EVALUATION FOR THE PLACEMENT OF LIENS

PART I (To be completed by the Applicant/Recipient or Representative)

The State is required to place a lien on the home property of certain individuals who receive medical assistance in a medical institution. The information you give us will be used to determine if the State should place a lien on your home property. The lien will be for Medicaid payments made on your behalf. The lien does not affect your ownership in the property nor does it require you to sell the property. The lien may be dissolved if you are discharged from the medical institution and return to live in the home.

Female ☐ **Male** ☐ **Married** ☐ **Divorced** ☐ **Widow** ☐ **Single** ☐

PRINT: Last Name _____ First Name _____ M.I. _____ Date of Birth _____ Social Security Number _____

Name of Medical Institution _____ Date of Admission _____

Check the appropriate box:

1. a. Do you own an interest in a house, condominium, apartment or other property that you lived in before you were admitted to the medical institution? ☐ YES ☐ NO
   b. Do you own a life interest or life estate, lease or leasehold interest in a house, condominium, apartment or other property? ☐ YES ☐ NO
   c. Do you have a trust that owns a house, condominium, apartment or other property? ☐ YES ☐ NO
   If yes, must provide copy of the trust.

IMPORTANT: If YES is checked for items #a, #b, or #c, provide the address and approximate value of the property.

Street Address _____ City _____ State _____ $ _____ Approximate Value

2. **Check the appropriate box** if your spouse, your children or your siblings are currently living in your home. For items #d and #e, indicate how long they have continuously lived there:
   a. ☐ Spouse
   b. ☐ Minor Child (Under 21 years old)
   c. ☐ Adult Child Who is Blind or Disabled (As certified by the State or the Social Security Administration)
   d. ☐ Adult Child Who Is Not Blind or Disabled ☐ Less than two years ☐ Two or more years
   e. ☐ Sibling Who has Equity in the Home Property ☐ Less than one year ☐ One or more years

IMPORTANT: If any of the above boxes are checked, please complete Part III.

3. Are you likely to be discharged from the medical institution within the next six months and return to live in your home? Your response does not affect the exempt status of your home in determining your Medicaid eligibility.
   ☐ YES ☐ NO If yes, when? DATE: _____

I have read or had this document read to me and I understand what is stated on this document.

(**Printed** Name of Recipient) _____ **Signature or Mark** _____ Telephone # _____ Date _____

(**Printed** Name of Representative or Witness) _____ **Signature** _____ Telephone # _____ Date _____

Print Mailing Address of Representative or Witness _____ City _____ State _____ Zip Code _____

Representative: Do you have Power of Attorney (POA)? ☐ YES ☐ NO

- If "YES" is checked, representative signing on behalf of a recipient must attach a copy of POA or guardianship document and provide a mailing address.
- Person witnessing a recipient's mark "X" has determined to the best of the witness' knowledge that the recipient is competent and understands his or her actions in signing this document. The use of an "X" is because the recipient can not physically sign the document. (Witness must also sign this document and provide a mailing address.)

PART II (To be completed by DHS)

Case Name: _____ Case Number: _____ Date sent to MQD/FO: _____

PRINT Worker's Name/Telephone #: _____ Section/Unit: _____

Comment: _____

PART III (To be completed by the Recipient)

You indicated in Part I that your spouse, your children or your siblings are currently living in your home. Please list them below. If you need more space, please list the extra members on a separate sheet of paper. You must provide proof of your relationship to these listed individuals. Examples of acceptable verification include: **birth certificates, marriage licenses, joint tax returns or baptismal records.**

Also, if an adult child living in the home is blind or disabled, provide proof of the condition. Examples of acceptable verification include **a Social Security disability award letter or SSI disability award letter.**

You must also provide proof that the listed individuals are living in the home. Examples of acceptable verification must include the individual's name and address on any of the following documents: **a driver's license, State ID, bank statement, utility bill, voter registration or tax return.**

____

PRINT: Name Date of Birth Social Security Number

Relationship to the Recipient:
☐ Spouse ☐ Minor Child ☐ Adult Child: Blind/Disabled ☐ Adult Child: Not Blind/Disabled ☐ Sibling

____

PRINT: Name Date of Birth Social Security Number

Relationship to the Recipient:
☐ Spouse ☐ Minor Child ☐ Adult Child: Blind/Disabled ☐ Adult Child: Not Blind/Disabled ☐ Sibling

____

PRINT: Name Date of Birth Social Security Number

Relationship to the Recipient:
☐ Spouse ☐ Minor Child ☐ Adult Child: Blind/Disabled ☐ Adult Child: Not Blind/Disabled ☐ Sibling

____

PRINT: Name Date of Birth Social Security Number

Relationship to the Recipient:
☐ Spouse ☐ Minor Child ☐ Adult Child: Blind/Disabled ☐ Adult Child: Not Blind/Disabled ☐ Sibling

Did your adult child, **who is not blind or disabled** and has continuously lived with you in your home for 2 or more years, provide services that helped delay your admission to a medical institution? ☐ YES ☐ NO

If yes, briefly describe the services.

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PART IV: (To be completed by DHS)

REQUIREMENTS MET	**YES**	**NO**
Recipient's relationship to family members residing on recipient's home property.	☐	☐
Sibling's equity interest ____% and length of stay ____ mos. on recipient's home property.	☐	☐
Blind/disabled status of adult child(ren) residing on recipient's home property.	☐	☐
Non-blind/disabled adult child(ren) performed services to help delay admission of parent to medical institution and length of stay ____ mos. on recipient's home property.	☐	☐