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|  | **Asset VerificationAuthorization** | 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 |