

**WISCONSIN DEPARTMENT OF HEALTH SERVICES**  
**Division of Health Care Access and Accountability**  
**1 W. Wilson St.**  
**Madison WI 53703**

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To: Medicaid Eligibility Handbook (MEH) Users

From: Angela Dombrowicki, Director  
Bureau of Enrollment Management

Re: **Medicaid Eligibility Handbook Release 09-05**

Release Date: 09/16/09  
Effective Date: 09/16/09

**EFFECTIVE DATE**

The following policy additions or changes are effective 09/16/09, unless otherwise noted. **Bold text denotes new text. Text with a strike through it in the old policy section denotes deleted text.**

**CHANGES**

**Nonfinancial (Chs. 4 - 14) > 5  
Elderly, Blind, or Disabled  
(EBD) > 5.9 Presumptive  
Disability > 5.9.3 PD  
Determined by DDB**

This process is electronic now and faxes are no longer required, but can be used as a backup.

**New Text:**

If the applicant has an urgent need, but does not have one of the listed impairments, the IM worker must request DDB to make a presumptive disability determination. The IM worker must take the following actions once a medical professional has attested in writing, with the Medicaid Presumptive Disability form ([HCF 10130](#)), that there is an urgent need for medical services.

**Note:** If someone has an impairment, but not an urgent need, follow the normal disability application process (See [5.3 Disability Application Process](#)).

1. Document the urgent need by placing the Medicaid Presumptive Disability form ([F-10130](#)) in the case file.
2. Complete, with assistance from the applicant as necessary, the following two forms:
  - a. The Medicaid Disability Application form [F-10112](#), formerly DES 3071).
  - b. Release to Disability Determination Bureau form ([F-14014](#)).
3. See [Process Help 12.0](#) for submissions of the forms, if necessary. **This process is now automated. However, if the automated process isn't working**, send via fax (608-266-8297) each of the three forms listed above to DDB for both a presumptive and final disability determination. ~~The FAX number is also on the request form (HCF 40125).~~

**Nonfinancial (Chs. 4 - 14) > 7  
U.S. Citizen or Qualifying  
Immigrant > 7.3 Immigrants >  
7.3.1 Immigrants Introduction**

Information from Ops Memo 09-57 was added to this section.  
Effective 10/01/09

**New Text:**

**Beginning, October 1, 2009, children under the age of 19 and pregnant women who are either:**

1. **Lawfully Admitted for Permanent Residence (CARES TCTZ Code #1 in the Immigration Status Chart below),**

2. Lawfully present under Section 203(a)(7) (Code #3 in the Immigration Status Chart below),
3. Lawfully present under Section 212(d)(5) (Code #6 in the Immigration Status Chart below), or
4. Who suffer from domestic abuse and are considered to be a battered immigrant (Code #16 in the Immigration Status Chart below),

no longer have to wait 5 years to be eligible for full benefit Medicaid and BadgerCare Plus. This policy applies to both persons in existing open cases and new applicants. Women have the 5-year ban lifted when their pregnancy is verified and continues for an additional 60 days after the last day of pregnancy and through the end of the month in which the 60th day occurs.

**Nonfinancial (Chs. 4 - 14) > 7  
U.S. Citizen or Qualifying  
Immigrant > 7.3 Immigrants >  
7.3.4 Immigration Status Chart**

Information from Ops Memo 09-57 was added to this section.  
Effective 10/01/09

The Immigration Status Chart in 7.3.4 was updated to include the policy changes for immigrant children and immigrant pregnant women.

**Nonfinancial (Chs. 4 - 14) > 9  
Third Party Liability (TPL) >  
9.4 Health Insurance Premium  
Payment (HIPP)> 9.4.3  
Cooperation**

Information from Ops Memo 09-53 was added to this section.

**New Text:**

**Beginning October 1, 2009, parents may no longer be sanctioned for failing to cooperate with the HIPP program when other family members are in BadgerCare Plus. This policy applies to both current members and new applicants.**

**Financial (Chs. 15 - 19) > 15  
Income > 15.1 Income  
Introduction> 15.1.2 Special  
Financial Tests for Disabled  
Minors**

References to verifying and counting assets were deleted since assets are no longer counted for disabled or institutionalized children.

**Old Text:**

~~Calculate the countable assets of all eligible children and their parents in the household. Count all of the person's assets except those that are exempt or unavailable. See Chapter [16.1 Assets Introduction](#). Before deeming the countable assets of the parent/parents to the eligible children in the household *disregard* \$2000 of these countable assets if there is one parent in the household and \$3000 if there are two parents in the household.~~

~~**Example 1:** A single parent with a disabled minor owns \$4500 in nonexempt assets. \$2500 of that asset would be deemed to the disabled minor when determining the minor's Medicaid eligibility.~~

~~**Example 2:** A parent and his/her spouse own \$4500 in non-exempt assets. The parent has a disabled minor. \$1500 of the parent's and the spouse's assets would be deemed to the disabled minor when determining the minor's Medicaid eligibility.~~

- ~~1. Divide parental countable assets equally among the eligible children in the household. Add each child's assets to his or her share of parental assets.~~

~~Enter the total on line 4 of the EBD-Related Determination worksheet (40.1 Worksheet 6).~~

~~If the child's asset amount is greater than the medically needy asset limit, he or she does not pass the asset test and cannot receive Medicaid.~~

Go to #2, if any child has passed the asset test.

**New Text:**

Calculate the countable income of everyone in the Household using the following 6 steps. Count all of the person's income except that which is exempt or unavailable. See Chapter 15.1 Income Introduction.

Financial (Chs. 15 - 19) > 15  
Income > 15.3 Disregarded  
Income > 15.3.30 Subsidized  
Guardianship Payments

**New Text:**

**15.3.30 Disregard Subsidized Guardianship Payments.**

This text was deleted due to changes in Operations Memo 09-56.

**New Text:**

3. Disregard work-related retirement benefit plans or individually owned retirement accounts, such as IRAs or Keoghs, of an ineligible spouse in an EBD case. ~~Disregard work-related retirement benefit plans or individually owned retirement benefit plans or individually owned retirement accounts, such as IRAs or Keoghs, of an ineligible parent in a Disabled Minor case.~~ This policy includes the disregard of retirement funds held by the community spouse in spousal impoverishment cases.

Financial (Chs. 15 - 19) > 16  
Assets > 16.7 Liquid Assets >  
16.7.21 Retirement Benefits

Financial (Chs. 15 - 19) > 17  
Divestment > 17.5 Penalty  
Period >

The average nursing home cost to a private pay patient was increased to \$6,362 from \$6,259, as announced in Operations Memo 09-43 (Effective 07-01-09). This amount is used to calculate divestments. Examples were updated to reflect the new amount.

Also, the phone extension for an EDS contact was updated.

**Old Text**

The divestment report, CRM1403A, doesn't register divestment penalty changes. If it is necessary to remove a divestment penalty, update AAAT, run eligibility, and confirm. Then contact EDS (608-221-4746 extension ~~80204~~).

**New Text:**

The divestment report, CRM1403A, doesn't register divestment penalty changes. If it is necessary to remove a divestment penalty, update AAAT, run eligibility, and confirm. Then contact EDS (608-221-4746 extension **80213**).

Financial (Chs. 15 - 19) > 18  
Spousal Impoverishment >  
18.6 Spousal Impoverishment  
Income Allocation > 18.6.4  
Section C -- Cost of Care #6

**Old Text:**

~~Community waivers only:~~ Enter on Line 10 the ~~community waiver~~ person's medical/remedial expenses and the cost of his/her health insurance premiums.

~~Nursing home cases only:~~ Enter on Line 10 the cost of the nursing home person's health insurance premiums.

**New Text:**

Enter on Line 10 the **institutionalized** person's medical/remedial expenses and the cost of his/her health insurance premiums.

Subprograms (Chs. 24- 38) >  
27 Institutional Long Term  
Care (ILTC) > 27.7 ILTC Cost  
of Care Calculation > 27.7.1  
ILTC Cost of Care Calculation  
Introduction

Two links in this section were changed to take the user to the correct sections of the handbook.

Subprograms (Chs. 24- 38) >  
29 Family Care Long Term  
Care (FCLTC) > 29.3 FCLTC

Information from Ops Memo 09-51 was added to this section.

**New Text:**

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Medicaid and Non-Medicaid>  
29.3.1 Family Care Medicaid

There are 3 types of eligibility in Family Care Medicaid:

**Group A eligibility**

1. People 18 and over who meet full benefit EBD Medicaid financial and non-financial requirements and who are also functionally eligible for FC at either the nursing home or non-nursing home level of care.
2. People 18 and over who meet BC+ Standard Plan, Well Woman Medicaid, Medicaid through Adoption Assistance or Foster Care financial and non-financial requirements and who are functionally eligible for FC at either the nursing home or non-nursing home level of care.

**Group B eligibility**

People 18 and over who meet full benefit EBD Medicaid non-financial and financial requirements except for income, who are functionally eligible for FC at the nursing home level of care, and whose income is at or below the special income limit (See the Community Waivers Special Income Limit in 39.4.1)

**Group C eligibility**

People 18 and over who meet full benefit EBD Medicaid non-financial and financial requirements except for income, who are functionally eligible for FC at the nursing home level of care, and whose income is above the special income limit (see the Community Waivers Special Income Limit in 39.4.1), but whose allowable monthly expenses are sufficient to reduce their income to the medically needy limit (See EBD Medically Needy Limits in 39.4.1.)

Subprograms (Chs. 24- 38) >  
32 Medicare Beneficiaries >  
32.4 SLMB+> 32.4.1 SLMB+  
Introduction

**New Text:**

To be eligible for SLMB+ the person must:

1. Meet non-financial Medicaid requirements.
2. Be receiving Medicare Part A.
3. Have been determined ineligible for MA (including Community Waivers, ~~BadgerCare~~, **BadgerCare Plus**, QMB, SLMB, and QDWI). Consider a person with an unmet deductible ineligible for MA until s/he meets the deductible.

**Glossary**

The following definition was added to the glossary:

**Subsidized Guardianship payments** - A long-term placement option for children in out-of-home care. Caretakers willing to become permanent legal guardians for children in out-of-home care, receive monthly subsidized guardianship payments, similar to foster care payments.