AGED AND DISABLED WAIVER
PARTICIPANT ENROLLMENT REQUEST FORM

Please use this form to request Participant Enrollment in the Medicaid Aged & Disabled Waiver Program. **The completed form and DHS-2 must be attached to the person's record in CareConnection©.**

The Bureau of Senior Services will attach a Participant Enrollment Confirmation Notice to the person's record in CareConnection© after the person is enrolled.

There will be no Medicaid reimbursement for services provided before the date of the Participant Enrollment Confirmation Notice.

NAME: _____

DATE: _____ Date of Birth: _____

ADDRESS: _____

COUNTY: _____

MEDICAID NUMBER: _____
(Must be 11 numbers)

I, _____, confirm that _____ is at
(Print Case Manager's /PO RC Name (Print Person's Name)
least 18 years of age, a permanent resident of West Virginia, medically and financially eligible for the Program and has chosen to participate in the Medicaid Aged & Disabled Waiver Program as an alternative to Nursing Home care. Documentation verifying this is maintained in the person's file.

Case Manager/PO RC Signature: _____

CM Agency Name: _____

Phone Number: _____

Personal Attendant Agency Name: _____

Phone Number: _____