

**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: Shawn Smith, Bureau Director  
Bureau of Enrollment Policy and Systems

Re: **Medicaid Eligibility Handbook Release 15-01**

Release Date: June 10, 2015  
Effective Date: June 10, 2015

**EFFECTIVE DATE** The following policy additions or changes are **effective June 10, 2015**, unless otherwise noted. Grey highlighted text denotes new text. Text with a strike through it denotes deleted text.

**POLICY UPDATES**

**1.1.2 Subprograms of Medicaid**

There are different subprograms of Medicaid:

- [SSI](#)-related Medicaid
- [MAPP](#)
- Institutional Long Term Care
- Home and Community-Based Waivers Long Term Care
- Family Care Long Term Care
- Partnership Long Term Care
- Program of All-Inclusive Care for the [Elderly](#) (PACE)
- Include, Respect, I Self-Direct (IRIS)
- Katie Beckett
- Tuberculosis ( [TB](#) ) –related
- Medicare Premium Assistance ( [MPA](#) ): [QMB](#), [SLMB](#), SLMB+, [QDWI](#);
- Emergency Medicaid
- SeniorCare
- Wisconsin Well Woman Medicaid (WWWMA)

**1.1.3.1 Assets**

~~Use the EBD Related Determination worksheet when doing manual eligibility determinations for non-institutionalized EBD Medicaid applicants and recipients.~~  
The EBD fiscal group's assets must be within the appropriate categorically needy or medically needy asset limit before any member of that group can qualify for Medicaid. EBD fiscal groups who have assets in excess of the appropriate EBD ~~medically needy~~ asset limit are ineligible for Medicaid.

**1.1.3.2 EBD Fiscal Group**

An EBD fiscal group includes the individual who is non-financially eligible for Medicaid and anyone who lives with them, who is legally responsible for them. EBD fiscal test groups will always be a group of one or two. Spouses who live together are in each other's fiscal group. This means that the income and assets of both spouses are counted when determining Medicaid eligibility for either or both spouses. The fiscal group size for this situation/living arrangement is two.

There are some exceptions to this concept. A blind or disabled minor living with their parents would be a one person fiscal group. Special instructions for deeming parental income and assets to the disabled minor are described in 24.1 SSI Related Medicaid Introduction.

Another exception to the fiscal group policy involves SSI recipients. If one

spouse is applying for EBD Medicaid and the other spouse is an SSI recipient, the SSI recipient spouse is not included in the other spouse's fiscal group. For this situation you would again have a one person fiscal group when determining the Medicaid eligibility of the non-SSI spouse.

An individual applying for Long Term Care Medicaid, including institutional, Home and Community-Based Waivers, Family, PACE, Partnership or IRIS living in a medical institution for 30 or more consecutive days would be a one person fiscal group. If the institutionalized person individual is married, refer to 18.1 Spousal Impoverishment Introduction for special instructions regarding spousal impoverishment procedures.

### 2.3.1 Where To Apply Introduction

Click [here](#) to view the directory of local Income Maintenance (IM) agencies in Wisconsin or call 1-800-362-3002. The applicant must apply with the agency serving their county or tribe, in the county in which s/he resides. If applying online via ACCESS, the application must be processed by the county in which the applicant resides. Click here to view the Directory of local Income Maintenance agencies in Wisconsin or call Member Services at (800) 362-3002.

An individual who resides in a nursing home/ hospital for 30 days or more and will have his or her Medicaid eligibility determined as an institutionalized person is considered a resident of the county in which the nursing home/hospital is located.

The applicant's county of residence at the time of admission must receive and process applications for persons living in these state institutions:

1. Northern, Central, and Southern Centers.
2. Winnebago and Mendota Mental Health Institutes.
3. The University of Wisconsin Hospital.

Waupaca County receives and processes all applications and reviews for residents of the Wisconsin Veterans Home at King, regardless of the county of residence.

### 2.3.2 Intercounty Placements

When a county 51.42 board, 51.437 board, human services department or social services department places a person in a congregate care facility that is located in another county, the placing county remains responsible for determining and reviewing the applicant's Medicaid eligibility. This does not include situations where a guardian or the member elects to move the member to another county. A congregate care facility is a:

1. Child care institution.
2. Group home.
3. Foster home.
4. Nursing home.
5. Adult Family Home (AFH).
6. Community Based Residential Facility (CBRF).
7. Any other like facility.

The placing county may request the assistance of the receiving county in completing applications for persons who are not enrolled in Medicaid and reviews for Medicaid members. The receiving county must then forward the information to the placing county. The placing county remains responsible for determining the applicant's eligibility. If the placing county requests assistance from the receiving county, the placing county must provide the other agency with:

1. The applicant's name, age, and SSN.
2. The date of placement.

3. The applicant's current Medicaid status.
4. The name and address of the congregate care facility in which the applicant has been placed.
5. The name of the county and agency making the placement.

When there is a dispute about responsibility, the social or human services department of the receiving county may initiate referral to the Department of Health and Family Services' Area Administration office for resolution. Pending a decision, the county where the person is physically present must process the application, any changes, and reviews.

## 2.4 Valid Application

A valid application for Medicaid must include the applicant's:

1. Name,
2. Address, and
3. Signature:
  - in the Signature Section of the Medicaid application (F-10101),
  - on the Medicaid, BadgerCare Plus, and Family Planning Only Services Registration Application (F-10129),
  - in the Signature Section of the BadgerCare Plus Application Packet (F-10182),
  - an electronic signature in ACCESS, or
  - a telephonic signature Telephonically.

~~The date the application is received by the IM agency with the applicant's name, address and a valid signature is the filing date. If an application is received after 4:30 p.m. or on a weekend or holiday, the date of receipt will be the next business day. This includes paper and online applications. Applications must be processed within 30 days of the filing date. (See 2.7 Timeframes)~~

## 2.5.1 Valid Signature Introduction

The applicant or his or her representative (see below) must sign ~~(using his/her own signature):~~

1. The paper application form,
2. The signature page of the Application Summary ~~(telephone or face to face), or~~
3. The ACCESS or FFM application form with an electronic signature, or
4. Telephonically.

### Signatures from Representatives

Except when:

1. ~~A guardian signs for him/her. Guardian:~~ When an application is submitted with a signature of someone claiming to be the applicant's guardian, obtain a copy of the document that designates the signer of the application as the guardian. From the documents provided, ensure that the individual claiming to be the applicant's guardian can file an application on his or her behalf. ~~Only the person designated as the guardian of the estate, guardian of the person and the estate, or guardian in general may sign the application. When someone has been designated as the guardian of the estate, guardian of the person and the estate, or guardian in general, only the guardian, not the applicant, may sign the application, or appoint another representative. Scan the copy of the document in the Electronic Case File.~~

~~Your agency's social services department determines the need for a guardian or conservator. Determine the guardian type specified by the court.~~

~~Only the person designated as the guardian of the estate, guardian of the person and the estate, or guardian in general may sign the application. You may not require a conservator or guardian of the person to sign the application, or~~

2. ~~An Authorized Representative: signs for the applicant.~~ The applicant may authorize someone to represent him/her. An authorized representative must be an individual, not an organization.

If the applicant wishes to authorize someone to represent him/her when applying by mail, instruct him/her to complete the authorized representative section of the application form.

If the applicant needs to appoint an authorized representative when applying by telephone or in person, instruct the applicant to complete the Authorization of Representative form (F-10126).

An authorized representative is responsible for submitting ~~the a~~ **completed**, signed application (~~completed insofar as able~~) and any required documents.

When appointing an authorized representative, someone other than the authorized representative must witness the applicant's signature. If the applicant signs with a mark, two witness signatures are required, ~~or,~~

3. ~~The applicant's d~~ Durable power of attorney: (§ 243.07, Wis. Stats.) ~~signs the application.~~ A durable power of attorney is a person to whom the applicant has given power of attorney authority and agrees that the authority will continue even if the applicant later becomes disabled or otherwise incapacitated.

When a submitted application is signed by someone claiming to be the applicant's durable power of attorney:

- a. Obtain a copy of the document the applicant used to designate the signer of the application as the durable power of attorney.
- b. Review the document for a reference that indicates the power of attorney authority continues notwithstanding any subsequent disability or incapacity of the applicant.

Do not consider the application properly signed unless both of these conditions are met. ~~File a copy of the document in the case record.~~ An individual's Durable Power of Attorney may appoint an authorized representative for purposes of making a Medicaid application if authorized on the power of attorney form. The Durable Power of Attorney Form will specify what authority is granted.

The appointment of a Durable Power of Attorney does not prevent an individual from filing his or her own application for Medicaid nor does it prevent the individual from granting authority to someone else, to apply for public assistance on his or her behalf, ~~or.~~

4. Someone acting responsibly for ~~the individual signs the form on behalf of the individual, if the individual is an incompetent or incapacitated individual pending a guardianship determination, or.~~

**Example 1:** Was updated.

5. A superintendent of a state mental health institute or center for the developmentally disabled, ~~signs on behalf of a patient, or~~
6. A warden ~~or warden's designee~~ signs the application for an applicant that is for an inmate of a state correctional institution that ~~who is a hospital inpatient~~ out for more than 24 hours, ~~or.~~
7. ~~The director of a county social or human services department delegates, in writing (retain a copy of this written authorization), to the superintendent of the county psychiatric institution, who has been designated by the county social or human services director, the authority to sign and witness an application for residents of the institution: The social or human services director may end the delegation when there's reason to believe that the delegated authority is not being carried out properly.~~

~~The social or human services director may end the delegation when there's reason to believe that the delegated authority is not being carried out properly.~~

### 2.6.1 In Person

### 2.6.1 In Person/Mail/Fax

The filing date is the day a signed valid application/registration form (F-10101 or F-10182) or registration (F-10129) form is ~~delivered to~~ received by the Income Maintenance agency or the next business day if it is ~~delivered~~ received after the agency's regularly scheduled business hours.

### 2.6.2 By Mail or Fax

This section was deleted.

### 2.6.3 By Phone

### ~~2.6.3~~ 2.6.2 By Phone

When a request for assistance is made by phone, the filing date is ~~not set until a~~ when a telephonic signature, or signed application/ ~~and/or~~ registration form is received by the agency.

### 2.6.4 By ACCESS

### ~~2.6.4~~ 2.6.3 By ACCESS

The filing date on an ACCESS application is the date the application is electronically submitted or the next business day if submitted after ~~the agency's~~ regularly scheduled business hours ~~4:30 PM or on a weekend or holiday.~~

### 2.6.5 Low Income Subsidy (LIS) Program of Medicare Savings Programs (MSPs)

### ~~2.6.5~~ 2.6.4 Low Income Subsidy (LIS) Program of Medicare Savings Programs (MSPs)

Effective January 1, 2010, LIS data sent electronically to CARES from the SSA is considered a request for MSP and must be processed using the same processing guidelines that would be followed if a request for MSP was submitted directly by the applicant.

### 2.6.6 Federal Facilitated Marketplace (FFM)

### ~~2.6.6~~ 2.6.5 Federal Facilitated Marketplace (FFM)

The filing date for applications received from the Federally Facilitated Marketplace (FFM) is the date the application was submitted to the FFM.

### 2.7.1 Time Frames Introduction

All applications, ~~except those submitted from the FFM,~~ received by an agency must be processed and eligibility approved or denied as soon as possible but no later than 30 calendar days from the filing date. This includes issuing a notice of decision.

The 30 day time frame for processing applications submitted through the FFM begins the date the FFM application is submitted to the agency inbox.

IM workers should not delay eligibility for an individual in a household when waiting for another household member 's citizenship or identity verification. The individual pending for citizenship/identity should be counted as part of the group when determining eligibility for other group members.

The 30 day processing timeframe must be extended to allow the applicant at least 10 days to provide requested verification.

Extend Workers may also extend the 30-day processing time up to an additional 10 days if you are waiting for to allow the applicant additional time to provide additional the information. CARES will issue a pending notice indicating the reason for the delay when appropriate entries are made on the Verification Due Page.

For more information on application denials for failure to provide verification, see Chapter 20.7.

Deny the application for failure to provide information or verification if:

1. Requested information or verification is required by program policy to determine eligibility (See 20.1 Verification), and
2. The applicant had the power to produce the information or verification within the period, but failed to do so, and
3. The applicant had a minimum of 10 days to produce the verification.

**2.8.1 Begin Dates Introduction**

8. QMB - The first of the month following the eligibility determination confirmation.

**2.8.2 Backdated Eligibility**

Medicaid eligibility can be backdated up to three months prior to the month of application.

If certifying for retroactive Medicaid, do not go back further than the first of the month, three months prior to the application month. Certify the person for any backdate month in which s/he would have been eligible had s/he applied in that month.

A backdate request can be made at any time, except in the case where the member is already enrolled and backdating the member's eligibility would result in a deductible for the backdated period.

**2.9.2 Denial**

If less than 30 days has passed since the client's eligibility was denied, allow the client to re-sign and date the application or page one of the CAF Form 03-07 Combined Application Form to set a new filing date.

**3.0 Reviews Renewals**

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**3.1 Reviews**

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- 3.1.1 Reviews Renewals Introduction
- 3.1.2 Choice of Review Renewal
- 3.1.3 Review Renewal Processing
- 3.1.4 Signature at Review Renewal
- 3.1.5 Administrative Renewals
- 3.1.6 Late Renewals

**3.1.1 Reviews Introduction**

**3.1.1 Reviews Renewals Introduction**

A **review renewal** is the process during which all eligibility factors subject to change are reexamined and a decision is made if eligibility should continue. The group's continued eligibility depends on its timely completion of a **review renewal**. Each **review renewal** results in a determination to continue or discontinue eligibility.

The first required eligibility **review renewal** for a Medicaid case is 12 months from the certification month except for **cases open with a deductible**. A **review renewal** is not scheduled for a case that did not meet its deductible unless someone in the case was open for Medicaid. For cases that did meet the deductible, the **review renewal** date is six months from the start of the deductible period.

Note: For manually certified Medicaid cases, send a manual **review renewal** notice 45 days prior to the end of the **review renewal** month.

### Agency Option

The agency may **review renew** any case at any other time when the agency can justify the need. Examples include:

1. Loss of contact, or
2. Member request

Note: Shortening certification periods in an attempt to balance agency workload is not permissible.

### 3.1.2 Choice of Review

### 3.1.2 Choice of **Review-Renewal**

The member has the choice of the following methods for any Medicaid **review renewal**:

### 3.1.3 Review Processing

### 3.1.3 **Review-Renewal** Processing

A Medicaid eligibility **review renewal** notice is generated on the first Friday of the 11<sup>th</sup> month of the certification period. The notice states that "some or all of your benefits will end" if a **review renewal** is not completed by the end of the following month. Do not process a **review renewal** until after adverse action in the month prior to the month of **review renewal**.

**Example 1:** CARES sends out the **review renewal** letter on July 7 for a **review renewal** due in August, do not process the **review renewal** prior to July 18.

Do not require a new Authorized Representative form at **review renewal** if the person signing the **review renewal** is the Authorized Representative on file.

If the **review renewal** is not completed by the end of the certification period, the case will close. The closure notice is generated through CARES at adverse action in the review month.

### 3.1.4 Signature at Review

### 3.1.4 Signature at **Review-Renewal**

The member must include a valid signature at the time of **review renewal**. This includes signing ~~one of the following~~:

- ~~1. The MA application (F-10101), the Medicaid, BadgerCare and Family Planning Waiver Registration Application (F-10129), or the BadgerCare Plus Application Packet (F-10182) used for the review, or~~
- ~~2. The signature page of the CAF (telephone or face-to-face), or~~
- ~~3. The ACCESS application form with an electronic signature.~~

1. The paper application form,
2. The signature page of the Application Summary,
3. The ACCESS or FFM application form with an electronic signature, or
4. Telephonically.

The signature requirements for ~~reviews~~ renewals are the same as those for applications. See 2.5 Valid Signature.

### 3.1.5 Administrative Renewals

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~~ renewal month. Cases selected for administrative renewal are cases that are highly unlikely to lose eligibility at renewal due to increases in income or assets.

### 5.3.6 Routine SSI-MA Extension

An SSI-MA recipient is eligible for a redetermination of MA eligibility when SSI is terminated. The individual is allowed an extra month of SSI-MA eligibility to allow the member time to have eligibility re-determined by the IM agency. The IM agency must fill the gap in Medicaid eligibility between the ~~loss~~ last date of SSI-MA and the date an eligibility determination is completed by the IM Agency. ~~Certify the member for the period between the loss of SSI-MA eligibility that appears on MMIS and when you will be able to determine their Medicaid eligibility.~~ Determining Medicaid eligibility should usually occur within the month after he or she loses SSI.

When a person applies for SSI and is denied, there is no obligation to "fill gaps." The exception to this is in 5.3.5 SSI Application Date.

~~The IM agency will fill the gap in eligibility when an ongoing SSI case is terminated. The person is eligible for a re-determination of Medicaid eligibility by the IM agency. S/he should apply within the calendar month of notification of termination. An extra month of SSI-MA eligibility is posted on MMIS to allow the member time to have eligibility determined by the IM agency.~~

#### 5.3.6.1 Case Processing

The processes differ based on if the member is already open for another program in CARES or if they aren't open in CARES. ~~The starting point for both CARES and non-CARES cases is an MMIS and SOLQ query.~~

#### 5.4.1 DDB Action Introduction

DDB will attempt to process the disability determination within ~~60~~90 days of the date it receives the signed application. If the DDB determines that ~~a delay in processing the application~~ needs to be Medically Deferred ~~occurs~~ because the extent of an impairment will not be known until several months after its onset, DDB will notify the applicant in writing that additional evaluation time is necessary. ~~DDB will give the reason for the delay and will inform the person of the right to appeal the delay. The IM agency will receive a copy of the letter.~~

A DDB disability decision on a SSDI or SSI case generally has binding authority. A Medicare, SSI or SSDI disability certification notice is acceptable verification of disability.

To check on the status of a disability case, call (608) 266-1565 and DDB will connect you with the examiner assigned to the case. Direct procedural or policy questions to ~~Vickie Davis at (608) 267-9857~~ Cassandra Quinn at (608) 266-8730.



## 5.4.2 Diary Date

## 5.4.2 ~~Diary Date~~ Allowances

~~Files on persons found disabled will be returned to the IM agency with a completed SSA-831 Determination of Disability.~~

The DDB does not notify the claimant of allowance determination made by DDB.

**Claims in the CARES system:** For claimants found disabled, DDB will send all the evidence and a completed SSA-831 (Determination of Disability form) to the CARES system. The paper file at DDB will be destroyed after it is confirmed that the information is in CARES.

**Claims NOT in CARES (paper claims):** For claimant found disabled, DDB will send the paper file with all the evidence and SSA-831 to the IM Agency for storage for future use in the Redetermination Process.

## 5.4.3 Allowances

## 5.4.3 Allowances ~~Diary Date~~

Item 17 on the SSA -831 form indicates whether or not medical re-examination is required for recipients not on SSI or SSDI. ~~A re-examination is required on all allowance cases. An exam is required when improvement is expected to occur in a person's condition.~~ A date on the box to the right of item 17, "Diary Type", tells you when DDB wants to review the case again. You may also find it in CARES on the Disability page under Disability Dates. When the Diary Date is earlier than the current date refer to the instructions that follow under 5.7 Redetermination.

## 5.4.4 Denials

Persons found not disabled will be sent a notice by DDB ~~(a copy will be sent to the IM agency)~~ along with forms to apply for a Reconsideration/Hearing. ~~Files~~ The paper files on denied cases will be kept at DDB waiting for the appeal application for 60 days. If the IM agency needs a file after 60 days, call Robin Kast at (608) 266-3300 and the files will be returned to the IM agency.

**Claims in the CARES system:** DDB will send all the evidence and a completed SSA-831 electronically to the CARES system. The paper folder will be kept at DDB for 60 and then destroyed if an appeal application is not received.

**Claims NOT in the CARES system (Paper Claims):** The paper folder will be kept at DDB for 60 and then destroyed if an appeal application is not received.

## 5.5.1 Reconsideration/ Hearing Introduction

Send reconsideration/hearing requests to:

Disability Determination Bureau  
~~Medicaid Reconsideration Unit~~  
P.O. Box 7886  
Madison, WI 53707-7886

Requests for Reconsideration/Hearing must be received by DDB within 45 days of the date of the Denial Notice. Late requests cannot be honored. If the claimant's request was received by DDB **after** the 45 day deadline, DDB will notify the **claimant** that his or her request for a reconsideration/hearing has been denied. ~~DDB will notify the member that his/her request for a reconsideration/hearing has been denied if the member's request was not received by DDB within the 45-day deadline.~~

DDB will conduct a reconsideration of the denial when the appeal application is received within the 45 day deadline.

If DDB reverses the decision to an allowance, ~~the determination and folder will be sent to the IM Agency:~~

**Claims in the CARES system:** For claimants found disabled, DDB will send all the evidence and a completed SSA-831 (Determination of Disability form) to the CARES system. The paper file at DDB will be destroyed after it is confirmed that the information is in CARES.

**Claims NOT in the CARES system (paper claims):** The paper folder will be kept at DDB for 60 and then destroyed if an appeal application is not received.

If DDB affirms the denial, a ~~Reconsideration Denial notice will be sent to the applicant (a copy will be sent to the IM Agency)~~ and the paper file will be sent directly to the Division of Hearings and Appeals (DHA), which will then schedule a hearing.

**Claims in the CARES system:** DDB will send all the evidence, a completed SSA-831, worksheet notes and a flag sheet electronically to CARES. The flag sheet is the first page of the worksheet notes and it indicates that the paper folder was sent to DHA for a hearing.

**Claims NOT in CARES (Paper Claims):** DDB does not send any notification to the IM Agency.

If, in a fair hearing, a person is found to be disabled, and the Administrative Law Judge (ALJ) ~~hearing officer~~ does not specify a diary date for review, contact DDB and request a diary date to review the disability.

## 5.5.2 Reversed Disability Denial Decision

When DDB or DHA notifies the IM agency that a disability denial decision has been reversed (approved) as a result of a Reconsideration/Hearing request, the IM agency must redetermine the individual's Medicaid eligibility.

## 5.9.5 Eligibility

Do not grant retroactive eligibility prior to the date the PD was determined until DDB makes a formal disability determination, (when the case folder is returned to the IM Agency). Once DDB does the final determination, the case may be backdated up to three months prior to the month of application but no earlier than the date of disability onset, provided all other eligibility requirements are met.

## 6.1.1 Residency Eligibility Introduction

A person must be a Wisconsin resident to be eligible for Medicaid. He or she must:

1. Be physically present in Wisconsin. ~~There is no required length of time the person has to have been physically present,~~ There is no minimum requirement for the length of time the person has been physically present in Wisconsin. Wisconsin residents who are temporarily out of state, (see [6.5 Absence](#)), including students going to school in another state, do not have to be physically present to apply. However, individuals who are not Wisconsin residents and intend to move to Wisconsin must be physically present in Wisconsin to apply.

And

2. Express intent to reside here (See 6.2 Intent to Reside). Effective January 1, 2014, an individual can also be considered a resident of Wisconsin if they are physically present in the State and have entered Wisconsin with a job commitment or seeking employment, whether or not they are employed at the time of application.

**Example 2:** Is new.

## 6.2 Intent to Reside

The intent to reside requirement applies to any adult age 18 or older who is capable of indicating intent. An adult is incapable of, and thus exempt from,

indicating intent when:

1. His or her I.Q. is 49 or less or he or she has a mental age of 7 or less, based on tests acceptable to Wisconsin's Department of Health Services (DHS); or
2. He or she is judged legally incompetent by a court of record; or
3. Medical documentation obtained from a physician, psychologist, or other person licensed by Wisconsin in the field of developmental disability supports a finding that he or she is incapable of indicating intent.

If the applicant / member is incapable of indicating intent, the guardian or person acting on behalf of the applicant/member can indicate the applicant's/member's intent to reside.

"Intent to reside" does not mean an intent to stay permanently or indefinitely in the State, nor does it require an intent to reside at a fixed address.

### 6.3.1.2 Not in Institution

A person under age 21 and not residing in an institution is a Wisconsin resident if he or she is:

- Age 18 or under age 18 and emancipated from his or her parents, or married, and is:
  - Living in Wisconsin with the intent to remain living in Wisconsin, or
  - Living in Wisconsin and entered Wisconsin with a job commitment or to seek employment.
- Under age 18 and not emancipated from his or her parents and not married, and is:
  - Living here more than temporarily.
  - Living here temporarily, not receiving Medicaid from another state, and is a migrant farm worker or living with a family member who is a migrant farm worker.
  - Living in another state when Wisconsin or one of its county agencies has legal custody of him/her.
  - Living here and is an EBD Medicaid case (the person's eligibility is based on blindness or disability.)

### 6.5.1 Absence Introduction

Once established, Wisconsin residence is retained until: ~~abandoned. Being out of state, in and of itself, is not abandoning residence. Residence is not abandoned when a Medicaid group or group member is temporarily out of state.~~

1. The person notifies states that they no longer intend to reside in Wisconsin,
2. Another state determines the person is a resident in that state for Medicaid/Medical Assistance , or
3. Other information is provided that indicates the person is no longer a resident.

### 6.6 Effective Date of Medicaid for SSI Recipients

This section was deleted and marked reserved.

### 6.7 Wisconsin Veterans Home

This section was deleted and marked reserved.

### 7.2.1 Documenting Citizenship and Identity Introduction

The applicant will have 9095 days after the request for verification to provide the requested documentation. If the requested verification is not provided by the end of the 9095 days, the eligibility will be terminated with Adverse Action notice unless the eligibility worker believes a good-faith effort is being made by the applicant/member and the worker chooses to extend the good-faith period. This 9095 day period applies to applications, reviews and person adds. An individual can only receive one 95 day good-faith effort period in his or her lifetime.

### 8.2.2 Failure to Cooperate

The following individuals are not sanctioned for non-cooperation:

1. Pregnant women.
2. Minors.
- ~~3. Caretakers, while family income is over 150% of the FPL.~~
4. ~~Caretakers~~ Parents or caretaker relatives while the family is in a BadgerCare Plus Extension.

### 9.1.5 Assignment Process

This section was deleted.

### 9.2.1 Nursing Home and Hospital Insurance Introduction

All members must cooperate in providing Third Party Liability (TPL) coverage and access information for nursing home and hospital insurance policies. All members must:

1. Sign over to the State of Wisconsin all their rights to payments from hospital or nursing home insurance (See 9.2.2 Assignment). Members enrolled in a Managed Long Term Care program must assign payments to the Managed Care Organization (MCO).
2. Turn over any payments to the State of Wisconsin (See 9.2.3 Recovery of Payments) that he or she received from nursing home or hospital insurance while receiving Medicaid. Members enrolled in a Managed Long Term Care program must turn over payments to the Managed Care Organization (MCO).

### 9.4.3 Cooperation

~~Effective January 1, 2014, HIPP is now voluntary for MAPP members as well as BadgerCare Plus members. To remain eligible for MAPP, the adult whose employer can provide insurance must:~~

- ~~1. Cooperate in providing information necessary to assess cost-effectiveness, and~~
- ~~2. Agree to enroll and actually enroll in the employer's health care plan if the plan is determined to be cost-effective.~~

~~Failure to cooperate or enroll in the employer's plan is non-cooperation. The adult who could get insurance coverage is not eligible for MAPP. If one adult fails to cooperate, it does not affect the spouse or children's Medicaid eligibility.~~

~~The fiscal agent HIPP unit worker will communicate HIPP non-cooperation directly to you. Enter the non-cooperation and the ineligible adult will close after the next adverse action.~~

~~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.~~

### 9.4.4 Exceptions

This section was deleted.

### 9.4.5 Not Cost-Effective

#### ~~9.4.5~~ 9.4.4 Not Cost-Effective

### 9.6.2 Policies Not To Report

The following policies should not be entered on the Medical Coverage Page in CWW or reported to the fiscal agent on the Health Insurance Information form (F-10115).

1. HMOs for which the State pays all or part of the premium.
- ~~2. Health Insurance Risk Sharing Plans (HIRSP).~~
3. Medicare (enter in CWW on the Medicare Page).
- ~~4. General Assistance Medical Program (GAMP).~~
5. Indian Health Service (IHS). IHS is the exception to the rule that Medicaid is the payer of last resort. For Native Americans who are Medicaid members, IHS is the payer of last resort. Do not enter these policies on CARES.
6. Policies that pay benefits only for treatment of accidental injury.

7. Policies that may be described as health insurance, but which pay only weekly or monthly based on the insured's disability.
8. Limited insurance plans that pay only if there is a specific diagnosis, such as cancer policy. Report them only if the person insured has been diagnosed as having the disease he or she is insured against and if the benefits are assignable.
9. Life Insurance.
10. Other types of insurance types that do not cover medical services.

**9.7 Third Party Liability (TPL) Ending**

This section was deleted and marked reserved.

**9.8 Double Payment**

This section was deleted and marked reserved.

**9.9 Health Insurance Form**

This section was deleted and marked reserved.

**10.1.1 SSN Requirements Introduction**

An applicant does not need to provide a document or social security card. He or she only needs to provide a number, which is verified through the ~~CARES SSN validation~~ State On-Line Query (SOLQ-I) process.

Verify the SSN only once.

**10.1.3 SSN Mismatches**

~~Refer to Process Help 44.4 if the SSN validation SOLQ-I process returns a mismatch record, then the member must provide the social security card or another official government document with the SSN displayed. If an applicant does not yet have a SSN, then s/he must be willing to apply for one.~~

Inform the member if the ~~SSN validation SOLQ-I~~ process suggests that another individual is using the same SSN. Advise the member to contact the Social Security Administration. The member may request Social Security Administration to conduct an investigation. Do not provide the member with any information that would identify the individual who is using the member's SSN.

**10.1.4 SSN Fraud**

This section was deleted.

**10.1.5 Failure to Provide SSN**

~~40.1.5~~ **10.1.4 Failure to Provide SSN**

**11.1 Premium or Cost Share**

Nonpayment of a ~~Family Care or Home and Community-Based Waivers~~ cost share will result in nonfinancial ineligibility. See 28.1 Home and Community-Based Waivers Long Term Care Introduction and ~~29.1 Family Care Long Term Care (FCLTC) Introduction~~ for more information.

**15.1.1 EBD Fiscal Group**

An EBD fiscal group includes the individual who is non-financially eligible for Medicaid and anyone who lives with them, and who is legally responsible for them. ~~EBD fiscal test groups will always be a group of one (1) or two (2).~~ Spouses who live together are in each other's fiscal group. This means that the income and assets of both spouses are counted when determining Medicaid eligibility for either or both spouses. The fiscal group size for this situation/living arrangement is two.

There are some exceptions to this concept. A blind or disabled minor (or dependent 18 year old), living with their parents would be a one person fiscal group. Special instructions for deeming parental income to the disabled minor are described in 15.1.2 Special Financial Tests for Disabled Minors.

Another exception to the fiscal group policy involves SSI recipients. If one spouse is applying for EBD Medicaid and the other spouse is an SSI recipient, the SSI recipient spouse is not included in the other spouse's fiscal group. For this situation you would again have a one person fiscal group when determining the Medicaid eligibility of the non-SSI spouse.

An individual living in a medical institution for 30 or more consecutive days would be a one person fiscal group. If the institutionalized person is married, refer to chapter 18.1 Spousal Impoverishment for special instructions regarding spousal impoverishment procedures.

An individual applying for Long Term Care Medicaid, including Institutional MA, Home and Community-Based Waivers, Family, PACE, Partnership or IRIS would be a one person fiscal group. If the individual is married, refer to 18.1 Spousal Impoverishment Introduction for special instructions regarding spousal impoverishment procedures.

#### 15.1.4 EBD Related Test

When doing manual EBD income eligibility determinations, use the EBD Related Determination worksheet. Apply the income disregards in the order in which they appear on the worksheet. The 65 & ½ earned income disregard and \$20.00 SSI general income disregard are applied to the fiscal group's income. They are not applied separately to each individual fiscal group member's income. Special Exempt Income is also an allowable income deduction and a list of Special Exempt Income types can be found in chapter 15.7.2 Special Exempt Income.

#### 15.1.5 Availability

**Example 3:** Was updated.

Income is unavailable when it will not be available for 31 days or more. The person must document that 1) It will not be available for 31 days or more, and 2) They have started the process to make it available.

Unavailability is usually documented by a letter from an agency stating when the person will receive the benefit. Thus, if he or she has just applied for benefits, do not add it to his or her income yet. The income is not ignored; it is only suspended until it becomes available. Schedule an eligibility review for no later than the 60th day.

#### 15.2.2 Prorating Income

Income received on a yearly basis or less often than monthly, that is predictable in both amount and frequency, must be converted to a monthly amount or prorated over the months between payments.

Prorate means "to distribute proportionately."

**Example 1:** Sally receives a \$1,500 Tribal Distribution Payment quarterly. This payment should be prorated for the months between payments. \$1,500 is distributed over three months by dividing the amount of money by the number of months between payments. The prorated amount is \$1,500/3= \$500 a month.

Prorating is applied to a member's income when the income is received less often than monthly. By prorating, income is distributed evenly over the number of months between payments.

#### 15.3.14 Payments to Native Americans

16. Payments under the settlement of the *Cobell v. Salazar* class-action trust case.

17. Non-gaming tribal income from the following sources:

- Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:
  - Rights of ownership or possession in any lands held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior; or
  - Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;
- Distributions resulting from real property ownership interests related

to natural resources and improvements:

- o Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or
- o Resulting from the exercise of federally-protected rights relating to such real property ownership interests.

18. Disregard Tribal Per Capita payments from gaming revenue up to the first \$500 of the monthly payment per individual. If the payments are received less than monthly, prorate the gross payment amount over the months it is intended to cover and disregard \$500 from the monthly amount.

This applies to eligibility determinations for ~~BadgerCare Plus~~ and all Medicaid subprograms for elderly, blind, or disabled persons **except:**

Senior Care and Long Term Care programs such as Institutional Medicaid, Family Care (FC) and Home and Community-Based Waivers (HCBW) including Partnership and Pace. For these subprograms, count all income from Tribal Per Capita payments from gaming revenue as unearned income.

### 15.3.26 VA Allowances

Disregard the following VA allowances:

1. Unusual medical expenses that are received by a veteran, their surviving spouse, or dependent.
2. Aid and attendance and housebound allowances received by veterans, spouses of disabled veterans and surviving spouses.

Unusual medical expenses, aid and attendance, and housebound allowances for institutionalized and community waiver cases, in eligibility and post-eligibility determinations, except for residents of the State Veterans Homes at King, Chippewa Falls, or Union Grove (see 15.3.26.1 Residents of a State Veterans Home).

#### 15.3.26.1 Residents of a State Veterans Home

For any veteran who resides at a State Veterans Home at King, Chippewa Falls or Union Grove, in the eligibility determination, exempt the amounts identified by the VA as unusual medical expenses, aid and attendance, and housebound allowances.

### 15.3.28 W2 Payments

Disregard Wisconsin Works (W2) payments for Transitional Jobs, Transform Milwaukee Jobs (TMJ) and Community Service Jobs. Do not disregard payments for Trial Jobs.

### 15.3.29 The American Recovery and Reinvestment Act (ARRA) of 2009

#### 15.3.30 Subsidized Guardianship Payments

#### 15.4.3 Unemployment Compensation ( UC )

This section was deleted.

#### ~~15.3.30~~ 15.3.30 Subsidized Guardianship Payments

Count normal UC that is received. Count UC that is intercepted to collect child support as if the UC beneficiary actually received the intercepted dollars. ~~Do not count the temporary supplemental benefit of \$25 per week as issued under section 2002(h) of the ARRA. These supplemental benefits are issued between March 16, 2009 and June 30, 2010.~~

### 15.4.8 Loans

#### 15.4.8 Loans/Promissory Notes

If an AG member makes a loan or promissory note (except a land contract), treat the repayments as follows:

1. Count the interest as unearned income in the month received. ~~In the months following the month the interest payment was received, count~~

~~the interest payment as an asset.~~

#### 15.4.9.1 EBD Interest/Dividend Income

Most interest and dividend earnings are ~~considered~~ excluded income and ~~so are~~ not counted when determining Medicaid eligibility. See 15.4.9.1.1 for excluded sources of interest or dividend Income and 15.4.9.1.2 for Interest and Dividend Income not excluded for EBD.

Most interest and dividend income from a resource excluded under SSI rules ~~(and therefore exempt resource for Medicaid)~~, will be an excluded source of income for all Medicaid Eligibility and post-eligibility determinations. There are, however, some exceptions (See 15.4.9.1.2)

#### 15.4.9.1.2 Interest and Dividends Income not excluded for EBD

Count the ~~non-excluded~~ interest and dividend income ~~listed above~~ as unearned income ~~only~~ when it:

1. Is received regularly and frequently, and
2. Is more than \$20 a month.

~~When income is received less often than monthly, prorate (See 15.2.2 Prorating Income) it to a monthly amount. Wait until the person first receives it after becoming eligible, and then begin prorating with the month in which the payment is received.~~

~~If the prorated amount is \$20 or less, disregard it as inconsequential income. If more than \$20, budget it as unearned income.~~

**Example 5:** In a Medicaid application, made June 16, 2009, a group member receives interest payments of \$54 every three months. The next interest payment date is July 30, 2009. Do not count any of this interest income during June. Prorate the payment over July, August, and September. The interest is:  $\$54/3 = \$18$ . Since \$18 is less than \$20, do not count the interest.

~~When interest or dividends are paid regularly, but the amount fluctuates, average the payments to get a monthly amount.~~

~~When you discover that interest has accumulated in an account, count all of the accumulated interest as unearned income. Do not count these interest dollars as an asset.~~

**Example 6:** In May, \$12 is posted to an account as monthly interest on principal of \$800. May income is \$12 and the May asset is \$800. In June, \$12.50 is posted as interest on a balance of \$812. June income is \$12.50 and the June asset is \$812.

~~If interest or dividends are not paid regularly (neither you nor the member can reasonably predict when it will be available), count the interest as unearned income in the month in which it is received.~~

#### 15.4.17 Federal Match Grants for Refugees

Some refugee resettlement agencies have grants available for refugees for their second, third, and fourth month after arrival in the U.S. These are cash grants and can vary in the amount issued. Count these payments as unearned income. Budget as "OT" on AFUI and document the grant in case comments.

#### 15.4.19 Payments to Native Americans

This applies to eligibility determinations for ~~BadgerCare Plus~~ and all Medicaid subprograms for elderly, blind, or disabled persons except:

#### 15.4.20 First Time Home Buyer Tax Credits

This section was deleted.

#### 15.4.21 Alimony, Maintenance, and Other Spousal Support Payments

This section was deleted.



## 15.5 Earned Income

Earned income is income from gainful employment. The gross earned income before any deductions are taken out is counted. Count earned income only for the month in which it is received, except when the average number of payments increase due to mailing cycle adjustments.

### 15.5.1 Income In-Kind

Count in-kind benefits as earned income if they are:

1. Regular, and
2. Predictable, and
3. Received in return for a service or product.

Do not count meals and lodging for armed services members.

- ~~1. Meals and lodging for armed services members.~~
- ~~2. In-kind services that do not meet all three of the above criteria.~~

### 15.5.7 Governor's Central City Initiative

This section was deleted.

### 15.5.13 Income Received by Members of a Religious Order

### ~~15.5.13~~ 15.5.12 Income Received by Members of a Religious Order

Count any compensation that a member of a religious order receives as earned income if the compensation is for gainful employment, even if the compensation is turned back over to the order.

~~Count the compensation as unearned income if it is not earned through gainful employment.~~

### 15.6.2.1 By Organization

A farm or other business is organized in one of the following ways:

1. A sole proprietorship, which is an unincorporated business owned by one person.
2. A partnership, which exists when 2 or more persons associate to conduct business. Each person contributes money, property, labor, or skills, and expects to share in the profits and losses. Partnerships are unincorporated.
3. A corporation is a legal entity authorized by a state to operate under the rules of the entity's charter. There may be one or more owners. A corporation differs from the other forms because a corporation:
  - a. Is taxed as a separate entity rather than the owners being taxed as individuals, and
  - b. Provides only limited liability. Each owners' loss is limited to their investment in the corporation while the owners of unincorporated business is also personally liable.
4. A limited liability company (LLC), a business structure that combines the pass-through taxation of a partnership or sole proprietorship (the members are taxed directly) with the limited liability of a corporation.

### 15.6.2.2 By IRS Tax Forms

IRS tax forms for reporting self-employment income are listed below.

1. Form 1065 – Partnership or multi-member LLC
2. Form 1120 – Corporation or LLC electing to be taxed as a corporation
3. Form 1120S - S Corporation
4. Form 4562 - Depreciation & Amortization
5. Form 1040 - Sole Proprietorship or single member LLC
  - a. Schedule C ( Form 1040 ) - Business (non-farm)
  - b. Schedule E ( Form 1040 ) - Rental and Royalty
  - c. Schedule F ( Form 1040 ) - Farm Income
  - d. Schedule SE ( Form 1040 ) - Social Security Self-Employment

### 15.6.2.3 Employee Status

~~Examples of self-employment are:~~

1. ~~Businesses that receive income regularly ( for example, daily, weekly or monthly):-~~
  - a. ~~Merchant,~~
  - b. ~~Small business,~~
  - c. ~~Commercial boarding house owner or operator, or~~
  - d. ~~Owner of rental property~~
2. ~~Service businesses that receive income frequently, and possibly, sporadically:~~
  - a. ~~Craft persons,~~
  - b. ~~Repair persons,~~
  - c. ~~Franchise holders,~~
  - d. ~~Subcontractors,~~
  - e. ~~Sellers of blood and plasma, or~~
  - f. ~~Commission sales persons ( such as door-to-door delivery ).~~
3. ~~Businesses that receive income seasonally:~~
  - a. ~~Summer or tourist oriented business,~~
  - b. ~~Seasonal farmers (custom machine operators),~~
  - c. ~~Migrant farm worker crew leaders,~~
  - d. ~~Fishers, trappers, or hunters, or~~
  - e. ~~Roofers.~~
4. ~~Farming, including income from cultivating the soil, or raising or harvesting any agricultural commodities. It may be earned from full-time, part-time or hobby farming.~~

#### 15.6.4 Self-Employed Income Sources

Self-employment income sources are:

1. **Business.** Income from operating a business.
2. **Capital Gains.** Business income from selling securities and other property is counted. Personal capital gains are not counted as income. ~~Income from selling securities and other property.~~
3. **Rental.** Rental income is rent received from properties owned or controlled. Rental income is either earned or unearned. It is earned only if the owner actively manages the property on an average of 20 or more hours per week. It is unearned when the owner reports it to the IRS as other than self-employment income.

#### 15.6.5.2 Worksheets

~~If you use more than one worksheet because there is more than one operation, combine the results of each worksheet into one monthly IM income amount before adding that total to any other income. Remember that while a salary or wage paid to a FTG member is an allowable business expense, you must count it as earned income to the payee.~~

~~Continue to process the group through the balance of the handbook, including some additional work-related expenses that IRS doesn't allow as business expenses (See 15.7.5 \$65 and ½ Earned Income Deduction).~~

#### 15.6.5.2.1 Depreciation

~~Depreciation is an allowable deduction for EBD MA cases must deduct depreciation from their self-employment income. The amount of the depreciation deduction is the same as the amount they claim on their tax forms.~~

#### 15.6.5.3 Anticipated Earnings

~~The date of an income change is the date you agree that a change occurred. You must also judge whether the person's report was timely to decide if the case was over or underpaid. Changes are then effective according to the normal prospective budgeting cycle. Don't recover payments made before the agreed on date.~~

**Examples of change circumstances are:**

7. Sales, for an unknown reason, are consistently below previous levels. The relevant period may vary depending on the type of business (consider normal sales fluctuations).

**Examples 1-3:** Were updated.

### 15.6.6 Verification

~~Self-employment income is not available through data exchange and therefore must be verified (20.4.1 Questionable Items Introduction #7).~~

### 15.7.1 Maintaining Home or Apartment

If an institutionalized person residing in a medical institution has a home or apartment, deduct an amount from his or her income to allow for maintaining the home or apartment that does not exceed the SSI payment level plus the E supplement for one person (See 39.4.1). The amount is in addition to the personal needs allowance (See 39.4.2 EBD Deductions and Allowances). It should be enough for mortgage, rent, property taxes (including special assessments), home or renters insurance, utilities (heat, water, sewer, electricity), and other incidental costs.

Make the deduction only when the following conditions are met:

1. A physician certifies (verbally or in writing) that the person is likely to return to the home or apartment within six months, and
2. The person's spouse is not living in the home or apartment.

Deduct this amount for no more than six months. If the person is re-admitted to the institution, grant a six month continuance. A physician must again certify that he or she is likely to return to the home or apartment within six months.

The home maintenance allowance can be granted at any time as long as the person is institutionalized. It is not limited to the first six months of institutionalization the person resides in the medical institution.

**Example 1:** Was updated.

### 15.7.2.3.1 Countable

#### 15.7.2.3.1 ~~Countable~~ Disallowed Deductions

~~Count as available income any payments an institutionalized person makes to~~  
The following fees to guardians or attorneys are not allowed income deductions:

1. ~~A Fees paid to a~~ legal guardian or attorney, which are not court-ordered payments. Do not include such payments in the person's monthly need, and do not deduct them from his or her monthly income.
2. ~~A Fees paid to a~~ third party to reimburse a prepayment the third party made of a guardianship fee. ~~Count~~ Do not allow the payment even if the third party obtained a court order to recoup the pre-payment.

### 15.7.2.3.2 Not Countable

#### 15.7.2.3.2 ~~Not Countable~~ Allowable Deductions

~~Do not count the following as available income~~ The following fees to guardians or attorneys are allowable income deductions:

1. Court-ordered guardian and/or attorney fees paid directly out of the person's monthly income.
2. Expenses paid by the person for establishing and maintaining a court-ordered guardianship or protective placement for him/herself.

### 15.7.3 Medical/Remedial Expenses (MRE)

8. Community Options Program, expenses that are included in the person's service plan.

### 15.7.4 Impairment Related Work Expenses ( IRWE )

**Example 2:** Was updated.

Deduct any ~~EBD person's~~ MAPP member's expenses which:

1. Do not exceed his or her gross monthly earned income (plus room and board income, if any).
2. Are reasonably related to his or her earned income. Expenses which are reasonably related to earned income include those incurred in performing on the job and improving the person's ability to do the job.

## 16.1 Assets Introduction

Effective 10/01/2009, Children under the age of 19 are not subject to an asset test for any category of EBD Medicaid, including MAPP, Community Waivers, FamilyCare, etc.

Do not count income as an asset in the month it was received when determining the countable asset amount.

**Example 1:** Was updated.

**Example 2:** Is new.

Add together all countable, available assets (See 16.2 Assets Availability), the fiscal group owns including:

1. Joint accounts. (16.4.1 Joint Accounts)
2. Burial Assets (16.5 Burial Assets)
3. Savings account
4. Checking account
5. Cash available
6. Stocks, bonds, CDs.
7. Loans (16.7.2 Loans)
8. Life Insurance (16.7.5 Life Insurance)
9. Non- Burial Trusts (16.6 Non-Burial Trusts)
10. Land Contract (16.7.12 Land Contract)
11. Mortgage (16.7.13 Mortgage)
12. Trailer Home (16.8.1.2 Non-Motorized Trailer Homes)
13. Nonhome Real Property. (16.8 Real Property)
14. Some Vehicles (16.7.9 Vehicle, 18.4 Spousal Impoverishment)

~~Use the EBD Related Determination worksheet when doing manual eligibility determinations for non-institutionalized EBD Medicaid applicants and recipients.~~ The EBD fiscal group's assets must be within the appropriate ~~categorically needy or medically needy~~ asset limit before any member of that group can qualify for Medicaid. EBD fiscal groups who have assets in excess of the appropriate ~~EBD medically needy~~ asset limit are ineligible for Medicaid.

## 16.2.1 Assets Availability Introduction

Consider an asset as unavailable if **either**:

1. The member lacks the ability to provide legal access to the assets, and
2. No one else can access the assets, and
3. A process has been started to get legal access to the assets.

**Or,**

When the owner or owner's representative documents that the asset will not be available for 30 days or more, **and the process has been started to obtain the assets.**

Use the criteria above to determine whether an asset was available in a backdate month unless an asset is deemed unavailable in the month of application because it will not be available for 30 or more days (considered unavailable in any or all backdate months).

**Example 1:** Was updated.

## 16.2.2 Real Property

Non-exempt real property (See 16.8 Real Property) is unavailable when:

1. The person who owns the property lists it for sale with a realtor. See 16.9 Non-Home Property Exclusions.

If an institutionalized person owns property that's unavailable because it's listed for sale, he or she can use some of her income to maintain the property until it is sold. Allow minimal heat and electricity costs so as to avoid physical damage to the property while it is waiting to be sold. Also allow a minimum amount of property insurance coverage. Do not allow taxes and mortgage payments; they must be paid from the proceeds of the sale.

Allow these minimal maintenance costs for as long as the person is making a good faith effort to sell the property at current market value.

2. A joint owner who is outside the fiscal test group refuses to sell the property.

When the member is a co-owner of the property with someone outside the fiscal group, you must determine whether s/he is a joint owner or an owner-in-common. It is owned as a joint tenancy or tenancy-in-common.

Joint ownership has tenants have a right of survivorship. That is, upon the death of one joint owner-tenant, the other inherits the share of the deceased. A joint owner's share tenant's interest may not be sold without forcing the sale of the entire property.

Ownership-Tenants-in-common has no right of survivorship. A owner-tenant-in-common may bequeath his or her share of the property to anyone he or she chooses. He or she may also sell his or her share during his or her lifetime.

~~If an institutionalized person owns property that's unavailable because it's listed for sale, s/he can use some of her income to maintain the property until it is sold. Allow minimal heat and electricity costs so as to avoid physical damage to the property while it is waiting to be sold. Also allow a minimum amount of property insurance coverage. Do not allow taxes and mortgage payments; they must be paid from the proceeds of the sale.~~

~~Allow these minimal maintenance costs for as long as the person is making a good faith effort to sell the property at current market value.~~

### 16.3 Separate and Mixed Assets

When a Medicaid group keeps an exempt asset in:

1. A separate account or an account with other exempt assets, exempt the exempt asset:
  - a. Indefinitely, for example, most payments to Native Americans (15.3.14 Payments to Native Americans), or
  - b. For as long as the exemption can be applied to the asset, for example, EITC (See 16.7.8 Earned Income Tax Credit (EITC)), which is exempt only through the month for 12 months following the month of receipt.

### 16.4.1 Joint Accounts

Account means a deposit of funds with a financial institution (bank, savings and loan, credit union, insurance company, brokerage firm, etc.).

Apply the following policy to savings, checking and share accounts, certificates of deposit, NOW accounts, and similar arrangements where the account holders have equal access to the funds.

~~Deem amounts from joint accounts differently depending upon whether or not~~

~~the account is shared with an EBD Medicaid applicant / member.~~

~~EBD Medicaid applicant/ members also include any of the Medicare Beneficiary programs QMB, SLMB, SLMB+, and QDWI.~~

~~SeniorCare applicant/members are not considered an EBD related applicant/member when deeming joint accounts.~~

#### 16.4.1.1 EBD Medicaid Applicant/Recipient EBD co-owner

When an EBD Medicaid applicant/member shares a joint account with a co-owner who is another EBD applicant/member, deem an “equal share” to each account holder.

“Equal Share” means an amount in proportion to the number of EBD-related applicant/member account holders. If there are three holders, an equal share means each is deemed 1/3 of the account balance.

~~EBD Medicaid applicant/ members also include any of the Medicare Beneficiary programs QMB , SLMB , SLMB +, and QDWI .~~

~~SeniorCare applicant/members are not considered an EBD related applicant/member when deeming joint accounts.~~

#### 16.4.1.2 EBD Medicaid Applicant/Recipient Non EBD Co-Owner

When an EBD Medicaid applicant/member shares an account with an individual or individuals who are not EBD Medicaid applicant(s)/member (s) ~~deem count the full share to the amount of the account as a countable asset for the EBD Medicaid applicant/member.~~

~~Full share” means an amount equal to the account balance. The account balance is the total of the principle and any interest retained in the account, minus any withdrawal penalties or charges.~~

~~Applying the preceding policy may result in considering available to a fiscal test group more money from a joint account than is actually in that account. If that occurs, deem an equal share to each account holder who is in the fiscal test group.~~

~~**Example 1:** Joe is an EBD Medicaid member who shares a \$4000 account with his spouse Connie. Joe and Connie reside together and are therefore in the same Fiscal Test Group ( FTG ). Rather than assigning \$4000 from this account as Joe’s asset and \$4000 as Connie’s asset, which would result in \$8000 being counted as the fiscal test group’s asset, deem an equal share to each account holder who is in the FTG so that only \$4000 would be counted as the group’s total asset.~~

#### 16.6.6 Pooled Trusts

4. For WISH Trusts, if the account includes a residential dwelling, the individual must reside in that dwelling, but a spouse, caregiver or housemate can also live there with the Medicaid applicant/recipient. This requirement does not apply to WisPACT trusts.

#### 16.7.5 Life Insurance

Count the cash value of all life insurance policies. For persons age 65 or over, blind or disabled, count it only when the total face value of all policies, including riders and attachments, owned by each person exceeds \$1,500. Do this calculation for each EBD person. In determining the face value, do not include any life insurance which has no cash value.

~~Workers should enter the total of the face value plus any riders or other attachments as the “Face Value” on the Life Insurance Assets Page.~~

Face value is the basic death benefit of the policy including the value of riders

and other attachments.

Cash value means the net amount of cash for which the policy could be surrendered after deducting any loans or liens against it.

Workers should enter the total of the face value plus any riders or other attachments as the "Face Value" on the Life Insurance Assets Page.

~~Count the cash value of all life insurance policies. For persons age 65 or over, blind or disabled, count it only when the total face value of all policies, including riders and attachments, owned by each person exceeds \$1,500. Do this calculation for each EBD person. In determining the face value, do not include any life insurance which has no cash value.~~

#### 16.7.6 Treatment Of Continuing Care Retirement Community Entrance Fees

Effective January 1, 2009, Entrance fees paid by an individual to a CCRC or LCC are counted as an available non-exempt asset of the individual for Medicaid eligibility determinations when all of the following conditions apply:

~~This provision must be applied to all Medicaid applications and eligibility reviews that occur on or after January 1, 2009, regardless of when the entrance fee was actually paid.~~

#### 16.7.8 Earned Income Tax Credit (EITC)

Disregard all Earned Income Tax Credit ( EITC ) in the month received and for 9 12 months following the month of receipt.

After the 9-12 month disregard period has passed, count any remaining EITC payments as available, non-exempt assets.

#### 16.7.9 Vehicles (Automobiles)

Vehicle or automobile means any registered or unregistered vehicle used for transportation. Vehicles used for transportation include but are not limited to cars, trucks, motorcycles, boats, snowmobiles. ~~A temporarily broken down vehicle used for transportation meets the definition of an automobile.~~

#### 16.7.9.2 When to Count, When to Exempt

Count vehicle values as follows:

1. One automobile per household is excluded regardless of the value if it is used for transportation of the eligible individual/couple or a member of the eligible individual's/couple's household. Assume the automobile is used for transportation, absent evidence to the contrary.
2. When an individual owns more than one automobile apply the exclusion as follows:
  - a. Apply the exclusion in the manner most advantageous to the individual.
  - b. Apply the total exclusion to the automobile with the greatest equity value if the eligible individual/couple own more than one automobile used for transportation of the eligible individual/couple or a member of the individual's/couple's household.
  - c. The equity value of any automobile, other than the one wholly excluded is a resource when it:
    - Is owned by an eligible individual/couple; and
    - Cannot be excluded under another provision (e.g. property essential to self-support, plan to achieve self-support.)

Do not apply the vehicle exclusion to the following vehicles:

- a. A vehicle that has been junked;
- b. A vehicle that is used only as a for recreational vehicle purposes (e.g., a boat used for pleasure).

~~The equity value of such a vehicle is a resource.~~

3. When an individual owns two or more automobiles, apply the following rules:
  - a. If only one automobile is used for transportation, totally exclude the value of that automobile.
  - b. If more than one automobile is used for transportation, totally exclude the automobile with the greatest equity value.

For any automobile that cannot be excluded for transportation reasons, consider excluding it under the provisions for property essential to self-support, plan to achieve self support. If the automobile does not qualify for the exclusion, count the equity value of the automobile as a resource.

4. If an individual who owns an automobile that is temporarily inoperable (e.g., needs repairs) and states that the automobile will be repaired and used for transportation within the next twelve calendar months, exclude the total value of the automobile until the repairs are completed. At that point, apply the rules for determining if the automobile should be excluded.

#### 16.7.12 Land Contract

**Example 6:** Was updated.

#### 16.7.18 Institutionalized Person's Assets

This section was deleted.

#### 16.7.19 Blind/Disabled Set-Aside

#### ~~16.7.19 Blind/Disabled Set-Aside~~ 16.7.18 Self-Support Plan Assets

Disregard the following for a blind or disabled person:

- ~~1. Assets essential to the continuing operation of her/his trade or business.~~
- ~~2. Other income-producing property.~~

Disregard assets set aside to carry out an approved self-support plan (See 15.7.2.2 Self-Support Plan). The set-aside must be segregated from other funds. Disregard interest that accumulates, provided the set-aside does not exceed the provisions of the plan.

#### 16.7.24 Make Work Pay

This section was deleted.

#### 16.7.32 First Time Home Buyer's Tax Credit

This section was deleted.

#### 16.9 Non-Home Property Exclusions

Non-home property is any countable asset other than a homestead. See 17.4 Exceptions for divestment. Exclusions of non-home property in EBD cases include:

1. Real property that is listed for sale with a realtor at a price consistent with its fair market value.
2. Property excluded regardless of value or rate of return. Property used in a trade or business is in this category. See 15.6.3.1 Business Assets. The property may be excluded as used in a trade or business when the applicant/member is actively involved in the business operation on a day to day basis. The information reported on the Schedule E, Supplemental Income and Loss, should be checked to determine whether the individual is actively engaged in the business. If the income is listed as Non-Passive Income, the individual is actively engaged in the business.

When determining if a trade or business exists in an LLC or other questionable situations workers should consider:

- Does the IRS regard this as a trade or business?



- Does the individual have documents to support the claim of trade or business such as licenses, permits, registration, etc.?
- Is the individual a member of a business or trade association?

3. Property excluded up to \$6,000, regardless of rate of return. This category includes non-business property used to produce goods or services essential to self-support. Any portion of the property's equity value in excess of \$6,000 is not excluded.

Non-business property essential to self-support can be real or personal property. It produces goods or services essential to self-support when it is used, for example, to grow produce or livestock solely for personal consumption, or to perform activities essential to the production of food solely for home consumption.

**Example 1:** Is new.

4. Property excluded up to \$6,000 if it is non-business property that produces a net annual income (either cash or in-kind income) of at least 6%. If the excluded portion produces less than a 6% return due to circumstances beyond the person's control (e.g., crop failure, illness), and there is reasonable expectation that it will again produce at least a 6% return, continue to consider the first \$6,000 in equity as excluded.

Nonbusiness income producing property is land or non-liquid property which provides rental or other income but is not used as a part of a trade or business. Nonbusiness income producing property includes, but is not limited to, the following:

- Structures producing rental income
- Land producing rent or other land use fees (non-liquid notes or mortgages, royalties for timber rights, mineral exploration, etc.)

**Example 2:** Is new.

**Example 3:** Is new.

## 17.1 Divestment Introduction

Divestment can affect the eligibility for Long Term Care Medicaid. If it is determined that divestment occurred some time in the past, the applicant or recipient may be found ineligible for Long Term Care Medicaid for a period of time. Divestment does not affect eligibility for Medicaid card services for a person residing in a medical institution. An individual ineligible for Home and Community-Based Waivers due to a divestment may still be eligible for other non-Long Term Care Medicaid.

**Example 1 and 2:** Are new.

**Note:** Effective 10/1/09, assets are no longer counted for disabled or institutionalized children. Since assets are disregarded, there can be no divestment in a Medicaid case for a child.

The definitions and general rules found in sections 17.2- 17.5 apply to all divestments. The special situations in 17.6 - 17.14, while falling under the same definitions and general rules, require extra treatment because of their complexity.

### 17.2.1 Divestment

f. Refusing to take action to claim the statutorily required portion of a deceased spouse's or parent's estate. Count the action as a divestment only if:

- The value of the abandoned portion is clearly identified, and

- There is certainty that a legal claim action will be successful. The agency Corporation Counsel makes this determination.

3. The purchase of certain types of assets, even at the fair market value, may be considered a divestment, including:

- a. The purchase of a life estate interest in another individual's home on or after January 1, 2009, is a divestment unless the purchaser resides in the home for a period of at least 12 consecutive months after the date of purchase. See 17.10.3 Purchase of a Life Estate in the Home of Another Person.
- b. The purchase of a promissory note, loan or mortgage, on or after January 1, 2009 is a divestment unless such note, loan or mortgage meets several criteria. See 17.12.2 Promissory Notes On or After 01/01/09.
- c. The purchase of certain annuities may be considered a divestment. See 17.11.2 Annuities Purchased On Or After 01/01/09 Or Had Transactions To Them On Or After 01/01/09.

4. Gambling losses at a casino, racetrack or in some other type of regulated gambling is not divestment. It is divestment if the member makes personal bets with friends or relatives or has losses from unregulated gambling.

#### 17.2.2.1 Date of Transfer

**Example 1:** Was deleted.

#### 17.2.7 Divested Amount

" Divested amount " is the net market value minus the value received. To determine the divested amount for a life estate, see MEH 17.10.

#### 17.2.9 Value Received

5. Services which shall be assigned a valuation equal to the cost of purchase on the open market. Assume that services and accommodations provided to each other by family members or other relatives were free of charge, unless there exists a written contract (made prior to the date of transfer) for payment. See MEH 17.8 Divesting by Paying Relatives.

#### 17.3 Look Back Period

The look back period begins when an individual is both institutionalized and has applied for Long Term Care Medicaid or has applied for requested one of the Home and Community Based Waiver or Managed Long Term Care programs.

Look back from the:

- ~~1. Institutionalized person's date of application or review, or~~
- ~~2. Medicaid recipient's date of entry into the institution.~~

#### 17.4 Exceptions

7. The institutionalized person or his or her spouse divests homestead property to his or her:

- a. Spouse
- b. Child who meets at least 1 of the following conditions/situations:
  - Under 21 years of age  
OR
  - Blind  
OR
  - Permanently & totally disabled  
OR
  - Been residing in the institutionalized person's home for at least 2 years immediately before the person became institutionalized moved to a medical institution, and provided care to him/her which permitted him/her to reside at home rather than in the institution. This care must have been provided for the entire 2 years immediately before the person became institutionalized moved to a medical institution. Get a notarized statement that the person was able to remain in his or her home because of the care

provided by the child.

**Note:** The statement must be from his or her physician or from someone else who has personal knowledge of his or her living circumstances. A notarized statement from the child does not satisfy these requirements.

c. Sibling who:

- Was residing in the institutionalized person's home for at least 1 year immediately before the date the person ~~became institutionalized~~ moved to a medical institution.

Verify that the sibling was residing in the institutionalized person's home for at least 1 year immediately before the person ~~became institutionalized~~ moved to a medical institution. Don't require a specific type of verification. Some examples of verification are written statements from nonrelatives, social services records, tax records, and utility bills with the address and the sibling's name on them.

### 17.5.1 Penalty Period Introduction

If there was a divestment during the lookback period or any time after, and if none of the above exceptions apply, the institutionalized person must be determined ineligible for a period of time.

During this penalty period Medicaid will not pay the institutionalized person's daily care rate in the nursing home. ~~A Community Waivers applicant or recipient is ineligible for Community Waivers.~~ He or she may, however, still be eligible for Medicaid card services (See 17.15 Medicaid Card Services). ~~An individual ineligible for Home and Community-Based Waivers due to a divestment may still be eligible for other non-Long Term Care Medicaid.~~

### 17.5.2 Calculating the Penalty Period

For divestments on or after January 1, 2009, the divestment penalties are calculated in days. Use the average daily nursing home private pay rate of ~~\$249.49~~ \$241.78 per day. ~~The average daily rate was computed by multiplying the average monthly rate by 12 and dividing by 365. ( $\$7,406 \times 12 = 88,872$  divided by 365 = 243.49)~~

**Example 1:** Was updated.

### 17.5.5.2 No Reduction for Partial Refund

~~As of November 11, 2013, individuals who are currently serving a divestment penalty may no longer reduce this penalty period by receiving a partial refund of a previously transferred resource.~~ Beginning with penalty periods with a start date of November 11, 2013 or later, the total value of the divested amount must be returned in order to 'cure' the divestment. A penalty period will no longer be re-calculated based on a partial repayment. (Wis. Stat. 49.453(8)(a)).

**Example 9:** Is new.

### 17.5.5.3 Divestments During a Penalty Period 17.11 Annuities

**Example 10:** Was updated.

This section was rewritten.

### 17.13.4 Exceptions

I. Pooled Trusts Not Subject to Divestment

These are trusts for disabled persons as determined by SSI rules. Disregard them if they meet the following conditions:

- a. Are established and managed by a non-profit association, and
- b. Have separate accounts, within each fund, which are maintained for

each beneficiary or the trust, but for purposes of investment and management of funds, the trust pools these accounts. There may be a separate fund with accounts that include or benefit persons who do not have a disability , and

- c. Contain accounts with the funds of disabled individuals (based upon SSI and Medicaid rules) that are established solely for their benefit by a parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

**Note:** If a WISH trust ~~if the account~~ includes a residential dwelling, the individual must reside in that dwelling, but a spouse, caregiver or housemate can also live there with the Medicaid applicant /recipient. ~~This does not apply to a WisPACT trust,~~ and

- d. Repay Medicaid to the extent that amounts remaining upon death are not retained by the trust.
    - i. This requirement can be satisfied when the individual trust account contains liquid assets and has a balance by returning that amount to the Medicaid program after subtracting a reasonable amount for administrative costs.
    - ii. This requirement can also be satisfied when the pooled trust account includes real property , and the real property is retained by the pooled trust so long as the property continues to be used by another Medicaid recipient who is disabled (as established under SSI rules) or elderly (age 65 years or older). In addition, if the account contains liquid assets that had been used to help maintain the real property, the account funds may be retained to continue to maintain the housing that will be used by another Medicaid recipient, and
  - e. The trust was established with the funds of a disabled individual of any age. These would be considered “self-funded” trusts, and the age of the disabled individual at the time the trust was created, is irrelevant.
6. Trusts for Disabled Individuals. A trust for a disabled individual is a trust established ~~with an individual's funds~~ solely for the benefit of ~~his/her~~ the grantor's disabled child (regardless of the child's age), or solely for the benefit of any other disabled individual who is under 65 years of age. The disability status is the same as that which is determined under SSI rules. The exception continues after the ~~person~~ beneficiary turns age 65, provided he or she continues to be disabled. However, a grantor cannot add to the trust after the beneficiary turns age 65, unless the beneficiary is his or her disabled child. Anything added to the trust after the beneficiary turns age 65 (except for a beneficiary who is the grantor's disabled child) is a divestment. Money added before the beneficiary turns age 65 is not a divestment.

#### 17.14 Both Spouses Institutionalized

**Example 1:** Was updated.

Apportion the penalty period as follows:

1. Find the divested amount that was used to calculate the original penalty period.
2. Calculate how much of the divested amount remains to be satisfied by:
  - a. Multiplying the average nursing home private pay rate x the number of ~~days of the penalty period already served~~
    - ~~Complete months of the penalty period already served for divestments prior to 1/1/09, or~~
    - ~~The days of the penalty period already served for divestments on or after 1/1/09~~
  - b. Subtracting the result from the original divested amount.
3. Calculate the penalty period for the remaining divested amount.
4. Divide the new penalty period equally between the 2 spouses.

## 17.15.2 Community Waivers

## 17.15.2 Home and Community-Based Waivers

~~Community waivers (CW) members who have divested cannot receive CW benefits and can't use CW eligibility criteria. They may be eligible for Medicaid card services. Determine eligibility using regular Medicaid methodology. Home and Community-Based Waivers (HCBW) applicants/members who have divested cannot be tested using HCBW eligibility criteria. They are only eligible for card services if eligible under non-LTC Medicaid methodology (such as for SSI Related MA, MAPP).~~

~~Send a notice to the CW case manager telling him/her of the member's ineligibility for waiver services.~~

## 17.16 Gambling

This section was deleted and marked reserved.

### 17.17.4.1 Timely Request- Received Within 20 days After Notification Is Mailed

**Example 1:** Was updated.

### 17.17.4.2 Untimely Request- Received Later Than 20 days After Notification Is Mailed

A request may be submitted later than 20 days after the local agency mails out the Divestment Penalty and Undue Hardship Notice (F-10187), (for example, when there is a change in circumstances), but if approved, the **hardship** waiver effective date will not be earlier than the date of the request.

**Example 2:** Was updated.

### 17.17.5 Required Documentation

- If the **member is applying for Community Waivers HCBW COP, including FamilyCare, IRIS, PACE or Partnership**, he or she must submit an estimate of the cost of the LTC services needed to meet his or her medical and remedial needs (as determined by the waivers case manager) and an estimate of costs for food, shelter, clothing and other necessities of life.

### 17.17.7 Bed Hold Payments and Notification

If the request for an undue hardship waiver is approved, the penalty period will be waived and the need for a bed hold payment is therefore unnecessary. If the undue hardship waiver request is denied, indicate on the **Undue Hardship Waiver Decision** form the dates for which the State will make the bed hold payments. Attach a copy of the **Undue Hardship Waiver Decision** form to the manual Negative Notice of Decision that you send the member/applicant.

The Negative Notice must include the agency's reason for the denial, "You have not proven that the divestment penalty will create an undue hardship for you." The Notice must also inform the member/applicant that Medicaid/ ForwardHealth will pay for LTC services received during the bed hold period. Manually certify the bed hold period by completing a manual Medicaid certification form (F-10110 - formerly DES 3070 - See PH 81.3) and sending it to the fiscal agent for processing.

Only one bed hold payment will be made for each divestment penalty period. Bed hold payments can only be made on behalf of individuals residing in medical institutions (i.e. nursing homes, etc.) who are requesting an undue hardship determination. They will not be made for ~~Community Waivers or Family Care applicants~~ individuals not residing in a medical institution.

## 18.1 Spousal Impoverishment Introduction

Spousal impoverishment is a Medicaid policy that allows persons to retain assets and income that are above the regular MA financial limits. Spousal impoverishment policy applies to institutionalized persons (~~See 18.2.3 Institutionalized~~) and their community spouse (~~18.2.1 Community Spouse~~). For purposes of Spousal Impoverishment an institutionalized person means

someone who:

1. Participates in Home and Community-Based Waivers, or
2. Has resided in a medical institution for 30 or more consecutive days, or
3. Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution, or
4. Is residing in an IMD. There is no 30 day requirement for this population.

The policy's purpose is to prevent impoverishment of the community spouse. A community spouse is:

1. Married to an institutionalized person and
2. Not living in a nursing home or other medical institution for 30 or more consecutive days.

As long as the community spouse is not an institutionalized person residing in an institution, his or her living arrangement can have no effect on his or her asset share (See 18.2.2 Community Spouse Asset Share below) or income allocation (See 18.6 Spousal Impoverishment Income Allocation).

**Example 1:** Is new.

Before enactment of the Medicare Catastrophic Coverage Act of 1988, the community spouse was legally obliged to provide financial support to the institutionalized person. After enactment, he or she is allowed to have substantial retain additional assets and income without liability for the institutionalized spouse and without affecting the Medicaid eligibility of the institutionalized spouse.

See 2.5.3 Spousal Impoverishment MA Signatures for application and review signature requirements.

## 18.2 Spousal Impoverishment Useful Terms

## 18.3 Spousal Impoverishment Requirements

### 18.4.2 Asset Assessment

This section was deleted and marked reserved.

**1. Assets.** The assets of both the institutionalized person and his or her community spouse are counted in the asset test.

The IM Agency must make an assessment of the total countable assets of the couple at the:

1. Beginning of the person's first continuous period of institutionalization of 30 days or more, or
2. Date of the first request for Home and Community-Based Waivers, whichever is earlier.

Complete an asset assessment using the F-10095 "Medicaid Asset Assessment" when someone applies, even if he or she had one done in the past, to get the most current asset share.

If the member was not married on the first date of institutionalization or waivers request, apply the policy from the point he or she is married. If he or she has remarried since the first date of institutionalization or waivers request, apply the policy from the date he or she got married to his or her current spouse.

~~The IM agency must also do an asset assessment at any other time the institutionalized person or his/her spouse requests it.~~

### 18.4.3 Calculate the CSAS

~~CARES will send each member of the couple a letter that states the couple's total countable assets, the CSAS, how much the institutionalized spouse must transfer to the community spouse, the date by which the transfer must be made, and the institutionalized person's asset limit.~~

**18.4.6.1 Asset Transfer Period**

**Example 2:** Was updated.

**18.6.1 Spousal Impoverishment Income Allocation Introduction**

Use the ~~Spousal Impoverishment Income Allocation Worksheet (See WKST 07)~~ To determine how much of the institutionalized spouse's income ~~to allocate:~~

- ~~1. May be allocated to his/her spouse (Section A).~~
- ~~2. Will be deducted, regardless of whether or not s/he actually allocated it to other dependent family members (Section B).~~
- ~~3. Will be paid toward his/her cost of care (Section C).~~

~~On the Spousal Impoverishment Income Allocation Worksheet (See WKST 07), do the following:~~

**18.6.2 Worksheet 7 Section A - Community Spouse Income Allocation**

**18.6.2 ~~Worksheet 7 Section A~~ -- Community Spouse Income Allocation**

~~Enter on Line 1-1. The community spouse maximum income allocation is: Unless a larger amount is ordered by a fair hearing or court, the maximum allocation is the lesser of:~~

- ~~a. \$2,980.50 or~~
- ~~b. \$2,621.67 plus excess shelter allowance. (See 39.4.2) up to a maximum of \$2,931.00, or~~
- ~~c. A larger amount ordered by a fair hearing court.~~

~~“Excess shelter allowance” means shelter expenses above \$786.50. Subtract \$786.50 from the community spouse’s shelter costs. If there is a remainder, add the remainder to \$2,621.67. (See 39.4.2)~~

~~Community spouse shelter costs include the community spouse’s expenses for:~~

- ~~i. Rent.~~
- ~~ii. Mortgage principal and interest.~~
- ~~iii. Taxes and insurance for principal place of residence. This includes renters insurance.~~
- ~~iv. Any required maintenance fee if the community spouse lives in a condominium or cooperative.~~
- ~~v. The standard utility allowance established under the FoodShare program:~~

<del>If Community Spouse pays:</del>	<del>Add</del>
<del>Heat and utilities</del>	<del>See 8.1.3 of the FoodShare Handbook for the standard utility allowances.</del>
<del>Utilities only</del>	<del>“</del>
<del>Telephone only</del>	<del>“</del>
<del>If the community spouse lives in a condominium or cooperative where the maintenance fee includes utility expenses, reduce the standard utility allowance by the amount of utility expenses included in the maintenance fee.</del>	

~~For **Home and Community-Based Waivers** cases, follow these rules to determine when to add the excess shelter cost to the community spouse income allocation:~~

- ~~• If the waiver person's community spouse lives with him/her, do not add the excess shelter cost to the income allocation.~~
- ~~• If the waiver person's community spouse does not live with him/her, add the excess shelter cost to the income allocation.~~

~~A court or fair hearing can increase the community spouse income allocation if it determines the spouse is not able to provide for his or her necessary and basic~~

maintenance needs with the amount allocated.

~~If a court or a fair hearing decision orders a larger Community Spouse Income Allocation, enter the court or fair hearing ordered amount on Line 1.~~

- ~~1. Enter on Line 2 the community spouse's monthly gross income. 2. The maximum allocated amount is the difference between the allowable community spouse income allocation and the community spouse's monthly gross income. Use the EBD income rules, but do not give earned income, unearned income, and work related deductions.~~
- ~~2. Do the math from Line 1 through Line 3. The result on Line 3 is the maximum amount of income the institutionalized spouse may allocate to his/her community spouse.~~

~~If the institutionalized spouse does not may choose to allocate less than the maximum amount, the amount s/he retains counts as income in determining the amount contributed to the patient liability.~~

### 18.6.3 Worksheet 7 Section B - - Family Member Income Allowance

### 18.6.3 Worksheet 7 Section B -- Family Member Income Allowance

- ~~1. Enter \$655.42 on Line 1 under the name of each dependent family member who lives with the community spouse.~~
- ~~2. Enter the gross monthly income of each dependent family member under his/her name. Use the EBD income rules, but do not give earned income, unearned income, and work related deductions.~~
- ~~3. Do the math from Line 1 through Line 3.~~
- ~~4. Add the Line 3 amounts together and enter the total on Line 4. Deduct the amount on Line 4 from the institutionalized spouse's income.~~

The institutionalized person can allocate up to \$646.25 per month to each dependent family member who lives with the community spouse.

The allocated amount is the difference between \$646.25 and the actual monthly income of the dependent family member.

### 18.6.4 Section C -- Cost of Care 18.7 Spousal Impoverishment Effective Date 18.8 Spousal Impoverishment Notices

This section was deleted.

This section was deleted and marked reserved.

After the institutionalized person has been determined MA eligible, **the worker must send the following manual notices** ~~are sent~~ to both spouses:

### 18.10 Dual Spousal Impoverishment Cases 20.1.1 Verification Definition

This section is new.

Verification is part of determining eligibility. To verify means to establish the accuracy of verbal or written statements made about a group's circumstances. ~~Documentation is a method by which you accomplish verification.~~

~~You will ask the questions needed to determine eligibility, but only need to verify mandatory and questionable items.~~

### 20.1.2 Documentation

Documentation is a method by which you accomplish verification. Case comments in CARES CWW provide documentation, including worker. ~~Your notes report what happened in regarding collateral contacts, viewing documents, home visits, etc. Include enough data to describe the nature and source of information if follow up is needed. There is no requirement to photocopy and file verification items.~~

### 20.1.4 Verification Rules

1. Avoid over-verification (requiring excessive pieces of evidence for any



one item or requesting verification that is not needed to determine eligibility). Do not require additional verification once the accuracy of a written or verbal statement has been established.

2. Do not verify information already verified unless there is reason to believe the information is fraudulent or differs from more recent information. If fraud is suspected, determine if a referral for fraud or for front-end verification should be made.
3. Do not exclusively require one particular type of verification when various types are adequate and available.
4. Verification need not be presented in person. Verification may be submitted by mail, fax, e-mail, or through another electronic device or through an authorized representative.
5. Do not target special groups or persons on the basis of race, religion, national origin or migrant status for special verification requirements.
6. Do not require the member to sign a release form (either blanket or specialized) when the member provides required verification.
7. Do not require verification of information that is not used to determine eligibility.

The member has primary responsibility for providing verification and resolving questionable information. However, the IM worker must use all available data exchanges to verify information rather than requiring the applicant to provide it.

Assist the member in obtaining verification if he or she requests help or has difficulty in obtaining it.

Use the best information available to process the application or change within the time limit and issue benefits when the following two conditions exist:

1. The applicant/member does not have the power to produce verification, and
2. Information is not obtainable timely even with your assistance.

Do not deny eligibility in this situation, but continue in your attempts to obtain verification. When you have received the verification, you may need to adjust or recover benefits based on the new information. Explain this to the applicant/member when requesting verification.

## 20.2 General Rules

This section was deleted and marked reserved.

### 20.3.2 Social Security Number

~~Social Security Numbers (SSNs) need to be furnished for household members requesting Medicaid, but are not required from non-applicants.~~

~~SSNs should be recorded in CARES if obtained voluntarily from the member, or if the information is available through other information sources (e.g. bank statement).~~

An applicant does not need to provide a document or social security card. He or she only needs to provide a number, which is verified through the CARES SSN validation process data exchange with Social Security.

If the SSN validation process returns a mismatch record, then the member must provide the social security card or another official government document with the SSN displayed. If an applicant does not yet have a SSN he or she must be

willing to apply for one.

~~Inform the member if the SSN validation process suggests that another individual is using the same SSN. Advise the member to contact the Social Security Administration. The member may request Social Security Administration to conduct an investigation. Do not provide the member with any information that would identify the individual who is using the member's SSN.~~

~~If the Social Security Administration finds that the SSN has been used fraudulently it may:~~

- ~~1. Recommend further action be taken, and/or~~
- ~~2. Provide the member with the information on the fraudulent action so that the member may pursue action through the legal system.~~

Verify the SSN only once.

### 20.3.2.1 Emergency Services

This section was deleted.

### 20.3.3 Alien Status

#### 20.3.3 Alien Immigration Status

A member who indicates he or she is not a citizen must provide an official government document that lists his or her alien registration number. Verify the individual's alien immigration status by using the Systematic Alien Verification for Entitlement (SAVE) system. Women applying for BCPP (See the BadgerCare Plus Handbook) and persons applying for EMA who do not provide proof of alien/immigration status can still qualify for those benefits.

An alien immigrant that presents documentation of his or her alien immigration status and meets all other eligibility criteria is presumptively eligible. Begin benefits and determine, through SAVE, that he or she is in a satisfactory immigration status.

~~Verification of alien immigration status is not needed if the person already provided proof when s/he applied for an SSN.~~

Do not re-verify alien immigration status unless the member reports a change in citizenship or alien immigration status.

### 20.3.4 Disability

~~For any person who wants to be considered disabled for Medicaid, including the Medicaid Purchase Plan (MAPP), DDB must complete a disability determination (5.3 Disability Application Process). There is no need to re-verify after the initial determination. Disability reviews are scheduled by DDB and they will send any new information to you. Receipt of SSI or OASDI benefits is verification of disability. Disability and blindness determinations are made by the Disability Determination Bureau (DDB) in the Department of Health Services. Items that can be used to verify disability status include, but are not limited to:~~

- ~~• Proof of SSI or other SS Disability payment,~~
- ~~• SOLQ-I,~~
- ~~• Award letter or verbal statement from SSA, or~~
- ~~• Proof of MADA approval, including presumptive disability~~

### 20.3.5 Assets

Verification of countable assets is mandatory. ~~for members requesting the following Medicaid subprograms:~~

- ~~1. EBD (categorically and medically needy).~~
- ~~2. EBD Special Status (503, Disabled Adult Child, Widow/widowers).~~
- ~~3. Medicaid Purchase Plan ( MAPP).~~
- ~~4. Institutional Medicaid.~~
- ~~5. Community Waivers, including PACE and Partnership.~~

- ~~6. Family Care.~~
- ~~7. Medicare Premium Assistance Programs.~~

~~Also verify assets of community spouses for community waivers, institutional Medicaid and Family Care non-Medicaid. If reported assets exceed the asset limit, do not pursue verification.~~

~~Do not verify exempt assets.~~

**Example 1:** An EBD Medicaid member's burial plot is not counted in determining his or her Medicaid eligibility. Do not require verification of its value in determining the group's Medicaid eligibility.

**If reported assets exceed the asset limit, do not pursue verification.**

Do not verify cash on hand.

### 20.7.1.1 Application

Do not deny eligibility for failure to provide the required verification until the later of:

- 1. The ~~44th~~ 10th day after requesting verification, or
- 2. The ~~34st~~ 30th day after the application filing date.

### 20.7.1.2 Eligibility Reviews

Do not deny the group's eligibility for failure to provide the required verification until the ~~44th-10th~~ day after requesting verification ~~or the end of the review month, whichever is later.~~

**Example 1:** Was updated.

**Example 2:** Was updated.

### 20.7.1.3 Late Renewals

This section is new.

### 20.10 Verification Resources

Workers can access many sources of information through data exchanges such as income, Social Security (SS), Unemployment Compensation (UC), and birth records. See the ~~CARES Guide, Chapter 10~~ Process Help Handbook Chapter 44 for instructions. See the IM Manual, Ch. 1, Part D, 4.0.0 for instructions on the ~~SAVE (Alien Verification) System.~~ For instructions on using the SAVE (Systematic Alien Verification for Entitlements) system to verify immigration status, see Process Help Chapter 82.

### 21.2 Full-Benefit Medicaid

Those subprograms of Medicaid that are eligible to receive full-benefit Medicaid services include:

- 1. Katie Beckett Medicaid (25.6 Katie Beckett).
- 2. Home and Community-Based Waivers Long Term Care (28.1 HCBWLTC Introduction).
- 3. Institutional Medicaid (27.1 Institutions).
- 4. ~~BadgerCare Plus BC+ and BC+ Extensions Standard Plan~~ (see the BadgerCare Plus Handbook)
- 5. EBD Medicaid (cat or med needy).
- ~~6. BC+ Continuously Eligible Newborn (CEN) (See the BC+ Handbook)~~
- 7. Foster Care Medicaid (see the BadgerCare Plus Handbook)
- 8. Adoption Assistance Medicaid
- 9. Medicaid Met Deductibles (24.2 Medicaid Deductible Introduction)
- 10. Medicaid Purchase Plan (MAPP) (26.1 MAPP)
- 11. Wisconsin Well Woman Medicaid (see the BadgerCare Plus Handbook)
- 12. SSI-Medicaid

### 21.3 Limited Benefit Medicaid

Limited benefit subprograms of Medicaid includes:

- 1. ~~Medicare Buy-In~~ Savings Programs (32.1 Medicare Beneficiaries)

- Introduction).
- 2. Emergency Services for Non-Qualifying Aliens
- 3. Tuberculosis-Related Medicaid (25.7 Tuberculosis).
- 4. Presumptively Eligible Pregnant Women (See the BadgerCare Handbook)
- 5. ~~Family Care Non-MA (See the BC+ Handbook)~~
- 6. SeniorCare (33.1 SeniorCare Introduction)
- 7. Family Planning ~~Waiver~~ **Only Services** (See the BadgerCare Plus Handbook)
- 8. ~~BadgerCare Plus Benchmark Plan~~
- 9. ~~BadgerCare Plus Core Plan~~

**21.4.1 Covered Services Introduction**

A covered service is any medical service that Medicaid will pay for an eligible member, if billed. The Division of Health Care Access and Accountability (DHCAA) ~~certifies~~ **enrolls** qualified health care providers and reimburses them for providing Medicaid covered services to eligible Medicaid members. Members may receive Medicaid services only from ~~certified~~ **enrolled** providers, except in medical emergencies. Medicaid reimburses emergency medical services necessary to prevent the death or serious impairment of the health of a member even when provided by a non-certified provider.

**21.7.2 Appeals**

This section was deleted.

**22.2.1.1 Recoverable Overpayments**

**Examples 2-4:** Were updated.

**2. Fraud**

~~Fraud is also known as Intentional Program Violation (IPV).~~

Fraud exists when an applicant, recipient, or any other person responsible for giving information on the member's behalf does any of the following:

- 1. Intentionally makes or causes to be made a false statement or representation of fact in an application for a benefit or payment.
- 2. Intentionally makes or causes to be made a false statement or representation of a fact for use in determining rights to benefits or payments.
- 3. Having knowledge of an event affecting initial or continued right to a benefit or payment and intentionally failing to disclose such event.
- 4. Having made application to receive a benefit or payment and intentionally uses any or all of the benefit or payment for something other than the intended use and benefit of such persons listed on the application.

~~If there is a suspicion that fraud has occurred, see 22.2.4 Refer to District Attorney for information about referral to the District Attorney (DA).~~

**3. Member Loss of an Appeal**

~~Benefits a member receives due only to a fair hearing order can be recovered if the member loses the appeal.~~

A member may choose to continue to receive benefits pending an appeal decision. If the appeal decision is that the member was ineligible, the benefits received while awaiting the decision can be recovered. If an appeal results in an increased patient liability, cost share, or premium, recover the difference between the initial amount and the new amount.

**22.2.1.2 Non-Recoverable Overpayments**

- 1. The member reported the change timely, but **you the worker** could not close the case or reduce the benefit due to the 10-day notice requirement.

**Example 5:** Was updated.

### 22.2.2.1 Overpayment Period

If the overpayment is a result of a misstatement or omission of fact during an initial Medicaid application, determine the period for which the benefits were determined incorrectly and determine the appropriate overpayment amount (22.2.2.2 Overpayment Amount).

The ineligible period should begin with the application month.

#### Failure to Report

For ineligible cases, if the overpayment is a result of failure to report a change, calculate the date the change should have been reported and which month the case would have closed or been adversely affected if the change had been reported timely.

#### Fraud/IPV

For ineligible cases, if the overpayment was the result of fraud, determine the date the fraudulent act occurred. The period of ineligibility should begin the date the case would have closed or been adversely affected allowing for proper notice. If an overpayment exists, but the case is still being investigated for fraud, establish the claim so collection can begin promptly. Prosecution should not delay recovery of a claim.

### 22.3 Interagency Case Transfer

A case transfer occurs when the primary person, receiving benefits from a county or tribal Income Maintenance agency for a particular month, applies for aid from another Income Maintenance agency for the same or next month. The primary person must be a member of a currently open Medicaid BadgerCare Plus, Child Care, EBD Medicaid, FoodShare, or W2 Assistance Group or one that has been closed for less than a calendar month.

The agency to which the member reports the move must collect information about the changes, for example, the new address. If the agency does not have sufficient information about the changed circumstances, it must request information from the member, according to the Medicaid verification policy in Chapter 20 (20.1 Verification Introduction).

CARES will automatically set a review date for one month after the transfer. Correct the review date in CARES, so that it is the end of certification period. Run eligibility in CARES.

The renewal date will remain the same after case transfer.

### 24.1 SSI Related Medicaid Introduction

SSI related Medicaid is the original, basic Medicaid program for individuals who are elderly, blind, or disabled (EBD). SSI related individuals must meet all appropriate Medicaid nonfinancial eligibility requirements. SSI related Medicaid has the lowest income and asset limits (link to appropriate reference table) of all EBD Medicaid programs/categories. It has two income limits which are referred to as the Categorically Needy limit and the Medically needy limit.

When doing manual EBD income eligibility determinations, use the EBD Related Determination worksheet. Apply Allow the following income disregards to the fiscal group's income in the order in which they appear on the worksheet below to determine the countable net income.

- The 65 & ½ earned income disregard,
- Special exempt income (15.7.2 Special Exempt Income),
- and \$20.00 SSI general income disregard are applied to the fiscal group's income.

They are not applied separately to each individual fiscal group member's income. Special Exempt Income is also an allowable income deduction and a list of Special Exempt Income types can be found in chapter 15.7.2 Special Exempt

## Income

The EBD categorically needy income limit consists of two components; an income amount plus a shelter/ utility amount. The EBD fiscal group's total actual shelter, fuel, and utility expenses are compared to a maximum allowance that is found in chapter 39.4 Elderly, Blind, and Disabled (EBD) Assets & Income Tables. The actual shelter/utility costs or the shelter/utility maximum, whichever is less, is added to the categorically needy income amount (chapter 39.4), and this total becomes the EBD categorically needy income limit. A fiscal group with countable net income that does not exceed the categorically needy income limit passes the Medicaid EBD categorically needy income test.

### 24.3 Deductible Period

**Example 7:** Mansour applies for Medicaid in July. He is found to be eligible. He had medical bills in April and May. He also had excess income in April and May. He wants a Medicaid deductible period that includes April and May. Unfortunately, he was the recipient of a \$5,000 cash gift on June 29. It was several days before he was able to spend it on groceries and other legitimate purchases. Mansour will not be able to include April or May in the deductible period because on June 30, had he applied, he would have been determined ineligible.

An individual can establish a new deductible period at any time if they file an application for Medicaid. This includes situations where someone has already established a deductible period, hasn't yet met the deductible, and wishes to establish a new deductible period. ~~This will usually occur as a result of a recent decrease in their monthly income.~~

**Example 8:** Was updated.

### 24.5.3 Deductible Examples

**Examples 1 and 4:** Were updated.

### 24.7 Meeting the Deductible

If the group ~~does~~ has not ~~meet~~ met the deductible within the deductible period, it can choose to begin a new deductible period starting with a later month in the current deductible period without a new application. (24.3 Deductible Period)

**Example 1:** Is new.

### 24.7.1 Countable Costs

**Examples 2- 5, 7- 9, 11, and 13:** Were updated.

### 24.7.2 Non-countable Costs

**Example 14:** ~~The court orders a health insurer or other third party to pay for medical services.~~

### 24.11 Deductibles and Inter-Agency Transfers

This section was deleted and marked reserved.

### 24.14 Medicaid Deductible, Cost of Care

This section was deleted and marked reserved.

### 25.0 Special Status Medicaid

When you are calculating a Medicaid deductible, a patient liability amount, a community waivers cost share or a community waivers spenddown for a "503" AG, a DAC Disabled Adult Child, or a widow or widower, use the total income before any COLAs or OASDI ( DAC or widow/widower) increases were subtracted.

### 25.1.1 503 Introduction

Federal law requires that the IM Agency provide Medicaid ( Medicaid ) eligibility to any applicant for whom the following two conditions exist:

1. He or she is receiving Old Age, Survivors, Health and Disability Insurance ( OASDI ) Benefits
2. He or she was receiving Supplemental Security Income ( SSI ) concurrently with OASDI but became ineligible for SSI.
3. Total countable income, excluding the 503 disregarded income, is within the program limits.

**Example 1:** Was deleted.

**25.1.2 Identifying a "503" AG**

SSI-E AGs are SSI recipients who receive a higher state supplement than regular SSI. Persons who receive SSI-E payments must live:

- a. In substitute care of eight or fewer beds, or
- b. At home and need more than 40 hours a month of primary long term support services.

**25.8.2 Simplified Application**

~~Use the following simplified application procedure to determine Medicaid eligibility for migrant workers and their families who have come into Wisconsin and who:~~ Migrant workers and their families can have their eligibility for Medicaid determined using a simplified application process if they:

1. Have current Medicaid eligibility from another state. ("Current Medicaid eligibility" means eligibility that includes at least months one and two of the application process.) Or had Medicaid eligibility in Wisconsin that was certified through months one and two of the application and that ended only because the family left Wisconsin.
2. And have the same members or fewer in the case as there were when the case had eligibility in the other state.

**Examples 1-2:** Were updated.

**25.8.4 Reviews**

**25.8.4 Reviews Renewal Dates**

**26.3.1 MAPP Nonfinancial Requirements Introduction**

Clients must meet all of the following:

1. Meet general MA non-financial requirements (4.1 Who is Nonfinancially Eligible for Medicaid),
2. Be at least 18-years-old, (there is no maximum age limit).
3. Be determined disabled, presumptively disabled, or MAPP disabled by the Disability Determination Bureau ( DDB ) (5.2 Determination of Disability and 5.10 MAPP ), regardless of age, and
4. Be working in a paid position or participating in a Health and Employment Counseling ( HEC ) program (26.3.4 Work Requirement Exemption).

**26.3.9.1 Special Managed Care Programs**

This section was deleted.

**26.4.1.1 Independence Accounts**

**Example 2:** Was updated.

**26.4.2 Income**

~~9. Subtract the historical COLA Disregard Amount (39.6 COLA) for MAPP members who are also determined to be a 503 (25.1 503 Eligibility) or Disabled Adult Child (DAC) (25.2 DAC). Do not allow the historical COLA disregard amount (39.6 COLA) in the premium calculation for MAPP members who are also determined to be a 503 or a DAC.~~

**26.5.1 Calculation**

1. From gross monthly unearned income, subtract the following:
  - a. Special Exempt Income (15.7.2 Special Exempt Income).
  - b. Standard Living Allowance (39.4.2 EBD Deductions and Allowances).
  - c. Impairment Related Work Expenses (IRWE). For MAPP , use only anticipated incurred expenses, past medical expenses are not allowed. (15.7.4 Impairment Related Work Expenses (IRWE)).
  - d. Medical Remedial Expenses (MRE). For MAPP, use only anticipated incurred expenses, past medical expenses are not allowed. (15.7.3 Medical/Remedial Expenses (MRE))
  - e. Current COLA Disregard from January 1st through the date the FPL is effective in CARES for that year.

- f. 503, DAC, widow/widower disregards allowed in eligibility determinations can not be allowed in premium calculations.

**26.5.1.1 Penalty**

**26.5.1.1 Independence Account Penalty**

**26.5.2 Initial Premium**

Complete the premium Medicaid Purchase Plan Premium Information/Payment (F-00332) and the Medicaid Purchase Plan ( MAPP ) Recipient/Premium Information (F-10122) for benefit months prior to January 2002. For benefit months beginning January 2002, CARES will send premium information to MMIS, but the IM worker continues to be responsible for collecting the premium due for initial month(s) and any backdated months for which the member elects coverage. Complete the premium Medicaid Purchase Plan Premium Information/Payment (F-00332) and record receipt of the premium payment in CARES.

**26.5.5.2 Between Adverse Action of the Benefit Month and the Last Day of Benefit Month**

If the member pays between adverse action of the benefit month and the last day of the benefit month, he or she can reopen. Run SFED eligibility with dates and confirm.

**26.5.7 Opting Out**

**Example 7:** Was updated.

**27.7.3 Managed Care Programs**

This section was deleted.

**27.7.4.1 Death**

**27.7.4.1 27.7.3.1 Death**

If the patient liability amount in the month of death is greater than the nursing home's cost of care for that month send a completed F-10110 ( formerly DES 3070 ) form to:

**27.7.7 Personal Needs Allowance**

**27.7.6 27.7.6 Personal Needs Allowance**

Deduct the personal needs allowance (39.4.2 EBD Deductions and Allowances) for all institutionalized members in both the eligibility test and the patient liability calculation.

An institutionalized person's personal needs allowance may accumulate to where he or she may lose eligibility due to excess assets. To prevent this, he or she can spend money on personal needs or make a refund to Medicaid. See Voluntary Recovery 22.1.10.

**27.7.8.1 Introduction**

**27.7.8.1 27.7.7.1 Introduction**

**Examples 1-3:** Were updated.

**27.7.8.2 Disallowed Expenses**

**27.7.8.2 27.7.7.2 Disallowed Expenses**

**Examples 4-6:** Were updated.

**CARES Process**

Until changes in CARES can be made to accommodate this policy and process change for institutional cases, enter the allowable medical and remedial expenses as a court ordered support payment on the Support Obligations/Payments page in CWW. Be sure to document detailed information about the expense and cost share calculations in case comments.

Remember, Medical/remedial expenses for group B waiver cases are still entered on AFME the Medical Expense page. There are no CARES processing changes/overrides required for community waiver/FC cases.

**28.2 Home and Community-Medicaid Eligibility Handbook Release 15-01**

All waiver clients applicants being discharged from a nursing home, and persons



**Based Waivers Long Term Care (HCBWLTC) Application**

in non-institutional living arrangements must complete an a Medicaid application form unless they are already receiving full-benefit Medicaid (21.2 Full Benefit Medicaid). Waiver applicants receive level of care assessment and case planning services from the ADRC. The ADRC will submit the waiver program start date to the income maintenance agency along with the waiver functional eligibility determination.

**28.2.1 Case Manager**

This section was deleted.

**28.2.3 Minors**

This section was deleted.

**28.2.4 Tentative Approval**

**~~28.2.4~~ 28.2.2 Tentative Approval**

Persons who apply for waivers other than PACE and WPP may receive tentative waiver approval from the Division of Disability and Elder Services (DDES) while their Medicaid eligibility is being determined.

The tentative approval process begins when the case care manager refers the waiver applicant to the IM Agency with accompanying information about the type of waiver, waiver begin date, medical/remedial expenses, and Medicaid card coverable expenses. Enter the case into CARES and send the case manager the CARES screen prints showing the eligibility determination, cost share amount, family member allowance, and spenddown amount.

If it is a spousal impoverishment case, also send along the CARES screen prints or manual worksheets which show the spousal and family member income allocations. Complete a manual Spousal Impoverishment Income Allocation Worksheet (40.1 WKST 07) for any spousal impoverishment case that is Group C eligible. Send a copy of this worksheet or a modified copy of ECSC to the case manager. Send a manual notice to the client with the corrected cost share amount, if the cost share calculated on WKST 07 differs from the amount calculated in CARES.

The case manager then submits the screen prints and the service plan packet to DDES for tentative approval. Until the case manager informs you the case has been tentatively approved, keep it in pending status in CARES. After tentative approval is received, confirm the case on CARES. This will certify the person for Medicaid.

**28.7 Home and Community-Based Waivers Long Term Care (HCBWLTC) Effective Date**

The begin date of waiver eligibility is the date given in the approval letter sent by the Division of Disability and Elder Services (DDES) waiver staff to the county case manager/social worker program start date submitted to the IM agency by the ADRC.

**28.8.1 HCBWLTC Instructions Introduction**

Eligibility for Group A, B, and C Community Waivers cases are determined in CARES. Group A Katie Beckett cases are processed manually outside of CARES.

Care managers will determine and certify community waiver eligibility for children already eligible for Medicaid through the Katie Beckett program. In addition, care managers will determine if divestment of the child's assets has taken place.

If so, a referral will be made to IM workers to determine manually if a penalty period exists. If a penalty period exists, the IM worker will notify the care manager, and the care manager will notify the applicant.

Katie Beckett waiver cases will now be considered "Group A". The Katie Beckett medical status code will be retained. Because of the small number of these cases, the certification process will not be automated in CARES. Certification will be processed manually by care managers and Katie Beckett staff.

~~Complete the Waiver Eligibility and Cost Sharing Worksheet (F-20919) when an institutionalized member is going to be discharged, and enter the Community Waivers program.~~

~~When CARES screens are unavailable, use simulation or complete the DDE-919 as follows:~~

- ~~1. Fill out the identifying information at the top. The Medicaid eligibility date is the date of most recent Medicaid eligibility.~~
- ~~2. Fill out the financial information in Section I, Lines 1-4. When you have determined that the person is financially eligible, set the effective begin date of eligibility (See 28.7 HCBLTC Effective Date).~~

~~Read the descriptions of Groups A, B, and C below. After deciding which group the person is in, check the appropriate box in Section I. A person cannot be in more than one group at the same time.~~

### 28.8.3 Group B

Group B members are defined as those not in Group A, but who have gross income at or below the nursing home institutions categorically needy income limit. (See 39.4 EBD Assets and Income Tables) Calculate a cost share based on the member's income and allowable deductions. **Count only the income of each individual when you calculate that individual's cost share.**

~~Put a check before Group B in Section I. Then complete Sections III and V on the worksheet. Count only the income of each individual when you calculate that individual's cost share.~~

#### 28.8.3.4 Health Insurance

**Example 8:** Was updated.

#### 28.8.3.5 Medical/Remedial Expenses

Obtain the dollar amount for medical and remedial expenses (~~Line 10~~) from the **case care** manager. See 15.7.3 Medical/Remedial Expenses (MRE).

**Note:** **Case Care** Managers should refer to the limitations associated with allowable medical/remedial expenses that are described in 27.7.8 Medical/Remedial Expenses and Payments for Non-Covered Services.

#### 28.8.3.6 Cost Share Amount

The waiver cost share amount (~~Line 12~~) is the monthly amount he or she must pay toward the cost of his or her waiver services.

Institutionalized Pace/Partnership or Family Care **members** pay their cost share to the Managed Care Program instead of the institution.

### 28.8.4 Group C

Persons in Group C meet the medically needy income test for waiver members.

~~Put a check before Group C in Section I. Complete Sections IV and V.~~

Most Group C members have a monthly spenddown. They must meet the spenddown each month to remain eligible. The **case care** manager monitors the monthly spenddown.

### 28.10 Home and Community-Based Waivers Long Term Care (HCBWLTC) Review

Review financial eligibility annually. The **case care** manager reviews level of care eligibility annually. Do not discontinue eligibility if the **case care** manager has not yet made the level of care review.

The **case care** manager informs the IM Agency if the person is no longer level of care eligible. Notify the **case care** manager if the person is no longer Medicaid eligible.

### 28.11 Home and Community-Based Waivers Long Term Care (HCBWLTC) Community

When a community waivers person and his or her community spouse are both applying for Medicaid, they are one case, but separate AGs. Enter them in CARES on the same application. ~~Only one of the spouse's signature is needed~~

**Spouse's Medicaid Application**

on the application.

**29.0 Family Care Long Term Care (FCLTC)**

This chapter was deleted and marked reserved.

**30.0 Partnership Long Term Care**

This chapter was deleted and marked reserved.

**31.0 PACE (Program of All-Inclusive Care for the Elderly)**

This chapter was deleted and marked reserved.

**32.1.3 MSP Benefits**

1. QMB Medicaid pays Medicare Part A & B premiums and Medicare deductibles, copays, and coinsurance.

**32.1.5 Part B Enrollment Via The MSP Buy-In Program**

**Example 1:** Was updated.

**32.2.2 Entitled to Medicare**

**Examples 1-3:** Were updated

**32.7.1.1 QMB Applications**

**Example 1:** Was updated.

**32.7.1.2 QMB Recertifications**

**Example 2:** Was updated.

**37.0 IRIS**

This chapter was deleted and marked reserved.

**38.0 Reserved**

**38.0 Reserved Community Long-Term Care (non-institutional Medicaid)**

This chapter is new.

**39.4.2 EBD Deductions and Allowances**

	<b>Description</b>	<b>Amount</b>
6	MAPP Standard Living Allowance ( SLA ) SLA = SSI + State Supplement + \$20	<del>\$824.00</del> \$836.00

**39.5 Federal Poverty Level (FPL) Table**

The table was updated for FPL income limits effective February 1, 2015.