RIGHTS AND RESPONSIBILITIES
MEDICAID - PAYMENT FOR NURSING HOME OR ICF/MR ONLY

West Virginia Department of Health and Human Resources (WV DHHR)
Bureau for Children & Families
Division of Family Assistance

MEDICAID PROGRAM

In accordance with Federal law and U.S. Department of Health and Human Services policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, contact HHS. Write HHS, Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, DC 20201 or call 202-619-0403 (voice) or 202-619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

Read each statement carefully and answer yes or no to <u>each</u> statement.

Yes ☐ No ☐ 1) **I understand** by accepting Medicaid 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 (DHHR) 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 DHHR and with any provider of medical services in pursuing any resource available to meet the medical expenses of any Medicaid recipient. **I agree** to assign to the Department benefits available to any Medicaid 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 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 providing my Social Security Number (SSN) to the DHHR is mandatory and is required by Federal law. The only use of the SSN is in the administration of the Medicaid Program, with no disclosure or use of the SSN for any other purpose. I further understand that an SSN is required only for those people who receive benefits and not for any other person.

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 make 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 hereby consent** to be referred to the Social Security Administration to be issued a Social Security Number (SSN) and to have my SSN released only for the purposes described above.

Yes ☐ No ☐ 6) **I agree** to let the local DHHR office know within **10 days** if:

A) I am discharged from a nursing or intermediate care facility to go to another facility or return home.

B) There are changes in my gross unearned or earned income or the income of my spouse and any dependent children who live with my spouse.

C) There are changes in my assets or those of my spouse, including receiving, selling, purchasing or giving away assets.

I understand that failure to provide this information may result in a penalty or case closure.

Yes ☐ No ☐ 7) **I understand** that if my income is above the Medicaid limits, I may still be eligible to receive a medical card if I have excess medical bills. **I further understand** that my Worker will advise me of the amount of medical bills I have to show and that I have 30 days from the date I apply to provide the bills. The bills can be paid or unpaid and can be bills for me, my husband/wife or dependent minor children who live with me. My Worker will explain which bills cannot be used and why.

Yes ☐ No ☐ 8) **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 about each member of my group. This information will be obtained by the use of the Social Security Number of each recipient.

Yes ☐ No ☐ 9) **I understand** if I am not satisfied with any action taken on my case, 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. (Please see Page 1 for the address for Medicaid Program discrimination complaints.) **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-B, State Capitol Complex, Charleston, WV 25305.

Yes ☐ No ☐ 10) **I understand** that I may receive information and a referral to receive Family Planning Services upon request.

Yes ☐ No ☐ 11) **I further understand** that I may receive information and a referral for Domestic Violence services upon request.

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, but I also understand that I am not required to allow the Quality Assurance Reviewer to enter my home.

Yes ☐ No ☐ 13) **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 DHHR 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 DHHR policy.

Yes ☐ No ☐ 14) **I give my permission** to the DHHR 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 services.

Yes ☐ No ☐ 15) **I understand** the WV DHHR does not discriminate on the basis of disability in admission to or access to its programs or in its operations, services, or activities.

This notice is available in large print, on audio tape, in Braille from any local office. This Notice is provided as required by Title II of the Americans with Disabilities Act (ADA) of 1990. If I have questions or complaints or if I want to talk about whether I have a disability, I may contact the State ADA coordinator at:

West Virginia State ADA Coordinator
Department of Administration, Building 6, Room 438
1900 Kanawha Blvd., East
Charleston, WV 25305-0139
(304) 558-3950
Monday through Friday 9:00 a.m. to 5:00 p.m.

Yes ☐ No ☐ 16) **I understand** that I may be qualified to apply for a low-priced telephone service called Link-Up/Tel-Assistance Service that the telephone company in my area offers. **I give permission** to the DHHR to release information to the telephone company concerning my eligibility for this service. If my eligibility for DHHR programs is stopped, **I understand** the DHHR will notify the telephone company.

Yes ☐ No ☐ 17) **I understand,** if I give incorrect or false information or if I fail to report changes that I am required to report, 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 DHHR. Also, it is **understood** that any person who obtains or attempts to obtain welfare benefits from the DHHR 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 5 years.

Yes ☐ No ☐ 18) **I give my permission** for any of the following entities to release any information to a DHHR employee when this information is related to my receipt of assistance. **I understand** that only information which is required by federal regulations and/or DHHR policy will be requested and that it will be used only in determining or redetermining my eligibility for assistance or the level of assistance received. The entities that may release my information include any: financial institution; government agency or department; physician, including psychiatrists; psychologist or other counselor; drug testing facility; hospital, including psychiatric hospitals; business concern; HIV/AIDS testing services; other person with related information.

Yes ☐ No ☐ 19) **I understand** that a period of ineligibility for Medicaid long term care may result if resources were transferred within the thirty-six (36) month period prior to the date of application by the applicant or applicant's spouse.

I understand for a transfer of resources to certain trusts the period of ineligibility is sixty (60) months.

Yes ☐ No ☐ 20) **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 recover or will defer recovery from the estate when:

- The individual has a surviving spouse
- The individual has a surviving child who is under age 21 or who is blind or disabled.

The amount of the recovery is the amount Medicaid pays for these 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 ☐ 21) **I certify** that all statements on this form have been read by me or read to me and that I understand them. **I certify** that all the information I have given is true and correct and I accept these responsibilities.

Applicant's or Authorized Representative's Signature	**Date**
Co-Applicant's Signature	**Date**
Signature of Interviewing Worker Who Witnessed Signature	**Date**