WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
APPLICATION FOR ADULT/FAMILY MEDICAID

I. Applicant Information

Name: _____
LAST FIRST MI

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

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

County of Residence: _____

Telephone/Message Phone
(Where you may be reached during the day) (__ __ __) __ __ __ - __ __ __ __
Area Code

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

Household Information

Household Members	Birthdate (Month, Day, Year)	Social Security Number	U.S. Citizen (Circle One)	Sex (Circle One)	Relationship	Race	Ethnicity 1)Hispanic or Latino 2) None of the above (Circle One)	Primary Language	High School Diploma or GED	Last Grade Attended	Intends To Reside in WV
			Y N	M F			1 2		Y N		Y N
			Y N	M F			1 2		Y N		Y N
			Y N	M F			1 2		Y N		Y N
			Y N	M F			1 2		Y N		Y N
			Y N	M F			1 2		Y N		Y N
			Y N	M F			1 2		Y N		Y N
			Y N	M F			1 2		Y N		Y N
			Y N	M F			1 2		Y N		Y N

Household Members	**Birthdate** (Month, Day, Year)	**Social Security Number**	**U.S. Citizen** (Circle One)	**Sex** (Circle One)	**Relationship**	**Race**	**Ethnicity** 1)Hispanic or Latino 2) None of the above (Circle One)	**Primary Language**	**High School Diploma or GED**	**Last Grade Attended**	**Intends To Reside in WV**
			Y N	M F			1 2		Y N		Y N
			Y N	M F			1 2		Y N		Y N
			Y N	M F			1 2		Y N		Y N
			Y N	M F			1 2		Y N		Y N
			Y N	M F			1 2		Y N		Y N
			Y N	M F			1 2		Y N		Y N

Did anyone attend schooling after High School or GED?
YES _____ NO _____ If "Yes," list person and if they hold any degrees, licenses or certificates

_____

Is anyone under the control of the courts and working without pay? If "Yes", list person.
YES _____ **NO** _____ Name: _____

Is anyone acting as a parent to a child under age 18 who is not a biological or adopted child?
If 'Yes", list person and child.
YES _____ **NO** _____ Name: _____ Child's Name: _____

Have you or any member of your household had any unpaid medical expense in any of the past three (3) months?
YES _____ **NO** _____ If "Yes", do you wish to have your Medical Coverage backdated to cover these expenses?
YES _____ NO _____ Indicate starting date: _____

Is anyone pregnant? If "Yes", list pregnant person and due date.
YES _____ **NO** _____ Name: _____ Due Date: _____

Is any adult unable to work due to disability, blindness or incapacity?
YES _____ NO _____ If "Yes," list person and date disability/blindness/incapacity began. (top of page 3)

List person and date disability/blindness/incapacity began (continued.)

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: _____

II. 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				
Certificates of Deposit				
Trust Funds				
IRA/Keogh				

TYPE OF ASSET	YES	NO	VALUE	Owner
Profit Sharing				
Escrow Account/Home Sale				
Life Insurance				
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 or 3 Wheeler			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 _____

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 _____ Transferred to _____

(mm/dd/yy)

Value of Asset _____ Amount Received _____

III. INCOME OF HOUSEHOLD MEMBERS

Please mark "yes" or "no" for each income.

TYPE OF INCOME	YES	NO	PERSON WHO RECEIVES INCOME	AMOUNT BEFORE ANY DEDUCTIONS	HOW OFTEN RECEIVED
Employment					
Employment					
Employment					
Dividends/Interest/ Royalties/Annuities					
Trust Fund Payments					
Farming					
Self-Employment					
Rental Income					
Social Security					
UMWA Benefits					
Veteran's Pension / Compensation					
Military Allotment					
Retirement/Pension					
Supplemental Security Income (SSI)					
Black Lung					
Sick/Disability Benefits					
Job Corp Allotment					
Child Support					
Spousal Support					
Contributions from Friends/Relatives					
Adoption Assistance					
Guardianship/Foster Care Programs					

TYPE OF INCOME	YES	NO	PERSON WHO RECEIVES INCOME	AMOUNT BEFORE ANY DEDUCTIONS	HOW OFTEN RECEIVED
Unemployment Benefits					
Workers' Compensation					
Student Loans/Grants					
Roomers/Boarders					
Insurance Payments/Settlements					
Other					

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 _____

EMPLOYMENT HISTORY

List last 4 places of employment for each adult household member.

Person Employed	Employer's Name	Employer's Address	Job Title/ Occupation	Reason No Longer Employed	Length/Dates of Employment	Type of Employment	Hourly Wage
						Part-Time ☐ Full-Time ☐ Temporary ☐	
						Part-Time ☐ Full-Time ☐ Temporary ☐	
						Part-Time ☐ Full-Time ☐ Temporary ☐	
						Part-Time ☐ Full-Time ☐ Temporary ☐	
						Part-Time ☐ Full-Time ☐ Temporary ☐	
						Part-Time ☐ Full-Time ☐ Temporary ☐	
						Part-Time ☐ Full-Time ☐ Temporary ☐	
						Part-Time ☐ Full-Time ☐ Temporary ☐	

IV. OTHER HOUSEHOLD INFORMATION

Does anyone in your household pay anyone else to care for a dependent child or disabled/incapacitated adult so a household member can get to work or training/school?

YES _____ NO _____ If "Yes," complete the following information.

Child or Disabled/ Incapacitated Adult's Name	Care Provider	Care Provider's Address	Payment Amount	How Often
				Every 2 Weeks ☐ Twice a Month ☐ Once a Week ☐ Once a Month ☐ Other (Specify) ☐
				Every 2 Weeks ☐ Twice a Month ☐ Once a Week ☐ Once a Month ☐ Other (Specify) ☐
				Every 2 Weeks ☐ Twice a Month ☐ Once a Week ☐ Once a Month ☐ Other (Specify) ☐
				Every 2 Weeks ☐ Twice a Month ☐ Once a Week ☐ Once a Month ☐ Other (Specify) ☐

Does anyone have health or medical insurance other than Medicaid?

YES _____ NO _____ If "Yes," complete the following information about your health insurance.

List Medical Insurance

Person(s) Insured	Insurance Company	Policy Number	Premium Amount	How Often Paid

Is anyone entitled to or enrolled in Medicare Part A or Part B?

YES _____ NO . If "Yes," complete the following information (top of page 8)

Is anyone entitled to or enrolled in Medicare Part A or Part B? (continued)

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

Is there a child in this household who has a parent who does not live with them?
YES _____ NO _____ If "Yes," list the child and non-custodial parent's information.

Child's Name	Non-Custodial Parent's Name	Non-Custodial Parent's Address	Non-Custodial Parent's Employer	Absence Date	Is the Non-Custodial Parent court-ordered to provide medical support/insurance?
					Y N
					Y N
					Y N

Does anyone have a Legal Guardian, Power of Attorney, or Authorized Representative?
YES _____ NO _____ If "Yes," list person and name, address and phone number of legal guardian, power of attorney (POA) or authorized representative.

Name of household member : _____

Name of legal guardian/POA/authorized representative: _____

Address: _____ Phone 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** that if my income is above the Medicaid limits, I may 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 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** ☐	6.	**I understand** that a period of ineligibility for Medicaid long term care may result if resources were transferred within the sixty (60) month period prior to the date of application by the applicant or applicant's spouse. This includes transfers into certain trusts.

YES ☐	**NO** ☐	7.	**I understand** that I am required to disclose to the State any interest my spouse or I have in an annuity. I understand the State must be named as the remainder beneficiary or as the second remainder beneficiary after a spouse or a minor or disabled child, for an amount at least equal to the amount of Medicaid benefits provided. Failure to comply with these requirements may be considered a transfer of resources for less than fair market value and result in ineligibility for Medicaid long term care services.

YES	NO		
☐	☐	8.	**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 a 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		
☐	☐	9.	**I understand** if I am in a nursing home, I must notify the local DHHR office 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		
☐	☐	10.	**I understand** that any information given is subject to verification by an authorized representative of DHHR.

YES	NO		
☐	☐	11.	**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 ☐	12.	**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 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 ☐	13.	**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 ☐	14.	**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 ☐	15.	**I understand** that I may receive information and services regarding Family Planning upon request.

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

YES	NO		
☐	☐	17.	**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		
☐	☐	18.	**I understand** that I may be qualified to apply for low-priced telephone services called Link-Up America and Tel-Assistance/Lifeline that the telephone company in my area offers. I give permission to DHHR to release information to the telephone company concerning my eligibility for this service. If my eligibility for DHHR programs is stopped, I understand DHHR will notify the telephone company.

YES	NO		
☐	☐	19.	**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		
☐	☐	20.	**I give my permission** for any financial institution, government agency or department; landlords, both private and public housing authorities; physician, including psychiatrists, psychologist or other counselor; drug testing facility; hospital, including psychiatric hospitals; business concern/employers; HIV/AIDS testing services; other person with related information 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. This release authorizes schools to provide information including, but not limited to, enrollment, attendance, address, custodian, and all information related to the receipt of public assistance for my child(ren) under my care and custody.

YES	NO		
☐	☐	21.	**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		
☐	☐	22.	**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. This includes filing status, dependents, address, income, deductions, and any other pertinent information requested by DHHR.

YES	NO		
☐	☐	23.	**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		
☐	☐	24.	**I understand** 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, or in Braille from any DHHR 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 1, Room 127 E 1900 Kanawha Blvd., East Charleston, WV 25305 (304) 558-1783 Monday through Friday 9:00 a.m. to 5:00 p.m.

YES	NO		
☐	☐	25.	**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.

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
Worker's Signature	Date Signed
Representative Completing Application Form	Date Signed