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

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

Commonwealth of Virginia
Department of Social Services
Questions? Call: 540-955-3700

Clarke County (043)
311 E. Main St.
Berryville, VA 22611

Letter Date: March 13, 2023
Response Due: April 12, 2023
Case Number: [redacted]
Case Worker Name: [redacted]
Worker User ID: [redacted]

Blue Mom
311 E Main ST
Berryville, VA 22611

Please complete your renewal by: April 12, 2023

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

If you do not complete your renewal, you will lose your Medicaid health coverage

Renew your Medicaid in any one of these ways

❶ **Online*:**
Go to **CommonHelp.Virginia.gov.**
Click on "Renew My Benefits."

To create an account:

- Go to **CommonHelp.Virginia.gov**
- Click "Check My Benefits."
- To link your case to your CommonHelp account using the information below, log in and select "Manage My Account."

Case Number: [redacted]
Client ID: [redacted]

❷ **By Phone:**
Call 1 855 242 8282/ TTY: 1 888 221 1590; this call is free.

❸ **By mail or fax:**
Clarke County (043)
9501 LUCY CORR CIRCLE, PO BOX 430
CHESTERFIELD, VA 22611
Fax: (540) 955 3958

❹ **In Person:**
Bring the completed form to:
Clarke County (043)
311 E. MAIN ST.
BERRYVILLE, VA 22611

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

*This is a renewal of your Medicaid benefits. Information regarding open enrollment to change health plans (such as Anthem or Optima) will be mailed separately. Open enrollment dates depend on where you live. Go to **https://www.virginiamanagedcare.com** for more information.*
**Free Internet access may be available at your local Department of Social Services or public library.*

How to complete this renewal form

1. Answer all the questions on the form.
2. Review the information about you and each member in your household and/or on your tax return. Cross out wrong information. Write in new information and add anything that is missing. If you have household members who are new to the home and/or would like to apply, please fill out all applicable sections of the renewal for that person.
3. **Sign and date the form at the end of the renewal.**

What we need

We filled out the form with the information we have in our records. Cross out wrong information. Write in new information and add anything that's missing.

This form will ask about:

- Section 1: Information about how we can contact you
- Section 2: Information about your federal tax return
- Section 3: Your household members
- Section 4: Other health insurance coverage
- Section 5: Information about income
- Section 6: Information about resources and nursing facility care
- Next, fill out all appendices, if any, that apply to your household or individuals listed on your tax return:
  - Appendix A: Complete ONLY if someone in your household is eligible for new health coverage from a job
  - Appendix B: Complete ONLY if someone in your household is an American Indian or Alaska Native
  - Appendix C: Complete ONLY if you are choosing someone to help with your application
  - Appendix D: Complete ONLY for someone who is now applying for health coverage from Virginia Medicaid or whose circumstances may have changed
  - Additional Information: Voter registration and Non discrimination information

We need information about each person living in your household or listed on your tax return, including those who:

- Have Medicaid health coverage now,
- Do not get Medicaid health coverage, but want to apply
- Do not have Medicaid health coverage and do not want to apply.

We will check your answers using information available in data sources, like the Internal Revenue Service (IRS), the Social Security Administration (SSA), and the Department of Homeland Security (DHS). If the information does not match our records, we may ask you to send more information.

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

1 Information about how we can contact you

▼ Review the contact information we have on file for you below.	▼ Cross out wrong information. Write in new information and add anything that is missing.		
Blue Mom	Name		
Home address *311 E Main ST* *Berryville* *VA 22611*	Home address		Apartment #
	City	State	Zip code
Mailing address	Mailing address		Apartment #
	City	State	Zip code

Phone number:
Cell: **Home:** **Work:**

Best phone number to reach you during the day: ☐ Cell ☐ Home ☐ Work

Email address, if you have one:

2 Information about your federal tax return

You can still renew if you do not file a tax return.

- Review the information about you and each member in your household and/or on your tax return.
- Cross out any information that is wrong. Write in any new information about how you plan to file your next federal tax return.

▼ Review your tax information here

Person filing tax return: *Blue Mom* If this person is filling a joint return, write the name of the spouse: **Name** *(first, middle, last & suffix)*	**Tax dependents** (if anyone is missing, write their name below): *Blue Girl*

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

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

3 Your household members

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

Person 1: *Blue Mom* This person's Social Security number is ☒ on file ☐ not on file

If not on file, write this person's Social Security number here, if they have one:

☐ This person is no longer living in the household. Date person left the household: (mm/dd/yyyy)

Person 2: *Blue Girl* This person's Social Security number is ☒ on file ☐ not on file

If not on file, write this person's Social Security number here, if they have one:

☐ This person is no longer living in the household. Date person left the household: (mm/dd/yyyy)

▸ Review people in your household not receiving Medicaid and write in any new people in your household

Person 1:

☐ This person is no longer living in the household. Date person left the household: (mm/dd/yyyy)

New Household Member(s) Name: (*firs middle, last & suffix*)

If anyone in your household is not currently enrolled in Virginia Medicaid and wants to apply, complete Appendix D.

▸ Answer these questions for **everyone** in your household or on your tax return.

Is anyone in your household or on your tax return pregnant or was pregnant within the last 12 months?

☐ Yes ☐ No ***If yes,*** fill in the information below.

Name *(first, middle, last & suffix)*	How many babies are/were expected?	What is/was the expected due date/pregnancy end date? (mm/dd/yyyy)

Is anyone in your household or on your tax return an American Indian or Alaska Native?

☐ Yes ☐ No ***If yes,*** fill out **Appendix B.**

▸ Answer these questions for anyone who is **renewing or applying** for health coverage.

- Does anyone need help with every day activities, like bathing, dressing, eating, walking, or using the bathroom in order to live safely in your home? **or**

  Has a doctor or nurse told anyone in your household that they have a physical disability, a long term disease, a mental or emotional illness, or an addiction problem?

☐ Yes ☐ No ***If yes,*** write the name(s) below.

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

Has anyone turned age 65 years old or become blind or disabled?

☐ Yes ☐ No ***If yes,*** fill out **Appendix D.**

Has anyone entered a nursing home, assisted living facility, or started receiving nursing care in the home?

☐ Yes ☐ No ***If yes,*** fill out **Appendix D.**

Is anyone who is renewing or applying for health coverage incarcerated (detained or jailed)?

☐ Yes ☐ No ***If yes,*** write the name(s) below.

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

Facility Name *(place of incarceration)*

Plan First is a limited benefits program that covers services like family planning exams, prescription contraceptives, testing, and family planning related lab services. Learn more: www.coverva.org/planfirst.
Individuals between the ages of 19 and 64 are automatically evaluated for Plan First.

If you do **not** want household members between the ages of 19 and 64 to be evaluated for Plan First, write their name(s):

Household Members Younger than 19 and Older than 64:
If you want us to see if household members younger than 19 and older than 64 qualify for Plan First, write their name(s):

In the past, the following household members chose not to be evaluated for Plan First coverage. If they now want to be evaluated, **circle their name(s) below**:

4 Other health insurance coverage

Does any person who is **renewing or applying for health coverage** have other health insurance?

- Review the information and cross out any information that is wrong. Write in any new insurance information for your household.
- If someone in the household has new insurance through an employer complete **Appendix A.**

Name(s) of person with other health insurance:	**Policy number:**
Insurance company name:	**Monthly Premium Amount: $**

Type of insurance: ☐ Medicare ☐ TRICARE ☐ Veteran's health coverage ☐ Marketplace ☐ Premium Assistance (HIPP or FAMIS Select) ☐ Other insurance (write below)

☐ **Check here if this other health insurance has ended. Coverage End Date:** (mm/dd/yyyy)

If you have indicated that health insurance has ended for any household member(s), please provide proof of the date of termination of the member's other health insurance.

List everyone renewing or applying for health coverage who has this other insurance policy:

☐ Check here if this other health insurance coverage is offered through a job.

5 Information about income

- Provide the information below for anyone in your household or on your federal tax return who has income, whether or not they are renewing or applying for health coverage.
- If someone has more than one type of income, tell us about **all of their income**.
- If you need more space, make a copy of this page or call your local office for copies.
- Cross out wrong information. Write in new information and add anything that is missing.

Person who has the job: **Name** *(first, middle, last & suffix)*
Blue Mom

Employer name and address:
Swim shop

Address: City: State: *VA* Zip code: Phone number:

Monthly gross income currently on file: *$3,200.00*

Is this person still employed at this job? ☐ Yes ☐ No ***if No,*** *date they left the job:* _____ (mm/dd/yyyy)

How often are wages and tips paid?

☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month ☐ Yearly ☐ Other _____

☐ Not regularly (for example, if this person works under a contract)

How much does this person earn (before taxes are taken out)? $ _____

Average hours worked each week: _____

If anyone in the household has **changed or has a new job**, list him or her and answer the questions below.

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

Employer name and address: City: State: Zip code: Phone number:

Start Date:

How often are wages and tips paid?

☐ Weekly ☐ Every two weeks ☐ Monthly ☐ Twice a month ☐ Yearly ☐ Other _____

How much does this person get paid (before taxes)? _____

Average hours worked each week: _____

- If anyone in your household is **self-employed or does odd jobs,** we need to know about their work.
- Cross out wrong information. Write in new information and add anything that's missing.

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

Type of work:

What do you expect his or her income to be this year? Amount: $

How much **net income** will this person get from self employment (or odd jobs) this month?

Amount: $

Net income means the profits left over after business expenses are paid. For more information about business expenses visit **https://www.coverva.org/.**

- **Information about other income.** If anyone in your household has income from sources other than a job, like Social Security income, pensions, Veterans benefits, or annuities.
- Cross out wrong information. Write in new information and add anything that is missing.

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

Income Type: **How much? $**

How often?

☐ Yearly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Other _____

☐ Not regularly (for example, if this person works under a contract)

Deductions – Only certain individuals are eligible to receive deductions.

- If anyone in your household has pre tax deductions from pay, tell us what kind. Deductions are amounts, listed on your tax return, that are subtracted from your income for certain expenses.
- You should not include expenses that members of your household subtracted from their self employment gross income. Common deductions include student loan interest paid, contributions to individual retirement arrangements (IRAs), and contributions to health savings accounts (HSAs).

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

Deduction Type _____ **How much monthly? $**_____

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

Deduction Type _____ **How much monthly? $**_____

6 Information about resources and nursing facility care

- This section refers to individuals who are 65 or older, blind, or disabled and/or receiving nursing care in a facility or in the home.
- If this section does not apply to anyone in your home, continue to section 7.
- Cross out wrong information. Write in new information and add anything that's missing.

Resources include things like checking/savings accounts, stocks, bonds, life insurance, and retirement funds. Resources also include property, vehicles, annuities, and trusts.

Owner	Resource	Amount
		$
		$

If this person or their spouse who lives with them are working, do either of them have expenses related to work? ☐ **No** ☐ **Yes** ***If yes, attach proof.***

Does this person or their spouse or child have medical expenses not covered by Medicaid?
☐ **No** ☐ **Yes** ***If yes, attach proof.***

Name of the nursing facility, state institution, or community based care provider:

Has this person or their spouse sold or given away any resources within the last year?

☐ No ☐ Yes ***If yes,*** fill out below.

Resource Type	Value	Date Sold or Given Away
	$	

If married or separated, spouse's name: Name *(first, middle, last & suffix):*

Does this person's spouse have any home expenses? If yes, tell us below.

Rent/Mortgage: $ _____ Utilities ☐ Yes ☐ No

Homeowner's/Renter's Insurance: $ _____ Real Estate Taxes: $ _____

Maintenance Charges for Condominium: $ _____

Does this person's dependent(s) have any income? If yes, tell us below.

Social Security: $ _____ Social Security Income: $ _____

Civil Service: $ _____ Veterans Administration: $ _____

Retirement/Pension: $ _____ Disability: $ _____

Wages: $ _____ Other (Trust, Stocks, Annuities, Dividends, Interest, etc.): $ _____

7 STOP Sign the application

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

- I know that I must tell my local Department of Social Services if anything changes and is different from what I wrote on this form within 10 days. I can call 1 855 242 8282 (TTY: 1 888 221 1590), contact or visit my local agency, or visit **CommonHelp.Virginia.gov** to report any changes. A change in my information might affect whether someone in my household qualifies for coverage.
- I understand that if I do not qualify for health coverage, my local Department of Social Services may send my information to the Health Insurance Marketplace **(www.healthcare.gov)** to see if I qualify.
- I understand that I am authorizing the local Department of Social Service (LDSS) and the Department of Medical Assistance Services (DMAS) to obtain verification/information necessary to determine my eligibility for Medicaid or FAMIS.
- I have permission from everyone whose information is on this form to submit their information to Virginia Medicaid and to receive any communications about their eligibility and enrollment.

Renewal of Coverage in Future Years: Read the statements below and choose.

Giving the Virginia Medicaid program permission to use my federal tax return to confirm my income can make it easier to renew health coverage and may allow renewals to happen automatically. I understand that I can change my mind at any time by contacting my local Department of Social Services.

I give permission to use updated income information from my tax returns for the next (check one):

☐ 5 years ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Do not use my tax information to renew coverage.

To confirm or change your authorized representative or Certified Application Counselor/Navigator/Broker, fill out **Appendix C.**

I am signing this renewal form (including any appendices) under penalty of perjury. I have provided true answers to all questions on this form and I know that I may be subject to penalties under federal law if I provide false or untrue information.

STOP

Signature of Household Contact or Authorized Representative **Date**

ALL individuals in the home 21 or older (or 18 or older in a home without a parent) who are renewing or applying for health coverage MUST sign below. A spouse can sign for their spouse.

Print Name	Signature	Date

Appendix A - Renewal	Complete ONLY if someone in your household is eligible for new health coverage from a job

- Tell us about the job that offers coverage for your household.
- Take the Employer Coverage Tool on the back of this page to the employer who offers the coverage to help you answer these questions.
- If more than one person has coverage offered through a job, make a copy of this page.

Employee Information

Employee Name *(first, middle, last & suffix)*	**Employee Social Security Number**

Employer Information

Employer Name	**Employer Identification Number**
Employer Address	**Employer Phone Number**

City	**State**	**ZIP Code**

Name and title of person who can be contacted about employee health coverage at this job

Name	**Title**
Phone Number	**Email Address**

If you are currently eligible for coverage offered by this employer, or will become eligible in the next 3 months fill in the information below:

If in a waiting or probationary period, what date can you enroll in coverage?_____
(mm/dd/yyyy)

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

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

Tell us about the health plan offered by this employer

Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No
For the lowest cost plan that meets the minimum value standard offered only to the employee (don't include family plans) provide the premium that the employee would pay is the maximum discount was received for any tobacco cessation without any other discounts. $

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

What changes will the employer make for the new plan year (if known)?

☐ Health coverage will not be offered

☐ Employer will offer or change health coverage for the lowest cost plan available to the employee that meets the minimum value standard*.

Employee premium cost $_____

Date of change _____ (mm/dd/yyyy)

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

Employer Coverage Tool

This section should be completed by the employer to help answer questions about any employer health coverage that you are eligible for (even if it is from another person's job, like a parent or a spouse).

Is the employee currently eligible for coverage or will the employee be eligible in the next three months? ☐ Yes ☐ No *(If yes, fill in information below. If no, stop and return form to employee.)*

If in a waiting or probationary period, when can the employee enroll in coverage?_____ (mm/dd/yyyy)

Does the employer offer a health plan that covers an employee's spouse or dependent? ☐ Yes ☐ No
If yes, which people? ☐ Spouse ☐ Dependents

Tell us about the health plan offered by this employer

Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No
(If yes, please complete the information below. If no, stop and return form to employee.)

For the lowest cost plan that meets the minimum value standard offered only to the employee (don't include family plans) provide the premium that the employee would pay is the maximum discount was received for any tobacco cessation without any other discounts. $

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

If the plan year will end soon and you know that the health plans offered will change, write in the information below. If you do not know, stop and return form to the employee.

☐ Health coverage will not be offered

☐ Employer will offer or change health coverage for the lowest cost plan available to the employee that meets the minimum value standard*.

Employee premium cost $_____ Date of change_____ (mm/dd/yyyy)
(Premium should reflect the discount for the wellness program.)

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

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

Appendix B - Renewal

Complete ONLY if someone in your household is an American Indian or Alaska Native

- Tell us about your American Indian or Alaska Native family members(s).
- American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They may not have to pay co pays and may get special monthly enrollment periods.
- If more than two people are American Indian or Alaska Native, make a copy of this page.

Person One Name (first, middle, last & suffix):

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program? ☐ Yes ☐ No

If no, does this person qualify to get these services? ☐ Yes ☐ No

List any income that includes money from these sources: · Payments from a tribe for natural resources, usage rights, leases, or royalties. · Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations). · Money from selling things that have cultural significance.	How much income? $ How often? ☐ Weekly ☐ Twice a month ☐ Every two weeks ☐ Monthly ☐ Yearly ☐ Not regular (for example, if this person works under a contract) ☐ Other

Person Two Name *(first, middle, last & suffix):*

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program? ☐ Yes ☐ No

If no, does this person qualify to get these services? ☐ Yes ☐ No

List any income that includes money from these sources: · Payments from a tribe for natural resources, usage rights, leases, or royalties. · Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations). · Money from selling things that have cultural significance.	How much income? $ How often? ☐ Weekly ☐ Twice a month ☐ Every two weeks ☐ Monthly ☐ Yearly ☐ Not regular (for example, if this person works under a contract) ☐ Other

Appendix C - Renewal

Complete ONLY if you are choosing someone to help with your application

- An authorized representative is a trusted friend, partner, or lawyer you choose to sign your renewal form, get information about this renewal form, and act for you with this agency.
- If we have an authorized representative on file for you, their information is shown below. Review the information. Write in any changes to the information.
- If you want to name an authorized representative, complete below. Make a copy of this page if you need additional space or if you need to add an additional authorized representative.

If you have an authorized representative on file, their name is shown below. Complete this section to confirm this information is still correct.

We show this person is your authorized representative:	Do you still want this person to be your representative? ☐ Yes ☐ No ***If yes***, has any information changed? ☐ Yes ☐ No

If your authorized representative's information has changed, or if you would like to name a new or different authorized representative, write in the information below.

Name of authorized representative and/or organization:

Address:	City	State	Zip Code

Phone number: Phone type: ☐ Home ☐ Cell ☐ Work ☐ Other

Relationship to Applicant:

Please indicate the duties the you would like to authorize for this person.
☐ Apply for benefits ☐ Receive benefits ☐ Receive letters regarding actions taken on your case
☐ Receive request for information needed to determine eligibility
☐ Other:

Your Signature (person applying or renewing for coverage):	**Date**

You can choose one Outreach Worker/Application Assister/Certified Application Counselor/ Navigator/Broker

- Complete this section to authorize a certified application counselor/navigator/broker to be able to access confidential information related to your health coverage case.
- If we have a person/organization on file for you, the name is shown below. If you want to add/change your certified application counselor /navigator/broker, write in the information below.

Outreach Worker/Application Assister/Certified Application Counselor/Navigator/Broker name and name of organization:
ID Number (if applicable):

Do you still want this person to be your representative? ☐ Yes ☐ No
If yes, has any information changed? ☐ Yes ☐ No
Write in any new information below:

Appendix D - Renewal

Complete ONLY for someone who is now applying for health coverage from Virginia Medicaid or whose circumstances may have changed.

- Fill out this page for people who are listed in Section 3 who are **applying for Medicaid or whose circumstances have changed.**
- Make a copy first if you need space for more people.

Tell us about this person's citizenship or immigration status.

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

Date of Birth:	**Social Security Number:**

Is this person a U.S. citizen or U.S. national? ☐ Yes ☐ No ***If yes,*** go to Additional Information. ***If no,*** answer all of the questions below.

Document Type	Alien or I 94 number	Card or foreign passport number

Visit www.coverva.org for more information about eligible immigration status and document types.

☐ Check here if this person has arrived in the U.S. before 1996.

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

Additional Information

☐ Check here if this person lives with and is the main person taking care of a child under the age of 19.

☐ Check here if this person wants help paying for medical bills from the last three months.

☐ Check here if this person was in foster care at age 18 or older and had Medicaid health coverage.

If this person is Hispanic/Latino, check all that apply. *You do not have to answer this question to be eligible for Medicaid.*

☐ Chicano/a
☐ Cuban
☐ Mexican
☐ Mexican American
☐ Puerto Rican
☐ Non Hispanic/Unknown

What is this person's race? Check all that apply. *You may choose not to answer this question. You do not have to answer this question to be eligible for Medicaid.*

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

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

Complete ONLY if someone in your household who is 65 or older, blind, or disabled.

Person's Name

What resources does this person or their spouse have? Resources include things like checking/savings accounts, stocks, bonds, life insurance, and retirement funds.

Resource	Amount
	$
	$
	$
	$

STOP! Continue ONLY if someone in your home is receiving care in a nursing facility or in the home by a medical professional.

Complete ONLY for someone in your household who is in a nursing facility or receiving nursing care in the home.

Name of the nursing facility, state institution, or community based care provider:

If married or separated, spouse's name: Name *(first, midd e, last & suffix)*:

Does this person's spouse have any home expenses? If yes, tell us below.

Rent/Mortgage: $ Utilities ☐ Yes ☐ No

Homeowner's/Renter's Insurance: $ Real Estate Taxes: $

Maintenance Charges for Condominium: $

Does this person's dependent(s) have any income? If yes, tell us below.

Social Security: $_____ Social Security Income: $_____

Civil Service: $_____ Veterans Administration: $_____

Retirement/Pension: $_____ Disability: $_____

Wages: $_____ Other (Trusts, Stocks, Annuities, Dividends, Interest, etc): $_____

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

☐ No ☐ Yes ***If yes,*** fill out below.

Property Transferred	Value of Transfer	Date of Transfer
	$	

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

Additional Information

Voter Registration & Non-discrimination Information

Voter Registration

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.)

Please check one box only:

☐ Yes, I would like to apply to register to vote.
☐ No, I would not like to apply to register to vote.
☐ I am already register to vote.

IF YOU DO NOT CHECK ANY BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, or your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with the **Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219 3497, 804-864-8901.**

WARNING: INTENTIONALLY MAKING A MATERIALLY FALSE STATEMENT ON THIS FORM CONSTITUTES THE CRIME OF ELECTION FRAUD, WHICH IS PUNISHABLE UNDER VIRGINIA LAW AS A FELONY. VIOLATORS MAY BE SENTENCED TO UP TO 10 YEARS IN PRISON, OR UP TO 12 MONTHS IN JAIL AND/OR FINED UP TO $2,500

To register to vote visit: **https://vote.elections.virginia.gov** or call or go to your local agency to request a paper voter registration form. If you need help completing the form, visit your local agency.

(for agency use only)

Voter Registration form completed: ☐ Yes ☐ No
Voter Registration form given to applicant for later mailling (at applicant's request): ☐

_____ _____
Agency Staff Signature Date

Non-discrimination Information

It is important we treat you fairly. We will keep your information secure and private.

This agency complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This agency does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This agency provides free aids and services to people with disabilities to communicate effectively with us, such as, qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). If you need these services, call us at **(804) 786- 7933 (TTY: 1-800-343-0634).** This agency also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call us at **1-855-242-8282 (TTY: 1-888-221-1590).**

If you believe that this agency has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, or by phone at: Civil Rights Coordinator, DMAS 600 E. Broad St., Richmond, VA 23219, Telephone: **(804) 786-7933 (TTY: 1-800-343-0634)**

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201;**1-800-368-1019 (TTY 800-537-7697).** Complaint forms are available at **https://hhs.gov/ocr/office/file/index.html.**

English: Get help in your language
This Notice has important information about your benefits or application for health coverage from Virginia Medicaid. Look for important dates. You might need to take action by certain dates to keep your benefits. You have the right to get this letter for free in your language, in large print, or in another way that is best for you. Call us at 1-855-242-8282 (TTY: 1-888-221-1590).

Spanish: Obtenga ayuda en su idioma
Este aviso tiene información importante de Virginia Medicaid sobre sus beneficios o solicitud de cobertura de salud. Busque fechas importantes. Puede que necesite hacer algo antes de ciertas fechas para conservar sus beneficios. Tiene derecho a obtener esta carta en su idioma, con letra grande, o de cualquier otra manera que sea mejor para usted, de manera gratuita. Llámenos al 1-855-242-8282 (telefonía de texto [TTY]: 1-888-221-1590).

Korean: 본인의 언어로 도움을 받으세요.
이 통지서에는 버지니아 메디케이드의 의료 보험 혜택 또는 의료 보험 신청에 대한 중요한 정보가 들어 있습니다. 이에 대한 중요한 마감일도 공지하고 있습니다. 혜택을 받으려면 마감일까지 조치를 취하셔야 합니다. 이 통지서는 본인이 사용하는 언어로 또는 큰 글자로 인쇄된 서신으로 또는 본인에게 최선이 될 수 있는 방법으로 무료로 받을 수 있는 권리가 있습니다. 저희에게 문의해 주십시오. 문의처 1-855-242-8282 (TTY: 1-888-221-1590)로 전화하십시오.

Vietnamese: Nhận giúp đỡ bằng ngôn ngữ của quý vị
Thông báo này có thông tin quan trọng về cách quý vị nhận phúc lợi hoặc cách nạp đơn nhận bảo hiểm y tế thuộc chương trình Medicaid của tiểu bang Virginia. Hãy chú ý đến những ngày quan trọng. Quý vị có thể phải hành động trước một số ngày trong Thông báo này để tiếp tục nhận phúc lợi. Quý vị có quyền nhận thư này miễn phí bằng tiếng Việt, bằng chữ khổ lớn hoặc theo cách nào phù hợp nhất với quý vị. Xin gọi cho chúng tôi theo số 1-855-242-8282 (máy TTY: 1-888-221-1590).

Chinese (Traditional): 用您使用的語言獲得幫助
本通知包含有關您的Virginia Medicaid福利或醫療承保申請的重要資訊。請查看重要的日期。您可能需要在某些日期之前採取行動，才能保持您的福利。您有權免費用您使用的語言、大印刷體或其他最適合您的方式收到本信函。請電洽 1-855-242-8282（TTY: 1-888-221-1590）。

Arabic: احصل على المساعدة بلغتك
يتضمن هذا الإخطار معلومات مهمة عن المزايا التي سوف تحصل عليها -أو عند التقدم للحصول عليها- من التأمين الصحي المقدم من فيرجينيا ميديكيد Virginia Medicaid. ابحث عن التواريخ المهمة. قد يتعين عليك القيام بإجراءات بحلول تواريخ محددة للاحتفاظ بمزاياك. يحق لك الحصول على هذا الخطاب مجانًا بلغتك، مطبوعًا طباعة كبيرة، أو بأفضل طريقة تراها. اتصل بنا على رقم 1-855-242-8282 (TTY: 1-888-221-1590).

Urdu: اپنی زبان میں مدد حاصل کریں
اس نوٹس میں آپ کے بینیفٹس یا Virginia Medicaid سے صحت کے کوریج کے لیے درخواست کے بارے میں اہم معلومات ہیں۔ اہم تاریخوں پر نظر رکھیں۔ آپ کو اپنے بینفٹس برقرار رکھنے کے لیے مخصوص تاریخوں تک کارروائی کرنے کی ضرورت ہوسکتی ہے۔ آپ کو یہ خط اپنی زبان میں، بڑے حروف میں، یا کسی دوسرے طریقے سے جو آپ کے لیے بہترین ہو، مفت حاصل کرنے کا حق ہے۔ ہمیں 1-855-242-8282 (ٹی ٹی وائی: 1-888-221-1590) پر کال کریں۔

Hind अपनी भाषा में मदद लें
इस नोटिस में Virginia Medicaid से प्राप्त होने वाले आपके लाभों या हेल्थ कवरेज हेतु आवेदन के बारे में महत्वपूर्ण जानकारी दी गयी है। महत्वपूर्ण तारीखें देखें। आपको अपने लाभों को बनाये रखने के लिए निश्चित तारीखों तक कार्यवाही करने की आवश्यकता हो सकती है। आपको इस पत्र को अपनी भाषा में, बड़े प्रिंट में, या ऐसे किसी अन्य ढंग में जो आपके लिए सबसे अच्छा हो, नि:शुल्क प्राप्त करने का अधिकार है। हमें 1-855-242-8282 (TTY: 1-888-221-1590) पर फोन करें।

Farsi:دریافت کمک به زبان خود
این اطلاعیه حاوی اطلاعات و مطالب مهمی درباره مزایا یا درخواست شما برای پوشش بهداشتی و درمانی از Virginia Medicaid می باشد. به تاریخهای مهم توجه داشته باشید. شاید لازم باشد برای حفظ مزایا در تاریخهای مشخصی اقداماتی بعمل آورید. شما حق دارید این نامه را به رایگان به زبان خود، با حروف چاپی درشت یا هر روش دیگری که برایتان مناسب است دریافت کنید. لطفاً با ما در شماره 1-855-242-8282 (TTY: 1-888-221-1590) تماس بگیرید.

Bengali: আপনার নজিরে ভাষায় সাহায্য পান
Virginia Medicaid এর স্বাস্থ্য বমিা বষিয়ক আপনার সুযে·াগ-সুবধিা অথবা আবদেন সম্পরকতি গুরুত্বপূর্ণ তথ্য এই নে·াটশিে আছে। গুরুত্বপূর্ণ তারখিগুলরি অনুসন্ধান করুন। আপনার প্রাপ্য সুযে·াগ-সুবধিা চালু রাখতে হলে আপনাকে নর্দিষ্টি তারখিরে মধ্যে পদক্ষপে গ্রহণ করতে হতে পারে। আপনার অধকিার আছে নজিরে ভাষায়, বড় অক্ষরে ছাপা অথবা আপনার পক্ষে সর্বশ্রষ্ঠে এমন যে কে·ানও উপায়ে এই চঠিটি বনিামূল্যে পাওয়ার। আমাদরে টলেফি·োন করুন এই নম্বরে: 1-855-242-8282 (TTY: 1-888-221-1590)।

Tagalog: Tumanggap ng tulong sa inyong wika
May mahalagang impormasyon ang patalastas na ito tungkol sa inyong mga benefit [kapakanan] o paghiling na masakop ng segurong pangkalusugan ng Virginia Medicaid. Tignan ang mga mahahalagang petsa. Maaaring dapat kumilos kayo sa ilan mga petsa upang mapanatili ang inyong mga benefit. May karapatan kayong matanggap ang sulat na ito sa iyong wika. malaking mga letra, o sa anumang paraan na pinakamahusay sa inyo. Tawagan kami sa 1-855-242-8282 (TTY: 1-888-221-1590).

Amharic: በቋንቋዎ እርዳታ ያግኙ
ይህ ማስታወቅያ ከቨርጂንያ ሜዲኬይድ የሚያገኙትን ጥቅሞችዎን ወይም የጤና ሽፋን ማመልከቻን አስመልክቶ አስፈላጊ መረጃ ያዘለ ነው። አስፈላጊ ቀኖችን ይመልከቱ። ጥቅሞችዎ እንዳይቋረጥብዎ፣ በተወሰኑ ቀኖች ውስጥ እርምጃዎችን መውሰድ ሊያስፈልግዎ ይችል ይሆናል። ይህን ደብዳቤ፣ በነጻ፣ በቋንቋዎ፣ ተለቅ ባሉ ፊደሎች ታትሞ፣ ወይም ለእርስዎ በሚያመቹ በሌላ መንገዶች የማግኘት መብት አልዎት። ወደኛ በ 1-855-242-8282 (TTY: 1-888-221-1590) መደወል ይችላሉ።

French: Obtenez de l'aide dans votre langue
Cet avis contient des informations importantes sur vos prestations ou votre demande d'assurance-maladie auprès de Virginia Medicaid. Recherchez les dates importantes. Vous devrez peut-être prend e des mesures avant certaines dates pour conserver vos prestations. Vous avez le droit d'obteni cette lettre gratuitement dans votre langue en gros caractères ou de la manière qui vous c nvien le mieux. Appelez-nous au 1-855 242-828 (ATS: 1-888-221-1590).

Russian: Получите помощь на вашем языке
В этом уведомлении содержится важная информация о ваших льготах или заявке на медицинское страховое покрытие Medicaid штата Вирджиния. Обратите внимание на важны даты. От вас может требоваться выполнение тех или иных действий в определенные сроки для сохранения ваших льгот. Вы имеете право на бесплатное получение этого письма на вашем языке, крупным шрифтом или в другом удобном для вас формате. Позвоните нам по номеру 1-855-242-8282 (TTY: 1-888-221-1590).

German: Holen Sie sich Hilfe in Ihrer Sprache
Diese Mitteilung enthält wichtige Informationen zu Ihren Krankenversicherungsleistungen oder zu Ihrem Antrag auf Krankenversicherung von Virginia Medicaid. Achten Sie auf wichtige Daten. Sie müssen möglicherweise zu bestimmten Terminen Maßnahmen ergreifen, um Ihre Leistungen weiterhin zu erhalten. Sie haben das Recht, diesen Brief kostenlos in Ihrer Sprache, in Großdruck oder auf eine andere Weise zu erhalten, die für Sie am besten ist. Rufen Sie uns bitte an unter 1-855-242-8282 (TTY: 1-888-221-1590).

Bassa: Ṁ ɓɛ̀ìn gbo-kpá-kpá dyéɛ ɖé wuɖu ṁ poɛɛ mú
Céè-ɖɛ̀ nìà kɛ ɓéɖé bɔ̃ kpa ɖɛ ɓě ɓó wé ɓě kɔ̃ ɓaɖa ṁ ɓɛ̀ìn gbo-kpá-kpá ɓě dyéɛ ɔ jǔ ké ṁ dyi gbo-kpá-kpá zɔ̀ ɓó nì kpóɖó-dyùàɔ̀ dyi káná jè sɔ̀ìn ɖé nyɔ Kũùn jè gbo-kpáìn-naín nìà ɖé Vɔ̀jínìà kɛɛ ní. Dè wé kpa ɖɛ ɓě kɔ̃ mú ṁ ɓɛ̀ìn gbo-kpá-kpá ɓě nìà kɛ dyéɛ kɛɛ jè dyéɖé gbo. Ṁ kɔ̃ ɓé ṁ ké gbo-kpá-kpá nìà kɛ zɔ̀ ɓó wé jéɛ́ ɓě baɖa, ɓé ṁ ké nì gbo-kpá-kpá ɓěɔ̀ dyé. Ṁ ɓɛ̀ìn céè-ɖɛ̀ nìà kɛ dyéɛ pidyi ɖé wuɖu ṁ poɛɛ mú ɖé céè-ɖɛ̀-dyèɖè boo-boo mú, mɔɔ ɖé hwìè kà kò dò kɔ̃ mú ṁ mɔ́ ɓɛ wa ké nì céè-ɖɛ̀ɔ̀ céè kɛɛ mú. Ɖá à nìì ɖé nɔ̀ɓà nìà kɛ kɔ̃ 1-855-242-8282 (TTY: 1-888-221-1590).

Ibo: Nweta enyemaka n'asusu gị
Nkwupụta nke a nwere ozi dị mkpa banyere uru ndị gị maọbụ arịrịọ gị maka mkpuchi ahụike site na Virginia Medicaid. Chọọ maka deeti dị mkpa. Aga-achọrọ ka ịme ufọdu i e n'ufọdu ubọchị iji dowe uru gị gasị. Ị nwere ikike ịnwet akwukwọ ozi nke a n'efu n'asụsụ gị, e iputa a n'iji nnukwu mkpụrụedemede, maọbu n'uzọ ọzọ kacha mma maka gị. Kpọọ anyị na 1-855-242 8282 (TTY: 1-888-221-1590).

Yoruba: Gba iranlowo ni ede rẹ
Akiyesi yi ni iwifun-ni pataki nipa awon anfaani tabi iwe ìbẹwẹ fun agbegbe ilera lati Virginia Medicaid. Wa awọn ọjọ pataki. Ó se é se lati gbe igbésẹ ni awọn ọjọ kan lati fi awọn anfaani rẹ pamọ. Ó ni ẹtọ lati gba lẹtà yi ni ọfẹ ni ede rẹ, ni kikọsilẹ gàdàgbà tabi ni ọnà miran ti ó dara fun ọ. Pè wá ni 1-855-242-8282 (TTY: 1-888-221-1590).