WEST VIRGINIA Department of Health & Human Resources

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
SUPPLEMENT TO APPLICATION FOR HEALTH COVERAGE

This supplement is being used to collect additional information to determine potential eligibility for other health coverage.

Applicant Information

Legal Name: _____
LAST FIRST MI

Mailing Address: _____
Route and Box or Number and Street Apt. Number City/Town State Zip Code

Physical Address: _____
If different than Mailing
Route and Box or Number and Street Apt. Number City / Town State Zip Code

Social Security Number: — — — - — — - — — — —

Name of Legal Spouse: _____
LAST FIRST MI

List person and date disability/blindness/incapacity began:

Name: _____ Date: _____

Is this application for anyone who needs or is already receiving nursing home services or other specialized medical care?
If "Yes", list person, facility and date entered the facility.

YES ☐ NO ☐ Name: _____ Facility: _____ Date: _____

Is anyone in your household who was an SSI recipient in the past not receiving SSI now?
If "Yes", list person and date SSI ended.

YES ☐ NO ☐ Name: Date:

INCOME OF APPLICANT AND LEGAL SPOUSE

Please mark "yes' or "no" for each type of income listed. Include any income not reported on the application for Health Coverage

			TYPE OF INCOME	PERSON WHO RECEIVES INCOME	AMOUNT BEFORE ANY DEDUCTION	HOW OFTEN RECEIVED
YES	☐	NO ☐	Social Security			
YES	☐	NO ☐	Veteran's Pension / Compensation			
YES	☐	NO ☐	Retirement			
YES	☐	NO ☐	Employment			

YES	☐	NO ☐	Annuity			
YES	☐	NO ☐	Other			
YES	☐	NO ☐	Does anyone in your household have impairment related work expenses?			
			If yes, what type of expenses: _____			
			Amount of monthly expenses: $ _____			
			For whom? Is this person blind? ☐ Yes ☐ No			
YES	☐	NO ☐	Does any household member pay anyone else to care for a dependent child or disabled/incapacitated adult so a household member can get to work or training/school? If **yes**, complete the following information:			

Name	Child or Disabled/ Incapacitated Adult's Name	Care Provider	Payment Amount	How Often

ASSETS OF HOUSEHOLD MEMBERS

Please mark "yes" or "no" for each type of asset listed.

TYPE OF ASSET	YES	NO	VALUE	Owner
Vehicles			Model _____ Year ____ Value _____ Amount Owed _____ Model _____ Year ____ Value _____ Amount Owed _____	
Home			Value _____ Amount Owed _____	
Do you own property other than your home?			Value _____ Amount Owed _____	
Mobile Home			Model _____ Year ____ Value _____ Amount Owed _____	
Checking Account(s)				
Savings Account(s)				
Money Market Account				
Credit Union				
Cash on Hand				
Christmas Club				
Stocks				
Bonds/Savings Bonds				

TYPE OF ASSET	YES	NO	VALUE	Owner
Certificates of Deposit				
Trust Funds				
IRA/Keogh				
Profit Sharing				
Escrow Account/Home Sale				
Life Insurance			Policy No.: Date purchased: Face value: Cash surrender value:	
Funeral/Burial Funds				
Burial Plots				
Livestock				
Mineral Rights				
Business Equipment			Model _____ Year ____ Value _____ Amount Owed _____	
Farm/Tractor Equipment			Model _____ Year ____ Value _____ Amount Owed _____	
Camper/Trailer			Model _____ Year ____ Value _____ Amount Owed _____	
ATV, 3 Wheeler, UTV			Model _____ Year ____ Value _____ Amount Owed _____	
Boat			Model _____ Year ____ Value _____ Amount Owed _____	
Other Recreational Vehicle			Model _____ Year ____ Value _____ Amount Owed _____	
Personal Collection				
Other				
Other				

NOTE: You may be required to provide additional information and/or verification.

Are any of the assets listed not available to the owner due to joint ownership, court proceedings/orders, etc?
YES ____ NO ____ If "Yes," which assets and why? _____

Are any of the assets listed set aside for burial?
YES ____ NO ____ If "Yes," which assets? _____

Has anyone received a lump sum payment? If "Yes," list person, type and date.
YES ____ NO ____ Name _____ Type of Payment _____ Date _____

Do you or anyone in your household expect to receive any benefits or income, such as, but not limited to, Social Security Benefits, Wages from Employment, Unemployment Benefits, Child Support or Insurance Settlements that you are not now receiving?
YES ___ NO ___ If "Yes," list person, type and expected date of receipt.

Name _____ Type _____ Expected Date of Receipt _____

Has anyone transferred or divested (disposed of), sold, or given away property, income, or any other asset, including vehicles or life insurance or established a trust fund within the last five (5) years (60 months)?
YES ___ NO ___ If yes, Name _____
Date of Transfer _____ (mm/dd/yy) Transferred to _____
Value of Asset _____ Amount Received _____

Is anyone entitled to or enrolled in Medicare Part A or Part B?
YES ___ NO ___ If "Yes," complete the following information

Person	Medicare Claim Number	Part A Begin Date	Part A End Date	Part B Begin Date	Part B End Date	Premium Amount

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

_____ _____
Co-Applicant's Signature Date Signed

_____ _____
Representative Completing Application Form Date Signed