

PROPOSED 45-DAY

Application for Hardship Waiver

Submission of this application is necessary to apply for a waiver of the claim due to substantial hardship. Only the applicant's proportionate share of the claim can be waived. An applicant has **60 days** from the date stated on the Department of Health Care Services' (Department) notice of claim in which to submit an application. All of the information requested in the application is voluntary; however, failure to completely and accurately provide the information may result in a denial of the waiver application.

A substantial hardship shall not exist when the decedent or applicant created the hardship by using estate planning methods to divert or shelter assets in order to avoid estate recovery.

A. ESTATE OF: Case Number: Date of Application:

Total Value of Estate: Claim Amount: Your Share of Estate: (50%, 75%, 100% etc). Attach a copy of the Will or Trust

B. APPLICANT'S NAME (First, Middle, Last): Social Security Number: Driver's License/ID Number: Birth Date (mm/dd/yy):

Relationship to Decedent:

Street Address: City: State: Zip: Telephone Number: ()

P. O. Box City: State: Zip:

Spouse/Registered Domestic Partner's Name: Social Security Number: Driver's License/ID Number: Birth Date (mm/dd/yy): (First, Middle, Last)

Applicant's Employer: Address: City/State/Zip: Telephone Number: ()

Spouse/Registered Domestic Partner's Employer: Address: City/State/Zip: Telephone Number: ()

Are there any unmarried children, or any other persons, living with the applicant? Yes () No ()

If yes, list their name, birth date, and relationship to applicant.

Name (First, Middle, Last): Birth Date (mm/dd/yy): Relationship to Applicant:

Name (First, Middle, Last): Birth Date (mm/dd/yy): Relationship to Applicant:

Name (First, Middle, Last): Birth Date (mm/dd/yy): Relationship to Applicant:

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C. Criteria for Hardship Waiver consideration can be found in the California Code of Regulations, Section 50963. Please check the criteria below that qualifies the applicant for a hardship waiver. Attach documentation that provides substantiation for the criteria selected. Failure to provide sufficient substantiation may result in a denial of the waiver.

- () Receiving the inheritance from the estate will enable the applicant to discontinue eligibility for public assistance payments and/or medical assistance programs.
- () The estate property is part of an income-producing business, including a working farm or ranch, and recovery of medical assistance expenditures would result in the applicant losing his or her primary source of income.
- () The applicant is aged, blind, or disabled and has continuously lived in the decedent's home for at least one year prior to the decedent's death and continues to reside there, and is unable to obtain financing to repay the State. The applicant shall apply to obtain financing, for an amount not to exceed his or her proportionate share of the claim, from a financial institution as defined in Probate Code Section 40. The applicant shall provide the Department with a denial letter(s) from the financial institution.
- () The applicant provided care to the decedent for two or more years that prevented or delayed the decedent's admission to a medical or long-term care institution. The applicant must have resided in the decedent's home during the period care was provided and continue to reside in the decedent's home. The applicant must provide written medical substantiation from a licensed health care provider(s), which clearly indicates that the level and duration of care provided prevented or delayed the decedent from being placed in a medical or long-term care institution.
- () The applicant transferred the property to the decedent for no consideration.
- () The equity in the real property is needed by the applicant to make the property habitable, or to acquire the necessities of life, such as food, clothing, shelter or medical care.

D. DECEDENT'S ESTATE CONSISTS OF: Check all applicable assets and complete all related information. List all estate assets including property conveyed through joint tenancy, tenancy in common, life estate, living, trust, annuities purchased on or after September 1, 2004, life insurance policy, or retirement account. Please attach copies of recorded deed(s), registration(s), bank statement(s), listing agreements/contracts, life insurance policy statements, stocks, bonds, and annuity documentation, etc.

	Market Value \$	Mortgage Owed \$	Is the property listed for sale? Yes () No () If no, Please explain.
() Real Property	_____	_____	_____
() Mobile Home	_____	_____	_____

Estate Property Street Address: _____ City: _____ State: _____ Zip: _____

Is anyone living in the property? Yes () No () If yes, how long have they lived in the property? _____

Is the property being rented? Yes () No () Amount of monthly rent collected. Name and relationship to decedent, (if any). _____

Are you paying space rent for the mobile home? Yes () No () If yes, how much? (Attach statement) _____

Is the estate property held in a trust? Yes () No () Type of trust? (Attach copy of Trust document) _____

Is this estate property part of an income producing business, including a working farm or ranch? Yes () No ()
If yes, is this your primary source of income? Yes () No ()
(Please include as other income in Section E.)

() Bank Account	Checking \$	Savings \$	Name and Address of Bank	Account Number
() Annuities	Value \$	Type	Date Purchased	
() Life Estate	Value \$	Type		

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() Life Insurance Policy	Value \$	Beneficiary(s)	
() Retirement Accounts	Value \$	Beneficiary(s)	Type (CDs/IRA/ROTH IRA/Other)
() Stocks/Bonds/Notes/Other	Value \$	Type	Date Purchased

E. APPLICANT'S MONTHLY INCOME. Please attach copy of most recent federal and state income tax return.

Applicant's Net Pay (Attach two months most recent pay stubs) (If not monthly, please indicate weekly, bi-weekly, etc.)	\$ _____
Spouse/Registered Domestic Partner's Net Pay (Attach two months most recent pay stubs) (If not monthly, please indicate weekly, bi-weekly, etc.)	\$ _____
Rent/household contributions Paid to Applicant (Please provide rental agreement)	\$ _____
Social Security/Retirement/Pensions/Annuities (Attach two most recent stubs)	\$ _____
Business Income (Attach Profit & Loss statement)	\$ _____
Disability (Attach award letter)	\$ _____
Public Assistance (Attach award letter)	\$ _____
Other income (source): _____	\$ _____
Dividends, interest, child support, alimony, tips, commissions, etc. (Attach documentation supporting other income)	
TOTAL INCOME	\$ _____

**F. APPLICANT'S MONTHLY EXPENSES.
If monthly expenses exceed monthly income, an explanation must be provided (please attach separately):**

Mortgage/Rent (Attach copy of annual mortgage statement/rent agreement/receipts)	\$ _____
Alimony/Child Support paid to: (Please provide documentation of 3 months of payments)	\$ _____
Name: _____	
Address: _____	
Telephone: _____	
Groceries	\$ _____
Utilities (Attach documentation of 3 months of bills)	\$ _____
Medical (Attach copy of outstanding bills not paid by insurance)	\$ _____
Insurance (Attach copy of statement for auto, health, life, homeowners, etc.)	\$ _____
Auto Expenses (Include car payments, gas, maintenance receipts)	\$ _____
Installment Payments (Attach copy of statements)	\$ _____
Other Expenses (Explain) _____ (Attach documentation supporting other expenses)	\$ _____
TOTAL MONTHLY EXPENSES	\$ _____

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PRIVACY STATEMENT

The Information Practices Act of 1977 (California Civil Code, section 1798.1, et. seq.) and the Federal Privacy Act of 1974 (Title 5, United States Code, section 552a, et. seq.) require that this notice be provided when collecting personal information from individuals.

The California Department of Health Care Services' (Department) Third Party Liability and Recovery Division's Recovery Branch, is seeking the information requested on the Application for Hardship Waiver. The person responsible for the system of records for information obtained from the application is the Chief of the Third Party Liability and Recovery Division, MS 4718, P.O. Box 997425, Sacramento, CA, 95899-7425.

This information is being collected pursuant to the authority granted to the Department by Welfare & Institutions Code, section 14009.5, and, Title 22, California Code of Regulations, section 50960, et. seq.

All of the information requested in the application is voluntary; however, failure to completely and accurately provide the information may result in a denial of the waiver application. The principle purpose for which the information will be used is to assess an applicant's financial condition, to determine if hardship criteria apply to the applicant, and to verify information stated in the application in an effort to circumvent any form of fraud against the Medi-Cal program.

The Department does not have any known or foreseeable disclosures that may be made of the information. The applicant has a right of access to records containing personal information maintained by the Department.