Table of Contents

State Name: West Virginia

State Plan Amendment (SPA) #: 13-0015-MM2

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

SWIFT #012420144022

FEB 12 2014

Nancy V. Atkins, MSN, RNC, NP
Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3706

Dear Commissioner Atkins:

Enclosed is an approved copy of West Virginia's (WV) State Plan Amendment (SPA) WV 13-0015-MM2, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on November 22, 2013. WV SPA 13-0015-MM2 incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into West Virginia's Medicaid State Plan in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of WV SPA 13-0015-MM2 includes full approval of the State's alternative paper application used to apply for multiple human service programs. The State is also using an interim alternative single streamlined online application and by March 31, 2014 will implement a revised alternative single streamlined online application that addresses CMS's concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the following S94 State Plan pages and attachments to be incorporated within a separate section at the end of West Virginia's approved State Plan:

- S94, pages S94-1, S94-2
- Attachment 1 – State of West Virginia alternative multi-benefit paper application
- Attachment 2 – Statement of use with respect to the alternative single, streamlined online application

In addition, enclosed is a summary of State Plan pages which are superseded by WV SPA 13-0015-MM2, which should also be incorporated into a separate section in the front of the State Plan.

- Superseding Pages of State Plan Material, 13-0015-MM2

The CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. We continue to be available to provide technical assistance. If you have any questions about your application, please contact Dena Greenblum at 410-786-8684 or Dena.Greenblum@cms.hhs.gov. If you have any questions about this letter or need any additional information, please contact Margaret Kosherzenko at 215-861-4288 or Margaret.Kosherzenko@cms.hhs.gov.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

SWIFT #012420144022

FEB 12 2014

Nancy V. Atkins, MSN, RNC, NP
Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3706

Dear Commissioner Atkins:

Dear Ms. Atkins:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of State Plan Amendment (SPA) 13-0015-MM2, which was submitted to CMS on November 22, 2013. Our review of this submission included a review of West Virginia's alternative single streamlined online application.

Through March 31, 2014 the State is using an interim alternative single streamlined online application. This interim online application will need to be revised to reflect the following changes.

Necessary changes:	**Date by which changes will be completed:**
The addition of language to clarify that SSNs are optional for non-applicants.	March 31, 2014
Clarification of income types countable under MAGI for Medicaid and CHIP determinations.	March 31, 2014

Please submit the revised alternative single, streamlined online application to CMS for review no later than March 10, 2014 to ensure approval by March 31, 2014. We continue to be available to provide technical assistance.

If you have any questions about your application, please contact Dena Greenblum at Dena.Greenblum@cms.hhs.gov or 410-786-8684. If you have any questions about this letter or need any additional information, please contact Margaret Kosherzenko at 215-861-4288 or Margaret.Kosherzenko@cms.hhs.gov.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **West Virginia**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

WV-13-0015

Proposed Effective Date

10/01/2013 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

Eligibility Process

Governor's Office Review

Governor's office reported no comment

Comments of Governor's office received

Describe:

No reply received within 45 days of submittal

Other, as specified

Describe:

Not Required.

Signature of State Agency Official

Submitted By:	**Sarah Young**
Last Revision Date:	**Feb 10, 2014**
Submit Date:	**Nov 22, 2013**

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0015 MM2	**STATE:** West Virginia
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S94 – Eligibility Process	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Section 2, Page 10, section 2.1(a), TN 94-15 Effective date: July 1, 1994, Approved: June 30, 1995 Section 2, Page 11a, section 2.1(d), TN 91-13 Effective date: October 1, 1991, Approved: January 1, 1992

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process	S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☒ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Indicate the other electronic means below:

	Name of Method	Description	
+	Fax	Paper application may be sent via Facsimile	x

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☒ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application	☒ Online Application
TRANSMITTAL NUMBER: WV 13-0015 MM	**STATE:** West Virginia

Through March 31, 2014, the state is using an interim online alternative single streamlined application. After March 31, 2014, the state will use a revised online alternative single streamlined application, which will address the issues outlined in the CMS letter concerning the state's application. The revised application will be incorporated by reference into the state plan.

WEST VIRGINIA Department of Health & Human Resources

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
APPLICATION FOR BENEFITS

The application will be considered if it contains a minimum of the Name, Address, and Signature below. The amount of SNAP benefits will be determined from the date of application. The amount of cash assistance will be determined from the date eligibility requirements are met, including signing the Personal Responsibility Contract (PRC), Self-Sufficiency Plan (SSP), and participating in orientation.

Your Name (first, middle, last)			**Birth Date (month, day, year)**
Mailing Address		**Street Address, if Different**	
City	**State**	**Zip Code**	**Telephone/Message Number During the Day**

HEALTH COVERAGE ONLY

☐ Yes ☐ No	Do you want to get information about this application by email?
	Email address: County:
	Health Care and SNAP: Preferred spoken or written language (if not English):
☐ Yes ☐ No	Have you had a Presumptive Eligibility Period at a Hospital Emergency room in the last 12 months?
	If so, what is your temporary MAID Number (can be found on your card):

AUTHORIZED REPRESENTATIVE/LEGAL GUARDIAN/PROTECTIVE PAYEE (HEALTH COVERAGE, SNAP, WV WORKS)

You may appoint someone outside your household to act for your household to make an application and to be interviewed. This person should know your household's situation well enough to give any information needed to determine your eligibility and will include information from your tax returns. You are still responsible for the information that anyone acting as your authorized representative gives, including any information that may be incorrect. If you want to appoint someone for this, write his/her name and address here. For health coverage only, complete Appendix C.

Name: Address:

SNAP EXPEDITED SERVICES

You may receive SNAP benefits within 7 calendar days if: your SNAP household has less than $150 in monthly gross income and liquid resources such as cash, checking or savings accounts are less than or equal to $100; or your rent/mortgage and utilities are more than your household's combined monthly income and liquid resources; or a member of your household is a migrant or seasonal farm worker.

1. How much money do the members of your household have in cash or a bank account? $ _____
2. What is the **total** amount of income you expect your household to receive this month? $ _____
3. What is your **current** monthly rent/mortgage payment? $ _____ Utilities $ _____
4. Is anyone in your household a migrant or seasonal farm worker? ☐ Yes ☐ No

   If yes, answer these questions: Did all of your household income stop recently? ☐ Yes ☐ No

   Does anyone in your household expect to receive income from a new source this month? ☐ Yes How ☐ No

Have you or anyone in your household received or do you expect to receive SNAP benefits from any other state this month?

☐ Yes Where ☐ No

Your Signature	**Date**

DFA-2 (Revised 1/2014)

BENEFIT QUESTIONS **Please check the box beside the benefit(s) you want to receive (HEALTH COVERAGE, SNAP, WV WORKS)**

☐ WV WORKS (Cash Assistance)
☐ Health Coverage (Medicaid/CHIP/Marketplace)
☐ SNAP (Supplemental Nutrition Assistance Program)
☐ EA (Emergency Assistance)
☐ LIEAP (Low-Income Energy Assistance, when available)
☐ Emergency LIEAP (Low-Income Energy Assistance, when available)
☐ SCA (School Clothing Allowance, when available)

Evaluated for automatic issuance of LIEAP ☐ Yes ☐ No

Evaluated for automatic issuance of SCA ☐ Yes ☐ No

Have you or any member of your household had any unpaid medical expenses in any of the past three (3) months? ☐ Yes ☐ No

If yes, do you wish to have your Medicaid backdated to cover these expenses? ☐ Yes ☐ No If yes, indicate starting date

HOUSEHOLD MEMBER No. 1 **List all individuals who live in your household (HEALTH COVERAGE, SNAP, WV WORKS)**
For health coverage only, list anyone on your same federal income tax return

LEGAL NAME (Last, First, MI)

* Social Security Number or date applied for one	Date of birth	Sex	Marital Status	Relationship to you	Buy/cook food together	*Citizenship Y/N	*Alien Registration Number	In school Y/N	Last grade attended	High School Diploma or GED	Full time student Y/N

****If Hispanic, Latino, ethnicity (OPTIONAL – check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

****Race (OPTIONAL – check all that apply.)**
☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

*~~For SNAP,~~ You may leave this blank for anyone not in the assistance request. We need this if you are applying for benefits and have an SSN or alien registration number for health coverage. Providing your SSN can be helpful even if you are not applying since it can speed up the application process.

**Not required. This information is voluntary. Your benefits will not be affected if you do not answer the race and/or ethnicity questions above. Giving us this information will help ensure program benefits are distributed without regard to race, color, or national origin.

HEALTH COVERAGE ONLY

☐ Yes	☐ No	Do you plan to file a federal income tax return **NEXT YEAR**? If **yes**, please answer questions a – c. If **no**, skip to question c.
☐ Yes	☐ No	a. Will you file jointly with a spouse? If yes, name of spouse:
☐ Yes	☐ No	b. Will you claim any dependents on your tax return? If yes, list name of dependents:
☐ Yes	☐ No	c. Will you be claimed as a dependent on someone's tax return? If **yes**, list name of tax filer: _____ How are you related to tax filer
☐ Yes	☐ No	Is this individual applying for health coverage?
☐ Yes	☐ No	Are you pregnant? If yes, how many babies are expected during this pregnancy? _____
☐ Yes	☐ No	Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, et or live in a medical facility or nursing home?
☐ Yes	☐ No	Do you live with at least one child under the age of 19, and are you the main person taking care of this child?
☐ Yes	☐ No	Were you in foster care in West Virginia at age 18 or older?
☐ Yes	☐ No	Were you an SSI recipient in the past but not receiving SSI now? If **yes**, date SSI ended:
☐ Yes	☐ No	Are you an American Indian or Alaska Native? If **yes,** complete Appendix B.

HOUSEHOLD MEMBER No. 2 List all individuals who live in your household (HEALTH COVERAGE, SNAP, WV WORKS) For health coverage only, list anyone on your same federal income tax return											
LEGAL NAME (Last, First, MI)											
* Social Security Number or date applied for one	Date of birth	Sex	Marital Status	Relationship to you	Buy/cook food together	*Citizenship Y/N	*Alien Registration Number	In school Y/N	Last grade attended	High School Diploma or GED	Full time student Y/N

**If Hispanic, Latino, ethnicity (OPTIONAL – check all that apply.)

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

**Race (OPTIONAL – check all that apply.)

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

* ~~For SNAP,~~ You may leave this blank for anyone not in the assistance request. We need this if you are applying for benefits and have an SSN or alien registration number for health coverage. Providing your SSN can be helpful even if you are not applying since it can speed up the application process.
**Not required. This information is voluntary. Your benefits will not be affected if you do not answer the race and/or ethnicity questions above. Giving us this information will help ensure program benefits are distributed without regard to race, color, or national origin.

HEALTH COVERAGE ONLY		
☐ Yes	☐ No	Do you plan to file a federal income tax return **NEXT YEAR**? If **yes**, please answer questions a – c. If **no**, skip to question c.
☐ Yes	☐ No	a. Will you file jointly with a spouse? If yes, name of spouse:
☐ Yes	☐ No	b. Will you claim any dependents on your tax return? If yes, list name of dependents:
☐ Yes	☐ No	c. Will you be claimed as a dependent on someone's tax return? If **yes**, list name of tax filer: _____ How are you related to tax filer
☐ Yes	☐ No	Is this individual applying for health coverage?
☐ Yes	☐ No	Are you pregnant? If yes, how many babies are expected during this pregnancy? _____
☐ Yes	☐ No	Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, et or live in a medical facility or nursing home?
☐ Yes	☐ No	Do you live with at least one child under the age of 19, and are you the main person taking care of this child?
☐ Yes	☐ No	Were you in foster care in West Virginia at age 18 or older?
☐ Yes	☐ No	Were you an SSI recipient in the past but not receiving SSI now? If **yes**, date SSI ended:
☐ Yes	☐ No	Are you an American Indian or Alaska Native? If **yes**, complete Appendix B.

HOUSEHOLD MEMBER No. 3 List all individuals who live in your household (HEALTH COVERAGE, SNAP, WV WORKS) For health coverage only, list anyone on your same federal income tax return											
LEGAL NAME (Last, First, MI)											
* Social Security Number or date applied for one	Date of birth	Sex	Marital Status	Relationship to you	Buy/cook food together	*Citizenship Y/N	*Alien Registration Number	In school Y/N	Last grade attended	High School Diploma or GED	Full time student Y/N

**If Hispanic, Latino, ethnicity (OPTIONAL – check all that apply.)
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

**Race (OPTIONAL – check all that apply.)

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

* ~~For SNAP,~~ you may leave this blank for anyone not in the assistance request. We need this if you are applying for benefits and have an SSN or alien registration number for health coverage. Providing your SSN can be helpful even if you are not applying since it can speed up the application process.
**Not required. This information is voluntary. Your benefits will not be affected if you do not answer the race and/or ethnicity questions above. Giving us this information will help ensure program benefits are distributed without regard to race, color, or national origin.

HEALTH COVERAGE ONLY		
☐ Yes	☐ No	Do you plan to file a federal income tax return **NEXT YEAR**? If **yes**, please answer questions a – c. If **no**, skip to question c.
☐ Yes	☐ No	a. Will you file jointly with a spouse? If yes, name of spouse:
☐ Yes	☐ No	b. Will you claim any dependents on your tax return? If yes, list name of dependents:
☐ Yes	☐ No	c. Will you be claimed as a dependent on someone's tax return? If **yes**, list name of tax filer: _____ How are you related to tax filer
☐ Yes	☐ No	Is this individual applying for health coverage?
☐ Yes	☐ No	Are you pregnant? If yes, how many babies are expected during this pregnancy? _____
☐ Yes	☐ No	Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, et or live in a medical facility or nursing home?
☐ Yes	☐ No	Do you live with at least one child under the age of 19, and are you the main person taking care of this child?
☐ Yes	☐ No	Were you in foster care in West Virginia at age 18 or older?
☐ Yes	☐ No	Were you an SSI recipient in the past but not receiving SSI now? If **yes**, date SSI ended:
☐ Yes	☐ No	Are you an American Indian or Alaska Native? If **yes,** complete Appendix B.

HOUSEHOLD MEMBER No. 4 List all individuals who live in your household (HEALTH COVERAGE, SNAP, WV WORKS)
For health coverage only, list anyone on your same federal income tax return

LEGAL NAME (Last, First, MI)

* Social Security Number or date applied for one	Date of birth	Sex	Marital Status	Relationship to you	Buy/cook food together	*Citizenship Y/N	*Alien Registration Number	In school Y/N	Last grade attended	High School Diploma or GED	Full time student Y/N

****If Hispanic, Latino, ethnicity (OPTIONAL – check all that apply.)**
☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

****Race (OPTIONAL – check all that apply.)**

☐ White	☐ American Indian or Alaska Native	☐ Filipino	☐ Vietnamese	☐ Guamanian or Chamorro
☐ Black or African American	☐ Asian Indian	☐ Japanese	☐ Other Asian	☐ Samoan
	☐ Chinese	☐ Korean	☐ Native Hawaiian	☐ Other Pacific Islander
				☐ Other _____

* ~~For SNAP,~~ you may leave this blank for anyone not in the assistance request. We need this if you are applying for benefits and have an SSN or alien registration number for health coverage. Providing your SSN can be helpful even if you are not applying since it can speed up the application process.
**Not required. This information is voluntary. Your benefits will not be affected if you do not answer the race and/or ethnicity questions above. Giving us this information will help ensure program benefits are distributed without regard to race, color, or national origin.

HEALTH COVERAGE ONLY

☐ Yes	☐ No	Do you plan to file a federal income tax return **NEXT YEAR**? If **yes**, please answer questions a – c. If **no**, skip to question c.
☐ Yes	☐ No	a. Will you file jointly with a spouse? If yes, name of spouse:
☐ Yes	☐ No	b. Will you claim any dependents on your tax return? If yes, list name of dependents:
☐ Yes	☐ No	c. Will you be claimed as a dependent on someone's tax return? If **yes**, list name of tax filer: _____ How are you related to tax filer
☐ Yes	☐ No	Is this individual applying for health coverage?
☐ Yes	☐ No	Are you pregnant? If yes, how many babies are expected during this pregnancy? _____
☐ Yes	☐ No	Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, et or live in a medical facility or nursing home?
☐ Yes	☐ No	Do you live with at least one child under the age of 19, and are you the main person taking care of this child?
☐ Yes	☐ No	Were you in foster care in West Virginia at age 18 or older?
☐ Yes	☐ No	Were you an SSI recipient in the past but not receiving SSI now? If **yes**, date SSI ended:
☐ Yes	☐ No	Are you an American Indian or Alaska Native? If **yes,** complete Appendix B.

For additional household members, make copies of this page.

HOUSEHOLD INFORMATION (SNAP)			
☐ Yes	☐ No	1	Is anyone a boarder?
☐ Yes	☐ No	2	Is anyone a foster child or foster adult?
☐ Yes	☐ No	3	Is anyone on strike?
☐ Yes	☐ No	4	Is anyone disabled?

HOUSEHOLD'S DECLARATION INQUIRY (WV WORKS and SNAP)			
☐ Yes	☐ No	1	Have you or any member of your household been convicted of trading SNAP benefits for drugs after September 22, 1996?
☐ Yes	☐ No	2	Have you or any member of your household been convicted of buying or selling SNAP benefits over $500 after September 22, 1996?
☐ Yes	☐ No	3	Have you or any member of your household been convicted of a felony under Federal or State law for possession, use or distribution of a controlled substance (felony drug conviction) after August 22, 1996?
☐ Yes	☐ No	4	Have you or any member of your household been convicted of fraudulently receiving duplicate SNAP benefits in any State after September 22, 1996?
☐ Yes	☐ No	5	Are you or any member of your household hiding or running from the law to avoid prosecution, being taken into custody or going to jail for a felony crime or attempted felony crime, or violation of parole or probation?
☐ Yes	☐ No	6	Have you or any member of your household been convicted of trading SNAP benefits for guns, ammunitions, or explosive after September 22, 1996?
If you answered "YES" to any of the above questions, please explain here.			

Verification of some information is required. Vehicles are excluded for SNAP.
If you have an expense that you do not report and/or provide proof of, you will not receive the deduction for the expense.

ASSETS OF HOUSEHOLD MEMBERS

Please mark "yes" or "no" for each type of asset listed.

TYPE OF ASSET	YES	NO	VALUE	Owner
Vehicles			Model _____ Year ____ Value _____ Amount Owed _____ Model Year Value Amount Owed	
Home			Value Amount Owed	
Do you own property other than your home?			Value Amount Owed	
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											
Certificates of Deposit											
Trust Funds											
IRA/Keogh											
Profit Sharing											
Escrow Account/Home Sale											
Life Insurance			Policy No:			Face Value:			Cash 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, UTV or 3 Wheeler			Model		Year		Value		Amount Owed		
Boat			Model		Year		Value		Amount Owed		
Personal Collection											
Other											

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? _____

LONG-TERM CARE (MEDICAID)		
Is this application for anyone who needs nursing home or other specialized medical care? ☐ Yes ☐ No If yes, Facility name:		
Date of admission (month, day, year):		
Is this person expected to return home within six (6) months of date of admission? ☐ Yes ☐ No		
Has anyone transferred or divested (disposed of), sold, or given away property or any other asset, including vehicles or life insurance or established a trust fund within the last five (5) years (60 months)? ☐ Yes ☐ No		
If yes, name:		
Date of Transfer (month, day, year):		
Transferred to:	Value of Asset $	Amount Received $

EARNED INCOME (HEALTH COVERAGE, SNAP, WV WORKS)

Does anyone in your household receive any income from employment? ☐ Yes ☐ No If yes, list all gross income **before deductions** (such as full or part-time employment, self-employment, baby-sitting, odd jobs, days work, roomer/boarder payments, etc.)

NAME	NAME OF EMPLOYER (Include address and phone number)	RATE OF PAY	NUMBER OF HOURS WORKED	AMOUNT PER PAY PERIOD	HOW OFTEN RECEIVED

In the past year, did any household member: ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

SELF EMPLOYMENT (HEALTH COVERAGE, SNAP, WV WORKS)

Name	Type of Name of Business	Monthly Income Received	List Business Expenses and Amounts
Does this person receive this self-employment income regularly?			

OTHER INCOME AND BENEFITS (HEALTH COVERAGE, SNAP, WV WORKS)

If anyone in your household receives, applied for or was denied any benefit listed below, place a check in the box next to the benefit.

- ☐ Alimony
- ☐ Railroad Retirement
- ☐ Worker's Compensation
- ☐ Military Allotment
- ☐ Lump Sum Cash Amounts
- ☐ Adoption Assistance
- ☐ Child Support
- ☐ Veteran's Pension/Benefit
- ☐ Pension or Retirement
- ☐ Money from Rental Income
- ☐ Social Security
- ☐ Rent or Utility Supplement
- ☐ Unemployment Benefits
- ☐ Union Benefits
- ☐ Black Lung Benefits
- ☐ Temporary Cash Assistance
- ☐ SSI
- ☐ Education Grants or Loans
- ☐ Disability/Sick, Maternity Benefits
- ☐ Money from friends or relatives
- ☐ Mineral Rights
- ☐ Student Income
- ☐ Foster Care Payments
- ☐ Interest Dividends from Stocks, Bonds, Savings or Other Investments

If you checked yes to receiving, applying for or being denied any benefits, fill in below.

NAME	TYPE OF BENEFIT	APPLIED		CLAIM NUMBER	RECEIVED		AMOUNT
		Yes	No		Yes	No	
		Yes	No		Yes	No	
		Yes	No		Yes	No	
		Yes	No		Yes	No	

YEARLY INCOME (HEALTH COVERAGE,SNAP, WV WORKS)

Complete only if your income changes from month to month

Your total income this year: $ Your total income next year, if you think it will be different: $

INCOME DEDUCTIONS (HEALTH COVERAGE)

Does any household member pay for certain things that can be deducted on a federal income tax return? Telling us about them could make the cost of health coverage a little lower. **NOTE:** You shouldn't include a cost you already considered in your answer to net self-employment.

Name	Type	Amount Paid	How Often?
	☐ Alimony		
	☐ Student Loan Interest		
	☐ Other deductions Type:		

POTENTIAL RESOURCES (HEALTH COVERAGE, SNAP, WV WORKS)

☐ Yes	☐ No	Do you or anyone who lives in your household expect to receive any benefits or income, such as, but not limited to, Social Security Benefits, Wages from Employment, Unemployment Benefits, Child Support or Insurance Settlements that you are not now receiving? If yes, who: Type: Expected Date of Receipt: To: (mm/dd/yyyy)
		If yes, who: Type: Expected Date of Receipt: To: (mm/dd/yyyy)
☐ Yes	☐ No	Has anyone been involved in an accident with a settlement pending?

DEDUCTIONS (SNAP, WV WORKS)

Does any household member pay legally obligated child support to a **NON-HOUSEHOLD** member? ☐ Yes Who? ☐ No
(includes current payments, arrearages, health insurance, alimony, student loan interest or daycare expenses)

PERSON WHO PAYS	TYPE OF PAYMENT	MONTHS PAID IN LAST 3 MONTHS	LEGALLY OBLIGATED AMOUNT	AMOUNT ACTUALLY PAID

DEDUCTIONS (MEDICAID, SNAP, WV WORKS)

☐ 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	Payment Amount	How Often

MEDICAID

☐ 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? ☐ Yes ☐ No

MEDICAL EXPENSES (SNAP and MEDICAID)

SNAP – Do you or any household members pay medical expenses for any person age 60 or over, or any person receiving disability benefits? ☐ Yes ☐ No If yes, check the appropriate box and list the monthly amount you pay.

☐ Health/Medicaid Insurance	$	☐ Medical/Dental Insurance	$	Others	
☐ Dentures/Glasses/Hearing Aids	$	☐ Transportation Costs	$		
☐ Hospital	$	☐ Nursing	$		
☐ Attendant Care	$	☐ Pharmacy Expense	$		

SHELTER AND UTILITY COSTS (SNAP)

Is anyone in your household paying for any of the following? Check all those paid and answer the questions.

√	EXPENSES	AMOUNT	How Often?	Who pays?	√	EXPENSES	AMOUNT	How Often?	Who Pays?
	Rent					Water			

	Mortgage					Sewer			
	Electric					Garbage			
	Gas					Wood/Coal			
	Oil					Property Tax			
	Telephone					Homeowner's Insurance			
	Land Contract					Other			

Is heat included in your rent? ☐ Yes ☐ No

If heat is not included in the rent, what is your source of heat? _____ Do you pay for air conditioning/heating? ☐ Yes ☐ No

Did your household receive LIEAP or does your household expect to receive LIEAP? ☐ Yes ☐ No

EMERGENCY ASSISTANCE

☐ Yes	☐ No	1	Do you have eviction or foreclosure notice? If yes, how much is needed to avoid eviction/foreclosure? $
☐ Yes	☐ No	2	Do you have a notice of utility service termination? If yes, what utility or utilities?
☐ Yes	☐ No	3	Are you without bulk fuel? If yes, how much is needed for a 30-day supply of fuel? $
☐ Yes	☐ No	4	Are you in need of telephone service and everyone who lives in your home is 65 years of age or older, or is disabled or temporarily incapacitated for at least the next 30 days?
☐ Yes	☐ No	5	Are you without food?
☐ Yes	☐ No	6	Are you in need of shelter, clothing, and/or household supplies/furnishings due to a fire or some other man-made or natural disaster?
☐ Yes	☐ No	7	Are you in need of emergency child care? If yes, what is the reason for the emergency?
☐ Yes	☐ No	8	Are you in need of emergency transportation? If yes, what is your destination and transportation need?
☐ Yes	☐ No	9	Are you in need of emergency medical care? If yes, what is your medical emergency?

NON-CUSTODIAL PARENT INFORMATION (WV WORKS)

☐ Yes ☐ No Are there children in this household who have a parent that does not live with them?

Child's Name	Non-Custodial Parent's Name	Non-Custodial Parent's SSN	Non-Custodial Parent's Address

RENEWAL OF HEALTH COVERAGE

To determine my eligibility for help paying for health coverage in future years, I agree to allow the local office to use my 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	5 years (the maximum number of years allowed), or for a shorter number of years:
	4 years
	3 years
	2 years
	1 year
No	Don't use information from tax returns to renew my coverage.

HEALTH COVERAGE		
Yes	☐ No	Is anyone listed on this application incarcerated, detained or jailed? If yes, who?

HEALTH COVERAGE			
☐ Yes	☐ No	1.	Is anyone enrolled in health coverage now from the following: If **yes**, check the type of coverage and write the person(s) name(s) next to the coverage they have. ☐ Medicaid: _____ ☐ CHIP: _____ ☐ Medicare: _____ ☐ TRICARE (don't check if you have direct care or Line of Duty): _____ ☐ VA Health Care Programs: _____ ☐ Peace Corps: _____ ☐ Employer Insurance: _____ ☐ Name of Health Insurance: _____ ☐ Policy Number: _____ Is this COBRA coverage? ☐ Yes ☐ No Is this a retiree health plan? ☐ Yes ☐ No ☐ Other: Name of Health Insurance: _____ Policy Number: _____ Is this a limited-benefit plan (like a school accident policy)? ☐ Yes ☐ No
☐ Yes	☐ No	2.	Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone's else's job, such as a parent or spouse. If **yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

If you want to register to vote, you can complete a voter registration form at www.sos.wv.gov.

IMPORTANT INFORMATION ABOUT SNAP

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U. S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

For any other information dealing with Supplemental Nutrition Assistance program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Number at (800) 642-8589.

USDA is an equal opportunity provider and employer.

I understand that DHHR will obtain income and eligibility information from the Systematic Alien Verification and Eligibility (SAVE) System, and U.S.

Citizenship and Immigration Services (USCIS) about each member of my group. This information will be obtained by the use of the SSN of each applicant/recipient.

IMPORTANT INFORMATION ABOUT SNAP (Continued)

I understand if I or any member of my household:

a. Is found guilty in a federal, state, or local court of trading SNAP benefits for firearms, ammunition, explosives, or controlled substances; is a convicted felon, for possession, use or distribution of a controlled substance(s); or is found guilty of trafficking $500 or more in SNAP benefits, the guilty party will be permanently disqualified from participating in the SNAP Program.
b. Makes a false statement or misrepresentation of identity and/or residence or receive duplicate benefits at the same time, the responsible party will be disqualified from the SNAP program for 10 years.
c. Is found guilty of using or receiving benefits in a transaction involving the sale of a controlled substance, you will not be eligible for benefits for two years for the first offense and permanently for the second offense.

I understand if I am found (by court action or an administrative disqualification hearing) to have committed an act of intentional program violation, I will not receive SNAP benefits as follows: First Offense – one year; Second Offense – two years; Third Offense – permanently. In addition, I will have to repay any benefits received for which I was not eligible.

I also understand that any person who obtains benefits from the DHHR by means of a willfully false statement, impersonation, misrepresentation, or any other fraudulent device can be charged with fraud. Upon a conviction, punishment may be a fine up to $5,000 and/or sentence of 5 years in jail. Federal penalties may include a maximum fine of $250,000 and a jail sentence of up to 20 years.

~~I certify under penalty of perjury, by signing my name below, that I am a United States Citizen or alien in lawful immigration status. This declaration of citizenship or alien status is a condition of eligibility for WV WORKS, Health Coverage, and SNAP.~~ I certify by signing my name below, under penalty of perjury, that I have correctly listed the citizenship or alien status of the individuals applying for benefits on this application. This declaration of United States Citizenship or alien in lawful immigration status if a condition of eligibility for WV WORKS, Health Coverage, and SNAP. Any household member for whom citizenship is not declared is not eligible to receive benefits. However, his income and assets will be considered available to the remaining members of the household.

I understand that it is a criminal violation of federal and state law to provide false or misleading information for the purpose of receiving benefits to which I am not entitled. I understand it is my responsibility to provide complete and truthful information.

Applicant's Signature	Date	Co-Applicant's Signature (WV WORKS only)	Date

Worker's Signature (Worker Who Interviewed Client)	Date

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APPENDIX A

Health Coverage from Employment

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	4. Employee Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN) ___ - ___ ___ ___ ___ ___ ___ ___
5. Employer address	6. Employer phone number ( ) -

7. City	8. State	9. Zip

10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above)	12. Email address

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (continue)

13a. If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy)

List the name of anyone else who is eligible for coverage from this job.
Name: _____ Name: _____ Name: _____

☐ **No** (Stop here and go to Step 5 in the application).

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes ☐ No
15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
    a. How much would the employee have to pay in premiums for this plan? $ _____
    b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly
16. What change will the employer make for the new plan year (if known)?
    ☐ Employer won't offer health coverage.
    ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
        a. How much would the employee have to pay in premiums for this plan? $ _____
        b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly
        Date of change (mm/dd/yyyy): _____

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EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Appendix A. For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.

EMPLOYEE Information

1. Employee name (First, Middle, Last)	4. Employee Social Security number ___ ___ ____ - ___ ___ - ____ ____ ____

EMPLOYER Information

3. Employer name	4. Employer Identification Number (EIN) ___ _____ - ____ ____ ____
5. Employer address (the Marketplace will send notices to this address)	6. Employer phone number ( ) -
7. City	8. State / 9. Zip code
10. Who can we contact about employee health coverage at this job?	
11. Phone number (if different from above) ( ) -	12. Email address

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **Yes** (continue)

If you're in a waiting or probationary period, when can you enroll in coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (Stop *and* return this form to employee)

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
   a. How much would the employee have to pay in premiums for this plan? $ _____
   b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year (if known)?
   ☐ Employer won't offer health coverage.
   ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
      a. How much would the employee have to pay in premiums for this plan? $ _____
      b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly
      Date of change (mm/dd/yyyy): _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B©(2)©(ii) of the Internal Revenue code of 1986).

New 10/13

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APPENDIX B

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Coverage & Help Paying Costs.

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 also may not have to pay cost sharing and may be special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more people to include, make a copy of this page and attach.

	AI/AN PERSON 1	AI/AN PERSON 2
1. Name (First name, Middle name, Last name)	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes **If yes,** tribe name ☐ No	☐ Yes **If yes,** tribe name ☐ No
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program or urban Indian Health program, or through a referral from one of these programs?	☐ Yes ☐ No If **no,** is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian Health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If **no,** is this person eligible to get services from the Indian Health Service, tribal health programs or urban Indian Health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from 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 often: _____	$ _____ How often? _____

New 10/13

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APPENDIX C

Assistance with Completing this Application.

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local DHHR office. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. Zip code
7. Phone number ( ) -		
8. Organization name		ID number (if applicable)
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.
Complete this section if you're a certified application counselor, navigator, agent or broker filling out this application for someone else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name & Suffix	
3. Organization name	ID number (if applicable)

New 10/13