SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

# REBUTTAL OF OWNERSHIP OF JOINT CHECKING / SAVINGS ACCOUNT

*If the applicant/beneficiary wishes to rebut ownership of a joint checking/savings account, this form must be completed and signed by each of the joint account holders.*

Name of Applicant/Beneficiary _____

Name of Financial Institution _____

Account Number for Joint Checking/Savings Account _____

Names listed on the Joint Checking/Savings Account _____

***Answer questions 1-9 about joint account, then sign/date below.***

1. How much of the money in this account belongs to you? ☐ All ☐ Part
2. To whom does the money belong? _____
3. If some of the money belongs to you, how much of the money is yours? _____
4. Why is there more than one name on the account?
5. Who makes deposits into the account? **(Please attach verification.)** _____
6. Who withdraws money from the account? **(Please attach verification.)** _____
7. How have the withdrawals been spent?
8. Other information:

9. I certify that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any information regarding any situation, I am liable for prosecution for fraud and/or perjury.

10. I understand that if this rebuttal successfully establishes the applicant/beneficiary has partial ownership of the funds, his portion is a countable resource. I also understand that records of his deposits and withdrawals from the account must be provided at review so his countable resources can be determined.

11. I understand that if this rebuttal successfully establishes the applicant/beneficiary has no ownership of the funds that he must not add any of his funds to the account in the future or the rebuttal will be negated.

_____ _____

***Signature*** ***Date***

**For Agency Use Only**

☐ This rebuttal has successfully established that
- ☐ The applicant/beneficiary has partial ownership of funds.
- ☐ The applicant/beneficiary has no ownership of the funds; none of his funds can be added to the account.

☐ This rebuttal has not successfully established the applicant/beneficiaries limited ownership or non-ownership of the account funds.

_____ _____

***Eligibility Worker/Supervisor Signature*** ***Date***

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html