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	☐ Male ☐Female
Phone Number		Email Address (if applicable)	
Legal Representative Information			
☐N/A (Own representative)	☐ Parent/Relative	☐ Non-Relative	☐ State/County
First Name, MI, Last Name			
Mailing Address			
Phone Number		Email Address (if applicable)	
Other Representative Information			
☐ Medical Power of Atty	☐ Non-Legal Rep.	☐ Payee	☐ 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.

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Printed Name of Applicant or Legal Representative Date

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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: wviddwaiver@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:

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Signature of ASO Representative Receiving Form Date