

WEST VIRGINIA I/DD WAIVER APPLICATION

Applicant must be at least 3 years of age and a WV resident on the date of submission

Applicant Information*				
First Name, MI, Last Name*		Date of Birth*		
Mailing Address*				
Phone Number*		Social Security Number*		
Medicaid Number		Gender*	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Email Address		County of Residence*		
Legal Representative Information <i>(select one of the boxes below)</i>				
<input type="checkbox"/> N/A (member is own representative)	<input type="checkbox"/> Parent of a Child under the Age of 18	<input type="checkbox"/> Medical Power of Attorney	<input type="checkbox"/> Legal Guardian	<input type="checkbox"/> WVDHHR Guardian
First Name, MI, Last Name			Phone Number	
Mailing Address				
Email Address				
Non-Legal Representative Information <i>(if applicable)</i>				
First Name, MI, Last Name		Relationship to Applicant		
Mailing Address				
Phone Number		Email Address (if applicable)		
Applicant/Legal Representative Signature				
<input type="checkbox"/> 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. I certify that the above-named applicant is a permanent resident of West Virginia.				
**Proof of residency must be included with this application including a photo ID or utility bill showing the WV physical address in the name of the applicant (or legal representative if applicable).				
**For applicants aged 18 and older who have a legal guardian, proof of guardianship must be submitted with this application.				
Printed Name of Applicant or Legal Representative*			Date*	
Signature of Applicant or Legal Representative*			Date*	
Form Submission (forms may be mailed, faxed, or emailed)				
Mail: Acentra Health – 1007 Bullitt Street, Suite 200 Charleston, WV 25301 Fax#: (866)521-6882 Email: wviddwaiver@acentra.com If you have not heard back from Acentra Health within 5 business days, please call toll free 866-385-8920.				
DO NOT WRITE BELOW THIS LINE				
<input type="checkbox"/> Application can be processed (applicant is at least 3 years of age at time of application, and proof of residency was included).				
<input type="checkbox"/> Application cannot be processed and will be closed (include description): _____				
Signature of UMC Representative Receiving Form			Date	