# 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