WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES MEDICAID APPLICATION FOR WVBCCSP PARTICIPANTS

Please answer all questions as completely and accurately as possible. If you do not understand a question, please call a WVBCCSP Case Manager at (304) 558-5388 or 1-800-642-8522.

Last Name: _____ First Name: _____ Middle Initial: _____ SSN#: _____- _____- _____

Address: _____ Home Phone: ( ) _____
Box / Route / Street Apt. #

Address: _____ Work Phone: ( ) _____
City / Town State Zip (If you may receive calls at work.)

Age: _____ Date of Birth: _____

In case of emergency, please contact: _____ Phone Number: _____

Contact person with whom a message may be left: _____ Phone Number: _____

ADDITIONAL INFORMATION

Do you have medical insurance? ☐ Yes ☐ No
If yes, what type? ☐ Medical ☐ Hospital ☐ Cancer Other: _____

Company Name: _____ Policy Number: _____

Address: _____

* Household Size: (Include yourself, if married your spouse and dependents) _____ * Household Annual Income: $ _____

* Do you have asset (excluding your home) that total more than $2,000? ☐ Yes ☐ No

*** These questions are being asked to evaluate your potential eligibility for other Medicaid coverage, but your answers will not affect your eligibility under the Breast and Cervical Cancer Prevention and Treatment Act.**

Provider is required to read this to patient

1. I certify that all statements on this form have been read to me and I understand the questions. I certify that all the information I have given is true and correct.
2. I give my permission for any financial institution, government agency or department, doctor, hospital, business concern, or person to give any information to an employee of the Department which would have to do with my receiving medical benefits.
3. I know that no person may be denied Medicaid benefits on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.
4. I understand, if I give incorrect of false information or if I fail to report changes, then I may be required to repay any benefits I receive. I may also be prosecuted for fraud, and I understand that any information given is subject to verification by an authorized representative of the Department.
5. I understand by accepting medical assistance under the BCCSP option I agree to give back to the State any and all money that is received from an insurance company for repayment of medical and/or hospital bills for which the Medicaid Program has made or will make payment.

Applicant Signature: _____ Date: _____

Witness, if signed by mark: _____ Signature of the person helping to complete the form: _____