STATE OF NEW YORK
DEPARTMENT OF HEALTH

Date:

Request for Assessment Form

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 # if different from above

_____

_____

_____