

UNDUE HARDSHIP WAIVER (UHW) DECISION FORM

SECTION I – COMPLETED BY CAO

Date of PA 162 Notice: _____ CAO Name: _____
Date UHW Requested: _____ Address: _____
Individual's Name: _____
Cty/Case #: _____ CAO FAX #: _____

Amount transferred for less than FMV \$ _____.

The CAO has reviewed the undue hardship waiver request and all supporting documents for the penalty period incurred from _____ to _____ for _____ days. The CAO recommends the following:

Approval _____
 Denial _____ *IMCW Signature* _____ *Date* _____ *Telephone #* _____
 Partial _____ *IMCW Printed Name*

Approval _____
 Denial _____ *IMC Supervisor Signature* _____ *Date* _____ *Telephone #* _____
 Partial _____ *IMC Supervisor Printed Name*

Reason for CAO recommendation: _____

Supporting Documents Attached? Yes _____ No _____

Forwarded to Bureau of Policy, Division of Health Services on: _____ via Fax/mail.
Date

SECTION II – COMPLETED BY BUREAU OF POLICY (BOP)

The attached request for Undue Hardship is:

Approved for the following time frame: _____ to _____

Denied for the following time frame: _____ to _____

Reason for decision: _____

BOP Representative Signature _____ *BOP Printed Name* _____ *Date* _____