WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-22539 (01/10)
Wis. Stats. 49.77

REQUEST FOR WAIVER OF STATE SSI OR CARETAKER SUPPLEMENT OVERPAYMENT RECOVERY OR CHANGE IN REPAYMENT RATE

Instructions: We will use your answers on this form to decide if we can waive collection of the overpayment or change the amount you must pay us back each month. If we cannot waive collection, we may use this form to decide how you should repay the money.

If you need assistance in completing this form, contact the appropriate organization listed on page 10.

You can complete and mail in this form right away, but please note that if this is a request for a waiver of state **Supplemental Security Income (SSI) only, or a combination of state SSI and Caretaker Supplement (CTS) overpayment,** generally the state will wait until you have obtained a decision on your waiver request from the Social Security Administration (SSA) for the **federal portion of SSI overpayment** before making a decision on this waiver request. If you have not yet requested a waiver for the federal SSI portion of the overpayment from SSA, please do so right away.

When you receive the SSA decision, regardless of whether the decision is in your favor or not, **please mail a copy of the SSA decision, and a copy of the SSA letter that informed you of the overpayment to**:

HP / State SSI, Waiver Requests
P.O. Box 6680
Madison, WI 53716-0680

If you have already received a decision on the federal portion of the SSI waiver request from SSA, please attach it to this form **with a copy of the SSA letter that informed you of the overpayment**. If you have lost the decision from SSA, please call 1-800-772-1213 and ask them to send you a duplicate.

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) indicating the number and letter (if any), of the question you are answering. After completion, mail to the Department of Health Services, P.O. Box 6680, Madison, WI 53716-0680.

1.	A.	Name of person who received the overpayment -
	B.	Social Security Number -

2. Check any of the following that apply. Fill in the dollar amount in B., C., or D.

☐	A.	The overpayment was not my fault and I cannot afford to pay the money back and/or it is unfair for some other reason(s).						
☐	B.	I cannot afford to use all of my monthly benefit to pay back the overpayment. However, I can afford to have $ withheld each month.						
☐	C.	I am no longer receiving Supplement Security Income (SSI) payments. I want to pay back each month instead of paying all of the money at once.				$		
☐	D.	I am receiving SSI payments. I want to pay back of my total income	$		each month instead of paying 10%			

3. Why did you think you were due the overpaid money and why do you think you were not at fault in causing the overpayment or accepting the money?

4.	☐ Yes	☐ No	A.	Did you notify us about the change or event that made you overpaid? If "No," why didn't you notify us?
			B.	If "Yes," how, when and where did you notify us? If you notified us by phone or in person, who did you talk with and what was said?
	☐ Yes	☐ No	C.	If you did not hear from us after your report, and/or your benefits did not change, did you contact us again?
5.	☐ Yes	☐ No	A.	Have we ever overpaid you before? If "Yes," on what Social Security number?
			B.	Why were you overpaid before? If the reason is similar to why you are overpaid now, explain what you did to try to prevent the present overpayment.

YOUR FINANCIAL STATEMENT

You need to complete this section if you are asking us either to waive the collection of the overpayment or to change the monthly rate we asked you to repay. Answer all questions as fully and as carefully as possible. We may ask to see some documents to support your statements.

Document examples:

- Current rent or mortgage books
- Pay stubs
- Savings passbooks
- Cancelled Checks
- Your most recent tax return
- 2 or 3 recent utility, medical, charge card, and insurance bills
- Similar documents for your spouse or dependent family members

NOTE: Enter only whole dollar amounts when answering the following questions. Round any cents to the nearest dollar.

6.	☐ Yes ☐ No	A.	Do you now have any of the overpaid checks or money in your possession, or in a savings or other type of account?	
			If "Yes," specify amount	$
			Return this amount to the Department of Health Services, P.O. Box 6680, Madison, WI 53716-0680. Please write the name and last four (4) digits of the overpaid person's Social Security Number on the check.	
	☐ Yes ☐ No	B.	Did you have any of the overpaid checks or money in your possession, or in a savings or other type of account, at the time you received the overpayment notice?	
			If "Yes," specify amount:	$ Answer question 7.
7.	Explain why you believe you should not have to return this amount.			
8.	☐ Yes ☐ No	A.	Did you lend or give away any property or cash after notification of the overpayment? If "Yes," answer Part B. If "No," proceed to question 9.	
		B.	Who received it, relationship (if any), description and value?	
9.	☐ Yes ☐ No	A.	Did you receive or sell any property or receive any cash (other than earnings) after notification of this overpayment? If "Yes," answer Part B. If "No," proceed to question 10.	
		B.	Describe property and sale price or amount of cash received.	

Members Of Household

10. List any person (child, parent, friend, etc.) who depends on you for support AND who lives with you.

Name	Age	Relationship (If none, explain why person is dependent on you.)

Assets - Things You Have And Own

11. A. How much money do you and any person(s) listed in question 10 above have as cash on hand, in a checking account, or otherwise readily available?
$

☐ Yes ☐ No B. Does your name, or that of any other member of your household appear, either alone or with any other person, on any of the following?

Type of Asset	Owner	Balance or Value	Per Month	Show the Income (Interest, dividends, EARNED EACH MONTH.) If none, explain below.
Savings (Bank, Savings and Loan, Credit Union)		$	$	
		$	$	
Certificates of Deposit (CD)		$	$	
Individual Retirement Account (IRA)		$	$	
Money or Mutual Funds		$	$	
Bonds, Stocks		$	$	
Trust Fund		$	$	
Checking Account(s)		$	$	
Other - Specify		$	$	
	TOTALS →	$	$	Enter the "Per Month" total on line K. of question 14.

If there is no Income from any of the Assets listed above, explain here.

Monthly Household Income

12.	☐ Yes	☐ No	A.	Are you employed? If "Yes," provide information below. If "No," proceed to B.		
				Employer (Name, Address, Telephone Number) (Write "self" if self-employed.)		Monthly pay before deductions (Gross) $
						Monthly TAKE-HOME pay (Net) $
	☐ Yes	☐ No	B.	Is your spouse employed? If "Yes," provide information below. If "No," proceed to C.		
				Employer(s) (Name, Address, Telephone Number) (Write "self" if self-employed.)		Monthly pay before deductions (Gross) $
						Monthly TAKE-HOME pay (Net) $
	☐ Yes	☐ No	C.	Is any other person listed in question 10. employed? Name(s) If "No", proceed to 13.		
				Employer(s) (Name, Address, Telephone Number) (Write "self" if self-employed.)		Monthly pay before deductions (Gross) $
						Monthly TAKE-HOME pay (Net) $
13.	☐ Yes	☐ No	A.	Do you, your spouse or any dependent member of your household receive support or contributions from any person or organization? If "Yes," answer B. If "No," proceed to 14.		
			B.	How much money is received each month?	$	SOURCE

14.	Income from numbers 11 and 12 above and other income to you.					
	NOTE: Be sure to show **monthly** amounts below.					
	A.	TAKE-HOME pay (Net) (From number 12. A., B., and C., above)			$	
	B.	Social Security benefits			$	
	C.	Supplemental Security Income (SSI)			$	
	D.	Pension(s); e.g., VA, military, civil service, railroad, etc.	TYPE		$	
			TYPE		$	
	E.	Public Assistance (Other than SSI)	TYPE		$	
	F.	FoodShare—Show full face value of your allotment.			$	
	G	Income from real estate; e.g., rent, etc.			$	
	H.	Room and/or board payments paid to you—Explain in "Remarks" below.			$	
	I.	Child support/alimony			$	
	J.	Other support (From Number 13. B. above)			$	
	K.	Income from assets (From question 11.)			$	
	L.	Other (From any source; explain in "Remarks" below.)			$	
		TOTAL			$	

Remarks

Monthly Household Expenses

		Expense				Amount Per Month	State SSI Use ONLY
15.	A.	Rent or mortgage If mortgage payment includes property or other local taxes, insurance, etc., DO NOT list again below.				$	
	B.	Food; e.g., groceries (include value of food stamps), food at restaurants, work, etc.				$	
	C.	Utilities; e.g., gas, electric, telephone.				$	
	D.	Other heating/cooking fuel; e.g., oil, propane, coal, wood, etc.				$	
	E.	Clothing				$	
	F.	Credit card payments. Show minimum monthly payment allowed.				$	
	G.	Property tax - (State and local)				$	
	H.	Other taxes or fees related to your home; e.g., trash collection, water/sewer fees.				$	
	I.	Insurance; e.g., life, health, homeowner, renter, car, and any other casualty or liability policies.				$	
	J.	Medical/dental. Enter amount not covered by insurance company, if any.				$	
	K.	Car operation and maintenance. Enter any car loan payment in item N. below.				$	
	L.	Other transportation				$	
	M.	Church/charity cash donations				$	
	N.	Loan, credit, layaway payments. If payment amount is optional, enter minimum.				$	
	O.	Support to someone NOT in household. Identify below.					
		Name	Address	Age	Relationship (If any)	$	
		Name	Address	Age	Relationship (If any)	$	

P.	Other expense(s) not listed above.				
	Expense - Specify:		$		
	Expense - Specify:		$		
	Expense - Specify:		$		
		TOTAL	$		

Expense Comments. Explain any unusual or very large expenses; e.g., medical expense(s), education, etc.

Income and Expenses Comparison

16.	A.	Monthly income. Enter amount from "Total" of number 14.	$	
	B.	Monthly expenses. Enter amount from "Total" of number 15.	$	
	C.	Adjusted household expenses	+$25.00	
	D.	Adjusted monthly expenses. Add B. and C.	$	
17.	If your expenses listed in D. are more than your income listed in A., explain how you are paying your bills.			

Financial Expectation and Funds Availability

☐ Yes	☐ No	18.	A.	Do you, your spouse or any dependent member of your household expect your or their financial situation to change in any way in the next six months; e.g., tax refund, pay raise or full repayment? If "Yes," explain.
☐ Yes	☐ No		B.	Is there is an amount of cash on hand or in accounts shown in item 11. B. which is being held for a special purpose? If "Yes," explain.
☐ Yes	☐ No		C.	Is there any reason you CANNOT convert to cash the "Balance of Value" of any financial asset shown in item 11. B. If "Yes," explain.

Penalty Clause, Certification and Privacy Act Statement

I know that anyone who makes or causes to be made a false statement of representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law and/or State law. I affirm that all information I have provided on this document is true.

Signature of Overpaid Person or Representative Payee

SIGNATURE - (First , Middle Initial, Last Name) Signature must be in ink. **SIGN HERE** ➔	Date Signed - (mm/dd/yyyy) Telephone Number - Home (Include area code) Telephone Number - Work (Include area code) * Provide only if you may be contacted at work.

Mailing Address (Street, Apt. No., P.O. Box, or Rural Route)

(City, State, Zip Code)	Enter Name of County (If Any) in Which You Now Live

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full addresses.

SIGNATURE - Witness	Address (Street, City, State, Zip Code)
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About the Privacy Act

The Social Security Act (Sections 204, 1631(b), and 1870) and Wis. Stats. 49.77 allow us to collect the facts on this form. This form is voluntary. However, if you do not give us the facts we ask for, we will not be able to approve your waiver request.

Sometimes the law requires us to give out the facts on this form without your consent. We must give these facts to another person or government agency if Federal law requires that we do so or to do the research and audits needed to monitor and improve the programs we manage.

We may also give these facts to the Justice Department to investigate and prosecute violations of the Social Security Act or we may use the facts in computer matching programs. Matching programs compare our records with those of other Federal, State, or local government agencies. All the Agencies may use matching programs to find or prove that a person qualifies for benefits paid for or managed by the Federal government. Another use is to identify and collect overpayments or to collect overdue loans under these benefits programs.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

ORGANIZATIONS THAT CAN ASSIST YOU IN COMPLETING THIS FORM

If you are 60 years old or older, contact the Elderly Benefit Specialist located in your County Aging Unit (also called County Aging Commission, Department on Aging, or similar names). Look in the County Government section of the telephone book. If you have access to the Internet, you can find this information at: dhs.wisconsin.gov/aging/Genage/BENSPECS.htm.

If you are under age 60, contact a Disability Benefit Specialist (DBS); information about DBSs is also available on the internet at: dhs.wisconsin.gov/disabilities/benspecs/program.htm. Note that eventually all counties will have a DBS. You may contact the DBS Program Manager to inquire about availability at 608-266-8905.

If your county has no Disability Benefit Specialist at present and you reside in Columbia, Dane, Dodge, Iowa, Jefferson, Lafayette, Rock, or Sauk County, contact **Legal Action of Wisconsin at 1-800-362-3904.**

If you reside in one of these counties: Ashland, Bayfield, Burnett, Chippewa, Clark, Douglas, Dunn, Eau Claire, Florence, Iron, Langlade, Lincoln, Marathon, Marinette, Menominee, Oconto, Oneida, Pepin, Pierce, Polk, Price, Rusk, St. Croix, Sawyer, Shawano, Taylor, Vilas, Washburn, or Wood, contact **Wisconsin Judicare, Inc., at 1-800-472-1638.**