EXHIBIT (PAGE 1)

ASSETS DECLARATION
PATIENT AND SPOUSE
Michigan Family Independence Agency

FOR OFFICE USE ONLY				
Grantee Name				
Grantee Client ID				
Case Number				
County	District	Section	Unit	Specialist

PLEASE PRINT

Patient's Name *(First, Middle, Last)*		Phone No. of Nursing Home	Spouse's Name *(First, Middle, Last)*		Spouse's Phone Number
Address of Nursing Home *(Number, Street, Rural Route)*			Spouse's Address *(Number, Street, Rural Route)*		
City	State	Zip Code	City	State	Zip Code
Patient's Birthdate *(Mo/Day/Yr)*	Patient's Social Security Number		Spouse's Birthdate *(Mo/Day/Yr)*	Spouse's Social Security No. (Optional)	

This form asks questions about the property or assets owned by you and/or your spouse. This information is needed to determine your eligibility for Medicaid and the amount of assets that can be protected for the benefit of your spouse.

Answer the following questions by providing information about all assets owned by you and/or your spouse as of _____. Include assets you or your spouse owned jointly with family or other persons.

ASSETS

Do you and/or your spouse have any of the following? Each item must be answered YES or NO. Check YES even if the item is jointly owned. "Jointly owned" means your name and someone else's name is listed on the asset. For example, your name is not the only name listed on an account or on a registration or title to property.

	YES NO	Amount or Value		YES NO	Amount or Value
1. Cash on hand or in a safety deposit box	☐ ☐	$	10. Life estate/life lease	☐ ☐	$
2. Cash in a patient trust fund	☐ ☐	$	11. Home	☐ ☐	$
3. Savings bonds	☐ ☐	$	12. Real estate, not your home	☐ ☐	$
4. Money market funds	☐ ☐	$	13. Cars, vans, trucks, campers, boats, trailers, snowmobiles or other vehicles	☐ ☐	$
5. Pension, IRA, KEOGH, 401K or deferred compensation account(s)	☐ ☐	$	14. Tools and equipment, livestock or crops	☐ ☐	$
6. Trust funds	☐ ☐	$	15. Funeral contracts	☐ ☐	$
7. Stocks or mutual funds	☐ ☐	$	16. Annuity	☐ ☐	$
8. Mortgage, land contract or other notes payable to you	☐ ☐	$	17. Burial plots, casket, etc.	☐ ☐	$
9. Life insurance	☐ ☐	$	18. Other (please specify)	☐ ☐	$

AUTHORITY: 42 CFR Part 435.
COMPLETION: Voluntary.
PENALTY: No Medicaid.

The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act you are invited to make your needs known to an FIA Office in your county.

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EXHIBIT (PAGE 2)

ASSETS

COMPLETE THIS PAGE BY CHECKING YES OR NO OR WRITING IN THE ANSWER.

The Family Independence Agency may check records with banks, credit unions, and savings and loans concerning any accounts that you may have. These accounts may be verified by computer cross-checking.

1. Is your name, or your spouse's name, on one or more checking/draft accounts in any bank, credit union or savings and loan?
   ☐ YES ☐ NO
2. Is your name, or your spouse's name, on one or more savings/share accounts or certificates of deposit in any bank, credit union or savings and loan?
   ☐ YES ☐ NO
3. List each account, the name and address where the account is located, the account number and the balance in the account. Include all accounts, even those held jointly with other persons, those with small balances, Christmas clubs and accounts used for direct deposit. List the name of every person on the account.

CHECKING/DRAFT ACCOUNTS

Name(s) on the Account	Name and Address of Bank, Credit Union, or Savings and Loan	Account Number	Balance
A.			
B.			
C.			

SAVINGS/SHARE ACCOUNTS OR CERTIFICATES OF DEPOSIT

Name(s) on the Account	Name and Address of Bank, Credit Union, or Savings and Loan	Account Number	Balance
A.			
B.			
C.			
D.			

4. Do you have an account that is not listed above? ☐ YES ☐ NO
5. Have you, your spouse or someone acting for either of you ever put any money, income, lawsuit settlement or assets in a trust, annuity or similar device? ☐ YES ☐ NO
6. Do you have any other assets not already listed on this form? ☐ YES ☐ NO

   If yes, explain: _____

AFFIDAVIT

I swear or affirm that all the information that I have written on this form or told to a specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. I also know that if I have intentionally left out any information or if I have given false information, which causes me to receive assistance I am not entitled to or more assistance than I am entitled to, I can be prosecuted for fraud.

Signature (Patient or Representative)		Date (Month, Day, Year)
Two Witnesses Only If Signed by Mark X	Signature of First Witness	Signature of Second Witness

NOTE: If you signed this application on behalf of someone else, complete the information below.

Name (First, Middle, Last)	Phone Number	Relationship to patient	
Street Address	City	State	Zip Code

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INTRODUCTION

The FIA-4574-B must be completed by a patient to request an initial asset assessment. When determining an L/H or waiver patient's MA eligibility, the FIA-4574-B may be used to collect information about the L/H or waiver patient's and community spouse's assets for a specific month if this information is not already available. See PEM 402.

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Item Number	Item Instructions
Unnumbered	Complete the ID box.
Unnumbered	The entry in the ". . . as of (date) ." space is: • Initial Asset Assessment - The patient's date of approval for waiver services or admission (M/D/Y) to the hospital or LTC facility for the first continuous period of care that began on or after September 30, 1989. • Eligibility for MA - The specific L/H or waiver month (M/Y) for which asset information is needed.
1-18	If any of these items are answered **YES,** obtain verification for each asset except an excluded homestead.

FIA-4574-B, BACK PAGE

1-2	If answered **YES**, obtain verification for each asset.
4	If this item is answered **YES,** give the customer another FIA-4574-B to list additional accounts. Attach all FIA-4574-Bs together.
5	If this item is answered **YES,** investigate as a possible (PEM 401): • countable asset for initial asset assessment, and • countable asset, income source or divestment for MA eligibility.
6	If this item is answered **YES,** obtain verification.