Elder and Disability Benefit Specialist Programs

ADRC and Aging Operations Manual

I. Introduction

Wisconsin's elder benefit specialists (EBS) and disability benefit specialists (DBS) follow similar service models and share policy and process guidelines for specific topics. This chapter provides guidance on administering policy and process for those topics.

For more detailed information about EBS and DBS program policies and procedures, please refer to the ADRC/Aging Operations Manual.

Questions should be directed to the elder benefit specialist program manager and/or disability benefit specialist program manager in the Bureau of Aging and Disability Resources (BADR).

II. Responding to Requests for Benefit Specialist Services

A. Customer walk-ins

1. Customers who request assistance in person at an agency without an appointment are referred to as "walk-ins." Agencies need to establish a process for assisting walk-ins. If benefit specialist assistance is not provided in the moment, the benefit specialist is expected to follow up with the customer. Benefit specialists may choose to prioritize follow-up using the triage system described in the Caseload Management Guidelines section of this chapter.
2. It is important to maintain balance and boundary between working directly with clients and having sufficient time available to complete other job duties. With the continually growing demand for services, maintaining the balance between appointments, and dedicated non-appointment worktime is essential to help support a healthy workload and prevent burnout. It is the expectation of the state that this type of workload balance exists for benefit specialists.

   The agency's process for assisting walk-ins must account for these considerations:

a. Mandatory trainings take priority over walk-ins.

b. Generally, benefit specialists should not be expected to interrupt a scheduled appointment to assist walk-ins.

c. Agencies may schedule dedicated time for benefit specialists to assist walk-ins. If a benefit specialist schedules an appointment during time dedicated to walk-ins, the customer should be made aware that their appointment may be interrupted.

d. Benefit specialists should have time on their calendars that is not dedicated to appointments or seeing walk-in customers so that they can attend to other job duties, such as addressing urgent customers' benefit issues as they come up, keeping current on program updates, and completing data entry.

e. Consult with the EBS and/or DBS program manager if additional clarification is needed.

B. Responding to referrals

1. Benefit specialist programs provide voluntary services. Benefit specialists help customers who willingly request and agree to accept benefit counseling services. Note: an exception may exist if the customer has an alternate legal decision-maker. See the EBS and DBS Operations Manual chapters and for additional guidance on working with alternate decision-makers.
2. Benefit specialists may receive requests for assistance directly from customers, internal referrals (for example, from aging and disability resource center specialists), or external referrals (for example, medical providers or family members).
3. Benefit specialists must not reach out to an individual unless it is known that the customer is aware that the referral was made and consents to contact from the benefit specialist. Best practice is to encourage the person making the referral to call the agency with the customer present.
4. Benefit specialists cannot share information about the customer or the outcome of a referral without a customer's informed consent.

C. Cold calls

1. Benefit specialists will not engage in cold calls. A cold call is defined as a call or contact with an individual who has not had prior contact with the benefit specialist and is not aware that a referral has been made to the benefit specialist.
2. Posting information (for example on websites, social media, or public bulletin boards) or distributing outreach materials within the community (for example, direct mail) is not considered a cold call.

III. Caseload Management Guidelines for Benefit Specialist Services

A. Introduction

The following guidelines are designed to assist aging and disability resource centers (ADRCs), county aging units, Tribes, and other local agencies that employ benefit specialists in generating strategies to provide prompt service to customers while making the best use of limited staff and resources.

B. Caseload management strategies

Benefit specialists are sometimes challenged by a high demand for services, prompting managers to wonder whether it is appropriate to cut back on services, establish a wait list, or implement other measures to control caseloads. The best approach to caseload management for benefit specialists begins with a careful assessment of the current caseload and incorporates a range of tactics—call triage, trained volunteers and staff coordination, public outreach, and other time-saving techniques—to ensure that core program services are available to community members who need them.

Any caseload management strategy to address the demand for benefit specialist services must take into consideration the workload of all staff at the agency. The local agency supervisor must take the lead role in developing and implementing strategies for managing a benefit specialist's caseload. Benefit specialists' assigned attorneys can provide valuable input during the assessment of the benefit specialist's caseload and the development of strategies that will best serve customers. Decisions to restrict or eliminate services that fall within the traditional scope of benefit specialist services must be reviewed with the DHS EBS and/or DBS program manager prior to implementation.

1. **Assess current caseload.**
    a. Any caseload management strategy requires an initial assessment and ongoing monitoring of the caseload. A benefit specialist's **caseload** is defined as the number of intakes open at any given time.
    b. Benefit specialists open an intake after agreeing to assist a customer in resolving one or more benefit issues. The intake is closed when all benefit issues associated with the intake are resolved. The length of time that an intake remains open varies depending upon the nature of the customer's benefit issue(s). Some intakes are closed in one or two days; others remain open for several weeks or months, while others remain open for a year or more. Some open intakes are relatively inactive while a customer is awaiting a decision.
    c. The optimal caseload for a benefit specialist will vary based on the following factors:
        i. **Availability and experience level:** The number of intakes regarded as manageable depends on a benefit specialist's full-time equivalency (FTE) status and their level of experience.
        ii. **Type of issues:** Intakes can be categorized according to the issues involved. When an increase in intakes is clearly related to a specific issue, the caseload management strategy should take this into account. For example, the benefit specialist might observe a high percentage of intakes in January related to Medicare Part D enrollment errors. Because Medicare Part D enrollment errors are generally seasonal and resolved in a matter of weeks, a short-term strategy may be implemented to handle the increase in demand.
        iii. **Complexity of issues:** Some intakes involve complex issues that require extensive research or writing, while other intakes are simple and straightforward. For example, appeals and hearing requests are time-consuming, while questions about Medicare coverage of home health care may be relatively easy to address.
        iv. **Status of disability determinations:** The majority of DBS intakes involve disability determinations. During preparation for an initial application or an appeal, these intakes are time-consuming. By contrast, when an application or appeal decision is pending, the intake remains open but requires little action. When considering whether a DBS caseload is manageable, it is important to consider the proportion and status of open intakes that involve disability determinations.
        v. **Information-only contacts:** In addition to open intakes, a caseload management strategy should consider the number and nature of brief information-only contacts that a benefit specialist handles. In some agencies,

information-only services represent a significant portion of the benefit specialist's workload. The number and nature of a benefit specialist's information-only contacts will vary depending upon the extent to which information and assistance (I&A) specialists are able to answer basic questions about public benefits and what is defined as an appropriate benefit specialist referral.

vi. **Level of assistance provided**: Benefit specialists may adjust their level of involvement in assisting a customer depending upon the customer's ability to perform tasks independently and the customer's system of supports (for example, legal guardian, case manager). Some customers need basic information and advice; others need help filling out forms and gathering documentation; and some require direct representation.

d. It is best to monitor and assess a benefit specialist's caseload on a routine basis to detect and respond to caseload management problems quickly. By monitoring the caseload, supervisors will be in a better position to respond when a benefit specialist is absent for an extended period or when a benefit specialist position becomes vacant. Caseload assessment will be easier if the benefit specialist maintains current and complete customer records in the reporting and case management system. If data is kept current, the benefit specialist should be able to provide a report to their local supervisor about their caseload, including the number of open intakes and the type of benefit issues on a quarterly basis, or as often as needed.

e. Since attorneys are responsible for substantive assistance to the benefit specialist, they are often the first to learn about caseload management problems. The assigned attorney should alert the local agency supervisor to any such problems. When a benefit specialist's caseload is too large, an agency must allow for a gradual decrease in the existing caseload through a combination of intake closing and prioritization. Together, the local supervisor and the assigned attorney can work with benefit specialists to develop an approach that includes both local organizational adjustments and close monitoring of customer services.

2. **Limit scope of services.**

Benefit specialists help customers with a wide variety of public and private benefits issues. At times of high demand, it may be helpful to examine the types of issues your benefit specialist assists with to ensure the focus remains on core program services. Core services for the DBS program are outlined in the DBS Program Services Scope (password required). The priorities of the EBS program are defined in the Elder Benefit Specialist Program ADRC Operations

Manual (P-03062-06). Services that are identified as lower priority or "discretionary," such as assistance in filling out low-income tax credit forms, should be eliminated first. None of the core benefit specialist program services, such as Medicare Part D counseling and help with Social Security overpayments, may be eliminated without prior approval from the state EBS and/or DBS program manager.

3. **Limit level of involvement.**

   If the caseload becomes unmanageable, a benefit specialist may need to exercise greater discretion in their level of involvement with customer issues. If a customer is capable, they should retain the primary responsibility for completing paperwork, gathering documentation, and meeting deadlines. The decision to act as the customer's appointed representative for the purposes of a public benefits application must not be taken lightly, as this responsibility may increase the time it takes for a benefit specialist to develop and resolve a benefit issue.

4. **Develop a call triage system for handling referrals.**

   a. If a benefit specialist is struggling with an unmanageable caseload, it is important to examine the current referral system. The local agency should have a system for filtering calls before they are referred to a benefit specialist. Generally, a customer should not be directly transferred to the benefit specialist prior to a conversation with the receptionist or the I&A specialist unless they are a current customer of the benefit specialist or ask specifically for the benefit specialist. The benefit specialist's direct phone number should not be provided to the general public.

   b. A call triage system may be an effective way to help the benefit specialist handle a high volume of requests for service. In a call triage system, the receptionist or I&A specialist attempts to determine the urgency of a particular customer's need for benefit specialist services. After gathering information from the customer about their immediate needs, the receptionist or I&A specialist rates the urgency of the customer's needs as Level 1, 2 or 3, according to the criteria outlined in section II-D: Call triage system model. This rating system is used by the benefit specialist in prioritizing return calls to the customers who are referred to them.

   c. The estimated call-back time for each level of urgency should be periodically reviewed and adjusted to accurately reflect the amount of time it will take for a benefit specialist to contact customers.

5. **Consider implementing a wait list.**

a. When the demand for benefit specialist services has become unmanageable, a wait list may be an effective strategy to ensure that a benefit specialist can continue to provide high quality services. However, the decision to implement a wait list must be carefully considered. This strategy should not be implemented until other caseload management strategies have been explored. If possible, a wait list should be maintained on a temporary or seasonal basis only. Prior to implementing a wait list, local agency staff are encouraged to review their wait list plan with the benefit specialist's assigned attorneys, as well as the state EBS and/or DBS program manager.

b. Some instances for which a wait list may be appropriate include:

   i. During the annual Medicare Open Enrollment Period.

   ii. Upon the introduction of a new benefit program.

   iii. When a benefit specialist is on vacation or medical leave for an extended period.

   iv. During an extended benefit specialist position vacancy.

   v. During hiring and training of a new benefit specialist.

   vi. For temporary relief while other solutions are being explored.

c. The basic guidelines and principles for a benefit specialist services wait list are:

   i. A call triaging system must be in place to ensure that customers with urgent needs are served within one business day. Only customers whose needs are not identified as urgent should be placed on a wait list.

   ii. Agency staff should record the date of the initial contact and any subsequent contacts.

   iii. Customers placed on a wait list should be notified that they are being placed on a wait list and offered other appropriate agency services.

   iv. The benefit specialist will respond to customers on the wait list on a "first come, first served" basis, contacting those with Level 2 concerns prior to those with Level 3 concerns.

   v. For intakes involving public benefits denials, agency staff should err on the side of giving the customer a high priority.

vi. See section II-D: Call triage system model for an example of how to implement a wait list.

6. **Train volunteers and other staff to assist with benefits-related issues.**

   See the Guidelines for Benefit Specialist Program Assistant Positions.

7. **Identify and address commonly asked questions through public outreach.**

   a. When it is clear there is a widespread need for basic information about a particular benefit program or issue, the benefit specialist may save time by disseminating information through public workshops, newsletters, written publications, social media, or an agency website. Reviewing the number and nature of information-only contacts and the number of intakes in which advice or brief service were provided may help to identify the target audience and topics for outreach.

   b. Public outreach to customers and community partners on topics, such as the online disability application process or use of the Medicare Plan Finder tool, can reduce the need for individualized counseling from a benefit specialist. A presentation to community partners that clarifies the scope of benefit counseling services may help reduce the number of inappropriate referrals. Benefit specialists are encouraged to consult with their assigned attorneys in the development of presentation materials because the attorneys are often able to assist in locating existing resources or developing something new to meet an identified need.

8. **Prioritize data entry.**

   Prioritize data entry to ensure that time-sensitive information is captured before lower priority information.

   a. Time-sensitive, high priority tasks are:

      i. Recording activities in the 100% Time and Task report.

      ii. For disability benefit specialists, entering activities such as filing dates and hearing dates for disability determination intakes.

      iii. Correcting demographic data errors required for federal reporting.

   b. Lower priority tasks are:

      i. Correcting errors regarding monetary impact

ii. Entering SHIP Media Outreach data, such as articles and email blasts

C. Technical assistance for case escalation

For case escalation guidelines, see the ADRC/Aging SharePoint site.

D. Call triage system model

As described in section II-B, agencies may choose to implement a call triage system. Suggested criteria for prioritizing requests for benefit specialist services within the agency follow. The criteria set forth in this document may be adjusted as necessary to meet the agency's needs. For example, consider current wait times for an appointment when determining priority level.

It's recommended to include priority levels and relevant deadlines in the referral subject line.

1. **Level 1: Urgent**
   a. **Estimated wait time:** Same day or one business day
   b. **Information & assistance (I&A) or receptionist action:**

      Notify the benefit specialist that there is a customer with a Level 1 need. The benefit specialist may choose to speak with the customer immediately, or they will call the customer back within one business day (unless the benefit specialist is on vacation or otherwise out of the office). If in doubt as to whether a customer's need is urgent, it is best to err on the side of caution and identify the call as Level 1.

   c. **Description:**

      High-priority issues that require immediate attention include:
      i. **Urgent need for medications:** less than four days' supply of prescription available
      ii. **Appeals with an approaching deadline:** claims or coverage appeal when the deadline to file an appeal is less than two weeks away or has already passed for Social Security Disability, Medicaid, Medicare Savings Program, Medicare, FoodShare, etc.

iii. **Reduction of benefits with approaching deadline:** reduction of benefits when the deadline to appeal is less than two weeks away or has already passed; receiving Social Security benefits as their only source of income and whose benefits are reduced or terminated due to an overpayment or loss of disability status

iv. **Court proceedings**: small claims, administrative law hearings, etc.

v. **Difficult to contact**: experiencing homelessness or in danger of becoming homeless, living in unsafe/unstable home environments, seem to have a severe mental illness

vi. **Housing issues:** eviction (make an immediate referral to a legal services agency that provides representation in eviction hearings, as appropriate), loss of subsidized housing, landlord/tenant issues

vii. **Limited income:** adults 65 or older receiving income less than 75% of the Federal Poverty Level, who might qualify for Supplemental Security Income (SSI)

viii. **Terminally ill** or who have catastrophic new conditions (for example, lung cancer, severe brain damage). Note: It is not permissible to ask the person if they have a terminal illness or what their prognosis is; however, if they volunteer such information, include this information in the referral.

ix. **Records requests:** requests for a current or former customer record

2. **Level 2: Current Need and/or Brief Concern**

   a. **Estimated wait time:** One to three business days

   b. **I&A or receptionist action:**

      Inform the customer that the benefit specialist will return their call in one to three business days. If an appointment is necessary, explain to the customer that they may be seen within one to two weeks, depending on the benefit specialist's schedule.

   c. **Description:**

      Normal-priority issues that merit a timely but not immediate response include:

      i. **Appeals without an approaching deadline:** appeal for an eligibility or coverage determination when the appeal deadline is over two weeks away.

1) Medicare coverage appeal, denial, or billing issues (for example, ambulance ride denial, emergency room denial, diagnostic test coverage issue, etc.)
2) Loss or reduction of benefit, or an incorrect benefit payment, when these problems do not cause extreme financial hardship
3) Social Security disability denial
4) Social Security overpayment notice

ii. **Debt collection or consumer law issues**

iii. **Questions about health care**

1) Coordination of benefits issues with COBRA, Medicare, Marketplace, retiree coverage, etc.
2) Drug coverage issues without immediate need
3) General questions about Medicare Part D or Medicare Advantage or want to switch to a different Medicare plan (be aware of Medicare enrollment period deadlines)

iv. **Questions about benefits**

1) General questions about the disability process or about any other resources available to people with disabilities. Included in this category may be customers who state they have previously received services from the benefit specialist. These calls are more in-depth than benefits questions (for example, "How do I apply for disability?") fielded by I&A specialists.
2) Medicaid estate recovery or divestment issues
3) General questions about Medicaid spousal impoverishment; income and asset transfer questions

3. **Level 3: Non-urgent**
   a. **Estimated wait time:** Up to five business days
   b. **I&A or receptionist action:**

Make a referral to the benefit specialist and inform the customer that the benefit specialist will return their call in one to five business days. If an appointment is necessary, explain to the customer that they may be seen within one month, depending on the benefit specialist's schedule.

Or refer the customer to another agency, per the Medicare, Medicaid, Marketplace, and Social Security Administration Referral Resources for Wisconsin Residents (P-03326).

c. **Description:**

Low priority issues include:

i. **Disability determination assistance requests without an approaching deadline:** assistance with an initial application for Social Security Disability

ii. **Assistance with private payment for equipment:** assistance with applications for charitable funding for equipment or services that are not covered by public disability funds unless there is an urgent need for the equipment or services

iii. **Discretionary services:** request a service that is considered "discretionary," rather than a core service for the benefit specialist programs, including: Homestead Tax Credit forms, landlord-tenant issues, problems with creditors, and others, as outlined in the DBS Program Services Scope (P-00416) and EBS Program ADRC Operations Manual (P-03062-06)

iv. Plan comparisons for Medicare health coverage

v. Coordination of benefits between Medicare and other types of insurance

IV. Vacancies, Absences, and Transitions

A. Introduction

1. Agencies are responsible for serving benefit specialist customers by performing benefit specialist functions and responsibilities during a benefit specialist absence caused by vacancy, vacation, or leave of absence.

2. The agency supervisor notifies the DHS EBS and/or DBS program manager and program attorney as soon as possible after learning of a benefit specialist's departure or vacancy. The agency may also wish to contact community partners and agencies that work closely with the benefit specialist.
3. In short-term absences (for example, vacation, family medical leave, or parental leave), the agency can adopt the portions of this policy that are appropriate based on the length of the leave. For example, a short-term absence would not automatically require the revocation of an appointment of representation or written notice to customers. To the extent possible, the benefit specialist should discuss open intakes with the supervisor, the staff person providing interim coverage, and/or the program attorney prior to taking their leave.

B. Caseload management during a vacancy

1. **Caseload management plan**

   The agency supervisor chooses how to manage the benefit specialist's caseload during a vacancy or absence. Some permissible ways to do so include:

   a. Distributing workload to other staff within the agency.

   b. Enlisting the help of a benefit specialist in another county.

   c. Referring customers to the local Social Security field office, income maintenance consortium, or other appropriate entity to apply for benefits. See the Caseload Management Guidelines for details.

   d. Working with the DHS EBS and/or DBS program manager and the program attorney, using the Caseload Management Guidelines, to develop a workload management plan if the remaining caseload is unmanageable given existing resources.

2. **Interim benefit specialist**

   a. The agency supervisor designates an interim benefit specialist. The interim benefit specialist can be another benefit specialist within the agency, a benefit specialist from a nearby agency, or (for DBS vacancies) the local supervisor. It is preferable that the interim benefit specialist is another benefit specialist rather than the local supervisor. The interim benefit specialist:

i. Assumes the benefit specialist functions and responsibilities or oversees these responsibilities if responsibilities are delegated to more than one employee.

ii. Receives technical assistance from the program attorney. These services are only provided to the interim benefit specialist.

iii. Accesses and utilizes the reporting and case management system, the program's SharePoint site, and other systems necessary to perform benefit specialist services. If the interim benefit specialist does not have access, contact the DHS EBS and/or DBS program manager to discuss the possibility of receiving temporary access to the client-tracking system.

iv. Adheres to program confidentiality standards, as outlined in the Operations Manual.

v. Adheres to the limitations of combined activities governed by the prohibited activities policy, as outlined in the Operations Manual.

b. The agency supervisor may decide to distribute individual intakes or discrete functions or activities to more than one staff person. For example, agencies may delegate responsibility for helping with Medicaid applications to one or more employees instead of the interim benefit specialist.

c. If the interim benefit specialist is at another agency, the agencies may decide whether they would prefer an informal agreement regarding caseload management or a formal or memorandum of understanding or contract.

3. **Existing intakes**

The benefit specialist takes the following actions prior to vacating the position or starting a planned long-term absence, as time allows:

a. Reviews and updates all files, including the client-tracking system, paper, and electronic files.

b. Files or documents customer communications, intake status, customer documents, decisions, and actions for each intake.

c. Withdraws authorized representative status on all applicable intakes.

i. The departing benefit specialist discontinues the representation with written notice to the customer.

ii. If authorized representation needs to continue, then the interim benefit specialist should work with the customer to complete and submit a new appointment of representation. The newly appointed representative must understand the associated responsibilities of taking on the role of authorized representative.

iii. The program attorney is available to assist the agency supervisor and/or interim benefit specialist in these decisions and to provide information to them about the process of becoming an authorized representative.

d. Reviews all open intakes to select one of the following actions, as appropriate, on each intake:

i. Closes the intake.

ii. Refers the customer to a private attorney.

iii. Refers the customer to the program attorney for representation.

iv. Transitions the customer to the interim benefit specialist.

v. Sends a letter to each customer with an open intake informing them of the benefit specialist's departure and what to expect regarding continued assistance on their intake. The written notice requirement does not preclude contacting the customer verbally in addition to sending a written notice.

e. If the benefit specialist's departure is too sudden or unexpected to complete the above tasks, the local supervisor should confer with the program attorney to discuss how to handle open intakes.

f. If the interim benefit specialist is located at a different agency, then the local supervisor must decide whether:

i. Open intakes will be closed in the client-tracking system and customers are referred to the interim benefit specialist's agency.

ii. The interim benefit specialist will be given temporary access to the agency's client-tracking system. The DHS EBS and/or DBS program manager must approve this arrangement.

4. **New or prospective intakes**

See the Caseload Management Guidelines for guidance on how to handle new or prospective intakes.

C. Filling a vacancy

1. Sample EBS and DBS position descriptions and hiring materials are available on the ADRC/Aging SharePoint site.
2. Upon filling a vacancy, the agency supervisor:
   a. Notifies the DHS EBS and/or DBS program manager and the program attorney of the anticipated start date.
   b. Provides the newly hired benefit specialist's email address to the EBS and/or DBS program manager and the program attorney as soon as possible.
   c. Works with the benefit specialist to request systems access for all needed systems using Form 02000 and the accompanying instructions.
   d. Works with the benefit specialist to engage in required program orientation and training.
3. Transitioning the caseload to the newly hired benefit specialist:
   a. The newly hired benefit specialist sends a letter to all open customers providing their contact information for continued assistance.
   b. The interim benefit specialist transfers open intakes to the newly hired benefit specialist. The program attorney is available to review the open intakes with the newly hired benefit specialist to determine the next steps on an intake.
   c. The newly hired benefit specialist notifies the program attorney when they start accepting new intakes.

V. Benefit Specialist Program Assistant Positions

A. Introduction

1. ADRCs, county aging units, Tribes, and other agencies employing DBSs and EBSs may utilize benefit specialist assistants to perform routine DBS and/or EBS functions and certain benefits counseling services in coordination with the DBS and/or EBS. Benefit specialist assistants may be agency staff, interns, or volunteers.
2. Benefit specialist assistants are not subject to the education and experience requirements applicable to benefit specialists. Benefit specialist assistant roles vary widely across the state and can be designed to fit the needs of a

specific agency. Agencies and Tribes may set the education and experience requirements for a benefit specialist assistant role based on the position description. Experience working with older adults and/or individuals with disabilities and, if applicable, experience working with insurance policies, public benefits, and/or private benefits is preferred. Agencies and Tribes are encouraged to consult with the Department of Health Services (DHS) elder and/or disability benefit specialist program manager when designing a benefit specialist assistant role.

3. Benefit specialist assistants **must** comply with the following policies in the EBS and DBS Operations Manual chapters (P-03062)**:**
    a. Confidentiality requirements
    b. Case acceptance, case closure, and case termination policies, if providing benefits counseling services
4. Depending on their role, benefit specialist assistants **may:**
    a. Provide administrative support.
    b. Provide basic benefit counseling services with sufficient training and support.
    c. Complete the online initial training courses in the learning management system (LMS). Benefit specialist assistants are not required or expected to complete live initial training classes.
    d. Obtain access to the State Health Insurance Assistance Program (SHIP) Technical Assistance (TA) Center to complete the SHIP Basic Certification exam.
    e. Obtain access to the ADRC and Aging SharePoint site and the EBS SharePoint site and/or DBS SharePoint site by having their supervisor fill out form F-02000.
    f. Complete and maintain appropriate and timely documentation on customers in the customer records and databases.
    g. Complete and maintain required agency documentation for 100% Time and Task (T&T) Reporting purposes, if providing information and assistance services is a component of their role.
5. Benefit specialist assistants **cannot**:
    a. Receive program attorney services.

b. Perform prohibited activities as described in the EBS and DBS Operations Manual chapters (P-03062).

c. Perform advanced benefit counseling services. Customer benefit issues requiring advanced services must be referred or transferred to the DBS or EBS.

6. If the benefit specialist team is unsure of whether a specific activity or role is appropriate for a benefit specialist assistant, they should consult the DHS EBS and/or DBS program manager.

B. Allowable administrative support

Examples of administrative support services include, but are not limited to:

1. Sending information to customers who request basic materials, for example, a starter packet for the disability benefit application.
2. Preparing the prescription list to be entered in the online Medicare Plan Finder tool.
3. Assisting with creating a Medicare account, my Social Security account, or ACCESS account.
4. Sending correspondence to clients on behalf of the benefit specialist.
5. Contacting clients with appointment reminders.
6. Following up with clients to gather financial information or documentation in the application process, determine outcomes, or assess whether additional assistance is needed to secure benefits.

C. Allowable basic benefit counseling services

1. Examples of basic benefit counseling services that benefit specialist assistants may perform include, but are not limited to:

   a. Conducting SHIP and/or Medicare Improvements for Patients and Providers Act (MIPPA) grant activities, including outreach and/or one-on-one counseling for basic Medicare appointments.

Note: Providing this level of service requires that the benefit specialist assistant passes the Basic SHIP Certification Exam and has access to or is supervised by an Advanced-Level SHIP Counselor, as described in the Volunteer Risk and Program Management Policy Standards (VRPM) (P-02236).

b. Assisting with the online initial disability application and online disability report through the Social Security Administration, after completing the Social Security initial training courses and passing related quizzes.

c. Assisting with the initial application for FoodShare, Medicaid, or BadgerCare Plus by paper, by phone, or through the online ACCESS tool, after completing the related initial training courses and related quizzes.

d. Submitting a client's documents to agencies. For example:

   i. Faxing or uploading verification documents provided by the client to the income maintenance agency

   ii. Faxing or uploading medical records provided by the client to the Social Security Administration

e. Providing services that are considered optional within the program's scope; for example, with Homestead Tax Credits or phone and internet service.

f. Obtaining access to state reporting systems to resolve client-tracking error reports or to enter data about benefit specialist activities. To obtain access, the benefit specialist assistant and their supervisor fill out forms F-02000 and F-00044. The supervisor sends the completed forms to DHS BADRTech. Assistants must complete the related initial training courses and pass related quizzes for the reporting system(s).

g. Providing support to volunteer programs that provide legal and benefit outreach to the community. This could include training, developing resources, and partnering at outreach activities in the community.

h. Providing outreach activities in the form of booths and/or public speaking engagements for educational purposes on aging and disability services in the community.

2. It is best practice that, given the variety and complexity of benefits, customers meet with a benefit specialist to obtain a thorough benefits check-up prior to filling out an initial application for benefits. Customers should always be referred to a benefit specialist if their initial application for benefits is denied. Issues that require support from the benefit specialist's assigned attorney must be handled directly by a benefit specialist.

D. Prohibited Advanced Benefit Counseling Services

Benefit specialist assistants cannot provide advanced benefit counseling services, which require in-depth programmatic knowledge, training in specific advocacy skills, professional discretion, and/or technical assistance from the program attorney. Examples of advanced benefit counseling services that cannot be provided by a benefit specialist assistant include, but are not limited to:

1. Completing complex activities that require advanced advocacy skills. For example:
    a. Providing information about or assisting with a disability application for a customer who discloses that they have a terminal illness, a complex work history, or other complex issue (such as income and/or asset situations for a Supplemental Security Income [SSI] application)
    b. Providing information about or assisting with estate recovery, divestment, and benefit applications with complicated income and/or asset situations
2. Submitting appeals for eligibility denials, coverage denials, or disability denials.
3. Representing clients in benefit applications or appeals in accordance with direct representation guidelines, as described in the EBS and DBS Operations Manual chapters (P-03062).
4. Negotiating with decision-makers to seek a favorable resolution of a dispute; for example, working to resolve a billing error.
5. Developing a theory of the case or strategy to support the theory of the case, for disability claim intakes.
6. Implementing strategies to support the theory of the case; for example, writing advocacy letters, seeking new evidence, contacting medical professionals to discuss a client's claim, or reviewing documents to determine facts that support a theory of the case.

E. Quality Assurance Expectations

1. Agencies must establish an intake or referral mechanism that provides careful assessment of the client's needs to determine whether those needs can be met through basic counseling services or are complex and require advanced benefit counseling services.
2. Agencies must establish a communication or consultation process for benefit specialists to be updated on benefit specialist assistant counseling services. Best practices would include regularly scheduled status check-ins or staffing meetings between the benefit specialist and the benefit specialist assistant. These meetings can serve a function similar to the technical assistance meetings the benefit specialist has with their program attorney. These check-in meetings can also be used to identify intakes that require additional advocacy and should be transferred to the benefit specialist.
3. Agencies must establish a quality review process to review the quality of the work performed by the benefit specialist assistant. At a minimum, this should occur annually.

VI. Reporting Requirements

A. Time and task reporting

Elder benefit specialists employed by ADRCs and all disability benefit specialists must complete monthly 100% time and task reports. See the Time and Task Reporting chapter of the ADRC Operations Manual (P-030602-10) for more information.

B. Data reporting

1. Benefit specialists are required to use the reporting and case management system stipulated by DHS for creation and storage of confidential customer information generated within the course of their work. Exceptions to this policy will be granted only by the program manager, in consultation with the data systems specialist, on a case-by-case basis. See the EBS Program SharePoint and DBS Program SharePoint sites for resource materials, including instructions for requesting access to the reporting and case management system, training materials, and guidance documents.
2. Timely recording of contacts is essential to high quality service. Best practice is for each contact to be entered into the reporting and case management system within one to two business days of the date of the original contact. At a

minimum, documentation must be entered, and any corresponding State Health Insurance Assistance Program (SHIP) assessments completed, by the end of the month following the month of contact. For example, any contacts that occurred in February must be documented and SHIP assessments completed by March 31.

3. Guidance for prioritization of data entry tasks can be found in the Caseload Management Guidelines section in this chapter.

C. Monetary impact

Benefit specialists are required to track the monetary impact of their services to clients. Monetary impact is defined as the value of benefits or services that are obtained or preserved for a client, as well as money that is saved or recovered for a client, with the help of a benefit specialist.

Note: Monetary impact is just one way to measure the positive impact of benefit specialists' services. The time spent helping clients to understand and exercise their legal rights is always time well spent even if the result is an unfavorable decision.

Monetary impact is entered in the reporting and case management system after a benefit topic has been resolved favorably. The monetary value is auto populated for topics that have a standard value. Benefit specialists must enter the monetary impact value for topics that do not have a standard value. Note: EBS employed by SeniorLAW record monetary impact in a local database rather than the DHS reporting and case management system.

Instructions on how to enter monetary impact in the reporting and case management system are available on the EBS SharePoint and DBS SharePoint sites.

1. **When to report monetary impact**

   Benefit specialists may report monetary impact whenever they can demonstrate that they have been instrumental in helping a client to successfully:

   a. Obtain eligibility for a public benefit (for example, initial application, appeal of an application denial).

   b. Preserve eligibility for a public benefit (for example, annual renewal, continuing disability review).

   c. Obtain an increase in the amount of a public benefit.

d. Obtain help in paying for an item or service through a public or private benefit or charitable assistance program. This includes the savings gained through enrolling in a program designed for people receiving public assistance (for example, prime access or Walmart+).

e. Obtain a refund for items or service that should have been covered under a public or private benefit program.

f. Obtain a coverage exception for a medication normally not covered under a Medicare plan.

g. Compare options for coverage under Original Medicare, Medicare Part D, Medicare Advantage, or Medigap.

h. Obtain an increase in the community spouse income allocation under long-term care Medicaid.

i. Obtain a charitable write-off of an uncovered medical or other outstanding bill.

j. Contest the allegation of a Social Security overpayment or obtain a waiver.

k. Navigate the Marketplace to obtain an individual health insurance policy.

Instrumental help from a benefit specialist should include, at a minimum, assessment of the client's potential financial and non-financial eligibility for a program, and provision of information or assistance during the application, enrollment, or appeal process.

A benefit specialist may not report monetary impact in an intake that involves an eligibility or coverage determination without first verifying that the client has successfully obtained the benefit, monetary award, item, or service.

Verification may occur through:

a. Receiving verbal confirmation from the client.

b. Reviewing a copy of a client's determination notice, award letter, or billing statement.

c. Contacting an entity, with a client's permission, to find out whether the benefit was obtained.

d. Checking a client's status in the ForwardHealth interChange (FHiC) or CARES Worker Web (CWW).

The exception is intakes for which the benefit specialist's primary purpose was to help the client to explore enrollment options rather than obtain an eligibility or coverage determination [for example, SeniorCare renewals, Medigap,

Medicare Advantage (including Dual Special Needs Plans (D-SNPs), or Part D enrollments], it is not necessary to confirm that benefits have been awarded.

2. **Services ineligible for monetary impact**

   A benefit specialist may not report monetary impact for:

   a. Providing general information or referral services.

   b. Referring a client to another entity (for example, a vocational rehabilitation provider, insurance agent, or legal services provider) for counseling or representation that is outside the scope of the benefit specialist program.

   c. Providing services that are not within the benefit specialist program scope of services.

   d. Helping to write a cease-and-desist letter in response to harassment by debt collectors.

   e. Conducting public workshops or other general outreach events.

   f. Referring a client to a private attorney for representation at an Administrative Law Judge hearing after an unsuccessful reconsideration appeal.

3. **General guidance for determining monetary impact values**

   a. **One-time awards and lump sum settlements:** The monetary impact for one-time awards is equivalent to the actual value of the award. One-time awards may include:

      i. Coverage for an item or service.

      ii. A back payment.

      iii. Waiver or dispute of a Social Security overpayment.

      iv. Recovery of a Social Security underpayment.

      v. A settlement or a charitable write-off.

   The value of monetary impact from a one-time award is not auto populated in the reporting and case management system. Benefit specialists must enter the amount when closing the benefit issue. Ongoing Benefits

The monetary impact of ongoing benefits, such as Medicaid, Social Security Disability Insurance (SSDI), or FoodShare, is defined generally as the average value of one year of benefits. While many clients will receive public benefits for many years to come because of benefit specialist services and a few clients will lose benefits within one year due to a change in circumstances (for example, death or increase in income), benefit specialists should always use a standard average yearly value to estimate monetary impact. This saves time and helps ensure consistency in the way monetary impact is measured statewide.

The average annual values of most public benefit programs are auto populated in the client-tracking data system and are updated annually.

b. **Secondary benefits**: In some situations, a client's eligibility for one public benefit results in automatic eligibility for other programs. For instance, all individuals who are awarded at least one dollar of Supplemental Security Income (SSI) will automatically receive the state SSI supplement and be enrolled in Medicaid. Furthermore, SSDI recipients will receive Medicare benefits after 24 months, and Medicare Savings Program participants automatically receive the full Low-Income Subsidy (LIS) for Medicare Part D. Benefit specialists must include the value of applicable secondary benefits when entering monetary impact amounts. The primary benefit's monetary impact value includes secondary benefits that always accompany the primary benefit when auto populated in the reporting and case management system. Benefit specialists can overwrite the auto populated value to include optional secondary benefits when applicable.

c. **Benefits to household members:** Benefits that are awarded to a household include FoodShare; Wisconsin Heat and Energy Assistance Programs; and other food, shelter, and utility benefits. If two or more clients are members of the same household and benefit equally from the benefit specialist's help to obtain a household benefit, the monetary impact may be divided equally between the two household members, or the entire amount may be attributed to one client.

   Do not report monetary impact for health or income benefits awarded to a client's family member because of benefit specialist services, unless either:

   i. The benefit falls within the scope of the benefit specialist programs and the family member is a tax dependent of the client.

   ii. The family member also meets the criteria for benefit specialist services and is also recorded as a client.