# ASSET ASSESSMENT

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES/Medicaid Eligibility

SFN 200 (Rev. 2-2017)

Clear Fields

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

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

**SPOUSE IN COMMUNITY:**

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

* 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.

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 of the date that all verifications are provided to the county 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

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

| TYPE OF ACCOUNT/OWNER | COST BASIS (amount of money invested) | Cash Surrender Value | FACE VALUE | *Countable Amount* | *Comments* |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**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 | | |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
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**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 | MARKET VALUE | 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 | AGENCY USE ONLY: *Countable Amount* | AGENCY USE ONLY: *Comments* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

| TYPE OF ASSET/OWNER | VALUE AMOUNT | AMOUNT OWED | AGENCY USE ONLY: *Countable Amount* | AGENCY USE ONLY: *Comments* |
|---|---|---|---|---|
| | | | | |
| | | | | |
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| | | | | |

**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. The amount you keep may change if it is determined you are at the minimum or maximum asset limit, and these limits 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 |
|---|---|
| | |

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) | |
| 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)) | |

| Comments | | | |
|---|---|---|---|
| | | | |
| Completed By | | County | 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: County Office