WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
QUALIFIED MEDICARE BENEFICIARIES (QMB)
SPECIFIED LOW INCOME MEDICARE BENEFICIARIES (SLIMB)
QUALIFIED INDIVIDUALS (QI-1)

I. Applicant 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
____ Asian
____ Hispanic
____ Other

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

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

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

Address: (If different from Applicant) _____
Route and Box or Number and Street Apt. Number

Address: _____
City / Town State Zip Code

Social Security Number: (only if applying) __ __ __ - __ __ - __ __ __ __

Medicare Claim Number: (only if applying) _____

Have you (or your legal spouse) ever applied for or received Medicaid in the past?

YES ____ **NO** ____ **If "YES", in which County:** _____

II. INCOME OF APPLICANT AND LEGAL SPOUSE (if living in the home)
Please mark "yes" or "no" for each type of income listed.

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 APPLICANT AND LEGAL SPOUSE (if living in the home)
Please mark "yes" or "no" for each asset.

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				

▶ **NOTE: If you answered "YES" about assets other than a home or vehicle, you may use this form to apply for Medicaid, BUT you must be interviewed by a Worker.** ◀

IV. MEDICAL INSURANCE OF APPLICANT AND LEGAL SPOUSE, if living in the home

Do you (or your legal spouse) have health or medical insurance other than Medicaid?

YES _____ **NO** _____ **If "YES", complete the following information about your health insurance for the applicant and legal spouse, who lives in the home.**

List Medical Insurance for applicant and/or legal spouse.

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** that I may receive medical assistance for my child(ren), including Early Periodic Screening, Diagnosis, and Treatment (EPSDT).

YES	NO		
☐	☐	5.	**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 ☐		
		6.	**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) Anyone obtains/loses employment; C) There are changes in my household's amount of unearned income or gross monthly income; D) There are changes in the source of employment and hours worked; E) Anyone moves into/out of my household. F) There are changes in my household's assets, including receiving, selling, purchasing, or loss of a vehicle G) Anyone in my household receives a lump sum payment because this may affect our eligibility for continuing benefits and I may be expected to live on this income for a specific period of time.

YES ☐	NO ☐		
		7.	**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 and Child Health, Office of Inspector General, Bureau for Medical Services, Division of Rehabilitation Services and Immigration and Naturalization Service on each member of my group. This information will be obtained by the use of the Social Security Number of each recipient.

YES ☐	NO ☐		
		8.	**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 ☐		
		9.	**I understand** that I may receive information and services regarding Family Planning upon request.

YES ☐	NO ☐		
		10.	**I further understand** that I may receive information/services on Domestic Violence upon request.

YES ☐	NO ☐		
		11.	**I understand** that appointments/meetings with my Worker may include scheduled/unscheduled home visits, but **I also understand** that I am not required to allow the DHHR Worker to enter my home.

YES	NO		
☐	☐	12.	**I understand** that I will be required to cooperate with the Quality Assurance Reviewer in any review of my benefits as a matter of eligibility. This may require a home visit by the Reviewer and include additional verification of my situation.

YES	NO		
☐	☐	13.	**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		
☐	☐	14.	**I give my permission** to the Department of Health and Human Resources to refer my family to any helping agency for needed service after my benefits end.

YES	NO		
☐	☐	15.	**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		
☐	☐	16.	**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		
☐	☐	17.	**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		
☐	☐	18.	**I understand that federal and West Virginia law mandates the recovery of Medicaid paid after June 9, 1995 on behalf of individuals age 55 or older who receive Medicaid payment for nursing care or home and community based waiver services and related hospital and prescription drug services. These laws also mandate the recovery of Medicaid paid for nursing care, care in an intermediate care facility for the mentally retarded or other medical institutions when an individual is determined permanently institutionalized.** **The state will not impose a lien or will defer recovery from the estate when:** • **The individual has a surviving spouse living in the home; or** • **The individual has a surviving child who is under age 21 living in the home; or** • **The individual has an adult child living in the home who meets the Social Security Act's definition of blindness or permanent and total disability; or,** • **The individual's sibling has an equity interest in the home and was residing in the home for a period of at least one year immediately before the date of the individual's admission to a medical institution.** **The amount of the recovery is the amount Medicaid pays for these medical services for the individual.** **After a proof of claim is filed against the estate, heirs affected by Estate Recovery may file a hardship waiver.** **Estate Recovery is not an eligibility requirement to receive Medicaid or payment for the services.**

YES	NO		
☐	☐	19.	**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.

Applicant's Signature	Date Signed
Worker's Signature	Date Signed
Signature of Telephone Interviewer (Representative Completing Application Form)	Date Signed