

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 residency with current Virginia address?
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: _____ Date: _____
 Signature: _____

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 Household Income: \$ _____ <input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Other, specify _____			
Number of persons in your family unit (include yourself): _____			Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please check any other types of income you receive: <input type="checkbox"/> Alimony <input type="checkbox"/> Child Support <input type="checkbox"/> Unemployment <input type="checkbox"/> Retirement/Pension <input type="checkbox"/> SSI/SSDI <input type="checkbox"/> Other, Specify _____			

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

I understand my information is being entered into a 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 VA MAP 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

Relationship (If signature is not of Client)

Signature of Person Obtaining Consent

Date Signed