

COMMONWEALTH OF VIRGINIA DEPARTMENT OF SOCIAL SERVICES MEDICAID APPLICATION FOR MEDICALLY INDIGENT PREGNANT WOMEN	AGENCY USE ONLY	
	DATE RECEIVED	
	CASE NAME/NUMBER	
	LOCALITY	WORKER

Please complete all sections of this form and return it to the local department of social services in the city/county in which the pregnant woman resides. If you need assistance in completing the form, please contact an eligibility worker at the local department of social services.

I. IDENTIFYING INFORMATION: List the name, address, and phone number of the pregnant woman. If you are her authorized representative, please complete the application as if you were the pregnant woman.

Last Name	First	Mi	Home Phone #	Daytime Phone #
Address	City	State	Zip	City/County of Residence
Mailing Address (If Different)	City	State	Zip	
Language (Enter Code): _____ 1 - English 2 - Spanish 3 - Cambodian 4 - Vietnamese 5 - Farsi 6 - Haitian-Creole 7 - Laotian 8 - Chinese 9 - Korean A - Somali B - Kurdish C - Arabic F - French G - German J - Japanese O - Other				

II. HOUSEHOLD INFORMATION: List the pregnant woman as person 1. Then list the following individuals in the home as persons 2, 3, and 4: her parents if she is under 21, her children, and her spouse. If there are more than four people, please complete a second form. A social security number is required only for the pregnant woman.

	PERSON 1	PERSON 2	PERSON 3	PERSON 4
Full Name				
Relationship to Person 1	Self			
Sex/Race/Ethnicity (Enter Code)				
Sex "M" or "F"				
Race	1 - White 2 - Black/African-American 3 - American Indian/Alaskan Native 4 - Asian 5 - Native Hawaiian/Other Pacific Islander 6 - American Indian/Alaskan Native and White 7 - Asian and White 8 - Black/African-American and White 9 - American Indian/Alaskan Native and Black/African-American A - Asian and Black B - Other			
Ethnicity	1 - Hispanic or Latino 2 - Not Hispanic or Latino			
Marital Status – (Married, Never Married, Divorced, Widowed)				
Date of Birth				
Place of Birth				
Social Security #				
US Citizen? (Y/N)? If no, alien #.				
Date pregnancy began				
Do you have health insurance? (Y/N) If yes, list company name and policy number.				

III. List all income received by the household. Include earnings, Social Security benefits, support, unemployment benefits, pensions, sick pay, student loans, farm income, and property or room rental.

	PERSON 1	PERSON 2	PERSON 3	PERSON 4
Name of employer or source of income				
How often is the income received?				
Amount before deductions?				
Are you paying adult or child care while you work? (Y/N) For whom? _____ How much? _____ How often? _____				

IV. Have you been to a doctor's office or clinic, received a prescription drug, or received a medical service in the three months before this month? [] Yes [] No If yes, list months: _____

V. Have there been any changes in your living arrangements, marital status, or income in the last three months? [] Yes [] No If yes, describe the changes: _____

RIGHTS AND RESPONSIBILITIES

I understand that to receive benefits from the Medicaid program, I must agree to assign my right to medical support and other third-party payments to the Department of Medical Assistance Services. I understand that all money I receive for diagnosis or treatment of any injury, disease, disability, or medical care support must be sent to the Third-Party Liability Section, Department of Medical Assistance Services, Suite 1300, 600 East Broad Street, Richmond, VA 23219. I understand that my refusal to assign my rights will result in my ineligibility for Medicaid.

I understand that I have the right to file a complaint if I feel I have been discriminated against because of race, color, national origin, sex, age, handicap, or religious belief. I understand that I have the right to appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application within 10 days; (2) denied benefits from the Medicaid Program; or (3) dissatisfied with any other decision that affects my receipt of Medicaid.

I understand that refusal to cooperate with a review of my Medicaid eligibility by Quality Control will make me ineligible for Medicaid until I cooperate with the review.

I authorize the Department of Social Services and the Department of Medical Assistance Services to obtain any verifications necessary to establish my eligibility for assistance. I authorize the release to the Department of Medical Assistance Services of any information in any medical records pertaining to any services received by me.

I received the booklet: Medicaid Handbook YES NO

I filled in this form myself. YES NO If no, it was read back to me when completed. YES NO

I agree to report any changes in information on this form within 10 days of the change to my local department of social services.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I may be breaking the law and could be prosecuted for perjury, larceny, and/or welfare fraud. I understand that my signature on this application certifies, under penalty of perjury, that I am (unless applying for emergency services only) a U.S. Citizen or alien in lawful immigration status.

Signature or Mark: _____ Date: _____

Witness/Authorized Representative: _____ Date: _____

I completed this application/redetermination for _____. I understand that if I aided or abetted her to obtain assistance for which she is not eligible that I may be breaking the law and could be prosecuted.

Signature: _____

Address: _____

Relationship: _____ Date: _____ Telephone #: _____

VOTER REGISTRATION

Check one of the following:

- I am not registered to vote where I currently live now, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
- I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
- I do not want to apply to register to vote.
- I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. 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 to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.

Agency Use Only: Face to face interview not required. A voter registration form was mailed.