APPLICANT INFORMATION *(Name of parent, guardian, or other person who lives with children.)*

Name: _____
First Name *Middle Initial* *Last Name*

Mailing Address: _____
Route/Box Number *or* *Street/Apt. Number*

_____
County *City/Town* *State* *Zip*

Address Where You Live: *(If different from above.)* _____
Route/Box Number *or* *Street/Apt. Number*

Telephone: _____
Home Number *Work Number (If you can take calls.)* *Emergency Number*

WV Health Care Coverage for Kids & Expectant Moms

Check all that apply.

☐ West Virginia CHIP Children's Health Insurance Program

☐ Office of Maternal, Child & Family Health, West Virginia

WVCHIP Premium Plan ☐ ☐

Health & Human Resources Medicaid
Bureau for Medical Services

HOUSEHOLD INFORMATION (Note: Social Security #'s and U.S. Citizenship must be filled in for persons to be insured, but optional for others in household.)

	List below all of the people who live with you (include yourself) and fill in the spaces by each name. *If there are more than 7 in your household, please fill out another copy of Page 1 for other names.*	Birthdate *(Fill in the Month, Day, and Year)* **MO-DA-YEAR**	Social Security Number	U.S. Citizen **Circle One**	Sex **Circle One**	Relation of Applicant To Others in Household (Example: Mother, Father, Husband, Wife, Step-Parent, Grandparent, etc.)	Race **Circle All That Apply** B) Black/African American C) Asian **&** White D) Black/African American **&** White E) Asian F) American Indian/Alaska Native **&** Black/African American G) Asian **&** Black/African American I) American Indian/Alaska Native N) American Indian/Alaska Native **&** White P) Native Hawaiian/Other Pacific Islander W) White	Ethnicity 1) Hispanic or Latino 2) None of the Above **Circle One**	Primary Language 1) English 2) Spanish 3) Serbo-Croatian 4) French 5) Haitian-Creole 6) Vietnamese 7) Other **Circle One**
1				Y N	M F		B C D E F G I N P W	1 2	1 2 3 4 5 6 7
2				Y N	M F		B C D E F G I N P W	1 2	1 2 3 4 5 6 7
3				Y N	M F		B C D E F G I N P W	1 2	1 2 3 4 5 6 7
4				Y N	M F		B C D E F G I N P W	1 2	1 2 3 4 5 6 7
5				Y N	M F		B C D E F G I N P W	1 2	1 2 3 4 5 6 7
6				Y N	M F		B C D E F G I N P W	1 2	1 2 3 4 5 6 7
7				Y N	M F		B C D E F G I N P W	1 2	1 2 3 4 5 6 7

INSURANCE: Do any children currently have insurance (except Medicaid)? ☐ Yes ☐ No List insurer and premiums paid within the last 3 months.
If you currently have insurance or have lost insurance in the past 3 months, please attach a copy of your Insurance Card (front & back).

	Insurance Company Name	Ins. Policy #	Type of Ins. Plan	List Everyone Covered Under Policy	Premium Amt.	Date Coverage Started	Date Coverage Ended
1							
2							

Is anyone in your household covered or eligible for coverage under the WV Public Employees Insurance Program? ☐ Yes ☐ No If yes, please specify who:
Does any person for whom you are applying have medical bills in the 3 months prior to this month? ***(Backdated coverage applies to Medicaid ONLY.)*** ☐ Yes ☐ No

☐ **Check this box if you are applying under an insurance exception.**
Exception because: ☐ Premium is over 10% of income? ☐ Other, specify: _____

➢ **NATIVE AMERICAN CO-PAYMENT EXCLUSION:** If you are a Native American, you can be excluded from co-payments. Call 1-877-982-2447 to confirm you are a member of a federally recognized tribe. This does not apply to individuals covered under WV Medicaid.

WV CHILDREN'S HEALTH INSURANCE APPLICATION

DOES ANYBODY IN YOUR HOME HAVE INCOME FROM ANY OF THE FOLLOWING?				
Type of Income	You must ✓ Yes or No for each item.	Gross Amount – Before Deductions	How often received?	Who receives it?
Job Wages – **Mother**	☐ Yes ☐ No			
Job Wages – **Father**	☐ Yes ☐ No			
Job Wages – **Child Who Works**	☐ Yes ☐ No			
Job Wages – **Spouse of Child**	☐ Yes ☐ No			
Dividends/Interest/Royalties	☐ Yes ☐ No			
Farming	☐ Yes ☐ No			
Self-Employment *Please attach business expenses for month applying.*	☐ Yes ☐ No			
Rental Income	☐ Yes ☐ No			
Retirement or Pension	☐ Yes ☐ No			
Social Security Check	☐ Yes ☐ No			
SSI	☐ Yes ☐ No			
UMWA Benefits	☐ Yes ☐ No			
WV WORKS Check	☐ Yes ☐ No			
Veteran's Benefits	☐ Yes ☐ No			
Military Allotment	☐ Yes ☐ No			
Job Corps Allotment	☐ Yes ☐ No			
Child Support	☐ Yes ☐ No			
Spousal Support	☐ Yes ☐ No			
Contributions from Friends/Relatives	☐ Yes ☐ No			
Unemployment Benefits	☐ Yes ☐ No			
Workers' Compensation	☐ Yes ☐ No			
Student Loans, Grants	☐ Yes ☐ No			
Roomers or Boarders	☐ Yes ☐ No			
Insurance	☐ Yes ☐ No			
Other – (such as baby-sitting, odd jobs, etc.)	☐ Yes ☐ No			

➢ ***Not submitting documents needed to verify your income or other statements may cause delay or denial of your application. (See application guide.)***

EXPECTING A CHILD?

(This child can be counted as part of your family size now.)

1. Is any member of your household pregnant?
   ☐ Yes ☐ No (If yes, due date: (mm/dd/yyyy) _____)
2. What is the name of the individual pregnant?
   Parent _____ Child _____
3. Has the pregnancy been medically verified?
   ☐ Yes ☐ No
4. Have you been told you are carrying more than one baby?
   ☐ Yes ☐ No (If yes, how many? _____)
5. Are you seeing a doctor? ☐ Yes ☐ No
6. Is anyone else in the household pregnant? ☐ Yes ☐ No
   If yes, please attach the above information for that person on a separate sheet.

CHILD CARE/DEPENDENT ADULT CARE

This information may lower your countable income.

Caretaker Name	Monthly Amt. Pd.	How Often?	Care for Whom?

SIGNING THIS FORM MEANS THAT I UNDERSTAND THE FOLLOWING PROTECTIONS AND RESPONSIBILITIES: ι

1) Information on this form is confidential and can only be used as necessary to determine eligibility and administer the programs; **2)** The agency must determine eligibility and issue a decision within 13 days of receiving your application, unless you are notified that your application is being held waiting for you to provide other information; **3)** No person can be denied benefits as a result of race, color, sex, age, disability, religion, national origin, or political belief; **4)** I may request a Fair Hearing before a State Hearings Officer if I disagree with a decision on my eligibility or, if the decision on my eligibility was not reached within a proper time frame; **5)** This form is used to determine health care coverage under WVCHIP or Medicaid only, but there may be other benefits for which I may be eligible or apply by contacting my local DHHR Office; **6)** To correctly determine benefits, information may be computer matched through social security number with the IRS, Social Security Administration, US Department of Labor, other governmental agencies or private financial institutions; social security numbers will also be given to the US Immigration and Naturalization for named applicants only, but not other household members; **7)** Anyone receiving benefits under WVCHIP or Medicaid who receives repayment of medical and/or hospital services from another insurance company, agrees that all medical payments or support paid or owed as a result of a court order, must be sent to the State for repayment for past or current medical expenses paid on their behalf by WVCHIP or Medicaid. This reassignment of funds continues for as long as any person listed on the application continues to receive WVCHIP or Medicaid benefits; **8)** I may be required to make repayments that result from incorrect or false information or failing to report changes on this form; Willfully giving false statements, (misrepresentations, impersonations or other fraudulent devices), can result in charges of fraud. Convictions for fraud are punishable by fines of up to $5,000 and/or jail sentences of up to five years.

_____ _____

Applicant's Signature **Date**

ι Large print copy of this statement is available or can be read to the applicant by calling 1-877-982-2447.