

Personal Information		
Applicant / Recipient Last Name	First Name	M.I.
Applicant / Recipient Social Security Number	Applicant / Recipient Date of Birth	
Street Address	Telephone Number	
City	State	Zip Code
Asset Transfer Information		
What asset(s) was transferred? Describe:		What was the value of the asset(s)? \$
When was asset(s) transferred? Date(s):	What amount of compensation was received for the transferred asset(s)? \$	
Who was the asset(s) transferred to (Transferee)?		What is the Transferee's relationship to the applicant / recipient?
Transferee's Street Address		Transferee's Telephone Number
City	State	Zip Code
Why was the asset(s) transferred? Explain:		
Additional Information		
How does the denial of payment of Long Term Care (LTC) Services deprive you of medical care such that your health or life would be endangered or the denial would deprive your of food, clothing, shelter or other necessities of life? Explain:		
What actions have you taken to recover your asset(s)? Include the name and telephone number of any attorney you have contacted to assist you in recovering your asset(s). Explain:		
Signatures		
I agree that if the undue hardship waiver is granted and I am approved for payment of LTC Services, I will cooperate with the Department of Public Welfare in taking any action necessary to recover the asset(s).		
Signature of applicant or recipient	Date	
Signature of representative	Date	
Facility contact signature (if applicable)	Date	