MARYLAND MEDICAL ASSISTANCE PROGRAM
HOME EXCLUSION – STATEMENT OF INTENT

Date: _____

PART I. INSTITUTIONALIZED PERSON'S IDENTIFICATION
(To be completed by the Local Department of Social Services)

1. _____ _____
Name Client ID

2. _____ _____
Name of Facility Telephone Number

_____
Address

3. _____ _____
Representative's Name Telephone Number

_____
Address

4. _____ _____ _____
Case Manager Department of Social Services Telephone Number

_____
Address

PART II. STATEMENT OF INTENT TO RESUME LIVING IN HOME PROPERTY

Read this entire section before answering the question below. The person's representative may answer the question.

If "no" is checked, the equity value of the person's home may be a countable resource which could cause the person to be ineligible for Medical Assistance. If "yes" is checked, the person's home property will not be a countable resource; however, the State may place a lien on the home and other real property.

Does the institutionalized person ever intend to live in his/her home property located at

_____ again?

☐ Yes ☐ No

Signature of Applicant
or Representative _____ Date _____