COPY

DHHR GREENBRIER COUNTY
150 MAPLEWOOD AVE.
LEWISBURG WV 24901

Mailing Date:

MARK

WELCH WV 24801

West Virginia Department of Health & Human Resources

Case Name: MARK
Case Number: **5090925551**
Worker Name: THOMAS
Telephone: (304) 647-7476

Your Medicaid / WV CHIP Coverage is due for review by 08/31/2022.

You can review your benefits in any one of these ways	• ***By mail***: Complete this form and mail it to the local DHHR office listed above by ***08/01/2022*** • ***Online***: Go to ***wvPATH.org*** and create or log into your PATH account. Select Begin Review button to start your review. If a Community Partner is helping you complete the review, please provide them with the following information: - Date of Birth for the person to whom the letter was addressed - Case number: ***5090925551*** - PATH Access Date: ***08/01/22*** (Note: This is not the review due date) - County: ***GREENBRIER*** • ***In-person:*** Call for an appointment ***(304) 647-7476*** or visit your local office.
How to complete this review form	1. Answer all of the questions on the form. 2. Read the information about you and each member of your household. Add any missing information. If any information has changed, add the correct information. 3. Sign and return the form by ***08/01/2022*** or complete it online at wvPATH.org. If you do not return the form by this deadline, you will lose your benefits coverage effective ***08/31/2022***. 4. If you need assistance completing your review, contact your local office.
What we need for Medicaid	We need information about each person living in your household or listed on your tax return, including: • those who get Medicaid now, • those who do not get Medicaid now but would like to apply, ***and*** • others who live in the household who do not get Medicaid and do not want to apply. We will check your answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration, and the Department of Homeland Security. If the information does not match, we may ask you to provide more information.

1 Your contact information

▼Review your contact information here.	▼Correct any wrong or missing information here.
MARK	Name *(first, middle, last & suffix)*
Home address:	***Home*** address — Apartment #
WELCH WV 24801	City *(home)* — State — Zip code
Mailing address:	***Mailing*** address — Apartment #
WELCH WV 24801	City *(mailing)* — State — Zip code
Phone:	Best phone number to reach you: ☐ Home ☐ Cell ☐ Work
Home: ***(000) 000-0000***	Number:
Other: ***(000) 000-0000***	Other phone number, if you have one: ☐ Home ☐ Cell ☐ Work
Email:	Number: Email address:

2 We need information about who files tax returns.

Will anyone in the household file a **federal tax return *next year*** to report income earned ***this year***?

☐ Yes ***If yes,*** answer all of the questions below. ☐ No ***If no,*** answer the question marked with an asterisk (*) below.

Person filing tax return: Name *(first, middle, last & suffix)*
MARK

If this person is filing a joint return, write the name of the spouse:

If this person will claim dependents, write the names of the dependents:
LARRY ***BOBBY***

Person filing tax return: Name *(first, middle, last & suffix)*

If this person is filing a joint return, write the name of the spouse:

If this person will claim dependents, write the names of the dependents:

* If anyone will be claimed as a dependent on someone else's tax return, write the name of the filer and the dependents. Answer only if different than what you reported above.

Name of filer:

Names of dependents:

3 Information about the people in your household

Person 1 ***MARK***

☐ This person is due for Medicaid/WV CHIP review

This person's Social Security number is ☒ On file ☐ Not on file

If not on file, write this person's Social Security number here: ___-___-_____

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

If this person is no longer living in the household, check here ☐

Date of birth (month/day/year): ***11/19/1993***

Gender: ☒ **Male** ☐ Female

How is this person related to you? ***SELF***

If this person wants health insurance, check here ☐ and fill out Appendix A.

If this person is an immigrant, for their immigration status:

☐ You need to provide the information below. ☒ **You *do not* need to provide the information below.**

If this person has eligible immigration status, check here ☐ and provide the document type: _____

and ID number: _____ See Appendix D for more information about eligible immigration status

Person 2 ***LARRY***

☒ **This person is due for Medicaid/WV CHIP review**

This person's Social Security number is ☒ **On file** ☐ Not on file

If not on file, write this person's Social Security number here: ___-___-_____

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

If this person is no longer living in the household, check here ☐

Date of birth (month/day/year): ***05/15/2015***

Gender: ☒ **Male** ☐ Female

How is this person related to you? ***SON***

If this person is an immigrant, for their immigration status:

☐ You need to provide the information below. ☒ **You *do not* need to provide the information below.**

If this person has eligible immigration status, check here ☐ and provide the document type: _____

and ID number: _____ See Appendix D for more information about eligible immigration status

Person 3 ***BOBBY***

☒ **This person is due for Medicaid/WV CHIP review**

This person's Social Security number is ☒ **On file** ☐ Not on file

If not on file, write this person's Social Security number here: ___-___-_____

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

If this person is no longer living in the household, check here ☐

Date of birth (month/day/year): ***09/19/2017***

Gender: ☒ **Male** ☐ Female

How is this person related to you? ***SON***

If this person is an immigrant, for their immigration status:

☐ You need to provide the information below. ☒ **You *do not* need to provide the information below.**

If this person has eligible immigration status, check here ☐ and provide the document type: _____

and ID number: _____ See Appendix D for more information about eligible immigration status

> *List the other people in your household*

Other person living in home: Name (first, middle, last & suffix):

This person's Social Security number is ☐ On file ☐ Not on file

If not on file, write the Social Security number if this person is applying for health insurance: ___-___-_____

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

If this person wants health insurance, check here ☐ and fill out Appendix A.

If this person is no longer living in the household, check here ☐

Date of birth (month/day/year):

This person is: ☐ Male ☐ Female

How is this person related to you?

Other person living in home: Name (first, middle, last & suffix):

This person's Social Security number is ☐ On file ☐ Not on file

If not on file, write the Social Security number if this person is applying for health insurance: ____-___-______

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

If this person wants health insurance, check here ☐ and fill out Appendix A.

If this person is no longer living in the household, check here ☐

Date of birth (month/day/year):

This person is: ☐ Male ☐ Female

How is this person related to you?

> List the other people on your tax return

Other person: Name (first, middle, last & suffix):

This person's Social Security number is ☐ On file ☐ Not on file

If not on file, write the Social Security number if this person is applying for health insurance: ____-___-______

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

If this person is no longer living in the household, check here ☐

Date of birth (month/day/year):

This person is: ☐ Male ☐ Female

How is this person related to you?

Other person: Name (first, middle, last & suffix):

This person's Social Security number is ☐ On file ☐ Not on file

If not on file, write the Social Security number if this person is applying for health insurance: ____-___-______

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

If this person is no longer living in the household, check here ☐

Date of birth (month/day/year):

This person is: ☐ Male ☐ Female

How is this person related to you?

Other person: Name (first, middle, last & suffix):

This person's Social Security number is ☐ On file ☐ Not on file

If not on file, write the Social Security number if this person is applying for health insurance: ____-___-______

This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.

If this person is no longer living in the household, check here ☐

Date of birth (month/day/year):

This person is: ☐ Male ☐ Female

How is this person related to you?

4 Tell us about other health insurance

> If anyone who is renewing or applying for Medicaid/WV CHIP is enrolled in some other type of health insurance, list him or her below.

Name of insurance company:

Policy number:

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance ____________

Who is the policy owner? ______________________________

Who is covered in the policy? ______________________________

Name of insurance company:

Policy number:

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance ____________

Who is the policy owner? ______________________________

Who is covered in the policy? ______________________________

Name of insurance company: | Policy number:

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance

Who is the policy owner?

Who is covered in the policy?

> If anyone on this form is offered health insurance through a job, check here ☐

> If this is a state employee benefit plan, check here ☐

5 *Tell us more about the people listed on this form*

> If anyone who is renewing or applying for health insurance has a physical, mental, emotional, or development disability , write his or her name and disability date here.

Name (first, middle, last & suffix) Disability Date

> If anyone who is renewing or applying for health insurance lives in a medical facility or nursing home, write his or her name here.

Name (first, middle, last & suffix)

> If anyone who is renewing or applying for health insurance is between the ages of 18 and 26 and was in foster care at age 18, write his or her name here.

Name (first, middle, last & suffix)

> If anyone listed on this form (whether renewing or applying for health insurance or not) is pregnant, write her information below.

Name (first, middle, last & suffix) How many babies are expected?

> If anyone who is renewing or applying is an American Indian or Alaska Native, check here and fill out Appendix B. ☐

6 *Tell us about work*

> Provide the information below for anyone in your household who is working. If someone has more than one job, tell about all jobs. Make a copy of this page if you need more space. Cross out any information that is not correct about members of your household. Write in the new information.

Person who has the job: Name (first, middle, last & suffix)

Employer name:

Employer address: City: State: ZIP code: | ***Employer*** phone number:

How often are wages or tips paid? ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly ☐ Hourly

How much does this person get paid (before taxes)? $ Average hours worked each week:

Employee begin date: Employee end date:

Person who has the job: Name (first, middle, last & suffix)

Employer name:

Employer address: City: State: ZIP code: ***Employer*** phone number:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? $ ______ Average hours worked each week:

Employee begin date: ______ Employee end date: ______

Person who has the job: Name (first, middle, last & suffix)

Employer name:

Employer address: City: State: ZIP code: ***Employer*** phone number:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? $ ______ Average hours worked each week:

Employee begin date: ______ Employee end date: ______

Person who has the job: Name (first, middle, last & suffix)

Employer name:

Employer address: City: State: ZIP code: ***Employer*** phone number:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? $ ______ Average hours worked each week:

Employee begin date: ______ Employee end date: ______

> ***If anyone in your household is self-employed, we need to know about their work.***
> ***See the instructions for more information about deductions.***
> ***Examples of self-employment: farming, odd jobs, hair stylist, lawn care, adult care & child care, etc.***

1. Name (first, middle, last & suffix):

Type of work:

How much ***gross income*** will this person get from self-employment this month? Amount: $ ______

Expenses: $ ______

Gross income means the amount of income before expenses are deducted. For more information about business expenses, see Appendix D.

2. Name (first, middle, last & suffix):

Type of work:

How much ***gross income*** will this person get from self-employment this month? Amount: $ ______

Expenses: $ ______

Gross income means the amount of income before expenses are deducted. For more information about business expenses, see Appendix D.

> If any household member's income changes from month to month, tell us this person's name and what you think he or she will be making this year.

1. Name (first, middle, last & suffix):

What do you expect his or her income to be ***this*** year? Amount: **$**

2. Name (first, middle, last & suffix):

What do you expect his or her income to be ***this*** year? Amount: **$**

7 *Tell us about other income*

> Cross out any information that is ***not correct*** about members of your household. Write in the new information.

Examples of other income: adoption assistance, black lung, child support, foster care, military allotment, money from another person, royalties, rent/utility supplement, social security, united mine workers, veterans benefits, ...

Type: SOCIAL SECURITY	***How much?***	***How often?***
Name (first, middle, last & suffix): ***MARK JACKSON***	***$ 3900.00***	☐ Hourly ☐ Every two weeks ☒ **Monthly** ☐ Weekly ☐ Twice a month ☐ Yearly
Type:	***How much?***	***How often?***
Name (first, middle, last & suffix):	***$***	☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly
Type:	***How much?***	***How often?***
Name (first, middle, last & suffix):	***$***	☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly
Type:	***How much?***	***How often?***
Name (first, middle, last & suffix):	***$***	☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly
Type:	***How much?***	***How often?***
Name (first, middle, last & suffix):	***$***	☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

> If anyone in your household has deductions, tell us what kind.

Examples of deduction are : Alimony, dependent care, impairment related work experience, or student loan interest.

Type:	***How much?***	***How often?***
Name (first, middle, last & suffix):	***$***	☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly
Other deductions	***How much?***	***How often?***
Name (first, middle, last & suffix):	***$***	☐ Weekly ☐ Monthly ☐ Every two weeks ☐ Twice a month ☐ Yearly

8 Assets

> Cross out any information that is not correct about members of your household. Write in the new information.

Examples : checking/savings accounts, stocks, bonds, burial funds, life insurance.

Type:	***How much?***	***Other Information***
Name (first, middle, last & suffix):	$	
Type:	***How much?***	***Other Information***
Name (first, middle, last & suffix):	$	
Type:	***How much?***	***Other Information***
Name (first, middle, last & suffix):	$	
Type:	***How much?***	***Other Information***
Name (first, middle, last & suffix):	$	
Type:	***How much?***	***Other Information***
Name (first, middle, last & suffix):	$	

9 Read and sign this application

RIGHTS AND RESPONSIBILITIES
West Virginia Department of Health and Human Resources (WV DHHR) Bureau for Children & Families
Division of Family *Assistance*

HEALTH COVERAGE PROGRAMS

HEALTH COVERAGE PROGRAMS

Federal law prohibits discrimination on the basis of race, color, national origin, sex, age, sexual orientation , gender identity or disability . A complaint of discrimination may be filed by visiting www.hhs . gov/ocr/office/file or by writing HHS Director, Office of Civil Rights, Room 506-F, 200 Independence Avenue , S.W., Washington , DC 20201, or call 202-619-0403 (voice) or 202-619-3257 (TDD) . HHS is an equal opportunity provider and employer .

I **understand** that as a recipient of Medicaid, I may be required to cooperate with the Bureau for Child Support Enforcement (BCSE) in child support activities, including obtaining medical support . If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

I **understand** I may receive medical assistance for my child(ren), including Early Periodic Screening, Diagnosis and Treatment (EPSDT).

I **understand** that if my income is above the Medicaid limits, I may be eligible to receive a medical card if I have excess medical bills. I **further understand** that my Worker will advise me of the amount of medical bills I have to show and that I have 30 days from the date I apply to provide the bills. The bills can be paid or unpaid and can be bills for me, my husband/wife , or dependent minor children who live with me. My Worker will explain which bills cannot be used and why .

I **understand** that a period of ineligibility for Medicaid long term care may result if resources were transferred within the sixty (60) month period prior to the date of application by the applicant or applicant's spouse . This includes transfers into certain trusts.

I understand that I am required to disclose to the State any interest my spouse or I have in an annuity .I **understand** the State must be named as the remainder beneficiary or as the second remainder beneficiary after a spouse or a minor or disabled child, for an amount at least equal to the amount of Medicaid benefits provided. Failure to comply with these requirements may be considered a transfer of resources for less than fair market value and result in ineligibility for Medicaid long term care services.

I understand that federal and West Virginia law mandates the recovery of Medicaid payments made after June 9, 1995 for nursing care or home and community-based waiver services and related hospital and prescription drug services on behalf of individuals age 55 or older at the time the payment is made. These laws also mandate the recovery of Medicaid paid for nursing care, care in an intermediate care facility for the mentally retarded or other medical institutions when an individual is determined permanently institutionalized.

The state will not impose a lien or will defer recovery from the estate when :

- The individual qualifies for Medicaid under the adult expansion provisions of the Affordable Care Act ; or
- The individual has a surviving spouse living in the home; or
- The individual has a surviving child who is under age 21 living in the home; or
- The individual has a child living in the home who meets the Social Security Act's definition of blindness or permanent and total disability; or,
- The individual's sibling has an equity interest in the home and was residing in the home for a period of at least one year immediately before the date of the individual's admission to a medical institution.The amount of the recovery is the amount Medicaid pays for these medical services for the individual.

After a proof of claim is filed against the estate, heirs affected by Estate Recovery may file a hardship waiver.

Estate Recovery is not an eligibility requirement to receive Medicaid or payment for the services.

I understand if I am in a nursing home, I must notify the local DHHR office within ten days if:

A) I am discharged from a nursing or intermediate care facility to go to another facility or return home.

B) There are changes in my gross unearned or earned income or the income of my spouse and any dependent children who live with my spouse.

C) There are changes in my assets or those of my spouse, including receiving, selling , purchasing or giving away assets.

I understand that failure to provide this information may result in a penalty or case closure.

I understand that certain adult Medicaid recipients (identified on this application as having a chronic substance use disorder; serious and complex medical condition; or a physical, behavioral, intellectual, or developmental disorder for which assistance is needed) will have the option to choose the benefit that best fits their health needs. West Virginia Medicaid will provide additional information about selecting a benefit package with their eligibility notice by calling 1-877-716-1212.

I understand it is an eligibility requirement that I must cooperate with DHHR and with any provider of medical services in pursuing any resource available to meet the medical expenses of any Medicaid recipient. I agree to assign to the DHHR benefits available to any Medicaid recipient from any third-party source as a result of injury, accident , or illness. I understand that the amount payable to DHHR will never exceed the amount of the Medicaid liability . I authorize payment of any such third party resources directly to DHHR. If the liable third-party makes payment directly to me, I agree to refund to DHHR an amount up to, but not exceeding , the amount of Medicaid liability. I understand that this repayment must be made even if my eligibility for Medicaid has stopped prior to my receiving such monies. I further authorize the release of any medical information or any information regarding medical insurance to DHHR and also authorize the release of any medical insurance information to medical provider(s) for billing purposes and the release of medical payment information to attorneys and/or insurance companies for the resolution of third-party claims.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information .
- I know that I must tell my local office if anything changes (and is different than) what I wrote on this application. I can visit www.wvPATH.org or call 1-877-716-1212 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household .
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin , sex, age, sexual orientation , gender identity, or disability . I can file a complaint of discrimination by visiting www.hhs .gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed), or I confirm that _____ is incarcerated .

(name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply . We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security , and/or a consumer reporting agency . If the information doesn't match, we may ask you to send us proof .

Renewal of coverage in future years.

To make it easier to determine my eligibility for help paying for health coverage in future years . I agree to allow the local office to use income data, including information from tax returns. The local office will send me a notice , let me make any changes , and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

☐ 5 years (the maximum number of years allowed), or for a shorter number of years.

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

My right to appeal.
If I think the Health Insurance Marketplace or Medicaid/Children's Health Insurance Program (CHIP) has made a mistake , I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace of Medicaid/CHIP that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at 1-800-321-9256 or my local office. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

I understand that any information given is subject to verification by an authorized representative of DHHR.

I understand that providing my Social Security Number (SSN) to DHHR is mandatory and is required by federal law. The only use of the SSN is in the administration of the Medicaid, WV WORKS and/or SNAP Programs, with no disclosure or use of the SSN for any other purpose. I further understand that an SSN is required only for those people who apply for and/or receive benefits and not for any other person.

I understand for all programs that all persons included in the benefit must provide a Social Security Number (SSN). The SSN will be used to check the identity of household members, prevent duplicate participation and to make mass changes. It will also be used in computer matching and program reviews or audits to make sure my household is eligible for the benefits received. Any fraudulent acts discovered may result in criminal or civil action or administrative claims against any person found to have committed such acts.

I hereby consent to be referred to the Social Security Administration to be issued a Social Security Number (SSN) and to have my SSN released only for the purposes described above.

I understand that DHHR may obtain income and eligibility information from the Social Security Administration , Internal Revenue Service, Department of Homeland Security, a consumer reporting agency , the Department of Motor Vehicles , Veteran's Administration, Workers' Compensation Carriers, Bureau of Employment Programs, Bureau for Child Support Enforcement , Bureau for Public Health - Division of Vital Statistics and Office of Maternal, Child and Family Health, Office of Inspector General, Bureau for Medical Services, Division of Rehabilitation Services and Immigration and Naturalization Service about each member of my group . This information will be obtained by the use of the Social Security Number of each recipient.

I understand it is an eligibility requirement to cooperate with the Quality Control Reviewer in any review of my benefits. This may require a home visit by the Reviewer and include additional verification of my situation , but I also understand that I am not required to permit the Quality Control Reviewer to enter my home.

I understand that I may receive information and a referral to receive Family Planning Services upon request.

I understand that I may receive information and a referral for Domestic Violence Services upon request.

I agree to notify DHHR of the following changes within 10 days if:

A) We move and/or change our address, name, or telephone number;
B) There are changes in my shelter costs because I have moved;
C) Anyone obtains/loses employment;
D) There are changes in my household's amount or source of unearned income;
E) There are changes in my household's amount or source of earned income or number of hours worked;
F) Anyone moves into/out of my household;
G) Any individual in my home starts, finishes or drops out of school or job training;
H) There are changes in my household's assets, including receiving , selling;
purchasing , or losing a vehicle , including recreational vehicles and equipment;
I) Anyone in my household receives a lump sum payment because this may affect our eligibility for continuing benefits and I may be expected to live on this income for a specific period of time;

For SNAP Benefits Only: these requirements do not apply. My reporting requirements were explained in the SNAP program section.
I understand that failure to provide this information may result in a penalty or sanction.

I understand if I am not satisfied with any action taken on my case or I feel I have been treated unfairly because of my race, color, national origin, sex, religious creed, age, disability , political beliefs, or retaliation , I can ask for a Fair Hearing orally or in writing. I **understand** that anyone may attend the Fair Hearing but, if I choose to have a lawyer attend, the Department will not pay the lawyer's fee. I also may complete a civil rights complaint form, IG-CR-3, at my local DHHR office.

I understand that appointments/meetings with my Worker may include scheduled/unscheduled home visits, but I **also understand** that I am not required to permit the DHHR Worker to enter my home.

I give my permission to DHHR to refer my family to any agency for needed services.

I give my permission specifically to the West Virginia State Tax and Revenue Department and the Internal Revenue Service to release to DHHR any and all information from my personal and/or business income tax returns for any and all tax years that would have to do with my receiving benefits and which is required by federal regulations and/or DHHR policy. This includes filing status, dependents , address, income, deductions , and any other pertinent information requested by DHHR.
I give my permission to the DHHR to provide information contained in my confidential case record, regarding me or any member of my family or assistance group, to Immigration and Naturalization Services, Social Security Administration , Bureau for Child Support Enforcement, Bureau for Medical Services , Bureau for Public Health, Division of Rehabilitation Services, or any other State or Federal Department Agency/Organization primarily for the purpose of providing me with access to the services and benefits offered by these Departments/Agencies/ Organizations in an efficient manner that allows for coordination rather that duplication of service(s).
I understand DHHR does not discriminate on the basis of disability in admission to or access to its programs or in its operations , services or activities . This notice is available in large print, on audio tape, or in Braille from any DHHR office. This Notice is provided as required by Title II of the Americans with Disabilities Act (ADA) of 1990. If I have questions I may contact the Equal Employment Opportunity and Civil Rights Compliance Officer, DHHR Office of Human Resources Employee Management, One Davis Square, Suite 400, Charleston, WV, 25301, by phone Monday through Friday, 9:00 am to 5:00 pm, at 304-558-5727 or by e mail at dhhremployeemgmt@wv.gov.
I give my permission for any of the following entities to release any information to DHHR when this information is related to my receipt of assistance , including LIEAP. I understand that only information which is required by federal regulations and/or DHHR policy will be requested and that it will be used only in determining or redetermining my eligibility for assistance or the level of assistance received. The entities that may release my information include any financial institution; government agency or department ; landlords, both private and public housing authorities ; physician, including psychiatrists, psychologist or other counselor ; drug testing facility ; hospital, including psychiatric hospitals; business concern/employers ; HIV/AIDS testing services or other person(s) with related information. This release authorizes schools to provide information including, but not limited to, enrollment , attendance, address, custodian , and all information related to the receipt of public assistance for my child(ren) under my care and custody.
I understand that my assistance group may be required to repay any benefits paid to or on behalf of it for which I was not eligible because of unintentional errors made by me or by DHHR. I also understand that if I give incorrect or false information or if I fail to report changes that I am required to report, my assistance group may be required to repay any benefits I receive and I may also be prosecuted for fraud. Additionally, I understand that all adult members of my assistance group are equally and separately responsible for an overpayment of assistance. I also understand that any person who obtains or attempts to obtain benefits from DHHR by means of a willfully false statement or misrepresentation or by impersonation or any other fraudulent device can be charged with fraud. Punishment upon a conviction may be a fine up to $10,000 and/or a jail sentence of 10 years in state correctional facility . For the SNAP Program Only - federal penalties may include a maximum fine of $250,000 and a jail sentence of up to 20 years .
I certify that all statements on this form have been read by me or read to me and that I understand them. **I certify** that all the information I have given is true and correct and I accept these responsibilities .

> Sign and date below. If you want an authorized representative or want to change the authorized representative you have now, fill out Appendix C.

X _____ _____

Signature of Household Member or Authorized Representative **Date**

Please complete, sign and return this entire form to the address on the first page by the due date.

Appendix A

Tell us about anyone in your household who wants to apply for Health Coverage. ***Do not answer*** these questions for people ***who already have Health Coverage***. If more than two people are applying, make a copy of this page.

Name of person applying: Name (first, middle, last & suffix)

> Tell us about citizenship

Is this person a U.S. citizen or U.S. national? ☐ Yes ***If yes, answer all of the questions below.***

☐ No **If no,** *go to "Tell us more information about this person"*

If this person ***is not*** a U.S. citizen or U.S. national, but has eligible immigration status check here, ☐

and write the document type: _____ and ID number: _____

See Appendix D for more information about eligible immigration status.

If this person has lived in the U.S. since 1996, check here, ☐

If this person, his or her spouse, or a parent is a veteran or an active duty member in the U.S. military, check here ☐

> Tell us more information about this person

If this person lives with at least one child under the age of 19, and is the main person taking care of this child, check here ☐

If this person is 18 years or younger and has a parent living outside of the household, check here ☐

If this person wants help paying for medical bills from the last three months, check here ☐

> Tell us about race and ethnicity. You may choose not to answer these questions.

If this person is Hispanic/Latino, check all that apply:

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other

What is this person's race? Check all that apply:

☐ White ☐ Asian Indian ☐ Korean ☐ Guamanian or Chamorro

☐ Black or African American ☐ Chinese ☐ Vietnamese ☐ Samoan

☐ American Indian or Alaska Native ☐ Filipino ☐ Other Asian ☐ Other Pacific Islander

☐ Japanese ☐ Native Hawaiian ☐ Other

Appendix B

Tell us about your American Indian or Alaska Native family member(s)

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They may not have to pay co-pays and may get special monthly enrollment periods.

If more than two people are American Indian or Alaska Native, make a copy of this page.

1. Name (first, middle, last & suffix):

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program?

☐ Yes ☐ No

If no, does this person qualify to get these services?

☐ Yes ☐ No

List any income that includes money from these sources:

- Payments from a tribe for natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

How much income? $

How often?

☐ Weekly ☐ Twice a month ☐ Every two weeks ☐ Yearly ☐ Monthly

Appendix C

You can choose an authorized representative

> An authorized representative is a trusted friend, partner, or lawyer you choose to sign your renewal form, get information about this renewal form, and act for you with this agency.

> Do you want an authorized representative? ☐ Yes ☐ No

If yes, you want an authorized representative, answer the questions below.

We show that you chose this person as your authorized representative:	Do you still want this person to be your authorized representative? ☐ Yes ☐ No *If yes,* has any of his or her information changed? ☐ Yes ☐ No

If your authorized representative's information has ***changed,*** or if you would like a ***different*** authorized representative, please write the new information here:

Name of authorized representative:

Address: Apartment #: City: State: ZIP code:

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other

Number:

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your signature: Date:

Appendix D

Eligible immigration status list

> If you see the person's status below, go back to the question and check the Yes box.

- Lawful Permanent Resident (LPR or Greencard holder)
- Asylee
- Refugee
- Cuban or Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child and parent
- Victim of Trafficking and his/her spouse, child, sibling or parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws and under the Convention against Torture (CAT)
- Individual with Non-immigrant Status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS) and Applicant for Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Family Unity beneficiary
- Deferred Action Status (Deferred Action for Childhood A)
- Applicant for Special Immigrant Juvenile Status
- Applicant for Adjustment to LPR Status
- Applicant for Asylum
- Applicant for Withholding of Deportation of Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Registry Applicants (with Employment Authorization)
- Order of Supervision (with Employment Authorization)
- Applicant for Cancellation of Removal or Suspension of Deportation (with EAD Employment Authorization)
- Applicant for Legalization under IRCA (with Employment Authorization)
- Legalization under the LIFE Act (with Employment Authorization)
- Lawful Temporary Resident
- Member of a federally-recognized Indian tribe or American Indian born in Canada
- Resident of American Samoa
- Administrative order staying removal issued by the Department of Homeland Security

Immigration document types

> Eligible non-citizens applying for health coverage also need to list their immigration document.
Below are some common types. If the document you have is not listed, you can still write its name. If you are not sure, or you have an eligible status but no document, call (304) 647-7476 so we can help.

- Permanent Resident Card (I-551, also known as Green Card)
- Temporary I-551 Stamp (on passport or I-94, I-94A)
- Immigrant Visa (with temporary I-551 language)
- Employment Authorization Card (EAD or I-766)
- Arrival/Departure Record (I-94 or I-94A)
- Arrival/Departure Record in foreign passport (I-94)
- Foreign passport
- Reentry Permit (I-327)
- Refugee travel document (I-571)
- Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- Notice of Action (I-797)
- Other document with an Alien Number or I-94 number, or other document showing you have an eligible immigration status listed above

Self-employment business expenses

> You can subtract the business expenses listed below from your gross income to get an amount for your net self-employment income.

- Car and truck expenses (for travel during the workday, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals.
- Deductible self-employment taxes.
- Cost of self-employed health insurance.
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan.

Office Use Only

Name	Program Code	Reason
LARRY	***MGCP***	***Update Periodic Reporting Status screen***
BOBBY	***MGCP***	