

Ohio Department of Medicaid
**NOTICE OF FAILURE TO SUBMIT RESOURCE DOCUMENTATION
 FOR THE RESOURCE ASSESSMENT**

Name	Assistance Group Name	
Street Address	Assistance Group Number	
City, State, and Zip Code	County	Mailing Date

Institutionalized Individual's Name _____

Community Spouse's Name _____

Your request for a Resource Assessment on _____, cannot be completed because we have not received all of the requested documentation of resources.

The following documentation of resources were not submitted:

The time limit for completing your Resource Assessment has expired. If you request another Resource Assessment, an additional fee will be necessary. If you have any questions about this notice call:

Caseworker	Unique Identifier	Telephone Number
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NOTE: There are no state hearing rights associated with this notice.