WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

APPLICATION FOR UNDUE HARDSHIP WAIVER

Applicant Information

Name: _____
LAST FIRST MI

Address: _____
Route and Box or Number and Street Apt. Number

Address: _____
City / Town State Zip Code

County of Residence: _____ **Date of Birth:** __ __ / __ __ / __ __
Month Day Year

Telephone
(Where you may be reached): _____ _____
Area Code

Social Security Number: _____ - _____ - _____

Person Making Request (If not applicant):

Name: _____
LAST FIRST MI

Address: _____
Route and Box or Number and Street Apt. # City / Town State Zip Code

Relationship to Applicant: ☐ Spouse ☐ Parent ☐ Sister ☐ Brother
☐ Child ☐ Grandparent ☐ Grandchild ☐ Great Grandchild

Please indicate which of the following conditions is the basis for your claim of undue hardship.

☐ Enforcement of the trust or transfer policy will cause the applicant's life to be endangered.

☐ Enforcement of the trust or transfer policy will cause the applicant loss of food, clothing, shelter or other necessities of life.

Do you have any other sources available to provide medical care, food, clothing, shelter or other necessities of life? ☐ **Yes** ☐ **No**

If YES, please explain: _____

_____

_____

_____

_____

Are you or a person / facility, acting on your behalf, making a good faith effort to pursue all reasonable means to recover the transferred asset(s) or obtain fair market value for the transferred asset(s)? ☐ **Yes** ☐ **No**

If YES, please explain and attach documentation: _____

_____

_____

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_____

Please describe any other relevant factors or circumstances that you think should be considered in reviewing this request for an Undue Hardship Waiver. (Attach additional sheets if necessary.)

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Please attach all supporting documentation to support your claim of undue hardship.

I affirm that the foregoing information and any attachments are true and accurate to the best of my knowledge.

_____ _____

Signature of Applicant or Representative Date Signed

Submit completed form and all supporting documentation to:

WV DHHR - _____ **County Office**
Attn: _____

_____

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