# AGED AND DISABLED WAIVER AND PERSONAL CARE MEMBER ENROLLMENT REQUEST FORM

Please use this form to request Member Enrollment in the Medicaid Aged & Disabled Waiver Program. **The completed form must be attached to the member's record in CareConnection©.**

The Bureau of Senior Services will attach a Member Enrollment Confirmation Notice to the member's record in CareConnection© after the member is enrolled.

There will be no Medicaid reimbursement for services provided before the date of the Member Enrollment Confirmation Notice.

NAME _____

DATE _____ DATE OF BIRTH _____

ADDRESS _____

COUNTY _____

MEDICAID NUMBER _____
(Must be 11 numbers)

I, _____, confirm that _____ is at least
(Print Case Manager's/PO Manager Name) (Print Member's Name)

18 years of age, a permanent resident of West Virginia, medically and financially eligible for the Program and has chosen to participate in the Medicaid Aged & Disabled Waiver Program as an alternative to Nursing Home care. Documentation verifying this is maintained in the member's file.

Case Manager/PO Manager Signature _____

CM Agency Name _____

Phone Number _____

PA/Homemaker Agency Name _____

Phone Number _____