Georgia Department of Human Services
Division of Family and Children Services
Undue Hardship Waiver Application

I, _____ , Medicaid applicant/recipient, request undue hardship consideration and a waiver of the penalty imposed by the transfer of assets for less than fair market value.

The transfer penalty will deprive the applicant/recipient (A/R) of:

_____ medical care, such that A/R's health or life would be endangered
_____ food, clothing, shelter, or other necessities of life.

Please indicate above the reason for deprivation and provide:

- Documentation of how the condition is met and why the A/R will suffer irrevocable harm if Medicaid is denied or discontinued.

- Notarized/Certified signed statement from a medical doctor with knowledge of the individual's medical condition at the time of the transfer that in his or her professional opinion, the individual's health and age did not indicate a need for long-term care services.

If application for Medicaid was made **on or after February 8, 2006**, the applicant must have taken legal action or equitable remedies to recover the asset before the state can consider undue hardship. Please provide the following:

- Evidence of legal action and equitable remedies.

If your request for an Undue Hardship Waiver is denied, you may be required to repay the state for any Medicaid funds spent on your behalf during this period.

_____ _____
Medicaid Applicant/Recipient or Responsible Party Signature Date

Consent if requested by Nursing Facility

The Nursing Facility is filing this undue hardship waiver request on behalf of the A/R with the consent of the individual or the personal representative of the A/R.

_____ _____
Medicaid Applicant/Recipient or Responsible Party Signature Date

_____ _____
Nursing Facility Representative Title