

## BROADCAST DMAS-65

DATE: May 24, 2021

TO: Local directors and Medicaid staff

FROM: Cindy Olson, Director, Eligibility and Enrollment Services, Department of Medical Assistance Services (DMAS)

SUBJECT: Extension of the Public Health Emergency Period

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The purpose of this broadcast is to inform local agencies that the Department of Health and Human Services has extended the Public Health Emergency (PHE) through July 20, 2021.

Please continue to follow policies and procedures as outlined in previous broadcasts, including but not limited to:

- Local agency workers **are not** to reduce or terminate coverage, unless one of following exceptions has occurred while in the PHE:
  - Member's death
  - Member requests termination of their benefits
  - Member permanently leaves Virginia
  - Member is a CHIP or CHIPRA individual who turns 19 or whose postpartum period ends
  - Member becomes incarcerated. Members who become incarcerated during this time should continue to have their enrollment moved to an incarcerated aid category and their case transferred to the Cover Virginia Incarcerated Unit, as these individuals are not authorized to receive Medicaid coverage for any services other than inpatient hospital care.
- Exclusion of receipt of unemployment income increases due to the CARES Act and Stimulus Checks/Economic Impact Payments
- Attestation of medical expenses in lieu of documentation for the purposes of meeting a Medically Needy Spenddown
- Patient Pay cannot be increased, but valid reductions **MUST** continue. Agencies must allow these deductions if the member has patient pay available to be adjusted and the medical service or equipment is either approvable by the agency or approvable by DMAS.
- The Automated Ex Parte, CHIP and CHIPRA, and Former Foster Care batch runs will continue to occur during the PHE.
- For the duration of the PHE, individuals/entities are authorized to provide assistance to applicants for Medical Assistance upon receipt of verbal consent using the Acknowledgement of Receipt of Verbal Consent form attached to this broadcast. This verbal consent is limited to the completion and submission of an application for Medical Assistance. This form should be used by individuals and entities such as application assisters, navigators, hospital outstation workers

and Certified Application Counselors (CACs). **The authorization of verbal consent will expire at the end of the PHE.**

Virginia has not yet received any guidance from the Centers for Medicare & Medicaid Services (CMS) regarding any unwinding methodology, plan or protocol relative to the PHE; however, CMS has indicated that they will provide states with a 60-day notice of unwinding requirements. Please be assured that communications will be made available when plans for moving ahead are disclosed, and authorized for distribution.

We thank you for your patience and understanding during this time.

# Acknowledgment of Receipt of Verbal Consent

In response to COVID-19, individuals/entities are authorized to provide assistance to applicants for Medical Assistance upon receipt of verbal consent. **The authorization of verbal consent will expire at the end of the COVID-19 public health emergency.** This form is used to document an applicant's assignment of verbal consent to an individual/entity. This verbal consent is limited to the completion and submission of an application for Medical Assistance. This form should be used by individuals and entities such as application assisters, navigators, hospital outstation workers and Certified Application Counselors (CACs).

**ApplicantName:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Apartment Number:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_ **Date of Verbal Authorization:** \_\_\_\_\_

This form should be submitted along with the application for Medical Assistance. **This form is required to complete the application process.**

- If applying online at [www.commonhelp.virginia.gov](http://www.commonhelp.virginia.gov), upload and submit this consent form with the application.
  - In the Comment Section of the CommonHelp application enter "This application is being filed with verbal consent from the applicant."
  - Application assisters must still must complete the appropriate sections within CommonHelp.
- If calling the Cover Virginia Call Center at 1-855-242-8282 (TDD: 1-888-221-1590), the call center representative will provide instructions for submitting this consent form and will document "This application is being submitted with verbal consent and the instructions for completion of the acknowledgement form have been given to the individual."
- If submitting a paper application to your local Department of Social Services, submit this consent form along with the paper application. Application assisters must still complete Appendix C

Your signature on this form certifies:

- The applicant has been informed and understands your role and responsibilities as an application assister.
- The applicant has granted you permission to create, collect, disclose, access, maintain, store, and/or use personal information in order to carry out the roles and responsibilities of an application assister as authorized by federal and state statutes and regulations.
- The applicant understands this grants you the limited authority to complete, sign, and act on the application for Medical Assistance. *Additional written consent and authorization is required for appointment as an applicant's authorized representative.*
- The applicant understands this verbal consent authorizes the Department of Social Services and/or Department of Medical Assistance Services permission to release information to you/and your organization.
- The applicant understands this authorization can be revoked at any time.
- The applicant has received a copy of this consent form.

Your signature certifies, under penalty of perjury, the information provided on this form and on the associated application is true and accurate to the best of your knowledge. You may be subject to penalties under federal law if you provide false and or untrue information.

**Your Name:** \_\_\_\_\_

**Organization Name:** \_\_\_\_\_

**Organization Address:** \_\_\_\_\_ **Suite Number:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_