

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

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To: FoodShare Wisconsin Handbook Users

From: Rich Albertoni, Director  
Bureau of Enrollment Policy and Systems

Re: **FS Handbook Release 11-02**

Release Date: 07/08/11  
Effective Date: 07/08/11

**EFFECTIVE DATE**

The following policy additions or changes are effective 07/08/11, unless otherwise noted. **Yellow text denotes new text. Text with a strike through it in the old policy section denotes deleted text.**

**POLICY CLARIFICATIONS**

**1 General Program Requirements > 1.2 Verification > 1.2.1 Verification Introduction > 1.2.1.2 Request for Verification**

**Old Text:**

Requests for verification MUST be made in writing. Verbal requests are not acceptable and will not stand up in a fair hearing. Workers are required to give the customer notice regarding required verification, when it is due to the agency, and the consequences of not verifying timely.

Do not deny the *FS* group for failure to provide the required verification until the:

1. ~~44<sup>th</sup>~~ day after requesting the verification, or
2. ~~31<sup>st</sup>~~ day of the application or review processing period, whichever is later.

If the ~~44<sup>th</sup> or 31<sup>st</sup>~~ day falls on a weekend or *postal holiday*, the action should be taken the next business day.

**New Text:**

Requests for verification MUST be made in writing. Verbal requests are not acceptable and will not stand up in a fair hearing. Workers are required to give the customer notice regarding required verification, when it is due to the agency, and the consequences of not verifying timely.

Do not deny the *FS* group for failure to provide the required verification until the:

1. **10<sup>th</sup>** day after requesting the verification, or
2. **30<sup>th</sup>** day of the application or review processing period, whichever is later.

If the **10<sup>th</sup> or 30<sup>th</sup>** day falls on a weekend or *postal holiday*:

- **For negative actions** - the action should be taken the next business day.
- **For approvals or positive actions**- the approval must be processed no later than the due date. Waiting until the next business day or later to process verification for an eligible household is untimely and therefore not allowable.

**1 General Program Requirements > 1.2 Verification > 1.2.4 Financial Verification > 1.2.4.8 Medical**

Information from Ops Memo 11-09 was added.

**Old Text:**

~~Medical expenses are not required to be verified in order for the expense to be used~~

## Expense Verification

in the FoodShare benefit calculation, unless the applicant or member's statement is deemed questionable. Examples of applicant/member statements that may be considered questionable include:

- Applicant or member has private health insurance or is covered by Medicaid or BadgerCare Plus and is claiming unusually high out-of-pocket expenses for a time period when s/he had coverage.
- Claimed monthly medical expenses exceed monthly income.

If questionable request verification, which includes: date of service, billing date, amount owed, and date amount is due.

Medical expenses are budgeted prospectively, so do not require eligible elderly, disabled, or blind household members to verify recurrent medical expenses monthly. Rely on estimates of recurring medical expenses during the certification period. Include changes that can be anticipated based on available information. Consider the group member's medical condition, public or private medical insurance coverage, and the current verified medical expenses incurred by the FS group member.

When converting medical expenses to monthly amounts, use the same calculation methods used for budgeting prospective income.

### **New Text:**

7 CFR 273.2(f)(1)(iv)

#### **Verification at Application**

The amount of medical expenses claimed by an elderly, blind, or disabled individual must be verified at application in order for the expense to be used in the FoodShare benefit calculation.

7 CFR 273.2(f)(8)(ii) and 273.12(c)

#### **Verification During the Certification Period**

Verify changes in medical expenses reported by the household during the certification period if they are from a new source, if the total amount of previously verified medical expenses has changed by more than \$25, or when the information is questionable. Do not act on changes reported by a source other than the household, which require you to contact the household for verification. Only act on changes in medical expenses that are reported by a source other than the household if those changes are verified upon receipt and do not require contact with the household.

**Example 1:** Edith, a disabled FS member, provided proof of her \$200 monthly prescription costs from her pharmacy at application. In the third month of her FS certification period, she reports that she was hospitalized last month and now has a \$1,300 obligation for a hospital bill. Edith and her worker agree that this bill will be averaged over the remaining months in Edith's FS certification. Edith's worker explains that in order to receive the deduction for this new medical expense, verification is required. If verification is not provided, only the \$200 deduction is allowed.

**Example 2:** Mario, an elderly FS member, reported and provided proof of his \$90 monthly prescription costs at his most recent FS renewal in December. In March, he reports that his prescription costs have increased to \$114 per month. Mario's agency updates his case and does not require verification of the increased medical expense because the total medical expenses did not change by more than \$25.

**Example 3:** Violet, a disabled FS member is also eligible for Home and Community Based Waivers as a Group B. At application, Violet reports and provides proof of a recurring monthly medical expense for FoodShare. In the fifth month of her certification period, Violet's worker receives notice of a medical/remedial cost from her care manager for Long Term Care (LTC) purposes. Because this change is not

considered as verified upon receipt for FS purposes, her worker updates her case using the 'OP – Out of Pocket Med/Remedial' code on the Medical Expenses page when creating a new sequence that will budget the expense correctly for LTC purposes and not impact her FS determination. If the care manager had provided verification of the medical/remedial expense that could be used as a FS expense at the time the change was reported, the new FS expense amount would be entered using the appropriate code on the Medical Expense page and used in the benefit calculation. Note: The CM (Case Management) and OP (Out of Pocket Med/Remedial) codes are NOT applicable for FS. To see what Expense Type codes will work in CWW for FS vs. EBD MA, click on the Reference Table Pop Up.

7 CFR 273.2(f)(8)(i)(A)

**Verification at Renewal**

Previously unreported medical expenses and changes in total recurring medical expenses of more than \$25 since last verified must be verified at renewal.

**Example 4:** Sally reports and provides proof of a \$150 recurring monthly prescription medical expense at her FS application. At her renewal, she states that this monthly expense continues but that it has increased by \$10. Sally's worker updates her case and does not require verification.

If Sally had reported at renewal that she also had a new recurring medical expense of \$90 for monthly chiropractic visits, verification of this new expense would be required.

1 General Program Requirements > 1.2 Verification > 1.2.6 Suggested Verification Sources > 1.2.6.2 Verify Only If Questionable

The Medical Expenses section of this chart was moved to **1.2.6.3 Verify For A Household To Receive A Deduction (Not Required For Eligibility)**. No other changes were made. This change was first announced in Ops Memo 11-09.

**Old Text:**

<b>Medical Expenses</b>	<ul style="list-style-type: none"> <li>• Billing statement</li> <li>• Itemized receipts</li> <li>• Medicare card showing Part "B" coverage</li> <li>• Health insurance policy showing premium, coinsurance, co-payment, or deductible.</li> <li>• Medicine or pill bottle with price on label</li> <li>• Statement from pharmacy</li> <li>• Repayment agreement with provider</li> <li>• Statement from doctor verifying over-the-counter drug was prescribed</li> <li>• Bill for services of a visiting nurse, home-maker, home health aide</li> <li>• Lodging or transportation receipts, or both, for obtaining medical treatment or services</li> <li>• Bill or receipts for dog food or veterinarian services, or both, for a seeing eye or hearing dog.</li> <li>• Bill or receipt for purchase or rental of prescribed equipment or medical supplies, or both</li> <li>• MA case record for MA deductible</li> </ul>
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Information from Ops Memo 11-09 was added.

1 General Program Requirements > 1.2 Verification > 1.2.6 Suggested Verification Sources > 1.2.6.3 Verify For A Household To Receive A Deduction (Not Required For Eligibility)

**New Text:**

<b>Medical Expenses</b>	<ul style="list-style-type: none"> <li>• Billing statement</li> <li>• Itemized receipts</li> <li>• Medicare card showing Part "B" coverage</li> <li>• Health insurance policy showing premium, coinsurance, co-payment, or deductible.</li> <li>• Medicine or pill bottle with price on label</li> </ul>
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	<ul style="list-style-type: none"> <li>• Statement from pharmacy</li> <li>• Repayment agreement with provider</li> <li>• Statement from doctor verifying over-the-counter drug was prescribed</li> <li>• Bill for services of a visiting nurse, home-maker, home health aide</li> <li>• Lodging or transportation receipts, or both, for obtaining medical treatment or services</li> <li>• Bill or receipts for dog food or veterinarian services, or both, for a seeing eye or hearing dog.</li> <li>• Bill or receipt for purchase or rental of prescribed equipment or medical supplies, or both</li> <li>• <i>MA</i> case record for MA deductible</li> </ul>
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**2 Applications and Reviews  
> 2.1 Applications > 2.1.2  
Application Processing  
Timeframe**

**New Text:**

See 1.2.1.2 for details on verification due date processing.

**2 Applications and Reviews  
> 2.1 Applications > 2.1.3  
Interviews> 2.1.3.1  
Scheduling the Interview>**

Ops Memo 11-01 clarified that FNS did not approve of the current CARES generated NOMI letters. Follow this process until the notices are updated in CARES.

**New Text:**

Local agencies must notify each household that misses their initial application interview or review appointment that they missed the scheduled interview and that the household is responsible for rescheduling a missed interview. The use of Client Scheduling in CARES will ensure that households receive this notice. (At this time the current CARES notice is not sufficient. See [2.1.3.1.1 Notice of Missed Interview\(NOMI\) requirements](#) below). If Client Scheduling is not used, notices of missed interview appointments and client responsibility to reschedule must be issued by the local agency. Keep a copy of the agency notice in the case file. Agencies may not deny a household's application prior to the 30th day after the application filing date if the household fails to appear for the first interview.

**New Text:**

**2.1.3.1.1 Notice of Missed Interview (NOMI) Requirements**

**Application (not expedited)**

The agency must send a separate NOMI letter to each applicant who does not meet the criteria for expedited issuance and misses the scheduled interview appointment. The NOMI letter must inform the applicant that they missed their appointment and are responsible for rescheduling the interview. If the applicant contacts the agency within the 30 day application processing period, the agency must schedule a second interview. The application may not be denied for not completing the interview prior to the 30th day after the application filing date.

**Application (expedited with postponed interview)**

When the interview that has been postponed for a FS application eligible for expedited benefits, a NOMI letter is not required if the applicant misses the interview scheduled for ongoing benefits. When the applicant misses an interview that has been scheduled within the seven day processing period for a FS application that meets expedited benefits criteria and the interview cannot be completed within the seven day timeframe due to household delay, a NOMI letter is required to be sent.

**Renewal**

Language contained in the CARES generated Renewal Notice and closure notice meet NOMI requirements, therefore an additional NOMI letter does not have to be sent if the member misses the scheduled interview appointment.

**2 Applications and Reviews Old Text:**

> 2.1 Applications > 2.1.4 Expedited Service at Application > 2.1.4.1 Eligibility for Expedited Services at Application

A person or food unit may be eligible for priority services and expedited issuance if:

1. Their total monthly gross income and available assets are less than the monthly ~~costs for utilities~~ and rent or mortgage; or

**New Text:**

A person or food unit may be eligible for priority services and expedited issuance if:

1. Their total monthly gross income and available assets are less than the monthly Heating Standard Utility Allowance (HSUA) (See 8.1.3 Deductions) and rent or mortgage; or

2 Applications and Reviews > 2.1 Applications > 2.1.4 Expedited Service at Application > 2.1.4.4 Postponing The Interview For Expedited Benefits

This new subsection was added based on changes in Ops Memo 11-02.

**New Text:**

Households that meet criteria for expedited benefit through a CARES eligibility determination may be allowed to postpone their interview under certain circumstances.

Postponement of the interview prior to benefit issuance only applies when:

1. A household meets criteria for expedited benefits as determined by CARES; **and**
2. The agency has made 2 attempts, but was unable to contact the household to complete the interview, or the agency determines that the interview cannot be scheduled in time to complete the expedited issuance process timely; **and**
3. Identity of the applicant can be verified.

Postponement of the interview only applies to the above households at application and not at time of review. Postponing the application interview for expedited benefits does not exempt the household from the interview and verification requirements for ongoing FS benefits. The agency may treat the interview like other required verification and postpone it during the month of application.

In all cases, the applicant's or authorized representative's identity must be verified through a collateral contact or readily available documentary evidence. Any documents which reasonably establish the applicant's identity must be accepted. If identity cannot be verified by the agency, the applicant does not qualify for a postponed interview and eligibility should be processed under normal FS application processing guidelines, including the requirement to complete an interview prior to issuing benefits.

Information on the application and readily available verification, such as those submitted with the application or verified via data exchange should be used to determine eligibility. This may include items that can be verified upon receipt such as unemployment compensation and Social Security Administration records, and others such as New Hire, State Wage. If the household is not eligible for expedited benefits because unreported income was discovered through data exchange or for any other reason, FS benefits should remain in pending status for completion of the interview.

If a phone number is not provided on the application the agency must attempt to obtain a phone number through other means, such as a previous CARES case or by using online tools. If the agency is able to contact the applicant but the applicant is unable to complete the interview during the phone call or within seven days, the interview can be postponed and expedited benefits issued.

**Note:** The timeframe for issuing expedited benefits has remained unchanged. Expedited benefits must be issued no later than 7 calendar days from the date of application to avoid a Quality Control finding of untimely application processing.

Agencies do not have to wait until day 7 to issue expedited benefits. The benefit may be issued when the worker has determined that the criteria for postponing the

interview has been met.

**2 Applications and Reviews**  
**> 2.2 Reviews > 2.2.1**  
**Certification Periods**  
**(Reviews)> 2.2.1.6**  
**Administrative Renewals**

This new subsection was added based on changes in Ops Memo 11-21.

**New Text:**

An administrative renewal is an extension of program eligibility for certain low-risk cases based on the information in CARES as of the month prior to the review month. Cases selected for administrative renewal are cases that are highly unlikely to lose eligibility at renewal due to increases in income or assets.

The extension of program eligibility under an administrative renewal is based on the information in CWW as of the month prior to the month a full renewal would otherwise have been due. An administrative renewal case will not receive an eligibility renewal notice and is not required to provide the IM agency with any additional information in order to have program eligibility continued.

Administrative renewal cases remain subject to change reporting requirements. The administrative renewal notice identifies program specific change reporting requirements, as well as the potential consequences for not reporting changes timely. Changes reported for a case that has undergone an administrative renewal should be processed under existing policy.

EBD only FoodShare cases may be selected for administrative renewal if the case meets all the following criteria:

- There is no earned income
- The countable income is at or below 200% of the FPL

**Open for Multiple Programs**

If the case is open for EBD only FoodShare and one or more of the affected Medicaid programs, the case may be selected for administrative renewal if the FS renewal is due and the case meets all the selection criteria listed above. If any of the programs does not meet the twelve month continuous eligibility criteria, the case will go through the regular renewal process.

**Continuous Eligibility**

To be selected for an administrative renewal, the case must be open and currently eligible with continuous program eligibility for at least the twelve month period prior to the month in which the case is being considered for an administrative renewal. Additionally, the case must have had at least one full regular renewal.

**Alternate Years**

Cases will not be selected for administrative renewal if the last renewal requirement was met through an administrative renewal. Administrative renewals will be done every other year. The exceptions to this rule are:

- HCBW or MLTC members who are Group A due to their eligibility for SSI or 1619b
- Family Planning Only Services cases where the only eligible case member is under 18 and will not turn age 18 in the current or next month.

Persons meeting these criteria may be selected for administrative renewal annually as long as the detailed selection criteria are met.

**Schedule**

Administrative renewal case selection will occur prior to sending the regular renewal notices. Any cases not selected for an administrative renewal will be sent the regular renewal notice.

**Review Mode**

Cases in review mode will not be selected for administrative renewal.

**CARES:**

CWW will automatically:

- Select cases subject to administrative renewal,
- Determine the continued eligibility, and
- Notify the member of the administrative renewal and eligibility determination.

Worker intervention is not necessary to complete the administrative renewal process. Cases selected for Administrative Renewal will run through a batch eligibility process. Cases that have a pending or fail status after running through the batch eligibility process will not continue through the Administrative Renewal process and will be set for regular renewal.

Cases that are passing after eligibility batch run will go through the administrative renewal confirmation process.

During the confirmation process:

- Case level review dates are set.
- A case comment is added indicating that the case has gone through an Administrative Renewal.
- The Application/Review Interview Details page will display 'Renewal'.
- The Notice of Decision process is triggered and will generate an administrative renewal letter. The letter will be stored in the ECF.
- The Enrollment and Benefit brochure is sent to the customer.

**3 Nonfinancial Requirements > 3.12.1 Citizenship and Immigration Status > 3.12.1.1 Qualified Alien or Immigration Status**

**New Text:**

The following individuals are eligible for FoodShare as U.S. Citizens.

- U.S. Citizens,
- Non-citizen nationals (People born in American Samoa or Swain's Island),
- American Indians born in Canada,
- Members (born outside the U.S.) of Indian tribes under Section 450b(e) of the Indian Self-Determination and Education Assistance Act,
- Members of Hmong or Highland Laotian tribes that helped the U.S. military during the Vietnam era prior to May 8, 1975, and who are legally living in the U.S., their spouses or surviving spouses and dependent children, including a full-time students under the age of 22.

<b>Federal FoodShare</b>	
Eligible as U.S. Citizens	
<ul style="list-style-type: none"> <li>• U.S. Citizens,</li> <li>• Non-citizen nationals (People born in American Samoa or Swain's Island),</li> <li>• American Indians born in Canada,</li> <li>• Members (born outside the U.S.) of Indian tribes under Section 450b(e) of the Indian Self-Determination and Education Assistance Act,</li> <li>• Members of Hmong or Highland Laotian tribes that helped the U.S. military during the Vietnam era prior to May 8, 1975, and who are legally living in the U.S., their spouses or surviving spouses and dependent children, including a full-time students under the age of 22.</li> </ul>	
<b>Alien Status Code</b>	<b>Eligible if:</b>
01-Lawfully admitted for permanent (LPR) residence	<ul style="list-style-type: none"> <li>• meets work quarters, or</li> <li>• meets military requirement, or</li> <li>• receives disability benefit, or</li> <li>• under age 18, or</li> <li>• has lived in the US as a qualified alien for 5 years from the date of entry, or</li> <li>• a legal resident on August 22, 1996, and born before August 22, 1931.</li> </ul>
02-Permanent Resident under color of law (PRUCOL)	Ineligible
03-Conditional Entrant Lawfully present under Section 203(a)(7)	<ul style="list-style-type: none"> <li>• meets work quarters, or</li> <li>• meets military requirement, or</li> <li>• receives disability benefit, or</li> <li>• under age 18, or</li> <li>• born before August 22, 1931, or</li> <li>• has lived in the US as a qualified alien for 5 years from the date of entry, or</li> <li>• a legal resident on August 22, 1996, and born before August 22, 1931.</li> </ul>
04-Refugee Lawfully present under Section 207	Eligible
05-Asylee Lawfully present under Section 208	Eligible
06-Parolee Lawfully present under Section 212(d)(5)	<ul style="list-style-type: none"> <li>• meets work quarters, or</li> <li>• meets military requirement, or</li> <li>• receives disability benefit, or</li> <li>• under age 18, or</li> <li>• born before August 22, 1931, or</li> <li>• has lived in the US as a qualified alien for 5 years from the date of entry, or</li> <li>• a legal resident on August 22, 1996, and born before August 22, 1931.</li> </ul>
07-IRCA	Ineligible
08-Work Authorization: Temp.	Ineligible
09-Undocumented Alien	Ineligible
10-Illegal Alien	Ineligible
11-Cuban/Haitian Entrant (Section 501(e) of the Refugee Education Act of 1980)	Eligible
12-Considered a permanent resident by INS	Ineligible
13-Special AG worker under Section 210(A)	Ineligible
14-Additional Special AG worker under Section 210A	Ineligible
15-Withheld Deportation-Section 243(h) or 241(b)(3)	Eligible
16-Battered Alien  Code the battered immigrant adult or child or parent with the broadest immigrant eligibility category that applies to that person (e.g., a battered refugee immigrant, code as refugee). Document in case comments that the person is a battered immigrant and therefore exempt from sponsor deeming. Do not list the sponsor in CARES on ACCH. Do not list any of the sponsor's income and assets.	Ineligible unless: <ul style="list-style-type: none"> <li>• meets work quarter requirement, or</li> <li>• meets military requirement, or</li> <li>• receives disability benefit, or</li> <li>• has lived in the US as a qualified alien for 5 years from the date of entry, or</li> <li>• under age 18, or</li> <li>• was a legal resident on August 22, 1996, and born before August 22, 1931.</li> </ul>
17-Amerasians	Eligible
18 - Native Americans born abroad	Eligible
19 - Trafficking Victims - Including the minor children, spouses, and in some cases the parents and siblings of victims of severe trafficking (Treat as refugee under section 207 of the INA), The spouse, child, parent or unmarried minor sibling of a victim of a severe form of trafficking in persons under 21 years of age, or the spouse or child older than 21 who has received a derivative T visa, to the same extent as an alien who is admitted to the United States as a refugee under Section 207 of the INA.	Eligible

**3 Nonfinancial Requirements > 3.12.1 Citizenship and Immigration Status> 3.12.1.6 State Option FoodShare Program (SOFSP)**

**Old Text:**

Effective August 1, 1998, Wisconsin issued benefits to qualifying aliens who were made ineligible for FS under sections 402 and 403 of the Personal Responsibility and Work Opportunity Act (PRWORA). It will not be apparent in CARES whether the non-citizen is receiving federal or state funded FS, as long as status codes, dates of entry, and birth dates are entered correctly.

**New Text:**

With the passage of the 2011-13 Wisconsin State budget the State funded SOFSP program is ending effective July 1, 2011. Federally eligible members that live with a previously eligible SOFSP member will remain eligible for Federal benefits. There is no change to the Federal eligibility

**Ongoing Cases**

A mass change ran on July 9, 2011 to re-determine ongoing benefits for all ongoing members receiving benefits under the SOFSP. If the member does not meet the Federal FS requirements his or her FS benefits will be terminated effective August 1, 2011.

**4 Financial Requirements > 4.3 Income > 4.3.4 Unearned Income> 4.3.4.2 Counted Unearned Income**

**Old Text:**

10. VA disability pension adjustments

**New Text:**

10. VA disability and pension benefits, COLA and other adjustments made to the payments. The adjustments that are excluded are "Aid and Attendant Allowances" referenced in [4.3.4.3 Disregarded Unearned Income](#) below.

**4 Financial Requirements > 4.3 Income > 4.3.4 Unearned Income> 4.3.4.3 Disregarded Unearned Income**

**New Text:**

**SSI-E**

SSI-E income is disregarded income for FS. It is not necessary to determine if a SSI-E payment is being used to for its intended purpose in order to disregard the income.

**4 Financial Requirements > 4.4 Assets > 4.4.1 Assets> 4.4.1.5 Liquid Assets**

**Old Text:**

**Stocks, Bonds, and Other Investments**

Count the current cash value of any available investment that includes, but is not limited to: stocks, bonds, mutual funds, ~~or~~ IRAs. Available means that the asset could be cashed in at any time. Investments that are part of retirement plans are generally not available until someone is of retirement age.

**New Text:**

**Stocks, Bonds, and Other Investments**

Count the current cash value of any available investment that includes, but is not limited to: stocks, bonds, **or** mutual funds. Available means that the asset could be cashed in at any time. Investments that are part of retirement plans are generally not available until someone is of retirement age.

**4 Financial Requirements > 4.6 Deductions and Expenses > 4.6.4 Medical Expenses> 4.6.4.1 Allowable Medical Expenses**

**Old Text:**

Allow previously acquired charges (not yet paid) and current payments when calculating a medical expense deduction. Previously acquired charges include charges incurred anytime before or during the certification period, as long as the individual has an agreement to pay the charges and is still obligated for the expense.

**New Text:**

Allow previously acquired charges (not yet paid) and current payments when calculating a medical expense deduction. Previously acquired charges include charges incurred anytime before or during the certification period, as long as the individual is still obligated **to pay the expense and the incurred expense has not been**

previously allowed as a FS deduction.

**4 Financial Requirements >  
4.6 Deductions and  
Expenses > 4.6.4 Medical  
Expenses > 4.6.4.2 Medical  
Expenses Not Allowed**

**New Text:**

Do not allow:

1. Expenses paid by or that will be paid by insurance.
2. Expenses paid by or to be paid by any governmental program, including MA and Medicare.
3. Costs of health and accident policies such as: any payable in lump sum settlements for dismemberment or death, or income maintenance policies covering mortgage or loan payments while the beneficiary is disabled.
4. Loan repayments for anything other than the loan's principal.
5. Premiums for nursing home insurance policies that would not be used to cover allowed medical expenses.
6. Lying in costs for the birth of a child.
7. Special diets whether or not the diet is related to a medical condition.

**4 Financial Requirements >  
4.6 Deductions and  
Expenses > 4.6.4 Medical  
Expenses > 4.6.4.3  
Budgeting Medical  
Expenses including MA  
Deductible Expenses**

**New Text:**

Medical expenses for elderly, blind, or disabled members may be entered through one of the following budgeting methods:

- Budgeted as a recurring monthly expense,
- Budgeted as a one time lump sum expense for one month,
- Budgeted for the remainder of a FS certification period,
- Budgeted based on the terms of a payment plan, or
- Averaged over the time period a one-time medical expense was intended to cover (such as a prepaid or met medical deductible).

Under all of the budgeting options, the obligation amount (amount incurred) is counted rather than the amount paid. The member may or may not pay the bill so it is important to make sure that the expense is not counted more than once.

A monthly medical expense obligation budgeted based on the terms of a payment plan can be claimed for as long as the original payment plan is in place. Amounts still due after they were budgeted during a previous FS certification period may not be included as part of the monthly expense.

The averaging of the one time medical expense cannot extend past the certification period in which the expense was originally counted.

Except when an expense is averaged during a certification period, the expense should be budgeted starting with the month it is billed or otherwise becomes due, regardless of when the member intends to pay the expense. Allow the expense in the next possible benefit month.

For instructions on how to enter allowable medical expenses into CWW, see Process Help, Section [18.2.4](#) Other Medical Expenses - Medical Expenses Page.

**4.6.4.3.1 Deductible Expenses**

Deductible expenses actually incurred or anticipated to be incurred on a monthly basis may be used to determine the amount of the FS medical expense deduction.

The MA deductible amount itself does not necessarily determine the amount of the FS medical expense deduction, and should not automatically be averaged over the FS certification period to arrive at an excess medical expense deduction.

However, if an individual makes a pre-payment or incurs a one time medical expense that may be used to meet the MA deductible, s/he may choose to have the expense budgeted as a lump sum one month deduction, averaged over the remainder of the FS certification period, averaged over the period it was intended to cover (the deductible period), or budgeted based on the terms of a payment plan (if a payment agreement exists).

**4.6.4.3.2 Examples**

**Example 3:** Worker M is processing a FS application for Ernie. Ernie is

disabled. He has provided verification of an outstanding payment agreement for dental care he received. The terms of the payment agreement include a repayment obligation of \$40 per month for 24 months. Ernie has been making his monthly payments and has 17 months remaining in his payment plan (total remaining responsibility of \$680). The remaining obligation of \$680 is an allowable deduction. The \$280 that Ernie has already paid is not.

**Example 4:** Worker C is processing an application for Alena, a disabled FS member in October. Alena has an outstanding hospital bill from September with a remaining patient responsibility of \$230 and November due date. Alena may choose to have the expense budgeted as a lump sum for one month or budgeted over the FS certification period. After discussing the budgeting options for FS with Alena, Worker C determines that budgeting the expense for one month (the month of November) will result in the best outcome for Alena.

**5 Specific Programs > 5.1.1 Transitional FoodShare Benefits (TFS)> 5.1.1.1 TFS Introduction**

**Old Text:**

Households are not eligible for TFS after Wisconsin Works (W-2 ) or Tribal TANF (TT) cash assistance ends when:

The W-2 or TT payment ends due to a W-2 or TT sanction, or

**New Text:**

Households are not eligible for TFS after Wisconsin Works (W-2 ) or Tribal TANF (TT) cash assistance ends when:

1. The W-2 or TT payment is sanctioned to zero for nonparticipation, or

**7 Benefits > 7.3.1 Benefit Overissuance> 7.3.1.2 Liability**

**New Text:**

**Example 1:** Susan is receiving FoodShare, her daughter Jane is 21 and living with her. By policy, Jane must be included in the FoodShare determination, but the agency failed to include her. The overpayment must be calculated using Jane's income and information and she will be liable for the overpayment the same as Susan.

**7 Benefits > 7.3.1 Benefit Overissuance> 7.3.1.9 Overissuances Due to Client & Non-Client Error**

**Old Text:**

Do not establish a claim if an overissuance occurs because the agency did not ensure that a household did any of the following:

1. Signed the application form.
2. Completed a current work registration form.
3. Applied in the correct project area.

**New Text:**

Do not establish a claim if an overissuance occurs because the agency did not ensure that a household did any of the following:

1. Signed the application form.
2. Completed a current work registration form.

Do not establish a claim when appropriate notice of a renewal or SMRF requirement was not sent due to an incorrect certification period in CARES.

**Example 2:** Mary's W-2 payment ended and she became eligible for TFS. CARES incorrectly set a 12 month certification period instead of a 5 month certification period. Because Mary did not receive a timely notice that her TFS benefits were ending after the 5th month, she would not be responsible for paying back any benefits that were issue incorrectly after the 5th month.

**7 Benefits > 7.3.2 Calculating Overissuance Claim Amount> 7.3.2.1 Client and Non-client Error**

**New Text:**

Consider the FS group's reporting requirements when calculating the overissuance. Do not use income or expenses, or changes in income and expenses that were not reported and were not required to be reported.

Enter the converted income amount to determine ongoing benefit eligibility and the overpayment calculation. Only use the income and expenses reported or required to be reported for each month of the adjustment period. In claim calculations, disregard income that was not previously reported and was not required to be reported.

#### **Client Error**

Establish a claim for a client error that occurred when the FS group unintentionally:

1. Failed to provide correct or complete information.
2. Failed to report a change that was required to be reported.
3. Received FS for which it was not entitled pending a fair hearing decision.

When overissuance is because the group did not timely report a change, begin with the month the overissuance was discovered and extend backward:

1. Six years, or
2. To the month the change would have been effective had the group timely reported it, whichever is most recent.

The month the change would have been effective cannot be more than 2 months after the change in circumstance actually occurred.

When determining if an overissuance occurred due to an unreported increase in total gross monthly income, compare the total actual unconverted income amount to the income reporting limit for the household size to determine if the income should have been reported.