



County of Fairfax, Virginia

MEMORANDUM

DATE: March 26, 2015
TO: Board of Supervisors
FROM: Susan W. Datta, Chief Financial Officer
SUBJECT: Responses to FY 2016 BOS Budget Questions – Package 2

Attached for your review is Package 2 of responses to Board questions on the FY 2016 budget. Additional responses will be included in subsequent packages. If you have any questions or need additional information, please contact me.

The following responses are included in this package:

Question Number	Question	Supervisor	Pages
	<i>Questions 1-15 answered in Package 1 dated March 11, 2015</i>		<i>1-36</i>
16	If the Healthy Families Fairfax Program is eliminated, does the County offer these or similar services in other programs that these individuals can access? If so, please detail those services and programs.	Foust	37-38
17	Please explain what is driving the need for additional public assistance positions over the last several years.	Bulova	39-55
18	Please explain the SACC proposal for fee increases including data on market comparison to private providers.	Frey	56-61
19	Why are 401(k) retirement funds included as part of net assets under the Tax Relief program for the Elderly and Disabled, especially when pension funds are not included?	Gross	62
20	What was the recent Supreme Court decision pertaining to BPOL and how will this affect Fairfax County?	Bulova	63
21	Please provide a history of the sequestration reserve, including how it was originally funded, how funds in it have been utilized, and (if applicable) note any guidelines for usage that were approved.	McKay	64
22	Please provide an overview of what the library system does with donations given to the library system by "Friends of the Libraries" groups. Please include the accounting of funds and what programs/materials they support.	Cook	65
23	What options are there to fully fund the MRA for County staff?	Gross	66
24	Please provide a breakdown of the \$19.7 million included in the FCPS budget for the 1.0% Market Rate Adjustment by employee category (teachers etc.)	Herrity	67

Attachment

cc: Edward L. Long Jr., County Executive
Patricia Harrison, Deputy County Executive
David J. Molchany, Deputy County Executive
David M. Rohrer, Deputy County Executive
Robert A. Stalzer, Deputy County Executive

Response to Questions on the FY 2016 Budget

Request By: Supervisor Foust

Question: If the Healthy Families Fairfax Program is eliminated, does the County offer these or similar services in other programs that these individuals can access? If so, please detail those services and programs.

Response: The Healthy Families Fairfax (HFF) program is a collaborative partnership between the Department of Family Services, the Health Department and three nonprofit organizations. HFF is an accredited, home-visiting program offering families at-risk of maltreating their child an opportunity to learn parenting skills and receive emotional support and case management services. Services are voluntary and begin during pregnancy or right after the birth of a baby and last until the child reaches age three and is enrolled in an early group education experience.

There are no other programs that are comparable to HFF. There are a limited number of other County and community early childhood home visiting programs available; however, these programs do not provide a good alternative to the HFF services. Whereas HFF supports families with any number of children of any age and income who reside throughout the County, other early childhood home visiting programs only serve first-time mothers or teens, are income-restricted, or are only available in designated zip codes. Therefore, the ability of other programs to absorb and adequately serve those individuals who receive services through HFF is limited not only by their capacity and target population restrictions, but also by the types of services provided.

The HFF program is delivered by a team of human services professionals and nurses that provide the most holistic, comprehensive, intensive case management services of all the early childhood home visiting programs. While early childhood home visiting programs focus on the health outcomes of women and their babies as well as the development of children, HFF goes further by addressing the social, emotional, and environmental factors that impact parenting (e.g. child abuse and neglect, domestic violence and substance abuse) and the preparation of children for school readiness. The integration of these additional factors is unique to HFF and is part of an evidence-based curriculum used to serve the highest risk families. No other available programs provide the integrated range of services, staff, and support offered by HFF, which can also include referrals and access to resources such as child care, transportation and employment training. In FY 2014, 87 percent of all early childhood home visiting services in Fairfax County aimed at strengthening parenting skills and that serve all areas of the County were provided by HFF. See Attachment 1 for more detailed program descriptions of all available early childhood home visiting programs, including HFF, in Fairfax County.

Serving families through prevention programs like HFF is less expensive than if children have to enter the child welfare system. On average it costs the County \$78,658 per year to support a child in foster care. In contrast, it costs \$3,473 per year to serve an entire family in HFF, which aims to keep children out of foster care. It is not anticipated that any community organizations have the capacity to absorb the number of families that would be displaced by this program elimination.

Early Childhood Home Visiting Services in Fairfax County

Home Visiting Program	Agency	Area Served	Description of Services	Characteristics of Population Served	Number Served	Frequency of Home Visits	Home Visitor Staffing
Resource Mothers	Northern VA Urban League	County-Wide	Mentoring and other supportive services to at-risk pregnant and parenting teens. Focus is on improving the health of pregnant teens and their infants, helping them make the transition to parenthood.	At-risk pregnant and parenting teens	57	Variable. Visits occur throughout pregnancy and up until the baby's first birthday.	Community Health Workers
Early Head Start Home Visiting	Fairfax County Department of Family Services	County-Wide	Provides case management/Home Visiting to prenatal mothers enrolled in Early Head Start programs.	Low-income	14	Monthly	Registered nurses
Healthy Families Fairfax	Fairfax County Department of Family Services, Fairfax County Health Department, Cornerstones NVFS, UCM	County-Wide	Provides home visiting services for families at-risk of abusing and/or neglecting their children an opportunity to learn parenting skills and receive emotional support and case management services. Pre- and post-natal health care to ensure healthy births and continued healthy growth and development during a child's critical early years.	First time mothers; prenatal until age 3 and in a preschool setting (focus on school readiness)	613 families	Biweekly through 2nd trimester, then weekly until baby is 6 months old. As child gets older, visits then become monthly.	Family Support Workers, Nurses, Social Workers
Naomi Project Partnership	Our Daily Bread	Varies depending on mentor availability	One on one mentoring. Support healthy pregnancies, foster good parenting skills/support clients to plan a productive future for their child/children.	High risk pregnant/newly parenting women. Referral source: Health Department & INOVA	21	Variable. Ages 0 - 2	Volunteer mentors
Nurse Family Partnership	Fairfax County Health Department	Specific zip codes: MV 22306, 22309, Baileys 22041, 22042, 22043, 22044 Lincolnia 22003	Nurse home visitation program. Aims to improve pregnancy outcomes, foster healthy infant and toddler growth and development and help families work towards self-sufficiency.	Low-income first time mothers through child's 2nd birthday. Must enroll by 28 weeks gestation.	98	Weekly or bi-weekly depending on the pregnancy status.	Public Health Nurses

Total Number of Families Served in Fairfax County Early Childhood Home Visiting Services in FY 2014: 803

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.

Current Caseload and Workload Challenges

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.

Old Application
Medicaid for Families and Children

Attachment 1

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.

<u>Name</u>	<u>Date of Birth</u>	<u>Place of Birth</u>	<u>For children, list the names of parents living in the home:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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.

<u>Who Receives Income?</u>	<u>Amount</u>	<u>Source</u>	<u>How Often Received (daily, weekly, monthly, etc.)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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)

032-03-0187-00-eng (08/07)

A-4

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.

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**.



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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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.



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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 ☐ American Indian or Alaska Native ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro
☐ Black or African American ☐ Asian Indian ☐ Japanese ☐ Other Asian ☐ Samoan
☐ Chinese ☐ Korean ☐ Native Hawaiian ☐ 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?

☐ Net farming/fishing \$ How often?

☐ Pensions \$ How often?

☐ Net rental/royalty \$ How often?

☐ Social Security \$ How often?

☐ Other income \$ How often?

☐ Retirement accounts \$ How often?

Type: _____

☐ Alimony received \$ How often?

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

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

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

☐ Alimony paid \$ How often?

☐ Other deductions \$ How often?

☐ Student loan interest \$ How often?

Type: _____

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

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

Your total income this year

\$

Your total income next year (If you think it will be different)

\$

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

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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 <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.) <input type="checkbox"/> YES. If yes, please answer questions a-c. <input type="checkbox"/> NO. If no, skip to question c. a. Will PERSON 2 file jointly with a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____ b. Will PERSON 2 claim any dependents on his or her tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name(s) of dependents: _____ c. Will PERSON 2 be claimed as a dependent on someone's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.) <input type="checkbox"/> YES. If yes, answer all the questions below. <input type="checkbox"/> YES. If not eligible for full coverage, do you wish to be evaluated for Plan First (family planning coverage only)? <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
11. Is PERSON 2 a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No		
12. If PERSON 2 isn't a U.S. citizen or U.S. national, do they have eligible immigration status? <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? <input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Does PERSON 2 want help paying for medical bills from the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Was PERSON 2 in foster care in Virginia at age 18 or older? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
18. If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.) <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Other _____		
19. Race (OPTIONAL—check all that apply.) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"><input type="checkbox"/> White</div> <div style="width: 25%;"><input type="checkbox"/> American Indian or Alaska Native</div> <div style="width: 25%;"><input type="checkbox"/> Filipino</div> <div style="width: 25%;"><input type="checkbox"/> Vietnamese</div> <div style="width: 25%;"><input type="checkbox"/> Guamanian or Chamorro</div> <div style="width: 25%;"><input type="checkbox"/> Black or African American</div> <div style="width: 25%;"><input type="checkbox"/> Asian Indian</div> <div style="width: 25%;"><input type="checkbox"/> Japanese</div> <div style="width: 25%;"><input type="checkbox"/> Other Asian</div> <div style="width: 25%;"><input type="checkbox"/> Samoan</div> <div style="width: 25%;"><input type="checkbox"/> Chinese</div> <div style="width: 25%;"><input type="checkbox"/> Korean</div> <div style="width: 25%;"><input type="checkbox"/> Native Hawaiian</div> <div style="width: 25%;"><input type="checkbox"/> Other Pacific Islander</div> <div style="width: 25%;"><input type="checkbox"/> Other _____</div> </div>		



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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?

☐ Net farming/fishing \$ How often?

☐ Pensions \$ How often?

☐ Net rental/royalty \$ How often?

☐ Social Security \$ How often?

☐ Other income \$ How often?

☐ Retirement accounts \$ How often?

Type: _____

☐ Alimony received \$ How often?

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?

☐ Other deductions \$ How often?

☐ Student loan interest \$ 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.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1191. The time required to complete this information collection is estimated to average [Insert Time (hours or minutes)] per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



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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 eligibility for 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



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?	
<input type="checkbox"/> 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: _____
<input type="checkbox"/> 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*? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly	
16. What change will the employer make for the new plan year (if known)?	
<input type="checkbox"/> Employer won't offer health coverage	
<input type="checkbox"/> 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? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Once a month <input type="checkbox"/> Quarterly <input type="checkbox"/> 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



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)	<div>First Middle</div> <div>Last</div>	<div>First Middle</div> <div>Last</div>
2. Member of a federally recognized tribe?	<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> No	<input type="checkbox"/> Yes If yes, tribe name _____ <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <ul style="list-style-type: none"> 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 	<div>\$ _____</div> <div>How often? _____</div>	<div>\$ _____</div> <div>How often? _____</div>



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10/1/2013

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.

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Response to Questions on the FY 2016 Budget

Request By: Supervisor Frey

Question: Please explain the SACC proposal for fee increases including data on market comparison to private providers.

Response: The School-Age Child Care (SACC) program supports working families and helps children to thrive by providing out-of-school time programs for children in kindergarten through sixth grade, as well as older children with multiple disabilities. In the fall of 1974, SACC programs opened their doors to children and families in eight FCPS elementary schools, serving 160 children daily. Today, SACC is available throughout the County in 137 schools, one recreation center, and one community center and serves approximately 10,000 children daily.

In response to Board of Supervisors budget guidance, the FY 2016 Advertised Budget Plan includes more than \$0.8 million in new revenue as a result of increasing the after school rate for the families paying the full rate by 8 percent as well as implementing an annual registration of \$45. An additional rate increase is anticipated in FY 2017. Furthermore, per the budget guidance, the sliding fee scale was reviewed, capacity analyzed, and a survey was conducted on the fees and policies in adjacent jurisdictions and private sector school age programs within Fairfax County. Each of these areas is discussed in greater detail below.

Proposed Rate

SACC fees are collected from parents as payment for child care services. The proposed full rate recovers the cost of the program which includes average Personnel Costs, Fringe Benefits and Operating Expenses for a typical SACC room as well as the County's \$1.0 million contribution to Fairfax County Public Schools. The full rate does not include capital costs (debt service). This is consistent with other County facilities (e.g. community centers) that do not include debt service calculations when setting program fees. It is proposed that families paying the full rate pay \$386 for After School SACC. This is an 8 percent increase over the current rate of \$357.

The County General Fund will continue to subsidize the program for those families paying on the sliding fee scale and costs associated with serving children with special needs. Parents paying the full rate are not subsidizing other families' participation. If the rate in FY 2016 is increased further, parents paying the full rate would be paying more than the cost of the program and thus subsidizing families on the sliding fee scale and children with special needs. This would be a departure from current Board policy. It is also possible that if fees are raised too high families paying the full rate may leave the program. If this happens then the County General Fund subsidy may actually increase since the program will not generate the same level of revenue.

Sliding fee scale

When staff reviewed the current sliding fee scale, it became apparent that fees on the sliding fee scale were not affordable for families. This was based on the following two areas of concern:

- There was a low participation rate for families in tiers 2 to 10 on the sliding fee scale. Overall, families in tiers 2 to 10 account for only 7.9 percent of the total children receiving after school SACC. The sliding fee scale has more tiers than what is captured in the Demographic Reports 2013 published by the Department of Neighborhood and Community Services; however, using this data as a proxy, the percent of families earning between \$25,000 and \$53,999 in Fairfax County is around 10 percent while the number of families being served on the sliding fee scale is 4.1 percent.

Staff does not collect income data for families in tier 1 (families paying the full rate); however, it is believed that since tier 2 families account for only 28 children or 0.3 percent of the total after school SACC program then there are probably few families in tier 1 with incomes on the lower end of the tier (e.g. \$54,000). If families in tier 2 earning \$47,000 to \$53,999 cannot afford SACC then families in tier 1 earning \$54,000 cannot afford SACC and thus the scale needed to be adjusted.

- The rate as a percent of income was higher for families paying on the sliding fee scale than for families paying the full rate. The rate as a percent of income for families paying the full rate is 6.6 percent for families earning \$54,000 (note, the rate as a percent of income decreases as income increases) while for families with incomes at tiers 2 to 10 on the sliding fee scale it ranges from 5.4 percent to 8.9 percent. Staff determined that as a percent of income, families paying on the sliding fee scale should not pay more than families paying the full rate.

The table below summarizes the current sliding fee scale.

After School Sliding Fee Scale-Current					
Tier	Household Income (Adjusted)	# Children Served After School ¹	Percent of Total Served	Current Rates (After-School)	Rate as Percent of Income
1	\$54,000 and above	6,988	81.5%	\$357	6.6%
2	\$47,000 - \$53,999	28	0.3%	\$337	7.2%
3	\$41,000 - \$46,999	35	0.4%	\$329	8.0%
4	\$36,000 - \$40,999	64	0.7%	\$297	8.3%
5	\$32,000 - \$35,999	67	0.8%	\$273	8.5%
6	\$28,000 - \$31,999	98	1.1%	\$246	8.8%
7	\$25,000 - \$27,999	66	0.8%	\$223	8.9%
8	\$22,000 - \$24,999	66	0.8%	\$174	7.9%
9	\$19,000 - \$21,999	97	1.1%	\$125	6.6%
10	\$16,000 - \$18,999	159	1.9%	\$86	5.4%
11	\$15,999 and below	907	10.6%	\$13	0.8%
Total		8,575	100.0%		

¹ Enrollment from the 2013-2014 school year

Based on these factors, staff determined that the current sliding fee scale was no longer adequately serving income eligible families. In order to increase participation both the tiers on the sliding fee scale, as well as the percent of income were adjusted. The table below summarizes the proposed sliding fee scale.

After School Sliding Fee Scale-Proposed			
Tier	Adjusted Household Income	Rate as a Percent of Income	Proposed FY 2016 Rates
1	\$83,000 and above	4.6%	\$386
2	\$76,000 - \$82,999	4.6%	\$357
3	\$69,000 - \$75,999	4.6%	\$323
4	\$62,000 - \$68,999	4.6%	\$291
5	\$55,000 - \$61,999	4.6%	\$258
6	\$48,000 - \$54,999	4.6%	\$225
7	\$41,000 - \$47,999	4.6%	\$193
8	\$34,000 - \$40,999	4.6%	\$159
9	\$27,000 - \$33,999	4.6%	\$126
10	\$20,000 - \$26,999	4.6%	\$94
11	\$16,000 - \$19,999	3.6%	\$59
12	\$12,000 - \$15,999	2.3%	\$19
13	\$11,999 and below	2.3%	\$15

Families at these income levels will pay the same or more than the current rate of \$357

The proposed scale increases the top tier from \$54,000 to \$83,000 which is 66 percent of the Fairfax County median family income for a family of four. Children are only eligible to attend SACC when all adults living in the child's home meet one or more of the following criteria:

- Work 30 or more hours a week;
- Attend school full time;
- Attend a job training program 30 or more hours a week; and/or
- Are unable to work due to a disability.

This means that families on the sliding fee scale (dual income or single parent households) have adjusted incomes less than \$83,000 a year, and/or are attending school, a job training program or have a disability and are unable to work.

Families at income levels in proposed tiers 1 and 2 will be paying the same or more than the current rate of \$357. Additionally, the proposed fee scale establishes rates as a consistent percent of income for tiers 1 to 10 at 4.6 percent, with slightly lower percentages for the lowest income tiers (11 to 13). Adjusting the rates so they are proportionate to income results in a decrease to the rates in the middle of the scale with an intended result to serve more families. When determining how much families should pay as a percent of income, staff considered the following:

- Many families have more than one child in SACC and/or other child care settings,
- In addition to after school SACC families may be paying for before school SACC, winter or spring break SACC sessions, and/or summer camps.

As a reminder, the proposed \$386 rate is for after school SACC only. Families pay additional fees if a child is enrolled in before school SACC or if they participate in SACC's winter or spring break sessions as well as summer SACC. Therefore, a family paying the full rate with one child in SACC may pay almost 10 percent of their income on child care and if two children are in SACC, a family paying the full rate may pay up to 18.5 percent of their income on child care. The chart below details the costs of SACC for each program.

SACC Program	Child #1	Child #2¹	Total
Before School	\$1,750	\$1,575	\$3,325
After School	\$3,860	\$3,474	\$7,334
Christmas Break	\$248	\$223	\$471
Spring Break	\$248	\$223	\$471
Summer - 8 week program ²	\$1,984	\$1,784	\$3,768
Total	\$8,090	\$7,279	\$15,369
Percent of Income³	9.7%	8.8%	18.5%

¹ A 10 percent discount is applied to the second child

² Summer break is 11 weeks so families still need to cover 3 weeks of care

³ Full Rate Paying Family Earning \$83,000

Staff determined that given the high cost of living in Fairfax County, in particular, housing costs, families earning less than \$83,000 will have difficulty paying the full cost of child care. By providing subsidized child care to these families, it is hoped that they do not need to make a choice between other basic needs and child care or possibly forgoing child care altogether resulting in children in settings without adult supervision.

Capacity

SACC was designed to be one component of child care in the community and to complement center- and home-based child care options. The network of child care around the County is different from neighborhood to neighborhood. Similarly, the waiting list for SACC fluctuates across the County. There are 104 SACC centers, 74.8 percent, with either no waitlist or a waitlist with less than 25 children; 25 SACC centers, 18 percent, have between 25 and 74 children on the waitlist; only 10 SACC centers have larger waiting lists with 75 to 175 families requesting care. Though demand remains consistent, anecdotal information indicates that families on the SACC waiting list often have alternate arrangements in place and choose to remain on the waitlist for future placements. The table below summarizes the SACC waitlist as of March 2015.

March 2015		
Children on Waitlist	Number of Centers	Percent of Total
0	76	54.7%
1-24	28	20.1%
25-49	13	9.4%
50-74	12	8.6%
75-175	10	7.2%
Total	139	100.0%

In neighborhoods where the supply of child care options do not meet the full needs of the community, SACC has worked with community groups and child care providers to support their capacity to meet the child care needs of working families.

Fee Study

Staff reviewed fees and policies in adjacent jurisdictions and private sector school age programs within Fairfax County. Staff only reviewed center-based programs that were licensed and/or licensed-exempt.

Surrounding Jurisdictions

Looking at rates alone, SACC charges the second highest fee compared to the surrounding jurisdictions. This is true for both the current rate and the proposed new rate. Only the City of Alexandria has a higher rate at \$405 and they offer a sliding fee scale for any family earning less than \$165,000. The table below summarizes the rates and income requirements for the surrounding jurisdictions, as well as the current and proposed Fairfax County rates and income requirements.

Jurisdiction	Prince William County	Arlington County	City of Falls Church	Loudoun County	Current Fairfax County	Proposed Fairfax County	City of Alexandria
Monthly After-School Fees	\$279.50	\$270-\$362	\$312	\$325	\$357	\$386	\$405
Sliding Fee Scale	Scholarships	Yes	Yes	No	Yes	Yes	Yes
Income Levels-Full Fee	Free/Reduced Lunches	\$65,000	\$80,000	NA	\$54,000	\$83,000	\$165,000

Community Providers

Staff conducted a random sample phone survey of 50 percent of the 186 licensed and/or licensed exempt private sector community programs providing school age child care services in Fairfax County. The 50 percent random sample yielded 93 responses; however, only 86 of the respondents had a distinct after school program rate. Therefore, this analysis is based on the 86 respondents who had distinct after school rates.

Looking at all respondents who provide after school care, the monthly after school fees in Fairfax County range from \$125 to \$830, with an average monthly fee of \$509. The range of fees reflect the variety of program policies and services provided, such as hours and transportation, and providing care for infants, toddlers, and preschool age children. Excluding actual program design which was not included in the fee study, there are several reasons why the SACC rates remain lower than the monthly average for all community providers. They are:

- **Transportation** – SACC does not provide transportation, most community providers do. Providers must follow transportation licensing requirements, as well as bear the additional costs associated with vehicles, insurance, and maintenance that SACC does not incur.
- **Staffing Ratios** – It is typically more expensive to provide care to infants, toddlers and preschoolers because of the lower mandated staffing ratios; therefore, some of these costs are spread across all age groups. SACC staffing ratios start at 1:18 while community providers who serve infants must maintain a 1:4 ratio in those classrooms. The table below illustrates the staffing ratios.

Birth to 16 months	16 months to 2 years	2 years	3 to 5 years	5 to 9 years	10 to 12 years
1:4	1:5	1:8	1:10	1:18	1:20

- **Infrastructure** – In order to meet licensing standards, community providers have to maintain more physical infrastructure than the SACC program. A good example is the use of bathrooms. Toddler and preschool rooms often have multiple bathrooms since a staff member otherwise would need to accompany a child to a common area bathroom outside the classroom. While some SACC rooms do have one bathroom, the SACC program is also able to use the common area girls and boys bathrooms already in place at schools.
- **Playgrounds** – In order to meet licensing standards, community providers must maintain playgrounds/outdoor space, SACC has the benefit of utilizing school playgrounds/outdoor space.
- **Hours of Operation** – Program rates reflect program hours of operation. There is a wide variation of the hours of operation for all community providers with some opening as early as 6:00am and closing as late as 7:30pm. The core hours of SACC are 7:00am until school begins and end of the school day until 6:15pm.

The two areas that significantly impact the rates are transportation and the ages of children served by the program. The County's proposed rate of \$386 for the family paying the full rate is slightly higher than those community providers who do not provide transportation, average monthly rate of \$379 and for those providers who only provide school-age care, average monthly rate of \$378. The table below details the average monthly rate for all community providers and then breaks out transportation and ages of children served.

	Providers Reporting After School Rates Only	
	Number of Providers	Average Monthly Rate
Community Providers		
All Community Providers	86	\$509
Transportation Break-out		
Transportation Provided	64	\$554
Transportation Not Provided	22	\$379
Level of Care Break-out		
School-Age Only	5	\$378
Preschool, School-Age	26	\$397
Toddler, Preschool, School-Age	30	\$401
Infant, Toddler, Preschool, School-Age	86	\$509
SACC Proposed Rate		\$386

Since these two components most closely align to the SACC program, staff believes the SACC proposed rate is consistent with community providers offering similar services.

Response to Questions on the FY 2016 Budget

Request By: Supervisor Gross

Question: Why are 401(k) retirement funds included as part of net assets under the Tax Relief program for the Elderly and Disabled, especially when pension funds are not included?

Response: Retirement vehicles such as 401(k) funds are treated as assets for purposes of Tax Relief. Unlike a pension, a 401(k) is owned by and is accessible to the applicant. The owner has a measure of control over these funds. Any penalties and taxes that might apply to cashing out a 401(k) would be netted against the asset as a liability. The net asset would be reportable on the Tax Relief application.

Regular distributions from a 401(k) would be treated as income, consistent with a Virginia Attorney General's Opinion. The remainder after the annual distributions would be part of the applicant's assets.

Upon retirement under a pension plan, a vested employee will get a defined payment. These payments are also treated as income for Tax Relief purposes, the same as 401(k) distributions. However, once a person starts receiving pension payments, there is no way to suddenly 'cash out' the remaining annuity. The pensioner has no access to these funds except through the initial selected payment distribution plan. In addition, upon one's death, a 401(k) would be treated as an asset as part of the person's estate. While a pensioner may elect to take lower payments throughout their life time so that a spouse may have partial access to the pension after death, pensions do not automatically pass to beneficiaries of an estate.

The fact that both pensions and 401(k)'s are retirement funds is immaterial to the determination of assets. The determination is based more on the access to and availability of the funds.

Response to Questions on the FY 2016 Budget

Request By: Chairman Bulova

Question: What was the recent Supreme Court decision pertaining to BPOL and how will this affect Fairfax County?

Response: In a case appealed from the Arlington County Circuit Court, the Supreme Court looked at how multi-state (and multi-national) companies apportion their revenue in order to exclude from local BPOL taxation receipts already being taxed elsewhere. The apportionment process can be complicated, but the goal is to avoid a sense of double taxation. The Supreme Court ruling simply considered a formula developed by the State Tax Commissioner to calculate this apportionment.

The Supreme Court's decision actually remanded the case back to the Arlington County Circuit Court for further action, so to that extent the case is still ongoing. It is too early to determine the future fiscal impact from this case. Moreover, not all companies apportion receipts so this ruling does not apply to everyone. At present the Department of Tax Administration (DTA) has appeals from only 8 businesses, with refund requests totaling approximately \$31 million. Any refunds that might stem from these cases would be covered by the litigation reserve set aside by the Board. Staff will monitor the future fiscal impact and report back to the Board as necessary.

Response to Questions on the FY 2016 Budget

Request By: Supervisor McKay

Question: Please provide a history of the sequestration reserve, including how it was originally funded, how funds in it have been utilized, and (if applicable) note any guidelines for usage that were approved.

Response: The Sequestration Reserve was established in the amount of \$8,099,768 at the *FY 2012 Carryover Review* using available FY 2012 year-end balances. The Board of Supervisors requested that staff return with recommendations for Board approval of any use of the reserve and an explanation of the impact of sequestration on the specific program. As sequestration unfolded, staff identified all of the prospective sequestration reductions and provided periodic updates to the Board.

As part of the County Executive's proposed *FY 2013 Carryover Review*, \$401,888 of the reserve was utilized to offset federal sequestration reductions for the Head Start and Early Head Start grant programs. Use of the reserve funding was consistent with the direction given by the Board as part of the June 25, 2013 Human Services Committee meeting. As a result of this action, the balance in the reserve was \$7,697,880. In addition, the Board earmarked \$1,000,000 of the reserve during their deliberations on the *FY 2013 Carryover Review* to serve as a backstop to prevent terminations in the Housing Choice Voucher (HCV) program due to lack of funding. As a result of updated HCV funding and the successful implementation of critical programmatic changes by the Fairfax County Redevelopment and Housing Authority, no families participating in the HCV program lost their homes due to sequestration and none of this \$1,000,000 has been used, nor is it anticipated to be used, as a result of sequestration reductions.

This one-time funding totaling \$7,697,880 has been recommended by the County Executive to be transferred to Fund 10010, Revenue Stabilization, as part of the *FY 2015 Third Quarter Review* to address rating agency concerns over the County's reserve levels.

Response to Questions on the FY 2016 Budget

Request By: Supervisor Cook

Question: Please provide an overview of what the library system does with donations given to the library system by “Friends of the Libraries” groups. Please include the accounting of funds and what programs/materials they support.

Response: The Library enjoys a robust donation program mostly attributable to Friends of the Library groups which provided over \$218,000 in support in FY 2014 reflecting over 275 donations. Donors to the library are required to complete a Gift Donation Form which indicates the donor’s wishes and intent when providing funds to the library. In completing the form, a detailed description is provided that indicates how the gift is to be spent. In FY 2014, approximately \$246,000 was spent from Friends’ supported gift funds, which consist mostly of Friends’ donations but which may also include gifts from individuals. It should be noted that spending from gift funds generally ranges from \$200,000 to \$275,000 annually; however, this total fluctuates from year to year, and the spending of a particular donation is not always completed in the fiscal year the donation was received.

Primarily, gifts fall into 4 major categories; materials, furniture, programming and miscellaneous in support of a wide variety of projects and programs. Friends also contribute directly to branches by supporting a myriad of smaller programs, such as volunteer and staff events or programming supplies. Examples of expenditures have included:

- Furniture for teen spaces
- Children’s books
- Performers for the Summer Reading Program
- Specialized magazine subscriptions
- Meeting room chairs
- Author programs
- Display cases

Donations are managed by the Financial Services Division in Library Administration. Close scrutiny is maintained over the life of the donation to ensure the management of gifts complies with the Department of Finance’s policy governing donations, Accounting Technical Bulletin (ATB) 40050, Internal Audit recommendations and the donor’s wishes. Donations are segregated into 32 separate funds in the County’s financial system, including one for each branch where all donations and corresponding expenses are posted. Activity is reported to the receiving branches quarterly and to individual Friends groups annually. Each of the funds is reconciled monthly and at fiscal year end by the Library’s Financial Services Division as per Department of Finance policy, ATB 020 and year end guidelines.

Response to Questions on the FY 2016 Budget

Request By: Supervisor Gross

Question: What options are there to fully fund the MRA for County staff?

Response: The cost to provide a 1.68% Market Rate Adjustment (MRA) to County staff would require an additional \$9.46 million. Currently, there is a balance of \$5.7 million available to the Board. Additional reductions totaling \$3.76 million would be required to fully fund the MRA for county staff.

It should be noted that the cost to increase the MRA to 1.0% is \$1.8 million.

Response to Questions on the FY 2016 Budget

Request By: Supervisor Herrity

Question: Please provide a breakdown of the \$19.7 million included in the FCPS budget for the 1.0% Market Rate Adjustment by employee category (teachers etc.)

Response: The following response was prepared by Fairfax County Public Schools (FCPS):

The following chart shows the 1.0% market scale adjustment (MSA) by expenditure type in millions of dollars.

EXPENDITURE TYPE	1% MSA
LEADERSHIP TEAM	\$ 0.04
PRINCIPALS	\$ 0.32
ASSISTANT PRINCIPALS	\$ 0.60
SUPERVISORS	\$ 0.22
SPECIALISTS	\$ 1.44
TECHNICAL/OFFICE ASSISTANT PERSONNEL	\$ 1.02
TEACHERS	\$ 12.51
INSTRUCTIONAL/SPECIALIZED ASSISTANTS	\$ 1.08
TRADES/CUSTODIAL PERSONNEL	\$ 0.95
TRANSPORTATION PERSONNEL	\$ 0.74
HOURLY SALARIES	\$ 0.81
Grand Total	\$ 19.73

Specialists include psychologists, social workers, technology support specialists (TSSpecs), school-based technology specialists (SBTS), and after school specialists, among others.

Included in technical/office assistant personnel are safety and security specialists and assistants, school finance technicians, career center specialists, and administrative/office assistants.

Instructional/Specialized Assistants include instructional assistants, public health attendants, and public health training assistants.

Hourly salaries primarily include hourly personnel, substitute costs, overtime, and supplements.