



State of Wisconsin

Case #:
PIN:



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 . These services are free.

DIVESTMENT PENALTY AND UNDUE HARDSHIP NOTICE PLUS WAIVER REQUEST

This letter is for:

Previously, you got a letter letting you know that you cannot get Medicaid coverage for long-term care services for the following reason(s):

- ☐ You have a divestment penalty period.
- ☐ Your home has more than \$750,000 in equity interest.
- ☐ Your community spouse did not sign the application and/or cooperate with the application process.
- ☐ You and your community spouse have assets over the program limit.

If this would cause you undue hardship, you may be able to have any 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 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** _____ and your request is approved, any divestment penalty period will be removed. If your agency gets your Undue Hardship Waiver Request **after** _____ and your request is approved, any 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 dhs.wisconsin.gov/library/P-10058.htm.

Questions

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

UNDUE HARDSHIP WAIVER REQUEST

Name – Applicant/Member	Case Number	PIN
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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 the following:
 - If you were denied Medicaid long-term care services coverage because you have a **divestment penalty period**, explain if you can get back the assets you no longer have. These assets are listed on your benefits notice. If you cannot get these assets back, explain how you tried to get these assets back.
 - If you were denied Medicaid long-term care services coverage because you have a **community spouse** who refuses to cooperate with the application or renewal process, explain how you have tried to get cooperation from him or her.
 - If you were denied Medicaid long-term care services coverage because you have more than \$750,000 in **home equity**, explain why you do not have access to this home equity.
 - If you were denied Medicaid long-term care services coverage because you have **excess assets**, explain why you do not have access to the excess assets.

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.
 - 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
 - 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 IRIS (Include, Respect, I Self-Direct), 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.
 - 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 the denial of 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 waiver 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. 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.

Name – Person in Medical Facility	Name – Medical Facility
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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
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