APPLICATION FOR REDUCTION OF COST SHARE

Although completion of this form is voluntary, all the information requested on this form needs to be submitted as part of the approval process. Personally identifiable information is collected on this form for the sole purpose of identifying the program participant and processing the request, and will not be used for any other purpose.

Request for Reduction of Cost Share

- Are you a 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 yes, you may qualify for a reduction of your cost share.

A cost share reduction may make your monthly living expenses more affordable, and allow you to stay enrolled in Family Care, Partnership, or PACE. Necessary monthly living expenses include costs such as mortgage payments, rent, home/renter's insurance, property taxes, utilities, food, clothing, hygiene items, and the cost of operating and maintaining a vehicle.

To request a reduction of your cost share, please complete the attached form, "Application for Reduction of Cost Share," and mail or fax it to the Bureau of Managed Care at:

Member Rights Specialist
Department of Health Services
Bureau of Managed Care
1 West Wilson Street, Room 518
P.O. Box 7851
Madison, WI 53707-7851
Phone: 1-855-885-0287
TTY: 711
Fax: 608-266-5629

Along with the application, you will need to submit proof of your monthly income, your monthly expenses, and the cost share you owe to your MCO each month. The application will tell you what kind of proof is needed and gives examples of the types of documents that provide that proof. The Wisconsin Department of Health Services will review your application to decide if the amount of cost share you pay each month can be reduced. The Department of Health Services will send you a letter approving or disapproving your request. If you have questions, please call 1-855-885-0287.

Who Can Help Me Complete This Form?

If you need help completing this form, you can obtain assistance, free of charge, from the following resource:

Benefit Specialists

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

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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
Telephone Number	Email Address		

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

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
Telephone 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. Source of income

TYPE	AMOUNT
☐ Social Security	$
☐ Pension	$
☐ Annuity	$
☐ Other Specify:	$
☐ Other Specify:	$
☐ Other Specify:	$
☐ Other Specify:	$

Section 7—Current Monthly Living Expenses

A. 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.

TYPE	AMOUNT
☐ Mortgage	$
☐ Rent	$

☐ Home owner's insurance	$
☐ Renter's insurance	$
☐ Property taxes	$
☐ Condo fees	$
☐ Phone	$
☐ Gas	$
☐ Electric	$
☐ Sewer/septic	$
☐ Water	$
☐ Food	$
☐ Clothing	$
☐ Hygiene	$
☐ Maintenance and operation of vehicle	$
☐ Other Specify:	$
☐ Other Specify:	$
☐ Other Specify:	$
☐ Other Specify:	$

Section 8—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