

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.

Applicant Information

Lega	al Nan	ne:					
			LAST		FIR	ST	MI
Mail	ing Ad	dress:					
		-	Route and Box or Number and Street	Apt. Number	City/Town	n State	Zip Code
		Address:					
If diffe	rent than	Mailing	Route and Box or Number and Street	Apt. Number	City / Towr	n State	Zip Code
Socia	al Sec	urity Nun	nber:				
Name	e of Le	egal Spou	use:				
		• •	LAST	LAST FIRST			
List p	erson	and date	disability/blindness/incapacity be	gan:			
			Name:		Date:		
Is this	s appli	cation for	anyone who needs or is already	receiving nursing h	nome services	or other specialized me	edical care?
			acility and date entered the facilit			·	
YES		-	Name:	Facility:		Date:	
Is any	yone ir	n your hou	usehold who was an SSI recipien	t in the past not red	eiving SSI no	w?	
	-	-	If "Yes", list person and	l date SSI ended.	-		
	_						
YES		NO 🗆	Name:		Date:		
			T AND LEGAL SPOUSE				
			' for each type of income listed. Include	any income not report	ed on the application	ation for Health Coverage	
		,		PERSON WHO F		AMOUNT BEFORE ANY	HOW OFTEN
			TYPE OF INCOME	INCOM		DEDUCTION	RECEIVED
YES		NO 🗆	Social Security				
			Veteran's Pension / Compensation				
YES		NO 🗆					
YES		NO 🗆	Retirement				
YES		NO 🗆	Employment				

DFA-SLA-S1 (New 10/2013)

YES		NO 🗆	Annuity							
YES		NO 🗆	Other							
YES		NO 🗆	Does anyone in your household have impairment related work expenses?							
			If yes, what type of expenses:							
			Amount of monthly expenses: \$							
			For whom? Is this person blind? I Yes I No							
YES		NO 🗆	Does any household member pay anyone else to care for a dependent child or disabled/incapacitated adult so a household							
			member can get to work or training/school? If yes, complete the following information:							
Name			Child or Disabled/ Incapacitated Adult's Name	Care Provider	Care Provider Payment Amount					

ASSETS OF HOUSEH		EMB	ERS					
Please mark "yes" or	"no" f	or ead	ch type of asse	t listed.				
TYPE OF ASSET	YES	NO	VALUE				Owner	
			Model	Year	Value		Amount Owed	
Vehicles			Model ——	Year	- Value -		Amount Owed	
Home			Value			Amount Owed		
Do you own property other than your home?			Value		/	Amount Dwed		
Mobile Home			Model	Year	Value _		Amount Owed -	
Checking Account(s)								
Savings Account(s)								
Money Market Account								
Credit Union								
Cash on Hand								
Christmas Club								
Stocks								
Bonds/Savings Bonds								

	VEC				_	Owner
TYPE OF ASSET	YES	NO		VALUI		
Certificates of Deposit						
Trust Funds						
IRA/Keogh						
Profit Sharing						
Escrow Account/Home Sale						
					Face value:	
Life Insurance			Policy No.:	Date purchased:	Cash surrender value:	
Funeral/Burial Funds						
Burial Plots						
Livestock						
Mineral Rights						
Business Equipment			Model	Year Value	Amount Owed	
Farm/Tractor Equipment			Model	Year Value	Amount Owed	
Camper/Trailer			Model	Year Value	Amount Owed	
ATV, 3 Wheeler, UTV			Model	Year Value	Amount Owed	
Boat			Model	—— Year —— Value ——	Amount Owed	
Other Recreational Vehicle			Model	Year Value	Amount Owed	
Personal Collection						
Other						
Other						
►						· · · · · · · · · · · · · · · · · · ·

NOTE: You may be required to provide additional information and/or verification.

Are any of the assets listed not available to the owner due to joint ownership, court proceedings/orders, etc? YES ____ NO ____ If "Yes," which assets and why? _____

Are any of the assets listed set aside for burial?

YES ____ NO ____ If "Yes," which assets? _____

		•••		Date					
Employment, Unen	nployment Bene	efits, Child Sup	oport or Insurar		· · · ·				
	·		Expec	ted Date of					
ne	Recei	ot							
ished a trust fund wi If yes, Name		(5) years (60 n	nonths)?	or any other asset, i	including vehicles or				
Date of Transfer			ansferred to						
value of Asset		All							
Is anyone entitled to or enrolled in Medicare Part A or Part B? YES NO If "Yes," complete the following information									
Medicare Claim Number	Part A Begin Date	Part A End Date	Part B Begin Date	Part B End Date	Premium Amount				
n is true and correct a	and I accept the		d responsibilitie	S.	I certify that all the				
	Name	Name	Name	your household expect to receive any benefits or income, such a Employment, Unemployment Benefits, Child Support or Insurar Yes," list person, type and expected date of receipt. me Type me Type d or divested (disposed of), sold, or given away property, income, or lished a trust fund within the last five (5) years (60 months)? If yes, Name Transferred to (mm/dd/yy) Date of Transfer Transferred to (mm/dd/yy) Value of Asset Amount Received r enrolled in Medicare Part A or Part B? Medicare Claim Medicare Claim Part A Begin Part A End Part B Begin Date Date Date Date Date Amount Received Transferred to Independent the following information Date Date Date Medicare Claim Part A Begin Part A End Part B Begin Date Date ents on this form have been read by me or read to me and I underst in is true and correct and I accept the aforementioned responsibilities Date Date Date Applicant's Signature Date Date Date Date Date Date	Name				