VIRGINIA RECERTIFICATION APPLICATION

If you need assistance completing this application, please contact the Virginia Department of Health at 1-855-362-0658. The application may be mailed to Virginia Department of Health, HCS Unit, 1st Floor, James Madison Building, 109 Governor Street, Richmond, VA 23219 or faxed to 804-864-8050.

Did you:

1. Yes ☐ No☐ Answer all of the questions on the application?
2. Yes ☐ No☐ Include proof of Virginia residency if your current address is not in Virginia?
3. Yes ☐ No☐ Include proof of current income?
4. Yes ☐ I have health insurance ☐ Include a copy (front & back) of your health insurance card (if applicable)? ☐ No, I don't have health insurance.
5. Yes ☐ No ☐ Sign and date application?

- If you checked "yes" to all questions above, your application will be processed.
- If you checked "I don't have health insurance" to question 4 above but checked "yes" to all other questions, your application will be processed.
- If you answered "No" to any questions above, not including question 4, your application cannot be processed. Please send only completed application.

Please use the checklist above to confirm that the application is complete. Who is submitting this application (Client, Case Manager, Other)?:

Name: Contact Phone Number:

Relationship to Client:

Signature: Date:

APPLICANT AND CONTACT INFORMATION			
Last Name	First	M.I.	Date
Street Address		Apartment/Unit	
City	State	ZIP	
Social Security #		Date of Birth	
Primary Phone	Secondary Phone		

INCOME			
Current Family Income: $______________	☐ Annual	☐ Monthly	☐Other, specify______________
Number of persons in your family unit (include yourself):_______		**Are you currently employed?** ☐ Yes ☐ No	
Please check any other types of income you receive: ☐ Alimony ☐ Child Support ☐ Unemployment ☐ Retirement/Pension ☐ SSI/SSDI ☐ Other, Specify _________			

INSURANCE INFORMATION				
1. Do you currently have any type of insurance?	☐Yes	☐No		☐ Don't Know
ACA Insurance	☐ Yes	☐ No		☐ Don't Know
Private Insurance, Employer	☐ Yes	☐ No		☐ Don't Know
Private Insurance, Individual	☐ Yes	☐ No		☐ Don't Know
Indian Health Services	☐ Yes	☐ No		☐ Don't Know
Medicaid/CHIP/Other Public Plan	☐ Yes	☐ No		☐ Don't Know
VA/TRICARE/Other Military Plan	☐ Yes	☐ No		☐ Don't Know
Medicaid	☐ Yes	☐No		☐ Don't Know
Medicare	☐ Yes	☐No		☐ Don't Know
If Yes, Have you applied for Medicare Part D (medication coverage)?	☐ Yes	☐No		☐ Don't Know
If Yes to Medicare Part D, have you applied for the Low Income Subsidy (LIS)?	☐ Yes	☐No		☐ Don't Know
Social Security Income (SSI) or Social Security Disability Income (SSDI)?	☐ Yes, for SSI	☐Yes, for SSDI	☐ No	☐ Don't Know

MEDICAL PROVIDER INFORMATION

Name of prescribing physician:

Phone:	Fax:

CONSENT AND SIGNATURE

I understand it is my responsibility to provide medical status and proof of income every six months. I further understand it is my responsibility to notify VDH of any changes in my contact information, income or insurance status (if applicable). Failure to provide the necessary documentation could jeopardize my approved assistance through the Virginia Department of Health.

My information is being entered into a statewide database by the Virginia Department of Health. I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and/or other health care benefits. I request a third party payer to pay any authorized benefits to VDH on my behalf. I hereby give my consent to VDH to obtain, verify, and/or release my demographic, medical, prescription, and/or insurance coverage information, with other entities as necessary to effectively manage my medication access. Information may be shared with but is not limited to the following: physician, health department personnel, other Division of Disease Prevention programs (including Surveillance, Care and Prevention), treatment center personnel, pharmacy services provider, referral source, clinic, insurance broker and/or insurance carrier. VDH agrees to treat any and all such information as confidential.

I understand that this consent will remain in effect as long as my dependent or I remain on ADAP or until I withdraw it.

I have read, understand and agree to the above Client Responsibilities and Release of Consent. I verify that the information provided in this application is complete and accurate to the best of my knowledge.

____ ________________________

Signature of Client, Parent/Legal Guardian or Person acting in Loco Parentis — Date Signed

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Relationship (If signature is not of Client)

____ ________________________

Signature of Person Obtaining Consent — Date Signed