Department of Health Services
Division of Medicaid Services
F-20919D (03/2025)

State of Wisconsin
Wis. Stat. 49.453 and 49.47 42 USC 1396p

Declaration Regarding Transfer of Resources, Annuity Ownership, and Home Equity

Long-Term Care Medicaid

The State of Wisconsin is an equal opportunity service provider. This letter contains information that affects your benefits. If you need this material in a different format because of disability or if you need this letter translated or explained in your own language, please call Member Services at 1-800-362-3002. You will be able to choose your language. These services are free.

This form collects information about asset transfers, annuities, and home equity. It must be completed by all Medicaid, BadgerCare Plus, and Medicare Savings program members who are requesting to enroll in a community-based long-term care program (Family Care, Family Care Partnership, PACE, or IRIS).

You do not need to complete this form if you are applying for long-term care and are not yet enrolled in Medicaid, BadgerCare Plus, or Medicare Savings programs. This information will be assessed during that application process.

Section 1: Member information

Name (First, middle initial, and last name)	Date of birth
Medicaid number	CARES case number (if applicable)

Section 2: Asset/Income transfer

Tell us about any income or assets you and/or your spouse have given away or sold for less than fair market value in the last five years. Examples include cash and cash gifts, real estate, stocks, or bonds. This includes any amounts you have gifted to minors, such as a college fund for your grandchild.

1. In the last five years, did you and/or your spouse:
   - Sell any assets for less than fair market value? By fair market value, we mean the amount that you would get if you sold it on the open market. ☐ Yes ☐ No
   - Trade assets or income? ☐ Yes ☐ No
   - Transfer or give away assets or income? ☐ Yes ☐ No
   - Establish or fund a trust? ☐ Yes ☐ No
   - Decline or refuse to accept an inheritance? ☐ Yes ☐ No
   - Purchase an annuity, life estate in another person's home, promissory note, loan, or mortgage? ☐ Yes ☐ No

If you answered **yes** to any of the questions above, fill out the asset and income information below. Use an additional sheet of paper if more room is needed.
If you answered **no** to all the above questions, go to Section 3.

Asset or income 1

Type of asset or income	Date given away or sold	Value of asset or income $
What did you get in return?	Who was the asset given or sold to?	

Asset or income 2		
Type of asset or income	Date given away or sold	Value of asset or income $
What did you get in return?	Who was the asset given or sold to?	

Section 3: Annuity ownership

1. Do you or your spouse own an annuity? If no, go to Section 4.	☐ Yes	☐ No
2. Did you or your spouse purchase an annuity on or after 01/01/2009?	☐ Yes	☐ No
3. Did you or your spouse make any substantive changes on after 01/01/2009 to any annuity that either you or your spouse own, regardless of when it was purchased? A "substantive change" is an addition to principal, an elective withdrawal, a distribution change request, a change in ownership, or other similar action.	☐ Yes	☐ No

If you answered yes to any of the questions above, you will be required to provide additional information about this annuity in order to qualify for Medicaid long-term care services.

If you or your spouse own an annuity that was purchased or substantively changed on or after 01/01/2009, the State of Wisconsin must be named as a remainder beneficiary on the annuity if you receive Medicaid long-term care services. We must be named as the remainder beneficiary in the annuity in the first position unless you are married or have a minor child or a child with a disability. In that case, we must be named as a remainder beneficiary in the next position after your spouse, minor child, or child with a disability. By signing this form, you acknowledge that you and/or your spouse are naming the State of Wisconsin as a remainder beneficiary on the annuity.

Section 4: Home equity

1. Do you own a home? If no, go to Section 5	☐ Yes	☐ No
If you answered yes to question 1. 2. Are any of the following currently living in the home? • Your spouse • Any of your children who are blind or have a disability (as determined by the Disability Determination Bureau) • Any of your children under the age of 21.	☐ Yes	☐ No

Only answer question 3 if you answered yes to question 1 and no to question 2.

3. Approximately how much equity do you have in your home? The equity value of a home is the current fair market value minus any debt on it, such as a mortgage, reverse mortgage, or home equity loan.

Home equity calculation

Fair market value:	$
Minus debt on house:	- $
Equals home equity:	= $

Section 5: Signature and date

By signing this form, I am confirming that I have provided true and accurate information. I understand that the agency may request more detailed information and documents for proof.

By signing this form, I also acknowledge that I have received information about the Estate Recovery Program, if applicable.

Signature – Applicant or representative*	Date signed

Printed name – Applicant or representative*

***** A representative can be an authorized representative, a guardian of the estate, a guardian of the person who has been granted authority to apply for public benefits on behalf of their ward, a conservator, or an agent with durable power of attorney for finances.

Nondiscrimination notice for health care-related programs: Discrimination is against the law

The Wisconsin Department of Health Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, gender identity, and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity. The Department of Health Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Department of Health Services:

- Provides free aids and services to people with disabilities to communicate effectively with DHS, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to help people communicate with DHS, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services and have questions about health care and/or nutritional assistance benefit programs, call your local agency or ForwardHealth Member Services at 800-362-3002. For other DHS-related questions, call 844-201-6870 (TTY:711) and the DHS Civil Rights Coordinator will guide you to the appropriate area for assistance.

If you believe that the Department of Health Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity, you can file a grievance with: Department of Health Services, Attn: Civil Rights Coordinator, 1 West Wilson Street, Room 651, PO Box 7850, Madison, WI 53707-7850, 608-267-4955, TTY: 711, Fax: 608-267-1434, dhscrc@dhs.wisconsin.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Department of Health Services civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844-201-6870 (TTY: 711).	**Deitsch (Pennsylvania Dutch)** Wann du Deitsch (Pennsylvania Dutch) schwetzscht, kannscht du ebber griege as dich helfe kann mit Englisch, unni as es dich ennich eppes koschte zellt. Ruf 844-201-6870 uff (TTY: 711).
Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 844-201-6870 (TTY: 711).	**ພາສາລາວ (Laotian)** ເຊີນຊາບ: ຖ້າທ່ານເວ້າພາສາລາວ ແມ່ນມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໃຫ້ໂທຫາເບີ 844-201-6870 (TTY: 711).
繁體中文 (Traditional Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 844-201-6870 (TTY: 711).	**Français (French)** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 844-201-6870 (ATS : 711).
Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 844-201-6870 (TTY: 711).	**Polski (Polish)** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 844-201-6870 (TTY: 711).
العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 844-201-6870 (رقم هاتف الصم والبكم: 711).	**हिंदी (Hindi)** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 844-201-6870 (TTY: 711) पर कॉल करें।
Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844-201-6870 (телетайп: 711).	**Shqip (Albanian)** KUJDES: Nëse flisni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 844-201-6870 (TTY: 711).
한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 844-201-6870 (TTY: 711) 번으로 전화해 주십시오.	**Tagalog (Tagalog – Filipino)** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 844-201-6870 (TTY: 711).
Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844-201-6870 (TTY: 711).	**Soomaali (Somali)** FIIRO GAAR AH: Haddii aad ku hadashid af Soomaali, adeegyada caawinta luuqada, oo bilaash ah, ayaa laguu heli karaa. Soo wac 844-201-6870 (TTY: 711).

For agency use only

Instructions for ADRC specialist/Tribal ADRS

- ☐ Assist the member in completing this form and save a copy of the completed form in their case file.
- ☐ Provide the member with a copy of Wisconsin Estate Recovery Program Handbook, P-13032, if applicable. The member's signature on this form acknowledges they received the handbook if applicable.
- ☐ Send the completed form to the local agency (dhs.wi.gov/im-agency) **only** if there are reported asset transfers, annuities, or excess home equity. Do not enroll the member in the long-term care program until confirmation is received from the agency that the member is eligible.

Instructions for income maintenance worker

- ☐ Scan the completed form into the electronic case file (ECF) if there is a case in CWW.
- ☐ Review the completed form and assess any potential divestments, annuity disclosure and remainder beneficiary designation requirements, and home equity more than the long-term care limit.
- ☐ Let the ADRC contact listed below know the status as soon as possible, but no later than 10 calendar days from the date this form was received. Follow up within 10 calendar days even if the member needs additional time to provide requested information or verification.
- ☐ If the member is denied long-term care benefits due to divestment, excess home equity, or failure to comply with annuity disclosure requirements, send a notice of decision informing them of the denial, their fair hearing rights, and undue hardship information.

Agency contact information

ADRC/Tribal ADRS address

Name of ADRC specialist/Tribal ADRS

Phone	Fax

Email

Notes