Washington State Department of Social & Health Services
ALTSA Aging and Long-Term Support Administration

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

Barcode label

10438

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
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		