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 Acknowledgment of Receipt of Verbal Consent form will remain valid until the expiration of Virginia's 1902(e)14 waiver.*** *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, and Certified Application Counselors (CACs).*

Applicant Name:

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, 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:**