APPLICATION FOR REDUCTION OF COST SHARE

This process is optional. However, if you would like to request a reduction of cost share, completing this form is required. All the information requested on this form needs to be submitted. Under s 49.45(4), Wis Stats, personally identifiable information about members is confidential and is used for purposes directly related to Family Care, PACE, and Family Care Partnership administration.

Who can request a cost share reduction?

- Are you a Family Care, Family Care Partnership, or PACE member?
- Do you have to pay a monthly cost share?
- Are you unable to pay your monthly cost share due to your necessary monthly living expenses?

If you answered yes to all three questions above, you may qualify for a reduction of your cost share.

NOTE: Members who live in nursing homes are NOT eligible for cost share reduction.

Necessary monthly living expenses include costs such as mortgage payments, rent, home/renter's insurance, property taxes, clothing, food, hygiene items, internet, phone, utilities, and the cost of operating and maintaining a vehicle.

NOTE: If your monthly living expenses have significantly increased, please contact your managed care organization (MCO) care manager to update your information. This may automatically reduce your cost share to the appropriate amount without requiring completion of this application.

To request a reduction of your cost share, please complete this form or provide the same information in your own format and mail, fax, or email it to:

Member Rights Specialist
Department of Health Services
Bureau of Programs and Policy
1 West Wilson Street, Room 518
P.O. Box 7851
Madison, WI 53707-7851
Fax: 608-266-5629
Email: DHSLTCFax@dhs.wisconsin.gov

Along with your application, you will need to submit proof of your monthly income, your monthly expenses, and the cost share you owe to your MCO. The form tells you what type of proof is needed and examples of the types of documents to provide. The Wisconsin Department of Health Services (DHS) will review your application and proof to calculate if the amount of cost share you pay each month can be reduced. Please note processing takes approximately 30 days after receipt of the complete application. DHS will send you a letter approving or disapproving your request. If you have questions, please call:
1-855-885-0287. TTY: 711

Who can help me complete this form?

You can obtain assistance, free of charge, from the following resources:

- **Your MCO care manager**
  Contact your MCO care manager for assistance.
  https://www.dhs.wisconsin.gov/familycare/mcocontacts.pdf
- **If you are age 18-59,** contact the **ombudsman program through Disability Rights Wisconsin.** An ombudsman can provide free and confidential support toll free at 1-800-928 8778, mention Family Care.
- **If you are age 60+,** contact an **elder benefit specialist.**

An elder benefit specialist can help answer your questions. Services are free and confidential. To find an elder benefit specialist in your county or Tribe, contact your local Aging and Disability Resource Center or aging office: https://www.dhs.wisconsin.gov/benefit-specialists/counties.htm

APPLICATION FOR REDUCTION OF COST SHARE

Answer the questions on this form as completely as you can. If you are filling out this form for someone else, answer the questions as they apply to that person. If more space is needed, attach a separate sheet(s) of paper and indicate the number and letter (if any) of the question you are answering.

Section 1—Applicant Information

Last Name	First Name		Middle Initial
Mailing Address—Street	City	State	Zip Code
Phone Number	Email Address		

Name of Managed Care Organization (MCO) Member is Enrolled in

Name of MCO Care Manager

Date of Birth (mm/dd/yyyy)	Medicaid ID Number or CARES ID

Section 2—Authorized Representative (complete this section if applicable)

Last Name—Representative	First Name—Representative		Middle Initial
Mailing Address—Street	City	State	Zip Code
Phone Number	Email Address		

A. Source of Authority to Act as Member's Representative:

Check the boxes that apply. *Proof Required:* For any box you have checked, attach a copy of the document that grants you the authority to act as the member's representative. For example, a signed guardianship order or activated power of attorney document.

☐ Guardian of Estate ☐ Guardian of the Person ☐ Power of Attorney for Finances ☐ Attorney

☐ Power of Attorney for Health Care ☐ Other—Specify:

Section 3—Current Cost Share and Amount of Cost Share Reduction Requested

Answer the questions below. *Proof Required:* Attach a copy of your monthly cost share bill from the MCO or the State of Wisconsin.

A. What is your current monthly cost share amount? *(This is the amount of cost share you must pay to the MCO now.)*	$	per month
B. What is the amount of monthly cost share you can afford to pay? (*This is the amount of cost share you would pay the MCO if your request is fully granted.)*	$	per month

Section 4—Why Cost Share Reduction is Necessary

Please explain why you need a reduction in cost share (attach additional pages, if needed):

Section 5—Past Cost Share Amount

A. Do you owe the MCO cost share for past months?	☐ Yes ☐ No
B. If yes, how much do you owe?	$

Section 6—Current Income Amount

List all types of income you receive below. *Proof required:* Attach documentation such as copy of social security statement, annual tax return, statement from a pension or annuity company, paystubs, bank records of deposits into your checking or savings account from social security, pension, or annuity.

A. Total monthly *gross* income (This is income before taxes, Medicare Part B and D premiums, and other deductions are taken out).	$ per month
B. Total monthly *net* income (This is the actual income you receive after taxes, Medicare Part B and D premiums, and other deductions are taken out). Also known as "take-home" pay.	$ per month

C.	**D. Source of income**	
TYPE	**AMOUNT**	
☐ Social Security	□ Attached Supporting Document	$
☐ Pension	□ Attached Supporting Document	$
☐ Annuity	□ Attached Supporting Document	$
☐ Other Specify:	□ Attached Supporting Document	$
☐ Other Specify:	□ Attached Supporting Document	$
☐ Other Specify:	□ Attached Supporting Document	$
☐ Other Specify:	□ Attached Supporting Document	$

	Section 7—Current Monthly Living Expenses	
A.	**B. List your total monthly necessary living expenses below**. *Proof required*: Attach documentation such as a copy of a mortgage statement, rental agreement or lease, condo fee invoice, property tax bill, insurance bill, utility bill, bank statement, or cancelled check.	
TYPE		**AMOUNT**
☐ Mortgage	□ Attached mortgage bill or other supporting document	$
☐ Rent	□ Attached lease or other supporting document	$
☐ Homeowner's insurance	□ Attached homeowner's insurance bill or other supporting document	$
☐ Renter's insurance	□ Attached insurance bill or other supporting document	$
☐ Property taxes	□ Attached property tax bill or other supporting document	$
☐ Condo fees	□ Attached condo association fee or other supporting document	$
☐ Clothing	□ Attached supporting documentation	$
☐ Electric/Gas	□ Attached electric/gas bill or other supporting document	$
☐ Food	□ Attached supporting documentation	$
☐ Hygiene	□ Attached supporting documentation	$
☐ Internet	□ Attached internet bill	$
☐ Maintenance and operation of vehicle	□ Attached supporting documentation	$
☐ Phone (landline **or** cell, not both)	□ Attached phone bill or other supporting document	$
☐ Sewer/Septic	□ Attached sewer/septic bill or other supporting document	$
☐ Water	□ Attached water bill or other supporting document	$
☐ Other Specify:	□ Attached supporting documentation	$
☐ Other Specify:	□ Attached supporting documentation	$
☐ Other Specify:	□ Attached supporting documentation	$

Section 8—Contact Information for Person who Assisted Member with Form (complete this if applicable)	
NAME– MCO Care Manager, Ombuds, Family Member, or Other	**Title**
Email or Phone	Date

Section 9—Fair Hearing Request
Have you requested a fair hearing with the Wisconsin Department of Administration, Division of Hearings and Appeals regarding your cost share amount? ☐ Yes ☐ No
If yes, what is the date the hearing occurred or is set to occur? Date (mm/dd/yyyy)

SIGNATURE – Member or Authorized Representative	Date Signed