Application for Hardship Waiver

Submission of this Application for Hardship Waiver (Application) and documentation is necessary to apply for a waiver of the applicant's proportionate share of the estate claim. An applicant has 60 days from the date stated on the Department of Health Care Services' (Department/DHCS) notice of claim to submit an Application. All of the information requested in the Application is voluntary; however, failure to provide accurate documentation to substantiate hardship may result in a denial of the Application. A signature is required to process an Application. It is not necessary for the applicant to submit documentation previously received by the Department. The Department reserves the right to request additional documentation.

A substantial hardship shall not exist when the decedent or applicant created the hardship by using estate planning methods to divert or shelter assets in order to avoid estate recovery.

Please mail completed forms to:

Department of Health Care Services
Estate Recovery Section
P.O. Box 997425, MS 4720
Sacramento, CA 95899-7425

For questions on the form, please call the collection representative assigned to your case or the Estate Recovery mainline at 916-650-0490.

Si prefiere acceso a esta forma en Español, por favor visite nuestra pagina de web http://www.dhcs.ca.gov/services/Pages/SubstantialHardshipCriteria.aspx o puede contactar a su representante de colección para solicitar una copia.

All applicants must complete Sections A, B, C and G. Applicants must also submit requested documentation and complete other sections, as specified in Section C.

Section A - Decedent's Estate Information

Complete all applicable estate information.

- Decedent's Name: _____
- DHCS Account Number: _____

Did the decedent have a spouse or registered domestic partner who died before the decedent and who was also on Medi-Cal?

☐ Yes ☐ No If yes, please provide the following:

- Predeceased Spouse/Registered Domestic Partner's Name: _____
- DHCS Account Number: _____

Section A continued:

Is the **estate property** held in a trust?

☐ Yes ☐ No If yes, attach a complete copy of the trust document with amendments.

Is there a will?

☐ Yes ☐ No If yes, attach a copy of the will.

Estate Property Street Address _____ City _____ State ____ Zip _____

☐ Real Property/House(s)

Market Value: $_____ Mortgage Owed: $_____
(Attach deed, mortgage statement and appraisal or comparative market analysis that values the property at the time of the decedent's death, if applicable)

☐ Mobile Home(s)

Market Value: $_____ Mortgage Owed: $_____
(Attach registration, mortgage statement and appraisal that values the property at the time of the decedent's death, if applicable)

Is/Was the property listed for sale?

☐ Yes ☐ No

If yes, provide a copy of the listing agreement. If the property has sold, attach a copy of the settlement statement.

Other Assets in the decedent's name at the time of death (Attach copies of statements, contracts, policies, etc.):

☐ Bank Account(s) (Attach statement(s) as of date of death)

Checking ☐ Yes ☐ No Amount: $_____

Savings ☐ Yes ☐ No Amount: $_____

☐ Annuities (Attach contract with proof of purchase date) Value: $_____

☐ Life Insurance Policy Value: $_____
Beneficiary(s): _____
(Attach copy of paperwork showing named beneficiary(s), if applicable)

☐ Retirement Accounts (CD/IRA/401K/Other) Value: $_____
Beneficiary(s): _____
(Attach copy of paperwork showing named beneficiary(s), if applicable)

Section A continued:

☐ Stocks/Bonds/Notes/Other Personal Property (automobiles, etc.) in the decedent's name at the time of death

Type of Other Property: _____ Value: $_____

Type of Other Property: _____ Value: $_____

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Type of Other Property: _____ Value: $_____

Type of Other Property: _____ Value: $_____

Are there estate expenses?

☐ Yes ☐ No

(Bills or expenses paid by the applicant after the decedent's death on his/her behalf, including burial expenses, out-of-pocket administration expenses, such as mortgage payments, attorney fees, taxes, insurance, etc.) Please list expenses and provide copies of receipts or statements.

Type of Expense: _____ Amount: $_____

Type of Expense: _____ Amount: $_____

Type of Expense: _____ Amount: $_____

Type of Expense: _____ Amount: $_____

Type of Expense: _____ Amount: $_____

Section B - Applicant Information

Name (First, Middle, Last) _____ Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

Address _____ City _____ State _____ Zip _____ Telephone Number _____

Relationship to Decedent

_____

Section C - Hardship Waiver Criteria

Check all applicable criteria below (1-6) that qualify the applicant for a hardship waiver (see Title 22, California Code of Regulations, section 50963). Applicants must also submit the requested documentation and complete other sections as listed below each criterion. Criteria are found on pages 4, 5 and 6.

1. ☐ **Receiving the inheritance from the estate will enable the applicant to discontinue eligibility for public assistance payments and/or medical assistance programs.**

Please submit:

- A letter from the applicant's county social services worker that proves receipt of the inheritance would discontinue the applicant's eligibility from public assistance payments and/or medical assistance programs, **or**
- Proof of eligibility for benefits received by the applicant, **and**
- Proof that the inheritance would discontinue the benefits received by the applicant.

Please complete:

- "Certification," Section G, on page 7.
- If criterion 1 is the only basis for the applicant's request, skip Sections D, E and F.

2. ☐ **The estate property is part of an income-producing business, including a working farm or ranch, and recovery of medical assistance expenditures would result in the applicant losing his or her primary source of income.**

Please complete:

- "Applicant's Monthly Income," Section D, on page 6 and "Certification," Section G, on page 7.
- If criterion 2 is the only basis for the applicant's request, skip Sections E and F.

3. ☐ **The applicant is aged, blind, or disabled and has continuously lived in the decedent's home for at least one year prior to the decedent's death and continues to reside there, and is unable to obtain financing to repay the State.**

The applicant shall apply to obtain financing, for an amount not to exceed his or her proportionate share of the claim, from a financial institution as defined in Probate Code Section 40. The applicant shall provide the Department with a denial letter(s) from the financial institution.

Please submit:

- Proof that the applicant is aged (65 years or older), blind, or disabled within the meaning of Section 1614 of the Federal Social Security Act (42 USC Section 1382c); documentation may include a Supplemental Security Income or Social Security Disability Insurance award letter, etc., **and**
- Proof that the applicant lived in the decedent's home for at least one year prior to the decedent's death; documentation may include a utility bill, bank statement in applicant's name, etc., **and**

Section C Continued:

- Proof that the applicant continues to reside in the decedent's home; documentation may include a utility bill, bank statement in the applicant's name, etc., **and**
- A denial letter from a financial institution (a bank, savings and loan, credit union, etc.) for the applicant's share of the claim or the applicant's share of the estate, whichever is less.

Please complete:

- "Certification," Section G, on page 7.
- If criterion 3 is the only basis for the applicant's request, skip Sections D, E and F.

4. ☐ **The applicant provided care to the decedent for two or more years that prevented or delayed the decedent's admission to a medical or long-term care institution. The applicant must have resided in the decedent's home during the period of time that care was provided and continues to reside in the decedent's home.**

The applicant must provide written medical substantiation from a licensed health care provider(s), which clearly indicates that the level and duration of care provided prevented or delayed the decedent from being placed in a medical or long-term care institution.

Please submit:

- Written medical substantiation from a licensed health care provider(s) stating that the applicant provided care to the decedent for two or more years that prevented or delayed the decedent's admission to a medical or long-term care institution, **and**
- Proof that the applicant resided in the decedent's home and continues to reside in the decedent's home; documentation may include a utility bill, bank statement in the applicant's name, etc.

Please complete:

- "Certification," Section G, on page 7.
- If criterion 4 is the only basis for the applicant's request, skip Sections D, E and F.

5. ☐ **The applicant transferred the property to the decedent for no consideration.**

Please submit:

- Documentation to substantiate that the property was transferred to the decedent for no consideration. Documentation may include, deed history, bank statements, mortgage statements, etc.

Please complete:

- "Certification," Section G, on page 7.
- If criterion 5 is the only basis for the applicant's request, skip Sections D, E and

6. ☐ **A) The equity in the real property is needed by the applicant to make the property habitable.**

Please submit:

- Proof that there is equity in the estate real property; documentation may include an appraisal or comparative market analysis, mortgage statement, etc., **and**

Section C Continued:

- Proof that the property is not habitable; documentation may include an inspection report from a licensed contractor documenting the repairs needed and associated costs to make the property habitable, etc.

Please complete:

- "Certification," Section G, on page 7.
- If criterion 6A is the only basis for the applicant's request, skip Sections D, E and F.

OR

6. ☐ **B) The equity in the real property is needed to acquire the necessities of life, such as food, clothing, shelter, or medical care.**

Please submit:

- Proof that there is equity in the estate real property; documentation may include an appraisal or comparative market analysis, mortgage statement, etc.

Please complete:

- "Applicant's Monthly Income," Section D, on page 6 and "Applicant's Monthly Expenses," "Applicant's Value of Assets," and "Certification," Sections E, F and G, on page 7.

Section D - Applicant's Monthly Income

Please complete Section D for Criteria 2 and 6B, as instructed under Section C, and submit the documentation listed below (as applicable). Skip this section if you are only applying based on Section C, criteria 1, 3, 4, 5 or 6A.

Your Gross Pay: $_____ Spouse's/Other Adult's Gross Pay: $_____

Rents/Contribution Paid to You: $_____ Retirement/Pensions: $_____

Social Security: $_____ Disability: $_____ Public Assistance $_____

Profit from Your Business: $_____ Commissions: $_____

Other Income (Source): Dividends, Interest, Child Support, Alimony, Tips, etc. $_____

TOTAL MONTHLY INCOME: $_____

Please submit copies of: most recent tax statements, (IRS Form 1040, 1040E, 1040A); two most recent pay stubs for each adult member of the household; two most recent retirement/pension stubs; Supplemental Security Income or Social Security Disability Insurance award letter.

Section E - Applicant's Monthly Expenses

Please complete Section E for criterion 6B, as instructed under Section C, and submit the documentation requested below (as applicable). Skip this section if you are only applying based on Section C, criteria 1, 2, 3, 4, 5 or 6A.

Mortgage/Rent : $_____ Alimony/Child Support: $_____ Auto Expenses: $_____

Groceries: $_____ Utilities: $_____ Medical: $_____ Insurance: $_____

Total Installment Payments (Credit Card, Student Loans, etc.): $_____ Other Expenses: $_____

TOTAL MONTHLY EXPENSES: $_____

Please submit copies of mortgage statements or rent receipts.

Section F - Applicant's Value of Assets

Please complete Section F for criterion 6B, as instructed under Section C. Skip this section if you are only applying based on Section C, criteria 1, 2, 3, 4, 5 or 6A.

Real Property Value: $_____ Checking/Savings Account: $_____

Money Market Account: $_____ CD: $_____ Stocks/Bonds: $_____

IRA/401K: $_____ Life Insurance/Annuities: $_____ Rental Property: $_____

Automobiles: $_____ Other Assets: $_____ **TOTAL ASSETS: $**_____

Section G - Certification

I understand that the information provided on this Application and the documentation submitted are subject to investigation and verification and that additional information or documentation may be requested. I declare under penalty of perjury that the information provided on this form and documentation submitted are true and correct to the best of my knowledge.

Signature of Applicant	Print or Type Full Name	Telephone Number	Date

(if different from applicant)

Signature of Person Completing Form	Print or Type Full Name	Telephone Number	Date

PRIVACY STATEMENT

The Information Practices Act of 1977 (California Civil Code, section 1798.1 et seq.) and the Federal Privacy Act of 1974 (Title 5, United States Code, section 552a et seq.) require that this notice be provided when collecting personal information from individuals.

The Estate Recovery Section of the California Department of Health Care Services' (Department) Third Party Liability and Recovery Division is seeking the information requested on the Application for Hardship Waiver pursuant to the authority granted to the Department by Welfare and Institutions Code section 14009.5, and Title 22, California Code of Regulations, section 50960 et seq. The person responsible for maintaining records of the information obtained from the Application is the Chief of the Third Party Liability and Recovery Division, MS 4718, P.O. Box 997425, Sacramento, CA, 95899-7425.

The information requested in the Application is voluntary; however, failure to completely and accurately provide the information may result in a denial of the Application. The principal purpose for which the information will be used is to determine whether an applicant qualifies for a hardship waiver of the Department's estate recovery claim and to verify information provided in the Application in order to circumvent fraud against the Medi-Cal program.

The Department does not have any known or foreseeable disclosures that may be made of the information. The applicant has a right of access to records containing personal information maintained by the Department.