

Applicant Information

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES SUPPLEMENT TO APPLICATION FOR HEALTH COVERAGE

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

Legal Name: FIRST **Mailing Address:** Route and Box or Number and Street City/Town Apt. Number State Zip Code **Physical Address:** Route and Box or Number and Street If different than Mailing Apt. Number City / Town Zip Code State **Social Security Number:** Name of Legal Spouse: 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. Name: Facility: Date: YES NO 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. YES 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 PERSON WHO RECEIVES AMOUNT BEFORE ANY HOW OFTEN TYPE OF INCOME **INCOME DEDUCTION** RECEIVED YES NO □ Social Security Veteran's Pension / Compensation YES NO 🗆 YES NO \square Retirement YES NO \square **Employment**

YES		NO 🗆	А	nnuity							
YES		NO 🗆	0	ther							
YES		NO 🗆	If yes, what type of expenses:								
	Amount of monthly expenses: \$ For whom? Is this person blind? Yes No										
YES		NO 🗆				ald mambar pay an					d adult so a household
123		INO L				to work or training/s					d addit so a flouseffold
Name				Child or Disabled/ Incapacitated Adult's Name			Care Provider Payment Amount			How Often	
ASSE	TS OF	HOUSEH	OLD I	ИЕМВ	FRS						
						of asset listed.					
		, , , , , ,									
TYP	E OF	ASSET	YES	NO			VALUE				Owner
					Model	Yea	r Value		Amount Owed		
Vehicl	es				Madal	Year			Amount		
				Model	——— Yea	r —— value		Owed			
					Value			Amount			
Home	Home				value	ValueOwed					
Do you other thome?	than yo	oroperty ur			Value			Amount Owed			
Mobile	e Home	:			Model	Year	r Value		Amount –		_
Check	ing Ac	count(s)									
Saving	gs Acc	ount(s)									
Money Accou		et									
	Union										
Cash	on Har	d									
Christi	mas Cl	ub									
Stocks											
Bonds Bonds	s/Savin	gs									

TYPE OF ASSET YES				Owner		
Certificates of Deposit	1.20	NO		VALU	<u>′—</u>	
Trust Funds						
IRA/Keogh						
Profit Sharing						
Escrow Account/Home Sale						
Account/Home Sale					Face value:	
Life Insurance			Policy No.:	Date purchased:	Cash surrender value:	
Funeral/Burial Funds			1 oney 14o	Bato paronacoa.	Cach canonaci valde.	
Burial Plots						
Livestock						
Mineral Rights						
					Amount	
Business Equipment			Model	Year Value	Owed	
Farm/Tractor					Amount	
Equipment			Model	—— Year —— Value ——	Owed	
· ·						
Camper/Trailer			Model	Year Value	Amount Owed	
- Campon Hanor						
			Model	Year Value	Amount	
ATV, 3 Wheeler, UTV			Woder _	Tour — Value —	Owed	
			Model	—— Year —— Value ——	Amount	
Boat			iviodei ———	—— real —— value ——	Owed	
Other Recreational					Amount	
Vehicle			Model	Year Value	Owed	
Personal Collection						
Other						
Other						
>	1	1	l			-
		NO	TE: You may be	e required to provide additiona	I information and/or verification.	
Are any of the ass	ets lis	ted n	ot available to	the owner due to joint owner	ership, court proceedings/orders, et	c?
YES NO	If	"Yes	s," which asset	s and why?		
			,			
Are any of the ass	ets lis	ted s	et aside for hu	rial?		
YES NO			et aside for bu " which assets			
ILO INO	- 11	162	, พบบบบลออยเจ) :		

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Has anyone receive	ed a lump sum payment	t? If "Yes," list p	erson, type an	d date.						
YES NO	Name	Ty	·	Date						
Benefits, Wages freeeiving?	in your household export in your household export of Employment, Uner	nployment Bene	efits, Child Su	pport or Insurar						
	Expected Date of									
1	Name	Тур	e							
	erred or divested (dispostablished a trust fund wind wind the last fund wind arrange in the last fund wind arrange in the last fundament in the last funda		(5) years (60 r	months)?	or any other asset,	including vehicles or				
	Date of Transfer	/ 100 100 / cl cl /		ansferred to						
	Value of Asset	(mm/dd/	• • /	nount Received						
•	o or enrolled in Medicar If "Yes," complete the									
Person	Medicare Claim Number	Part A Begin Date	Part A End Date	Part B Begin Date	Part B End Date	Premium Amount				
	ements on this form have ven is true and correct					I certify that all the				
	Applica	nt's Signature		Da	_					
	Co-Applic	cant's Signature		Da	_					
	Representative Cor	mpleting Application	Form	Da						