

**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**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 |