Appendix E is not a stand-alone application. Submit at LDSS request after filing The Application for Health Coverage and Help Paying Costs.

COVER VIRGINIA
Connecting Virginians to Affordable Health Insurance

**Name of Applicant**_____
**Case Number**_____
**Date Received**_____

# Application for Health Coverage and Help Paying Costs APPENDIX E (Medically Needy Spenddown)

**Complete Appendix E if you have applied for Health care Coverage for someone who is medically needy (has income greater than the Medicaid limit and would like to be evaluated based on income, resources and medical expenses). LIFC (low income families with children) applicants cannot be evaluated as medically needy.**

## SECTION 1 Resources and Assets

Answer for the applicant and his or her husband, wife and/or parents and siblings (if applicant is a child). Include any resources anyone owns, or that are jointly owned with someone else, even if that person does not live with you. List the names of all joint owners.

**Do you or anyone who lives with you have any of the following resources or assets?**

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Cash $_____ | ☐ | ☐ | Motor Vehicles | ☐ | ☐ | Stocks or Bonds |
| ☐ | ☐ | Checking, Savings | ☐ | ☐ | Real Property | ☐ | ☐ | Annuities |
| ☐ | ☐ | Credit Union | ☐ | ☐ | Life Insurance | ☐ | ☐ | Deeds of Trust |
| ☐ | ☐ | Money Market Funds | ☐ | ☐ | Burial Arrangements | ☐ | ☐ | Trust Funds |
| ☐ | ☐ | Certificate of Deposit (CD) | ☐ | ☐ | Retirement Accounts | ☐ | ☐ | Other |
| ☐ | ☐ | Self Sufficiency Account | ☐ | ☐ | Pension Plan | | | |

**IMPORTANT:** If you have **any of the above** resources, please provide the following information and return documents, such as bank statements, life insurance policies, or a letter from the bank or company documenting the **cash value of the resource**. Verify any liens which reduce cash value. Use additional pages to list additional resources.

Complete the following section for any **"Yes"** answers

| Owner Name (last, first, middle initial) **a.** | | Co-owner Name (last, first, middle initial) | |
|---|---|---|---|
| Name of Bank, Institution or Company | Resource Type | Identifying Number | Balance or Value **$** |
| Address of Bank, Institution or Company (if applicable) | | | |
| Owner Name (last, first, middle initial) **b.** | | Co-owner Name (last, first, middle initial) | |
| Name of Bank, Institution or Company | Resource Type | Identifying Number | Balance or Value **$** |
| Address of Bank, Institution or Company (if applicable) | | | |
| Owner Name (last, first, middle initial) **c.** | | Co-owner Name (last, first, middle initial) | |
| Name of Bank, Institution or Company | Resource Type | Identifying Number | Balance or Value **$** |
| Address of Bank, Institution or Company (if applicable) | | | |

| Owner Name (last, first, middle initial)<br>**d.** | | Co-owner Name (last, first, middle initial) | |
|---|---|---|---|
| Name of Bank, Institution or Company | Resource Type | Identifying Number | Balance or Value |
| Address of Bank, Institution or Company (if applicable) | | | |

# SECTION 2 Additional Income

**Do you or anyone who lives with you (including children) receive or expect to receive any of the following?**

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Worker's Compensation | ☐ | ☐ | VA Benefits | ☐ | ☐ | Other (including Gifts, Life Insurance Proceeds, Inheritances) |
| ☐ | ☐ | Child Support | ☐ | ☐ | Lump Sums | | | |

**IMPORTANT:** If you answered "yes" above, please provide the following information and return documents, such as a letter from the source documenting the **monthly gross amount of income**. Use additional pages if needed to list additional income sources.

Complete the following section for any **"Yes"** answers

| Name of Person<br>**a.** | Amount<br>**$** | Type of Money or Help | How Often Received? |
|---|---|---|---|
| Name of Person<br>**b.** | Amount<br>**$** | Type of Money or Help | How Often Received? |
| Name of Person<br>**c.** | Amount<br>**$** | Type of Money or Help | How Often Received? |
| Name of Person<br>**d.** | Amount<br>**$** | Type of Money or Help | How Often Received? |

**Does anyone have a day care expense for a child, an elderly person, or an adult with a disability?**

☐ **Yes** ☐ **No**

— If **yes**, give name of person being cared for, name of person providing care, monthly cost and attach verification.

| Name of Person Being Cared For | Name of Person Providing Care | Monthly Cost<br>**$** |
|---|---|---|
| | | |

## Sign the Form

I am signing this appendix 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 or untrue information.

| Signature | Relationship to Applicant | Date |
|---|---|---|

Return:

- Signed Appendix E
- Bank statements, life insurance policies, or a letter from the bank or company documenting the **cash value of the resource** and verification of any liens which reduce cash value.
- Pay stubs or a letter from the source documenting the **monthly gross amount of income.**