Tony Evers
Governor

Andrea Palm
Secretary

DIVISION OF MEDICAID SERVICES

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State of Wisconsin
Department of Health Services

[Date]

[Name]
[Address]
[City, State Zip]

Re: Cost-Share Reduction Request:
[Name]
CARES Case No.: [ ]
Member MAID: [ ]

Dear Mr./Mrs./Ms. [Name],

On [date], you submitted a request to the Department for a cost-share reduction in an amount sufficient to allow you to meet your monthly necessary living expenses and maintain eligibility for the Family Care program.

The reduction request was based on the monthly necessary living expenses, as documented in the materials submitted with the request. We have reviewed this documentation and determined that it demonstrates that your income is insufficient to cover your monthly necessary living expenses and cost-share obligation. Consequently, we have determined that a cost-share reduction is appropriate and we will be:

1) Reducing your cost-share responsibility by $[ ] for the month of [month/year], $[ ] for the month of [month/year] and $[ ] for the [month/year]; and

2) Beginning with [month/year] and going forward, reducing your cost-share responsibility by $[ ] per month.

If you have any questions or concerns, please contact [Name], [Position], at [phone number].

Sincerely,

[ ], Director
Bureau of Adult Programs and Policy

cc: [Name of Legal Decision Maker, if any]
[Name], [CEO or CPO], [MCO name spelled out]
[Name], [title], [MCO Name spelled out]
[Name], Quality Oversight Section Chief, Bureau of Adult Quality and Oversight
[Name], Contract Coordinator, Bureau of Adult Quality and Oversight
MDPU [If member resides in Milwaukee County]
CDPU [If member resides in a county other than Milwaukee]
[Name], IT Liaison, Office of Long Term Care Systems