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.

Name	Date of Birth	Place of Birth	For children, list the names of parents living in the home:

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. Attach all verification/documentation to this form.

Who Receives Income?	Amount	Source	How Often Received (daily, weekly, monthly, etc.)

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)**

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**

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**

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:** __________

7. **INELIGIBLE INDIVIDUALS:** ______________________

REASONS: ______________________ **MANUAL CITATION:** __________

B. MN (SPENDDOWN) EVALUATION **RESOURCE INFORMATION MUST BE OBTAINED AND EVALUATED**

8. **RESOURCE TYPE** **VALUE** **VERIFICATION**

RESOURCE TYPE	VALUE	VERIFICATION

COUNTABLE RESOURCES: ______________ RESOURCE LIMIT: ______________

SPENDDOWN BUDGET PERIOD FROM: ______________ **TO** ______________

VOTER REGISTRATION FORM COMPLETED: ❑ YES ❑ NO
VOTER REGISTRATION FORM GIVEN TO APPLICANT FOR LATER MAILING (AT APPLICANT'S REQUEST): ❑

WORKER'S SIGNATURE: ______________________ DATE: ______________

SUPERVISOR'S SIGNATURE: ______________________ DATE: ______________