MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

MO HEALTHNET UNDUE HARDSHIP WAIVER REQUEST

FROM	Family Support Division	TELEPHONE NUMBER (855) 373-4636	DATE 12/29/2023
	OFFICE ADDRESS (MAILING, CITY, STATE, ZIP CODE) PO BOX 2700, Jefferson City, MO 65102		

TO	NAME		CASE NAME
	ADDRESS (MAILING)		DCN
	CITY, STATE ZIP CODE		TELEPHONE NUMBER

Family Support Division (FSD) has determined that you had an improper transfer of assets that resulted in a penalty period. If you believe an undue hardship will exist due to this penalty period, you may use this form to request an undue hardship waiver, or to authorize the nursing facility where you reside to request the waiver on your behalf.

In addition to completing and signing this form (front and back), you will need to submit the following verification:

1. A statement signed by you (or your authorized representative) which describes whether the transferred assets are recoverable. If they are not recoverable, the legal attempts that were made to recover the transferred assets.
2. Proof that an undue hardship will exist if the penalty period is imposed.

If you are currently in a nursing facility, you must submit:

- A copy of the notification sent from the nursing facility, which states both the date of the involuntary discharge and alternate location, or other proof that if the hardship waiver is not granted you will be deprived of medical care such that your health or life would be endangered, or you will be deprived of food, clothing, shelter, or other necessities of life.

If you are applying for or receiving Home and Community Based Service (HCB) or Missouri's Children with Developmental Disabilities (MOCDD) submit:

- An estimate of the cost of the Long Term Care services needed to meet your medical and remedial needs, as determined by your Department of Health and Senior Services (DHSS) Care Manager; and
- An estimate of your monthly costs for food, shelter, clothing and other necessities of life.

Authorization for the Nursing Facility Administrator to Represent You

The nursing facility where you reside can also make the undue hardship request for you, but they must have your permission to do so.

If you would like the nursing facility where you reside to help you request an undue hardship waiver, please check the following box and list the facility administrator's name.

☐ I, _____ authorize _____
Your Name — Name of Facility Administrator

_____ _____
Facility Name — Facility Address

to file an undue hardship waiver request on my behalf, for the purpose of determining whether or not an undue hardship exists.

Authorization for the Nursing Facility Administrator to Appeal a Denial

If the nursing facility administrator has your permission to do so, the administrator can represent you during the appeal process if your undue hardship request is denied. Check the box next to the following statement and identify the administrator of the facility where you reside to authorize the administrator to represent you throughout the appeal process.

☐ I, _____ authorize _____
Your Name — Name of Facility Administrator

_____ _____
Facility Name — Facility Address

to represent me and/or file an appeal on my behalf regarding the denial of my undue hardship request.

Required for All Requests

Use the space below to explain your hardship and how this transfer of assets penalty will endanger your health, life, or deprive you of food, clothing, shelter or other necessities of life. Attach additional pages if you need more space.

My signature below certifies under penalty of perjury that all declarations made in this waiver request are true, accurate, and complete.

If submitting electronically – I have agreed to submit this form by electronic means. I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature. ☐ I agree

_____ _____
SIGNATURE – APPLICANT/PARTICIPANT — DATE SIGNED

_____ _____
LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE — DATE SIGNED

SAVE PRINT RESET