child cancelled for failure to complete annual renewal may reapply for FAMIS Plus/FAMIS at any time.

During the renewal process, if the family's income has risen, the eligibility worker may determine that a FAMIS Plus child is now eligible for FAMIS instead. The child will be enrolled in that program and the family will receive a *Notice of Action* with the new dates of coverage. The same is true if a FAMIS family has a decrease in income or increase in family size, that child might now be eligible for FAMIS Plus instead.

If the child is not eligible for either FAMIS or FAMIS Plus (i.e. the family's income has risen above 205% of FPL), coverage will be cancelled. The LDSS will send the information to the VIM so the family may be evaluated for financial assistance toward purchasing private health insurance on the Marketplace. Losing Medicaid coverage at annual renewal opens a 90-day Special Enrollment Period that allows the family to shop for private coverage, if eligible.



## **LIFC**

At annual renewal, if a LIFC parent/caretaker's income has risen above program guidelines, s/he may still be eligible for LIFC coverage for an additional period of time. If the income increase is as a result of an increase in **spousal support**, the LIFC recipient may be eligible for four additional months of coverage. If the income increase is as a result of an increase in **earned income**, the LIFC recipient may be eligible for twelve months of coverage. The second six months of coverage is contingent upon cooperation with reporting requirements during the first six months.

After this additional period, the parent/caretaker can be evaluated for Medicaid Expansion for Adults and, if found eligible, be enrolled in that coverage.

If the person's income is over 138% FPL at that time, the LDSS will send the case information to the VIM so the person may be evaluated for financial assistance toward purchasing private health insurance on the Marketplace. Losing Medicaid coverage at annual renewal opens a 90-day Special Enrollment Period that allows the person to shop for private coverage, if eligible. The individual would also be evaluated for the Plan First program.

A parent/caretaker relative cancelled from LIFC for failure to complete annual renewal may reapply for LIFC at any time.

**LIFC coverage will end when there is no longer a dependent child** under the age of 18 **living in the home**, or if an 18 year old in their care is not a full time student. At that time, the LIFC enrollee will be reevaluated for ongoing coverage in other available Virginia health coverage programs.

## **Program Age Limits**

A person can also **age out of coverage**:

- The **MedEx** coverage category is for people **ages 19 to 64 only**. Coverage will end on the last day of the month in which the enrollee turns 65.
- **Medicaid for Former Foster Care Youth is for 19-25 year olds**. Coverage ends on the last day of the month in which the enrollee turns 26. At that time, s/he will be reevaluated for ongoing coverage in any other available state-sponsored health coverage category.
- **FAMIS Plus/FAMIS provide coverage from birth through the age of 18**. Coverage would end at the last day of the month in which the enrollee turns 19. At that time, s/he will be reevaluated for ongoing coverage in any other available state-sponsored health coverage category.

## Managed Care Enrollment Process

A letter is sent from DMAS giving approximately **30 days** for the individual/family to choose an MCO. A comparison chart with the five MCO choices is provided. They are told that if they do not call the Enrollment HelpLine or go to its website to choose, 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.<sup>1</sup>

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

**NO**

Gets assigned an MCO and the MCO assigns a PCP.<sup>1</sup>

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

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

Enrollees still have about **60 days left** to contact the HelpLine and change to a different MCO. After that they can only change during the annual regional MCO "Open Enrollment"<sup>2</sup> period or by writing DMAS and providing "good cause" to change.

1. The enrollee can call the MCO and change their PCP at any time.

2. Open enrollment varies by region and the dates/region localities are available at:  
<https://www.virginiamanagedcare.com/learn/open-enrollment>

*If choice of MCO is made with the Enrollment HelpLine on or before the 18th of the month, the MCO assignment will begin the 1st of the next month. Changes/choices received after the 18th, will happen the month after next.*

*Example: A choice made by September 10th will be effective October 1. A choice made by September 25th will be effective November 1.*

# Sample Managed Care Enrollment Choice Letter



## COMMONWEALTH of VIRGINIA

### Department of Medical Assistance Services

FIRST LAST  
12 SAMPLE RD APT 123  
STAFFORD VA 22554-3949

Date:  
Case: 123-123456-123  
RSO###

Dear Member,

### Welcome to Cardinal Care, Virginia Medicaid Program!

Starting **(Insert Effective Date)**, your health care services will be covered through a Health Plan also known as a Managed Care Organization (MCO). Enrolling in a Managed Care Organization means you will have access to care when you are sick or if you have special medical problems. You can see your primary care provider and receive regular checkups.

You have a choice of MCOs. Each of the MCOs have different doctors and health care providers in their networks. You can select a MCO that is best for you and/or your family members. Your family members are not required to be in the MCO. If you do not call to choose your MCO promptly, you will start in the MCO that we chose for you effective **(Insert Effective Date)**. You have 90 days from **(Insert Effective Date)** to choose a different MCO.

### How to Choose a Managed Care Organization (MCO)-Scan the QR code



- **Learn:** You can learn more about the benefits MCOs provide on the Enrollment website, <https://www.virginiamanagedcare.com>. To compare the added benefits each MCO offers, review the "Health Plan Chart"
- **Choose:** You can select a MCO that is best for you and/or your family members. Your family members are not required to be in the MCO. Make a list of your health care providers and places you get care including hospitals, doctors, specialists, pharmacies, therapists, and other health care providers. Each of the MCOs have different doctors and health care providers in their networks. If you already have a doctor, you can check to see which MCO works with them. **You have 90 days from (Insert Effective Date) to choose a different MCO. If you do not call to choose your MCO promptly, you will start in the MCO that we chose for you effective (Insert Effective Date).**
- **Enroll:** Call the Enrollment Helpline at **1-800-643-2273 (TTY: 1-800-817-6608)**, Monday through Friday between **8:30 a.m. to 6:00 p.m.** (Free interpretation services are available) or use the Enrollment website to see which MCO participate with your health care providers; Or download the free **Virginia Cardinal Care Mobile App** on your Android or iPhone. Search for "**Virginia Cardinal Care**" on Google Play or the App Store to find which health plans work with your doctors.

Your Managed Care Organization will call to schedule a screening with you if required to discuss your health care needs in the next few months. **It is very important for you to complete this screening.**

If you receive long-term services and supports (reside in a nursing facility or receive nursing facility level of care services in your home), have multiple chronic health conditions, and/or have Medicare please see the insert included with this letter.

NAME  
FIRST

LAST

ID#  
123-999999-001

BARCODE

# MCO Sample 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).

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| <p>Aetna Better Health® of Virginia<br/> <b>1-800-279-1878</b>   TTY: 711<br/> <a href="http://AetnaBetterHealth.com/Virginia">AetnaBetterHealth.com/Virginia</a></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <p>Anthem. HealthKeepers<br/> <b>1-800-901-0020</b>   TTY: 711<br/> <a href="http://anthem.com/vamedicaid">anthem.com/vamedicaid</a></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <p>Humana<br/>Healthy Horizons®<br/>In Virginia<br/> <b>1-844-881-4482</b>   TTY: 711<br/> <a href="http://humana.com/HealthyVirginia">humana.com/HealthyVirginia</a></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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| <p><b>Adult vision and hearing</b></p> <ul style="list-style-type: none"> <li>1 eye exam, \$125 for glasses or contacts per year</li> <li>1 hearing exam, \$1,500 for hearing aids, 60 batteries per year</li> </ul> <p><b>Healthy moms and kids</b></p> <ul style="list-style-type: none"> <li>300 free diapers, virtual baby showers, portable cribs, \$25 monthly for mom and baby</li> <li>Free swim lessons, sports physicals</li> <li>24/7 lactation and doula support</li> <li>\$20 monthly for period products</li> <li>\$200 for youth activities and sports</li> </ul> <p><b>Phone and online tools</b></p> <ul style="list-style-type: none"> <li>Free smartphone, with unlimited minutes, text, and 5 GB data</li> </ul> <p><b>Wellness programs</b></p> <ul style="list-style-type: none"> <li>Weight management program</li> <li>\$50 monthly for groceries for members who qualify (\$600 per year)</li> </ul> <p><b>Other benefits</b></p> <ul style="list-style-type: none"> <li>15 free round-trip rides per year</li> <li>14 meals after hospital stay</li> <li>GED certificate incentive, plus extra \$500 for higher ed, trade, or military</li> <li>Free mattress cover, pillowcase and \$150-\$400 per year for carpet cleaning for asthma</li> <li>\$250 for ESL classes</li> <li>\$300 for legal supports</li> </ul> | <p><b>Adult vision and hearing</b></p> <ul style="list-style-type: none"> <li>1 eye exam, up to \$200 for glasses or contacts per year</li> <li>Adult hearing exam, \$2,000 for hearing aids, 60 batteries per year</li> </ul> <p><b>Healthy moms and kids</b></p> <ul style="list-style-type: none"> <li>Up to \$300 gift card for baby items (diapers, car seat, and more)</li> <li>\$100 gift card for youth club membership</li> <li>\$35 Barnes &amp; Noble card for books</li> <li>\$400 for period products</li> </ul> <p><b>Phone and online tools</b></p> <ul style="list-style-type: none"> <li>Free smartphone, with unlimited minutes, text, and data</li> </ul> <p><b>Wellness programs</b></p> <ul style="list-style-type: none"> <li>\$120 for Weight Watchers (WW)®</li> <li>24/7 doctor video visits</li> <li>\$400 healthy grocery gift card</li> <li>Mental health programs</li> </ul> <p><b>Other benefits</b></p> <ul style="list-style-type: none"> <li>24 round-trip non-medical rides</li> <li>56 meals after hospital stay</li> <li>\$120 in GED testing vouchers</li> <li>2 items from Healthy Lifestyle Aids catalog (BP cuff, scale, reacher, etc.)</li> <li>1 item from Asthma/COPD Catalog</li> <li>\$400 for over-the-counter supplies</li> <li>\$100 for employment support</li> </ul> | <p><b>Adult vision and hearing</b></p> <ul style="list-style-type: none"> <li>1 eye exam, up to \$150 for glasses or contacts per year</li> <li>1 hearing exam per year, hearing aids every 3 years, 60 batteries per year</li> </ul> <p><b>Healthy moms and kids</b></p> <ul style="list-style-type: none"> <li>Up to \$125 in maternal care rewards</li> <li>Convertible car seat or portable crib</li> <li>4 boxes of produce for pregnant moms</li> <li>\$160 per year for childcare</li> <li>\$250 for youth activities</li> <li>Free yearly sports physicals</li> <li>\$40 for haircuts for kids, ages 5-20</li> </ul> <p><b>Phone and online tools</b></p> <ul style="list-style-type: none"> <li>Free smartphone with unlimited minutes, text, 10 GB data monthly</li> <li>24/7 doctor video visits</li> <li>Echo Dot® for dementia support</li> </ul> <p><b>Wellness programs</b></p> <ul style="list-style-type: none"> <li>Weight management and financial coaching</li> </ul> <p><b>Other benefits</b></p> <ul style="list-style-type: none"> <li>Up to \$95 for health plan onboarding activities</li> <li>\$65 per quarter for OTC supplies</li> <li>30 free round-trip rides per year</li> <li>Up to 56 meals delivered to home after hospital stay</li> <li>Virtual GED test prep assistance</li> <li>Fall prevention kit</li> </ul> | <p><b>Adult vision and hearing</b></p> <ul style="list-style-type: none"> <li>1 eye exam, \$100 for frames per year</li> <li>1 hearing exam, fitting, and up to \$2,000 for hearing aids per year</li> </ul> <p><b>Healthy moms and kids</b></p> <ul style="list-style-type: none"> <li>400 free diapers</li> <li>Grocery card for pregnant moms</li> <li>Free yearly sports physicals</li> <li>\$20 quarterly for period products</li> <li>Free baby monitor, sleep sack, or pack-n-play (restrictions apply)</li> </ul> <p><b>Phone and online tools</b></p> <ul style="list-style-type: none"> <li>Up to \$25 for iPad or tablet cover (restrictions apply)</li> </ul> <p><b>Wellness programs</b></p> <ul style="list-style-type: none"> <li>Up to \$50 wellness rewards</li> <li>Weight management</li> </ul> <p><b>Other benefits</b></p> <ul style="list-style-type: none"> <li>24 free round-trip non-medical rides</li> <li>56 meals after hospital stay</li> <li>Up to \$275 for GED prep, test (restrictions apply)</li> <li>Up to \$75 for college application help (restrictions apply)</li> <li>Free mattress cover, pillowcase for asthma and COPD</li> <li>\$30 quarterly for adult incontinence products</li> <li>24 free round-trip rides for LTSS caregivers (restrictions apply)</li> </ul> | <p><b>Adult vision and hearing</b></p> <ul style="list-style-type: none"> <li>1 eye exam per year, glasses 2 years</li> </ul> <p><b>Healthy moms and kids</b></p> <ul style="list-style-type: none"> <li>Up to \$100 in maternal health rewards</li> <li>Up to 500 free diapers for new moms</li> <li>Meals sent home after delivery</li> <li>Free period underwear</li> <li>Up to \$100 vaccine incentives at Footlocker® or Walmart® up to age 18</li> <li>Free Boys &amp; Girls Club membership</li> <li>Free yearly sports physicals</li> </ul> <p><b>Phone and online tools</b></p> <ul style="list-style-type: none"> <li>Low-cost smartphone with 3000 mins, unlimited texts, 4.5 GB data monthly</li> <li>Self Care® app for mental health</li> <li>24/7 doctor video visits</li> </ul> <p><b>Wellness programs</b></p> <ul style="list-style-type: none"> <li>Free gym membership to 300+ gyms &amp; YMCAs, free virtual fitness options</li> <li>13 Weight Watchers (WW)® vouchers</li> <li>Up to \$50 healthy rewards</li> </ul> <p><b>Other benefits</b></p> <ul style="list-style-type: none"> <li>12 free round-trip rides to places of worship, grocery, DMV, DSS, library</li> <li>14 meals after hospital stay</li> <li>Unlimited support to get GED, ages 18+</li> <li>Housing application reimbursement</li> <li>Mattress cover &amp; pillowcase for asthma</li> </ul> |



## PART II: Medicaid for Pregnant Women, FAMIS MOMS and FAMIS Prenatal Coverage

### Once Approved

A woman approved for **Medicaid for Pregnant Women (MPW)** will receive a *Notice of Action on Benefits* stating that she has been approved for full benefit Medicaid. Women approved for **FAMIS MOMS** or **FAMIS Prenatal Coverage** will receive a *Notice of Action on Benefits* stating that they have been approved for full benefit FAMIS programs coverage. (*A sample form is located on page 2.35*)

In a separate mailing, she will receive a permanent Cardinal Care ID card from DMAS. This card enables her to receive services from any Medicaid/FAMIS provider while her permanent benefits delivery method is determined. (*A sample of this card can be seen on page 3.1*)

### Selecting a Provider

The five MCOs providing services to Medicaid for Pregnant Women, FAMIS MOMS, and FAMIS Prenatal Coverage enrollees are listed on [page 3.1](#).

The enrollee will receive a letter from DMAS about the managed care enrollment process. The letter directs her to call the **Enrollment HelpLine** at **(800) 643-2273** Monday through Friday between 8:30AM and 6PM to select her MCO. She can also go online to [www.virginiamanagedcare.com](http://www.virginiamanagedcare.com) to make her choice. **Note:** *The HelpLine has access to interpreter services, if English is not the recipient's primary or preferred language. (A sample enrollment letter is on page 3.15)*

On the website there is a comparison tool where she can compare the MCOs and the "added benefits" each MCO offers in addition to the core package of covered benefits. She can also check to see if any of her current doctors participate in one of the MCOs with the "Find a Provider" tool. (*A sample of the types of added maternity related benefits offered by the MCOs can be seen on page 3.16*)

If she does not respond to the letter by the date indicated, she will be assigned to the MCO listed in the letter and will get the welcome packet and ID cards from that MCO. After receiving this information, she **still has about 60 days to change to another MCO**. After this period, she can only change MCOs during the annual regional Medicaid MCO "Open Enrollment Period" in her locality or if she requests a change and demonstrate good cause as to why she should be allowed to switch MCOs. *Note: At any time, an enrollee may switch to a different PCP within their MCO. (For clarification of the enrollment process see the chart on page 3.8)*

Once the MCO is chosen, either actively by the enrollee or assigned by DMAS, she will receive an ID card and welcome packet from her MCO. This card will be used during her entire enrollment period.

### Using the Cardinal Care and the MCO Health Insurance Cards

Upon receipt of the DMAS/Cardinal Care ID card, the enrollee should check the information on it to be sure it is correct. If it is not correct, she must inform her local DSS or the Cover Virginia Call Center of any needed changes/corrections. A listing of all 120 local DSSs, including addresses and phone numbers, is in [Section 5](#). If the problem is with her MCO card, she will need to call her MCO.

The enrollee should report the loss or theft of her DMAS/Cardinal Care ID card to the local DSS or Cover Virginia Call Center immediately. If the MCO card is lost or stolen, she should report this to her MCO. These cards should never be lent to anyone.

It is the enrollee's responsibility to show her MCO ID card and her DMAS/Cardinal Care ID card to providers each time medical services are received and to make sure the provider participates in the Medicaid/FAMIS MOMS/FAMIS Prenatal program. The provider uses the information on the card(s) to verify enrollment prior to delivering services. Failure to present the card(s) at the time of service may result in the enrollee being held responsible for any incurred expenses.

### Covered Services Overview

The MPW, FAMIS MOMS and FAMIS Prenatal Coverage programs provide a comprehensive package of benefits for pregnant women. The coverage is basically the same as FAMIS Plus coverage for children, although certain services are not available to participants over age 21 (i.e. EPSDT, orthodontia, and eyeglasses/contacts). In addition to covering traditional health care services such as hospitalizations, doctor visits and prescriptions, they also cover services such as non-emergency transportation to medical appointments, doula services, dental care, breastfeeding support and breast pumps, behavioral health/substance abuse treatment services, case management and health education for new mothers and babies with potential health risks, smoking cessation services, and treatment for substance abuse. MCOs may provide additional "added benefits" such as health education, 24-hour nurse advice line access, and disease management programs.

For a full listing of benefits for **Medicaid for Pregnant Women**, see the Medicaid Handbook ([coverva.dmas.virginia.gov/media/qy4mthbc/medical-assistance-handbook-en-final-06-03-25.pdf](https://coverva.dmas.virginia.gov/media/qy4mthbc/medical-assistance-handbook-en-final-06-03-25.pdf)).

For a full listing of benefits for **FAMIS MOMS**, see the FAMIS MOMS Handbook (<https://coverva.dmas.virginia.gov/media/djyqz2v/famis-moms-handbook-en-final-06-03-25.pdf>).



## Period of Coverage and Reporting Requirements

When a pregnant woman is determined to be eligible for **Medicaid for Pregnant Women**, coverage goes back to the **first day of the month** in which she applied. If she requested **retroactive coverage**, by answering the question on the Application about help paying for medical bills in the last **3 months**, the program may retroactively pay for outstanding medical bills for up to three months prior to her application. For example, if a signed application is received in March and ultimately results in enrollment, the enrollee's outstanding medical bills may be covered for December, January, and February, if she was determined eligible for Medicaid during that time and requested retroactive coverage.

**FAMIS MOMS** and **FAMIS Prenatal** coverage begins the **first day of the month in which the application was received**, so only outstanding medical bills incurred during that month may be covered retroactively by the program.

If a **FAMIS Prenatal Coverage enrollee** has outstanding medical bills incurred in the three months prior to the month of application, **she may be evaluated for Emergency Services eligibility for those months**.

Once enrolled in **MPW/FAMIS MOMS**, the enrollee is **covered for the duration of her pregnancy and 12 months postpartum regardless of any changes in income or insurance status**.

After the 12 month postpartum period, a **MPW** enrollee may be eligible for LIFC or Medicaid Expansion for Adults. At the end of a **FAMIS MOMS/MPW** enrollee's post partum-period if her income is above 138% of FPL, she may be eligible to purchase subsidized coverage through the Virginia Insurance Marketplace. Coming off of state-sponsored health insurance coverage opens a Special Enrollment Period for her to shop on the Marketplace. She may also be eligible for family planning services through Plan First. (*For more information on Plan First see pages 3.18-3.19*)

Once enrolled in **FAMIS Prenatal Coverage**, the enrollee is **covered for the duration of her pregnancy and 60 days postpartum regardless of any changes in income or insurance status**. Coverage ends the last day of the month in which the 60th day postpartum occurs. She will not be eligible for any sort of ongoing coverage after the 60 day post-partum period unless her immigration status has changed.

**Note:** *It important for enrollees to report a **change of address** to LDSS or the Cover Virginia Call Center. This information may also be reported on the CommonHelp website if the enrollee has linked her case.*

## Coverage of the Newborn

### **Medicaid for Pregnant Women and FAMIS MOMS**

A **child** born to a woman enrolled in **MPW (or FAMIS MOMS)** is **automatically enrolled in FAMIS Plus (or FAMIS) for one year once she calls her local DSS or the Cover Virginia Call Center to report the**

**birth.** She will report the name of the child, the gender, the race, and the date of birth. This information may also be reported via the CommonHelp website. The hospital or the pregnant woman's MCO may also report the birth to the local DSS on the family's behalf.

A renewal is required in order to retain health coverage at the child's first birthday. The family will receive a renewal application in the mail about 45 days before the child turns 1, the family should check it over, correct/add any needed information and return it. If determined to be still eligible, a *Notice of Action* will be mailed indicating coverage has been renewed for a year.

**Note:** *This child's coverage should remain active until the renewal application is processed, even if it is past the child's first birthday.*

### **FAMIS Prenatal Coverage**

After the baby's birth, a FAMIS Prenatal Coverage enrollee **must report the birth to the state** by calling Cover Virginia (855) 242-8282 or her local Department of Social Services ([See Section 5 for a listing of all local DSSs and their contact information](#)), or by going online to CommonHelp ([www.commonhelp.virginia.gov](http://www.commonhelp.virginia.gov)). She will report the name of the child, the gender, the race, and the date of birth.

She will also be **asked for proof of application for a Social Security Number (SSN) for the child**. The easiest way to apply for a SSN for the child is to do this at the hospital in conjunction with the filing of the birth record at the time of the child's birth.

The LDSS will treat the addition of the child as a "Change in Circumstance." The infant is not a deemed-eligible newborn, but rather has been enrolled prenatally through the mother's enrollment in FAMIS Prenatal Coverage. The child's birth is treated as an "Add A Person" case change in the enrollment system. The child will be enrolled in Medicaid/FAMIS Plus or FAMIS based on the mother's countable income at the time of application and the infant's renewal will be due 12 months from the month of the infant's enrollment.

Once the SSN has been received for the child, the family should report it to their Local DSS.

**Sample Maternity MCO Enrollment Letter**

<DATE>

<CASE NAME>

<ADDRESS>

<CITY><STATE><ZIP>

Case ID: xxx-xxxxxx-xxx

MCF412AP

**Welcome to Cardinal Care, Virginia's Medicaid Program**

Beginning <DATE> you will get health care coverage through a managed care health plan.

The health plan selected for you offers special benefits and services for you during your pregnancy, for the birth of your child and for the first 12 months after delivery. The health plan will connect you with doctors, hospitals, and specialists that work together to give you and your baby the care you need. Your health plan offers additional maternity benefits. Please refer to the Maternity Comparison Chart attached with this letter or visit <https://virginiamanagedcare.com/en/member-materials> online for more information.

Although a health plan has been selected for you, you have the right to choose a different plan.

**How to Choose a Different Managed Care Health Plan - Scan the QR code**



- **Learn:** Find out more about the advantages offered by Managed Care Organizations (MCOs) at the Managed Care website, <https://www.virginiamanagedcare.com>. To see the different benefits that each MCO provides, check out the **"Health Plan Chart."**
- **Choose:** When it comes to choosing a Health Plan, you can pick one that best fits the needs of you and your family. It's not required for everyone in your family to choose the same plan. If you have a preferred doctor, you can confirm which health plans accept them.
- **Enroll:** Download the free **Virginia Cardinal Care Mobile App** available for both Android and iPhone. Just search for **"Virginia Cardinal Care"** in Google Play or the App Store. Also, you can visit the Managed Care website or call the Managed Care Helpline at **1-800-643-2273 (TTY: 1-800-817-6608)**. **The helpline is open Monday to Friday from 8:30 a.m. to 6:00 p.m.,** and free interpretation services are also available.

To keep the health plan we have assigned you, you do not have to do anything. You will receive an identification card, welcome packet, and phone call from your new health plan. You should show both cards when receiving care and you should never throw away your Medicaid ID card.

Your baby qualifies for health insurance for the first year of life. Please tell us as soon as your baby is born. You can enroll your newborn by calling Cover Virginia at **1-855-242-8282** or report the birth to your Eligibility Worker at your local Department of Social Services.

**If you are no longer in need of Medicaid Coverage, please contact Cover Virginia at 1-855-242-8282 (TTY: 1-888-221-1590) or contact your caseworker at the Local Department of Social Services.**

NAME

<Recipient Name>

RECIPIENT ID#

<12-Digit Recipient ID #>

MCO PLAN

<MCO Plan>

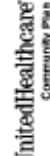
# Maternity Programs Sample Added Benefits

## MATERNAL HEALTH – ENHANCED BENEFITS HEALTH PLAN COMPARISON CHART

Supporting maternal health is a priority for Virginia Medicaid. Use this chart to compare each health plan's extra benefits. For a full list of services, visit [www.virginiamanagedcare.com](http://www.virginiamanagedcare.com)



SCAN  
ME!

| <br><b>Aetna</b><br>Aetna Better Health<br><b>Baby Matters</b><br>1-800-279-1878<br>TTY: 711                                                                                                                                                                                                                                                                                                                                                                                                          | <br><b>Anthem</b><br>HealthKeepers Plus<br><b>New Baby New Life</b><br>1-844-533-1994 – Option #3<br>TTY: 711                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Humana</b><br>Healthy Horizons<br>In Virginia<br><b>Humana Beginnings</b><br>1-888-847-9960<br>TTY: 711                                                                                                                                                                                                                                                                                                                                                                                                                                        | <br><b>Sentara</b><br>Health Plans<br><b>Welcoming Baby</b><br>1-844-671-2108<br>TTY: 711                                                                                                                                                                                                                            | <br><b>UnitedHealthcare</b><br>Community Plan<br><b>Healthy First Steps</b><br>1-800-599-5985<br>TTY: 711                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>During Pregnancy</b> <ul style="list-style-type: none"> <li>• \$25 each month to spend on over-the-counter items for yourself and baby through CVS Pharmacy®</li> <li>• \$50 Healthy Food Card- Every month for high-risk pregnant woman to buy healthy foods</li> <li>• \$50 Wellness Reward- For going to prenatal and postpartum visits</li> <li>• 24/7 Get information on preparing for breastfeeding with live video chats</li> </ul>                                                                                                                                            | <b>During Pregnancy</b> <ul style="list-style-type: none"> <li>• \$50 Healthy Reward for 1st prenatal visit</li> <li>• Online support for your mental health during pregnancy (Twill)</li> <li>• Women's Wellness and Recovery Program for women experiencing problems with drugs or alcohol (Empower)</li> <li>• OB Concierge Care- a digital app to access resources and added benefits to support a healthy pregnancy</li> <li>• 24/7 Online Medical Practice to improve maternal health outcomes (Pomelo)</li> </ul>                                                                                                             | <b>During Pregnancy</b> <ul style="list-style-type: none"> <li>• \$25 for reporting a pregnancy and joining HumanaBeginnings</li> <li>• Up to \$100 reward for completing prenatal visits</li> <li>• Up to 4 boxes of fruits and vegetables for pregnant moms (if standards are met)</li> </ul>                                                                                                                                                                                                                                                   | <b>During Pregnancy</b> <ul style="list-style-type: none"> <li>• Up to \$50 in rewards, education &amp; resources via Baby Scripts™ digital app</li> <li>• Gestational Diabetes</li> <li>• Healthy food box program</li> <li>• Virtual prenatal care &amp; education (Pomelo Care)</li> <li>• Online support for your mental health (AbleTo)</li> <li>• 24/7 live video chat with a doctor</li> </ul> | <b>During Pregnancy</b> <ul style="list-style-type: none"> <li>• Up to \$50 in rewards, education &amp; resources via Baby Scripts™ digital app</li> <li>• Meal delivery service after giving birth</li> <li>• Free supply of absorbable menstrual undergarments</li> <li>• 24/7 virtual breastfeeding support and education (Pomelo Care)</li> <li>• Online support for your mental health (AbleTo)</li> </ul>                                     |
| <b>After Giving Birth</b> <ul style="list-style-type: none"> <li>• \$25 each month to spend on over-the-counter items for yourself and your baby at CVS Pharmacy®</li> <li>• \$50 Wellness Reward- For going to prenatal and postpartum visits</li> <li>• New Mom's Gift Box for those that participate in care management with their MCO during the month after giving birth</li> <li>• Up to 300 size 1 baby diapers delivered to your home</li> <li>• Free home-delivered meals for 7 days after leaving hospital</li> <li>• 24/7 Breastfeeding help with live video chats</li> </ul> | <b>After Giving Birth</b> <ul style="list-style-type: none"> <li>• \$25 Healthy Reward for postpartum care visit</li> <li>• Baby Essentials Catalog- Pick up to 3 items for you or your baby (car seats, baby carriers, diapers and more to choose from)</li> <li>• Online support for your mental health during your pregnancy (Twill)</li> <li>• Wellness and Recovery Program for women experiencing problems with drugs or alcohol (Empower)</li> <li>• Home delivered meals after pregnancy- (Nourished Well offers dietician services)</li> <li>• Online Medical Access Program to improve maternal health (Pomelo)</li> </ul> | <b>After Giving Birth</b> <ul style="list-style-type: none"> <li>• 1 convertible car seat or portable crib per infant (if standards are met)</li> <li>• \$25 reward for completing postpartum visit</li> <li>• \$10 for completing safe sleep health education</li> <li>• Up to \$65 per quarter for OTC items such as diapers</li> <li>• Up to 56 meals delivered to home after hospital stay</li> <li>• Up to \$160 per year for childcare assistance</li> <li>• Up to 30 round trips to locations such as WIC and SNAP appointments</li> </ul> | <b>After Giving Birth</b> <ul style="list-style-type: none"> <li>• Up to 400 Free Diapers (size newborn to size 2)</li> <li>• Home Delivered Meals – Up to 56 freshly prepared meals</li> <li>• Free baby monitor or sleep sack with the Safe Sleep Program</li> <li>• Up to \$50 - Healthy Member Incentive - For going to prenatal and postpartum visits</li> </ul>                                 | <b>After Giving Birth</b> <ul style="list-style-type: none"> <li>• Up to 500 free diapers</li> <li>• Up to \$50 in rewards, education &amp; resources via Baby Scripts™ digital app</li> <li>• Meal delivery service after giving birth</li> <li>• Free supply of absorbable menstrual undergarments</li> <li>• 24/7 virtual breastfeeding support and education (Pomelo Care)</li> <li>• Online support for your mental health (AbleTo)</li> </ul> |

# Virginia Medicaid Dental Coverage

## 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 COVERAGE?

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).

## WHAT SERVICES ARE COVERED?

### 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
- Partial 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.



## PART III: Plan First

### Plan First

Plan First began in January 2008. It is a **limited coverage** Medicaid program that pays for birth control and family planning services for women and men with incomes up to 205% FPL. The income guidelines for this program are on [Page 2.11](#).

### Who is Eligible?

US citizen or qualified legal immigrant\* men and women who are residents of Virginia, whose incomes fall within the program guidelines, and who do not qualify for any other full coverage Medicaid program. Medicaid for Pregnant Women and FAMIS MOMS enrollees may be eligible for Plan First coverage at the end of their postpartum coverage.

*\*Lawful permanent residents (LPRs) may be eligible after the first 5 years of residence in the US.*

### How to Apply

People wishing to apply for Plan First use the same Application to apply for coverage as for Medicaid/FAMIS. They may also apply over the phone via the Cover Virginia Call Center, online via CommonHelp, or via paper application mailed or delivered to their local DSS. It may take DSS or Cover Virginia CPU up to 45 days to make an eligibility determination of eligibility.

On the Application, in **Step 2: (Person 1 Question 8A or Person 2 Question 9A)**, check "Yes" in to be evaluated for Plan First.

*Note: In December 2024, Plan First became an "Opt-In" program. No longer will people automatically be screened for Plan First coverage if they do not meet the requirements for a Full Benefit Program.*

### Term of Coverage

Once enrolled, the man or woman is enrolled for up to one year unless any changes of circumstances happen (i.e. increase in income, moving out of state). Annual renewal of coverage is required to retain ongoing coverage. This procedure is the same as that detailed for other programs in this section.

### Covered Services

- Family planning education and birth control counseling
- Pap smears for women to screen for cervical cancer, if appropriate
- Prostate exams for men
- Sexually transmitted infection (STI) testing
- Lab services for family planning and STI testing

- Sterilizations - tubal ligation for women and vasectomies for men (the enrollee must be age 21 or over and wait 30 days after signing the consent form for these services)
- Prescription and over-the-counter contraceptives (with a doctor's order), including implants, rings, patches, IUDs, birth control pills, diaphragms, Depo Provera injections, and condoms
- Non-emergency transportation to a family planning service or to pick up a prescription for birth control

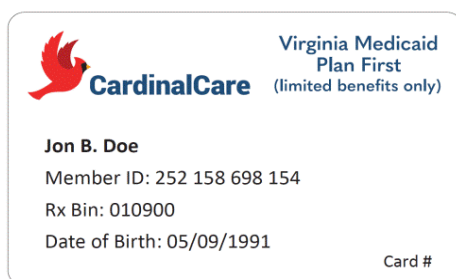
The following services are **not** covered:

- Medical exams for women/men who do not want or no longer need pregnancy prevention services
- Treatment for any medical problems (including STIs or other reproductive health problems)
- Repeat Pap tests due to a problem or Pap tests for women who do not need birth control
- Vaccinations, mammograms, hysterectomies, and treatment for infertility
- Abortions
- Emergency transportation - ground or air ambulance

## How to Access Services

Enrollees receive a Cardinal Care Plan First Card and they can see any provider **who takes Medicaid and provides family planning services**. Services can be received at Health Department Family Planning Clinics and most community health centers.

### Card since January 2024



## PART IV: FAMIS *Select* and HIPP

### FAMIS *Select*

FAMIS *Select* is the name for the “premium assistance” component of the FAMIS program. The program has been streamlined and simplified to be more easily understood by families and employers, and to allow a greater number of families to participate. The program is also open to self-employed families that get their insurance through private insurance plans.

FAMIS *Select* is a “rebate” program. **ONCE A CHILD HAS BEEN ENROLLED IN FAMIS**, the family can select this option that allows them to cover their children with health insurance offered through an employer or a private company, and be reimbursed for a portion of the cost of coverage for the FAMIS children.

If a family decides to participate in FAMIS *Select*, they will fill out an additional application, and once approved, they will sign up for their employer/private plan. Once they send in their pay stub (cancelled check for a private plan) as proof of payment, the family will be reimbursed up to \$100 per FAMIS enrolled child per month. (*See pages 3.23-3.24 for the FAMIS Select application*)

For example: a FAMIS *Select* family of five (mother, father and three FAMIS enrolled children) would receive \$300 per month toward the cost of family coverage. *Note: FAMIS Select will not reimburse an amount greater than the actual cost of the coverage, so if the total cost paid for insurance was only \$200, then this family would only receive \$200.*

The FAMIS *Select* option may allow a family to afford family coverage that truly does cover the entire family, including family members not otherwise eligible for FAMIS (i.e. an uninsured spouse, a child over age 19). It may also allow the entire family to see the same providers who all participate in the employer/private plan.

It is important to note that **under FAMIS *Select* any deductibles, co-insurance and copayments required by the employer/private plan are the responsibility of the family.** Over time these can add up to a significant financial outlay. “Regular” FAMIS has no copays. Also, the family will be **limited to the services provided by their employer/private plan** and use that plan’s participating providers.

While it may seem like a “deal” to cover the family through FAMIS *Select*, it may make more sense in the long run to have children on “regular” FAMIS and just add coverage for a spouse through work. Families will need to consider this carefully when deciding whether to participate in FAMIS *Select*. There is a helpful decision tool on the Cover Virginia website to help families decide if FAMIS *Select* is the best option for them: [https://coverva.dmas.virginia.gov/media/2067/famis\\_famis\\_select\\_decision\\_aid-031423.pdf](https://coverva.dmas.virginia.gov/media/2067/famis_famis_select_decision_aid-031423.pdf)

If at any time a family in FAMIS *Select* drops the private/employer coverage, the family should notify the FAMIS *Select* Office and the eligible children will

revert to “regular” FAMIS coverage. Children enrolled in this program still need to renew their FAMIS Coverage every 12 months in order to stay enrolled.

The application process consists of:

- Complete the FAMIS *Select* Application
- Attached copies of the front and back of all health, dental, vision and pharmacy insurance cards (private insurance only) for all family members (in PDF form)
- Attach a copy of the most recent pay stub.

To apply or for more information contact FAMIS *Select* at:  
FAMIS *Select* Unit  
VA Department of Medical Assistance Services  
600 East Broad Street  
Richmond, VA 23219  
1-888-802-KIDS (1-888-802-5437)

For general questions and to submit the application and required attachments email: [FAMIS.Select@dmass.virginia.gov](mailto:FAMIS.Select@dmass.virginia.gov)

## Health Insurance Premium Program (HIPP)

The Virginia Department of Medical Assistance Services offers two premium assistance programs for Medicaid members without Medicare coverage. **Both programs are completely voluntary.**

**HIPP** is the premium assistant program for adults. It may be available to people with Medicaid and may help pay for part or all of their health insurance premiums. To be eligible:

- A household member must have Medicaid full coverage
- The person must have or be able to get insurance through his/her employer
- The health insurance available must meet program criteria, including cost effectiveness

**HIPP for Kids (HFK)** is the premium assistance program that may be available to children under the age of 19 who are also eligible for Medicaid. It pays for their entire health insurance premium. Cost sharing may apply to non-covered copayments, deductibles, and other expenses not covered by the primary insurer. To be eligible:

- a household is under age 19 and enrolled in full coverage Medicaid.
- have access to a group health plan or COBRA and maintain it through an employer.
- The health insurance available must meet program criteria, including “qualified employer-sponsored coverage” requirements and cost-effectiveness.

### HIPP Application Checklist:

- Complete all parts of the HIPP application
- Complete Employer Insurance Verification (EIV) Form
- Submit a copy of the health insurance plan summary showing services covered, copays, individual/family deductibles, and co-insurance amounts
- Provide copies of current paystubs showing insurance premium payments
- Submit front and back images of insurance card(s) of Medicaid eligible family member(s).

All applications are evaluated for HFK first. If not eligible under that program, then the application will be evaluated for HIPP.

If approved for HIPP or HFK, verification documents must be submitted on a quarterly basis (in the form of paystubs) to prove the health policy premium is being paid and what the premium amount is. This is a reimbursement process. Once verified, DMAS will send a paper check for the previous month's premium at the end of the next month. If the person has incurred costs for copays, prescriptions, etc., they would submit a cost sharing packet and a HIPP analyst will determine if any of those items can be reimbursed.

More information on these programs including the application and other resources can be found on the Cover Virginia website at: <https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs/>

To contact DMAS for information regarding these programs, people should send an email to [HIPPcustomerservice@dmas.virginia.gov](mailto:HIPPcustomerservice@dmas.virginia.gov) or call (800) 432-5924. These customer service numbers are available Monday - Friday from 7:30AM to 4PM, excluding holidays. The HIPP Unit fax number is (804) 452-5447; please email the address above to confirm the faxed document was received successfully and completely. The mailing address for the HIPP Unit is:

VA Department of Medical Assistance Services  
ATTN: HIPP Unit  
600 East Broad Street, Suite 1300  
Richmond, VA 23219





# FAMIS Select – Application

## WHAT IS FAMIS Select?

FAMIS Select is a voluntary program that gives families with children **approved for FAMIS** greater flexibility and choice in providing for their family's health care coverage. FAMIS Select can help families pay for part of their health insurance premiums at work or for a private insurance plan.

**INSTRUCTIONS:** The policyholder or person who carries the insurance plan should complete this application. Please print all information and check application for completeness. FAMIS Select enrollment will begin the month after approval of your FAMIS Select Application. Read the back of this application for detailed instructions. **Proof of Insurance payment must be included with the application in order to process.** When you have answered all the questions, sign and return to: **FAMIS Select Unit, DMAS, Suite 1300, 600 East Broad Street, Richmond, VA. 23219. Phone: (804) 786-7024 (Richmond Area), 1- 888-802-5437 (Rest of State) or Fax to (804) 225-3961 Attn: FAMIS Select.**

## SECTION 1 - Personal Information of Applicant (Policyholder)

|                                        |               |                                                  |                                                    |
|----------------------------------------|---------------|--------------------------------------------------|----------------------------------------------------|
| <b>Name:</b>                           |               | <b>Social Security Number:</b><br>(Not Required) |                                                    |
| <b>Address (Street, PO Box, etc.):</b> |               |                                                  |                                                    |
| <b>City:</b>                           | <b>State:</b> | <b>Zip Code:</b>                                 | <b>Home Phone # ( )</b><br><b>Work Phone # ( )</b> |

## SECTION 2 – Information on Health Insurance Policy

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                              |                                             |                                               |                                      |                                                    |                                        |                                      |                                       |                                             |                                             |                                                                                                                                          |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-----------------------------------------------|--------------------------------------|----------------------------------------------------|----------------------------------------|--------------------------------------|---------------------------------------|---------------------------------------------|---------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| <b>Name and Address of Insurance Company:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>Employer's Plan</b> <input type="checkbox"/> <b>Private Insurance Plan</b> <input type="checkbox"/><br><b>Effective Date:</b> /     /<br><b>Policy #:</b> |                                             |                                               |                                      |                                                    |                                        |                                      |                                       |                                             |                                             |                                                                                                                                          |  |  |
| <b>Check the Benefits Covered by the Plan:</b><br><table border="0"><tr><td><input type="checkbox"/> Doctor visits</td><td><input type="checkbox"/> Well-child check-ups</td><td><input type="checkbox"/> Dental care</td></tr><tr><td><input type="checkbox"/> Hospital &amp; emergency care</td><td><input type="checkbox"/> Immunizations</td><td><input type="checkbox"/> Vision Care</td></tr><tr><td><input type="checkbox"/> Lab &amp; X-rays</td><td><input type="checkbox"/> Prescription drugs</td><td><input type="checkbox"/> Mental Health Care</td></tr><tr><td colspan="3"><input type="checkbox"/> Other (Please explain if this policy has special or limited benefits such as for accidents only or cancer only)</td></tr></table> |                                                                                                                                                              | <input type="checkbox"/> Doctor visits      | <input type="checkbox"/> Well-child check-ups | <input type="checkbox"/> Dental care | <input type="checkbox"/> Hospital & emergency care | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Vision Care | <input type="checkbox"/> Lab & X-rays | <input type="checkbox"/> Prescription drugs | <input type="checkbox"/> Mental Health Care | <input type="checkbox"/> Other (Please explain if this policy has special or limited benefits such as for accidents only or cancer only) |  |  |
| <input type="checkbox"/> Doctor visits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> Well-child check-ups                                                                                                                | <input type="checkbox"/> Dental care        |                                               |                                      |                                                    |                                        |                                      |                                       |                                             |                                             |                                                                                                                                          |  |  |
| <input type="checkbox"/> Hospital & emergency care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Immunizations                                                                                                                       | <input type="checkbox"/> Vision Care        |                                               |                                      |                                                    |                                        |                                      |                                       |                                             |                                             |                                                                                                                                          |  |  |
| <input type="checkbox"/> Lab & X-rays                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Prescription drugs                                                                                                                  | <input type="checkbox"/> Mental Health Care |                                               |                                      |                                                    |                                        |                                      |                                       |                                             |                                             |                                                                                                                                          |  |  |
| <input type="checkbox"/> Other (Please explain if this policy has special or limited benefits such as for accidents only or cancer only)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                              |                                             |                                               |                                      |                                                    |                                        |                                      |                                       |                                             |                                             |                                                                                                                                          |  |  |

**Note: The employee must apply for the full premium contribution from the employer.**

## SECTION 3 - List ALL Family Members Covered by Plan and Check if Approved by FAMIS

| NAME | DATE OF BIRTH | RELATIONSHIP | FAMIS-APPROVED                                           |
|------|---------------|--------------|----------------------------------------------------------|
|      |               |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|      |               |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|      |               |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|      |               |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|      |               |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|      |               |              | <input type="checkbox"/> Yes <input type="checkbox"/> No |

## SECTION 4 – Insurance Premium Information (Amount paid by policyholder does not include employer's contribution)

|                                                                                            |                                                            |                                                            |                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Amount paid for Health Insurance<br><b>Per paycheck \$</b>                                 | Amount paid for Dental Insurance<br><b>Per paycheck \$</b> | Amount paid for Vision Insurance<br><b>Per paycheck \$</b> | Number of Pay Periods per month insurance is deducted from<br><b>4 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> other <input type="checkbox"/></b> |
| <b>For Private Health Plans</b><br>Amount paid for Health Insurance<br><b>Per month \$</b> | Amount paid for Dental Insurance<br><b>Per month \$</b>    | Amount paid for Vision Insurance<br><b>Per month \$</b>    |                                                                                                                                                                                      |

**Disclaimer:** The FAMIS Select program will not provide premium assistance payments to a non-custodial parent who is under a court order to provide medical support.

|                                                                           |              |
|---------------------------------------------------------------------------|--------------|
| <b>Signature of Policyholder:</b>                                         | <b>Date:</b> |
| <b>Signature of Custodial Parent:</b><br>(if different than policyholder) | <b>Date:</b> |

## FAMIS *Select* -Application Instructions

### How do I apply?

To get started, simply fill-out the application. **If you have additional questions, contact the FAMIS *Select* Unit at (804) 786-7024 or toll-free at 1-888-802-5437.**

**Section 1 Personal Information of Applicant (Policyholder):** The policyholder is the person who carries the insurance plan. Complete this section by listing your name, social security number (not required) address, city/county of residence and phone numbers (work and home).

**Section 2 Information on Health Insurance Policy:** Complete this section by indicating the name and address of your health insurance company/plan, check if your plan is an employer's plan or a private plan and include the effective date and policy number. In the next box, check the benefits that are covered by your plan.

**Note:** The applicant completing this form and receiving health insurance from an employer must apply for the full contribution available from the employer.

**Section 3 List ALL Family Members Covered by Plan and Check if Approved by FAMIS:** Provide information on all family members, including adults, that will be covered by the applicant's employer-

sponsored health plan or by a private health plan. For each person, write the name, date of birth, your relationship to the person, and if the person is a child, check if they are approved for FAMIS.

**Section 4 Insurance Premium for Health and Dental:** Write in "amount paid" by policyholder per paycheck for health, vision, and dental. In the next box, check the box that indicates the number of pay periods for insurance deductions each month. 4 is weekly, 2 is bi-weekly, 1 is monthly) Please state if other.

**Proof of Insurance payment must be included with the application in order to process.**

**Signature:** If you are the policyholder, sign on the first line. If the policyholder is not a custodial parent, then a custodial parent must also sign the second line.

### **Final checklist:**

- ☐ did you answer all the questions?
- ☐ did you attach your pay-stub or proof of an insurance payment?
- ☐ did you sign the application?

**Mail to FAMIS *Select***  
**600 East Broad Street, Suite 1300**  
**Richmond, VA 23219, or Fax to (804) 225-3961.**

Each month send to FAMIS *Select* a pay-stub that shows insurance is being deducted or proof you have paid for private health insurance. It is very important that you report any changes in your health care coverage to FAMIS *Select* IMMEDIATELY. Failure to do so may result in repayments to the Virginia Department of Medical Assistance Service

**HELP US KEEP YOUR CHILDREN COVERED – TELL US IF YOU CHANGE JOBS, DROP THE INSURANCE PLAN, HAVE A NEW ADDRESS (CHECKS CANNOT BE FORWARDED), OR PURCHASE A NEW PLAN.**

## Sample Renewal Approval

Henry County (089)  
PO Box 832  
20 Progress Street  
Martinsville, VA 24114

Commonwealth of Virginia  
Department of Social Services  
Questions? Call: (276) 656-4300

Letter Date: August 02, 2025  
Case Number: 115831519

Test X Employee  
53 Hartsock LN  
Bassette, VA 24055

### News for your household

An automatic 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)            |
|-----------------------|----------|----------|------------------------------|
| Test X Employee       | Closed   | FULL     | August 31, 2025              |
| Test X Employee       | Eligible | FULL     | September 01, 2025 - Ongoing |

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



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

Case #: 115831519

Page 1 of X

Correspondence #: 718705669



## 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](http://www.coverva.org). If your information has changed since you applied or you think we made a mistake call us. You can also file an appeal. For more information on how to file an appeal see the page titled "If you think we made a mistake."

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 **(276) 656-4300**.

When Medicaid or FAMIS has been approved for children, continuous eligibility policy allows the children to remain enrolled for 12 months or their renewal, whichever comes later. The following exceptions apply:

- a. Death
- b. Left Virginia permanently
- c. Voluntary withdraw/termination (customer request)
- d. A member can move from FAMIS to Medicaid if their countable income decreases into Medicaid eligibility levels, or to a higher level of coverage based on other changes.
- e. A member can be re-evaluated for all other covered groups once they turn 19 without a renewal.

Medicaid and FAMIS children are protected from changes in income or address (as long as they remain residing in Virginia). For FAMIS applicants, health insurance gained after approval does not affect eligibility until the 12th month of enrollment or renewal, whichever comes later.

## Approvals

### Update for Test X Employee

Client ID: 2109624173

You qualify for health coverage from Virginia Medicaid.

| Medicaid ID Number                                                                                                                                                                                        | Coverage | Effective Date               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|------------------------------|
| 351365839015                                                                                                                                                                                              | FULL     | September 01, 2025 - Ongoing |
| Test X Employee qualifies for full coverage Medicaid. This covers services like doctor visits, hospital care, prescriptions, dental coverage and more.                                                    |          |                              |
| <b>Health Coverage must be renewed every year.</b> The next renewal is due <b>October 31, 2026</b> . 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.



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



Case #: 115831519

Page 2 of X

Correspondence #: 718705669

### 3.26 Sample Renewal Approval

## 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.viriniamedicaid.dmas.virginia.gov](http://www.viriniamedicaid.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 **(276) 656-4300**.

## Closures

### Update for Test X Employee August 31, 2025

Client ID: 2109624173

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; M0450.400; M0320.000; M0330.001.

### 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.



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)**.





- » 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.
- » If you did not intend to apply for Medical Assistance, or you or someone in your household needs your coverage closed for some other reason.

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 **(276) 656-4300**.

### 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: 115831519**

**Client ID: 2109624173**

### Information about other programs

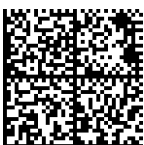
You and others in your household may qualify for other assistance, like help buying food or paying heating and cooling bills. If you already applied for other assistance, information about those programs may come in a separate letter.

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

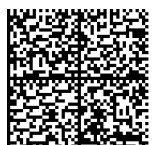
| Worker Name: | Telephone Number: | For Free Legal Advice Call: |
|--------------|-------------------|-----------------------------|
| S. CHANDA    | (804) 726-7130    | 1-866-534-5243              |

### Additional Information from Your Case Worker:

*Note: Some pages in this notice have been omitted to save space. One was the "If You Think We Made a Mistake" section that can be viewed on Page 2.40. Another is the "It is Important We Treat You Fairly" wording that can be seen on Page 2.41. The final two pages would be information about the right to get this information in other languages - these are included in the Sample Renewal on Pages 3.33-3.54.*



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)**.



**Sample Cancellation Notice**

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: August 04, 2025  
Case Number: 116024526

Gluten Free  
454 R ST NW  
Lynchburg, VA 24515

**News for your household**

A change to the information affecting members of your household has been identified and used to determine your health coverage for Virginia Medicaid. When possible this information is used to redetermine your eligibility and give you a new certification period. 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) |
|-----------------------|----------|----------|-------------------|
| Gluten Free           | Closed   | FULL     | August 31, 2025   |

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



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)**.



## 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](http://www.coverva.org). If your information has changed since you applied or you think we made a mistake call us. You can also file an appeal. For more information on how to file an appeal see the page titled "If you think we made a mistake."

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**.

When Medicaid or FAMIS has been approved for children, continuous eligibility policy allows the children to remain enrolled for 12 months or their renewal, whichever comes later. The following exceptions apply:

- a. Death
- b. Left Virginia permanently
- c. Voluntary withdraw/termination (customer request)
- d. A member can move from FAMIS to Medicaid if their countable income decreases into Medicaid eligibility levels, or to a higher level of coverage based on other changes.
- e. A member can be re-evaluated for all other covered groups once they turn 19 without a renewal.

Medicaid and FAMIS children are protected from changes in income or address (as long as they remain residing in Virginia). For FAMIS applicants, health insurance gained after approval does not affect eligibility until the 12th month of enrollment or renewal, whichever comes later.

## Closures

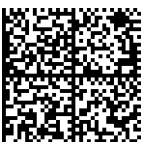
**Update for Gluten Free  
August 31, 2025**

**Client ID: 2110066199**

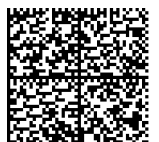
You no longer qualify for health coverage from Virginia Medicaid.

This individual does not qualify for health coverage from Virginia Medicaid because the countable household income is over the income limit. We made our decisions based on these rules: Virginia Medical Assistance Manual Reference M0440.100; M0710.700; M0810.002 ; M0450.400; M0320.000; M0330.001.

Individuals who do not qualify for full health coverage might still be able to get full health coverage—and help paying for it—through Virginia’s Insurance Marketplace. In some situations, we send your information to the Marketplace. If so, Virginia’s Insurance Marketplace will send you an email or mail notification. **To learn more, read the “How to Complete the application for Virginia’s Insurance Marketplace” insert with this notification.**



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



Case #: 116024526

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Correspondence #: 718715169

**Information about other programs**

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

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

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

*Note: Several pages of this notices have been omitted to save space. They can be seen on pages 2.40 and 2.41.*



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)**.



## What is Virginia's Insurance Marketplace?

Virginia's Insurance Marketplace is the place to shop for and buy affordable private health insurance online, over the phone, or with in-person help. There is financial help available for people who qualify.

**You or someone in your household was found not eligible for Medicaid. You may still be able to get help paying for health coverage through the Virginia's Insurance Marketplace. Your information has been sent to the Virginia's Insurance Marketplace to start an application, but you must take action to see if you qualify!**

You can apply and enroll in a Marketplace plan as early as 60 days before your Medicaid or CHIP coverage ends to help prevent a gap in coverage.

## How to Complete the Application for Virginia's Insurance Marketplace:

You should complete the Marketplace application within 90 days of loss of Medicaid coverage. The sooner you apply for coverage; the sooner new coverage can begin. You should complete the Marketplace application as soon as you can to see if you can get coverage now. To complete your application, you can:

1. **Wait for a notification from the Marketplace (email or regular mail).** The notice will tell you how to complete your application with them. The Marketplace is starting a health insurance application for the following individual(s): **Gluten Free**

Or

2. **Start a new application.** You can go to **marketplace.virginia.gov** or contact the Call Center at **888-687-1501 or (TTY: 711)**. You will need to:
  - » Create a Virginia's Insurance Marketplace user account for Virginia's Insurance Marketplace online or by phone with a Call Center Representative.
  - » Have this letter/notice with you to help answer questions.
  - » Provide the information you gave us already.
  - » Answer "yes" when asked if anyone has been found not eligible for Medicaid or the Children's Health Insurance Program (CHIP) in the past 90 days, if this applies.

If you have questions or need help completing your application, call Virginia's Insurance Marketplace customer service center at **888-687-1501 (TTY: 711)** or go online to **marketplace.virginia.gov**.

After you complete your application, Virginia's Insurance Marketplace will tell you if you qualify to enroll in Marketplace insurance, if you can enroll right away, or if you have to wait to enroll. The Marketplace will tell you if you qualify for help paying for your coverage. **If you qualify for coverage right away, select and enroll in a plan!**

If the Marketplace tells you that you have to wait, you can reapply during Open Enrollment (November 1st -January 15th). Some individuals who experience a life event will qualify for a Special Enrollment Period and can enroll outside of Open Enrollment. Examples of life events that may qualify you for a Special Enrollment Period include losing Medicaid or other health insurance, having a baby or getting married. You usually only have 60 days after the date of the life change to apply for Marketplace coverage.



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)**.



**Sample Renewal Notice**

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

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

Commonwealth of Virginia  
Questions? Call: 999-999-9999

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

Letter Date: August 04, 2025  
**Response Due: September 03, 2025**  
Case Number: 116024926  
Case Worker Name: J. WATKINS  
Worker User ID: jxw680

Nut Thin  
11 Gluten Free FT  
Lynchburg, VA 24515

Please  
complete  
your renewal by:  
**September 03,  
2025**

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

**Some or all of the household members are due for a renewal and if renewal is not completed their coverage may close or be reduced. Please see section 3 for details.**

- |                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>① Online*:</b><br/>Go to <b>CommonHelp.Virginia.gov</b>.<br/>Click on “Renew My Benefits.”<br/>To create an account:</p> <ul style="list-style-type: none"><li>▪ Go to <b>CommonHelp.Virginia.gov</b></li><li>▪ Click “Check My Benefits.”</li><li>▪ To link your case to your CommonHelp account using the information below, log in</li></ul> | <p><b>② By Phone:</b><br/>Call 1-855-242-8282/ TTY: 1-888- 221-1590; this call is free.</p> <p><b>③ By mail or fax:</b><br/>Cardinal Care Correspondence Center,<br/>PO box 1820,<br/>Richmond, VA 23218<br/>Fax: (888) 221-9402<br/><br/>If you’re unable to complete your renewal online or by phone, please mail or fax your renewal for faster service.</p> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



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

Case #: 116024926

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Correspondence #: 718710716





and select "Manage My Account."

**Case Number: 116024926**

**Client ID: 2110066700**

**④ In Person:**

If you're unable to complete your renewal online, by phone, mail, or fax, then you can take your completed renewal to:

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

*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:
  - o Appendix A: Complete ONLY if someone in your household is eligible for new health coverage from a job
  - o Appendix B: Complete ONLY if someone in your household is an American Indian or Alaska Native
  - o Appendix C: Complete ONLY if you are choosing someone to help with your application
  - o Appendix D: Complete ONLY for someone who is now applying for health coverage from Virginia Medicaid or whose circumstances may have changed
  - o 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.

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)**.

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.

|                          |                                                                                                                                                                                     |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What happens next</b> | After you return the renewal form, we will review it to see if you and others in your household are eligible for Virginia Medicaid. If we have more questions, we will contact you. |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



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



Case #: 116024926

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Correspondence #: 718710716

## 1

## Information about how we can contact you

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

*Nut Thin*

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

Name

**Home address**

*11 Gluten Free FT  
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:**

*Nut Thin*

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

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

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

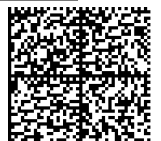
*Rice Thin*

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

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



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



## 3

## Your household members

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

**\*\*** Indicates member is due for renewal. If not renewed, Medicaid health coverage may be terminated

**Person 1:** *Nut Thin* **\*\*** 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)

**Person 2:** *Rice Thin* **\*\*** 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 <i>(first, middle, last &amp; suffix)</i> | How many babies are/were expected? | What is/was the expected due date/pregnancy end date?<br><br>(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.



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)**.



- 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 Virginia's FREE family planning program for men and women. Plan First offers FREE yearly family planning exams, contraceptives, lab testing, family planning education, and more. You will not be evaluated for Plan First unless you request it.

If you want household members to be evaluated for Plan First, write their name(s):

## 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

☐ Virginia's Insurance Marketplace ☐ Premium Assistance (HIPP or FAMIS Select)

☐ Other insurance (write below)



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



☐ 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*)

*Nut Thin*

**Employer name** and address:

*Non-Glutinous*

Address:

City:

State:

Zip code:

Phone number:

**Monthly gross income** currently on file: *\$2,500.00*

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:



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)**.





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*): \_\_\_\_\_

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? \$ \_\_\_\_\_

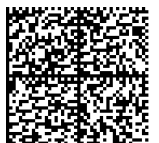
Name (*first, middle, last & suffix*): \_\_\_\_\_

Deduction Type \_\_\_\_\_

How much monthly? \$ \_\_\_\_\_



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)**.



## 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 |
|-------|----------|--------|
|       |          | \$     |
|       |          | \$     |

**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.): \$ \_\_\_\_\_



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)**.





## 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 through Medicaid, and my local Department of Social Services may send my information to Virginia's Insurance Marketplace (**marketplace.virginia.gov**) to see if I qualify for coverage and financial assistance to help me pay for insurance coverage.
- 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.

\_\_\_\_\_  
 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 |
|------------|-----------|------|
|            |           |      |
|            |           |      |

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

**Appendix 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)?



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)**.



☐ 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 \$ \_\_\_\_\_  
*(Premium should reflect the discount for the wellness program.)*

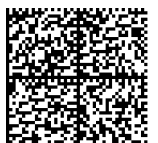
Date of change \_\_\_\_\_  
(mm/dd/yyyy)

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

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



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



**Appendix 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:

- 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 much \$  
income?

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:

- 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 much \$  
income?

How often?

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



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

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**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.

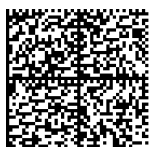
Outreach Worker/Application Assister/Certified Application Counselor/Navigator/Broker name and name of organization:

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

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

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



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



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



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.**

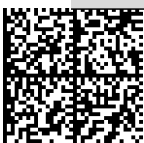
Social Security: \$\_\_\_\_\_ Social Security Income: \$\_\_\_\_\_  
Civil Service: \$\_\_\_\_\_ Veterans Administration: \$\_\_\_\_\_  
Retirement/Pension: \$\_\_\_\_\_ Disability: \$\_\_\_\_\_  
Wages: \$\_\_\_\_\_ Other (Trusts, Stocks, Annuities, Dividends, Interest, etc): \$\_\_\_\_\_

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

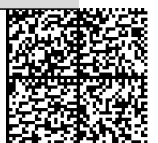
☐ No ☐ Yes *If yes*, fill out below.

| Property Transferred | Value of Transfer | Date of Transfer |
|----------------------|-------------------|------------------|
|                      | \$                |                  |

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



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



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 mailing (at applicant's request): ☐

\_\_\_\_\_  
Agency Staff Signature

\_\_\_\_\_  
Date



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



**For health coverage from Virginia Medicaid:**

**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 less favorably because of race, color, national origin, age, disability, or sex.

This agency provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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). This agency also provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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). If you need help filing a grievance, the DMAS Civil Rights Coordinator is available to help you.

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>.

This notice is available at <https://coverva.dmas.virginia.gov/non-discrimination/>

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If you are visually impaired and need large print or other assistance to access this document, please contact us at 1-855-242-8282 (TTY: 1-888-221-1590).



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)**.



## Important changes to Plan First!

Plan First is Virginia's limited-benefit Medicaid program that covers family planning services only. The Department of Medical Assistance Services is reaching out to all Plan First members to let them know about important program changes.

Prior to December 1, 2024, most individuals found ineligible for full-benefit Medicaid were automatically reviewed for, and, if eligible, enrolled in Plan First. All applications were evaluated for Plan First eligibility unless the individual selected on their Medicaid application that they did not want Plan First.

## What is changing?

Effective December 1, 2024, the program changed to an 'opt-in' program. This means that **applicants and members must select that they want Plan First coverage to be evaluated for and enrolled in the program.** The Plan First selection is made on the application and updated on the renewal form or by reporting the change to the CoverVA call center, 1-855-242-8282, or through the member's account at [www.commonhelp.virginia.gov](http://www.commonhelp.virginia.gov).

## What's not changing?

Eligibility for full-benefit Medicaid is always reviewed before eligibility for Plan First. Individuals not eligible for full-benefit Medicaid will also continue to be referred to Virginia's Insurance Marketplace, [www.marketplace.virginia.gov](http://www.marketplace.virginia.gov), where they may be able to enroll in low-cost comprehensive health insurance. This referral happens even if someone is enrolled in Plan First (since Plan First coverage is limited to family planning services).

## What do I need to do?

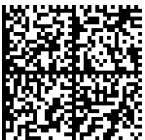
As a current Plan First member, your eligibility for Plan First will continue to be reviewed at each renewal. If you would like to continue in Plan First, you do not need to do anything.

If you no longer wish to be enrolled in Plan First, you may call CoverVA, 1-855-242-8585, or login to your account at [www.commonhelp.virginia.gov](http://www.commonhelp.virginia.gov) to report that you no longer wish to be enrolled in Plan First.



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)**.





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

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**3.52**



**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 nộp 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**

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 بطباعة كبيرة، أو بأفضل طريقة تراها. اتصل بنا على رقم (TTY: 1-888-221-1590) 1-855-242-8282.

**Amharic: በቋንቋዎ እርዳታ ያግኙ**

ይህ ማስታወቂያ ከሽርጂንያ ሜዲኬይድ የሚያገኙትን ጥቅሞች ወይም የጤና ሽፋን ማመልከቻን አስመልክቶ አስፈላጊ መረጃ ያዘለ ነው። አስፈላጊ ቀናትን ይመልከቱ። ጥቅሞች እንዳይቋረጡዎ፣ በተወሰኑ ቀናት ውስጥ እርምጃዎችን መውሰድ ሊያስፈልግዎ ይችላል። ይህን ደብዳቤ፣ በነፃ፣ 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።

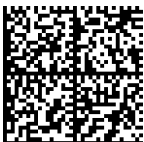
**Urdu: اپنی زبان میں مدد حاصل کریں**

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 بینیفٹس 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۔

**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 inyong wika. malaking mga letra, o sa anumang paraan na pinakamahusay sa inyo. Tawagan kami sa 1-855-242-8282 (TTY: 1-888-221-1590).



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)**.



### Farsi: دریافت کمک به

زبان خود این اطلاعاتی 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 با شماره 1-855-242-8282 (TTY: 1-888-221-1590) تماس بگیرید.

### 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).

### Bengali: আপনার নিজের ভাষায় সাহায্য পান

Virginia Medicaid এর স্বাস্থ্য বিমা বিষয়ক সনাক্তকরণ অথবা আবেদন সম্পর্কিত গুরুত্বপূর্ণ তথ্য এই নোটিশে আছে। গুরুত্বপূর্ণ তারিখগুলির অনুসন্ধান করুন। আপনার প্রাপ্য সুযোগ-সুবিধা চালু রাখতে হলে আপনাকে নির্দিষ্ট তারিখের মধ্যে পদক্ষেপ গ্রহণ করতে হতে পারে। আপনার অধিকার আছে নিজের ভাষায়, বড় অক্ষরে ছাপা অথবা আপনার পক্ষে সর্বশ্রেষ্ঠ এমন যে কোনও উপায়ে এই চিঠিটি বিনামূল্যে পাওয়ার। আমাদের টেলিফোন করুন এই নম্বরে: 1-855-242-8282 (TTY: 1-888-221-1590)।

### Telugu: మీ భాషలో సహాయం పొందండి

ఈ నోటీసులో మీ ప్రయోజనాలు లేదా వర్తనీనియా మెడిసిన్ నుండి ఆరోగ్య కవరేజ్ కోసం అప్లికేషన్ గురించి ముఖ్యమైన సమాచారం ఉంది. ముఖ్యమైన తేదీల కోసం చూడండి. మీ ప్రయోజనాలను కొనసాగించడానికి మీరు నిర్దిష్ట తేదీలలోగా చర్య తీసుకోవలసి రావచ్చు.

ఈ లేఖను మీ భాషలో, పెద్ద ముద్రణలో లేదా మీకు ఉత్తమమైన మరొక విధంగా ఉచితంగా పొందే హక్కు మీకు ఉంది. 1-855-242-8282 (TTY: 1-888-221-1590) ద్వారా మాకు కాల్ చేయండి.

### Hindi: अपनी भाषा में मदद ल

इस नोटिस में Virginia Medicaid से प्राप्त होने वाले लाभ या हथ कवरेज हेतु आवेदन के बारे में महत्वपूर्ण जानकारी दी गयी है। महत्वपूर्ण तारीखें देखें। आपको अपने लाभ को बचें रखने के लिए निम्न तारीखों तक कर्त्ताही करने की आवश्यकता हो सकती है। आपको इस पत्र को अपनी भाषा में, बड़े फ़ॉन्ट में, या ऐसे किसी अन्य ढंग में जो आपके लिए सबसे अच्छा हो, निःशुल्क प्राप्त करने का अधिकार है। हमें 1-855-242-8282 (TTY: 1-888-221-1590) पर फोन करें।

### Nepali: तपाईंको भाषामा मद्दत प्राप्त गर्नुहोस्

यस सूचनामा Virginia Medicaid मा स्वास्थ्य कभरेजका लागि तपाईंका लाभ वा आवेदनका बारेमा महत्वपूर्ण जानकारी छ। महत्वपूर्ण मितिहरू खोज्नुहोस्। तपाईंले आफ्ना लाभहरू राख्न निश्चित मितिहरूभित्र कदम चाल्न आवश्यक हुन सक्छ। तपाईंसँग यस पत्रलाई तपाईंको भाषामा, ठूला अक्षरमा वा तपाईंका लागि उत्तम हुने अन्य तरिकामा निःशुल्क प्राप्त गर्ने अधिकार छ। 1-855-242-8282 (TTY: 1-888-221-1590) मा कल गर्नुहोस्।

### 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 потребоваться 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).

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