W-850
(Rev. 9/98)

STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES

LEGALLY LIABLE RELATIVE (LLR) FORM FOR SPOUSES OF CLIENTS RECEIVING MEDICAID LONG TERM CARE SERVICES, MEDICAID HOME AND COMMUNITY BASED WAIVER SERVICES OR THE STATE-FUNDED CONNECTICUT HOME CARE PROGRAM FOR ELDERS

Applicant/Recipient Name____________________ Spouse Name____________________

Spouse Address____

Spouse Telephone Number____________________ Spouse SS#____________________

If your spouse is receiving Medicaid long term care services, Medicaid Home and Community Based Waiver Services or the State-Funded Connecticut Home Care Program for Elders, we may require you to contribute to your spouse's cost of care. We are aware that you will need income to meet your monthly needs. In order for us to calculate the amount of income we will allow for your needs, we need the following information as well as verification of each of the monthly amounts reported below:

1.	Your monthly rental or mortgage payments:		$__________
2.	Your monthly real estate taxes:	+	$__________
3.	Your monthly real estate insurance costs:	+	$__________
4.	Your required monthly maintenance fees if you live in a cooperative or condominium: *(Do not include costs for utilities in this figure since we must use a Department utility standard.)*	+	$__________
5.	**TOTAL:**	=	$__________
6.	Your present monthly gross income: *(Attach verification(s) of your monthly income to this form)*	=	$__________
7.	Your net adjusted taxable income for last year: *(Attach a copy of your last year's 1040 tax form)*	=	$__________
8.	Any in-kind support provided to your spouse, during the last calendar year, along with verification of such support, which is over and above that provided to a healthy spouse, such as the following:		
	• cost of medical supplies which are not covered by insurance or Medicaid:		$__________
	• cost of a special diet;		$__________
	• cost of special transportation;		$__________
	• cost of adapting a home for the needs of your spouse;		$__________
	• other *(please specify)*		$__________

List below the persons living with you. Place a check mark (✓) next to the names of those dependent upon you for support.

✓	Name of Household Members	Age	Relationship

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (860) 424-5016 OR TDD/TTY (800) 842-4524.

If you have any questions about the completion of this form, you may contact the Resource Unit located in the Department of Social Services Regional Office. The Department may contact you for further information since this form may not cover all situations.

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In order to compute the Department's claim against the community spouse, the worker should complete the following worksheet:

1.	The community spouse's net adjusted taxable income for last year:		$__________
2.	Subtract the State median income for two people: *(Table located in UPM procedures)*	–	$__________
3.	The difference between line #1 and #2:	=	$__________
4.	Multiply the amount on line #3 by 12% *(If greater than zero)*:	=	$__________
5.	Subtract in-kind support provided by the LLR which is over and above those that would be provided to a healthy spouse:	–	$__________
6.	***LLR CONTRIBUTION:***	=	$__________

The LLR DISTRIBUTION represents the claim the Department will impose against the community spouse's share of the cost of care of the spouse unless circumstances referred to in UPM 7520.05 exist and our claim would result in the LLR having income below the MMNA.

COMPLETE THE FOLLOWING TO DETERMINE THE COMMUNITY SPOUSE'S MMNA AMOUNT

The community spouse's MMNA is the result of adding his or her excess shelter costs to the 150% of the monthly FPL for 2 persons.

1.	Enter current amount of 150% FPL for 2 persons:		$__________
2.	Add the Standard Utility Allowance	+	$__________
3.	Add the community spouse's excess shelter needs as computed by the individual and verified by the Department. (Line 5 from page 1):	+	$__________
4.	***EQUALS:***	=	$__________
5.	Subtract 30% of 150% FPL for 2 persons:	–	$__________
6.	The LLR's MMNA equals this figure, or the maximum MMNA if it is less, or the MMNA figure determined by a hearing:	=	$__________

COMPLETE THE FOLLOWING TO DETERMINE IF THE CS MUST CONTRIBUTE

1.	LLR's Gross Income (Line 6 from page 1):		$__________
2.	Subtract the LLR's contribution (from #7 above):	–	$__________
3.	***EQUALS:***	=	$__________

If the LLR's Gross Income minus the LLR contribution is greater than the MMNA then the Department can recover from the LLR.

WORKER NAME:____________________ DATE:__________

Information Sheet

Legally Liable Relative (LLR) Form for Spouses of Clients Receiving Medicaid Long Term Care Services, Medicaid Home and Community Based Waiver Services or the State-Funded Connecticut Home Care Program for Elders

The purpose of this form is to obtain financial information necessary to determine if a spouse of an applicant or recipient of Medicaid long term care services, Medicaid Home and Community Based Waiver Services or the State-Funded Connecticut Home Care Program for Elders is required to contribute to his or her spouse's cost of care in accordance with Connecticut General Statutes 17b-81 and 17b-342. Departmental policy requires an applicant or recipient to cooperate in securing support from legally liable relatives (LLR contribution) except when the Department determines that good cause exists for failure to do so.

If your spouse is receiving Medicaid long term care services, Medicaid Home and Community Based Waiver Services or the State-Funded Connecticut Home Care Program for Elders we may require you to contribute to your spouse's cost of care. We are aware that you will need income to meet your monthly needs. However, we must follow policy to calculate how much we will ask you to pay. According to our policy, we cannot require you to pay towards your spouse's cost of care if that payment would leave you with less than an amount to meet your monthly needs which we call your minimum monthly needs allowance. The Department determines your minimum monthly needs allowance based upon your shelter costs. In order for us to calculate this figure, we need verification of your shelter costs and your gross monthly income. This is the reason we request that you complete the first page of the W-850 form and return it, alone or combined with your spouse's application or redetermination form, to your spouse's Department of Social Services eligibility worker. A self-addressed stamped envelope is enclosed for your convenience. Along with this form we will need a copy of your last year's Federal Income Tax return as well as verification of your monthly rent or mortgage amount. If you do not have last year's Federal Income Tax form, you must send us verification of your gross income for the last quarter of last year. If you do not have either of these verifications, you should contact your spouse's eligibility worker to ascertain what other types of verification the Department will accept. If you are required to pay property taxes and/or property insurance, we request that you send us proof of these payments along with this completed form. In addition, we would like to know about any services you provide for your spouse that would ordinarily be provided by a trained professional. These services could include changing dressings; operating oxygen or other medical equipment; providing remedial instruction, speech therapy, physical exercise, mental or visual stimulation; therapeutic services or other services and goods that you provide over and above what would be provided to a healthy spouse. We will consider the goods and services you provide along with all other information in determining the amount of your LLR contribution.

The eligibility worker will send your W-850 form and all your verifications to the Regional Office Resource Unit. The Resource Unit will use the information you provide to calculate whether or not you have to contribute to your spouse's cost of care. You will be billed for either your calculated monthly LLR contribution amount or the amount of services the Department provided to your spouse during the month, whichever is less. If necessary, the Resource Unit will contact you regarding an interview. If you desire a specific date and time for this interview, you should so indicate; otherwise an appointment will be scheduled at our convenience. Appointments may be scheduled between 8:30 A.M. and 4:00 P.M., Monday through Friday. The Department will try to schedule the date and time you request; however, appointments depend upon the availability of the worker. At the time of the interview, the Resource worker will explain to you how your contribution was figured and the amount of your monthly payment. We will request that you sign a "Voluntary Support Agreement" form. If you are aggrieved by the Department's action, you have the right to request a hearing. **(See attached form for information regarding hearings.)**