WEST VIRGINIA I/DD WAIVER APPLICATION

Applicant Information			
First Name, MI, Last Name		Date of Birth	
Mailing Address			
Physical Address			
Phone Number		Social Security Number	
Medicaid Number (if applicable)		Gender	☐ Male ☐ Female
Email Address (if applicable)		County of Residence	State of Residence

Legal Representative Information			
☐ N/A if member is own representative	☐ Parent/relative	☐ Non-relative	☐ DHHR County
First Name, MI, Last Name		Phone Number	
Mailing Address			
Email Address (if applicable)			

Other Representative Information			
☐ Medical Power of Attorney	☐ Non-legal Representative	☐ Payee	☐ Other_____
First Name, MI, Last Name		Relationship to Applicant	
Address			
Phone Number		Email Address (if applicable)	

Applicant/Legal Representative Signature

I certify the above information is accurate and complete to the best of my knowledge. I understand the information provided in this document will be treated confidentially.

_____

Printed Name of Applicant or Legal Representative Date

_____

Signature of Applicant or Legal Representative Date

Form Submission

Fax, email or mail I/DD-1 to: APS Healthcare, Inc.-WV 100 Capitol Street, Suite 600 Charleston, WV 25301 Fax#: (866)521-6882 Email: wviddwaiver@apshealthcare.com

If you have not heard back from APS Healthcare within 5 business days, please call toll free 866-385-8920

DO NOT WRITE BELOW THIS LINE

Received by the Administrative Service Organization:

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Signature of ASO Representative Receiving Form Date