



## State of New Jersey

DEPARTMENT OF HUMAN SERVICES  
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES  
P.O. Box 712  
Trenton, NJ 08625-0712

CHRIS CHRISTIE  
*Governor*

JENNIFER VELEZ  
*Commissioner*

KIM GUADAGNO  
*Lt. Governor*

VALERIE HARR  
*Director*

**MEDICAID COMMUNICATION NO. 13-02**

**DATE: March 15, 2013**

**TO:** County Welfare Agency Directors

**SUBJECT:** Addendum to PA-1G Medicaid Application  
Transfer of Assets Self-Attestation Form

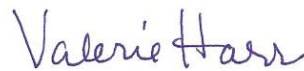
The New Jersey Comprehensive Medicaid Waiver (CMW) was submitted to the Centers for Medicare and Medicaid Services (CMS) and was approved on October 1, 2012. This is a five year demonstration which reforms our current delivery system by: 1) offering Managed Long Term Services and Supports through a Managed Care Organization; 2) establishes a managed adult behavioral health system; and 3) streamlines eligibility. This collection of reforms will help to rebalance the system and reduce costs by building capacity for Home and Community Based Service options.

To streamline the eligibility process, the CMW permits self-attestation that assets or resources have not been transferred for individuals who have income that is equal to or below 100% of the Federal Poverty Level (FPL) and are applying for institutional or Home and Community Based Services. This self-attestation process is for new applicants and current Medicaid recipients who require these levels of care. In response to this policy change, the Division of Medical Assistance and Health Services (DMAHS) developed a Transfer of Assets Self-Attestation form which will serve as an Addendum to the PA-1G Medicaid Application. This form must be completed when an individual: 1) has income equal to or below 100% FPL; 2) is applying for institutional care or Home and Community Based Services; and 3) has stated that no assets or resources have been transferred in the previous 60 months for less than fair market value. The addendum is a sworn statement that also outlines that anyone who reports false information will be required to reimburse the State of New Jersey for any benefits received or be subject to a period of ineligibility and/or civil and criminal prosecution.

It is important to note that the addendum cannot be completed by anyone other than the individual, spouse, domestic partner, guardian or Power of Attorney. These are the people who would know if someone has transferred an asset. If none of the above can complete this form and/or, if they cannot meet for a face to face interview with a caseworker, then a five year look back will be required. The caseworker will serve as the witness to this sworn statement.

If you have any questions regarding this Medicaid Communication, please refer them to the Division's Office of Eligibility Policy field service staff for your agency at 609-588-2556.

Sincerely,



Valerie Harr  
Director

VH:m

- c: Jennifer Velez, Commissioner  
Department of Human Services
- Dawn Apgar, Deputy Commissioner  
Division of Developmental Disabilities
- Lowell Arye, Deputy Commissioner  
Aging and Community Services
- Lynn Kovich, Assistant Commissioner  
Division of Mental Health and Addiction Services
- Joseph Amoroso, Director  
Division of Disability Services
- Kathleen M. Mason, Director  
Division of Aging Services
- Jeanette Page-Hawkins, Director  
Division of Family Development
- Allison Blake, Commissioner  
Department of Children and Families
- Mary E. O'Dowd, Commissioner  
Department of Health

**State of New Jersey**  
**Division of Medical Assistance and Health Services**  
**Addendum to the PA-1G Medicaid Application**  
**Transfer of Assets Self-Attestation**

Applicant Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_

County: \_\_\_\_\_

This addendum is to be completed, signed and dated by all individuals who are applying for institutional or Home and Community Based Services with income levels at or below 100% of the Federal Poverty Level and has stated that no assets or resources have been transferred in the previous 60 months for less than fair market value. **This addendum cannot be completed by anyone other than the individual, spouse, domestic partner, guardian, or Power of Attorney.**

Please initial:

\_\_\_\_\_ I certify that my monthly income is equal to or below \$\_\_\_\_\_ (100% of the Federal Poverty Level).

\_\_\_\_\_ I certify that I, my spouse, my domestic partner or anyone acting at my direction or on my behalf **have not** transferred any assets or resources for **less than fair market value** or waived the right to receive any assets or resources during the **60 month** period prior to \_\_\_\_\_ (Date of request for institutional or Home and Community Based Services). Please see Page 4 of the application for examples of assets.

I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, would be required to reimburse the State of New Jersey for any benefits the Medicaid beneficiary received incorrectly or would cause the beneficiary to be subject to a period of ineligibility. I understand this does not prevent any other civil or criminal penalties that may arise from a false or misleading statement.

\_\_\_\_\_

|            |           |      |
|------------|-----------|------|
| Print Name | Signature | Date |
|------------|-----------|------|

\_\_\_\_\_

Relationship to beneficiary

\_\_\_\_\_

|                    |           |
|--------------------|-----------|
| Witness Print Name | Signature |
|--------------------|-----------|