



Date: _____

Request for Assessment Form

Institutionalized Spouse's Name:
Address:
Telephone Number:
Community Spouse's Name:
Current Address:
Telephone Number:

/we request an assessment of the items checked below:

- Couple's countable resources and the community spouse resource allowance
- Community spouse monthly income allowance
- Family member allowance(s)

Check if you are a representative acting on behalf of either spouse. Please call your local department of social services if we do not contact you within 10 days of this request.

NOTE: If an assessment is requested without a Medicaid application, the local department of social services may charge up to \$25 for the cost of preparing and copying the assessment and documentation.

Signature of Requesting Individual

Address and telephone # if different from above