Asset Assessment for Potential MassHealth Eligibility

Date ______________

This assessment is important in deciding if you might be eligible for MassHealth long-term-care benefits.

You asked MassHealth to determine the amount of your assets. To help us determine your assets, you must list all assets owned by you and your spouse **as of the date you or your spouse were admitted to the nursing facility or medical institution**. You must also give MassHealth proof of all assets listed.

According to MassHealth regulations, the spouse who is living at home may keep up to $ _______________ in assets when the spouse who is living in a nursing facility or medical institution applies for MassHealth. This asset amount may be increased due to certain circumstances, which will be explained in your asset assessment notice. This amount may also change due to federal cost-of-living changes.

Please answer all questions and fill out all sections. Each section has a list of information that you must give to MassHealth so we can decide the value of each asset. If you need more space, use a separate sheet of paper and attach it to this form. Once you fill out this form and send us proof of your assets, MassHealth will decide which assets the spouse who is living at home can keep. We will send you this decision in writing.

If you decide to apply for MassHealth, you must give MassHealth proof of all assets that are available to you and your spouse **as of the date of application for MassHealth**. You must also give MassHealth proof of all resources (income and assets) transferred generally within the last 60 months.

If you want someone to act on your behalf as your authorized representative, use the enclosed MassHealth Authorized Representative Designation Form to tell us.

If you have any questions about this form, please contact a MassHealth Enrollment Center at **1-888-665-9993** (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled).

Please print clearly. Answer all questions and fill out all sections. If you need more space to finish any section on this form, please use a separate sheet of paper and attach it to this form.

SPOUSE IN NURSING FACILITY OR MEDICAL INSTITUTION

Last name	First name	MI	Social security number ____ ____ ____ - ____ ____ - ____ ____ ____ ____
Date of birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female		
Name of facility			
Date admitted (mm/dd/yyyy)	Phone number ( )		
Street address	City	State	ZIP code

SPOUSE AT HOME

Last name	First name	MI	Social security number ____ ____ ____ - ____ ____ - ____ ____ ____ ____
Date of birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Phone number ( )	
Street address	City	State	ZIP code

ASSETS

Fill out the following sections by listing all information about assets owned by you and/or your spouse **as of the date of admission to the nursing facility or medical institution**.

BANK ACCOUNTS/PENSION FUNDS

Do you or your spouse have any bank accounts or certificates of deposit, including checking, savings, personal-needs accounts (PNAs), credit union, NOW, and money-market accounts, or any retirement accounts, including individual retirement accounts (IRAs), Keogh accounts, pension funds, and/or other bank accounts? ☐ Yes ☐ No

If **no**, go to the next section (Life Insurance).
If **yes**, fill out this section.

Attach a copy of your bank passbook or bank statement that shows each account balance **as of the date of admission to the nursing facility or medical institution**.

Name(s) on account	Name/address of bank or credit union		
	Account number	Account type	Balance $
Name(s) on account	Name/address of bank or credit union		
	Account number	Account type	Balance $
Name(s) on account	Name/address of bank or credit union		
	Account number	Account type	Balance $

LIFE INSURANCE

Do you or your spouse have any life insurance? ☐ Yes ☐ No

If **no**, go to the next section (Trusts).
If **yes**, fill out this section.

Attach a copy of each life-insurance policy and/or a written statement from the insurance company showing the face value and the cash-surrender value of each policy **as of the date of admission to the nursing facility or medical institution**.

Name of insured	Name of insurance company	Face value $	Cash-surrender value $
Name of insured	Name of insurance company	Face value $	Cash-surrender value $
Name of insured	Name of insurance company	Face value $	Cash-surrender value $

TRUSTS

Are you or your spouse the grantor, trustee, or beneficiary of any trust(s)? ☐ Yes ☐ No

If **no**, go to the next section (Stocks/Bonds/Other).
If **yes**, fill out this section.

Attach a copy of the trust document and trust accounting, Schedule A, and/or other documentation about the assets and income of each trust **as of the date of admission to the nursing facility or medical institution**.

Name of trust	Grantor(s)	Trustee(s)	
Beneficiaries		Trust principal $	Trust income $
Name of trust	Grantor(s)	Trustee(s)	
Beneficiaries		Trust principal $	Trust income $
Name of trust	Grantor(s)	Trustee(s)	
Beneficiaries		Trust principal $	Trust income $

STOCKS / BONDS / OTHER

Do you or your spouse own any stocks, bonds, savings bonds, securities, mutual funds, annuities, assets held in safe-deposit boxes, or cash not in the bank? ☐ Yes ☐ No

If **no**, go to the next section (Health-Care / Residential Facility Deposits).
If **yes**, fill out this section.

Attach a quote from your stockbroker or bank or investment firm for securities, stocks, mutual funds, etc., to prove the value of the asset **as of the date of admission to the nursing facility or medical institution**.

	You		Your spouse	
	Company	Value	Company	Value
Stocks		$		$
Bonds		$		$
Savings bonds		$		$
Mutual funds		$		$
Securities		$		$
Other		$		$

HEALTH-CARE / RESIDENTIAL FACILITY DEPOSITS

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? ☐ Yes ☐ No

If **no**, go to the next section (Vehicles / Mobile Homes).
If **yes**, give us the name and address of the facility, the amount of the deposit, and the date it was given to the facility.

Attach a copy of the facility's documents about this deposit.

Name of facility	Address of facility	Amount	Date
		$	/ /

VEHICLES / MOBILE HOMES

Do you or your spouse own any vehicles, including cars, vans, trucks, recreational vehicles, mobile homes, and boats?
☐ Yes ☐ No

If **no**, go to the next section (Real Estate).
If **yes**, fill out this section.

Attach a copy of your payment book or finance company's statement and a written statement from a licensed vehicle dealer about the fair-market value of the vehicle and amount owed **as of the date of admission to the nursing facility or medical institution**.

Name of owner	Year/Make/Model	Fair-market value $	Amount owed $
Name of owner	Year/Make/Model	Fair-market value $	Amount owed $
Name of owner	Year/Make/Model	Fair-market value $	Amount owed $

REAL ESTATE

Do you or your spouse own individually or jointly (with any other person or entity), or have a legal interest in any real estate, for example: vacation property, rental property, time sharing, vacant lots, and other property (include all property located in and outside of Massachusetts)? ☐ Yes ☐ No

If **no**, go to the next section (Signature).
If **yes**, fill out this section.

Attach a copy of your current tax bill and deed for each property listed.

Name(s) on ownership papers (deed)	Description/Location	Market value $
Name(s) on ownership papers (deed)	Description/Location	Market value $
Name(s) on ownership papers (deed)	Description/Location	Market value $

SIGNATURE

I certify that I have read or had read to me the asset assessment form. I further certify under penalty of perjury that the information given on this assessment form is correct and complete to the best of my knowledge.

If you are acting on behalf of someone in filling out this asset assessment, the enclosed MassHealth Authorized Representative Designation Form must also be filled out and sent back with this assessment. Your signature on this form as an authorized representative certifies that the information on this asset assessment is correct and complete to the best of your knowledge.

Signature of spouse in nursing facility or medical institution or authorized representative   Date

Signature of spouse living at home or authorized representative   Date

Once you have filled out this form, send it to:
MassHealth Enrollment Center (MEC)
Central Processing Unit
P.O. Box 290794
Charlestown, MA 02129-0214
Fax: 617-887-8799

Or hand deliver it to:
MassHealth Enrollment Center
Central Processing Unit
The Schrafft Center
529 Main St., Suite 1M
Charlestown, MA 02129

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