Washington State Department of Social & Health Services
Transforming lives

Eligibility Review for Long Term Services and Supports

Client Name (first, middle initial, last)			Client ID Number
Client Address	City	State	Zip Code
Client Mailing Address	City	State	Zip Code
Spouse or Parent of Minor Child Name (first, middle initial, last)			
Spouse / Parent Address (if different)	City	State	Zip Code
Client Phone Number (include area code) ☐ Home ☐ Cell ☐ Message	Client Email		

Authorized Representative

An Authorized Representative is someone you allow the agency or their designee to talk with about your benefits. You can name someone, but it's not required. Examples are guardian, spouse, relative, attorney-in-fact.

Do you have an Authorized Representative? ☐ Yes ☐ No

Name	Relationship		
Mailing Address	City	State	Zip Code
Phone Number (include area code)	Email		

Client's Unearned Income	Amount
Social Security Benefits	$
Retirement / Pension / Annuity	$
Other - Veterans benefits, L&I, alimony, dividends, interest, rental or quarterly income (list below)	
	$
	$
	$
	$
	$

Client's Earned Income			
Employer	Start Date	Gross Amount Received	Pay Frequency

Is this income from Self Employment? ☐ Yes ☐ No

Client Resources		
	Value	Financial Institution / Company / Location
Checking Accounts	$	
Savings Accounts	$	
Other Financial Accounts:	$	
	$	
Certificates of Deposit (CD)	$	
Account held by Facility	$	
Cash on hand / held by others	$	
Life / Burial Insurance policies	$	
Burial Funds	$	
Trusts	$	
Annuities	$	
Home (including life estate)	$	
Other Property:	$	
	$	
Other – vehicles, stocks, bonds, mutual funds, retirement accounts (list below)		
	$	
	$	
	$	

Have you sold, traded or given away your money, home, property or other resources in the last five years? ☐ Yes ☐ No

If yes, complete the following:

Type	To Whom	Amount	Date Transferred
		$	
		$	
		$	

Client's Medical Expenses and Guardian / Payee Fees (attach proof)	Amount
Health Insurance (list providers)	$
	$
Long-term Care Insurance (list provider)	$
Monthly Guardian Fees	$
Monthly Payee Fees	$
Unpaid Medical Bills (list)	$
	$
Marital Status	
Has your marital status changed? ☐ Yes ☐ No	
Spouse / Dependent Income	**Amount**
Social Security Benefits	$
Retirement / Pension / Annuity	$
	$
Earnings	$
	$
Veteran's Benefits	$
Other – L&I, alimony, dividends, interest, rental or quarterly income (list below)	
	$
	$
Housing Expenses	**Amount**
Rent / Mortgage	$
Property Tax / Home Insurance	$
Utilities	$
Other - Assessments, Condo or Co-Op Fees, Space Rent, etc.	$

Authorization for Asset Verification

I understand the information I provide to apply for or renew assistance will be subject to verification by federal and state officials to determine if it is correct. I authorize the Washington State Health Care Authority (HCA) and Department of Social and Health Services (DSHS) to conduct asset verification to determine my eligibility and to verify the accuracy of my financial information. I understand the HCA and DSHS may investigate and contact any financial institution as part of the asset verification process. I understand this authorization ends when a final adverse decision is made on my application, my eligibility for benefits ends, or if I revoke this authorization at any time by providing HCA or DSHS with written notice. Should I revoke or refuse to provide authorization, I understand that I will not be eligible for any Washington Apple Health Aged, Blind or Disabled Medicaid program. Revocation or refusal to authorize asset verification does not impact eligibility for Tailored Supports for Older Adults (TSOA).

Declaration and Signature(s)

I have read, or have had explained to me, the eligibility review form and my rights and responsibilities and received a copy of the Health Care Coverage Rights and Responsibilities form, HCA 18-011.

I understand the information I provide to apply for assistance will be subject to verification by federal and state officials to determine if it is correct. If I have an interest in an annuity, I must name the State of Washington as a remainder beneficiary.

I declare, under penalty of perjury under the laws of the State of Washington, that the information I have given in this form is true, correct, and complete to the best of my knowledge.

Signature of Client	Phone Number	Date
Signature of Spouse	Phone Number	Date
Signature of Parent for Minor Child Client	Phone Number	Date
Signature of Authorized Representative or Helper	Phone Number	Date