ASSET ASSESSMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID ELIGIBILITY
SFN 200 (12-2024)

Clear Fields

* The Privacy Act of 1974 requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary and it is requested for identification purposes. It will not be disclosed for any reason. Failure to provide social security numbers could affect participation in this program per North Dakota Administrative Code 75-02-02.1-02.1.

SPOUSE IN NURSING FACILITY OR RECEIVING HOME AND COMMUNITY BASED SERVICES:

Name of Spouse	Date of Birth	Social Security Number*	
Name of Facility		Date of Entry	
Facility Address	City	State	ZIP Code

SPOUSE IN COMMUNITY:

Name of Spouse			
Telephone Number	Date of Birth	Social Security Number*	
Home Address	City	State	ZIP Code

Complete this section of the form by listing all of the assets that either you or your spouse owned **on the day you entered the facility, or began receiving home and community based services.** Include any assets that you or your spouse own with someone else. If you need more space, please attach another sheet of paper. **The answers that you give on this form will have to be verified.** When you are done with PART I, return it to the Human Service Zone Office listed on the back of this form along with your verifications. The Human Service Zone Office will then complete PART II of the form and return it to you within thirty days of the date that all verifications are provided to the Human Service Zone Office.

		AGENCY USE ONLY	
		Countable Amount	*Comments*
1. Cash on Hand (include savings at home or at the facility)	$		

2. Bank Accounts (savings, checking, credit union, CD's, etc.):

BANK NAME/ACCOUNT NUMBER	TYPE OF ACCOUNT/OWNER	DESIGNATED FOR BURIAL	AMOUNT	
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

3. Stocks, Bonds, etc.:

NAME OF COMPANY	TYPE/OWNER	DESIGNATED FOR BURIAL	AMOUNT	
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

	AGENCY USE ONLY	
	Countable Amount	*Comments*

4. Burial Plans/Accounts: (describe and give value)

TYPE OF ACCOUNT/OWNER	COST BASIS (amount of money invested)	Cash Surrender Value	FACE VALUE		

5. Life/Burial Insurance:

Name of Insurance Company	Type of Policy	Name of Policy Owner		
Cost Basis (amount of money invested)	Cash Surrender Value	Face Value		
Name of Insurance Company	Type of Policy	Name of Policy Owner		
Cost Basis (amount of money invested)	Cash Surrender Value	Face Value		
Name of Insurance Company	Type of Policy	Name of Policy Owner		
Cost Basis (amount of money invested)	Cash Surrender Value	Face Value		

6. IRA, Pensions:

NAME OF COMPANY	OWNER	Date of First Payment	Amount of Payment	Cash Surrender Value		

7. Annuities: (**attach a complete copy**)

NAME OF COMPANY	OWNER/ANNUITANT	Date of First Payment	Amount of Payment	Cash Surrender Value		

8. Vehicles:

MAKE/MODEL/YEAR	VALUE AMOUNT	AMOUNT OWED		
List Any Vehicles for Sale				

9. Land, Buildings, Contract -for-Deed, etc

LEGAL DESCRIPTION/ADDRESS	VALUE AMOUNT	AMOUNT OWED		
List any of the above property that is for sale				
List any of the above property that is income producing				

10. Trusts

OWNER	IS THE TRUST AVAILABLE?	IF YES, LIST VALUE	AGENCY USE ONLY: *Countable Amount*	AGENCY USE ONLY: *Comments*
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

11. Mineral Acres/Rights

OWNER	LOCATION		

12. Other Assets: (campers, mobile homes, boats, machinery, livestock, etc.)

TYPE OF ASSET/OWNER	VALUE AMOUNT	AMOUNT OWED		
		TOTAL ASSETS		

READ ALL OF THE INFORMATION BELOW BEFORE YOU SIGN THIS FORM!

When PART I of this form is received, we can determine which assets are not counted, the amount of assets that you and your spouse may keep, and the amount you need to spend down. When we complete PART II of this form a copy will be sent to you.

Line 1 shows the total amount of your assets that are countable.
Line 2 is the community spouse share which is 1/2 of the total countable assets.
Line 3 is the amount the community spouse is allowed to keep based on minimum and maximum limits. *
Line 4 is the amount the institutionalized or home and community based care spouse is allowed to keep.
Line 5 is the amount you will need to spend down.

*** The amount of assets which the community spouse may keep is determined by this assessment. This amount will NOT change if your total assets go up or down between now and the time you become eligible for Medicaid. You have the right, at the time you apply for Medicaid, to request an appeal if you feel that the community spouse asset allowance is wrong or that it will cause a hardship to your spouse.**

If you have questions about this form contact:

Human Service Zone	Telephone Number

I declare that this form has been read by me and I believe the information provided by me is true and correct to the best of my knowledge.

Signature of Institutionalized Person, Their Spouse, or Authorized Representative	Date

PART II

To be completed by the county social service board.

1. Total countable assets	
2. Community spouse share (1/2 of the total countable assets)	$0.00
3. Community spouse asset allowance (the community spouse share, but not less than the minimum, or more than the maximum allowed) based on minimum and maximum in the year of the first continuous period of institutionalization	
4. Institutionalized/home and community based care spouse asset allowance	$ 3,000.00
5. Excess assets (Line 1 minus Line 3 minus Line 4)	($3,000.00)

Comments			
Completed By		Human Service Zone	Date
Date Part I Received	Case Number	Application for Medicaid on file? ☐ Yes ☐ No	

Distribution: Original: Spouse in Facility; Copy: Spouse in community; Copy: Medicaid Policy (hccpolicy@nd.gov); Copy: Human Service Zone