



WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Burial Billing Form

INV #: IB- \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
SFY County Sequence (4 digits)

PART I INFORMATION REGARDING DECEASED

WV DHHR County Office: \_\_\_\_\_
Address: \_\_\_\_\_ F.E.I.N.: \_\_\_\_\_
Date of Death: \_\_\_\_\_
Name of Deceased: \_\_\_\_\_ Date of Interment: \_\_\_\_\_
Address: \_\_\_\_\_ Date of Cremation: \_\_\_\_\_

IMPORTANT:

Application must be made in local DHHR office within 30 days of the date of interment or cremation.

Is the Deceased potentially eligible for Social Security or Veteran's Administration Death Benefits?

[ ] Yes [ ] No

If yes, have you made application for these benefits? [ ] Yes [ ] No

Is the Deceased a resident of West Virginia? [ ] Yes [ ] No

PART II PERSON ARRANGING FOR BURIAL SERVICE

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_
Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

PART III LIST KNOWN LIVING RELATIVES OF DECEASED AND THEIR CURRENT LOCATION

(Complete only if person arranging for burial service is a specified relative of the deceased.)

Table with 4 columns: NAME, RELATIONSHIP, COUNTY, STATE

PART IV DESIGNATED RELATIVE'S STATEMENT

I hereby certify and swear that neither the estate of the deceased nor the above-listed relatives of the deceased, including but not limited to myself, either by virtue of our combined assets or by virtue of the individual assets of each, possess sufficient resources equal to or in excess of the maximum allowable payment of \$2,450. I understand, under penalty of perjury, that I am certifying not only that I do not possess the assets to pay for the funeral expenses referenced herein, but that each statutory family member listed above does not have the ability to pay, nor do the combined assets of all the above-listed family members equal enough to pay for the funeral expenses of my deceased relative.

Signature in blue ink

Relative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

BCF DPVM Use Only
Date: \_\_\_\_\_
Doc ID: \_\_\_\_\_
By: \_\_\_\_\_

**PART V TO BE COMPLETED BY FUNERAL HOME**

Line 1.	<b>Maximum Cost of Indigent Burial Services that Funeral Home may collect:</b>			<b>\$2,450</b>
Line 2.	<b>Maximum Cost of the Indigent Burial Services that Funeral Home may collect from DHHR:</b>			<b>\$1,250</b>
Line 3.	<b>Less exempted resources received at time of burial arrangement:</b>			
	(a)	Pre-paid Burial Trust		
	(b)	Insurance Benefits		
	(c)	Worker's Compensation		
	(d)	United Mine Workers' Compensation		
	(e)	Social Security		
	(f)	Veterans' Benefits		
	(g)	Contribution from Friends and Relatives		
	(h)	Other (Specify)		
Line 4.	<b>Total Exempted Resources</b>			
Line 5.	<b>Does Line 4 exceed \$1,250? Check box.</b>			Yes <input type="checkbox"/> No <input type="checkbox"/>
Line 6.	<b>If yes, subtract the amount in Line 4 from \$2,450. This is the amount you are eligible to receive.</b>			
Line 7.	<b>If no, enter \$1,250 into the box. That is the amount you may be eligible to receive.</b>			
Line 8.	<b>Have you applied for or expect to receive any resource, not reported above? Check box.</b>			Yes <input type="checkbox"/> No <input type="checkbox"/>
Line 9.	<b>If so, please indicate the type and amount of resource, and the date you expect to receive it.</b>			
	Type of Resource		Amount of Resource	Date to be Received

This is to certify that the foregoing information is true, accurate and complete; that the services covered by this billing form were provided without regard to race, color or national origin; and that the billing is submitted in compliance with the WV Department of Health and Human Resources' rules and fee structure in effect on date of service. The charges reported herein for the funeral services provided are the usual and customary charges made by the undersigned funeral establishment for similar services provided the general public.

I further certify that if I later receive any resources as indicated in Item 9, I will reimburse the Department of Health and Human Resources for the appropriate amount if these resources, above or in addition to resources received at the time of burial, exceed the exempted resource level of \$1,200 (State Code § 9-5-18).

If more than one body is to be placed in a single casket, it must be approved by a family member or the person making the burial arrangements. The Funeral Home Director must also agree with this arrangement and must notify the Department of this type of burial arrangement prior to the burial.

I agree       I do not agree       Not applicable

FUNERAL DIRECTORS: DO NOT write in this Box

<b>DHHR District Office Use Only</b>	
Worker's Signature _____	
Date _____	
Supervisor's Signature _____	
Date _____	

Signature: (Blue Ink) \_\_\_\_\_

Title: \_\_\_\_\_

Funeral Home: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Date: \_\_\_\_\_



## INSTRUCTIONS FOR COMPLETING THE BURIAL BILLING FORM

### **PART I**      **INFORMATION REGARDING DECEASED**

**West Virginia Department of Health & Human Resources (WV DHHR) Address:** Enter local Health and Human Resources county and address.

**F.E.I.N.:** Enter the number assigned to you by the Department. If you do not have an F.E.I.N. Number, contact your local DHHR office for instructions on how to secure this number. Payment cannot be made without this number.

**Name of Deceased and address:** Self-explanatory.

**Date of Death:** Self-explanatory.

**Date of Interment:** Self-explanatory.

**Is the Deceased potentially eligible for Social Security or Veterans' Administration Death Benefits?** Indicate via "X" in "Yes" or "No" for the appropriate response.

### **PART II**      **PERSON ARRANGING FOR BURIAL SERVICE**

Enter the name of the person arranging for the burial service (e.g., relative, friend, Funeral Home Director, etc.) and the address of this person.

### **PART III**      **LIST KNOWN LIVING RELATIVES OF DECEASED AND THEIR CURRENT LOCATION**

Only list Designated Relatives of the deceased as follows and by their order of priority: children, father, brothers and sisters, and mother. Also provide the county and state of residence for each Specified Relative listed if known.

### **PART IV**      **DESIGNATED RELATIVE'S STATEMENT**

Complete and have signed only if the person arranging the burial service is a Designated Relative as defined above (child, father, brothers or sisters, or mother of deceased).

### **PART V**      **TO BE COMPLETED BY FUNERAL HOME**

**Item 1:** The maximum allowable payment established by the DHHR is \$2,450.

**Item 2:** The amount of exempted resource of \$1,200.

**Item 3:** The maximum DHHR burial rate of \$1,250.

**Item 4:** List the amount of resources available and enter the total.

**Item 5:** If the total resources available (Item 5) exceeds the amount of exempted resources (Item 3) enter the amount of excess.

**Item 6:** Subtract Item 6 from Item 4 and enter amount of payment requested from the DHHR.

**Item 7:** Enter the excess amount when the payment requested from the Department (Item 7) and/or the total resources (Item 5) exceed the actual cost incurred.

**EXAMPLE:**

Item 7 is \$1,250 and

Item 5 is \$1,300,

The excess would be  $\$1,250 - \$1,300 - \$2,400 = 0$ .

**Item 8:** Enter payment requested from the Department.

**EXAMPLE:**

\$1,150 (rate)

       - 0 (excess)

\$1,150 payment from Department

**Item 9:** Check appropriate response. It is your responsibility to explore/develop other resources. A Department representative may contact you to determine the amount of additional resources received.

**Signature:** The Funeral Home Director shall enter his signature and title in the space provided. (Blue ink only on original.) The name and address of the Funeral Home should be legibly entered in the spaces provided. The Funeral Home Director must date the form.