

**WEST VIRGINIA I/DD WAIVER APPLICATION**

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

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| **Applicant Information\*** | | | | | | | | |
| First Name, MI, Last Name\* |  | | Date of Birth\* | | |  | | |
| Mailing Address\* |  | | | | | | | |
| Phone Number\* |  | | Social Security Number\* | | |  | | |
| Medicaid Number |  | | Gender\* | | | Male  Female | | |
| Email Address |  | | County of Residence\* | | |  | | |
| **Legal Representative Information** *(select one of the boxes below)* | | | | | | | | |
| N/A (member is own representative) | Parent of a Child under the Age of 18 | Medical Power of Attorney | | | Legal Guardian | | | WVDHHR Guardian |
| First Name, MI, Last Name |  | | | | Phone Number | | |  |
| Mailing Address |  | | | | | | | |
| Email Address |  | | | | | | | |
| **Non-Legal Representative Information** *(if applicable)* | | | | | | | | |
| First Name, MI, Last Name |  | | | Relationship to Applicant | | |  | |
| Mailing Address |  | | | | | | | |
| Phone Number |  | | | Email Address (if applicable) | | |  | |
| **Applicant/Legal Representative Signature** | | | | | | | | |
| 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](mailto: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** | | | | | | | | |
| Application can be processed (applicant is at least 3 years of age at time of application, and proof of residency was included).  Application cannot be processed and will be closed (include description): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of UMC Representative Receiving Form Date | | | | | | | | |