Local Office Address

Oregon Department of Human Services

Application for Hardship Waiver

You will receive a decision on this application within 45 days.

Seniors and People with Disabilities

SDS 0544

Client

Date sent

Case number

Prime number

Date of birth

Program

Branch code

Worker

Worker phone #

Transfer information 1

Asset transferred

Transfer to

Relationship to client Phone number

Address

City State Zip code

Date of transfer Uncompensated value $

Please complete both questions 1 & 2 or the form will be returned.

1. Explain what basic need(s) you will have to do without if you are disqualified from Medicaid. Examples of basic needs are shelter, food and medical care without which your health or life will be in danger.

2. Explain what actions you have taken to try to get your resources back. Include the name and telephone number for any attorney you have contacted.

Facility 2

Facility name

Contact name Phone number

Signature 3

I agree that if this hardship waiver is granted and I am approved for Medicaid, I will cooperate with the Department in taking action to get my resource back.

Client signature Date

Facility contact signature Date