AGED AND DISABLED WAIVER MEMBER EXPENDITURE FORM

If you have issues with the following, notify the agency RN, Supervisor, Case Manager or Resource Consultant (Personal Options) immediately

Member Name:		**Worker Name:**		**Provider Agency or Employer:**	

Directions: Circle one of the payment options below and circle "Yes or No" responses below.

 Food Stamp Card  Debit or Credit Card  Cash  Check

1. **Where are you planning on purchasing your items or paying your bills (Wal-Mart, Kroger's, CVS, Rite Aid, Cable Company, etc.)?**
   Comments: _____
   If you have a travel sheet or travel log at your agency, please complete the form indicating where you are planning to purchase your items or pay your bills.

2. **Do your receipts match the purchases or payments?** Yes No
   Comments: _____

3. **Did you receive the items purchased?** Yes No
   Comments: _____
   If yes, please answer the following questions:
   a. **Did you receive your card or accurate cash back from the vendor (food stamp card, debit card or credit card)?** Yes No **Comments:** _____
   b. **Did you receive a receipt?** Yes No **Comments:** _____

4. **Was your pharmacy (drug store) bag sealed and unopened when you received it?**
   Yes No **If no, did you count your pills?** Yes No
   Comments:_____

5. **Are receipts attached?** Yes No **Comments:** _____

Member Signature: _____ **Date:** _____

Worker Signature: _____ **Date:** _____

If a member has a legal representative, the legal representative may sign these forms on behalf of the member.

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES