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

I. Appl	icant	Informat	ion
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Name:						
		LAST	FI	IRST	MI	
Sex:	M	F	Date of Birth:	/ Month	/ Day Year	
Address:					·	
	Route	and Box or Numb	er and Street	Apt. Numbe		
Address:		City / Town	\$	State	Zip Code	
County of	Residence	:				
Telephone	(Where you ma	ay be reached):	()	_ -		
Social Sec	curity Numb	ner:				

		Ho	usehold	Inform	nation			
Household Members	Birthdate	Social Security Number	U.S. Citizen	Sex	Relationship	Race	Ethnicity 1)Hispanic or Latino 2) None of the above	Primary Language
	(Month, Day, Year)		(Circle One)	(Circle One)			(Circle One)	
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			Y N	MF			1 2	

II. INCOME OF HOUSEHOLD MEMBERS

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
Employment					

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

III. ASSETS OF HOUSEHOLD MEMBERS Please mark "yes" or "no" for each asset.

TYPE OF ASSET	YES	NO	VALUE	OWNER(S)
Vehicles			Model	
			YearValue	
			ModelValue	
Home				
Do you own property other than your home?				
Mobile Home				
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 Trust Funds IRA/Keogh Profit Sharing Escrow Account/Home Sale Life Insurance Eymeral/Purial Funds Funeral/Purial Funds Burial Plots Burial Plots Livestock Mineral Rights Business Equipment Model	TYPE OF ASSET	YES	NO		VALUE	OWNER(S)
Christmas Club Stocks St	Credit Union					
Stocks Sonds/Savings Bonds Sonds/Savin	Cash on Hand					
Bonds/Savings Bonds	Christmas Club					
Certificates of Deposit ITrust Funds IRA/Keogh IRA/Keogh Profit Sharing IERA/Keogh Escrow Account/Home Sale IERA/Keogh Life Insurance IERA/Keogh Funeral/Burial Funds IERA/Keogh Burial Plots IERA/Keogh Livestock IERA/Keogh Mineral Rights IERA/Keogh Business Equipment IERA/Keogh Model Year Value Camper/Trailer IERA/Keogh Model Year Value ATV or 3-4 Wheeler IERA/Keogh Model Year Value Boat IERA/Keogh Model Year Value Other Recreational IERA/Keogh Wodel Year Value Personal Collection IERA/Keogh	Stocks					
Trust Funds IRA/Keogh Profit Sharing Escrow Account/Home Sale Life Insurance Funeral/Burial Funds Elivestock Elivestock Elivestock Equipment	Bonds/Savings Bonds					
RA/Keogh	Certificates of Deposit					
Profit Sharing Escrow Account/Home Sale Es	Trust Funds					
Escrow Account/Home Sale	IRA/Keogh					
Life Insurance Funeral/Burial Funds Burial Plots Suit Plots Livestock Mineral Rights Business Equipment Model	Profit Sharing					
Funeral/Burial Funds Burial Plots Elivestock Surial Plots Surial Plots	Escrow Account/Home Sale					
Burial Plots	Life Insurance					
Livestock Mineral Rights Business Equipment Model Year Farm/Tractor Model Year Equipment Model Year Camper/Trailer Model Year ATV or 3-4 Wheeler Model Year Boat Model Year Other Recreational Vehicle Model Year Personal Collection Value	Funeral/Burial Funds					
Mineral Rights Model	Burial Plots					
Business Equipment	Livestock					
Model						
Farm/Tractor Model	Business Equipment					
Farm/Tractor Model				Model	Volue	
Equipment Model Year Value Camper/Trailer Model Year Value ATV or 3-4 Wheeler Model Year Value Boat Model Year Value Other Recreational Vehicle Model Year Value Personal Collection Other	Farm/Tractor			Teal	value	_
Year				Model		
Model					Value	
ATV or 3-4 Wheeler Model YearValue Boat Model YearValue Other Recreational Vehicle Personal Collection Other	Camper/Trailer			Martal		
ATV or 3-4 Wheeler Model				Wodel	Value	—
Boat Model	ATV or 3-4 Wheeler			Tour	vaido	
Boat Model						
Other Recreational Vehicle Model Year Value Model Year Year Value Personal Collection Other				Year	Value	_
Other Recreational Vehicle Model Year Value Personal Collection Other	Boat			Model		
Other Recreational Vehicle Model Year Value Personal Collection Other					Value	_
Personal Collection Other	Other Recreational					_
Personal Collection Other	Vehicle					
Other				Year	Value	_
	Personal Collection					
Other	Other					
	Other					

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

IV. OTHER HOUSEHOLD INFORMATION

Does anyone	e have health or r	edical insurance other than Medicaid?
_		If "YES", complete the following information about your health
YES	NO	insurance

List Medical Insurance

Person(s) Insured	Insurance Company	Policy Number

Is anyo	ne pregr	nant? If "Yes", list pregnant person and due date.
		Name:
YES	NO	Due Date:
Has an	yone rec	eived a lump sum payment? If "Yes", list person, type and date.
		Name:
YES	NO	Type of Payment:
		Date:
Is anyo	ne disab	led, blind or incapacitated? If "Yes", list person and disability date.
		Name:
YES	NO	Date:
Is anyo		ving nursing home services or other specialized medical care?
	IT YE	es", list person, facility and date entered the facility.
		Name:
YES	NO	•
		Date:
	•	ave a Legal Guardian, Power of Attorney, or Authorized
		? If "Yes", list person and name, address and phone number of legal
guardia	n, powe	r of attorney (POA) or authorized representative?
		Name of household member :
YES	NO	Name of legal guardian/POA/authorized representative:
		Address:
		Phone Number:
		There is a manual contract of the contract of
Has an	vone tra	nsferred or divested (disposed of), sold, or given away property, income,
		set, including vehicles or life insurance or established a trust fund within
		years (60 months)?
tile last	1140 (0)	
VEQ	NO	If yes, Name: Date of Transfer:
123	NO	(mm/dd/yy)
		Transferred to:
		Value of Asset: \$
		Amount Received: \$
		Amount Received. $\psi_{\phantom{aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa$
Read an	d check	"YES" or "NO" for each statement
•		T
ES 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.
VES	NO	10	Lundarstand that any information given is subject to verification by an
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
		11.	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.		
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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.		
		r			
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		

			with access to the se	ion primarily for the purpose of providing me ervices and benefits offered by these zations in an efficient manner that allows for cation 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.		
	T	Т	T		
YES	NO	25.	changes, then I may be required be prosecuted for fraud and I subject to verification by an at Also, it is understood that any welfare benefits from the Depor misrepresentation or by important the prosecution of the prosec	ct or false information or if I fail to report red to repay any benefits I receive. I may also understand that any information given is uthorized representative of the Department. If person who obtains or attempts to obtain partment by means of a willfully false statement personation or any other fraudulent device can ment upon a conviction may be a fine up to of five (5) years in jail.	
YES	NO	26.	me and I understand the ques	n this form have been read by me or read to stions. I certify that all the information I have I accept the aforementioned responsibilities	
			oplicant's Signature	Date Signed	
			Vorker's Signature	Date Signed	
	Repre	esentativ	e Completing Application Form	Date Signed	