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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 THE  ASSET  (YOU, SPOUSE, JOINTLY) | WHERE IS ASSET LOCATED? | | ACCOUNT/ PARCEL/ CERTIFICATE NUMBER | AMOUNT OR VALUE OF ASSET (ATTACH PROOF) | **FOR OFFICE USE ONLY** | |
| COUNTABLE  ASSET  VALUE | VALUE OF ASSET  EXCLUDED 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** |
|  |  |
| **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 | | |

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