Kansas
Department of Health and Environment
Division of Health Care Finance

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# NOTICE OF INTENT TO ALLOCATE INCOME

Case Number: _____

Name of Applicant or Recipient: _____

Social Security Number: _____

Name of Spouse: _____

Social Security Number: _____

A spouse in a long term care arrangement may allocate all, some or none of their own income to the community spouse and/or a dependent family member. The allocated amount is sheltered for the community spouse and/or dependent family member and not counted in determining the long term care spouse's share of cost for medical services provided. The amount of the allocation is determined by the agency and is based on the income of both spouses and/or dependent family member.

In anticipation of qualifying for Medical Assistance, I/we agree to the following income allocation (choose one):

___ I/we want the maximum income allocation permitted as determined by the agency.

___ I/we want the maximum income allocation permitted without adversely affecting my spouse's and/or dependent family member's own eligibility for medical assistance.

___ I/we do not want to make any income allocation to my spouse and/or dependent family member.

I/we understand that the agency will determine eligibility for medical assistance based on the choice made on this document. If approved for medical assistance, I/we also understand that the income allowance(s) determined by the agency will be made available each month to (or used for the benefit of) the community spouse and/or dependent family member. The amount of the income allocation may be adjusted by the agency if income changes.

Date: _____

_____ _____

Applicant or Recipient signature Spouse signature

_____ _____

Witness signature Witness signature