WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

MEDICARE BUY-IN PROGRAM

I. Applicant Information

Name: _____
LAST FIRST MI

Sex: M ____ F ____ **Date of Birth:** __ __ / __ __ / __ __
Month Day Year

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

Address: _____
City / Town State Zip Code

County of Residence: _____

Telephone (Where you may be reached): (__ __ __) __ __ __ - __ __ __ __
Area Code

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 (if living in the home): _____
LAST FIRST M.I.

Sex: M ____ F ____ **Date of Birth:** __ __ / __ __ / __ __
Month Day Year

Address: (If different from Applicant) _____
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, in which County:** _____

Applicant's Signature	Date Signed
Representative Completing Application Form	Date Signed