

**WEST VIRGINIA MR/DD WAIVER PROGRAM
APPLICATION FORM (DD-14)**

1 _____ / _____ / _____ **2** DOB _____ / _____ / _____
First Name Last Name M Month Day Year

3 _____ / _____ / _____ / _____
Street/Apt# Address City State Zip Code County

4 Telephone #(_____) _____ **5** Social Security # _____ **6** Medicaid # _____

7 Parent's Name _____ / _____ / _____ **8** Parent's Phone #(_____) _____
First Name Last Name M

9 Parent's Address _____ / _____ / _____ / _____
Street/Apt# City State Zip Code County

10 Does the applicant have a legal guardian or legal representative? **9** YES **9** NO

11 Guardian's Name's _____ / _____ / _____ **12** Guardian's Phone #(_____) _____
First Name Last Name M

13 Guardian Address _____ / _____ / _____ / _____
Street/Apt# City State Zip Code County

14 Service Coordination Agency Name _____ / _____
Phone Number

15 Please indicate anticipated time frame the applicant requires MR/DD Waiver Services to begin?
9 0 - 90 Days (APPLICATION) **9** 91 Days or Greater (STATEMENT OF INTEREST)

16 If "91 Days or Greater" was checked in #15, please indicate the anticipated month and year the applicant requires MR/DD Waiver Services to begin: _____ / _____
Month Year

17 I certify the above information is accurate and complete to the best of my knowledge. I authorize the West Virginia State MR/DD Waiver Office to review and release the above information to the Service Coordination Agency I have selected on this application. I understand the information provided in this document will be treated confidentially.

Print Name of Applicant or Legal Representative

Signature of Applicant or Legal Representative

Date

DO NOT WRITE BELOW THIS LINE

Received by the Local Behavioral Health Center (Date/Signature): _____
Received by the Local DHHR Office (Date/Signature): _____
Date Received by the State MR/DD Waiver Office (Date/Signature): _____

DD-14 Revised
February 2002