



Permission to Share Long-Term Care Insurance Information

Case number: _____
Case name: _____
Worker name: _____
Worker phone number: _____
Fax number: _____
Agency name: _____
Agency address: _____

Date: _____
To: _____

Why am I getting this letter?

We are writing to you because you have asked for Medical Assistance to help pay for your long-term care costs and you have long-term care insurance.

Some long-term care insurance policies are qualified for the Long-Term Care Partnership and are known as Partnership policies. People who get Medical Assistance for Long-Term Care can normally have countable assets at or below the Medical Assistance asset limit. You may be able to keep more assets and still get Medical Assistance for Long-Term Care when you have a Partnership policy. In other words, you may "protect" assets. Assets that you protect will also be protected during estate recovery when you die.

What do I need to do?

You need to give the Department of Human Services permission to contact your long-term care insurance company. The insurer needs to tell the Department if your insurance is a qualified Partnership policy and how much the policy has paid for your care. This will help us see if you can get Medical Assistance for Long-Term Care and if you can protect any assets.

1. Fill out the enclosed Permission to Share Long-Term Insurance Information form.
2. Sign and date the form. If you are unable to sign, ask a person legally authorized to act on your behalf to sign and date the form.
3. Send the completed form to the Agency listed above by _____.

What will happen if I do not return the form?

Your eligibility for Medical Assistance for Long-Term Care will be decided without information about your long-term care policy and without possible asset protection under the Long-Term Care Partnership. You may not be able to get Medical Assistance for Long-Term Care.

Questions

Call your worker at the number above if you have questions or need help.

Permission to Share Long-Term Care Insurance Information

NAME OF INSURED PERSON			DATE OF BIRTH
STREET ADDRESS	CITY	STATE	ZIP CODE
INSURANCE COMPANY			POLICY NUMBER
MAILING ADDRESS	CITY	STATE	ZIP CODE

Is this a group policy? ☐ NO ☐ YES – fill in below

INSURANCE CERTIFICATE NUMBER	NAME OF EMPLOYER OR ASSOCIATION
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I give permission to the agency listed above to share information about my long-term care insurance coverage.

I know that state and federal privacy laws protect my records. I know:

- Why I am being asked to release this information.
- I do not have to consent to the release of this information, but it may affect my benefits or services if I do not give my consent.
- That, generally, I must give my written permission for the agencies listed above to give out this information.
- If I do not give my permission, the information will not be released unless the law otherwise allows it.
- I may stop this request to share information with a written notice at any time but the written notice will not affect information that has already been shared.
- The person or agency that gets my information may be able pass it on to others.
- If my information is passed on to others, it may no longer be protected by this permission form.
- This permission form will end one year from the date I sign it unless the law allows for a longer period.

SIGNATURE	DATE
SIGNATURE OF PERSON LEGALLY AUTHORIZED TO ACT ON YOUR BEHALF	DATE

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ຟຣີ, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍວຽກຂອງທ່ານຫຼືໂທ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjamadda macluumaadkani oo lacag la'aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông-tin này miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB32-0008 (1-08)

This information is available in alternative formats to individuals with disabilities by calling your agency at (651) 431-2670 or (800) 657-3739. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services benefits, contact your agency's ADA coordinator.