Name of Applicant: _____

CardinalCare
Virginia's Medicaid Program

Application for Health Coverage and Help Paying Costs
APPENDIX D

Complete Appendix D if you are applying for Health Care Coverage for:

- **Someone who has disabilities**
- **Someone age 65 years or over**
- **All people, including children, in need of Long-term Care Services** (nursing facility or community based care)
- **Someone who is enrolled in or eligible for Medicare**
- **Someone interested in applying for Medicaid Works**

What is Appendix D Used For?

Appendix D gathers additional information needed to determine your eligibility for Health Care Coverage. Appendix D is not a stand-alone application. You must also complete the Application for Health Coverage and Help Paying Costs and submit Appendix D with the application. If completing Appendix D for someone else, please answer the questions for that person.

SECTION 1 Household Information

1. Are You? ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

2. Has anyone in your household ever applied for or received any Health Care Coverage from a social service agency in another state or Virginia city or county? ☐ **Yes** ☐ **No**

— If **yes**, please indicate which state or Virginia city or county below:

State or Virginia city or county:

3. Is anyone in your household temporarily away from home? ☐ **Yes** ☐ **No**

Name	Date Left mm/dd/yyyy
Reason for Leaving	
Where is the person currently staying?	Expected Return Date mm/dd/yyyy

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

Answer questions 4-11a if any applicants are under age 65 years.

4. Are you or is anyone for whom you are applying disabled? ☐ **Yes** ☐ **No**

— If **yes**, please provide the name of the persons:

Name of Person	Name of Person

4a. Medicaid Works is Virginia's Medicaid program for people with disabilities who are employed or who want to work. Are you interested in applying for Medicaid Works? ☐ **Yes** ☐ **No**

5. Have you or anyone for whom you are applying ever applied for Social Security, Supplemental Security Income (SSI) or Railroad Retirement benefits as a disabled person? ☐ **Yes** ☐ **No**

— If **yes**, please provide the name of the persons and date of application:

Name of Person and Date of Application	Name of Person and Date of Application

6. Have you or anyone in your household for whom you are applying been approved for disability for Social Security, SSI, Railroad Retirement or Medicaid purposes? ☐ **Yes** ☐ **No**

— If **yes**, please provide the name of the individual:

Name	Name

7. If the application for Social Security, SSI or Railroad Retirement benefits was denied, did you file an appeal of the denial? ☐ **Yes** ☐ **No**

If yes, please tell us the outcome of the appeal:

8. Has it been less than 12 months since the most recent application for Social Security, SSI or Railroad Retirement benefits was denied? ☐ **Yes** ☐ **No**

9. Has the condition changed or worsened since the most recent application for disability was denied? ☐ **Yes** ☐ **No**

10. Do you or anyone for whom you are applying have a new medical condition since the most recent application for disability was denied? ☐ **Yes** ☐ **No**

11. Have you or anyone for whom you are applying ever received SSI, disability benefits from the Social Security Administration or Auxiliary Grant payments?

☐ **Yes** ☐ **No**

Has the payment stopped? ☐ **Yes** ☐ **No**

11a. If yes, explain why the payments stopped:

SECTION 2 Long-Term Services and Supports

Answer questions 12-14 if you are applying for anyone who is in a nursing facility or assisted living facility, or who requires nursing home care or assistance to remain in the home

12. Do you or anyone for whom you are applying need nursing facility care or help with activities such as bathing, dressing, toileting, etc., so that you can remain in your own home? ☐ **Yes** ☐ **No**

12a. Does that person have a spouse who lives somewhere else? ☐ **Yes** ☐ **No**
If yes, provide the name and address of the spouse. Note: Under Virginia law persons are considered married and legally responsible for each other until they divorce.

Name
Address

13. Do you or anyone for whom you are applying live in one of the following?
☐ Assisted Living Facility (ALF) ☐ Nursing Facility ☐ Group Home ☐ Hospital or other Medical Facility
— If you checked one of the above, please provide the following information:

Name	Date of Entry	County of the prior address
Person's address prior to entering the facility		
Facility Name	Facility Address	
Was Placement made by a State agency?		

14. Does the individual in the nursing facility or requiring assistance in the home have long-term care insurance? ☐ **Yes** ☐ **No** — If **yes**, please provide the following information:

Name of Insurance Company	Address	City, State, ZIP
Policy Number	Person(s) Insured	Is this a Partnership Policy? ☐ **Yes** ☐ **No**

15. Have you or your spouse sold, transferred, placed in a trust/annuity, or given away any resources, such as your home or other real property, cash, bank accounts, or cars in the last sixty (60) months (5 years)?
☐ **Yes** ☐ **No** — If **yes**, please provide the following information:

Type of Property Transferred	Value at Transfer **$**	Amount Received **$**	Date of Transfer
From Whom		To Whom	
Explain the Reason for Transfer			

Note: If more than one transfer has occured, please attach documentation of each transfer.

SECTION 3 Resources and Assets

16. Do you or your spouse have any money/cash on hand that is not in the bank? ☐ **Yes** ☐ **No**
— If **yes**, please provide the following information:

Name	Amount **$**
Name	Amount **$**

17. Do you or your spouse have any of the following resources?
Check the boxes that apply and provide the information requested below:

☐ Checking, Savings ☐ Deferred Compensation Plan ☐ Christmas Club
☐ Credit Union ☐ Certificate of Deposit (CD) ☐ Money Market Funds
☐ Direct Express Card
☐ I/my spouse do not have any of these resources

1. Owner Name		Co-Owner Name	
Name of Bank	Account Type	Account Number	Balance/Value **$**
2. Owner Name		Co-Owner Name	
Name of Bank	Account Type	Account Number	Balance/Value **$**
3. Owner Name		Co-Owner Name	
Name of Bank	Account Type	Account Number	Balance/Value **$**

Is your income (Social Security or SSI benefits, retirement pension, wages, etc.) deposited directly into any of the accounts? ☐ **Yes** ☐ **No** — If **yes**, which account?

☐ Checking, Savings ☐ Deferred Compensation Plan ☐ Christmas Club
☐ Credit Union ☐ Certificate of Deposit (CD) ☐ Money Market Funds
☐ Direct Express Card

18. You must report ownership of all annuities you and your spouse have. You and your spouse may have to name the Commonwealth of Virginia as the beneficiary of any annuity you or your spouse own.

Do you or your spouse have any stocks or bonds, trust funds, pension plans, retirement accounts, trusts, annuities, promissory notes, or deeds of trust? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

1. Owner Name		Co-Owner Name	
Where is the Account Held?	Account Type	Account Number	Balance/Value **$**
2. Owner Name		Co-Owner Name	
Where is the Account Held?	Account Type	Account Number	Balance/Value **$**
3. Owner Name		Co-Owner Name	
Where is the Account Held?	Account Type	Account Number	Balance/Value **$**

19. Do you or your spouse have any life insurance? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

1. Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	Policy Number	Face Value **$**	Cash Value **$**
2. Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	Policy Number	Face Value **$**	Cash Value **$**
3. Owner Name	Person Insured	Type of Insurance (whole life or term)	
Company Name	Policy Number	Face Value **$**	Cash Value **$**

20. Do you or your spouse have burial plots, burial arrangements, or trust funds for burial? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

Owner(s)	Item/Type	Value/Amount Owned **$**
Owner(s)	Item/Type	Value/Amount Owned **$**
Owner(s)	Item/Type	Value/Amount Owned **$**

21. Do you or your spouse have real property, including home property, life rights/estates, shares in undivided heir property, land, buildings, or mobile homes? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

Owner(s)	Type of Property/Number of Acres	Value/Amount Owned **$**
Do you live on this property? ☐ **Yes** ☐ **No**	Is this property currently for sale? ☐ **Yes** ☐ **No**	
Is this property rented? ☐ **Yes** ☐ **No**	Do you receive money from this property? ☐ **Yes** ☐ **No**	

22. Do you or your spouse have any licensed or unlicensed cars, trucks, vans, boats, motors homes, recreational vehicles, utility trailers, motorcycles, or mopeds? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

Owner(s)	Year-Make-Model	Value/Amount Owned **$**
Owner(s)	Year-Make-Model	Value/Amount Owned **$**
Owner(s)	Year-Make Model	Value/Amount Owned **$**

23. Do you or your spouse have any property that is used in the operation of a business, such as farm equipment, tools, or livestock? ☐ **Yes** ☐ **No**

— If **yes**, please provide the following information:

Owner(s)	Type	Value **$**	Amount Owned **$**
Owner(s)	Type	Value **$**	Amount Owned **$**

24. Do you or your spouse expect a change in resources this month or next month? ☐ **Yes** ☐ **No**

— If **yes**, please explain below and give the date the change is expected:

Explain
Date Change Expected

25. Do you receive child support? ☐ **Yes** ☐ **No**

Amount **$**	How Often?	Is the payment for past-due child support payments? ☐ **Yes** ☐ **No**

SECTION 4 Other Income

26. Do you receive Veteran's Administration benefits? ☐ **Yes** ☐ **No**		
Amount **$**	How Often?	Type

27. Does anyone help you pay, or lend you money to pay rent, utilities, medical bills, or any other bills? ☐ **Yes** ☐ **No** — If **yes**, please provide the following information:	
Person Receiving Money	Person Providing Help
Type of Help Received	Amount **$**
Does the money come directly to you? ☐ **Yes** ☐ **No**	
Is this a loan? ☐ **Yes** ☐ **No**	
Is repayment expected? ☐ **Yes** ☐ **No**	
Person Receiving Money	Person Providing Help
Type of Help Received	Amount **$**
Does the money come directly to you? ☐ **Yes** ☐ **No**	
Is this a loan? ☐ **Yes** ☐ **No**	
Is repayment expected? ☐ **Yes** ☐ **No**	

Sign the application

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

Signature of Applicant	Relationship to Applicant	Date (mm/dd/yyyy)