STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10095 (07/15)

AST

MEDICAID ASSET ASSESSMENT
MEDICAL INSTITUTION / COMMUNITY WAIVER RESIDENT AND COMMUNITY SPOUSE

Providing or applying for a Social Security Number (SSN) is voluntary; however, any person who wants Medicaid benefits but does not provide an SSN or apply for one will not be eligible for benefits. SSNs and personally identifiable information will be used only for the direct administration of the Medicaid Program.

INSTRUCTIONS:
Do not write in shaded areas. "Resident" means the person who resides in a medical institution or is a community waivers participant.

This form requests information about the property or assets owned by you and/or your spouse. This information is needed to determine the following:

- The total amount of assets owned by you (resident) and your spouse,
- Your spouse's share of those assets; and
- The amount of assets you and your spouse may keep and meet the Medicaid asset limit.

Answer the following questions by providing information about all assets owned by you (resident) and/or your spouse as of _____. Include assets owned jointly with your spouse, family members or other persons. Include your share and/or your spouse's share of jointly owned assets. You may be asked to verify some or all of the information you provide.

Case Name	Case Number
County	Worker Name

SECTION I – MEDICAL INSTITUTION / COMMUNITY WAIVER RESIDENT INFORMATION

Resident Name (Last, First, MI)

Institution / Community Program Address (Street, City, State, Zip Code)

Resident's Social Security Number	Resident's Birthdate (mm/dd/yy)	Resident's Telephone Number

SECTION II – SPOUSE INFORMATION

Spouse Name (Last, First, MI)

Spouse's Address (City, State, Zip Code)

Spouse's Social Security Number (only if applying)	Spouse's Birthdate (mm/dd/yy)	Spouse's Telephone Number

SECTION III – ASSET INFORMATION

		RESIDENT OWNED ASSETS	SPOUSE OWNED ASSETS	NAME OF PERSON WHO JOINTLY OWNS ASSETS	**OFFICE USE ONLY**
1. Life Insurance	CASH VALUE	$	$		
	FACE VALUE	$	$		
2. Checking / Share-Draft Account		$	$		
3. Other accounts in a bank, credit union, savings and loan or other financial institutions		$	$		
4. Cash that belongs to you (include the current amount in a nursing home/institution patient account).		$	$		
5. Money paid for anyone into a burial trust, or to another person or place to pay for burial expenses.		$	$		
6. Other property or money, not listed below:					
Cash in a safety deposit box		$	$		
Certificates of deposit		$	$		
Farm equipment and livestock		$	$		
Land/building (other than the place in which you live)		$	$		
Money owed to you or your spouse		$	$		
Notes / contracts of value		$	$		
Retirement Accounts (IRA and Keough accounts)		$	$		
Stocks or bonds (including U.S. Savings Bonds)		$	$		
Commodities (Kruggerands, etc.)		$	$		
Trust fund		$	$		
7. Vehicles (List each vehicle and its value)					
Vehicle 1:		$	$		
Vehicle 2:		$	$		
Vehicle 3:		$	$		
8. Other Assets		$	$		
SUB-TOTAL – Assets - Listed Above		$	$		
TOTAL – Assets (Add sub-total amounts of resident and spouse)		$			

SECTION IV – RIGHTS AND RESPONSIBILITIES

I certify, under penalty of false swearing, that all my answers are correct and complete to the best of my knowledge. I also understand that I may be asked to provide proof of any information given on this assessment form and that giving false information may subject me to prosecution for fraud. I understand that if my spouse or I disagree with the findings of this assessment that my spouse or I cannot file for a fair hearing until my or my spouse's application for Medicaid benefits has been filed and eligibility determined.

I understand that after a decision has been made on my application for Medicaid, my spouse or I have a right to appeal the decision, by requesting a fair hearing if we disagree with the amount or the method of computing the community spouse asset share. We may request a hearing at the county/tribal social or human services agency where I applied. I may also request a fair hearing by writing to:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

Or by calling 1-608-266-3096

This form can also be downloaded from the Division of Hearings and Appeals website at

https://doa.wi.gov/Pages/AboutDOA/HearingsAndAppeals.aspx.

SECTION V – SIGNATURE

I understand that if any of the information provided by myself, my spouse or my authorized representative is incomplete or false, then the amount of the community spouse asset share is not binding in any department determination and is subject to change.

Two witnesses are required if you sign with an "X".

SIGNATURE – Resident	Date Signed
SIGNATURE – Community Spouse	Date Signed
SIGNATURE – Witness	Date Signed
SIGNATURE – Witness	Date Signed

RESET FORM