WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
PICKLE AMENDMENT COVERAGE
MEDICAID REDETERMINATION

I. Recipient Information

Name: ____
LAST FIRST MI

Sex: M ____ F ____ **Date of Birth:** __ __ / __ __ / __ __
Month Day Year

Address: ____
Route and Box or Number and Street Apt. Number

Address: ____
City / Town State Zip Code

County of Residence: ______________________________

Telephone (Where you may be reached): (__ __ __) __ __ __ - __ __ __ __
Area Code

Social Security Number: __ __ __ - __ __ - __ __ __ __

Medicare Claim Number: ______________________________

RACE:

____ White
____ Black
____ American Indian / Alaska Native
____ Native Hawaiian / Pacific Islander
____ Other

MARITAL STATUS:

____ Never Married
____ Widowed
____ Divorced
____ Separated
____ Married, living with spouse
____ Married, Spouse in Nursing Facility

ETHNICITY: ____ Hispanic or Latino ____ Not Hispanic or Latino

Name of Legal Spouse (if living in the home) ______________________________
LAST First M.I.

Sex: M ____ F ____ **Date of Birth:** __ __ / __ __ / __ __
Month Day Year

Name of Parent(s) Who lives with the Medicaid Recipient (if the Medicaid recipient is under age 18)

____
LAST First M.I.

____
LAST First M.I.

DFA-PAC-4
(New 1/06)

II. INCOME OF RECIPIENT, LEGAL SPOUSE WHO LIVES IN THE HOME OR PARENT(S) WHO LIVES WITH UNMARRIED RECIPIENT UNDER AGE 18

TYPE OF INCOME	YES	NO	PERSON WHO RECEIVES INCOME	AMOUNT BEFORE ANY DEDUCTIONS	HOW OFTEN RECEIVED
Social Security					
Veteran's Pension / Compensation					
Retirement					
Supplemental Security Income (SSI)					
Employment					
Other					
Other					

III. ASSETS OF RECIPIENT, LEGAL SPOUSE WHO LIVES IN THE HOME OR PARENT(S) WHO LIVES WITH UNMARRIED RECIPIENT UNDER AGE 18

TYPE OF ASSET	YES	NO	OTHER INFORMATION	OWNER(S)
Vehicles			Model ____________________ Year __________	
			Model ____________________ Year __________	
Home				
Do you own property other than your home?				
Bank Account(s)				
Bank Account(s)				
Life Insurance				
Other				
Other				

IV. MEDICAL INSURANCE

Do you have health or medical insurance other than Medicaid?

YES ______ **NO** _____

If "YES", complete the following information about your health insurance.

List Medical Insurance for recipient.

Person(s) Insured	Insurance Company	Policy Number

Read and check "YES" or "NO" for each statement

YES	NO		
☐	☐	1.	**I understand** by accepting medical assistance under any category, **I agree** to give back to the State any and all money that is received by anyone listed on this application from an insurance company for repayment of medical and/or hospital bills for which the Medicaid Program has or will make payment. In addition, **I agree** that all medical payments or medical support paid or owed due to a court order for me or anyone listed on this application must be sent to the State to repay past or current medical expenses paid by the State. This includes insurance settlements resulting from an accident. **I** further **agree** to notify the local Department of Health and Human Resources office if I or anyone listed on this application is involved in any accident. **I understand** that this assignment of funds continues as long as I or anyone listed on this application receives Medicaid.

YES	NO		
☐	☐	2.	**I understand** it is an eligibility requirement that I must cooperate with the Department of Health and Human Resources and with any provider of medical services in pursuing any resource available to meet the medical expenses of any medical assistance recipient. **I agree** to assign to the Department benefits available to any medical assistance recipient from any third-party source as a result of injury, accident or illness. **I understand** that the amount payable to the Department will never exceed the amount of the Medicaid liability. **I authorize** payment of any such third-party resources directly to the Department. If the liable third-party makes payment directly to me, **I agree** to refund the Department an amount up to but not exceeding the amount of Medicaid liability. I understand that this repayment must be made even if my eligibility for Medicaid assistance has stopped prior to my receiving such monies. **I further authorize** the release of any medical information or any information regarding medical insurance to the Department and also authorize the release of any medical insurance information to medical provider(s) for billing purposes. **Authorization** is also given to the Department to release medical payment information to attorneys and/or insurance companies for the resolution of third-party claims.

YES	NO		
☐	☐	3.	**I understand** that as a recipient of medical assistance, I may be required to cooperate with the Bureau for Child Support Enforcement (BCSE) in child support activities including obtaining medical support.

YES	NO		
☐	☐	4.	**I understand** for all programs all persons included must provide a Social Security Number (SSN). The SSN will be used to check the identity of household members, prevent duplicate participation and to facilitate mass changes. It will also be used in computer matching and program reviews or audits to make sure my household is eligible for the benefits we are receiving. Any fraudulent acts discovered may result in criminal or civil action or administrative claims against any person found to have committed such acts.

YES	NO		
☐	☐	5.	**I agree** to let the local Department of Health and Human Resources office know within **10 days if:** A) We move and/or change our address, name, or telephone number; B) There are changes in my household's amount of earned or unearned gross monthly income. This includes obtaining or losing employment C) Anyone moves in or out of my household; D) There are changes in my household's assets, including receiving, selling, purchasing, or loss of a vehicle

YES	NO		
☐	☐	6.	**I understand** the Department will obtain income and eligibility information from the Social Security Administration, Internal Revenue Service, Department of Motor Vehicles, Veteran's Administration, Workers' Compensation, Bureau of Employment Programs, Bureau for Child Support Enforcement, Bureau for Public Health – Division of Vital Statistics and Office of Maternal, Child and Family Health, Office of Inspector General, Bureau for Medical Services, Division of Rehabilitation Services and Immigration and Naturalization Service for each member of my group. This information will be obtained by the use of the Social Security Number of each recipient.

YES	NO		
☐	☐	7.	**I understand** if I am not satisfied with any action taken on my case(s), I can ask for a Fair Hearing orally or in writing. Also, if I feel I have been treated unfairly because of my race, age, color, national origin, sex, disability, religion, or political belief, I may ask for a Fair Hearing. I understand that anyone may attend the Fair Hearing but, if I choose to have a lawyer attend, the Department will not pay the lawyer's fee. I also may complete a civil rights complaint form, IG-CR-1, at my local county office, or contact the **Office of the Inspector General,** Building 6, Room 817, State Capitol Complex, Charleston, WV 25305. I may also file a complaint in writing to Secretary, Department of Health and Human Services, Washington, D. C. 20201.

YES	NO		
☐	☐	8.	**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 assistance and which is required by federal regulations and/or Department policy.

YES	NO		
☐	☐	9.	**I give my permission** specifically to the West Virginia State Tax and Revenue Department and the Internal Revenue Service to release to the West Virginia Department of Health and Human Resources any and all information from my personal and/or business income tax returns for any and all tax years that would have to do with my receiving benefits and which is required by federal regulations and/or department policy.

YES	NO		
☐	☐	10.	**I give my permission** to the Department of Health and Human Resources to provide information contained in my confidential case record, regarding me or any member of my family or assistance group, to Immigration and Naturalization Services, Social Security Administration, Bureau for Child Support Enforcement, Bureau for Medical Services, Bureau for Public Health, Division of Rehabilitation Services, or any other State or Federal department/agency/organization primarily for the purpose of providing me with access to the services and benefits offered by these departments/agencies/organizations in an efficient manner that allows for coordination rather than duplication of service(s).

YES	NO		
☐	☐	11.	**I understand** if I give incorrect or 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. Also, it is understood that any person who obtains or attempts to obtain welfare benefits from the Department by means of a willfully false statement or misrepresentation or by impersonation or any other fraudulent device can be charged with fraud. Punishment upon a conviction may be a fine up to $5,000 and/or a jail sentence of five (5) years in jail.

YES	NO		
☐	☐	12.	**I certify** that all statements on this form have been read by me or read to me and I understand the questions. I certify that all the information I have given is true and correct and I accept the aforementioned responsibilities.

______________________________ ________________

Recipient's or Representative's Signature — Date Signed

______________________________ ________________

Worker's Signature — Date Signed