RESET FIELDS

Certification of Payment of Income to Community Spouse or Child

County: Case #

Name:

Mailing Date:

An individual residing in a Long Term Care (LTC) Facility may make income available, within specific state limits, for the support and maintenance of a spouse, dependent child or disabled child remaining at home. This income, when combined with the income of the spouse, dependent child or disabled child at home, may not exceed the monthly amount of $_____.

I understand that I may decrease the amount of the payment or stop making the payment at any time. However, my payment towards the cost of care will be affected if I decrease or stop making the payment to my spouse or child. I agree to notify the county assistance office (CAO) within 10-days if I decrease or stop payments.

I understand that if this form is **not signed and returned to the CAO by** _____, my payment towards the cost of care will be affected.

I hereby certify that I will pay the amount stated below each month to my spouse or child, beginning on the date shown.

DATE PAYMENTS WILL BEGIN: _____ AMOUNT TO BE PAID:_____

Name (Please Print) | Individual or Representative Signature | Date

The signature and address of a witness is required, if the individual in the LTC Facility signed with an "X".

Name (Please Print) | Witness Signature | Date

Address | City | State | Zip