

Long-Term Care Services and Supports



- Do you need long-term-care services and supports in a **nursing home type facility**? Yes No
If **Yes**, you must answer all questions and fill out all sections of this supplement.
- Are you applying for or getting long-term-care services and supports at home under a **Home- and Community-Based Services (HCBS) Waiver**? Yes No
If **Yes**, you need to fill out “**Resource Transfers**” and “**Long –Term Care Insurance.**”
- Are you applying for or getting long-term-care services and supports through **Program of All-Inclusive Care for the Elderly (PACE)**? Yes No

Please print clearly. If you need more space to finish any section, use a separate sheet of paper (include your name and Social Security number), and attach it to this supplement.

Applicant/Member Information

Last name, first name, middle initial	Social Security number
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Name and address of hospital, nursing facility, or other institution	
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Date of admission (mm/dd/yyyy)	Were you placed here by another state? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , what state?
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1. Do you have to pay guardianship expenses for a court-appointed guardian? Yes No

Living expenses of the spouse and family members living at home

(Do not complete this section if you are applying for a Home- and Community-Based Services Waiver or PACE.)

Your spouse living at home may be able to keep some of your income. Fill out the following information about your spouse’s current living expenses. **If you do not have a spouse**, go to the next section (**Resource Transfers**).

Send proof of your spouse’s current living expenses.

Spouse's last name, first name, middle initial	Social Security number
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2. How much does your spouse pay each month for:

Rent? _____ Mortgage (principal and interest)? _____
Homeowner’s/tenant’s insurance? _____ Real estate taxes? _____
Required maintenance charge for a condo or co-op? _____ Room and board for assisted living? _____

3. Does your spouse pay for heat? Yes No

4. Does your spouse pay for utilities? Yes No

5. Is a child, parent, and/or sibling living with your spouse? Yes No

If **Yes**, fill out this section. If **No**, go to the next section (**Resource Transfers**).

Send proof of their monthly income before deductions. A deduction may be allowed for their maintenance needs. These persons must be related to you or your spouse, and one of you must claim them as dependents on your federal income tax return.

Name	Social Security number
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Relationship	Date of birth (mm/dd/yyyy)	Monthly income before deductions \$
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Name	Social Security number
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Relationship	Date of birth (mm/dd/yyyy)	Monthly income before deductions \$
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Resource Transfers (resources include both income and assets)

6. In the past 60 months:

- a. Has any property that was available or belonged to you or your spouse been transferred into or out of a trust? Yes No
- b. Did you, your spouse, or someone on your behalf transfer income or the right to income? Yes No
- c. Did you, your spouse, or someone on your behalf transfer, change ownership in, give away, or sell any assets, including your home or other real estate? Yes No
- d. Did you, your spouse, or someone on your behalf change the deed or the ownership of any real estate, including creating a life estate, even if the life estate was purchased in another person's residence? Yes No
- e. If you purchased a life estate in another person's home, did you live in the home for at least one year after you purchased the life estate? Yes No
- f. Did you, your spouse, or someone on your behalf add another name to the deed of any property you own? Yes No
- g. Did you, your spouse, or someone on your behalf receive or give anyone a mortgage, loan, or promissory note on any property or other asset? Yes No
- h. Did you, your spouse, or someone on your behalf purchase or in any way change an annuity? Yes No

If you answered yes to any of the questions above, you must fill out the following, and send us proof of this information.

Description of asset/income		Date of transfer (mm/dd/yyyy)
Transferred to whom	Relationship to you or your spouse	Amount of transfer \$
Description of asset/income		Date of transfer (mm/dd/yyyy)
Transferred to whom	Relationship to you or your spouse	Amount of transfer \$
Description of asset/income		Date of transfer (mm/dd/yyyy)
Transferred to whom	Relationship to you or your spouse	Amount of transfer \$

7. Have you, your spouse, or someone acting on your behalf given a deposit to any health care or residential facility, like an assisted living facility, a continuing care retirement community, or life care community? Yes No

If **Yes**, give us the name and address of the facility, the amount of the deposit, answer the following questions, and **send us a copy** of the contract you signed with the facility and any documents about this deposit.

Name of facility _____

Address of facility _____ Amount \$ _____

- a. Does the facility still have the deposit? Yes No
- b. Did the facility return the deposit? Yes No

If **Yes**, give us the name and address of the person who got the deposit from the facility.

Name of person _____

Address _____

Real Estate

The answers to the following questions will be used to decide if: (1) your real estate will be counted as an asset; or (2) a lien will be placed against your real estate.

Note: If the equity interest in your principal place of residence is over a certain limit, you may be ineligible for payment of long-term-care services and supports, unless certain conditions are met.

8. Do you or your spouse own or have a legal interest in your home, including a life estate? Yes No

If **Yes**, fill out the following information and answer questions 9 through 15. If **No**, answer question 15 only.

Name and address of person(s) on ownership papers _____

Description and address of property location _____

Type of ownership (Check one.)

Individual (*Fair-market value*) \$ _____ Tenancy in common (*Fair-market value*) \$ _____

Joint tenancy (*Fair-market value*) \$ _____ Life estate (*Fair-market value*) \$ _____

Name and address of person(s) on ownership papers _____

Description and address of property location _____

Type of ownership (Check one.)

Individual (*Fair-market value*) \$ _____ Tenancy in common (*Fair-market value*) \$ _____

Joint tenancy (*Fair-market value*) \$ _____ Life estate (*Fair-market value*) \$ _____

9. Do you have a spouse? Yes No. If **Yes**, fill out this section.

Name _____ Is this person living in your home? Yes No

10. Do you have a permanently and totally disabled or blind child? Yes No. If **Yes**, fill out this section.

Name _____ Is this person living in your home? Yes No

11. Do you have a child under 21 years old? Yes No. If **Yes**, fill out this section.

Name _____ Date of birth (mm/dd/yyyy) _____ Is this person living in your home? Yes No

12. Do you have a brother or sister with a legal interest in the home who was living in the home for at least one year immediately before your admission to the medical institution? Yes No. If **Yes**, fill out this section.

Name _____ Is this person living in your home? Yes No

13. Do you have a child who has lived in the home for at least the last two years before your admission to the medical institution and has provided care to you that allowed you to live in the home? Yes No. If **Yes**, fill out this section.

Name _____ Is this person living in your home? Yes No

14. Do you have a dependent relative? Yes No. If **Yes**, fill out this section.

Name _____ Is this person living in your home? Yes No

Describe the relationship and the nature of the dependency: _____

15. Do you intend to return to your home? Yes No

(Do not answer this question if you are applying for a Home- and Community-Based Services Waiver.)

16. Do you or your spouse own or have a legal interest in **other** real estate not listed in Question 8 above? Yes No
If **Yes**, please describe the property and list its address below.

If you need more space, use a separate sheet of paper.

Long-Term-Care Insurance

17. Do you or your spouse have long-term-care insurance? Yes No

If **Yes**, fill out this section. If **No**, go to the next section (**Tax Returns**).

Send a copy of the policy.

Company name/Policy number

Policyholder name	Effective date (mm/dd/yyyy)	Premium amount \$
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Company name/Policy number

Policyholder name	Effective date (mm/dd/yyyy)	Premium amount \$
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Tax Returns

18. Did you or your spouse file US income tax returns in the last two years? (Check one.)

Yes, both years Yes, one of these years No, neither year

If **yes**, you must **send copies** of these returns. If you did not keep copies of one or more of these returns, **you must send in a filled-out and signed IRS Form 4506**. Form 4506 is included at the end of this application.

SIGN THIS SUPPLEMENT.

By signing this supplement below, I hereby certify under the pains and penalties of perjury that the submissions and statements I have made in this supplement are true and complete to the best of my knowledge, and I agree to accept and comply with the above rights and responsibilities.

Important: If you are submitting this supplement as an authorized representative, you must submit an Authorized Representative Designation Form (ARD) to us for us to process this application. It is important to complete this form as this is the only way we may speak to you about this application.

Signature of applicant/member or authorized representative	Print name	Date
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