

**WEST VIRGINIA I/DD WAIVER
APPLICATION**

Applicant Information			
First Name, MI, Last Name		Date of Birth	
Mailing Address			
Physical Address			
Phone Number		Social Security Number	
Medicaid Number (if applicable)		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Email Address (if applicable)		County of Residence	State of Residence
Legal Representative Information			
<input type="checkbox"/> N/A if member is own representative	<input type="checkbox"/> Parent/relative	<input type="checkbox"/> Non-relative	<input type="checkbox"/> DHHR County
First Name, MI, Last Name		Phone Number	
Mailing Address			
Email Address (if applicable)			
Other Representative Information			
<input type="checkbox"/> Medical Power of Attorney	<input type="checkbox"/> Non-legal Representative	<input type="checkbox"/> Payee	<input type="checkbox"/> Other _____
First Name, MI, Last Name		Relationship to Applicant	
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			
Fax, email or mail I/DD-1 to: APS Healthcare, Inc.-WV 100 Capitol Street, Suite 600 Charleston, WV 25301 Fax#: (866)521-6882 Email: widdwaiver@apshealthcare.com If you have not heard back from APS Healthcare within 5 business days, please call toll free 866-385-8920			
DO NOT WRITE BELOW THIS LINE			
Received by the Administrative Service Organization:			
Signature of ASO Representative Receiving Form			Date