WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

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SUPPLEMENT TO APPLICATION FOR HEALTH COVERAGE

This supplement is being used to collect information to determine potential eligibility for health coverage.

Applicant Information

Legal Name: _____

Last First Middle

Mailing Address: _____

Street Address City State Zip Code

Physician Address: _____

Street Address City State Zip Code

Social Security Number: _____-_____-_____

Name of Legal Spouse: _____

Last First Middle

List person and date disability/blindness/incapacity began: _____ _____

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.

Name Date

INCOME OF APPLICANT AND LEGAL SPOUSE

Please mark "yes" or "no" for each type of income listed. Include any income not reported on the application for Health Coverage.

	TYPE OF INCOME	PERSON WHO RECEIVES INCOME	AMOUNT BEFORE ANY DEDUCTION	HOW OFTEN RECEIVED
☐ Yes ☐ No	Social Security			
☐ Yes ☐ No	Veteran's Pension/ Compensation			

☐ Yes ☐ No	Retirement			
☐ Yes ☐ No	Employment			

☐ Yes ☐ No	Annuity			
☐ Yes ☐ No	Other			
☐ Yes ☐ No	Does anyone in your household have impairment related work expenses: If yes, what type of expenses: _____ Amount of monthly expenses: $_____ For whom? _____ Is this person blind? ☐ Yes ☐ No			
☐ Yes ☐ No	Does any household member pay anyone else to care for a dependent child or disabled/incapacitated adult so a household member can get to work or training/school? If, **yes**, complete the following information:			

Name	Child or Disabled/ Incapacitated Adult's Name	Care Provider	Payment Amount	How Often

ASSETS OF HOUSEHOLD MEMBERS

Please mark "yes" or "no" for each type of income 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 Accounts				
Saving Accounts				
Money Market Account				
Credit Union				

Cash on Hand				
Christmas Club				
Stocks				
Bonds/Savings Bonds				
Certificates of Deposit				
Type of Asset	Yes	No	**Value**	**Owner**
Life Insurance			Policy No.:_____ Date purchased:_____ Face value: _____ Cash surrender value: _____	
Trust Funds				
IRA/Keogh				
Profit Sharing				
Escrow Account/ Home Sale				
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/3 Wheeler, UTV			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? _____

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 and date? _____

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? _____

Has anyone transferred or divested (deposed 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 name _____, date of transfer _____, transferred to _____, value of asset _____ and amount received _____.

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

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

_____ _____
Co-Applicant's Signature Date

_____ _____
Representative's Completing Application Form Date