



**ASSET ASSESSMENT**  
 ND DEPARTMENT OF HUMAN SERVICES/Medicaid Eligibility  
 SFN 200 (Rev. 8-2003)

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

Name:		
Facility:	Date of Entry/Beginning of Care:	
Facility Address:		
City:	State:	Zip Code:

**SPOUSE IN COMMUNITY:**

Name:		
Address:	Telephone Number:	
City:	State:	Zip Code:

**PART I**

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 county social service office listed on the back of this form, along with your verifications. The county will then complete PART II of the form and return it to you within thirty days.

1. Cash on hand (include savings at home or at the facility)		\$	AGENCY USE ONLY
2. Bank accounts (savings, checking, credit union, CD's, etc.)			
<b>BANK NAME</b>	<b>TYPE OF ACCOUNT</b>	<b>AMOUNT</b>	
3. Stocks, bonds, IRAs, contract-for-deed, etc.:			
<b>TYPE</b>	<b>OWNER</b>	<b>AMOUNT</b>	
4. Life/Burial Insurance:			
Insurance Co.	Policy Owner:		
Face Value:	Cash Surrender Value:		
Insurance Co.	Policy Owner:		
Face Value:	Cash Surrender Value:		
5. Burial plans/accounts/trusts: (Please describe and give value)			
6. Annuities: (Please identify owner and attach copy)			
7. Vehicles:			
<b>MAKE/MODEL/YEAR</b>	<b>VALUE AMOUNT</b>	<b>AMOUNT OWED</b>	
8. Land, buildings, contract for deed, etc.			
<b>DESCRIPTION</b>	<b>EST. MARKET VALUE</b>	<b>BALANCE OWED</b>	
List any of the above property that is for sale:			
List any of the above property that is income producing:			
9. Other Assets: (campers, mobile homes, boats, machinery, livestock, etc.)			
<b>SPECIFY</b>	<b>VALUE AMOUNT</b>	<b>AMOUNT OWED</b>	

**GO TO BACK**

**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 and will NOT change if your total assets go up or down between now and the time you become eligible for Medicaid. It may only change if you are at the minimum or maximum and if those amounts are different at the time you apply 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:**

County Agency:	Telephone Number:
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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:
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**PART II**

**To be completed by the county social service board.**

1. Total countable assets:	\$
2. Community spouse share: (1/2 of total accountable assets)	\$
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 year completed:	\$
4. Institutionalized/home and community based care spouse asset allowance:	\$ 3,000.00
5. Excess assets: (Total countable assets less the community spouse asset allowance, and less the institutionalized/home and community based care spouse asset allowance)	\$
Comments:	

Completed By:	County:	Date:
Date Part I Received:	Application for Medicaid on file? Yes      No	