



STEVE SISOLAK
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES

RICHARD WHITLEY, MS
Director

STEVE H. FISHER
Administrator

TANF MEDICAID SNAP

Date: _____
Case Name: _____
Case ID: _____



SPOUSAL HOUSING, INCOME AND RESOURCE QUESTIONNAIRE

Due to mandated spousal impoverishment provisions in the Medicare Catastrophic Coverage Act, portions of your community income and resources must be made available for the benefit of your spouse. Please complete the following information concerning **your spouse** and provide **verification** of income, resources and housing expenses by _____. **FAILURE TO PROVIDE THIS INFORMATION MAY CAUSE INELIGIBILITY FOR MEDICAID COVERAGE.**

Spouse's Name: _____ Social Security No.: _____

Address: _____

Spousal Income (Monthly)

Source	Amount

Spousal Expenses (Monthly) for Rent or Mortgage. Include mortgage principal and interest, taxes and insurance.

Type	Amount

Does your spouse live in the same residence as a minor dependent or child, dependent parents or dependent siblings? (Claimed as dependents for Federal Income Tax purposes) YES NO

If YES, please list their name(s) and relationship to you or your spouse. What is their monthly income and source(s)?

Name	Relationship	Income Amount	Source

Check the box for each item below that your spouse owns or jointly owns with someone else:



- a. Life Insurance YES NO
- b. Funds Set Aside for Burial YES NO
- c. Savings (Time) Certificates YES NO
- d. Individual Retirement Account YES NO
- e. Stocks or Bonds YES NO
- f. Banking/Credit Union Accounts YES NO
- g. Safe Deposit Box YES NO
- h. Cash on Hand YES NO
- i. Livestock YES NO
- j. Machinery or Equipment YES NO
- k. Real Property (located anywhere) YES NO
- l. Vehicles (all kinds) YES NO
- m. Other (specify) _____ YES NO

Client Signature
Print Name
Date
Telephone Number

