WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10097A (06/2022)

NOD

COMMUNITY-BASED LONG-TERM CARE MEDICAID INCOME ALLOCATION

You are getting this notice because you get long-term care services through Medicaid and you have a spouse who lives in the community (also called your community spouse). This form has been completed by a staff member at your local agency. A copy is also being provided to your community spouse.

This form tells you the maximum amount of your income you can give to your community spouse each month. It also tells you the amount you are required to pay for your community-based long-term care services each month (also known as your cost share).

Name — Medicaid Member	Name — Community Spouse
Case Number	Date Determined

You can give some of your income to your community spouse to raise their income up to the maximum allowable amount, as determined by law:

- If you live together with your spouse, the maximum allowable amount is $_____.
- If you do not live with your spouse, the maximum allowable amount is $_____ plus an excess shelter allowance, up to a total of no more than $_____.

Section 1 below shows the steps used to calculate how much you can give to your community spouse.

You can also give some of your income to qualifying dependent family members living with your community spouse. This is known as a dependent family member income allowance (shown in **Section 2** line 4).

You, your community spouse, and dependent family members **must report any change in monthly income within 10 days** of the change to your agency so that the amounts shown below can be recalculated.

Section 1: Steps to Calculate the Maximum Income Amount That Can Be Given to the Community Spouse	**Amount**
1. A. Minimum income allocation amount, as determined by law.	
B. Plus the excess shelter allowance. These are the community spouse's shelter expenses that exceed the shelter base amount of $_____, as determined by law. They include rent, mortgage principal and interest, taxes and insurance, any required maintenance fees, and a standard utility allowance.	**+**
C. **Equals** the maximum monthly income allowance. This amount cannot be over $_____, as determined by law.	**=**
2. Minus the actual monthly gross income of the community spouse.	**-**

NOD

3. **Equals** the maximum amount of income that the community-based long-term care Medicaid member can give to their community spouse. The community-based long-term care Medicaid member may give an amount less than this, but not more unless ordered by a fair hearing or court order.	**=**

Note: If the maximum amount you can give to your community spouse (shown in **Section 1** line 3 above) is greater than the amount you are currently giving (shown in **Section 2** line 3 below), you can change that. Contact your agency right away if you want to change how much you are giving to your community spouse.

The monthly amount you are required to pay for community-based long-term care services is called your cost share. The steps used to calculate your cost share are shown in **Section 2** below.

Section 2: Steps to Calculate the Medicaid Member's Cost Share	**Amount**
1. Member's gross monthly income.	
2. Minus the personal maintenance allowance. This is calculated as the total of A, B, and C below, up to a maximum of $_____, as determined by law.	
A. Basic needs allowance, as determined by law.	**-**
B. Earned income disregard. This is calculated by subtracting $65 from the member's monthly earned income, dividing the result by two, and adding $65.	**-**
C. Special housing amount, if applicable. This is equal to the member's total housing costs over $350. Housing costs may include rent, home or renters insurance, mortgage, property tax, utilities, and room amount for members in community home settings. If the spouses live together, both have income, and both get community-based long-term care services through Medicaid, this allowance is distributed between the spouses to get the lowest total cost share amount for the couple.	**-**
3. Minus amount the member is giving to the community spouse (cannot be more than line 3 in Section 1 above unless ordered by a fair hearing or court order).	**-**
4. Minus dependent family member income allowances, if applicable. For each qualifying dependent family member, this is calculated as $_____ minus the dependent family member's income, divided by three.	**-**
5. Minus special exempt income, if applicable. This may include support payments, some court-ordered fees, expenses associated with a guardianship or a Social Security Administration-approved PASS Plan, impairment-related work expenses (IRWE), and some costs associated with real property listed for sale.	**-**
6. Minus allowable health insurance premiums, including Medicare premiums, paid by the member.	**-**
7. Minus medical and remedial expenses paid out of pocket by the member as provided by the aging and disability resource center staff, managed care organization care manager, or IRIS (Include, Respect, I Self-Direct) consultant.	**-**
8. **Equals** the member's community-based long-term care Medicaid cost share.	**=**

You, as the Medicaid member, and your community spouse have the right to appeal a Medicaid decision by asking for a fair hearing about:

- The income counted for you, your spouse, and any dependent family members.
- The community spouse's income allocation amount.
- The dependent family member's income allowance amount.
- Requesting a community spouse income allocation amount that is greater than the maximum lawful amount due to exceptional circumstances.

Please see the attached fair hearing information. If you have any questions, you can contact your agency.

If you are in Family Care, Family Care Partnership, or PACE (Program of All-Inclusive Care for the Elderly) and having difficulty paying your cost share because of necessary monthly living expenses, you can ask for a waiver or reduction of your cost share from the Wisconsin Department of Health Services.

To ask for a waiver or reduction of cost share, complete and submit the Application for Reduction of Cost Share form, F-01827. You can get this form by calling the Wisconsin Department of Health Services at 855-885-0287 or going to www.dhs.wisconsin.gov/library/f-01827.htm. You will need to provide proof of all of the income and expenses claimed on the form.

Note: Your income maintenance or tribal agency **does not** handle requests for reduction of cost share. Please do not contact them to ask for the form or send the form to them.

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-10151 (06/2018)

MEDICAID/BADGERCARE PLUS FAIR HEARING INFORMATION

Any time your benefits are denied, reduced or ended, and you think the county or tribal office made a mistake, contact the local agency. If the local agency does not agree, you can ask the local office worker to help you in asking for a prehearing conference and a fair hearing.

Prehearing Conference

You may be able to come to an agreement with the local agency through a prehearing conference without having to wait for a fair hearing to take place. At a conference you get to tell your side of the story, and the local agency will explain to you why s/he feels that the action was taken. If the local agency finds that it has made a mistake, it will change its decision and will take corrective action. If the local agency decides that its initial decision is correct, and you feel that the local agency is still wrong, you have the right to go through the fair hearing process.

Please Note: The fact that you agreed to have a prehearing conference doesn't affect your right to have a fair hearing. You can ask for a fair hearing and if you are satisfied with the action of the prehearing conference you can then cancel your fair hearing.

Fair Hearing

A fair hearing gives you the chance to tell why you think the decision about your application or benefits were wrong. At the hearing, a hearing officer will hear from you and the local agency to find out if the decision was right or wrong. You may bring a friend or family member with you to the hearing. You may also get free legal help. (See Legal Help.)

When to Use The Fair Hearing Process

If you believe that your local agency made a wrong decision on your case, the fair hearing process may be used to have the decision reviewed. Examples include:

- Your application was denied or your benefits were suspended, reduced or ended, and you think the local agency made a mistake.
- You believe that your application for BadgerCare Plus was wrongly denied.
- Your application wasn't acted on within 30 days.
- Prior authorization request was denied.

Read each notice or letter of decision carefully to help you understand the action taken. If the reason for the change in your benefits is a federal or state rule change, the Division of Hearings and Appeals needn't grant a request for a fair hearing.

How to Ask for a Fair Hearing

Ask your local agency to help you file for a fair hearing or write directly to:

Department of Administration
Division of Hearings and Appeals
PO Box 7875
Madison WI 53707-7875

Or call 608-266-7709.

If you have access to the internet, the Fair Hearing Request form can be found at www.dhs.wisconsin.gov/forwardhealth/resources.htm. If you chose to write a letter in place of the form, you must include the following:

- Your name
- Your mailing address
- A brief description of the problem
- The name of the local agency that took the action or denied the service
- Your Social Security number
- Your signature

Your request should include the important facts of the matter and your BadgerCare Plus identification number. An appeal must be made no later than 45 days after the date of the action. Your latest notice will have the date by which you must request a hearing.

If you need an accommodation for a disability or an interpreter services, please call 608-266-7709. This telephone number is only for the administrative hearing process.

You or your chosen representative (if any), and the local agency will get written notice of the time, date and place of the hearing at least 10 days before the fair hearing. The hearing will be held in the county where you live.

Preparing for a Fair Hearing
You have the right to bring witnesses, your own lawyer or other advisor to the fair hearing. The agency can't pay for a lawyer to represent you, but they may be able to help you find free legal help for any questions you may have or to represent you at the fair hearing. (See Legal Help to learn more.)

You have the right, both before the hearing and during the hearing, to see the local agency's written materials about the case, including your case record, on which the local agency based its decision.

You or your representative have the right to question anyone who testifies against you at the fair hearing. You also have the right to present your own arguments and bring written materials showing why you think you're right.

If the fair hearing is about whether you are or are not incapacitated or disabled, you have the right to present medical evidence for proof, paid for by the agency.

If you can't speak English or use sign language, you have the right to have an interpreter at the hearing. The Division of Hearings and Appeals may allow payment for translation or interpreters if you ask.

You Can Keep Getting Benefits
If you ask for a fair hearing before the effective date of the local agency's action, you can ask that your benefits not be reduced or ended until after the results of the fair hearing are known. If the fair hearing isn't in your favor, you'll have to repay any benefits that you should not have received. You still must report any required changes while your hearing is pending which may affect the level of your benefits. You must complete any reviews, even if you're asking for a fair hearing.

Effects of the Fair Hearing
If the fair hearing decision is in your favor:

- No action will be taken against you by the local agency.
- Benefits will be reinstated if they were ended.
- The date of reinstatement will be listed in the copy of the decision you get, ordering the local agency to reinstate your benefits.

If the fair hearing decision isn't in your favor, the local agency's action will stand, and you will have to pay back any benefits that you shouldn't have gotten.

Rehearings
After you get the fair hearing decision, you have the right to ask for a rehearing if:

- You have new evidence that you couldn't have made available before the hearing, even if you tried, that could change the decision.
- You feel that there was a mistake in the facts of the decision.
- You feel that there was a mistake in the legal basis of the decision.

The Division of Hearings and Appeals must get a written request for a rehearing within 20 days from the date of the written decision. The state hearing agency will decide within 30 days if a rehearing is justified. If the office doesn't issue a written response to the request in 30 days, it is assumed your request is denied.

Appealing a Fair Hearing or Rehearing Decision
If you don't agree with the fair hearing or rehearing decision, it is still possible for you to appeal to the Circuit Court in your county. This must be done within 30 days after you get the written decision about the fair hearing or within 30 days of the denial of the rehearing request. An appeal to the Circuit Court must be done by filing a petition with the Clerk of Courts in your county. It's best to have legal help, if you decide to appeal a fair hearing decision in Circuit Court.

Legal help
Legal help may be available through Wisconsin Judicare, Inc. or Legal Action of Wisconsin, Inc (LAW). To find the office closest to you, call:

- Judicare at 715-842-1681 or www.judicare.org or
- LAW at 888-278-0633 or www.legalaction.org.