WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

APPLICATION FOR LONG TERM CARE MEDICAID AND CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM

1. Applicant Information

Name: _____
LAST FIRST MI

Sex: **M** ___ **F** ___ **Date of Birth:** _____ **Marital Status:** _____

Social Security Number: _____ **Medicare Claim Number:** _____

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

Physical Address: _____
(*If different from Mailing*) Route and Box or Number Apt. Number City/Town State Zip Code

County of Residence: _____ **Telephone/Message Phone:** _____
(*Where you may be reached during the day*)

Do you or anyone in your house need an accommodation because of a condition that would prevent you from completing the application process? **Yes** _____ **No** _____

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	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

HOUSEHOLD INFORMATION CONTINUED

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	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

Have you or any member of your household had any unpaid medical expenses 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 of requested coverage: _____

Is any adult unable to work due to disability, blindness, or incapacity?
Yes _____ No _____
If yes, list the person and date disability, blindness, or incapacity began:
Name: _____ Date: _____

Is this application for anyone who needs or is already receiving nursing home services or other specialized medical care?
Yes_____ No _____
If yes, list the person, facility, and date entered the facility:
Name: _____ Facility: _____ Date: _____

Is anyone in your household who was an SSI recipient in the past not receiving SSI now?
Yes_____ No _____
If yes, list the person and date SSI ended:
Name: _____ Date: _____

2. 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 Plan				
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/UTV/3-wheeler			Model _____ Year _____ Value _____ Amount Owed _____	
Boat			Model _____ Year _____ Value _____ Amount Owed _____	
Personal Collection				
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?
Yes _____ No _____
If yes, list person, type of payment, and date?
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, list information below:
Name: _____ Date of Transfer: _____ Transferred to: _____

Value of Asset: _____ Amount Received: _____

3. 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					
Child Support					
Spousal Support					
Contributions from Friends/Relatives					
Adoption Assistance					
Guardianship/Foster Care					
Unemployment Benefits					
Workers' Compensation					
Student Loans/Grants					
Roomers/Boarders					
Insurance Payments/Settlements					
Other					

Do you or does 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 _____

4. OTHER HOUSEHOLD INFORMATION

Does anyone have health or medical insurance other than Medicaid?
Yes _____ No _____
If yes, complete the following information about your health 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.

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

You can choose an authorized representative
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local DHHR office. If you're a legally appointed representative for someone on this application, submit proof with the application.

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

Does anyone have a Legal Guardian, Power of Attorney, or an Authorized Representative?
Yes _____ No _____
Name of Legal Guardian / POA / Authorized Representative : _____
Address : _____
_____
Phone Number : _____
Applicant Signature : _____ Date: _____

5. RIGHTS AND RESPONSIBILITIES *Read and check "YES" or "NO" for each statement.*

1.	**YES**	**NO**	**I understand** that as a recipient of Medicaid, I may volunteer for the Bureau for Child Support Enforcement (BCSE) services, including obtaining medical support. These services are provided by BCSE at no charge to me.
2.	**YES**	**NO**	**I understand** I may receive medical assistance for my child(ren), including Early Periodic Screening, Diagnosis and Treatment (EPSDT).
3.	**YES**	**NO**	**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 bills for me, my husband/wife (spouse), or dependent minor children who live with me. My Worker will explain which bills cannot be used and why.
4.	**YES**	**NO**	**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.
5.	**YES**	**NO**	**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.
6.	**YES**	**NO**	**I understand** that federal and West Virginia law mandates the recovery of Medicaid payments made after June 9, 1995, for nursing care or home and community-based waiver services and related hospital and prescription drug services on behalf of individuals age 55 or older at the time the payment is made. These laws also mandate the recovery of Medicaid paid for nursing care, care in an intermediate care facility for an intellectual for development disability or other medical institutions when an individual is determined to be permanently institutionalized. The state will not impose a lien or will defer recovery from the estate when: ● The individual qualifies for Medicaid under the adult expansion provisions of the Affordable Care Act; or ● 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.

7.	**YES**	**NO**	**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.
8.	**YES**	**NO**	**I understand** that any information given is subject to verification by an authorized representative of DHHR.
9	**YES**	**NO**	**I understand** that providing my Social Security Number (SSN) to DHHR is mandatory and is required by federal law. The only use of the SSN is in the administration of the Medicaid, WV WORKS and/or SNAP Programs, 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 apply for and/or receive benefits and not for any other person.
10.	**YES**	**NO**	**I understand** for all programs that all persons included in the benefit 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 received. Any fraudulent acts discovered may result in criminal or civil action or administrative claims against any person found to have committed such acts.
11.	**YES**	**NO**	**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.
12.	**YES**	**NO**	**I understand** that DHHR may obtain income and eligibility information from the Social Security Administration, Internal Revenue Service, Department of Homeland Security, a consumer reporting agency, the Department of Motor Vehicles, Veterans Administration, Workers' Compensation Carriers, Bureau of Employment Programs, Bureau for Child Support Enforcement, Bureau for Public Health – Division of Vital Statistics and Office of Maternal, Child and Family 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.
13.	**YES**	**NO**	**I understand** it is an eligibility requirement to cooperate with the Quality Control Reviewer in any review of my benefits. 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 permit the Quality Control Reviewer to enter my home.
14.	**YES**	**NO**	**I understand** that I may receive information and a referral to receive Family Planning Services upon request.

15.	**YES**	**NO**	**I understand** that I may receive information and a referral for Domestic Violence services upon request.
16.	**YES**	**NO**	**I agree** to notify DHHR of the following changes 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 or source of unearned income; D) There are changes in my household's amount or source of earned income or number of hours worked; E) Anyone moves in to/out of my household; F) There are changes in my household's assets, including receiving, selling, purchasing, or losing a vehicle, including recreational vehicles and equipment; G) 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. I understand that failure to provide this information may result in a penalty or sanction.
17.	**YES**	**NO**	**I understand** if I am not satisfied with any action taken on my case or I feel I have been treated unfairly because of my race, color, national origin, sex, religious creed, age, disability, political beliefs, or retaliation, I can ask for a Fair Hearing orally or in writing. 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, IGCR-3, at my local DHHR office.
18.	**YES**	**NO**	**I understand** that appointments/meetings with my Worker may include scheduled/unscheduled home visits, but I also understand that I am not required to permit the DHHR Worker to enter my home.
19.	**YES**	**NO**	**I understand** that I may be qualified to apply for low-priced telephone services called 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.
20.	**YES**	**NO**	I give my permission to DHHR to refer my family to any agency for needed services.

21.	**YES**	**NO**	I give my permission specifically to the West Virginia State Tax and Revenue Department and the Internal Revenue Service to release to 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. This includes filing status, dependents, address, income, deductions, and any other pertinent information requested by DHHR.
22.	**YES**	**NO**	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 that duplication of service(s).
23.	**YES**	**NO**	**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, audio, 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 BFA ADA Coordinator at: State BFA ADA Coordinator 350 Capitol Street, Room 730 Charleston, WV 25305 (304) 558-0628 Monday through Friday, 9:00 a.m. to 5:00 p.m.
24.	**YES**	**NO**	**I give my permission** for any of the following entities to release any information to DHHR 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; landlords, both private and public housing authorities; physicians, including psychiatrists; psychologists or other counselors; drug testing facility; hospital, including psychiatric hospitals; business concern/employers; HIV/AIDS testing services; other persons with related information. 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.
25.	**YES**	**NO**	**I understand** that my assistance group may be required to repay any benefits paid to me or on my behalf for which I was not eligible because of unintentional errors made by me or by DHHR. I also understand that if I give incorrect or false information or if I fail to report changes that I am required to report, my assistance group may be required to repay any benefits I receive and I may also be prosecuted for fraud. Additionally, I understand that all adult members of my assistance group are equally and separately responsible for an overpayment of assistance. I also understand any person who obtains or attempts to obtain benefits from 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 $10,000 and/or a jail sentence of 10 years in a state correctional facility.

26.	**YES**	**NO**	**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 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 received Medicaid.
27.	**YES**	**NO**	**I understand** it is an eligibility requirement that I must cooperate with 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 DHHR 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 DHHR will never exceed the amount of the Medicaid liability. I authorize payment of any such third-party resources directly to DHHR. If the liable third-party makes payment directly to me, I agree to refund to DHHR 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 DHHR and also authorize the release of any medical insurance information to medical provider(s) for billing purposes and the release of medical payment information to attorneys and/or insurance companies for the resolution of third-party claims.
28.	**YES**	**NO**	**I understand** that certain adult Medicaid recipients identified on this application as having a chronic substance use disorder, serious and complex medical condition, or a physical, behavioral, intellectual, or developmental disorder for which assistance is needed will have the option to choose the benefit that best fits their health needs. West Virginia Medicaid will provide additional information about selecting a benefit package with their eligibility notice by calling 1-877-716-1212.
29.	**YES**	**NO**	**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.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.

- I know that I must tell my local office if anything changes (and is different than) what I wrote on this application. I can visit www.wvpath.wv.gov or call 1-877-716-1212 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.

- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed), or I confirm that _____ is incarcerated.
  (Name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

If anyone on this application is eligible for Medicaid:

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.

- Does any child on this application have a parent living outside of the home? □ Yes □ No

- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

My right to appeal.

If I think the Health Insurance Marketplace or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid/CHIP that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at 1-800-318-2596 or my local office. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

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
Representative Completing Application Form	Date Signed