COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

APPLICATION/REDETERMINATION FOR MEDICAID FOR SSI RECIPIENTS

AGENCY USE ONLY		
CASE NAME		LOCALITY
CASE NUMBER	WORKER	DATE RECEIVED

A. IDENTIFYING INFORMATION

NAME: _____ SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

ADDRESS: _____ TELEPHONE NUMBER: _____

MARITAL STATUS: NEVER MARRIED _____ MARRIED _____ SEPARATED _____ WIDOWED _____ DIVORCED _____ SEX: _____

COUNTRY OF ORIGIN: _____ CITIZEN/ALIEN STATUS: _____

LANGUAGE (Enter Code): _____ 1 - English 2 - Spanish 3 - Cambodian 4 - Vietnamese 5 - Farsi 6 - Haitian-Creole 7 - Laotian 8 - Chinese
9 - Korean A - Somali B - Kurdish C. - Arabic F - French G - German J - Japanese O - Other

RACE (Enter Code): _____ 1 - White 2 - Black/African-American 3 - American Indian/Alaskan Native 4 - Asian 5 - Native Hawaiian/Other Pacific Islander
6 - American India/Alaskan Native and White 7 - Asian and White 8 - Black/African-American and White
9 - American Indian/Alaskan Native and Black/African-American A - Asian and Black B - Other

ETHNICITY (Enter Code): _____ 1 - Hispanic or Latino 2 - Not Hispanic or Latino

B. ADDITIONAL INFORMATION

CIRCLE ONE

1. I AM A RESIDENT OF VIRGINIA. YES NO

2. I RECEIVE A SUPPLEMENTAL SECURITY INCOME (SSI) CHECK. YES NO

3. I OWN, HAVE AN INTEREST IN, OR HAVE INHERITED REAL PROPERTY (LAND OR BUILDINGS). YES NO

TYPE OF PROPERTY: _____ ACREAGE: _____

VALUE: $ _____ LOCATION: _____

4. I HAVE OTHER RESOURCES SUCH AS LIVESTOCK, CAR, TRUCK, CAMPER, MOBILE HOME,RETIREMENT ACCCOUNT, LIFE INSURANCE, BANK ACCOUNT, STOCKS, BONDS, SAVINGS CERTIFICATES, PATIENT FUND ACCOUNT, TRUST FUNDS, CASH, BURIAL PLOTS, OR BURIAL ARRANGEMENTS. YES NO

RESOURCE: _____ VALUE:_____

RESOURCE: _____ VALUE:_____

RESOURCE: _____ VALUE:_____

5. I HAVE SOLD, TRADED, OR GIVEN AWAY ASSETS (LAND, BUILDINGS, BANK ACCOUNTS, MONEY, CARS, STOCKS, TRUST FUNDS, INCOME, ETC.) DURING THE PREVIOUS 60 MONTHS. YES NO

WHEN: _____ TO WHOM: _____

WHAT: _____ AMOUNT RECEIVED: $ _____

6. I HAVE MEDICARE. YES NO

MEDICARE #: _____

PART A EFFECTIVE DATE: _____ PART B EFFECTIVE DATE: _____

7. I HAVE OTHER HEALTH INSURANCE. YES NO

COMPANY NAME: _____ POLICY #: _____

TYPE OF COVERAGE: _____ EFFECTIVE DATE: _____

8. I LIVE IN A NURSING FACILITY OR STATE INSTITUTION. YES NO

IF YOU STILL OWN YOUR HOME, WHO LIVES IN IT. _____
(NAME AND RELATIONSHIP)

10. I RECEIVED MEDICAL CARE DURING THE THREE MONTHS BEFORE THIS APPLICATION. YES NO

FROM: _____ DATE: _____

RIGHTS AND RESPONSIBILITIES

I UNDERSTAND THAT I MUST REPORT ANY CHANGES THAT OCCUR IN MY SITUATION TO THE DEPARTMENT OF SOCIAL SERVICES WITHIN TEN DAYS. I AGREE TO ASSIGN MY RIGHTS TO MEDICAL SUPPORT AND OTHER THIRD-PARTY PAYMENTS TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES, EFFECTIVE WITH MY COVERAGE UNDER MEDICAID. ALL MONEY I RECEIVE FOR (1) DIAGNOSIS OR TREATMENT OF ANY INJURY, DISEASE OR DISABILITY OR (2) MEDICAL CARE SUPPORT MUST BE SENT TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES, THIRD PARTY LIABILITY SECTION. I UNDERSTAND REFUSAL TO ASSIGN MY RIGHTS WILL MAKE ME INELIGIBLE FOR MEDICAID.

I UNDERSTAND THAT I HAVE THE RIGHT TO FILE A COMPLAINT IF I FEEL I HAVE BEEN DISCRIMINATED AGAINST BECAUSE OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE, HANDICAP, OR RELIGIOUS BELIEF. I UNDERSTAND THAT I HAVE THE RIGHT TO APPEAL AND HAVE A FAIR HEARING IF I AM (1) NOT NOTIFIED IN WRITING OF THE DECISION REGARDING MY APPLICATION WITHIN 45 DAYS; (2) DENIED MEDICAID; OR (3) DISSATISFIED WITH ANY OTHER DECISION THAT AFFECTS MY RECEIPT OF MEDICAID. I UNDERSTAND THAT REFUSAL TO COOPERATE WITH A REVIEW OF MY MEDICAID ELIGIBILITY BY QUALITY CONTROL WILL MAKE ME INELIGIBLE FOR MEDICAID UNTIL I COOPERATE WITH THE REVIEW.
I AUTHORIZE THE DEPARTMENT OF SOCIAL SERVICES AND THE DEPARTMENT OF MEDICAL ASSISTANCE TO OBTAIN ANY VERIFICATIONS NECESSARY TO ESTABLISH MY ELIGIBILITY FOR ASSISTANCE. I AUTHORIZE RELEASE TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES ANY INFORMATION IN ANY MEDICAL RECORDS PERTAINING TO ANY SERVICES RECEIVED BY ME AS A BENEFIT UNDER MY MEDICAL ASSISTANCE (MEDICAID) ELIGIBILITY.

I RECEIVED THE BOOKLETS: MEDICAID HANDBOOK [ ] YES [ ] NO BENEFIT PROGRAMS [ ] YES [ ] NO
I FILLED IN THIS FORM MYSELF. [ ] YES [ ] NO IF NO, IT WAS READ BACK TO ME WHEN COMPLETED. [ ] YES [ ] NO

I DECLARE THAT ALL INFORMATION I HAVE GIVEN ON THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT IF I GIVE FALSE INFORMATION, WITHHOLD INFORMATION, OR FAIL TO REPORT A CHANGE PROMPTLY OR ON PURPOSE, I MAY BE BREAKING THE LAW AND COULD BE PROSECUTED FOR PERJURY, LARCENY, AND/OR WELFARE FRAUD. I UNDERSTAND THAT MY SIGNATURE ON THIS APPLICATION CERTIFIES, UNDER PENALTY OF PERJURY, THAT I AM A U.S. CITIZEN OR ALIEN IN LAWFUL IMMIGRATION STATUS.

SIGNATURE OR MARK: _____ DATE: _____

WITNESS/AUTHORIZED
REPRESENTATIVE: _____ DATE: _____

I COMPLETED THIS APPLICATION/REDETERMINATION FOR _____. I UNDERSTAND THAT IF I AIDED OR ABETTED THIS INDIVIDUAL IN OBTAINING ASSISTANCE FOR WHICH HE IS NOT ELIGIBLE, THAT I MAY BE BREAKING THE LAW AND COULD BE PROSECUTED.
SIGNATURE: _____ RELATIONSHIP: _____ DATE: _____
ADDRESS: _____ TELEPHONE#: _____

Commonwealth of Virginia Voter Registration Agency Certification

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Please check only one)

❑ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.

❑ Yes, I would like to apply to register to vote. (please fill out the voter registration application form)

❑ No, I do not want to register to vote.

If you do not check any box, you will be considered to have decided **not to** register to vote at this time. Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency. If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

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 or in applying to register to vote, you may file a complaint with: Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219-3497, phone (804) 864-8901.

_____ _____ _____
Applicant Name Signature Date

(For agency use only)
Voter Registration form completed: ❑ Yes ❑ No
Voter Registration form given to applicant for later mailing (at applicant's request): ❑

_____ _____
Agency Staff Signature Date

AGENCY USE ONLY * *

A.	ELEMENTS OF EVALUATION	VERIFICATION/PERTINENT INFORMATION	MEETS ELIGIBILITY REQUIREMENTS
1.	VA RESIDENCY, IF QUESTIONABLE	_____	YES NO
2.	RECEIVES SSI CHECK	SDX_____SVES_____OTHER_____	YES NO
	If no, have the individual complete the Application for Benefits.		
3.	SSI CONDITIONAL/PRESUMPTIVE		YES NO
4.	ASSET TRANSFER		YES NO
5.	RESOURCES (IF HAS A TRUST OR OWNS UNDIVIDED HEIR PROPERTY, CONTIGUOUS PROPERTY, FORMER HOME, OR OTHER REAL PROPERTY)	_____ _____	
	VALUE OF COUNTABLE RESOURCES	$_____	YES NO

B. RECOMMENDATION

1. CURRENT ELIGIBILITY: ELIGIBLE: _____ EFFECTIVE DATE: _____ INELIGIBLE_____
2. RETROACTIVE ELIGIBILITY: ELIGIBLE: _____ EFFECTIVE DATE: _____ INELIGIBLE_____

WORKER'S SIGNATURE; _____ DATE: _____

SUPERVISOR'S SIGNATURE: _____ DATE: _____

C. ENROLLMENT

SPEC REVIEW: _____ CTY: _____ CI: _____ BEGIN: _____ END: _____ TYPE: _____

PD: 11 _____ 31 _____ 51 _____ APP DATE: _____ MEDICAL RESOURCE: _____ TYPE COV: _____

INS CO: _____ POLICY NUMBER: _____ BEGIN DATE: _____ END DATE: _____