Clear Form Data
FILLABLE FORM

Minnesota Department of **Human Services**

MINNESOTA Long Term Care Partnership™

Attachment D

DHS-5426C-ENG 8-08

Case number: _____

Case name: _____

Worker name: _____

Worker phone number: _____

Fax number: _____

Agency name: _____

Agency address: _____

_____

Long-Term Care Partnership Protected Assets

Date: _____

To: _____

_____

_____

Why am I getting this letter?

We are writing to you because you have insurance that qualifies for the Long-Term Care Partnership (also known as a Partnership policy) and have asked for Medical Assistance to help pay for your long-term care. Because your Partnership policy paid for some of your care, you can tell us not to count some of your assets when we decide if Medical Assistance can help pay for your long-term care costs. Assets that we will not count are called "protected" assets.

What amount of assets can I protect?

You can protect assets with a total value equal to the amount that your Partnership policy paid for your care after July 1, 2006. Assets are items of value you own, such as bank accounts, stocks, bonds, cars, a home or other real estate.

You are allowed to protect $_____ of your assets. This amount is called your Protected Asset Limit.

What do I need to do?

1. Read the enclosed brochure Long-Term Care Partnership and Medical Assistance Asset Protection (DHS-5426).
2. Decide what assets you want to protect. **You cannot protect certain trusts or annuities.**
3. Fill out the enclosed Long-Term Care Partnership Protected Assets form
4. Get proof of how much each protected asset listed on the Long-Term Care Partnership Protected Asset form is worth. Proof can be bank statements, property tax statements or other papers showing current value.
5. Send the completed form and proofs to the Agency listed above by _____.

What will happen if I do not return the form and proofs?

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.
- Talk to your accountant, financial advisor or attorney.
- Read the enclosed brochure called Long-Term Care Partnership and Medical Assistance Asset Protection (DHS-5426)
- Review information at www.mnltcpartnership.org
- Call the Senior LinkAge Line® at (800) 333-2433 (TTY (800) 627-3529) or e-mail senior.linkage@state.mn.us

Minnesota Department of **Human Services**

MINNESOTA Long Term Care Partnership™

Case number: _____

Case name: _____

Worker name: _____

Long-Term Care Partnership Protected Assets Form

Choosing protected assets is a big decision. You may need to talk to people who advise you about your assets, such as your attorney, accountant and/or financial advisor. Before you choose your protected assets, think about these things:

- Your counted assets must be less than the asset limit for Medical Assistance. Assets over the limit must either be reduced or protected under the Long-Term Care Partnership.
- The total value of all your protected assets can only add up to your Protected Asset Limit.
- It may be easier to protect the full value of an asset instead of portions of different assets.
- Your Protected Asset Limit may be less than the full value of an asset. You can protect part of that asset or a different asset, or you can wait to protect something in the future.

You may protect $_____ of your assets. These assets will not be counted for Medical Assistance for Long-Term Care and will be protected from estate recovery.

1. List each asset you would like to protect below.
2. Add another page if you need more space.
3. The total amount of your protected assets cannot be more than the amount written above.

Protected asset *Examples: Bank account or Real estate*	**Asset identification** *Examples: Account No. or Property Tax ID*	**Location of asset** *Examples: Name and address of bank or address of property*	**Asset value**
			$
			$
			$
			$
			$
			$
			$
		Total value of protected assets listed.	$

Give the county this completed form as soon as possible. They may need to know what assets you want to protect before they can decide if you can get Medical Assistance for Long-Term Care.

This is important information you must read before signing.

I understand that if I am getting health care coverage, the State may deny or change my benefits without 10 days advance notice. However, the State will send me written notice no later than the effective date of the change.

Authorization to Share Information for Fraud Investigation

I give permission to authorized investigators and third parties to share information about me during the course of investigations regarding fraud, fraud prevention and misrepresentation. Third parties who can share information about me with investigators include but are not limited to financial institutions, credit reporting agencies, landlords, public housing agencies, schools, utility companies, insurance agencies, employers, other government agencies and others as they apply. I further authorize taxing authorities to release copies of my income tax returns. I also understand that my permission to share information about me remains in effect for six months after my benefits stop.

Telling the Truth

I declare that, under penalty of perjury, all parts of this form are true and correct statements, to the best of my knowledge. I understand what happens to people convicted of perjury (not telling the truth). They may be sentenced to prison for up to five years, a fine up to $10,000, or both.

SIGNATURE OF ENROLLEE		DATE
SIGNATURE OF PERSON ACTING ON YOUR BEHALF	PHONE NUMBER	DATE

WORKER NOTES
Document any changes in protected assets based on verifications and discussions with the client.

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.

កំណាត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែពត៌មាននេះដោយមិនគិតថ្លៃ 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, ຈົ່ງຖາມນຳພນັກງານຊ່ວຍອຽກຂອງທ່ານຫຼືໂທຣ໌ ຫາຕາມເລກໂທຣ໌ 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 nầy miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0008 (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.