

Request for Assessment – Spousal Impoverishment

Date: _____

Institutionalized Spouse's Name: _____

Address: _____

Telephone Number: _____

Community Spouse's Name: _____

Current Address: _____

Telephone Number: _____

I/we request an assessment of the items checked below:

- Couple's countable resources and the community spouse resource allowance
- Community spouse monthly income allowance
- Family member allowance(s)

Check if you are a representative acting on behalf of either spouse. Please call your local department of social services if we do not contact you within 10 days of this request.

NOTE:

If an assessment is requested without a Medicaid application, the local department of social services may charge up to \$25 for the cost of preparing and copying the assessment and documentation.

Signature of Requesting Individual _____

Address and telephone number is different from above

