WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia Department of Health and Human Resources

Application for MEDICARE BUY-IN PROGRAM

1. *Applicant Information*

Name: _____
LAST FIRST MI

Sex: M ____ F _____ **Date of Birth:** _____

Address: _____
Route and Box or Number and Street Apt. Number

Address: _____
City/Town State Zip Code

County of Residence: _____ **Telephone:** _____

Social Security Number: _____

Medicare Claim Number: _____

Race: _____ White
_____ Black
_____ American Indian
_____ Asian
_____ Hispanic
_____ Other

Marital Status: _____ Never Married
_____ Widowed
_____ Divorced
_____ Separated
_____ Married, Living with Spouse
_____ Married, Spouse in Nursing Facility

Name of Legal Spouse: _____
LAST FIRST MI

Sex: M ____ F _____ **Date of Birth:** _____

Address: _____
Route and Box or Number and Street Apt. Number

Address: _____
City/Town State Zip Code

Social Security Number: (only if applying) _____

Medicare Claim Number: (only if applying) _____

Have you (or your legal spouse) ever applied for or received Medicaid in the past?

YES _____ **NO** _____ **If "YES," which County?** _____

Do you want help paying your Medicare Premium in any of the last 3 months? YES___

NO ___ If "YES", how many months? ____

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** _____
If "YES", please explain _____

2. *INCOME OF APPLICANT AND LEGAL SPOUSE (if living in the home)*

Please mark "YES" or "NO" for each type of income listed.

TYPE OF INCOME	YES	NO	PERSON WHO RECEIVES INCOME	AMOUNT BEFORE DEDUCTIONS	HOW OFTEN RECEIVED
Social Security					
Veteran's Pension/ Compensation					
Supplemental Security Income (SSI)					
Employment Income					
Retirement Income					
Annuity					
Other					
Other					

3. *ASSETS OF APPLICANT AND LEGAL SPOUSE (if living in the home)*

Please mark "YES" or "NO" for each asset listed.

****If you answer "YES" about assets other than a home or vehicle, you may be required to provide additional information and/or verification****

TYPE OF ASSET	YES	NO	OTHER INFORMATION	OWNER(S)
Vehicles			Model: _____. Year: _____.	
Home				
Do you own property other than your home?				
Bank Account			Type of Account:	
Bank Account			Type of Account:	
Life Insurance				
Annuity				
Other				

4. *MEDICAL INSURANCE OF APPLICANT AND LEGAL SPOUSE*

Do you (or your legal spouse) have health or medical insurance other than Medicaid?

YES _____ NO _____

If "YES," please complete the following information about your health insurance for the applicant and legal spouse, who lives in the home.

List Medical Insurance for applicant and/or legal spouse.

Person(s) Insured	Insurance Company	Policy Number	Person Paying Premium	Amount of Premium

5. RIGHTS AND RESPONSIBILITIES

Read and check "YES" or "NO" for each statement.

1.	**YES** ☐ **NO** ☐	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.
2.	**YES** ☐ **NO** ☐	**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.

3.	**YES** ☐ **NO** ☐	**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.
4.	**YES** ☐ **NO** ☐	**I agree** to let the local DHHR 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 gross unearned 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; and/or 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.
5.	**YES** ☐ **NO** ☐	**I understand** the Department will obtain income and eligibility information from the Social Security Administration, Internal Revenue Service, Department of Motor Vehicles, Veterans 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.
6.	**YES** ☐ **NO** ☐	**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. I may also file a complaint in writing to Secretary, Department of Health and Human Services, Washington, D.C. 20201.
7.	**YES** ☐ **NO** ☐	**I understand** that I will be required to cooperate with the Quality Control 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.
8.	**YES** ☐ **NO** ☐	**I give my permission** for any financial institution, government agency or department, doctor, hospital, business concern, or person to give any information to an employee of the Department which would have to do with my receiving assistance, and which is by required federal regulations and/or Department policy.

9.	**YES** ☐ **NO** ☐	**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.
10.	**YES** ☐ **NO** ☐	**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).
11.	**YES** ☐ **NO** ☐	**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.
12.	**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 resulting in ineligibility for Medicaid long term care services.
13.	**YES** ☐ **NO** ☐	**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