WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10098 (11/13)

NOD

MEDICAID MEMBER ASSET ALLOCATION NOTICE

Instructions: This form is to be completed by an Income Maintenance (IM) worker. Provide a copy to the member, community spouse and a copy placed in the case file.

Member Name (Last, First, MI)	Spouse's Name (Last, First, MI)

The above named Medicaid member has been enrolled in Medicaid.

The community spouse's assets is the community spouse's share of the couple's total combined assets as of the date that the Medicaid member entered the institution or initially requested to participate in a community waiver program.

To be able to enroll in Medicaid, the Medicaid member and the community spouse together cannot have countable assets in excess of $_____ as shown on the community spouse asset share notice. At the time the Medicaid member was enrolled in Medicaid the couple had $_____ in countable assets. The Medicaid member must transfer $_____ in assets to the community spouse by _____ (date) in order to retain Medicaid enrollment. All assets that are owned by the Medicaid member on that date will be counted in determining the Medicaid member's continued enrollment in Medicaid. The Medicaid member may not own assets in excess of $_____ and continue to be enrolled in Medicaid. Transfer of non-exempt assets or homestead property for less than fair market value by the Medicaid member to anyone other than the community spouse may result in a divestment penalty.

Transfer of non-exempt assets or homestead property for less than fair market value by the community spouse, within the first five years after the Medicaid member is found eligible will result in a divestment penalty for the Medicaid member.

The Medicaid member and community spouse have the right to request and receive a fair hearing concerning:

1) The ownership and availability of assets.
2) The computation of the community spouse's asset allocation.
3) The amount of the community spouse's asset share.

Please see the attached fair hearing information on when and how to request a fair hearing.

SIGNATURE – Income Maintenance Worker	Date Signed

Do not complete shaded area.

Case Name	Case Number	Agency

Reset Form

WI Stats. s. 49.455
Public Law 100-360

YOUR RIGHTS AND RESPONSIBILITIES FOR HEALTH CARE

YOU HAVE THE RIGHT TO A WRITTEN NOTICE from this agency before any action is taken to stop or reduce your health care (Medicaid, BadgerCare Plus, Family Planning Only Services) benefits. For most actions, you will receive a letter at least 10 days before the action is taken.

YOU MAY REQUEST A FAIR HEARING, if you disagree with any agency action. You may request a fair hearing in writing or in person with the agency listed on the front of this notice. You may also request a fair hearing by writing to the Department of Administration, Division of Hearings and Appeals, PO Box 7875, Madison, WI 53707-7875 or by calling 1-608-266-3096. Your request must be received within 45 days of the action's effective.

In most cases, if your Fair Hearing request is received by the Division of Hearings and Appeals prior to the action's effective date, your health care and/or FoodShare benefits will not stop or be reduced. Your benefits will continue, at least, until a decision is made about your appeal. During this time, if another unrelated change occurs, your benefits may change. If another change occurs, you will get a new letter. If you are not satisfied with the fair hearing decision, you may appeal and request a second fair hearing. If the fair hearing decision ends or reduces your benefits, you may have to repay any benefits you got while your appeal was pending. You may ask not to receive continued benefits.

YOU MAY REPRESENT YOURSELF OR BE REPRESENTED at the hearing or conference by an attorney, friend or anyone else you choose. We cannot pay for your attorney. However, free legal services may be available to you if you qualify.

If you fail to appear, or your representative fails to appear at the hearing without good cause, your appeal is considered abandoned and will be dismissed.

IF YOU ARE RECEIVING HEALTH CARE BENEFITS, you must cooperate with the Child Support Agency, unless you have a good cause reason. Your worker can provide more information about child support cooperation. Even if you are not able to enroll in health care, help is available to get or increase your child support payments. Contact your county Child Support Agency for more information.

COMPUTER CHECK: If you work, the wages you report will be checked by computer against the wages your employer reports to the Department of Workforce Development. The Internal Revenue Service, Social Security Administration, Unemployment Insurance Division and Department of Transportation may also be contacted about income and assets you may have.

FORWARDHEALTH CARD, each time you go to a BadgerCare Plus or Medicaid provider you may be asked to see your ForwardHealth card. For some services, you may have to pay a copay to the provider. The amount will depend on the type of service and the cost of the service cost. Your provider should tell you if a copay is required or if a service is not covered by your health care plan. If you have questions about your health care plan, contact Member Services at 1-800-362-3002.

IF YOU RECEIVE BENEFITS OR SERVICES, you must follow these rules:

- **DO NOT** give false information or hide information to get or continue to get benefits.
- **DO NOT** trade or sell ForwardHealth cards.
- **DO NOT** alter cards to get benefits you are not entitled to receive.
- **DO NOT** use someone else's ForwardHealth card.

DISCRIMINATION

The Department of Health Services is an equal opportunity employer and service provider. All people applying for or who get benefits are protected against discrimination based on race, color, national origin, disability, age, sex or religion. State and federal laws require all BadgerCare Plus health care benefits to be provided on a nondiscriminatory basis.

For civil rights questions, call (608) 266-9372 (voice) or 1-888-701-1251 (TTY).

To file a complaint of discrimination, contact either the:

Wisconsin Department of Health Services
Affirmative Action/Civil Rights Compliance Office
1 W. Wilson, Room 555
Madison, WI 53707-7850

Telephone: (608) 266-9372 (voice)
(888) 701-1251 (TTY)
(608) 267-2147 (fax)

OR

U.S. Department of Health and Human Services
Office for Civil Rights – Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601

Telephone: (312) 886-5077 (voice) or
(312) 353-5693 (TTY)

RE: Federal Regulations	42 CFR 431, 42 CFR 433, 42 CFR 435
Wisconsin Statutes	49.22, 49.45, 49.49, 49.95