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|  | HOME AND COMMUNITY SERVICES**Long-Term Care Partnership (LTCP)Asset Designation** | **FOR OFFICE USE ONLY** |
| CLIENT ID NUMBER |
| NAME | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
| **Part A. This section must be completed by the insurance company that issued your LTC Partnership Policy (LTCP).** |
| NAME OF INSURED |
| POLICY / CERTIFICATE NUMBER | EFFECTIVE DATE OF COVERAGE |
| This policy / certificate was issued in the state of:  Date policy issue:  The current cumulative dollar amount of insurance benefits paid: **$** The current total dollar amount of insurance benefits remaining available under the policy: **$**  |
| NAME OF PERSON COMPLETING THIS FORM | INSURANCE COMPANY PHONE NUMBER |
| E-MAIL ADDRESS OF INDIVIDUAL FROM INSURANCE COMPANY COMPLETING PART A |
| INSURANCE COMPANY NAME |
| ADDRESS OF INSURANCE COMPANY |
| **I hereby certify the above information is true and accurate and that the coverage has partnership status in Washington at the time of this certification.** |
| **[ ]  Meets LTCP criteria [ ]  Does not meet LTCP criteria based on Chapter 284-83 WAC** |
| SIGNATURE OF INDIVIDUAL FROM INSURANCE COMPANY COMPLETING PART A DATE |
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| **DSHS 10-438 (REV. 12/2013)** |  |  |

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| **Part B. LTC Medicaid client completes this section. List and attach proof of the current value of assets you designate for Asset Protection. Note: Assets are only protected up to an amount equal to the benefits you have received from your qualifying LTC Partnership policy.**  |
| TYPE OF ASSET | WHO OWNS THEASSET(YOU, SPOUSE, JOINTLY) | WHERE IS ASSET LOCATED? | ACCOUNT/ PARCEL/ CERTIFICATE NUMBER | AMOUNT OR VALUE OF ASSET (ATTACH PROOF) | **FOR OFFICE USE ONLY** |
| COUNTABLEASSETVALUE | VALUE OF ASSETEXCLUDED DUE TO PAID LTCP |
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| Your resource exemption is based on the dollar amount paid out by a qualified long-term care partnership insurance policy as described in WAC 388-513-1400. Return this completed form to the DSHS office handling your Medicaid eligibility.  | **TOTAL VALUE** | **TOTAL EXCLUDED RESOURCES** |
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| **I declare under penalty of perjury the information I gave in this declaration is true and complete.** |
| CLIENT’S SIGNATURE DATE  | SPOUSE’S SIGNATURE DATE  |
| FINANCIAL SERVICES SPECIALIST SIGNATURE DATE  |

**DSHS 10-438 (REV. 12/2013)**