

IMPORTANT



DECLARATION OF THE LEGALLY RESPONSIBLE RELATIVE

DATE: _____

CASE NAME: _____

CASE NUMBER: _____

HOSPITAL ADMISSION DATE: _____

HRA InfoLine: 1-877-472-8411

Dear _____:

fold

fold

An application/recertification for Medicaid has been submitted by or on behalf of the above named person or family household.

If found eligible, Medicaid will cover that part of a recipient's care for which he or she is unable to pay because of the absence of the legally responsible relative or the refusal of failure of the legally responsible relative to make available income and/or resources for the cost of necessary medical care and services.

Legally responsible relatives are: Husband for wife, wife for husband, and parents for children under 21. Legally responsible relatives may be taken to court for failure to support their spouses or minor children.

Please complete the section below, including your signature and the date, and return it the enclosed envelope within 10 days.

TO BE COMPLETED BY THE LEGALLY RESPONSIBLE RELATIVE

Name of Legally Responsible Relative _____

Relationship to the Medicaid Applicant/Recipient (check box)

Spouse Parent Other, Specify: _____

Social Security Number: _____

Health Insurance covering your relative: _____

Policy Number: _____

I declare that I refuse to make my income and/or resources available for the cost of necessary medical care and services for the Medicaid applicant/recipient listed above.

Signature of the Legally Responsible Relative _____ Date _____

If you have any questions, contact:

SUPERVISOR	SECTION	TELEPHONE NUMBER
------------	---------	------------------

**DECLARATION OF THE APPLICANT/RECIPIENT
CONCERNING LEGALLY RESPONSIBLE RELATIVE'S REFUSAL TO MAKE AVAILABLE INCOME
AND/OR RESOURCES FOR THE COST OF NECESSARY MEDICAL CARE AND SERVICES**

CASE NAME: _____

CASE NUMBER: _____

This form is to be completed and signed by the applicant or recipient in all instances where the applicant/recipient is living with a legally responsible relative (LRR) who is refusing to make available income and/or resources for the cost of necessary medical care and services.

MEDICAID APPLICATION/RECIPIENT COMPLETE SECTION BELOW:

I declare that my Spouse Parent

has refused to make his/her income and/or resources available for the cost of necessary medical care and services.

SIGNATURE OF MEDICAID APPLICANT/RECIPIENT

DATE