

NOTICE OF REQUIREMENT TO TRANSFER EXCESS RESOURCES

Community Spouse's Name	Assistance Group Name	
Street Address	Assistance Group Number	
City, State and Zip Code	County	Mailing Date

Dear _____:
(Community Spouse's Name)

We have determined that you have resources in your name in the amount of \$_____, which are in excess of the amount allowed for your spouse to be eligible for Medicaid. Enclosed are copies of the ODM 04076 "Resource Assessment Worksheet" and the ODM 04077 "Resource Transfer Worksheet" to support our determination of the amount of your resources that must be transferred.

Ohio laws require that a husband and wife support each other. Because of these laws and the rules that govern Medicaid eligibility, you must share \$_____ of your resources with your spouse.

If you refuse to share your resources with your spouse, the Ohio Department of Medicaid and the Attorney General's office will take legal action against you for the costs of the medical services paid by Medicaid for your spouse. Ohio Revised Code Section 5101.58 is the law that allows the Ohio Department of Medicaid to collect this money.

You must check one of the following boxes, sign your name and date, and send this letter back to the county department of job and family services within seven calendar days of the mailing date of this notice.

<input type="checkbox"/>	I agree to share \$_____ of my resources with my spouse. I understand that my spouse will not receive Medicaid until the amount of my resources that are determined to be my spouse's share falls below the Medicaid resource limit for an individual. I understand that legal action against me will not occur.
<input type="checkbox"/>	I refuse to share my resources with my spouse. I understand that by refusing to share resources with my spouse the Ohio Department of Medicaid and the Attorney General's office will take legal action against me.
_____	_____
(Community Spouse's Signature)	(Date)

If this letter is not returned to the county department of job and family services within seven calendar days of the mailing of this notice, with one of the blocks checked, signed and dated, the Ohio Department of Medicaid will begin to take legal action against you.

If you have any questions about this notice, please call your spouse's caseworker.

Caseworker Name	Unique Identifier	Telephone Number
-----------------	-------------------	------------------

DISTRIBUTION: Original to Community Spouse; One Copy to the Institutionalized Spouse; One copy to Authorized Representative, One copy to Assistance Group Record