PART 4

Instructions for Completing Resource Assessment Form, PA 1572

(To be used by a couple when one of them is in a nursing facility, other medical institution or assessed eligible for Home and Community Based Services (HCBS), and the other lives in the community.)

Important information for nursing facility residents and their spouses. If you need this information in another language or someone to interpret it, please notify the nursing facility or contact your local County Assistance Office. Language assistance will be provided free of charge.

Información importante para los residentes en hogares de ancianos y sus esposos. Si usted necesita esta información en otro idioma o alguien que se la traduzca, favor de notificar al personal de la residencia o comunicarse con la oficina local de Asistencia del Condado (CAO). Asistencia lingüística será proveída gratis.

ពត៌មានសំខាន់សម្រាប់អ្នករស់នៅក្នុងមណ្ឌលគិលានុបដ្ឋាក/នុបដ្ឋាយិការនិងសម្រាប់ប្តី/ប្រពន្ធរបស់គេ។ បើលោកអ្នកត្រូវការពត៌មាននេះជាភាសាផ្សេងផ្សែត ឬអ្នកណាម្នាក់ឲ្យបកប្រែឲ្យ សូមជំរាបមណ្ឌល គិលានុបដ្ឋាក/នុបដ្ឋាយិការ ឬចាក់ទងទៅការិយាល័យជើងរបៀបរស់លោកអ្នក។ ជំនួយក្នុងការបកប្រែនឹងត្រូវផ្តល់ឲ្យដោយឥតគិតថ្លៃ។

Thông tin quan trọng về cơ sở dưỡng lão dành cho thường trú nhân và vị phối ngẫu. Nếu quí vị cần thông tin này bằng một thứ tiếng khác hay một phiên dịch viên, xin thông báo cho cơ sở dưỡng lão hay liên lạc với Văn Phòng Trợ Cấp Quận Hạt. Trợ giúp về ngôn ngữ sẽ được cung cấp miễn phí.

Важные сведения относительно жителей домов престарелых и их супруг (супругов). Если вам нужен данный документ на другом языке или его устный перевод, обращайтесь в дом престарелых либо в местное Бюро помощи (County Assistance Office). Помощь переводчика предоставляется бесплатно.

这是发给疗养所的居民及其配偶的重要通知。如果您需要此通知翻译成其他语种或需要为您提供翻译，请通知疗养所或联系您所在地区的郡县协助办事处(County Assistance Office)。可提供免费语言协助。

The Medical Assistance Program - known as MA - helps meet the medical costs of individuals in need of payment of Long Term Care (LTC) services. Generally, an individual must use most of his own resources and income before Medical Assistance will help pay for LTC services. There are, however, special rules (sometimes called the Spousal Impoverishment Provisions) which recognize the importance of *protecting* a portion of a married couple's total resources and evaluating the income needs of the spouse who remains in the community.

The purpose of this Resource Assessment Form is to determine how much of a married couple's total resources may be protected or set aside for the community spouse, and how much, if any, must be spent before the individual in the nursing facility or assessed eligible for HCBS may be eligible for Medical Assistance benefits. Completing this form will help you to protect the maximum amount of your resources under the law.

The Resource Assessment is not an application for Medical Assistance, and you are not obligated to apply for Medical Assistance. If you need help in completing this form, your spouse, family member, friend, attorney, or legal services agency can help you. If you or your spouse are over 60 years of age, your local Area Agency on Aging also can help you. If you need Medical Assistance now, contact your county assistance office or your local Area Agency on Aging *BEFORE* you fill out this form.

A community spouse may keep a minimum amount of resources, or one-half of the couple's combined countable resources, up to a maximum amount. Some resources do *not* affect the determination of the protected amount. In order to make the determination as to which resources do and do not count and the protected amount, it is very important that you list *all* resources regardless of whether they are wholly owned by one person (e.g., an IRA owned by the community spouse), are owned by both spouses, or owned with others. The information on this form should reflect the value of the resources as of the DATE OF ADMISSION to the nursing facility, or the DATE OF ASSESSMENT for HCBS, NOT the date you fill out this form.

Photocopies *verifying* all resources MUST be sent with this form. Do *not* send original documents as they will NOT be returned to you. *An assessment cannot be completed unless all resources are verified and the verification is submitted with the Resource Assessment Form.*

Please read and complete this form carefully. Do NOT complete shaded areas. Sign the form and review the checklist to be certain you have provided all necessary verification. You, your spouse, and if applicable, your legal representative, will be notified in writing of the amount of resources that can be set aside and the amount, if any, that must be spent before you apply for Medical Assistance.

Mail (or deliver) the completed form and verification to the county assistance office in the county where the nursing facility is located, or you are receiving HCBS. The LTC Service Provider can provide you with the address, or check the telephone book.

RESOURCES/ACCEPTABLE PROOF

VERIFICATION OF ALL RESOURCES MUST BE ATTACHED TO THE FORM. FOR EXAMPLE:

CODE	RESOURCE	VERIFICATION *Value as of date of admission to nursing facility or date of assessment for home and community based services (HCBS).
01	CASH ON HAND	Your written statement showing the total amount of money not in the bank or otherwise invested.
02	SAVINGS ACCOUNT(S)	Photocopies of your bank statements, bank books or a written statement from the financial institution.*
03	CHECKING ACCOUNT(S)	Photocopies of your bank statement or written statement from the financial institution.*
04	CHRISTMAS AND/OR VACATION CLUB	Photocopies of the bank statement or written statement from the financial institution.*
05	STOCKS AND/OR BONDS, ETC.	A written statement from the brokerage firm, issuing agent or authority or institution where the stocks, bonds, etc. were purchased or held; or copy of the stock certificate or bond and a statement of the value.*
06	TRUST FUND	Photocopy of the trust agreement and inventory of trust assets or other documentation of value.*
07	IRREVOCABLE BURIAL RESERVE	Photocopy of the burial reserve agreement.
08	REVOCABLE BURIAL RESERVE	Photocopy of the burial reserve agreement.
09	RESERVED	
10	LIFE INSURANCE	A document identifying ownership for each insurance policy and a written statement of cash value from the insurance company.*
11	NON-RESIDENT REAL PROPERTY	Your real estate tax bill or a broker's statement of the fair market value of the property; and if the property is rented, the rental agreement or lease.*
12	MOTOR VEHICLE(S)	A written statement of the value, from a car dealer; or list the year, make, and model of the vehicle, and we will use the automobile red book to determine the value.
13	BOATS, SNOWMOBILES, TRAILERS AND OTHER VEHICLES	A written statement of the fair market value of the vehicle, from a dealer.*
14	CERTIFICATES OF DEPOSIT	A written statement from the financial institution listing the value and ownership.*
15	ANNUITIES	A photocopy of the document that explains the terms, date of purchase, and value of the annuity at the time of admission/or assessment for HCBS.*
16	SAVINGS BONDS	Photocopies of the bonds or a written statement from a bank that identifies the owner(s) of the bonds, the serial number(s), purchase date, and the value of the bonds at the time of admission.*
17	MUTUAL FUNDS	An itemized written statement of the value from the mutual fund or brokerage firm.*
18	INCORPORATED OR UNINCORPORATED BUSINESS (PARTNERSHIP/SOLE PROPRIETORSHIP)	For a corporation, a statement of the value of your stock; for an unincorporated business, documents that established the business and that verify the value of your share of the business.
19	IRA OR KEOGH	A written statement from the bank or financial institution that identifies the owner(s) and the value.*
20	OTHER	Photocopy(ies) of any agreement(s) or statement(s) regarding any money or other resources not already listed.*

RESET FIELDS

COMMONWEALTH OF PENNSYLVANIA - DEPARTMENT OF PUBLIC WELFARE

RESOURCE ASSESSMENT

YOUR INFORMATION IS CONFIDENTIAL FOR USE ONLY BY THE DEPARTMENT OF PUBLIC WELFARE

GENERAL INFORMATION

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	SOCIAL SECURITY NO.	
ADDRESS	(STREET AND CITY)		COUNTY	STATE	ZIP CODE
NAME OF LTC SERVICE PROVIDER			TELEPHONE NO. ( )	DATE OF ADMISSION OR HCBS ASSESSMENT / /	
SPOUSE'S LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH / /	SOCIAL SECURITY NO.	
SPOUSE'S STREET ADDRESS	CITY		STATE	ZIP CODE	SPOUSE'S TELEPHONE NO. ( )

RESOURCES

VERIFICATION MUST ACCOMPANY THIS FORM FOR EACH RESOURCE LISTED. ACCEPTABLE VERIFICATION AND CORRESPONDING RESOURCE CODES ARE **LISTED ON THE BACK OF THE INSTRUCTION PAGE.**

DO NOT SEND ORIGINAL DOCUMENTS, AS VERIFICATIONS WILL NOT BE RETURNED. If a resource is owned by you and another person other than your spouse, list on a separate sheet of paper the resource and the names of the joint owners. Indicate if you or someone else purchased the asset. If it is not owned in equal shares, provide proof of the division of ownership as well as total value.*

BE CERTAIN TO LIST ***ALL*** RESOURCES, SINGLY OR JOINTLY-OWNED

OWNER(S) OF RESOURCE			RESOURCE	*As of the date of admission or HCBS assessment.			DOCUMENTED	
LAST NAME	FIRST NAME	M.I.	CODE	TOTAL VALUE	AMOUNT OWED	NET VALUE	YES	NO

IF YOU NEED ADDITIONAL SPACE, USE NOTES/INFORMATION SECTION OF THE FORM

NOTE: IF YOUR INTEREST IN ANY RESOURCE IS A LIFE INTEREST, PLEASE INDICATE

ENTER THE TWO DIGIT CODE IN THE "RESOURCE CODE" COLUMN THAT BEST DESCRIBES THE RESOURCE THAT YOU ARE IDENTIFYING

01	CASH ON HAND	07	IRREVOCABLE BURIAL RESERVE	13	BOATS, SNOWMOBILES, TRAILERS & OTHER VEHICLES	18	BUSINESS
02	SAVINGS ACCOUNT(S)	08	REVOCABLE BURIAL RESERVE			19	IRA OR KEOGH
03	CHECKING ACCOUNT(S)	09	RESERVED	14	CERTIFICATES OF DEPOSIT	20	OTHER
04	CHRISTMAS/VACATION CLUB	10	LIFE INSURANCE	15	ANNUITIES		
05	STOCKS, BONDS, ETC.	11	NON-RESIDENT REAL ESTATE	16	SAVINGS BONDS		
06	TRUST FUND	12	MOTOR VEHICLE(S)	17	MUTUAL FUNDS		

LIFE INSURANCE - COMPLETE THE INFORMATION BELOW FOR EACH LIFE INSURANCE POLICY

NAME OF INSURED	INSURANCE COMPANY	POLICY NUMBER	NAME OF BENEFICIARY	FACE VALUE	CASH* VALUE	DATE ACQUIRED	DOCUMENTED YES	DOCUMENTED NO
							☐	☐
							☐	☐
							☐	☐
							☐	☐

*As of the date of admission to the facility or assessment for HCBS.

NOTES/INFORMATION SECTION -- USE ADDITIONAL SHEET(S) IF NECESSARY

LIST ANY PRIOR ADMISSION TO A FACILITY OR ASSESSMENT FOR HCBS

NAME AND ADDRESS OF LTC SERVICE PROVIDER .....

DATE OF ADMISSION OR ASSESSMENT FOR HCBS ▶

NAME AND ADDRESS OF LTC SERVICE PROVIDER .....

DATE OF ADMISSION OR ASSESSMENT FOR HCBS ▶

LEGAL REPRESENTATION

☐ YES ☐ NO DOES THE INDIVIDUAL HAVE A LEGAL REPRESENTATIVE OTHER THAN THE SPOUSE (e.g. Court-appointed Guardian, Power-of-Attorney, etc.)

IF YES ▶

NAME		TELEPHONE NUMBER		
STREET ADDRESS	CITY	STATE	ZIP CODE	RELATIONSHIP OF RESIDENT

NOTE: YOUR LEGAL REPRESENTATIVE WILL BE SENT A COPY OF THE RESULTS OF THE RESOURCE ASSESSMENT.

I swear or affirm that all of the information I have provided on this form is true and correct to the best of my ability, knowledge and belief.

SIGNATURE _____ DATE _____ RELATIONSHIP TO INDIVIDUAL IN NEED OF LTC SERVICE _____

CHECKLIST

1. DID YOU COMPLETE THE INFORMATION FOR THE INDIVIDUAL IN NEED OF LTC SERVICES?
2. DID YOU COMPLETE THE INFORMATION FOR THE COMMUNITY SPOUSE?
3. DID YOU LIST ALL RESOURCES OWNED ON THE DATE OF ADMISSION OR ASSESSMENT FOR HCBS?
4. DID YOU COMPLETE THE LIFE INSURANCE SECTION?
5. DID YOU READ THE STATEMENT REGARDING THE INFORMATION YOU PROVIDED? DID YOU SIGN THE FORM, INDICATE YOUR RELATIONSHIP TO THE INDIVIDUAL IN NEED OF LTC SERVICES AND DATE THE FORM?
6. DID YOU ATTACH PHOTOCOPIES OF THE DOCUMENTATION TO VERIFY YOUR RESOURCES?

FOR DPW USE ONLY

TOTAL VERIFIED COUNTABLE RESOURCES $ _____

SPOUSE'S SHARE 1/2 TOTAL NET VERIFIED RESOURCES $ _____

ASSESSOR'S SIGNATURE _____ DATE _____

NOTICE SENT TO ▶ INDIVIDUAL RECEIVING LTC SERVICES ☐ YES ☐ NO | SPOUSE ☐ YES ☐ NO | LEGAL REPRESENTATIVE ☐ YES ☐ NO