

Nursing Home

In-Home Care

This form is used to gather other information needed to make a decision about eligibility for Nursing Home, Institutional or In-Home Care. Please answer the following questions as completely as possible as they apply to **the person who is applying and their spouse**. If you are applying on behalf of someone else, enter your name as the Authorized Representative. The rights and responsibilities you agreed to on the original application are still in effect. If you have questions, please contact Healthy Connections at (888) 549-0820. We may ask for additional information or documentation to establish your eligibility.

Name of person needing assistance (First, Middle, Last)

Social Security Number	Medicaid ID	Date of Birth (mm/dd/yyyy)
Authorized Representative (if applicable):		Relationship to Applicant

I. Statement of Transfers

1. In the past five years have you: Yes No
 Closed a Bank Account Closed an Investment Account Closed a Retirement Account
 Transferred Life-Estate Interest In Your Home or Any Other Property

If YES, fill in the following values, if known:

Accounts

Account	Date Closed	Closing Balance	Account	Date Closed	Closing Balance
		\$			\$
		\$			\$

Life Estate Interest

Property	Transfer Date	Appraised Value	Property	Transfer Date	Appraised Value
		\$			\$

2. In the past five years have you sold or given away your home? Yes No

If YES, fill in the following, if known:

Appraised Value Sale Price
 \$ _____ \$ _____

3. In the past five years have you sold or given away other real estate? Yes No

If YES, fill in the following values, if known:

Property	Appraised Value	Sale Price	Property	Appraised Value	Sale Price
	\$	\$		\$	\$
	\$	\$		\$	\$
			TOTAL	\$	\$

4. In the past five years have you sold or given away any motor vehicles, boats, or other recreational vehicle? Yes No

If YES, fill in the following values, if known:

Vehicle	Appraised Value	Sale Price	Vehicle	Appraised Value	Sale Price
_____	\$ _____	\$ _____	_____	\$ _____	\$ _____
Vehicle	Appraised Value	Sale Price			
_____	\$ _____	\$ _____	TOTAL	\$ _____	\$ _____

5. In the past five years have you given away cash? Yes No

If YES:

Person to whom it was given	Date given	Amount
_____	_____	\$ _____
_____	_____	\$ _____

DHHS USE ONLY	CLTC Worker (If Applicable) (Print)		DHHS USE ONLY
	CLTC Worker Signature	Date	

II. Additional Information

6. Please check if anyone has Conservatorship, Guardianship, or Power of Attorney for the applicant. If yes, please enclose a copy of the legal papers.

Conservatorship Name: _____ Phone _____

Guardianship Name: _____ Phone _____

Power of Attorney Name: _____ Phone _____

7. Where is the applicant right now? Home Hospital Nursing Home Other

If not at home, tell us where the applicant is:

Name of facility: _____

Date entered facility: _____

Did the applicant live at home at any time during the month he/she entered the nursing facility? Yes No

8. Where has the applicant lived in the past five (5) years?

Street Address	City	County	State	From (date)	To (date)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

9. If married and entering a nursing home, does the applicant want to give (allocate) part or all of income to a spouse remaining at home? Yes No

10. Does the applicant want to give (allocate) income to dependent adults living in the home or to dependent children? Yes No

11. Does anyone in the applicant's home (including the applicant or applicant's spouse, children or dependent adults) receive or has anyone applied for any other income? Yes No

Before we can make a decision on your application, you may have to give us proof of income for the past 4 weeks. In addition to the income you listed on your application, do you have any of the following? If YES, check all boxes that apply and complete the table below.

- Supplemental Security Income (SSI) Child support Disability benefits
 - Veterans Administration (VA) benefits Military Allotments Other
 - Federal Retirement (Civil Service, FERS) Money from friends or relatives
 - Land contract, mortgage or other notes payable to a household member.
- (Please provide a copy of the contract, mortgage, note or other agreement.)

Person receiving/expecting money	Income source/type	How often received	Amount received
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

12. Has the applicant or spouse ever worked somewhere that has a retirement benefit, military retirement or VA benefit for which he or she may be eligible to receive money? Yes No

If YES, who was working? _____
 Where? _____
 For how long? _____

13. Has the applicant received an inheritance in the last five years? Yes No

If YES, from whom? _____
 Date of Death: _____ State/County where estate was probated _____

Additional Inheritance

If YES, from whom? _____
 Date of Death: _____ State/County where estate was probated _____

14. Do you or your spouse own any property? (Include property in other states.) If YES, check the boxes that apply and tell us about the property. Yes No

- Home (house, buildings and land where you live) Land (not connected to current home)
 Other House or Building (not your home) Vacation Home or Time Share Property

a. What is the address/location of the property? **b. What is the address/location of other property?**
 (List home property first)

Owner's Name: _____ Owner's Name: _____

Is 14-a your Home Property or Primary Residence where you currently live or where you want to return to live if you are living somewhere else? Yes No

15. Please check the box beside any of the items that the applicant, applicant's spouse or applicant's dependent(s) owns or are buying. Tell us about it in the table below.

- | | | |
|---|--|---|
| <input type="checkbox"/> Bank Checking Account | <input type="checkbox"/> Bank Savings Account | <input type="checkbox"/> Car, Truck, Van |
| <input type="checkbox"/> Certificate of Deposit | <input type="checkbox"/> Motorcycle, Boat, Camper | <input type="checkbox"/> Annuity (provide a copy) |
| <input type="checkbox"/> Trust Fund or Trust Account | <input type="checkbox"/> Pre-Need Burial Contract | <input type="checkbox"/> Cash on Hand |
| <input type="checkbox"/> Money Set Aside for Burial | <input type="checkbox"/> Cemetery Burial Space | <input type="checkbox"/> Life Insurance |
| <input type="checkbox"/> 401k, IRA, or Retirement Account | <input type="checkbox"/> Stocks, Bonds, Mutual Funds | |
| <input type="checkbox"/> Farm Machinery or Business Equipment | <input type="checkbox"/> DirectExpress Debit Card for SSA, SSI or other benefits | |
| <input type="checkbox"/> Other: _____ | | |

Owned by	Tell Us About the Asset Include the name of bank or funeral home and any account numbers or other information used to identify the asset.	Current Value or Balance
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

NOTE: When you return this form, you must send proof of these assets or resources, including any supporting documents. You will be asked to send information for the month of application and at least three months prior to the application month.

16. If ever married, give the following information about the applicant's spouse(s).

Never been married

Name of most recent spouse: _____

Living

In a medical facility

Separated: When or How Long? _____

Married, living together

Divorced

Married, living apart

Current Street Address

City

State

ZIP

Phone

Deceased - Date of Death: _____ State/County where estate was probated _____

Name of most recent spouse: _____

Living

In a medical facility

Separated: When or How Long? _____

Married, living together

Divorced

Married, living apart

Current Street Address

City

State

ZIP

Phone

Deceased - Date of Death: _____ State/County where estate was probated _____

ESTATE RECOVERY

(BE SURE TO GET A COPY OF THE ESTATE RECOVERY BROCHURE)

As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:

- A person of any age who was a patient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
- A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

I understand that upon receiving any of these services, the Department of Health and Human Services may file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.

Applicant or Authorized Representative's Signature | **Date**

Mail to: SCDHHS-Central Mail
PO Box 100101
Columbia, SC 29202-3101