

**WEST VIRGINIA I/DD WAIVER
APPLICATION**

| Applicant Information | | | |
|--|--|--|------|
| First Name, MI, Last Name | | | |
| Date of Birth | | | |
| Mailing Address | | | |
| County of Residence | | Social Security Number | |
| Medicaid # (if applicable) | | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Phone Number | | Email Address (if applicable) | |
| Legal Representative Information | | | |
| <input type="checkbox"/> N/A (Own representative) | | <input type="checkbox"/> Parent/Relative | |
| | | <input type="checkbox"/> Non-Relative | |
| | | <input type="checkbox"/> State/County | |
| First Name, MI, Last Name | | | |
| Mailing Address | | | |
| Phone Number | | Email Address (if applicable) | |
| Other Representative Information | | | |
| <input type="checkbox"/> Medical Power of Atty | | <input type="checkbox"/> Non-Legal Rep. | |
| | | <input type="checkbox"/> Payee | |
| | | <input type="checkbox"/> Other: | |
| 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. | | | |
| Printed Name of Applicant or Legal Representative | | | Date |
| Signature of Applicant or Legal Representative | | | Date |
| Form Submission | | | |
| <p>Fax, email or mail I/DD-1 to: APS Healthcare, Inc.-WV 100 Capitol Street, Suite 600 Charleston, WV 25301 Fax#: (866)521-6881 ; Email: widdwaiver@apshealthcare.com If you have not heard back from APS Healthcare within 5 business days, please call toll free 866-385-8920</p> | | | |
| DO NOT WRITE BELOW THIS LINE | | | |
| Received by the Administrative Service Organization: | | | |
| Signature of ASO Representative Receiving Form | | | Date |