Response to Questions on the FY 2016 Budget

Request By: Chairman Bulova

Question: Please explain what is driving the need for additional public assistance positions over the last several years.

Response: In accordance with federal and state policy, the County is required to determine eligibility for public assistance and deliver benefits within a certain timeframe. Public Assistance is a general term for federal and state funded programs that are designed to help people become self-sufficient and independent. The Department of Family Services determines eligibility for these programs but does not directly administer benefits. Once the County determines eligibility and enrolls the individual into the state computer system, the state issues benefits directly to the clients and/or the service providers such as doctors or hospitals. Examples of public assistance programs include:

- Family Access to Medical Insurance (FAMIS): Virginia's health coverage for children 0-18 without health insurance coverage; designed to cover children of working families.
- Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps: electronic benefit card to buy food at participating grocery stores; intended to help prevent hunger, malnutrition.
- Medicaid: assistance in medical and health care to elderly, disabled, or blind individuals; pregnant women; and needy children and their caretakers.
- Temporary Assistance to Needy Families (TANF): monthly payments to children/families deprived of support.

It is important to note that eligibility determination is done for each public assistance program.

<u>Current Caseload and Workload Challenges</u>
The current caseload is more than 93,000 which is an increase of nearly 80 percent since FY 2008. Factors driving the increase include:

- Downturn in the economy,
- Changing demographics, and
- Increase in the length of time participants receive services.

For many years, the Department of Family Services successfully addressed the rising caseloads through technology enhancements and service redesign. For example, DFS developed an electronic management system which eliminated paper files and eased access to client records which allowed better use of staff time. Additionally, DFS hired a consultant to help increase capacity within existing resources and based on recommendations from the consultant, moved from a traditional Case Management model to a Process Management model. This change was successful and increased capacity but quickly eroded due to the implementation of the federal Patient Protection and Affordability Care Act and IT changes made by the state.

Today, staff is not only challenged by rising caseloads but also legislative changes and changes in technology by the state. Workload challenges can be summarized as follows:

- *Staff not able to keep up with demand* – Ongoing workload consists of applications, renewals and changes that need to be processed. It includes both current and overdue requests. The number of applications that need to be processed continues to grow and the department, on average, is currently processing 78.9% of the new applications received (68.3% for Medicaid, 86.6% for SNAP and 82.5% for TANF) and 88.9% of Medicaid renewal applications (data not available for SNAP and TANF renewals). These are well below the 100% rate mandated by the federal government and the state.

- *Legislative changes* – Most notably the implementation of the Patient Protection and Affordability Care Act has increased the volume of applications being received, and the amount of time each application takes to process. Medicaid renewal form, which was originally two pages, has increased to 18 pages but may be as long as 27 pages depending on family size. Attachment 1 is an example of the new and old application for those applying for Medicaid for families and children.

- *Changes in technology by the state* – The state has implemented a new system (VaCMS) which has increased the time it takes to process each case and does not support the Process Management System implemented by the County in 2011. As a result, staff has determined a case management model is more effective in dealing with the state system.

Not Meeting Federal and State Compliance Mandates

The continuing increases in workload over the last six years along with new application forms that have increased from two pages to as many as 27 pages, have resulted in caseloads that exceed industry standards as well as an ever growing backlog of applications and renewals that have been received but staff has not yet been able to process. Once an application is filed, in accordance with federal and state policy, the County is required to determine eligibility and authorize benefits within a certain timeframe. The KPMG audit for the year ending June 30, 2014 found material noncompliance in both the TANF and Medicaid programs. As a result, an additional 20/20.0 FTE positions are included in the FY 2016 Advertised Budget Plan. Additional positions have been included in the FY 2017 multi-year budget as it is expected that additional resources will still be needed to bring the County back in compliance with federal and state mandates.

Attachment 1

Old Application
Medicaid for Families and Children

Commonwealth of Virginia
Department of Social Services (DSS)
FAMILIES & CHILDREN MEDICAID & FAMIS PLUS RENEWAL

Name: _____

Mailing Address: _____

_____

CASE NAME: _____

CASE NUMBER: _____

DATE MAILED NAME: _____

WORKER'S NAME: _____

TELEPHONE NUMBER: _____

LOCAL AGENCY: _____
ADDRESS

Please answer all questions and return this form to your eligibility worker by: _____.
If you have any questions or need help completing the form, please call the worker listed above.

1. Has your address changed? What's changed? ☐ Mailing address ☐ Home address

   Give us your new address: _____

2. Please give us your current telephone number: _____

3. List all children and parents or caretaker relatives who live in the home.

Name	Date of Birth	Place of Birth	For children, list the names of parents living in the home:

4. If both parents are in living the home, are they married to each other? ☐ No ☐ Yes

5. List the income (money) received by household members during the past month and attach proof, such as paycheck stubs. Include income from sources such as work, support, disability, retirement, VA benefits, unemployment, etc. Do not include the wages of any child under age 19 who is a student.

Who Receives Income?	Amount	Source	How Often Received (daily, weekly, monthly, etc.)

6. If you are working, and have child or adult day care expenses, list who receives care and monthly costs for each:

   _____

7. List changes in your health insurance, including the company name, policy number, coverage, date of change, type of change (coverage started, stopped, etc.):

   _____

I have given true and correct information on this form to the best of my knowledge and belief. I understand that the information I have provided will be used to document the identity of my child under age 16. I understand that if I give false information, withhold information, or fail to report a change, I may be breaking the law and could be prosecuted. I agree to assign my rights to medical support and third party payments, and the rights of my children for whom I am applying, to the Department of Medical Assistance Services for services paid by Medicaid. I authorize DSS and the Department of Medical Assistance Services (DMAS) to obtain from any source any information needed to review my eligibility.

_____ _____
Signature of Recipient or Authorized Representative — Date

_____ _____
Relationship to Recipient — Telephone Number(s)

Voter Registration - Check one of the following:

( ) I am not registered to vote where I currently live, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration form, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)

( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote).

( ) I do not want to apply to register to vote.

( ) I want to apply to register to vote. Please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services provided to you by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.

DO NOT WRITE IN THIS SECTION ******** AGENCY USE ONLY **********

A. CN ELIGIBILITY EVALUATION VERIFICATION/INFORMATION ELIGIBILITY MET

1. NON-FINANCIAL CRITERIA: YES NO

2. COVERED GROUP: YES NO

3. FAMILY UNIT/BUDGET UNIT DETERMINATION:

4. INCOME: SOURCE AMOUNT DATE REC FREQUENCY VERIFICATION

COUNTABLE INCOME: INCOME LIMIT:

5. HEALTH INSURANCE CHANGES SINCE LAST ELIGIBILITY DETERMINATION:

6. ELIGIBLE INDIVIDUALS and ACs:

NEXT RENEWAL DATE:

8. INELIGIBLE INDIVIDUALS:

REASONS: MANUAL CITATION:

B. MN (SPENDDOWN) EVALUATION RESOURCE INFORMATION MUST BE OBTAINED AND EVALUATED

8. RESOURCE TYPE VALUE VERIFICATION

COUNTABLE RESOURCES: RESOURCE LIMIT:

SPENDDOWN BUDGET PERIOD FROM: TO:

WORKER'S SIGNATURE: DATE:

SUPERVISOR'S SIGNATURE: DATE:

Attach all verification/documentation to this form.

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

New Application
Medicaid for Families and Children

Application for Health Coverage & Help Paying Costs

THINGS TO KNOW

Use this application to see what coverage choices you qualify for

- Free or low-cost insurance from Medicaid, FAMIS or Plan First
- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage

You may qualify for a low-cost program even if you earn as much as $94,000 a year (for a family of 4).

Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.
- If you are disabled and/or need assistance with nursing home or community based care, you may need to complete Appendix D.

Apply faster online

Apply faster online at **commonhelp.virginia.gov**.
For more information about Medicaid, FAMIS and Plan First visit **coverva.org**.

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.**

What happens next?

If you use this paper application, send your complete, signed application to the local Department of Social Services in the city or county where you live. They will follow up with you to obtain additional information. Your application should be processed within 45 days from the date it was received.

Get help with this application

- **Phone:** Call Cover Virginia at **1-855-242-8282.**
- **In person:** There may be application assisters in your area who can help. Visit our website at **coverva.org** or call **1-855-242-8282** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-855-242-8282.**

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

COVER VIRGINIA

STEP 1 Tell us about yourself.

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

1. First name, Middle name, Last name, & Suffix

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

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

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

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

14. Phone number ( ) –

15. Other phone number ( ) –

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

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

STEP 2 Tell us about your family.

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to include copies of the Additional Person single page supplement form and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

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

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

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

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

a. Will you file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

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

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

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

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____ Expected due date: _____

8. **Do you need health coverage?** *(Even if you have insurance, there might be a program with better coverage or lower costs.)*

☐ **YES. If yes,** answer all the questions below.

☐ **YES.** If not eligible for full coverage, do you wish to be evaluated for Plan First (family planning coverage only)?

☐ **NO. If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____ b. Document ID number _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

Please answer the following questions if you are 18 or younger:

14. Did you have insurance that ended within the past 4 months? ☐ Yes ☐ No
a. **If yes,** end date: _____ b. Reason the insurance ended: _____

*For a list of reasons, please see page 6.

15. Are you a full-time student? ☐ Yes ☐ No

16. Were you in foster care in Virginia at age 18 or older? ☐ Yes ☐ No

17. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

18. **Race (OPTIONAL—check all that apply.)**

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

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STEP 2: PERSON 1 (Continue with yourself)

Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 19.

☐ **Not employed**
Skip to question 29.

☐ **Self-employed**
Skip to question 28.

CURRENT JOB 1:

19. Employer name and address

20. Employer phone number
( ) –

21. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

22. Average hours worked each WEEK

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

23. Employer name and address

24. Employer phone number
( ) –

25. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

26. Average hours worked each WEEK

27. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

28. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

29. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____

Type: _____

30. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____

Type: _____

31. **YEARLY INCOME: Complete only if your income changes from month to month.**

If you don't expect changes to your monthly income, skip to the next person.

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

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

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STEP 2: PERSON 2

Complete Step 2 for your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
We need this if you want health coverage and have an SSN.

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

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

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

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No
If yes, name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____ Expected due date: _____

9. **Does PERSON 2 need health coverage?**
(Even if they have insurance, there might be a program with better coverage or lower costs.)

☐ **YES. If yes,** answer all the questions below.

☐ **YES.** If not eligible for full coverage, do you wish to be evaluated for Plan First (family planning coverage only)?

☐ **NO. If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?

☐ Yes. Fill in their document type and ID number below.

a. Document type _____ b. Document ID number _____

c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 2 in foster care in Virginia at age 18 or older? ☐ Yes ☐ No

Please answer the following questions if PERSON 2 is 18 or younger:

16. Did PERSON 2 have insurance that ended within the past 4 months? ☐ Yes ☐ No
a. **If yes,** end date: _____ b. Reason the insurance ended: _____

*For a list of reasons, please see page 6.

17. Is PERSON 2 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

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

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STEP 2: PERSON 2

Current Job & Income Information

☐ **Employed**
If PERSON 2 is currently employed, tell us about their income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
( ) –

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

23. Average hours worked each WEEK

CURRENT JOB 2: (If PERSON 2 has more jobs and needs more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
( ) –

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will PERSON 2 get from this self-employment this month?

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often they get it.

NOTE: You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____

Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often they get it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

NOTE: You shouldn't include a cost that you already considered in the answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____

Type: _____

32. **YEARLY INCOME: Complete only if PERSON 2's income changes from month to month.**

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

PERSON 2's total income **this year**	PERSON 2's total income **next year** (if you think it will be different)
$	$

THANKS! This is all we need to know about PERSON 2.

If you have more than two people to include, complete the Additional Person single page supplement form.

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

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

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** go to Appendix B.

STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ **YES. If yes,** check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ **NO.**

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

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ **YES. If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ **NO. If no, continue to Step 5.**

*** REASONS CHILD'S HEALTH INSURANCE ENDED: 1** Parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage. **2** Parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage. **3** Insurance company discontinued coverage because child is uninsurable. **4** Cost of insurance exceeded 10% of monthly income (before taxes). **5** Insurance stopped/dropped by someone other than parent or stepparent living with child. **6** Stopped/dropped a COBRA policy. **7** Other.

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STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I understand that for individuals enrolled in managed care, a premium is paid each month to the MCO for the person's coverage. If the child or pregnant woman is not eligible for FAMIS, FAMIS Plus, FAMIS MOMS, or Medicaid because I did not report truthful information or failed to report required changes in my family size or income, I may have to repay the monthly premiums paid to the MCO. I may have to repay these premiums even if no medical services were received during those months.
- I know that I must tell the local Department of Social Services if anything changes and is different than what I wrote on this application. I can visit **www.commonhelp** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
  (name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Medicaid or FAMIS programs or the Marketplace to use income data, including information from tax returns. I understand that I will receive notification of the outcome of my renewal. I understand that I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal

If I think Medicaid, FAMIS or Plan First has made a mistake I can contact them at **www.coverva.org** or call **1-855-242-8282**. Instructions for filing an appeal will be included on my notice and are also available on the coverva.org website.

If I think the Health Insurance Marketplace has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at **1-800-318-2596**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)

STEP 6 Mail completed application.

Mail your signed application to:

The local Department of Social Services in the city or county in which you live

As a citizen of the Commonwealth of Virginia, we are required to provide you with the opportunity to register to vote when applying for benefits. If you are not already registered and you want to register to vote, you can complete a voter registration form at **www.sbe.virginia.gov.**

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STEP 7 Consent to Share User Profile Information

The Virginia Department of Social Services (VDSS) would like to use some of the personal information that you have provided on your application about you and your dependents to create your User Profile. VDSS is asking for permission to share your User Profile electronically with the state agencies listed below. Each agency will be told when you make a change to the information in your User Profile. This will allow you to save time by only providing User Profile information once when visiting these agencies.

Legal notice

The data being shared

Your User Profile will only be created if you agree to share it and you are eligible for assistance. Your User Profile will contain first name, last name, middle initial, suffix (Jr., Sr., etc.), current home address, date of birth, Social Security Number and Medicaid identification number (if applicable), email address, home phone, driver's license ID and cell phone number. However, you can share your User Profile without sharing your Social Security number; this will not affect your eligibility. Your Medicaid identification number will only be shared with VDSS and your local department of social services. Because the User Profile is based on your application for assistance, the agencies named below also will know that you are receiving assistance.

Agencies Included and Allowed Use

Below are the agencies that will get your information. The reasons they have requested your User Profile and what they will be allowed to do with your User Profile are listed.

Sharing your User Profile will allow them to update the information in their computers, saving taxpayer dollars. It may save you a visit to one of these agencies because your information has been changed electronically.

The Department of Motor Vehicles (DMV) would like a copy of your User Profile when it changes. DMV can change your address for cars you own or driver's license/identification card information they have for you. They will send you a card automatically through the mail to complete this update.

The Virginia Information Technologies Agency (VITA) operates an electronic system known as Enterprise Data Management (EDM). EDM contains data that you have already provided to DMV for your driver's license or identification card. If you give permission to share your User Profile, EDM will match the DMV data and your User Profile, and share this information with your local department of social services and DMV. If the data does not match, DMV or your local department of social services may contact you to confirm the information. Email address, home phone number, cell phone number and Medicaid identification number may be reviewed by a local department of social services worker inside EDM to identify possible duplicate User Profiles.

If you choose not to share your User Profile

Your information will remain only with the Department of Social Services. Choosing not to share your User Profile will not affect your eligibilityfor assistance.

Social Security Number

Including your Social Security Number (SSN) in your User Profile is your choice. The SSN is used to match your User Profile with DMV data in EDM easily. Your SSN is kept confidential.

Dependents

This request is for your own User Profile and for the User Profile of any person who is your legal dependent, including your children under age 18, any person for whom you serve as legal guardian, or any other person for whom you have the authority to agree to share information.

To stop sharing of your User Profile

You can stop sharing your User Profile at any time by going to www.commonhelp.virginia.gov and changing your decision to share. You can also change your decision to share your User Profile by visiting your local department of social services.

How long consent to share lasts

Your permission to share your User Profile will remain active for one (1) year from the date you approve, unless you change your decision to share sooner. Your agreement for any minor child who turns 18 will be stopped on the date of the child's 18th birthday. That individual then will be asked to agree to share his information.
You will be asked to share your information every time you make a change to the information that is used in your User Profile.

Giving Consent

I have reviewed the Consent language contained here and hereby authorize the Commonwealth to:

- ☐ Share my User Profile with the specified agencies. Include Social Security Number when creating my User Profile.
- ☐ My User Profile can be shared with the specified agencies, but do not include Social Security Number when creating my User Profile.
- ☐ Do not allow my User Profile to be shared.

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APPENDIX A

COVER VIRGINIA

Health Coverage from Jobs

You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	2. Employee Social Security number ___-___-____

EMPLOYER Information

3. Employer name		4. Employer Identification Number (EIN) ___-_____
5. Employer address		6. Employer phone number ( ) -
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) -	12. Email address	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ Yes (Continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the names of anyone else who is eligible for coverage from this job.

Name: _____ Name: _____ Name: _____

☐ No (Stop here and go to Step 5 in the application)

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

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

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.

* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ _____

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

Date of change (mm/dd/yyyy): _____

*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)

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EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

The employee needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

Ask the employer for this information.

3. Employer name		4. Employer Identification Number (EIN) ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer address (the Marketplace will send notices to this address)		6. Employer phone number ( ) –
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above) ( ) –	12. Email address	

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)

☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. 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, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.

* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $ _____

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

Date of change (mm/dd/yyyy): _____

*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)

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APPENDIX B

COVER VIRGINIA

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

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

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

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

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

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes**, tribe name _____ ☐ No	☐ Yes **If yes**, tribe name _____ ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No **If no**, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid, FAMIS or Plan First. List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	$ _____ How often? _____	$ _____ How often? _____

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APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the local Department of Social Services. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number ( ) –		
8. Organization name		9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

10. Your signature	11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

2. First name, Middle name, Last name, & Suffix

3. Organization name	4. ID number (if applicable)

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