W-849
(Rev. 4/04)

State of Connecticut - Department of Social Services

Legally Liable Relative (LLR) Form for Institutionalized Children Receiving Medicaid Long Term Care Services or Medicaid Home and Community Based Waiver Services

Applicant/Recipient Name_____

Parent(s) Name(s)_____ Phone #_____

Parent(s) Address _____

If your child is receiving Medicaid long term care services or Medicaid Home and Community Based Waiver Services, we may require you to contribute to your child's cost of care. This amount cannot exceed the amount of assistance paid to or on behalf of the child by the Department of Social Services.

In order for us to determine your share of the cost of your child's care, we need the following information:

1. The father's net adjusted taxable income for the last calendar year; if applicable: ***(Attach a copy of your 1040 tax form to verify your net adjusted taxable income.)*** $_____
2. The mother's net adjusted taxable income for the last calendar year; if applicable: ***(Attach a copy of your 1040 tax form to verify your net adjusted taxable income.)*** $_____
3. The joint net adjusted taxable income of the father and mother for the last calendar year; if applicable: ***(Attach a copy of your 1040 tax form to verify your net adjusted taxable income.)*** $_____
4. If you are divorced or legally separated and are under a court order to pay support please indicate your monthly court ordered support payment: ***(Attach a copy of your court order verifying the payment amount.)*** $_____
5. Any in-kind support provided by the parent(s) during the last calendar year while living with the child, along with verification of such support, which is over and above that provided to a healthy child. Examples of in-kind support include, but are not limited to, the following:
   - cost of medical supplies which are not covered by insurance or Medicaid; $_____
   - cost of special diet; $_____
   - cost of special transportation; $_____
   - cost of adaptations to a home to accommodate the special need of the child; $_____
   - other ***(please indicate specific service)*** $_____

List below the people living in your household. Place a check mark (4) next to the names of those dependent on you for support.

4	Name of Household Members	Age	Relationship

THIS INFORMATION IS AVAILABLE IN ALTERNATE FORMATS. PHONE (800) 842-1508 OR TDD/TTY (800) 842-4524.

THE FOLLOWING WILL BE COMPLETED BY THE DSS WORKER		
1. Last year's net adjusted taxable income of the parent(s):		$_____
2. Subtract the state median income figure appropriate for the legally liable relatives family size. 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 any in-kind support:	-	$_____
Balance:	=	$_____
6. LLR Contribution equals the above balance if that balance is greater than zero.		
OR		
7. Use the amount of the monthly court ordered support payment as the LLR Contribution minus any in-kind support:	=	$_____
OR		
8. Use the divorced and remarried parent's contribution when not under a court ordered support payment obligation minus any in-kind support: (See UPM 7520.05 for this calculation)	=	$_____

Worker Name:_____ Date:_____

Information Sheet

Legally Liable Relative (LLR) Form for Institutionalized Children Receiving Medicaid Long Term Care Services or Medicaid Home and Community Based Waiver Services

The purpose of this form is to obtain financial information necessary to determine if the parent(s) of an applicant or recipient of Medicaid long term care services or Medicaid Home and Community Based Waiver Services is required to contribute to his or her child'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 child is receiving assistance under Medicaid long term care services or Medicaid Home and Community Based Waiver Services, we may require you to contribute to your child's cost of care. Our claim is equal to twelve percent of the difference, if any, between the previous year's federal taxable income of the separated spouse, and Connecticut's median income for the size family which consist of the legally liable relative and the number of dependents reported on his or her federal income tax return. The median income figure is taken from a table developed by the Department by using the median income guideline from the Federal Register. We cannot charge you more than the amount of assistance we have paid on your child's behalf.

If you are divorced and under a court order to pay for your child's support, we will consider this amount to be your liability. However, the Department has the right to pursue a modification of the court order if a financial determination discloses a greater ability to contribute to the child's support.

If you are divorced and remarried and not under a court order to pay support, we will determine your share of your child's cost of care. We will need information regarding your last year's net taxable income, whether you file separately or jointly with your current spouse. If you file jointly we will calculate your income according to Department regulations.

In order to determine your contribution towards your child's cost of care, we need information about your income, your dependents, and any court ordered support you are required to pay. For this reason, we request that you complete the first page of the W-849 form and return it, alone or combined with your child's application or redetermination form and verifications of the above mentioned information, to your child's Department of Social Services eligibility worker. A self-addressed stamped envelope is enclosed for your convenience. In addition, we would like to know about any services you provide for your child 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 child. We will consider the goods and services you provide along with other information in determining the amount of your LLR contribution.

The Eligibility worker will send your returned W-849 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 child's cost of care. 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 W-162 "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.)**

YOUR RIGHT TO A HEARING

You have the right to request a hearing if you disagree with any of our decisions. A hearing is a meeting between you, an agency representative and a Hearing Officer. The Hearing Officer is impartial and will decide if our decision is correct based solely on the facts.

At the hearing, you can explain why you disagree. You can speak for yourself or have someone else speak for you, such as a friend or relative. You also can have an attorney represent you. If you cannot afford an attorney, free legal help may be available from the Statewide Legal Services of Connecticut. Statewide Legal Services of Connecticut can be reached by calling 1-800-453-3320.

There are limits to the amount of time you have to request a hearing. The time limit for asking for a hearing regarding the Department's recovery of income or assets from legally liable relatives is 60 days. The time limit begins with the date of the notice informing you of your legally liable relative contribution amount.

The hearing request must be in writing. You can use the form on the other side of this page or mail us a signed statement. Please mail the request to the address listed on the form. Remember to include your child's name, child's client identification number, your name, date, address, worker name, your phone number and the reason you disagree. Please make sure you sign the request. **Your request for a hearing regarding your support obligation will not affect your child's Medicaid long term care services or Medicaid Home and Community Based Waiver Services.**

We will not take any actions against you because of your race, color, religion, creed, sex, age, national origin, ancestry, marital status, criminal record, past or present mental disorders, mental retardation, sexual orientation, physical disability, or learning disability. If you feel we have, you or your representative has the right to file a discrimination complaint. Your complaint can be filed in writing or by calling one or more of the following agencies:

Commissioner of the Department of Social Services,
25 Sigourney Street, Hartford, CT 06106-5033
860-424-5040/800-842-4524 (TDD)

Connecticut Commission on Human Rights and Opportunities
21 Grand Street, Hartford, CT 06106
860-541-3400/860-541-3459 (TDD)

US Department of Health and Human Services, Office of Civil Rights,
Room 506-F, 200 Independence Avenue SW, Washington, D.C. 20201
202-619-0403/202-619-3257(TDD)

US Department of Agriculture, Office of Civil Rights, Whitten Building,
Room 326-W, 1400 Independence Avenue SW, Washington, D.C. 20250-9410,
202-720-5964 (voice and TDD)

(The request form is on the reverse side.)

State of Connecticut
Department of Social Services

Client Name:_____ Client ID:_____

Requestor Name:_____ Date:_____

Requestor Address:_____ Requestor Phone #:_____

_____ Worker:_____

REQUEST FOR A HEARING

I want a hearing because:

_____ _____
Signature *Date*

Please mail this form to:

Department of Social Services
Office of Legal Counsel, Regulations, and Administrative Hearings
25 Sigourney Street
Hartford, Connecticut 06106-5033