Reset Form

REQUEST FOR HARDSHIP EXCEPTION – TRANSFER OF PROPERTY

State Form 54167 (R2 / 12-12)

INSTRUCTIONS:

This Request may be filed by or on behalf of a Medicaid recipient who has received official notification imposing a period of ineligibility for Medicaid nursing facility services and home and community-based waiver services for a transfer of property that occurred on or after November 1, 2009.

In submitting this request, you agree that there is no dispute about the factual situation that resulted in the transfer penalty and have not filed an appeal. Refer to Page 2 for information on hardship criteria.

The completed form and all supporting documents must be received by the Office of Medicaid Policy and Planning no later than thirty (30) calendar days from date of the notice of transfer penalty. Mail the completed form and all supporting documents to:

Mail Stop 07
Family & Social Services Administration
Office of Medicaid Policy & Planning- Eligibility
402 West Washington Street
Indianapolis, Indiana 46204

RECIPIENT INFORMATION

Name and address of recipient *(number and street, city, state, and ZIP code)*		Medicaid Case number Date of notice imposing penalty period (if known) *(month, day, year)*
Date of birth *(month, day, year)*	Last four (4) digits of Social Security number xxx-xx-	County of residence

REQUESTOR INFORMATION

Name and address *(number and street, city, state, and ZIP code)*	Relationship to recipient ☐ Self ☐ Legal Guardian ☐ Attorney in fact holding POA ☐ Authorized Representative ☐ Nursing Facility
E-mail address *(optional)*	

AUTHORIZATION FOR NURSING FACILITY TO SUBMIT HARDSHIP REQUEST

Written consent must be given by the recipient or the authorized representative of the recipient if the nursing facility is making the request.

Name and title of nursing facility staff filing the hardship exception request

I hereby authorize _____ to submit the hardship request on my behalf.

Signature of Recipient / Authorized Representative	Date *(month, day, year)*

SIGNATURE OF REQUESTOR

All information provided with this hardship exception request is true to the best of my knowledge and belief. All documents supporting this request are included and listed on Page 2.

Signature of Requestor	Date *(month, day, year)*

You may request a hardship exception when a period of ineligibility for payment of long term care services would deprive you of:

- Medical care causing your health to be endangered, or
- Food, clothing, shelter, or other necessities of life.

Circumstances in which a hardship exception will not be approved include, but are not limited, to:

- The application of a transfer penalty merely causes you inconvenience or restricts your lifestyle without risk of serious deprivation.
- The return of transferred assets would have adverse tax consequences or cause penalties, or other contract damages.
- An allegation is made that the penalty will cause dissolution of marriage.
- The return of transferred assets would cause a hardship to someone other than the person to whom the penalty has been imposed.

The burden of proof to show that undue hardship exists is the responsibility of the individual submitting this request and must include all efforts, including legal action, to get the transferred property returned. The decision to approve or deny a hardship exception request will be made in accordance with Section 1917(c) of the Social Security Act and 405 IAC 2-3-24. The decision will be based on the information and written evidence included with this request along with documentation in the Medicaid case file. A written decision will be issued by the Office of Medicaid Policy and Planning within forty-five (45) days of receiving the request.

List attachments and explain the circumstances supporting the request for hardship exception. Use additional pages as needed.