MILWAUKEE
MILWAUKEE ENROLLMENT SERVICES
PO BOX 05676
MADISON WI 53205

Mailing Date: MM/DD/CCYY

000007

ANNA MEMBER
123 MAIN ST
ANYTOWN WI 55555

State of Wisconsin

PIN #: 9876543210

Milwaukee Enrollment Services
Worker: A WORKER
Phone #: 1-888-947-6583
Fax #: (414) 438-4580
Use fax # to send verifications.

The State of Wisconsin is an equal opportunity service provider. This letter contains information that affects your benefits. If you need this material in a different format because of a disability or if you need this letter translated or explained in your own language, please call 1-888-947-6583. These services are free.

YOU CAN REQUEST AN UNDUE HARDSHIP WAIVER FOR YOUR DENIED MEDICAID LONG-TERM CARE SERVICES

This letter is for: ANNA MEMBER

Previously, you got a letter letting you know that you cannot get Medicaid coverage for long-term care services because you have a divestment penalty period. If this would cause you undue hardship, you may be able to have your divestment penalty period removed and get Medicaid coverage for long term-care services sooner. You must **provide proof** of undue hardship. Undue hardship means that you would not be able to pay for:

- Medical care, which would put your health or life at risk
- Food
- Clothing
- Shelter
- Other necessities of life

How to Request an Undue Hardship Waiver
To request an undue hardship waiver, fill out the attached Undue Hardship Waiver Request and submit it to your agency (your agency is listed at the top of the first page of this letter). If you reside in a medical facility, you can also use this form to allow the medical facility to apply on your behalf.

Deadline to Submit an Undue Hardship Waiver Request
The date your agency gets your Undue Hardship Waiver Request determines when your Medicaid coverage for long-term care services could start.

If your agency gets your Undue Hardship Waiver Request **on or before <Date>**, and your request is approved, your divestment penalty period will be removed. If your agency gets your Undue Hardship Waiver Request **after <Date>**, and your request is approved, your divestment penalty period will end on the date your agency got your Undue Hardship Waiver Request.

Decision About Your Undue Hardship Waiver Request
You will get a letter with your agency's decision about your Undue Hardship Waiver Request. Your agency has up to 30 days to make a decision. If your Undue Hardship Waiver Request is approved, you will get a letter with more information about your start date for Medicaid coverage of long-term care services.

If you do not agree with the agency's decision, you may request a fair hearing. Information about how to request a fair hearing will be in the letter from your agency.

More Information

For more information about divestment, refer to the Medicaid for the Elderly, Blind, or Disabled Divestment Fact Sheet (P-10058) at www.dhs.wisconsin.gov/library/P-10058.htm.

Questions

If you have questions about this letter, contact your agency, which is listed at the top of the first page of this letter.

UNDUE HARDSHIP WAIVER REQUEST

Applicant/Member Name	Case Number	PIN
ANNA MEMBER	1234567890	9876543210

Instructions to applicant: Use this form to request an undue hardship waiver or to authorize the medical facility where you reside to file an undue hardship waiver request on your behalf. Send this completed form, along with the requested proof, to your agency. Your agency contact information is at the top of your undue hardship letter.

Section 1: Proof (required)
You must submit the **two** types of proof (1 and 2) listed below.

1. A statement signed by you (or your authorized representative) that describes if you can get back the assets you no longer have. These assets are listed on your benefits notice. If you can get these assets back, explain how you tried to get these assets back.

AND

2. You must submit **one** of the following documents (a or b) that show you will have an undue hardship by not being able to get Medicaid long-term care services coverage.

   a. If you are currently **residing in a medical facility**, you must submit **one** (i or ii) of the following:
      i. A copy of the notice from the facility that states both of the following:
         - The date you are required to leave the medical facility and
         - The location you will be going to when you leave the medical facility.

      OR

      ii. Proof that if the undue hardship waiver request is not approved, you will not be able to pay for one of the following:
         - Medical care, which would put your health or life at risk;
         - Food;
         - Clothing;
         - Shelter; or
         - Other necessities of life.

   b. If you applied for any of these programs: Home and Community-Based Waivers (HCBW), Family Care, Program of All-Inclusive Care for the Elderly (PACE), Partnership, or Include, Respect, I Self-Direct (IRIS), you must submit **both** of the following documents:
      - An estimate of the cost of the Medicaid long-term care services needed to meet your medical and remedial needs and
      - An estimate of your monthly costs for food, shelter, clothing, and other necessities of life.

Section 2: Description (required)

You must describe in the space provided below how your denied Medicaid long-term care services coverage or divestment penalty period will endanger your health or life, or how you will not be able to get food, clothing, shelter, or other necessities of life. Attach a separate piece of paper if you need more room.

Section 3: Authorize Your Medical Facility (optional)

This section only applies if you are currently residing in a medical facility. This section should only be filled out if you want the medical facility where you reside to:

- Request an undue hardship for you.
- If necessary, request a fair hearing for you and represent you during the fair hearing process for your undue hardship request or denial.

To provide your consent, select which option(s) below you want your medical facility to do for you, and write your name and your medical facility's name in the boxes below.

□ I authorize the medical facility stated below to fill out and submit an Undue Hardship Waiver Request on my behalf.

□ I authorize the medical facility stated below to request a fair hearing on my behalf (if needed) and represent me during the fair hearing process for my undue hardship request or denial.

Print the name of the person in the medical facility

Print medical facility's name

Section 4: Signature (required)

I declare under penalty of perjury or false swearing that all of the information I have provided is correct and complete to the best of my knowledge.

Signature – Applicant/Member/Authorized Representative/ Guardian/Power of Attorney/Conservator

Date signed