Scott Walker
Governor

Kitty Rhoades
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF LONG TERM CARE

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December 2, 2014ATE

Name, Title
Address
City, State, Zip Code

Dear Mr./Ms. XXXX:

This letter and the attached form provide specific information regarding XXXX County's required contribution under Wis. Stat.§ 46.281(4) for the Family Care program. 2014 LTC Fiscal Update Memo #1 provides details on how the county contribution is calculated, collected, and the options that counties have for paying contributions. All 2014 LTC Fiscal Update memos may be found at:

PASTE LINK HERE

The attached Family Care County Contribution Agreement form should be reviewed and sent back to the Department. This form will serve as a binding agreement between XXXX County and the Wisconsin Department of Health Services, and specifies three key pieces of information surrounding the County Contribution:

1) The County's total Family Care contribution;
2) Annual contribution payment due date; and,
3) Method and number of payments that the County is electing to make.

Amount of County Contribution

XXXX County transitioned to Family Care on DATE. The Department has completed the statutorily required buy-down to reduce the County's contribution amount to no more than 22% of its Calendar Year (CY) 2006 Basic County Allocation (BCA) within five years of transition to Family Care. XXXX County's ongoing contribution amount is $XXXX annually. This amount must be paid in full each year, with no end date. For more information on the buy-down formula, please refer to the 2014 LTC Fiscal Update Memo #1.

Contribution Due Date

The County's ongoing county contribution payments are due no later than the anniversary of its Long Term Care implementation date. XXXX County's Family Care Contribution payments are due DATE of each year.

Method and Number of Payments

State statute allows counties two options to pay the county contribution:

1) Direct payment to the Department (i.e., a check); or
2) Reduction in the County's community aids distribution.

In addition to selecting a payment method, the Department allows counties to decide whether they prefer to make one lump sum payment each year or if they prefer to make four equal payments on a quarterly basis. The form contains a place for each county to select their choice for each of these items. If the County wishes to change the payment method, or change from payments to lump sum or vice versa, it may do so prior to the Long Term Care implementation anniversary date by sending a request to DHSDLTCBFM@wisconsin.gov.

If you have questions on any of the information contained in this letter or the attached form, including the county's liability or the date on which payments are due, please contact DHSDLTCBFM@wisconsin.gov.

Sincerely,

Brian Shoup, Administrator

Family Care
County Contribution Agreement Form

COUNTY:

FAMILY CARE START DATE:

Under Wis. Stat. § 46.281(4), counties in which managed long term care, commonly referred to as Family Care, is operating are required to contribute county funds to assist in funding the cost of care for individuals in the program. This form certifies that XXXX **County** agrees to pay **$XXXX** annually to the Department of Health Services by August 30 of each year. The funds collected from the county will be used to fund the cost of the services in Family Care.

The Department of Health Services has provided two options for counties to pay their county contribution.

A) Through a direct payment to the Department, i.e., payment with a check.

B) Through a reduction in the community aids distribution to the county.

XXXX County selects OPTION _____ as their method of paying their county contribution. (Please choose option A or B described above, and fill in the blank.)

In addition, the Department of Health Services is allowing counties to determine whether they want to make their county contribution in:

1) One lump sum payment, or

2) Four equal payments due quarterly throughout the year.

XXXX County selects OPTION _____ for the number of annual payments. (Please choose option 1 or 2 described above, and fill in the blank.)

By signing this form, XXXX **County** is committed to paying the above stated county contribution by the deadlines provided using the method selected above. If XXXX **County** does not make the required payment with the above agreement, the Department of Health Services will reduce the county's Basic County Allocation (BCA) to cover the annual county contribution. In the event XXXX **County** selects or defaults to having

their BCA reduced and the amount of BCA available is insufficient to fully fund the county contribution, the amount of any insufficiency will be met by reducing other payments made by DHS through the CARS system in current or future years.

Please return this completed and signed form by DATE to the following address:

Department of Health Services
Division of Long Term Care
Bureau of Long Term Care Financing, Room 550
1 West Wilson Street
P.O. Box 7850
Madison, WI 53707-7850

DHS SIGNATURE	COUNTY SIGNATURE
TITLE	TITLE
DATE	DATE