

# West Volusia Hospital Authority (WVHA)

---

## *Health Card Program*

### *Eligibility Guidelines and Procedures*

*Revised – May 18, 2017*

Contents

WVHA Statement of Purpose ..... 4

    Section 1.01 Purpose.....4

    Section 1.02 Policy.....4

Article II. WVHA Summary of Criteria..... 5

    Section 2.01 Purpose.....5

    Section 2.02 Policy.....5

Article III. WVHA Eligibility Determination Process..... 7

    Section 3.01 Purpose.....7

**Section 3.02 Policy** .....7

Article IV. WVHA Application Time Standards .....10

    Section 4.01 Purpose..... 10

    Section 4.02 Policy..... 10

Article V. WVHA Family Size .....11

    Section 5.01 Purpose..... 11

    Section 5.02 Policy..... 11

    Section 5.03 Definitions..... 11

Article VI. WVHA Qualifying Levels .....12

    Section 6.01 Purpose..... 12

    Section 6.02 Policy..... 12

    Section 6.03 Guideline ..... 12

Article VII. WVHA Termination.....13

    Section 7.01 Purpose..... 13

    Section 7.02 Policy..... 13

Article VIII. WVHA Residency.....14

    Section 8.01 Purpose..... 14

    Section 8.02 Policy..... 14

    Section 8.03 Procedures ..... 14

    Section 8.04 Definitions..... 15

Article IX. WVHA Identification.....16

    Section 9.01 Purpose..... 16

    Section 9.02 Policy..... 16

    Section 9.03 Procedures ..... 16

Article X. WVHA Income .....17

    Section 10.01 Purpose..... 17

    Section 10.02 Policy..... 17

    Section 10.03 Definitions..... 17

    Section 10.04 Procedures ..... 17

        (a) Verification of Income.....18

        (b) Calculation of Income.....18

Article XI. WVHA Assets .....20

    Section 11.01 Purpose..... 20

    Section 11.02 Policy..... 20

    Section 11.03 Procedures ..... 20

Article XII. Appendices .....22

    Section 12.01 Appendix A – Current Federal Poverty Guidelines..... 22

    Section 12.02 Appendix B - Asset Limits..... 23

Section 12.03 Appendix C - WVHA Taxing District (Zip Codes Included in District)..... 24  
Section 12.04 Appendix D – WVHA Health Card Application Form..... 25  
Section 12.05 Appendix E – WVHA Health Card Assessment Form..... 27  
Section 12.04 Appendix F – WVHA Homeless Verification Form ..... 31  
Section 12.05 Appendix G - WVHA Verification of Support Form ..... 32  
Section 12.06 Appendix H – WVHA Verification of Rent Form ..... 33  
Section 12.07 Appendix I - ACA Pre-Qualifying Form..... 34  
Section 12.08 Appendix J – WVHA Self-Employment Quarterly Statement ..... 35

# WVHA Statement of Purpose

## Section 1.01 Purpose

To document the establishment of an eligibility policy.

## Section 1.02 Policy

The West Volusia Hospital Authority (WVHA) Enabling Act recognizes that it is in the public interest to provide a source of funding for indigent and medically needy residents of the West Volusia Hospital Authority Taxing District and to maximize the health and well-being of residents by providing comprehensive planning, funding, and coordination of health care service delivery. Program elements may include, but not be limited to, preventive health services, community nursing services, ambulatory care, outpatient services, hospital services, trauma health services, and rehabilitative services, as feasible. All programs should be coordinated to maximize the delivery of quality health care.

The WVHA Board of Commissioners has established policies and procedures to qualify clients who are in need of medical services, who do not have the ability to pay, and are residents of the WVHA Taxing District.

WVHA Health Card availability is restricted until all other means of payment have been exhausted, including, but not limited to, bank accounts, certificates of deposit, stock ownership, bank loans, savings accounts, mutual funds, non-exempt property, insurance loans, family member loans and the like. If an individual or a family member receives benefits under WVHA Health Card to treat an injury or medical condition that was caused by a third party, then WVHA hereby claims a right to be subrogated to the rights of that beneficiary to recover damages from that third party (e.g. a defendant in a lawsuit or a defendant's insurer). WVHA must be reimbursed for the benefits it has paid if the WVHA Health Card member or his/her family recovers any damages or receives payments from that third party or an insurer on account of that injury or medical condition.

As this policy cannot cover all variables, it should be noted that on occasion a determination must be made upon the available facts coupled with the good judgment of the WVHA Enrollment Certifying Agent.

## Article II. WVHA Summary of Criteria

### Section 2.01 Purpose

To provide an overview of the WVHA criteria for eligibility.

### Section 2.02 Policy

Each applicant must meet the following criteria for consideration of enrollment:

1. Residency ([Article VIII](#)).

All applicants must reside within the WVHA District (refer to Section 12.03)

- a. Residency exists when the applicant has been residing for at least three (3) months within the District.
- b. Exception - Those qualified as "homeless" are subject to a one (1) month residency requirement.

2. Identification (Article IX).

An applicant must provide the forms of identification that are required under this policy.

3. Income (Article X).

The calculated family income must be equal to or below the West Volusia Hospital Authority Board approved percentage of the Federal Poverty Level Guidelines for that family unit size.

4. Medical Coverage.

All applicants must produce proof of Medicaid application or denial before consideration for WVHA programs. Denials for reasons of noncompliance will not be accepted.

Note: The ACA insurance exchange will also be a point of entry for Medicaid applications

5. WVHA Affordable Care Act (ACA) Requirements

The WVHA policy is that the WVHA Health Care Program funds health care for indigent residents only as a payer of last resort (thereby avoiding replacement of affordable private insurance or displacement of available federal programs). It is the policy of the WVHA Board of Commissioners that an application for insurance coverage, tax credits, and subsidies under the ACA insurance exchange ([www.healthcare.gov](http://www.healthcare.gov)) is a requirement before an applicant can qualify for a WVHA health card. All other provisions of the WVHA Eligibility Guidelines are in addition to the ACA requirements.

Denials of eligibility, tax credits or cost-sharing subsidies for reasons of noncompliance with established exchange procedures will not be accepted.

WVHA reserves the right to verify all information. Verification includes but is not limited to income, assets, credit, and employment. This may be accomplished at any time during the application process, enrollment or after benefits have been assigned. If any information is discovered to be false or altered in any way, WVHA may deny the application or dis-enroll the member and recover any charges previously adjusted under this program. Any member or applicant denied for falsification of information may be prohibited from ever applying again.

WVHA is the payer of last resort and assists patients with no medical benefits. Patients that have health coverage are excluded from the program. Certain programs, such as 'Aids Drugs Assistance Program' (ADAP) that are targeted to offer limited services towards one specific disease, will not disqualify an applicant from the WVHA Health Card program because such programs are not considered inclusive medical benefits.



## Article III. WVHA Eligibility Determination Process

### Section 3.01 Purpose

To summarize the eligibility process.

### Section 3.02 Policy

All applicants follow a three (3) step process to verify enrollment into WVHA programs. The steps include: Application, Evaluation and Determination, and Enrollment. The Evaluation, Determination, and Enrollment steps are performed exclusively by a WVHA Enrollment Certifying Agent.

#### *Procedures*

The following is the procedure used for determining eligibility for the WVHA program:

1. Application: The application ([Section 12.04](#)) and assessment form ([Section 12.05](#)) must be fully completed by the applicant. The following documentation is required to complete the application.
  - a. Proof of residency in WVHA Taxing District ([Article VIII](#))
  - b. Identification ([Article IX](#))
  - c. Proof of Income ([Article X](#))
  - d. Proof of Assets ([Article XI](#))
  - e. Proof of Medicaid Application or Medicaid Application Denial Letter
  - f. Proof of Affordable Care Act ([www.healthcare.gov](http://www.healthcare.gov)) Application
  - g. Applicants can only apply for WVHA Assistance during periods of Open Enrollment as defined by the Federal Government for coverage under the Affordable Care Act. WVHA adopts the Open Enrollment Period set forth by the Federal Government, including Special Enrollment Periods.
    - i. Exceptions:
      1. New applicants: applicants that were not eligible during the prior six (6) months AND were NOT eligible during the last Open Enrollment Period may apply for WVHA assistance outside of the Open Enrollment Period set forth by the Federal Government.
        - a. Unless the new applicant is determined to have a non-citizen resident exemption, all new applicants must still apply for and obtain an ACA Determination Letter to be submitted with their application for WVHA Assistance.
          - i. If a Special Enrollment Period is indicated, and the cost of a plan, net of premium tax credits, is less than 8% of gross income, the WVHA application will be denied.
          - ii. If no Special Enrollment Period is indicated, the patient may obtain WVHA assistance if all other WVHA eligibility requirements are met.
        2. Renewal applicants: applicants that were eligible on the date that their application was received by the Enrollment Certifying Agent.
          - a. Unless the renewal applicant is determined to have a non-citizen resident exemption, all renewal applicants must still apply for and obtain an ACA Determination Letter to be submitted with their application for WVHA Assistance.
            - i. If a Special Enrollment Period is indicated, and the cost of a plan, net of premium tax credits, is less than 8% of gross income, the WVHA application will be denied.
            - ii. If no Special Enrollment Period is indicated, the patient may obtain WVHA assistance if all other WVHA eligibility requirements are met.
        3. Applicants Eligible for ACA Special Enrollment Periods

- i. If a Special Enrollment Period is indicated on the ACA Determination Letter, and the cost of a plan, net of premium tax credits, is less than 8% of gross income, the WVHA application will be denied.
- ii. If a Special Enrollment Period is indicated, but the cost of a plan is more than 8%, the patient may obtain WVHA assistance if all other WVHA eligibility requirements are met.

h. Available ACA Plans

- i. If the cost of a plan, net of premium tax credits, is less than 8% of gross income (excluding child support, gifts, Supplemental Security Income (SSI), Veteran's disability payments, Worker's compensation, proceeds from loans (like student, home equity or bank loans)), the WVHA application may be denied entirely, or approved for a shortened period of assistance.
  - 1. The WVHA Enrollment Certifying Agent will make the determination of whether or not a plan is available at a cost of less than 8% of the applicant's annual gross income by reviewing premium costs for the applicant (based upon age, gender, residence) indicated on the ACA Marketplace website in concert with the ACA Determination Letter information.
    - a. In this case, the WVHA Application will be denied
    - b. If, however, the applicant submits proof of coverage within the month they enroll for the ACA plan, and the applicant meets all other WVHA eligibility guidelines, the WVHA Enrollment Certifying Agent may approve a shortened period of eligibility, This is to allow for WVHA assistance during the short period prior to the patient's effective date with the ACA Plan.
      - i. Patients that apply for an ACA plan prior to the 15<sup>th</sup> of the month become effective for the ACA plan on the 1st day of the following month.
      - ii. Patients that apply for an ACA plan after the 15<sup>th</sup> of the month become effective on the first day of the second month following enrollment.
        - 1. WVHA assistance for the gap between the date the patient enrolled in an ACA plan and the ACA plan effective date shall not exceed a period of 45 days.

2. Evaluation and Determination:

- a. Upon receipt of the application and assessment form, the WVHA Enrollment Certifying Agent will evaluate the application and documentation for accuracy and appropriateness.
- b. Prior to submitting an application for WVHA, applicants must first submit an application for insurance on the ACA insurance exchange ([www.healthcare.gov](http://www.healthcare.gov))
  - i. Note: The ACA insurance exchange will also be a point of entry for Medicaid applications.
  - ii. Note: Non-citizen Residents of the WVHA Taxing District may submit an attestation from the Farm Workers Association (FWA) in lieu of an ACA Application. The date of the FWA attestation shall not be dated any earlier than 30 days prior to the receipt of the WVHA Application to the WVHA Enrollment Certifying Agent.
  - iii. Note: Deferred Action for Childhood Arrivals (DACA) residents may submit proof of their Employment Authorization Card in lieu of an ACA determination letter.
  - iv. Note: Homeless residents of the WVHA Taxing District may submit a Homeless Verification Form (See Appendix G, Section 12.11) in lieu of an ACA Application. The date of the Homeless Verification Form shall not be dated any earlier than 30 days prior to receipt of the WVHA Application to the WVHA Enrollment Certifying Agent.
- c. WVHA Applicants must submit an ACA determination letter along with their WVHA application as proof of their ACA application. The date of the ACA Determination Letter shall not be dated any earlier than 30 days prior to the receipt of the WVHA Application to the WVHA Enrollment Certifying Agent; provided however, the ACA may be dated up to and including a date 6 months prior to the receipt of the WVHA Application by the WVHA Enrollment Certifying Agent if the ACA Determination



Letter is accompanied by a ACA Pre-Qualifying Form (See Appendix K, Section 12.07) which is completed by a Person Assisting who is approved by WVHA.

- i. Note: Non-citizen Residents of the WVHA Taxing District may submit an attestation from the Farm Workers Association in lieu of an ACA Determination Letter. The date of the attestation from FWA must be within 30 days of the application.
  - ii. Note: Homeless residents of the WVHA Taxing District may submit a Homeless Verification Form (See Appendix G, Section 12.11) in lieu of an ACA Determination Letter. The date of the Homeless Verification Form shall not be dated any earlier than 30 days prior to receipt of the WVHA Application to the WVHA Enrollment Certifying Agent.
  - iii. If the WVHA Applicant's Household income is less than 100% of the Federal Poverty Guidelines, and the ACA Determination Letter requests additional information in order to process the ACA insurance application, the WVHA applicant must provide the information in order for their WVHA application to be considered complete.
    1. If the only item that the ACA Determination Letter requests additional information to complete the application is to confirm tax filing status, the ACA Determination Letter shall be considered complete.
  - iv. If the WVHA Applicant's Household income is greater than or equal to 100% of the Federal Poverty Guidelines, and the ACA Determination Letter requests additional information in order to process the ACA insurance application, the WVHA applicant must provide the information in order for their WVHA application to be considered complete.
    1. The WVHA applicant **CANNOT** be approved for WVHA assistance unless the ACA Determination Letter is complete (does not require additional information to determine eligibility for coverage or eligibility for premium tax credits or out of pocket costs credits/subsidies).
  - v. The WVHA Enrollment Certifying Agent has discretion to approve an applicant if the ACA Determination Letter is plainly in error based on a generally known computer glitch or other similar problem that prevents the issuance of accurate ACA Determination Letters, but the Agent may exercise this discretion only after verifying that this computer glitch or other problem has been reported in writing to CMS and/or HHS officials who have responsibility to work on a solution. This includes the attestation process where FHS has assisted the applicant with uploading documentation after verifying that the application would not meet the ACA subsidy or tax credit requirement based on income.
  - d. The information provided in the application and accompanying documentation is the basis for one of three determinations. The application determination must be made on a timely basis.
    - a. Denied- The case is denied and a "Notice of Determination" is sent to the applicant and documented. Applicant does not proceed to enrollment.
    - b. Pending - The case may be returned for corrections or the submission of additional information. Cases can only be pending for a total of 30 calendar days. While an application is pending submission of additional information, the WVHA Enrollment Certifying Agent has discretion to accept in lieu of requested documents the written clarifications on basic questions about an applicant (e.g., marital status, relationship to applicant) submitted by a supervisory level staff member at a WVHA funded agency; provided however, the applicant must be mailed a copy of any such clarification with notice that it will be considered as a part of the application unless objected. If the required information or some such clarification is not received, the case will be denied on the 31st calendar day.
    - c. Approved - The case is approved. "Notice of Determination" is sent to the applicant. Applicant proceeds to enrollment.
3. Enrollment: The enrollment process includes:
- a. Explanation of the benefits covered under the assigned plan and how to receive care.
  - b. Explaining the policy and providing a copy of the WVHA guidelines.
  - c. The issuance and explanation of the WVHA Health Card.

## Article IV. WVHA Application Time Standards

### Section 4.01 Purpose

To define the allowable time standards for submission of applications and supporting documentation for the purpose of eligibility determination.

### Section 4.02 Policy

Time Standards – Applications:

1. Date of Application: The application date is determined in one of the following ways:
  - a. The date the application is received by WVHA Enrollment Certifying Agent becomes the enrollment date should the applicant be found to be eligible.
  - b. The date of emergency room treatment or date of discharge if patient was subsequently admitted to an approved WVHA area hospital. These applicants must be instructed to make arrangements for initial screening and application at designated primary clinic within fifteen (15) business days.
2. Time Standards – Submission for eligibility determination:
  - a. WVHA Enrollment Certifying Agent will respond to applications and make a determination in a timely manner.
3. Reapplication – (after denial)
  - a. Effective February 16, 2016, an applicant may reapply 21 days from date of denial should there be a material change in application circumstances. After submitting three (3) applications and receiving three (3) denials, the applicant may reapply ONLY after presenting a money order in the amount of \$21.00 and payable to the WVHA.
4. Renewal
  - a. A WVHA Enrollee can apply for renewal no earlier than 30 days prior to expiration date of existing card. If a cardholder applies at renewal, and a lapse occurs within 30 days from coverage term date, dates will be adjusted to avoid a lapse in coverage. Each reapplication is treated as a new application and all forms and updated documents need to be submitted accordingly.
5. Eligibility Term
  - a. WVHA Health Cards are issued for a period of six (6) months. WVHA reserves the right to issue short term eligibility periods for special circumstances to be determined by WVHA Enrollment Certifying Agent.

## Article V. WVHA Family Size

### Section 5.01 Purpose

To identify the person or persons to be considered as part or all of a family unit.

### Section 5.02 Policy

WVHA Enrollment Certifying Agent shall consider family size as part of the eligibility process. Inmates under the control of a law enforcement authority or under prison control are excluded from consideration.

### Section 5.03 Definitions

To determine if the family unit's gross income is within the WVHA income standards, it must first be determined who is in the applicant's family unit.

A family unit is defined as one or more persons residing together in the same household, whose needs, income, and assets are included in the household budget (excluding: roomers, boarders, lodgers, wards, employees, foster children, or adult dependents who are not Full Time Students). Members include the applicant, legal spouse, dependent children, stepchildren, adopted children, unrelated minor children for whom the individual has legal guardianship or custody, legal guardian, or natural parents of minor children, or minor siblings.

**Other relatives under the age of 18 and living in the household** must be dependent on the Head of the Family for financial support and claimed as a dependent for income tax purposes and does not have an independent income, to be considered part of the family unit.

**Full Time Students**-Persons 18 years of age or older who are full-time students (this must be proven and documented by IRS tax documentation in which the student is claimed as a dependent) are considered part of the family unit size until 24 years of age, after which they are considered as a separate family unit. Documentation must be provided and placed in the eligibility file.

**Persons Not Considered Part of the Family Unit**- Parent, grandparent, son, daughter, brother, or sister 18 years of age or older who resides in the family residence is not considered part of the family unit size, but a separate family except as described above. (Full Time Students)

**Emancipated persons** are not considered part of the family unit size, but rather as a separate family.

If a residence is shared by one or more family units, the Federal Poverty Level Guideline levels are applied to each family unit and not to the residence as a whole.

Eligibility is based on the entire family unit.

**Qualifying Levels** - The family size along with the gross income is compared to approved qualifying levels for the purpose of determining eligibility.

## **Article VI. WVHA Qualifying Levels**

### **Section 6.01 Purpose**

To identify the application of qualifying levels based on family size and income.

### **Section 6.02 Policy**

WVHA utilizes the Federal Poverty Level Guidelines, published annually in the Federal Register and approved for use on April 1 of each year. The guidelines are used to determine qualifying levels for eligibility. The WVHA Board establishes the qualifying percentages which cannot be modified without WVHA Board approval.

### **Section 6.03 Guideline**

150% of the approved Federal Poverty Level Guidelines for children and adults - Link below: (See [Appendix A – Current Federal Poverty Guidelines](#)).

<http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html>

## Article VII. WVHA Termination

### Section 7.01 Purpose

To establish criteria for the termination of member eligibility for WVHA Health Card programs.

### Section 7.02 Policy

Termination of individuals from assigned programs may occur if evidence of the following is discovered:

1. Providing false information by evidence of submission or omission.
2. Failure to keep appointments
3. Abusive or disruptive behavior
4. Inappropriate or excessive use of Emergency Room Services
5. Inappropriate or excessive use of other provided services, including altered RX Prescriptions
6. Illegal possession of firearms or weapons
7. Physical or verbal threats
8. Enrollment in a Health Insurance Plan
9. Eligible for Medicaid
10. Eligible to enroll in ACA Marketplace private insurance, net of premium tax credits, for cost that is less than 8% of gross income.

If terminated for reasons 1,3,4,5,6,or 7, individuals are ineligible for future consideration.

Termination of entire family unit from assigned programs may occur if evidence of the following is discovered:

1. Providing false information by evidence of submission or omission; changing, tampering or altering information printed on a Health Card in any way
2. Income exceeds guidelines
3. Assets exceed guidelines

If terminated for reason 1, entire family unit is ineligible for future consideration.

## Article VIII. WVHA Residency

### Section 8.01 Purpose

This section defines residency as it relates to the WVHA Health Card eligibility process and identifies acceptable documentation to prove residency in the WVHA Taxing District ([Appendix C - WVHA Taxing District \(Zip Codes Included in District\)](#)).

### Section 8.02 Policy

The applicant must reside in WVHA Taxing District. Except for those qualified as “homeless”, residency exists when the applicant has lived within the WVHA Taxing District and has been a permanent resident for a minimum of three (3) months.

- Homeless residency is established when a homeless applicant registers at an approved social service agency and has been seen by that agency for at least one (1) month.
- Residency does not exist when the stay is for a temporary purpose or there is intent to return to another location outside of the WVHA Taxing District.
- Admission to an institution located within WVHA Taxing District does not constitute fulfillment of the residency requirement.
- A student attending school away from home is considered a resident of the county in which his parents reside if he is claimed as a dependent for federal income tax purposes.
- A visit to West Volusia County for any purpose does not qualify as residency.
- A temporary living arrangement in WVHA Taxing District prior to admission/treatment in a medical facility does not qualify as residency.
- Documentation supplied by the applicant to prove residency may not be used to verify the applicant’s identity.
- For applications containing multiple applicants from the same household, documents for the head of household shall apply to all applicants in the same application for the purposes of establishing residency.

### Section 8.03 Procedures

All residency documentation must be copied and placed in the applicant’s permanent case file. WVHA may request to see original documentation.

Residency for WVHA programs is satisfied when an applicant provides proof of WVHA Taxing District residency by presenting any two (2) of the following documents (The documents may be from different street addresses, as long as the street addresses are within the WVHA Tax District).

APPLICANT IS HOMELESS (only one (1) document required):

- WVHA Homeless Verification Form ([Section 12.06](#)) from an approved social service agency. (must have a valid mailing address)

APPLICANT LIVES WITH OTHERS **OR** RENTS/OWNS (Two (2) Documents required):

- WVHA Verification of Support ([Section 12.07](#))
- Vehicle Registration
- Children registered in West Volusia Schools
- Mail received by applicant in West Volusia County for three (3) month period. (i.e. government correspondence, USPO change of address, court documents, other bills) If mail sent to a P.O. Box, the applicant’s physical address must be noted in document. If online bills are provided they must include Date (Billing Period), Name, & Address.
- Property tax bill
- Mortgage payment
- Lease Agreement/Contract

- WVHA Verification of Rent ([Section 12.08](#))
- Utility bills

APPLICANT IS ENROLLED IN A FACILITY OR AGENCY PROGRAM:

- Letter from agency or group home where applicant is enrolled.
- Proof of West Volusia residency as outlined above for immediate past three (3) month period,
- If applicant was homeless prior to enrollment, then proof of residency for one (1) month as outlined above.

**Section 8.04 Definitions**

- Property Tax Bill - For current or prior year depending on the date of application (most recent bill issued). WVHA Enrollment Certifying Agent will confirm data from Volusia County website.
- Lease Agreement/Contract - The lease must be for the current year. The documentation must include landlord's name, address, telephone number, and lease start and end date.
- Rent Receipts – The rent receipts must be for the immediate past three (3) months. If the required receipts are not available, a WVHA Verification of Rent form may be completed and signed by the rentor/lessor ([Section 12.08](#)).
- Utility Bills - Electric, water, telephone, gas or other city or county utilities or other contracted service (i.e. pest control, cable service...) that would indicate the address the service is provided, for the past immediate three (3) months. These are only accepted as proof of residency for applicants that own or rent and must be in the same name as the applicant.
- Enrollment in a Facility or Agency Program - Letter from agency or group home where applicant is enrolled. This form of documentation must be accompanied by an approved proof of residence for the past immediate three (3) months in the WVHA Taxing District prior to enrollment in the facility program. (Homeless – one (1) month –([Section 12.06](#)))
- WVHA Verification of Support- if the applicant is living with another party ([Section 12.07](#)).
- WVHA Homeless Verification Form from a WVHA approved social service agency ([Section 12.06](#))
- Vehicle Registration in the name of applicant/spouse. Must be current and include address in the WVHA Taxing District.
- Proof of children registered in area schools.
  - Applicants that provide a WVHA Verification of Support, may be subject to verification through skip tracing, credit report and property search tools. The relationship between the applicant(s) and the person providing support to the applicant must be indicated.
  - All proof of residency documents must show street address within the WVHA Tax District.
  - Post office boxes may be used for mailing purposes only. Applicants mailing address must include their residence physical address. Applicants with post office boxes are still required to meet all residency requirements. The USPO will deliver mail to a post office box shown on the line directly above City and State line and physical address shown below name.

Example:        Name of applicant  
                      Street Address  
                      Post Office Box  
                      City, State and Zip

Note: Any WVHA member mail or correspondence returned to WVHA Enrollment Certifying Agent as undeliverable or with an invalid address will be subject to suspension of coverage until a new application can be processed or address is verified by applicant.

## **Article IX. WVHA Identification**

### **Section 9.01 Purpose**

To define identification as it relates to WVHA eligibility.

### **Section 9.02 Policy**

Every applicant must provide copies of two (2) acceptable documents (one must be a photo I.D.) to prove his/her identity. Identification must be current.

### **Section 9.03 Procedures**

The following define acceptable documentation for proving identification.

- a. Birth Certificate
- b. Florida Picture Identification Card (Such as Florida Driver's License with West Volusia address)
- c. Social Security Card
- d. The Farmworker Association of Florida, Inc. (Photo Identification with correct address)
- e. Passport
- f. Certificate or official document that includes name, address, and social security number (such as a tax form or social security document).
- g. Alien Registration receipt card, (Green card, Form I-151 or I-551)
- h. Any government issued photo identification



## **Article X. WVHA Income**

### **Section 10.01 Purpose**

To identify the sources, calculation, and verification of income and how it relates to the WVHA Health Card eligibility process.

### **Section 10.02 Policy**

The WVHA Board will set the income levels allowable for inclusion into the WVHA programs.

All income must be verified by the source of the income.

Income will be calculated using a Quarterly (thirteen weeks) or Annual (fifty-two weeks) method.

### **Section 10.03 Definitions**

Gross Income-The amount of income received as of the date of the application for the prior twelve (12) month time period under consideration. For family size of two or more, income for all household members must be included.

### **Section 10.04 Procedures**

The following are considered as sources of income or value for the purposes of determining eligibility:

1. Wages, salaries and gratuities, Pay Stubs for previous 8 weeks
2. Social Security Benefits for any household member
3. Supplemental Social Security Income (SSI) or Disability Benefits
4. Temporary Assistance for Needy Families (TANF)
5. Retirement or Pension Benefits, Stocks, Bonds and Annuities (e.g., 401K, 403B, IRA, SEP)
6. Royalties and Rents/Income from Rental Property
7. Unemployment/Worker's Compensation Statement
8. Veterans or Military Benefits/Allotments
9. Strike Benefits
10. Insurance and Annuity Income
11. Dividends and Interest Earnings (stocks, bonds, etc...)
12. Estate and Trust Fund Income
13. Private Loans of a Recurring Nature
14. Training Stipends
15. Alimony/Child Support
16. Inheritance
17. Compensation for an Injury/Settlements
18. Gifts-(include donations from churches, other organizations and family members.)
19. Insurance Payments
20. Self-employment Income. Defined as the amount of "net profit (loss)" as reported on tax return Form 1040 Schedule C, line 31. The WVHA Enrollment Certifying Agent may request supporting documentation for deductions not in line with industry standards. Deductions for personal expenses and wages will be adjusted accordingly. (Include last Quarter Financial Statements, bank settlements and most recent Tax Return)
21. All sources of value including free rent and barter goods will be used to determine the applicant's income
22. Housing Assistance Statement (Section Eight)
23. Food Stamps/Social Pensions
24. DCF Verification of Employment/Loss of Income Form

25. WVHA Verification of Support Form ([Section 12.07](#)) (unemployed applicants)
26. Most Recent Tax Return, 1040
27. Other income from any other source

**(a) Verification of Income**

1. Income verification is accomplished by submitting copies of the
  - a. Most recent individual income tax return, Form 1040 and W-2's for all wage earners in household
  - b. Recent paystubs- Eight (8) weeks prior or Florida DCF Verification of Employment/Loss of Income Form from current employer and/or Year to Date for all jobs.
    1. If applicant has recently lost their job, the Loss of Income Section of the DCF Verification of Employment/Loss of Income Form must be completed.
  - c. Bank Statements (previous three (3) months) include all pages
  - d. Medicaid Denial Letter or proof of Medicaid application and date of application. (Clinics, specialists, pharmacy and hospitals should check for Medicaid eligibility each time a patient presents for services, even if the patient has a current WVHA Health Card). Applicants unable to provide documentation of citizenship will be exempt from applying for Medicaid.
  - e. Unemployment/Worker's Compensation Statement. Applicants unable to provide documentation of citizenship will be exempt from applying for unemployment benefits.
  - f. Child Support/Alimony
  - g. Social Security Benefits for any family member
  - h. Pensions/Retirements/Interest
  - i. Veterans Benefits
  - j. Any settlements, court ordered or otherwise. Evidence of amount and duration of all settlements are required.
  - k. Other appropriate supporting documents.
  - l. Self-Employment
    1. Bank Statements for all business accounts for the last 3 (three) months; all pages must be included
    2. Previous Year's Business Tax Return-complete w/attachments/schedules
    3. Most recent self-employment quarterly financial statement

**(b) Calculation of Income**

2. The calculation of income is calculated by the annual method. This method calculates the previous twelve (12) months of gross earnings received to establish a monthly average income (MAI). This MAI is compared to the WVHA Board approved level as it relates to the Federal Poverty Level Guidelines, to determine qualification for the WVHA programs.
3. The following methods shall be used to compute MAI:
  - a. Hourly rate known x 2080 hours (year) divided by 12 = monthly income
  - b. Weekly rate known x 52 weeks (year) divided by 12 = monthly income
  - c. Bi-weekly rate known x 26 weeks (year) divided by 12 = monthly income
  - d. Yearly rate known divided by 12 = monthly income
  - e. If the applicant has worked or will work part of the year, the monthly income amount will be determined predicated upon the number of months worked. For example, if the applicant

works 9 months, then the total amount of earnings during the 9 months will be divided by 12 to arrive at a monthly income amount.

If an applicant is claiming \$0 income and **lives alone**, the applicant must provide a notarized WVHA Verification of Support Form which includes statement of monthly household expenses that are paid on his/her behalf. This amount is considered applicant's monthly income. The relationship between the applicant(s) and the person providing support to the applicant must be indicated.

If an applicant is claiming \$0 income and **resides with others** the applicant must provide a notarized Verification of Support Form which includes statement of monthly household expenses and the number of people in the household. (Divide the total expenses by the number of people in household to calculate the applicant's monthly income amount) The relationship between the applicant(s) and the person providing support to the applicant must be indicated.

## Article XI. WVHA Assets

### Section 11.01 Purpose

To identify sources, calculation and verification of assets and how it relates to the WVHA Health Card eligibility process

### Section 11.02 Policy

The WVHA Board will set the asset levels allowable for inclusion into the WVHA programs.

### Section 11.03 Procedures

The following are considered assets that are *excluded* from asset calculations.

#### 1. Assets Excluded

- a. One homestead-A homestead is defined as a house, trailer, boat or motor vehicle in which the family unit resides.
- b. Household furnishings
- c. One automobile in operating condition
- d. Clothing
- e. Tools used in employment
- f. Cemetery plots, crypts, vaults, mausoleums and urns
- g. Produce and animals raised for the applicant's personal home consumption
- h. Long term fixed retirement accounts (e.g., 401K, 403B, IRA, SEP). Income from these accounts will still be included when calculating household income.
- i. Assets that are jointly owned by an applicant who is deemed a victim of domestic violence can be excluded when that asset is jointly owned with the accused and the applicant is no longer residing in the homestead.
  - i. Official court documentation, such as a restraining order, must be supplied as proof that the applicant is a victim of domestic violence.
  - ii. The WVHA Health Card program will require a certified statement from a court official, or a notarized statement from the applicant attesting that the applicant is unable to liquidate the subject asset because of a domestic violence situation.

In order to be considered, an asset must first be "available" to the applicant or family unit. An asset is available if the applicant or member of the family unit has the right, authority or power to liquidate the property or his share of the property. The following assets, if "available," must be considered toward the asset limit:

#### 2. Assets to be considered

- a. Checking and saving accounts- the value of a checking or savings account excludes amounts deposited in the four (4) weeks prior to application because such funds are counted as income.
- b. Equity value of real property other than homestead. The value is verified by the county appraiser of the county in which the property is located. The equity value is determined by subtracting the amount of any encumbrances from the value of the asset. The encumbrances subtracted from the property value (for the purpose of the asset calculation under this program) must be tied to the property through formalized legal obligation. Generally this is a recorded lien or mortgage where the financial institution retains the title to a property until the borrower repays the amount, in turn prohibiting the owner from exercising full control over their property (i.e.: receiving payment from a buyer when selling or transferring the title). An unrecorded loan provided to the property owner [for example a loan from a friend or family member] is not considered an encumbrance for asset amount determination.
- c. Cash surrender value of life insurance, if the combined face value of all policies owned by the family unit exceeds \$1,500.

- d. Additional automobiles or motor vehicles- applicant should provide either the N.A.D.A. Book value or the vehicle registration and mileage. Otherwise, the WVHA Enrollment Certifying Agent will assign value at the average N.A.D.A. value of the vehicle.
  - e. Recreational vehicles-With value determined by a statement from a commercial seller of such vehicles and verified by photocopies of registration.
  - f. Trusts. With value based on the principal of the trust and verified by a statement from the Trustee.
  - g. Stocks, bonds and other investment assets. With value verified by the value listed in stock value of newspaper or statement from other reliable sources.
- 
- To determine whether Assets are within the Limits for the WVHA Health Card Program, refer to the chart located in [Section 12.03](#).
  - If family unit's available assets are less than or equal to the amount shown on the chart for a household of the same size, then the applicant has met the asset criterion for the WVHA Health Card Program.
  - If family unit's available assets are greater than the amount shown on the chart for a household of the same size, then the applicant is not eligible to participate in the WVHA Health Card Program.

## Article XII. Appendices

### Section 12.01 Appendix A – Current Federal Poverty Guidelines

#### 2017 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household	Poverty guideline	150%
1	\$12,060	\$18,090
2	\$16,240	\$24,360
3	\$20,420	\$30,630
4	\$24,600	\$36,900
5	\$28,780	\$43,170
6	\$32,960	\$49,440
7	\$37,140	\$55,710
8	\$41,320	\$61,980
For families/households with more than 8 people, add \$4,180 for each additional person.		

SOURCE: <https://aspe.hhs.gov/poverty-guidelines>

## Section 12.02 Appendix B - Asset Limits

### WVHA Health Card Program

#### ASSET LIMITS

If family unit's available assets are  $\leq$  the amount shown on the chart for a household of the same size, then the patient has met the asset criterion for the WVHA Health Card Program.

If family unit's available assets are  $>$  the amount shown on the chart for a household of the same size, then the applicant is not eligible to participate in the WVHA Health Card Program.

<b>FAMILY SIZE</b>	<b>ASSET LIMIT</b>
1	\$5,000
2	\$5,500
3	\$6,000
4	\$6,500
5	\$7,000
6	\$7,500
7	\$8,000
8	\$8,500
9	\$9,000
10	\$9,500

Each Additional Person \$500

[http://ahca.myflorida.com/Medicaid/statewide\\_mc/pdf/mma/Public Notice.pdf](http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Public Notice.pdf)

These limits follow limits set forth in the Medicaid Medically Needy guidelines and may be updated accordingly.

## West Volusia Hospital Authority Taxing District

### Zip Codes

32102	Astor * (Only Volusia County Side) If address has 5 numbers- Lake County
32105	Barberville
32130	DeLeon Springs
32180	Pierson
32190	Seville
32706	Cassadaga
32713	DeBary
32720	DeLand * (Only Volusia County Side) If address has 5 numbers – Lake County Side
32721	DeLand (P.O. Boxes)
32722	Glenwood
32723	DeLand
32724	DeLand
32725	Deltona
32728	Deltona
32738	Deltona
32739	Deltona
32744	Lake Helen
32754	Mims * (Only Volusia County)
32763	Orange City
32764	Osteen
32774	Orange City

\* These zip codes overlap other counties. Look up record on **Volusia County Property Appraiser** or **Volusia County Tax Collector** websites to confirm they are located within the county.



Section 12.04 Appendix D – WVHA Health Card Application Form



# WVHA HEALTH CARD APPLICATION

Application Date:

**Section 1: Applicant Information.** All members of Household may apply through same application. Please indicate all applicants in Section 2 'Members of the Household'.

Last		First	Middle	Maiden or Other Name
Physical Address (where you reside)				
City		County	State	Zip
Mailing Address				
City			State	Zip
How long have you lived at residence?	Temp/Perm	Rent/Own/Other	Daytime Telephone	Evening Telephone
Date of Birth	Sex (circle one) Male      Female		Social Security Number	
Previous address if less than 3 months				
City			State	Zip

**Section 2: Members of the Household.** List legal spouse, dependent children, stepchildren, adopted children, unrelated minor with proof of custody, children over 18 up to 24 years old that are full time students and claimed on parent's income taxes as dependents.

Name	Applying for Health Card	DOB	Relationship	SS#
1.	Yes No (circle one)			
2.	Yes No (circle one)			
3.	Yes No (circle one)			
4.	Yes No (circle one)			
5.	Yes No (circle one)			
6.	Yes No (circle one)			
7.	Yes No (circle one)			
8.	Yes No (circle one)			

**Section 3: Authorization to Release Medical and Individually-Identifiable Protected Health Information (PHI).**

*All Applicants over 18 must sign below or application will be pending.*

I on my behalf and on behalf of any applying family member under the age of 18, do hereby authorize West Volusia Hospital Authority (WVHA), Northeast Florida Health Services, Inc. (NFHS), and any of their successors and/or assigns and any of their independent sub-contractors and participating providers, to release and exchange any and all data, records and information related to medical records and individually identifiable protected health information (PHI) in their respective capacities as covered entities under HIPAA, and as allowable under federal and state laws, including but not limited to the data, records and information as necessary to provide care and/or administer the WVHA Indigent Health Card Program.

I hereby waive, relinquish and release the organizations referenced above, who have been granted the authority to release information to each other and otherwise, from any and all claims arising out of my authorization to release this information in accordance with the terms of this document.

A photocopy of this Authorization is considered as valid as the original. You are entitled to make and return a photocopy of this authorization. The authorization referenced above in regards to medical records shall remain in effect indefinitely unless properly terminated by written notice.

I certify that the information given by me for the purpose of qualifying for the WVHA Health Card Program is true and correct. I understand and hereby authorize WVHA and its agents to conduct such investigation, including, but not limited to obtaining my credit report, as necessary to verify the accuracy of the information provided. I understand that any misrepresentation by evidence of submission or omission may result in my termination from the WVHA Health Card Program.

\_\_\_\_\_  
Signature of Applicant or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant or Legal Representative

\_\_\_\_\_  
Date



# WVHA HEALTH CARD ASSESSMENT FORM

Screened by  
(THND Representative): \_\_\_\_\_

**Instructions:** Please complete this form in its entirety. This form must be completed by all applicants over 18, including legal spouses who are not applying. *Failure to provide separate WVHA Health Card Assessment Forms will result in a Pended application.*

## Section 1: General Information.

Date	Applicant Name	Date of Birth	Clinic
------	----------------	---------------	--------

How did you hear about the WVHA Health Card Program? Check one box:

- WVHA Webpage    
  Printed advertisement or flyer    
  Public meeting    
  Florida Hospital    
  The House Next Door  
 Rising Against All Odds    
 The Neighborhood Center    
 Healthy Start    
 Hispanic Health    
 Other

## Section 2: Insurance Information.

<b>2.1</b> Do you have any Medical Insurance?	<input type="checkbox"/> Yes If Yes, please indicate Carrier and ID #: _____	<input type="checkbox"/> No
<b>2.2</b> Are you eligible for COBRA Benefits from a current/prior employer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>2.3</b> Do you have Medicare A or B?	<input type="checkbox"/> Yes If Yes, please indicate which coverage you are enrolled in & effective date _____	<input type="checkbox"/> No
<b>2.4</b> Do receive healthcare assistance or aid other than WVHA?	<input type="checkbox"/> Yes If Yes, please indicate the assistance and/or aid you receive & effective date _____	<input type="checkbox"/> No
<b>2.5</b> If you are seeking services for an injury, is your injury due to a work related or auto accident?	<input type="checkbox"/> Yes If Yes, please describe _____	<input type="checkbox"/> No

**2.6** Proof of Medicaid application or denial is required. Please ensure to include this with your submission

## Section 3: Family Size.

<b>3.1</b> Marital Status (Circle One):	Married                      Separated                      Divorced                      Single                      Widow	
<b>3.2</b> Do you have any dependent children living in the household?	<input type="checkbox"/> Yes If Yes, how many? _____	<input type="checkbox"/> No

## Section 4: Identification.

<b>4.1</b> Do you have a Driver License or other Government ID?	<input type="checkbox"/> Yes If Yes, please provide a copy of ID _____	<input type="checkbox"/> No
---	---	-----------------------------

4.2 Two (2) forms of ID are required, one (1) must be a picture ID. Please circle any other proof of identification provided other than a Driver License.

Non-Picture ID:

- Social Security Card
- Birth Certificate
- Certificate or Official Document w/ Name, Address, & SSN

Picture ID:

- Passport
- Green Card
- Form I-151
- Form I-551
- Farmworkers Association of Florida-Photo ID

**Section 5: Residency.**

5.1 Do you own the house where you live?	<input type="checkbox"/> Yes <i>If Yes, please provide Property Tax Bill of current or prior year</i>	<input type="checkbox"/> No
5.2 Do you rent?	<input type="checkbox"/> Yes <i>If Yes, please provide a copy of current Lease Contract or Verification of Rent Form</i>	<input type="checkbox"/> No
5.3 Do you live in someone else's house?	<input type="checkbox"/> Yes <i>If Yes, please provide Verification of Support Form</i>	<input type="checkbox"/> No
5.4 Do you consider yourself homeless?	<input type="checkbox"/> Yes <i>If Yes, please provide Homeless Verification Form</i>	<input type="checkbox"/> No

5.5 All proof of residency documents must show street address within the WVHA Tax District and must be for the past immediate 3 months. Two (2) forms of residency are required, unless you are homeless applicant. Homeless applications only need to submit the Homeless Verification Form.

Please circle any other proof of residency provided:

- Utility Bills (Electric, Water, Telephone, Gas, etc.)
- Mail received for three (3) month period
- Vehicle Registration in the applicant/spouse's name
- Mortgage Payment
- Proof of children registered in West Volusia School

**Section 6: Financial Information.**

6.1 Have you been employed in the last 8 weeks?	<input type="checkbox"/> Yes <i>If Yes, complete the below &amp; provide previous 8 weeks worth of paystubs or DCF Verification of Employment/Loss of Income Form</i>	<input type="checkbox"/> No			
Employer Name	Pay Rate (circle one)				
	Hourly	Daily	Weekly	Biweekly	Monthly
Employer Address					
City	State	Zip			

6.2 Have you lost your job in the last 8 weeks?	<input type="checkbox"/> Yes <i>If Yes, please provide a DCF Verification of Employment/Loss of Income Form</i>	<input type="checkbox"/> No
6.3 Are you self-employed?	<input type="checkbox"/> Yes <i>If Yes, please provide most recent tax return (complete with all schedules/forms) or self-employment quarterly statement</i>	<input type="checkbox"/> No
6.4 Are you receiving Unemployment or Worker's Comp benefits?	<input type="checkbox"/> Yes <i>If Yes, please provide Unemployment or Worker's Comp Documents</i>	<input type="checkbox"/> No
6.5 Is someone else supporting you financially?	<input type="checkbox"/> Yes <i>If Yes, please provide notarized Verification of Support Form</i>	<input type="checkbox"/> No
6.6 Do you receive Veteran or Military Benefits?	<input type="checkbox"/> Yes <i>If Yes, please provide benefits paperwork</i>	<input type="checkbox"/> No
6.7 Do you receive any settlements?	<input type="checkbox"/> Yes <i>If Yes, please provide settlement paperwork</i>	<input type="checkbox"/> No
6.8 Do you receive Food Stamps?	<input type="checkbox"/> Yes <i>If Yes, please provide supporting documentation from Florida DCF along with approved amount.</i>	<input type="checkbox"/> No
6.9 Are you receiving any monthly Pension or Retirement Income?	<input type="checkbox"/> Yes <i>If Yes, please provide documentation with amount you receive, if applicable</i>	<input type="checkbox"/> No
6.10 Do you receive Alimony/Child Support Income?	<input type="checkbox"/> Yes <i>If Yes, please provide documentation with amount you receive, if applicable</i>	<input type="checkbox"/> No
6.11 Do you receive any income from rental properties?	<input type="checkbox"/> Yes <i>If Yes, please provide rental income amount and rental agreement</i>	<input type="checkbox"/> No
6.12 Do you receive Social Security Income/Disability Benefits?	<input type="checkbox"/> Yes <i>If Yes, please provide supporting documentation</i>	<input type="checkbox"/> No

**Section 7: List All Sources of Income for the Household** (i.e. Temporary Assistance for Needy Families, Strike Benefits, Insurance/Annuity Income, Dividend/Interest Earning, Training Stipends, Compensation for Injury/Settlement, Gifts-from Churches/family/organizations, etc.) Please provide all supporting documentation for any income listed below.

Individual's Name	Type of Income	Source of Income or Employer	Monthly Amount (before deductions)

Section 8: Assets			
8.1 Do you have a checking/savings account?	<input type="checkbox"/> Yes <i>If Yes, please provide copy of statements for all the accounts for last 3 months</i>		<input type="checkbox"/> No
8.2 Do you own a Business?	<input type="checkbox"/> Yes <i>If Yes, please provide last Quarter Business Financial Statements and Bank Statements</i>		<input type="checkbox"/> No
8.3 Do you own property(ies) in other counties/states or country (including rental properties that you own)?	<input type="checkbox"/> Yes <i>If Yes, please list all the properties you own below, including lots, &amp; provide any outstanding mortgage documentation outside of your permanent residence</i>		<input type="checkbox"/> No
Property Address	Is this a rental property? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Property Address	Is this a rental property? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Property Address	Is this a rental property? <input type="checkbox"/> Yes <input type="checkbox"/> No		
8.4 Have you sold or transferred title to any property in the last 3 years?	<input type="checkbox"/> Yes <i>If Yes, please list all the properties, including lots and supply supporting documentation as proof of this sale</i>		<input type="checkbox"/> No
Property Address	Date of Sale: ____/____/____	Is this a rental property? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Property Address	Date of Sale: ____/____/____	Is this a rental property? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Property Address	Date of Sale: ____/____/____	Is this a rental property? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8.5 How many automobiles, motorized vehicles or motorcycles do you own? <small>Single automobile should only be recorded on <u>one</u> applicant's assessment form</small>	_____ <i>For two or more vehicles also include the value as determined by N.A.D.A book along with vehicle(s) registration.</i>		
8.6 Do you own any recreational vehicles?	<input type="checkbox"/> Yes <i>If you do own, please provide vehicle(s) registration along with the value determined by a statement from a commercial seller of such vehicle(s)</i>		<input type="checkbox"/> No
Section 9: List All Sources of Assets for the Household (i.e. IRAs, CDs, Inheritances, pensions, stocks, trust funds, cash surrender value of life insurance, etc.). Please provide all supporting documentation for any assets listed below.			
Asset Type	Source of Asset	Amount	Monthly or Lump Sum
			<input type="checkbox"/> Monthly <input type="checkbox"/> Lump Sum
			<input type="checkbox"/> Monthly <input type="checkbox"/> Lump Sum
			<input type="checkbox"/> Monthly <input type="checkbox"/> Lump Sum
			<input type="checkbox"/> Monthly <input type="checkbox"/> Lump Sum
			<input type="checkbox"/> Monthly <input type="checkbox"/> Lump Sum
Section 10: Applicant Certification.			
I certify that the information given by me for the purpose of qualifying for the WVHA Health Card Program is true and correct. I understand and hereby authorize WVHA and its agents to conduct such investigation, including, but not limited to obtaining my credit report, as necessary and at any time during the application process, enrollment or after benefits have been assigned to verify the accuracy of the information provided. I understand that any misrepresentation by evidence of submission or omission may result in my termination from the WVHA Health Card Program.			
Signature of Individual or Legal Representative			Date



# WVHA Homeless Verification Form

**Agency Instructions:** *To be printed on Agency letterhead. Please complete this form in its entirety. Failure to provide all information on Homeless Verification Form will result in a Pended application.*

**Section 1: General Information.**

Date	Client Name	Date of Birth	Photo ID Number
------	-------------	---------------	-----------------

**Section 2: Mailing Address.**

Mailing Address (where your WVHA Health Card correspondences should be mailed)

City	County	State	Zip
------	--------	-------	-----

Length of time in Volusia County

**Section 3: Agency Assessment.**

I, \_\_\_\_\_, based on my assessment certify that the client has met the H.U.D. definition of homeless and has been within the West Volusia Tax District for at least one month.

Agency Signature:	Date:
Client Signature:	Date:

## Section 12.05 Appendix G - WVHA Verification of Support Form



### WVHA Verification of Support

**Instructions:** Please complete this form in its entirety. Failure to provide all information on Verification of Support Form will result in a Pended application.

**Section 1: General Information.**

Date	Applicant Name	Date of Birth	Last Four Digits of SSN
------	----------------	---------------	-------------------------

**Section 2: I am presently residing at.**

Physical Address \_\_\_\_\_

City	County	State	Zip
------	--------	-------	-----

I have been residing at the above address since: \_\_\_\_\_

**Section 3: My previous address was.**

Address \_\_\_\_\_

City	County	State	Zip
------	--------	-------	-----

I lived at this previous address for: \_\_\_\_\_

**Section 4: My food and/or living expenses are provided by.**

Provider Name \_\_\_\_\_

Applicant Signature	Date
---------------------	------

**Section 5: To be completed by Provider.**

5.1 Do you only provide a place to stay (rent free) and no monthly expenses are provided to the applicant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
--	------------------------------	-----------------------------

5.2 Does the applicant reside with you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
---	------------------------------	-----------------------------

**- INSTRUCTIONS FOR QUESTIONS 5.3, 5.4, AND 5.5 -**

- The amount listed below should be the household expenses for where the applicant resides.
- If the provider pays for household expenses on behalf of the applicant (even if they live in separate homes) the dollar amount must be listed here. Question 5.4 would then indicate the qualified family members on the WVHA Health Card application that the provider is supporting.
- If the provider DOES NOT pay for household expenses on behalf of the applicant, please indicate \$0 or N/A on 5.3 and 5.4

5.3 Total monthly household expenses covering all residents (rent, electric, water, groceries, etc.) \$ \_\_\_\_\_

5.4 Total number of people residing in household (including the applicant) \_\_\_\_\_

5.5 In addition to the monthly household expenses, I provide \$ \_\_\_\_\_ per month to the applicant.

Provider Name	Relationship to Applicant
---------------	---------------------------

Provider Address	City
------------------	------

State	Zip	Provider Phone No.
-------	-----	--------------------

**Section 6: Provider Signature & Notary.**

I, the undersigned, being responsible for the named applicant, do hereby swear that the information contained herein is true and correct, and that I am providing support for named applicant.

Provider Signature:	Date:
---------------------	-------

Notary Public	Notary Public Seal:
---------------	---------------------





# WVHA Verification of Rent

**Instructions:** Please complete this form in its entirety. *Failure to provide all information on Verification of Rent Form will result in a Pended application.*

**Section 1: General Information.**

Date:	Applicant Name:	Date of Birth:	Last Four Digits of SSN:
-------	-----------------	----------------	--------------------------

**Section 2: I am presently residing at.**

Physical Address

City	County	State	Zip
------	--------	-------	-----

**2.1** The monthly rent is \$\_\_\_\_\_.

**2.2** I began renting at the above location on the following date \_\_\_\_\_.

Applicant Signature	Date
---------------------	------

**Section 3: Rentor/Lessor Information.** Must be completed by the Rentor/Lessor

Rentor/Lessor Name	Rentor/Lessor Phone Number
--------------------	----------------------------

Rentor/Lessor Address

City	State	Zip
------	-------	-----

Relationship to Tenant

Tenant Name

**3.1** I am renting the address listed above in Section 2 to the applicant since \_\_\_\_\_ (date).

**3.2** The current monthly rental rate is \$\_\_\_\_\_.

<b>3.3</b> The monthly rent does / does not (circle one) include utilities.	<b>3.4</b> If yes, list utilities included.
---	---

**Section 4: Rentor/Lessor Signature**

I, the undersigned, do hereby swear that the information contained herein is true and correct.

Rentor/Lessor Signature	Date
-------------------------	------

**Section 12.07 Appendix I - ACA Pre-Qualifying Form**

**Affordable Care Act Enrollment Prequalifying Intake Interview 2016**

Person Assisting \_\_\_\_\_ DATE: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Phone # \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

The below set of questions will help us determine if you are eligible for the Affordable Care Marketplace. Upon qualification the Person Assisting will help you enroll in HealthCare.Gov.

In the event you're not eligible at this time, you will be given this supporting document which will serve as proof you attempted to apply for the marketplace. At such time you will be given options for health care and instructions on how to apply for alternative coverage.

**Those that are not covered by the marketplace due to ineligibility are protected from the:**

- 2% yearly household income penalty or
- \$325 per person for the year (\$162 per child under 18. The maximum penalty per family using this method is \$925 per family.

*If you don't have coverage in 2016, you'll pay the higher of these two amounts.*

1. A Veteran? Yes\_\_ No\_\_ If yes, will they be willing to drop all of their coverage through VA? (If both Yes, proceed with enrollment)
2. A Native American? Yes\_\_\_\_\_ No\_\_\_\_\_ (If yes, will not qualify for subsidy.)
3. Parent of children already on Healthy Kids plan? Yes\_\_\_\_\_ No\_\_\_\_\_
4. Under age 64? Yes\_\_\_\_\_No\_\_\_\_\_ If older, they are or soon will be covered by Medicare
5. Currently Covered by Medicaid? Yes\_\_\_\_\_ No\_\_\_\_\_
6. Do you or anyone in your household have employer coverage or been offered employer coverage? Yes\_\_ No\_\_ (If Yes, will not qualify for subsidy but may still shop the marketplace)
7. Do you have verifiable income? Yes\_\_ No\_\_ Threshold is \$11,770 for 1 person or \$15,930 for a couple.

2017 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES & DISTRICT OF COLUMBIA		
Persons in family/household	Poverty guideline	150%
1	\$12,060	\$18,090
2	\$16,240	\$24,360
3	\$20,420	\$30,630
4	\$24,600	\$36,900
5	\$28,780	\$43,170
6	\$32,960	\$49,440
7	\$37,140	\$55,710
8	\$41,320	\$61,980
For families/households with more than 8 people, add \$4,180 for each additional person.		

**I attest that the Person Assisting has discussed the qualifications to enroll and that I understand my eligibility and options for healthcare. (Check circle that applies)**

- I qualify for the Marketplace and I'm enrolling today
- I don't qualify for the Marketplace because my income falls below the poverty guideline
- I qualify for the Marketplace but the cost of the premiums (net of any tax credits/subsidies) is more than 8% of my gross annual income.

\_\_\_\_\_  
Signature of Consumer

\_\_\_\_\_  
Signature of Person Assisting

Section 12.08 Appendix J - WVHA Self-Employment Quarterly Statement



**WVHA Health Card: Self Employment Quarterly Statement**

**Instructions:** Please complete this form in its entirety. This form must be completed if you are self-employed and do not make enough to file on income taxes. *Failure to provide all information on the form will result in a Pended application.*

1. **APPLICANT'S NAME:** (First) (M.I.) (Last)

2. **APPLICANT'S PERCENTAGE OF OWNERSHIP IN THIS BUSINESS:** \_\_\_\_\_%

3. **BUSINESS OWNER NAME(S)** (First) (M.I.) (Last)

4. **BUSINESS NAME:**

5. **BUSINESS ADDRESS:** 6. **BUSINESS PHONE #**

Section 1: -Total Gross Income- <small>Add total monthly income and sales from your business each of the past 3 months.</small>	MONTH 1	MONTH 2	MONTH 3
	_____/_____ <small>(MM) (YY)</small>	_____/_____ <small>(MM) (YY)</small>	_____/_____ <small>(MM) (YY)</small>
<b>1A: \$</b>	<b>2A: \$</b>	<b>3A: \$</b>	

Section 2: Business Expenses	DEDUCTIONS	DEDUCTIONS	DEDUCTIONS
Supplies	\$	\$	\$
Heat/Utilities/Phone			
Business property rent			
Business Equipment Rent			
Business Vehicle Expenses			
Business Taxes			
Advertising			
Insurance			
Bank Charges			
Other (specify)			
<b>TOTAL Business Expenses</b>	<b>1B: \$</b>	<b>2B: \$</b>	<b>3B: \$</b>
<b>NET INCOME:</b> <small>Subtract A FROM B = C</small>	<b>1C: \$</b> <small>(1A minus 1B)</small>	<b>2C: \$</b> <small>(2A minus 2B)</small>	<b>3C: \$</b> <small>(3A minus 3C)</small>

**Section 3: Calculate average monthly income**

<b>TOTAL 3 MONTHS:</b> \$ _____ <small>(ADD 1C, 2C, 3C)</small>	<b>AVERAGE 3 MONTHS:</b> \$ _____ <small>(DIVIDE TOTAL 3 MONTHS BY 3)</small>
--	--

**APPLICANT SIGNATURE:** Applicants must read and sign the below

I certify that I have no other way to document the above self-employment income and that all of the above information is true and correct. I attest that all income and expenses on this form are truly for my self-employment business.

**Signature** **Date**