UNDUE HARDSHIP WAIVER REQUEST FORM

Do not leave any blank spaces. If the question does not apply, write not applicable (n/a). If we do not have the documentation to review this waiver request within sixty (60) days from receipt of this waiver form, we will submit this recovery to an attorney in the county where the client resided to handle as an unadministered estate.

DECEDENT'S NAME:	
DECEDENT'S SOCIAL SECURITY NUMBER:	
DECEDENT'S DATE OF BIRTH:	
CLIENT INFORMATION SYSTEM (CIS) NUMBER: (if known)	
DECEDENT'S PROPERTY ADDRESS:	
	(CITY, STATE, ZIP CODE)
COUNTY WHERE DECEDENT'S PROPERTY IS LOCATED:	
FORM COMPLETED BY: **NAME:**	
RELATIONSHIP TO DECEDENT:	
ADDRESS:	
	(CITY, STATE, ZIP CODE)
TELEPHONE NUMBER:	( )
FAIR MARKET VALUE OF DECEDENT'S PROPERTY: (include a copy of certified appraisal)	
INDIVIDUAL REQUESTING WAIVER: (if same as above, do not complete)	
RELATIONSHIP TO DECEDENT:	
ADDRESS:	
	(CITY, STATE, ZIP CODE)
TELEPHONE NUMBER:	( )

THE DEPARTMENT WILL MAKE THE DECISION WHETHER TO GRANT THE WAIVER AFTER ALL OF THE FOLLOWING CONDITIONS ARE MET:

DECEDENT'S PRIMARY RESIDENCE

1. Date the individual requesting the waiver moved into the residence: _____
2. Date the individual requesting the waiver began providing care for the decedent: _____
3. Has the individual requesting the waiver lived there continuously for two years immediately prior to the decedent's receipt of nursing home care or for two years during the time which home and community based services were received?
   Yes _____ No _____
   IF YES: Provide documentation indicating residency during the two year time period. For example: copy of driver's license, pay stubs, W-2 form, etc.
4. Did the individual requesting the waiver provide care or support to the decedent for two years immediately prior to the decedent's receipt of nursing home care or for two years during the time which home and community based services were received? Yes _____ No _____
   IF YES: For the estate of a decedent who resided in a long term care facility, we need a statement containing the following information from the physician who treated the decedent during the two year time noted above:
   A. Decedent's primary diagnosis; and
   B. A statement that the decedent would have needed, at a minimum, intermediate care in a nursing facility if the person requesting the waiver had not provided care to the decedent in the home of the decedent for at least two years immediately prior to admission to the nursing facility.
   For the estate of a decedent who received Medicaid funded home and community based waiver services, we need a statement containing the following information from the physician who treated the decedent during the two year time noted above.
   A. Decedent's primary diagnosis; and
   B. A statement that the decedent would have needed, at a minimum, intermediate care in a nursing facility if the person requesting the waiver had not provided care to the decedent in the home of the decedent for at least two years while the decedent was receiving home and community based services.
5. Does the individual requesting the waiver have any other alternative permanent residence?
   Yes _____ No _____
   IF NO: Complete and return the attached notarized No Alternative Permanent Residence Affidavit which must be notarized.

INCOME PRODUCING ASSET (Examples would be a family farm or family business, etc.)

1. Is the income producing asset the primary source of income for the household? Yes _____ No _____
2. What was the family's gross income generated by the income producing asset in the year preceding the death of the decedent? Please provide two documents indicating the family's gross income generated by the family's income producing asset. For example: W-2 forms, Federal and State Income Tax Returns, 1099 forms, etc.
3. Excluding the income producing asset, what was the family's gross income in the year preceding the death of the decedent? Please provide documentation. For example: W-2 forms, Federal and State Income Tax Returns, 1099 forms, etc.

OTHER INFORMATION

Please provide any other information you feel may be important to the department in order to make its decision.

ACKNOWLEDGEMENT:

I ACKNOWLEDGE THAT THE INFORMATION I HAVE SUPPLIED ON THIS FORM IS SUBJECT TO THE PENALTIES SET FORTH IN 18 Pa.C.S.A. §4904 (relating to unsworn falsification to authorities).

_____ _____

SIGNATURE **DATE**

SEND ALL CORRESPONDENCE TO:

DEPARTMENT OF HUMAN SERVICES
DIVISION OF THIRD PARTY LIABILITY
ESTATE RECOVERY PROGRAM
P.O. BOX 8486
HARRISBURG, PA 17105-8486

FACSIMILE#: (717) 772-6553 **ESTATE RECOVERY HOTLINE: 1-800-528-3708**

pennsylvania
DEPARTMENT OF HUMAN SERVICES

No Alternative Permanent Residence Affidavit

BUREAU OF PROGRAM INTEGRITY
DIVISION OF THIRD PARTY LIABILITY
PO BOX 8486
HARRISBURG, PA 17105-84

I, _____, am the individual requesting that the department find undue hardship and permanently waive its estate recovery claim with respect to the

real property of the decedent _____ located at

_____.

I, _____, do solemnly swear that I have no permanent residence other than the real property of the decedent described above, that I currently reside solely in that property, that I use the address of the property as my permanent address for tax and legal purposes, and I have resided in that property for at least two years.

_____
Printed Name

_____ _____
Signature Date

Commonwealth of Pennsylvania)
) : SS
County of _____)

On this, the _____ day of _____, 20____, before me a notary public, the undersigned

officer, personally appeared _____, known to me, (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he/she executed the same for the purposes therein contained. In witness thereof, I herunto set my hand and official seal.

_____
Notary Public