WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Burial Billing Form

PART I. INFORMATION REGARDING DECEASED

WV DHHR County Office: _____
Address: _____
_____
Name of Deceased: _____
Address: _____
_____

F.E.I.N.: _____
Date of Death: _____
Date of Interment: _____

Is the Deceased potentially eligible for Social Security or Veteran's Administration Death Benefits?
☐ Yes ☐ No
If Yes, have you made application for these benefits? ☐ Yes ☐ No

PART II. PERSON ARRANGING FOR BURIAL SERVICE

Name: _____
Address: _____
_____

Phone Number: _____
Relationship: _____

PART III. LIST KNOWN LIVING RELATIVES OF DECEASED AND THEIR CURRENT LOCATION

(Complete only if person arranging for burial service is a specified relative of the deceased.

NAME	RELATIONSHIP	COUNTY	STATE

PART IV. DESIGNATED RELATIVE'S STATEMENT

I hereby certify and swear that neither the estate of the deceased nor the above-listed relatives of the deceased, including but not limited to myself, either by virtue of our combined assets or by virtue of the individual assets of each, possess sufficient resources equal to or in excess of the maximum allowable payment of $2,450. I understand, under penalty of perjury, that I am certifying not only that I do not possess the assets to pay for the funeral expenses referenced herein, but that each statutory family member listed above does not have the ability to pay, nor do the combined assets of all the above-listed family members equal enough to pay for the funeral expenses of my deceased relative.

Relative's Signature: _____ **Date:** _____

Witness's Signature: _____ **Date:** _____

PART V. TO BE COMPLETED BY FUNERAL HOME

(1)	ACTUAL COST INCURRED. (Merchandise and Services)	$ _____ (1)	
(2)	Maximum allowable payment for all burial related items		$ 2,450 (2)
(3)	Less Exempted Resources		$ - 1,200 (3)
(4)	Maximum Department Burial Rate		$ 1,250 (4)
(5)	Resources received at time of burial arrangement:		
	(a) Pre-paid Burial Trust	$ _____ (5a)	
	(b) Insurance Benefits	$ _____ (5b)	
	(c) Worker's Compensation	$ _____ (5c)	
	(d) United Mine Workers' Compensation	$ _____ (5d)	
	(e) Social Security	$ _____ (5e)	
	(f) Veterans' Benefits	$ _____ (5f)	
	(g) Contribution from Friends and Relatives	$ _____ (5g)	
	(h) Other (Specify)	$ _____ (5h)	
	TOTAL	_____	
(6)	If total of Items 5a – 5h is more than Item 3, enter amount of excess.		$ _____ (6)
(7)	Payment requested from Department of Health & Human Resources. (Item 4 minus Item 6)		$ _____ (7)
(8)	If Item 7 AND/OR total of Item 5 exceeds Item 1, enter amount of excess. (Item 7 and/or Item 5 minus Item 1)		$ _____ (8)
(9)	Payment requested from Department of Health & Human Resources. (Item 7 minus Item 8)		$ _____ (9)
(10)	Have you applied for or expect to receive any resource, not reported above?	☐ Yes ☐ No	

If so, please indicate the type and amount of resource, and the date you expect to receive it.

Type of Resource	Amount of Resource	Date to be Received

This is to certify that the foregoing information is true, accurate and complete; that the services covered by this billing form were provided without regard to race, color or national origin; and that the billing is submitted in compliance with the WV Department of Health and Human Resources' rules and fee structure in effect on date of service. The charges reported herein for the funeral services provided are the usual and customary charges made by the undersigned funeral establishment for similar services provided the general public.

I further certify that if I later receive any resources as indicated in Item 10, I will reimburse the Department of Health and Human Resources for the appropriate amount if these resources, above or in addition to resources received at the time of burial, exceed the exempted resource level of $1,200.

FUNERAL DIRECTORS: DO NOT write in this Box

Approval
Worker's Signature _____
Date _____
Supervisor's Signature _____
Date

Signed: _____
Title: _____
Funeral Home: _____
Address: _____
City, State, Zip _____
Date: _____

SEE INSTRUCTIONS IN COMPLETING THIS FORM

INSTRUCTIONS FOR COMPLETING THE BURIAL BILLING FORM

PART I. INFORMATION REGARDING DECEASED

West Virginia Department of Health & Human Resources Address: Enter local Health and Human Resources County and Address.

F.E.I.N.: Enter the number assigned to you by the Department. If you do not have an F.E.I.N. Number, contact your local Health and Human Resources office for instructions about how to secure this number. PAYMENT CANNOT BE MADE WITHOUT THIS NUMBER.

Name of Deceased and address: Self-explanatory.

Date of Death: Self-explanatory.

Date of Interment: Self-explanatory.

Is the Deceased potentially eligible for Social Security or Veterans' Administration Death Benefits? Indicate via "X" in "Yes" or "No" for the appropriate response.

PART II. PERSON ARRANGING FOR BURIAL SERVICE

Enter the name of the person arranging for the burial service (e.g., relative, friend, Funeral Director, etc.) and the address of this person.

PART III. LIST KNOWN LIVING RELATIVES OF DECEASED AND THEIR CURRENT LOCATION

Only list Designated Relatives of the deceased as follows and by their order of priority: children, father, brothers and sisters and mother. Also provide the county and state of residence for each Specified Relative listed if known.

PART IV. DESIGNATED RELATIVE'S STATEMENT

Complete and have signed only if the person arranging the burial service is a Designated Relative as defined above (child, father, brothers or sisters or mother of deceased).

PART V. TO BE COMPLETED BY FUNERAL HOME

Item 1: Enter the actual cost incurred.

Item 2: The maximum allowable payment established by the Department of Health and Human Resources. The maximum payment for a burial is $2,450.

Item 3: The amount of exempted resource of $1,200.

Item 4: The maximum Department of Health and Human Resources' burial rate of $1,250.

Item 5: List the amount of resources available and enter the total.

Item 6: If the total resources available (Item 5) exceeds the amount of exempted resources (Item 3), ENTER THE AMOUNT OF EXCESS.

Item 7: Subtract Item 6 from Item 4 and enter amount of payment requested from the Department of Health and Human Resources.

Item 8: Enter the excess amount when the payment requested from the Department (item 7) AND/OR the total resources (Item 5) exceed the actual cost incurred.

EXAMPLE:
If Item 1 is $2,450,
Item 7 is $1,250 and
Item 5 is $1,300,
the excess would be $1,250 - $1,300 - $2,400 = 0.

Item 9: Enter payment requested from the Department.

EXAMPLE:
$1,150 (rate)
– 0 (excess)
$1,150 payment from Department.

Item 10: Check appropriate response. It is your responsibility to explore/develop other resources. A Department representative may contact you to determine the amount of additional resources received.

Signature: The Funeral Home Director shall enter his signature and title in the space provided. **(BLUE INK ONLY ON ORIGINAL).** The name and address of the Funeral Home should be legibly entered in the spaces provided. The Funeral Director must date the form.