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|  | **Asset Verification Authorization** | | Client’s Name |
| ACES ID Number |
| I understand the following:   * Information provided to apply for or renew medical assistance is subject to verification by federal and state officials to determine if it is correct. * The Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) may investigate and contact any financial institution as part of the asset verification process. * This authorization ends when:   + A final adverse decision is made on my application, or   + My benefits end, or   + I revoke the authorization, at any time, by providing HCA or DSHS written notice.   If I revoke or refuse to provide authorization, I understand that I won’t be eligible for any Washington Apple Health aged, blind or disabled SSI-related Medicaid programs. This doesn’t affect my ability to apply for cash, food, and/or childcare.  I authorize HCA and DSHS to conduct asset verification to determine eligibility and to verify the accuracy of financial institution information.  Sign acknowledgement below as appropriate and provide printed name. | | | |
| Signature of Client Date | | Printed Name | |
| Signature of Spouse Date | | Printed Name | |
| Signature of Parent for Minor Child Client Date | | Printed Name | |
| Signature of Authorized Representative Date | | Printed Name | |