

Medicaid Eligibility Handbook Release

15-02

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INTRODUCTION (CH. 1)

1.1 INTRODUCTION TO MEDICAID

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1.1.1 Introduction

Wisconsin Medicaid is a state/federal program that provides health coverage for Wisconsin residents who are [elderly](#), [blind](#), or [disabled](#) (EBD) or receive [WWWMA](#). Medicaid is also known as Medical Assistance, MA, and Title 19.

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
- [PACE](#)
- [IRIS](#)
- Katie Beckett
- [TB](#)-related
- [MSP: QMB, SLMB, SLMB+, QDWI](#)
- Emergency Medicaid
- SeniorCare
- WWWMA

A person may fit into one (or more) of the above subprograms based on non-financial factors. A person is eligible if he or she meets all Medicaid non-financial and financial requirements. Individuals who are not elderly, blind or disabled (EBD) may be eligible for BadgerCare Plus. See the [BadgerCare Plus Handbook](#) for more information.

1.1.3 Financial Introduction

See [Section 39.4 Elderly, Blind, and Disabled Assets and Income Tables](#) for EBD asset limits. See [Section 25.7.2 Financial Tests](#) for TB-related asset limits. See [Section 1.1.3.3 Disabled Minors](#) to determine Medicaid eligibility for disabled minors that fail BadgerCare Plus financial tests.

1.1.3.1 Assets

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 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 [Section 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 would be a one person fiscal group. If the individual is married, refer to [Section 18.1 Spousal Impoverishment Introduction](#) for special instructions regarding *spousal impoverishment* procedures.

1.1.3.3 Disabled Minors

A blind or disabled minor (or dependent 18 year old) can have their Medicaid eligibility determined according to special procedures when the disabled minor fails BadgerCare Plus eligibility test or when the parent chooses to decline BadgerCare Plus for their child and have their child receive EBD Medicaid if eligible. See [Section 15.1.2 Special Financial Tests for Disabled Minors](#).

1.1.3.4 Income

See [Section 39.4 Elderly, Blind, and Disabled Assets and Income Tables](#) for EBD income limits. See 39.5 *FPL* Table for all other Medicaid income limits. Chapters for each type of Medicaid explain how to determine the income that you compare to the income limits.

See [Section 39.4.2 EBD Deductions and Allowances](#) for TB-related income limits.

1.1.4 Health Care Choice

Once an individual has been determined eligible for Elderly, Blind, or Disabled Medicaid (EBD MA), he or she must be enrolled in EBD MA, even if they are also eligible for BadgerCare Plus (BadgerCare Plus), unless they have a change in circumstances that results in ineligibility for EBD MA. The only exception to this policy is pregnant women who are eligible for both EBD MA and BadgerCare Plus. In these instances, the pregnant woman will be enrolled in BadgerCare Plus.

If someone is pending for EBD MA or if they have an unmet deductible for EBD MA, the individual is not considered eligible for EBD MA and can enroll in BadgerCare Plus. Pending for EBD MA includes, but is not limited to, waiting for a *disability* determination from *DDB* or not eligible for Medicare. If an individual enrolled in EBD MA becomes ineligible for EBD MA for any reason, including going over the asset limit or failure to pay a MAPP premium, he or she can enroll in BadgerCare Plus if he or she is still eligible to do so.

1.1.5 How to Apply

The following application options are available for anyone who is applying for EBD Medicaid:

1. ACCESS online application at [https:// access.wisconsin.gov/](https://access.wisconsin.gov/).
2. Face-to-face Interview at the agency.
3. Mail-in.
4. Telephone interview.

Click [here](#) to view the directory of local *IM* agencies in Wisconsin or call Member Services at (800) 362-3002.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

APPS AND REVIEWS (CHS. 2-3)

2 APPLICATIONS

2.1 APPLICATIONS INTRODUCTION

Anyone has the right to apply for Medicaid. However, individuals under 18 years of age must have a parent or a legal guardian apply for Medicaid on their behalf unless living independently.

They may be assisted by any person he or she chooses in completing an application.

Encourage anyone who expresses interest in applying to file an application as soon as possible. When an application is requested:

1. Suggest the *applicant* use the ACCESS online application at the following site: <http://access.wisconsin.gov>; or
2. Mail-in using the Wisconsin Medicaid for the Elderly, Blind or Disabled Application Packet (F-10101); or
3. Schedule a telephone or face-to-face interview.

Provide any information, instruction, and/or materials needed to complete the application process. Provide a Notice of Assignment: Child Support, Family Support, Maintenance and Medical Support form (DWSP 2477) and Good Cause Notice (DWSP 2018) to each applicant with children applying for Medicaid or to anyone that requests either of these.

Refer requests for applications and other outreach materials from groups and persons involved in outreach efforts to <https://www.dhs.wisconsin.gov/forms/index.htm>.

Note: An application can be filed on behalf of a deceased person. If the application is filed within the same calendar month as the date of death or within the three months after the date of death, the application should be processed as if the applicant were alive. If the application is filed more than four months after the date of death, he or she is not eligible.

2.1.1 Affirmative Action and Civil Rights

The Rehabilitation Act of 1973 requires a person with impaired sensory, manual, or speaking skills have an opportunity to participate in programs equivalent to those afforded non-disabled persons.

Notify members during intake that assistance is available to assure effective communication. This includes certified interpreters for deaf persons and translators for

non-English speaking persons. See the ForwardHealth Enrollment and Benefits Handbook ([P-00079](#)).

The Civil Rights Act of 1964 requires that applicants for public assistance have an equal opportunity to participate regardless of race, color, or national origin.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

2.2 APPLICATION TYPES/METHODS

Medicaid applicants have the choice of one of the four following methods:

1. ACCESS: <https://access.wisconsin.gov/access/>.
2. Mail-in using the Wisconsin Medicaid for the [Elderly](#), Blind, or Disabled Application Packet ([F-10101](#)).
3. Telephone interview. When a request for assistance is made by phone, the filing date is not set until a signed application and/or registration form is received by the agency.
4. Face-to-face interview.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

2.3 WHERE TO APPLY

[2.3.1 Where To Apply Introduction](#)

[2.3.2 Intercounty Placements](#)

[2.3.3 Applications Outside Wisconsin](#)

2.3.1 Where To Apply Introduction

Click [here](#) to view the directory of *IM* agencies in Wisconsin or call 1-800-362-3002. The *applicant* must apply with the local agency serving their county or tribe. The applicant must apply with the agency serving their county or tribe.

An individual who resides in a nursing home/hospital for 30 days or more 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.

When an applicant contacts the wrong agency, redirect him or her to the agency responsible for processing the application immediately. Anytime an application is received in the wrong agency, it must be redirected to the agency responsible for processing that application no later than the next business day. A paper application must be date stamped before it is redirected. The filing date remains the date originally received by the wrong agency.

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. *AFH*.
6. *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 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.

2.3.3 Applications Outside Wisconsin

Generally, an application should not be taken for a resident of Wisconsin when he or she is living outside of Wisconsin. An exception is when a Wisconsin resident becomes ill or injured outside of the state or is taken out of the state for medical treatment. In this case, the application may be taken, using Wisconsin's application forms (see [Section 2.2 Application Types/Methods](#)), by the public assistance agency in the other state. The forms should be forwarded to the IM agency in the other state. The Wisconsin IM agency determines eligibility when the forms are returned.

This page last updated in Release Number: 15-01

Release Date: 06/10/2015

Effective Date: 06/10/2015

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**
 - Telephonically.

This page last updated in Release Number: 15-01

Release Date: 06/10/2015

Effective Date: 06/10/2015

2.5 VALID SIGNATURE

[2.5.1 Valid Signature Introduction](#)

[2.5.2 Witnessing the Signature](#)

[2.5.3 Spousal Impoverishment MA Signatures](#)

2.5.1 Valid Signature Introduction

The *applicant* or his or her representative (see below) must sign:

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.

Signatures from Representatives

Except when:

1. **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.

or

2. ***Authorized Representative:*** The applicant may authorize someone to represent him or her. An authorized representative must be an individual, not an organization.

If the applicant wishes to authorize someone to represent him or her when applying by mail, instruct him or 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 a completed signed application 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.

3. Durable power of attorney (§ 243.07, Wis. Stats.): 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. 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.

4. Someone acting responsibly for an incompetent or incapacitated individual pending a guardianship determination.

Example 1: Carl is in a coma in the hospital. A guardianship proceeding has been started. Sherry, a nurse who works at the hospital, can apply for Medicaid on Carl's behalf.

5. A superintendent of a state mental health institute or center for the developmentally disabled.
6. A warden or warden's designee for an inmate of a state correctional institution who is a hospital inpatient for more than 24 hours.
7. The superintendent of the county psychiatric institution, who has been designated by the county social or human services director, 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.

2.5.2 Witnessing the Signature

The signatures of two witnesses are required when the application is signed with a mark.

An agency staff person is not required to witness the signature of a mail-in, online or telephone application.

Note: This does not affect the State of Wisconsin's ability to prosecute for fraud nor does it prevent the Medicaid program from recovering benefits provided incorrectly due to an applicant or member's misstatement or omission of fact.

2.5.3 Spousal Impoverishment Medicaid Signatures

All *spousal impoverishment* Medicaid applications and reviews require the signatures of both the institutionalized person and the community *spouse*, or of a person authorized to sign for them.

If the institutionalized person's signature is missing, deny the application.

Beginning with applications dated November 11, 2013, if the community spouse refuses to sign the application, refuses to disclose the value of assets, or refuses to provide required information on income or resources, deny the application unless the agency determines that denial of eligibility would result in undue hardship for the person (see [Section 17.17 Undue Hardship](#)).

If the community spouse refuses to sign the application or provide required information, enter an "N-No" in the Health Care Signature field on the General Case Information page.

When policy requires a witness to the institutionalized person's signature, the community spouse's signature must also be witnessed.

For ongoing cases where eligibility was determined without using spousal impoverishment rules, apply the spousal impoverishment rules at the next renewal. This includes completing an asset assessment using the couples assets on the first day of the month of the review month and determining eligibility for the next certification period by comparing the current combined assets of the couple to the total of the Community Spouse Asset Share plus the \$2,000 asset limit for the institutionalized spouse.

2.6 FILING DATE

[2.6.1 In Person/Mail/Fax](#)

[2.6.2 By Phone](#)

[2.6.3 By ACCESS](#)

[2.6.4 Low Income Subsidy Program of Medicare Savings Programs](#)

[2.6.5 Federal Facilitated Marketplace](#)

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 received by the *IM* agency or the next business day if it is received after the agency's regularly scheduled business hours.

2.6.2 By Phone

When a request for assistance is made by phone, the filing date is set when a telephonic signature, or signed application/registration form is received by the agency.

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.

2.6.4 Low Income Subsidy Program of Medicare Savings Programs

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*.

Because the data sent by SSA is not sufficient to determine Medicaid or MSP eligibility, the data from the LIS application will be used to establish a Request for Assistance (RFA) in CARES. The contact date on the RFA is the date the LIS data was received by *DHS* from SSA. The filing date for the MSP request is the filing date for LIS application set by SSA.

A completed, timely application will have to be submitted by the applicant to the local agency in order to determine Medicaid and MSP eligibility for the person. If an application is not submitted within 30 days of the RFA contact date, the RFA will be automatically withdrawn and a notice generated.

2.6.5 Federally-Facilitated Marketplace

The filing date for applications received from the **FFM** is the date the application was submitted to the FFM.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

2.7 TIME FRAMES

[2.7.1 Time Frames Introduction](#)

[2.7.2 Changes](#)

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.

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

Workers may also extend the 30-day processing time up to 10 days to allow the applicant additional time to provide 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 [Section 20.7 When to Verify](#).

Example 1: A signed application was received on March 15. The worker processed the application on April 7 and requested verification. Verification was due April 17, but was not received by that date. Even though the end of the 30-day application processing period was April 14, the application should not be denied until April 17 to allow at least 10 days to provide verification.

If the agency fails to take action (positive or negative) during the 30-day processing period, and the applicant is subsequently found eligible, as a result of their most recent Medicaid application, redetermine eligibility using the filing date associated with that most recent application.

Example 2: A signed application was received on May 15. The first day of the 30-day period was May 16. The end of the 30-day period would have been June 14. The application was approved on June 20, and the applicant is determined eligible beginning May 1.

2.7.2 Changes

Changes that occur between the filing date and the confirmation date should be used in the initial eligibility determination.

For changes that occur after the confirmation date, follow the adequate and timely notice requirements outlined in [Income Maintenance Manual Section 3.2 Adverse Action and Appeal Rights](#).

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

2.8 BEGIN DATES

[2.8.1 Begin Dates Introduction](#)

[2.8.2 Backdated Eligibility](#)

2.8.1 Begin Dates Introduction

Medicaid eligibility begins the first day of the month in which the valid application is submitted and all program requirements are met with the following exceptions. Those begin dates are the date a valid application is submitted, all program requirements are met, and:

1. Deductible – The date the deductible was met.
2. Inmates – The date the *member* is no longer an inmate of a *public institution*.
3. Person Adds – The date the person moved into the household.
4. Recent Moves – The date the member moved to Wisconsin.

Exception: The begin date for an *SSI* recipient who moves to Wisconsin is the 1st of the month of the move.

Example 1: SSI recipient Mr. Nebble moves to Wisconsin from Vermont in April 2009. He becomes eligible 04-01-09 in Wisconsin.

5. Home and Community-Based Waivers – The program start date provided by the care manager.

6. Family Care and **PACE** or Partnership – The date the individual is enrolled in the **MCO**.
7. Institutionalized – His or her entry into the nursing home or hospital.
8. **QMB** – The first of the month following the eligibility confirmation.
9. SeniorCare – The first of the month following the month in which all program requirements have been met.

2.8.2 Backdated Eligibility

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

If a member has incurred a bill from a Medicaid-certified provider during a backdate period, instruct the member to contact the provider to inform them to bill Medicaid. The member may be eligible to receive a refund, up to the amount already paid to the provider.

Example 2: Mary who is 66 years old, applied for Medicaid on April 6, and was found eligible. At the time of application, Mary did not request a backdate.

In September Mary is billed for a doctor's appointment she had at the end of February. Mary can ask to have her eligibility backdated through February. She meets all non-financial and financial eligibility criteria in the months of February and March. Her worker certifies her for Medicaid for both months.

For backdating rules for Medicare Beneficiaries, see [Section 32.8 Medicare Savings Programs Backdating](#).

Assets

A person's asset eligibility in a backdate month is determined by whether or not he or she had excess assets on the last day of the month. If he or she had excess assets on the last day of the month, he or she is ineligible for the entire month. If he or she was asset eligible on the last day of the month, he or she is eligible for the whole month.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

2.9 DENIALS AND TERMINATIONS

[2.9.1 Termination](#)

[2.9.2 Denial](#)

2.9.1 Termination

If less than a calendar month has passed since a member's enrollment has been terminated, the *applicant* can provide the necessary information to reopen Medicaid without filing a new application.

If more than a calendar month has passed since a member's enrollment was terminated, the applicant must file a new application to reopen his or her Medicaid.

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 Form 03-07 Combined Application Form to set a new filing date.

If more than 30 days has passed since a client's eligibility was denied and the client is not open for any other program, the client must file a new application to reopen his or her MA.

If the client is open for any other program of assistance, do not require him or her to re-sign his or her application or sign a new application.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

3 RENEWALS

3.1 RENEWALS

[3.1.1 Renewals Introduction](#)

[3.1.2 Choice of Renewal](#)

[3.1.3 Renewal Processing](#)

[3.1.4 Signature at Renewal](#)

[3.1.5 Administrative Renewals](#)

[3.1.6 Late Renewals](#)

3.1.1 Renewals Introduction

A 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 renewal. Each renewal results in a determination to continue or discontinue eligibility.

The first required eligibility renewal for a Medicaid case is 12 months from the certification month except for cases open with a deductible. A 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 renewal date is six months from the start of the deductible period.

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

Agency Option

The agency may 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 Renewal

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

1. Face-to-face Interview,
2. Telephone Interview.
3. Mail in: Mail in renewals can be submitted using the paper application ([F-10101](#)) or the pre-printed renewal packet generated through *CWW*. Cases requesting to complete a Mail-in renewal must be sent the pre-printed renewal packet if the case includes a blind or disabled child, **or**
4. ACCESS

3.1.3 Renewal Processing

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

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

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

If the 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 renewal month.

3.1.4 Signature at Renewal

The member must include a valid signature at the time of renewal. This includes signing:

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 renewals are the same as those for applications. See [Section 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 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.

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

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

MA cases that could be selected for administrative renewal include:

- *SSI*-related Medicaid
- Home and Community-Based Waivers (HCBW)
- Managed Long Term Care (MLTC including Family Care, Partnership, *PACE*)
- *MSP*

MA cases must also meet all the following criteria to be selected for an administrative renewal:

SSI-related Medicaid

- No *MAPP* eligibility
- No earned income
- No Medicaid deductible
- Countable income at or below 84 percent *FPL*
- Countable assets at or below 50 percent of the asset limit

HCBW, MLTC (Family Care, PACE/Partnership)

- No *spouse*
- Living at home (i.e., living arrangement code must be "01")
- No Group B or C eligibility
- No Group A eligibility due to BadgerCare Plus, MAPP, or Medicaid deductible
- No earned income
- Countable income at or below 223 percent FPL
- Countable assets at or below 50 percent of the asset limit

Medicare Savings Programs

- Countable income at or below 120 percent FPL
- Countable assets at or below 50 percent of the asset limit

Open for Multiple Programs

If the case is open for MSP and one of the Medicaid categories listed above, the case may be selected for administrative renewal if the Medicaid renewal is due and the case meets all the selection criteria listed above. If the MSP renewal is due but not the Medicaid renewal, or the case does not meet all the selection criteria listed above, the case will not be selected for administrative renewal.

Continuous Eligibility

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

Alternate Years

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

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

3.1.6 Late Renewals

Late renewals are only permitted for individuals whose eligibility ended because of lack of renewal and not for any other reasons for the following EBD programs:

- Elderly, Blind or Disabled Medicaid (EBD MA)
- Home and Community Based Waivers (HCBW)
- Institutional Medicaid
- MAPP
- MSP (*QMB/SLMB/SLMB+/QDWI*).

Late renewals and related-renewal verifications should be accepted for up to three calendar months after the renewal date. Members whose health care benefits are closed more than three months due to lack of renewal must reapply.

Consider late submissions of an online or paper renewal form or a late renewal request by phone or in person as a valid request for health care. The new health care certification date should be set based on receipt of the signed renewal. If verification is required to complete the renewal, the member will have 10 days to provide it.

If the health care renewal was completed timely but the requested verifications were not provided as part of the renewal, the health care program can be reopened without a new application if these verifications are submitted within three months of the renewal month. The verifications must include information for the current month of eligibility. If verification was submitted for a past month, a new Verification Checklist must be generated to request current verification. The member will have 10 days to provide it.

If a gap in coverage occurs because of a late renewal, the member may request coverage of the past month in which the gap occurred. The member must provide all necessary information and verification for those months and must pay any required premiums to be covered for those months. For EBD MA renewals, the member must provide the missing verification and verify assets or the current month if there was a gap in coverage.

Note: QMB coverage is not retroactive. Members cannot request backdated eligibility for this program.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

NONFINANCIAL (CHS. 4 - 14)

4 WHO IS NONFINANCIALY ELIGIBLE FOR MEDICAID?

4.1 WHO IS NONFINANCIALY ELIGIBLE FOR MEDICAID?

To be eligible for Medicaid, an individual must meet the following criteria:

1. Be *elderly*, blind, or disabled (see [Section 5.1 Elderly](#) or [Section 5.2 Determination of Disability](#))
2. Be a resident of the state of Wisconsin (see [Section 6.1 Residency Eligibility](#))
3. Be a U.S. citizen or Qualifying Immigrant (see [Section 7.1 US Citizens and Nationals](#))
4. Cooperate with medical support liability (see [Section 8.1 Medical Support](#))
5. Cooperate with *TPL* (see [Section 9.1 Third Party Liability](#))
6. Provide *SSN* or apply (see [Section 10.1 SSN Requirements](#))
7. Pay a premium if required (see [Section 11.1 Premium or Cost Share](#))
8. Pay a community waiver/FamilyCare cost share if required (see [Section 11.1 Premium or Cost Share](#))

*This page last updated in Release Number: 08-03
Release Date: 08/13/08
Effective Date: 08/13/08*

5 ELDERLY, BLIND, OR DISABLED (EBD)

5.1 ELDERLY

Elderly is defined as an individual 65 years of age or older (see [Section 4.1 Who is Nonfinancially Eligible for Medicaid?](#)). An individual who is elderly is non-financially eligible.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

5.2 DETERMINATION OF DISABILITY

Definition of Disability

The law defines **disability** for Medicaid as: "The inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." See [Section 39.4.1 EBD Assets and Income Table](#) for the current SGA limits. See [Section 26.1 Medicaid Purchase Plan Introduction](#) for the **MAPP** disability definition.

An individual who is blind or disabled is non-financially eligible (see [Section 4.1 Who is Nonfinancially Eligible for Medicaid?](#)). Disability and blindness determinations are made by the **DDB** in the Department of Health and Family Services. The **IM** agency should submit an application for a disability determination even if the **member** has already applied for **SSI** or **SSDI** (see [Section 5.3 Disability Application Process](#)).

*This page last updated in Release Number: 09-03
Release Date: 06/05/09
Effective Date: 06/05/09*

5.3 DISABILITY APPLICATION PROCESS

[5.3.1 Application Form](#)

[5.3.2 Agency Form Processing](#)

[5.3.3 Release Form](#)

[5.3.4 Medical Report](#)

[5.3.5 SSI Application Date](#)

[5.3.6 Routine SSI-MA Extension](#)

[5.3.6.1 Case Processing](#)

[5.3.7 Other SSI-MA Extensions](#)

5.3.1 Application Form

Give a **MADA** ([F-10112](#)) to each person applying for Medicaid Disability. The MADA must be completed by the Medicaid **applicant** or his or her representative.

The applicant must send the following to the local/county/tribal human or social service agency:

1. The completed MADA form ([F-10112](#)).
Applicants must list information about all of their medical problems and contact information for all medical providers that have treated them,
2. One copy of the Authorization to Disclose Information to Disability Determination Bureau (**DDB**) ([F-14014](#)),
and if applicable
3. The Medicaid/FoodShare Wisconsin Authorization of Representative form ([F-10126](#)).

5.3.1.1 Claims filed on behalf of Deceased Applicants

Even when the applicant is deceased DDB needs medical and other information upon which to base the disability decision. If available, the *IM* worker should send copies of the following to DDB, along with all other application materials:

1. Medical reports (if available from the person filing the Medicaid disability application on the decedent's behalf.)
2. Death Certificate.
3. Medical releases ([F-14014](#)). If the claim was initiated prior to the applicant's death and the applicant signed medical releases, those should be sent to DDB. If the applicant was able to sign the releases only with an "X" or other mark, two witness signatures are needed on the release form.
4. Documentation of guardianship or power of attorney should be included if medical releases are signed by a guardian or person with power of attorney.

The IM worker should complete the MADA form as thoroughly as possible, including:

1. Name, address, and phone number of next of kin, friend, or other person initiating the Medicaid application on the decedent's behalf (Section I).
2. The date on which the applicant became unable to work (Section I, number 2).
3. Contact information for medical sources treating the applicant prior to and at time of death (Section III).

If Medicaid coverage is needed for less than three full months prior to application the IM worker should include a statement regarding the necessary coverage dates in Part VI of the MADA. For example, when the applicant died shortly after an accident or start of illness and coverage is needed only for brief medical care and/or burial expenses.

5.3.2 Agency Form Processing

See [Process Help Chapter 12 Automated Medicaid Disability Determination](#).

When completed MADA forms are received by the local agency, the IM worker must:

Determine if the applicant meets all other Medicaid eligibility requirements, with the exception of the disability determination and income. Do not send the MADA to DDB if the applicant does not meet all other Medicaid eligibility requirements aside from disability and income, with one exception:

If a non-qualifying immigrant would qualify for Emergency Services Medicaid only if he or she was disabled, send the MADA to DDB.

5.3.3 Release Form

Ask the applicant to sign a Confidential Information Release Authorization - Release to Disability Determination Bureau form ([F-14014](#)). This is the only form DDB can accept.

See [Process Help Chapter 12 Automated Medicaid Disability Determination](#).

Leave the box blank that asks for the "Name and Address - Agency/Organization Authorized to Release Information." DDB has scanners that will automatically fill in the blank. Filling it in creates problems for them.

Applications for disability made by the applicant must include releases that are signed personally by the disabled applicant. Applications made on behalf of a disabled applicant must be accompanied by release forms signed by a legally appointed representative. A copy of the court order appointing a representative must be included with the application. An authorized representative's signature on the release is not acceptable unless he or she has a court order.

5.3.4 Medical Report

If the applicant has copies of any medical records, school records, etc., include them with the application.

A medical report of disability does not need to be submitted with the application. DDB will obtain all of the medical reports necessary for the disability determination. However, if the applicant or the representative has already provided medical records/reports to the IM agency, this evidence must either scanned into the *ECF* along with the completed MADA form.

DDB will contact the IM agency for applications that are not fully completed with names and addresses and work information. See [Process Help 12.5 How to Resend an Application to DDB](#).

5.3.5 SSI Application Date

Occasionally a person applies for *SSI* and is determined ineligible for SSI payments. In these cases, determine Medicaid eligibility from the SSI application date, if it is earlier than the Medicaid application date.

An application for SSI is also an application for Medicaid.

He or she must still meet all Medicaid eligibility requirements. You must request the SSI application date by using the state on line query (SOLQ).

Use the SSI application date as the filing date if the *member* contacts the IM agency within the calendar month following the month of the SSI denial. If the contact to the IM agency is later than the above, the filing date is the regular date he or she applied at the IM agency.

5.3.6 Routine SSI-MA Extension

An SSI-MA member 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 last date of SSI-MA and the date an eligibility determination is completed. 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 [Section 5.3.5 SSI Application Date](#).

There is no fill the gap provision for those who lose their SSI eligibility because of:

1. Death
2. Leaving Wisconsin
3. Incarceration
4. Fleeing drug felon

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 are not open in CARES.

Active CARES cases- An active case in CARES is one in which the person is part of a case where at least one person is currently open, or closed less than 30 days for at least one program of assistance. If the member has an active case in CARES, the fiscal agent sends a list to the agency's CARES coordinator of those losing SSI and sends those members a letter saying the IM worker will contact them if there is not enough information to determine eligibility.

As soon as the IM worker receives the list of those in active CARES cases, he or she:

1. Opens the member for Medicaid in CARES. This may seem unusual since he or she will show eligibility on MMIS for a grace month. The reason you open all of them in CARES is to provide a tracking mechanism to show you "filled the gap" and that the member receives the correct notice, if he or she fails eligibility later. CARES instructions are:
 - a. Case Information> **Request Medicaid** page- Request Medicaid
 - b. Benefits and School> **Benefits Received** page- Change the Y in the SSI field to N or on the **Benefits Received** page - change the Y in the 1619(b) field to N.
 - c. Don't change any financial information (unless you need to in order to make the person eligible). Complete any other required demographic information.
 - d. Verifications aren't required at this point.
 - e. Run eligibility and confirm.
2. The day after you open the case, request verification of any items you need to determine continued Medicaid eligibility. At this point, treat the case as a regular case, and all verification rules, etc. apply. The member has 10 days to provide verifications.

Non CARES- If the member does not have an active case on CARES, the fiscal agent sends a letter along with an application telling him or her that he or she must apply. The member sends the application to the fiscal agent and the fiscal agent forwards it to the CARES coordinator, who assigns it to a worker. The worker enters the case and determines eligibility. MMIS will close those cases that do not send an application within 30 days of their request.

3. **Reminder:** For all cases (CARES and non-CARES), even if the member does not meet Medicaid eligibility requirements for the months between when he or she lost SSI and when you are re-determining eligibility, he or she is still eligible. Do not require the member to come into the office. Ineligibility starts, following timely notice, when he or she:
 - a. Does not return the application (the fiscal agent takes care of this, or
 - b. Fails to respond to an information request, or
 - c. No longer meets eligibility requirements (only forward from when the review or application is done).

5.3.7 Other SSI-MA Extensions

Fill the gap between the loss of SSI-MA and an eligibility determination by the IM agency when:

1. Retroactive SSI approval and termination occurs. A person applies for SSI and is approved. The approval is retroactive and the SSI also is terminated retroactively.
2. Eligibility for Medicaid is not determined timely by the IM agency through no fault of the member.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

5.4 DDB ACTION

[5.4.1 DDB Action Introduction](#)

[5.4.2 Allowances](#)

[5.4.3 Diary Date](#)

[5.4.4 Denials](#)

5.4.1 DDB Action Introduction

DDB will attempt to process the *disability* determination within 90 days of the date it receives the signed application. If the DDB determines that the application needs to be

Medically Deferred 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.

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 Cassandra Quinn at 608-266-8730.

5.4.2 Allowances

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 claimants 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 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. 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 [Section 5.7 Redetermination](#).

5.4.4 Denials

Persons found not disabled will be sent a notice by DDB along with forms to apply for a Reconsideration/Hearing. The paper files on denied cases will be kept at DDB waiting for the appeal application.

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.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

5.5 RECONSIDERATION / HEARING

[5.5.1 Reconsideration/Hearing Introduction](#)

[5.5.2 Reversed Disability Denial Decision](#)

[5.5.3 CARES Processing](#)

5.5.1 Reconsideration/Hearing Introduction

Send reconsideration/hearing requests to the following address:

Disability Determination Bureau
P.O. Box 7886
Madison, WI 53707-7886

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

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:

Claims in the CARES system: For claimants found disabled, DDB will send all the evidence and a completed **SSA-831 (Disability Determination and Transmittal)** 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): For claimants found disabled, DDB will send the paper file with all the evidence and a completed **SSA-831** to the **IM** agency for storage for future use in the redetermination process.

If DDB affirms the denial, the paper file will be sent directly to the **DHA**, which will then schedule a hearing.

Claims in the CARES system: DDB will electronically send all the evidence, a completed **SSA-831**, worksheet notes, and a flag sheet to CARES. The flag sheet, the

first page of the worksheet notes, indicates that the paper folder was sent to DHA for a hearing.

Claims NOT in the CARES system (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 *ALJ* does not specify a diary date for review, contact DDB and request a diary date to review the disability.

When a DDB disability denial decision is overturned by the DHA, the disability determination is valid as of the disability approval and disability onset dates established by DHA.

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.

1. Use the original Medicaid application filing date that was associated with the *MADA* decision that has now been reversed (approved).
2. Re-evaluate the member's Medicaid eligibility for all months between the Medicaid application filing date (and three-month backdate period if appropriate) and the date of the DDB approval. For this retroactive period, certify the member only for those months for which he or she met all Medicaid eligibility requirements.
3. Send the member a positive notice, advising him or her of the months of retroactive eligibility and current ongoing eligibility, if appropriate. If the member was ineligible for Medicaid for some of the prior months, send the member a negative notice, advising him or her of his or her retroactive ineligibility for those specific months.

For these types of cases, the IM worker is simply doing what ordinarily would have been done if the original DDB decision had been approved rather than denied.

5.5.3 CARES Processing

Based on the assumption that the Medicaid CARES case has been closed for more than 30 days since the original denial decision date, you will now have to enter a new application in CARES using the application function. Do not require the member to file a new application. Use the recent DDB disability approval date as the Medicaid application filing date. You should now be able to use CARES to determine and certify the current month's Medicaid eligibility and up to three backdate months. If you need to go back any further than this, do the eligibility determination and certification manually.

When the disability denial decision is overturned by DHA, enter the disability approval and disability onset date established by DHA on the Disability page in **CWW** as if it was approved by DDB. Document in the case comments that this disability approval decision was actually made by DHA and not DDB and record the fair hearing case number. Run eligibility to determine Medicaid eligibility for current and future months and also for any past months in which the person was determined disabled.

This page last updated in Release Number: 15-02

Release Date: 07/30/2015

Effective Date: 07/30/2015

5.6 MEDICAL EXAM COST

If the person's Medicaid application is approved, Medicaid will pay the cost of any medical examination necessary for the completion of a current medical report. If it is denied, you may claim the cost of the examination as an administrative expense. Reimbursement is from the Medicaid administrative account.

This page last updated in Release Number: 08-01

Release Date: 02/01/08

Effective Date: 02/01/08

5.7 REDETERMINATION

[5.7.1 Redetermination Introduction](#)

[5.7.1.1 Example of Medicaid Disability Cessation Case Notice Text](#)

[5.7.2 Recipients Exceeding the Substantial Gainful Activity Level](#)

5.7.1 Redetermination Introduction

Review a **disability** determination when:

1. The Disability Determination and Transmittal (SSA -831) indicates medical re-examination in item 17 of that form, **or**
2. The person is younger than 65 years of age and no longer receives **OASDI** (Social Security) disability benefits,

Note: Disability determinations should not be done for members over age 65, except in some circumstances for **MAPP** (see [Section 26.1 Medicaid Purchase Plan Introduction](#)), **or**

3. The medical circumstances have significantly improved (see [Section 5.7.2 Recipients Exceeding the Substantial Gainful Activity Level](#)), **or**
4. The person has returned to work.

Complete and/or forward the following to **DDB** at

- a.
 - a. Medicaid Disability Redetermination Report ([F-10114](#)).
 - b. Signed Confidential Information Release forms.
 - c. The original Disability Determination form (SSA-831) and any subsequent disability determinations and all prior medical evidence and forms.

Disability Determination Bureau

P.O. Box 7886

Madison, WI 53707-7886

DDB will make a decision, which will be indicated on a Cessation or Continuance of Disability form (SSA-832).

Item 9 (SSA-832) indicates the decision of (A) continuing, or (B) ceased.

Item 23B (SSA-832) indicates a medical re-examination date when necessary.

If DDB determines that the member is no longer disabled, DDB will first send written notice to the member explaining the basis for the proposed decision and offering the right to appeal. Appeal forms are enclosed with this letter, and members are told that completed appeal forms must be mailed directly to DDB and be received within 45 days of the date on the letter. Members are also told that if a timely appeal is filed, Medicaid benefits will continue until a Hearing is held and a decision is made.

DDB will immediately send the SSA-832 to the **IM** agency whenever disability continues, but the form will be held by DDB in disability cessations.

If the member appeals the proposed cessation and DDB is able to reverse the decision to a continuance, a revised SSA-832 will be sent to the IM agency at that time.

If the member appeals the proposed cessation and DDB is unable to reverse this decision, the file will be forwarded directly to the **DHA** for a hearing. DHA will notify the IM agency of their final decision.

If the member chooses not to appeal or fails to file the appeal on a timely basis, DDB will send the original SSA-832 to the IM agency following the expiration of the 45-day appeal period. DDB will add a **Medicaid Disability Cessation Case** note to the front of the folder to highlight these cases. See [Section 5.7.1.1 Example of Medicaid Disability Cessation Case Notice Text](#) for an example.

Once the IM agency receives final notice of a cessation, then they must follow existing procedures to notify the member of the termination of Medicaid benefits (unless the member qualifies for Medicaid on some other basis). The member will be given another 45 days to appeal that decision.

Note: The process described above provides the Medicaid member with two opportunities to file an appeal regarding whether or not they continue to be disabled. This is the result of federal laws which require the DDB to notify a disabled member of Medicaid or Social Security benefits that they no longer meet the disability criteria necessary to continue receiving those benefits. These notice requirements for DDB also include an opportunity for the member to appeal the DDB decision within 45 days. Medicaid benefits must be continued during this potential 45 day appeal period, whether or not the client actually files an appeal. DDB cannot notify the IM agency that the client is no longer disabled until this 45 day appeal period has expired, and the client did not file an appeal within that timeframe. Once this initial 45 day appeal period expires, with no appeal request from the client, DDB will then notify the IM agency that the Medicaid member is no longer disabled.

Upon receipt of the notification (Medicaid Disability Cessation) from DDB, the IM agency must then re-determine whether or not the member qualifies for some category of Medicaid other than that related to disability. If the member is not eligible for any other Medicaid category, the IM agency would then take the necessary action to discontinue the recipient's Medicaid eligibility in the normal manner, issuing all required notices. The member would then have another opportunity to appeal the termination of their Medicaid eligibility. The fact that this second potential fair hearing essentially involves the same issue (disability) that was the subject of the first appeal is irrelevant. As stated earlier, this process is required by federal law.

5.7.1.1 Example of Medicaid Disability Cessation Case Notice Text

To: _____
Medicaid Disability Cessation Case

The Disability Determination Bureau has determined that _____
SSN: _____ *is no longer disabled. (See the SSA-832 decision in file.)*

The member has not appealed this decision within the 45-day appeal period that expired on _____.

Unless this individual qualifies for Medicaid on some basis other than disability, please initiate action to terminate MA coverage. See MA Eligibility Determination Handbook instructions in section [5.7.1](#).

5.7.2 Recipients Exceeding the Substantial Gainful Activity Level

A Medicaid member who loses **SSDI** because he or she exceeds the Substantial Gainful Activity level does not lose Medicaid coverage if:

1. He or she is a member with a disability, who was receiving non-MAPP full-benefit Medicaid, and is currently working, **or**
2. He or she is a current MAPP member.

In these cases, a MAPP disability determination must be done and MAPP continued until the determination is made.

*This page last updated in Release Number: 12-02
Release Date: 06/15/12
Effective Date: 06/15/12*

5.8 CONFLICTING CLAIMS

Disability determinations for Social Security, **SSI**, and Medicaid are completed under the same regulations. **DDB**'s decisions will be consistent if the person files for any of these programs. If a decision on one program is later changed by appeal or because of new evidence, etc., DDB will notify the other program's to change their determinations to match.

DDB may request return of Medicaid disability files when reviews of conflicting or updated decisions are needed.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

5.9 PRESUMPTIVE DISABILITY (PD)

[5.9.1 Presumptive Disability Introduction](#)

[5.9.2 PD Determined by the IM Worker](#)

[5.9.2.1 Definition of Urgent Need](#)

[5.9.2.2 Impairments](#)

- [5.9.2.3 PD Certification Process](#)
- [5.9.3 PD Determined by DDB](#)
- [5.9.4 Deceased Applicants](#)
- [5.9.5 Eligibility](#)
- [5.9.6 Disability Application Denials](#)
 - [5.9.6.1 DDB returns a negative Presumptive Disability decision](#)
 - [5.9.6.2 Recipient ineligible for non-medical reasons](#)
 - [5.9.6.3 DDB Reverses PD Decision Made by DDB or by the IM Worker](#)

5.9.1 Presumptive Disability Introduction

Federal **SSI** law and regulations state that the SSI program can find an individual to be presumptively disabled and will be treated as a person with a **disability** until a final disability determination can be completed. To be treated as presumptively disabled by SSI means that the applicant's benefits can begin before SSA, or its contracted agency, has formally determined the individual to be disabled.

Wisconsin's Medicaid program also allows a determination of presumptive disability.

Presumptive **Disability** (PD) is a method for temporarily determining a disability for an individual while a formal disability determination is being done by **DDB**. Presumptive disability is determined either by the DDB, or in some circumstances, by the **IM** worker. The regular disability application process (see [Section 5.3 Disability Application Process](#)) must still be completed for persons with a presumptive disability. A presumptive disability decision stands until the DDB makes its final disability determination.

When the regular disability determination is denied by DDB, a new presumptive disability determination cannot be made for that individual unless there has been a change in the person's condition.

5.9.2 PD Determined By the IM Workers

When a **member** has an urgent need for medical services attested to in writing by a medical professional, and is likely to be found disabled by DDB because of an apparent impairment, the member may be certified as presumptively disabled by the IM worker. When the IM worker is making the PD decision, they should do so as quickly as possible. However, the normal 30 day application processing requirements (see [Section 2.7.1 Time Frames Introduction](#)) are still applicable even for PD determinations.

In determining that the **applicant** is presumptively disabled, the IM worker will need a "medical professional" to attest in writing that:

1. The individual's circumstances constitutes an urgent need (see [Section 5.9.2.1 Definition of Urgent Need](#)) for medical services, **and**
2. The individual has one of a certain set of impairments (see [Section 5.9.2.2 Impairments](#)).

A "medical professional" is defined as any health care provider or health care worker who is familiar with the applicant and is qualified to confirm the presence of an 'urgent need' and the presence of one of the impairments. (A medical professional is a licensed physician, physician's assistant, nurse practitioner, licensed or registered nurse, psychologist, osteopath, podiatrist, optometrist, hospice coordinator, medical records custodian, or social worker.)

5.9.2.1 Definition of Urgent Need

A person must be in one of the following situations to be considered to have an urgent need:

1. The applicant is a patient in a hospital or other medical institution; **or**
2. The applicant will be admitted to a hospital or other medical institution without immediate health care treatment; **or**
3. The applicant is in need of long-term care and the nursing home will not admit the applicant until Medicaid benefits are in effect; **or**
4. The applicant is unable to return home from a nursing home unless in-home service or equipment is available and this cannot be obtained without Medicaid benefits.

Note: In addition to health conditions of a physical nature, the above criteria may also apply to an urgent need resulting from an individual's serious and persistent mental illness.

Example 1: An individual with schizophrenia who will need to be hospitalized if he or she does not take prescribed medication has an 'urgent need' if such medication is not available without Medicaid coverage.

5.9.2.2 Impairments

When an urgent need for medical services has been identified, the IM worker can certify the member as presumptively disabled if the member has one of the following readily apparent impairments, as attested to in writing by a medical professional:

1. Amputation of a leg at the hip.
2. Allegation of total deafness.
3. Allegation of total blindness.
4. Allegation of bed confinement or immobility without a wheelchair, walker, or crutches due to a condition that's expected to last 12 months or longer.
5. Allegation of a stroke (cerebral vascular accident) more than three months in the past and continued marked difficulty in walking or using a hand or arm.
6. Allegation of cerebral palsy, muscular dystrophy or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking, or coordination of the hands or arms.
7. Allegation of Down's syndrome.

8. Allegation of severe mental deficiency made by another individual filing on behalf of a claimant who is at least seven years of age. For example, a mother filing for benefits for her child states that the child attends (or attended) a special school, or special classes in school, because of mental deficiency or is unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities. Note: 'Mental deficiency' means mental retardation. This category pertains to individuals whose dependence upon others for meeting personal care needs (e.g., hygiene) and in doing other routine disability activities (e.g., fastening a seat belt) grossly exceeds age appropriate dependence as a result of mental retardation.
9. A physician or knowledgeable hospice official (hospice coordinator, staff nurse, social worker or medical records custodian) confirms an individual is receiving hospice services because of a terminal condition, including but not limited to terminal cancer.
10. Allegation of spinal cord injury producing inability to ambulate without the use of a walker or bilateral hand-held devices for more than two weeks, with confirmation of such status from an appropriate medical professional.
11. End stage renal dialysis confirmed by a medical professional.
12. The applicant's attending physician states the applicant will be unable to work or return to normal functioning for at least 12 months or the condition will result in death within the next 12 months.
13. The member has a positive diagnosis of HIV with other serious health conditions and will be unable to work or return to normal functioning for at least 12 months or the condition will result in death within the next 12 months.

5.9.2.3 PD Certification Process

A medical professional must complete and sign the Medicaid Presumptive Disability form ([F-10130](#)) attesting to both the urgent need and the impairment, before an IM worker may certify the applicant as presumptively disabled. The worker should not require any additional documentation from the medical professional beyond the Medicaid Presumptive Disability form. Once completed, place a copy of this form in the case file to document the Medicaid Presumptive Disability decision. If the applicant is otherwise eligible for EBD Medicaid, certify Medicaid eligibility (see [Section 5.9.5 Eligibility](#)).

Changes in Urgent Need Prior to PD Medicaid Certification

Sometimes, an individual's medical condition improves between the date of the PD Medicaid application and the date of the PD Medicaid certification. This improvement results in the individual no longer meeting the urgent need criteria at the time of the PD Medicaid eligibility determination. The most common example of this situation is that of a person who is hospitalized on the date of the PD Medicaid application, but released from the hospital prior to being certified by the IM worker for PD Medicaid eligibility. Under these circumstances, if the PD applicant no longer has an urgent need as of the date that you are making the PD Medicaid eligibility determination/certification, the PD request must be denied. Follow the procedures described in [Section 5.9.6.1 DDB](#)

[Returns a Negative Presumptive Disability Decision](#) when notifying the applicant that their request for a PD eligibility determination has been denied.

Example 2: Bob is 55 years old and has been hospitalized since February 01, 2008 after suffering his second stroke in the last 4 months. Bob applies for Medicaid on February 07, 2008. His physician attests in writing that Bob has an urgent need (he is hospitalized), and that he has one of the impairments listed on the Medicaid Presumptive Disability form ([F-10130](#)). The IM worker has requested verification of Bob's non exempt assets and completion of the **MADA** ([F-10112](#)). On February 14, 2008 Bob returns the completed MADA and asset verification information to his IM worker. He also indicates that he was released from the hospital on February 11, 2008 and is recuperating at home. On February 14, 2008, the IM worker has all the necessary information to make a PD Medicaid eligibility determination. Since Bob no longer has an urgent need on that date, his request for PD Medicaid must be denied.

Once a presumptive disability decision has been made, the IM worker must still follow the disability application process (see [Section 5.3 Disability Application Process](#)). The MADA form ([F-10112](#), formerly DES 3071) must be completed and sent to the DDB along with the necessary copies of the Confidential Information Release Authorization form ([F-14014](#)).

Note: Whether the IM worker makes the PD determination or DDB makes the PD determination, the Medicaid Disability Application [F-10112](#) must be completed "before" the IM worker certifies the member for PD.

The DDB will then process the disability application and make a final disability determination.

5.9.3 PD Determined By DDB

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

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

1. Document the urgent need by placing the Medicaid Presumptive Disability form ([F-10130](#)) in the case file.
2. Complete, with assistance from the applicant as necessary, the following two forms:
 - a. The MADA form ([F-10112](#), formerly DES 3071).
 - b. Release to Disability Determination Bureau form ([F-14014](#)).

3. See [Process Help Chapter 12 Automated Medicaid Disability Determination](#) for submissions of the forms, if necessary. This process is now automated. However, if the automated process isn't working, send via fax (608-266-8297) each of the three forms listed above to DDB for both a presumptive and final disability determination.

DDB will make a presumptive disability finding on these cases and communicate their finding to the local IM agency within three business days of receiving the request for presumptive disability and the [F-10112](#) form (not including the day the fax was received).

Federal Regulations generally require the evaluation of certain disabilities after a three month period of recovery from the original injury or medical event (major head injuries, strokes, heart attacks, etc.) It may not be possible to establish disability, either on a presumptive or final basis during that period. However, all applications should be submitted and a complete medical review will be made.

5.9.4 Deceased Applicants

While a deceased person can be eligible for Medicaid in the months prior to his or her death, presumptive disability determinations are not allowed for individuals that are deceased. Process such requests for a final disability determination through the disability process through DDB.

5.9.5 Eligibility

PD Medicaid coverage begins on the date on which the presumptive disability finding is made by DDB or the IM worker.

Because CARES usually certifies Medicaid from the beginning of the month, you must do a manual [F-10110](#) (formerly DES 3070) to apply the correct begin date.

The [F-10110](#) may be returned by:

1. Mail:
HP Enterprise Services
P.O. Box 7636
Madison, WI 53707
2. Fax:
(608) 221-8815

Do not grant 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.

When backdating eligibility after DDB has made the formal disability determination, the member could qualify for Medicaid by meeting a three-month deductible even if he or she had excess income in the three month backdate period. This is an exception to the normal six month Medicaid deductible requirements. The deductible amount for this three-month deductible period will be the total excess income for those same three months. All other deductible rules will apply and the individual can be certified for Medicaid for that period on the first day they meet the deductible during that three month period.

5.9.6 Disability Application Denials

5.9.6.1 DDB Returns a Negative Presumptive Disability Decision

If the DDB returns a negative Presumptive Disability decision, the IM worker must send a manual notice of decision to the applicant. The notice must state:

"Your request for Medicaid is based upon your statement that you are disabled. The final decision on your disability has not yet been made, however we have determined that you cannot be considered presumptively disabled. This means that you cannot be certified as eligible for Medicaid as a person with a disability until a final disability decision has been made. You will be informed when the Disability Determination Bureau makes the final disability decision. (Wis. Stats. ss. 49.46 and 49.47)"

5.9.6.2 Recipient Ineligible for Non-Medical Reasons

If a member is determined ineligible for non-medical reasons, you may terminate PD with timely notice without waiting for DDB's final disability decision. In such a case, notify DDB immediately at, (608) 266-1565, that a medical determination is no longer needed.

5.9.6.3 DDB Reverses PD Decision Made by DDB or by the IM Worker

If the DDB denies a disability application their decision reverses a PD decision made by the IM worker or by DDB. Terminate Medicaid eligibility following timely notice requirements. Medicaid eligibility based on a PD decision does not continue during the period a person is appealing DDB's decision that they are not disabled.

Benefits received while the disability decision was pending are not subject to recovery, unless the individual made misstatements or omissions of fact at the time of the presumptive disability determination.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

5.10 MAPP (MEDICAID PURCHASE PLAN) DISABILITY

[5.10.1 MAPP Introduction](#)

[5.10.2 MAPP Recipients over Age 65](#)

5.10.1 MAPP Introduction

When a *disability* determination for the *MAPP* is required, complete the application process in [Section 5.3 Disability Application Process](#).

Sections 12 and 13 of the Application for Medicaid Disability form ([F-10112](#)) must be completed in full detail in all MAPP disability determination requests. The Disability page in *CWW* should be coded to indicate whether the request is for a MAPP disability determination or both a regular Medicaid disability determination and a MAPP disability. It is advisable to have both determinations completed if an *applicant* may move from regular Medicaid disability to MAPP disability.

A determination of disability for MAPP excludes consideration of Substantial Gainful Activity (SGA), while a regular Medicaid disability determination does not.

5.10.2 MAPP Recipients over Age 65

A MAPP member who loses *SSDI* benefits solely because he or she turns 65 does not need a disability re-determination until the next scheduled diary date. If there is no scheduled diary date, a MAPP disability determination must be done, and MAPP eligibility continued until the MAPP disability determination is made by the *DDB*.

For more information on MAPP, see [Section. 26.1 Medicaid Purchase Plan Introduction](#).

*This page last updated in Release Number: 10-02
Release Date: 06/22/10
Effective Date: 06/22/10*

6 RESIDENCY

6.1 RESIDENCY ELIGIBILITY

[6.1.1 Residency Eligibility Introduction](#)

[6.1.2 Migrant Farm Worker](#)

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 minimum requirement for the length of time the person has been physically present in Wisconsin. Wisconsin residents who are temporarily out of state, (see [Section 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 [Section 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 1: This is George's first day in Wisconsin. He states that he intends to reside in Wisconsin. For Medicaid purposes, George is a Wisconsin resident.

Example 2: Margie lives in Florida. She is planning to move to Wisconsin in the next few months. Margie would not be considered a resident of Wisconsin until she is physically present in Wisconsin.

6.1.2 Migrant Farm Worker

A migrant who meets the following conditions is a Wisconsin resident:

1. His or her primary employment in Wisconsin is in the agricultural field or cannery work, **and**
2. He or she is authorized to work in the US, **and**
3. He or she is not related (immediate family) by blood or marriage to the employer (as distinguished from a "crewleader"), **and**
4. He or she routinely leaves an established place of residence to travel to another locality to accept seasonal or temporary employment.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

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 **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.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

6.3 DETERMINING RESIDENCE

[6.3.1 Under Age 21](#)

[6.3.1.1 In an Institution](#)

[6.3.1.2 Not in Institution](#)

[6.3.2 Age 21 and Over](#)

[6.3.2.1 In an Institution](#)

6.3.1 Under Age 21

6.3.1.1 In an Institution

The residence of an institutionalized person under age 21 when his or her parents or legal guardian lives outside of Wisconsin is the state in which the parent or legal guardian states the institutionalized person is present, and intends to stay.

If the parents have abandoned him or her and no legal guardian has been appointed, his or her residence is the state in which the institution is, if the person making the Medicaid application lives in that same state.

If he or she is married, his or her residence is the institution's state.

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:
 1. 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.
 2. Living in another state when Wisconsin or one of its county agencies has legal custody of him or her.
 3. Living here and is an EBD Medicaid case (the person's eligibility is based on blindness or *disability*).

6.3.2 Age 21 and Over

6.3.2.1 In an Institution

The residence of an institutionalized person aged 21 or over is the state in which he or she is residing with the intent to remain.

If he or she is incapable of indicating intent, his or her residence is determined in the same way as the residence of an institutionalized person under age 21.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

6.4 SPECIAL SITUATIONS

[6.4.1 State Supplementary Payment](#)

[6.4.2 Homeless Persons](#)

6.4.1 State Supplementary Payment

The State Supplementary Payment (SSP) is the portion of an **SSI** payment paid by a state, not by the federal government. An SSP recipient's residence is the state making the SSP payment.

6.4.2 Homeless Persons

A homeless person living in Wisconsin meets the requirement of being physically present in Wisconsin. The agency must, by using its own address or some other fixed address, make Medicaid cards available to eligible applicants who have no fixed dwelling place or mailing address.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

6.5 ABSENCE

[6.5.1 Absence Introduction](#)

[6.5.2 Temporary Absence](#)

6.5.1 Absence Introduction

Once established, Wisconsin residence is retained until:

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.

6.5.2 Temporary Absence

Temporary absence ends when another state determines the person is a resident there for Medicaid purposes.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

6.6 RESERVED

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

6.7 RESERVED

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

6.8 INTERSTATE PLACEMENTS

[6.8.1 Interstate Placements Introduction](#)

[6.8.2 Reciprocal Agreement](#)

[6.8.3 Disputes](#)

6.8.1 Interstate Placements Introduction

An interstate placement occurs when a state or state contracted agency arranges for an individual to be admitted to an institution in another state.

"Arranges for" means any action by a state or state-contracted agency beyond providing information to the person or the person's family (or both). Do not consider the following to indicate interstate placement:

1. Giving information to individuals about another state's Medicaid program.
2. Giving information to persons about the availability of health care services and facilities in another state.
3. Helping a person locate an institution in another state when that person is capable of indicating intent and independently decides to move.

When a state or state-contracted agency makes the placement, the state making the placement is the person's Medicaid residence. The person's intent makes no difference. If Wisconsin places a person into an institution in Tennessee, Wisconsin remains the state of residence for Medicaid even if the person expresses an intent to reside in Tennessee.

If Tennessee places a person in Wisconsin, Tennessee is the Medicaid residence despite an indicated intent by the person to make his or her home in Wisconsin.

Follow this rule even when placement is made by a state because that state lacks a sufficient number of appropriate facilities to provide services to its residents.

Use the general rule of residency when a competent person leaves an institution in which he or she was placed by another state. If the person is not able to indicate intent, Medicaid residence continues to be that of the state that made the placement.

6.8.2 Reciprocal Agreement

Wisconsin has a reciprocal agreement with some other states (see the list below) in which persons that are placed in out-of-state institutions (not placed there as a result of an interstate placement) are the residents of the state where the institution is. For example, a person institutionalized in Wisconsin who would otherwise be considered a resident of Minnesota is a Wisconsin resident for Medicaid purposes.

These are the states with which we have this agreement:

- Alabama
- Arkansas
- California
- Georgia
- Idaho
- Kansas
- Kentucky
- Maryland
- Minnesota
- Mississippi
- New Mexico
- N. Dakota
- Ohio
- Pennsylvania
- S. Carolina
- S. Dakota
- Texas
- Virginia
- W. Virginia

6.8.3 Disputes

The state in which the person is physically present is the Medicaid residence when two or more states disagree about the person's residence.

If you determine that a state other than Wisconsin is the person's legal residence, contact the other state about providing Medicaid coverage.

*This page last updated in Release Number: 14-01
Release Date: 05/01/14
Effective Date: 05/01/14*

6.9 INMATES

[6.9.1 Definitions](#)

[6.9.2 Inmates Introduction](#)

[6.9.3 Inmates of State Correctional Institutions](#)

[6.9.4 State Correctional Institutions](#)

6.9.1 Definitions

An "inmate" is a person residing in a **public institution** on an involuntary basis. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate. A staff person voluntarily residing in a public institution is not considered an inmate. An individual voluntarily residing in an institution while waiting for other living arrangements to be made which are appropriate to the person's needs is not considered an inmate.

"Public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term "public institution" does not include a medical institution (see [Section 27.1 Institutions](#)), a publicly operated community residence that serves no more than 16 residents, or a child care institution in which **foster care** maintenance payments are made under title IV-E.

Note: The following are not publicly operated community residences, even though they may accommodate 16 or fewer residents:

1. Residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex, **or**
2. Correctional or holding facilities for individuals who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles.

6.9.2 Inmates Introduction

Individuals who are inmates of a public institution are not eligible for Medicaid, with two exceptions (outlined below). An inmate is a person who is residing in a public institution on an involuntary basis. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate. A staff person voluntarily residing in a public institution is not considered an inmate. An individual voluntarily residing in an institution while

waiting for other living arrangements to be made which are appropriate to the person's needs is not considered an inmate.

Inmates are ineligible for Medicaid services on any day in which they are residing in a public institution. Providers are prohibited from receiving payment for any services rendered to an inmate even if the inmate is still certified as eligible for Medicaid and has not received any negative notice. Inmates may never be considered temporarily absent from a household and receive Medicaid benefits. Temporary absence policies do not apply in the case of inmates.

Individuals who are inmates of a public institution are not eligible for Medicaid, with the following two exceptions:

1. **Prenatal Exception** - Pregnant women may apply for and receive BCPP while they are an inmate.
2. **Inpatient Exception** - If an inmate resides outside of a public correctional institution for more than 24 hours at any one time, he or she can qualify for Medicaid during that time period if he or she meets all other eligibility criteria. For example, if an inmate of a public institution is admitted, as an inpatient to a medical institution for 24 hours or more, and is otherwise eligible, manually certify him or her for Medicaid from the admission date through the discharge date.

Procedures for processing inmates of state facilities are covered in 6.9.3 Inmates of State Correctional Institutions below.

6.9.3 Inmates of State Correctional Institutions

Use the following process for inmates of state correctional institutions:

1. **DOC** staff submits an ACCESS application, which will be systematically routed to EM CAPO. Superintendents of state correctional facilities (wardens) or their designee may sign the application for the inmate. Refer to [Section 6.9.4 State Correctional Institutions](#) for the list of state correctional facilities at which the Warden may sign the application.
2. Process the inmate as a one-person household with a living arrangement of "01-Independent (Home/Apt/Tlrlr)" on the demographics page.
3. If the inmate is 65 years or older or ineligible for BadgerCare Plus due to excess income, test for EBD, collecting asset information from DOC. If there is no **disability** determination on file, instruct, DOC to submit a Medicaid Disability Application ([F-10112](#)) along with the Medicaid application ([F-10101](#)). Suppress the verification checklist for the **MADA**.
4. If the individual is eligible, close the case in CARES by changing the Health Care Request page to "N". Suppress CARES-generated notices for Medicaid and any program the individual has not requested. Manually certify the individual with the appropriate medical status code (see below), from the hospital admission date through the date of discharge. If the individual has not yet been discharged,

certify the individual from the date of admission through the estimated discharge date. Send a manual positive notice to DOC indicating the dates of eligibility.

Note: It is not necessary to provide a 10-day notice of termination for Medicaid when the reason for termination is the return of the individual to prison.

5. If the individual is ineligible, confirm the denial on CARES, and allow CARES generated notices to be sent to the designated DOC staff person.

For a list of Med Stat Codes, see [Process Help Section 81.5 Med Stat Code Chart](#).

6.9.4 State Correctional Institutions

Brown

Green Bay Correctional Institution (GBCI)
Sanger Powers Correctional Institution (SPCI)

Chippewa

Chippewa Valley Correctional Treatment Facility (CVCTF)
Stanley Correctional Institution (SCI)

Columbia

Columbia Correctional Institution (CCI)

Crawford

Prairie du Chien Correctional Institution (PDCI)

Dane

Oakhill Correctional Institution (OCI)
Oregon Correctional Center (OCC)
Thompson Correctional Center (TCC)
Mendota Juvenile Treatment Center (MJTC)

Dodge

John Burke Correctional Center (JBCC)
Dodge Correctional Institution (DCI)
Fox Lake Correctional Institution (FLCI)
Waupun Correctional Institution (WCI)

Douglas

Gordon Correctional Center (GCC)

Fond du Lac

McNaughton Correctional Center (MCC)
Taycheedah Correctional Institution (TCI)

Wisconsin's Women Correctional System (WWCS)

Grant

Wisconsin Secure Program Facility (WSPF)

Jackson

Black River Correctional Center (BRCC)

Jackson Correctional Institution (JCI)

Kenosha

Kenosha Correctional Center (KCC)

Lincoln

Lincoln Hills School (LHS)

Milwaukee

Marshall E. Sherrer Correctional Center (MSCC)

Milwaukee Secure Detention Facility (MSDF)

Milwaukee Women's Correctional Center (MWCC)

Felmers O. Chaney Correctional Center (FCCC)

Racine

Robert E. Ellsworth Correctional Center (RECC)

Racine Correctional Institution (RCI)

Racine Youthful Offender Correctional Facility (RYOCF)

St. Croix

St. Croix Correctional Center (SCCC)

Sauk

New Lisbon Correctional Institution (NLCI)

Sawyer

Flambeau Correctional Center (FCC)

Sheboygan

Kettle Moraine Correctional Institution (KMCI)

Waushara

Redgranite Correctional Institution (RCI)

Winnebago

Drug Abuse Correctional Center (DACC)

Oshkosh Correctional Institution (OSCI)

Winnebago Correctional Center (WCC)

Wisconsin Resource Center (WRC)

*This page last updated in Release Number: 14-01
Release Date: 05/01/14
Effective Date: 04/01/14*

7 U.S. CITIZEN OR QUALIFYING IMMIGRANT

7.1 US CITIZENS AND NATIONALS

[7.1.1 US Citizens and Nationals Introduction](#)

[7.1.2 Child Citizenship Act of 2000](#)

[7.1.3 Compact of Free Association States](#)

7.1.1 US Citizens and Nationals Introduction

All U.S. citizens and U.S. nationals are entitled to apply for and receive Medicaid if they provide documentation of their citizenship and identity and meet all other eligibility requirements.

A U.S. citizen is anyone who:

1. Was born in the United States, the Commonwealth of Northern Mariana Islands, Puerto Rico, Guam or the U.S. Virgin Islands.
2. Was born to a U.S. citizen who was living abroad.
3. Is a naturalized U.S. citizen.

A U.S. national is anyone who was born in American Samoa (including Swain's Island). The Independent State of Samoa (also known as Western Samoa) is not part of American Samoa, therefore individuals from this country are not U.S. nationals.

7.1.2 Child Citizenship Act of 2000

The Child Citizenship Act (CCA) of 2000 amended the Immigration and Naturalization Act (INA) to provide derivative citizenship to certain foreign-born children of U.S. citizens. This applies to individuals who were under 18 years old on February 27, 2001 and anyone born since that date. The children included in the act are:

- Adopted children meeting the two year custody requirement ,
- Orphans with a full and final adoption abroad or adoption finalized in the U.S,
- Biological or legitimated children, **or**
- Certain children born out of wedlock to a mother who naturalizes

The CCA provides that foreign-born children who meet the conditions below automatically acquire U.S. citizenship on the date the conditions are met. They are not

required to apply for a certificate of naturalization or citizenship to prove U.S. citizenship. These conditions are that the child:

- Has at least one parent who is a U.S. citizen (whether by birth or naturalization),
- Is under 18 years of age,
- Has entered the U.S. as a legal immigrant,
- If adopted, has completed a full and final adoption; **and**,
- Lives in the legal and physical custody of the U.S. citizen parent in the U.S.

Adopted children automatically become U.S. citizens if they meet all the above conditions and were:

1. **Adopted under the age of 16**, and have been in the legal custody of and have resided with the adopting parent or parents for at least two years,
2. **Adopted while under the age of 18**, and have been in the legal custody of and have resided with the adopting parent or parents for at least two years and are a sibling of another adopted child who is under 16,
3. **Orphans adopted while under the age of 16**, who have had their adoption and immigration status approved by the **USCIS** (Form I-171, "Notice of Approval of Relative Immigrant Visa Petition"). These children need not have lived with the adoptive parents for two years, **or**
4. **Orphans adopted under the age of 18**, who have had their adoption and immigration status approved by the USCIS, and are siblings of another adopted child who is under the age of 16. These children need not have lived with the adoptive parents for two years.

7.1.3 Compact of Free Association States

Persons from the Compact of Free Association States (**CFAS**) are not considered U.S. citizens or nationals. The Compact of Free Association States include the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau. Citizens of the Compact of Free Association States have a special status with the US that allows them to enter the country, work here and acquire an **SSN** without obtaining an immigration status. They are not eligible for Medicaid, unless they have obtained a qualifying immigration status. Those CFAS citizens who do not have one of the immigration statuses listed in [Section 7.3.4 Immigration Status Chart](#) may qualify for Medicaid Emergency Services only.

*This page last updated in Release Number: 08-03
Release Date: 08/13/08
Effective Date: 08/13/08*

7.2 DOCUMENTING CITIZENSHIP AND IDENTITY

[7.2.1 Documenting Citizenship and Identity Introduction](#)

[7.2.1.1 Covered Programs](#)

[7.2.1.2 Exempt Populations](#)

[7.2.2 Reserved](#)

[7.2.3 Reserved](#)

[7.2.4 Hierarchy of Documentation](#)

[7.2.4.1 Levels of Documentation](#)

[7.2.4.2 Naturalized Citizens](#)

[7.2.4.3 Agencies Paying for Documentation](#)

[7.2.4.4 Tribes With An International Border](#)

[7.2.5 Policy for Special Populations](#)

[7.2.6 Situations Which Require Special Documentation Processing](#)

[7.2.6.1 Person Add](#)

[7.2.6.2 Individuals Without Verification and Affect on Household Eligibility](#)

[7.2.6.3 Individuals Gaining Citizenship Through The Child Citizenship Act of 2000](#)

[7.2.6.4 Non-citizens](#)

[7.2.6.5 Individuals in Institutional Care Facilities](#)

7.2.1 Documenting Citizenship and Identity Introduction

The Federal Deficit Reduction Act of 2005 requires persons applying for or receiving Medicaid, BadgerCare Plus, or Family Planning Waiver (FPW) benefits, who have declared that they are a U.S. citizen, to provide documentation of their U.S. citizenship and identity.

Agencies must comply with the new Medicaid requirement to document citizenship and identity in order for the state to obtain federal matching funds. As part of on-going *DHS* quality assurance initiatives, periodic quality control reviews will be done on randomly selected cases throughout the state to monitor agency compliance. Cases will be examined to determine if proper documentation was used to verify citizenship/identity and if the proper verification code was used. The Department will work with non-compliant agencies to achieve compliance.

Any document used to establish U.S. citizenship must show either a birthplace in the U.S., or that the person is otherwise a U.S. citizen. In addition, any document used to establish identity must show identifying information that relates to the person named on the document. For a list of all the allowable documentation, see [Process Help Section 68.3 Acceptable Citizenship and Identity Documentation](#).

If an individual has provided proof of citizenship in a state other than Wisconsin, the *IM* worker can either request that the individual resubmit the documentation or request and obtain a copy or electronic copy of the original documentation reviewed by the other state to keep on file in Wisconsin.

Agencies may accept citizenship and identity documents from a woman whose last name has changed due to marriage or divorce if the documentation matches in every

way with the exception of the last name. If there is any doubt, the agency may request that the individual provide an official document verifying the change such as a marriage license or divorce decree. If an individual has changed his or her first and last name, he or she must produce documentation from a court or governing agency documenting the change.

A document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with the tribe (such as a tribal enrollment card or certificate of degree of Indian blood) is now considered a “Level 1” form of documentation of citizenship and identity.

Applicants who are otherwise eligible and are only pending for verification of citizenship and identity must be certified for health care benefits, within the normal application processing timeframe (30 days from the filing date), as long as the *applicant* has notified the worker that he or she is taking steps to obtain the necessary documentation or has asked for the worker’s assistance to obtain it.

The applicant will have 95 days after the request for verification to provide the requested documentation. If the requested verification is not provided by the end of the 95 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 95 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.

Once the citizenship and identity requirement is met, it need not be applied again, even if the person loses Medicaid at some point and later re-applies. A person should ordinarily be required to submit evidence of citizenship and identification only once, unless other information is received causing the evidence to be questionable.

Note: Do not re-verify identity for a person who has had his or her identity verified through the signing of a Statement of Identity for Children Under 18 Years of Age, F-10154 ([English](#)) ([Spanish](#)).

Documentation submitted by the applicant or *member* to satisfy the new requirement must be maintained in the case record.

See [Process Help Section 68.1 General Citizenship And Identity Verification Requirement Information For Medicaid, BadgerCare Plus And Family Planning Only Services Benefits](#) for tools that IM workers can use to assist clients and applicants in meeting this requirement.

7.2.1.1 Covered Programs

The citizenship and identity documentation requirement covers all non-exempt applicants and members of:

- BadgerCare Plus
- Medicaid
- Katie Becket

Note: Eligibility for Katie Becket is determined by Division of Long Term Care staff, therefore they will be ensuring citizenship and identity verification.

- **TB**-related Medicaid **and**
- **WWWMA**

Note: TB and WWWMA eligibility is not determined in **CWW**, therefore it is important to ensure that citizenship and identity verification is done only once.

7.2.1.2 Exempt Populations

The following populations are exempt from the new citizenship and identity documentation requirement:

- Anyone currently receiving **SSDI**.
- Anyone who is currently receiving **SSI** benefits.
- Anyone currently receiving Medicare.
- Anyone currently receiving **Foster Care** (Title IV-E and Non IV-E).
- Anyone currently receiving Adoption Assistance.
- Inmates applying for or receiving BadgerCare Prenatal Program benefits.
- All persons who have ever been eligible for Wisconsin Medicaid or BadgerCare Plus as a CEN, are now exempt from ever having to provide documentation of citizenship.

Former SSI and Medicare Recipients

States cannot consider individuals who received Medicare or SSI in the past to be exempt. An individual is not required to be a citizen to receive these benefits. Since **SSA** does not share information regarding the reason benefits were lost, it is not possible to determine if the termination was due to citizenship status or not.

Note: Confirm the receipt of SSI, SSDI, and Medicare through the following data exchanges:

- For SSI: use DXSX
- For SSDI: use DXSA
- For Medicare: use DXSA

7.2.2 Reserved

7.2.3 Reserved

7.2.4 Hierarchy of Documentation

The list of valid documents used to verify citizenship and identity is divided into five levels in accordance with federal regulations. Level 1 consists of documents of the highest reliability and can prove both citizenship and identity. Levels 2 through 4 consists of documents that can prove citizenship only with Level 2 being the most reliable and Level 4 the least reliable. Level 5 consists of documents that can prove identity only. Applicants and members must provide documentation from the highest level available that can be obtained during the reasonable opportunity period.

If an individual needs to verify citizenship and/or identity at the point of application or renewal he or she should try to fulfill the requirement with proof he or she already has available. If an applicant/member contacts the agency, work with him or her to check Documentation Levels 1 through 5 to determine if anything on the list is readily available to the applicant/ member. If an applicant/member was born in Wisconsin, use the online Birth Query to verify citizenship.

In certain circumstances the agency can authorize payment of documentation for an applicant/member. See [Section 7.2.4.3 Agencies Paying for Documentation](#).

7.2.4.1 Levels of Documentation

See [Process Help Section 68.3 Acceptable Citizenship and Identity Documentation](#).

Level 1 – Evidence of Citizenship and Identity

Primary evidence documents both citizenship and identity. Primary evidence of citizenship and identity is the most reliable way to establish that the person is a U.S. citizen. If an individual presents documents from level 1, no other information is required; however, relatively few Medicaid applicants and members may be able to provide documents from this group.

Level 2 – Evidence of Citizenship

Secondary evidence of citizenship is the next most reliable way to establish someone is a U.S. citizen. Many Medicaid applicants and members will be able to present documents from level 2 during the reasonable opportunity period and should be encouraged to do so. Note, however, that a document from this group is evidence of U.S. citizenship only and must be accompanied by evidence of identity.

Note: Completing an on-line birth query (level 2 documentation) can be done for all persons born in Wisconsin. Enter TRAN code MNOS on CARES mainframe screen, hit enter, then F2. There is no cost to the agency to use this method of verification.

Level 3 – Evidence of Citizenship

Third level evidence of U.S. citizenship is acceptable and may be presented by applicants and members who are unable to obtain level 1 or level 2 evidence during the reasonable opportunity period. As with level 2 evidence, a document from this group is evidence of U.S. citizenship only and must be accompanied by evidence of identity.

Level 4 – Evidence of Citizenship

Fourth level evidence of U.S. citizenship is acceptable evidence of the lowest reliability. While most Medicaid applicants and members will be able to present documents at this level, they should do so only if unable to obtain evidence of citizenship from the other levels during the reasonable opportunity period. As with second and third level evidence, a document from this group is evidence of U.S. citizenship only and must be accompanied by evidence of identity.

Level 5 – Evidence of Identity

Level 5 documentation can only be used to verify identity. Documentation of citizenship from levels two through four must be accompanied by evidence of the applicant's or member's identity.

The applicant may provide three or more corroborating documents, such as a marriage license, divorce decree, high school or college diploma, property *deed*/title, death certificate, or employer ID card, to prove identity. This option can only be used if the applicant submitted level 2 or 3, not level 4, citizenship documentation. The applicant may not use a document that was also used for citizenship verification.

7.2.4.2 Naturalized Citizens

Naturalized citizens must provide level 1 or 2 citizenship documentation. The Citizenship Affidavit is also available for this population if no document from level 1 or 2 is available. This group cannot use level 3 or 4 documentation.

7.2.4.3 Agencies Paying for Documentation

The worker can authorize payment for a birth certificate from the state where the applicant was born and/or a WI State ID if an applicant/member:

- Has no documentation from Levels 1-5.
- Needs either an out of state birth certificate and/or has no identity documentation, **and**
- Requests financial assistance.

Note: If a member has obtained and already paid for his or her own documentation and later asks the IM agency for reimbursement of those costs, the IM agency should not provide reimbursement. If an individual has requested and paid for documentation before applying but does not yet have the documentation, do not confirm program

eligibility for this individual. Eligibility can only be granted once the individual receives documentation and provides it to the agency.

If an individual was born in Wisconsin and not found in the Wisconsin online birth query, agencies may authorize payment for a WI birth certificate to verify citizenship.

IM agencies should pay for a birth certificate or state ID card before using the "Special Populations" option (see [Section 7.2.5 Policy for Special Populations](#)). If there is an opportunity to obtain a document that meets federal guidelines then that should be pursued.

However, when an applicant/member lacks any identity documentation needed to apply for a birth certificate or lacks any citizenship documentation to be able to apply for an ID card, it is appropriate to consider using the Written Affidavit for citizenship and/or "Special Populations Policy.

In order to obtain birth certificates or state ID cards for applicants/members, agencies need to follow the process outlined in [Process Help Section 68.2.5 Citizenship and ID>Documentation and Verification Codes](#).

7.2.4.4 Tribes With An International Border

For tribes having an international border and whose membership includes non-U.S. citizens, tribal enrollment/membership documents may be used for purposes of proving both citizenship and identity.

7.2.5 Policy for Special Populations

It is expected that all non-exempt individuals requesting or receiving Medicaid provide acceptable documentation to verify citizenship and identity from the federally approved Levels 1 through 5 at application or review. However, certain special populations may be particularly disadvantaged with regard to providing the required documentation. For some persons within a special population, it will be allowable to accept other documents besides those listed in Levels 1-5, once it is determined that the person is unable to produce any Level 1-5 documentation.

This policy only applies when it is determined that an individual within a special population is in a situation where he or she does not have the ability to obtain citizenship or identity documentation from Level 1-5. This policy should be used with discretion and only when an individual has no other means of meeting the requirement.

Examples of individuals in special populations include, but are not limited to, persons who:

- Are physically or mentally incapacitated and whose condition renders them unable to provide necessary documentation.

- Are chronically homeless and whose living arrangement makes it extremely difficult to provide the necessary documentation.
- Are minors.
- Have religious beliefs that prevent them from securing the documentation.

There are two ways for individuals in special populations to meet the citizenship and identity documentation requirement:

1. Present other documents besides those listed in Levels 1-5 to meet the requirement as long as the document meets the general documentation requirement stated here:

“Any document used to establish U.S. citizenship must show either a birthplace in the U.S. or that the person is otherwise a U.S. citizen. Any document used to establish identity must show identifying information that relates to the person named on the document.”

Some examples of documents that could be used to establish citizenship for special populations as long the document shows a birthplace in the U.S. or that the person is otherwise a U.S. citizen are:

- Hospital “souvenir” birth certificate
- Baptismal certificate
- Native American documentation

Below are examples of documents that could be used to establish identity for special populations as long the document shows some identifying information (e.g., name, address, telephone number, etc.) that relates to the individual:

- Social Security Card
- Driver education course completion certificate
- School record or transcript
- Credit card with signature
- Voter registration materials
- Permanent Resident card

Example 3: Due to their religious practices, an Amish family is not able to present a birth certificate for their child because the child was not born in a traditional hospital setting and no record of the child’s birth exists within the state system. In addition, the child is home schooled so there is no school identification card to present for identification verification. However, the family is able to produce a signed letter from their church leader that states the child’s birth place and birth date. This document can be used to satisfy the citizenship and identification requirement under the temporary policy for Special Populations.

2. The newly developed Statement of Citizenship and/or Identity for Special Populations form ([F-10161](#)) can be used to meet the new requirement only when no other documentation is available from Levels 1-5 or item #1 above.

This form can be completed by a related or unrelated individual who knows the applicant/member, an *authorized representative*, an IM Agency worker, a worker for a housing agency who is aware of the individual's living situation, a Medicaid provider for a *minor*, etc. Additional requirements concerning the [F-10161](#) are as follows:

- The person completing the form attesting to another person's citizenship must be a U.S. citizen.
- IM agencies are not required to verify the citizenship of the person signing the form.
- Do not accept a form attesting to the citizenship of another individual when you know the person completing the form is not a U.S. citizen.

Note: An [F-10161](#) can be signed by the authorized representative of an individual who is not able to procure any other documents on his or her own.

While an IM worker is obligated to assist an applicant or member who asks for help in meeting the citizenship and identity requirement, this does not necessarily mean the IM worker must sign the [F-10161](#). The signatory to the [F-10161](#) must know and be able to truthfully attest to the applicant/member's citizenship or identity. If an IM worker can do this for an applicant/member, then he or she may sign the form.

Maintain copies of any documents secured under this temporary policy in the case record. Enter Case Comments to document why this policy was used and note whether the [F-10161](#) or another document was used to verify citizenship and identity.

Note: An individual who met the citizenship requirement by using documents obtained under the Special Populations policy or by using the [F-10161](#) has complied with the federal requirement and is not required to provide other documentation at his/ her next review.

If you are aware of an individual who meets the special population category outlined above and whose Medicaid application has been denied or eligibility has ended because of his or her inability to provide acceptable documentation, contact the individual to see if the Special Populations policy may be applied. See Documentation Level 7 of the [Acceptable Citizenship and Identity Documentation](#).

7.2.6 Situations Which Require Special Documentation Processing

7.2.6.1 Person Add

A person being added to a case is subject to the new verification requirement at the time of his or her application. Inform the applicant of the documentation requirement

and give him or her the “reasonable opportunity period” to comply. Do not grant eligibility for the individual until he/she has submitted valid documentation. If documentation is not received timely, deny Medicaid for that individual only. Do not require other non-exempt household members to submit citizenship or identification documentation until their next review.

7.2.6.2 Individuals Without Verification and Affect on Household Eligibility

IM workers should not delay an individual household member’s eligibility when awaiting another household members’ 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. See [Process Help Section 68.2 Documentation And Verification Codes](#) for processing instructions.

7.2.6.3 Individuals Gaining Citizenship Through The Child Citizenship Act of 2000

Certain foreign-born individuals have derivative U.S. citizenship as a result of the Child Citizenship Act (CCA). Within the context of the Medicaid citizenship verification requirement, this means that for any applicant or member claiming citizenship through the CCA, IM workers should not request documentation for that person. In these cases, IM workers need to acquire documentation proving the citizenship and identity of at least one U.S. citizen parent. The parent’s U.S. citizenship is the basis for the child receiving derivative citizenship.

For persons who meet the citizenship verification requirement through the means allowed in the CCA, this is considered level 2 evidence. Therefore this counts for citizenship only and the individual needs to provide another document to verify identity. The code <CA> should be used in the Medicaid Citizenship Verification field.

See [Section 7.1.2 Child Citizenship Act of 2000](#).

7.2.6.4 Non-citizens

As a reminder, do not request or require citizenship and identity documentation from individuals who have not declared that they are citizens. Non-citizens who apply for IM programs are not subject to this policy. Legal non-citizens are subject to the verification process through SAVE and undocumented non-citizens do not have any status that can be verified. Undocumented non-citizens can apply for Emergency Medicaid or BadgerCare Plus Prenatal Program and should not be subject to the citizenship verification policy.

When an individual who had legal non-citizen status subsequently gains U.S. citizenship, this is recorded in SAVE. Therefore, SAVE can be used to verify these individuals’ citizenship. The verification result from SAVE will be used to verify these individuals’ citizenship. The verification result from SAVE will be “individual is a US Citizen”. Please consult [Process Help Chapter 82 SAVE](#) for instructions on using SAVE. Use the <SV> code in the Medicaid Citizenship verification field when using SAVE for

this population. These individuals do still need proof of identity since the SAVE verification is considered to be Level 2 citizenship documentation.

7.2.6.5 Individuals in Institutional Care Facilities

Disabled individuals in institutional care facilities may have their identity attested to by the facility director or administrator when nothing else is available. Use the State of Identity for Persons In Institutional Care Facilities form ([F-10175](#)) for this purpose. A medical institution can be, but is not limited to, *SNF*, *ICF*, institutions for mental disease (IMD), and hospitals.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

7.3 IMMIGRANTS

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7.3.1 Immigrants Introduction

Immigrants are persons who reside in the U.S., but are not U.S. citizens or nationals. The immigrants described below, who apply for Medicaid and meet all eligibility requirements, are entitled to receive Medicaid benefits.

1. A refugee admitted under Immigration and Nationality Act (INA) Section 207.

A refugee is a person who flees his or her country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group.

An immigrant admitted under this refugee status may be eligible for Medicaid even if his or her immigration status later changes.

2. An asylee admitted under INA Section 208.

Similar to a refugee, this is a person who seeks asylum and is already present in the U.S. when he or she requests permission to stay.

An immigrant admitted under this asylee status may be eligible for Medicaid even if his or her immigration status later changes.

3. An immigrant whose deportation is withheld under INA Section 243(h) and such status was granted prior to April 1, 1997, or an immigrant whose removal is withheld under INA Section 241(b)(3) on or after April 1, 1997.

An immigrant admitted under this status may be eligible for Medicaid even if his or her immigration status later changes.

4. A Cuban/Haitian entrant.

An immigrant admitted under this Cuban/Haitian entrant status may be eligible for Medicaid even if his or her immigration status later changes.

5. An American Indian born in Canada who is at least 50 percent American Indian by blood or an American Indian born outside the U.S. who is a member of a federally recognized Indian tribe.

6. Victims of a severe form of trafficking in accordance with 107(b)(1) of the Trafficking Victims Protection Act of 2000 (P.L. 106-386).

7. [Lawfully admitted for permanent residence under the INA.](#)

8. [Paroled into the U.S. under INA Section 212\(d\)\(5\).](#)

9. [Granted conditional entry under immigration law in effect before April 1, 1980 \[INA Section 203\(a\)\(7\)\]](#)

10. [An immigrant who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.](#)

11. [An immigrant whose child has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.](#)

12. [An immigrant child who resides with a parent who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.](#)

7.3.1.1 Special Provisions for Immigrants in items 7-12

**If these immigrants (from items 7-12) lawfully entered the U.S. on or after August 22, 1996, they must also be *one* of the following:

- a. Lawfully residing in Wisconsin and an honorably discharged veteran of the U.S. Armed Forces, **or**

- b. Lawfully residing in Wisconsin and on active duty (other than active duty for training) in the U.S. Armed Forces, **or**
- c. Lawfully residing in Wisconsin and the [spouse](#), unmarried dependent child, or surviving spouse of a person described in "a" or "b" **or**
- d. An Amerasian, **or**
- e. Resided in the U.S. for at least five years since his or her date of entry.

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

- 1. Lawfully Admitted for Permanent Residence (CARES TCTZ Code #1 in the [Immigration Status Chart](#) below),
- 2. Lawfully present under Section 203(a)(7) (Code #3 in the [Immigration Status Chart](#) below),
- 3. Lawfully present under Section 212(d)(5) (Code #6 in the [Immigration Status Chart](#) below), **or**
- 4. Who suffer from domestic abuse and are considered to be a battered immigrant (Code #16 in the [Immigration Status Chart](#) below),

no longer have to wait 5 years to be eligible for full benefit Medicaid and BadgerCare Plus. This policy applies to both persons in existing open cases and new applicants.

Women have the 5-year ban lifted when their pregnancy is verified and continues for an additional 60 days after the last day of pregnancy and through the end of the month in which the 60th day occurs.

Immigrants, who do not appear in the lists above, who apply for Medicaid and meet all eligibility requirements except for citizenship are entitled to receive Medicaid Emergency Services only (see the [BadgerCare Plus Eligibility Handbook](#)).

Pregnant immigrants who do not appear in the list above, who apply for the BadgerCare Plus Prenatal Program (BC+PP) (see the [BadgerCare Plus Eligibility Handbook](#)) and who meet the eligibility requirements except for citizenship are entitled to receive those benefits.

Immigration status is an individual eligibility requirement. It does not affect the eligibility of the Medicaid Group. The citizen spouse or child of an ineligible immigrant may still be eligible even though the immigrant is not.

Verify immigration status using the procedures in the [SAVE Program Guide](#).

7.3.2 Public Charge

The receipt of Medicaid by an undocumented, non-qualifying, or qualifying immigrant or by the children or spouse for whom the individual is legally responsible does not establish the person as a public charge.

Undocumented, non-qualifying, or qualifying immigrants are considered to be a public charge if while receiving Medicaid, he or she is in a medical institution for more than the length of a rehabilitative stay.

Undocumented, non-qualifying, or qualifying immigrants concerned about being considered a "public charge," should be directed to contact the [INS field office](#) to seek clarification of the difference between rehabilitative and other types of institutional stays.

7.3.3 INS Reporting

Do not refer an immigrant to Immigration and Naturalization Service (INS) unless information for administering the Medicaid program is needed. For example, if Medicaid needs to determine an individual's location for repayment or fraud prosecution, or to determine his or her immigration status.

7.3.4 Immigration Status Chart

CARES TCTZ Code	Alien Status	Arrived Before 08/22/96	Veteran*/Amerasian Arrived before 8-22-96	Arrived on or after 8-22-96	Veteran*/Amerasian Arrived on or after 8-22-96	Children under 19 and pregnant women
01	Lawfully admitted for permanent residence	Eligible	Eligible	Ineligible for 5 years	Eligible	Eligible effective 10-01-09
02	Permanent resident under color of law (PRUCOL)	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
03	Lawfully present under Section 203(a)(7)	Eligible	Eligible	Ineligible for 5 years	Eligible	Eligible effective 10-01-09
04	Lawfully present under Section 207(c)	Eligible	Eligible	Eligible	Eligible	Eligible
05	Lawfully present under Section 208	Eligible	Eligible	Eligible	Eligible	Eligible
06	Lawfully present under Section 212(d)(5)	Eligible	Eligible	Ineligible for 5 years	Ineligible for 5 years	Eligible effective 10-01-09
07	IRCA (No longer valid)	N/A	N/A	N/A	N/A	N/A

08	Lawfully admitted - temporary	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
09	Undocumented Alien	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
10	Illegal Alien	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
11	Cuban/Haitian Entrant	Eligible	Eligible	Eligible	Eligible	Eligible
12	Permanent Resident	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
13	Special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
14	Additional special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
15	Withheld deportation - Section 243(h)	Eligible	Eligible	Eligible	Eligible	Eligible
16	Battered Alien	Eligible	Eligible	Ineligible for 5 years	Ineligible for 5 years	Eligible effective 10-01-09
17	Amerasian	Eligible	Eligible	Eligible	Eligible	Eligible
18	Foreign-born American Indian	Eligible	Eligible	Eligible	Eligible	Eligible
19	Victims of Trafficking	Eligible	Eligible	Eligible	Eligible	Eligible
20	Lawfully Residing - to be used for all persons admitted under one of the Class of Admission Codes found in the table in section 7.4.4	Ineligible	Ineligible	Ineligible	Ineligible	Eligible

* "Veteran" includes certain veterans and active duty servicemen and women, their spouses, dependent children, or certain surviving spouses.

7.3.5 Iraqis and Afghans with Special Immigrant Status

Some Afghan and Iraqi aliens have been granted special immigrant status. Individuals and family members granted this special status are eligible for resettlement assistance, entitlement programs and other benefits the same as refugees admitted under section 207 of the INA. These groups have been admitted to the U.S. in Lawful Permanent Resident status; however for a limited time upon arrival they are treated as if they are in Refugee status for public benefits purposes.

Though treated like refugees, the individuals in this special immigrant status category are only able to access benefits for a limited time:

- Afghan special immigrants are eligible for Medicaid benefits for up to six months from the date they enter the country.
- Iraqi special immigrants are eligible for Medicaid benefits for up to eight months from the date they enter the country.

At the end of the six or eight month period, the immigration status for these populations becomes Lawful Permanent Resident (LPR). According to federal law, LPRs are subject to the five year bar on receiving public benefits. See [Section 7.3.4 Immigration Status Chart](#).

Spouses and unmarried children under age 21, who accompany or follow-to-join the principal special immigrant *applicant* are eligible for the same benefits as the principal applicant.

Any Iraqi or Afghan immigrant granted the special status, who applied after 12/26/2007 and was denied Medicaid benefits due to citizenship or immigration status, may request Medicaid benefits back to the original application filing date.

7.3.5.1 End of Temporary Benefit Period

Medicaid eligibility for special immigrants and family members must end within six or eight months after their US entry as special immigrants or conversion to special immigrant status, regardless of rules that are otherwise applied for their eligibility group (e.g., coverage of pregnant women until the end of their postpartum period).

These individuals would not be able to receive benefits until they have been here for five years from the date of entry. The five year clock begins from the individual's original date of entry and it does not start over once the limited special status benefits expire.

Iraqi and Afghan special immigrants and their families may qualify for Medicaid coverage of emergency services, until they meet the 5-year bar for qualified immigrants.

Note: An infant born in the U.S to a woman who was Medicaid eligible as an Iraqi or Afghan special immigrant on the baby's date of birth, is a U.S. citizen and deemed Medicaid eligible as a newborn until turning age one.

7.3.5.2 Counting Refugee Related Income

Refugee Cash Assistance (RCA) program payments are not counted as income for Medicaid. RCA is administered by Wisconsin Works agencies and is made available for refugees who do not qualify for Wisconsin Works.

Refugee "Reception and Placement" (R&P) payments are not counted as income for Medicaid. R & P payments are made to refugees during the first 30 days after their arrival in the U.S. R & P payments are made by voluntary resettlement agencies and may be a direct payment to the refugee individual/ family or to a vendor.

7.3.5.3 Refugee Medical Assistance

If an individual does not meet the other eligibility requirements for Medicaid, he or she may apply for Refugee Medical Assistance (RMA), which is not funded by Medicaid. RMA is considered a separate benefit from Medicaid but provides the same level of benefits as these programs. RMA is available only in the first eight months after a special immigrant's date of entry. If it is not applied for in that eight-month period, it cannot be applied for later. Iraqi immigrants may be eligible for RMA for eight months and Afghan immigrants may be eligible for RMA for six months.

While W-2 agencies have contractual responsibility for providing RMA, they need to coordinate with economic support agencies to ensure eligibility for all regular Medicaid subprograms is tested first.

More information about this program is in the [W-2 Manual Chapter 20](#)

Note: The federal Medicaid eligibility for all other refugees admitted under Alien Status Code 04 remains the same.

*This page last updated in Release Number: 11-02
Release Date: 07/27/11
Effective Date: 01/31/11*

[View History](#)

7.4 NON-IMMIGRANT, NON-CITIZENS

[7.4.1 Introduction](#)

[7.4.2 New Age Group](#)

[7.4.3 VIS SAVE Verification Responses](#)

[7.4.4 Class Of Admission \(COA\) Codes](#)

7.4.1 Introduction

Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3), offers states the option to cover children and pregnant women under the federal Medicaid and State Children's Health Insurance Programs who are not Qualified Aliens.

The law also affects children and pregnant women in a number of non-immigration statuses/classes (see table below) who are lawfully residing in the country for an indefinite period. This policy clarification allows children and pregnant women admitted to the United States in these statuses/classes to qualify for Medicaid and BadgerCare Plus, if they are otherwise eligible, starting October 1, 2009.

7.4.2 New Age Group

CMS requires that the new policies that apply to children also be applied to persons under age 21 who are institutionalized, including residents of **IMDs**). These changes are effective October 1, 2009.

7.4.3 VIS SAVE Verification Responses

All non-immigrants admitted legally to the United States for any reason will have some type of **USCIS** document, for example, a Non-immigrant Visa, Employment Authorization card, Passport, etc. The USCIS document proof provided by the non-immigrant individual will usually include a two to three digit code called the "Class of Admission Code" (COA) or the Section of Federal Law citation. The COA code is also found in the SAVE response when doing a SAVE query.



U.S. Citizenship and Immigration Services
WEB-3 Case Details

Case Verification Number: 201001912511100

Online Resources | Tutorial | Return to Home | Contact Us | Exit

Case Administration

Initial Verification
Search Cases
User Administration
Change Password
Pwd Challenge Q&A
Change Profile
Reports
View Reports

Initial Verification

Alien Number: 111111111 Benefits: Medicaid
I-94 Number:
Card Number:
Naturalization Number: Citizenship Cert. Number:
Visa Number: SEVIS ID:
Passport Number: Document Exp. Date:
Document Type: I-327 Other Document Desc:
Last Name: Test First Name: Test
Middle Name: Test Date of Birth: 06/15/1962
Initiated By: PWRWSOPH Initiated On: 01/19/2010

Initial Verification Results

Last Name: Test First Name: Test
Middle Name: Test COA Code: SE7
Country: LAOS - LAOS Date of Birth: 06/15/1962
Date of Entry: 12/07/1992 Date Admitted To: INDEFINITE
EAD Expiration Date:
System Response: LAWFUL PERMANENT RESIDENT-EMPLOYMENT AUTHORIZED

Print Case Details | Request Additional Verification | Complete and Close Case

A table of the COA codes or the Section of Law citation for this new non-immigrant population is included below. The non-immigrant children and pregnant women with the admission code or Federal law citation found in this table who are otherwise eligible are now able to receive full benefit Medicaid or BadgerCare Plus.

7.4.4 Class Of Admission (COA) Codes

USCIS Class of Admission Code or Section of the Federal Law Citation Authorizing Class	
Description	Class of Admission Code (COA)/Section of Law Citation
Aliens currently in temporary resident status pursuant to section 210 or 245A of the Act.	S16, S26, W16, W25, W26, W36 or 8 CFR 103.12(a)(4)(i)
Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the Act. Child accompanying or following to join a K-3 alien.	8 CFR 103.12(a)(4)(ii)
Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649. (These are the spouses and unmarried children of individuals granted temporary or permanent residence under Section 210 or 245A above.)	8 CFR 103.12(a)(4)(iv)
Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President.	8 CFR 103.12(a)(4)(v)
Aliens currently in deferred action status pursuant to Service Operations Instructions at OI 242.1(a)(22).	8 CFR 103.12(a)(4)(vi)
Aliens who are the spouse or child of a	8 CFR 103.12(a)(4)(vii)

United States citizen whose visa petition has been approved and who have a pending application for adjustment of status	
Legal non-immigrants from the Compact of Free Association states (Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau) who are considered permanent non-immigrants.	NA
An alien who is the fiancée or fiancé of a U.S. citizen entering solely to conclude a valid marriage contract.	K-1
Child of K-1	K-2
Spouse of a U.S. citizen who is a beneficiary of a petition for status as the immediate relatives of a U.S. citizen (I-130).	K-3
Child accompanying or following to join a K-3 alien.	K-4
Parent of an alien classified SK3 or SN3	N-8
Child of N-8 or of an alien classified SK1, SK2, SK4, SN1, SN2, SN4.	N-9
Temporary worker to perform work in religious occupations.	R1
Spouse and children of R1	R2
An alien who is in possession of critical reliable information concerning a criminal organization or enterprise, is willing to supply or has supplied such information to Federal or State law enforcement authorities or a Federal or State court; and whose presence in the United States the Attorney General determines is essential to the success of an authorized criminal investigation or the successful prosecution of an individual involved in the criminal organization or enterprise	8 U.S.C. 1101(a)(15)(S)(i)
An alien who the Secretary of State and the Attorney General jointly determine is in possession of critical reliable information concerning a terrorist organization, enterprise, or operation; is willing to supply or has supplied such information to Federal law enforcement authorities or a	8 U.S.C. 1101(a)(15)(S)(ii)

Federal court; will be or has been placed in danger as a result of providing such information; and is eligible to receive a reward from the State Department.	
An alien who is the spouse, married and unmarried sons and daughters, and parents of an alien in possession of critical reliable information concerning either criminal activities or terrorist operations.	8 U.S.C. 1101(a)(15)(S)
Individuals who have suffered substantial physical or mental abuse as victim of criminal activity.	U-1
An alien who is the spouse, child, unmarried sibling or parent of the victim of the criminal activity above.	U-2, U-3, U-4, U-5
An alien who are the spouses or children of an alien lawfully admitted for permanent residence and who have been waiting since at least December 2000 for their visa application to be approved.	V-1, V-2, V-3

For a complete table of the USCIS Class of Admission (COA) Codes log into the [SAVE system](#) and click on the "Online Resources" tab.

Note: There is no change in Medicaid or BadgerCare Plus eligibility policy for individuals in any other status or for those who are undocumented.

*This page last updated in Release Number: 10-01
Release Date: 04-02-10
Effective Date: 04-02-10*

8 MEDICAL SUPPORT

8.1 MEDICAL SUPPORT

[8.1.1 Medical Support Introduction](#)

[8.1.2 Recovery of Birth Costs](#)

[8.1.3 Referral to CSA](#)

8.1.1 Medical Support Introduction

Medical Support refers to the obligation that a parent has to pay for his or her child's medical care, either through the provision of health insurance coverage or direct

payment of medical bills. The **CSA** is responsible for establishing Medical support orders for some children receiving Medicaid who have an absent parent. The CSA is also responsible for establishing paternity and establishing medical support obligations for unpaid and ongoing medical support (including recovery of birth costs.)

8.1.2 Recovery of Birth Costs

When the non marital father of the unborn child is not included in the Medicaid group at the initial eligibility determination he could be held responsible for repayment of birth costs.

8.1.3 Referral to CSA

The **IM** agency provides the CSA with information vital to opening medical support cases. The IM agency also supplies continuing information, which assists the CSA in providing medical support services. At confirmation, CARES automatically sends a referral to the CSA for all Medicaid applications and person adds that include minors, unless the referral field on the Absent Parent Page is answered "No." The information on the Absent Parent page must be filled out completely and accurately.

Note: A Referral to Child Support form ([DWSP 3080](#)) only needs to be completed when the Absent Parent page cannot be completed in **CWW**.

BadgerCare Plus Note: While IM agencies are to continue referring the following individuals who are receiving BadgerCare Plus, the CSA's will be determining on their own, which cases will be provided Child Support Services. Not all BadgerCare Plus members will qualify for free Child Support services and be required to cooperate with CSA's.

The following individuals (including minors) for whom Medicaid is requested or being received, must be referred to the local CSA unless an exception is noted:

1. A pregnant woman who is unmarried or married and not living with her husband. Pregnant women are not required to cooperate with the CSA during the pregnancy and for two months after the end of pregnancy. The woman's eligibility for Medicaid will continue during this period, regardless of her cooperation.
2. A child receiving **SSI** only if the caretaker requests child support services for the child. Do not sanction this caretaker if he or she does not cooperate with the CSA.
3. Non-marital co-parents when paternity has not been legally established. This includes a non-marital co-parent even when:
 - a. A Statement of Paternity has been completed,
 - b. Both parents are in the home.

Exception: Do not refer parents to the CSA when both parents are in the home and the father's paternity has been legally established. (Paternity is legally

established by a court order or by a Voluntary Paternity Acknowledgment Form signed on or after May 1, 1998 and filed with the Wisconsin Vital Records office.)

Note: If a father's name appears on a Wisconsin Birth Certificate for a child born after 5/11/1998, it means paternity has been established.

4. Natural or adoptive parent(s) not living in the household.

Exception: Do not refer to the CSA when the only reason a parent or stepparent is not in the home is because he or she is in the military.

5. Married natural parents in the home, but:
 - a. Child was born prior to their marriage, and
 - b. Paternity was not established by court action or the birth was not legitimized after their marriage.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

8.2 MEDICAL SUPPORT/ CSA COOPERATION

[8.2.1 Medical Support / Child Support Agency \(CSA\) Cooperation](#)

[8.2.2 Failure to Cooperate](#)

8.2.1 Medical Support / Child Support Agency (CSA) Cooperation

Unless the person is exempt, or has good cause for refusal to cooperate (see [Section 8.3 Claiming Good Cause](#)), each *applicant/member* that is referred, must, as a condition of eligibility, cooperate in:

1. Establishing the paternity of any child born out of wedlock for whom Medicaid is requested or received, **and**
2. Obtaining medical support for the applicant and for any child for whom Medicaid is requested or received.

Cooperation includes any relevant and necessary action to achieve the above. As a part of cooperation, the applicant may be required to:

1. Provide verbal or written information known to, possessed by, or reasonably obtainable by the applicant.
2. Appear as a witness at judicial or other hearings or proceedings.
3. Provide information, or attest to the lack of information, under penalty of perjury.
4. Pay to the **CSA** any court-ordered medical support payments received directly from the absent parent after support has been assigned.
5. Attend office appointments as well as hearings and scheduled genetic tests.

Note: The applicant or member is only required to cooperate if the child under their care is eligible for benefits funded under Title XIX. If the child's Medicaid benefit is funded through any other source (Title XXI or GPR) the caretaker is not required to cooperate and can not be sanctioned for non-cooperation. Check the Medical Status codes to determine funding source. The CSA will monitor the child's Medicaid funding source.

8.2.2 Failure to Cooperate

The CSA determines if there is non-cooperation for individuals required to cooperate. The *IM* agency determines if good cause exists (see [Section 8.3.7 Determination](#)). If there is a dispute, the CSA makes the final determination of cooperation. The member remains ineligible until he or she cooperates, establishes good cause, or cooperation is no longer required.

The following individuals are not sanctioned for non cooperation:

1. Pregnant women.
2. Minors.
3. Parents or caretaker relatives while the family is in a BadgerCare Plus Extension.

For a pregnant woman, failure to cooperate cannot be determined prior to the end of the month in which the 60th day after the termination of pregnancy occurs.

Note: If the local CSA determines that a parent is not cooperating because court ordered birth costs are not paid, the parent or caretaker is not sanctioned.

Example 1: Mary, a disabled parent, is applying for Medicaid for her and her son, Michael. She refuses to cooperate in obtaining medical support for Michael. Mary meets all other non-financial and financial criteria for Medicaid and EBD Medicaid.

Mary is not eligible for EBD Medicaid or Medicaid, because she will not cooperate in obtaining medical support for Michael. Even though Mary has not cooperated in obtaining medical support for Michael, he remains eligible for Medicaid.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

8.3 CLAIMING GOOD CAUSE

[8.3.1 Claiming Good Cause Introduction](#)

[8.3.2 Notice](#)

[8.3.3 Good Cause Claim](#)

[8.3.4 Circumstances](#)

[8.3.5 Evidence](#)

[8.3.6 Investigation](#)

[8.3.7 Determination](#)

[8.3.8 Good Cause Found](#)

[8.3.9 Good Cause Not Found](#)

[8.3.10 Review](#)

8.3.1 Claiming Good Cause Introduction

Any parent or other caretaker relative who is required to cooperate in establishing paternity and obtaining medical support may claim good cause. He or she must:

1. Specify the circumstance that is the basis for good cause, **and**
2. Corroborate the circumstance according to the evidence requirements in [Section 8.3.5 Evidence](#)

8.3.2 Notice

The **IM** agency must provide a Good Cause Notice (DWSP 2018) to all applicants and to members whenever a child is added to the Medicaid case. The notice describes the right to refuse to cooperate for good cause in establishing paternity and securing medical support.

The IM worker and the parent or caretaker must sign and date the notice. File the original in the case record and give the **applicant/member** a copy. The **CSA** refers anyone who wants to claim good cause back to the IM agency for a determination of whether or not good cause exists.

8.3.3 Good Cause Claim

The Good Cause Claim form ([DWSP 2019](#)) must be provided to any Medicaid parent or caretaker who requests one. It describes the circumstances that support a claim and how to document a claim.

The parent or caretaker must sign and date the claim in the presence of an IM worker or a notary public. The applicant/member's signature initiates the claim.

The original copy is filed in the case record, a copy is given to the parent or caretaker and a copy is attached to the referral document when a good cause claim is made at application.

A copy of good cause claims must be sent to the CSA within two days after a claim is signed. When the CSA is informed of a good cause claim, they will immediately

suspend all activities to establish paternity or secure medical support until notified of your final determination.

8.3.4 Circumstances

The IM agency must determine whether or not cooperation is against the best interests of the child. Cooperation is waived only if:

1. The parent or caretaker's cooperation is reasonably anticipated to result in physical or emotional harm to the:
 - a. Child. This means that the child is so emotionally impaired, that his or her normal functioning is substantially affected, **or**
 - b. Parent or Caretaker. This means the impairment is of such a nature or degree that it reduces that person's capacity to adequately care for the child.
2. At least one of the following circumstances exists and it is reasonably anticipated that proceeding to establish paternity or secure support or both would be detrimental to the child:
 - a. The child was conceived as a result of incest or sexual assault, **or**
 - b. A petition for the child's adoption has been filed with a court, **or**
 - c. The parent or caretaker is being assisted by a public or private social agency in deciding whether or not to terminate parental rights and this has not gone on for more than three months.

8.3.5 Evidence

An initial good cause claim may be based only on evidence in existence at the time of the claim. There is no limit to the age of the evidence. Once a final determination is made, including any fair hearing decision, any subsequent claim must be based on new evidence.

The following may be used as evidence:

1. Birth certificates or medical or law enforcement records that indicate that the child may have been conceived as a result of incest or sexual assault.
2. Court documents or other records which indicate that a petition for the adoption of the child has been filed with a court.
3. Court, medical, criminal, child protective services, social services, psychological school, or law enforcement records which indicate that the alleged father or absent parent might inflict physical or emotional harm on the member or the child.
4. Medical records which give the emotional health history and present emotional health status of the member or the child.
5. A written statement from a mental health professional indicating a diagnosis of or prognosis on the emotional health of the member or the child.
6. A written statement from a public or private social agency that the agency is assisting the parent to decide whether or not to terminate parental rights.

7. A sworn statement from someone other than the member with knowledge of the circumstance on which the claim is based.
8. Any other supporting or corroborative evidence.

When a claim is based on emotional harm to the child or the member, the IM agency must consider the:

1. Person's present emotional state, **and**
2. Person's emotional health history, **and**
3. Intensity and probable duration of the emotional impairment, **and**
4. Degree of cooperation required, **and**
5. Extent of the child's involvement in the paternity or the support enforcement activity to be undertaken. If the member submits only one piece of evidence or inclusive evidence, you may refer him or her to a mental health professional for a report relating to the claim.

When a claim is based on his or her undocumented statement that the child was conceived as a result of incest or sexual assault, it should be reviewed as one based on emotional harm.

The IM agency must conduct an investigation when a claim is based on anticipated physical harm and no evidence is submitted.

The member has 20 days, from the date the claim is signed, to submit evidence. The IM agency, with supervisory approval, may determine that more time is needed.

There must be at least one document of evidence, in addition to any sworn statements from the member.

The IM agency should encourage the provision of as many types of evidence as possible and offer any assistance necessary in obtaining necessary evidence.

When insufficient evidence has been submitted:

1. The member must be notified and the specific evidence needed must be requested, **and**
2. The IM agency must advise that person on how to obtain the evidence, **and**
3. The IM agency must make a reasonable effort to obtain specific documents that are not reasonably obtainable without assistance.

If the parent or caretaker continues to refuse to cooperate or the evidence is still insufficient, a 10-day notice must be sent informing the parent or caretaker that if no further action is taken within ten days from the notification date, good cause will not be found and that he or she may first:

1. Withdraw the claim and cooperate, **or**
2. Exclude allowable individuals, **or**
3. Request a hearing, **or**
4. Withdraw the application or request that the case be closed.

If no option above has been taken when the ten days have expired the IM worker will deny Medicaid to the applicant or disenroll the member from Medicaid. The sanctions remain in effect until there is cooperation or until it is no longer required.

8.3.6 Investigation

The IM agency must investigate all claims based on anticipated physical harm both when the claim is credible without corroborative evidence and when such evidence is not available.

Good cause must be granted when both the member's statement and the investigation satisfy you that he or she has good cause.

Any claim must be investigated when the member's statement together with any corroborative evidence does not provide a sufficient basis for a determination.

In the course of the investigation, neither the IM agency nor the CSA may contact the absent parent or alleged father without first notifying the member of your intention. Once notified the parent or caretaker has ten days from the notification date to:

1. Present additional supporting or corroborative evidence of information so that contact is unnecessary, **or**
2. Exclude allowable individuals, **or**
3. Withdraw the application or request that the case be closed, **or**
4. Request a fair hearing.

When the ten days have expired and no option has been taken the IM agency will deny Medicaid to the applicant or remove the member from the Medicaid card, and the sanctions shall remain in effect until there is cooperation or until it is no longer an issue.

8.3.7 Determination

The IM staff must determine whether or not there is good cause. This should be done within 45 days from the date a claim is signed. The time may be extended if it is documented in the case record that additional time is necessary because:

1. The IM agency cannot obtain the information needed to verify the claim within the 45 days, **or**
2. The parent or caretaker does not submit corroborative evidence within 20 days.

The good cause determination and all evidence submitted filed in the case record along with a statement on how the determination was reached.

If there is no evidence or verifiable information available that suggests otherwise, it must be concluded that an alleged refusal to cooperate was, in fact, a case of cooperation to the fullest extent possible.

If the parent or caretaker is cooperating in furnishing evidence and information, do not deny, delay, or discontinue Medicaid pending the determination.

If a fair hearing is requested on a good cause determination, Medicaid certification is continued until the decision is made.

The 45-day period for determining good cause is not used to extend an eligibility determination. The 30-day limit on processing an application is still a requirement.

The IM must notify the applicant/member in writing of the final determination and of the right to a fair hearing. Send the CSA a copy. The CSA may also participate in any fair hearing.

8.3.8 Good Cause Found

When good cause is granted, the IM must direct the CSA to not initiate any or to suspend all further case activities.

However, when the CSA's activities, without the member's participation are reasonably anticipated to not result in physical or emotional harm, the IM agency must:

1. First notify the person of the determination and the proposed directive to the CSA to proceed without his or her participation.
2. He or she has ten days from the notification date to:
 - a. Exclude allowable individuals, **or**
 - b. Request a hearing, **or**
 - c. Withdraw the application, or request that the case be closed.
3. At the end of the ten days, direct the CSA to proceed if no option was taken. The CSA may decide to not proceed based on its own assessment.

The IM agency determination to proceed without the member's participation must be in writing. Include your findings and the basis for the determination. File it in the case record.

8.3.9 Good Cause Not Found

When good cause is not granted, the IM agency must notify the parent or caretaker. It must be stated in the notice that he or she has ten days from the notification date to:

1. Cooperate, **or**
2. Exclude allowable individuals, **or**
3. Request a hearing, **or**
4. Withdraw the application or request that the case be closed.

When the ten days have expired, and if none of the options listed above has been taken, the IM agency must deny Medicaid to the applicant or terminate the member's Medicaid eligibility. The sanctions remain in effect until there is cooperation or until it is no longer an issue.

8.3.10 Review

The IM agency does not have to review determinations based on permanent circumstances. Review good cause determinations that were based on circumstances subject to change when there is new evidence or at redeterminations.

The parent or caretaker must be notified when it is determined that good cause no longer exists. It must be stated in the notice that he or she has ten days from the notification date to:

1. Cooperate, **or**
2. Exclude allowable individuals, **or**
3. Request that the case be closed, **or**
4. Request a hearing.

When the ten days have expired, and if none options listed above has been taken, the IM agency must deny the individual's Medicaid eligibility. The sanctions remain in effect until there is cooperation or until it is no longer an issue.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

8.4 COOPERATION BETWEEN IM & CSA

[8.4.1 Information](#)

[8.4.2 Medicaid Discontinued](#)

[8.4.3 Fraud](#)

The relationship between the **IM** agency and the **CSA** requires ongoing cooperation.

8.4.1 Information

The IM agency provides the CSA with information vital to opening medical support cases. The IM agency also supplies continuing information, which assists them in providing medical support services. Therefore, the CSA may request information from the IM agency in addition to that included in the referral and as contained in the case record.

CARES automatically shares information with KIDS so it is important to enter the data accurately.

8.4.2 Medicaid Discontinued

The CSA is notified through CARES when Medicaid is discontinued.

8.4.3 Fraud

When the CSA has knowledge of possible fraud, they will refer the case back to the IM agency. For example, if in the process of collecting support the CSA establishes that a parent is in fact not absent, the CSA will give that information to the IM agency for appropriate action ([Income Maintenance Manual Section 11.1 Public Assistance Fraud Program](#)).

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

9 THIRD PARTY LIABILITY (TPL)

9.1 THIRD PARTY LIABILITY (TPL)

[9.1.1 Third Party Liability Introduction](#)

[9.1.2 TPL Cooperation](#)

[9.1.3 TPL Cooperation Requirements](#)

[9.1.4 TPL Good Cause Claim](#)

9.1.1 Third Party Liability Introduction

TPL refers to the obligation a third party (not Wisconsin Medicaid program or the Medicaid *member*), has to pay the bills for a Medicaid member's medical services. Medicaid is the payer of last resort for the cost of medical care. This means that if a Medicaid member also has coverage under a private health insurance plan, that plan is to be billed first for any medical services. Medicaid then pays any amount remaining after the private insurer has paid what they owe, up to the Medicaid reimbursement rate. Another common example of TPL is when someone receives an insurance settlement resulting from an accident. If Medicaid paid for any medical services resulting from that accident, the Medicaid program is to be reimbursed the cost of those medical services from the proceeds of the insurance settlement. Third party payers include health insurers, court ordered medical support, and any other third party that has a legal obligation to pay for medical services.

9.1.2 TPL Cooperation

All Medicaid members must assign to the state of Wisconsin their rights to payments for medical services from third party payers. A member complies with this requirement by signing the application form. The assignment includes all unpaid medical support and all ongoing medical support obligations for as long as Medicaid is received. In addition, Medicaid members must cooperate in identifying and providing information to assist the state in pursuing third parties who may be liable to pay for care and services, unless the individual establishes good cause for not cooperating. If a member fails to cooperate with TPL requirements, he or she could be sanctioned.

9.1.3 TPL Cooperation Requirements

The Medicaid member must cooperate in providing TPL information unless he or she is exempt or there is good cause for refusing to cooperate. TPL information could include the name and address of an insurance company, insurance policy number, and the name and address of the policy owner.

If an **adult** refuses, without good cause, to provide health insurance information for themselves, or anyone for whom they are legally responsible and is receiving Medicaid, the adult is ineligible until he or she cooperates.

Do not sanction the following for non-cooperation:

1. Minors, including **minor** caretakers.
2. A parent or caretaker requesting child support services for a child receiving **SSI**.
3. Pregnant woman – She may not be sanctioned during the pregnancy, or for two months after the pregnancy has ended, if the TPL source is the absent parent of her child(ren).

9.1.4 TPL Good Cause Claim

When good cause is claimed (see [Section 8.3 Claiming Good Cause](#)), the **IM** agency must review the circumstances and decide on whether it is an appropriate claim of good cause. The appropriate entry on the Medical Coverage page in **CWW** regarding the good cause determination must be made, and the reason for the decision must be documented in case comments.

TPL good cause reasons are the same as those for Medical Support.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

9.2 NURSING HOME, HOSPITAL, AND LONG-TERM CARE INSURANCE

[9.2.1 Nursing Home and Hospital Insurance Introduction](#)

[9.2.2 Assignment](#)

[9.2.3 Recovery of Payments](#)

9.2.1 Nursing Home, Hospital, and Long-term Care Insurance Introduction

All members must cooperate in providing *TPL* coverage information for nursing home, hospital, and long-term care insurance policies. All members must do the following:

1. Assign to the state of Wisconsin their rights to payments from a nursing home, hospital, or long-term care insurance policy (see [Section 9.2.2 Assignment](#)).
2. Send any payments to the state of Wisconsin that they received from a nursing home, hospital, or long-term care insurance carrier while receiving Medicaid (see [Section 9.2.3 Recovery of Payments](#)).

Any nursing home, hospital, or long-term care insurance payments that exceed the amount that Medicaid has paid in benefits for that *member* will be refunded to that member.

Terminate Medicaid eligibility for the individual who is not cooperating in providing TPL insurance information (see [Section 9.1.2 TPL Cooperation](#)), unless they have good cause (see [Section 9.1.4 TPL Good Cause Claim](#)).

9.2.2 Assignment

To assign hospital or long-term care insurance payments, the member must complete the Long-Term Care Insurance Policy – Assignment of Benefits form ([F-01567](#)) that requests all current or future payments be made payable to the state of Wisconsin.

The member must send the completed Long-Term Care Policy-Assignment of Benefits form to his or her long-term care carrier and mail a copy to the following address:

Wisconsin *DHS*
TPL Unit
PO Box 6220
Madison, WI 53784-6220

The long-term care carrier must mail payments to the following address:

Wisconsin DHS
TPL Unit
PO Box 6220
Madison, WI 53784-6220

The assignment of payments includes all ongoing payments for as long as the member receives Medicaid. Terminate Medicaid eligibility for the individual who refuses to assign these payments.

9.2.3 Recovery of Payments

In some cases, the insurance policy will require that payments be made directly to the patient or member. The member must forward these payments to the state of Wisconsin. Failure to forward any payment may result in the member losing his or her eligibility for not cooperating with providing TPL coverage and access information. When forwarding payments, the member must write on the back of the check "Pay to the order of the state of Wisconsin" and sign the check.

Members should mail payments, along with the corresponding *EOB*, to the following address:

Wisconsin DHS
TPL Unit
PO Box 6220
Madison, WI 53784-6220

Close the case for non-cooperation with TPL requirements if the member refuses to forward the third-party payments to the state.

*This page last updated in Release Number: 15-02
Release Date: 07/30/2015
Effective Date: 07/30/2015*

9.3 HEALTH INSURANCE RISK SHARING PLAN

Coverage under the *HIRSP* ended as of April 1, 2014.

For information about coverage prior to April 1, 2014, please call HIRSP Customer Service at 1.800.828.4777 or go to <http://www.hirsp.org/>.

*This page last updated in Release Number: 14-01
Release Date: 05/01/14
Effective Date: 04/01/14*

9.4 HEALTH INSURANCE PREMIUM PAYMENT

[9.4.1 Cost-Effective](#)

[9.4.2 Participation in HIPP](#)

[9.4.3 Cooperation](#)

[9.4.4 Not Cost-Effective](#)

HIPP pays the employee's portion of the employer subsidized health care coverage. The fiscal agent determines if it is cost effective to buy the employer's insurance.

9.4.1 Cost-Effective

If it is cost-effective to buy the employer-subsidized insurance, the HIPP Unit will notify those members who are required to enroll in an employer's health plan and provide additional information related to enrollment, coverage, and cooperation.

HIPP may pay the premium for a non-Medicaid family **member** if that member needs to enroll in the group health plan in order to obtain coverage for the Medicaid member. Medicaid will only pay for the premiums of the ineligible family member(s) and not any of their other cost sharing expenses (e.g., prescription co-pays). Medicaid will continue to cover the employer's health insurance premium, deductibles, and co-insurance for the Medicaid member.

9.4.2 Participation in HIPP

Members participating in HIPP will have Medicaid as a backup. If the employer's health insurance does not cover something that Medicaid does, then Medicaid will pick up the payment.

9.4.3 Cooperation

Effective January 1, 2014, HIPP is now voluntary for **MAPP** members as well as BadgerCare Plus members.

9.4.4 Not Cost-Effective

If it is not cost-effective to buy the employer-subsidized insurance, the member will remain eligible for MAPP.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

9.5 CASUALTY CLAIM PROCESS (SUBROGATION)

[9.5.1 Casualty Claims \(Subrogation\) Introduction](#)

[9.5.2 Reporting Accident or Injury Claims](#)

9.5.1 Casualty Claims (Subrogation) Introduction

Casualty claims are those claims for Medicaid benefits resulting from an accident or injury for which a third party may be liable.

Example 1: Mike receives treatment for injuries suffered when he was hit by a car. The vehicle owner is the third party and may be responsible for reimbursing Medicaid for those benefits. If Mike is working with an attorney or insurance agency to settle the claim, he is legally obligated to give notification to the local agency.

Medicaid members should report any casualty claims before the case is settled. The Medicaid ID number of the Medicaid *member*, date of the accident, and the insurance company or name of the attorney to bill should be included with the referral.

9.5.2 Reporting Accident or Injury Claims

If members are in an accident or are injured and receive a cash award or settlement due to the accident or injury and Medicaid pays for part or all of the care, it must be reported.

If a member has hired an attorney or is working with an insurance agency to settle the claim, that must also be reported.

1. If a member reports a claim and is:
 - a. getting *SSI* or
 - b. on the date of the accident or injury, lived in Clark, Douglas, Eau Claire, Fond du Lac, Green Lake, Juneau, LaCrosse, Lincoln, Marinette, Milwaukee, Rock, Sheboygan, Trempealeau, Vilas, Walworth, Waushara, or Winnebago County,

they must report the accident or injury case to the Casualty Recovery Unit at :

WI Casualty Recovery - HMS
5615 Highpoint Dr., Suite 100
Irving, TX 75038-9984

Telephone: (877)391-7471
Fax: (469)359-4319
Email: wicasualty@hms.com
Website: <http://www.wicasualty.com/wi/index.htm>

If the member is enrolled in an HMO or *MCO* they must also report the accident or injury to that organization.

2. All other Medicaid members should report in person or phone their local agency and any HMO or MCO that may have provided services, before the case is

settled. Members should include the date of the accident and any insurance/attorney information.

*This page last updated in Release Number: 11-02
Release Date: 07/27/11
Effective Date: 07/27/11*

9.6 OTHER HEALTH INSURANCE

[9.6.1 Other Health Insurance Introduction](#)

[9.6.2 Policies Not To Report](#)

9.6.1 Other Health Insurance Introduction

The **IM** agency should collect insurance coverage information about applicants and members at application, review, person add, or when insurance changes and enter it into the Medical Coverage page in **CWW**. The fiscal agent will complete an insurance search and return verified insurance information through the CWW/MMIS interface. This is because Medicaid is usually the payor of last resort, and any other insurance coverage will be billed before the Medicaid program.

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. Medicare (enter in CWW on the Medicare page).
3. **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.
4. Policies that pay benefits only for treatment of accidental injury.
5. Policies that may be described as health insurance, but which pay only weekly or monthly based on the insured's **disability**.
6. 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.
7. Life Insurance.
8. Other types of insurance types that do not cover medical services.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

9.7 RESERVED

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

9.8 RESERVED

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

9.9 RESERVED

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

10 SSN

10.1 SSN REQUIREMENTS

[10.1.1 SSN Requirements Introduction](#)

[10.1.2 Emergency Services](#)

[10.1.3 SSN Mismatches](#)

[10.1.4 Failure to Provide SSN](#)

10.1.1 SSN Requirements Introduction

Medicaid applicants must provide a **SSN** or be willing to apply for one. Assist the **member** in applying for an SSN for any group member who does not have one. Non-applicants are not required to provide SSN.

Do not deny benefits pending issuance of a SSN if you have any documentation that an SSN application was made.

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 State On-Line Query (SOLQ-I) process.

Verify the SSN only once.

10.1.2 Emergency Services

Do not require or verify SSNs of member's who receive emergency services only.

10.1.3 SSN Mismatches

Refer to [Process Help Section 44.4](#) if the SOLQ-I process returns a mismatch record.

Inform the member if the SOLQ-I process suggests that another individual is using the same SSN. Advise the member to contact the *SSA*. The member may request SSA 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 Failure to Provide SSN

If the caretaker is unwilling to provide or apply for the SSN of a *minor* or 18-year-old, then the person who does not have the SSN is ineligible.

Medicaid applicants and members who belong to a recognized religious sect that conscientiously opposes applying for or using a SSN are exempt from meeting the SSN requirements. A person who refuses to apply for or use a SSN due to religious beliefs must provide verification from a church elder or other officiant that doing so is against the church doctrine.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

11 PREMIUM OR COST SHARE

11.1 PREMIUM OR COST SHARE

Nonpayment of a *MAPP* premium will result in nonfinancial ineligibility. See [Section 26.1 Medicaid Purchase Plan Introduction](#) for more information.

Nonpayment of a Home and Community-Based Waivers cost share will result in nonfinancial ineligibility. See [Section 28.1 Home and Community Based Waivers Long-term Care Introduction](#) for more information.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

12 CHANGE REPORTING

[View History](#)

12.1 CHANGE REPORTING INTRODUCTION

Clients must report to the *IM* agency, within 10 days of the occurrence, a change in address, income, assets, need, medical expenses or living arrangements which may affect eligibility.

Some changes may be reported through the ACCESS website (access.wisconsin.gov).

*This page last updated in Release Number: 08-05
Release Date: 11/17/08
Effective Date: 11/17/08*

13-14 RESERVED

13 - 14 RESERVED

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

FINANCIAL (CHS. 15 - 19)

15 INCOME

15.1 INCOME INTRODUCTION

[15.1.1 EBD Fiscal Group](#)

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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 his or her parents would be a one person fiscal group. Special instructions for deeming parental income to the disabled minor are described in [Section 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 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 [Section 18.1 Spousal Impoverishment Introduction](#) for special instructions regarding spousal impoverishment procedures.

15.1.2 Special Financial Tests for Disabled Minors

A blind or disabled minor (or dependent 18 year old) would have his or her Medicaid eligibility determined according to the following special procedures when the disabled minor fails Family Medicaid financial tests. This process essentially deems parental income to the disabled minor. The deemed parental income is added to the disabled

minor's income when determining the disabled minor's financial eligibility for EBD Medicaid.

The disabled minor is a separate fiscal group of one. A child who is an SSI recipient is not considered to be a household member and therefore not included in any of the following procedures.

An ineligible child in this section is a minor child who is neither disabled nor blind.

An eligible child in this section is a minor child who is disabled or blind or both.

Calculate the countable income of everyone in the household using the following six steps. Count all of the person's income except that which is exempt or unavailable. See [Section 15.1 Income Introduction](#).

1. For each ineligible child in the household:
 - a. Subtract the ineligible child's unearned and earned income from the EBD Deeming Amount to an Ineligible Minor ([Section 39.4.2 EBD Deductions and Allowances](#)).

- b. The remainder is the amount to be allocated to the ineligible child from parental gross unearned income.

If there is not enough parental unearned income, allocate the rest from parental gross earned income.

Go to 2.

2. Subtract \$20, the general income exclusion, from any remaining parental unearned income.

If there is not enough unearned income to subtract the full \$20, subtract the rest of the \$20 from parental earned income.

Go to 3.

3. Subtract \$65 & 1/2 from the remaining parental earned income.

Go to 4.

4. Add:

- a. Remaining parental unearned income resulting from step 03, and
 - b. Remaining parental earned income resulting from step 04

Go to 5.

5. From the total parent income resulting from 5., subtract:

- a. The Parental Living Allowance ([Section 39.4.2 EBD Deductions and Allowances](#)) for a couple if both parents (or one parent and his or her spouse) live in the household; or
- b. The Parental Living Allowance ([Section 39.4.2 EBD Deductions and Allowances](#)) for an individual if only one parent lives in the household.

The remainder is the total parental income to be deemed to the eligible child(ren).

Go to 6.

6. Divide the parental deemed income equally among the eligible children. Use the EBD-Related Determination worksheet ([Section 40.1 Worksheet 6](#)) to calculate each child's Medicaid eligibility.

Example 1: Mr. and Mrs. Darwin have two children. Matthew, eight years old, is disabled, and is the eligible child. Jenny, 10 years old, is the ineligible child. Neither child has income. The Darwins have no unearned income. Parental earned income is \$2,775 a month. The parents' earned income of \$2,775 minus \$367 (deeming amount to an ineligible minor, see [39.4.2](#)) = \$2,408.

 Remaining earned income \$2,408.

General income exclusion -20.00

Remainder \$2,388.

Earned income exclusion -65.00

Remainder \$2,323

1/2 remaining earned income -\$1,161.50

Add in the \$65 income exclusion

Total Disregarded amount \$1,226.50

Remaining earned income \$1,161.50 (2,388 - 1,226.50 = 1,161.50)

Parental living allowance -\$1,100

Income deemed to eligible child = \$61.50

Example 2: Lawrence has three children. One is disabled. None has any income. His monthly income is \$2,050 earned, \$390 unearned.

Lawrence's unearned income \$ 390.00

EBD Deeming Amount for 2 ineligible minors -\$734.00

Excess allocation \$ -410

Lawrence's earned income \$2,050.00

Excess allocation \$ -410

Lawrence's remaining earned income \$1,706

General income exclusion -20.00

Remainder \$1,686

Earned income exclusion -65.00

Remainder \$1,621

1/2 remaining earned income -\$810.50

Remaining earned income \$810.50

Parental living allowance \$ -\$733.00

Income deemed to eligible child \$77.50

15.1.3 Income

See [Section 39.4 Elderly, Blind, and Disabled Assets and Income Tables](#) for EBD income limits. See [Section 39.5 Federal Poverty Level Table](#) for all other Medicaid income limits. Chapters for each type of Medicaid explain how to determine the income that you compare to the income limits.

See [Section 39.4.2 EBD Deductions and Allowances](#) for **TB**-Related income limits.

15.1.4 EBD Related Test

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 [Section 39.4 Elderly, Blind, and Disabled Assets and Income Tables](#). The actual shelter/utility costs or the shelter/utility maximum, whichever is less, is added to the categorically needy income amount ([Section 39.4 Elderly, Blind, and Disabled Assets and Income Tables](#)), and this total becomes the EBD categorically needy income limit. A fiscal group with income that does not exceed the categorically needy income limit passes the Medicaid EBD categorically needy income test.

If an EBD related fiscal group's income exceeds the categorically needy income limit, their income is then compared to a medically needy limit, which is found in [Section 39.4 Elderly, Blind, and Disabled Assets and Income Tables](#). If the fiscal group's income is between the categorically needy limit and the medically needy limit, the group passes the Medicaid EBD medically needy income test.

If an EBD fiscal group fails the medically needy income test because their net income exceeds the medically needy income limit, they can still qualify for Medicaid if they can meet a Medicaid deductible. Refer to [Section 24.2 Medicaid Deductible Introduction](#) for more information about Medicaid deductibles and to [Section 24.5 Calculating the Deductible](#) for instructions on how to calculate a Medicaid Deductible.

15.1.5 Availability

General Rules:

1. Only count income when it is available (see [Section 15.1.5 Availability](#)).
2. Some income is disregarded (see [Section 15.3 Exempt/Disregarded Income](#)).
3. Always use gross income when calculating income.
4. Some income, even though it is unavailable income, must be counted (e.g., garnishments).

Income is available when:

1. It is actually available, and
2. The person has a legal interest in it, and
3. The person has the legal ability to make it available for support and maintenance.

Note: Available income can include more than a person actually receives if amounts are withheld from earned or unearned income because of a garnishment or to pay a debt or any other legal obligation.

Examples of income sources that someone can make available are social security and unemployment compensation. This includes income increases such as **COLAs**.

When it is known that a member of the assistance group is eligible for some sort of income or an increased amount of income:

1. Count the income if the amount is known. Count it as if the person is receiving it.
2. Ignore the income if the amount is not known.

Example 3: Ms. M. turned 62 years old and is entitled to Social Security benefits of \$900. However, she opted to wait until she turns 65 to start collecting her benefits. Since she is entitled to \$900 at age 62, \$900 is considered available income.

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.

15.1.6 Countable Income

Countable income is the prospective gross monthly amount used in the eligibility determination and post-eligibility calculations.

15.1.6.1 Migrant Workers

Annualize migrant workers income. See [Section 25.8 Migrant Workers](#).

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

15.2 PROSPECTIVE INCOME

[15.2.1 Prospective Budgeting](#)

[15.2.2 Prorating Income](#)

[15.2.3 Fluctuating Income](#)

15.2.1 Prospective Budgeting

Budget the gross monthly earned and unearned income amount. See [Process Help Section 16.3 Unearned Income](#) for instructions on budgeting unearned income when other programs are requested along with Medicaid.

Verification is required for all sources of non-exempt income for EBD Medicaid applicants and members at the time of application, review or change in income source or amount.

Use all available data exchanges to verify income.

Note: The Employment Wage Match Query should not be used to verify current income. The income displayed on this match is the total income for a past quarter. It does not verify current monthly wages.

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 and prorated over the months between payments.

<p>Example 1: Sally receives a \$1,500 Tribal Distribution Payment quarterly. This payment should be prorated for the months between payments. \$1,500 is</p>
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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.

Farm and self-employment income (see [Section 15.6 Self Employment Income](#)) is either averaged or prorated.

When an assistance group applies, do not count the prorated income until it is received.

Example 2: Joe receives semiannual land contract installments of \$900. This equals a monthly income of \$150 (\$900 prorated over six months). He becomes eligible in May. He receives payments in January and July each year. Do not budget any prorated income until July, the first month of receipt after Joe becomes eligible.

If the group becomes ineligible and reapplies before they receive the next installment, use the same prorated amount as before.

Prorated Income Is an Unavailable Asset

A source of income which is received in a particular month cannot also be counted as an asset for that same month. This policy also applies to income which has been prorated and will be budgeted over the appropriate prorated period (e.g., 12 months). The client is expected to use this prorated income for their personal needs over an extended period of time. Therefore, any unbudgeted balance is an unavailable asset during the period of time for which the prorated income is being counted. The amount of the unavailable asset will decrease with each month in which the prorated income is budgeted.

Example 3: Jay regularly receives a \$1200.00 annual payment from a wealthy relative every January. This income is prorated over 12 month so \$100 per month is counted as unearned income beginning in January. The initial \$1200 payment and any remaining unbudgeted balance is an unavailable asset during the 12 month budgeting period. In January the entire \$1200.00 is considered unavailable. In February, \$1100.00 is considered unavailable. The unavailable amount will decrease with every month that income from this source is counted.

15.2.3 Fluctuating Income

If the amount or frequency of regularly received income is known, average the income over the period between payments. If neither the amount nor the frequency is predictable, do not average; count income only for the month in which it is received.

15.3 EXEMPT/DISREGARDED INCOME

- [15.3.1 Adoption Assistance](#)
- [15.3.2 Agent Orange Settlement Fund](#)
- [15.3.3 Combat Pay](#)
- [15.3.4 Crime Victim Restitution Program](#)
- [15.3.5 Disaster and Emergency Assistance](#)
- [15.3.6 Dottie Moore Payments](#)
- [15.3.7 Foster Care](#)
- [15.3.8 General Income Disregard](#)
- [15.3.9 IDA Payments](#)
- [15.3.10 Inconsequential](#)
- [15.3.11 Kinship Care](#)
- [15.3.12 Life Insurance](#)
- [15.3.13 Nutrition Benefits](#)
- [15.3.14 Payments to Native Americans](#)
- [15.3.15 Payments to Nazi Victims](#)
- [15.3.16 Radiation Exposure Compensation Act](#)
- [15.3.17 Refugee "Reception and Placement" \(R&P\) payments](#)
- [15.3.18 Refugee Cash Assistance \(RCA\)](#)
- [15.3.19 Reimbursements](#)
- [15.3.20 Relocation Payments](#)
- [15.3.21 Repayments](#)
- [15.3.22 Special Programs](#)
- [15.3.23 Spina Bifida Child](#)
- [15.3.24 Susan Walker Payments](#)
- [15.3.25 Travel Tickets](#)
- [15.3.26 VA Allowances](#)
 - [15.3.26.1 Residents of the State Veterans Home](#)
- [15.3.27 Wartime Relocation of Citizens](#)
- [15.3.28 W2 Payments](#)
- [15.3.29 Subsidized Guardianship Payments.](#)

"*Disregard*" and "exempt" in this instance means "do not count." When you are calculating the total amount of income a person has received, disregard the following kinds of income:

15.3.1 Adoption Assistance

Disregard adoption assistance payments.

15.3.2 Agent Orange Settlement Fund

Disregard payments received from the Agent Orange Settlement Fund or any other fund established in settling "In Re: Agent Orange product liability Settlement Fund litigation, M.D.L. No. 381 (E.D.N.Y.)."

Apply this disregard retroactively to January 1, 1989 and continue to disregard these payments for as long as they are identified separately.

15.3.3 Combat Pay

Disregard combat zone pay that goes to the household that is in excess of the military person's pre-deployment pay. The exclusion lasts while the military person is deployed to the combat area.

If the amount of military pay from the deployed absent family member is equal to or less than the amount the household was receiving prior to deployment, count all of the income to the household. Any portion of the military pay that exceeds the amount the household was receiving prior to deployment to a designated combat zone should be excluded when determining the household's income.

Example 1: John's wife Bonnie and their daughter have an open Medicaid case. John is in the military stationed overseas, his monthly income is \$1,000. John sends his wife \$1,000 every month.

When John is deployed to a combat zone his pay is increased to \$1,300 a month, which is deposited into a joint account. Because the \$300 is combat zone pay, it is exempt income and not counted in the determination. The pre-combat pay of \$1,000 is budgeted as unearned income for Medicaid.

15.3.4 Crime Victim Restitution Program

Disregard any payments received from a state established fund to aid victims of a crime.

15.3.5 Disaster and Emergency Assistance

Disregard major disaster and emergency assistance payments made by federal, state, county, and local agencies, and other disaster assistance organizations.

15.3.6 Dottie Moore Payments

Disregard any penalty payment paid as a result of the Dottie Moore lawsuit.

These court-ordered \$50-\$200 penalty payments can be imposed when the *IM* agency or *CSA* does not correctly process child support refunds.

15.3.7 Foster Care

Disregard *foster care* payments. Foster care payments are considered to be the income of the child or *adult* who is receiving foster care and these payments are exempt income for the foster care recipient. However in some situations the foster care recipient uses these payments to pay the foster parent for their room and board expenses. The room and board payments that are received by the foster parent are not disregarded and should be counted as non-exempt earned income (see [Section 15.5.15 Earned Income Tax Credit](#)) for the foster parent's Medicaid eligibility determination.

15.3.8 General Income Disregard

Disregard \$20 from the EBD fiscal test group's net income.

15.3.9 Individual Development Account (IDA) Payments

Disregard Individual Development Account (IDA) payments that are made in the form of matching funds to buy a home, start a business, or to complete post-secondary education.

15.3.10 Inconsequential

Disregard income which is infrequent, irregular, and has no appreciable effect on ongoing need.

Infrequent income is defined as income that an individual receives only once during a calendar quarter from a single source, and which the individual did not receive in the month immediately preceding that month or in the month immediately subsequent to that month, regardless of whether or not those payments occur in different calendar quarters.

Income is considered to be received irregularly if an individual cannot reasonably expect to receive it.

Exclude the following amount of income which is received either infrequently or irregularly:

- The first \$30 per calendar quarter of earned income; and
- The first \$60 per calendar quarter of unearned income.

15.3.11 Kinship Care

Disregard kinship care payments.

15.3.12 Life Insurance

Disregard life insurance policy dividends.

15.3.13 Nutrition Benefits

Disregard benefits received from the following:

1. Emergency Food and Shelter National Board.
2. Federal Emergency Management Assistance (FEMA).
3. FoodShare coupon allotment.
4. Home produce for household consumption.
5. National School Lunch Act.
6. Supplemental food assistance under the Child Nutrition Act of 1966.
7. Title VII Nutrition Program for the [Elderly](#), Older Americans Act of 1965.
8. USDA Child Care Food Program.
9. USDA donated food and other emergency food.
10. WIC - the supplemental food program for women, infants, and children.

15.3.14 Payments to Native Americans

Disregard the following payments to Native Americans:

1. Menominee Indian Bond interest payments.
2. All judgment payments to tribes through the Indian Claims Commission or Court of Claims.
3. Payments under the Alaskan Native Claims Settlement Act.
4. Payments under the Maine Indian Claims Settlement Fund.
5. Payments under PL 93-124 to the Sisseton-Wahpeton Sioux Tribe, except individual shares over \$2,000.
6. Payments under PL 93-134 to the Maricopa Ak-Chin Indian Community, Navajo Tribe, Coast Indian Community of the Resighini Rancheria, Stillaguamish Tribe, Pueblo of Taos Tribe, Walker River Paiute Tribe, and White Earth Band of the Minnesota Chippewa Tribe, except individual shares over \$2,000.
7. Payments under PL 94-114 to the Bad River Band and Lac Courte Oreilles Band of Chippewa Indians and the Stockbridge Munsee Indian Community of Mohicans.
8. Payments under PL 96-318 to the Delaware Tribe of Kansas and of Idaho.
9. Payments under PL 96-420 to the Houlton Band of Muliseet Indians, the Passamoquoddy, and Penobscot.
10. For EBD Medicaid cases, under PL 98-64, disregard all Indian judgment funds held in trust by the Secretary of the Interior for an Indian tribe and distributed on an individual basis to members of the tribe. Also disregard interest and investment income from these funds.
11. Payments under PL 99-346, Saginaw Chippewa Indian Tribe of Michigan.
12. Payments under PL 99-377 to the Mille Lacs, Leech Lake, and White Earth, MN, reservations.
13. Payments under PL 101-41, Puyallup Tribe of Indians Settlement Act of 1989.
14. Payments under the Distribution of Judgment Funds Act of 1987 to the Cow Creek Band, Umpqua Tribe.

15. Payments under the Distribution of Indian Judgment to the Crow Creek and Lower Brule Sioux except individual shares over \$2,000.
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:
 - Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or
 - 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 all Medicaid subprograms for elderly, blind, or disabled persons **except**:

Senior Care and Long Term Care programs such as Institutional Medicaid, Family Care, and *HCBWs* including Partnership and *PACE*. For these subprograms, count all income from Tribal Per Capita payments from gaming revenue as unearned income.

19. Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties.
20. Payment from natural resources, farming, ranching, fishing, leases or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations).
21. Money from selling things that have cultural significance.

15.3.15 Payments to Nazi Victims

Disregard payments made under PL 103-286 to victims of Nazi persecution.

15.3.16 Radiation Exposure Compensation Act

Disregard payments from any program under the Radiation Exposure Act (PL 101-426) paid to persons to compensate injury or death due to exposure to radiation from nuclear testing (\$50,000) and uranium mining (\$100,000). The federal Department of Justice reviews the claims and makes the payments. If the affected person is dead, payments are made to his or her surviving *spouse*, children, parents, or grandparents.

Apply this disregard retroactively to October 15, 1990, and continue to disregard these payments for as long as they are identified separately.

15.3.17 Refugee Cash Assistance (RCA)

Disregard cash payments from the Refugee Cash Assistance (RCA) program. RCA is administered by Wisconsin Works agencies and is made available for refugees who do not qualify for Wisconsin Works.

15.3.18 Refugee "Reception and Placement" (R&P) payments

Disregard federally funded "Reception and Placement" (R &P) payments made to refugees during the first 30 days after their arrival in the U.S. R & P payments are made by voluntary resettlement agencies and may be a direct payment to the refugee individual/family or to a vendor.

15.3.19 Reimbursements

A reimbursement is a payment which a person receives for out-of-pocket expenses. Disregard reimbursements for expenses an **AG** member has incurred or paid. Do not disregard reimbursements for normal household living expenses (rent, clothing, or food eaten at home).

Here are some examples of reimbursements you should disregard:

1. For job or training related expenses. The expenses may be for travel, food, uniforms, and transportation to and from the job or training site. This includes travel expenses of migrant workers.
2. For volunteers' out-of-pocket expenses incurred during their work.
3. Medical or dependent care reimbursements.
4. Reimbursement from the Indianhead Community Action Agency (Ladysmith) under its JUMP Start Program for start-up costs to set up an in-home child care business in the person's home.
5. Reimbursements received from the Social Services Block Grant Program for expenses in purchasing Social Services Block Grant services, for example, transportation, chore services, and child care services.

The reimbursement payment should not be more than the person's actual out-of-pocket expenses. If it is more, count the excess amount as unearned income.

15.3.20 Relocation Payments

Under s. 32.19, Wis. Stats., relocation payments are available to displaced persons. The following are examples of costs which the relocation payments are intended to cover: moving expenses, replacement housing and property transfer expenses. Disregard the amounts paid by any governmental agency or organization listed in s. 32.02, Wis. Stats. Disregard Title II, Uniform Relocation Assistance and Real Property Acquisition Policies Act payments. Its purpose is to treat persons displaced by federal and federally aided programs fairly so that they do not suffer disproportionate injuries as a result of programs designed for the public's benefit.

Disregard Experimental Housing Allowance Program (EHAP) payments. Its purpose is to study housing supply. Test areas, which include Brown County, were selected throughout the United States, and contracts were entered into prior to January 1, 1975. A sample of families was selected to receive monthly housing allowance payments.

For Medicaid applicants/members, disregard housing assistance payments received under the following Acts:

1. United States Housing Act of 1937.
2. The National Housing Act.
3. Section 101 of the Housing and Urban Development Act of 1965.
4. Title V of the Housing Act of 1949.
5. Section 202(h) of the Housing Act of 1959.

15.3.21 Repayments

A repayment is money the member has received from an IM program and must give back because of a program error or violation. Since he or she is not entitled to the money, he or she must repay it. Therefore it should not be counted as income to the member.

Disregard the following repayments:

1. Money withheld from an economic assistance check due to a prior overpayment.
2. Money from a particular income source that is voluntarily or involuntarily paid to repay a prior overpayment received from that same source of income.

If money from a particular income source is mixed with money from other types of income, disregard only an amount up to the amount of the current payment from the particular source.

Example 2: Richard receives \$50 a month from the Veterans Administration (VA) and \$250 from Social Security. The income from the two sources is mixed together in one lump of \$300. If the VA overpays Richard by \$200, he can pay back to the VA only the \$50 a month he receives from the VA. If he repays more, for instance, \$75 a month, disregard only \$50.

3. Social Security income used to repay an overpayment previously received from the Social Security Administration, whether **SSA** or **SSI**.

15.3.22 Special Programs

Disregard income from all of the following:

1. Active Corp. of Executives (ACE)
2. All wages paid by the Census Bureau for temporary employment related to Census 2010
3. Emergency Fuel Assistance
4. Foster Grandparents Program
5. Governmental rent or housing subsidy, including reimbursements due to federal regulatory changes in computing **HUD** housing rent
6. [Homestead](#) Tax Credit
7. Low Income Energy Assistance Program
8. Programs funded under Title V of the Older Americans Act of 1965 ([15.5.14 Title V - Older Americans Act of 1965](#)), except wages or salaries, which are counted as earned income.
9. Retired Senior Volunteer Program (RSVP)
10. Service Corp. of Retired Executives (SCORE)
11. University Year for Action Program (UYA)
12. Volunteers in Service to America (VISTA)
13. Wisconsin's Family Support Program (s. 46.985, WI Stats.) This program funds the unique needs of severely disabled children. They may be a vendor or a money payment
14. Senior Companion Program
15. AmeriCorps State and National, and AmeriCorps NCCC

15.3.23 Spina Bifida Child

Disregard payments made under PL 104-204 to any child of a Vietnam veteran for any **disability** resulting from the child's spina bifida.

15.3.24 Susan Walker Payments

Disregard payments received from the class action settlement of Susan Walker vs. Bayer Corporation. These payments are to hemophiliacs who contracted the HIV virus from contaminated blood products.

15.3.25 Travel Tickets

In Medicaid cases, disregard the value of any commercial transportation ticket which the member, his or her spouse or parents (if the member is a **minor**) receives as a gift if it is:

1. For travel among the 50 states, District of Columbia, American Samoa, Guam, Northern Mariana Island, Puerto Rico, and the Virgin Islands, and
2. Not converted to cash.

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 [Section 15.3.26.1 Residents of a State Veterans Home](#)).

Example 3: Jack is a single veteran living in his home. He is disabled (as determined by the VA) and receives VA pension benefits in the amount of \$1,450 per month. Because he requires assistance with his daily living tasks, Jack receives an aid and attendance allowance which is part of the \$1,450. The aid and attendance allowance that Jack receives is \$589 per month. Aid and attendance is disregarded income.

\$1,450 VA pension
- 589 aid and attendance allowance (disregarded income)
\$ 861 budgetable income

Example 4: Donald is a married veteran living with his wife and two children. He is disabled (as determined by the VA) and receives VA compensation benefits in the amount of \$2,600 per month. He does not receive aid and attendance, housebound, or unusual medical expense allowances.

The full \$2,600 is budgetable income to the household.

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.

In the post eligibility test, exempt \$90 for those who meet the following conditions:

1. He or she receives aid and attendance, unusual medical expense or housebound allowance payments in an amount greater than \$90, **and**
2. He or she is a veteran who has no spouse or child or is a childless surviving spouse of a veteran.

Example 5: John is a veteran residing at the State Veterans Home at King. His total

monthly income consists of a \$90 VA pension and a \$55 annuity payment. The \$90 VA pension is totally disregarded in eligibility and post eligibility determinations. The personal needs allowance for institutionalized members is deducted from the \$55 annuity payment. John's remaining budgetable income in the Medicaid post-eligibility determination is \$10, and that \$10 will be applied to his patient liability.

Example 6: Scott is a veteran residing at the State Veterans Home at King. His total monthly income consists of a \$590 VA pension (\$200 of which is for unusual medical expenses) and a \$50 annuity payment. The portion of the VA pension for unusual medical expenses is totally disregarded in the Medicaid eligibility test. The \$50 annuity payment and remaining \$390 of the VA pension is non-exempt income. For the post-eligibility test, only \$90 of the VA pension is disregarded. The patient liability calculation includes the personal needs allowance, so Scott will have to contribute \$505 to his patient liability.

Eligibility Calculation

\$590 VA Pension

+ 50 Annuity

\$640

-200 (exempt income)

\$440 countable income

Liability Calculation

\$590 VA Pension

+ 50 Annuity

\$640

- 90 (exempt income)

- 45 (personal needs)

\$505 patient liability

15.3.27 Wartime Relocation of Citizens

Disregard restitution payments under PL 100-383 to individual Japanese-Americans (or their survivors) and Aleuts who were interned or relocated during WWII. There is no child support and maintenance disregard for Medicaid.

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 Subsidized Guardianship Payments.

Disregard Subsidized Guardianship payments.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

15.4 UNEARNED INCOME

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[15.4.2 Sick Benefits](#)

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[15.4.19 Payments to Native Americans](#)

[15.4.20 Alimony, Maintenance, and Other Spousal Support Payments](#)

Unearned income is income that the *member* receives from sources other than employment. Unless it is disregarded income (see [Section 15.3 Exempt/Disregarded Income](#)) or an income deduction (see [Section 15.7 Income Deductions](#)), count gross unearned income in the person's income total.

When two payments from the same income source are received the same month due to mailing cycle adjustments, count each payment only for the month it is intended. Income

sources commonly affected by such mailing cycle fluctuations include general assistance, other public assistance programs, **SSI**, and **SSA** benefits.

Note: Occasionally, a regular periodic payment (e.g., title II, or VA benefits) is received in a month other than the month of normal receipt. As long as there is no intent to interrupt the regular payment schedule, consider the funds to be income in the normal month of receipt.

15.4.1 Income from Trusts

A trust is any arrangement in which a person (the "grantor") transfers property to another person with the intention that the person (the "trustee") hold, manage, or administer the property for the benefit of the grantor or of someone designated by the grantor (the "beneficiary").

The term "trust" includes any legal instrument or device or arrangement which, even though not called a trust under state law, has the same attributes as a trust. That is, the grantor transfers property to the trustee and the grantor's intention is that the trustee hold, manage, or administer the property for the benefit of the grantor or of the beneficiary.

The grantor can be:

1. The Medicaid member.
2. The **spouse** of the Medicaid member.
3. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the member or the member's spouse. This includes a power of attorney or guardian.
4. A person, including a court or an administrative body, acting at the direction or upon the request of the member or the member's spouse. This includes relatives, friends, volunteers, or authorized representatives.

All payments (including interest, and dividends,) from a trust to the beneficiary are unearned income to the beneficiary. See [Section 15.4.9 Interest/Dividend Income](#) for instructions on counting interest.

If the beneficiary does not receive payments (including interest and dividends) from the trust, but they are added back to the trust principal, do not count them as income to the beneficiary if the beneficiary is **elderly** , blind, or disabled.

Note: If the grantor is an institutionalized person, or acting on behalf of an institutionalized person, payments from any trust, both revocable and irrevocable, that are not to or for the benefit of the institutionalized person are divestment (see [Section 17.13 Trusts](#)).

15.4.2 Sick Benefits

Sick benefits are payments received from insurance such as income continuation.

15.4.3 Unemployment Compensation

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.

15.4.4 Retirement Benefits

Retirement benefits include work-related plans for providing income when employment ends. Examples of retirement benefits include:

- Pension disability or retirement plans administered by an employer or union
- Accounts owned by the individual, such as **IRAs**
- Plans for self-employed individuals, sometimes referred to as Keogh plans.

Periodic payments made from a work-related retirement benefit plan should be counted as income in the month of receipt.

Any periodic payments from individually owned accounts (e.g., IRA) should not be counted as income in the month of receipt. They are considered the same as withdrawals from an applicant's savings account.

Consider IRAs, Keoghs, or other retirement funds that are completely cashed in as a conversion from one asset form to another.

Example 1: Mike withdraws \$2,000 he has in an IRA and deposits it into a savings account. Continue to treat the \$2,000 as a countable asset. This is just a conversion from one form of an asset to another.

15.4.5 General Relief and Charity

Count unrestricted General Relief and charitable payments as follows:

1. Subtract the process month's Family Allowance from the [AFDC Assistance Standard](#) for this size fiscal group.
2. Multiply the difference by 12 to get the maximum payment you can disregard.
3. Ignore any payment that is less than the maximum.
4. Subtract from the maximum the amount of any payment that is greater than the maximum.
5. Count the remainder as unearned income.

15.4.6 Gifts

A gift is something a person receives which is not repayment for goods or services the person provided and is not given because of a legal obligation on the giver's part. To be a gift, something must be given irrevocably (that is, the donor relinquishes all control).

Treat non-cash gifts as an asset, as you would an asset of a similar type. A cash gift is unearned income only in the month of receipt. Count the gift as an asset in the months following the month of receipt

Disregard cash gifts (such as for birthdays, graduation, and Christmas) that total \$30 or less, for each **AG** member, for each calendar quarter.

15.4.7 Land Contract

Count any portion of monthly payments received that are considered interest from a land contract as unearned income. Do not count the principal as income, because it is the conversion of one asset form to another. Deduct from the gross amount any expenses the person is required to pay by the terms of the contract.

If the income is received less often than monthly, prorate the income to a monthly amount. Do not begin budgeting this monthly amount until the person first receives a payment after becoming eligible.

Example 2: Bob receives land contract payments from Farmer Brown twice a year, one \$500 payment in March and another \$500 payment in September.

If Bob is applying in February prorate the land contract payments Bob receives after he becomes eligible. In March when Bob receives a \$500 land contract payment, divide the total income (\$500) by the frequency of the payments (six months) to get the budgeted income amount of \$83.33 per month ($\$500/6 \text{ months} = \83.33). Begin budgeting this amount in March.

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.
2. Count any repayments toward the principal of the loan, whether it is a full payment, a partial payment, or an installment payment, as an asset.
3. If an AG member receives a loan and it is available for current living expenses, count it as an asset. Do this even if there is a repayment agreement. If it is not available for current living expenses, disregard it.

15.4.9 Interest/Dividend Income

15.4.9.1 EBD Interest/Dividend Income

15.4.9.1.1 Excluded Sources of Interest or Dividend Income

15.4.9.1.2 Interest and Dividends Income not excluded for EBD

15.4.9.1 EBD Interest/Dividend Income

Most interest and dividend earnings are excluded income so are not counted when determining Medicaid eligibility. See [Section 15.4.9.1.1 Excluded Sources of Interest or Dividend Income](#) for excluded sources of interest or dividend income and [Section 15.4.9.1.2 Interest and Dividends Income Not Excluded for EBD](#) for interest and dividend income not excluded for EBD.

Most interest and dividend income from a resource excluded under SSI rules, will be an excluded source of income for all Medicaid Eligibility and post-eligibility determinations. There are, however, some exceptions (see [Section 15.4.9.1.2 Interest and Dividends Income Not Excluded for EBD](#)).

15.4.9.1.1 Excluded Sources of Interest or Dividend Income

Do not count the following sources of interest or dividend payments:

1.
 1. Interest or dividend income from a non-exempt resource, such as savings accounts, checking accounts, stocks, bonds, etc.
 2. Medicaid resources that are exempt by federal statute other than the Social Security Act:
 - Agent Orange Settlement Payments.
 - Austrian Social Insurance Payments.
 - Corporation for National Community Service (CNCS) (formerly ACTION) Programs.
 - Interests of Individual Development Accounts (IDAs) - TANF Funded.
 - Individual Development Accounts (IDAs) - Demonstrated Project.
 - Japanese-American and Aleutian Restitution Payments.
 - Low Income Energy Assistance.
 - Payments to Victims of Nazi Persecution.
 - Netherlands WUV Payments to Victims of Persecution.
 - Department of Defense (DOD) Payments to Certain Persons Captured and Interned by North Vietnam.
 - Radiation Exposure Compensation Trust Fund.
 - Ricky Ray Hemophilia Relief Fund.
 - Payments to Veterans' Children with Certain Birth Defects.
 3. Interest and dividends that accrue to revocable and irrevocable trusts.
 4. Interest and dividends from a life insurance policy.

15.4.9.1.2 Interest and Dividends Income Not Excluded for EBD

Count the following interest and dividends income for Medicaid:

1. Interest earned on the unspent portion of Earned Income Tax Credits.

2. Interest earned on the unspent portion of Child Tax Credits.
3. Interest and dividends on gifts to children with life threatening conditions.
4. Interest earned on the unspent portion of federal, state, or local relocation assistance payments.
5. Interest earned on the unspent portion of retroactive Social Security or SSI Payments.
6. Interest earned on the unspent portion of Crime Victim's Compensation Payments.
7. Interest portion on repayments of promissory notes or other loan agreements as non-exempt unearned income.
8. Count interest and dividend payments from a revocable or irrevocable trust as non-exempt unearned income, only when the trustee makes an actual payment of the interest or dividend to the trust beneficiary.

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.

15.4.10 Social Security Benefits

Count Social Security Benefits as unearned income in the month received.

15.4.11 Property Settlement

See [Section 16.7.10 Property Settlement](#).

15.4.12 Lump Sum Payments

See [Section 16.7.11 Lump Sums Payments](#).

15.4.13 Money for School

[15.4.13.1 Total Disregards](#)

[15.4.13.2 Partial Disregards](#)

[15.4.13.3 Workforce Investment Act \(WIA\)](#)

For elderly/disabled cases, apply the disregards listed in [Section 15.4.13.1 Total Disregards](#) and [Section 15.4.13.2 Partial Disregards](#) but count all other money that is derived from any other student loan or grant not listed below. Use the Student Financial Aids Report ([F-16021](#)) to obtain the type and amount of the student's aid package. Also, use it to inform the student financial aids office of assistance granted.

See [Section 15.4.13.3 Workforce Investment Act](#) for instructions on how to treat income that is earned under the *WIA*.

15.4.13.1 Total Disregards

For elderly/disabled cases, totally disregard all of the following sources of money for education or training:

1. Supplemental Educational Opportunity Grant (SEOG),
2. Perkins Loans (formerly NDSL),
3. Federal Direct Student Loan Program (Formerly GSL & FFELP),
4. Wisconsin Direct Student Loan (WDL),
5. Talent Incentive Program/State Student
6. Incentive Grant (TIP/SSIG),
7. College Work Study Program (CWSP), and
8. Basic Educational Opportunity Grants (BEOG or PELL).
9. Wisconsin Indian Grant (WIG), and
10. Bureau of Indian Affairs Grant (BIAG).
11. Any other undergraduate loan or grant made or insured under any program administered by the U.S. Commissioner of Education.
12. Any other loans and grants obtained and used under conditions that prevent their use for current living costs.
13. County training program allowances granted by the *IM* agency.

15.4.13.2 Partial Disregards

For elderly/disabled cases, partially disregard all other money for education or training as follows:

- a. Determine the cost of tuition, fees, books, transportation essential to education or training, and day care.
- b. Subtract the total in "1" from the grant, loan, scholarship, etc. total.
- c. Count any remaining money as unearned income:
 - iv. Only as of when the student gets the money; **and**
 - v. Over the months the money is intended to cover.

Example 1: The remaining \$600 of a grant is intended to cover January through June.

If it's received in:

- May, count \$100 in each of the income months of May and June;
- July, budget \$0;
- December, count \$100 in each of the income months of January through June.

15.4.13.3 Workforce Investment Act

For both Family and *Elderly*/Disabled MA cases, disregard all unearned income from WIA to any *adult* or *minor* participating in WIA, including:

1. "Need-based payments" paid to persons as allowances to enable them to participate in a training program.
2. "Compensation in lieu of wages" paid to persons in "tryout employment". This is arranged when private-for-profit opportunities aren't available and is generally limited to persons under age 22. Ask any *applicant* under age 23, or the local WIA staff if he or she is participating in "tryout employment". If he or she is, count this as unearned income.
3. "Payments for supportive services" paid to persons in training programs who are not able to pay for training related expenses (e.g., transportation, health care, child care, meals).

Earned WIA income is paid in the form of wages from on-the-job training (OJT) and work experience activities. Disregard all earned WIA income of a minor for up to a total of six months per calendar year. Negotiate with the MA group which six months of income to disregard. The six months need not be consecutive. Budget WIA income earned by a minor in other than these six months according to ([Section 15.5.8. Student Income](#)).

Count the **earned** WIA income of adult participants.

The **Job Corps Program** is a part of WIA. Consider a minor who's participating in the Job Corps a student when you calculate the income disregards for full-time students, and part-time students who are not employed full-time.

Consider Job Corps payments to adult participants as unearned WIA income.

15.4.14 Child Support

Count child support income as unearned income.

Child support payments (including arrearage payments) made to or on behalf of a disabled child are counted as unearned income to the child.

One-third of the amount of a child support payment made to or for a disabled child by an absent parent is excluded as income. This income exclusion applies to both court ordered and voluntary child support payments.

This exclusion only applies to payments made by an absent parent. Sometimes a family is reunited, and the parent is still making child support payments, in compliance with a court order, even though that parent is now living with the child. Under these circumstances, the one third income exclusion is not allowed, since the parent is no longer considered to be an absent parent.

The one third income exclusion described above only applies to EBD Medicaid eligibility determinations; it does not apply to BadgerCare Plus eligibility determinations.

15.4.15 Profit Sharing

Count profit sharing income as unearned income.

15.4.16 Income Received by Members of a Religious Order

Count any compensation that a member of a religious order receives, not related to gainful employment, as unearned income even if the compensation is turned over to the order.

Count the compensation as earned income if it meets the criteria in [Section 15.5.12 Income Received by Members of a Religious Order](#).

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.

15.4.18 Gambling winnings

Gambling winnings are counted as unearned income in the month of receipt. Gambling losses cannot be used to offset the winnings.

15.4.19 Payments to Native Americans

Disregard the first \$500 of the monthly income from Tribal Per Capita payments from gaming revenue. 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 all Medicaid subprograms for elderly, blind, or disabled persons **except**:

Senior Care and Long Term Care programs such as Institutional Medicaid, Family Care, and *HCBWs* including Partnership and *PACE*. For these subprograms, count all income from Tribal Per Capita payments from gaming revenue as unearned income.

15.4.20 Alimony, Maintenance, and Other Spousal Support Payments

Count all alimony, maintenance, and other spousal support payments.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

15.5 EARNED INCOME

[15.5.1 Income In Kind](#)

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[15.5.15 Earned Income Tax Credit](#)

[15.5.16 Make Work Pay Credit](#)

[15.5.17 Special Tax Credit for Certain Government Retirees](#)

Earned income is income from 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.

Note: Occasionally, a regular periodic payment (e.g., wages, title II, or VA benefits) is received in a month other than the month of normal receipt. As long as there is no intent to interrupt the regular payment schedule, consider the funds to be income in the normal month of receipt.

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.

To determine the value of in-kind benefits, use the prevailing wage (but not less than the minimum wage) in the community for the type of work the person does to earn the benefits.

15.5.2 Contractual Income

This provision applies primarily to teachers and other school employees.

When an employed Medicaid group *member* is paid under a contract, either written or verbal, rather than on an hourly or piecework basis, determine the period of the contract and then prorate the income from the contract over that period. For example, if the contract is for 18 months, prorate the contract's income over 18 months no matter the number of installments made in paying the income. Do this even if:

1. There are predetermined vacation periods, or
2. He or she will only be paid during work periods, or
3. He or she will be paid only at the end of the work period, season, semester or school year.

15.5.3 Rental Income

When a Medicaid group member reports rental income to the *IRS* as self-employment income, see [Section 15.6.3 Self-Employment Income and Assets](#).

If he or she does not report it as self-employment income, add "net rent" to any other unearned income on the appropriate worksheet. Determine "net rent" as follows:

1. When the owner is not an occupant, "net rent" is the rent payment received minus the interest portion of the mortgage payment, and other verifiable operational costs. Operational costs include ordinary and necessary expenses such as insurance, taxes, advertising for tenants, and repairs. Repairs include expenses such as repainting, fixing gutters or floors, plastering, and replacing broken windows.

Capital expenditures are not deductible from gross rent. A capital expenditure is an expense for an addition or increase in the value of the property. It would include improvements such as finishing a basement, adding a room, putting up a fence, putting in new plumbing, wiring or cabinets, paving a driveway.

If an institutionalized person has excess operational costs above the monthly rental income, carry the excess costs over into later months until they are offset completely by rental income. But do the carryover only until the end of the year in which the expenses were incurred.

When a life estate (see [Section 16.8.1.6 Life Estate](#)) holder moves off the property and the property is rented, count the net rental income the holder is entitled to

receive. The operational costs are the same as the costs the holder was liable for when living on the property.

2. When he or she receives income from a duplex, triplex, etc. and lives in one of the units, determine "net rent" as follows:
 - a. Add the interest portion of the mortgage payment and other verifiable operational costs common to the entire operation.
 - b. Multiply the number of rental units by the total in "a."
 - c. Divide the result in "b." by the total number of units. This is the proportionate share.
 - d. Add the proportionate share "c." to any operational costs paid by the member that are unique to any rental unit. The result is the total member expense.
 - e. Subtract the total member expense "d." from the total rent payments to get "net rent."

15.5.4 Jury Duty Payments

Count any portion of a jury payment that is over and above expenses as earned income for the month in which it is received.

15.5.5 Wage Advances

Count advances on wages as earned income in the month received.

15.5.6 Worker's Compensation

Worker's compensation is compensation for lost wages which would have been earned, except for an injury suffered during the course of employment. Count worker's compensation as earned income in Family Care Non-Medicaid. For EBD cases, it is unearned income.

15.5.7 Income Tax Refunds

Effective 01/01/10

Income tax refunds are disregarded income (see [Section 16.7.7 Income Tax Refunds](#)).

15.5.8 Student Income

Disregard a member's income if he or she:

1. Meets the definition of a *dependent 18-year-old*, **or**
2. Is under age 19 and enrolled as a full-time student, **or**
3. Is under age 19 and enrolled as a part-time student working less than 30 hours per week.

Count the earned income of anyone under age 19 who does not meet any of the criteria listed above.

15.5.9 AmeriCorps

Disregard any benefit whether cash or in-kind, including but not limited to living allowance payments, stipends, food and shelter, clothing allowance, and educational awards or payments in lieu of educational awards. Disregard any child care allowance to the extent it was used to meet child care expenses to participate in AmeriCorps. Disregard any basic health insurance policy, child care services, auxiliary aid, and services to people with disabilities and the national service.

15.5.10 Census 2010

Disregard all wages paid by the Census Bureau for temporary employment related to Census 2010.

15.5.11 Severance Pay

Count severance pay as earned income in the month of receipt. Count severance pay that has been deferred at the employee's request or through a mutual agreement with his or her employer as earned income when he or she would have received the amount had it not been deferred.

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 employment, even if the compensation is turned back over to the order.

15.5.13 Title V - Older Americans Act of 1965

Count only wages and salaries paid to individuals as a result of their participation in a program funded under Title V of the Older Americans Act of 1965 as earned income.

These programs include, but are not limited to:

1. Green Thumb.
2. Experience Works.
3. The National Urban League.
4. National Senior Citizens Education and Research Center (Senior Aides).
5. National Indian Council on Aging.
6. U.S.D.A. Forest Service.
7. Wisconsin Senior Employment Program (WISE).
8. Community service employment programs, such as the Older Americans Community Service Program.

Identify programs funded under the Title V of the Older Americans Act using documents provided by the member, contacts with the provider, or a local council on aging.

Do not count reimbursements (see [Section 15.3.19 Reimbursements](#)).

15.5.14 Room and Board Income

Calculate net amount by deducting one of the following from the gross amount received from each roomer/boarder: \$15 roomer only, \$111 boarder only, \$126 roomer and boarder.

15.5.15 Earned Income Tax Credit

Effective 01/01/10

Disregard *EITC* payments.

15.5.16 Make Work Pay Credit

Effective 01/01/10

Disregard actual payments made under Make Work Pay.

15.5.17 Special Tax Credit for Certain Government Retirees

Effective 01/01/10

Disregard actual payments made under the Special Tax Credit for Certain Government Retirees.

This page last updated in Release Number: 15-01

Release Date: 06/10/2015

Effective Date: 06/10/2015

15.6 SELF EMPLOYMENT INCOME

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15.6.1 Definitions

15.6.1.1 Income

Self-employment income is income directly from one's own business rather than as an employee with a specified salary or wages from an employer.

15.6.1.2 Business

Business means an occupation, work, or trade in which a person is engaged as a means of livelihood.

15.6.1.3 Operating

A business is operating when it is ready to function in its specific purpose. The period of operation begins when the business first opens and generally continues uninterrupted up to the present. A business is operating even if there are no sales and no work is being performed. Thus a seasonal business operates in the off season unless there has been a significant change in circumstances (see [Section 15.6.5.3 Anticipating Earnings](#)).

A business is not operating when it cannot function in its specific purpose. For instance, if a mechanic cannot work for four months because of an illness or injury, he or she may claim his or her business was not in operation for those months.

15.6.1.4 Income Maintenance Income

IM income is self-employment income that is counted in determining IM eligibility and benefits.

15.6.1.5 Real Property

Real property means land and most things attached to the land, such as buildings and vegetation.

15.6.1.6 Non-real Property

Non- *real property* means all property other than real property.

15.6.2 Ways to Identify

[Section 15.6.2.1 By Organization](#)

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[Section 15.6.2.3 Employee Status](#)

Identify a farm or other business according to the following criteria.

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. An *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

A self-employed person who earns more than \$400 net income must file an end-of-year return with the *IRS*. A person who will owe more than \$400 in taxes at the end of the year must file quarterly estimates.

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

A person is an employee if he or she is under the direct "wield and control" of an employer. The employer has the right to control the method and result of the employee's service. A self-employed person earns income directly from his or her own business, and all of the following applies:

1. Does not have federal income tax and FICA payments withheld from a paycheck.
Note: A babysitter who works in someone else's home is considered an employee of that household, even if the individual employing him or her does not withhold taxes or FICA.
2. Does not complete a W-4 for an employer.
3. Is not covered by employer liability insurance or worker's compensation.
4. Is responsible for his or her own work schedule.

15.6.3 Self Employment Income Assets

[Section 15.6.3.1 Business Assets](#)

[Section 15.6.3.2 Bank Accounts](#)

[Section 15.6.3.3 Disallowed Expenses](#)

15.6.3.1 Business Assets

Business assets are generally income producing property. Exclude assets directly related and essential to producing goods or services.

In EBD cases, all real and non-real business property is exempt if the business is currently operating (see [Section 15.6.1.3 Operating](#)) for the self-support of the EBD individual. There is no profitability test.

Note: See [Section 16.9 Non-Home Property Exclusions](#).

Ask the EBD person to furnish the documents needed to:

1. Describe the business, its properties, and its assets.
2. Show the number of years it has been operating.
3. Identify any co-owners.
4. Show the estimated gross and net earnings for the current tax year.

If the property is not currently operating, exempt it if there is reasonable expectation it will resume operating within the next 12 months. Base your reasonable expectation on the following information:

1. Date of last use.
2. Reason property is not in current use.
3. Estimated date the person expects to resume use.

If he or she decides not to resume, the property becomes a countable asset in the month after the decision not to resume.

Extend the 12 months only when a disabling condition prevents the person from resuming business use of the property.

15.6.3.2 Bank Accounts

With corporations you can easily distinguish between personal and business checking and savings accounts. A corporation is a separate legal entity and the accounts it owns must be in the corporation's name. Accounts in the name of the owners are personal accounts.

For partnerships and sole-proprietorships, a cash account is a business account if the person claims that it is a business account. Disregard a business account, if the profitability test is passed, even if a partner or sole-proprietor makes withdrawals from the account for personal use. You don't need a profitability test for EBD cases.

15.6.3.3 Disallowed Expenses

Expenses that are allowed self-employment deductions on the IRS business tax forms are allowed expenses for Medicaid. Some specific expenses that have been identified as not allowed in the calculation of Self Employment Income on the IRS tax forms and therefore not allowed for Medicaid are:

1. Net loss carryover from previous periods,
2. Federal, State, and local income taxes,
3. Charitable donations,
4. Work-related personal expenses, such as transportation to and from work,
5. Work-related personal expenses such as pensions, employee benefit and retirement programs and/or profit sharing expenses (Business expenses for employees' pensions, benefits, retirement programs, and profit sharing expenses are allowable, but the work-related personal expenses of the employer are not),
or
6. Principal payments on loans for the purchase price of income producing real estate, capital assets/equipment, and durable goods.

15.6.4 Self-Employed Income Sources

All self-employment income is earned income, except royalty income and some rental income.

Self-employment income is income that is reported to IRS as farm or other self-employment income or as rental or royalty income. When income is not reported to the IRS, you must judge whether or not it is self-employment income.

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.
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.

Use "net" rental income in the eligibility determination. "Net" rental income means gross rental receipts minus business expenses.

When the owner is not an occupant, net rental income is the rent payment received minus the interest portion of the mortgage payment and other verified operational costs.

When a life estate (see [Section 16.8.1.6 Life Estate](#)) holder moves off the property and the property is rented, net rental income is the rent payment received minus taxes, insurance, and operational costs. The operational costs are the same as the costs the holder was liable for when living on the property.

When the owner lives in one of the units of a multiple unit dwelling, compute the annual net rental income as follows:

1. Add the annual interest portion of the mortgage payment and other annual operational costs (including taxes) common to the entire operation.
2. Divide the result in step 1 by the *total* number of units to get the proportionate share.
3. Multiply the amount in step 2 (the proportionate share) by the number of *rental* units. Rental units means the total number of units minus the unit the owner lives in.
4. This equals total expenses.
5. Subtract total annual expenses from the total annual rental income to get net annual rental income.
6. Divide the net annual rental income by 12 to get the net monthly rental income. Budget this amount.

Example 1: George owns a 4 unit apartment building and lives in unit 1. His annual interest paid on his mortgage for the most recent tax year is \$9,765. His operational expenses, including taxes on the house from the most recent taxes is \$12,359. This totals \$22,124. This amount divided by 4 units = a proportionate share of \$5,531.

\$5,531 * 3 rental units = \$16,593. This represents his total budgetable annual expenses. His total annual rental income = \$28, 800 (\$800 per unit per month).

\$28,800
<u>-\$16,593</u>
\$12,207

$\$12,207 / 12 = \$1,017.25$ net monthly rental income.

Royalties. Royalty income is unearned income received for granting the use of property owned or controlled. Examples are patents, copyrighted materials, or a natural resource. The right to income is often expressed as a percentage of receipts from using the property or as an amount per unit produced.

15.6.5 Calculating Income Maintenance Income

[Section 15.6.5.1 IRS Tax Forms](#)

[Section 15.6.5.2 Worksheets](#)

[Section 15.6.5.2.1 Depreciation](#)

[Section 15.6.5.3 Anticipated Earnings](#)

IM income (see [Section 15.6.1.1 Income](#)) is anything you receive in cash or in-kind that you can use to meet your needs for food, clothing, and shelter by either:

1. Using IRS tax forms completed for the previous year, or
2. Anticipating earnings (see [Section 15.6.5.3 Anticipated Earnings](#))

15.6.5.1 IRS Tax Forms

Do not fill out any IRS tax forms (or the Self-Employment Income Report Form [\[F-00107\]](#)) yourself. This is the responsibility of the member.

Consult IRS tax forms only if:

1. The business was in operation at least one full month during the previous tax year, and
2. The business has been in operation six or more months at the time of the application, and
3. The person does not claim a change in circumstances since the previous year.

If all three conditions are not met, use anticipated earnings (see [Section 15.6.5.3 Anticipating Earnings](#)).

15.6.5.2 Worksheets

If you decide to use IRS tax forms, use them together with the self-employment income worksheets ([F-16034](#), [F-16035](#), [F-16036](#), and [F-16037](#)).

The worksheets identify net income and depreciation by line on the IRS tax forms.

For each operation, select the worksheet you need and, using the provided tax forms and/or schedule, complete the worksheet. These are:

1. **Sole Proprietor** - Farm and Other Business
 - a. IRS Schedule C (Form 1040) - Non-farm Business Income
 - b. IRS Schedule E (Form 1040) - Rental and Royalty Income
 - c. IRS Schedule F (Form 1040) - Farm Income
 - d. IRS Form 4797 - Capital & Ordinary Gains
2. Partnership
 - a. IRS Form 1065 - Partnership Income
 - b. IRS Schedule K-1 (Form 1065) - Partner's Share of Income
3. Corporation
IRS Form 1120 - Corporation Income
4. Subchapter S Corporation
 - a. IRS Form - 1120S - Small Business Corporation Income
 - b. IRS Schedule K-1 (Form 1120S - Shareholder's Share of Income

Next, divide IM income by the number of months that the business was in operation during the previous tax year.

The result is monthly IM income. Add this to the fiscal test group's other earned and unearned income. If monthly IM income is a loss, add zero to the non self-employment income.

When a household has more than one self-employment operation, the losses of one may be used to offset the profits of another. Apply this offset only to those self-employment operations that produced earned income. Do not apply a loss from unearned income to a gain in earned income. Losses from self-employment cannot be used to offset other earned or unearned income.

15.6.5.2.1 Depreciation

Depreciation is an allowable deduction for EBD MA cases.

15.6.5.3 Anticipated Earnings

If past circumstances don't represent present circumstances, calculate self-employment income based on anticipated earnings. A change in circumstances is any change that can be expected to affect income over time. It is the person's responsibility to report changes.

Other instances when you would use anticipated earnings:

1. The business wasn't operating at least one full month during the previous tax year.
2. The business wasn't operating six or more months at the time of the interview.

Examples of changed circumstances are:

1. The owner sold or simply closed down the business.
2. The owner sold a part of his business (e.g., one of two retail stores).
3. The owner is ill or injured and will be unable to operate the business for a period of time.
4. A plumber gets the contract on a new apartment complex. The job will take nine months and his or her income will increase.
5. A farmer suffers unusual crop loss due to the weather or other circumstances.
6. There is a substantial cost increase for a particular material such that there will be less profit per unit sold.

The Self-Employment Income Report Form (SEIRF) ([F-00107](#)) simplifies reporting income and expenses when earnings must be anticipated. It is modeled after IRS Form 1040, Schedule C, and can be used to report income for any type of business with any form of organization. However, some, especially farm operators, may find it easier to complete the IRS tax form when income and expense items are more complex.

To compute anticipated earnings, the person must complete a SEIRF for those months of operation since the change in circumstances occurred following the guidelines below (remember, the beginning of a business is a change in circumstances). He or she may complete the SEIRF for each month separately or combine the months on one SEIRF.

When a new self-employment business is reported or when a change in circumstance occurs and the past circumstances no longer represent the present, recalculate self-employment income:

1. When two or more months of actual self-employment information is available, calculate a monthly self-employment net income average using all of the actual income information beginning from the date self employment began or the date of the significant change. See [Example 1](#).
2. When at least one full month but less than two full months of actual self-employment income information is available, calculate a monthly net income average using the actual net income received in any partial month of operation, the one full month of operation and an estimate of net income for the next month. See [Example 2](#).
3. When there is less than one full month of actual income information available, calculate a monthly net self-employment income average using the actual net income received in the partial month (since the change in circumstance occurred) and estimated income and expenses for the next two months. See [Example 3](#).

Use the average until the person's next review or if a significant change in circumstances is reported between reviews.

Example 1: Bonnie applies for CC and Medicaid on April 5, 2014. She reports that she started self-employment in January 2014. The agency uses a SEIRF for January, February, and March to determine the prospective self-employment income estimate for Bonnie's CC and Medicaid certification period (April 2014 - March 2015).

Example 2: Ricardo is applying for FS and Medicaid eligibility on February 5, 2014. He started self-employment on December 15th. To calculate his prospective self-employment income, he completes a SEIRF for December, January, and February including his actual and expected income and expenses for three months. The worker divides this total by three to determine an anticipated monthly average income amount. This amount is used until a change in self-employment is reported, or until Ricardo completes a new application or a review.

Example 3: Jenny is a Medicaid member who has been self-employed as a hair dresser since 2002. Jenny's Medicaid certification period is December 2013 to November 2014. The worker used Jenny's 2012 tax return to establish a monthly income amount.

In March 2014 Jenny reports that she has been unable to work since breaking her arm on February 17. She is not sure when she will be able to return to work, but it will not be until at least May. The worker has Jenny complete a SEIRF for February 17 - February 28 (actual income since the change in circumstance occurred) and for March and April using the best estimate of income to establish her prospective self-employment income. The worker will use these three months to determine a prospective self-employment income estimate for the remainder of the certification period. Jenny does not need to submit any additional SEIRFs.

Use the anticipated earnings amount until the person completes an IRS tax form or reports a change in circumstances.

15.6.6 Verification

Completed and signed IRS tax forms (see [Section 15.6.2.2 By IRS Tax Forms](#)) are sufficient verification of farm and self-employment income. A completed and signed SEIRF is sufficient verification.

It is not necessary to collect copies of supportive items such as receipts from sales and purchases. However, you can require verification when the information given is in question. Document the reason for the request.

15.6.7 Self-Employment Hours

Count the time a self-employed person puts in on business-related activities involving planning, selling, advertising, and management along with time put in on production of goods and providing of services as hours of work.

This page last updated in Release Number: 15-01

Release Date: 06/10/2015

Effective Date: 06/10/2015

15.7 INCOME DEDUCTIONS

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[15.7.4 Impairment Related Work Expenses](#)

[15.7.5 \\$65 and ½ Earned Income Deduction](#)

15.7.1 Maintaining Home or Apartment

If a 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 [Section 39.4.1 EBD Assets and Income Table](#)). The amount is in addition to the personal needs allowance (see [Section 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. It is not limited to the first six months the person resides in the medical institution.

Example 1: Bob entered the nursing home in June 2013 as a private pay patient. In June 2014, he qualifies for Medicaid and is potentially eligible for the home maintenance allowance. Bob's doctor says he is expected to return home by November 2014. He is eligible for a home maintenance deduction from his income, when determining the amount of his income available for his cost of

care, starting in June 2014.

15.7.2 Special Exempt Income

Special exempt income includes:

1. Income used for supporting others (see [Section 15.7.2.1 Support Payments](#)).
2. Court-ordered attorney fees (see [Section 15.7.2.3 Fees to Guardians or Attorneys](#)).
3. Court-ordered guardian and guardian ad litem fees (see [Section 15.7.2.3 Fees to Guardians or Attorneys](#)).
4. Expenses associated with establishing and maintaining a guardianship (see [Section 15.7.2.3 Fees to Guardians or Attorneys](#)).
5. Expenses associated with a Self-Support Plan (see [Section 15.7.2.2 Self-Support Plan](#)).
6. *IRWE* (see [Section 15.7.4 Impairment Related Work Expenses](#)).
7. Maintaining a home or apartment (see [Section 15.7.1 Maintaining Home or Apartment](#)).
8. Costs associated with *real property* listed for sale (see [Section 16.2 Assets Availability](#)).

For specific exemptions, see [Section 15.3 Exempt/Disregarded Income](#).

15.7.2.1 Support Payments

Support payments are payments which a Medicaid *member* makes to another person outside of the *FTG* for the purpose of supporting and maintaining that person. Support payments are either court-ordered (see [Section 15.7.2.1.1 Court-Ordered](#)) or non-court-ordered (see [Section 15.7.2.1.2 Non-court-Ordered](#)).

Include the support payment amount as part of an institutionalized person's monthly need (see [Section 27.6 ILTC Monthly Need](#)) and cost of care (see [Section 27.7 ILTC Cost of Care Calculation](#)).

A person in the fiscal group who has legal responsibility for a person in a nursing home may be paying that person's patient liability. If so, deduct this amount from the group's income.

15.7.2.1.1 Court-Ordered

The income deduction for monthly court ordered support expenses is the amount that the member is "obligated" to pay as stipulated in the court order. Do not allow payments for *arrearages* and annual R & D expenses.

Actual payments may be deducted for court ordered lying in costs for the costs of the birth of the child. Unlike monthly court ordered expenses, actual payments for lying in

costs are frequently paid at various times and are usually not tied to a regular payment schedule.

Note: If the court order stipulates that the individual must pay a monthly amount toward lying in costs, allow the court-ordered amount (obligated amount) as an income deduction. If the member is required to pay lying in costs, but no specific monthly amount is ordered, allow actual payments for lying in costs as an income deduction.

15.7.2.1.2 Non-court-Ordered

Include non-court-ordered support payments only if they are paid to the following:

1. Institutionalized spouse. The maximum amount that can be included is the AFDC Cat Needy income limit for a group size of one (see [Section 39.3 AFDC Related Income Table](#)) minus the spouse's net income.
2. *Minor* child who is living with a non-legally responsible relative (NLRR). The maximum amount that can be included is the AFDC cat needy income limit for a group size of one plus the child's medical expenses minus the child's net income.

Do not include non-court-ordered payments if they are to:

1. A spouse or minor child who receives SSI, or
2. A spouse who is eligible for SSI but refuses to apply for it.

15.7.2.2 Self-Support Plan

A member whose eligibility is based on blindness or *disability* may deduct income that is received under an approved self-support plan. This allows a handicapped person to receive income and accumulate resources for training or purchasing equipment necessary for self support. Where all requirements are met, income from any source, earned or unearned, is deducted and allowed to accumulate to the extent specified in the plan.

To qualify for this deduction, the member must perform in accordance with the plan. The plan must:

1. Be specific, current, and in writing.
2. Be approved by the county or tribal agency.
3. Specify the amount to be set aside, and the expected cost and time required to accomplish the objective.
4. Provide for identification and segregation of goods and money accumulated and conserved.

15.7.2.3 Fees to Guardians or Attorneys

15.7.2.3.1 Disallowed Deductions

The following fees to guardians or attorneys are not allowed income deductions:

1. 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. Fees paid to a third party to reimburse a prepayment the third party made of a guardianship fee. Do not allow the payment even if the third party obtained a court order to recoup the pre-payment.

Exception: Deduct this third party prepayment if:

- a. The third party was the county acting as guardian ad litem. A guardian ad litem is someone appointed by the court to represent the best interests of a juvenile or disabled person during a particular court proceeding, and
- b. The prepayment was to an attorney who was not a county employee at the time the services were delivered, and
- c. A court ordered the institutionalized person to reimburse the county's prepayment.

15.7.2.3.2 Allowed Deductions

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 or herself.

15.7.3 Medical/Remedial Expenses

Medical/remedial expenses (MRE) are used in:

1. The home and community-based waiver programs,
2. Patient liability calculations for residents of a medical institution, and
3. Cost share and **MAPP** premium calculations.

Medical expenses are anticipated incurred expenses for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state). The expense is for diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body. These are expenses that are the responsibility of the member, and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

The following are examples of medical expenses:

1. Deductibles and copayments for Medicaid, Medicare, and private health insurances.
2. Health insurance premiums.
3. Bills for medical services that are not covered by the Wisconsin Medicaid program.

4. For purposes of meeting a Medicaid deductible, medical services received before the person became eligible for Medicaid. (Past medical bills cannot be used for MAPP premium calculations.)

Remedial expenses are costs incurred for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. These are expenses that are the responsibility of the member and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

Some examples of remedial expenses are:

1. Case management.
2. Day care.
3. Housing modifications for accessibility.
4. Respite care.
5. Supportive home care.
6. Transportation.
7. Services recognized under s.46.27, Wis. Stats.
8. Community Options Program, expenses that are included in the person's service plan.

Remedial expenses do not include housing or room and board services.

15.7.4 Impairment-Related Work Expenses

IRWE are expenses used to determine eligibility for Medicaid, MAPP eligibility and premium calculations. IRWE are anticipated incurred expenses by the member related to the member's impairment and employment. The expense cannot be one that a similar worker without a disability would have, such as uniforms. The expense cannot be reimbursable by a legally obligated third party such as Medicaid, private insurance, or the member's employer. If an anticipated IRWE is later paid by an unanticipated source, it is still allowable for past months in which it was budgeted but not for future months.

Example 2: On March 25, Cecil was told by Harvey's Auto Repair Shop that his wheelchair accessible van required repairs to fix the specialized door ramp. Cecil received an estimate of \$2,000 for the repairs. The \$2,000 estimate was determined to be a standard charge for this type of repair in the community.

On March 26, Cecil applied for MAPP in Milwaukee County. At this time the anticipated expense of the van repair was deducted from Cecil's income.

Cecil delayed making the repairs until May 27, when the van's wheelchair accessible door completely quit working. At that time Cecil's friend Robin paid Harvey's Auto Repair Shop for the repairs to Cecil's van door. Cecil reported the repairs and the source of the money for the repairs to his *IM* worker.

Cecil's IM worker should not deduct the anticipated cost of the van repairs for

any subsequent eligibility and premium determinations.

Deduct any 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.

Bills from months prior to the months for which eligibility is being determined are not an allowable IRWE. This is true even if it is currently being paid.

Determine a standard charge for the item or service based on what is representative for the member's community. If you count an expense as an IRWE, do not also use the expense as a MRE.

Some examples of IRWE are: Modified audio/visual equipment, typing aides specialized keyboards, prostheses, reading aids, vehicle modification (plus installation, maintenance, and associated repair costs), and wheelchairs.

Do not allow the expense of getting to and from work as an IRWE, unless the expense is related to the member's disability.

Exceptions: Always count the expenses of getting to and from work and the child care expenses as an IRWE for blind individuals.

15.7.5 \$65 and ½ Earned Income Deduction

The \$65 and ½ earned income deduction is an EBD fiscal test group deduction.

To calculate the \$65 and ½ earned income deduction, subtract \$65 from the member's monthly earned income. Divide the result by two, and add \$65. This is the earned income deduction.

Example 3: Michelle has monthly income of \$1,240. Her \$65 and ½ earned income deduction is

\$1,240.00
- 65.00
\$1,175.00

$\$1,175.00 / 2 = \587.50 Countable Income

\$ 587.50
+ 65.00
\$ 652.50 Earned Income <i>Disregard</i>

Michelle's earned income deduction amount is \$652.50.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

16 ASSETS

16.1 ASSETS INTRODUCTION

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: Mr. Johnson has \$2,600.00 in his checking account for the month of March. This includes his Social Security check of \$700.00 that was deposited into the account on March 10. His countable asset amount for March is \$1,900.00.

Example 2: Mrs. Jones has \$2,400.00 in her checking account for the month of March. She receives Social Security of \$1,000.00 each month. She cashed her Social Security check and used the cash to pay her bills. Because her income is not included in the checking account balance, the income should not be deducted from the checking account balance.

Add together all countable, available assets (see [Section 16.2 Assets Availability](#)), the fiscal group owns including:

1. Joint accounts (see [Section 16.4.1 Joint Accounts](#))
2. Burial assets (see [Section 16.5 Burial Assets](#))
3. Savings account
4. Checking account
5. Cash available
6. Stocks, bonds, CDs.
7. Loans (see [Section 16.7.2 Loans](#))
8. Life insurance (see [Section 16.7.5 Life Insurance](#))
9. Non-burial trusts (see [Section 16.6 Non-burial Trusts](#))
10. Land contract (see [Section 16.7.12 Land Contract](#))
11. Mortgage (see [Section 16.7.13 Mortgage](#))

12. Trailer home (see [Section 16.8.1.2 Non-motorized Trailer Homes](#))
13. Non-home *real property*. (see [Section 16.8 Real Property](#))
14. Some vehicles (see [Section 16.7.9 Vehicles \(Automobiles\)](#), [18.4 Spousal Impoverishment Assets](#))

The EBD fiscal group's assets must be within the appropriate asset limit before any member of that group can qualify for Medicaid. EBD fiscal groups who have assets in excess of the appropriate asset limit are ineligible for Medicaid.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

16.2 ASSETS AVAILABILITY

[16.2.1 Assets Availability Introduction](#)

[16.2.2 Real Property](#)

16.2.1 Assets Availability Introduction

An asset is available when:

1. It can be sold, transferred, or disposed of by the owner or the owner's representative, and
2. The owner has a legal right to the money obtained from sale of the asset, and
3. The owner has the legal ability to make the money available for support and maintenance, and
4. The asset can be made available in less than 30 days.

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: Sylvia has life insurance that she cannot convert to cash within 30 days. She has a letter from the insurance company stating when she will receive the money. It becomes available the day she receives the money. Enter an expected

change in *CWW* with the date the asset is expected to be available.

16.2.2 Real Property

Non-exempt *real property* (see [Section 16.8 Real Property](#)) is unavailable when:

1. The person who owns the property lists it for sale with a realtor (see [Section 16.9 Non-home Property Exclusions](#)).

If an institutionalized person owns property that is unavailable because it is listed for sale, he or she can use some of his or 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 it is owned as a joint tenancy or tenancy-in-common.

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

Tenants-in-common has no right of survivorship. A 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.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

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 (see [Section 15.3.14 Payments to Native Americans](#)), or

- b. For as long as the exemption can be applied to the asset, for example, *ETC* (see [Section 16.7.8 Earned Income Tax Credit](#)), which is exempt for 12 months following the month of receipt.
- 2. An account mixed with other assets (some of which are non-exempt), exempt only the portion that is considered the exempt asset:
 - a. For six months from the date the exempt asset was mixed with the non-exempt assets, **or**
 - b. If the exempt asset has been prorated as income, exempt it for the period over which it is prorated.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

16.4 ACCOUNTS

[16.4.1 Joint Accounts](#)

[16.4.1.1 EBD Medicaid Applicant/Member EBD Co-owner](#)

[16.4.1.2 EBD Medicaid Applicant/Member Non EBD Co-owner](#)

[16.4.1.3 Exception to Joint- Accounts policy](#)

[16.4.2 Jointly Held Real Property](#)

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 accounts where the account holders have equal access to the funds.

16.4.1.1 EBD Medicaid Applicant/Member 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) count the full amount of the account as a countable asset for the EBD Medicaid applicant/member.

16.4.1.3 Exception to Joint Accounts policy

Do not apply Joint Accounts policies (see [Section 16.4.1 Joint Accounts](#)) to the following kinds of joint accounts:

1. Accounts established for business, charitable or civic purposes.
2. Trust or restricted accounts. A trust or restricted account is one in which the person named as holder of the account has no access or limited access to the funds in it.
3. Special purpose accounts. A special purpose account has at least one holder acting as the power-of-attorney, guardian or conservator for at least one of the other holders of the account.
4. Convenience accounts. The following policy applies only to joint accounts of persons who are not married to one another:

When a person's name appears on a joint account, assume he or she is part owner of the assets in the account. Inform the member that he or she has a right to present evidence showing he or she did not deposit any assets into the account.

To show that he or she does not own or co-own any assets in the account, he or she must present all of the following:

1. A signed statement explaining:
 - b. Who owns the funds in the joint account.
 - c. The reason for establishing it.
 - d. Who made the deposits to the account.
2. A signed corroborating statement from the co-holder of the account.
3. A copy of the change in the account which removes his or her name or restricts his or her access.

If the co-holder is incompetent or a *minor*, obtain a statement from a knowledgeable third party. Then, decide whether to accept the person's statement. If you decide he or she is not a co-holder, apply the decision retroactively as well as prospectively. When no third party is available, document the reason.

16.4.2 Jointly Held Real Property

Apportion an equal share of any *real property* or any income derived from real property to each owner. To apportion, the equity or income must be available.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

16.5 BURIAL ASSETS

[16.5.1 Burial Trusts](#)

[16.5.2 Burial Insurance](#)

[16.5.3 Life Insurance Funded Burial Contracts \(LIFBC\)](#)

[16.5.3.1 Irrevocable Assignment of LIFBC](#)

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[16.5.4 Spaces](#)

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[16.5.6 Wisconsin Funeral Trust Program](#)

[16.5.6.1 Statement of Funeral Goods & Services](#)

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16.5.1 Burial Trusts

Exempt all burial trusts made in Wisconsin that are irrevocable by Wisconsin law, as noted in the trust agreement. If made in another state, exempt all that are irrevocable by the laws of that state. Refer any question about any state's law to your corporation counsel.

Interest and dividends are irrevocable if they accrue to irrevocable trusts and if the trust agreement specifies they are irrevocable. If the interest or dividends are irrevocable, exempt them. If interest or dividends are revocable, they are a countable asset.

In non-*spousal impoverishment* EBD Medicaid cases, each fiscal group member may have one or more irrevocable burial trust, of which the total *face value* may not exceed \$3,000. Any principal amount over \$3,000 is a countable asset (see [Section 18.4 Spousal Impoverishment Assets](#) for information about burial assets for persons with a *community spouse*).

16.5.2 Burial Insurance

A burial insurance policy is a contract whose terms preclude the use of its proceeds for anything other than the payment of the insured's burial expense. It is an insurance product sold by a state licensed insurance company, and is typically funded with an annuity or life insurance policy.

The following are not burial insurance policies:

1. If a policy has *cash surrender value* to which the member has access, the policy is not burial insurance; it is life insurance.
2. If a burial policy calls for any excess proceeds to be paid to secondary beneficiary (other than the deceased person's estate), it is life insurance, not burial insurance.
3. Similarly, if a policy calls for the proceeds to be paid to a private party who is expected but not legally required to use the funds for the burial costs of the insured, the policy is life insurance.

The ownership of the annuity or life insurance policy is irrevocably assigned by the policyholder to a funeral expense trust established by the insurance company. The trustee or trust administrator is required to pay all trust proceeds toward the policy holder's funeral expenses at the time of the policy holder's death. If a trust's proceeds exceed burial costs, the excess must revert back to the deceased person's estate.

A burial insurance policy is unavailable if:

1. It includes language that says it is irrevocable, and
2. It states that all of the proceeds must be used for burial expenses.

The purchase of a burial insurance policy that meets the above conditions is not a divestment because the purchaser is presumed to receive *fair market value*.

16.5.3 Life Insurance Funded Burial Contracts

A life insurance funded burial contract involves a person purchasing a life insurance policy on his or her own life and then assigning, revocably or irrevocably, either the proceeds or ownership of the policy to a third party, generally a funeral provider. The purpose of the assignment is to fund a burial contract.

Death benefits which exceed the actual costs of burial expenses must be paid to the insured's estate or the insured's beneficiary.

A burial contract that is funded with a life insurance policy must be in writing and must contain all of the following:

1. Name of funeral home and the insurer.
2. Statement of funeral goods and services.
3. Effect of canceling or surrendering the insurance policy.
4. Effect of changing the assignment of the policy proceeds.
5. Nature and extent of any price guarantees for goods and services.

The assignment option (revocable or irrevocable) chosen by the customer impacts the determination of countable asset and/or divestment amount.

16.5.3.1 Irrevocable Assignment of Life Insurance Funded Burial Contracts

An irrevocably assigned *LIFBC* is an unavailable asset because the member no longer owns it.

If a member has chosen irrevocable assignment of his or her LIFBC the burial space exemption (see [Section 16.5.4 Spaces](#)) may apply, depending on the nature of the contract. Any portion of the contract that represents the purchase of a burial space is exempt and has no effect on the burial funds exclusion (see [Section 16.5.5 Burial Funds](#)).

If the face value of the burial funds portion of the contract exceeds \$1,500, it offsets the burial fund exclusion described in [Section 16.5.5 Burial Funds](#).

If the face value of the burial funds portion does not exceed \$1,500, determine the cash surrender value (CSV) of the LIFBC at the time that it was assigned and proceed in the following order:

1. Apply the CSV to burial spaces.
2. Apply the burial fund logic described in [Section 16.5.5 Burial Funds](#) to any remaining CSV.
3. Apply the CSV to any itemized goods or services, not accounted for by items #1 and #2 above, purchased at fair market value .
4. Apply divestment policy to any remaining CSV (see [Section 17.13.2 Revocable Trusts](#)).

Example 1: Mr Atkins has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value of the LIFBC is \$3,000. The Statement of Funeral Goods and Services shows \$3,000 for the pre-arrangement of the funeral, of which \$1,300 is designated for a casket and \$1,700 for funeral expenses (services and cash advances for such things as flowers and the obituary). The \$1,700 funeral expense portion reduces the \$1,500 burial fund exclusion (see [Section 16.5.5 Burial Funds](#)), and so \$1,500 of this LIFBC will be considered his exempt burial fund. The \$1,300 casket does not reduce the burial fund exclusion (see [Section 16.5.5 Burial Funds](#)) and is not a countable asset because it is a purchase of a burial space.

Because the LIFBC was assigned irrevocably, determine if Mr. Atkins is receiving other goods or services at fair market value for the remaining \$200 designated for funeral expenses. If he is not receiving goods or services at fair market value, consider the remaining \$200 divestment (see [Section 17.13.2 Revocable Trusts](#)).

If the face value of the LIFBC exceeds the total amount shown on the Statement of Funeral Goods and Services, determine the cash surrender value (of the LIFBC at the time that it was assigned) and apply the divestment policy (see [Section 17.13.2 Revocable Trusts](#)). Any portion of an irrevocably assigned LIFBC for which no goods and services are received at fair market value is the *divested amount*.

Example 2: Mr. Atkins has irrevocably assigned the ownership of his life insurance

policy to a funeral home to fund a burial contract. The face value and the cash value of the LIFBC is \$3,200. The Statement of Funeral Goods and Services shows \$3,000 for the pre-arrangement of the funeral. A divestment in the amount of \$200 occurred, because the cash value of the LIFBC exceeds the expenses of the pre-arrangement of the funeral.

16.5.3.2 Revocable Assignment of LIFBC

When a member has chosen revocable assignment of their LIFBC, use the following procedures to determine the countable asset amount.

Identify all other burial assets and life insurance policies the customer may have. Use burial fund logic (see [Section 16.5.5 Burial Funds](#)) to determine what portion of the LIFBC is a countable asset.

The value of the burial contract is equal to the cash surrender value (CSV) of the life insurance policy. If the face value of all life insurance policies is \$1,500 or less, exempt the CSV under the life insurance exclusion.

If the face value of all policies exceeds \$1,500, treat the CSV of the policy according to the burial funds exclusion (see [Section 16.5.5 Burial Funds](#)), if applicable.

If one or more burial spaces are included in the statement of funeral goods and services, the burial space exclusion (see [Section 16.5.4 Spaces](#)) does not apply. This is because the provider has not received payment and therefore no purchase of burial space(s) has been made.

Example 3: Mrs. White has a revocably assigned LIFBC and no other burial assets or life insurance policies. The face value of the LIFBC is \$3,000 and the CSV is \$1,700. The total value of the LIFBC is equal to the CSV of \$1,700.

The burial contract designates \$1,300 for a casket and \$1,700 for funeral expenses. The burial space exclusion (see [Section 16.5.4 Spaces](#)) does not apply to Mrs. White's contract, but \$1,500 of the CSV is exempt under the burial funds exclusion (see [Section 16.5.5 Burial Funds](#)). The remaining \$200 of the CSV is a countable asset.

Example 4: Mrs. White has a revocably assigned LIFBC. She additionally has a burial plot already paid for and a whole life insurance policy with a face value of \$1,500 and cash surrender value (CSV) of \$1,000. The face value of the LIFBC is \$3,000 and the CSV is \$1,700. The total value of the LIFBC is equal to the CSV of \$1,700.

The burial contract designates \$1,300 for a casket and \$1,700 for funeral expenses. The burial space exclusion (see [Section 16.5.4 Spaces](#)) does not apply to Mrs. White's contract. No portion of the CSV is exempt under the burial funds exclusion

(see [Section 16.5.5 Burial Funds](#)), because the face value of her whole life insurance policy is \$1,500. The burial plot is exempt, because it is paid for. The entire value of the LIFBC (\$1,700) is a countable asset.

16.5.4 Spaces

Burial space exemptions apply only to EBD fiscal group members. Burial space exemptions include the following, if they have been paid for:

1. Plots, vaults, caskets, crypts, mausoleums, urns, or other repositories customarily used for the remains of deceased persons, and
2. Necessary and reasonable improvements upon the burial space with items such as headstones, markers, plaques, and
3. Arrangements for opening and closing the gravesite.

Exempt multiple spaces of any value under the following conditions:

1. The space(s) must be owned by the EBD person, that person's *spouse*, or, when the EBD person is a *minor*, by the minor's parents.
2. Both a plot and a mausoleum space cannot be exempted for the same person.
3. Each person may have more than one type of space.
4. The space(s) must be for the use of the EBD member or one of the following:
 - a. Spouse.
 - b. Minor or *adult* natural, adoptive, or stepchild.
 - c. Brother or sister.
 - d. Natural or adoptive parent.
 - e. Spouse of any of the above.

Example 5: Bob, age 12, lives with his parents and is tested for EBD Medicaid. His father owns five burial plots and spaces: #1 is for Bob, #2 and #3 are for his parents, #4 is for his older brother, who does not live at home, and #5 is for Bob's uncle. All the plots and spaces are exempt except #5.

16.5.5 Burial Funds

Burial fund exemptions apply only to EBD Medicaid fiscal group members. Burial funds are funds that are set aside for burial expenses. EBD Medicaid members and their spouses may each have one burial fund.

To find the amount of a burial fund that can be exempted, add:

1. The face value of the person's irrevocable burial trusts.
2. The face value of all of his or her life insurance policies whose cash value is exempt.
3. The face value of his or her exempt burial insurance (see [Section 16.5.2 Burial Insurance](#)).
4. The cash surrender value of revocably assigned life insurance funded burial contracts (LIFBC) (see [Section 16.5.3.2 Revocable Assignment of LIFBC](#)).

5. The burial funds portion of irrevocably assigned LIFBC (see [Section 16.5.3.1 Irrevocable Assignment of LIFBC](#)).

If the total value of above items is \$1,500 or more, do not exempt any more burial funds. If the total is less than \$1,500, subtract the total from \$1,500. The result is the amount of his or her burial fund total that is exempt.

Example 6: Mrs. Smith, age 74, applies for EBD Medicaid. She has a \$1,600 savings account designated as a burial fund, a \$1,300 irrevocable burial trust, and two life insurance policies. The combined face values of the life insurance policies total \$900. Add up the values of exempted assets. The irrevocable burial trust is exempt. The life insurance cash values are exempt when the total of their face values does not exceed \$1,500.

\$1,300	Irrevocable burial trust
+900	Face value life insurance
<u>\$2,200</u>	

The total is more than \$1,500 so no portion of the burial fund (savings account) is exempt.

Example 7: This time, Mrs. Smith, in addition to her \$1,600 savings account designated as a burial fund, has a \$300 irrevocable burial trust and two life insurance policies with a combined face value of \$900.

\$ 300	Irrevocable trust
+ 900	Face value life insurance
<u>\$1,200</u>	

The total is less than \$1,500, so determine what portion of Mrs. Smith's savings account can be exempted as a burial fund.

\$1,500	Maximum burial fund exclusion
- 1,200	
<u>\$ 300</u>	

Mrs. Smith can exempt \$300 from her savings account as a burial fund. The remaining \$1,300 is an available asset.

Anyone claiming a burial fund must sign a statement identifying the fund's location, type, amount, and account number. The statement must specify the month and year in which he or she first intended to set the fund aside for burial.

The fund can be excluded retroactively back to the first day of the specified month, but no earlier than November 1, 1982. It loses its exemption if it is used for anything other than the person's burial.

The fund set aside for burial must be identifiable, but not necessarily segregated from other funds.

16.5.6 Wisconsin Pre-Need Funeral Trust Program

The Wisconsin Funeral Trust is a single trust owned and operated by the Wisconsin Funeral Directors Association (WFDA). It was established and maintained according to the rules of the Wisconsin Department of Financial Institutions. It is available for use by all WFDA members statewide. Funds placed in the Trust will be invested in accordance with applicable state law.

WFDA has created two preneed funeral contracts: one is for a guaranteed price and another is for a non-guaranteed price. These contracts are available to all individuals, not just those who are or may be EBD Medicaid applicants/members.

The agreement by the purchaser with the funeral home constitutes a purchase, even if revocable in whole or part. The contract nearly always includes burial spaces, which are excluded assets. The contract is not:

1. An installment burial contract.
2. An insurance funded burial contract.
3. Divestment as the funds transferred are in exchange for equal amounts of goods and/or services.

In determining countable asset value:

1. Deduct first the amount identified as irrevocable under Wisconsin law.
2. Deduct next the amount equal to the value of all burial spaces purchased by the contract. Remember that "burial spaces" includes caskets and outer burial containers vaults, liners, etc.
3. Deduct any amount that can be included in the applicant's/member's burial fund.
4. The remainder is the countable asset.

Example 8:

Total Contract Value	=	\$5,200
Amount Designated as Irrevocable	=	<u>- \$3,000</u>
		\$2,200
Value of Excluded Burial Spaces	=	<u>- \$1,300</u>
		\$900
Amount of Excluded Burial Funds* =		<u>- 0</u>
Countable Asset	=	\$900

* The amount of funds that may be excluded as the \$1,500 "burial fund" is reduced by any amount of cash value in his or her life insurance and the amount of irrevocable burial trust. Whenever the burial contract specifies \$1,500 or more as

irrevocable, no funds can be excluded as "burial fund."

Example 9:

Total Contract Value	=	\$4,200
Amount Designated as Irrevocable	=	<u>- \$1,300</u>
		\$2,900
Value of Excluded Burial Spaces	=	<u>- \$1,300</u>
		\$1,600
Amount of Excluded Burial Funds*	=	<u>- 200**</u>
Countable Asset	=	\$1,400

**This example assumes that the person has not identified another insurance or irrevocable burial funds toward his or her "burial fund." \$1,500 maximum burial fund allowance, less the \$1,300 this contract makes irrevocable, leaves room for an additional \$200 to be allocated to the "burial fund". Note that in example 1, the purchaser was able to achieve a higher exemption.

16.5.6.1 Statement of Funeral Goods & Services

The US Federal Trade Commission (FTC) requires funeral directors nationwide to use a "Statement of Funeral Goods and Services" as a way of indicating to their customers what is being purchased and their charges. This form looks a great deal like the first page of the WFDA preneed funeral contract. WFDA has advised their members to complete and provide to the family a copy of the Statement of Funeral Goods and Service along with the preneed funeral contract as a service to their customers and in compliance with FTC rules.

16.5.6.2 Cash Advances

On both the WFDA preneed funeral contract and the FTC's Statement of Funeral Goods and Services is an area called "Cash Advance Items". These are expenses for services and goods not provided by the funeral home but often related to the funeral.

Usually, the funeral home asks the purchaser/family to reimburse it dollar-for-dollar equal to what was advanced. A funeral home can, however, charge additional sums for their service in making cash advances on behalf of the deceased's family. For example, a funeral home may advance a \$175.00 payment for an obituary charge to the local newspaper; when billing the family, the funeral home adds a \$20.00 service fee for a total of \$195.00. By FTC rule, whenever the funeral home bills for more than the actual amount of the cash advance, it must identify this to the purchaser/family with a standard phrase added to the Statement of Funeral Goods and Services; the phrase is "We charge you for our services in obtaining ..." This phrase appears on the WFDA preneed agreement and comes into effect whenever the small box to the left of each line under "Cash Advance Item" is marked.

Amounts identified on a preneed agreement under "Cash Advances Items" are not disregarded and are part of the "Total Contract Value" in the asset calculations (see the formula above) for EBD Medicaid. This is true whether there is an additional charge on the cash advance item or not.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

16.6 NON-BURIAL TRUSTS

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[16.6.5 Special Needs Trust](#)

[16.6.6 Pooled Trusts](#)

[16.6.7 Ho-Chunk Tribal Trusts](#)

16.6.1 Non-Burial Trusts Introduction

A trust is any arrangement in which a person (the "grantor") transfers property to another person with the intention that the person (the "trustee") hold, manage, or administer the property for the benefit of the grantor or of someone designated by the grantor (the "beneficiary").

The term "trust" includes any legal instrument or device or arrangement, which, even though not called a trust under state law, has the same attributes as a trust. That is, the grantor transfers property to the trustee and the grantor's intention is that the trustee hold, manage, or administer the property for the benefit of the grantor or of the beneficiary.

The grantor can be:

1. The EBD Medicaid *member*,
2. His or her *spouse*,
3. A person, including a court or an administrative body, with legal authority to act in place of or on behalf of the member or the member's spouse. This includes a power of attorney or a guardian, **or**
4. A person, including a court or an administrative body, acting at the direction or upon the request of the member or the member's spouse. This includes relatives, friends, volunteers or authorized representatives.

If the principal of a trust includes assets of the *applicant*/member or spouse, and the assets of any other person or persons, apply the policies in [Section 16.6.3 Revocable Trusts](#) and [Section 16.6.4 Irrevocable Trusts](#) to the portion of the trust attributable to the assets of the applicant/member or spouse.

16.6.2 Trust Principal

The trust principal is the amount placed in trust by the grantor plus any trust earnings paid into the trust and left to accumulate.

16.6.3 Revocable Trusts

A *revocable trust* is a trust which can be revoked, canceled or modified by the grantor or by a court. A trust which is called irrevocable, but which will terminate if some action is taken by the grantor, is considered a revocable trust.

The trust principal of a revocable trust is an available asset.

16.6.4 Irrevocable Trusts

An irrevocable trust is a trust that cannot, in any way, be revoked by the grantor.

16.6.4.1 Trust Established With Resources of a Third Party

If the resources of someone other than the individual or their spouse (i.e., a third party), were used to form the principal of an irrevocable trust, the trust principal is not an available asset unless the terms of the trust permit the individual to require that the trustee distribute principal or income to him or her.

16.6.4.2 Trust Established With Resources of the Individual or Spouse

If the resources of the individual or the individual's spouse were used to form all or part of the principal of the trust, some or all of the trust principal and income may be considered a non-exempt asset, available to the individual. If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual at any time no matter how distant, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered non-exempt assets, available to the individual.

This treatment applies regardless of:

- the purpose for which a trust is established;
- whether the trustees have or exercise any discretion under the trust;
- any restrictions on when or whether distributions may be made from the trust; **or**,
- any restrictions on the use of distributions from the trust.

Example 1: Doug is a 65 year old Medicaid applicant. Several years ago, Doug transferred his life savings of \$60,000 to an irrevocable trust, naming himself as the beneficiary. Doug's brother, Jim was appointed as the trustee. Under the terms of the trust, Jim could disburse up to \$10,000 annually, from either trust principal or trust income, either directly to Doug or indirectly to provide some benefit for Doug. The trustee had sole discretion as to when and how these trust disbursements would be made, but under no circumstance could they exceed \$10,000 in a 12 month period. Because the entire *corpus* (principal of the fund) could eventually be distributed, \$60,000 would be considered an available non-exempt asset for Doug's Medicaid eligibility determination, even if the trustee decides not to make any actual disbursements.

Example 2: Al is a 65 year old Medicaid applicant. Six years ago, Al sold his farm for \$300,000 and put the entire proceeds from the sale into an irrevocable trust, naming himself as the beneficiary. Al's friend, Scott was appointed as the trustee. Under the terms of the trust, Scott could disburse any amount of trust principal or trust income, at any time, either directly to Al or indirectly to provide some benefit for Al. The trustee had sole discretion as to when and how disbursements would be made as well as the amount that could be disbursed. Therefore \$300,000 would be considered an available non-exempt asset for Al's Medicaid eligibility determination, even if the trustee never makes an actual disbursement.

Example 3: Dave is a 65 year old Medicaid applicant who won a \$250,000 lottery several years ago and put the entire amount into an irrevocable trust, naming himself as the beneficiary. Dave appointed his brother Don as the trustee. Under the terms of the trust, none of the trust principal could ever be distributed to Dave during his lifetime. Don could only distribute the income that is produced by the trust to his brother Dave, and Don has sole discretion as to whether or not any income is actually distributed.

The trust principal would be an unavailable asset since the terms of the trust prohibit any distribution of trust principal during Dave's lifetime. Any disbursements of trust income to Dave would be counted as income to Dave in the month of receipt. Because Don has the authority to distribute all of the income, any trust income which is not disbursed by Don, but instead remains in the trust, is considered to be an available asset.

Example 4: In this example, use the same facts as in example 3, except that the trust requires Don to distribute fifty percent of the generated income to Dave and add the remaining fifty percent to the principal where it will accumulate without distribution.

The half of the generated income that is paid to Don would be income in the month of receipt. The other half of the income would be an unavailable asset and tested for divestment

Note: If the grantor is an institutionalized person, their spouse, or someone acting on behalf of an institutionalized person, setting up an irrevocable trust may be a divestment (see [Section 17.13 Trusts](#) and [Section 17.13.4 Exceptions](#)).

The policies described above regarding irrevocable trusts do not apply to Special Needs and Pooled Trusts described in [Section 16.6.5 Special Needs Trust](#) and [Section 16.6.6 Pooled Trusts](#). The policies described above also do not apply to irrevocable trusts created by a will, unless the terms of the trust permit the individual/beneficiary to require that the trustee distribute principal or income to him or her.

16.6.5 Special Needs Trust

Disregard special needs trusts whose sole beneficiary is under age 65 and totally and permanently disabled (under *SSI* program rules) if it meets these conditions:

1. The trust must be established for the sole benefit of the disabled person by his or her parent, grandparent, legal guardian, or a court, and
2. Contain a provision that, upon the death of the beneficiary, the Wisconsin Medicaid program will receive all amounts remaining in the trust not in excess of the total amount of Medicaid paid on behalf of the beneficiary.

The exception continues after the person turns 65, provided he or she continues to be disabled. However, a grantor cannot add to the trust after the beneficiary turns 65. Anything added to the trust after the beneficiary turns 65 is a divestment. Money added before the beneficiary turns 65 is not a divestment.

16.6.6 Pooled Trusts

Disregard pooled trusts for disabled persons managed by:

1. WISH Pooled Trust
2. WisPACT Trust I
3. ARC of Greater Milwaukee, Inc. Community Trust II

Note: Contact the CARES CALL Center for instructions on treating any other pooled trusts.

The WISH Pooled Trust and the WisPACT Trust I must meet the following conditions:

1. Are established and managed by a non-profit association. The pooled trust can contain funds that hold accounts funded by third parties for the benefit of the disabled person's own assets or income.
2. 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*.
3. 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. 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/member.

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/member. This requirement does not apply to WisPACT trusts.
5. Repay Medicaid to the extent that amounts remaining upon death are not retained by the trust.
 - 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.
 - 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 member 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 member.

Note: The assets that have been placed in a potential pooled trust pending a disability determination are unavailable assets until the disability determination has been made. If the individual has been determined disabled by *DDB*, the pooled trust is an exempt asset as of the disability onset date. If the individual is not determined disabled, the assets are counted.

16.6.7 Ho-Chunk Tribal Trusts

The Ho-Chunk Tribe, under its tribal ordinances and in conjunction with the Indian Gaming Regulatory Act, establishes irrevocable trusts for tribal members who are minors or determined to be legally incompetent. These irrevocable trusts are funded primarily with per capita distribution payments derived from gaming revenue. *DHS* has determined that funds placed in these trusts, for the benefit of minors and individuals who are legally incompetent, are considered to be owned by the Ho-Chunk Tribe and not the trust beneficiary. Therefore, the irrevocable Ho-Chunk Tribal Trusts established for minors or legally incompetent tribal members are considered to be unavailable assets for the tribal member's Medicaid eligibility determination.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

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16.7.1 Personal Property

16.7.1.1 Household Goods

Do not count household goods as an asset.

Household goods include:

1. Items of personal property, found in or near the home, that are used on a regular basis; **and**
2. Items needed by the household for maintenance, use and occupancy of the premises as a home.

Examples of household goods include but are not limited to:

1. Furniture,
2. Appliances,
3. Electronic equipment such as personal computers and television sets,
4. Carpets,
5. Cooking and eating utensils, **and**
6. Dishes.

Note: Items that are acquired or held because of their value or as an investment are not considered household goods (see [Section 16.7.1.3 Other Personal Property](#)).

16.7.1.2 Personal Effects

Do not count personal effects as an asset.

Personal effects are:

1. Items of personal property originally worn or carried by the individual, **or**
2. Articles otherwise having an intimate relation to the individual.

Examples of personal effects include but are not limited to:

1. Personal jewelry including wedding and engagement rings,
2. Personal care items,
3. educational or recreational items such as books or musical instruments,
4. Items of cultural or religious significance to an individual, such as ceremonial attire, **or**
5. Items required because of an individual's physical or mental impairment, such as prosthetic devices or wheelchairs.

Note: Items that are acquired or held because of their value or as an investment are not considered personal effects.

16.7.1.3 Other Personal Property

Personal property that an individual acquires or holds because of its value or as an investment:

1. Is a countable resource (asset); **and**
2. Is not considered to be a household good or personal effect.

Other personal property items include, but are not limited to:

1. Gems acquired or held because of their value or as an investment,
2. Jewelry that is not worn or held for family significance, and
3. Collectibles acquired or held because of their value or as an investment.

Example 1: Mr. Hollenback received \$10,000 from an insurance settlement. Mr. Hollenback paid back creditors with \$7,000 and purchased \$3,000 in jewelry. Mr. Hollenback does not wear the jewelry. The *IM* workers must determine whether the jewelry is excluded from resources as a personal effect or is a countable resource in the form of other personal property. Mr. Hollenback's statements establish that the jewelry has no family significance and that he purchased the jewelry for its value as a means to spend down the \$10,000. The IM workers correctly determines that the jewelry is not an excludable personal effect because an item purchased for its value cannot be a personal effect.

The IM worker correctly determines the jewelry as a countable asset.

16.7.2 Loans

If an *AG member* receives a loan and it is available for current living expenses, count it as an asset. Do this even if there is a repayment agreement. If it is not available for current living expenses, *disregard* it.

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

1. Count any repayments toward the principal of the loan, whether it is a full payment, a partial payment, or an installment payment, as an asset.
2. Count any interest payment on the loan as unearned income in the month received, and as an asset in the months following the month it was received.

16.7.2.1 Reverse Mortgage

A reverse mortgage loan is a loan, or an agreement to lend, which is secured by a first mortgage on the borrower's principal residence. The terms of the loan specify regular payments to the borrower. Repayment (through sale of the residence) is required at the time all the borrowers have died or when they have sold the residence or moved to a new one.

Treat reverse mortgage loan payments to the borrower as assets in the month received and thereafter. Do not count undisbursed funds (not yet paid to the borrower) as assets. They are considered equity in the borrower's residence.

16.7.3 HUD Payments

Disregard reimbursements resulting from federal regulatory changes in computing *HUD* housing rent as income in the month paid and assets in the next month.

16.7.4 Annuities

An annuity is a written contract under which, in return for payment of a premium or premiums, an individual will receive a series of payments at regular intervals for a specified time period.

The annuitant is the person entitled to the payments. A purchaser can name himself or herself or another person as the annuitant. The purchaser may also name a beneficiary to receive annuity payments after the annuitant's death.

16.7.4.1 Annuities Purchased After March 1, 2004

(For annuities purchased before March 1, 2004, refer to [Section 16.7.4.2 Annuities Purchased Before March 1, 2004](#)).

Treat annuities purchased after March 1, 2004, as available assets in accordance with the following:

16.7.4.1.1 Annuities That Can Be Surrendered:

If the annuity's cash value is available for withdrawal (minus any penalty) the annuity can be "surrendered."

To determine the value of annuities that can be surrendered (for example, an annuity in the accumulation phase), use the following formula:

- | |
|--|
| 1. Total deposits made to the annuity. |
| Plus |
| 2. Earnings on the deposits not previously paid out. |
| Minus |
| 3. Withdrawals and surrender costs charged for withdrawal. |
| Equals |
| 4. Annuity's value |

16.7.4.1.2 Annuities That Cannot Be Surrendered (this subsection effective 03-01-09)

It has been established that a market exists for annuities that cannot be surrendered. Some companies have purchased such annuities. Check the annuity contract to see if it can be sold. If it is capable of being sold, consider it to be an available asset unless the *applicant* or member demonstrates that he or she has made reasonable attempts to obtain a fair market price by offering the annuity for sale to companies active in the annuities market.

If it appears that the annuity cannot be sold, verify this by having the annuity contract reviewed by a company active in the annuities market for an opinion of its value to the company. If the company documents an amount at which it values the annuity, that amount will be considered an available asset.

The annuity will be considered to be an unavailable asset if documentation is provided from the company stating that it places no value on the annuity. Payments from an annuity that is considered to be unavailable must be counted as income. Annuities that are considered to be unavailable must also be evaluated for possible divestment, in accordance with [Section 17.11 Annuities](#).

Example 2: Cynthia is 83 years old and applying for Medicaid. She owns an annuity purchased for \$110,000 after March 1, 2004. The annuity is paying out and cannot be surrendered. It is irrevocable and non-transferable. The agency has the annuity contract reviewed by a company in the annuities market. The company provides the agency with a written statement that it would value Cynthia's annuity contract at \$82,000. Cynthia's annuity is therefore considered to be an available asset with a value of \$82,000 which is the amount used to determine Cynthia's Medicaid eligibility.

Example 3: Sam is 66 years old and applying for Medicaid. He owns an annuity purchased for \$110,000 after March 1, 2004. The annuity is paying out and cannot be surrendered. It is irrevocable and non-transferrable. It appears from the contract that it cannot be sold. The agency verifies this by having the annuity contract reviewed by a company in the annuities market. The company provides the agency with a written statement that it places no value on Sam's annuity contract. Sam's annuity is therefore considered to be an unavailable asset in determining his Medicaid eligibility.

16.7.4.2 Annuities Purchased Before March 1, 2004

Annuities that can be surrendered (In the accumulation phase)

The accumulation phase of an annuity is the period when the purchaser puts money into the annuity. During the accumulation phase, an annuity is an available asset because the annuitant can cash it in for its cash value.

Cash value (also known as surrender value) equals:

1. Total deposits made to the annuity.
- +
2. Earnings on the deposits not previously paid out.
-
3. Withdrawals and surrender costs charged for withdrawal.

In determining the cash value, do not deduct income tax withheld or tax penalties for early withdrawal.

Annuities in the Pay-Out Phase (can not be surrendered)

The pay-out (annuitization) phase begins at the time payments start going to the annuitant in accordance with the settlement option. The settlement option specifies the way the funds from the annuity will be paid out. It involves choosing the amount of each payment, how often payments will be made, and the length of time over which the payments will be made.

An annuity becomes an unavailable asset on the date the settlement option is made final. This means even if the payment starts months later, it is unavailable on the date the settlement option is made final.

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.

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.

Life insurance policies always have a face value, but do not always have a cash value. Term life insurance is limited to a defined time period as stated in the policy and does not usually have cash value. Group life insurance is usually term insurance and usually has no cash value. An endowment insurance plan generally has cash value.

Note: In calendar year 2000, some VA Term Life Insurance Policies were assigned a cash value. The Department of Veteran's Affairs put into effect a regulation to provide paid-up life insurance on term policies. When the veteran chooses this option to purchase paid-up insurance with their term insurance, the policy at that point has a *cash surrender value*. The cash value amount is a countable asset.

16.7.6 Treatment Of Continuing Care Retirement Community Entrance Fees

A Continuing Care Retirement Community (CCRC) or Life Care Community (LCC) typically provides a variety of living arrangements, from independent living through

skilled nursing care. Potential residents frequently must pay substantial entrance fees and sign detailed contracts before moving to the community.

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:

1. The person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, even in part, to pay for care if the person's other resources or income are insufficient to pay for their care. It is not necessary for the CCRC or LCC to provide a full, lump sum refund of the entrance fee to the resident. If even a portion of the fee can be refunded or applied to pay for care as required, this condition would be met,
2. The person is eligible for a refund of any remaining entrance fee when the person dies or terminates the contract and leaves the community. It is not necessary for the resident to actually receive a refund of the entrance fee or deposit. This second condition is met as long as the resident could receive a refund were the contract to be terminated or if the resident dies, **and**
3. The entrance fee does not confer an ownership interest in the continuing care retirement community or life care community. An ownership interest generally means the right to possess and convey property, but recognize that it might not be an all-inclusive definition. Therefore, the resident will be required to verify whether or not they have an ownership interest in the CCRC or LCC by presenting documentation from the facility to that effect. If the CCRC or LCC confirms that the entrance fee does not confer an ownership interest to the resident, then this third condition is met.

Entrance fees which meet all three conditions described above will be counted as an available non-exempt asset for all Medicaid eligibility determinations for the *elderly*, blind, and disabled, regardless of whether or not the individual is requesting long term care services. An entrance fee which does not meet all three conditions described above is an unavailable asset.

For Medicaid eligibility determinations, all normal *spousal impoverishment* rules regarding income and asset allocations for a *community spouse* are applicable to married couples who reside in a CCRC or LCC, when one *spouse* resides in the skilled nursing care section of the facility, and the other spouse (the community spouse) resides in a more independent living setting. CCRC and LCC contracts are required by federal law to account for spousal impoverishment income and asset allocations to a community spouse, before determining the amount of resources that a resident must spend on his or her own care.

16.7.7 Income Tax Refunds

Federal and state income tax refunds are available assets.

16.7.8 Earned Income Tax Credit

Disregard all *EITC* in the month received and for 12 months following the month of receipt.

After the 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.

16.7.9.1 Determining Equity Value

Equity value is:

1. The vehicle's wholesale value as given in a standard guide on motor vehicle values (blue book), or the value as estimated by a sales representative at a local dealership,
2. Minus any encumbrances (loans or mortgages) that are recorded on the vehicle's title as liens.

Do not increase a vehicle's value by adding the value of low mileage or other factors, such as optional equipment or apparatus for the handicapped.

Occasionally, a vehicle has more than one owner. Some of the owners may be in the fiscal test group, others not. To find what the fiscal test group's equity value in the vehicle is, do the following:

1. Find the vehicle's wholesale value.
2. Subtract the encumbrances (loans or mortgages) that are recorded as liens on the vehicle's title. The result is the equity value.
3. Divide the equity value by the total number of owners.
4. Add up the prorated equity values of the owners who are in the fiscal test group. The result is the fiscal test group's equity value in the vehicle.

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 for recreational purposes.
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 12 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.

If an individual states that the vehicle will not be repaired and used for transportation in the next 12 calendar months, count the equity value of the automobile as a resource.

16.7.10 Property Settlement

Money received as a property settlement is always an asset regardless of whether it is paid in one payment or in installments. It is never income.

16.7.11 Lump Sums Payments

Lump sum payments (rather than recurring payments) from such sources as insurance policies, sale of property, Railroad Retirement, Unemployment Compensation benefits, and retroactive corrective financial aid payments are counted as an asset when received.

16.7.11.1 Retroactive SS Payments

The unspent portion of retroactive **SSI** and Retirement Survivors Disability Insurance (RSDI) benefits received on or after March 2, 2004, is excluded from resources for the nine calendar months following the month in which the individual receives the benefits.

Do not count a retroactive social security or SSI payment as an asset either in the month of receipt or nine months following the month the payment is received. A retroactive payment means it is paid later than the month in which it is due. After nine months, treat any remaining available portion as an asset.

During the nine months in which it is not counted, the unspent portion of the payment can be mingled with other funds, provided it can be distinctly and separately identified.

The unspent portion of retroactive SSI and RSDI benefits received before March 2, 2004, is excluded from resources for the six calendar months following the month in which the individual received the benefits.

16.7.12 Land Contract

When a land contract is executed, the purchaser builds equity in the property through the payments he or she makes. The seller keeps legal title to the property until it is paid for. The seller's interest in the land contract is personal property, not **real property**.

The seller's legal title to the property can be sold and converted to cash for support and maintenance. To determine the value of the seller's legal interest in the land contract:

1. Find the original sale price or the **fair market value** (as determined by a qualified real estate appraiser). Of these two amounts choose the one which more accurately reflects the contract's true value on the date it was originated.
2. From this amount subtract:
 - a. Payments which the purchaser has already made on the principal.

Example 5: The fair market value of the land contract is \$50,000. The purchaser has already paid \$10,000 on the principal.

\$ 50,000	Fair Market Value
-10,000	Already Paid
\$ 40,000	Outstanding Balance

- b. Encumbrances on the contract, for example, a personal loan.
- c. The amount lost to a discount.

Example 6: Company ABD purchases land contracts. They have offered

to buy Mr. Graham's land contract at a 10 percent discount.

\$40,000 Outstanding Balance

- 4,000 10%

\$36,000 Value of Mr. Graham's Interest in the Land Contract

3. The remainder, after subtracting a., b., and c. from the original sale price, is the value of the seller's interest in the land contract. Count this as an available asset.

If the land contract is not an available asset, the person must document its unavailability by showing that either:

- a. The terms of the land contract prohibit its sale, **or**
- b. No one is willing to purchase it from him or her

When the claim is that no one will purchase the land contract, it must be offered for sale to at least one individual or organization active in the land contract purchasing market. A written statement from the individual or organization that they will not buy it is sufficient to establish the land contract as an unavailable asset.

Notice that if it has been offered only to an individual or organization that never purchases land contracts, it remains an available asset.

16.7.13 Mortgage

Treat any mortgage held by and owed to a member the same as a land contract.

16.7.14 Wisconsin Higher Education Bonds

The state of Wisconsin sells Wisconsin Higher Education Bonds to the public as a way to save for higher education. To determine their net value, subtract broker's fees from market value.

The bonds may be sold back to the state, under certain time restraints:

1. Before the maturity date, a portion of their value is withheld. The amount withheld equals the school's tuition and fees. Any excess goes to the person.
2. On or after the maturity date, the value is the total amount received.

The bonds may be sold on the "secondary" bond market at any time. Since they can be disposed of on the market with no time limit they are an available asset. To determine their net value, subtract broker's fees from market value. (Verify the amounts through a broker.)

16.7.15 Wartime Relocation of Citizens

Disregard restitution paid under PL 100-383 to Japanese-Americans and Aleuts or their survivors who were interned or relocated during World War II.

16.7.16 Agent Orange Settlement Fund

Disregard payment received from the Agent Orange Settlement Fund or any other fund established in settling "In Re: Agent Orange product liability Settlement Fund litigation, M.D.L. No. 381 (E.D.N.Y.)." Disregard as income in the month received and as an asset thereafter.

16.7.17 Radiation Exposure Compensation Act

Disregard payments from any program under the Radiation Exposure Act (PL 101-426) paid to persons to compensate injury or death resulting from exposure to radiation from nuclear testing (\$50,000) and uranium mining (\$100,000).

When the affected person is dead, payment is made to his or her surviving spouse, children, parents, or grandparents. The federal Department of Justice reviews the claims and makes the payments.

Apply this disregard retroactively to October 15, 1990 and continue to disregard the payment for as long as it is identified separately.

16.7.18 Self-Support Plan Assets

Disregard assets set aside to carry out an approved self-support plan (see [Section 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.

16.7.19 Replacing and Repairing Exempt Assets

Vehicles and homes are examples of exempt assets. If an exempt asset is lost, stolen, or damaged, disregard any cash (and interest earned) or in-kind replacement received from any source to repair or replace it.

The cash or in-kind payment must be used within nine months of the date it is received. After the end of the ninth month, count as an asset leftover cash not used for the repairs or replacement.

Extend the nine-month period for up to another nine months if the person has good cause for not repairing or replacing the thing. Good cause means circumstances beyond the person's control to prevent repair or replacement. This includes not being able to contract it out. When there is good cause, count as an asset any amount not used for repairs or replacement. Begin with the month after the end of the extension.

If, during a good cause extension, the person no longer intends to replace or repair the exempt asset, count the amount for replacement or repair as an asset. Begin with the month the person reports his or her change of intent.

16.7.20 Retirement Benefits

Retirement benefits include work-related plans for providing income when employment ends (e.g., pension disability or retirement plans administered by an employer or union).

Other examples of retirement funds include accounts owned by the individual, such as **IRAs** and plans for self-employed individuals, sometimes referred to as Keogh plans.

1. Employment related pension plans should be treated as follows.
 - a. If an applicant/member has the ability to cash in a work related benefit, the net amount of the benefit (after any penalties but before any tax withholding) available to the applicant/member should be treated as an available asset. Some retirement benefit plans allow employees to cash in their benefits as a lump sum payment when they leave their job instead of waiting until they reach retirement age to get the pension. However, do not count retirement funds as an available asset if the applicant/member has to quit a job to get at the retirement funds, or if the applicant/member is receiving periodic payments from the retirement benefit plan.
 - b. If the applicant/member does not have access to the account's principal in his or her retirement benefit plan, the principal should be treated as an unavailable asset.
 - c. Periodic payments made from a work-related retirement benefit plan should be counted as income in the month of receipt.
2. Individually owned retirement funds, such as IRA's Keogh plans, etc., that are owned by the applicant/ member should be counted as available non-exempt assets (minus any early withdrawal penalty) for the Medicaid applicant/member. The applicant/member always has access to the principal in these accounts, subject to an early withdrawal penalty.

Any periodic payments from these accounts should not be counted as income in the months of receipt. These payments are considered assets. They are considered the same as withdrawals from an applicant's saving account. Only interest earned on the funds in a retirement fund is to be counted as income (see [Section 15.4.9.1 EBD Interest/Dividend Income](#)).

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

Consider IRAs, Keoghs, or other retirement funds that are completely cashed in as a conversion from one asset form to another.

Example 7: Mike withdraws \$2,000 he has in an IRA, and deposits it into a savings account. Continue to treat the \$2,000 as a countable asset. This is just a conversion from one form of an asset to another. Treat any interest that Mark receives as income in the month received.

16.7.21 Gifts

A gift is something a person receives which is not repayment for goods or services the person provided and is not given because of a legal obligation on the giver's part. To be a gift, something must be given irrevocably (that is, the donor relinquishes all control).

Treat non-cash gifts as an asset, as you would an asset of a similar type. A cash gift is income in the month of receipt. It is an asset in the months after the month of receipt. Disregard cash gifts (such as for birthdays, graduation, and Christmas) that total \$30 or less, for each assistance group member, for each calendar quarter.

16.7.22 U.S. Savings Bonds

Count the cash value of a U.S. Savings Bond unless it is unavailable. A bond is unavailable only if the Medicaid group proves it tried to cash the bond and was refused.

16.7.23 Indian Judgment Fund Purchases

Disregard assets purchased with Indian judgment funds (see [Section 15.3.14 Payments to Native Americans](#), #10). But do not disregard:

1. Proceeds from the sale of these initial purchases.
2. Subsequent purchases made with the proceeds from the sale of these initial purchases.

16.7.24 Payments to Nazi Victims

Disregard payments made under PL 103-286 to victims of Nazi persecution.

16.7.25 Spina Bifida Child

Disregard payments made under PL 104-204 to any child of a Vietnam veteran for any disability resulting from the child's spina bifida.

16.7.26 Uniform Gifts to Minors Act

Do not count funds held in an account for the benefit of a *minor* that are the result of transfers under the Uniform Gifts to Minors Act. This act is also called the Uniform

Transfers to Minors Act. There is no asset test for minors for EBD eligibility determinations.

16.7.27 Individual Development Accounts Programs

Individual Development Accounts (IDA) are restricted accounts owned by low-income people. The IDA program provides matching funds for buying a home, starting a business, or post-secondary education. Member savings and interest are a countable asset if the IDA was established using the Assets for Independence Act or Refugee Assistance Act funds. However, if W-2 or Community Reinvestment funds support the IDA program, the assets are exempt.

16.7.28 Crime Victim Restitution Program

Disregard any payments received from a state established fund to aid victims of a crime. These payments are an excluded resource for nine months following the month of member.

16.7.29 The American Recovery and Reinvestment Act (ARRA) of 2009

Do not count the one-time \$250 payment under the ARRA as an asset either in the month of receipt or nine months following the month the payment is received.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

16.8 REAL PROPERTY

[16.8.1 Home/Homestead Property](#)

[16.8.1.1 Multiunit Dwelling](#)

[16.8.1.2 Non-Motorized Trailer Homes](#)

[16.8.1.3 Exempt Home Property](#)

[16.8.1.4 Home Equity over \\$750,000.00](#)

[16.8.1.5 Sale of Home Property](#)

[16.8.1.6 Life Estate](#)

Real property means land and most things attached to the land, such as buildings and vegetation.

16.8.1 Home/Homestead Property

A home is a place of abode and lands used or operated in connection with it. In urban situations the home usually consists of a house and lot. A home can consist of a house

and more than one lot. As long as the lots adjoin one another, they are considered part of the home.

Homestead property may have more than one building or house on it. This applies to urban home owners as well as farm families. In farm situations the home consists of the house and buildings together with the total acreage property upon which they are located that is considered a part of the farm. There will be farms where the land is on both sides of a road and considered a part of the home.

Land should be considered part of the home property if it is not completely separated from the home property by land in which neither the individual nor his or her *spouse* has an ownership interest.

Easements and public rights of way (utility lines, roads, etc.) do not separate other land from the home plot.

If land is completely separated from the home property by land in which neither the individual nor his or her spouse has ownership interest it should not be considered part of the homestead property.

16.8.1.1 Multi-unit Dwelling

When a Medicaid fiscal group member lives in one unit of a multi-unit dwelling and owns all of the units, exempt all of the units and the property they are on. Consider the whole multi-unit dwelling as the group member's home.

16.8.1.2 Non-Motorized Trailer Homes

A non-motorized trailer home is considered real property, regardless of whether or not the member owns the land that it is on. Consider the non-motorized trailer home:

1. Home property (see [Section 16.8.1 Home/ Homestead Property](#)) if the member currently lives in it or had lived in it before entering an institution, **or**

If the member owns the land that the non-motorized home is sitting on, consider it and any other buildings on that land as part of the homestead.

2. Non-home property if the member does not live in it or had not lived in it prior to entering an institution.

If the non-motorized trailer home is listed for sale, it is considered unavailable (see [Section 16.2 Assets Availability](#)).

16.8.1.3 Exempt Home Property

Although home property is an exempt asset under the conditions described in this subsection, there are limits on divesting home property (see [Section 17.2.3.1 Homestead Property](#)).

Non-Institutionalized Person. For a person who is not residing in an institution, the home is exempt as long as the person resides in it, or intends to return to it. There is no time limit for an intended return. The home remains exempt even if the person rents out part of it while he or she continues to reside there.

Institutionalized Person. When a person resides in an institution, the home is exempt if one of the following conditions is met:

1. His or her spouse or dependent relative resides in the home. The dependency of the relative may be of any kind, such as financial or medical. The relative may be father, mother, daughter, son, grandson, granddaughter, in-laws, stepmother, stepfather, stepson, stepdaughter, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, stepsister, half-sister, half-brother, niece, nephew, or cousin.
2. The institutionalized person expresses his or her intent to return to the home. If he or she is able to form an intent but unable to express it, determine his or her intent through other available evidence. Other evidence includes:
 - a. His or her written statements.
 - b. His or her oral statements made before incapacitation. Accept reports of these statements made by family members.
 - c. Accept reports of his or her intent made by an *authorized representative*. If there is no evidence he or she disagrees with the statement, accept the authorized representative's statement.

If he or she appears unable to form an intent but has not been judged incompetent by a court, accept a family member's statement as evidence of his or her intent.

If he or she has been judged incompetent, accept the intent statement of his or her guardian. Use the guardian's intent statement even if it differs from the member's.

If neither condition #1 nor #2 is met, the property is no longer the principal residence and becomes non-home property.

16.8.1.4 Home Equity over \$750,000.00

Effective January 1, 2009, persons who apply for Medicaid coverage of long term care (LTC) services (i.e., Institutional, community waivers, Family Care, Partnership or *PACE*) are not eligible for LTC services if the equity interest in their home is greater

than \$750,000. He or she is still eligible for care services if all other eligibility requirements are met.

This restriction does not apply if a spouse, *minor*, or disabled child resides in the home.

The \$750,000 LTC home equity limit can be waived in situations whereby the imposition of this eligibility requirement results in an "undue hardship" for the individual. When determining whether or not an undue hardship exists, follow the same undue hardship guidelines outlined in [Section 17.17 Undue Hardship](#).

The equity value of a home is the current *fair market value (FMV)* minus any encumbrance on it. An encumbrance is a legally binding debt against the home. This can be a mortgage, reverse mortgage, home equity loan, or other debt secured by the home.

Note: Property tax assessments can be used to determine a property's FMV if both the local agency and *applicant*/member agree that it accurately represents the price it would sell for on the open market in that geographic area. If both parties do not agree, statements from one or more realtors could be sufficient. If the local agency requests a comparative analysis, they are required to pay for it. Regardless of what process is used, the member always has the right to appeal the agency decision if they think it is incorrect.

Example 1: Bob is a 66 year old bachelor, living in his own home who applies for Medicaid on February 1, 2009. His home has a FMV of \$760,000 with no encumbrances. Bob meets all other Medicaid eligibility requirements and is certified for Medicaid effective February 1, 2009. In October 2009, Bob's health deteriorates and he applies for a community waiver program. That application is denied because Bob's equity interest in his home exceeds the LTC eligibility limit by \$10,000.

On December 15, 2009 Bob reapplies for a community waiver program and reports that on December 1, 2009, he took out a \$12,000 home equity loan and used the entire loan proceeds to purchase exempt burial assets and furniture for his home. Bob's December 15, 2009 application for community waivers is approved because Bob's equity interest in his home is now \$748,000, which is below the LTC eligibility limit, and he meets all other Medicaid eligibility requirements.

Example 2: Dave is 75 years old, married and living with his wife Ruth in their home which sits on a 75 acre parcel of property. The entire property qualifies as homestead property. It has a FMV of \$1,000,000 with no encumbrances. On March 5, 2009, Dave applies for Family Care. The Family Care application is approved because even though Dave's home equity value exceeds the \$750,000 LTC eligibility limit, his wife resides in the home, which negates the \$750,000 LTC home equity restriction.

This home equity provision applies only to individuals who apply for LTC Medicaid (i.e., nursing home, Family Care, etc.), on or after January 1, 2009. It does not apply to individuals

who are current members of Medicaid LTC programs as of January 1, 2009, as long as they remain continuously eligible for LTC Medicaid after that date. A Medicaid LTC member who becomes ineligible for Medicaid LTC after January 1, 2009, for a calendar month or more, would be subject to the \$750,000 home equity limit during any subsequent reapplication for Medicaid LTC programs.

16.8.1.5 Sale of Home Property

Money from the sale of real property is an asset. When the property that is sold is a homestead, *disregard* the proceeds if they are placed in an escrow account and used to purchase another home within three months.

16.8.1.6 Life Estate

A life estate allows an individual to gift a home or other possession but retain certain property rights for his or her lifetime. Generally a life estate provides an individual the right to possess and use a gifted property, and to make money from it. The person does not have the title to or the right to sell the property. He or she usually may not pass it on to his or her heirs as an inheritance. He or she also has the right to sell his or her interest in it. He or she is liable for all costs of the property such as taxes and repairs, unless the will (or *deed*) states otherwise.

When property is conveyed to one person for life (life estate holder) and to another person (the remainder man), both a life estate interest and remainder interest are created. When the life estate holder dies, the remainder man holds full and unconditional title to the property and can dispose of it as he or she wishes (fee simple). Life estate values need to be determined for divestment calculation.

Example 1: Sidney gifted away his \$100,000.00 home to his nephew Frank, but retained a \$30,000.00 life estate, the *divested amount* is \$70,000.00.

The life estate interest is an unavailable asset when determining Medicaid asset eligibility for Sidney. However, the remainder interest is an available non-exempt asset for Frank, the remainder person, for Medicaid eligibility determinations.

Determine the value of the remainder interest for the date you are determining Medicaid eligibility. To do this, use the age of the life estate holder on the date that you are determining eligibility for the remainder person. Also use the property's FMV as of that same date. Then select the remainder multiplier (the one that corresponds to the age of the life estate holder) from the life estate table and multiply the FMV by that number. The result should be the value of the property's remainder interest for the remainder person as of the date that eligibility for Medicaid is being determined for that person.

To determine the value of a life estate or remainder interest:

1. In the Life Estate and Remainder Interest Table (see [Section 39.1 Life Estate and Remainder Interest](#)), find the line for the person's age as of the transaction date.
2. Multiply the figure on that line in the Life Estate or Remainder column times the fair market value to determine the value of the life estate or remainder interest.

When a life estate holder moves off the property and the property is rented, follow the instructions in [Section 15.5.3 Rental Income](#) for counting the rental income.

If a remainder person sells the property for which a life estate is retained, the life estate holder is not entitled to any of the payments.

However, if the life estate holder gives up his or her life estate to secure the sale of the property, then the life estate holder would be entitled to some portion of the proceeds from the sale of the property. Treat money received as a result of property settlement as an asset (see [Section 16.7.10 Property Settlement](#)).

*This page last updated in Release Number: 10-02
Release Date: 06/22/10
Effective Date: 01/01/09*

16.9 NON-HOME PROPERTY EXCLUSIONS

Non-home property is any countable asset other than a *homestead*. See [Section 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 [Section 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: John owns two acres of land that he uses to grow fruits and vegetables for his personal consumption. Up to \$6,000 of the equity value of the property would be exempt.

4. Property excluded up to \$6,000 if it is nonbusiness property that produces a net annual income (either cash or in-kind income) of at least 6 percent.

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: James is applying for EBD Medicaid. He lives in a **CBRF** and is renting out his home which has an equity value of \$20,000. He does not intend to return to the home. The income from the rent exceeds 6 percent of the equity value of the home, so \$6,000.00 of the equity value is exempt. The remaining \$14,000.00 is a counted asset.

Example 3: Joan is applying for EBD Medicaid. She lives in her home but also owns a lake cottage in northern Wisconsin. She rents the cottage during the summer months. The income from the rent does not equal 6 percent of the equity value of the cottage. The entire equity value of the cottage is a countable asset.

If the excluded portion produces less than a 6 percent 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 percent return, continue to consider the first \$6,000 in equity as excluded.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

16.10 INDIAN LANDS

Exclude a Native American's interest in or possession of land that is held by an individual Native American or tribe, and that can only be disposed of with the approval of other individuals, the tribe, or the federal government.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

17 DIVESTMENT

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 member 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: Joe applied for HCBW and was found ineligible for HCBW for nine months due to a divestment. Joe can still be eligible for *SSI*-Related Medicaid or *MAPP* while he serves his divestment penalty, if otherwise eligible for those programs.

Example 1: Martha is residing in a nursing home and applied for Institutional Medicaid. Martha is ineligible for Institutional Medicaid for five months due to a divestment. During the penalty period, she is eligible for Medicaid card services.

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 Sections 17.6 - 17.14, while falling under the same definitions and general rules, require extra treatment because of their complexity.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

17.2 DIVESTMENT DEFINITIONS

[17.2.1 Divestment](#)

[17.2.2 Transfer](#)

[17.2.2.1 Date of Transfer](#)

[17.2.3 Nonexempt Assets](#)

[17.2.3.1 Homestead Property](#)

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[17.2.5 Community Spouse](#)

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[17.2.7 Divested Amount](#)

[17.2.8 Net Market Value](#)

[17.2.9 Value Received](#)

[17.2.10 Unavailability](#)

17.2.1 Divestment

"Divestment" is the transfer of income, non-exempt assets, and *homestead* property (see [Section 17.2.3.1 Homestead Property](#)), which belong to an institutionalized person or his or her *spouse* or both:

1. For less than the fair market value of the income or asset by:
 - a. An institutionalized person, or
 - b. His or her spouse, or
 - c. A person, including a court or an administrative body, with legal authority to act in place of or on behalf of the institutionalized person or the person's spouse, or
 - d. A person, including a court or an administrative body, acting at the direction or upon the request of the institutionalized person or the person's spouse. This includes relatives, friends, volunteers, and authorized representatives.
2. It is also divestment if a person takes an action to avoid receiving income or assets he or she is entitled to. Actions which would cause income or assets not to be received include:
 - a. Irrevocably waiving pension income.
 - b. Disclaiming an inheritance.
 - c. Not accepting or accessing injury settlements.

- d. Diverting tort settlements into a trust or similar device.
- e. Refusing to take legal action to obtain a court-ordered payment that is not being paid, such as child support or alimony.
- 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:
 - 1.
 - 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.

This includes situations in which the will of the institutionalized person's spouse precludes any inheritance for the institutionalized person. Under Wisconsin law, a person is entitled to a portion of his or her spouse's estate. If the institutionalized person does not contest his or her spouse's will in this instance, the inaction may be divestment.

- 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 [Section 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 [Section 17.12.2 Promissory Notes on or After 01/01/09](#)).
 - c. The purchase of certain annuities may be considered a divestment (see [Section 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 Transfer

"Transfer" is the act of changing the legal title or other right of ownership to another person. Converting an asset from one form to another is not divestment. For example, buying a race horse for \$12,000 and keeping the race horse is not divestment.

17.2.2.1 Date of Transfer

If the Medicaid member has transferred *real property*, such as a homestead, the official date of transfer is the date the Quit Claim *Deed* was signed. It is not the date the transfer was recorded with the county Register of Deeds.

17.2.3 Nonexempt Assets

"Nonexempt assets" are those that are counted in *SSI*-related asset tests. Assets that are not counted in these tests are called exempt assets. An available asset (see [Section 16.1 Assets Introduction](#)) can be either exempt or nonexempt.

17.2.3.1 Homestead Property

Homestead property, usually an exempt asset, is given special consideration in the Medicaid divestment policy. Homestead divestments are permitted only under the circumstances described in [Section 17.4 Exceptions, #7](#).

17.2.4 Institutionalized Person

See [Section 27.4 ILTC Definitions](#).

17.2.5 Community Spouse

See [Section 18.2.1 Community Spouse](#).

17.2.6 Fair Market Value

"Fair market value" is an estimate of the prevailing price an asset would have had if it had been sold on the open market at the time it was transferred.

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 [Section 17.10 Life Estates](#).

17.2.8 Net Market Value

"Net market value" is the fair market value at the time of the transfer minus any outstanding loans, mortgages, or other encumbrances on the property.

17.2.9 Value Received

"Value received" is the amount of money or value of any property or services received in return for the person's property. The value received may be in any of the following forms:

1. Cash.

2. Other assets such as accounts receivable and promissory notes (both of which must be valid and collectible to be of value), stocks, bonds, and both land contracts and life estates which are evaluated over an extended time period.
3. Discharge of a debt.
4. Prepayment of a bona fide and irrevocable contract such as a mortgage, shelter lease, loan, or prepayment of taxes.
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 [Section 17.8 Divesting by Paying Relatives](#)).

17.2.10 Unavailability

If a Medicaid member or his or her spouse uses an asset in a way that makes it unavailable and does not receive *FMV*, treat that asset as divestment. An example is using an asset as collateral for someone else's loan.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

17.3 LOOK BACK PERIOD

Effective January 1, 2014, the look back period is 60 months for all divestments.

The look back period is a period of time prior to application or entry into an institution. A divestment that has occurred in the look back period or any time thereafter can cause the *applicant* or member to be ineligible.

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

When you count backward, start counting with the month before the date of application or entry into the institution as month one. When determining which date to use, use the most recent date.

"Date of application" is the date the applicant or his or her representative signs the application. If he or she does not sign the application, it is not a complete application and no divestment penalty can be imposed.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015*

17.4 EXCEPTIONS

A divestment that occurred in the look-back period or any time after does not affect eligibility if any of the following exceptions apply:

1. The person who divested shows that the divestment was not made with the intent of receiving Medicaid.

The person must present evidence that shows the specific purpose and reason for making the transfer, and establish that the resource was transferred for a purpose other than to qualify for Medicaid. Verbal assurances that he or she was not trying to become financially eligible for Medicaid are not sufficient. Take into consideration statements from physicians, insurance agents, insurance documents, and bank records that confirm the person's statements.

Any of the following circumstances are sufficient to establish that the *applicant/member* transferred resources without an intent to qualify for Medicaid.

- The applicant/member had made arrangements to provide for his or her long term care needs by having sufficient financial resources and/or long term care insurance to pay for long term care services for at least a five-year period at the time of the transfer.

An exception to this requirement is allowed if the individual had a life expectancy of less than five years at the time of transfer. If the individual's life expectancy was less than five years at the time of the transfer, a divestment penalty is not applied if resources and/or insurance were sufficient to pay for his or her long term care services for his or her remaining life expectancy.

To measure "sufficient resources," use the average monthly nursing home cost of care in effect at the time of the divestment multiplied by 60. Compare that number to the income, assets, and insurance held by the individual at the time of the divestment, **or**

- Taking into consideration the individual's health and age at the time of the transfer, there was no expectation of long-term care services being needed for the next five years. For example, someone who was gainfully employed and 50 years old at the time of the divestment is not expected to have set aside sufficient resources for five years of long-term care, **or**
- If an individual or couple had a pattern of charitable gifting or gifting to family members (i.e., birthdays, graduations, weddings, etc.) prior to the look-back period, similar transfers during the look-back period would not be

considered to have been given with the intent to divest as long as the total yearly gifts did not exceed 15 percent of the individual's or couple's annual gross income. If the yearly gifted amount exceeds 15 percent of the individual's or couple's annual gross income, and/or there is a gap in the years the gifts occurred, the total amounts gifted for the years in the look-back period shall be considered divestment. This exception is not limited to gifts made on traditional gift-giving occasions and does not preclude a pattern of giving to assist family members with educational or vocational goals, or

- Resources spent on the current support of dependent relatives living with the individual are not considered to be divestments. The individual must either claim the relative as a dependent for *IRS* tax purposes, or otherwise provide more than 50 percent of the cost of care and support for the dependent relative.

This list is not intended to be all inclusive when describing divestments which are permissible because the transfer was made without the intent to qualify for Medicaid. Other situations will arise and in those instances, the person's "intent" must be evaluated on a case-by-case basis to determine whether or not a divestment occurred. The fact that a person does not meet the criteria for a specific exception does not create a presumption that the person cannot show that the transfer was made for a purpose other than qualification for Medicaid. For example, a person may be able to show that a transfer to a dependent relative not living at home was made for a purpose other than qualifying for Medicaid.

2. The community spouse divested assets that were part of the community spouse asset share AND this transfer occurred more than five years after the institutionalized spouse was determined eligible:
 - a. Five years after the institutionalized person is determined eligible, the community spouse can divest assets that are part of the community spouse asset share (see [Section 18.4.3 Calculate the CSAS](#)). He or she can give them to anyone without affecting the eligibility of the institutionalized spouse.

Example 1: When Ralph went into a nursing home and applied for Medicaid, Edith's community spouse asset share was \$42,000. After Ralph became eligible, Edith gave \$30,000 of the community spouse asset share to a favorite nephew. This divestment did not affect Ralph's eligibility. Edith is allowed to divest all or any part of the community spouse asset share.

- b. If the community spouse receives assets from the eligible institutionalized spouse that were not part of the community spouse asset share, he or she cannot give them to anyone except persons listed in [Section 17.4](#)

Exceptions, #8. Giving them to someone other than these persons could cause the institutionalized person to become ineligible.

Example 2: Ralph is an institutionalized Medicaid member. He recently inherited \$25,000, and immediately transferred it to Edith, his community spouse. This \$25,000 is not part of the community spouse asset share. Therefore, Edith cannot transfer the money to anyone except "a child of any age of either spouse who is either blind or permanently and totally disabled or both" (see [Section 17.4 Exceptions, #8](#)). If she transfers it to anyone else, Ralph's eligibility for institutional services may be affected.

Homestead property is an exception. After the institutionalized person has become eligible, he or she can transfer the homestead to the community spouse, and the community spouse can transfer it to anyone once five years have passed since the eligibility of the institutionalized spouse. The community spouse's divestment of homestead property five years after the institutionalized person has become eligible, does not affect the institutionalized person's eligibility.

Example 3: When Ralph applied for institutional Medicaid, he and Edith owned a home together. Homestead property is not counted as part of the community spouse asset share. After Ralph became eligible, he signed his 1/2 share of the home over to Edith. Edith can divest the part of the homestead that Ralph gave to her without affecting Ralph's eligibility

Note: While these examples show that in some circumstances the community spouse's divestments occurring more than five years after the determination do not affect the institutionalized person's eligibility, they may affect the community spouse's eligibility if he or she later enters an institution and applies for Medicaid.

3. The ownership of the property is returned to the person in the fiscal group who originally disposed of it.
4. Division of property as part of a divorce or separation action, and loss of property due to foreclosure or repossession are not divestment.
5. The person intended to dispose of the asset either at fair market value or other valuable consideration.

Example 5: Gary had a lucky 3-cent postage stamp that he carried in his wallet. A friend admired it, so Gary sold it to him for \$0.03, unaware that it was worth more. The friend sold it to a stamp dealer for \$7,300. When Gary applies for Medicaid, this divestment will be disregarded.

6. The agency determines that denial of eligibility would result in undue hardship for the person (see [Section 17.17 Undue Hardship](#)).

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

a. Spouse

b. Child who meets at least one of the following conditions/situations:

- Under 21 years of age

OR

- Blind

OR

- Permanently and totally disabled

OR

- Been residing in the institutionalized person's home for at least two years immediately before the person moved to a medical institution, and provided care to him or her which permitted him or her to reside at home rather than in the institution. This care must have been provided for the entire two years immediately before the person 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 one year immediately before the date the person moved to a medical institution.

Verify that the sibling was residing in the institutionalized person's home for at least one year immediately before the person moved to a medical institution. Do not 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.

and

- Has a verified equity interest in the home.

"Equity interest" means an ownership interest in a homestead.

Ask to see a copy of the *deed* or the land contract or some other document to verify the sibling's equity interest in the homestead. Since the sibling's name on the document is not sole proof, you may need to require other documentation such as canceled checks and receipts.

8. The institutionalized person or his or her community spouse divests a nonhomestead asset or assets to:
 - a. A spouse
 - b. A child of any age of either spouse who is either blind or permanently and totally disabled or both.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

17.5 PENALTY PERIOD

[17.5.1 Penalty Period Introduction](#)

[17.5.2 Calculating the Penalty Period](#)

[17.5.3 Penalty Period Begin Date For Applicants](#)

[17.5.4 Penalty Period Begin Date For Recipients](#)

[17.5.5 Recalculation of Penalty Periods](#)

[17.5.5.1 Full Refund](#)

[17.5.5.2 No Reduction for Partial Refund](#)

[17.5.5.3 Divestments During a Penalty Period](#)

17.5.1 Penalty Period Introduction

If there was a divestment during the look back 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. He or she may, however, still be eligible for Medicaid card services (see [Section 17.15 Medicaid Card Services](#)). An individual ineligible for *HCBW*s due to a divestment may still be eligible for other non-*LTC* 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 **\$252.95 per day**.

Example 1: Jeff applied for Family Care. One month earlier, Jeff had transferred \$18,500 in cash to his son. At the time of application Jeff is otherwise eligible for Family Care. Since \$18,500 divided by **\$252.95** equals **73.13** days, Jeff is ineligible for **73** days.

Once you have determined the number of days that will constitute the individual's divestment penalty period, use the following website to establish when the penalty period will end and the exact date on which eligibility for LTC services can begin:

<http://cgi.cs.duke.edu/%7Edes/datecalc/datecalc.cgi>.

This website contains two date calculators. Use the one titled, "Calculate the date some number of days from an initial date." Enter the penalty period begin date (see [Section 17.5.3 Penalty Period Begin Date for Applicants](#)) and the number of days of the penalty period. Click submit to receive the first date the person can be eligible.

17.5.3 Penalty Period Begin Date for Applicants

For divestments that occurred **on or after January 1, 2009**, the penalty period for an **applicant** for a HCBW program or Family Care begins on the date **all** of the following have occurred:

- The person applies for a HCBW program or Family Care.
- The person meets the appropriate **LOC** and functional screen criteria.
- The person meets all other Medicaid nonfinancial and financial eligibility requirements, regardless of whether or not the waiver funding is actually available.

Note: If a person who had excess assets divests those assets during the three month backdated period of an application, he or she is ineligible for excess assets until the date that he or she divested those assets. The divestment penalty period as well as the potential eligibility for card services would begin on the date of the divestment.

Example 2: Jeff applied for Family Care on **March 5**. One month earlier, Jeff had transferred \$18,500 in cash to his son. At the time of application Jeff is otherwise eligible for Family Care. Since \$18,500 divided by **\$252.95** equals **73.13** days, Jeff is ineligible for **73** days from the date he applied for Family Care. His penalty period begins on **March 5**. He will be eligible on **May 17**.

Example 3: Joan enters a nursing home on March 1 and applies for Medicaid on March 4. On her application, Joan reported that, **in the previous month**, she gave her **adult** daughter a \$100,000 cash gift, which is determined to be a divestment. Joan meets all other Medicaid eligibility requirements; therefore, Joan's divestment penalty period will begin on March 1. If Joan had been over

the asset limit at the time of application, she would not have been "otherwise eligible for Medicaid," so her divestment penalty period would not start until she was under the asset limit.

Example 4: John applies for a HCBW program on April 7. He indicates on his application that he gave his adult son a \$60,000 cash gift **three months earlier**. John meets the community waiver functional screen criteria and all other Medicaid eligibility requirements. He resides in a county that does not have any available waiver slots, and he is therefore put on a waiting list. The \$60,000 cash gift was determined to be a divestment. John is therefore ineligible for HCBW for the length of the penalty period. His penalty period would begin on April 7, **the day he applied for the HCBW program**.

Example 5: Jeff enters a nursing home on March 1. He applies for Medicaid on April 15 and requests that his eligibility be backdated to March 1. John meets all other Medicaid eligibility requirements in March and April; however, he reports transferring \$100,000 in stocks and bonds to his brother in February. John's divestment penalty period begins on March 1, which is the date he was institutionalized, applied for Medicaid LTC, and is otherwise eligible for Medicaid except for the imposition of the divestment penalty.

Example 6: Sam entered a nursing home on October 1. He applies **for Medicaid** on January 3 and asks for a three month backdate. He reports giving away an inheritance on November 23. Sam is denied Medicaid for being over assets until November 23. Sam's divestment penalty period begins on November 23, which is the date that he is institutionalized, has applied for Medicaid LTC, and is otherwise eligible for Medicaid except for the imposition of the divestment penalty.

17.5.4 Penalty Period Begin Date for Recipients

Beginning with penalty periods with a start date of November 11, 2013, or later, a member's penalty period begins on the first of the month after timely notice is given.

Example 7: Joe was determined eligible for institutional Medicaid effective March 1. On July 2 he sold his home and gave the proceeds to his son. Joe reported the divestment on July 12. The worker entered the divestment in CARES on July 16 and closed Joe's institutional Medicaid effective August 1. The penalty period begin date would be August 1, the date the worker was able to enter the divestment and give timely notice of the penalty period. If the worker had not entered the divestment in CARES until after **adverse action** in July, the penalty period begin date would be September 1, the first day the benefit could be terminated with timely notice.

When a member divests, the **IM** worker must enter the date the divestment was reported as the transfer date on the Transfer/Divestment of Assets page. CARES will close the person using adverse action logic. The actual penalty period should be calculated based on the first day of the month of closure. Those dates should be entered in case comments to be adjusted with the monthly Divestment Report completed by the CARES Call Center.

Manual notices must be sent with the correct divestment dates.

17.5.5 Recalculation of Penalty Periods

17.5.5.1 Full Refund

When the entire divested resource or equivalent value is returned to the individual, the entire penalty period is nullified. You must then re-evaluate the individual's Medicaid eligibility for LTC services retroactively, back to the beginning date of the previously imposed penalty period. The individual can then be certified for Medicaid LTC services if he or she met all other eligibility requirements during this retroactive adjustment period. The refunded resources will be counted as available assets beginning with the month in which they were returned.

Example 8: Scott gave a \$10,000 **CD** to his adult son on March 10. On October 1, Scott entered a nursing home and applied for Medicaid. Due to his prior divestment, Scott was ineligible for Medicaid coverage for the cost of his institutional care for 39 days. The divestment penalty period started on October 1 and ended on November 8. Scott was certified for Medicaid LTC on November 9.

Scott's son had already cashed in the CD, but, on December 5, he returned \$10,000 in cash to Scott as a refund of the prior gift from his father. Since the equivalent value of Scott's previously transferred asset has been returned, Scott is now potentially eligible for Medicaid LTC services for the period of October 1 through November 8. Scott met all other eligibility requirements during that retroactive period, and he is certified for Medicaid LTC services for that same period. The \$10,000 that Scott received and reported on December 5 is counted as an asset beginning in December and would make him ineligible for Medicaid, effective January 1, unless his assets are reduced to program limits prior to January 1.

17.5.5.2 No Reduction for Partial Refund

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 recalculated based on a partial repayment (Wis. Stat. § 49.453[8][a]).

Example 9: Jerry divested cash to his daughter prior to applying for institutional Medicaid. He has a 373 day penalty period. His daughter returned half of the *divested amount*. Jerry's penalty period remains 373 days. If Jerry's daughter returned the entire amount that was divested, the divestment would be "cured," and Jerry would no longer have a penalty period.

17.5.5.3 Divestments During a Penalty Period

If another divestment occurs when a penalty period is in effect, another penalty period must be calculated for the most recent divestment. This calculation would use the divestment penalty divisor currently effective. The new penalty period will not begin until the existing period has expired. The penalty periods cannot run concurrently.

Send the *member* a notice advising him or her that the consequence of the new divestment is an increased penalty period and specify the new penalty dates.

Example 10: Jeff had a penalty period that lasted until July 25. In June, he transferred another \$40,000 to friends. Since \$40,000 divided by \$252.95 equals 158.13, the divestment penalty period is 158 days. The new divestment period of 158 days begins July 26, the day after the original divestment penalty period has ended. The new divestment penalty period does not run concurrently with the original divestment period.

The divestment report does not register divestment penalty changes. If it is necessary to remove a divestment penalty or change an existing penalty period in interChange, update the Transfer/Divestment of Assets page, run eligibility, and confirm. Then contact the fiscal agent at (608) 224-6521. Provide the fiscal agent with the date that the divestment penalty was removed or the new end date. The LOC will then be revised. Also contact the appropriate individual at the member's nursing home to submit bills for the period that is now covered by institutional Medicaid.

Reminder: The divestment notices are inaccurate. Send a manual notice explaining eligibility for card services, the reason for service reduction, and the number of months in the penalty period when a case receives a divestment penalty. Include the legal citation Wis. Stat. § 49.453.

*This page last updated in Release Number: 15-02
Release Date: 07/30/2015
Effective Date: 07/30/2015*

17.6 MULTIPLE DIVESTMENTS

Multiple divestments are two or more separate divestments made within the look back period or at any time thereafter.

For multiple divestments that occurred prior to January 1, 2009:

1. Add together all the divested amounts of transfers in the look back period or any time thereafter that are connected in any of the following ways:
 - a. Transfers that occur in the same month.
 - b. Transfers that occur in both months of a period of any two consecutive months.
 - c. Transfers with a penalty period (see [Section 17.5 Penalty Period](#)) that extends into a month in which there is another transfer.
 - d. Transfers with a penalty period (see [Section 17.5 Penalty Period](#)) that extends into the month immediately preceding a month in which there is another transfer.
2. Calculate the penalty period (see [Section 17.5 Penalty Period](#)).

If there are divestments prior to January 1, 2009 in the look back period which are not connected in any of the ways described above, treat them as separate and calculate a separate penalty period for each.

For multiple divestments that occur on or after January 1, 2009, all transfers made by the institutionalized individual or his or her *spouse* that occur during the look-back period must be added together, to arrive at a total divestment amount. That total will be used to calculate the appropriate divestment penalty period. For these divestments it does not matter if the divestments were made in sequential months, have penalty periods that overlap, or penalty periods that extend into a month immediately preceding a month in which there was another transfer.

Note about penalty period begin date for multiple transfers:

When an *applicant* or *member* has penalty periods from transfers that occurred prior to January 1, 2009, and transfers that occurred on or after January 1, 2009, the penalty period for the transfers in 2009 may not begin until the month after the earlier penalty period ends.

Example 1: Ernie entered a nursing home and applied for Medicaid on June 3, 2010. He meets all the financial and non-financial criteria for Medicaid except he divested both prior to and after January 1, 2009. In the 36-month look-back period he made the following transfers:

06/01/2008 \$20,000 cash to a friend
09/01/2008 \$35,000 bond to his son
10/01/2008 \$50,000 bond to grandson
11/01/2008 \$50,000 bond to grandson
12/01/2008 \$25,000 bond to grandson

These transfers were made prior to January 1, 2009, so the worker would use the policy for multiple transfers prior to January 1, 2009, to determine the penalty period. The June 1, 2008, transfer has a penalty period of three months. Since it goes to August 31, 2008, it extends into the month that immediately precedes the month of another transfer, the September 1, 2009 transfer. Each of the later transfers, the October 1, 2009, November 1, 2009, and December 1, 2009, occur in consecutive months so the worker will add together all of the divested amounts from June 1, 2008 through December 1, 2008 to calculate the penalty period. From these divestments Ernie has a 28 month penalty period (180,000 divided by 6,362) with a begin date of June 1, 2008 and an end date of September 30, 2010.

02/1/2009 \$5,000 cash to his nephew

04/1/2009 \$10,000 CD to his son

Since these transfers were made on or after January 1, 2009, the divested amounts are totaled and divided by the daily nursing home rate of pay to determine the penalty period. The penalty period for these divestments is 71 days (15,000 divided by 209). Because this penalty period cannot start until the penalty period imposed for the transfers prior to January 1, 2009, is over, the begin date of this penalty period will be October 1, 2010.

*This page last updated in Release Number: 10-02
Release Date: 06-22-10
Effective Date: 01-01-09*

17.7 JOINTLY HELD ASSETS

When an institutionalized person owns an asset in common with another person and when he or she or the other person or any person acting on his or her behalf transfers the asset during the look back period or anytime thereafter, he or she may be penalized for divestment if the transfer:

1. Reduces or eliminates the institutionalized person's ownership or control of the asset, or
2. Limits the institutionalized person's right to sell or otherwise dispose of the asset.

"Holding an asset in common" means holding it through joint tenancy, tenancy in common, joint ownership, or partnership.

Example 1: For many years Debra held a joint account with her daughter, Donna. On October 15, 1996, Donna withdraws \$13,000 from it. On December 3, 1996, Debra enters a nursing home and applies for Medicaid. The \$13,000 withdrawal is a divestment. A penalty period must be calculated and imposed.

If placing another individual's name on the account, or asset actually limits the individual's right to sell or otherwise dispose of the asset, such placement would constitute a transfer of assets. For example, the addition of another individual's name requires that the other individual agree to the sale or the disposal of the asset, where no such agreement was necessary before.

Example 2: John bought a piece of property with his nephew, Carl. Three months later John requested to participate in the community waivers program. John explained that his nephew, Carl, refused to sell the property and, therefore, it was unavailable and should not be counted as an asset. The *IM* worker agreed with John that the land was not available and would not be counted as an asset. But, the purchase of the property and the nephew's refusal to make it available (through liquidation) to meet John's needs was divestment. Therefore, John is subject to a penalty period starting from the first of the month in which the jointly owned property was purchased.

When a person's name appears as co-owner of a jointly held asset, assume he or she is part owner of the property. However, you must inform him or her that he or she has a right to present evidence showing he or she is not an owner (see [Section 16.3 Separate and Mixed Assets](#)).

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

17.8 DIVESTING BY PAYING RELATIVES

[17.8.1 Divesting by Paying Relatives Introduction](#)

[17.8.2 Room & Board](#)

17.8.1 Divesting by Paying Relatives Introduction

It is divestment when an institutionalized person transfers resources to a relative in payment for care or services the relative provided to him or her. A relative is anyone related to the institutionalized person by blood, marriage, or adoption.

Count all the payments for care and services which the institutionalized person made to the relative in the last 36 months. The form of payment includes cash, property, or anything of value transferred to the relative. It is not divestment if all of the following conditions exist:

1. The services directly benefited the institutionalized person.
2. The payment did not exceed reasonable compensation for the services provided.

"Reasonable compensation" is the prevailing local market rate for the service at the time the service is provided.

Example 1: Ms. Rain applies for community waivers on January 10, 1995. She paid her son \$3,500 to remodel her bathroom the previous month. She shows that her son installed new tile and fixtures. You check with a local contractor who estimates the he would charge \$4,000 for the same job. Since Ms. Rain received *fair market value*, it is not divestment.

Example 2: Ms. M. enters a nursing home on December 12, 1995, and applies for Medicaid. She reports she paid her daughter \$7,000 in December for coming to her house each evening and fixing dinner for the previous two months. You check with a local agency that provides meals to homebound persons. They charge \$2 for each meal. Ms. M.'s daughter provided 61 meals. The fair market value of the meals was \$122. You determine Ms. M. overpaid her daughter. The *divested amount* is \$6,878 (\$7000-\$122).

3. If the amount of total payment exceeds 10 percent of the *community spouse* asset share (see [Section 18.4.3 Calculate the CSAS](#)), the institutionalized person must have a written, notarized agreement with the relative. The agreement must:
 - a. Specify the service and the amount to be paid, **and**
 - b. Exist at the time the service is provided.

Example 3: Ms. A enters a nursing home and applies for Medicaid on November 1, 1996. When asked if she has transferred any assets in the past 36 months, she reveals that she has. She paid her daughter \$10,000 in exchange for personal care that her daughter had provided to her the past two years. This \$10,000 payment would ordinarily be counted as a divestment, since it is above 10 percent of Ms. A's community spouse asset share.

But she shows you a written, notarized statement, dated October 9, 1994, in which she promises to pay \$10,000 to her daughter for the specified care. Therefore, there is no divestment.

If there is no community spouse, use 10 percent of the highest possible CSAS in [Section 18.4.3 Calculate the CSAS](#).

17.8.2 Room and Board

If an institutionalized person has made room and board payments to a relative, *disregard* them if:

1. The payments do not exceed fair market value of the room and board, **and**
2. Are for periods when the institutionalized person was receiving the room and board.

If the room and board is paid after the person has been institutionalized, treat the payment as divestment unless:

1. The payment is only for the month immediately preceding the month he or she entered the institution, **or**
2. He or she provides a written lease that existed during the time he or she was receiving room and board from the relative.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

17.9 INCOME DIVESTMENT

Income received by an institutionalized person and transferred in the month of receipt is considered divestment.

Example 1: Mr. M. resides in a nursing home. He receives a pension check of \$3,000 a month. Mr. M. immediately signs the check over to his son. This is a divestment.

Unless there is reason to believe otherwise, assume that ordinary household income was legitimately spent on the normal costs of living.

However, there may be divestment if the person transferred amounts of regularly scheduled income that he or she ordinarily would have received. Such a transfer usually takes the form of a transfer of the right to receive income.

When you find the institutionalized person has transferred income or the right to receive income, calculate a penalty period based on the total amount of income transferred.

Example 2: Donald transfers his rights to his \$325,000 pension to his daughter. The *divested amount* is \$325,000, not the \$4,500 the daughter expects to receive each month from the pension.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

17.10 LIFE ESTATES

[17.10.1 Life Estates Introduction](#)[17.10.2 Joint Owners](#)[17.10.3 Purchase of a Life Estate in the Home of Another Person](#)**17.10.1 Life Estates Introduction**

A life estate is created when a property holder transfers ownership of the property to someone else and retains the right to live on the property and the income from it. The new owner of the property is referred to as the remainder person.

Because he or she no longer owns the property the life estate holder does not have the right to sell or dispose of the property. Because he or she cannot sell or dispose of the property, it is not counted as an available asset to the life estate holder. If the remainder person applied for EBD Medicaid and did not live in the home, the property, minus the value of the life estate, would be counted as an available asset to him or her (the remainder interest).

The value of the life estate is also not considered an available asset to the life estate holder.

If the property holder transferred the property to the remainder person for less than fair-market-value (*FMV*), a divestment has occurred. The *divested amount* is the FMV of the property at the time of the transfer minus the life estate value. To find the life estate value, multiply the FMV of the property by the number from the [Section 39.1 Life Estate and Remainder Interest](#) table which corresponds to the age of the life estate holder at the time the property was transferred.

Note: Property tax assessments can be used to determine a property's FMV if both the local agency and *applicant member* agree that it accurately represents the price it would sell for on the open market in that geographic area. If both parties do not agree, statements from one or more realtors could be sufficient. If the local agency requests a comparative analysis, they are required to pay for it. Regardless of what process is used, the member always has the right to appeal the agency decision if they think it is incorrect.

There can also be divestment if the life estate is terminated and the life estate holder is not paid for the value of the life estate. To calculate the divested amount, multiply the FMV of the property at the time the life estate was terminated by the number from the [Section 39.1 Life Estate and Remainder Interest](#) table which corresponds to the age of the life estate holder at the time the life estate was terminated.

Example 1: Marion gave her home to her son John in December 2006. She was 83 at the time. The FMV of the house at the time of the transfer was \$87,000. Marion retained a life estate. In January 2009, she applied for Family Care. Since the transfer of her home occurred in the look back period, the worker will have to determine a divestment penalty period. The divestment amount is the FMV of the

house as of December 2006 minus the life estate value.

To determine the life estate value, multiply \$87,000 by .38642 (the number from the [Section 39.1 Life Estate and Remainder Interest](#) table that corresponds to age 83).

The divested amount is $\$87,000 - \$33,618.54 = \$53,381.46$. $\$53,381.46$ divided by 6,362 = 8.39 months. Marion would have been ineligible from December 2006 through July 2007. She was determined eligible beginning January 1, 2009.

Example 2: In June 2009, John sold the home for the current FMV of \$102,000, and Marion terminated the life estate. He took the proceeds from the home and bought another house. He did not pay Marion for the value of the life estate, so a divestment has occurred. The divestment amount is the life estate value at the time the life estate was terminated.

To determine the life estate value, multiply \$102,000 (value of the house at the time the life estate was terminated) by .33764. (The number is from the table in [Section 39.1 Life Estate and Remainder Interest](#) that corresponds to Marion's age, 86, at the time the life estate was terminated.)

$$\$102,000 \times .33764 = \$34,439.28$$

The divested amount is \$34,439.28. The average daily nursing home cost of care as of June 2009 was \$209.16. Marion's penalty period is 164 days. She is ineligible from June 2009 through November 12, 2009.

Since this is an open/ongoing case, you have to give timely notice to end her Institutional Medicaid. If the divestment has been reported timely, you would close her case using *adverse action* logic.

If the divestment were not reported timely you would have to calculate an overpayment for the months she would have been ineligible if the change would have been reported timely (see [Section 22.2.2.2 Overpayment Amount](#)).

Example 3: James sold his home to his son Robert on December 1, 2006. James was 75 years old and the home was worth \$95,000. Robert paid James \$50,000 for the home and James retained a life estate. The life estate value is \$49,541.55 ($95,000 \times .52149$). (See [Section 39.1 Life Estate and Remainder Interest](#) for this value.) Since James received both \$50,000 from Robert and retained a life estate worth \$49,541.55, the total value he received is more than the FMV of the home. Because the value he received is greater than the FMV of the home, there is not divestment.

In February 2007, James moved to a *CBRF* and the home was rented out and James continued to retain the life estate. The home is not an available asset to James even

though he is no longer living in the home. Because he holds a life estate on the home, James is entitled to any income produced by the property. The net rent from the home is countable income for James (see [Section 15.6.4 Self-Employed Income Sources](#)).

17.10.2 Joint Owners

When two or more people hold a life estate on a property, determine the life estate value for each individual by dividing the FMV of the property by the number of life estate holders to find each individual's share of the FMV. Then calculate the life estate value by multiplying the individual share of the FMV by the number in the [Section 39.1 Life Estate and Remainder Interest](#) table that corresponds with the individual's age at the time of the transfer or termination of the life estate.

Example 4: In June 2006, Marie and George transferred ownership of their home to their three sons and retained a life estate on the property. The FMV of the home at the time of the transfer was \$140,000. At the time George was 82 and Marie was 68. In February 2007, George applied for Family Care. Since the transfer occurred in the look back period, the worker must determine the amount of the divestment and the penalty period. To calculate the total divestment the worker must first determine the life estate values.

$\$140,000 \text{ divided by } 2 = \$70,000$

George's age at the time of the transfer was 82. Multiply $70,000 \times .40295$ (See [Section 39.1 Life Estate and Remainder Interest](#) for this value.) = 28,206.50
 Marie's age at the time of transfer was 68. Multiply $70,000 \times .63610 = 44,527.00$

The total life estate value for both Marie and George is \$72,733.50.

The divested amount is the FMV minus the life estate value ($\$140,000 - \$72,733.50 = \$67,266.50$).

To calculate the penalty period, divide the divested amount by the average nursing home cost of care at the time of application ($\$67,266.50 \text{ divided by } \5584). George has a 12 month penalty period so will be ineligible from June 2006 through May 2007.

17.10.3 Purchase of a Life Estate in the Home of Another Person

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; **and**

- Received *fair market value* for the purchase.

Residency

Apply the following rules to determine whether a person has resided in the home for 12 consecutive months:

- The 12-month period may start immediately after the purchase or at any time after the purchase.
- Absences from the life estate home for less than 30 consecutive days will not affect the 12-month determination.

Example 5: Ralph purchases a life estate interest in his brother's home on January 5, 2009, and moves into that home on the same date. He goes to Florida on January 20, 2009, and returns to the home on February 10, 2009. January and February count as whole months of residence because Ralph's absence was less than 30 consecutive days.

Absences from the life estate home for 30 days or more for vacations, trips, or to stay elsewhere result in the 12-month period starting over.

Example 6: Vicki purchases a life estate interest in her sister's home on January 20, 2009, and moves into that home on the same date. On March 3, 2009, Vicki goes to Bermuda for a family vacation and returns on April 15, 2009. Since Vicki was absent from the home for 30 or more consecutive days, the consecutive month of residency string is broken. Vicki's 12-month residency clock is reset with April 2009 being her "new" first month of residency.

Absences from the life estate home for 30 days or more because of hospitalization or a rehabilitation stay do not count towards the 12 consecutive months. However, such absences do not result in the 12-month period starting over.

Example 7: Jim purchases a life estate interest in his cousin's home on January 20, 2009, and moves into that home on the same date. Jim continues to reside in the home until April 10, 2009, at which time he is hospitalized as a result of an auto accident. Jim remains in the hospital until August 5, 2009, when he is discharged and returns home. Jim continues to reside in the home from August 5, 2009, until December 24, 2010.

Jim's residency in the home for the months of January, February, March, and part of April count as four consecutive months of residency. The months of May, June, and July are not included in the consecutive month count because he is absent from the home for those full calendar months. However, the absence from the home for those months does not cause the 12-month clock to be restarted because Jim's absence was the result of his hospitalization. When Jim returns to the home on August 5, 2009, August counts as the fifth month of continuous residency. Jim will meet the 12 months of continuous residency requirement in March of 2010.

If the 12-month residency requirement has not been met at the time of the application for LTC Medicaid, the full purchase price of the life estate is used to determine the divested amount.

The divestment penalty remains in effect until the penalty period ends or the date the individual meets the 12 month residency requirement, whichever occurs first. There is no pro-ration of the divestment penalty period for living in the home for part of the 12 months.

Fair Market Value

If the 12-month residency requirement has been met at the time of the application for LTC, the local agency must also determine whether the applicant paid the FMV for the life estate. The FMV of the life estate is determined using the age of the life estate holder on the date that the life estate was created and the property's FMV on that date. Multiply the FMV by the life estate multiplier on the Life Estate and Remainder Interest Table (see [Section 39.1 Life Estate and Remainder Interest](#)). The result is the value of the property's life estate interest as of that date. If the applicant paid more than the life estate interest value, the difference is the divested amount.

Example 8: Joyce, age 75, has \$200,000 in her savings account. On February 3, 2009, she gives \$200,000 to her son in exchange for a life estate interest in her son's home. The FMV of the son's home as of February 3, 2009, was \$300,000. Joyce moved into her son's home on March 5, 2009, and has resided there continuously for more than 12 consecutive months. On April 9, 2010, Joyce applies for a community waiver program, meets the functional screen and all other Medicaid eligibility requirements. Joyce also establishes that as of her application date for community waivers, she has resided in her son's home for more than 12 consecutive months.

The divestment issue that now needs to be resolved is whether or not Joyce received FMV for the \$200,000 that was used to purchase the life estate. Using the Life Estate and Remainder Interest Table in [Section 39.1 Life Estate and Remainder Interest](#), it is determined that Joyce's life estate interest was worth \$156,447 at the time of the purchase. Since Joyce paid \$200,000 for a life estate that was worth \$156,447, the divested amount is \$43,553. Joyce is ineligible for community waiver beginning on the date of her community waiver application

When a couple jointly holds a life estate, the institutionalized *spouse* must reside in the home for 12 consecutive months or his or her portion of the life estate value will be considered a divestment. See [Section 17.10.2 Joint Owners](#) for instructions on calculating the spouse's portion of the life estate value.

*This page last updated in Release Number: 10-02
Release Date: 06-22-10
Effective Date: 01-01-09*

17.11 ANNUITIES

[17.11.1 Treatment of Revocable Annuities](#)

[17.11.2 Evaluating Irrevocable Annuities for Divestment](#)

[17.11.2.1 Annuities that are not considered Divestment](#)

[17.11.2.2 Annuities that are considered Divestment](#)

[17.11.3 Verification](#)

[17.11.4 Disclosure](#)

[17.11.5 Remainder Beneficiary Designation](#)

17.11.1 Treatment of Revocable Annuities

The following policy applies to both an *annuity* purchased by a *member* and an annuity purchased by a *community spouse*.

1. Determining Resource Value
 - a. When the annuity is revocable and the funds deposited can be withdrawn, the value of the annuity principal, plus accumulated interest, is a countable resource.
 - b. When an annuity company will apply a financial penalty for early withdrawal of the funds in an annuity account, the amount that the member would receive upon full surrender of the annuity contract is the counted resource value of the annuity.
2. Treatment of Withdrawals and Interest
 - a. When a member makes withdrawals from the principal or accumulated interest on an annuity account, the withdrawals are a conversion of a resource.
 - b. Interest accruing on an annuity account that is paid to the *annuitant* as it is earned is excluded income.
 - c. Interest earned on a revocable annuity that is left in the account to accumulate is not considered income but instead is considered as an increase in the resource value of the annuity account.

17.11.2 Evaluating Irrevocable Annuities for Divestment

17.11.2.1 Irrevocable Annuities that are not considered divestment:

- a. Names "Wisconsin Department of Health Services Estate Recovery Program" (hereafter referred to as "the State") as the remainder *Beneficiary* if purchased or

created on or after January 1, 2009. In those cases where there is a spouse, disabled child or *minor* child, the State is beneficiary in the second position;

AND

- b. Is created from funds in a ROTH *IRA*, 408 IRA or other employer sponsored plan; or is purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business;
- c. Is considered an individual retirement annuity (according to Sec. 408(b)) of the Internal Revenue Code of 1986 (IRC), or a deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Sec. 408(q) of the IRC);
- d. Provides substantially equal monthly payments with no balloon, deferred or graduated payments (variations in payment amounts due to changes in interest rates are allowed);
- e. Is *Annuitized* for the individual or spouse (currently issuing payments);
- f. Is a period-certain annuity that will return the full principal and interest within the annuitant's life expectancy as listed in the [Period Life Table](#) (from socialsecurity.gov).
- g. The number of months that annuity payments will be issued should be less than the number of months of the individual's life expectancy (multiply figure from the [Period Life Table](#) (from socialsecurity.gov) by 12).

Note: Annuities that provide for indefinite "lifetime payments" will not return the full principal and interest within the member's life expectancy.

Example 1: The member applies for HBCW. He had invested in a ROTH IRA while he was working. He converted the IRA to an irrevocable annuity when he retired 6 months ago and named the State as the beneficiary. Since the annuity meets the conditions above, the purchase of the annuity is not considered divestment.

Example 2: The member applied for Institutional Medicaid on 7/28. This is a community spouse case. On 7/18, the community spouse used \$126,500.00 of the couple's resources to purchase an irrevocable 9-year period certain immediate annuity from the XYZ Life Insurance Company. The community spouse is the annuitant. The community spouse was 74-years-old on the date the annuity was purchased and had a life expectancy of 9.75 years (117 months). The annuity will issue regular monthly checks of \$1,488.75 for a set period of 9 years or 108 total months. The insurance company will pay out a total of \$160,785.00 over the period of the annuity contract.

The annuity names the State as the beneficiary in the position after the institutionalized spouse. The contract date of the annuity was 7/18 and the first monthly payment was issued on 8/18. The annuity, which was purchased by

the community spouse, names the State as the beneficiary, was purchased from a life insurance company, will issue regular monthly payments, is currently issuing payments and will provide for full return of principal and interest during the community spouse's life expectancy. Therefore, since the annuity meets the requirements above, the purchase of the annuity is not considered divestment. The monthly annuity payments count as income to the community spouse.

17.11.2.2 Irrevocable Annuities that are considered divestment:

When the annuity does not meet the criteria in Section 17.11.2.1 above, the annuity is considered as a divestment. The value of the annuity is considered a divestment as of the date the annuity was purchased, or the date it became irrevocable, whichever is later.

Example 3: The member applied for HCBW on 9/15. Also on 9/15, the member used \$20,000 of his cash resources to purchase an immediate annuity from the ABC Insurance Company. The contract date is 9/15 and the first payment will be issued on 10/15. The annuity will issue payments of \$200 per month for 10 years (120 monthly payments). This would result in a return of \$24,000 over the proposed period of the contract. The member is currently 79-years-old and has a life expectancy of 7.40 years (88.8 months). The annuity does not name the State as the primary beneficiary.

In this example, the annuity was purchased from a life insurance company, will issue regular monthly payments and is currently issuing payments. However, the annuity does not meet the requirements because the state is not named as the primary beneficiary and the proposed period of payments (10 years) exceeds the member's life expectancy (7.40 years). Therefore, the full purchase price of the annuity is considered divestment. (See MEH 17.5 for policy regarding the penalty period begin date.) The \$200 per month annuity payments are also counted as income in determining eligibility.

17.11.3 Verification

1. Verify the terms of a revocable or irrevocable annuity by obtaining a copy of the annuity contract and account statements from the annuity or insurance company;
2. Verify the beneficiary of an irrevocable annuity by obtaining:
 - a. A copy of the annuity application the member signed at the time the member purchased the annuity (Annuity contracts generally never contain the name of the annuity beneficiary. The beneficiary will be listed on the application that the member signed at the time the annuity was purchased. Usually, it is a one page form completed by hand.)

17.11.4 Disclosure

Beginning January 1, 2009, all applicants for Medicaid long term care services and all members of Medicaid long term care services undergoing an eligibility review are

required to disclose information about any annuities purchased on or after January 1, 2009, in which they or their community spouses have an interest.

This requirement also applies to annuities purchased before January 1, 2009, if any action is taken by the individual that changes either the course of payment from the annuity or the treatment of the income or principal of the annuity. These transactions include:

- Additions of principal,
- Elective withdrawals,
- Requests to change the distribution of the annuity,
- Elections to annuitize the contract,
- A change in ownership, **or**
- Any other non-routine action not listed below.

The following types of changes and events would not subject an annuity purchased prior to January 1, 2009 to treatment under the new policy rules:

- Routine transactions such as notification of an address change, notification of death or divorce of a remainder beneficiary, and other similar circumstances;
- Changes that occur based on terms of the annuities which existed prior to January 1, 2009 and which do not require a decision, election or action to take effect; **or**
- Changes beyond the control of the individual, such as a change in law, a change in the policy of the issuer, or a change in the terms based on other factors, such as the issuer's economic status.

A separate annuity disclosure form (Annuity Information - Disclosure F-10192) must be completed by applicants for each annuity owned by the *applicant* or the applicant's community spouse in order to meet the disclosure requirement. This form must also be sent to *SSI* recipients who are applying for HCBW and MLTC programs. The Disclosure form must be sent to all applicants and recipients who indicate that they have an annuity. A copy of the completed form and any documents verifying the status of the annuity must be scanned into the electronic case file (ECF).

The Wisconsin Medicaid for the *Elderly*, Blind, and Disabled Application (F-10101) has been updated to collect additional information about annuities and provide information about the requirement to designate the State as a remainder beneficiary of the annuities owned by applicants for LTC Medicaid or their spouses.

If the applicant/ member or his or her spouse (or representative) refuses to disclose the required information related to the annuity, the applicant/member is ineligible for Medicaid for the failure to cooperate in providing requested information.

17.11.5 Remainder Beneficiary Designation

The local agency must then send a copy of the completed and signed beneficiary designation form(s) to the annuity issuer with the cover form (Issuer of Annuity - Notice of Obligation, F-10190) that instructs the issuer to make the state a remainder beneficiary. Allow the issuer up to 30 days to confirm the designation has been made.

When the issuer responds and indicates that the State has been designated the remainder beneficiary, or that there is no death benefit available under this annuity, treat this annuity as meeting the designation requirement and proceed with the LTC eligibility determination.

If the issuer does not respond within 30 days of the date the Notice of Obligation form was sent, the **IM** agency must contact the issuer by phone and request that the issuer respond within 10 days. If the issuer does not respond 40 days after the Notice of Obligation form was sent, contact the CARES Call Center for further guidance.

If the form from the annuity issuer indicates that the remainder beneficiary designation change is in process and provides a date by when the designation will be completed, the IM agency should treat this annuity as meeting the designation requirement and proceed with the LTC eligibility determination. If the issuer fails to confirm that the designation change has been completed by the date indicated on the form, the IM agency must contact the issuer and request that they confirm within 10 days that the changes have been completed. If the issuer has not responded 10 days after the request was made, contact the CARES Call Center for further guidance.

Once the state has been designated as the remainder beneficiary, the annuity issuer must notify the local agency about any changes made to that annuity to ensure the annuitant does not change the terms of the annuity beneficiary designation at a later date. The issuer acknowledges this obligation by completing and returning the Issuer of Annuity - Notice of Obligation (F-10190). Copies of all of these completed forms must be scanned into the ECF.

Pend the Medicaid LTC application until one of the following occur:

- The applicant provides the required disclosure or beneficiary designation forms by the verification due date,
- Verification has been received that the State of Wisconsin has been legally named as the appropriate remainder beneficiary of the annuity, or that no death benefit is available under the annuity,

- Verification has been received that the beneficiary designation change is in process,
- The issuer indicates that the applicant, member or spouse failed to cooperate with the issuer's process to name the State as a remainder beneficiary, **or**
- You receive direction from the CARES Call Center to certify the applicant/member for LTC coverage.

A divestment penalty period must be imposed for applicants and members who refuse to cooperate in this annuity beneficiary designation process. The divestment date is the date the annuity was purchased, or the date of the latest annuity transaction. The amount of the divestment is the full purchase price of the annuity.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

17.12 PROMISSORY NOTES

[17.12.1 Promissory Notes Prior to 01/01/09](#)

[17.12.2 Promissory Notes on or After 01/01/09](#)

17.12.1 Promissory Notes Prior to 01/01/09

It is divestment if an institutionalized person signs a promissory note prior to January 1, 2009, that has at least one of the following:

1. A provision that forgives a portion of the principal,
2. A balloon payment,
3. Interest payments only, with no principal payments, **or**
4. An inadequate interest rate (relative to current market rates) at the time the promissory note was signed.

17.12.2 Promissory Notes on or After 01/01/09

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 all of the following criteria:

- Has a repayment term that is actuarially sound (paid out in the individual's life expectancy). The standards that must be used to decide whether or not a note, loan, or mortgage is actuarially sound are those determined by the Office of the Chief Actuary of the **SSA**. The standards are found in a table (called the Period Life Table), which can be found on the following SSA Web page: <http://www.ssa.gov/OACT/STATS/table4c6.html>. Use this table to calculate the individual's life expectancy as of the date the note, loan, or mortgage agreement

was initiated. Determine if the lender was expected to live long enough so that he or she would receive payment in full during his or her lifetime,

- Provides for payments to be made in equal amounts during the term of the loan, with no deferral or balloon payments made,
- Does not allow cancellation of the note, loan or mortgage upon the death of the lender. Under Wisconsin law, the outstanding loan balance on these types of contracts is not automatically cancelled upon the death of the lender. Cancellation of the loan balance can only occur if the contract contains specific language to this effect. If a note, loan or mortgage contains language to cancel the balance upon the death of the lender, the note, loan or mortgage can be amended to remove this language and avoid a divestment penalty, **and**

If all of the criteria above are not met, the purchase of the promissory note, loan, or mortgage is a divestment. The **divested amount** is the value of the outstanding balance due on the note, loan, or mortgage as of the date of application for Medicaid long-term care services.

Example 1: On February 1, 2009, Mary gave her **adult** daughter \$50,000 in exchange for a promissory note, which was expected to be paid back in full during her life expectancy. The terms of the note required Mary's daughter to repay the loan within a 48-month period by making payments of \$100 per month for the first 47 months and a \$45,300 payment in the 48th month. Twelve months later, on February 1, 2010, Mary enters a nursing home and applies for Medicaid. She is otherwise eligible for Medicaid but acknowledges the promissory note transaction that occurred during her look-back period.

Since the terms of the promissory note contained a provision for a balloon payment, the purchase of the promissory note is a divestment. As of the date of Mary's application for Medicaid long-term care services (February 1, 2010), Mary's daughter has repaid her mother only \$1,200, and the outstanding balance on the note is \$48,800. Mary's divested amount is \$48,800 which will be used to calculate a penalty period beginning February 1, 2010.

Example 2: John purchased a \$60,000 promissory note from his brother Al on April 1, 2009. At that time, John was 80 years old, with a life expectancy of 7.62 years. The terms of the note required equal monthly payments over a 10-year period. Since John's life expectancy was less than the repayment term, the note is not actuarially sound. Several years later, John enters a nursing home and applies for Medicaid. The outstanding balance on the promissory note on the date of John's application for Medicaid long-term care services is \$40,000. The divested amount that will be used in calculating John's divestment penalty period is \$40,000.

*This page last updated in Release Number: 10-02
Release Date: 06-22-10
Effective Date: 01-01-09*

17.13 TRUSTS

[17.13.1 Trusts Introduction](#)

[17.13.2 Revocable Trusts](#)

[17.13.3 Irrevocable Trusts](#)

[17.13.4 Exceptions](#)

17.13.1 Trusts Introduction

"Trust" is any arrangement in which a person (the "grantor") transfers property to another person with the intention that person (the "trustee") hold, manage, or administer the property for the benefit of the grantor or of someone designated by the grantor (the "*beneficiary*"). The term "trust" includes any legal instrument or device that is similar to a trust.

"Legal instrument or device similar to a trust" means any legal instrument, device, or arrangement which, even though not called a trust under state law, has the same attributes as a trust. That is, the grantor transfers property to the trustee and the grantor's intention is that the trustee hold, manage, or administer the property for the benefit of the grantor or of the beneficiary. For purposes of this section, an individual shall be considered to have established a trust if assets of the individual are used to form all or part of the *corpus* (principal) of the trust.

"Grantor" may be:

1. The Medicaid *member*.
2. His or her *spouse*.
3. A person, including a court or an administrative body, with legal authority to act in place of or on behalf of the member or his or her spouse. This includes a power of attorney or a guardian.
4. A person, including a court or an administrative body, acting at the direction or upon the request of the member or his or her spouse. This includes relatives, friends, volunteers, or authorized representatives.

17.13.2 Revocable Trusts

A **revocable trust** is a trust that can be revoked, canceled, or modified by the grantor or by a court. A trust which is called irrevocable, but which will terminate if some action is taken by the grantor, is considered a revocable trust.

1. The trust principal of a revocable trust is an available asset. "Trust principal" is the amount placed in trust by the grantor plus any trust earnings paid into the trust and left to accumulate.
2. All payments from the trust to or for the benefit of the institutionalized person are income.
3. All payments from the trust that are not to or for the benefit of the institutionalized person are divestment.

17.13.3 Irrevocable Trusts

An irrevocable trust is a trust that cannot, in any way, be revoked by the grantor.

The following actions are divestment if they took place during the look back period (see [Section 17.3 Look Back Period](#)) or any time after:

1. An irrevocable trust was created. The **divested amount** is the total amount of the created trust.

Sometimes revocable trusts contain a clause that causes them to become irrevocable at a later date in the life of the trust. Divestment occurs on the date the trust changed from revocable to irrevocable.

Example 1: In 1998, Benny created a revocable trust fund of \$100,000 for his daughter. There was a clause in the trust stating the trust would become irrevocable if Benny became incompetent. He was determined incompetent on February 2, 2007, and the trust changed from revocable to irrevocable. Benny entered an institution and applied for Medicaid in July 2008. He divested the total amount of the trust on February 2, 2007.

2. Funds were added to the irrevocable trust. The **divested amount** is the amount of the added funds.

If either of these actions took place before the look back period, apply the following rules:

1. Payments to the institutionalized person from trust income or from the body of the trust are income.
2. Payments that could be disbursed to the institutionalized person from trust income or from any portion of the body of the trust but that are not disbursed are available assets.
3. Payments from the trust to anyone other than the institutionalized person are divestment.

17.13.4 Exceptions

The policies described in this trusts section do not apply to any of the following trusts.

1. Annuities (see [Section 17.11 Annuities](#)).
2. Irrevocable burial trusts (see [Section 16.5.1 Burial Trusts](#)).
3. Trusts established by a will.
4. Special Needs Trusts - A trust containing assets of an individual under age 65 who is totally and permanently disabled (under **SSI** program rules). **Disregard** the trust if it meets these conditions.
 - a. The trust must be established for the sole benefit of the disabled person by his or her parent, grandparent, legal guardian or a court, **and**
 - b. Contain a provision that, upon the death of the beneficiary, the Wisconsin Medicaid program will receive all amounts remaining in the trust not in excess of the total amount of Medicaid paid on behalf of the beneficiary.

The exception continues after the person turns 65, provided he or she continues to be disabled. However, a grantor cannot add to the trust after the beneficiary turns 65. Anything added to the trust after the beneficiary turns 65 is a divestment. Money added before the beneficiary turns 65 is not a divestment.

5. Pooled trusts (Effective 09-01-08).
 - [Pooled Trusts Not Subject to Divestment](#)
 - [Pooled Trusts Subject to Divestment](#)
 - [Third Party Funded Pooled Trusts For Individuals Not Yet Declared Disabled](#)
 - [List of Pooled Trusts](#)

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.
 - 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.
 - d. **Note:** If a WISH trust 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**/member. This does not apply to a WisPACT trust, **and**
- b.

- d. Repay Medicaid to the extent that amounts remaining upon death are not retained by the trust.
 - v. 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.
 - vi. 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 member 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 member, 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.

II. Pooled Trusts Subject to Divestment

A pooled trust established with the funds of a third party on or after September 1, 2008, for a disabled individual, age 65 or over will not be exempt from the divestment penalty provisions, if the third party subsequently applies for Medicaid. The divestment penalty is applied to the third party who created the pooled trust unless the trust beneficiary is the third party's disabled child. Similarly, contributions/additions to a pooled trust by a third party, made after the disabled beneficiary turns 65 will also be subject to divestment penalty provisions if the third party (trust grantor) subsequently applies for Medicaid.

III. Third Party Funded Pooled Trusts For Individuals Not Yet Declared Disabled

Third party funded pooled trusts for individuals applying for disability status are not subject to divestment if:

- a. they have placed their assets in a potential pooled trust, and
- b. they meet all of the conditions in 5 I above, and
- c. the potential disabled individual has initiated the disability determination process prior to 09/01/08, and
- d. they are over age 65.

“Initiating the disability determination process” means that the individual must have asked either the county agency, the **SSA**, or **DDB** for a disability determination.

6. **Trusts for Disabled Individuals.** A trust for a disabled individual is a trust established solely for the benefit of 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 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.

Note: Unlike Special Needs and Pooled Trusts, trusts for disabled individuals are not required to have any type of Medicaid "payback provision" which becomes effective upon the death of the beneficiary.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

17.14 BOTH SPOUSES INSTITUTIONALIZED

If the **community spouse** made a divestment that resulted in a penalty period for the institutionalized **spouse** (see [Section 17.4 Exceptions 2. b.](#)), apportion the penalty period between the spouses at the time the community spouse enters an institution and applies for Medicaid.

Example 1: Joe is in a nursing home. Joe's wife, Mildred, is his community spouse. Joe inherited \$84,000 and immediately transferred it to Mildred. This \$84,000 was not part of the community spouse asset share. Mildred gave it to her church. This divestment resulted in a penalty period of 26 months for Joe. Now Mildred is entering the nursing home and applying for Medicaid. The time that remains on Joe's penalty period must be apportioned to both spouses.

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.
 - b. Subtracting the result from the original divested amount.

- c. Calculate the penalty period for the remaining divested amount.
- d. Divide the new penalty period equally between the two spouses.

If either spouse leaves the institution or dies, add the remainder of his or her penalty period to the other spouse's penalty period.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

17.15 MEDICAID CARD SERVICES

[17.15.1 Nursing Home](#)

[17.15.2 Home and Community-Based Waivers](#)

Medicaid card services are all the Medicaid-covered services (see [Section 21.1 Benefits Introduction](#)) except **SNF/ICF** payments and ancillary services (Wis. Admin. Code § DHS 107.09(2) and (4)(a). These excepted services consist of the routine, day-to-day health care services that are provided to Medicaid members by a nursing home and that are reimbursed within the daily care rate.

17.15.1 Nursing Home

A person who, because of divestment, is not eligible for services reimbursed within the daily institutional care rate is still eligible for Medicaid card services.

17.15.2 Home and Community-Based Waivers

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 Medicaid, MAPP**).

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

17.16 RESERVED

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

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17.17 UNDUE HARDSHIP

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[17.17.8 Fair Hearing Rights](#)

[17.17.9 Referral](#)

17.17.1 Introduction

A divestment penalty period must be waived when the imposition of the penalty period deprives the individual of:

- Medical care such that the individual's health or life would be endangered; **or**
- Food, clothing, shelter, or other necessities of life.

17.17.2 Hardship Waiver Request Process

At the same time that the worker issues the manual Negative Notice of Decision ([F-16001](#)) to the *applicant* or member informing the person of the divestment penalty period, the following forms must also be completed and mailed with the Negative Notice of Decision:

- Divestment Penalty and Undue Hardship Notice ([F-10187](#)).
- Undue Hardship Waiver Request form ([F-10193](#)) to the Hardship Notice, including the Case Name and Number.

17.17.3 Valid Request

The completed Undue Hardship Waiver Request form ([F-10193](#)) must be submitted to the *IM* agency. A written and signed request that fulfills the minimum request requirements is also acceptable.

The Long Term Care (LTC) facility in which the individual is residing may also file an undue hardship request on behalf of the institutionalized individual. However, the LTC

facility must have the client or their authorized representative's written permission, using the Undue Hardship Waiver Request form ([F-10193](#)) to file the undue hardship request.

The LTC facility can also represent the institutionalized individual in any subsequent fair hearing activity involving an undue hardship request/denial, as long as the facility has the *member's* (or his or her representative's) written permission to do so. This can also include the actual request for a fair hearing.

17.17.4 Effective Date of Approved Hardship Waivers

17.17.4.1 Timely Request - Received Within 20 Days After Notification Is Mailed

If the valid request for an undue hardship waiver is received by the local agency within 20 days after the local agency mails out the Divestment Penalty and Undue Hardship Notice ([F-10187](#)), and the request is approved, the effective date of the waiver will be the initial date of the penalty period.

Example 1: Amy receives a notice dated February 10 that her January 20 application for community waivers is being denied and that she will have a 100-day divestment penalty period beginning January 20. Amy submits an undue hardship request to the IM agency that is received on February 15. The undue hardship request is ultimately approved by the IM agency and Amy's penalty period is waived. Amy is subsequently certified for Community Waiver Medicaid beginning January 20.

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: Alice receives a notice dated February 10 that her January 20 application for Home and Community-Based Waivers (HCBW) is being denied and that she will have a 350-day divestment penalty period beginning January 20. In June, Alice's health deteriorates and her monthly income decreases by 60 percent. Alice submits an undue hardship request to the IM agency that is received on June 25. The undue hardship request is ultimately approved by the IM agency, and Alice's remaining penalty period is waived. Alice is subsequently certified for HCBW Medicaid beginning June 25.

17.17.5 Required Documentation

The applicant (or his or her representative) must submit the following verification of hardship:

1. A statement signed by the individual (or his or her representative) which describes whether the assets are recoverable, and if so, the attempts that were made to recover the divested assets, **and**
2. Proof that an undue hardship would exist if the penalty period is applied (as follows).
 - If the **member is currently institutionalized**, he or she must submit a copy of the notification sent from the LTC facility which states both the date of involuntary discharge and alternative placement location or other proof that if the hardship waiver is not granted, the individual will be deprived of medical care such that the individual's health or life would be endangered; or deprived of food, clothing, shelter, or other necessities of life.
 - If the **member is applying for HCBW, including FamilyCare, 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.

Compare the two estimates to the individual or couple's income and assets. If the IM agency determines that the individual does not have enough income and/or assets to pay for his or her LTC and other needs (i.e., food, shelter, etc.), consider the individual's health to be endangered.

If the required documentation is not submitted with the request for an undue hardship waiver, send a written request for verification. If the applicant/member fails to submit the required verification within 10 days after the request is mailed, deny the undue hardship waiver request and notify the individual with the Undue Hardship Decision Notice ([E-10188](#)). Extend the deadline to submit the required documentation for up to ten days when the individual communicates a need for additional time or assistance in obtaining it.

17.17.6 Determination Process Timeframe

A decision about whether to grant an undue hardship waiver shall be made by the local IM agency within 30 days after receipt of the request. Send the member/applicant the appropriate manual Positive or Negative Notice of Decision based on the IM agency's decision.

If an undue hardship is approved, a new hardship request does not have to be done at review. Once an undue hardship request is approved, either the entire penalty period is waived, or the remaining penalty period is waived, depending upon whether or not the client makes a timely or untimely undue hardship waiver request. If the undue hardship request is denied, the client has the right to make another subsequent request, if and when their circumstances change.

17.17.7 Bed Hold Payments and Notification

When a hardship waiver request is received by an IM agency from an institutionalized individual, the agency will send the institution the Undue Hardship Bed Hold Notice ([F-10189](#)) to inform them that the request was received. The Notice will inform the institution that a "bed hold" payment will be made on the client's behalf for the period of time while the IM agency is making a decision about the hardship waiver request. The period covered begins on the date a written hardship waiver request is received at the IM agency until the date the agency issues its decision on the waiver request, up to a maximum of 30 days.

Use the Undue Hardship Waiver Decision ([F-10188](#)) to notify the institution of the agency's decision about the undue hardship waiver and the availability of the bed hold payment (when applicable).

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 the [Process Help Handbook Section 81.3 Electronic F-10110 \[formerly the 3070 and HCF-10110\]](#)) 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 individuals not residing in a medical institution.

17.17.8 Fair Hearing Rights

If the request for an undue hardship waiver is denied, the individual has the right to appeal the decision through a written request to the *DHA* (see the [Income Maintenance Manual Chapter 3 Fair Hearings](#)). The individual has 45 days from the date of the notice issuance to file the appeal. These same hearing rights are also applicable to the facility in which the individual resides, as long as the facility has the institutionalized individual's written permission to represent him or her in the appeal process.

17.17.9 Referral

If a Power of Attorney (POA) or other *authorized representative* transferred the asset, the IM agency must consider making a referral to the local Adult-at-Risk agency for investigation of possible financial exploitation of an *elderly*, blind, or disabled individual.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

18 SPOUSAL IMPOVERISHMENT

18.1 SPOUSAL IMPOVERISHMENT INTRODUCTION

Spousal impoverishment is a Medicaid policy that allows persons to retain assets and income that are above the regular Medicaid financial limits. Spousal impoverishment policy applies to institutionalized persons. 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 [Section 18.2.2 Community Spouse Asset Share](#)) or income allocation (see [Section 18.6 Spousal Impoverishment Income Allocation](#)).

Example 1: Joe is an institutionalized person living in a nursing home. His wife, Carla, is receiving HCBW services in a *CBRF*. Because Carla is not residing in a medical institution, Joe's eligibility is determined using Spousal Impoverishment rules.

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 retain additional assets and income without

liability for the institutionalized spouse and without affecting the Medicaid eligibility of the institutionalized spouse.

See [Section 2.5.3 Spousal Impoverishment Medicaid Signatures](#) for application and review signature requirements.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

18.2 RESERVED

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

18.3 SPOUSAL IMPOVERISHMENT REQUIREMENTS

All institutionalized persons applying for Medicaid must meet the same nonfinancial requirements. *Spousal impoverishment* policy introduces no changes in Medicaid nonfinancial tests.

On the financial side:

1. **Assets.** The assets of both the institutionalized person and his or her *community spouse* are counted in the asset test.
2. **Income.** The income limit is the same as that for non-spousal impoverishment institutionalized persons. But, after the institutionalized person becomes eligible, he or she is allowed to allocate some of his or her income back to his or her community spouse and family.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

18.4 SPOUSAL IMPOVERISHMENT ASSETS

[18.4.1 Spousal Impoverishment Assets Introduction](#)

[18.4.2 Asset Assessment](#)

[18.4.3 Calculate the CSAS](#)

[18.4.4 Asset Test](#)

[18.4.5 Undue Hardship](#)

[18.4.6 Asset Transfer](#)

[18.4.6.1 Asset Transfer Period](#)

[18.4.6.1.1 Leaves Institution or Becomes Ineligible During the 12 Month Transfer Period](#)

[18.4.6.2 Institutionalized Spouse Is Eligible After the 12 Month Transfer Period](#)

[18.4.6.2.1 Leaves Institution for 30 or More Days then Re-institutionalized](#)

[18.4.6.2.2 Loses Medicaid Eligibility But Remains Institutionalized](#)

18.4.1 Spousal Impoverishment Assets Introduction

Count the combined assets of the institutionalized person and his or her *community spouse*. (**Note:** *Disregard* prenuptial agreements. They have no effect on *spousal impoverishment* determinations.) Add together all countable, available (see [Section 16.1 Assets Introduction](#)) assets the couple owns.

Do not count the following assets:

1. *Homestead* property. If the institutionalized person and the community spouse each owns home property and meets the criteria in [Section 16.8.1.3 Exempt Home Property](#) exempt the institutionalized person's home, but not the community spouse's home.

Example 1: One spouse is in a nursing home, the other lives in the community. They have lived apart for 10 years. The institutionalized person owns a home and intends to return. The community spouse owns a different home. The home that each spouse owns is the principal residence of that spouse. The institutionalized person's home is an exempt asset. The community spouse's home is not exempt.

If they both own homes and the institutionalized person's home is not exempt, count the institutionalized person's home, but exempt the spouse's home. Both homes cannot be exempt simultaneously.

2. One vehicle, regardless of value or purpose. If the *AG* has more than one vehicle, disregard one vehicle totally, regardless of value or purpose. Then, for the remaining vehicles, follow the EBD rules for vehicles (see [Section 16.7.9 Vehicles](#)).
3. All assets designated for burial purposes are exempt. Any unreasonable amount should be supported by documentation of the burial related costs or contract.

Do not allow applicants and members to simply state that they are setting aside an unreasonable amount of cash (e.g., \$1,000,000) as their burial fund for

unspecified funeral expenses. If they can document the funeral expense that they expect to incur, it can be totally exempt regardless of its cost.

For example, ask the *member* to document that they have arranged to purchase a \$100,000 casket or that a funeral home will provide them with a \$75,000 funeral along with an itemized listing of the funeral goods and services that will be provided.

This differs from EBD burial policies for non-institutionalized persons and institutionalized persons without a community spouse (see [Section 16.5 Burial Assets](#)).

4. Household goods and personal items, regardless of their value.
5. All assets not counted in determining EBD Medicaid eligibility.
6. *IRAs* of an ineligible community spouse (see [Section 16.7.20 Retirement Benefits](#)).

18.4.2 Asset Assessment

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 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 should inform the person for whom an assessment is being made what documentation is required. He or she must document ownership interest in and the value of any available assets the couple had at the time of his or her first period of continuous institutionalization. The same documentation procedures are used as when an application is filed (see [Section 20.1 Verification Introduction](#)).

18.4.3 Calculate the CSAS

The community spouse asset share (CSAS) is the amount of countable assets greater than \$2,000 that the community spouse, the institutionalized person, or both, can possess at the time the institutionalized person applies for Medicaid.

IF the total countable assets of the couple are:	Then the CSAS is:
\$238,440 or more	\$119,220
Less than \$238,440 but greater than \$100,000	½ of the total countable assets of the couple
\$100,000 or less	\$50,000

18.4.4 Asset Test

When the institutionalized person applies for Medicaid, compare the total countable assets of the couple to \$2,000 plus the greater of:

1. CSAS, **or**
2. An amount ordered by a court, or fair hearing.

If assets at the time of application are equal to or less than this amount, the institutionalized person is eligible. If they are more, he or she is not eligible.

18.4.5 Undue Hardship

The institutionalized person will not be denied Medicaid if the IM Agency determines that the ineligibility caused by excess assets creates undue hardship for him or her. Undue hardship means an immediate, serious impairment to the institutionalized person's health.

18.4.6 Asset Transfer

After the institutionalized person is found eligible, he or she may transfer assets to the community spouse. The maximum amount he or she can transfer is the CSAS (or a greater amount ordered by a court or a fair hearing). If the community spouse already has some assets, the institutionalized person can transfer assets which when added to the community spouse's assets equal the CSAS (or an amount ordered by a court or a fair hearing).

He or she is not allowed to transfer assets for less than *fair market value* to anyone other than the community spouse.

18.4.6.1 Asset Transfer Period

The institutionalized spouse must transfer the assets to the community spouse by the next regularly scheduled review (12 months). If his or her assets are above \$2,000 on the date of the next scheduled review, he or she will be determined ineligible. He or she

will remain ineligible until his or her assets no longer exceed the \$2,000 Medicaid asset limit.

Example 2: Robert was first institutionalized September 2013. Lucinda, Robert's wife, remained in the community. The couple passed the joint asset test and Robert was determined eligible in September 2013. The couple's total combined assets were \$42,000, \$32,000 of which were owned solely by Robert. Robert had until the next scheduled review (August 2014) to get his total assets under the \$2,000 Medicaid asset limit.

CARES does not generate sufficient notice regarding the transfer of assets by the next scheduled renewal. See [Section 18.8 Spousal Impoverishment Notices](#) for information on manual notices that must be sent to the couple.

By August 2014 Robert had only transferred \$23,000 to Lucinda. Robert still had \$9,000 in assets. Robert became ineligible September 2014 and will remain ineligible as long as his assets remain over \$2,000.

18.4.6.1.1 Leaves Institution or becomes ineligible during the 12 month transfer period.

If the institutionalized spouse during the 12 month transfer period:

1. Leaves the institution for 30 days or more and becomes institutionalized again,
or
2. Becomes ineligible for Medicaid and then becomes eligible for Medicaid once again.

The time allowed to transfer assets does not start over again.

18.4.6.2 Institutionalized Spouse Is Eligible After the 12 Month Transfer Period

18.4.6.2.1 Leaves Institution for 30 or More Days then Re-institutionalized

If the institutionalized spouse remains in the institution and Medicaid eligible after the expiration of the 12 month transfer period, but then leaves the institution for 30 days or more and subsequently becomes institutionalized once again for 30 days or more, he or she would be subject to all spousal impoverishment rules upon becoming re-institutionalized.

Including:

- An asset assessment (see [Section 18.4.2 Asset Assessment](#)) would be required for the purpose of determining the community spouse asset share,
and
- The couple would have to once again pass a joint asset test, **and**
- The institutionalized spouse would get another 12 month period to transfer all of his or her assets in excess of \$2,000 to his or her community spouse.

Example 3: Peter was institutionalized and determined Medicaid eligible in March of 2002. Janice, Peter's wife, remained in the community. In February 2003, Peter's assets were below \$2,000. Peter remained Medicaid eligible and institutionalized through May 2003. In June 2003, Peter left the nursing home and joined Janice in their home in the community. His Medicaid eligibility ended on June 30, 2003.

In August 2003, Peter inherited \$100,000. In September 2003, Peter's condition worsened and he was institutionalized again and applied for Medicaid. All spousal impoverishment rules would be applied to Peter's September 2003 application. His eligibility would be based on a joint asset test, and, if eligible, he would have 12 months to transfer assets in his name that exceed \$2,000 to his wife.

18.4.6.2.2 Loses Medicaid Eligibility But Remains Institutionalized

If the institutionalized spouse remains in the institution and remains Medicaid eligible after the 12 month transfer period but subsequently becomes ineligible and remains institutionalized, spousal impoverishment asset rules would not be applicable if he or she should reapply.

If the institutionalized person reapplies for Medicaid, his or her asset limit would be \$2,000 and the spouse's assets would not be counted.

If eligible, he or she would still be allowed to allocate some of his or her income to the community spouse.

Example 4: Gregory was institutionalized in December 2007. Gregory and his wife, Marcia, who remained in the community, passed the joint asset test. Gregory was found eligible and allowed until November 2008 to get under the \$2,000 asset limit. By November 2008, Greg had transferred enough assets to Marcia to get under the asset limit.

In March 2009, while Gregory remained institutionalized, he refused to sign over to Medicaid a health insurance payment check. His Medicaid eligibility was discontinued March 31, 2009, for failure to cooperate with **TPL** requirements. Greg has never left the institution and now reapplies for Medicaid on June 3, 2009. Since Greg never left the institution for 30 days or more since his original Medicaid spousal impoverishment application was approved (December 2007), the assets of his community spouse are not counted when determining eligibility for the application filed June 2009. Greg's asset limit for this application is \$2,000.00.

18.5 SPOUSAL IMPOVERISHMENT INCOME

[18.5.1 Nontrust Income](#)

[18.5.2 Trust Income](#)

The income limit is the same as for institutionalized persons who do not have a *community spouse* (see [Section 39.4 EBD Assets and Income Tables](#)).

18.5.1 Nontrust Income

Count non-trust income as belonging to the person who receives the payment.

1. If the payment is received in both *spouses'* names, count half for each.
2. If the payment does not specify the payee, count half for each spouse .
3. If the payment is shared with others, count amounts equal to each spouse's proportionate share.

Count as income to the institutionalized spouse any income that the community spouse actually makes available to him or her, whether voluntarily or under a court order.

18.5.2 Trust Income

Follow the specific terms of the trust as to which spouse is the payee and what percentage of the income belongs to him or her. If the percentage is unspecified, consider half the payment to belong to each spouse. If any trust income goes to dependent family members, attribute it to whom it is assigned; if it is not assigned to a specific family member, divide it equally between those who receive it.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

18.6 SPOUSAL IMPOVERISHMENT INCOME ALLOCATION

[18.6.1 Spousal Impoverishment Income Allocation Introduction](#)

[18.6.2 Community Spouse Income Allocation](#)

[18.6.3 Family Member Income Allowance](#)

18.6.1 Spousal Impoverishment Income Allocation Introduction

After the institutionalized person is found eligible, he or she may allocate some of his or her income to the **community spouse** and dependent family members living with the community spouse. Income that is allocated for the community spouse must actually be given to the community spouse each month in order for it to be allowed as a post eligibility income deduction for the institutionalized spouse. However, income that is allocated for a dependent family does not have to be actually given to the dependent family member.

Dependent family members include:

1. Dependent **minor** children (natural, adopted, step) of either parent who live with the community spouse.
2. Children (natural, adopted, step), 18 years of age or older, of either parent, who are claimed as dependents for tax purposes under the Service Code Internal Revenue (IRSC) and who live with the community spouse.
3. Siblings of either the institutionalized person or the community spouse who are claimed as dependents and who live with the community spouse.
4. Parents of either the institutionalized person or the community spouse who are claimed as dependents and who live with the community spouse.

The institutionalized person must decide how much income to allocate. He or she may allocate an amount that brings the community spouse's and family members' income up to the maximum allocation, or he or she may choose to allocate a lesser amount.

Since he or she may have medical costs that are not covered by Medicaid, he or she may wish to keep some income and not allocate it all.

Example 1: Caroline has monthly income of \$400. She transfers \$310 to her community spouse, keeping only her personal needs allowance (see [Section 39.4.2 EBD Deductions and Allowances](#)) and \$45 to pay as her monthly patient liability. She incurs \$80 in noncovered medical expenses each month. Those expenses will be charged first to her patient liability. But she must pay the remaining \$35.00 out of her personal needs allowance. If the personal needs allowance does not cover her expenses, the provider will try to obtain the balance from the community spouse.

To determine how much of the institutionalized spouse's income to allocate:

18.6.2 Community Spouse Income Allocation

1. The community spouse maximum income allocation is:
 - a. \$2,621.67 plus excess shelter allowance (see [Section 39.4.2 EBD Deductions and Allowances](#)) up to a maximum of \$2,931.00, or

- b. 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 [Section 39.4.2 EBD Deductions and Allowances](#)).

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:

If community spouse pays:	Add
Heat and utilities	See Section 8.1.3 Deductions of the FoodShare Handbook for the standard utility allowances.
Utilities only	" "
Telephone only	" "
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.	

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

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.

The institutionalized spouse may choose to allocate less than the maximum amount.

18.6.3 Family Member Income Allowance

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.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

18.7 RESERVED

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

18.8 SPOUSAL IMPOVERISHMENT NOTICES

After the institutionalized person has been determined Medicaid eligible, the worker must send the following manual notices to both spouses:

1. Notice of Medicaid Income Allocation ([F-10097](#)). This notice contains the amount of income allocated to the *community spouse* and the amount of the institutionalized person's cost of care contribution.
2. Medicaid Recipient Asset Allocation Notice ([F-10098](#)). This notice specifies the amount of assets the member must transfer to the community spouse in order to retain Medicaid eligibility. It also specifies the date by which the transfer must be made.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

18.9 COMMUNITY SPOUSE'S MEDICAID APPLICATION

Community spouses who apply for Medicaid must apply on a separate application from that of the institutionalized person. Count assets and income allocated and transferred to them by the institutionalized person when determining the community spouse's Medicaid eligibility. Beyond these, count only the assets and income belonging to the community spouse.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

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18.10 DUAL SPOUSAL IMPOVERISHMENT CASES

When both *spouses* are applying for community waivers, Family Care, or *PACE*/Partnership, and neither spouse resides in a medical institution, both eligibility determinations are done using spousal impoverishment policies.

The eligibility determination for both spouses is done on one case if the couple resides together.

Since income allocated to a *community spouse* is counted as income for that spouse, the couple should decide which spouse should allocate to the other spouse and how much to allocate.

One spouse may have more income or less expenses, so he or she could allocate to the other spouse with less income or more expenses. Each case will have to be assessed individually and the income allocation adjusted to meet the needs of the couple.

After determining how much income to allocate, and which spouse is allocating, the allocated amount must be entered on the *CWW* Community Spouse page for the spouse that is allocating as the Court Ordered/Fair Hearing amount to let CWW know to allocate that amount.

Do not create a Community Spouse page for the spouse that is not allocating income.

If the eligibility is determined for both spouses on one case, the income allocated must be entered as OTMA on the Unearned Income page for the spouse receiving the allocation. If the eligibility is determined on separate cases, the income should be entered as OT on the Unearned Income page for the spouse receiving the income allocation.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

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*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

PROGRAM ADMIN. (CHS. 20 - 23)

20 VERIFICATION

20.1 VERIFICATION INTRODUCTION

[20.1.1 Verification Definition](#)

[20.1.2 Documentation](#)

[20.1.3 Verification Receipt Date](#)

[20.1.4 Verification Rules](#)

20.1.1 Verification Definition

Verification is part of determining eligibility. To verify means to establish the accuracy of verbal or written statements made about a group's circumstances.

If the *member* is applying for other programs of assistance or if you are looking for sources of verification, see the specific verification chapters for those programs in their respective handbooks.

20.1.2 Documentation

Documentation is a method by which you accomplish verification. Case comments in *CWW* provide documentation, including worker notes regarding collateral contacts, viewing documents, home visits, etc. Include enough data to describe the nature and source of information if follow up is needed.

20.1.3 Verification Receipt Date

The verification receipt date is the day verification is delivered to the appropriate *IM* agency or the next business day if verification is delivered after the agency's regularly scheduled business hours. IM agencies must stamp the receipt date on each piece of verification provided.

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, email, 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.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

20.2 RESERVED

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

20.3 MANDATORY VERIFICATION ITEMS

[20.3.1 Mandatory Verification Items Introduction](#)

[20.3.2 Social Security Number](#)

[20.3.3 Immigration Status](#)

[20.3.4 Disability](#)

[20.3.5 Assets](#)

[20.3.5.1 Divestment](#)

[20.3.6 Medical Expenses](#)

[20.3.7 Power of Attorney and Guardianship](#)

[20.3.8 Income](#)

20.3.1 Mandatory Verification Items Introduction

Verify the following mandatory items:

1. **SSN** (see [Section 20.3.2 Social Security Number](#)).
2. Alien Status (see [Section 7.3 Immigrants](#)).
3. **Disability** and Incapacitation (see [Section 5.2 Determination of Disability](#)).
4. Assets for the **Elderly**, Blind, and Disabled (see [Section 16.1 Assets Introduction](#)).
5. Divestment, for EBD (see [Section 17.1 Divestment Introduction](#)).
6. Medical expenses, for deductibles only (see [Section 24.7 Meeting the Deductible](#)).
7. Medical/remedial expenses for noncovered services for an institutionalized person (see [Section 27.7.7.2 Disallowed Expenses](#)).
8. Documentation for Power of Attorney and Guardianship (see [Section 20.3.7 Power of Attorney and Guardianship](#)).
9. Migrant workers eligibility in another state (see [Section 25.8.4.1 Simplified Application](#)), if applicable.
10. Physician certification (verbally or in writing) that the person is likely to return to the home or apartment within six months for institutionalized persons maintaining a home or property (see [Section 15.7.1 Maintaining Home or Apartment](#)) and is entitled to a home maintenance allowance.
11. Income.
12. Citizenship and Identity (see [Section 7.2 Documenting Citizenship and Identity](#)).

Accept self declaration for all other items, unless you document them as questionable.

20.3.2 Social Security Number

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 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.

Verify the SSN only once.

20.3.3 Immigration Status

A member who indicates he or she is not a citizen must provide an official government document that lists his or her immigration registration number. Verify the individual's 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 immigration status can still qualify for those benefits.

An immigrant that presents documentation of his or her 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.

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

20.3.4 Disability

Disability and blindness determinations are made by the **DDB** in the **DHS**. 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.

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.

20.3.5.1 Divestment

Verify if a member or *spouse* has divested assets when determining eligibility for institutional Medicaid and community waivers (see [Section 17.1 Divestment Introduction](#)).

20.3.6 Medical Expenses

Verify medical expenses if they are used to meet a deductible. Verify the expense and date of service.

20.3.7 Power of Attorney and Guardianship

Verify power of attorney and any guardianship type as specified by the court. Ask for any documentation regarding durable power of attorney or court-ordered guardianship. For applications and other relevant applicant information, refer to Power of Attorney as "Power of Attorney for Finances."

The *IM* agency must determine the guardianship type specified by the court. Only the person designated as "guardian of the estate," "guardian of the person and estate," or "guardian in general" may attest to the accuracy of the information on the application form and sign it. Do not require a "conservator" or "guardian of the person" to sign the application form.

20.3.8 Income

Verify all sources of nonexempt income for EBD Medicaid applicants and members. Verify income using the automated data exchanges, when current (the month for which eligibility is being determined) information is available on a specific data exchange. If current income information is not available through a data exchange, the applicant/member is required to supply verification/documentation of their earned and unearned income.

In certain cases, data exchange resources do not exist or are unavailable to IM workers for eligibility determinations. For example, data exchanges are not available for persons who do not supply their SSN or where the income reported is not part of an existing data exchange. Under these circumstances, income must be verified by the member through other sources (i.e., checkstubs, award letters, etc.).

The following are examples of persons for whom a data exchange will never exist and, therefore, income verification is required at eligibility determination:

- a. Ineligible persons who do not provide an SSN and whose income would be counted in the eligibility determination (Fiscal Test Group member);
- b. Non-citizens without an SSN applying for emergency services. Persons whose employers do not report wages to the Department of Workforce Development (DWD) in Wisconsin, such as Wisconsin residents who work out of state and persons who work for the federal government.

- c. Persons with income from sources that are never available to IM workers through a data exchange, such as self-employment, pensions, retirement income, etc.

The applicant/member is responsible for providing verification of income that is not available through data exchange. For example, data exchanges are not available for persons who do not supply their SSN or where the income reported is not part of an existing data exchange. Under these circumstances, income must be verified by the applicant/member through other sources (i.e. check stubs, award letters, etc.).

Assist the applicant/member in obtaining verification if he or she has difficulty in obtaining it.

Do not deny eligibility if reasonable attempts to verify the income have been made. Use the best information available to process the application or change timely 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. In this situation, continue to attempt to obtain the verification. Once the verification is received, benefits may need to be adjusted based on the verified information.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

20.4 QUESTIONABLE ITEMS

[20.4.1 Questionable Items Introduction](#)

[20.4.2 Tuberculosis](#)

[20.4.3 Farm and Self-employment Income](#)

20.4.1 Questionable Items Introduction

Information is questionable when:

1. There are inconsistencies in the group's oral or written statements.
2. There are inconsistencies between the group's claims and collateral contacts, documents, or prior records.
3. The *member* or his or her representative is unsure of the accuracy of his or her own statements.
4. The member has been convicted of Medicaid member fraud or has legally acknowledged his or her guilt of member fraud.
5. The member is a *minor* who reports that he or she is living alone. This does not apply to minors applying solely for FPW.
6. Unclear or vague (i.e., information provided, but not clear).

20.4.2 Tuberculosis

See [Section 25.7 Tuberculosis](#) for appropriate verification items if information provided is questionable.

20.4.3 Farm and Self-employment Income

See [Section 15.6.6 Verification](#) for appropriate verification items if information provided is questionable.

*This page last updated in Release Number: 14-02
Release Date: 12/18/14
Effective Date: 09/28/14*

20.5 MEMBER RESPONSIBILITY

Assist the Member

The *IM* worker has a responsibility to use all available data exchanges to verify information, but the *member* has primary responsibility for providing verification. The member must likewise resolve questionable information. Do not deny eligibility when the member does not have the ability to produce verification.

Assist the member in obtaining verification if he or she 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 member does not have the power to produce verification, **and**
2. Information is not obtainable timely even with your assistance.

In this situation, seek verification later. When you have received the verification, you may need to adjust or recoup benefits based on the new information. Explain this to the member when requesting verification.

This page last updated in Release Number: 08-01

Release Date: 02/01/08

Effective Date: 02/01/08

20.6 FRONT END VERIFICATION

Front-End verification (FEV) is intensive verification of a case by a special unit or worker. Refer a group for FEV only when its characteristics meet a designated profile (see [Section 12.3 FEV Case Application of the Income Maintenance Manual](#)).

This page last updated in Release Number: 14-02

Release Date: 12/18/14

Effective Date: 09/28/14

20.7 WHEN TO VERIFY

[20.7.1 Application and Review](#)

[20.7.1.1 Application](#)

[20.7.1.2 Eligibility Reviews](#)

[20.7.1.3. Late Renewals](#)

[20.7.2 Changes](#)

Verify mandatory and questionable items at application, review, person addition or deletion, or when there is a change in circumstance that affects eligibility or benefit level. Do not reverify one time only verification items.

Exception: Veterans benefits, including allowances for Aid and Attendance, Housebound, and Unusual Medical Expenses usually increase only once a year, in January. If an *IM* agency verifies the January veterans benefit increase, it does not have to re-verify the veteran benefit income at the time of the next scheduled eligibility review, which occurs later in that same year. If another change in the veterans benefit does occur between January and the next scheduled eligibility review, that income change will have to be verified. This exception is being adopted to reduce the verification workload for both the IM agency and Veterans Administration staff, who routinely pursue and provide veterans benefit income verification every January.

20.7.1 Application and Review

20.7.1.1 Application

The time period for processing an application for Medicaid is 30 days. Advise the *applicant* of the specific verifications required within the 30 day processing time. Give the applicant a minimum of 10 calendar days to provide any necessary verification.

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

1. the 10th day after requesting verification, **or**
2. the 30th day after the application filing date.

If you request verification more than ten days prior to the 30th day you must still allow the applicant 30 days from the application filing date to provide the required verification.

20.7.1.2 Eligibility Reviews

Do not deny the group's eligibility for failure to provide the required verification until the 10th day after requesting verification.

Example 1: Fred's eligibility review is due in April. He submits a mail-in review form on April 10. The eligibility worker requests verification of his income on April 11 with a due date of April 21. If the verification is not submitted by April 21, the worker would update the verification code on April 21st to QV and close benefits effective April 30. If Fred submits the verification by April 30 and is otherwise eligible, his benefits would reopen for July.

Example 2: Shannon's eligibility review was due in June. At *adverse action* in June, a notice was sent to Shannon to let her know her Medicaid eligibility would end June 30 because she had not yet completed her review. A telephone interview was conducted on June 30. A request for verification, with a July 10 due date, was sent to Shannon. Because the required verification (including signature) was not submitted by July 10, her eligibility beginning July 1 was denied.

20.7.1.3. Late Renewals

Effective December 22, 2014, agencies must accept and process health care renewals and renewal-related verifications up to three calendar months after the renewal due date. Late renewals are only permitted for individuals whose eligibility has ended because of lack of renewal and not for other reasons. *Members* whose health care benefits are closed for more than three months because of lack of renewal must reapply.

This policy will apply to the following programs:

- BadgerCare Plus (BC+).
- Family Planning Only Services (FPOS).
- Elderly, Blind or Disabled Medicaid (EBD MA).
- Home and Community-Based Waivers (HCBW).
- Institutional Medicaid.
- *MAPP*.

- *MSP (QMB/SLMB/SLMB+/QDWI).*

The policy will apply to members receiving health care benefits based on a met deductible, but not to members with an unmet deductible.

Late submission of an online or paper renewal form, or a late renewal request by phone or in person, is a valid request for health care. The new certification period should be set based on the receipt date of the signed renewal. If verifications are required during the completion of a late renewal, the member will have 10 days to provide it.

Example 3: Jenny's renewal is due on January 31, 2015. She submits an online renewal via ACCESS on March 15, 2015. If the renewal is processed on the same day and verification is requested, the verification will be due on March 25, 2015. If she provides verification on or before this due date and meets all other eligibility criteria, her eligibility and certification period will start on March 1, 2015. Her next renewal will be due February 28, 2016.

The three-month period starts from the month the renewal was due. It does not restart when a late renewal has been submitted.

Example 4: Jenny's renewal is due on January 31, 2015. She submits an online renewal via ACCESS on March 15, 2015. If the renewal is processed on the same day, and verification is requested, the verification will be due on March 25, 2015. If Jenny does not provide verification until May, she will need to reapply after the three-month period that started with her January renewal date.

If a member has a gap in coverage because of his or her late renewal, he or she may request coverage of the past months in which the gap occurred and must provide all necessary information and verifications of income and assets for the current month and the gap months and must pay any required premiums to be covered for those months.

Because QMB coverage is not retroactive, the ability to request coverage for past months does not apply for this program.

Example 5: Jenny's renewal is due on January 31, 2015. She completes her renewal on January 20, 2015, and a VCL is generated requesting income verification for the 30 days prior to January 20. Jenny does not submit the requested verification, and her BadgerCare Plus eligibility is terminated as of January 31, 2015. On April 27, 2015, she submits her paystubs for April 10 and April 24. If she meets the eligibility criteria for BadgerCare Plus, her certification period will start on April 1, 2015, and her next renewal will be due March 31, 2016. If she had submitted the verification of her income for January, a new VCL should be generated asking for verification of her current income for April.

20.7.2 Changes

Advise the member of the specific verification required and allow a minimum of 10 days to provide it.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

20.8 ACTIONS

[20.8.1 Positive Actions](#)

[20.8.2 Delay](#)

[20.8.3 Negative Actions](#)

20.8.1 Positive Actions

Begin or continue benefits when:

1. The *member* provides requested verification within the specified time limits and is otherwise eligible.
2. Requested verification is mandatory, but the member does not have the power to produce the verification and he or she is otherwise eligible.

20.8.2 Delay

Notify the member of a processing delay when:

1. Verification is needed, and
2. He or she has the power to produce the verification, and
3. The minimum time period allowed for producing the verification has not passed.

CARES provides a verification checklist, to notify the member of the reason for the delay, the specific verification required, and the date the verification is due.

20.8.3 Negative Actions

Deny or reduce benefits when all of the following are true:

1. The member has the power to produce the verification.
2. The time allowed to produce the verification has passed.
3. The member has been given adequate notice of the verification required.
4. You need the requested verification to determine current eligibility. Do not deny current eligibility because a member does not verify some past circumstance not affecting current eligibility.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

20.9 RELEASE OF INFORMATION

You need someone's written release to get information from a verification source only when the source requires it.

When a source requires a written release:

1. Explain the requirement to the *member*.
2. Ask the member, his or her *spouse*, or another appropriate *adult* in the household to sign the necessary release form(s). The form may be:
 - a. The CARES-generated or alternate pre-printed application forms.
 - b. Release to Disability Determination Bureau form ([F-14014](#)).

Deny, discontinue or reduce benefits only when:

1. No appropriate person will sign the release form, and
2. The missing verification is necessary to determine eligibility, and
3. The member is unwilling or unable to provide the verification directly, and
4. The source requires a release, and
5. The release is the only way you can obtain the verification.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

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 [Process Help Handbook Chapter 44 Data Exchange](#) for instructions. For instructions on using the SAVE (Systematic Alien Verification for Entitlements) system to verify immigration status, see [Process Help Handbook Chapter 82 SAVE](#).

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

21 BENEFITS

21.1 BENEFITS INTRODUCTION

Medicaid covers many health care services. However, limitations apply that ensure only medically necessary services are provided.

The benefit and coverage information provided here is subject to change. The most current Medicaid coverage information is included in the ForwardHealth Online Handbook at <https://www.forwardhealth.wi.gov/WIPortal/Default.aspx>

*This page last updated in Release Number: 09-02
Release Date: 02/23/09
Effective Date: 02/23/09*

21.2 FULL-BENEFIT MEDICAID

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

1. Katie Beckett Medicaid (see [Section 25.6 Katie Beckett](#))
2. **HCBWLTC** (see [Section 28.1 Home and Community-Based Waivers Long-term Care Introduction](#))
3. Institutional Medicaid (see [Section 27.1 Institutions](#))
4. BadgerCare Plus (see the [BadgerCare Plus Handbook](#))

5. EBD Medicaid (cat or med needy)
6. *Foster Care* Medicaid (see the [BadgerCare Plus Handbook](#))
7. Adoption Assistance Medicaid
8. Medicaid Met Deductibles (see [Section 24.2 Medicaid Deductible Introduction](#))
9. *MAPP* (see [Section 26.1 Medicaid Purchase Plan Introduction](#))
10. *WWWMA* (see the [BadgerCare Plus Handbook](#))
11. *SSI*-Medicaid

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

21.3 LIMITED BENEFIT MEDICAID

Limited benefit subprograms of Medicaid includes:

1. Medicare Savings Programs (see [Section 32.1 Medicare Savings Programs](#)).
2. Emergency Services for Non-Qualifying Aliens
3. *TB*-Related Medicaid (see [Section 25.7 Tuberculosis](#)).
4. Presumptively Eligible Pregnant Women (see the [BadgerCare Plus Handbook](#))
5. SeniorCare (see [Section 33.1 SeniorCare Introduction](#))
6. Family Planning Only Services (see the [BadgerCare Plus Handbook](#))

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

21.4 COVERED SERVICES

[21.4.1 Covered Services Introduction](#)

[21.4.2 Transportation](#)

[21.4.2.1 Ambulance](#)

[21.4.2.2 Specialized Medical Vehicle](#)

[21.4.2.3 Common Carrier](#)

[21.4.2.4 Transportation Coordination](#)

21.4.1 Covered Services Introduction

The benefit and coverage information provided here is subject to change. The most current Medicaid coverage information is included in the ForwardHealth Online Handbook at:

<https://www.forwardhealth.wi.gov/WIPortal/Default.aspx>.

A covered service is any medical service that Medicaid will pay for an eligible *member*, if billed. The *DHCAA* enrolls qualified health care providers and reimburses them for providing Medicaid covered services to eligible Medicaid members. Members may receive Medicaid services only from 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.

Medicaid providers must submit a prior authorization request to the Medicaid fiscal agent before providing certain Medicaid services.

Individuals who are enrolled in Medicare (Part A and/or B) and are eligible for full-benefit Medicaid (see [Section 21.2 Full-Benefit Medicaid](#)), including *SSI* recipients, are referred to as dual eligible individuals. Effective January 1, 2006, Medicaid no longer provides prescription drug coverage for these individuals. These dual eligible individuals do not have to file an application for "Extra Help" and are deemed eligible for "Extra Help" from *CMS* to pay their Medicare Part D costs.

A Medicare Part D Preferred Drug Plan (PDP) card will be issued to them, and it must be used for prescription drugs instead of their Forward Card.

Individuals who are enrolled in Medicare (Part A and/or B) and are Medicare Beneficiaries (see [Section 32.1 Medicare Savings Programs](#)), except for *QDWI*, are also considered to be dual eligibles. These dual eligibles are also be deemed eligible for "Extra Help" from CMS to pay their Medicare Part D costs.

Examples of Medicaid covered services include:

1. Case management services.
2. Chiropractic services.
3. Dental services.
4. Family planning services and supplies.
5. *FQHC* services.
6. HealthCheck (Early and Periodic Screening, Diagnosis and Treatment & ESPDT) of people under 21 years of age.
7. Home and community-based services authorized under a waiver.
8. Home health services or nursing services if a home health agency is unavailable.
9. Hospice care.
10. Inpatient hospital services other than services in an institution for mental disease.
11. Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
 - a. under 21 years of age.
 - b. under 22 years of age and received services immediately before reaching age 21.
 - c. 65 years of age or older.
12. Intermediate care facility services, other than services at an institution for mental disease.

13. Laboratory and X-ray services.
14. Legend drugs and over-the counter drugs listed in Wisconsin Medicaid's drug index.
15. Medical supplies and equipment.
16. Mental health and medical day treatment.
17. Mental health and psychosocial rehabilitative services, including case management services provided by the staff of a certified community support program.
18. Nurse midwife services.
19. Nursing services, including services performed by a nurse practitioner.
20. Optometric or optical services, including eyeglasses.
21. Outpatient hospital services.
22. Personal care services.
23. Physical and occupational therapy.
24. Physician services.
25. Podiatry services.
26. Prenatal care coordination for women with high-risk pregnancies.
27. Respiratory care services for ventilator-dependent individuals.
28. Rural health clinic services.
29. Skilled nursing home services other than in an institution for mental disease.
30. Speech, hearing, and language disorder services.
31. Substance abuse (alcohol and other abuse services).
32. TB services.
33. Transportation to obtain medical care.

If you or the member have additional questions, contact Member Services at 1-800-362-3002.

21.4.2 Transportation

Federal regulations require the Medicaid program provide transportation for members who have no other way to receive a ride to their Medicaid health care appointments. Transportation can be by ambulance, **SMV**, or common carrier.

21.4.2.1 Ambulance

Ambulance transportation is a covered service if it is provided by a BadgerCare Plus certified ambulance provider and the member is suffering from an illness or injury that rules out other forms of transportation and only if it is for:

1. Emergency care when immediate medical treatment or examination is needed to deal with or guard against a worsening of the person's condition.
2. Non-emergency transportation when use of any other method of transportation is contraindicated and is authorized in writing by a physician, physician assistant, nurse midwife, nurse practitioner, or registered nurse.

21.4.2.2 Specialized Medical Vehicle

An SMV is a vehicle equipped with a lift or ramp for loading wheelchairs. The driver of an SMV must meet driver requirements in accordance with Wis. Admin. Code § [DHS 105.39](#).

SMV transportation is a covered service if provided by a BadgerCare Plus SMV enrolled provider and a health care provider has documented why the member's condition prevents him or her from using a common carrier or private vehicle.

21.4.2.3 Common Carrier

Common carrier means any mode of transportation other than an ambulance or an SMV.

21.4.2.4 Transportation Coordination

NEMT is coordinated by the **DHS** NEMT manager, Medical Transportation Management Inc. (MTM Inc.). As the NEMT manager, MTM Inc. arranges and pays for rides to covered Medicaid services for members who have no other way to receive a ride. Rides can include ambulance, SMV, or common carrier transportation depending on a member's medical and transportation needs.

The NEMT manager does not coordinate transportation for the following members:

- Members who are residing in a nursing home.
 - Members residing in a nursing home have their NEMT services coordinated by the nursing home.
- Members who are enrolled in Family Care.
 - Members enrolled in Family Care receive NEMT services from the Family Care **MCO**.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

21.5 COPAYMENT

An EBD Medicaid **member** may be required to pay a part of the cost of a service. This payment is called a “copayment” or “copay.”

Members who do not have to pay a copayment are:

1. Children under age 18 whose income is at or below 100 percent of the **FPL**,
2. Pregnant women,
3. Children that are members of a federally recognized tribe, **and**
4. Nursing home residents

Medical services exempt from copayments are:

1. Emergency hospital and ambulance services and emergency services related to the relief of dental pain.
2. Services related to pregnancy.
3. Family planning services and supplies.
4. Home Health Services
5. Personal care services.
6. Case management services.
7. Outpatient psychotherapy services received that exceed 15 hours or \$500, whichever occurs first, during one calendar year.
8. Occupational, physical, or speech therapy services received that exceed 30 hours or \$1,500 for any one therapy, whichever occurs first, during one calendar year.
9. Hospice care services.
10. Substance abuse (alcohol and other drug abuse) day treatment services.
11. Respiratory care for ventilator-assisted members.
12. **CSP** services.

Providers are required to make a reasonable effort to collect the copayment. Copayments range from \$0.50 to \$3.00 for each procedure or service. Providers may not refuse services to an EBD Medicaid member who fails to make a copayment.

*This page last updated in Release Number: 13-01
Release Date: 08/28/13
Effective Date: 08/28/13*

21.6 HMO ENROLLMENT

[21.6.1 HMO Enrollment Introduction](#)

[21.6.2 Exemptions](#)

[21.6.3 Change of Circumstances](#)

[21.6.4 Disenrollment](#)

[21.6.5 HP Enterprise Services Ombuds](#)

21.6.1 HMO Enrollment Introduction

Most Medicaid **members** who are eligible for Family Medicaid and reside in a Medicaid HMO service area must enroll in a HMO.

Members may choose their own HMO or work with the HMO Enrollment Specialist to choose the best one for their needs. They may choose at any time during the enrollment process. All eligible members of the member's family must choose the same HMO. However, individuals within a family may be eligible for exemption from enrollment.

This is the enrollment process:

1. Members residing in a HMO service area receive a HMO enrollment packet. The packet has an enrollment form, a list of available HMOs, instructions on how to choose a HMO and how to find out if a provider is affiliated with a HMO.
2. If the member does not choose a HMO within two weeks of receiving the enrollment packet, he or she receives a reminder card. Members in areas with only one available HMO will stop here in the process. They do not have to enroll in a HMO.
3. If the member has not chosen a HMO after four weeks and lives in an area covered by two or more HMOs, he or she will be assigned a HMO. A letter explaining the assignment will be sent to him or her. He or she will receive another enrollment form and have an opportunity to change the assigned HMO.
4. He or she will then receive a notice confirming enrollment in the assigned or chosen HMO for the following month. The member has up to three months to change HMOs, once enrolled. This is the open enrollment period. After the initial three months, the member is locked into the HMO and cannot change for nine months. If your member has questions about HMO enrollment, he or she should contact the Enrollment Specialist at 1-800-291-2002.

21.6.2 Exemptions

A member may qualify for an exemption from HMO enrollment if they meet certain criteria, such as a chronic illness, high-risk third trimester pregnancy, or continuity of care concerns.

If the member believes he or she has a valid reason for exemption, he or she should call the HMO Enrollment Specialist at 1-800-291-2002. The number is also in the enrollment materials they receive.

21.6.3 Change of Circumstances

Members who lose Medicaid eligibility but become eligible again may be automatically re-enrolled in their previous HMO.

If the member's eligibility is re-established after the six-month period, he or she will be automatically re-enrolled in the previous HMO, unless the HMO is no longer accepting reassignments.

After six months, or if the HMO is no longer accepting reassignments or has exceeded its enrollment level, he or she will receive an enrollment packet, and the enrollment process will start over.

21.6.4 Disenrollment

Members are automatically disenrolled from the HMO program if:

1. Their medical status code changes to a non-Family Medicaid subprogram.
2. They become eligible for Medicare.
3. They lose eligibility.
4. They move out of the HMO's service area.

Members who move out of the HMO service area receive a new packet showing the HMO(s) available in the new area and the enrollment process begins again. If no HMO covers the member's new area, he or she remains *fee-for-service*.

21.6.5 HP Enterprise Services Ombuds

Members with questions about their rights as HMO enrollees may call 1-800-760-0001 or write:

HMO Ombuds
P.O. Box 6470
Madison, WI 53791-9823

*This page last updated in Release Number: 12-02
Release Date: 06/15/12
Effective Date: 06/15/12*

21.7 FORWARDHEALTH (MEDICAID) CARDS

[21.7.1 ForwardHealth Cards Introduction](#)

[21.7.2 Homeless](#)

[21.7.3 Lock-in Program](#)

[21.7.4 Temporary Cards](#)

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21.7.1 Medicaid Cards Introduction

ForwardHealth cards are issued to Medicaid *members*. These cards are permanent, plastic, and display the word "ForwardHealth" on them. Members use the same ForwardHealth card each month. Monthly cards are not issued.

The cards do not display eligibility dates. Health care providers use the ID number on the front of the card to bill for services provided to the member.

Cards should not be thrown away. If a member becomes eligible again, he or she will use the same ForwardHealth card originally issued. If members have questions regarding their eligibility status, they can log into [ACCESS](#)>Change My Benefits or call Member Services at 1-800-362-3002.

BadgerCare Plus and Medicaid



SeniorCare



Each person in the family who is eligible for Medicaid receives his or her own card. The cards do not display eligibility dates. All Medicaid services are paid for under the Medicaid ID number on the card.

Members will know if they are eligible based on positive and negative notices sent from the *IM* agency. Members who receive a notice that they are no longer eligible for Medicaid should keep their ForwardHealth cards. Cards should not be thrown away. If a member becomes eligible again, he or she will use the same ForwardHealth card originally issued. If members have questions regarding their eligibility status, they can call you or Member Services at 1-800-362-3002.

21.7.2 Homeless

Make ID cards available to homeless Medicaid members who have no fixed address or mailing address. Use your agency address or some other fixed address for delivery.

21.7.3 Lock-in Program

A program called Lock-in is available in cases of benefit misuse. The member is assigned to a particular provider for services. When a member receives health care, the providers are told of the member's restriction(s) when verifying eligibility. If you have information that your member may be misusing benefits or his or her ForwardHealth card, send the member's name, address, card number, and a summary of the facts and any documentation to:

Division of Health Care Financing
Bureau of Health Care Program Integrity
P.O. Box 309
Madison, WI 53701-0309

Or call providers services at (800) 947-9627 or (608) 221-9883.

21.7.4 Temporary Cards

With implementation of the ForwardHealth ID card, temporary ID cards are no longer used or available for ordering from the fiscal agent.

21.7.5 Lost/Stolen Cards

If a member needs a replacement card, he or she or an *authorized representative*, can request a replacement card by:

1. Going to [ACCESS](#)
 - Create a [MyACCESS Account](#), then
 - Go to your [MyACCESS Page](#) and select a new ForwardHealth Card, or
2. Contacting Member Services at 1-800-362-3002.

Workers may also log into the [Partner Portal](#) and select "Replacement ID Card Request" under the Quick Links on the right side of the page.

If the member has multiple benefit ID cards, there will be a choice of which ID card to request. A new ForwardHealth card will be created the evening of the request and will be sent out the following business day.

Replacement cards are issued automatically when the card has been returned as undeliverable and the member's address changes.

You cannot request replacement cards using a F-10110 (formerly DES 3070) or CARES.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

21.8 WAIVER OF MEDICAID BENEFIT LIMITATIONS

Someone who is eligible for Medicaid but has been refused a specific Medicaid benefit by the provider can be given a waiver. The waiver lifts the limitation and allows the *member* to receive the benefit.

The provider of the service must request the waiver. The request goes to the Division of Health Care Financing (DHCF).

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

21.9 THIRD PARTY COVERAGE

See [Section 9.1 Third Party Liability](#).

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

21.10 GOOD FAITH CLAIMS

[21.10.1 Definition of Good Faith Claims](#)

[21.10.2 Denials](#)

[21.10.3 Causes and Resolutions](#)

[21.10.4 Process](#)

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21.10.1 Definition of Good Faith Claims

A good faith claim is a claim that has been denied by Medicaid with an eligibility-related *EOB* code. This occurs even though the provider verified eligibility for the dates of service billed and submitted a correct and complete claim. Providers can resubmit the claim to the fiscal agent to be processed as a good faith claim. If the eligibility file has

been updated by the time the claim is resubmitted, it will be paid automatically. If the file still does not reflect eligibility for the period covered by the claim, the fiscal agent will try to resolve the eligibility discrepancy. If they are unable to resolve it from the information available, they will contact you to verify eligibility. The Good Faith Medicaid/BadgerCare Plus Certification form ([F-10111](#)) is used for this purpose. A good faith claim cannot be reimbursed until the fiscal agent member file is updated.

21.10.2 Denials

If a provider receives a claim denial for one of the following reasons on the Remittance Advice, the provider can resubmit it as a good faith claim .

R/A Report Denial Code	Reason
029	Medicaid number doesn't match recipient's last name.
172	Recipient Medicaid ID number not eligible for dates of service.
281	Recipient Medicaid ID number is incorrect. Verify and correct the Medicaid number and resubmit claim.
614	Medicaid number doesn't match recipient's first name.

21.10.3 Causes and Resolutions

Causes and a good faith claim can occur when:

1. A member presents an ID card that is invalid because:
 - a. You issued a temporary ID card for a prior period or manually determined case and did not update CARES or send the fiscal agent an F-10110 (formerly DES 3070) to update the recipient's eligibility file. The fiscal agent will apply the dates of eligibility indicated on the card with med stat 71. A letter will be sent to you to confirm that the member is eligible for the dates on the card. The letter will include instructions on how to complete a [F-10111](#) and the information that is needed.
 - b. The provider suspects the member of misusing or abusing a Medicaid ID card (i.e., using an altered card or a card that belongs to someone else). If the provider submits a copy of the card and the fiscal agent can tell that it was altered, the fiscal agent will contact you to verify the member was eligible or forward it to the **DHCAA** for review.
2. The recipient's name has changed since the card was issued. The fiscal agent can usually resolve claims that are denied with code "029" and "614." If necessary, the fiscal agent will contact you to confirm the information.

With the implementation of the ForwardHealth ID cards, providers are less likely to receive one of the eligibility-related denials used for good faith claim submissions. Providers are told to verify eligibility using the variety of methods available

to them through the Eligibility Verification System (EVS). When the provider verifies the member's eligibility, they are getting the most current information available on the MMIS. Therefore, it is unlikely that they will be told the *member* is eligible when he or she is not.

The most likely reason a good faith situation arises is when a provider sees a temporary paper ID card issued by the agency. The provider may bill Medicaid before the eligibility is updated on MMIS, or perhaps the eligibility was never sent to MMIS. In either case, if the member presents a valid temporary Medicaid ID card for the dates of service, and the provider sends a copy of the card with the good faith claim, the fiscal agent will update the member's eligibility file with a good faith segment and pay the claim immediately.

The fiscal agent will then attempt to resolve the discrepancy from information on file or contact you to confirm eligibility and correct the eligibility segment. If the provider does not send a copy of the ID card with the claim, the fiscal agent must confirm eligibility with you before the claim can be paid.

The definition of a valid card is either a:

1. ForwardHealth card that indicates eligibility for the dates of service through the EVS.
2. A temporary paper card showing dates of eligibility.

21.10.4 Process

The fiscal agent initiates the good faith claim process by sending you a Good Faith Medicaid/BadgerCare Plus Certification form ([F-10111](#)) that they have partially completed and one or two letters, depending on what documentation of eligibility the provider included with their claim. Complete the [F-10111](#) form if this is a new member (cert. 1) or return a new [F-10110](#) (formerly DES 3070) for amended certifications (cert. 3). Send completed [F-10111](#) forms to:

HP Enterprise Services
Good Faith Unit
P.O. Box 6215
Madison, WI 53784

Send completed 3070 forms to:

1. Mail: HP Enterprise Services
P.O. Box 7636
Madison, WI 53707
2. Fax: (608) 221-8815

21.10.5 Instructions

Agency Denial

If the member identified on this Good Faith form was neither eligible nor possessed a valid ID card for the dates of service indicated in field six, place an "X" in this box. If you check "Yes" here, you must also check the reason in the field below.

Recipient Did Not Have ID Card After Date of Service

Place an "X" in this box if you are certain that the member did not possess a valid Medicaid ID card for the date of service. In the blank provided, enter the closing date of eligibility.

Recipient Not Eligible

Place an "X" in this box if the member was not eligible for any of the dates of service shown. If the member was eligible for some of the dates of service, follow the instructions for completing the Partial Deny box.

Record Not Found

Place an "X" in this box if the member has never been eligible for Medicaid in your agency.

Dates of Services

The fiscal agent enters the dates of service for the claim.

Partial Deny

Use this field only if the member had eligibility for some of the dates of service. Enter the "from" and "to" dates which cover the portion of the dates of service for which the member did not have eligibility.

Type of Certification

The fiscal agent will check one of these boxes:

1. Initial Certification

The fiscal agent will place an "X" in this box when the member and Medicaid number submitted on the claim cannot be found on the eligibility master file.

2. Amended Certification

The fiscal agent will place an "X" in this box when the member is on MMIS, but no eligibility exists for the claimed dates of service.

Agency Number

The fiscal agent will enter the three-digit code of the agency they believe may have certified the member during the dates in question.

Casehead ID Number

The fiscal agent will enter the known or suspected MMIS case number (primary person's **SSN** + tie-breaker) of the member listed on the provider's claim.

Action Date

The fiscal agent enters the date they completed the Good Faith form.

Medical Status Code

When the fiscal agent receives the provider's claim along with a photocopy of an ID card, a hard copy response received through EVS ,or a transaction log number from the Automated Voice Response (AVR), the fiscal agent compares the dates of service with the dates on the card. If the dates of service fall within the dates of eligibility for the ID number on the card, the fiscal agent enters a "71" medical status code and pays the claim immediately. The fiscal agent then enters the eligibility dates for the entire month in which services were provided.

If the member was eligible for the entire period of certification shown on the Good Faith form ([F-10111](#)), remove the "71" medical status code and write in the correct code. Attach a [F-10110](#) (formerly DES 3070) to add the certification period and appropriate medical status code for the time when the member was eligible for Medicaid.

Period of Certification

If the fiscal agent has entered the suspected period of certification to be added to the member master file, check it for accuracy. Then complete a [F-10110](#) (formerly DES 3070) and enter the period of certification if the member file does not show eligibility for the time when the member was eligible or for the time covered by an ID card issued to the member.

Control Name Year of Birth

The fiscal agent will enter the suspected control name and year of birth (YOB) for the member. This control name must be the first four letters of the member's last name. The YOB is the last two digits in the member's year of birth. Both of these items must match the information currently in the member's fiscal agent file.

Current ID Number

The fiscal agent will enter the member's current Medicaid ID number.

Date of Birth

The fiscal agent completes this field only for initial certifications. Change this birth date if the date entered is incorrect. Indicate birthdate as MM/DD/CCYY.

Signature of Agency Director

Good Faith forms must have an authorized signature for initial certifications.

Worker ID

On initial certifications, enter the six-digit worker code of the certifying **IM** worker.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

22 ADMINISTRATION

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22.1.1 Estate Recovery Program Definition

The state seeks repayment of certain correctly paid home health and *LTC* benefits by:

1. *Liens* against a home
2. Claims against estates

3. Affidavits
4. Voluntary recoveries

These procedures are the **ERP**. No ERP recovery may be made for Medicaid services provided before October 1, 1991.

22.1.2 Recoverable Services

Not all services provided by Medicaid are recoverable. Recoverability depends on what was provided and the **member's** age and residence when he or she received the benefit.

The following are the services for which ERP may seek recovery:

1. All Medicaid services received while living in a nursing home on or after October 1, 1991.
2. All Medicaid services received while institutionalized in an inpatient hospital on or after July 1, 1995.
3. Home health care services received by members age 55 or older on or after July 1, 1995, consisting of:
 - a. Skilled nursing services.
 - b. Home health aide services.
 - c. Home health therapy and speech pathology services.
 - d. Private duty nursing services.
 - e. Personal care services received by members age 55 or older on or after April 1, 2000.
4. All **HCBW** services (**COP-W**, **CIP** 1A, CIP 1B, CIP II, Brain Injury Waiver, Community Opportunities and Recovery, and Community Supported Living Arrangements) received by members age 55 or older between July 1, 1995, and July 31, 2014:
 - a. Prescription/legend drugs received by waiver participants.
 - b. Benefits paid associated with a waiver participant's inpatient hospital stay. These include inpatient services that are billed separately by providers and services that are noncovered hospital services.
5. Family Care services received by members age 55 or older between February 1, 2000, and July 31, 2014:
 - a. Prescription/legend drugs received by waiver participants.
 - b. Benefits paid associated with a waiver participant's inpatient hospital stay. This includes inpatient services that are billed separately by providers and that are noncovered hospital services.
6. All Family Care Partnership HCBW services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older between March 1, 2009, and July 31, 2014.
7. All **IRIS** services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older before August 1, 2014.

8. All Medicaid services received by members age 55 or older participating in a LTC program on or after August 1, 2014. LTC programs include all HCBW programs (including COP-W, CIP 1A, CIP 1B, CIP II, Brain Injury Waiver, Community Opportunities and Recovery, Community Supported Living Arrangements, FamilyCare, FamilyCare Partnership, IRIS, and **PACE**). The capitation payment made to the **MCO** on or after August 1, 2014, will be recovered for members receiving LTC program services through managed care.
9. Costs that may be recovered through a lien are:
 - a. Medicaid costs for services received on or after October 1, 1991, during a nursing home stay or services received while institutionalized in a hospital on or after July 1, 1995.
 - b. Medicaid costs of all other recoverable services as listed in Items 1-5 that are received on or after April 1, 2000, by members age 55 or older as of the date of the service.

22.1.2.1 Qualified Medicare Beneficiary

As of January 1, 2010, payments for premiums, copayments, and deductibles for Medicare Part B for a **QMB** are not recoverable through ERP.

22.1.3 Nursing Home Definition

For ERP purposes, a "nursing home" is a place that provides 24-hour services, including room and board, to three or more unrelated residents who, because of their mental or physical condition, require nursing or personal care more than seven hours a week. This includes **SNF**, **ICF**, in-patient psychiatric facilities, and Facilities for the Developmentally Disabled (FDD). A "nursing home" does not include:

1. A convent or facility owned or operated exclusively by and for members of a religious order that provides reception and care or treatment.
2. A hospice, as defined in Wis. Stat. § 50.90(1), that directly provides inpatient care.
3. Community waiver residence.
4. **IMD**.

22.1.4 Liens

[22.1.4.1 Notice of Intent to File a Lien](#)

[22.1.4.2 Out-of-State Property](#)

[22.1.4.3 Returns Home to Live](#)

[22.1.4.4 Change in Circumstances](#)

[22.1.4.5 Special Cases](#)

[22.1.4.6 Adjustment for Burial Trust](#)

[22.1.4.7 Administrative Hearing: Liens](#)

[22.1.4.8 Homes Placed in Revocable Trusts](#)

DHS will not file a lien on:

1. Non-home property.
2. **Homestead** property sold by land contract.
3. Property outside Wisconsin (see [Section 22.1.4.2 Out-of-State Property](#)).
4. A mobile home or the land it sits on when the [member](#) does not own the land.

DHS may file a lien on:

1. A home and all property used and operated in connection with that home.
2. A mobile home and the land it sits on, when the member owns the land.
3. A home placed in a **revocable trust** (see [Section 22.1.4.8 Homes Placed in Revocable Trusts](#)).
4. Life estates created on or after August 1, 2014.

When a home is sold, DHS uses the lien to recover certain payments for Medicaid services provided as listed in [Section 22.1.2 Recoverable Services](#). The lien's value is "open ended." The lien's value increases as the amount of recoverable Medicaid services paid accumulates.

Payment of the lien is made directly to DHS. Do not accept any payments relating to liens filed by DHS.

Contact the ERP Estate Recovery Specialist if the member's home is sold within 45 days after the Notice of Intent to File a Lien is completed.

The lien has no effect until filed.

Example 1: Mr. A applies for Medicaid on March 6, 1995. He has a home and his circumstances require a lien. The **IM** agency sends a Notice of Intent to File a Lien on March 10, 1995. ERP staff cannot file a lien until April 24, 1995, because of the required 45 day waiting period. Mr. A's legal representative sells the property on April 10, 1995. Recovery of Mr. A's Medicaid payments by a lien on that property is not possible as the property was sold before a lien was filed. The IM agency contacts the ERP Lien Specialist to report on the home's sale.

22.1.4.1 Notice of Intent to File a Lien

Complete a Notice of Intent to File a Lien ([F-13038](#) paper form) when a Medicaid member meets all the following criteria. He or she:

1. Lives in a nursing home or inpatient hospital and is required to contribute to the cost of care. (Individuals eligible under a **MAGI** group are not required to contribute to the cost of care and are not subject to liens on their homes.)
2. Has a home (see [Section 16.1 Assets Introduction](#)).
3. Is not expected to return to live at that home.

Base this decision on the person's medical condition. His or her physician's statement that he or she can reasonably be expected to return home is sufficient support for the person's claim that he or she will return.

The physician's statement should include a description of the diagnosis and prognosis for the member. A form asking for a physician to merely indicate by checking a box, etc., that there is a reasonable expectation that the institutionalized individual will return home is not acceptable or sufficient. Allow the physician a reasonable amount of time to provide this information.

When there is contradictory information (from a nursing home social worker, discharge planner, etc.) concerning the reasonable expectation of returning home, or you question the reasonableness of the statement by the member, family, guardian, power of attorney, or physician that the person will return home, consult with the ERP's Estate Recovery Specialist. Do **not** file a Notice of Intent to File a Lien until ERP staff has checked with DHS medical consultants. If ERP determines there is not a reasonable expectation, ERP will send you a letter listing the reasons for this decision. At that point, if all of the other conditions described in this section are met, file the Notice of Intent to File a Lien.

4. None of these relatives of the member reside in that home.
 - a. *Spouse.*
 - b. Child who is:
 - Under age 21, **or**
 - Blind, **or**
 - Disabled.
 - c. Sibling, if the sibling:
 - Has an equity interest in the home; **and**
 - Lived in the home continuously beginning at least 12 months before the member's nursing home or hospital admission.

When you have completed the Notice:

1. Mail or give the original to the member or his or her *authorized representative*.
2. Send a copy to the ERP office.
3. Attach a legible copy of the latest property tax bill or a copy of the property *deed* (if available) for any homestead property reported. This gives ERP staff the information necessary to obtain the legal description needed to file a lien.
4. File a copy in the case record.

ERP staff delays further action until the period given the member to request a fair hearing passes. If no hearing is requested, ERP staff will file a lien on the property with the Register of Deeds for the county in which the property is located. If a hearing is requested, a lien is not filed until approved by a hearing decision.

22.1.4.2 Out-of-State Property

If a Medicaid member has property outside Wisconsin that would be subject to a lien if located in Wisconsin, provide the same data you would provide on Wisconsin property. Do not give a Notice of Intent to File a Lien.

DHS may not file liens against out-of-state properties. However, ERP staff wants data on these cases to assist in negotiating lien agreements with other states.

22.1.4.3 Returns Home to Live

If, despite expectations, the resident is discharged from the nursing home or inpatient hospital, to return home to live, the lien must be released. Notify the ERP. ERP staff will release the lien.

22.1.4.4 Change in Circumstances

At review and other times, at local option, reexamine the circumstances of the member's home. If conditions change such that a lien must be filed, complete a Notice of Intent to File a Lien.

22.1.4.5 Special Cases

ERP staff applies special consideration for the following two case situations:

1. When a child (age 21 or older) of the member lives in the home, DHS is able to file a lien. It will not enforce the lien until that child moves or the home is sold if he or she:
 - a. Lived in the home with the member for at least two years before the resident's admission to the nursing home or hospital, **and**
 - b. Assisted the parent such that he or she helped delay the member's admission.
2. When a sibling of the member (other than a sibling described in [Section 22.1.4.1 Notice of Intent to File a Lien](#)) lives in the home, DHS is able to file a lien. It will not enforce the lien until that sibling moves or the home is sold if the sibling resided in the home for at least 12 months before the member's admission to the nursing home or hospital.

Alert the ERP when your member meets either of these two case situations.

22.1.4.6 Adjustment for Burial Trust

DHS may adjust the amount of its lien to allow a member to use proceeds from the sale of the home to establish or supplement a burial trust. ERP staff will review each situation individually. Refer any questions regarding lien satisfaction amounts or lien releases to the ERP staff.

22.1.4.7 Administrative Hearing: Liens

A member or his or her representative may request an administrative hearing if he or she feels the statutory requirements for imposing the lien have not been met. The IM agency attends the hearing to explain the decision to file the Notice of Intent to File a Lien. The only issue at the hearing will be whether the following requirements were satisfied:

1. The member has an ownership interest in a home.
2. The member resides in a nursing home or hospital.
3. The member cannot **reasonably** be expected to be discharged from the nursing home or hospital and return home to live.
4. None of the following lawfully reside in the home:
 - a. The member's spouse .
 - b. The member's child who is:
 - Under age 21, **or**
 - Disabled, **or**
 - Blind.
 - c. The member's sibling who has an ownership interest in the home and who has lived in the home continuously beginning at least 12 months before the member was admitted to the nursing home or hospital.

The request for an administrative hearing must be made in writing directly to the **DHA** at:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The request must be clearly marked "Medicaid Lien" and must be filed within 45 days of the mail date on the Notice of Intent to File a Lien. The date the written request is received by DHA is the date the hearing request is considered filed.

22.1.4.8 Homes Placed in Revocable Trusts

If a Medicaid member places his or her home in a revocable trust (see [Section 16.1 Assets Introduction](#)), he or she retains an ownership interest in the home. Complete a Notice of Intent to File a Lien if the member meets the conditions for a lien to be filed (see [Section 22.1.4.1 Notice of Intent to File a Lien](#)).

22.1.5 Estate Claims

[22.1.5.1 Waiver of Estate Claim](#)

[22.1.5.2 Notice of Hardship Waiver Rights](#)

[22.1.5.3 Administrative Hearings: Hardship Waivers](#)

[22.1.5.4 Personal Representative's Report](#)

[22.1.5.5 Real Property as Part of the Estate](#)

[22.1.5.6 Affidavits in Small Sum Estate and Non-Probate Property](#)

[22.1.5.7 Patient Fund Account](#)

[22.1.5.8 Native Americans](#)

[22.1.5.9 Reparation Payments to Individuals](#)

[22.1.5.10 Voluntary Recovery \(ERP\)](#)

DHS recovers Medicaid benefit costs from the member's estate or from the member's surviving spouse's estate

Recovery from a member's surviving spouse's estate will be limited to 50 percent of the marital property that the member had an interest in immediately prior to death.

When DHS learns of the death of a member or a member's surviving spouse, it files a claim in probate court in the amount of Medicaid recoverable benefits.

The probate court will not allow a claim on the estate to be paid if any of the following survives the member:

1. A spouse.
2. A child, if the child is:
 - a. Under age 21, **or**
 - b. Blind, **or**
 - c. Disabled.

Do not negotiate a settlement, accept any funds, or sign any release for estate claims that have been filed by DHS. ERP staff should be notified if a claim is filed by the county against an estate for recovery of overpayments or incorrect Medicaid benefits for those 55 years of age or older or for any member who has resided in a nursing home.

Refer any questions about specific estate claims to the ERP staff.

22.1.5.1 Waiver of Estate Claim

In estates of members who die on or after April 1, 1995, an heir or beneficiary of the deceased member's estate or co-owner or beneficiary of a member's non-probate property may apply for a waiver of an estate claim filed by ERP. To be successful, the person applying for the waiver must show one of these three hardships exist:

1. The waiver *applicant* would become or remain eligible for AFDC, *SSI*, FoodShare, or Medicaid if ERP pursued the estate claim.
2. The deceased member's *real property* is part of the waiver applicant's business (for example, a farm) and the ERP recovery claim would affect the property and result in the waiver applicant's loss of his or her means of livelihood.
3. The waiver applicant is receiving general relief or veteran's benefits based on need under Wis. Stat. § 45.40(1m).

The waiver application must be made in writing within 45 days after the day:

1. ERP mailed its recovery claim to the probate court or its affidavit to the heir, beneficiary, or co-owner **or**
2. ERP mailed its notice of waiver rights, whichever is latest.

The waiver application must include these points:

1. Relationship of the waiver applicant to the deceased member.
2. The hardship under which the waiver is requested.

ERP staff must issue a written decision granting or denying the waiver request within 90 days after the waiver application is received by ERP. In determining its decision, ERP must consider all information provided to it within 60 days of its receipt of the waiver application.

22.1.5.2 Notice of Hardship Waiver Rights

ERP will provide notice of the waiver provisions to the person handling the deceased member's estate. If ERP is not able to determine who that person is, the notice will be included with the claim when ERP files it with the claim court.

The person handling the estate is then responsible for notifying the decedent's heirs and beneficiaries of the waiver provisions.

ERP will provide notice of the waiver provisions to co-owners and beneficiaries of the member's non-probate property.

22.1.5.3 Administrative Hearings: Hardship Waivers

If a waiver application is denied, the waiver applicant may request an administrative hearing. ERP staff will attend the hearing to defend their denial of the hardship waiver.

The hearing request must be made within 45 days of the date the ERP decision was mailed.

The hearing request must:

1. Be made in writing.
2. Identify the basis for contesting the ERP decision.
3. Be made to the DHA at:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The date the request is received at DHA is used to determine the timeliness of the request.

ERP staff will maintain DHS' claim in the estate pending the administrative hearing decision. If collections are made and the waiver is ultimately approved, those funds will be returned.

To introduce evidence at a hearing not previously provided to DHS, the applicant must mail that evidence to DHS with a postmark at least seven working days before the hearing date.

22.1.5.4 Personal Representative's Notice

The personal representative of the estate of a Medicaid member must notify DHS that the estate is being probated (Wis. Stat. § 859.07[2]). The notification must be by certified mail and include the date by which claims against the estate must be filed.

22.1.5.5 Real Property as Part of the Estate

When a real property **is part of the estate**, ERP may file a lien equal to the Medicaid payments even if one of these persons is alive:

1. The spouse.
2. A child under age 21.
3. A disabled or blind child of any age.

Recovery through the lien will not be enforced as long as any of these persons meet the criteria and is alive.

Example 2: Mr. A dies. A claim on his estate is filed and the estate includes his real property. His spouse is deceased, and he has no blind or disabled child. He has a child, age 19. This child lives outside Mr. A's home. A lien is placed on the real property but cannot be enforced because the minor child is still alive. The child later turns 21. As there is then no living spouse, child under 21, or disabled or blind child, the lien can be enforced.

DHS will take a lien in full or partial settlement of an estate claim against the portion of an estate that is a home if:

1. A child, of any age of the deceased member:
 - a. Resides in the member's home, **and**
 - b. That child resided in that home for at least 24 months before the member entered the nursing home, hospital, or received HCBW services, **and**
 - c. That child provided care that delayed the member's move to the nursing home, hospital, or his or her receipt of HCBW services.
2. A sibling of the deceased member:
 - a. Resides in the member's home, **and**
 - b. Resided in that home for at least 12 months before the date the member entered a nursing home, hospital, or received home and community-based services.

The lien filed in one of these two instances will be payable at the death of the child or sibling or when the property is transferred, whichever comes first.

However, if the caretaker child or sibling sells the home covered by the DHS lien and uses the sale proceeds to buy another home to be used as that child's or sibling's primary residence, then:

1. DHS will transfer the lien to the new home if the amount of the child or sibling's payment or down payment for the new home is equal to or greater than the proceeds from the original home.
2. If the down payment on the new home is less than the proceeds from the sale of the original home, DHS will recover the amount of the proceeds above the down payment, but no greater than the lien amount. If there is an amount in the lien still not satisfied, DHS will file a lien for the remaining amount on the new home.

22.1.5.6 Affidavits in Small Sum Estates

Heirs, guardians, and trustees of revocable trusts created by a deceased Medicaid member must notify ERP before transferring any of the deceased's property through a Transfer by Affidavit (\$50,000 and under) (Wis. Stat. § 867.03). The heir, guardian, or trustee must send a copy of the affidavit to ERP by certified mail, return receipt requested. Examples of property include bank accounts (savings or checking); postal savings; credit union or building and loan shares; contents of safe deposit boxes; savings bonds; stocks and other securities; promissory notes and mortgages which are payable to the applicant/member and negotiable; real estate; etc.

If an heir, guardian, or trustee transfers the deceased's property, ERP will send an affidavit to the heir, guardian or trustee to recover any funds remaining after burial and estate administration costs have been paid. Funeral costs are limited to those expenses connected with the funeral service and burial. A marker for the grave is considered a burial cost. Memorials and/or donations to churches, organizations, persons, or institutions are not considered burial costs.

ERP will also send its affidavit to the co-owners and/or beneficiaries of a member's non-probate property. Non-probate property is property that passes outside an individual's estate. This means that non-probate property does not go through probate before it is transferred to those who inherit it. Non-probate property subject to recovery includes, but is not limited to, life estates, property held in joint tenancy, life insurance proceeds, property held in revocable trusts, and property that is payable-on-death or transfer-on-death to a beneficiary.

Co-owners and beneficiaries of a member's non-probate property have the right to request a fair hearing as on the value of the member's interest in the property.

The value of the member's interest for jointly owned property is the percentage interest attributed to the member when Medicaid eligibility was determined or, if not determined at eligibility, the fractional interest the member had in the property at his or her death.

For life estate interests, the value is the percentage of ownership based on the member's age at the date of death, according to the life estate tables used for Medicaid eligibility.

The value of the property is the *fair market value*. Fair market value is the price a willing buyer would pay to a willing seller for purchase of the property. It is the co-owners' or beneficiaries' responsibility to establish that value through a credible method like an appraisal by a licensed appraiser.

ERP staff will attend the fair hearing to present DHS' position on the value of the property.

Real property of a Medicaid member, whether non-probate or transferred by affidavit, is subject to a lien if the state's claim cannot be satisfied through other assets.

The DHS may not enforce the lien while any of the following survive:

1. Spouse,
2. Child who is:
 - a. Under age 21, **or**
 - b. Blind, **or**
 - c. Disabled.

ERP will recover any funds that remain from a burial trust after costs have been paid.

Direct specific questions about questionable allowable costs to ERP staff.

22.1.5.7 Patient Fund Account

Nursing homes are required to notify ERP when a Medicaid member dies with money left in his or her nursing home patient fund account if he or she has no surviving spouse or minor or disabled child.

ERP will claim from the nursing home any funds remaining in the patient account after payment of funeral and burial expenses and outstanding debts from the last month of illness that are not chargeable to Medicaid.

22.1.5.8 Native Americans

Native Americans: Income, Resources and Property Exempt from Medicaid Estate Recovery

The following income, resources, and property are exempt from Medicaid estate recovery:

1. Certain income and resources (such as interests in and income derived from Tribal land and other resources currently held in trust status and judgment funds

- from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
2. Ownership interest in trust or non-trust property, including real property and improvements:
 - a. Located on a reservation (any federally recognized Indian Tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Act and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
 - b. For any federally -recognized Tribe not described in (a), located within the most recent boundaries of a prior Federal reservation.
 - c. Protection of non-trust property described in (a) and (b) is limited to circumstances when it passes from an Indian (as defined in section 4 of the Indian Health Care Improvement Act) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a Tribe and non-Indians, such as spouses and step-children, that their culture would nevertheless protect as family members; to a Tribe or Tribal organization; and/or to one or more Indians;
 3. Income left as a remainder in an estate derived from property protected in 2 above, that was either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s), as long as the individual can clearly trace it as coming from the protected property.
 4. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally-protected rights, and income either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s) derived from these sources as long as the individual can clearly trace it as coming from protected sources; and
 5. Ownership interests in or usage rights to items not covered by 1-4 above that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom

Native Americans: Income, Resources and Property Not Exempt from Medicaid Estate Recovery

The following income, resources and property from the estates of Native Americans are not exempt from estate recovery:

1. Ownership interests in assets and property, both real and personal, that are not described in items 1-5 above.
2. Any income and assets left as a remainder in an estate that do not derive from protected property or sources in items 1-5.

22.1.5.9 Reparation Payments to Individuals

Government reparation payments to special populations are exempt from Medicaid estate recovery.

22.1.5.10 Voluntary Recovery (ERP)

When a member age 55 or older wishes to pay an amount to Medicaid to maintain Medicaid eligibility, prepay a Medicaid deductible, or reduce a potential claim in an estate, forward the payment to ERP. First check BVCI to make sure there is not an outstanding Medicaid claim for an overpayment since the money should be applied to an overpayment first. Voluntary payments, except for prepayment of a deductible, may only be up to the amount of Medicaid paid to date. (See [Section 22.1.10 Voluntary Recovery \(Not ERP\)](#) for voluntary recoveries for members under age 55.)

The check or money order should be made payable to DHS.

Mail the payment to:

Estate Recovery
313 Blettner Blvd
Madison WI
53714-2405

With the payment, include:

1. Documentation that the payment is voluntary.
2. The member's name and Medicaid ID number.
3. Name and address of the person who should receive the receipt.

These refunds will be credited to the member and will be used to offset any claim that may be filed in the member's estate.

Incentive payments of five percent will be paid to the IM agency for refunds.

Advise heirs and beneficiaries of deceased members who wish to make a voluntary refund to call ERP staff.

22.1.6 Match System

ERP maintains the Estate Recovery Database. Information you submit on the Estate Recovery Disclosure Form and data received through the **SSA** State Data Exchange (SDX) tape (for SSI/Medicaid members) is on the database.

The database is compared to the death record files of the **DHCAA**, Vital Records and State Registrar Section.

When a match shows a Medicaid member or his or her surviving spouse has died, a report record is produced. ERP staff checks the report against new probate proceedings

listed on the Wisconsin Circuit Court Access website. This is a back up to the requirement that DHS be notified of the last date for filing claims.

22.1.7 Notify Members

Provide a copy of the Wisconsin Medicaid Estate Recovery Program Handbook ([P-13032](#)) to every Medicaid member 54 1/2 years old or older or institutionalized at application and review. Have each member or his or her representative read the notice of liability on the application form ("Estate Recovery"). He or she acknowledges understanding of this notice when signing the application.

22.1.8 Disclosure Form

Complete an Estate Recovery Program Disclosure form whenever a Medicaid member:

1. Enters or resides in a nursing home, **or**
2. Enters or resides in an inpatient hospital and is required to pay a Medicaid cost of care liability, **or**
3. Becomes 55 years old.

Do this even if he or she has zero assets.

Complete the form with information about the member, his or her spouse, and his or her children that are blind, disabled, or under age 21.

Attach a legible copy of the latest property tax bill or a copy of the property deed for any real property reported if possible. This may give ERP staff the property's legal description needed to file a lien.

Attach a legible copy of any documents relating to trusts created by the member or the member's spouse.

Request the member or his/her agent to sign the completed form. If he or she will not sign the form:

1. Sign the form at the "Member Signature" line.
2. Note near your signature that you reviewed the data with the person or his or her agent. Indicate:
 - a. That he or she did or did not agree the data was accurate.
 - b. The reason he or she did not sign.

In a mail-in application situation, document if the form was not returned or was returned without a signature.

Send the completed form to the ERP. File a copy in the case record.

You need not update this form unless there is a substantial change in circumstances (for example, an inheritance).

22.1.9 Estate Recovery Program Contacts

The ERP address is:

Estate Recovery Program Section
Division of Health Care Access and Accountability
P.O. Box 309
Madison, WI 53701-0309

For general information regarding ERP, refer members to Member Services at 1-800-362-3002.

Direct case-specific questions about:

1. Estate recovery disclosure forms and liens to the Estate Recovery Specialist, (608) 264-6755.
2. For small estates of \$50,000 or less, provide the phone number of the "Affidavit Help Line," (608) 264-6756, to heirs of deceased members who have questions about ERP. The Help Line provides recorded messages that answer the most frequently asked questions regarding small sum estates. It also provides the caller with an opportunity to either leave a message or talk to ERP staff.
3. Tribal inquiries should be re-directed to the ERP Section Chief, (608) 261-7831.

22.1.10 Voluntary Recovery (Not ERP)

Accept payments from a member under age 55 made for purposes of Medicaid eligibility or prepaying a Medicaid deductible.

Instruct the member to make the payment payable to your IM agency. Report the receipt on the Community Aids Reporting System (CARS) on Line 909.

22.1.11 Incentive Payments

DHS will return to local agencies five percent of collections made through a lien, voluntary payments, and probated estate recoveries. We will pay this incentive to the last agency certifying the member for Medicaid.

The payments are discretionary. DHS will make them based on compliance with program requirements.

22.1.12 Other Programs

ERP also recovers for Community Options Program (COP), *WCDP*, Medicaid and non-Medicaid Family Care, and Partnership.

22.2 CORRECTIVE ACTION

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22.2.1 Overpayments

[22.2.1.1 Recoverable Overpayments](#)

[22.2.1.2 Non-Recoverable Overpayments](#)

An "overpayment" occurs when Medicaid benefits are paid for someone who was not eligible for them, or when Medicaid payments are made in an incorrect amount. The amount of recovery may not exceed the amount of the Medicaid benefits incorrectly provided. Some examples of how overpayments occur are:

1. Concealing or not reporting income.
2. Failure to report a change in income or assets.
3. Providing misinformation, at the time of application, regarding any information that would affect eligibility.

22.2.1.1 Recoverable Overpayments

Initiate recovery for a Medicaid overpayment if the incorrect payment resulted from one of the following:

1. Member Error

Member error exists when an *applicant, member*, or any other person responsible for giving information on the member's behalf, unintentionally misstates (financial or nonfinancial) facts, which results in the member receiving a benefit that he or she is not entitled to or more benefits than he or she is entitled. Failure to report nonfinancial facts that impact eligibility or cost share amounts is a recoverable overpayment effective July 27, 2005. For ongoing cases, September 1, 2005, is the earliest a claim can be established for failure to report a nonfinancial change. For applications on/after July 27, 2005, overpayment claims can be established effective with the application date.

Member error occurs when there is a:

- a. Misstatement or omission of facts by a member, or any other person responsible for giving information on the member's behalf, at a Medicaid application or review, **or**
- b. Failure on the part of the member, or any person responsible for giving information on the member's behalf, to report changes in financial (income, assets, expenses, etc.) or non-financial information that affects eligibility, premium, patient liability or cost share amount.

A Medicaid member is responsible for notifying his or her *IM* worker of changes within 10 days of the occurrence.

An overpayment occurs if the change would have adversely affected eligibility benefits or the post eligibility contribution amount (cost share, patient liability).

Example 1: Ed applied for EBD Medicaid and was found eligible effective November 1, 2013. Ed originally reported \$1,800 of nonexempt assets (checking and savings accounts), which were subsequently verified. At the time of his application, Ed failed to disclose ownership of several nonexempt vehicles with an equity value of \$1,000. The agency discovers Ed's ownership of these vehicles on February 10, 2014. On February 20, 2014, the agency receives verification that the equity value of Ed's nonexempt vehicles and other nonexempt assets has continuously exceeded the \$2,000 Medicaid asset limit since the Medicaid application date. The agency sends Ed a Notice of Decision on February 22, 2014, advising him that his eligibility is being discontinued effective March 31, 2014. The overpayment amount that is subject to recovery is the total of all Medicaid benefits that were received by Ed from November 1, 2013, through March 31, 2014.

Example 2: Sally, determined eligible for a *HCBW* in January with a cost share, experienced a reduction in her health insurance expense as of July 1, but did not report that to her worker until her November review. The worker made the

changes in CARES and increased her cost share for December.

Had Sally reported timely, her cost share would have increased beginning in August. The overpayment is the difference between the new cost share and the old cost share for August, September, October, and November.

Example 3: Shana was determined eligible for **WWWMA** in February. She had private insurance which covered treatment of breast or cervical cancer, but due to a waiting period for preexisting conditions, her treatments were not covered. The waiting period ended July 31, and the private insurance began to cover Shana's treatment effective August 1. Shana did not report this to her worker, so Medicaid continued to pay some service costs for Shana until the worker closed the case effective November 30.

Since her case would have closed August 31 if she had reported the change timely, Shana has an overpayment for September through November. The **fee-for-service** claims paid for September, October, and November are recoverable.

Example 4: Joe has been a Medicaid member since January 1, 2012. During a December 2013 eligibility review, the agency discovers that Joe won a \$10,000 lottery that was paid to him on June 12, 2013. Joe never reported the receipt of these lottery winnings and still has about \$8,000 from the lottery proceeds. The agency verifies that Joe's nonexempt assets have been in excess of the \$2,000 Medicaid asset limit since June 12, 2013, and sent him a Notice of Decision, advising him that his Medicaid eligibility is ending effective January 31, 2014. The overpayment amount that is subject to recovery is the total of all Medicaid benefits that were received by Joe from August 1, 2013, through January 31, 2014. June 2013 and July 2013 are not included in the overpayment period because Joe had 10 days to report the change that he had won a lottery. If Joe would have reported this change timely (no later than June 22, 2013), the earliest that the agency could have terminated Joe's eligibility with proper notice would have been July 31, 2013.

2. Fraud

Fraud exists when an applicant, member, 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.

3. Member Loss of an 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

Do not initiate recovery for a Medicaid overpayment if it resulted from a non-member error, including the following situations:

1. The member reported the change timely, but the worker could not close the case or reduce the benefit due to the 10-day notice requirement.
2. Agency error (keying error, math error, failure to act on a reported change, etc).
3. Normal prospective budgeting projections based on best available information.
4. A change in the Medicaid category if the benefits in the new category are the same as the original, and the post-eligibility contribution, if any, remains the same.

Example 5: A Medicaid EBD member reports on March 25, 2014 that they have received a \$50,000 inheritance on March 23, 2014. The agency sends the member the required Notice of Decision discontinuing their eligibility effective April 30, 2014. Even though the member had excess assets during March and April 2014, there is no Medicaid overpayment for those months because the change was reported timely, and the agency was required to provide appropriate and timely notice before discontinuing the member's eligibility. Benefits issued only because of our timely notice requirements are not overpayments and are not subject to recovery.

22.2.2 Overpayment Calculation

[22.2.2.1 Overpayment Period](#)

[22.2.2.2 Overpayment Amount](#)

[22.2.2.2.1 Institutional Overpayments](#)

[22.2.2.2.1.1 Overpayment as a Result of Misstatement or Omission of Fact](#)

[22.2.2.3 Deductible](#)

[22.2.2.4 Premiums](#)

[22.2.2.4.1 Overpayments for Individuals Eligible for FPW Benefits](#)

[22.2.2.4.2 Overpayments for QMB cases](#)

[22.2.2.5 Determining Liable Individual](#)

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.

22.2.2.2 Overpayment Amount

Use the simulation function in CARES to determine a member's eligibility, nursing home liability, premium or cost share (if applicable) based on the corrected information (CARES Guide Chapter VIII, 1.4.1). Use the actual income received by the member in determining if an overpayment has occurred.

To calculate the overpayment amount, use the RC (member claims) screen on MMIS. The overpayment amount depends on the Medicaid category and whether the case is *fee-for-service* or enrolled in a HMO.

If a case was ineligible due to excess income recover :

1. The lesser of FFS services Medicaid paid or the amount the member would have paid toward a deductible (If eligible for a deductible)
- or**
2. The lesser of what the member paid or would have paid toward the deductible and the amount Medicaid has spent on HMO capitation payments.

If a case/individual was ineligible for reasons other than excess income or not eligible for a deductible) recover the:

1. Amount paid for the medical services provided if the case is fee-for-service.
- or**

2. [Managed care](#) organization's capitation rate, less any contribution made by the member (ex. premium, cost share) if the case members are enrolled in a Medicaid managed care organization. The capitation rate is the monthly amount Medicaid pays to the member's managed care organization.

For the overpayment amounts for institutional ([22.2.2.1 Overpayment Period](#)), waiver ([22.2.2.1 Overpayment Period](#)), BadgerCare ([22.2.2.3 Deductible](#)), Medicaid Purchase Plan ([22.2.2.3 Deductible](#)), deductible ([22.2.2.2 Overpayment Amount](#)) and Family Planning Waiver (FPW) cases see the appropriate sections.

22.2.2.2.1 Institutional Overpayments

The overpayment amount for an institutional case is the amount Medicaid paid.

Note: Patient liability should not be subtracted from the claims paid by Medicaid when determining the overpayment amount.

22.2.2.2.1.1 Overpayment as a Result of Misstatement or Omission of Fact

If a misstatement or omission of fact results in an increased nursing home liability or waivers cost share, the difference between the correct liability/cost share amount and the one the member originally paid is the overpayment amount.

Do not send a [F-10110](#) (formerly DES 3070) to retroactively increase the patient liability on MMIS.

Family Care

For Family Care cases in which an omission of fact results in an increased Family Care liability or cost share, complete the following:

1. Recalculate the cost share or Family Care liability for any months that would have been affected.
2. Calculate the difference between the paid cost share or Family Care liability amount and the new cost share or Family Care liability amount.
3. Send the member a notice indicating the correct cost share for the months in question. Indicate on the notice the cost share amount still owed to the Care Management Organization ([CMO](#)) for each month in question. Do not attempt to recover the overpayment.
4. Report the new cost share amount to the CMO.

It is the CMO's responsibility to collect the difference between the cost share already paid and the correctly calculated cost share amount. This amount is not an overpayment of Medicaid funds, but is the amount that the member owes the CMO directly.

22.2.2.3 Deductible

If a member error increases the deductible before the deductible is met, there is no overpayment. Recalculate eligibility and notify the member of the new deductible amount.

If the member met the incorrect deductible and Medicaid paid for services after the deductible had been met, there is an overpayment. Recover the difference between the correct deductible amount and the previous deductible amount or the amount of claims over the six month period (whichever is less) .

If the member was ineligible for the deductible, determine the overpayment amount. If the member prepaid his or her deductible, deduct any amount he or she paid toward the deductible from the overpayment amount.

22.2.2.4 Premiums

If a BadgerCare or **MAPP** (MAPP offers people with disabilities who are working or interested in working the opportunity to obtain health care coverage through the Wisconsin Medicaid Program.) case was still open for the timeframe in question, but there was an increase in the premium, recover the difference between the premium paid and the amount owed for each month in question. To determine the difference, determine the premium owed and view the premium amount paid on CARES screen AGPT.

BadgerCare

If the case was ineligible for BC, recover the amount of medical claims paid by the state and/or the capitation rate. Deduct any amount paid in premiums (for each month in which an overpayment occurred) from the overpayment amount ([22.2.2.2 Overpayment Amount](#)).

The overpayment amount is the difference between the premium paid and premium owed even if the premium that was paid was \$0.

Example 7: Tom and his family became eligible for BadgerCare in June 2004 without a premium. In his application Tom failed to disclose income from a second job which would have resulted in a \$100 per month premium. This new information was discovered in July 2004.

Overpayment Calculation

\$100 premium owed for June
+ <u>\$100 premium owed for July</u>
\$200 Total premium owed
- <u>\$ 0 premium paid</u>
\$200 Overpayment

MAPP

If the case was ineligible for MAPP, recover the amount of medical claims paid by the state. Deduct any amount he or she paid in premiums (for each month in which an overpayment occurred) from the overpayment amount.

22.2.2.4.1 Overpayments for Individuals Eligible for FPW Benefits

If an individual or case was ineligible for Medicaid or BC but would have been eligible for FPW benefits, the calculation of the ultimate Medicaid overpayment amount is as follows:

If the incorrect/overpaid Medicaid benefits were "fee for service" medical claims paid by the state, recover the amount of benefits that were actually paid by the state minus any premiums which the member may have paid and the amount of any actual FPW services that were provided.

If the incorrect /overpaid Medicaid benefits were paid by an HMO, recover the HMO capitation rate paid by the state minus any premiums which the member may have paid and the "average" (currently \$28.60) monthly cost of Medicaid FPW services.

22.2.2.4.2 Overpayments for QMB cases

The overpayment amount for *QMB* cases is:

1. Medicare Part A premium if paid by the state (some are free others are paid by the state).

plus

2. Medicare Part B premium

plus

3. Medicare deductibles

plus

4. Medicare Co-insurance

Use the MMIS RC screen to determine if any Medicare deductibles and co-insurance payments were made by the state.

22.2.2.5 Determining Liable Individual

Except for minors, collect overpayments from the Medicaid member, even if the member has authorized a representative to complete the application or review for him or her.

Example 8: Sofie applied for Medicaid in December, and at that time designated her daughter, Lynn, as her [authorized representative](#). Lynn did not report some of her mother's assets when she applied, which

would have resulted in Sofie being ineligible for Medicaid. Sofie was determined to be ineligible for Medicaid from December through March. Recover from Sofie for any benefits that were provided to her from December through March.

If a *minor* received Medicaid in error, make the claim against the minor's parent(s) or legally responsible relative if the parent or legally responsible relative was living with the minor at the time of the overpayment.

22.2.3 Overpayment Process

[22.2.3.1 Overpayment Process Introduction](#)

[22.2.3.2 Member Notice](#)

22.2.3.1 Overpayment Process Introduction

Follow the instructions in Chapter VIII of the CARES Member Assistance for Re-employment & Economic Support Guide to enter the claim. CARES issues a repayment agreement the first business day of the month following the date the claim was entered.

You are responsible to:

1. Enter the claim into CARES.
2. Send a manual Medicaid Overpayment Notice ([F-10093](#)) indicating the reason for the overpayment and the period of ineligibility.
3. Record the completed and signed repayment agreement on CARES screen BVPA within five days of receipt.
4. Record payments on CARES screen BVCP within five days of receipt.

CARES will:

1. Track the issuance of notices of non-payment and send automated dunning notices (i.e. past due notices).
2. Refer past due claims for further collection action (i.e. tax intercept) to the Central Recoveries Enhanced System (CRES).
3. Close the claim when the balance is paid.

22.2.3.2 Member Notice

Notify the member or the member's representative of the period of ineligibility, the reason for his or her ineligibility, the amounts incorrectly paid, and request arrangement of repayment within a specified period of time.

22.2.4 Refer to District Attorney (DA)

See [IMM Chapter 3, Public Assistance Fraud Program](#) for referral criteria when fraud is suspected. The agency may refer the case to the state fraud investigation service provider where fraudulent activity by the member is suspected. If the investigation reveals a member may have committed fraud, refer the case to the district attorney or

corporation counsel for investigation. The district attorney or corporation counsel may prosecute for fraud under civil liability statutes. The agency may seek recovery through an order for restitution by the court of jurisdiction in which the member or former member is being prosecuted for fraud.

22.2.5 Fair Hearing

The IM Agency's decision concerning ineligibility and amounts owed may be appealed through a fair hearing. During the appeal process the agency may take no further recovery actions pending a decision.

22.2.6 Agency Retention

The IM Agency can retain 15% of the payments recovered. See [IMM Chapter 3.3.8 Local Agency Retention](#).

22.2.7 Restoration of Benefits

If it is determined that a member's benefits have been incorrectly denied or terminated, restore his or her Medicaid from the date of the incorrect denial or termination through the time period that he or she would have remained eligible.

If the member was incorrectly denied or terminated for BC or MAPP The Medicaid Purchase Plan (MAPP) offers people with disabilities who are working or interested in working the opportunity to obtain health care coverage through the Wisconsin Medicaid Program. with a premium obligation. Allow the member to pick which months he or she would like to receive benefits. Collect all premiums owed for all prior months before certifying the member for the months he or she chose.

If a member already paid for a Medicaid covered service, inform the member that he or she will need to contact his or her provider to bill Medicaid for services provided during that time. A Medicaid provider must refund the amount that Medicaid will reimburse for the service. The provider may choose to refund up to the full amount billed to the member, but that decision is entirely optional.

22.2.8 Incorrect Member Contribution

[22.2.8.1 Premiums](#)

[22.2.8.1.1 BadgerCare](#)

[22.2.8.1.2 Medicaid Purchase Plan \(MAPP\)](#)

22.2.8.1 Premiums

If it is determined that a premium amount was incorrectly calculated for BC or MAPP The Medicaid Purchase Plan (MAPP) offers people with disabilities who are working or interested in working the opportunity to obtain health care coverage through the

Wisconsin Medicaid Program. and would result in a refund for the member, determine the correct premium amount for each month in which it was incorrect.

When reporting the refund to the BadgerCare or MAPP Unit, include the:

1. The member's Social Security Number.
2. Months for which a refund needs to be issued.
3. New premium amount.
4. Old premium amount.

Indicate whether there is a hardship situation that requires the refund to be processed more quickly.

22.2.8.1.1 BadgerCare

If the premium was recalculated and reduced for prior month(s), report the premium refund to the BadgerCare Unit by:

Telephone: 1 (888) 907-4455

Fax: (608) 251-1513

When submitting a fax, write " Attn: BC Premium Refunds".

22.2.8.1.2 Medicaid Purchase Plan (MAPP)

If the premium was recalculated and reduced for prior month(s), report the premium refund to the MAPP Unit by:

Telephone: 1 (888) 907-4455

Fax: (608) 251-8185

When submitting a fax, write "Attn: MAPP Premium Refund"

This page last updated in Release Number: 15-01

Release Date: 06/10/2015

Effective Date: 06/10/2015

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 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 verification policy in [Chapter 20](#).

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.

Do not require a review or new application for case transfers, except in the following programs:

- Community Wavers ([28.1 HCBWLTC Introduction](#))
- Family Care ([29.1 Family Care Long Term Care \(FCLTC\) Introduction](#))
- Deductible Met ([24.11 Deductibles and Inter-Agency Transfers](#))

See [6.1 of the Process Help](#) for information on how to process case transfers.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

23 RESERVED

23 RESERVED

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

SUBPROGRAMS (CHS. 24- 38)

24 SSI RELATED MEDICAID AND DEDUCTIBLES

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](#) 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.

Allow the following income disregards to the fiscal group's income in the order below to determine the countable net income.

- The 65 & ½ earned income *disregard*,
- Special exempt income ([15.7.2](#) Special Exempt Income),
- \$20.00 SSI general income disregard.

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.

If an EBD related fiscal group's income exceeds the categorically needy income limit, their income is then compared to a medically needy limit, which is found in chapter [39.4](#). If the fiscal group's income is between the categorically needy limit and the medically needy limit, the group passes the Medicaid EBD medically needy income test.

If an EBD fiscal group fails the medically needy income test because their net income exceeds the medically needy income limit, they can still qualify for Medicaid if they can meet a Medicaid Deductible. Refer to chapter [24.2 Medicaid Deductible Introduction](#) for more information about Medicaid Deductibles and to chapter [24.5 Calculating the Deductible](#) for instructions on how to calculate a Medicaid Deductible.

See [39.4 EBD Assets and Income Table](#)

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

24.2 MEDICAID DEDUCTIBLE INTRODUCTION

When a Medicaid *applicant* is ineligible for Medicaid solely because he or she has income that exceeds the Medicaid medically needy income limit, he or she can become eligible by meeting the Medicaid deductible. "Meeting the Medicaid deductible" means incurring medical costs that equal the dollar amount of the deductible.

The Medicaid deductible is the group's total excess monthly income over the 6 consecutive months of the Medicaid deductible period (See [24.3 Deductible Period](#)).

"Excess monthly income" is the amount which is above the group's monthly medically needy income limit.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

24.3 DEDUCTIBLE PERIOD

The Medicaid deductible period is a period of six consecutive months. It is the length of time the group has for meeting the Medicaid deductible. It begins in the month which the *applicant* chooses, and it ends six months later. See [5.9.5 Eligibility](#) for an exception to the 6 month deductible period for backdate periods after a formal *disability* determination has been made for a *member* certified under a PD.

The applicant can choose to begin the Medicaid deductible period as early as three months prior to the month of application, and as late as the month of application.

Example 1: John applies for Medicaid in July. He can choose to begin his six month Medicaid deductible period in April, May, June, or July.

The applicant cannot choose a Medicaid deductible period which includes a month in which, if he or she had applied, he or she would have been ineligible due to excess assets.

Example 2: Doyle applies for Medicaid in July. He has excess income in July. He wants a Medicaid deductible period that goes from April through September. In addition to having excess income in April, Doyle had \$5,000 in his savings account on April 30. He cannot include April in his Medicaid deductible period. He no longer had the \$5,000 on May 31, so he can begin his Medicaid deductible period in May.

Example 3: Clarice applies for Medicaid in July. She has excess income in July. She wants a Medicaid deductible period that goes from April through September.

In addition to having excess income in April and May, Clarice had an inheritance of \$5,000 in May. She still retained it on May 31. Therefore, she cannot include May or any months prior to May in her Medicaid deductible period. She no longer had the \$5,000 on June 30, so she can begin her Medicaid deductible period in June.

The applicant can choose a Medicaid deductible period which includes a month in which, if he or she had applied, he or she would have been ineligible for a non-financial reason. Although excess income is still calculated over a six month period, the individual can only be certified for Medicaid during the dates when he or she was non-financially eligible.

Example 4: Marion applies for Medicaid in July. She has excess income in July. She wants a Medicaid deductible period that goes from April through September.

Marion was incarcerated from April 30th through May 18th. She meets the deductible with a countable expense from April 10th, so she should be certified from April 10th through April 29th, and May 19th through September 30th.

Example 5: Janet applies for Medicaid in July and requests a Medicaid deductible period from April through September. She gave birth on June 30th. Janet paid the full deductible amount, so is certified from April 1st through June 30th.

For backdate months, when a person had excess assets in any of the three months prior to the month of application, his or her eligibility in the backdate month is determined by whether or not he or she had excess assets on the last day of the month.

Example 6: Jack applies for Medicaid in July. He wants a Medicaid deductible period that goes back two months to include May and June. In May, he would have been eligible except for excess income. In June he had received a \$10,000 gift. On June 29 he went to the track and lost the \$10,000. Had he applied on June 30 he would have been eligible. Jack can include both May and June in his Medicaid 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.

Example 8: Jeff applies for Medicaid on 1/1/14 and his monthly excess income is \$100.00. His Medicaid deductible is \$600.00 and his deductible period is January 01, 2004 through June 30, 2014. In April 2014, Jeff's monthly excess income decreases to \$10.00 a month. Jeff reports the decreased income in April and now has a choice between two different deductible recalculations. He can either have his worker recalculate the original \$600.00 deductible which would then become a \$330.00 deductible (three months of \$100.00 excess income and three months of \$10.00 excess income) or since he hasn't yet met that deductible, he can file a new application in April and establish a new deductible period of April 2014 through September 30, 2014 with a \$60.00 deductible obligation ($\$10.00 \times 6 = \60.00). If Jeff hasn't already incurred any substantial medical expenses, he may want to file a new application, set a new deductible period, and be in a better position to meet a much smaller deductible. (See [24.6.1 Changes During the Deductible Period> Income Changes](#))

Individuals who have been certified for Medicaid after meeting a deductible, will have to complete a review to establish a new deductible period. CARES does not send a review notice to the member regarding the new deductible period if he or she did not meet the deductible for the current period.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

24.4 CHOOSING NOT TO HAVE A DEDUCTIBLE

An **applicant** who is ineligible for excess income in some backdate months, but has no excess income in others, does not have to choose to have a Medicaid deductible. He or she can choose to be certified in the months he or she is eligible and to accept the ineligibility of the other months where he or she has excess income.

Example 1: Horace applies for Medicaid in July. He has no income and does not expect any income in the future. He is financially eligible in July. He also wants

Medicaid eligibility for April to cover some medical expenses he had in April. In April he would have been eligible because he had no income or assets.

But in May and June he had excess income of \$20 each month. He has 2 choices:

Choose a Medicaid deductible period of April through September. After meeting the Medicaid deductible of \$40 he would be certified for Medicaid from April through September.

Not choose a Medicaid deductible period. He would not have to meet a Medicaid deductible. He could be certified immediately for April and July. But he would have to forego Medicaid for May and June because of the excess income in May and June.

If the applicant has excess income in the month of application, but no excess income in the 3 months prior to the month of application, he or she does not have to include them in a deductible period. He or she can be certified for them immediately, and can begin the Medicaid deductible period with the month of application.

Example 2: Roslyn applies for Medicaid in July. She is ineligible because she has excess income. She had no income in April, May, or June. She can be certified immediately for April, May, and June. She begins her Medicaid deductible period in July.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

24.5 CALCULATING THE DEDUCTIBLE

[24.5.1 Fiscal Test Groups](#)

[24.5.2 Institution Cases](#)

[24.5.2.1 Backdating](#)

[24.5.2.2 Deductible](#)

[24.5.3 Deductible Examples](#)

To calculate the dollar amount of the Medicaid deductible for a regular Medicaid fiscal test group:

24.5.1 Fiscal Test Groups

Determine the Medicaid deductible period ([24.3 Deductible Period](#)) for this fiscal test group.

Find the fiscal test group's total net income for each month in the deductible period.

For the months after the month of application, use prospective net income. (Income that may have been disregarded in the eligibility test which must now be counted, add back in, when determining the deductible period) (See [24.14 Medicaid Deductible, Cost of Care](#)).

Compare the total net income of each month with the group's medically needy income limit. If the group is an:

SSI-related fiscal test group, see [39.4 EBD Assets and Income Table](#).

If a month's income is less than or equal to the medically needy limit, ignore it.

If a month's income is more than the medically needy limit, find the excess income by subtracting the income limit from the net in-come of that month.

Add together the excess income of the months in the deductible period. The result is the Medicaid deductible.

24.5.2 Institution Cases

24.5.2.1 Backdating

Institutionalized and non-institutionalized persons can be eligible back to the 1st of the month, 3 months prior to the month of application. Even if they are ineligible in the month of application, they may still be eligible for retroactive coverage. When an institutionalized person requests retroactive Medicaid, test him or her against the nonfinancial and financial standards that are appropriate to the month being tested. For the months he or she was not institutionalized, use the EBD asset and income limits ([39.4 EBD Assets and Income Table](#)). For the months he or she was institutionalized, use the institutional eligibility criteria found in [27.1 Institutions](#).

24.5.2.2 Deductible

For the months in which he or she was not institutionalized, he or she may be eligible in some, but ineligible in others, due to excess income. In this situation, he or she has 2 choices:

1. To be certified for the months he or she is eligible, and accept the ineligibility of the other months in which he or she has excess income, **or**
2. To meet a deductible. The deductible period begins in the backdate month that he or she chooses, and extends 6 months. Calculate the deductible for the full 6-month deductible period. Calculate the deductible by comparing his or her

monthly income for each of the 6 months to the EBD medically needy income limit, not the institutional income limit.

Expenses which can be counted against the deductible are those listed in [24.7 Meeting the Deductible](#) plus his or her cost of care ([27.7 ILTC Cost of Care Calculation](#)).

Expenses that cannot be counted are listed in [24.7.2 Meeting the Deductible> Noncountable Costs](#).

When he or she meets the deductible, she can be certified to the end of the deductible period. At the end of the deductible period, redetermine his or her eligibility using the institutional financial tests.

24.5.3 Deductible Examples

Example 1: Artie applies for Medicaid in July. He wants to backdate his Medicaid three months. His Medicaid deductible period is April through September. In April, May, June, and July his AG had excess income of \$50 each month. His prospective excess income for August and September is \$50 each month. $6 \times \$50 = \300 . Artie's Medicaid deductible is \$300.

Example 2: Clarice applies for Medicaid in July. She wants to backdate her Medicaid to May 1. Her Medicaid deductible period is May 1 through October 31. In May and June her AG had excess income of \$100 each month. In July it has excess income of \$200. Its prospective excess income for August, September, and October is \$200 a month. Clarice's Medicaid deductible is \$1,000.

Example 3: Myron applies for Medicaid in July. He wants to backdate Medicaid to June 1. His Medicaid deductible period is June 1 through November 30. In June his AG had excess income of \$50. In July it has no excess income. Its prospective excess income for August, September, October, and November is \$0. Myron's Medicaid deductible is \$50.

Example 4: Tyler applies for Medicaid in July. He wants his Medicaid to begin July 1. His Medicaid deductible period is July 1 through December 31. In July his AG has \$100 excess income. Its prospective excess income for August, September, October, November, and December is \$100 each month. Tyler's Medicaid deductible is \$600.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

24.6 CHANGES DURING THE DEDUCTIBLE PERIOD

[24.6.1 Income Changes](#)

[24.6.2 Group Size Changes](#)

[24.6.3 Asset Changes](#)

[24.6.4 Non-Financial Changes](#)

If there are income changes during the Medicaid deductible period, recalculate the Medicaid deductible amount.

24.6.1 Income Changes

1. Add together the monthly excess income of the months of the Medicaid deductible period that have already gone by.
2. Subtract the medically needy income limit from the new monthly income. This will give the excess income for the month when the income changed.
3. Using prospective net income, find the excess income of the months in the deductible period after the month when income changed.
4. Add the results of #1, #2, and #3.

Example 1: Cicely applied for Medicaid in July. She had excess income of \$20 a month. Her Medicaid deductible was \$120. In November she reports a pay increase of \$10 a month. Now you must recalculate her Medicaid deductible.

1. Add together the excess income of months July through October. The result is \$80.
2. Calculate her November excess income. The result is excess income of \$30.
3. Prospective income for December is \$30.
4. Cicely's new Medicaid deductible: $\$80 + \$30 + \$30 = \140 .

If the income change results in **lower excess income** in the month of change, the *applicant* can choose to:

1. Recalculate the Medicaid deductible, **or**
2. Create a new deductible period.

Example 2: Winston goes from full time to part time employment in the fourth month of his Medicaid deductible period. He still has excess income, but it is lower than in the previous three months. He can choose either to recalculate his Medicaid deductible or to have a new deductible period.

If he recalculates, the resulting deductible will be lower than the previous one.

His other choice is to begin a new 6-month deductible period. He may want to do this if the new deductible is even lower than the recalculated one. If he makes this choice, he will forfeit any eligibility he might have acquired in the previous deductible period if he had met the previous deductible.

If the income change results in **no excess income** the applicant has an additional choice:

1. Recalculate the deductible.
2. Create a new deductible period.
3. **Begin eligibility immediately.**

Example 3: If Winston has no excess income in the month his income drops, and if his prospective monthly income shows no excess income, he can choose to begin eligibility immediately. In choosing this, he will forfeit the eligibility he would have had in the prior deductible period if he had met the prior deductible.

24.6.2 Group Size Changes

When the group size is different on the last day of the month from what it was on the last day of the previous month, you must recalculate the deductible. Compare the new group's income with the new group's medically needy income limit. If there is excess monthly income, recalculate the deductible in the same way as for income changes ([24.6.1 Income Changes](#)).

Example 4: John and Sally are married and reside together. Sally is disabled and has applied for Medicaid. Sally meets all Medicaid eligibility requirements except for the fact she and her husband have excess income and would have to meet a deductible before Sally can be certified for Medicaid. The deductible period is January through June and the deductible amount is based on a 2 person fiscal test group. On March 21, John moves out of the house to go live with his brother in another state. If John is still out of the house on March 31, Sally's deductible must be recalculated using the smaller group size (one person fiscal test group) as of March 1.

24.6.3 Asset Changes

If the fiscal group acquires new assets during the deductible period, wait until the last day of the month in which it acquired the assets. If the group has excess assets on the last day of the month, the group is not eligible. End the deductible period.

24.6.4 Non-Financial Changes

If there is a change in non-financial eligibility during the deductible period excess income may still be calculated during the dates the individual is non-financially ineligible, however the individual can only be certified for Medicaid during the dates he or she is/was non-financially eligible.

*This page last updated in Release Number: 10-02
Release Date: 06/22/10
Effective Date: 06/22/10*

24.7 MEETING THE DEDUCTIBLE

[24.7.1 Countable Costs](#)

[24.7.1.1 Countable Expenses](#)

[24.7.2 Noncountable Costs](#)

[24.7.3 Prepaying a Deductible](#)

[24.7.3.1 Payment of Entire Deductible Amount](#)

[24.7.3.2 Combination of Payment and Incurred Expenses](#)

[24.7.3.3 Combination of Payment and Outstanding Expenses](#)

[24.7.3.4 Calculation Errors](#)

[24.7.3.5 Insufficient Funds](#)

The fiscal test group meets the deductible by incurring medical costs that equal the dollar amount of the deductible. The countable costs are added together. When they are equal to or greater than the amount of the deductible, the group can be certified for Medicaid.

If the group has not met the deductible within the deductible period starting with a later month in the current deductible period without a new application ([24.3 Deductible Period](#)).

Example 1: Stanley's deductible period is from January through June. In April Stanley incurs a large medical expense that would meet his deductible. Stanley requests to start his deductible April 1st. His new deductible period is April through September. Stanley would not have to submit a new application.

If an expense was applied to a prior deductible but did not result in Medicaid certification, it can be applied to a later deductible, as long as it still meets the criteria listed in [24.7.1 Countable Costs](#) below.

24.7.1 Countable Costs

To be counted toward the deductible, a medical or remedial expense must meet all of the following conditions.

1. Be an expense for a [member](#) of the [applicant](#) /member's [FTG](#) .

Expenses may be counted if incurred for someone the member is legally responsible for if that individual could be counted in the member's FTG. The medical bill may be used even if the family member is no longer living or no longer in the current FTG.

Example 2: Sally's spouse died of leukemia in April 2014. In September 2014, Sally requests that a medical bill incurred for her spouse be used towards her deductible. Sally is still legally responsible for the bill. The bill can be used to meet the deductible as long it did not result in a Medicaid certification in an earlier period.

2. Meet the Definition of Medical or Remedial expense as defined in ([24.7.1.1 Countable Expenses](#))
3. Meet one of the following four conditions
 - a. Still be owed to the medical service provider sometime during the current deductible period.

Expenses which have been "deferred" by the provider are considered a countable cost still owed to the provider and can be used to meet a Medicaid deductible.

- The deferred charge should be viewed as an incurred expense that remains an unpaid obligation for the member.
- If only a portion of the deferred charge was used to meet a prior deductible, any remaining balance can be used to meet future deductibles.
- Many deferred charge situations involve very high costs for the services provided, it is extremely important to document in Case Comments which portion of the deferred charges are used to meet previous deductibles, and any remaining balance that can be used to meet current or future deductibles.

Example 3: From May- July 2013 Helen resided in an Institute for Mental Disease (IMD) and incurred a \$14,000 bill. As of October 2014, Helen has not paid this bill. In October Helen's social worker, Ruth, applies for Medicaid on Helen's behalf.

Ruth tried to help Helen meet her deductible by collecting Helen's medical bills. The "bill" for Helen's IMD stay listed \$14,000 in "Deferred Charges". Ruth questioned what deferred meant. The account's receivable person at the IMD indicated that charges for low-income people are often "deferred." "Deferred", she explained, means that the member would never be billed for the charges, but if he or she happens to come into a windfall of money (lottery or inheritance), they will change the status of those charges to current and try to collect the debt.

Helen can use this "deferred" charge toward her deductible.

Example 4: Lestat applies for Medicaid in July, 2014. An Medicaid deductible of \$700 is calculated for him. In 2013 he had a blood transfusion. The bill for the transfusion was \$800. He never paid it and still owes it to the service provider. He can use the unpaid bill to meet his Medicaid deductible, but must provide documentation to show that the charges are currently owed. The remaining \$100 can be applied to the next deductible period, as long as it is still owed.

- b. Paid or written off sometime during the current deductible period. Medical bills written off through bankruptcy proceedings are not allowed as a medical expense to meet a deductible.

Example 5: Frank and Estelle apply for Medicaid on March 1, 2014, requesting that their deductible period begin January 1, 2014. Their deductible for the period January 1 - June 30th is \$340. In April, they had a ten-year-old medical bill of \$300 written off. They can count the \$300 toward the January - June 2014 deductible because it was written off during the deductible period.

- c. Paid or written off sometime during the deductible period that immediately precedes and borders on the current deductible period. These bills can be used even if they were paid after the person met the deductible in the prior period.

Example 6: Jeffrey is in his second deductible period. He did not meet his deductible in the prior period, which borders on the current period. He has a bill that was written off in the prior period. He can apply this bill to his current deductible.

Example 7: Malcolm is in his second deductible period which began March 1, 2014. He did not meet his deductible in the prior deductible period, which immediately preceded the current deductible period. He has a medical bill that he paid in February 2013. He may not apply this toward his current deductible.

Example 8: Norah is in her second deductible period which began in September 2014. In June 2014, Norah met her first deductible period and was certified for Medicaid through August. After certification, and before the first deductible period ended in August, Norah paid for medical services that were not Medicaid covered services. Norah can apply these paid bills to the second deductible period that began in September 2014.

- d. Paid or written off some time during the three months prior to the date of application. This expense can only be used for the first deductible period. Balances cannot be carried forward to future deductible periods.

Example 9: Sierra and Skyler apply for Medicaid on August 10, 2014, requesting that their deductible period begin on August 1, 2014. Their deductible for the period from August through January is \$1500. On May 10th the couple had paid off a \$2000 outstanding medical bill. They can use that expense to meet their deductible because it was paid in the three months prior to the date of their application. The remaining \$500 cannot be applied to future deductible periods.

24.7.1.1 Countable Expenses

The following are expenses that can be counted against the deductible if they meet the conditions listed in [24.7.1 Countable Costs](#):

1. Medical expenses. Medical expenses are costs for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state) regardless of whether the services or goods are covered by Medicaid. Medical expenses for services or prescriptions acquired outside of the United States may be counted toward a deductible if a licensed medical practitioner or pharmacy provided the service or drug.

Some examples of medical expenses are deductibles and co-payments for Medicaid, for Medicare, for private health insurance; and bills for medical services which are not covered by the Wisconsin Medicaid program.

Note: ForwardHealth interChange (iC) data may be used to calculate Medicaid co-payments from the previous deductible period.

2. Remedial expenses. Remedial expenses are costs for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. Some examples of remedial expenses are:
 - a. Case management
 - b. Day care.
 - c. Housing modifications for accessibility.
 - d. Respite care.
 - e. Supportive home care.

Supportive Home Care is necessary assistance to help people meet their daily living needs, ensure adequate functioning in their home, and safely access their community. Services may include:

- Assistance with activities of daily living
- Attendant care
- Supervision
- Reporting changes in the participant's condition,

- Assistance with medication and medical procedures which are normally self-administered, or
 - The extension of therapy services, ambulation and exercise.
 - Tasks associated with routine household upkeep, including general housekeeping chores, lawn mowing, snow removal, changing storm or screen windows and other household services that are essential to the participant's safety, well being and care at home.
- f. Transportation.
- g. Community Based Residential Facility ([CBRF](#)), [Adult](#) Family/Foster Home ([AFH](#)), Residential Care Apartment Complex (RCAC), and all other community substitute care setting program costs not including room and board expenses.

Remedial expenses do not include housing or room and board expenses.

CBRF, AFH, RCAC, and all other community substitute care setting program costs, not including room and board expenses, can be counted as a remedial expense only as they are incurred. CBRF, AFH, RCAC and all other community substitute care setting program costs will be considered incurred as of the date that the member is billed for these expenses by the CBRF, AFH, RCAC or other community substitute care setting. The billing procedure used by the CBRF, AFH, RCAC or other community substitute care setting (one month in advance, bimonthly, etc.) for Medicaid residents should be the same as that which is used for its non-Medicaid residents.

In determining how much of a CBRF, AFH, RCAC or other community substitute care setting expense can be applied to meet a medical deductible, use the facility's breakdown of the room and board versus program costs, with the program costs to be applied to the deductible.

3. Ambulance service and other medical transportation ([21.4.2 Transportation](#)).
4. Medical insurance premiums paid by a member of the fiscal test group or FFU. These insurance premiums include disease specific and per diem hospital and nursing home insurance payments. Do not allow accidental insurance policy premiums as a countable cost.

Note: Unlike other expenses listed in this section that may not be applied toward a deductible until they are incurred, count medical insurance premiums from the first day of the deductible period, if the premium will be coming due anytime during the current deductible period.

5. Medical bills paid by a party who is not legally liable to pay them can be counted against a deductible..

Examples of parties that pay medical bills when not legally liable include, but are not limited to: Churches, fraternal organizations, Children's Special Health Needs Unit of the Division of Public Health, Veterans Administration and the AIDS Drug Assistance Program (ADAP).

6. Medical services received at a Hill-Burton facility. The Hill-Burton Act was enacted by Congress to provide federal assistance for the construction and modernization of health care facilities. Medical facilities which receive Hill-Burton assistance must provide without charge a reasonable volume of services to persons unable to pay for those services.
7. In-kind payments. These are services or goods supplied to the provider in lieu of cash. Self declaration of the bill being satisfied is adequate verification.
8. Medical or remedial expenses that are paid or will be paid by a state, county, city or township administered program that meets the conditions detailed in [24.7.1. # 3](#).

Examples include:

- a. General Assistance
- b. Community Options Program
- c. AIDS Drug Assistance Program (ADAP)

Example 10: Fred receives a medical service which will be paid by ADAP. When Fred comes in to apply for Medicaid and has to meet a deductible this medical bill that has not been paid can be used immediately because it will be paid by the state administered ADAP program.

Example 11: Sally received a medical service in January which was paid by the state administered, state funded Community Options Program in the same month. In February Sally applies for Medicaid requesting a backdate to January. Sally has excess income and must meet a deductible. Since the medical bill was paid by COP within three months of Sally's Medicaid application it can be used to meet Sally's Medicaid deductible.

9. Medical or remedial expenses that have been paid or will be paid by Indian Health Services that meet the conditions detailed in [24.7.1 # 3](#)

Example 12: On January 1, Michael received a medical service which will be paid by Indian Health Services. When Michael applies for Medicaid on January 10 he has to meet a deductible. The bill for the January 1 medical services may be used immediately because it will be paid by the Indian Health Services program.

Example 13: Charlie received a medical service in January which was paid by

Indian Health Services in the same month. In February Charlie applies for Medicaid requesting a backdate to January. Charlie has excess income and must meet a deductible. Since the bill was paid by Indian Health Services within three months of Charlie's Medicaid application it can be used to meet Charlie's Medicaid deductible.

10. SeniorCare Enrollment Fees

24.7.2 Noncountable Costs

Do not count the following toward the deductible:

1. Medical bills written off through bankruptcy.
2. Medicare Supplemental Medical Insurance (Plan B) premiums if they have already been deducted from the gross social security check.
3. Medical services payable or paid for by a third party who is legally liable for the bill. This includes bills that will be paid or have been paid by Medicaid, Medicare, or other Insurance.

Example 14: Medical services provided to an incarcerated person. In this case, the incarcerating authority is the legally liable third party.

4. A bill cannot be used if it has been used to meet a prior deductible. If only a portion of an unpaid bill was used to meet a prior deductible, any remaining balance that was not applied to the prior deductible, may be applied to a subsequent deductible period as long as it is still owed or meets criteria in [24.7.1 Countable Costs](#).

Example 15: An applicant incurs a \$300 medical bill. She applies the \$300 toward her deductible even though he or she has not made any payments on the bill. She meets her deductible and is certified for Medicaid. Three years later she applies for Medicaid again and a deductible is calculated for her. She now pays the \$300 bill. But she cannot use it to meet her current deductible because she already used it to meet the prior deductible.

24.7.3 Prepaying a Deductible

Anyone can prepay a deductible for himself/herself or for someone else. It can be paid in installments or all at once. A prepaid deductible may be refunded if the member requests a refund of the prepayment **prior** to the begin date of the corresponding deductible period.

If the member is **55 or older**, forward the payment to:

ForwardHealth
Estate Recovery/Casualty Collections
313 Blettner Blvd

Madison WI
53714-2405

Prepayment checks or money orders should be made payable to: " ;The Department of Health and Family Services."

With the payment, include:

1. Documentation that the payment is voluntary.
2. The member's name and Medicaid ID number.

If he or she is **under 55**, instruct the member to make the payment payable to your *IM* Agency. Report the receipt on the Community Aids Reporting System (CARS) on Line 909.

24.7.3.1 Payment of Entire Deductible Amount

If the entire deductible amount is paid at any point during the deductible period, eligibility begins on the first date of the deductible period.

Example 16: Laura's deductible period is from March 1st through August 31st. The total deductible amount is \$1,000. Laura submits payment of \$1,000 on August 15th. Laura's Medicaid eligibility begins on March 1st.

Enter the first date of the deductible period on AGTM as the date the payment was received.

24.7.3.2 Combination of Payment and Incurred Expenses

If the deductible is met through a combination of payment and incurred medical expenses, count the incurred medical expenses first. Eligibility, by paying the remaining deductible amount, can begin no earlier than the last date of incurred medical expense within the deductible period.

Example 17: Chad's deductible period is from March 1st through August 31st. The total Medicaid deductible amount is \$1,800. Chad submits a medical bill with a March 8th date of service for \$800. On July 15th, he submits payment of \$1,000. Chad's Medicaid eligibility begins March 8th. Submit a Wisconsin Medicaid/BadgerCare Plus Remaining Deductible Update ([F-10109](#)) identifying the provider of service on March 8th and the \$800 member share amount.

Enter the incurred medical expense first. Perform a PF23 sort. The remaining balance is the amount that can be paid to meet the deductible. Enter the payment date as the same date of the last incurred medical expense, which equals the balance of the deductible, on CARES Client Assistance for Re-employment & Economic Support screen AGTM. Complete and submit a Wisconsin Medicaid/BadgerCare Plus Remaining Deductible Update ([F-10109](#)) to the fiscal agent. Enter the deductible met

date as the date of the last incurred medical expense. Enter the member share as the amount of the last incurred medical expense.

24.7.3.3 Combination of Payment and Outstanding Expenses

If the deductible is met through a combination of payment and outstanding medical expenses (incurred prior to the beginning of the deductible period), eligibility begins on the first date of the deductible period.

Example 18: Roberta's deductible period is from March 1st through August 31st. The total Medicaid deductible amount is \$1,500. She submits an outstanding bill from January 10th for \$500. On August 15th, she submits payment of \$1,000. Roberta's Medicaid eligibility begins March 1st

Enter the first date of the deductible period on AGTM as the date the payment was received.

24.7.3.4 Calculation Errors

If any portion of the deductible is paid and you find the amount was wrong due to agency error, refund the paid amount that was incorrect and report the refund on CARS.

24.7.3.5 Insufficient Funds

If the deductible is paid with a check that is returned for insufficient funds, discontinue the person's eligibility, determine if an overpayment occurred and if so, establish a claim for benefit recovery.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

24.8 ORDER OF BILL DEDUCTION

[24.8.1 Hospital Bills](#)

[24.8.2 Pregnancy Fees](#)

When applying medical bills to the deductible, start with the earliest service date. If more than one bill has the same service date, use the bill with the highest amount first, then the next highest and so on down to the lowest bill with that same service date.

24.8.1 Hospital Bills

Hospitals do not always itemize the cost of their services according to the day and time of day the patient received the services. It is difficult sometimes to know when the patient met the deductible.

For this reason, if the patient's hospital bill for one continuous stay in the hospital is equal to or above whatever the deductible was on the date of admission, count the deductible as having been met on the date of admission. Set that date as the begin date of Medicaid certification. Apply the hospital bill to the deductible first before counting any other medical costs that were incurred during the hospital stay.

Example 1: Linda submits a \$2,000 bill toward her deductible, for hospitalization from July 12th through July 14th. She also submits a physician bill for \$2,500 with a date of service of July 12th. Apply the \$2,000 hospital bill to the deductible first.

24.8.2 Pregnancy Fees

Many providers charge a flat fee for pregnancy related services. The single-fee includes all prenatal care, office visits, delivery, and postnatal care.

In determining whether these "global" pregnancy fees meet the deductible, treat them the same way as you would a hospital bill. If the "global" pregnancy fee is equal to or above the deductible, count the deductible as having been met as of the date an agreement was signed.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

24.9 NOTICE TO FISCAL AGENT

When the *member* receives a medical bill that is equal to or greater than the amount he or she still owes on the deductible, he or she can be certified for Medicaid. He or she must pay the part of the bill that equals the deductible. Medicaid will consider the remainder of the bill for payment.

To make sure that Medicaid does not pay what the member still owes on the deductible, send a Medicaid Remaining Deductible Update ([F-10109](#)) to the fiscal agent indicating the amount of the bill that the member owes. The fiscal agent subtracts this amount from the bill and Medicaid pays the rest.

Fill out the Medicaid Remaining Deductible Update ([F-10109](#)) only if:

A Medicaid certified provider has provided the billed services.

The person, having met the deductible, is being certified. If he or she is not being certified, Medicaid will not pay any of the bill.

The date of the bill is the date the deductible was met. Since the member is not eligible until he or she has met the deductible, he or she still owes for all bills prior to that date.

Do not send more than one bill. In the series of bills which the member may submit to you, there will be only one bill which is larger than the amount needed to meet the deductible. Medicaid will consider the remainder of the bill for payment.

*This page last updated in Release Number: 11-01
Release Date: 04/04/11
Effective Date: 04/04/11*

24.10 LATE REPORTING OF DEDUCTIBLE INFORMATION

If the client turns in late reports on income changes or medical costs, recalculate the deductible as of the date the change took place or the medical cost was incurred. See what would have been the deductible had he or she reported the changes and the medical costs as they occurred. If the medical bills would have met the deductible for any past date, begin Medicaid certification on that date.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

24.11 RESERVED

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

24.12 CHANGES AFTER MEETING A DEDUCTIBLE

[24.12.1 Changes After Meeting a Deductible Introduction](#)

[24.12.2 Income Changes](#)

[24.12.3 Asset Changes](#)

[24.12.4 Non-Financial Changes](#)

24.12.1 Changes After Meeting a Deductible Introduction

When the fiscal group has met the deductible, it can be certified for Medicaid to the end of the deductible period.

24.12.2 Income Changes

Income changes do not affect the group's eligibility for the remainder of the deductible period.

24.12.3 Asset Changes

If the Medicaid group acquires new assets during the remainder of the deductible period, wait until the last day of the month in which it acquired the assets. If the group has excess assets on the last day of the month, discontinue Medicaid eligibility.

24.12.4 Non-Financial Changes

If there is a change in non-financial eligibility during the deductible period, discontinue Medicaid eligibility for those persons who have become non-financially ineligible.

The deductible period ([24.3 Deductible Period](#)) for which excess income is calculated may include a month(s) in which, if a *member* had applied, he or she would have been ineligible for a non-financial reason.

If a child enters the Medicaid group, the child's name will appear on the Medicaid card for the remainder of the deductible period.

If an **adult** caretaker relative who is EBD or is medically verified as pregnant enters the Medicaid group, his or her name will appear on the Medicaid card for the remainder of the deductible period.

If a member loses non-financial eligibility and regains it during the same deductible period, the member may choose:

1. to continue with the current deductible period, **or**
2. to reapply and establish a new deductible period if his or her income still exceeds the appropriate Medicaid income limit.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

24.13 DEATH DURING A DEDUCTIBLE PERIOD

[24.13.1 Death During a Deductible Period Introduction](#)

[24.13.2 Prepaid Deductible](#)

24.13.1 Death During a Deductible Period Introduction

If the **member** dies during the deductible period, and is not already certified, look at all countable costs ([24.7.1 Meeting the Deductible> Countable Costs](#)) prior to death. If those countable costs meet the deductible, certify the dead person. The time period for the deductible remains six months (no prorating). All months that remain of the six-month deductible period from the point the member dies, are considered to have \$0 income. The deductible amount should be recalculated. If the deductible was met, eligibility will be the point from which eligibility was determined to have been met through the date of death.

24.13.2 Prepaid Deductible

If the member prepays the deductible and dies after the deductible period starts, the deductible is non-refundable. If the member prepays and dies before the deductible period starts, the deductible is refundable.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

24.14 RESERVED

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

25 SPECIAL STATUS MEDICAID

25.0 SPECIAL STATUS MEDICAID

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

25.1 "503" ELIGIBILITY

[25.1.1 503 Introduction](#)

[25.1.2 Identifying a "503" AG](#)

[25.1.3 Calculating the COLA Disregard](#)

25.1.1 "503" Introduction

Federal law requires that the *IM* agency provide Medicaid eligibility to any *applicant* for whom the following conditions exist:

1. He or she is receiving OASDI benefits.
2. He or she was receiving *SSI* concurrently with OASDI but became ineligible for SSI.
3. Total countable income, excluding the "503" disregarded income, is within the program limits.

Note: "Concurrent" includes situations in which OASDI eligibility is granted retroactively for months in which the person was also receiving SSI. It also includes situations in which *SSA* recovers the SSI payment because the OASDI payment covers the same time period for which the person received SSI. On the other hand, "concurrent" does not include situations in which SSI eligibility is granted retroactively for a period in which the person was also receiving OASDI benefits.

An AG with these two characteristics is often referred to as a "503" AG. The name comes from Section 503 of the Medicaid Law.

25.1.2 Identifying a "503" Assistance Group

When a "503" AG applies for Medicaid, *disregard* all OASDI COLAs the AG has received since the last month he or she was eligible for and received both OASDI and SSI benefits.

To identify a "503" AG, do the following:

1. Determine whether, after April 1977, there has ever been a month in which one of the following conditions existed:
 - a. Was eligible for both OASDI and SSI (a person who received SSI fraudulently does not qualify as a "503" case)
 - b. Received an OASDI check or a retroactive OASDI check and a SSI check for the same month in which he or she was eligible for both OASDI (or retroactive OASDI) and SSI.

If "no," he or she is not a "503" AG. If "yes" and is no longer receiving SSI, do the following:

2. Determine if he or she is now receiving an OASDI check. If he or she is not, he or she is not a "503" AG. If he or she is, he or she is a "503" AG. He or she will receive a COLA disregard. Enter "Y" on the Individual Nonfinancial> Prior SSI page in the *CWW*.

If he or she was receiving **SSI-E**, the state SSI-E (see [Section 39.4.1 EBD Assets and Income Table](#)) will also be deducted.

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

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

25.1.3 Calculating the Cost-of-Living Adjustment Disregard

To calculate the COLA disregard amount, do the following:

1. Find the AG's current gross OASDI income. The gross OASDI income is the amount of the OASDI check plus any amount that has been withheld for a Medicare premium plus any amount withheld to repay an earlier overpayment.

Do not include in the **gross income** any Medicare Plan B premiums, which the state has paid for the AG.

2. On the COLA Disregard Amount Table (see [Section 39.6 Cost-of-Living Adjustment](#)) find the last month in which the person was eligible for and received a check for both OASDI (or retroactive OASDI) and SSI.
3. Find the decimal figure that applies to this month.
4. Multiply the person's current gross OASDI income by the applicable decimal figure. The result is the COLA disregard amount.

Example 1: Newby's current gross OASDI income is \$700. He is not currently receiving SSI benefits. The last month in which he was eligible for both OASDI and SSI and received benefits from both was April 1991. On the COLA Disregard Amount Table (see [Section 39.6 Cost-of-Living Adjustment](#)), April 1991 falls between January 1991 - December 1991.

Therefore, the decimal figure that applies to April 1991 is 0.239033048. Multiply 0.239033048 x \$700 to find Newby's COLA disregard amount.

Periods of Medicaid ineligibility do not affect this disregard. When the person reapplies, give the disregard again.

25.2 DISABLED ADULT CHILD (DAC)

[25.2.1 DAC Introduction](#)

[25.2.2 DAC Payment Disregard](#)

[25.2.3 COLA Disregard](#)

[25.2.4 Disregards For Individuals Who Lose SSI Eligibility As A Result of Initial Receipt Or An Increase In DAC Benefits.](#)

25.2.1 DAC Introduction

A Disabled *Adult* Child (*DAC*) is:

1. At least 18 years old at the time [SSI](#) was lost.
2. Classified by the Social Security Administration as disabled before age 22.
3. Receives an [OASDI](#) (DAC) payment that is based on the earnings of a parent who is disabled, retired, or deceased.

Note: Receipt of Railroad Retirement is not considered OASDI for this policy.

4. Was receiving SSI, but lost SSI eligibility because the OASDI (DAC) payment exceeded the SSI income limits.

25.2.2 DAC Payment Disregard

When a Disabled Adult Child applies for Medicaid, *disregard* all OASDI (DAC) payments which caused him or her to lose SSI eligibility.

Example 1: George is an SSI recipient. While his father worked, George received a monthly SSI payment of \$686.78. When his father retired and began receiving \$1000 a month in social security, George began receiving an OASDI (DAC) payment of \$500 a month (50% of his father's social security payment). His monthly check is \$706.78 (\$500 DAC + \$186.78 SSI + \$20 SSI unearned income disregard).

When George's father dies, George begins receiving a DAC payment of \$750 a month (75% of his father's social security payment). This puts him over the SSI income limit (\$686.78 + \$20 unearned income disregard = \$706.78). He loses SSI.

When he applies for EBD Medicaid, disregard the total increase of \$250 (\$750 - \$500 = \$250).

Example 2: Harvey is an SSI recipient. While his father works, Harvey receives a monthly SSI payment of \$686.78. When his father retires and receives \$1800 per month in social security, Harvey begins receiving an OASDI (DAC) payment of \$900 (50% of his father's Social Security payment). This \$900 payment makes Harvey ineligible for SSI.

When Harvey applies for EBD Medicaid, the initial DAC payment of \$900 will be

disregarded when his EBD Medicaid eligibility is determined.
--

Periods of Medicaid ineligibility do not affect this disregard. When the person reapplies, give the disregard to him or her again.

25.2.3 COLA Disregard

When a Disabled Adult Child applies for Medicaid, disregard all OASDI COLAs since the last month he or she was eligible for and received both OASDI and SSI benefits.

Calculate the **COLA** disregard amount ([25.1.2 Identifying a "503" AG](#)).

If the Disabled Adult Child was receiving **SSI-E**, disregard both the state SSI-E Supplement ([39.4 EBD Assets and Income Tables](#)) and the COLA.

Periods of Medicaid ineligibility do not affect this disregard. When the person reapplies, give the disregard to him or her again.

25.2.4 Disregards For Individuals Who Lose SSI Eligibility As A Result of Initial Receipt Or An Increase In DAC Benefits

An individual who loses their SSI eligibility due to the receipt of an initial DAC benefit or increase in their current DAC benefit is entitled to the following disregards when determining their eligibility for Medicaid:

1. The DAC payment, either initial or increase which made them ineligible for SSI.
2. The SSI-E supplement, if the individual was receiving the E supplement at the time they became ineligible for SSI.
3. All COLAs received since the last month that the individual was eligible for and received both OASDI and SSI benefits.

25.3 WIDOWS & WIDOWERS

A widow or widower who lost **SSI** remains eligible for Medicaid if he or she meets all of these conditions:

1. Disabled.
2. Age 50 or older.
3. Either:
 - a. Married to the deceased person at time of his or her death, or
 - b. Married to deceased person at least ten years, divorced from him or her, and now unmarried.

Receiving **OASDI** benefits as widow or widower (Section 202, Title II, Social Security Act).

4. Received SSI or a State Supplementary Payment (SSP) ([39.4 EBD Assets and Income Tables](#)) in the month before the month in which he or she began to receive OASDI payments.
5. Became ineligible for SSI or SSP.
6. Would be eligible for SSI or SSP except for the receipt of the OASDI payment. [Disregard](#) the entire OASDI amount.
7. Not entitled to Medicare Part A.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

25.4 MEDICAID DEDUCTIBLE, COST OF CARE

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

*This page last updated in Release Number: 15-02
Release Date: 07/30/15
Effective Date: 07/30/15*

25.5 1619 CASES

Section 1619 of the Social Security Act applies to severely impaired persons who work. If they would be ineligible for **SSI** because of their earnings, they keep their SSI Medicaid eligibility.

1619(a) - They are working individuals who continue to receive a small SSI check. They retain SSI Medicaid eligibility.

1619(b) - They are working individuals who do not receive a SSI check but are still eligible for SSI Medicaid. For the **COLA disregard** determination, use the date cash payments ended.

To determine the person's SSI status, contact the local Social Security Office. Social Security processes Medicaid eligibility for these members.

The SSI benefits of a 1619 person entering an institution continue for up to two months.

If a **member** loses 1619 status, but also is a widow/widower, **DAC**, or 503, he or she is entitled to all disregards that are appropriate for these special status cases when determining eligibility. Losing 1619 status is considered the same as losing SSI eligibility.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

25.6 KATIE BECKETT

The Katie Beckett program tests qualified blind and/or disabled minors for Medicaid. It does not deem assets and income from the natural or adoptive parents.

To qualify under the Katie Beckett program a blind or disabled **minor** :

1. Must require a level of care provided in a hospital, Skilled Nursing Facility (**SNF**), or Intermediate Care Facility (**ICF**), and
2. Can appropriately receive this care in his or her home, and
3. Would be non-financially eligible for Medicaid if he or she were in a hospital, SNF, or ICF.

If a minor child meets these requirements and if the parent wants him or her to remain in the home, contact:

Katie Beckett Program
Division of Long Term Care
Bureau of Long-Term Support
1 West Wilson Street, Room 418
Madison, WI 53707

Telephone (608) 266-3236

*This page last updated in Release Number: 11-03
Release Date: 10/13/11
Effective Date: 10/13/11*

25.7 TUBERCULOSIS

[25.7.1 Non-Financial Requirements](#)

[25.7.2 Financial Tests](#)

[25.7.3 TB-Related Services](#)

[25.7.4 QMB, SLMB and QDWI](#)

[25.7.5 Aliens](#)

[25.7.6 Processing](#)

Medicaid applicants who are infected with tuberculosis (**TB**) are non-financially eligible for TB-related Medicaid services.

25.7.1 Non-Financial Requirements

Consider these persons to be in a special category of Medicaid. They are non-financially eligible for TB-related Medicaid if they are infected with TB, even if they are not blind, disabled, or over age 65. Infected with TB” means that a physician has examined them and found that one or more of the following diagnoses apply to them:

1. Infected with latent or active TB.
2. Positive TB skin test.
3. Negative TB skin test, but a positive sputum culture for the TB organism.
4. Negative test for TB, but a physician certifies that they require TB-related drug therapy or surgical therapy or both.
5. A physician certifies that they require testing to confirm the presence or absence of TB.

Accept the member’s statement that they have one or more of the above conditions unless the information provided is questionable ([20.4 Questionable Items](#)). If questionable, accept any of the following as verification:

1. A physician's or registered nurse's written confirmation that the person has one or more of the above conditions.
2. Wisconsin Tuberculosis Record (Form DPH 4756). This card identifies the person and the physician's diagnosis, and has on it the name and telephone number of the treatment provider.

25.7.2 Financial Tests

Assets - The asset limit for one person is \$2,000. Count assets the same as for other EBD AGs.

Income - The income limit for one person is \$1,505. This is *gross income* . There is no net income test.

Deductible - TB-related AGs which fail the TB-related gross income test cannot become eligible for a Medicaid deductible.

If more than one person in the *AG* is TB-infected, test each person as a single individual with his or her own fiscal test group. Do not deem assets or income from any other *member* of the AG.

Example 1: Mary and her *spouse* George are both applying for TB-related Medicaid. Test Mary and George as separate fiscal test groups. Do not deem assets or income from Mary to George or from George to Mary. Test Mary's assets against the asset limit. Test her income against the income limit for one person. Test George's assets against the asset limit. Test his income against the income limit for one person.

Example 2: There are three children in the Kraan family. All of the children have TB. Consider each child to be a separate fiscal test group. Test each child using only his or her own assets and income. Each child's assets do not exceed the asset limit. Each child's income limit does not exceed the income limit. Do not deem assets or income from the child's parents or from any of his or her siblings.

If only one person in the AG is TB-infected, and that person is a:

1. TB-infected *minor* or 18-year-old:

Test him or her in the Financial Tests for Disabled Minors. Add the parents' deemed assets and income to the minor or 18- year-old's assets and income. Test him or her against the asset limit and the gross income limit.

2. TB-infected *adult* with assets/income, and spouse with no assets/income:

Test the TB-infected adult's assets/income against the asset limit and the gross income limit.

3. TB-infected adult with assets/income, and spouse with assets/income:

Use the EBD-Related Determination Worksheet ([WKST 06](#)) to determine the spouse's assets and net income. Add these totals to the TB-infected person's assets and gross income. Compare this total to the asset limit and the gross income limit.

4. TB-infected adult with no assets/income, and spouse with assets/income:

Use the [WKST 06](#) to determine the spouse's assets and net income. Compare these results to the asset limit and the gross income limit.

When using the WKST 06, *disregard* items 16-18. Replace item 19 with the TB-related income limit. *Disregard* item 20.

25.7.3 TB-Related Services

Persons who become eligible for TB-related Medicaid receive a Medicaid card that identifies them as eligible for only the following Medicaid services:

1. Prescribed drugs.
2. Physicians' services.
3. Laboratory and X-ray services, including services to diagnose and confirm the presence of infection.
4. Clinic services and federally qualified health care (FQHC) services.
5. Targeted case management services.
6. Services, other than room and board, designed to encourage completion of regimens of prescribed drugs by outpatients.
7. Services that are necessary as a result of the side effects of prescribed drugs for TB treatment.

25.7.4 QMB, SLMB and QDWI

QMB, *SLMB*, and *QDWI* recipients do not automatically qualify for TB-related Medicaid services. If they are eligible for EBD or Family Medicaid, they can receive TB-related services under regular Medicaid.

25.7.5 Aliens

TB-related services provided for the treatment of an emergency medical condition ([34.1 Emergency Services](#)) may be covered for persons who do not meet citizenship requirements ([7.3 Immigrants](#)).

25.7.6 Processing

Determine TB-related AGs manually in the following way:

1. Determine Medicaid eligibility for all other subprograms in CARES. Do not confirm unless there is eligibility for a category of Medicaid that is not QMB, SLMB, or QDWI.

If there is only QMB, SLMB, or QDWI eligibility, test the person against the TB-related financial tests. Complete and return a [F-10110](#) (formerly DES 3070) to the fiscal agent:

- a. Mail: HP Enterprise Services
P.O. Box 7636
Madison, WI 53707
 - a.
 - b. Fax: (608) 221-8815
2. If the member is eligible, certify him or her with a manual [F-10110](#) (formerly DES 3070) form, medical status code of TR. Confirm all denials in CARES and allow the CARES generated notices to be sent. Send him or her a manual positive notice with the effective date of his or her eligibility for TB-related services.
 3. If the person is not eligible for any Medicaid subprograms, including TB-related Medicaid, confirm all denials in CARES and allow the CARES generated notices to be sent. Send him or her a manual negative notice indicating that he or she is not eligible for TB-related Medicaid.

*This page last updated in Release Number: 13-01
Release Date: 08/28/13
Effective Date: 01/01/13*

25.8 MIGRANT WORKERS

[25.8.1 Migrant Workers Introduction](#)

[25.8.2 Simplified Application](#)

[25.8.3 Regular Application](#)

[25.8.4 Renewal Dates](#)

[25.8.4.1 Simplified Application](#)

[25.8.4.2 Regular Application](#)

25.8.1 Migrant Workers Introduction

“Migrant worker” means any person who:

1. Temporarily leaves a principal place of residence outside of Wisconsin, and

2. Comes to Wisconsin for not more than ten months in a year to accept seasonal employment in the planting, cultivating, raising, harvesting, handling, drying, packing, packaging, processing, freezing, grading or storing of any agricultural or horticultural commodity in its unmanufactured state.

“Migrant worker” does not include any of the following:

1. A person who is employed only by a state resident if the resident or the resident’s [spouse](#) is related to the person as the child, parent, grandchild, grandparent, brother, sister, aunt, uncle, niece, nephew, or the spouse of any such relative.
2. A student who is enrolled or, during the past six months has been enrolled, in any school, college or university unless the student is a [member](#) of a family or household which contains a migrant worker.

A migrant family includes the adults, including non-marital coparents, and their dependent children living in the migrant household.

25.8.2 Simplified Application

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.

The simplified application procedure is as follows:

1. For members with current Medicaid eligibility from another state, verify the eligibility and the end date. Accomplish the verification by copying the out-of-state Medicaid card or by contacting the other state.
2. For members previously eligible in Wisconsin find the CARES Member Assistance for Re-employment & Economic Support closure code and review date.
3. Ask if the same members, or fewer, are in the case compared to when the group was eligible in the other state.
4. Collect all non-financial information.
5. Do not collect any financial information.
6. Certify Medicaid benefits for the migrant family.

Example 1: A migrant family consisting of dad, mom, and their three children comes to Wisconsin. On September 3, dad applies for Medicaid in Wisconsin for himself and his family.

The family has current Medicaid eligibility from Texas. That is, eligibility extends beyond application months one and two.

The household composition of five members is the same as listed on the Medicaid card.

The fulfillment of these two conditions indicates that the case should be processed with the simplified application procedure.

The **IM** enters non-financial information into CARES, and completes the asset and income screens by answering “N” to all of the financial questions. He or she also makes sure to answer “Y” to the migrant question on ANDC for all family members.

CARES passes the case for MAOU eligibility with \$0 assets and \$0 income. The eligibility end date from Texas is November 30, 2008. The IM changes the review date on AGECE to November 30, 2008, to coincide with the end date from Texas.

Example 2: The same migrant family comes in for the November review. Verify all mandatory and questionable verification items. The family is determined eligible through October 31 of the following year..

The family leaves Wisconsin in December. Medicaid closes for failure to reside in the state. In March the family returns. There have been no non-financial changes and no changes in household composition. The family should be processed with the simplified application procedure because their case closed only for failure to reside in Wisconsin.

25.8.3 Regular Application

If migrant workers and their families have no current Medicaid eligibility, or if there are additional family members who were not eligible in the prior state of residence, process the case as a regular Medicaid application, with the following exception:

Use annualized earned income. “Annualized earned income” is a prospective monthly estimate of earned income based on the estimated total gross annual earnings divided by 12. Annualized income can be based on the past 12 months of the migrant family’s income if it is anticipated that last year’s income is the best estimate of the current year’s prospective income.

25.8.4 Renewal Dates

Offer the following three review choices for migrant families:

1. Mail.
2. Phone.
3. Face-to-face interview.

Income is always annualized.

See 2.2 for information on reviews.

25.8.4.1 Simplified Application

For migrant families that have been certified through the migrant simplified application process, the first review coincides with the date out-of-state eligibility ends. The next review is 12 months from the first review.

25.8.4.2 Regular Application

For migrant families that have been certified through the regular application process, the first review is 12 months from the month of application.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

26 MEDICAID PURCHASE PLAN (MAPP)

26.1 MEDICAID PURCHASE PLAN INTRODUCTION

MAPP is a subprogram of the Wisconsin Medicaid Program. It allows disabled people who are working or want to work to become or remain Medicaid eligible, even if employed, since there are higher income limits.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

26.2 MAPP APPLICATION

[26.2.1 Begin Month](#)

[26.2.2 Fiscal Test Group \(FTG \)](#)

26.2.1 Begin Month

Certify applicants for **MAPP** retroactively for any or all, up to three prior months, if he or she met all of the eligibility criteria at that time. The **member** is responsible for any premium due for the previous months in which he or she elects coverage.

Clients can also choose to begin MAPP eligibility during any future month that can be processed in CARES.

Example 1: Jack applies for MAPP on September 30th and requests a retroactive determination of eligibility. His application is processed on October 21st. He meets all eligibility requirements as of June. Jack can choose to begin MAPP eligibility in June, July, August, September, October, November or December.

26.2.2 Fiscal Test Group (FTG)

When both members of a married couple (living together) apply for MAPP, each person must be in a separate Assistance Group (**AG**). Enter them in CARES on the same application. The member's **spouse** is a countable member of the **FTG**. A separate financial test is done for each spouse's AG. The married couple is entered on the same case, but they are in two separate AGs.

If a spouse of a MAPP **applicant** chooses not to disclose or verify assets, a case may fail for a higher Medicaid eligibility and still cascade to MAPP eligibility.

If both members of a married couple (living apart) apply for MAPP, determine eligibility as two separate cases.

Include the member's spouse and test children in the FTG. Test children include the member's **minor** natural or adoptive children. Do not include the member's stepchildren in the FTG. Do not count the income or assets of the test children.

26.3 MAPP NON-FINANCIAL REQUIREMENTS

[26.3.1 MAPP Nonfinancial Requirements Introduction](#)

[26.3.2 Disability](#)

[26.3.3 Work Requirement](#)

[26.3.3.1 Self-Employment](#)

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[26.3.3.3 Employment Ending](#)

[26.3.3.4 Temporary Employment](#)

[26.3.4 Work Requirement Exemption](#)

[26.3.5 Health and Employment Counseling Program \(HEC\)](#)

[26.3.5.1 HEC Processing](#)

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[26.3.5.3 HEC Participation Changes](#)

[26.3.6 Health Insurance Premium Payment \(HIPP\)](#)

[26.3.7 Spousal Impoverishment](#)

[26.3.8 Institutionalization](#)

[26.3.9 Community Waivers](#)

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](#)) .

Note: Individuals who are receiving MA through SSI's 1619 (b) program are non financially eligible for MAPP. Those persons who are **SSI** eligible under 1619 (b) can be on SSI Medicaid and MAPP at the same time. These individuals are not receiving an SSI cash benefit because they are working, but they meet certain specific SSI requirements that allow them to keep their categorical eligibility for Medicaid. Because this group is the most likely to move from SSI Medicaid to MAPP, **DHS** has decided to allow them to be eligible for both at the same time.

26.3.2 Disability

DDB must certify disability ([5.10 MAPP](#)). There is no requirement that a *member* be a current or former SSI or *SSDI* beneficiary to qualify for MAPP. Earned income is not used as evidence in MAPP disability determinations.

If a member does not have a disability determination from *SSA*, a federal agency which administers the SSI, *OASDI*, and Medicare programs, complete the disability application process outlined in [5.3 Disability Application Process](#). The rest of the MAPP application must be completed at this time and MAPP eligibility pending only for the disability before the *MADA* will be sent to DDB through the automated process. (See the [Process Help Chapter 12 Automated Medicaid Disability Determination](#))

Follow the rules in section [5.7](#) Redetermination on when to review disability determination.

Note: A current MAPP member who loses SSDI because he or she exceeds the Substantial Gainful Activity level remains MAPP eligible until a MAPP disability determination is done by DDB. If DDB determines the individual is not disabled using the MAPP criteria, the MAPP eligibility will terminate with *adverse action* notice for the reason "not MAPP disabled."

26.3.3 Work Requirement

To meet the work requirement, a member must engage in a work activity at least once per month, or be enrolled in a Health and Employment Counseling (HEC) program (See [26.3.4 Work Requirement Exemption](#)). Consider a member to be working whenever he or she receives something of value as compensation for his or her work activity.

This includes wages or in-kind payments. The exceptions are loans, gifts, awards, prizes, and reimbursement for expenses.

26.3.3.1 Self-Employment

If a member engages in a self-employment activity that generates some compensation, at least once in the calendar month, the individual is employed for purposes of MAPP.

A member does not need to realize a profit from self-employment for it to be defined as work.

26.3.3.2 Contractual Employment

If an individual is under contractual employment for the entire year, he or she is employed for the purposes of determining MAPP eligibility for the entire year. Do not consider members employed for any months in which they do not have a contractual employment agreement.

26.3.3.3 Employment Ending

A member has until the last day of the next calendar month to become employed again. Do not take action to terminate eligibility until one full calendar month has passed since employment ended.

26.3.3.4 Temporary Employment

If a member has signed up with a temporary service agency and is not actually working, he or she is not working for purposes of MAPP. If a member is engaged in work activity for which compensation will be received, at least once in a calendar month, he or she is employed for the purposes of determining MAPP eligibility in that calendar month.

26.3.4 Work Requirement Exemption

If there is a serious illness or hospitalization that causes the member to be unable to work, the work requirement can be suspended for up to six months. He or she can continue to be MAPP eligible. The member must contact the **IM** agency to request the exemption. Have the member complete the Medicaid Purchase Plan (MAPP) Work Requirement Exemption ([F-10127](#)). This provision is not available unless he or she:

1. Has been enrolled in MAPP for six months and has paid any applicable premiums prior to the request of an exemption.
2. Is expected to return to work in the next six months.
3. Provides an expected date of recovery.
4. Provides the reason that an exemption is needed (i.e., illness or hospitalization).
5. Has had no more than two exemptions (maximum of six months each) to the work requirement in a three-year time period. The two exemptions cannot be consecutive.

Based on criteria outlined above, the IM agency will approve or deny the request. If a work exemption request is denied, the member has appeal rights in accordance with the Medicaid program.

In the sixth month of an exemption, mail to the member a notice indicating the date the Medical Work Exemption will end as well as steps the member may take to continue MAPP eligibility.

26.3.5 Health and Employment Counseling Program (HEC)

Health and Employment Counseling Program (HEC) is a program certified by the Department of Health and Family Services (DHS) to arrange services that help a member reach his or her employment goals. HEC participation can occur for up to nine months with a three-month extension, for a total of 12 months. After six months a member can re-enroll in HEC to meet the eligibility criteria for MAPP, as long as they have not already participated two times within a five-year period. HEC participation is limited to twice within a five-year period, and there must be six months between any two HEC participation periods.

Clients who are not working can meet the MAPP work requirement if participating in a HEC program. If an *applicant* is not currently working and wants to meet with a HEC screener, pend the case for up to 30 days beyond the application processing period.

For an ongoing case, pend the case for up to 30 days after the change is reported or eligibility review is completed. This allows time for the screener to determine if the person qualifies for HEC.

If a determination has not been provided by the HEC screener within the thirty days, deny the case. The member is responsible for reporting HEC participation to the IM agency. The IM agency is not responsible for tracking HEC participation.

26.3.5.1 HEC Processing

Beginning January 1, 2012 there will be no HEC specialists around the state. Individuals wishing to enroll in HEC will be required to fill out the MAPP Employment Plan form (<http://www.dhs.wisconsin.gov/forms/F0/f00004.doc>) and send it to the Department of Health Services MAPP Unit at the address below. A final approval/disapproval decision will be made by that unit within 10 working days.

Employment Initiatives Section
HEC Manager
Room 418
1 W. Wilson St
Madison, WI 53708
Fax: 608-223-7755
Phone: 866-278-6440

If the plan is not approved, the member will be informed he or she has not been approved and of his or her right to file a fair hearing.

The DHS MAPP Unit will send an approval letter to the member. In order to receive MAPP, the member is responsible for providing the IM worker with a copy of the approval letter.

Income Maintenance worker should give the form along with a MAPP factsheet (P-10071) to any MAPP applicant who is not yet employed. The applicant can complete the application on their own or with the assistance of the HEC Manager. IM workers are not expected to assist with filling out or submitting the form to the HEC Manager.

26.3.5.2 HEC Extension

A participant can extend a HEC period by contacting HEC to request an extension.

If the HEC period is ending prior to the member meeting his or her employment plan goals, but the goals can be met within the three months after the regular HEC period will end, the DHS MAPP Unit can extend the HEC participation for three months.

26.3.5.3 HEC Participation Changes

The HEC counselor/screener monitors the participation of the member as he or she pursues the goals described in his or her MAPP Employment Plan. Whenever a member notifies the IM agency that he or she has stopped participating in the HEC program, the eligibility will be terminated with an adverse action notice.

Whenever a HEC participant notifies the IM agency that he or she is now employed, information about the employment will be needed and eligibility redetermined.

26.3.6 Health Insurance Premium Payment (HIPP)

See [9.4 Health Insurance Premium Payment](#) for information about Health Insurance Premium Payment (HIPP) and cooperation requirements.

26.3.7 Spousal Impoverishment

There are no *spousal impoverishment* protections for MAPP. An institutionalized member who was determined ineligible for Medicaid using the Medicaid Institutions tests can qualify for Medicaid through MAPP. However, because only the member's assets count in determining MAPP eligibility, do not apply the spousal impoverishment provisions for assets. Similarly, because there is no post-eligibility treatment of income and instead calculate a premium using only the member's income, there is no *community spouse* income allocation or family member maintenance allowance for MAPP.

26.3.8 Institutionalization

Clients in an institution may qualify for MAPP if they fail institutional Medicaid. If the member's income exceeds 150% of the *FPL* (39.5 FPL Table), he or she is responsible to pay a monthly premium instead of a patient liability or cost share ([27.7 ILTC Cost of Care Calculation](#)) and ([27.7.4 Partial Months](#)).

26.3.9 Community Waivers

MAPP is a full-benefit Medicaid subprogram for community waiver participation ([21.2 Full Benefit Medicaid](#)). If the member's monthly income exceeds 150% of the FPL (39.5 FPL Table), he or she is responsible to pay a monthly premium instead of a cost share.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

26.4 MAPP FINANCIAL REQUIREMENTS

[26.4.1 Assets](#)

[26.4.1.1 Independence Accounts](#)

[26.4.1.2 Independence Account Exemption Status](#)

[26.4.1.3 Pension or Retirement Accounts](#)

[26.4.2 Income](#)

Follow EBD rules in Chapters [15.1 Income Introduction](#) and [16.1 Assets Introduction](#) to determine countable assets and income. The following are **MAPP** financial eligibility requirements.

26.4.1 Assets

Total countable assets of the **member** must be \$15,000 or less. Only count the assets of the MAPP **applicant** for the MAPP asset eligibility test.

26.4.1.1 Independence Accounts

Someone who has been determined eligible for MAPP can establish an Independence Account. These accounts are an exempt asset. There is no limit to the number of accounts, and no restriction on what the money can be used for.

Only assets deposited while MAPP eligible may be exempted. Deposits made between periods of MAPP eligibility are not exempt.

Example 1: Freda creates an Independence Account out of an existing pension account in January with a pre-existing \$5,000 when she becomes MAPP eligible. In March, while MAPP eligible Freda deposits another \$2,000 in her Independence Account. Freda became MAPP ineligible in April and deposited another \$1,200 in her Independence Account. Freda became MAPP eligible again in July. In the second period of MAPP eligibility the Independence Account pre-amount would change from \$5,000 to \$6,200. The only assets that can be exempted are the deposits made while MAPP eligible. In this case \$2,000 would be exempt and \$6,200 would be counted as an asset.

To qualify as an Independence Account, it must be:

1. Registered with the **IM** Agency. Completing the [F-10121](#) Medicaid Purchase Plan (MAPP) Independence Account Registration form registers the Independence Account with the IM agency. Place the completed [F-10121](#) in the member case file and provide a copy to the member.
2. A separate financial account owned solely by the MAPP member.
3. Established after MAPP eligibility is confirmed, with the exception of pension and retirement accounts (See [26.4.1.3 Pension or Retirement Accounts](#))

A member's deposits (earned or unearned) in an independence account may total up to 50% of gross earning over a 12-month period, without penalty. If the member's

deposits, from actual (earned or unearned income), exceed 50% of his or her actual gross earnings over the same twelve-month period, a penalty is assessed (See [26.5.1.1 Penalty](#)). Amounts withdrawn from a MAPP Independence Account during a twelve month period do not affect the limit on the gross amount that may be deposited during the same period without penalty.

Example 2: Fred earns \$5000 gross from January - December. Total deposits into the independence account were \$3000 for the same period. A \$500 withdrawal was made in December of that same year to pay for car repairs. The \$500 withdrawal is ignored when determining the penalty. The penalty is based solely on total deposits which exceeded 50% of gross earnings over a twelve month period. The result in this example would be a \$500 penalty. (See [26.4.1.3 Pension or Retirement Accounts](#))

26.4.1.2 Independence Account Exemption Status

If a member with an approved Independence Account loses MAPP eligibility, the exempt portion of the account (on the date eligibility ends) is exempt for future MAPP application(s). The entire balance is a countable asset for all other Medicaid subprograms.

26.4.1.3 Pension or Retirement Accounts

A member who has a pension or retirement account can designate that account as an Independence Account. The initial balance is a countable asset ([16.7.21 Retirement Benefits](#)). Any dividends, interest, and deposits to the account are exempt from the date the Independence Account is approved. Continue to count the initial balance as an asset.

26.4.2 Income

The *spouse* and member's net income must not exceed 250% of the *FPL* (See 39.5 FPL) for appropriate fiscal test group size. To determine this, do the following:

1. Determine family earned income. Count the member and his or her spouse's income if residing together.
2. Deduct the \$65 and ½ of the earned income *disregard* from the spouse and member's earnings ([15.7.5 \\$65 and ½ Earned Income Deduction](#)).
3. Deduct the member's IRWEs ([15.7.4 Impairment Related Work Expenses \(IRWE\)](#)). The result is the adjusted earned income.
4. Determine unearned income. Count the member and his or her spouse's income if residing together.

5. Add the adjusted earned and unearned income together.
6. Deduct \$20 from the combined income.
7. Deduct special exempt income ([15.7.2 Special Exempt Income](#)).
8. If a MAPP member receives Social Security payments, subtract the current **COLA** disregard between January 1st and the date the FPL is effective in CARES for that year.

Example 3: Ed's Social Security payment amounts were \$875 a month for the previous year and \$900 for the current year. Calculate the current COLA disregard by subtracting the Ed's previous Social Security payment amounts from the current payments. Allow \$25 as the current COLA disregard.

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](#)).
10. Compare the result to 250% of the FPL (39.5 FPL Table). Include the member's **minor** dependent children (natural or adoptive) when determining fiscal test group size. Do not include the member's stepchildren in the fiscal test group size.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

26.5 MAPP PREMIUMS

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[26.5.1.1 Independence Account Penalty](#)

[26.5.2 Initial Premium](#)

[26.5.3 Payment Information](#)

[26.5.3.1 Payment Methods](#)

[26.5.3.2 Advance Payments](#)

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[26.5.4 Ongoing Cases](#)

[26.5.5 Late Payments](#)

[26.5.5.1 Between Due Date and Adverse Action of the Benefit Month](#)

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[26.5.5.3 Anytime in Month After the Benefit Month](#)

[26.5.5.4 Two Months After the Benefit Month](#)

[26.5.6 Non-Payment](#)

[26.5.6.1 Insufficient Funds](#)

[26.5.7 Opting Out](#)

26.5.1 Calculation

Calculate premiums using only the *member's* income. Calculate a premium if the member's gross monthly amount exceeds 150% of *FPL* ([39.5 FPL Table](#)) for the appropriate fiscal test group size.

Steps to calculate monthly premium amount:

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.

The balance is the Adjusted Countable Unearned Income. This number may be a negative number.

2. From gross monthly earned income, subtract any remaining deductions from #1. If the result from #1 is a negative amount, change it to a positive number. The balance is the Adjusted Earned Income.
3. Multiply the adjusted earned income by three percent (.03).
4. Add the results of #3 and #1 together.
5. Compare the result from #4 to the Premium Schedule ([39.10 MAPP Premiums](#)) to determine monthly premium amount.

26.5.1.1 Independence Account Penalty

If the member puts (earned or unearned) in an amount that exceeds 50% of the actual earnings into an Independence Account, the member would be penalized using the following formula. At review, look back 12 months and take the:

Total verified Annual Deposits minus 50% of verified annual gross earned income divided by 12 = monthly assessment.

Add this monthly assessment to the premium for the next 12 months of eligibility. Only impose Independence Account penalties if the member is otherwise required to pay a premium.

Example 1: Brenda deposited \$1,200 more than 50% of her actual annual gross earned income in her Independence Account. If Brenda's income exceeds 150% of the FPL (39.5) and she is responsible for a monthly premium, add the monthly assessment of \$100 to her monthly premium for the next 12 months. If Brenda's income does not exceed 150% of the FPL (39.5), do not impose a penalty.

26.5.2 Initial Premium

There are no free premium months. Before eligibility confirmation, the member must pay applicable premiums for the initial benefit month and for any backdate months for which the member elects coverage. If determining eligibility in the month after application, the premium for the second month also must be paid before confirming eligibility.

Example 2: Eric applies for MAPP on January 29th, but his application is not processed until February 11th. The *IM* agency determines that he owes a \$50 premium per month. Before eligibility is approved (confirmed), Eric must pay a \$50 premium for January and a \$50 premium for February.

Example 3: If Eric applies for MAPP on January 29th. Eric is requesting MAPP for February but not January. CARES will not pend the case for February's premium because you are processing it in January. Confirm the case. The Medicaid fiscal agent will pursue collection of the premium for February.

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.

Send MAPP premium payments separate from BadgerCare premium payments and other agency funds. Send premium payments to the following address:

Medicaid Purchase Plan
P.O. Box 6738
Madison, WI 53716-0738

26.5.3 Payment Information

26.5.3.1 Payment Methods

When requested, the fiscal agent will provide members with instructions for choosing the payment method they want. Clients can contact Member Services at 1-800-362-3002.

The payment methods are:

1. Direct payment by check or money order.
2. Electronic Funds Transfer (EFT).
3. Wage withholding from each paycheck received. (Unlike Child Support, there is no statutory requirement that the employer participate in premium wage withholding. If the employer decides not to participate, the participant will have to choose direct pay or EFT.)

Provide members with the MAPP Premium Recipient/Employer Electronic Funds Transfer ([F-13023](#)) and MAPP Premium Employer Wage Withholding ([F-13024](#)) forms to allow the member to choose a payment method other than direct payment. Since it takes some time to set up EFT and wage withholding, the member pays directly until the fiscal agent informs them otherwise.

26.5.3.2 Advance Payments

Clients can make advance payments, but the payment cannot exceed the certification period. If paying in advance, the payments must be the full amount of subsequent month's premiums (no partial month payments). If the income amount changes, recalculate the premium. The member will be notified through CARES that their premium amount has changed. If the premium amount has decreased, the fiscal agent will refund any excess premium that was paid. If the premium amount has increased and the premium coupon has not been sent for that month, the member will receive a coupon with the new premium amount. If the premium coupons have already been sent, the member will need to pay the additional amount owed. The member will not receive a coupon for the difference that is owed.

26.5.3.3 Refunds

The fiscal agent issues refunds if the member:

1. Lost MAPP eligibility and already paid the premium. Refunds will only be given if [adverse action](#) notice requirements were met.
2. Overpaid. The member overpaid and the excess cannot be applied to the next month's premium.
3. Retroactive Adjustment. The premium was recalculated and reduced for prior month(s).
4. Requested to close MAPP and already paid the premium.

The member's estate can receive a refund if he or she dies between adverse action and the beginning of the benefit month.

26.5.4 Ongoing Cases

Ongoing premium payments are sent to the MAPP Premium Unit. Checks are made out to "Medicaid Purchase Plan." MAPP premiums are due on the tenth of the benefit month, no matter which payment method is chosen. For members who have chosen "direct pay" as their payment method, the fiscal agent sends out the premium coupon on the 20th of the month before the benefit month. The payment must be received by the fiscal agent by the tenth of the benefit month. EFT occurs on the third business day of the benefit month.

26.5.5 Late Payments

Cases are treated differently depending on when the late payment is received. The following explains the policy based on those time differences. Clients must pay the payment that closed them, but do not have to pay the following month right away to open, unless the late pay is made after the benefit month.

Example 4: If the member owed a premium for September, and does not pay it until October, then he or she will need to pay both September and October. October eligibility will pend until the payment is received by the agency and recorded in CARES.

26.5.5.1 Between Due Date and Adverse Action of the Benefit Month

The case will stay open for the benefit month even if no payment is received by the due date. It will close at the end of the benefit month if no payment is received by adverse action in the benefit month.

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 eligibility with dates and confirm.

Example 5: Adverse action is September 16th. Jim's September premium was due September 10th. Jim has not paid his September premium by September 16th. He does pay on September 26th. The case closed effective September 30th. Run with dates to open for October. Then run without dates for November eligibility.

26.5.5.3 Anytime in Month After the Benefit Month

If the member pays any time in the month after the benefit month, he or she can reopen. He or she must pay the premium that closed them. If they owe a premium for that following month, he or she must pay that premium before CARES will open MAPP. The member must pay the IM agency directly (not the fiscal agent). The IM Worker can check with the fiscal agent to see if a premium has already been collected for that month.

When the payment(s) is received, record the payment in CARES and run eligibility for the benefit month and confirm. Then run eligibility for the following month, and confirm.

Example 6: Adverse action is September 16th. Jim has not paid his September premium by September 16th. He pays on October 26th. His case closed for October. Jim must pay both the premiums for September and October since they were in arrears before he will open. To reopen it, run eligibility for October and confirm. Finally, run eligibility for November and confirm. (The November premium is not due until November 10th and does not have to be paid in advance.)

26.5.5.4 Two Months After the Benefit Month

If the member pays in the second month after the benefit month, it is a non-payment (See 26.5.6 Non-Payment below).

26.5.6 Non-Payment

If a MAPP member does not pay the monthly premium by adverse action in the benefit month, apply a restrictive re-enrollment period (RRP) ([26.6 MAPP Restrictive Re-enrollment Period \(RRP\)](#)), unless there is good cause ([26.6.2 Good Cause](#)). The RRP begins with the first month of closure. If a late payment is received by the end of the month after the benefit month, lift the RRP.

26.5.6.1 Insufficient Funds

You will be notified with an 056 Run SFED/SFEX alert in CARES if a MAPP member pays the monthly premium through EFT or direct payment by check, and the payment is rejected for insufficient funds. Apply a restrictive re-enrollment period (RRP), unless there is good cause (anything which is beyond the member's control), and close the case. The RRP begins with the first month after closure. Determine if an overpayment exists and process the overpayment.

26.5.7 Opting Out

If a MAPP member chooses to de-request MAPP coverage, or opt out, anytime prior to the beginning of the next benefit month, close the case in CARES for the next possible month. If the case cannot be closed in CARES at the end of the current benefit month, do not impose a RRP. Close the case in CARES. Submit a [F-10110](#) (formerly DES 3070) by mail or fax.

1. Mail:

HP Enterprise Services
P.O. Box 7636
Madison, WI 53707

2. **Fax:** (608) 221-8815

Enter MAPP OPT OUT in red in the comment section of the 3070.

Example 7: Sally calls her worker on July 25th to de-request MAPP for August. Since Sally opted out prior to the benefit month Sally should not owe a premium for August. The worker will need to change the request for MAPP on the MAPP page in **CWW** and zero out the premium due for August.

To zero out the premium the worker has to alter the income for the process month. The altered income should be low enough that MAPP still passes with no premium, and high enough that the [applicant](#) does not qualify for another MA subprogram. At this point the worker would have to run the eligibility with appropriate dates and confirm the results. A RRP should not be imposed because Sally de-requested August MAPP coverage prior to the beginning of the benefit month.

Her worker must override the RRP on the Restrictive Reenrollment page in CWW by entering an override RRP end date using the reason code SY, system problem. Change the request for MAPP on the MAPP page in CWW to N, and suppress the CARES notice stating that the member's MAPP eligibility will end August 31st. Send a manual negative notice indicating that the member's MAPP eligibility ends July 31st.

A MAPP applicant's decision to "opt out" does not affect other family members eligibility for MA or MA related Programs.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

26.6 MAPP RESTRICTIVE RE-ENROLLMENT PERIOD (RRP)

[26.6.1 MAPP RRP Introduction](#)

[26.6.2 Good Cause](#)

26.6.1 MAPP RRP Introduction

When a **member** is placed in a restrictive re-enrollment period (RRP), he or she is ineligible for the next six consecutive months following the closure of **MAPP**, unless there is good cause ([26.6.2 Good Cause](#)). After the six consecutive months, the member may regain eligibility if he or she pays all arrears and current premiums. After 12 calendar months, he or she may regain eligibility without paying the past due premiums.

RRPs are tied to non-payment of premiums only. RRP's do not apply to recipients who have not met HEC requirements.

26.6.2 Good Cause

The following are good cause reasons for not paying a MAPP premium:

1. Problems with electronic funds transfer.
2. Problems with an employer's wage withholding.
3. Administrative error in processing the premium.
4. Fair hearing decision.
5. Those you determine are beyond the member's control.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

26.7 MAPP CHANGES

[26.7.1 MAPP Changes Introduction](#)

[26.7.2 Reduced Premiums or No Premiums](#)

26.7.1 MAPP Changes Introduction

The **member** must report within ten days all changes to income, household composition, allowable deductions and other non-financial changes, including loss of employment, which affect eligibility. The **IM** worker should re-determine eligibility as a result of the changes. If it is determined that he or she remains eligible for **MAPP** and owes a premium, recalculate the premium amount.

26.7.2 Reduced Premiums or No Premiums

The effective date of a change that results in a reduced premium or no premium is the month of change or the month of report, whichever is later. If the change results in no premium, the IM agency may have to run eligibility with dates in CARES for the month the change occurred or was reported (which ever is later) and any subsequent months as well as for recurring.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

26.8 MAPP PREPAID DEDUCTIBLES

If the client prepaid a deductible and then becomes eligible for **MAPP** without a premium, he or she can only get a refund of the prepayment if the deductible period has not started. Use the Community Aids Reporting System (CARS) to report the accounting.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

26.9 MAPP NOTICES

For manual **MAPP** eligibility determinations:

1. Use the [F-16015](#), Medicaid / BadgerCare Manual Positive Notice, when MAPP is approved or the premium decreases.
2. Use the [F-16001](#), Medicaid / BadgerCare Manual Negative Notice, when eligibility is denied or terminated or the premium increases.

Note: The client must be given **adverse action** notice of any negative action (e.g. premium increase).

Use the following notice text that is applicable to the denial reason. Use §49.472 WIS STATS as the citation for each of the reasons.

You are not eligible for the MAPP because:

1. Your assets exceed the \$15,000 asset limit.

2. Your income exceeds 250% of the *FPL* (39.5 FPL Table) for your family size.
3. You have not paid your MAPP premium.
4. You have been determined 'not' disabled under MAPP rules by the [Disability Determination Bureau](#).
5. You are not working.
6. You no longer meet the work or HEC participation requirement of MAPP.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

26.10 MAPP / HEALTH AND EMPLOYMENT COUNSELING PROGRAM (HEC) SPECIALISTS

See [P-20222](#) for an updated list of *MAPP* / HEC specialists, by region.

*This page last updated in Release Number: 08-02
Release Date: 04/30/08
Effective Date: 04/30/08*

27 INSTITUTIONAL LONG TERM CARE (ILTC)

27.1 INSTITUTIONS

[27.1.1 Institutions Introduction](#)

[27.1.2 Institutions for Mental Disease](#)

[27.1.2.1 Eligible Age](#)

[27.1.2.2 Temporary Leave](#)

[27.1.2.3 Minors in IMD](#)

[27.1.3 Hospitals](#)

27.1.1 Institutions Introduction

For Medicaid purposes, "institution" means medical institution. A medical institution can be, but is not limited to, skilled nursing facilities (*SNF*), intermediate care facilities (*ICF*), institutions for mental disease (IMD), and hospitals.

Medical institution means a facility that:

1. Is organized to provide medical care, including nursing and convalescent care,
2. Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards,
3. Is authorized under State law to provide medical care, and,
4. Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

27.1.2 Institutions for Mental Disease

IMDs are medical institutions that care for persons with mental illness. See the list of IMDs ([27.11 Institutions for Mental Disease \(IMDs\)](#)).

27.1.2.1 Eligible Age

IMD residents under age 21 and over age 64 may be Medicaid eligible. Persons aged 21 through 64 are not eligible unless they were IMD residents immediately prior to turning age 21. If they were, they are eligible until discharge (a 21 year old can be transferred from one IMD into another and remain eligible for Medicaid) or until turning age 22, whichever comes first.

27.1.2.2 Temporary Leave

A person aged 21 through 64 can go on conditional release from an IMD or convalescent leave and become eligible for Medicaid while on leave.

1. Conditional release means a temporary release from an IMD for a trial period of residence in the community.
 - a. The trial period must last no less than four days. It must be no longer than 30 days.
 - b. The trial period begins after the initial three days of community residence following discharge.

- c. A person under age 22 who leaves the IMD for a trial period remains eligible as an IMD resident until he or she is unconditionally released from the IMD, or turns 22, whichever comes first.

For purposes of Medicaid, conditional release is permitted only once every calendar year.

2. Convalescent leave means a period of time following inpatient admission of a resident of an IMD to a general hospital for the purpose of treatment for a physical medical condition of a severity which medically contraindicates treatment of the condition in the IMD. A person under age 22 who leaves the IMD on Convalescent Leave remains eligible as an IMD resident until he or she is unconditionally released from the IMD, or turns 22, whichever comes first.

27.1.2.3 Minors in IMD

When a *minor* applies for Medicaid after being discharged from the IMD, certify the individual as a member, if eligible, for the inpatient IMD days only. Certify for the remainder of the month if he or she would be eligible after being tested for Family Medicaid with his or her parents and siblings.

27.1.3 Hospitals

Hospitals are medical institutions that:

1. Provide 24-hour continuous nursing care,
2. Provide dietary, diagnostic, and therapeutic services, and,
3. Have a professional staff composed only of physicians and surgeons, or of physicians, surgeons and doctors of dental surgery.

A person residing in a hospital is an institutionalized person ([27.4.1 Institutionalized Person](#)) if he or she:

1. Has resided in a medical institution for 30 or more consecutive days, or
2. Is likely to reside in a medical institution for 30 or more consecutive days.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days.

*This page last updated in Release Number: 10-02
Release Date: 06/22/10
Effective Date: 06/22/10*

27.2 ILTC LICENSING AND CERTIFICATION

Medical institutions (SNFs, ICFs, IMDs, hospitals) are licensed under Chapter 50, Wis. Stats. The Bureau of Quality Assurance, is the licensing agency.

In order to receive Medicaid payment for the care and services they provide, medical institutions must comply with federal MA requirements. The agency which certifies their compliance is the Division of Health Care Access and Accountability.

*This page last updated in Release Number: 13-01
Release Date: 08/26/13
Effective Date: 08/26/13*

27.3 FACILITIES NOT MEDICAID CERTIFIED

Determine the eligibility of persons in non-certified facilities in the same way as for those in certified facilities. Medicaid will not pay cost of care for these persons, but they may still be eligible for Medicaid card services ([17.15 Medicaid Card Services](#)).

*This page last updated in Release Number: 08-01
Release Date: 02/01/08*

27.4 ILTC DEFINITIONS

[27.4.1 Institutionalized Person](#)

[27.4.2 Community Spouse](#)

[27.4.3 SSI Recipient and Institutional Medicaid application](#)

27.4.1 Institutionalized Person

"Institutionalized person" means someone who:

1. Participates in Community 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.

An exception to the 30-day period is that a resident of an IMD is considered an institutionalized person until he or she is discharged.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days.

27.4.2 Community Spouse

See [18.2.1 Community Spouse](#).

27.4.3 SSI Recipient and Institutional Medicaid application

An **SSI** recipient who has resided or is likely to reside in a medical institution for 30 days or more may apply and be non-financially eligible for institutional Medicaid if the **SSA** will discontinue the person's SSI because of the financial effect of his or her residence in the medical institution.

An SSI recipient who has not resided or is not likely to reside in a medical institution for 30 days or more is non-financially ineligible for institutional Medicaid. The person remains Medicaid eligible through SSI.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

27.5 ILTC FINANCIAL

[27.5.1 ILTC Assets](#)

[27.5.2 ILTC Income](#)

[27.5.3 Divestment](#)

[27.5.4 Instructions for Manual Eligibility Determinations](#)

27.5.1 ILTC Assets

Refer to [16.1 Assets Introduction](#) to determine when an asset is countable. If countable assets exceed the appropriate limit, the Medicaid *applicant* /member is ineligible.

Note: Prepayment to a nursing home for the extra cost of a private room is an available asset. The applicant has the legal ability to make the prepayment available for his or her support and maintenance ([16.2 Assets Availability](#)).

1. Unmarried [member](#) - See [39.4 EBD Assets and Income Tables](#) or the EBT asset limits for an unmarried member

2. Married member ([Spousal Impoverishment](#)) -The assets of both the institutionalized person and his or her [community spouse](#) are counted in the initial asset test. For information about how to determine a married member's asset limit and the community [spouse](#) asset share refer to [18.4 Spousal Impoverishment Assets](#).

27.5.2 ILTC Income

Follow the policies listed in [15.1 Income Introduction](#) to determine an applicant's income. The income limit is the same for non-spousal impoverishment institutionalized persons as for spousal impoverishment cases. But, for spousal impoverishment cases, after the institutionalized person becomes eligible, he or she is allowed to allocate some of his or her income back to his or her community spouse. (See [18.6 Spousal Impoverishment Income Allocation](#))

If income is greater than Institutions Categorically Needy Income Limit ([39.4 EBD Assets and Income Tables](#)) the person is ineligible for categorically needy Medicaid.

If the income is greater than need (See [27.6 ILTC Monthly Need](#)) the person is ineligible for medical needy Medicaid.

Sometimes, when both spouses are institutionalized, the income of one is greater than his or her monthly need and the income of the other is less than his or her monthly need. When this occurs, calculate the couple's combined monthly need and compare it with their combined income. If the total need is greater than the total income, and if the spouse with greater income is willing to combine it with his or her spouse's lesser income, both spouses could be eligible.

27.5.3 Divestment

See [17.1 Divestment Introduction](#) for Divestment policies.

27.5.4 Instructions for Manual Eligibility Determinations

Use the following to determine which financial worksheet to use:

1. Medical institution ([27.1 Institutions](#)) residents with no community spouse ([18.2.1 Community Spouse](#)).
Use the Medicaid Institution Worksheet ([Worksheet #4](#)).
2. Medical institution residents who have a community spouse and who became institutionalized before 09-30-89:

Use the [F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse](#) Form and the Medicaid Institution Worksheet ([Worksheet #4](#)).

3. Medical institution residents who have a community spouse and who became institutionalized on or after 09-30-89:

Use the [F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse](#) form and the Spousal Impoverishment Income Allocation Worksheet ([Worksheet #7](#)).

4. Community waiver applicants with no community spouse:
Use the [F-20919](#)

5. Community waiver applicants with a community spouse:

Use the [F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse](#) form the [Medicaid Waiver Eligibility and Cost Sharing Worksheet](#) , and the Spousal Impoverishment Income Allocation Worksheet ([Worksheet #7](#)).

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

27.6 ILTC MONTHLY NEED

[27.6.1 ILTC Monthly Need Introduction](#)

[27.6.2 Hospitalized Persons](#)

[27.6.3 Both Spouses Institutionalized](#)

[27.6.4 Health Insurance](#)

[27.6.4.1 Nursing Home and Hospital Insurance](#)

[27.6.4.2 Assignment of Nursing Home and Hospital Insurance Payments](#)

[27.6.5 Support Payments](#)

[27.6.6 Fees to Guardians or Attorneys](#)

27.6.1 ILTC Monthly Need Introduction

Monthly need is the amount by which the institutionalized person's expenses exceed his or her income. It is computed by adding together the following monthly costs:

1. Personal needs allowance ([39.4 EBD Assets and Income Tables](#)).
2. Cost of institutional care (use private care rate).
3. Cost of health insurance ([27.6.4 Health Insurance](#)).
4. Support payments ([15.7.2.1 Support Payments](#)).
5. Out-of-pocket medical costs.
6. Work related expenses ([15.7.4 Impairment Related Work Expenses \(IRWE\)](#)).
7. Self-support plan ([15.7.2.2 Self-Support Plan](#)).
8. Expenses for establishing and maintaining a court- ordered guardianship or protective placement, including court ordered attorney or guardian fees.
9. Other medical expenses.
10. Other deductible expenses.

27.6.2 Hospitalized Persons

When you determine a hospitalized person's monthly need use the average daily charge for the hospital the person is in. See [39.7 Hospital Daily Rates](#). If his or her hospital is not on the list, enter \$2,318.08 on Long Term Care Gatepost/ Institutions screen.

27.6.3 Both Spouses Institutionalized

If both spouses are institutionalized and one has income greater than his or her monthly need, calculate the couple's combined monthly need and compare it to their monthly income. If their combined monthly need exceeds their combined monthly income, both spouses may become eligible.

27.6.4 Health Insurance

Allow health insurance costs only if the primary person is the owner of the policy and is billed for the premium.

Do not deduct health insurance premiums for health insurance that pays for more than the cost of medical care. An insurance policy which pays for accidental injuries, does not qualify as a health insurance premium and cannot be deducted.

When a person pays premiums less often than once a month, prorate the premium to find the monthly amount. Deduct the monthly amount from the monthly income.

The accumulation of these premium amounts is an exempt asset. Exempt them for a period over which they have been prorated.

Example 1: Mr. W. pays a health insurance premium of \$600 every quarter. The monthly amount, prorated over three months, is \$200. Deduct \$200 from Mr. W's monthly income. Each quarter, exempt \$600 of Mr. W's assets until that quarter's premium due date.

27.6.4.1 Nursing Home and Hospital Insurance

Nursing home and hospital insurance policies are indemnification policies. Indemnification policies provide benefits in a fixed amount for a confinement, such as a hospitalization, regardless of the expenses actually incurred by the insured.

Nursing home and hospital insurance policies pay a flat rate to the policy holder for each day that he or she resides in the nursing home or hospital, respectively.

Consider nursing home and hospital insurance as a type of medical insurance. Allow the premiums as a deduction in the eligibility test and post-eligibility calculation.

27.6.4.2 Assignment of Nursing Home and Hospital Insurance Payments

All members must cooperate in providing Third Party Liability (*TPL*) coverage and access information ([9.2 Nursing Home and Hospital Insurance](#)). All members must sign over to the State of Wisconsin all their rights to payments from hospital or nursing home insurance ([9.2.2 Assignment](#)). Terminate eligibility for any individual that will not cooperate in:

1. Providing TPL coverage and access information.
2. Turning over payments from indemnity insurance policies.

27.6.5 Support Payments

Support payments are payments which an institutionalized Medicaid *member* makes to another person for the purpose of supporting and maintaining that person. See [15.7.2.1 Support Payments](#).

27.6.6 Fees to Guardians or Attorneys

See [15.7.2.3 Fees to Guardians or Attorneys](#)

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

27.7 ILTC COST OF CARE CALCULATION

[27.7.1 ILTC Cost of Care Calculation Introduction](#)

[27.7.2 Hospitalized Persons](#)

[27.7.3 Partial Months](#)

[27.7.3.1 Death](#)

[27.7.3.2 Community and Nursing Home](#)

[27.7.4 Transfers Between Institutions](#)

[27.7.5 Retroactive Cost of Care](#)

[27.7.6 Personal Needs Allowance](#)

[27.7.7 Medical/Remedial Expenses and Payments for Non-Covered Services](#)

[27.7.7.1 Introduction](#)

[27.7.7.2 Disallowed Expenses](#)

27.7.1 ILTC Cost of Care Calculation Introduction

After an institutionalized person has been determined eligible for Medicaid, his or her cost of care must be calculated. Cost of care is the amount he or she will pay each month to partially offset the cost of his or her Medicaid services. It is called the patient liability amount when applied to a resident of a medical institution and cost share when applied to a community waivers client, Pace/ Partnership, or Family Care client. The institutionalized *member* will be expected to pay their patient liability to the institution that they are residing in as of the first day of the month.

Calculate the cost of care in the following way:

1. For a Medicaid member in a medical institution who does not have a [community spouse](#) , subtract the following from the person's monthly income:
 - a. \$65 and ½ earned income [disregard](#) ([15.7.5 \\$65 and ½ Earned Income Deduction](#)).
 - b. Monthly cost for health insurance ([27.6.4 Health Insurance](#)).
 - c. Support payments ([15.7.2.1 Support Payments](#)).
 - d. Personal needs allowance ([39.4 EBD Assets and Income Tables](#)).
 - e. Home maintenance costs, if applicable ([15.7.1 Maintaining Home or Apartment](#)).
 - f. Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court-ordered attorney and/or guardian fees ([27.6.6 Fees to Guardians or Attorneys](#)).
 - g. Medical Remedial Expenses. See [27.7.8 Payment for Non-Covered Services](#).
2. For a Medicaid member in a medical institution who has a community [spouse](#) , follow the directions in [18.6 Spousal Impoverishment Income Allocation](#).
3. For a community waivers member with or without a community spouse, follow the directions in [28.5 HCBWLTC Cost Sharing](#).
4. There is no cost of care for [SSI](#) recipients.
5. For a Medicaid member who was or could have been certified through a deductible before entering the institution, there is no cost of care until the deductible period ends.

If the cost of care amount is equal to or more than the medical institution's Medicaid rate, the individual is responsible for the entire cost of his or her institutional care. He or she would be entitled to keep any overage without restriction. He or she would remain eligible for the Medicaid program and have no further financial obligation to the Medicaid program for that month.

27.7.2 Hospitalized Persons

Effective December 1st, 2008, hospitalized individuals will be responsible for paying a patient liability. See [27.7.5 Transfers Between Institutions](#) for information about patient liability calculations when a person transfers between a hospital and nursing home(s).

27.7.3 Partial Months

If a member is not Medicaid eligible and residing in an institution ([27.1 Institutions](#)) as of the first of the month, there is no patient liability for that month.

Exception: There is a patient liability if the reason why the person didn't reside in the institution for the entire month was due to death or being on Therapeutic leave.

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:

1. **Mail:**
HP Enterprise Services
P.O. Box 7636
Madison, WI 53707

2. **Fax:** (608) 221-8815

Indicate the patient liability amount as equal to the nursing home charges for the month.

This is done for potential retroactive nursing home rate adjustments. The nursing home will notify the Estate Recovery Program (*ERP*) of who received the excess income. ERP will attempt recovery even if the money goes to the heir directly. ERP uses the same process to recover this excess income as it does for recovering patient fund accounts ([22.1.5.7 Patient Fund Account](#)).

27.7.3.2 Community and Nursing Home

There is no patient liability in a month a member moves from:

1. The community into a nursing home after the first of the month, or
2. From a nursing home to the community before the end of the month. This includes members moving from the nursing home to the community on the last day of the month.

27.7.4 Transfers Between Institutions

Effective 12/01/08:

When an institutionalized individual transfers between institutions (nursing homes, hospitals, hospices) in the same month, you will no longer pro rate the patient liability

between the various institutions that they resided in during that month. The client/member will pay their patient liability to the institution that they were residing in on the first day of the month. ForwardHealth will automatically deduct the appropriate patient liability amount from the **first** nursing home, hospice, or long term inpatient hospital claim received for the member. If the amount of the patient liability exceeds the reimbursement amount of the first claim, the remaining liability amount will be deducted from the next claim(s) received for services provided in the month that patient liability is owed. Patient liability amounts deducted from claims will appear in the provider's remittance information. Nursing home, hospice, and inpatient hospital providers may have to occasionally transfer a patient liability amount that they collected from a client/member, on the first day of a month, to the appropriate provider who ultimately had their claim adjusted to reflect the required patient liability amount.

27.7.5 Retroactive Cost of Care

Occasionally a nursing home or community waivers *applicant* becomes retroactively eligible. This might happen, for example, when a person, having been denied eligibility, goes to a fair hearing. If the fair hearing determines the person was eligible at the time of application, the agency must retroactively certify him or her and compute retroactive cost of care. The directions are the same as for current cost of care ([27.7.1 ILTC Cost of Care Calculation Introduction](#)).

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](#).

27.7.7 Medical/Remedial Expenses and Payments for Non-Covered Services

27.7.7.1 Introduction

Medicaid members in nursing homes are allowed to pay for some medically necessary non-covered services out of their patient liability. They are not required to use their personal needs allowance for these services.

Effective January 4, 2008, allowable payments that an institutionalized person is actually making for all medical/remedial expenses they have incurred and are legally obligated to pay, are used as a need item when determining their eligibility for MA. These actual payments are also allowed as an income deduction to reduce the cost share amount. This includes payments for medical/remedial expenses that the person is

currently incurring as well as payments for certain previously incurred medical/remedial expenses.

In order to use the medical/remedial expense as a need item and as an income deduction in the cost share calculation, the expense must meet the following criteria:

1. The institutionalized individual must be legally liable for payment of the incurred medical/remedial expense. Any portion that will be paid by a legally liable third party such as private health insurance, Medicare, Medicaid, etc. cannot be allowed as a deduction; and
2. The institutionalized individual must provide verification of the allowable expense. See [27.7.8.2 Disallowed Expenses](#)

Example 1: In February, Al had a root canal performed by a dentist who is not an MA provider. He is responsible for paying \$600 for the procedure. Al began making payments of \$100 per month on this medical bill in March. On April 1st, Al became institutionalized and eligible for MA. The \$100 payment that Al is making on a previously incurred medical expense should be used as a need item when determining Al's institutional MA eligibility. The expense should also be used as an income deduction when calculating Al's cost share obligation. The \$100 payment can be used as an income deduction in the cost share calculation until it is fully paid in August. Since Al will no longer be making payments in September, the expense should be decreased to zero prior to [adverse action](#) in August.

Example 2: In April, Edna applied for Institutional MA and requested a one-month backdate. Her request for eligibility in March was denied because her assets exceeded program limits, but was approved effective April 1st. Edna used her excess assets to make a partial payment to the nursing home for March costs, but still has an outstanding balance of \$1,800. Edna agrees to make payments to the nursing home of \$500 per month until the expense is paid in full. The \$500 payment to the nursing home should be used as an income deduction when calculating her cost share for the months of April through June. In July she will only owe \$300 to the nursing home so the deduction for July should be decreased to \$300 prior to adverse action in June. Edna will no longer be making payments in August so the expense should be decreased to zero prior to adverse action in July.

Example 3: Jack has been an institutionalized MA member since January. In March, he had a tooth extracted. The procedure was performed by a dentist who is not an MA provider, so it was a non-covered service. Jack contacts the agency in April to request a deduction from his cost share so that he can pay the expense. The cost of the extraction was \$209. Since this was a one-time expense and his patient liability exceeds this amount, the agency enters the expense in **CWW** to reduce the May cost share by \$209.

27.7.7.2 Disallowed Expenses

Do not allow payments that an institutionalized person is making, or requests to make, as a need item, or as a cost share adjustment if the medical or remedial expense meets any of the following exception reasons:

1. Remains unpaid, but was previously used to meet a Medicaid deductible.
2. Were incurred as the result of imposition of a divestment penalty period.
3. A patient liability or cost share from a previous budget period, whether paid or unpaid, cannot be used as an incurred medical or remedial care expense in a subsequent budget period.
4. Incurred medical and remedial care expenses deducted from income to determine patient liability or cost share in a month cannot be used to determine patient liability or cost share in a subsequent month.

Example 4: On September 17, Alice was hospitalized for injuries she sustained in a fall. Alice was uninsured at the time and incurred a \$2,000 hospital bill. Before leaving the hospital, she set up a payment agreement to pay \$100 per month until the debt was paid. Alice used the outstanding expense to satisfy a deductible in the amount of \$1,800 and was determined MA eligible from September through February.

In May, Alice was determined to be functionally eligible for Home and Community Based Waivers and was determined eligible for MA under Group B waiver rules. Without a medical/remedial expense, Alice's cost share would be \$100. Alice's Care Manager verified that Alice still owes \$1,200, but only \$200 of the expense is allowable because \$1,800 was already used to satisfy a deductible. Her Care Manager will include the \$100 payment in the medical/remedial expense amount submitted to the *IM* worker for determining her cost share, but will reevaluate Alice's medical/remedial expense amount in two months.

Example 5: On August 1, Alice moved to a nursing home. Her eligibility for Home and Community Based Waiver ended and she was determined eligible for Nursing Home MA beginning August 1st. She is still making the \$100 payments to the hospital, and has an outstanding balance of \$900. However, Alice used \$1,800 to meet a deductible and already received a deduction of \$200 from her community waiver cost share. The payment cannot be used as a medical expense deduction from her income when calculating the monthly patient liability.

Example 6: In January, Lyle was institutionalized and applied for MA. Due to a previous divestment, Lyle has a three-month divestment penalty period, beginning in December. During this three month period, MA will not cover the cost of Lyle's institutional care, but will only cover his card services. In March, the divestment penalty period expired, and Lyle is eligible for MA payment of his institutional cost share. He would like to use \$2,000 of his monthly income

to pay for the nursing home bills that he incurred in January and February and deduct this amount from his cost share. The request to allow an adjustment in Lyle's cost share must be denied because the medical expense that he wants deducted from his income is to pay for the cost of institutional care incurred during a prior MA divestment penalty period.

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 the Medical Expense page. There are no CARES processing changes/overrides required for community waiver/Family Care cases.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

27.8 ILTC NURSING HOME CONTRACTS

Certain nursing home contract provisions require prospective residents to be on private pay status for a period of time, usually 12 to 18 months, before applying for Medicaid (Medicaid).

In essence, this requires the prospective resident waive the right to apply for Medicaid for a period of time as a precondition to admittance. The prospective residents, who are typically on a higher private pay status at the time, would generally qualify for Medicaid before the contract provision expires.

Nursing homes must honor residents' rights guaranteed by HSS 132.31, Wis. Admin. Code, in order to participate in the Medicaid program. The standards must be enforced as a condition of federal funding. They apply to all residents in a Medicaid certified nursing home, both Medicaid and private pay, as a condition of participation in the Medicaid program.

A resident can be involuntarily discharged or transferred essentially only for:

1. medical reasons,
2. his or her welfare or that of other patients, **or**
3. nonpayment.

Changing status from private pay to Medicaid and any corresponding loss of revenue to the nursing home are not to be considered nonpayment.

Thus, contract provisions prohibiting a person from applying for Medicaid by requiring a certain length of stay as a private pay resident can't be enforced by threats of discharge.

DHS has notified all Wisconsin nursing home providers that:

1. violations of private pay duration of stay contract provisions aren't grounds for discharge, **and**
2. they must notify all present and prospective residents of this.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

27.9 ILTC NURSING HOME REFUNDS

When an institutionalized person becomes eligible for Medicaid, he or she is certified with a begin date of the first of the month in which he or she became eligible. If he or she prepaid his or her patient liability for that month, the member may ask the nursing home to send the bill to Wisconsin Medicaid and ask that he or she be reimbursed for the month.

Treat the refund as a reimbursement in the month it is received. ([15.3.19 Reimbursements](#)) Do not count it as income in the month it is received. Beginning with the month following the month of receipt, count any amount he or she keeps as an available asset. He or she can avoid having the reimbursement counted as an available asset by doing any of the following:

1. Transfer it for [fair market value](#) for an exempt asset.
2. Transfer it to his or her [spouse](#) .
3. Refund it to the Medicaid program in an amount equal to what Medicaid has already paid for his or her care up to the date of the reimbursement.

This page last updated in Release Number: 08-01

Release Date: 02/01/08

Effective Date: 02/01/08

27.10 ILTC LIABILITY EFFECTIVE DATES

Nursing homes, State centers, and State mental hospitals receive a CARES weekly paper report, #CCN150RA, that lists the patient liability amounts for their Medicaid residents. The report includes case number, primary person name, patient liability status (approval, closure, increase, decrease, unchanged), the date the action was confirmed on AGECE, prior patient liability amount, current patient liability amount, effective begin date, and effective end date.

Income changes which are reported timely and result in an increased patient liability have the following effective dates:

1. Before [cutoff](#) , effective the first of the following month.
2. After cutoff, effective the first of the month after the following month.

Do not complete [F-10110](#)'s (formerly DES 3070) for retroactive patient liability increases since the *member* must receive timely notice.

Decreases in patient liability are always effective the first of the month in which the decrease in income occurs or the decrease is reported, whichever is later. If the date of change that you enter into CARES will cause an incorrect effective date on the fiscal agent file, run with dates in CARES. Do not complete a [F-10110](#) (formerly DES 3070) unless you are unable to confirm the decrease after running with dates in CARES.

This page last updated in Release Number: 08-01

Release Date: 02/01/08

Effective Date: 02/01/08

27.11 INSTITUTIONS FOR MENTAL DISEASE (IMDS)

Brown

Bellin Psychiatric Center, Green Bay

Brown County Mental Health Center, Green Bay

Libertas Center, Green Bay (aka St. Joseph's)

Dane

Mendota Mental Health Institute, Madison

Fond du Lac

Fond du Lac County Health Care Center

Milwaukee

Aurora Psychiatric Hospital, Milwaukee

Rogers Memorial Hospital, Milwaukee

Milwaukee County Behavioral Health, 144 bed psychiatric hospital - license #229, Milwaukee

Trempealeau

Trempealeau County Health Care Center IMD, Whitehall - license # 2961

Trempealeau County IMD, Whitehall - license # 5001

Waukesha

Rogers Memorial Hospital, Oconomowoc

Waukesha County Mental Health Center, Waukesha

Winnebago

Winnebago Mental Health Institute, Winnebago

Note: The Milwaukee County Behavioral Health and the Trempealeau County Health Care Center are multi-purpose complexes which include Nursing Homes, Facilities for the Developmentally Disabled and IMD's. In order to make a correct Medicaid eligibility determination for the residents of these 2 complexes, it will be necessary to accurately identify the type of facility in which the Medicaid *applicant* /member resides.

*This page last updated in Release Number: 10-02
Release Date: 06/22/10
Effective Date: 06/22/10*

28 HOME AND COMMUNITY-BASED WAIVERS LONG TERM CARE (HCBWLTC)

28.1 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE INTRODUCTION

Community waivers enable *elderly*, blind, and disabled persons to live in community settings rather than in state institutions or nursing homes. They allow Medicaid to pay for community services, which normally are not covered by Medicaid.

Community waivers include the following programs:

1. *CIP* I (CIP 1A and CIP 1B).
2. CIP II.
3. *COP-W*.
4. *PACE*.
5. *WPP*.
6. *CLTS* waiver programs. These programs serve children with physical disabilities, developmental disabilities, and mental health needs.

To be eligible for these waivers, a person must:

1. Meet Medicaid level of care requirements for admission to nursing homes, and
2. Meet non-financial requirements for Medicaid, and
3. Meet financial requirements for Medicaid, and
4. Reside in a setting allowed by community waivers policies, and
5. Have a need for long term care services.
6. Have a *disability* determination if they are under age 65. (Disability is a non-financial eligibility requirement for community waiver programs for anyone under age 65.)

Note: A person who is *MAPP*-disabled may be eligible as a Group A participant even if a regular disability has not been determined by *DDB*.

*This page last updated in Release Number: 15-02
Release Date: 07/30/2015
Effective Date: 07/30/2015*

28.2 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE APPLICATION

[28.2.1 Spousal Impoverishment](#)

28.2.2 Tentative Approval

All waiver applicants must complete a Medicaid application form unless they are already receiving full-benefit Medicaid (see [Section 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 **IM** agency along with the waiver functional eligibility determination.

28.2.1 Spousal Impoverishment

Spousal impoverishment policy applies to waiver participants with a **community spouse**, with the exception of **MAPP** waiver participants (see [Section 18.2.3 Institutionalized](#) and [Section 26.3.7 Spousal Impoverishment](#)).

28.2.2 Tentative Approval

Persons who apply for waivers may receive tentative waiver approval while their Medicaid eligibility is being determined.

The tentative approval process begins when the care manager refers the waiver **applicant** to the IM agency with accompanying information about the type of waiver, waiver begin date, **and** medical/remedial expenses.

*This page last updated in Release Number: 15-02
Release Date: 07/30/2015
Effective Date: 07/30/2015*

28.3 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE FISCAL TEST GROUP

Form the fiscal test group as follows:

1. Single person = a fiscal test group of one.
2. Married couple, when one [spouse](#) is applying for community waivers, and the other is a [community spouse](#). This is a [spousal impoverishment](#) situation. Combine the assets ([18.4.3 Calculate the CSA](#)) and apply the spousal impoverishment asset test ([18.4.4 Asset Test](#)). The income limit is the same as for institutionalized persons who do not have a community spouse.
3. Married couple, both applying, are in two separate fiscal test groups. Spousal impoverishment policies may apply.

Example 1: Cathy and Bob, a married couple, are both applying for community waivers. Both are each other's community spouse. Combine the assets and apply the spousal impoverishment asset test. Calculate asset shares and asset limits for each.

Cathy and Bob each have one year to spend assets down to \$2,000, based on their individual application dates.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

28.4 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE DIVESTMENT

When requested, assist the case manager in assessing divestment. See [17.1 Divestment Introduction](#).

Note: Effective 10/01/09, 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.

*This page last updated in Release Number: 10-01
Release Date: 04-02-10
Effective Date: 10-01-09*

28.5 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE COST SHARING

[28.5.1 HCBWLTC Cost Sharing Introduction](#)
[28.5.2 Spenddown](#)

28.5.1 Home and Community-Based Waivers Long-term Care Cost Sharing Introduction

Cost sharing is the monthly amount a waivers participant may have to contribute toward the cost of his or her waiver services. Count only the income of the *member* when you calculate the cost share.

Payment of the cost share is a condition of eligibility. See [Section 28.8.3.1 Personal Maintenance Allowance](#) for instructions about how to calculate a cost share.

28.5.2 Spenddown

Effective July 1, 2015, Group C was replaced with Group B Plus, ending the group of members with a spenddown. See [Section 28.8.3 Group B and B Plus](#) for eligibility and cost share information.

*This page last updated in Release Number: 15-02
Release Date: 07/30/2015
Effective Date: 07/30/2015*

28.6 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE UNIFORM FEE SYSTEM

Following the procedures of the Uniform Fee System (Chap. HSS 1, Wisconsin Administrative Code), the case manager determines if the parent(s) must contribute toward the care of a child who is in *CIP* IA, IB, II, or *COP-W*. When the parents are already contributing according to the Uniform Fee System, no additional contribution is required.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

28.7 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE EFFECTIVE DATE

The begin date of waiver eligibility is the program start date submitted to the *IM* agency by the care manager or the *ADRC*.

For persons in Groups B and B Plus, this start date is considered tentative while the IM agency determines their Medicaid eligibility (see [Section 28.2.2 Tentative Approval](#)). If the Medicaid eligibility date is determined to be later than the tentative program start date, the effective date will become the Medicaid eligibility date.

*This page last updated in Release Number: 15-02
Release Date: 07/30/2015
Effective Date: 07/30/2015*

28.8 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE INSTRUCTIONS

[28.8.1 HCBWLTC Instructions Introduction](#)

[28.8.2 Group A](#)

[28.8.3 Group B](#)

[28.8.3.1 Personal Maintenance Allowance](#)

[28.8.3.2 Family Maintenance Allowance](#)

[28.8.3.3 Special Exempt Income](#)

[28.8.3.4 Health Insurance](#)

[28.8.3.5 Medical/Remedial Expenses](#)

[28.8.3.6 Cost Share Amount](#)

[28.8.4 Group C](#)

28.8.1 Home and Community-Based Waivers Long-term Care Instructions Introduction

Eligibility for Group A, B, and B Plus community waivers cases are determined in CARES.

Katie Beckett cases are Group A, and, because of the small number of these cases, are processed manually outside CARES by care managers and Katie Beckett staff.

Care managers will determine and certify community waiver eligibility for children already eligible for Medicaid through the Katie Beckett Program.

28.8.2 Group A

Group A members are waiver functionally eligible and Medicaid eligible via **SSI** (including **SSI-E** Supplement and **1619A** and B) or a full-benefit Medicaid subprogram (see [Section 21.2 Full-Benefit Medicaid](#)). This does not include someone solely eligible for any of the limited benefit Medicaid subprograms (see [Section 21.3 Limited Benefit Medicaid](#)).

Note: Group A members do not have an asset limit if they are Group A eligible via Family Medicaid. Family Medicaid and its subprograms do not have an asset test.

Clients who have met a deductible are eligible for community waivers as a Group A. The member remains eligible as a Group A until the end of the deductible period. At the next review the member will be able to make a choice between meeting the deductible to receive Medicaid (remaining a Group A) or becoming eligible for community waivers as a Group B or B Plus with a potential cost share.

Group A members are financially eligible with no cost share. Put a check before Group A in Section I. Then complete Sections II and V on the worksheet.

28.8.3 Group B and B Plus

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 [Section 39.4 EBD Assets and Income Tables](#)).

Group B Plus members are defined as those not in Group A, who have gross income above the nursing home institutions categorically needy income limit, but whose income does not exceed the cost of the appropriate institutional care by more than the medically needy income limit (see [Section 39.4 EBD Assets and Income Tables](#)).

For Group B and B Plus, 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.

28.8.3.1 Personal Maintenance Allowance

The personal maintenance allowance is an income deduction used when calculating a cost share for a Group B or B Plus waiver member.

The personal maintenance allowance (Line 6 and Page 2 of the worksheet) is for room, board, and personal expenses. It is the total of the following:

1. Community Waivers Basic Needs Allowance (see [Section 39.4.2 EBD Deductions and Allowances](#)).
2. Sixty-five dollars and $\frac{1}{2}$ earned income deduction (see [Section 15.7.5 \\$65 and \$\frac{1}{2}\$ Earned Income Deduction](#)).
3. Special housing amount. This is an amount of the person's income set aside to help pay housing costs. If the waiver applicant's housing costs are over \$350, add together the following costs:
 - a. Rent.
 - b. Home or renters insurance.
 - c. Mortgage.
 - d. Property tax (including special assessments).
 - e. Utilities (heat, water, sewer, electricity).
 - f. "Room" amount for members in a **CBRF**, Residential Care Apartment Complex, or an **Adult** Family/Foster Allowance Home. The case manager determines and provides this amount.

The total, minus \$350, equals the special housing amount. The person can set this amount aside from his or her income.

If both spouses are applying and both have income, divide the special housing amount equally between them.

Example 1: Two spouses applying with income:
\$600 rent

$\begin{aligned} & - 350 \\ & = 250/2 \text{ spouses} = \$125 \text{ that each can set aside} \end{aligned}$
--

If only one *spouse* has income and both spouses are applying, allocate the full special housing amount to the spouse with income.

When one spouse has income and both are applying:

1. And they reside together in the same residence, allocate the full special housing amount to the spouse with income.
2. And they reside in separate rooms in a substitute care facility, but there is only one room and board contract for both, allocate the full housing amount to the spouse with income.
3. And they reside in separate rooms in a substitute care facility, but each has an individual room and board contract, only the spouse with income gets a deduction for the special housing amount, and it is based on their individual "rent" costs that are obtained from the care manager.

<p>Example 2: Emma and Herbert are living in the same residence. Herbert has income of \$1,000 per month. Emma does not have any income. The total housing costs are \$650 for both of them. Allocate the full special housing amount to Herbert (\$650-<u>\$350</u> = \$300 special housing amount).</p>
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<p>Example 3: Bert and Ingrid live in separate rooms in a substitute care facility, but there is only one room and board contract for both. Bert has income of \$1,000 per month. Ingrid does not have any income. The total rent amount is \$650 for both of them. Allocate the full special housing amount to Bert (\$650-<u>\$350</u> = \$300 special housing amount).</p>
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<p>Example 4: Ned and Maria live in separate rooms in a substitute care facility, and each of them has an individual room and board contract. Ned has income of \$1,000 per month. Maria does not have any income. Ned's "rent" from the room and board amount is \$550 and Maria's "rent" from the room and board amount is \$400. Calculate Ned's special housing amount (\$550-<u>\$350</u> = \$200 special housing amount). Do not consider Maria's room and board amount when calculating Ned's special housing amount.</p>

When both spouses have income and both are applying:

1. And they reside together in the same residence, divide the special housing amount equally between them.
2. And they reside in separate rooms in a substitute care facility, but there is only one room and board contract for both, divide the special housing amount equally between them.
3. And they reside in separate living arrangements (e.g., they reside in two different substitute care facilities OR they reside in the same substitute care facility but each has a private room and his or her own individual room and board contract)

then calculate a separate special housing amount for each, based on their individual "rent" costs that are obtained from the care manager.

Example 5: Emma and Herbert are living in the same residence. Herbert has income of \$1,000 per month, and Emma has income of \$500 per month. The total housing cost for both of them is \$650. Divide the special housing amount equally between them ($\$650 - \$350 = \$300$ special housing amount, so the special housing amount for Emma and Herbert is \$150 each).

Example 6: Bert and Ingrid live in separate rooms in a substitute care facility, but there is only one room and board contract for both. Bert has income of \$1,000 per month, and Ingrid has income of \$500 per month. The total "rent" from the room and board amount for both of them is \$650. Divide the special housing amount equally between them ($\$650 - \$350 = \$300$ special housing amount, so the special housing amount for Bert and Ingrid is \$150 each).

Example 7: Ned and Maria live in separate rooms in a substitute care facility, and each of them has an individual room and board contract. Ned has income of \$1,000 per month, and Maria has income of \$500 per month. Ned's "rent" from the room and board amount is \$550 and Maria's "rent" from the room and board amount is \$400. Calculate the special housing amounts separately. Ned's is calculated as follows: $\$550 - \$350 = \$200$ special housing amount. Maria's is calculated as follows: $\$400 - \$350 = \$50$ special housing amount.

Do not give the special housing amount to waiver participants under age 18.

The total of 1, 2, and 3 must not be greater than the EBD Maximum Personal Maintenance Allowance (see [Section 39.4.2 EBD Deductions and Allowances](#)).

28.8.3.2 Family Maintenance Allowance

The family maintenance allowance is for the support of family members when *spousal impoverishment* policies do not apply. If the member is a disabled child, omit the family maintenance allowance.

Family Related - When the waiver participant is the custodial parent of a *minor* child living in the home, and there's no spouse in the home, do the following:

1. Minor children's gross earned income.
2. $-\$65$ and $\frac{1}{2}$ of gross earned income (see [Section 15.7.5 \\$65 and \$\frac{1}{2}\$ Earned Income Deduction](#)).
3. = _____.
4. + Minor Children's total unearned income.

5. = _____ Add (3) and (4).

6. AFDC Related med needy income limit _____ (see [Section 39.3 AFDC-Related Income Table](#)). (Do not include the waiver *applicant* in the group size.)

If (5) is greater than (6), there's no family maintenance allowance. If (5) is less than (6), the family maintenance allowance is the difference between (5) and (6).

EBD Related - If there are no minor children in the home, and spousal impoverishment policies do not apply, do the following:

1. Spouse's gross earned income.

2. -\$65 and ½ of total gross earned income (see [Section 15.7.5 \\$65 and ½ Earned Income Deduction](#)).

3. = _____.

4. +Spouse's total unearned income.

5. = _____ (3)+(4).

6. -\$20 *disregard*.

7. = _____ (6)-(5).

8. _____ Enter the SSI Payment Level Plus the E Supplement for one person (see [Section 39.4 EBD Assets and Income Tables](#)).

If (7) is greater than (8), there is no family maintenance allowance. If (7) is less than (8), the family maintenance allowance is the difference between (7) and (8).

28.8.3.3 Special Exempt Income

Deduct special exempt income (see [Section 15.7.2 Special Exempt Income](#)).

28.8.3.4 Health Insurance

Include all health and dental insurance premiums covering the waiver person and for which he or she is responsible and pays a premium. This includes any Medicare Premium obligation including Medicare Part D. See [Section 9.6.2 Policies Not To Report](#) for a list of insurance types for which premium deductions are not allowed.

If the waiver participant is part of a covered group but not responsible for the premium, find his or her proportionate share by dividing the premium by the number of people

covered. If both members of a couple apply, but only one pays the premium, divide the premium equally. Prorate premiums over the months payment covers.

Example 8: Sally pays a \$600 premium quarterly for her Medicare supplement policy. Six hundred dollars divided by three equals \$200. Enter \$200 as her monthly health insurance premium payment on the Medical Coverage page.

28.8.3.5 Medical/Remedial Expenses

Obtain the dollar amount for medical and remedial expenses from the care manager. See [Section 15.7.3 Medical/Remedial Expenses \(MRE\)](#).

Note: Care managers should refer to the limitations associated with allowable medical or remedial expenses that are described in [Section 27.7.8 Medical/Remedial Expenses and Payments for Non-Covered Services](#).

28.8.3.6 Cost Share Amount

The waiver cost share amount 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

Effective July 1, 2015, Group C has been replaced with Group B Plus.

*This page last updated in Release Number: 15-02
Release Date: 07/30/2015
Effective Date: 07/30/2015*

28.9 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE MEDICAL CODES

See the [Process Help Chapter 81.5](#) for Community Waiver medical status codes. These are not the same codes as nursing home medical status codes. A medically needy Medicaid client could be eligible as a categorically needy waiver client (Group B), thus requiring a change in the medical status code from medically needy to categorically needy.

This page last updated in Release Number: 09-04

Release Date: 09/09/09

Effective Date: 09/09/09

28.10 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE REVIEW

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

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

This page last updated in Release Number: 15-01

Release Date: 06/10/2015

Effective Date: 06/10/2015

28.11 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE COMMUNITY SPOUSE'S MEDICAID APPLICATION

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.

Both spouses are in the non-waiver spouse's fiscal test group (*FTG*). Since the waiver *spouse* is in the FTG, *disregard* any income that may have been allocated by the waiver spouse to the community spouse.

The waiver spouse is a FTG of one. CARES creates the separate FTG's and AG's.

This page last updated in Release Number: 15-01

Release Date: 06/10/2015

Effective Date: 06/10/2015

28.12 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE NOTICES

CARES generates a Notice of Decision each time the *IM* worker confirms a case.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

28.13 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE TRANSFERS

When a Community Waivers case transfers to a new county or tribe, and there is no slot available in the new agency, do the following:

Transfer the case to the new county through CARES. The transfer-in county takes care of the MA certification. The transfer-out county keeps the member in the waiver slot until a slot becomes available in the new county.

*This page last updated in Release Number: 10-02
Release Date: 06/04/10
Effective Date: 06/04/10*

28.14 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE CHILDREN'S LONG-TERM SUPPORT

[28.14.1 Children's Long-term Support Introduction](#)

[28.14.2 Children's Long-term Support CARES Processing](#)

[28.14.2.1 Processing a Children's Long-term Support Application When No Funding Is Available](#)

28.14.1 Children's Long-term Support Introduction

The **CLTS** waivers include the following three programs, differentiated by the population they serve:

- Developmental Disabilities
- Physical Disabilities
- Mental Health Disabilities

The CLTS is entered in **CWW** as a Children's Waiver type. All the Medicaid eligibility criteria for the CLTS are identical to the Community Integration Program IB Waiver except not all children will need a **disability** determination in order to qualify. See County

Funded Slot below. The care manager will inform the *IM* worker of the type of slot in which the child will be placed.

Not all children will require a disability determination to enroll in CLTS. It is the responsibility of the CLTS Support and Service Coordinator to identify to the IM workers which cases do not require a disability determination. If no disability determination is required, the "Is Disability Determination Required?" question on the Community Waivers page should be answered "No."

28.14.2 Children's Long-term Support CARES Processing

The child should first be tested with his or her family to see if there is eligibility for BadgerCare Plus and the Group A Waiver.

If the child is eligible for a type of non-CARES Medicaid such as *Foster Care* Medicaid, Adoption Assistance Medicaid, *SSI* Medicaid, or Katie Beckett Medicaid, the child will be eligible as a Group A Waiver (see [Section 28.8 Home and Community-Based Waivers Long Term Care Instructions](#) for waiver processing instructions).

If the child is not eligible for other categories of Medicaid or BadgerCare Plus, CARES will test the child for a Group B or B Plus Waiver, based on the child's income.

Since a disability determination is not always required for these members, it is the responsibility of the CLTS Support and Service Coordinator to identify to the IM workers which cases do not require a disability determination. Income Maintenance workers should update the Community Waivers page based on the information received from the CLTS case manager.

28.14.2.1 Processing a Children's Long-term Support Application When No Funding Is Available

In order to be put on the waiting list for a CLTS waiver slot, the child must be determined otherwise eligible.

Income Maintenance workers who receive Medicaid applications for one of the CLTS waiver programs should process those applications even if there is no funding available (no waiver slot). Complete the normal process as follows:

1. Determine Medicaid eligibility using community waiver methodology.
2. Assist in the completion of the *MADA*.
3. Forward the MADA to the *DDB*.

If DDB determines that the child is disabled and meets *LOC* criteria, the child will be put on a waiting list for a CLTS slot.

The IM worker should determine if the child is eligible with his or her family for BadgerCare Plus or Elderly, Blind, Disabled Medicaid. If the child and/or family do not

meet any other Medicaid or BadgerCare Plus eligibility requirements, then the application should be denied and confirmed in CARES accordingly.

Note: Do not keep the CLTS waivers case in pending status in CARES until funding becomes available.

If a CLTS waiver slot becomes available more than 30 days after the denial of the original application, a new application must be submitted and processed.

*This page last updated in Release Number: 15-02
Release Date: 07/30/2015
Effective Date: 07/30/2015*

29-31 RESERVED

29-31 RESERVED

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

32 MEDICARE SAVINGS PROGRAMS (MSP)

32.1 MEDICARE SAVINGS PROGRAMS

[32.1.1 Medicare Savings Programs \(MSP\) Introduction](#)

[32.1.2 MSP Fiscal Test Group](#)

[32.1.3 MSP Benefits](#)

[32.1.4 LIS Requests](#)

[32.1.5 Part B Enrollment Via The MSP Buy-In Program](#)

32.1.1 Medicare Savings Programs (MSP) Introduction

Medicare is the health insurance program administered by the federal Centers for Medicare & Medicaid Services (**CMS**) for people over 65 and for certain younger disabled people. People who receive Medicare are referred to as Medicare beneficiaries.

Medicare is divided into three types of health coverage. Hospitalization Insurance (Part A) pays hospital bills and certain skilled nursing facility expenses. Medical Insurance (Part B) pays doctors' bills and certain other charges. Drug Insurance (Part D) pays for prescription drug charges.

Medicare, being an insurance program, charges coinsurance, deductibles and monthly premiums. These out-of-pocket charges to Medicare beneficiaries are generally referred to as "Medicare cost-sharing." For certain Medicare beneficiaries participating in the programs described below, Wisconsin Medicaid pays some or all of their Medicare cost-sharing. These programs are called " *Medicare Savings Programs* ." (They are also referred to as " *Medicare Premium Assistance* ," or "Medicare Buy-In" programs.)

Use the same rules for determining financial eligibility as you do for Medicaid.

The following are types of Medicare beneficiaries that receive the Medicaid benefits described in [32.1.3](#):

1. Qualified Medicare Beneficiary ([QMB](#)). See [32.2 QMB](#).
2. Specified Low-Income Medicare Beneficiary ([SLMB](#)). See [32.3 SLMB](#).
3. Specified Low-Income Medicare Beneficiary Plus (SLMB+), also known as Qualifying Individuals - 1 (QI-1). See [32.4 SLMB+](#).
4. Qualified Disabled and Working Individuals ([QDWI](#)). See [32.5 QDWI](#).

If a *member* is also eligible for Medicaid, they will receive a [ForwardHealth card](#). The ForwardHealth card will indicate that they are Medicare Beneficiaries.

Members eligible for QMB will receive a forward card even if he or she is not eligible for any other subprograms of Medicaid.

32.1.2 MSP Fiscal Test Group

The fiscal test group (*FTG*) size is two when a couple is living together at home. If they are both living in the same nursing home, each person is an individual FTG.

32.1.3 MSP Benefits

1. QMB Medicaid pays Medicare Part A & B premiums and Medicare deductibles, copays, and coinsurance.
2. SLMB Medicaid pays Medicare Part B premiums.
3. SLMB +. Medicaid pays Medicare Part B premiums.
4. QDWI Medicaid pays Medicare Part A premiums.

32.1.4 LIS Requests

See [2.6.5 Low Income Subsidy \(LIS\) Program of Medicare Savings Programs \(MSPs\)](#) for information on *LIS* Requests for *MSP* .

32.1.5 Part B Enrollment Via The MSP Buy-In Program

Members receiving Medicare Part A coverage, who chose not to enroll in Part B, may be eligible for the State to enroll them into Part B with no increase in the premium, via the MSP Process. The MSP eligibility should be determined in **CWW**. If the member is eligible for MSP, the worker must contract the ForwardHealth Medicare Buyin Analyst by phone, email, or by filling out a [F-10110](#) stating when the member will begin their Buyin eligibility. The Buyin analyst will create a manual transaction to send to CMS with the appropriate MSP information. Once CMS processes the record, the member should be enrolled into Part B with coverage beginning the first month of MSP eligibility.

Example 1: In January, the member applies for QMB benefits and is only receiving Part A Coverage. The case worker determines the member qualifies for QMB starting February. After the confirmation is done in CARES, the worker contacts the ForwardHealth Buyin Analyst to report the enrollment. The Buyin Analyst creates a transaction with the QMB information. This transaction is sent to CMS in February.

Once CMS processes the record and bills the State, the member will show Part B coverage starting in February.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

32.2 QMB (QUALIFIED MEDICARE BENEFICIARY)

[32.2.1 QMB Introduction](#)

[32.2.2 Entitled to Medicare](#)

[32.2.3 QMB Income Limit](#)

32.2.1 QMB Introduction

The following persons are Medicaid members who are automatically eligible for **QMB** benefits.

1. Persons who are receiving or are eligible to receive [SSI](#) .
2. 503 AGs.
3. Disabled [adult](#) children.
4. Widows and Widowers.

Widow/widowers (See [25.3 Widows and Widowers](#)), DAC's (See [25.2 DAC](#)) and 503's (See [25.1 503 Eligibility](#)) have the option of not taking the QMB benefit.

If the person does not belong to one of the above named groups, he or she must:

1. Be non-financially eligible for Medicaid or BadgerCare Plus.
2. Be entitled to Medicare Part A.

32.2.2 Entitled to Medicare

A person is "entitled" to Medicare Part A if he or she meets one of the following conditions:

1. He or she does not have to pay Medicare Part A, and he or she is receiving Medicare Part A services as of the QMB determination.

Example 1: Mrs. Smith applies for QMB benefits August 15. She has a Medicare card with a Part A begin date of June 1. Since Medicare will pay for Part A services as of June 1, she is "entitled" to Part A at the time of the QMB determination.

2. He or she must pay a monthly premium to receive Medicare Part A, and he or she fits one of the following descriptions:
 - a. He or she is a Medicaid member and has been enrolled in Medicare sometime in the past. In this case the State will attempt to enroll him or her in Medicare Part A. QMB eligibility cannot begin prior to the Part A begin date.

Example 2: Eleanor's Part A lapsed because he did not work enough quarters for free enrollment and she could no longer afford the premiums. When he becomes eligible for Medicaid, the State will begin paying her Medicare premiums.

- b. He or she is a Medicaid member or QMB or [SLMB](#) or [QDWI applicant](#) and has never been enrolled in the federal Medicare system. In this case he or she must apply at the local [SSA](#) office for Part A Medicare eligibility. He or she will receive a receipt which entitles him or her to enrollment in Part A on the condition that he or she is found eligible for QMB or SLMB. The receipt from SSA will have a Part A begin date on it. QMB OR SLMB or QDWI eligibility cannot begin prior to the Part A begin date.

Example 3: Pearl was never enrolled in the federal Medicare system. She applies for QMB. Before she can become QMB eligible she must obtain a receipt for conditional eligibility for Part A Medicare. She goes to the SSA office during the January-March enrollment period and is conditionally determined eligible for Part A effective July 1st. She applies for QMB at the *IM* Agency on May 1st. She becomes QMB eligible as of July 1st.

32.2.3 QMB Income Limit

The QMB income limit is 100% of the federal poverty level (*FPL*). See 39.5 FPL Table.

The method of counting income is based on the SSI method, not on the *spousal impoverishment* method. (See [28.1 HCBWLTC Introduction](#)). Calculate QMB net income as follows:

\$ Earned income (See [15.5 Earned Income](#))
 - \$65 and ½ earned income deduction ([15.7.5 \\$65 and ½ Earned Income Deduction](#))
 + Unearned income (social security income, etc.) ([15.4 Unearned Income](#))
 - Special exempt income ([15.7.2 Special Exempt Income](#))
 - \$20 standard deduction
 = Net income used to determine QMB eligibility

When counting social security income, use gross social security income. Gross social security income:

1. Of a self-payer = the social security check amount + Medicare premiums he or she has paid.
2. Of someone for whom the State is paying the premiums = the social security check amount.

Disregard the *COLA* increase for the current year until the month after the new federal poverty limits become effective.

Example 4: Big Al is a QMB member. He has income of \$900.00. The QMB income limit in December is \$907.50. In January, a COLA increase of \$11.17 increases Big Al's income to \$911.17. Disregard the COLA increase in any determination of Big Al's continuing QMB eligibility. On April 1st, new, higher QMB in-come limits are published. Redetermine Big Al's QMB eligibility in May. At this redetermination, do not disregard the January COLA increase.

*This page last updated in Release Number: 15-01
 Release Date: 06/10/2015
 Effective Date: 06/10/2015*

32.3 SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB)

[32.3.1 SLMB Introduction](#)

[32.3.2 SLMB Income Limit](#)

32.3.1 SLMB Introduction

To be eligible for *SLMB* the person must:

1. Meet non-financial Medicaid requirements.

2. Be receiving Medicare Part A.

32.3.2 SLMB Income Limit

The SLMB income limit is at least 100% of the *FPL*, but less than 120%. See 39.5 FPL Table.

Calculate SLMB net income in the same way as *QMB* net income including the temporary *disregard* of the annual *COLA* increase. (See [32.2.2 QMB Income Limit](#)).

*This page last updated in Release Number: 09-01
Release Date: 01/15/09
Effective Date: 01/01/09*

32.4 SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PLUS (SLMB+)

[32.4.1 SLMB+ Introduction](#)

[32.4.2 SLMB+ Income Limit](#)

32.4.1 SLMB+ Introduction

To be eligible for **SLMB** + the person must:

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

32.4.2 SLMB+ Income Limit

SLMB+ income must be at least 120% of the **FPL**, but less than 135%. See 39.5 FPL Table.

Calculate SLMB+ net income in the same way as QMB net income including the temporary **disregard** of the annual **COLA** increase.(See [32.2.2 QMB Income Limit](#)).

Since enrollment for the SLMB+ program is not automated in CARES, it must be determined and managed manually by local agencies. See [Process Help 61.6 SLMB+ Processing](#).

*This page last updated in Release Number: 09-05
Release Date: 11/16/09
Effective Date: 11/16/09*

32.5 QUALIFIED DISABLED AND WORKING INDIVIDUAL (QDWI)

[32.5.1 QDWI Introduction](#)

[32.5.2 QDWI Income Limit](#)

32.5.1 QDWI Introduction

A Qualified Disabled and Working Individual (**QDWI**) is a person who:

1. Is entitled to enroll in Medicare Part A. (See [32.2.2 Entitled to Medicare](#)) **and**
2. Is not otherwise eligible for MA (including Community Waivers and BadgerCare).
Consider a person with an unmet deductible ineligible for MA until he or she meets the deductible.

32.5.2 QDWI Income Limit

The QDWI income limit is 200% of the **FPL**. See 39.5 FPL Table.

Calculate QDWI net income in the same way as **QMB** net income including the temporary **disregard** of the annual **COLA** increase.(See [32.2.2 QMB Income Limit](#)).

*This page last updated in Release Number: 09-01
Release Date: 01/15/09
Effective Date: 01/01/09*

32.6 MEDICARE SAVINGS PROGRAMS ASSET LIMITS

QDWI

Group Size	Asset Limit
1	\$4,000
2	\$6,000

QMB , **SLMB** , and SLMB+ have the same asset limit.

Group Size	Asset Limit
1	\$7,160

2	\$10,750
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Divestment of assets has no effect on QMB, SLMB, SLMB+, or QDWI eligibility.

*This page last updated in Release Number: 14-01
Release Date: 05/01/14
Effective Date: 01/01/14*

32.7 MEDICARE SAVINGS PROGRAMS BEGIN DATES

[32.7.1 QMB Begin Dates](#)

[32.7.1.1 QMB Applications](#)

[32.7.1.2 QMB Recertifications](#)

[32.7.2 SLMB, SLMB+,QDWI Begin Dates](#)

32.7.1 QMB Begin Dates

32.7.1.1 QMB Applications

For initial applications, **QMB** benefits begin on the first of the month after the month in which the individual is determined to be eligible/confirmed in CARES.

Example 1: Henry has been in the same nursing home since 2004 and applied for MA on January 23, 2008. He also requested QMB. His application was processed for both on January 23, 2008 and he was determined eligible for both. His MA begin date is January 1, 2008. His QMB begin date is February 1, 2008.

32.7.1.2 QMB Recertifications

For recertifications, QMB benefits begin on the first of the month following the review due month, regardless if the review was confirmed in the review due month or the month following the review due month.

Example 2: Diamond has been receiving MA and QMB since 2004. Her Medicaid/QMB was due for review February 2006. Her Medicaid/QMB review began on February 20, 2006. The worker received verification for the review on 2/28/06. The **IM** worker entered verification to complete the QMB review certification March 1, 2006. Her QMB review was confirmed eligible on March 1, 2006. QMB eligibility begins March 1, 2006 and not April 1, 2006. There is no gap in her QMB benefit.

32.7.2 SLMB, SLMB+,QDWI Begin Dates

SLMB , SLMB+, and **QDWI** benefits begin on the first of the month in which all eligibility requirements are met. They cannot begin earlier than three months prior to the month of application.

*This page last updated in Release Number: 14-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

32.8 MEDICARE SAVINGS PROGRAMS BACKDATING

[32.8.1 QMB Backdating](#)

[32.8.2 SLMB, SLMB+, QDWI Backdating](#)

32.8.1 QMB Backdating

Occasionally, the benefits of a person who is eligible for **QMB** did not begin on the first of the following month as they were supposed to. This can occur if:

1. The eligibility process was not completed within 30 days.
2. Certification of eligibility was not completed.
3. A fair hearing decision has ordered backdated QMB benefits.

To backdate QMB benefit, complete an [F-10110](#) (formerly DES 3070) certification form and return to:

1. Mail:
HP Enterprise Services
P.O. Box 7636
Madison, WI 53707
2. Fax: (608) 221-8815

32.8.2 SLMB, SLMB+, QDWI Backdating

Benefits can be backdated for up to three months prior to the month of application. Use the backdating guidelines given in [2.8.2 Backdated Eligibility](#) .

A person who would have been eligible as a QMB in the backdate period cannot receive backdated **SLMB** , SLMB+, or **QDWI** benefits.

Example: Henry Schoolcraft applied for QMB on June 15, 1996. He also requested backdated SLMB. His income for June 1996 was under the QMB limit (100% of the federal poverty level). He was determined eligible for QMB. But his request for backdated SLMB was denied because his income, in the backdate months of March, April, and May, 1996, was under the QMB limit (100% of the **FPL**).

If he had applied for QMB in those months, he would have been QMB eligible. Therefore, since he would have been QMB eligible in the backdate period, he cannot receive backdated SLMB benefits.

*This page last updated in Release Number: 10-01
Release Date: 04-02-10
Effective Date: 04-02-10*

32.9 MEDICARE SAVINGS PROGRAMS NO DEDUCTIBLE

There is no deductible (See [24.2 Medicaid Deductible Introduction](#)) in the *Medicare Savings programs*. If a person's income is above the appropriate income limit, he or she cannot qualify for an *MSP* by meeting a deductible.

Example 1: Mr. George's net monthly income is too high for him to be eligible for any of the MSPs. He cannot become eligible through the Medicaid deductible process. If he is also applying for Medicaid medically needy eligibility, calculate his

Medicaid deductible ([24.5 Calculating the Deductible](#)). When he meets his Medicaid deductible, he becomes eligible for Medicaid, but not for any of the Medicare Beneficiary programs.

*This page last updated in Release Number: 10-01
Release Date: 04-02-10
Effective Date: 04-02-10*

32.10 MEDICARE SAVINGS PROGRAMS REVIEWS

Review **MSP**-only AGs every 12 months. If there are other persons in the **AG** who are not MSP members, review whenever the case normally comes up for review.

*This page last updated in Release Number: 10-01
Release Date: 04-02-10
Effective Date: 04-02-10*

32.11 POTENTIAL ADVERSE EFFECT OF MSP PARTICIPATION

When the State pays a person's Part B premium, his or her Social Security (SS) check will increase by the same amount as the premium. This increase in the SS check may result in the person either losing Medicaid eligibility, or being reduced from categorically needy to medically needy.

When a person would be adversely affected in this way, he or she is allowed to choose between either losing his or her Medicaid current benefits and keeping free Medicare enrollment, or giving up the free Medicare enrollment and keeping his or her MA benefits. All but 503, DAC's and widow/widowers can opt out of the **QMB** buy-in through CARES.

When a 503, DAC, or widow/widower requests to not have the state pay the Part B premium, contact the Buy-In Analyst at 221-4746, extension 3107. He or she will update MMIS with the appropriate information to prevent the automatic buy-in.

*This page last updated in Release Number: 10-01
Release Date: 04-02-10
Effective Date: 04-02-10*

33 SENIORCARE (SC)

33.1 SENIORCARE INTRODUCTION

Wisconsin SeniorCare (**SC**) is a prescription drug assistance program for Wisconsin residents who are at least 65 years of age and meet the program's eligibility criteria. SeniorCare began September 1, 2002.

SeniorCare is designed to help seniors with covered prescription drug costs. Eligible participants are issued SeniorCare identification cards and may receive SeniorCare benefits.

There is neither an asset test nor estate recovery for SeniorCare. Participation levels are determined by comparing the anticipated annual income of the fiscal test group (**FTG**) to a percentage of the Federal Poverty Level (**FPL**) corresponding to the FTG size.

SeniorCare is administered by the Department of Health Services (**DHS**), through the Central Application Processing Operation (**CAPO**). County and tribal agencies are not responsible for determining eligibility, but may need to coordinate with workers in the CAPO for mixed cases. Mixed cases include those persons eligible for SeniorCare and:

1. FoodShare, **or**
2. Medicare premium assistance , **or**
3. An unmet Medicaid (MA) deductible, **or**

4. Child care assistance, **or**
5. Are participating in a Department of Workforce Development (DWD) employment program such as Wisconsin Works (W-2).

Although SeniorCare is a subprogram of Medicaid, only the portions of the handbook that are referenced in chapter 33 SeniorCare apply to SeniorCare policy.

SENIORCARE <small>Prescription Drugs for Wisconsin Seniors</small>	
RxBIN	610499
<small>Issuer (90842)</small>	
ID	1234567890
Name	IMA PARTICIPANT

Participants:
<ul style="list-style-type: none">• Show this card each time you get your prescription drugs.• For customer service, call 1-800-657-2038.
Pharmacists:
<p>Submit claims electronically or send paper claims to: Claims and Adjustments Unit 6406 Bridge Rd. Madison, WI 53784-0002</p>
Provider Services: 1-800-947-9627

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

33.2 SC APPLICATION

[33.2.1 SC Application Introduction](#)

[33.2.2 Application Processing](#)

[33.2.3 Signing the Application](#)

[33.2.3.1 Witnessing the Signature](#)

[33.2.4 Authorized Representative](#)

[33.2.5 Guardian and Power of Attorney](#)

33.2.1 SC Application Introduction

An individual interested in participating in *SeniorCare* must complete a SeniorCare Application Form ([F-10076](#)). An application may be obtained from a local Office on Aging, Senior Center, or Aging Resource Center. Applications may also be printed from the Department of Health Services web site at: <http://www.dhs.wisconsin.gov/seniorCare/index.htm> . If the *applicant* is unsure where to obtain an application or wants to have one mailed to him/her, he or she should call 1-800- 657-2038 (TTY and translation services are available).

A \$30 enrollment fee is required as a condition of eligibility. If the enrollment fee is not sent with the application, the eligibility begin date could be delayed (See [33.5.2 ID Cards](#)).

SeniorCare applications should be mailed to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Note: For benefit renewal requirements, see [33.5 SC Benefit Period](#).

33.2.2 Application Processing

A valid application for SeniorCare is a SeniorCare Application Form [F-10076](#)) with the applicant's:

1. Name, **and**
2. Address, **and**
3. Signature (See [33.2.3 Signing the Application](#)) in Section V. Applications that are not signed in Section V of [F-10076](#)) will be returned to the applicant.

However, non-financial ([33.3 SC NonFinancial Requirements](#)) and income ([33.6 SC Financial Requirements](#)) information is needed to determine eligibility.

"General Delivery" may be used for a mailing address but can not be used as a residence address.

The presence of a signature on a SeniorCare application indicates intent to apply. When a signed application is received without an enrollment fee, the department will send an enrollment fee request notice to the applicant(s). An application will not be approved until an enrollment fee is received.

When an application is received with an enrollment fee(s) where the applicant(s) has answered "No" to the question "Are you Requesting SeniorCare?", the department will assume that there is a request for at least one person. When an application is received without the enrollment fee where the applicant's answer to the question is "No", the department will follow up with the applicant(s) to determine his or her intent.

The date a valid application is received by the SeniorCare program is the application filing date. Eligibility for SeniorCare will be determined as soon as possible, but not later than 30 days from the date a valid application is received.

A delay in processing the application may occur if there is a delay in obtaining information or in receipt of the enrollment fee necessary for determining eligibility. If a delay occurs, the applicant will be notified in writing that there is a delay in processing the application. The notice will specify the reason for the delay and inform the applicant of his or her right to appeal the delay.

If the initial application is denied and the applicant wishes to reapply, he or she should check the "New Application" box on the application form. "Reapplication" refers to current participants who are requesting establishment of a new benefit period due to a change in circumstances.

33.2.3 Signing the Application

The applicant must sign the application form in Section V of [F-10076](#) (Section VI of the 07/02 version of [F-10076](#)) with his or her signature, a mark or an "X", unless one of the following signs for him or her:

1. A guardian.
2. An [authorized representative](#).
3. A power of attorney/durable power of attorney. (Health Care Power of Attorney is not accepted as proof of authority.)

33.2.3.1 Witnessing the Signature

If a SeniorCare applicant signs the application form in Section V of [F-10076](#) with a mark or an "X", the signature must be witnessed by two individuals. (Section VI of the 07/02 version of [F-10076](#)).

33.2.4 Authorized Representative

An authorized representative may act on behalf of the SeniorCare participant at application and/or reviews, and is authorized to provide information and any documentation that is necessary to establish SeniorCare eligibility.

A SeniorCare applicant may authorize someone to represent him or her by completing the authorized representative form [F-10080](#). (**Note:** The early version of SeniorCare application included Section V for authorizing a representative. If the 07/02 version of [F-10076](#) is submitted with Section V completed, SeniorCare will accept the authorization of the representative.)

33.2.5 Guardian and Power of Attorney

An applicant is not required to complete the *Authorized Representative* form [F-10080](#) if a legal guardian or power of attorney (POA) is applying on the SeniorCare applicant's behalf.

Copies of guardianship or POA documentation will be requested after the SeniorCare application has been submitted. Documentation must be submitted to the SeniorCare Program before information about the applicant or participant will be released to the guardian or POA. A POA may also be authorized for representation by completing the authorization of representation form ([F-10080](#)) SeniorCare Authorization of Information in lieu of submitting the POA papers.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

33.3 SC NONFINANCIAL REQUIREMENTS

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33.3.1 SC Nonfinancial Requirements Introduction

To be non-financially eligible for **SC**, an *applicant* must:

1. Be at least 65 years of age.
2. Be a Wisconsin resident.

A Wisconsin resident is an individual who meets at least one of the following criteria:

1. Has a permanent residence in Wisconsin.
2. Is considered a Wisconsin resident for tax purposes.
3. Is a registered voter in Wisconsin.

A SC participant may temporarily live outside the State of Wisconsin, as long as he or she maintains permanent residency in Wisconsin. Residency in a Wisconsin nursing home or an assisted living facility will meet this requirement.

4. Be a U.S. citizen or a qualifying legal alien ([7.1 US Citizens and Nationals](#)).

An applicant who is a resident alien will need to provide a copy of both sides of his or her alien card and identify his or her country of origin. If there are discrepancies between reported and verified data, supporting legal documentation must be provided by the applicant. When legal documentation is not available and **SSA** benefits have been verified, this requirement has been met.

Verification of alien status can be made through the U.S. Bureau of Citizenship and Immigration Services' Systematic Alien Verification for Entitlement (SAVE) program.

5. Provide a Social Security Number (**SSN**) or be willing to apply for one ([20.3.2 Social Security Number](#)).

Applications without the SSN will not be returned. Applicants will be contacted and given an opportunity to provide a SSN. Eligibility will not be confirmed until the SSN or proof of application for SSN has been supplied. If the SSN or the proof of application is not received within 30 days of application for SC, eligibility will be denied and any enrollment fee received will be refunded. The individual can reapply once they have their SSN. The Eligibility begin date will be based on the new application receipt date.

If a person requires assistance in obtaining a SSN, the SC Program will assist him or her in applying for one.

6. Not be a full-benefit Medicaid member ([21.2 Full Benefit Medicaid](#)). This includes participants who are covered by Family Care Medicaid. (See the [BadgerCare+ Handbook](#))

Individuals are not considered Medicaid recipients for SeniorCare if they have an unmet Medicaid deductible ([24.2 Medicaid Deductible Introduction](#)) or receive one of the following:

- a. Medicare premium assistance ([32.1 Medicare Beneficiaries Introduction](#)).
 - b. Family Care non-Medicaid (See the [BadgerCare+ Handbook](#))
 - c. [TB](#) -related Medicaid ([25.7 Tuberculosis](#))
 - d. Emergency Services.
7. Not be an inmate of a [public institution](#) ([6.9.3 Inmates of State Correctional Institutions](#)).
 8. Cooperate with providing information and/or verification necessary to determine eligibility ([20.2 General Rules](#)) and for quality assurance purposes.

If a person requires assistance in obtaining the required verification, the SeniorCare program will assist him or her.

If a person is not able to produce the required verification, and the SeniorCare program is not able to produce the required verification, the SeniorCare program may not deny assistance.

If a person is able to produce required verification but refuses or fails to do so, the application will be denied.

33.3.2 Enrollment Fee

In addition to the non-financial requirements listed above, each applicant must pay a \$30 annual enrollment fee. The enrollment fee must be paid prior to eligibility confirmation. When a participant reapplies for a new benefit period, a new enrollment fee is required.

When a SeniorCare enrollment fee check is returned for non-sufficient funds, the applicant is mailed a form letter and provided ten calendar days to submit a replacement check. If a replacement check is not received, a form letter giving another 10 days to replace the fee is sent to the participant. If the check is still not replaced, then the eligibility is terminated. A notice of decision is mailed to the participant. The termination date is 10 days after the notice of the decision (mail) date.

33.3.2.1 Refunds

No Application Received

If **CAPO** receives a fee without an application a manual notice and application will be sent, if possible, to the individual from whom the fee was received. If an Application is not received by CAPO within 45 days of the receipt of the fee, a refund will be processed at the request of the person who submitted the fee.

Application Denied

Anytime an application for SeniorCare is denied, a refund of the paid enrollment fee is automatically issued. A refund may be requested prior to eligibility being confirmed or within specified timelines outlined below.

Opt out

Refunds are based on individual participation. A SeniorCare participant may receive an enrollment fee refund if he or she received an initial eligibility notification, but has not received any SeniorCare prescription drug benefits or services and requests to withdraw from the program ([33.12.2 Withdrawal](#)).

SeniorCare prescription drug benefits include use of the SeniorCare card to receive discounted drug prices in levels 1, 2a, and 2b. A refund may be issued if such charges are reversed by the pharmacy.

Use of the SeniorCare card at Level 3 where a spenddown has not been met constitutes receipt of SeniorCare prescription drug services. A refund may be issued if such claims are reversed by the pharmacy.

Example 1: Henry was a SeniorCare participant at Level 1 whose benefit period began 12/01/04. Henry passed away on 12/04/04. His daughter reported Henry's death to the SeniorCare program on 12/10/04 and requested a refund of his \$30 enrollment fee. Henry's SeniorCare card had been used on 12/01/04 to purchase a prescription, however the pharmacy had reversed those charges on 12/05/04 since Henry's prescription had not been picked up. The \$30 enrollment fee should be refunded in this case since Henry did not receive any SeniorCare prescription drug benefits or services.

Example 2: Julie is a SeniorCare participant at Level 2b. Julie's SeniorCare application filing date was 10/26/04 and her benefit period began 11/01/04. On 11/15/04 Julie calls SeniorCare Customer Service Hotline to withdraw from the SeniorCare program and request a refund of her \$30 enrollment fee. Julie used her SeniorCare card on 11/10/04 when she purchased a prescription. Although Julie requested a refund within 30 days of her application filing date, she is not entitled to a refund, because she received her prescription at a discounted cost by using her SeniorCare card.

Example 3: Mike is a Level 3 SeniorCare participant . Mike's SeniorCare application filing date was 10/28/04 and his benefit period began 11/01/04. On 11/20/04, Mike requests to withdraw from the SeniorCare program and that his \$30 enrollment fee be refunded to him. Mike used his SeniorCare card on 11/18/04 when

he purchased a prescription, however, he had not met his Level 3 spenddown, so he did not receive a discounted price for his prescription. Mike is entitled to a refund of his enrollment fee if the pharmacy reverses this prescription claim. He made the refund request within 30 days of his application filing date and he has not received any SeniorCare prescription drug benefits or services. If the claims are not reversed, Mike is not entitled to a refund.

In all opt-out cases, a refund will be issued only if the request to withdraw from the SeniorCare program is received by the later of:

1. Ten days following issuance of the eligibility notice, **or**
2. 30 days from the application filing date.

The date by which a request for refund must be received will be printed on the initial eligibility determination notice. Filing of a hearing request will not delay these deadlines for refunds.

33.3.2.2 Refunds to Deceased Participants

A refund may also be requested by the family *member* of a deceased participant when all the following criteria are met:

1. He or she received an eligibility notification, and
2. Death occurs prior to the start of or within 30 days of the beginning of the SeniorCare benefit period, and
3. The request is made within 45 days of the date of death; and
4. He or she had not received any SeniorCare prescription drug benefits or services.

Note: If all of the above conditions are met, a refund will be issued even if the death is reported beyond the refund deadline date.

33.3.2.3 Opt In

Once the opt-out of eligibility is confirmed, the participant will have 30-days to contact the CAPO if he or she chooses to “opt in” to the program. He or she would need to send another enrollment fee if the original enrollment fee has been refunded. A new application is not required to opt in.

A participant who decides after the 30-day period that he or she wants to rejoin the program will need to complete a new application and submit the enrollment fee.

33.3.3 Age Limitation

A single applicant should apply for SeniorCare no sooner than the calendar month before his or her 65th birthday.

When a couple applies where one *spouse* is 65 or older and the other is under 65 at the time of application, only the spouse that is 65 or older can be determined eligible. If both apply, the younger spouse would be denied SeniorCare unless he or she is turning 65 within the current or next calendar month. If the younger spouse will turn 65 within the 12-month enrollment period, he or she will receive a notice pending his or her eligibility for the enrollment fee approximately one month prior to his or her 65th birthday.

33.3.4 Other Insurance

Applicants who have prescription drug coverage under other health insurance plans, including Medicare Parts A and B, may enroll in SeniorCare. SeniorCare is the payor of last resort except state funded only programs such as Wisconsin Chronic Disease Program (WCDP) and HIRSP.

SeniorCare will coordinate benefit coverage with all other health insurance coverage. SeniorCare may also coordinate benefits with pharmacies that accept discount cards. Questions about individual health insurance coverage should be directed to the health insurance company. Questions regarding insurance carriers should be directed to:

Office of Commissioner of Insurance
Bureau of Market Regulation
PO Box 7873
Madison, WI 53707-7873
1-800-236-8517

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

33.4 SC FISCAL TEST GROUP (FTG)

The **FTG** consists solely of an **applicant** , unless the applicant is married and resides with his or her **spouse** .

If the applicant is married and resides with his or her spouse, the FTG consists of both the applicant and his or her spouse. An applicant is considered to be residing with his or her spouse if the permanent residence of the spouse is the same as that of the applicant.

Exceptions: The FTG consists only of the applicant if:

1. One spouse is institutionalized and is expected to be out of the home for 30 or more days, **or**
2. The applicant's spouse is a [SSI](#) recipient, **or**
3. The applicants are married but are living separately, **or**
4. Both spouses are living in a nursing home.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

33.5 SC BENEFIT PERIOD

[33.5.1 SC Benefit Period Introduction](#)

[33.5.2 ID Cards](#)

[33.5.3 Eligibility Begin Date](#)

33.5.1 SC Benefit Period Introduction

The benefit period for **SC** is 12 consecutive months. The benefit period and eligibility remain intact unless the participant :

1. Moves out of state,
2. Reapplies ([33.11 SC Re-Application](#)),
3. Requests to withdraw from the program ([33.12 SC Early Termination](#)), **or**
4. Dies.

33.5.2 ID Cards

When an **applicant** is found eligible for SC, he or she is mailed a plastic SeniorCare ID card and information about how to use it. SC participants who renew their eligibility will continue to use their original card.

33.5.3 Eligibility Begin Date

SC begins on the first day of the month following the month in which all eligibility requirements have been met.

Exception: SC eligibility begins the day after MA eligibility ends if a SC application is submitted prior to the MA termination date and all eligibility requirements are met.

Example 1: Carol applies for SC on September 19th and meets all eligibility requirements. Her application is processed on October 10th, and eligibility is confirmed the same day. Carol's benefit period is from October 1st through September 30th.

Example 2: William applied for SC on September 19th but did not submit the enrollment fee with his application. His eligibility "pends" and a notice is issued. William submits the fee on October 1st and eligibility is confirmed the same day. William's benefit period is from November 1st through October 31st.

Example 3: Mary is notified that MA eligibility will end on November 30th because her assets exceed the limit. She applied for SC on November 29th and will meet all SC eligibility requirements on December 1st (when she is no longer an MA member). Mary's benefit period is from December 1st through November 30th.

Note: If a gap in coverage of not more than one month occurs due to an agency error, eligibility for a new 12 month benefit period begins the first of the month the completed application is received and all eligibility requirements are met, including payment of the annual enrollment fee.

Example 4: Harold's PPRA was mailed to him on December 13th to be completed for his new benefit period, that begins February 1st. The PPRA was mailed to the last known address in CARES which belonged to Harold's wife Mary who was in a nursing home. Mary passed away on May 2nd of this year and although the local agency worker ended her Medicaid eligibility, the case address was not updated in CARES. Harold has not moved, so he was not required to report a change of address to the SeniorCare program. Due to the incorrect address Harold did not receive the PPRA form to complete until late in January. The completed PPRA was received by the SeniorCare program on February 10th along with a letter explaining why it was late. Harold's new SeniorCare benefit period is February 1st through January 31st since the one month gap in coverage was due to an agency error.

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Release Date: 02/01/08
Effective Date: 02/01/08*

33.6 SC FINANCIAL REQUIREMENTS

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[33.6.8.2 Farm Subsidy](#)

[33.6.8.3 Rental Income](#)

[33.6.8.4 Veterans' Disability](#)

[33.6.9 Disregarded Income](#)

Income information for **SC** is based on the applicant's good faith estimate of income for the next 12 months beginning with the month of application. Last year's information

from tax returns or other sources may be used as a guide when determining the estimate.

All income should be rounded to the nearest whole dollar when entering the amount on the application or renewal application.

33.6.1 Assets

There is no asset test for SC. In general, cash that is received as a result of converting an asset from one form to another, is not income. This includes withdrawals from savings and/or checking accounts, certificates of deposit, or money market accounts. However, special provisions apply to retirement benefits (See [33.6.7.1 Retirement Benefits](#)). Income generated from any assets that the SC participant may have is considered budgetable income and must be reported on the application or renewal application.

Example 1: Eric has a savings account with \$5,000 in it. Eric's savings account is considered an asset, but the interest that he anticipates earning is countable income.

Eric anticipates withdrawing \$1,000 from his savings account during the coming year. This amount does not count as income. It is an asset that has been converted to cash. Only the interest Eric anticipates receiving from the savings account is countable income. Any withdrawals from his savings account are considered the conversion of an asset, and are not counted as income.

33.6.2 Income

The income of a *spouse* who is in the SC *FTG* is included in the estimate of the annual budgetable income, even if he or she does not apply or is non-financially ineligible.

Annual income is determined prospectively from the month of application through the next 12 calendar months. Income exempted for Medicaid eligibility is also exempted for SC ([15.3 Disregarded Income](#)), including Earned Income Tax Credit (*EITC*) and income tax refunds ([15.5.8 Income and EITC Tax Refunds](#)).

Budgetable income consists of projected gross annual income, except for self-employment income, which uses net income. ([33.6.6 Self-Employment Earnings](#)).

In the following income related sections, policy is defined according to the categories on the SeniorCare Application Form ([F-10076](#)). All income listed in the following sections should be prospectively budgeted for a 12-month period beginning with the month of application.

33.6.3 Gross Social Security

When calculating anticipated gross annual Social Security income, add any deductions for Medicare Part B or D and court ordered guardianship fees, alimony and/or child support to the net payment amount.

Exception: If a SC *applicant* is receiving *Medicare premium assistance* ([32.1 Medicare Beneficiaries Introduction](#)), his or her monthly payment already includes the Medicare Part B premium.

The applicant should contact the Social Security Administration at 1-800-772-1213 if he or she does not know his or her Medicare premium amount.

When the applicant is a surviving spouse receiving benefits under his or her spouse's Social Security number, the amount should be considered the applicant's income and reported under the applicant's income column of the application.

33.6.4 Gross Earnings

Budgetable gross earnings consist of all gross earned income, except for self-employment income, which uses net income ([33.6.6 Self-Employment Earnings](#)). Gross earnings include the following:

1. AmeriCorps ([15.5.10 AmeriCorps](#)),
2. Contractual Income ([15.5.2 Contractual Income](#)),
3. Governor's Central City Initiative ([15.5.7 Governor's Central City Initiative](#)),
4. Income In Kind ([15.5.1 Income In Kind](#)),
5. Income Received By Members of a Religious Order ([15.4.16 Income Received by Members of a Religious Order](#), [15.5.13 Income Received by Members of a Religious Order](#)),
6. Jury Duty Payments ([15.5.4 Jury Duty Payments](#)),
7. Salary,
8. Severance Pay ([15.5.12 Severance Pay](#)),
9. Wage Advances ([15.5.5 Wage Advances](#)),
10. Wages,
11. Wages and salaries received from a program funded under Title V – Older Americans Act of 1965 ([15.5.14 Title V – Older Americans Act of 1965](#)),
12. Worker's Compensation ([15.5.6 Worker's Compensation](#)),
13. Respite Care Payment for Services

33.6.5 Interest and Dividends

The SC applicant must report the estimated gross amount of all interest and dividends that he or she expects to receive in the next 12 months, beginning with the month of application. Sources of interest and dividends include, but are not limited to the following:

1. Bonds,

2. Certificates of Deposit (CD),
3. Checking Accounts,
4. Money Market Accounts,
5. Savings Accounts
6. Stocks,
7. Capital Gains ([33.6.5.1 Capital Gains](#))
8. Trusts ([33.6.5.2 Trusts](#))
9. Individual Retirement Accounts ([15.4.4 Retirement Benefits](#))
10. Annuities
11. Land Contracts ([15.4.7 Land Contract](#))
12. Loans ([15.4.8 Loans](#))

Payments do not need to be directly received. If they are rolled back into the asset, they still must be reported.

Irrevocable interest that a SC applicant receives for an irrevocable burial trust is not budgetable income.

Note: Unlike Medicaid, income that is received irregularly infrequently, and under \$20 per month should be reported as budgetable income for SC applicants.

33.6.5.1 Capital Gains

Budgetable income consists of all anticipated capital gains that would be reportable as capital gains to the IRS for tax purposes. All anticipated losses should be subtracted from the gross capital gains amount, and the net capital gain amount should be reported if it is greater than zero. Negative amounts should not be reported and shall not be used to offset other types of income.

The principal or initial investment in the capital asset that the person receives in cash when he or she sells the asset is not considered income. That portion is considered a conversion of an asset from one form to another.

33.6.5.2 Trusts

All anticipated payments (including interest, dividends and withdrawals from principal) from a trust to the applicant are counted as income.

Irrevocable interest that a SC applicant receives for an irrevocable burial trust is not budgetable income.

Note: Unlike Medicaid, withdrawals from principle are counted for SC as income in the month received.

33.6.5.3 Joint Savings

Each person who is a holder in a joint savings account is assigned an equal share of the interest earned. The applicant/applicant's spouse should report only his or her share of the interest.

If the applicant and his or her spouse are not living together and hold a joint savings account, the applicant should only report his or her share of the interest

33.6.6 Self-Employment Earnings

SC will budget net self-employment income, which is calculated by deducting estimated business expenses, losses, and depreciation from gross self-employment income.

If the net self-employment earnings are anticipated to be a loss, the amount should be reported as zero.

Negative amounts should not be reported and shall not be used to offset other income. ([15.6.5.2 Worksheets](#))

33.6.6.1 Rental Income

If rental income is reported to the IRS as self-employment income and is subject to the federal self-employment tax for rental income (usually real estate agents or individuals in a business where extensive services are provided to the renters), depreciation should also be deducted from the gross rental income.

Refer to [33.6.8.3 Rental Income](#) if rental income is not reported as self-employment income.

Note: See section [15.5.3 Rental Income](#), items #1 and 2, for more information about calculating net rental income for SC participants.

33.6.7 Gross Pension

Examples of income that should be included in the gross pension amount include:

1. Railroad Retirement Benefits,
2. Retirement Benefits ([33.6.7.1 Retirement Benefits](#)),
3. Veterans Benefits. ([15.3.26 VA Allowances](#))

33.6.7.1 Retirement Benefits

Retirement benefits are work-related plans for providing income when employment ends (e.g., pension, *disability*, or retirement plans administered by an employer or union). Other examples are funds held in an individual retirement account (IRA) and plans for self-employed individuals, sometimes referred to as Keogh plans.

Retirement accounts, including individual retirement accounts (IRA), Keogh, etc., are assets, and are therefore not counted for SC.

Periodic payments received from a retirement account or annuity are counted as income. A periodic payment is any partial payment from a retirement account.

Withdrawal of the full amount from any retirement account that has never had a withdrawal made from it is not considered a periodic payment and is not countable income.

Note: Rolling over an IRA (transferring the funds from one IRA to another) is the conversion of an asset from one form to another. Any potential income from an IRA rollover is countable income for SC.

Example 2: Mike owns a \$2000 IRA and plans to withdraw all of it this year. Mike has not withdrawn any money from this IRA in the past.

If Mike withdraws the full \$2,000 at one time, the \$2,000 continues to be considered an asset. This is a conversion from one form of an asset to another.

If Mike were planning to make a one time withdrawal of \$1,000 of the \$2,000 from his IRA in the next 12 months, the \$1,000 would be considered income on his SeniorCare application.

If Mike were planning to withdraw \$100 monthly from his IRA in the next 12 months, the \$100 he plans to receive monthly from the IRA is counted as income on his SeniorCare application.

33.6.8 Other Income

Examples of other income are:

1. Allocated income from a Medicaid member spouse ([33.6.8.1 Allocated Income from a Medicaid Recipient's Spouse](#)),
2. Child Support ([15.4.14 Child Support](#)),
3. Federal Farm Subsidy ([33.6.8.2 Farm Subsidy](#)),
4. Gifts ([15.4.6 Gifts](#)),
5. Profit sharing ([15.4.15 Profit Sharing](#)),
6. Sick/ *Disability* benefits ([15.4.2 Sick Benefits](#)),
7. Rental income ([33.6.8.3 Rental Income](#)),
8. Unemployment Compensation ([15.4.3 Unemployment Compensation \(UC \)](#)),
9. Veterans Disability Payments ([33.6.8.4 Veterans Disability](#))

33.6.8.1 Allocated Income from a Medicaid Recipient's Spouse

SC applicants with a Medicaid member spouse living outside of the home (e.g. in a nursing home) must report the spousal income allocation amount ([18.6 Spousal Impoverishment Income Allocation](#)) as income.

Example 3: Betty is a Medicaid member and in the nursing home. She is allowed to allocate up to \$1,000 to her spouse, Carl, according to the notice she receives. Betty only actually has \$650 available, and of that \$45 is set aside as her personal needs allowance. \$605 per month that she allocates to Carl would be counted as unearned income for Carl. He would report \$7,260 as “Other Income” on his SeniorCare Application.

A SC applicant with a Medicaid member spouse living in the home (e.g. a community waivers participant) should not report income that is allocated to him or her. The allocated amount must be included in the income estimate for the Medicaid member spouse, because he or she is living in the home.

33.6.8.2 Farm Subsidy

The SeniorCare applicant must report anticipated farm subsidy payments. The SeniorCare applicant must also report payments from the Conservation Reserve Enhancement Program (CREP), a program where the landowner is paid to install conservation practices for a period of 10 to 15 years.

33.6.8.3 Rental Income

All expected rental income will be budgeted for SeniorCare. Annual operating expenses should be deducted from the annual amount of gross rental income. Operating expenses include ordinary and necessary expenses such as insurance, utilities, taxes, advertising for tenants, and repairs. Repairs include expenses such as repainting, fixing gutters or floors, plastering and replacing broken windows.

Refer to [33.6.6.1 Rental](#) Income if rental income is reported to the IRS as self-employment income.

33.6.8.4 Veterans Disability

Veterans disability payments should be reported as income.

Do not count as income the portion of a veterans disability payment that is for: unusual medical expenses, aid and attendance, or a housebound allowance.

The applicant should check with the Veterans Administration at 1-800-827-1000 to determine if any portion of the payment is considered an allowance for unusual medical expenses, aid and attendance or housebound allowance.

Reimbursement from the Veterans Administration for medical costs does not count as income.

33.6.9 Disregarded Income

The applicant should not report income anticipated from any of the following:

1. Active Corp. of Executives (ACE) ([15.3.22 Special Programs](#))
2. Adoption assistance payments ([15.3.1 Adoption Assistance](#))
3. Agent Orange Settlement Fund payments ([15.3.2 Agent Orange Settlement Fund](#))
4. Disaster and emergency assistance payments made by federal, state, county and local agencies or other disaster assistance agencies ([15.3.5 Disaster and Emergency Assistance](#))
5. Earned Income Tax Credit ([16.7.8 Earned Income Tax Credit \(EITC\)](#))
6. Earnings of a census enumerator ([15.3.22 Special Programs](#))
7. Emergency Fuel Assistance payments ([15.3.22 Special Programs](#))
8. [Foster Care](#) payments ([15.3.7 Foster Care](#))
9. Foster Grandparents Program ([15.3.22 Special Programs](#))
10. Governmental rent or housing subsidies ([15.3.22 Special Programs](#))
11. [Homestead](#) Tax Credit ([15.3.22 Special Programs](#))
12. Income Tax Refunds (both state and federal) ([16.7.7 Income Tax Refunds](#))
13. Individual Development Account payments ([15.3.9 IDA Payments](#))
14. Kinship Care payments ([15.3.11 Kinship Care](#))
15. Low-Income Energy Assistance Program ([15.3.22 Special Programs](#))
16. Older American Community Service Program (except for wages or salaries which are counted) ([15.3.22 Special Programs](#))
17. Payments made to individuals because of their status as victims of Nazi persecution ([15.3.15 Payments to Nazi Victims](#))
18. Payments received from the class action settlement of Susan Walker vs. Bayer Corporation. These payments are to hemophiliacs who contracted the HIV virus from contaminated blood products ([15.3.24 Susan Walker Payments](#))
19. Penalty payments made when the state does not correctly process child support refunds.
20. Radiation Exposure Act program payments made to compensate injury or death due to radiation from nuclear testing and uranium mining ([15.3.16 Radiation Exposure Compensation Act](#)).
21. Reimbursement from private insurance company for medical, long-term care, or dependent care expenses ([15.3.19 Reimbursements](#)).
22. Restitution payments to individual Japanese-Americans (or their survivors) and Aleuts who were interned or relocated during WWII ([15.3.27 Wartime Relocation of Citizens](#)).
23. Retired Senior Volunteer Program (RSVP) ([15.3.22 Special Programs](#))
24. Reverse mortgage payments ([16.7.2.1 Reverse Mortgage](#))
25. Service Corp. of Retired Executives (SCORE) ([15.3.22 Special Programs](#))
26. University Year for Action Program ([15.3.22 Special Programs](#))

- 27. Volunteers in Service to America (VISTA) ([15.3.22 Special Programs](#))
- 28. W-2 payments for transitional jobs and community service jobs ([15.3.28 W2 Payments](#))
- 29. Wisconsin's Family Support Program ([15.3.22 Special Programs](#))
- 30. Do not count payments from Indian Health Services. **Note:** Payments to Native Americans listed in [15.3.14 Payments to Native Americans](#) must be counted.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

33.7 SC PARTICIPATION LEVELS

See [39.11 SeniorCare Income Limits](#)

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

33.8 SC COUNTABLE COSTS

[33.8.1 SC Countable Costs Introduction](#)

[33.8.2 Carryover](#)

[33.8.3 Date of Purchase](#)

33.8.1 SC Countable Costs Introduction

In order for the prescription drug purchase to count towards meeting a spenddown or deductible, it must be:

1. Prescribed for the eligible [SC](#) participant,
2. Purchased during the benefit period, and
3. Covered by the SeniorCare program ([33.6 SC Financial Requirements](#)).

All covered prescription drug costs the participant incurs will be tracked, and the SeniorCare Program will coordinate coverage with insurance companies. If the prescription is covered by insurance, only the portion not paid by insurance is applied toward the spenddown or deductible.

When a participant's out-of-pocket expense requirements are met for a deductible or spenddown, participating pharmacies will be informed.

33.8.2 Carryover

There is no carryover of prescription costs from one benefit period to the next. There are two instances, within a benefit period, when carryover covered prescription amounts are applied.

1. When the covered prescription cost exceeds the remaining deductible amount, SeniorCare pays the difference.

Example 1: Jeff earns between 160% and 200% of the *FPL* for a *FTG* size of one ([39.11 SeniorCare Income Limits and Participation Levels](#)). He is eligible for SeniorCare and has a \$500 deductible. In three months, Jeff has a remaining deductible amount of \$30.

During the fourth month of his benefit period, with a \$30 remaining deductible, Jeff purchases a covered prescription drug that costs \$100. The pharmacist informs him that he owes \$30 of the \$100 prescription drug cost. He has met his deductible. The remaining \$70 will be paid by SeniorCare.

For the next prescriptions that Jeff has filled during his benefit period, he will pay only co-payment amounts.

2. When the cost of a covered prescription drug is applied toward meeting the spenddown and the amount exceeds the remaining spenddown amount, the excess will be applied toward the deductible.

Example 2: Rachel earns \$27,793 which is \$1,800 more than 240% of the *FPL* for a *FTG* of one ([39.11 SeniorCare Income Limits and Participation Levels](#)). Her spenddown amount for the 12-month benefit period is \$1,800. In four months Rachel has incurred all but \$50 of her spenddown amount by purchasing covered prescription drugs at retail price.

During the fifth month of her benefit period, when she has \$50 of her spenddown left, Rachel purchases a covered prescription drug that costs \$100. Rachel pays the full \$100. Of the \$100, \$50 is applied to her spenddown, and \$50 is applied to her deductible. She now has satisfied the spenddown, and the remaining deductible amount is \$800.

33.8.3 Date of Purchase

A prescription is considered purchased on the date the prescription is filled. For the drug purchase to count toward either the spenddown or the deductible, the prescription must have been purchased during the benefit period.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

33.9 SC ADDITION OF A SPOUSE

[33.9.1 SC Addition of a Spouse Introduction](#)

[33.9.2 Adding a Spouse No Change in FTG](#)

[33.9.2.1 Adding a Spouse, No FTG Change, At Levels 2a and 2b](#)

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[33.9.3 FTG Changes](#)

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[33.9.4 Addition of a Spouse Summary Table](#)

33.9.1 SC Addition of a Spouse Introduction

The following exceptions apply when one *spouse* (hereafter referred to as *Spouse 2*) is determined eligible after the participating spouse's (hereafter referred to as Spouse 1) benefit period has begun.

In all of these situations, Spouse 1's eligibility and benefit period does not change, unless he or she chooses to reapply ([33.11 SC Re-Application](#)).

If Spouse 2 becomes eligible after Spouse 1's benefit period has begun, Spouse 2's benefit period ends on the same date that Spouse 1's benefit period ends.

The participation level for Spouse 2 depends on whether:

1. Spouse 2 was married and living with Spouse 1 at the time of Spouse 1's application ([33.9.2 Adding a Spouse No Change in FTG](#)).
 - a. If spouse 1's eligibility was determined at level 2a or 2b, then refer to [33.9.2 Adding a Spouse No Change in FTG](#).
 - b. If spouse 1's eligibility was determined at level 3 then refer to ([33.9.2.2 Adding a Spouse, No FTG Change, At level 3](#))
 - Met spenddown ([33.9.2.2.1 Unmet Spenddown](#))
 - Unmet spend ([33.9.2.2.2 Met Spenddown](#))

Or

2. Spouse 2 was not included in the [FTG](#) (e.g. single or not living with Spouse 1) at the time of Spouse 1's application. ([33.9.3 FTG Changes](#)), but they are now residing together.
 1.
 - a. If spouse 1's eligibility was determined at level at level 2a or 2b, refer to [33.9.3.1 FTG Changes at Level 2a and 2b](#))
 - b. If spouse 1's eligibility was determined at level 3, refer to [33.9.3.2 FTG Changes At Level 3](#)

See [33.9.4 Addition of a Spouse Summary Table](#)

33.9.2 Adding a Spouse No Change in FTG

If Spouse 2's participation level is determined after Spouse 1's and Spouse 2 was included in the original FTG (married and living with Spouse 1 at the time of Spouse 1's application) the participation level for Spouse 2 is determined based on annual *income* information provided on Spouse 1's application.

Example 1: Tyler and Anne are married and live together. Tyler has significant prescription drug expenses and applies for [SC](#). Anne takes no prescription drugs and does not request SeniorCare when Tyler applies in March. Tyler's participation level is based on a FTG of two. Tyler is found eligible, and his benefit period begins April 1st.

In September, Anne is diagnosed with a health problem and begins taking prescription drugs. She applies for SeniorCare on September 15th. The same income information provided in March is used to determine Anne's eligibility, even though Tyler has since obtained a part-time job and has additional income.

Anne's benefit period is from October 1st through March 31st so her benefit period ends at the same time as Tyler's. They will report the income from Tyler's part-time job when their SeniorCare eligibility is reviewed in March.

33.9.2.1 Adding A Spouse, No FTG Change, At Levels 2a and 2b

Spouse 2's deductible is prorated if the couple's gross annual income is between 160% and 240% of the *FPL*, and Spouse 2 becomes SeniorCare eligible after Spouse 1's benefit period has begun. To prorate the deductible, multiply the required deductible amount (\$500/\$850) by the number of months in Spouse 2's benefit period and divide by 12.

Example 2: Mary and Jim apply for SeniorCare in January. They have an annual income of \$28,800, which is between 160% and 200% of the FPL for a FTG of two ([39.11](#)). Their income places them in Level 2a (\$500 deductible).

Jim is determined eligible for SeniorCare, but Mary's eligibility for SeniorCare is denied because she is 64. Mary is refunded her enrollment fee. Jim's 12-month benefit period begins February 1st. Jim has a \$500 deductible.

In June, Mary will turn 65. At [adverse action](#) in the month of May, CARES will process this case through batch. At that time, the application status is updated if the [applicant](#) who is turning 65 is:

1. In an open SeniorCare case, **and**
2. The individual has requested SeniorCare.

A letter is sent to Mary notifying her that if she still wishes to participate in SeniorCare, she must submit her \$30 annual enrollment fee. If Mary's enrollment fee

is received before July 1st, she will be determined eligible beginning July 1st.

Mary's benefit period begins August 1st, and ends January 31st, when Jim's benefit period ends. Mary's deductible is prorated. Since there are six months in her benefit period, \$500 is multiplied by six and the total is divided by 12.

$$\$500 \times 6 = \$3,000 / 12 = \$250$$

Mary's deductible is \$250. Once Mary meets the \$250 deductible by purchasing covered prescription drugs, she is eligible to purchase covered prescription drugs at the co-payment amounts through the remainder of her benefit period.

Jim's eligibility and benefit period are not affected. If the couple's income were between 200% and 240% of the FPL, the example would be the same except that the \$500 deductible would be \$850.

33.9.2.2 Adding A Spouse, No FTG Change, At level 3

If the couple's income is greater than 240% of the FPL and Spouse 2 becomes eligible after Spouse 1's benefit period has begun, the procedure differs according to whether the spenddown has been met at the time Spouse 2's eligibility begins.

33.9.2.2.1 Unmet Spenddown

When Spouse 2 is added before Spouse 1 has met the spenddown, covered prescription drug purchases of both spouses will count toward the remaining spenddown requirement.

After the spenddown has been met, both spouses begin to participate at Level 2b, and each will have a deductible requirement. The deductible for Spouse 1 is \$850. The deductible for Spouse 2 is prorated ([33.9.3.1 FTG Changes at Level 2a and 2b](#)).

Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After a spouse has met his or her deductible, he or she purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period.

Example 3: Reginald and Elizabeth's joint income is \$35,856, which is \$3,000 more than 240% of the FPL for a FTG of two. Elizabeth applies in December and is determined eligible for SeniorCare effective January 1st. Only Elizabeth's covered prescription drug costs are applied toward the spenddown.

In March, Reginald turns 65 and is determined eligible for SeniorCare beginning April

1st. His benefit period ends December 31st, when Elizabeth's ends. Since Elizabeth has not yet met the spenddown when Reginald's eligibility begins, both spouses' covered prescription expenses are applied toward the remaining spenddown amount, beginning April 1st.

In June, Elizabeth and Reginald meet the spenddown. Elizabeth has a \$850 deductible, but Reginald's deductible is prorated. Since there are nine months in his benefit period, \$850 is multiplied by nine and the total is divided by 12.

$$\$850 \times 9 = \$7,650 / 12 = \$638$$

Reginald's deductible is \$638. Once Reginald meets the \$638 deductible, he purchases covered prescription drugs at the co-payment amounts through the remainder of his benefit period. Once Elizabeth meets her \$850 deductible, she purchases covered prescription drugs at the co-payment amounts through the remainder of the benefit period.

33.9.2.2.2 Met Spenddown

When a second spouse is added after the spenddown has been met, the eligibility and benefit period for Spouse 1 is not affected.

If Spouse 2's income was included in Spouse 1's determination and the spenddown has been met, the deductible for Spouse 2 is prorated (33.9.2.1).

Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After a spouse has met his or her deductible, he or she purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period.

Example 4: Bob and Bernice's joint income is \$33,856, which is \$1,000 more than 240% of the FPL for a FTG of two. Bernice applies in December and is determined eligible for SeniorCare effective January 1st. Bob does not apply because he is not yet 65 years old. Only Bernice's covered prescription drug costs are applied toward the spenddown amount of \$1,000.

Bernice meets the spenddown requirement in April. She then begins purchasing covered prescription drugs that count toward her \$850 deductible. In June, she has \$100 left before she will meet her deductible.

In May, Bob turns 65 and is determined eligible for SeniorCare. His eligibility begin date is June 1st. His benefit period ends December 31st, when Bernice's ends. Since Bernice has already met the spenddown requirement, Bob will begin participating at

Level 2b. His deductible will be prorated. Since there are seven months in his benefit period, \$850 is multiplied by seven and the total is divided by 12.

$$\$850 \times 7 = \$5,950/12 = \$496$$

Bob's deductible is \$496. After he meets the \$496 deductible by purchasing covered prescription drugs, he purchases covered prescription drugs at co-payment amounts for the remainder of his benefit period.

Bernice's eligibility and benefit period are not affected. Once she meets her deductible by purchasing another \$100 in covered prescription drugs, she purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period.

33.9.3 FTG Changes

When a married SeniorCare participant applies after Spouse 1's benefit period has begun, and Spouse 2 was not included in the FTG when the participation level for Spouse 1 was determined:

1. The gross annual income test for Spouse 2 is based on a FTG of two, **and**
2. Gross annual income for Spouse 2 is determined prospectively beginning with the month Spouse 2's request is received, **and**
3. The eligibility and benefit period for Spouse 1 is not affected, unless he or she chooses to reapply.

Example 5: Jim is a SeniorCare participant from September through August. Because he was not married and living with a spouse when he applied, Jim's benefit level was based on a FTG of one.

In January, Jim marries Helen. Helen applies for SeniorCare in February. Jim's eligibility is not re-determined when Helen applies.

Helen's participation level is determined based on a FTG of two. Income is estimated for Helen prospectively for the 12-month period beginning in February.

Helen's benefit period begins in March, if she met all eligibility requirements in February. Helen's benefit period ends in August, when Jim's benefit period ends.

33.9.3.1 FTG Changes at Level 2a and 2b

Spouse's 2 deductible is prorated ([33.9.3.1 FTG Changes at Level 2a and 2b](#)) when income for Spouse 2, based on a FTG of two, is determined to be above 160% but less

than or equal to 240% of the FPL and Spouse 2 is added to the case after Spouse 1's benefit period has begun.

Example 6: Will is married, but he and his wife Grace were separated at the time he applied for SeniorCare.

Will applies for SeniorCare in October. Will's benefit level is based on a FTG of one, using only his income. Will's gross annual income is \$13,176, which is less than 160% of the FPL for a FTG of one.

Will is determined to be SeniorCare eligible at Level 1 beginning November 1st. His 12-month benefit period ends the following October. Will does not pay a deductible or spenddown. He purchases covered prescription drugs at the co-payment amounts.

Grace returns home in January. She applies for SeniorCare in February and is determined eligible beginning March 1st. Grace's benefit level is determined based on a FTG of two. Their joint income is determined to be \$27,656, which is between 200% and 240% of the FPL for a FTG of two. Her benefit period ends October 31st, when Will's benefit period ends.

Since there are eight months in her benefit period, Grace's deductible amount is prorated. The deductible amount of \$850 is multiplied by eight and then divided by 12.

$$\$850 \times 8 = \$6,800 / 12 = \$567$$

Grace's deductible amount is \$567. After she has met her deductible, she purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period. Will's eligibility and benefit period are not affected.

33.9.3.2 FTG Changes At Level 3

Spouse 2's spenddown is prorated only if:

The income for Spouse 2, based on a FTG of two, is determined to be above 240% of the FPL, **and**

1. Spouse 2 becomes eligible after Spouse 1's benefit period has begun, **and**
2. Spouse 2 was not included in the FTG when the participation level for Spouse # 1 was determined.

To prorate Spouse 2's spenddown, multiply the amount of income exceeding 240% FPL by the number of months of Spouse 2's benefit period and divide by 12. The result is equal to the prorated spenddown amount of Spouse 2. Only covered prescription drug costs of Spouse 2 count toward the prorated spenddown.

After the spenddown has been met, the deductible for Spouse 2 is prorated ([33.9.3.1 FTG Changes at Level 2a and 2b](#)). Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After the deductible is met, he or she purchases covered remainder of the benefit period.

Example 7: Tim is married, but his wife Marsha was institutionalized at the time he applied for SeniorCare. Marsha was expected to be out of the home for five months.

Tim applies for SeniorCare in May. Tim's benefit level is based on a FTG of one.

Tim's gross annual income is \$13,176, which is less than 160% of the FPL for a FTG of one.

Tim is determined to be SeniorCare eligible beginning June 1st. His 12-month benefit period ends the following May. Tim does not pay a deductible or spenddown. He purchases covered prescription drugs at the co-payment amounts.

Tim's wife Marsha returns home in November. She applies for SeniorCare in November and is determined eligible beginning December 1st. Marsha's participation level is determined based on a FTG of two. Their joint income is determined to be \$35,969 which is \$1,000 above 240% of the FPL for a FTG of two. Her benefit period ends May 31st, when Tim's benefit period ends.

Since there are six months in her benefit period, Marsha's spenddown amount is prorated. The spenddown amount of \$1,000 is multiplied by six and then divided by 12.

$$\$1,000 \times 6 = \$6,000 / 12 = \$500$$

Marsha's spenddown amount is \$500. After she has met her spenddown, she then has a prorated deductible. Since there are six months in her benefit period, \$850 is multiplied by six and then divided by 12.

$$\$850 \times 6 = \$5,100 / 12 = \$425$$

Marsha pays for covered prescription drugs until she has met the \$425 deductible.

After Marsha has met the deductible, she purchases covered prescription drugs at the co-payment amounts for the remainder of benefit period.

Tim's eligibility and benefit period are not affected

33.9.4 Addition of a Spouse Summary Table

The following table assumes that Spouse 1 and Spouse 2 do not apply for SeniorCare at the same time.

	SPOUSE 1's Eligibility	SPOUSE 2's Eligibility
Benefit Period: Begin Date	First of month following receipt of a valid application and enrollment fee.	First of month following receipt of a valid application and enrollment fee. Will be later than Spouse 1's begin date.
Benefit Period: End Date	End of twelfth month of eligibility unless terminated early.	Same end date as Spouse 1 regardless of when Spouse 2 applies.
Participation Level: Married at time of Spouse 1's application	FTG of two. Participation Level determined based on annual self-reported income of both spouses.	FTG of two. Participation Level determined based on annual self-reported income from Spouse 1's application. Eligibility results will be the same as Spouse 1.
Participation Level: Single or not living together at time of Spouse 1's application.	Gross annual income test based on a FTG of one. When adding a new spouse, Spouse 1 does not need to reapply until the end of the twelve-month benefit period unless he or she chooses to do so.	Gross annual income test based on a FTG of two. Participation Level determined based on annual self-reported income of both spouses. Participation Level may be different than Spouse 1's. Spouse 2 must estimate income at the time he or she applies. Spouse 1's income remains the same.
Deductible:	Has a \$500/\$850 deductible based on Participation Level.	Required deductible is prorated based on number of months of eligibility and amount of deductible.
Spenddown: Unmet Original FTG of 2	Covered prescription drugs of Spouse 1 used to meet spenddown until Spouse 2 is added. Once spenddown is met, Spouse 1 has a deductible of \$850.	Projected income from Spouse 1's application will be used to determine Spouse 2's eligibility. Covered prescription drugs of both spouses are used to meet the spenddown. Once spenddown is met, Spouse 2 has a prorated deductible.
Spenddown: Met Original FTG of 2	No change in spenddown for Spouse 1.	No new spenddown when Spouse 2 is added. Spouse

		2 has a prorated deductible.
Spenddown: Unmet Original FTG of 1	No change in spenddown for Spouse 1.	Spouse 2 has a prorated spenddown and deductible.
Spenddown: Met Original FTG of 1	No change in spenddown for Spouse 1.	Spouse 2 has a prorated spenddown and deductible.

Note: If Spouse 1 terminates prior to spouse 2's request. A new application is required for a new 12- month benefit period.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

33.10 SC CHANGES

[33.10.1 SC Changes Introduction](#)

[33.10.2 Correction of Errors](#)

[33.10.2.1 Agency Error](#)

[33.10.2.2 Applicant/Participant Error](#)

[33.10.3 Fraud](#)

33.10.1 SC Changes Introduction

The following changes must be reported to the **SC** Program within ten days:

1. Address.
2. Household Composition (examples include marriage, divorce, separation)
3. Death.

Changes may be reported by phone to the SeniorCare Customer Service Hotline at 1-800-657-2038.

Changes may also be reported by writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Participants are asked to include an **SSN** on any written correspondence.

If a participant reports any changes before the case has been confirmed in CARES, the new information will be used in his or her SeniorCare eligibility determination.

Changes reported after the case has been confirmed in CARES will be applied to the participant's SeniorCare benefits as follows:

1. Address change:
 - a. Reports of address changes within Wisconsin will result in SeniorCare notices being sent to the new address. SeniorCare benefit levels will not change for the current benefit period.
 - b. Address changes that result in termination of Wisconsin residency result in discontinuation of SeniorCare benefits. Provide the participant with at least 10 days notice before the effective date of an [adverse action](#).

Note: Reporting an out-of-state address does not necessarily signify that an *applicant* is not a Wisconsin resident ([33.3 SC NonFinancial Requirements](#)).

2. Death

A participant's death ends SeniorCare eligibility on the date of death. A 10-day notice for adverse action is not required when an adverse action is the result of a participant's death. The "early termination date" for the participant should be equal to the participant's date of death.

If a participant's *spouse* dies, the participant will remain eligible at the same benefit level through the current SeniorCare benefit period. The participant may wish to re-apply to establish a new benefit level if the spouse's death will result in a reduction in income.

3. Change in household composition

If a participant experiences a change in household composition, the SeniorCare benefit level will not change through the remainder of the SeniorCare benefit period. The participant may wish to re-apply to establish a new benefit level if the change in household composition will result in a better level of participation.

4. Inmate of a [public institution](#) ([6.9.3 Inmates of State Correctional Institutions](#)).

An inmate of a public institution is ineligible for SeniorCare on the date incarceration begins. Provide the participant with adequate notice before the

effective date of the adverse action. The “early termination date” is equal to the notice mailing date.

If a participant’s spouse is an inmate of a public institution the participant benefit level will remain the same through the current benefit period. The participant may wish to re-apply to establish a new benefit level if the spouse’s incarceration will result in a better level of participation.

5. Change in Circumstance

An applicant who wishes to change or correct information on his or her submitted application may do so prior to eligibility being confirmed in CARES.

Depending on the nature of a client-reported error or agency discovered error, a participant’s eligibility will be re-determined (See [33.10.2 Correction of Errors](#)).

Provide the participant with at least 10 days notice before the effective date of an adverse action. If the case has already been confirmed in CARES, the applicant may opt out and reapply if he or she so desires.

Example 1: Sally and Fred are husband and wife and applied for SeniorCare in July. Both Sally and Fred were found eligible with a deductible (Level 2a) for August. In September, Fred loses his job. He reports the change to the SeniorCare program. This change will not affect Sally or Fred’s SeniorCare benefits, because Fred reported the change after his case had been confirmed in CARES. In order to have eligibility redetermined Fred and Sally will need to file a re-application ([33.11 SC Re-Application](#)) and submit enrollment fees for each. Without the income from Fred’s job, Sally and Fred would be able to purchase prescription drugs at the co-payment level, if a reapplication is filed.

If Fred had reported the change prior to his case being confirmed in CARES, the change would have been applied to Sally and Fred’s eligibility determination, and they would have paid the co-payment amounts for prescription drugs. If Fred and Sally wish, they may request to file a reapplication ([33.11 SC Re-Application](#)) to change their benefit level.

33.10.2 Correction of Errors

All errors made on the SeniorCare Application ([F -0076](#)) must be reported by the participant or his or her *Authorized Representative*, POA, or Guardian to the SeniorCare Customer Services Hotline at 1-800-657-2038 (TTY and translation services are available) or in writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

An error may include, but is not limited to:

1. Doubling of income (totaling income on the application).
2. Income amounts are off by a factor of 100. (lack of decimal)
3. Application processing errors.

An applicant who wishes to change/correct information on his or her submitted application may do so prior to eligibility being confirmed in CARES.

If a participant has been found eligible for either an incorrect SeniorCare benefit level or spenddown amount due to an error, action will be taken to correct the mistake. The effective date of the correction is based on whether the error is determined to be Agency Error or *Applicant* /Participant error, as follows:

33.10.2.1 Agency Error

Agency errors for SeniorCare will be determined on a case by case basis. If the error resulted in an overpayment, past benefits are not recoverable. If the error resulted in an underpayment, corrected benefits will be restored back to initial eligibility date of the current benefit period.

33.10.2.2 Applicant/Participant Error

If the error resulted in an overpayment, benefit recovery will be pursued, and the correction is processed with an effective date based on adverse action notice. Provide the participant with at least 10 days notice before the effective date of an adverse action.

If the error resulted in an underpayment and he or she reported the error within 45 days of the mail date of the notice of decision, restore corrected benefits back to the initial eligibility date of the benefit period. If the error is not reported within 45 days of the notice of decision mail date, the effective date of the correction is the first of the month in which the error is reported.

Example 2: In August, Charlie lost this job at the Burger Palace. In September, Charlie applied for SeniorCare. In his application Charlie erroneously reported income of \$1150 per month from the Burger Palace job. Charlie's notice of decision had a mail date of October 1, and stated that Charlie had a \$1500 spenddown.

Depending on when Charlie reports this error his benefits may be corrected back to the eligibility begin date or the first month in which the error was reported. ([33.10.2 Correction of Errors](#)).

If he reported the error by November 15, within the first 45 days after the notice of decision mail date, his benefits would be corrected back to the original effective date.

If he reported the error November 16 or later (more than 45 days after the notice of

decision mail date), the benefit level change would be made effective the first of the month in which the error was reported.

Example 3: Eric applied for SeniorCare in July and was determined eligible at level 1 effective August 1st. Prior to applying for SeniorCare, Eric got a part-time job that had begun in June. When Eric applied for SeniorCare, he neglected to report his anticipated part-time earnings on the SeniorCare application.

Eric receives his notice of decision, dated August 8th. The notice informs he is eligible at level 1. Eric reviews the income used in his eligibility determination that is printed in the notice. Eric realizes that he forgot to report his earnings from his part – time job and he calls the CS Hotline on August 21 to report his error.

Eric reports to the CS Correspondent that he is working 10 hours per week and earns \$10 per hour. He plans to keep the job as long as possible. He estimates that his earnings will be \$5200 for his 12-month benefit period. The only other income that Eric receives is Social Security. His earnings in addition to the annual Social Security income add up to an annual estimated income of \$19,700. Or level 2b.

Since the income correction will result in a negative impact on his eligibility, the effective date of the corrective benefit is October 1, providing Eric with a 10-day notice of the negative action in his case.

Prior to reporting this mistake, Eric had purchased several prescriptions at the co-pay levels with his SeniorCare Card. Since the correction resulted in Eric's eligibility at level 2b, he must now meet an \$850 deductible between October 1 and July 31 (the end of his 12- month benefit period), SeniorCare will have overpaid Eric's benefits and could seek recovery of the overpaid amount.

33.10.3 Fraud

Fraud is defined as intentionally getting or helping another person get benefits to which he or she is not entitled. Penalties for fraud include a fine of up to \$10,000, imprisonment up to one year, or both, and suspension from the SeniorCare program.

Fraudulent acts include:

1. Intent to provide misleading, fraudulent, omitted, or incomplete information on the SeniorCare application;
2. Not reporting an event that knowingly affects initial or continued eligibility for SeniorCare;
3. Applying for SeniorCare on behalf of another person and use of any part of the benefit for oneself;
4. Allowing another person to use someone else's card to get prescription drugs.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

33.11 SC RE-APPLICATION

SC participants may request to establish a new SeniorCare benefit period at any time. However, it is not beneficial for a SeniorCare participant to reapply unless he or she will experience a reduction in gross annual income. The reduction in annual income may occur for reasons varying from loss of income to household composition changes. This could result in SeniorCare eligibility at a lower income level resulting in a reduction/elimination of spenddown or deductible.

Such a change may result from divorce, marriage, institutionalization or death of a **spouse**, or any other change that results in a significant decrease in income.

To reapply, participants must submit a new application form and pay a \$30 enrollment fee per person. Eligibility will be re-determined for a new 12-month period (within 30 days) after a complete application is received.

When eligibility for a new benefit period is determined, the participant's previous benefit period is terminated, and he or she is not allowed to restart the previous benefit period. Any expenses applied to the previous benefit period will not be applied to the new benefit period.

Eligibility for a new benefit period begins on the first day of the month after a complete application is received and all eligibility requirements are met.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

33.12 SC EARLY TERMINATION

[33.12.1 Early Termination](#)

[33.12.2 Withdrawal](#)

33.12.1 SC Early Termination

SC eligibility is terminated prior to the end of the established benefit period if:

1. A participant no longer meets non-financial eligibility requirements, or
2. S/he requests to withdraw from the program, or
3. S/he requests to establish a new benefit period and eligibility for the new benefit period is confirmed ([33.11 SC Re-Application](#)).

When SeniorCare eligibility has been terminated prior to the end of the established benefit period and the SeniorCare Program is notified that all eligibility requirements are again satisfied, within one calendar month of SeniorCare eligibility termination, the benefit period is restored.

Exception: SeniorCare participants who lose SeniorCare eligibility solely due to receipt of MA benefits do not have their benefit period terminated; however, they are not eligible for SeniorCare benefits or services for the calendar months that they receive MA benefits.

If MA eligibility ends prior to the end of the SeniorCare benefit period, and the participant is still SeniorCare eligible, SeniorCare eligibility automatically resumes.

Example 1: Amy applies for SeniorCare on October 4th and is determined eligible
--

effective November 1st. In December she applies for MA and is determined eligible, effective December 1st. Amy is not eligible for SeniorCare benefits or services while she is receiving MA.

In January, Amy inherits \$5,000 and is notified that her MA eligibility ends January 31st, because her assets exceed the limit. Amy still meets SeniorCare eligibility requirements, so SeniorCare eligibility will resume from February 1st through October 31st.

See [33.15 SC Annual Eligibility Review](#) for termination as it applies to the need for an annual review.

33.12.2 Withdrawal

Applicants or participants may withdraw from the SeniorCare Program at any time. To withdraw by phone, call the SeniorCare Customer Service Hotline at 1-800-657-2038.

A request to withdraw can be made in writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

A SeniorCare participant is eligible for an enrollment fee refund only if he or she meets the requirements listed in [33.3.2.1 Refunds](#).

If an *applicant* chooses to withdraw his or her application prior to eligibility confirmation, he or she will get a refund. If he or she later wishes to “opt in”, he or she will have to re-apply. To re-apply, a new application and enrollment fee are required.

Once eligible, if a participant chooses to “opt-out” and SeniorCare receives the request to withdraw within the timeframe for obtaining a refund, he or she will get a refund of the original enrollment fee. If, within thirty calendar days of opting out, the participant requests to opt in, he or she would need to send in another enrollment fee but would not have to send in another application form. Eligibility will be restored back to the beginning of his or her benefit period, once the fee is received and processed.

The enrollment fee must be received by the deadline identified in the CARES notice to comply with the administrative rule requirement that he or she meets eligibility requirements. If within thirty calendar days of opting out he or she does not contact SeniorCare and SeniorCare does not receive the enrollment fee, he or she will have to submit a new application and another \$30 enrollment fee if he or she wants to come back into the program.

If the participant chooses to opt-out and does not do so within the timeframe for obtaining a refund, he or she will not get a refund. Customer Service should counsel

the participant that he or she will not be getting a refund, and he or she can keep his or her case open in the event his or her circumstances change and he or she wants to use the SeniorCare benefit in the next 12 months.

If the participant still opts out, but contacts SeniorCare within thirty calendar days of opting out to request to opt in, the original enrollment fee that had not been refunded will be applied. He or she will not have to send in another application form. The person will be made eligible back to their original eligibility begin date for that benefit period. This requires a manual work-around because the system will require another \$30 enrollment fee to be credited for CARES to process correctly.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

33.13 SC NOTICE OF DECISION

A written notice is sent to the *applicant* indicating *SC* certification, benefit reduction, denial, or termination.

The initial notice of decision will provide information regarding total income used for determining participant level. It will also provide the participant with information regarding spenddown, deductible and co-payment amounts.

For reductions, denials or terminations, the notice contains reasons for the action, with any supporting regulations. It also specifies the circumstances under which SeniorCare benefits will be continued if a hearing is requested.

SeniorCare participants will be notified of an *adverse action* at least 10 days prior to the effective date of adverse action, except under certain circumstances.

Timely notice requirements do not apply when:

1. A prescription drug billing must be reversed due to an incorrect billing, and that reversal results in a benefit or service change.
2. A participant chooses to withdraw from the program.
3. A participant requests to establish a new benefit period and eligibility for the previous benefit period is terminated ([33.11 SC Re-Application](#)).
4. A person is an inmate of a [Public Institution](#).
5. Death of a participant.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

33.14 SC APPEALS

[33.14.1 SC Appeals Introduction](#)

[33.14.2 Requesting a Hearing](#)

[33.14.3 Hearing](#)

33.14.1 SC Appeals Introduction

SC applicants, participants or representatives may file an appeal by writing to the Division of Hearings and Appeals (DHA) when one of the following occurs and the action is not the result of a general program policy change:

1. An application is denied, or the person is denied the right to apply.
2. An application is not acted upon within thirty calendar days.
3. A participant believes that the benefits he or she received, or the initial eligibility date of program benefits were not properly determined.
4. Program benefits are reduced, discontinued, suspended, or terminated.

An appeal may result in a hearing.

33.14.2 Requesting a Hearing

The SeniorCare *applicant* or participant, or his or her representative, may request a hearing. The request for a hearing must be made in writing to the DHA within 45 days from the effective date of the *adverse action*.

Benefits will be continued only if the participant requests a hearing prior to the effective date of the adverse action.

Hearings may be requested by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
PO Box 7875
Madison, WI 53707-7875

33.14.3 Hearing

The hearing will be held at a location determined by the DHA.

Hearings will be:

1. Held at a time reasonably convenient to the petitioner, department or agency staff and the administrative law judge.
2. Reasonably accessible to the petitioner.
3. Held on department or agency premises, subject to the judgement of the administrative law judge.
4. Accessible to those in need of accommodations for a [disability](#) or translation.
(For information about an accommodation for a disability or translation for a hearing, call 1-608-266-3096.

*This page last updated in Release Number: 08-04
Release Date: 10/17/08
Effective Date: 10/17/08*

33.15 SC ANNUAL ELIGIBILITY REVIEW

An annual eligibility review is required for each participant by the end of the current 12 month benefit period to prevent a gap in coverage. Eligibility for a new benefit period begins on the first day of the month immediately following the end of the previous benefit period when:

1. A valid pre-printed CARES renewal application or new application form ([F-10076](#)) is received by the end of the current benefit period, and
2. All eligibility requirements are met, including payment of the \$30 annual enrollment fee.

Note: For the definition of “valid,” see [33.2.2 Application Processing](#).

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

33.16 SC BENEFITS

[33.16.1 SC Benefits Introduction](#)

[33.16.2 Discount Pricing](#)

[33.16.3 Early Refills](#)

[33.16.4 Out-of-state Pharmacies](#)

33.16.1 SC Benefits Introduction

For all of the participation levels, **SC** allows the following:

1. The generic form of any covered prescription drug, unless the medical practitioner writes on the prescription that the brand name form of the covered prescription drug is medically necessary.
2. Insulins are the only general category of over-the-counter drugs that are covered.
3. For levels 1 and 2a all prescription drugs covered by Medicaid. Some limitations apply to prescription drug coverage for levels 2b and 3 if a rebate agreement has not been signed by the drug manufacturer.
4. Chemotherapy drugs that are FDA approved and the manufacturer has signed a rebate agreement.

Reimbursement for most drugs is limited to a 33-day supply. Some maintenance drugs may be provided in a 100-day supply.

The co-payment amount is not affected by the # of days in the supply.

Note: The participant should contact his or her provider to verify that SeniorCare covers a specific drug.

SeniorCare does not cover the following:

1. Prescription drugs administered in a physician's office.
2. Prescription drugs that are experimental or have a cosmetic, not a medical purpose.
3. Over-the-counter drugs (except for insulin) such as vitamins or aspirin, prilosec OTC, even with a prescription.
4. Prescription drugs for which prior authorization has been denied.
5. Colostomy supplies and other durable medical supplies (DMS) even though they may need a prescription.
6. Prescription drugs for participants in Levels 2b and 3 for which a rebate agreement has not been signed by the manufacturer.

33.16.2 Discount Pricing

The discount for a particular drug during the deductible period will be the same at every pharmacy. During the deductible period, the pharmacy must use the SeniorCare allowed price.

Exception: If a pharmacy's usual and customary charge is less than the SeniorCare allowed amount, then the participant would be charged the usual and customary charge and this amount will apply to SeniorCare spenddown and/or deductible.

33.16.3 Early Refills

When the participant is temporarily leaving the state and the supply on his or her prescriptions is insufficient, he or she will need to make arrangements with the pharmacist to have any additional refills mailed or have someone else pick-up the refill.

Postage costs are not covered by SeniorCare, nor do they count toward the deductible and/or spenddown. Requests for early refills will be denied.

33.16.4 Out-of-state Pharmacies

In an emergency, a participant can get a prescription filled out of state and have it count toward SeniorCare as long as the participant is within the US, Canada, or Mexico and the pharmacy completes the necessary forms.

Out-of-state pharmacies should contact 1-800-947-9627 to file a claim for reimbursement. Non-emergency prescriptions will be covered only when prior authorization has been granted.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

34 EMERGENCY SERVICES

34.1 EMERGENCY SERVICES

[34.1.1 Emergency Services Eligibility Introduction](#)

[34.1.2 Determination of Emergency Services Eligibility](#)

[34.1.2.1 Medicaid Deductible](#)

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[34.1.4 BC+ Emergency Services](#)

34.1.1 Emergency Services Eligibility Introduction

Documented and undocumented non-citizens ineligible under regular Medicaid due to alien status can be eligible for Emergency Services, if he or she meets all other eligibility requirements except having or applying for an **SSN**. Non-citizens may have an SSN and may still qualify for Emergency Services. If a non-citizen would otherwise be eligible for any type of EBD Medicaid, he or she would qualify for Emergency Services.

Emergency Services only covers medical services needed for the treatment of an emergency medical condition. Services related to organ transplant procedure are not covered by Emergency Services.

An emergency means a medical condition (including labor and delivery) that shows acute symptoms of sufficient severity (including severe pain) such that the lack of immediate Medicaid could result in one or more of the following:

1. Serious jeopardy to the patient's health.
2. Serious impairment to bodily functions.
3. Serious dysfunction of a bodily organ or part.

All labor and delivery services are emergency services and are covered under Emergency Services for eligible non-qualifying aliens.

The **IM** agency does not determine if an emergency condition is eligible for Emergency Services coverage.

The medical provider submits claims for emergency medical services to the fiscal agent. It determines if a condition is an emergency medical condition covered by Emergency Services.

A citizen is not eligible for Medicaid Emergency Services even when he or she cannot produce citizenship and/or identity verification.

Example 1: Jill applies for Medicaid, declares U.S. citizenship and is asked to provide documents proving her citizenship and identity. She has a driver license to prove identity but does not have anything to prove her citizenship. Since Emergency Services Medicaid does not require proof of citizenship and identity as an eligibility requirement, she then asks to be considered for this program. However the IM worker cannot process Emergency Services Medicaid eligibility for persons declaring to be U.S. citizens. Emergency Services Medicaid is reserved for non-qualifying non-citizens.

34.1.2 Determination of Emergency Services Eligibility

Certification of Emergency Services is not done by CARES and must be done manually. Emergency Services coverage lasts from the time of the first treatment for the emergency until the condition is no longer an emergency. Local agencies do not determine if an emergency exists. Local agency responsibility is to determine if the non-qualifying alien meets all other eligibility requirements during the dates of service and to certify if he or she is eligible for Emergency Services.

If a non-qualifying alien provides a "Certification of Emergency for Non-U.S. Citizens" ([F-01162](#)) at the time of application, determine his or her eligibility for Emergency Services for the dates of the emergency indicated on the form. If a non-qualifying alien

does not have the form at the time of application, ask him/her for the dates that he or she received emergency services. The [F-01162](#) is not required to certify Emergency Services eligibility.

Persons applying for Emergency Services have the same rights and responsibilities as persons applying for regular Medicaid. He or she must meet the eligibility requirements for his or her type of Medicaid, such as being *elderly* blind or disabled*, and provide required verifications. He or she is also entitled to all notice rights and must receive a manual positive or negative notice regarding his or her eligibility. Positive Notices must provide the dates of eligibility for Emergency Services. Negative Notices must provide the reasons for the denial or termination.

*If a non-qualifying alien would only qualify for Medicaid if he or she was disabled, follow *disability* determination procedures (including presumptive disability) before certifying Emergency Services eligibility.

34.1.2.1 Medicaid Deductible

Aliens who apply for emergency services may become eligible by way of the Medicaid deductible. If, on the date he or she applies, he or she is eligible in all respects except income, apply the same deductible policies ([24.2 Medicaid Deductible Introduction](#)) to him or her as any other client.

34.1.3 Certification of Emergency Services Eligibility

Certification of Emergency Services is not done by CARES and must be done manually. When an alien is determined eligible for Emergency Services, complete and submit a [F-10110](#) (Formerly DES 3070). Emergency Services only covers medical services needed for the treatment of an emergency medical condition. Services related to an organ transplant procedure are not covered by Emergency Services. The fiscal agent needs a beginning and end date to process eligibility. In setting the end date, use the last day of the emergency. If that is not known, use the last day of the month in which the emergency is expected to end. Use the AE medical status code.

The [F-10110](#) may be submitted to the fiscal agent in the following ways:

1. Mail:
HP Enterprise Services
P.O. Box 7636
Madison, WI 53707
2. Fax:
(608) 221-8815

An individual eligible for Emergency Services will not receive a ForwardHealth card because Emergency Services eligibility ends when the emergency ends.

34.1.4 BC+ Emergency Services

For Emergency Services for children, parents, caretakers, and pregnant women, see the [BadgerCare Plus Handbook](#) Chapters 39.1 Emergency Services and 41.1 BC+ Prenatal.

*This page last updated in Release Number: 08-02
Release Date: 04/30/08
Effective Date: 04/30/08*

35 LONG TERM CARE INSURANCE PARTNERSHIP (LTCIP)

[View History](#)

35.1 LONG TERM CARE INSURANCE PARTNERSHIP (LTCIP)

[35.1.1 LTCIP Introduction](#)

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35.1.1 LTCIP Introduction

The Wisconsin Long-Term Care Insurance Partnership (LTCIP) is a joint effort between the federal Medicaid Program, long-term care insurers, and the Wisconsin Department of Health Services (*DHS*) and Office of the Commissioner of Insurance (OCI). The program's main purpose is to provide an incentive for people to plan for meeting their future long-term care needs, whether in a community-based setting such as their own home, or in a nursing home.

35.1.2 LTCIP Asset Disregard

The LTCIP allows a person with a qualified long-term care insurance policy to have assets disregarded in the Medicaid eligibility determination, while at the same time protecting those assets from Medicaid estate recovery. Under the LTCIP, assets are disregarded when determining eligibility for EBD Medicaid programs, or any of the programs for Medicare beneficiaries (i.e., *QMB*, *SLMB*, SLMB+, *QDWI*), up to the total amount of long-term care services paid by the qualified WI LTCIP policy on or after January 1, 2009. The amount paid out by the qualified LTCIP policy on or after January 1, 2009 is not counted toward the WI Medicaid asset limit, nor is it recoverable under the estate recovery program.

Maximum Disregard

The maximum amount that can be disregarded for the purpose of Medicaid eligibility, or protected from estate recovery, is the verified amount of benefits paid out by the qualified WI LTCIP policy on or after January 1, 2009.

The disregarded asset amount is still counted in the Asset Assessment when determining the Community *Spouse* Asset Share (CSAS) in a *Spousal Impoverishment* case. However, the disregarded asset amount is not counted in the individual's eligibility determination.

The disregarded amount is exempt from divestment policies, i.e., transferring assets for less than *fair market value* up to the LTCIP payout amount will not result in a divestment penalty. However, a divestment may result in a reduction or elimination of the Medicaid eligibility and estate recovery protections under the LTCIP. See [35.1.3.3](#) for more information regarding the disregard.

35.1.3 Verification

Verify the following items as described.

35.1.3.1 Verification of the Qualified LTCIP Policy

A "qualified LTCIP policy" must meet all relevant requirements of federal and state law. Qualified LTCIP policies are certified by the Wisconsin Office of the Commissioner of Insurance (OCI). A more detailed definition of a qualified LTCIP can be found at <http://oci.wi.gov/srissues/ltpartnership.htm>.

OCI certification of the policy must be verified by assuring that the policy is listed on the OCI website, accessible via the following link:

<http://oci.wi.gov/srissues/ltpartner-qual.htm>

35.1.3.2 Reciprocity Standards

Participation in Wisconsin's LTCIP program is allowed for individuals who purchased qualified policies in any state that is subject to the LTCIP reciprocity standards as documented in that state's Medicaid State Plan. Such states are referred to as "Participating States." Information regarding reciprocity states can be found at:

<http://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php#approved>

If the policy was issued by a Participating Reciprocity State:

1. Apply the policies specified at [35.1.2 LTCIP Asset Disregard](#).
2. Apply the policies specified in this subsection, [35.1.3 Verification](#).

If the policy was not issued by a Participating State, the individual is not eligible to participate in Wisconsin's LTCIP program. The LTCIP asset disregards and estate recovery offsets do not apply to such individuals.

35.1.3.3 Verification of Benefits Paid

In addition, the amount paid out by a qualified LTCIP policy must be verified before it can be disregarded for Medicaid eligibility or estate recovery purposes. The qualified LTCIP policy carrier must document the amount paid for benefits on or after January 1, 2009 using the appropriate OCI approved form (OCI 26-114) and provide verification of the payout amount upon request. Only benefits paid on or after January 1, 2009 may be disregarded when determining eligibility for Medicaid programs. The OCI approved form is accessible via the following link:

<http://oci.wi.gov/ociforms/26-114.pdf>

35.1.4 Examples

Example 1: Ruth is a resident of a medical care facility. She has no [spouse](#). Her qualified \$90,000 LTCIP policy has been paying for her care. When Ruth applies for

WI Medicaid payment of long-term care services, she verifies that her qualified LTCIP policy has paid out \$80,000 in policy benefits since January 1, 2009. Ruth owns the following non-exempt assets:

- \$5,000 savings account
- \$6,000 checking account
- \$70,000 equity value in non- [homestead](#) property

The worker determines that Ruth's total non-exempt assets equal \$81,000 (\$5,000 + \$6,000 + \$70,000). Her WI Medicaid asset limit is \$2,000; however, because \$80,000 has been paid out by Ruth's qualified WI LTCIP policy, an additional \$80,000 in non-exempt assets is disregarded. Ruth passes the asset test for WI Medicaid because we disregard \$80,000 of her assets. The remaining non-exempt assets are less than \$2,000. If Ruth were to pass away at this point, \$80,000 of her assets would be protected from estate recovery.

Example 2: A year later, Ruth's eligibility for WI Medicaid is reviewed. At that time, she verifies that she has exhausted her qualified LTCIP policy benefit, which has paid out the full \$90,000 since January 1, 2009. Ruth owns the following non-exempt assets:

- \$4,000 savings account
- \$7,000 checking account
- \$80,000 equity value in non-homestead property

The worker determines that Ruth's total non-exempt assets equal \$91,000 (\$4,000 + \$7,000 + \$80,000). Her WI Medicaid asset limit is \$2,000; however, because \$90,000 has been paid out by Ruth's qualified LTCIP policy, an additional \$90,000 in non-exempt assets is disregarded. Ruth continues to qualify for WI Medicaid because we disregard \$90,000 of her assets. The remaining non-exempt assets are less than \$2,000. If Ruth were to pass away, \$90,000 of her assets would be protected from estate recovery.

Example 3: Edith is applying for Family Care. She and her spouse reside in their home and have \$100,000 in non-exempt assets. Her qualified \$80,000 LTCIP policy has been paying for long-term care she has received in her home and is now exhausted. When Edith applies for Family Care, she verifies that her LTCIP policy has paid out \$80,000 in benefits since January 1, 2009. Because this is a Spousal Impoverishment case, an Asset Assessment (AA) must be done to establish the Community Spouse Asset Share. The total \$100,000 is used in the AA and the CSAS is set at \$50,000. Edith's asset limit of \$2,000 is added to the CSAS when determining her eligibility. Since \$80,000 of her assets can be disregarded, the remaining non-exempt assets are \$20,000 which is less than the \$52,000 limit. Prior to her first review (12 months) Edith must transfer, to her spouse, any of her assets that exceed \$82,000 (the LTCIP policy pay out amount plus the regular WI

Medicaid asset limit of \$2,000) to remain eligible.

Example 4: Emma had been residing in a nursing home and had been eligible for Institutional Medicaid for the past 2 years. Her qualified \$90,000 LTCIP policy had been paying for a portion of her care. As of her last WI Medicaid review, the policy had paid out \$70,000 since January 1, 2009, an amount disregarded in determining her continued Medicaid eligibility. Ten months after her last review, Emma died. Emma's representatives verify that, during those ten months, her qualified LTCIP policy paid out an additional \$10,000 toward her long-term care. Emma's estate can protect a total of \$80,000 (i.e., the total amount paid out by the qualified policy) from estate recovery.

Example 5: Joe has a \$100,000 home and \$100,000 in non-exempt liquid assets. He needs home care and his qualified LTCIP policy begins paying out. By the time Joe applies for Medicaid, his LTCIP policy has paid out \$100,000. Joe can have up to \$102,000 in assets (\$2,000 limit plus \$100,000 disregarded) and still be eligible for Medicaid. His home is an exempt asset and his non exempt assets are less than \$102,000 so he qualifies for Family Care.

Over the next few months, Joe decides to give \$100,000 to his son. At his annual review, he reports that he has done so, but because he has given away no more than the LTCIP protected asset amount (i.e., the LTCIP payout amount of \$100,000), there is no divestment penalty. However, because he has divested the entire payout amount, he can no longer take advantage of the LTCIP protections with regard to his Medicaid eligibility. That means, when he's tested for Family Care, he must have assets below \$2,000 to remain eligible (instead of \$102,000). Also, because he already gave away the entire LTCIP protected amount during his lifetime, that amount will not be protected from estate recovery.

35.1.5 Process Help

Until CARES can be updated to accommodate this policy change, the amount of assets that are disregarded under this policy should be designated as 'unavailable' in CARES. When processing an Asset Assessment (AA) the whole asset amount should be counted as available. Once the AA is completed, update the availability question to indicate the amount paid out by the LTCIP is unavailable. Be sure to document in Case Comments why the asset is being treated as unavailable. The documentation provided for verification of the LTCIP policy and pay out should be scanned into the ECF under the Asset Information subfolder.

*This page last updated in Release Number: 14-02
Release Date: 12/18/14
Effective Date: 12/18/14*

36 WELL WOMAN MEDICAID (WWMA)

[View History](#)

36.1 WISCONSIN WELL WOMAN MEDICAID INTRODUCTION

WWWMA is administered by the **DHS** Division of Health Care Access and Accountability (DHCAA) and provides eligible women with access to full-benefit Medicaid through non-HMO providers.

Wisconsin Well Woman Medicaid Eligibility

WWWMA enrollment is limited to the following groups. A woman must be enrolled in one of the following ForwardHealth programs before she can initially enroll in WWWWMA:

1. **WWWP**,
2. Family Planning Waiver (FPW),
3. BadgerCare Plus Benchmark Plan, **or**
4. CORE Plan

As long as the woman is enrolled in WWWWMA, she does not have to reapply for any of the above programs. She will have full benefit **fee-for-service** Medicaid health care coverage through WWWWMA.

Effective October, 2009, all WWWWMA enrollments and renewals are administered by EM **CAPO**. The local certifying agencies have no role in recertifications or new WWWWMA enrollments (see [Section 36.2 Wisconsin Well Woman Medicaid Enrollment](#)).

*This page last updated in Release Number: 10-02
Release Date: 06/22/10
Effective Date: 09/01/09*

[View History](#)

36.2 WISCONSIN WELL WOMAN MEDICAID ENROLLMENT

[36.2.1 EM CAPO Administrating Enrollment for WWMA](#)

[36.2.2 Enrollment Through The Wisconsin Well Woman Program \(WWWP\)](#)

[36.2.2.1 Temporary Enrollment / Presumptive Eligibility \(TE\) Available Only To Women Enrolling Through WWWP](#)

[36.2.3 WWWP Clients Enrolling For Continuous WWMA](#)

[36.2.3.1 Applications For WWMA Through Well Woman Program \(WWWP\)](#)

[36.2.4 Enrollment For Family Planning Waiver \(FPW\), BadgerCare Plus CORE and Benchmark Members](#)

[36.2.4.1 Applications For Wisconsin Well Woman Medicaid Through the Family Planning Waiver \(FPW\), BadgerCare Plus CORE or Benchmark Plans](#)

36.2.1 EM CAPO Administrrating Enrollment for WWMA

All initial enrollments and renewals for continuous **WWWMA** are now processed by EM **CAPO**. Temporary Enrollment/Presumptive Eligibility enrollment is still processed by the fiscal agent.

Any applications received in local **IM**, ESC, or tribal agencies should be faxed to the EM CAPO at (608) 267-3381 immediately upon receipt to prevent any delay in eligibility determination or treatment for the **applicant**.

CONTACTS:

EM CAPO: DHSEMCAPO@dhs.wisconsin.gov

Fax: (608) 267-3381

Phone: 1-877-246-2276

Customer line: (608) 266-1720

36.2.2 Enrollment Through The Wisconsin Well Woman Program (WWWP)

The **WWWP** is administered by the **DHS** Division of Public Health (DPH). WWWP provides eligible women with various health screenings (including breast and cervical cancer screening), referrals, education and outreach.

The WWWP performs the financial and initial non-financial screening for WWMA for WWWP enrollees. A WWWP enrollee must have a health screening through WWWP, be diagnosed, and need treatment for breast or cervical cancer to be considered for WWMA.

WWWP Local Coordinating Agencies (**LCA**) enroll women in WWWP and perform some of the basic non-financial and all financial data gathering, and verification for Well Woman Medicaid. They also coordinate the WWWP client's referral to a health care provider for breast and cervical cancer screening.

1. The WWWP LCA will complete the F-44818 (formerly DPH-4818) with the assistance of the applicant prior to the applicant's health care screening. The F-44818 enrolls the woman in WWWP. Her WWWP eligibility will be recorded in interChange as "Med Stat CS".

2. The WWWP client will receive a breast and cervical cancer screening from a WWWP provider. If the WWWP client is diagnosed with breast or cervical cancer, her provider will complete the [F-10075](#) recording the diagnosis and indicating that treatment is required. The provider will sign & date the [F-10075](#). The WWWP client will also sign and date the [F-10075](#). The signature dates do not have to be the same date.
3. The provider will fill in the beginning and end dates of the temporary enrollment/presumptive eligibility for WWWMA on the [F-10075](#)
4. The provider will forward a copy of the [F-10075](#) to the WWWP LCA.
5. The LCA will provide the client with a copy of the signed [F-10075](#) and F-44818 forms.
6. The LCA will check to be sure correct temporary eligibility dates (if appropriate) are entered on the [F-10075](#) and explain that the client's temporary enrollment for WWWMA will end on the last day of the following calendar month.

36.2.2.1 Temporary Enrollment / Presumptive Eligibility (TE) Available Only To Women Enrolling Through WWWP

Temporary Enrollment (TE) for WWWMA is available for women to assure immediate access to cancer treatment. The provider doing the medical screening enters the TE dates in the section "Temporary Eligibility Begin Date" and "Temporary Eligibility End Date" on the [F-10075](#). The dates should cover the time period beginning on the date of diagnosis through the last day of the following calendar month.

The LCA should then fax a copy of the completed [F-10075](#) to the fiscal agent at (608) 221-8815 within five days of the diagnosis date. The fiscal agent will enter the temporary enrollment data in ForwardHealth interChange (with a medical status code of CB) and send the client a ForwardHealth card with the temporary enrollment dates activated on the card. (If the client had a previous ForwardHealth card, it will be reactivated.)

Until the ForwardHealth card arrives or is reactivated, the new WWWMA *member* may receive services by presenting both of the following completed forms to any Medicaid provider:

1. WWWP Enrollment Form F-44818
2. WWWMA Determination Form ([F-10075](#)).

To continue receiving WWWMA, the member or the Local Coordinating agency must submit an [F-10075](#) to the CAPO. If the member does not apply, her WWWMA benefits will terminate at the end of the month following the month of diagnosis.

The TE period extends from the date of diagnosis on the [F-10075](#) through the following month. A new TE period would only occur if a new cancer diagnosis was established for the same member.

Note: If the member applies during her TE certification period and the CAPO is not able to process her application, within the 30-day processing time frame, the CAPO will extend the members' eligibility for an additional 30 days from the last day of her Wisconsin Well Woman Medicaid TE with a medical status of "CB". Submit an [F-10110](#) (formerly DES 3070) to extend the Well Woman Medicaid TE for an additional calendar month.

36.2.3 WWWP Clients Enrolling For Continuous WWWMA

36.2.3.1 Applications For WWWMA Through Well Woman Program (WWWP)

To apply for WWWMA through the WWWP, the applicant or the Local Coordinating agency must send or fax the completed F-44818 and [F-10075](#) forms to the CAPO. The applicant may apply for WWWMA at any time after the WWWP screening and diagnosis. Eligibility may only be backdated to the first of the month up to three months prior to the application date or from the date of diagnosis, whichever is most recent. (For requests to back date farther than three months, refer to the *BEPS* policy analyst.)

Use the F-44818 and [F-10075](#) in place of the standard application forms. This program requires manual determination. Do not enter the woman's information into CARES as an application.

The date of receipt of the F-10075 is the filing date. Use the verification policy listed in [Chapter 20](#) for any items requiring verification.

Complete the following steps to certify the member for WWWMA:

1. Review the F-44818 . There should be a "No" answer to the following questions:
 - a. Does the applicant have any health insurance? (Item #32 on F-4818)
If the applicant answers "Yes", determine if the insurance is one of those listed in [36.3.3](#) that covers treatment for her breast or cervical cancer. If she has coverage for the treatment, she is ineligible for WWWMA.
 - b. Does the applicant have Medicare Part B? (Item #33 on F-44818)
 - c. Does the applicant have Medicare Part A.

If the applicant answered "Yes" to any of these questions in a-c, the applicant is ineligible for WWWMA. The CAPO will refer her back to the Well Woman Program and send a manual negative notice.

2. Review the F-44818 to ensure that the following fields have been completed: 1-5, 9-13, 16-25, and 27-45.

If the form is incomplete, the CAPO will request that the applicant provide any missing information. If the applicant does not provide all necessary information, there may be a delay in eligibility determination and benefits.

3. Review [F-10075](#) for an **SSN**. If the SSN is missing from the F-10075 and is not present on the F-44818 (# 6a); the CAPO will ask the applicant to provide her SSN. Providing an SSN for the Well Woman Program is voluntary, but providing an SSN, or applying for one, is required for WWWMA

If the applicant fails to provide an SSN, or fails to apply for an SSN within the 30-day application processing time or within ten days (whichever is later), the CAPO will send a manual negative notice to the applicant indicating that the she is not eligible for WWWMA because she did not provide an SSN.

4. Ask the applicant if she is a citizen.

If the applicant is not a citizen, ask her what her immigration status is and to provide her immigrant registration card. Verify that the applicant is in a qualified immigration status using the SAVE system.

Note: Some applicants with breast and cervical cancer who do not meet the immigration-related eligibility criteria may be eligible to receive emergency services. If a non-qualifying immigrant has been screened by Well Woman Program, determine her eligibility for emergency services using the criteria in [7.1 US Citizens and Nationals](#).

5. If there are any questionable items, contact the [Well Woman Program Local Coordinating Agency](#).
6. The CAPO will update interChange (iC) with the WWWMA eligibility information using a medical status code of "CB" to certify any member who has met the criteria listed above. Submit the completed [F-10110](#) to the fiscal agent through one of the following methods:

- a. Mail:

HP Enterprise Services
Attn: Eligibility Lead Worker WWMA
313 Blettner Blvd
Madison WI
53714-2405

- b. FAX: (608) 221-8815

- c. interChange

7. Certify the member for 12 months from the filing date and backdate to whichever is more recent:

- a. Up to three months prior to the filing date, **or**
- b. To the date of the diagnosis (F-10075),

Never certify a woman for Well Woman Medicaid prior to her date of diagnosis.

Example 1: Gina applies for Well Woman Medicaid (WWWMA) at the Local Coordinating Agency (LCA) on September 20th 2009. The LCA submits the F-44818 and F 10075 to CAPO. The F-10075 indicates that Gina is enrolled in Well Woman Program (WWWP). The LCA provides a copy of the F-4818 documenting Gina's enrollment in the WWWP. Gina's date of diagnosis on the F-10075 is August 6th 2009. Gina meets the following non-financial requirements: citizenship/ID documentation, provides a valid SSN and has no public or private insurance that will cover her cancer treatment and she is under 65 years of age.

CAPO will certify Gina in interChange (iC) effective August 6th, 2009 through July 31 2010 with a CB medical status code. CAPO will send Gina a notice indicating her eligibility dates. About one month from the end of Gina's eligibility period, CAPO will send Gina a recertification notice indicating she needs to recertify for WWWWMA.

For initial WWWWMA certifications, if the applicant applies during her WWWWMA TE certification period and CAPO is not able to process her application within the 30 day processing time frame, CAPO will extend the applicant's eligibility for an additional 30 days from the last day of her WWWWMA TE in iC with a medical status of "CB." Note this extension in the CARES Comments section if appropriate.

To contact the Local Coordinating Agencies refer to #27 of F-44818.

36.2.4 Enrollment For Family Planning Waiver (FPW), BadgerCare Plus CORE and Benchmark Members

Women enrolled in the Family Planning Waiver program (FPW), CORE, or Benchmark programs who meet the following criteria (regardless of age), will be eligible for WWWWMA. These are women who:

- 1. Are screened for, and diagnosed with, cervical cancer or a precancerous condition of the cervix, **or**
- 2. Receive a clinical breast exam through a Family Planning Waiver provider and through follow up medical testing (independent of the FPW,) ,or are screened for and are diagnosed with breast cancer while enrolled in the BadgerCare Plus CORE or Benchmark plans, and

- a. Are found to be in need of treatment for breast or cervical cancer or precancerous cervical condition **and**
- b. do not have other insurance that would cover their cancer treatment.

36.2.4.1 Applications For Wisconsin Well Woman Medicaid Through the Family Planning Waiver (FPW), BadgerCare Plus CORE or Benchmark Plans

A Wisconsin Well Woman Medicaid Determination form ([F-10075](#)) submitted by a FPW member or her representative is a request to enroll in WWWMA and disenroll from FPW. Women 15 through 44 years of age, enrolled in FPW in CARES who meet the criteria [36.2.4 Enrollment For Family Planning Waiver \(FPW\), BadgerCare Plus CORE and Benchmark Members](#) above, will be eligible for Well Woman Medicaid.

A Wisconsin Well Woman Medicaid Determination Form ([F-10075](#)) submitted by a FPW, CORE, or Benchmark member or her representative is a request to enroll in Well Woman MA and disenroll from FPW, CORE, or Benchmark. Women who are enrolled in FPW, CORE or Benchmark in CARES and meet the criteria in the [36.2.4](#) above, the BadgerCare Plus Handbook [43.4 Application for BadgerCare Plus CORE Plan](#), or BadgerCare Plus Handbook [1.1.1 BadgerCare Plus Health Plans](#) -Benchmark may be eligible for WWWMA.

*This page last updated in Release Number: 12-02
Release Date: 06/15/12
Effective Date: 04/16/12*

[View History](#)

36.3 WISCONSIN WELL WOMAN MEDICAID NONFINANCIAL REQUIREMENT

[36.3.1 WWMA Introduction](#)

[36.3.2 Disqualifying Insurance Coverage](#)

[36.3.3 Non-Disqualifying Insurance Coverage](#)

36.3.1 WWWMA Introduction

The following are **WWWMA** specific non-financial requirements:

1. Live in Wisconsin,
2. Meet general EBD citizenship and ID requirements.

3. Be under age 65.
4. Have been screened for breast or cervical cancer by the Well Woman Program, or enrolled in the Family Planning Waiver, CORE or Benchmark programs.
5. Be diagnosed for breast or cervical cancer, or certain pre-cancerous conditions of the cervix, as identified by the clinical screener.
6. Require treatment for the breast or cervical cancer, or pre-cancerous conditions of the cervix, as identified by the clinical screener.
7. Not be eligible for BadgerCare Plus without a premium or EBD MA.
8. Meet the insurance coverage requirements listed below in 36.3.2 Disqualifying Insurance Coverage

36.3.2 Disqualifying Insurance Coverage

A woman is ineligible for WWWMA if she is currently covered by *any* one of the following:

1. Group health plans that cover treatment for her breast or cervical cancer,
2. Full benefit health insurance that covers treatment for her breast or cervical cancer,
3. Medicare Part A,
4. Medicare Part B,
5. BadgerCare Plus without a premium or any other category of full benefit Medicaid that covers her treatment for breast or cervical cancer (Note: An unmet deductible is not full benefit Medicaid),
6. Veteran's benefits/TRICARE that cover treatment for her breast or cervical cancer,
7. HIRSP,
8. Federal employee health plans,
9. Peace Corps health plans, **or**
10. Other full benefit private or public health care plans that provide cancer treatment as determined by her health care team.

36.3.3 Non-Disqualifying Insurance Coverage

1. The following health care benefits *do not* disqualify an [applicant](#) from WWWMA:
 - a. Coverage only for accident or [disability](#) income insurance, or any combination thereof,
 - b. Liability insurance including general liability insurance and automobile liability insurance,
 - c. Workers' compensation or similar insurance, credit-only insurance,
 - d. Coverage for on-site medical clinics,
 - e. Other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits,
 - f. Indian Health Services,
 - g. Non-coverage of cancer treatment due to waiting period, **or**

- h. Non-coverage of breast or cervical cancer treatment due to exclusion (max out) of cancer treatment in the policy.
- 2. Separate health insurance benefits that are not considered health insurance if offered separately are:
 - a. Limited scope dental or vision benefits, **or**
 - b. Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof.
- 3. Independent uncoordinated benefits are not considered health care insurance if offered as independent and/or uncoordinated benefits (for example,, coverage only for specified disease or illness, hospital indemnity or other fixed indemnity insurance).
- 4. Separate insurance policies are not considered health insurance if offered as a separate insurance (Wrap Around) policy:
 - a. Coverage supplemental to military insurance (ex., TRICARE wrap around), **or**
 - b. Similar "wrap around" supplemental coverage under a group health plan.
- 5. Creditable coverage plans that do not cover treatment for the breast or cervical cancer due to a waiting period, exclusion or carve out restrictions.

Note: Medicare Parts A or B will disqualify an applicant from WWMA eligibility.

*This page last updated in Release Number: 09-03
Release Date: 06/05/09
Effective Date: 06/05/09*

[View History](#)

36.4 WISCONSIN WELL WOMAN MEDICAID (WWMA) FINANCIAL REQUIREMENT

Because enrollment in **WWMA** is dependent on financial eligibility for a gatepost program, there are no financial requirements for WWMA.

Do not test for assets or income. Financial requirements are addressed through the **WWWP**, FPW, or BadgerCare Plus CORE or Benchmark enrollment process. See the [BadgerCare Plus Handbook](#) Chs.16-20 for BadgerCare Plus and Ch. 40 for FPW.

Once a woman is enrolled in **WWWMA**, she may not be financially tested as a condition of her continuing eligibility in WWWWMA.

*This page last updated in Release Number: 10-02
Release Date: 06/22/10
Effective Date: 09/01/09*

[View History](#)

36.5 WISCONSIN WELL WOMAN MEDICAID (WWMA) CHANGES AND TRANSFERS

[36.5.1 Member Loses Eligibility](#)

[36.5.2 WWMA InterAgency Case Transfers](#)

36.5.1 Member Loses Eligibility

WWMA recipients are required to report changes that would affect eligibility. Reported changes that result in the **WWWMA** case closing are:

1. Reaching the age of 65 years,
2. Moving out of state,
3. Reporting that she no longer needs treatment for breast or cervical cancer,
4. Obtaining health insurance that covers her treatment for breast or cervical cancer, **or**
5. Obtaining Medicare Part A, Part B, or both.

If a case closes, the **CAPO** will send a manual negative notice to the **member** if one of these changes is reported, indicating that she is no longer eligible for WWWWMA. In situations 1, 3, 4, and 5 above, offer her a BadgerCare Plus / Medicaid Application, [F-10182](#), to test eligibility for other programs.

36.5.2 WWMA InterAgency Case Transfers

All WWWWMA cases are now processed through the CAPO. There should be no interagency transfers.

*This page last updated in Release Number: 10-02
Release Date: 06/22/10
Effective Date: 09/01/09*

[View History](#)

36.6 WISCONSIN WELL WOMAN MEDICAID (WWMA) REVIEWS /RECERTIFICATIONS

Reviews/recertifications are required every 12 months after the initial eligibility determination at the member's **WWMA** enrollment date. A review for WWMA only consists of receiving an updated [F-10075](#) WWMA Determination form. There is no financial test.

Notices identifying the **WWMA** members needing recertification are sent to the **CAPO** monthly. The CAPO notifies the client 45 days before a review is due, and indicates what materials or information the **member** needs to return. The CAPO includes a blank [F-10075](#) with the notice. In most cases the member will only need to supply the CAPO with an updated [F-10075](#).

Note: In order to eliminate unnecessary reviews, a best practice is to check interChange to be sure that the member has not become certified for BadgerCare Plus or another type of full benefit MA (for example **SSI** MA), turned 65 years of age (or will turn 65 in the next twelve months), or become eligible for Medicare Part(s) A, B or both, prior to notifying the member that a review is due.

The member or her representative must send or fax the [F-10075](#) to the CAPO via:

1. **Email:** DHSEMCAP0@dhs.wisconsin.gov,
2. **Fax:** (608) 267-3381, **or**
3. **Mail :**
WI **DHS** - EM CAPO
1 West Wilson St. Room 358
P.O. Box 309
Madison, WI 53701- 0309

At review, the member must provide a newly completed WWMA Determination form [F-10075](#) indicating she is still in need of treatment for breast or cervical cancer, as certified by a physician or nurse practitioner.

Members formerly enrolled in **WWWP** do not need to provide a new DPH 4818 at recertification.

The CAPO sends a manual positive notice if all requirements are met.

The CAPO will send a manual negative notice at least ten days prior to the case closing if the member does not provide an updated [F-10075](#) or if the member reports one of the changes listed in [36.5 WWMA Changes](#).

37 RESERVED

37 RESERVED

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

38 COMMUNITY LONG-TERM CARE (NON-INSTITUTIONAL MEDICAID)

[View History](#)

38.1 INTRODUCTION

Medicaid Eligible Individuals who meet the level of care requirements can receive their long term care (LTC) services through enrollment into a Managed Care Organization (MCO) or through the fee for service program Include, Respect, I Self-Direct (*IRIS*).

The Managed Long Term Care programs include:

- Family Care
- Partnership
- *PACE*

Income Maintenance (*IM*) workers are responsible for determining Medicaid eligibility as well as cost share amounts. In counties that have transitioned to Family Care, adults must be enrolled in a MLTC program or IRIS to continue eligibility using Home and Community Based Waiver (HCBW) rules. If the member disenrolls from the MLTC program and does not enroll in IRIS his or her Medicaid eligibility must be tested under non HCBW rules. Eligibility for HCBW would end following *adverse action* logic once the IM worker has been notified by the *ADRC* that the member has disenrolled from the program, MLTC, or IRIS.

Enrollment into the Managed Long Term Care or IRIS program is completed by the Aging and *Disability* Resource Center (ADRC). The ADRC will submit the following information to the IM workers:

- Program start date for Home and Community Based Waivers
- Disenrollment from the program, MLTC, or IRIS
- Potential divestment
- Referral to Estate Recovery required

Disability

To be eligible for EBD or LTC Medicaid the individual must be elderly, blind or disabled. A member eligible for the BadgerCare Plus Standard Plan, [WWWMA](#), Foster Care or AA is not required to be determined disabled to enroll in Family Care as long as the member meets the functional level of care. If the member later loses eligibility for that program and must be tested for EBD or LTC Medicaid, he or she must then be elderly, blind or disabled to remain enrolled in Family Care.

A finding of disability made prior to the person's 18th birthday, which remains in effect on the person's 18th birthday, will be considered to meet MLTC or IRIS disability requirements until:

1. An *adult* disability determination can be done, or
2. The child disability determination is no longer in effect (whichever occurs first).
Family Care eligibility will not be denied solely because the disability determination in effect at application was made prior to applicant's 18th birthday.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

[View History](#)

38.2 FAMILY CARE

Family Care is a managed long-term care program for adults 18 years of age or older. A person not yet 18 years of age may be enrolled in Family Care effective the first day of the month in which he or she turns 18, if the person meets all other Family Care financial and non-financial eligibility requirements.

To enroll in Family Care the individual must:

- Meet the financial and non-financial eligibility criteria for:
 - A full benefit category of EBD Medicaid, including Long Term Care Medicaid,
 - BadgerCare Plus (BCP) Standard Plan,

- Well Woman Medicaid (WWMA),
 - Adoption Assistance (AA), or
 - Foster Care Medicaid.
- Meet the appropriate functional level of care.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

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38.3 PARTNERSHIP

The Wisconsin Partnership program is a comprehensive waiver program integrating health and long term support services for people who are elderly or disabled. Services are delivered in the participant's home or a setting of his or her choice. Through team based care management, the participant, his or her physician, nurses and social workers together develop a care plan and coordinate all service delivery.

Partnership is a managed long-term care program for adults. A person not yet 18 years of age may be enrolled in Partnership effective the first day of the month in which he or she turns 18, to the extent that the person meets all other Partnership financial and non-financial eligibility requirements (including Partnership *disability* requirements).

To participate in the Partnership program, people must be eligible for MA and meet the MA nursing home level of care requirement.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

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38.4 PACE

PACE (Program of All-Inclusive Care for the Elderly) is a program that provides comprehensive community based services, including both acute and chronic care for frail elderly individuals. Most services are provided in a day health center and members must receive medical services from a PACE physician. PACE is only available in select counties.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015*

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38.5 IRIS

The Include, Respect I Self-Direct (*IRIS*) program is a fee for service alternative to Family Care, *PACE* or Partnership for individuals requesting a long-term care support program in Family Care counties.

Under IRIS, the participant has access to an individualized budget which they may use to purchase will be able to access services comparable to those provided under the Home- and Community-Based Waivers (HCBW) while managing an individual budget to meet their service needs.

The IRIS option is available to people living in Family Care counties when they come to the *ADRC* and are found in need of publicly-funded long term care services. It is also available to Family Care members (and Partnership members, if Partnership is also operated in the county) if the member requests to change to IRIS. (Such individuals would need to be disenrolled from their managed care long-term support program in order to participate in IRIS).

Individuals who wish to participate in IRIS must meet the following criteria in order to qualify:

- Reside in a county operating Family Care,
- Meet the financial and non-financial eligibility criteria for:
 - A full benefit category of EBD Medicaid, including Long Term Care Medicaid,
 - BadgerCare Plus (BCP) Standard Plan,
 - Well Woman Medicaid (WWMA),
 - Adoption Assistance (AA), or
 - Foster Care Medicaid.
- Meet the appropriate functional level of care.

*This page last updated in Release Number: 15-01
Release Date: 06/10/2015
Effective Date: 06/10/2015*

APPENDIX (CHS. 39-40)

39 TABLES

39.1 LIFE ESTATE AND REMAINDER INTEREST

AGE	LIFE ESTATE	REMAINDER	AGE	LIFE ESTATE	REMAINDER
0	.97188	.02812	42	.90457	.09543
1	.98988	.01012	43	.89855	.10145
2	.99017	.00983	44	.89221	.10779
3	.99008	.00992	45	.88558	.11442
4	.98981	.01019	46	.87863	.12137
5	.98938	.01062	47	.87137	.12863
6	.98884	.01116	48	.86374	.13626
7	.98822	.01178	49	.85578	.14422
8	.98748	.01252	50	.84743	.15257
9	.98663	.01337	51	.83674	.16126
10	.98565	.01435	52	.82969	.17031
11	.98453	.01547	53	.82028	.17972
12	.98329	.01671	54	.81054	.18946
13	.98198	.01802	55	.80046	.19954
14	.98066	.01934	56	.79006	.20994
15	.97937	.02063	57	.77931	.22068
16	.97815	.02185	58	.76822	.23178
17	.97700	.02300	59	.75675	.24325
18	.97590	.02410	60	.74491	.25509
19	.97480	.02520	61	.73267	.26733
20	.97365	.02635	62	.72002	.27998
21	.97245	.02755	63	.70696	.29304
22	.97120	.02880	64	.69352	.30648
23	.96986	.03014	65	.67970	.32030
24	.96841	.03159	66	.66551	.33449
25	.96678	.03322	67	.65098	.34902
26	.96495	.03505	68	.63610	.36390
27	.96290	.03710	69	.62086	.37914
28	.96062	.03938	70	.60522	.39478
29	.95813	.04187	71	.58914	.41086
30	.95543	.04457	72	.57261	.42739
31	.95254	.04746	73	.55571	.44429

32	.94942	.05058	74	.53862	.46138
33	.94608	.05392	75	.52149	.47851
34	.94250	.05750	76	.50441	.49559
35	.93868	.06132	77	.48742	.51258
36	.93460	.06540	78	.47049	.52951
37	.93026	.06974	79	.45357	.54643
38	.92567	.07433	80	.43659	.56341
39	.92083	.07917	81	.41967	.58033
40	.91571	.08429	82	.40295	.59705
41	.91030	.08970	83	.38642	.61358

AGE	LIFE ESTATE	REMAINDER	AGE	LIFE ESTATE	REMAINDER
84	.36998	.63002	99	.20486	.79514
85	.35359	.64641	100	.19975	.80025
86	.33764	.66236	101	.19532	.80468
87	.32262	.67738	102	.19054	.80946
88	.30859	.69141	103	.18437	.81563
89	.29526	.70474	104	.17856	.82144
90	.28221	.71779	105	.16962	.83038
91	.26955	.73045	106	.15488	.84512
92	.25771	.74229	107	.13409	.86591
93	.24692	.75308	108	.10068	.89932
94	.23728	.76272	109	.04545	.95455
95	.22887	.77113			
96	.22181	.77819			
97	.21550	.78450			
98	.21000	.79000			

The source of the Life Estate & Remainder Interest Table is 26 CFR 20.2031 (49 Federal Register, Vol. 49, No. 93, May 11, 1984). The version of the table published here is from the Social Security Administration's Policy & Operations Manual Series (POMS), Section 01140.120.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

39.2 COUNTY & TRIBE AREA

[39.2.1 Area 1](#)

39.2.2 Area 2

Use this list to determine which column to use in the AFDC-related categorically needy income test. If a municipality is in 2 counties, use the area for the county in which the Medicaid fiscal group resides. If a pregnant woman is in a maternity home, use the area in which the home is located, even though the county of residence making the payment is in the other area. For example, if her county of residence is Vilas (Area 2) and she is in a maternity home in Milwaukee (Area 1), Vilas county pays at the Area 1 rate.

39.2.1 Area 1

Brown	Kenosha	Outagamie	Sheboygan
Dane	La Crosse	Ozaukee	Washington
Dodge	Marathon	Racine	Waukesha
Dunn	Manitowoc	Rock	Winnebago
Eau Claire	Milwaukee	St. Croix	Winnebago Tribe*
Fond du Lac			

39.2.2 Area 2

Adams
 Ashland
 Bad River
 Barron
 Bayfield
 Buffalo
 Calumet
 Chippewa
 Clark
 Columbia
 Crawford
 Door
 Douglas
 Florence
 Forest
 Green
 Green Lake
 Grant
 Iowa
 Iron
 Jackson
 Jefferson
 Juneau
 Kewaunee
 Lafayette

Langlade
Lincoln
Marinette
Marquette
Menominee
Monroe
Oconto
Oneida
Pepin
Pierce
Polk
Portage
Price
Richland
Rusk
Sauk
Sawyer
Shawano
Taylor
Trempeleau
Vernon
Vilas
Walworth
Washburn
Waupaca
Waushara

Lac Courte Oreilles
Lac du Flambeau
Menominee Tribe
Mole Lake
Potawatomi
Red Cliff
St.Croix Tribe
Stockbridge -Munsee
Winnebago Tribe

*Only if residing on tax-free land in La Crosse or Marathon County. All other locations are Area 2.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

39.3 AFDC-RELATED INCOME TABLE

Group Size	Categorically Needy		Medically Needy
	Area I	Area II	
1	\$ 311	\$ 301	\$ 591.67
2	\$ 550	\$ 533	\$ 591.67
3	\$ 647	\$ 626	\$ 689.33
4	\$ 772	\$ 749	\$ 822.67
5	\$ 886	\$ 861	\$ 944.00
6	\$ 958	\$ 929	\$1,021.33
7	\$ 1,037	\$ 1,007	\$1,105.33
8	\$ 1,099	\$ 1,068	\$1,172.00
9	\$ 1,151	\$ 1,117	\$1,226.67
10	\$ 1,179	\$ 1,143	\$1,257.33
11	\$ 1,204	\$1,168	\$1,284.00
12	\$1,229	\$1,193	\$1,310.67
13	\$1,254	\$1,218	\$1,337.33
14	\$1,279	\$1,243	\$1,364.00
15	\$1,304	\$1,268	\$1,390.67
16	\$1,329	\$1,293	\$1,417.33
17	\$1,354	\$1,318	\$1,444.00
18	\$1,379	\$1,343	\$1,470.67

+	+25 each person above 18	+25 each person above 18	+26.67 each person above 18
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This page last updated in Release Number: 08-01

Release Date: 02/01/08

Effective Date: 02/01/08

39.4 ELDERLY, BLIND, AND DISABLED ASSETS AND INCOME TABLES

[39.4.1 EBD Assets and Income Table](#)

[39.4.2 EBD Deductions and Allowances](#)

39.4.1 Elderly, Blind, and Disabled Assets and Income Table

Effective January 1, 2015

Group Size				
Category		1		2
EBD Categorically Needy Limits	Assets	\$2,000	Assets	\$3,000
	Income	\$572.45 (+ actual shelter up to \$244.33)	Income	\$865.38 (+ actual shelter up to \$366.67)
EBD Medically Needy Limits	Assets	\$2,000	Assets	\$3,000
	Income	\$591.67	Income	\$591.67
SSI Payment Level				
Federal SSI Payment Level	Income	\$710.00	Income	\$1,066.00
State Supplementary Payment (SSP)	Income	\$83.78	Income	\$132.05
Total	Income	\$793.78	Income	\$1,198.05
SSI Payment Level + E Supplement	Income	\$900.77		
SSI E Supplement	Income	\$95.99		
Community Waivers Special Income Limit	Income	\$2,163		
Institutions Categorically Needy Income Limit	Income	\$2,199		

Substantial Gainful Activity Limit (non-blind individuals)	Income	\$1,040		
Substantial Gainful Activity Limit (blind individuals)	Income	\$1,740		

39.4.2 Elderly, Blind, and Disabled Deductions and Allowances

Effective January 1, 2015

	Description		Amount
1	Personal Needs Allowance (effective 7/1/01)		\$45.00
2	EBD Maximum Personal Maintenance Allowance		\$2,199.00
3	EBD Deeming Amount to an Ineligible <u>Minor</u>		\$367.00
4	Community Waivers Basic Needs Allowance		\$913
5	Parental Living Allowance for Disabled Minors	1 Parent	\$733.00
		2 Parent	\$1,100.00
6	<u>MAPP</u> Standard Living Allowance (SLA) SLA = SSI + State Supplement + \$20		\$836.00
7	<u>Community Spouse</u> Lower Income Allocation Limit		\$2,655.00
8	Community Spouse Excess Shelter Cost Limit		\$796.50
9	Family Member Income Allowance		\$663.75

This page last updated in Release Number: 15-02
Release Date: 07/30/2015
Effective Date: 07/30/2015

39.5 FEDERAL POVERTY LEVEL (FPL) TABLE

Effective February 1, 2015

group size	Annual FPL	100% FPL	120% FPL	135% FPL	150% FPL	160% FPL	185% FPL	200% FPL	240% FPL	250% FPL	300% FPL	306% FPL	30% of 200% FPL
1	\$11,770	\$980.83	\$1,177.00	\$1,324.13	\$1,471.25	\$1,569.33	\$1,814.54	\$1,961.67	\$2,354.00	\$2,452.08	\$2,942.50	\$3,001.35	-
2	15,930	\$1,327.50	\$1,593.00	\$1,792.13	\$1,991.25	\$2,124.00	\$2,455.88	\$2,655.00	\$3,186.00	\$3,318.75	\$3,982.50	\$4,062.15	\$796.50
3	20,090	\$1,674.17	\$2,009.00	\$2,260.13	\$2,511.25	\$2,678.67	\$3,097.21	\$3,348.33	\$4,018.00	\$4,185.42	\$5,022.50	\$5,122.95	-
4	24,250	\$2,020.83	\$2,425.00	\$2,728.13	\$3,031.25	\$3,233.33	\$3,738.54	\$4,041.67	\$4,850.00	\$5,052.08	\$6,062.50	\$6,183.75	-
5	28,410	\$2,367.50	\$2,841.00	\$3,196.13	\$3,551.25	\$3,788.00	\$4,379.88	\$4,735.00	\$5,682.00	\$5,918.75	\$7,102.50	\$7,244.55	-
6	32,570	\$2,714.17	\$3,257.00	\$3,664.13	\$4,071.25	\$4,342.67	\$5,021.21	\$5,428.33	\$6,514.00	\$6,785.42	\$8,142.50	\$8,305.35	-
7	36,730	\$3,060.83	\$3,673.00	\$4,132.13	\$4,591.25	\$4,897.33	\$5,662.54	\$6,121.67	\$7,346.00	\$7,652.08	\$9,182.50	\$9,366.15	-
8	40,890	\$3,407.50	\$4,089.00	\$4,600.13	\$5,111.25	\$5,452.00	\$6,303.88	\$6,815.00	\$8,178.00	\$8,518.75	\$10,222.50	\$10,426.95	-
9	45,050	\$3,754.17	\$4,505.00	\$5,068.13	\$5,631.25	\$6,006.67	\$6,945.21	\$7,508.33	\$9,010.00	\$9,385.42	\$11,262.50	\$11,487.75	-
10	49,210	\$4,100.83	\$4,921.00	\$5,536.13	\$6,151.25	\$6,561.33	\$7,586.54	\$8,201.67	\$9,842.00	\$10,252.08	\$12,302.50	\$12,548.55	-
11	53,370	\$4,447.50	\$5,337.00	\$6,004.13	\$6,671.25	\$7,116.00	\$8,227.88	\$8,895.00	\$10,674.00	\$11,118.75	\$13,342.50	\$13,609.35	-
12	57,530	\$4,794.17	\$5,753.00	\$6,472.13	\$7,191.25	\$7,670.67	\$8,869.21	\$9,588.33	\$11,506.00	\$11,985.42	\$14,382.50	\$14,670.15	-
13	61,690	\$5,140.83	\$6,169.00	\$6,940.13	\$7,711.25	\$8,225.33	\$9,510.54	\$10,281.67	\$12,338.00	\$12,852.08	\$15,422.50	\$15,730.95	-
14	65,850	\$5,487.50	\$6,585.00	\$7,408.13	\$8,231.25	\$8,780.00	\$10,151.88	\$10,975.00	\$13,170.00	\$13,718.75	\$16,462.50	\$16,791.75	-
15	70,010	\$5,834.17	\$7,001.00	\$7,876.13	\$8,751.25	\$9,334.67	\$10,793.21	\$11,668.33	\$14,002.00	\$14,585.42	\$17,502.50	\$17,852.55	-
16	74,170	\$6,180.83	\$7,417.00	\$8,344.13	\$9,271.25	\$9,889.33	\$11,434.54	\$12,361.67	\$14,834.00	\$15,452.08	\$18,542.50	\$18,913.35	-
17	78,330	\$6,527.50	\$7,833.00	\$8,812.13	\$9,791.25	\$10,444.00	\$12,075.88	\$13,055.00	\$15,666.00	\$16,318.75	\$19,582.50	\$19,974.15	-
18	82,490	\$6,874.17	\$8,249.00	\$9,280.13	\$10,311.25	\$10,998.67	\$12,717.21	\$13,748.33	\$16,498.00	\$17,185.42	\$20,622.50	\$21,034.95	-
19	86,650	\$7,220.83	\$8,665.00	\$9,748.13	\$10,831.25	\$11,553.33	\$13,358.54	\$14,441.67	\$17,330.00	\$18,052.08	\$21,662.50	\$22,095.75	-
20	90,810	\$7,567.50	\$9,081.00	\$10,216.13	\$11,351.25	\$12,108.00	\$13,999.88	\$15,135.00	\$18,162.00	\$18,918.75	\$22,702.50	\$23,156.55	-
21	94,970	\$7,914.17	\$9,497.00	\$10,684.13	\$11,871.25	\$12,662.67	\$14,641.21	\$15,828.33	\$18,994.00	\$19,785.42	\$23,742.50	\$24,217.35	-
22	99,130	\$8,260.83	\$9,913.00	\$11,152.13	\$12,391.25	\$13,217.33	\$15,282.54	\$16,521.67	\$19,826.00	\$20,652.08	\$24,782.50	\$25,278.15	-
23	103,290	\$8,607.50	\$10,329.00	\$11,620.13	\$12,911.25	\$13,772.00	\$15,923.88	\$17,215.00	\$20,658.00	\$21,518.75	\$25,822.50	\$26,338.95	-
24	107,450	\$8,954.17	\$10,745.00	\$12,088.13	\$13,431.25	\$14,326.67	\$16,565.21	\$17,908.33	\$21,490.00	\$22,385.42	\$26,862.50	\$27,399.75	-
each additional person	\$4,160	\$346.67	\$416.00	\$468.00	\$520.00	\$554.67	\$641.33	\$693.33	\$832.00	\$866.67	\$1,040.00	\$1,060.80	-
		QMB	SLMB	QL-1 (slmb+)	MAPP premium limit	SeniorCare tier one limit		QDWI & lower SI Inc Alloc	SeniorCare tier three limit	MAPP			excess shelter allowance
					Annual figures for SeniorCare	\$18,832.00		\$23,540.00	\$28,248.00				
						\$25,488.00		\$31,860.00	\$38,232.00				

This page last updated in Release Number: 15-01

Release Date: 06/10/2015

Effective Date: 02/01/2015

39.6 COST-OF-LIVING ADJUSTMENT

To calculate the Cost-of-Living Adjustment (**COLA**) *disregard* amount, do the following:

- Find the AG's current gross Old Age Survivors [Disability](#) Insurance ([OASDI](#)) Benefits income. The gross OASDI income is the amount of the OASDI check **plus** any amount that has been withheld for a Medicare premium **plus** any amount with-held to repay an earlier overpayment. Do not include in the gross income any Medicare Plan B premiums which the State has purchased for the **AG**.
- On the COLA [Disregard](#) Amount Table below find the last month in which the person was eligible for and received a check for both OASDI and Supplemental Security Income ([SSI](#)).
- Find the decimal figure that applies to this month.

4. Multiply the person's current gross OASDI income by the applicable decimal figure. The result is the COLA disregard amount.

COLA Disregard Amount Table

Medicaid Eligibility Handbook Release 15-02

Jan - Dec 2014	0.014778325
Jan - Dec 2013	0.031247124
Jan - Dec 2012	0.064910351
Jan - Dec 2011	0.064910351
Jan - Dec 2010	0.064910351
Jan - Dec 2009	0.116172355
Jan - Dec 2008	0.136043358
Jan - Dec 2007	0.163643134
Jan - Dec 2006	0.196583222
Jan - Dec 2005	0.217705182
Jan - Dec 2004	0.233795477
Jan - Dec 2003	0.244374238
Jan - Dec 2002	0.263522649
Jan - Dec 2001	0.288427680
Jan - Dec 2000	0.305105156
Jan - Dec 1999	0.314022859
Jan - Dec 1998	0.328132085
Jan - Dec 1997	0.347067138
Jan - Dec 1996	0.363613195
Jan - Dec 1995	0.380946688
Jan - Dec 1994	0.396634199
Jan - Dec 1993	0.414207960
Jan - Dec 1992	0.435108930
Jan - Dec 1991	0.464050218
Jan - Dec 1990	0.488109091
Jan - Dec 1989	0.507797203

*This page last updated in Release Number: 14-01
Release Date: 05/01/14
Effective Date: 01/01/14*

39.7 HOSPITAL DAILY RATES

City	Hospital Name	Average IP Daily Charge Based on Gross Inpatient Revenue*
Amery	Amery Regional Medical Center	2,089.80
Antigo	Langlade Memorial Hospital	2,138.75
Appleton	Appleton Medical Center	2,619.86
Appleton	St. Elizabeth Hospital	2,116.37
Arcadia	Franciscan Skemp Healthcare-Arcadia	3,092.15
Ashland	Memorial Medical Center, Inc.	1,482.73
Baldwin	Baldwin Area Medical Center, Inc.	2,533.16
Baraboo	St. Clare Hospital and Health Services	2,179.26
Barron	Barron Medical Center, Mayo Health System	1,954.05
Beaver Dam	Beaver Dam Community Hospitals, Inc.	2,668.64
Beloit	Beloit Memorial Hospital, Inc.	2,372.91
Berlin	Berlin Memorial Hospital	2,281.50
Black River Falls	Black River Memorial Hospital	2,008.27
Bloomer	Bloomer Medical Center, Mayo Health System, Inc.	2,650.71
Boscobel	Boscobel Area Health Care	2,223.16
Brookfield	Elmbrook Memorial Hospital	2,939.91
Burlington	Memorial Hospital Corporation of Burlington	3,388.85
Chilton	Calumet Medical Center, Inc.	2,275.09
Chippewa Falls	St. Joseph's Hospital	1,328.26
Columbus	Columbus Community Hospital, Inc.	2,189.11
Cumberland	Cumberland Memorial Hospital and ECU	1,401.31
Darlington	Memorial Hospital of Lafayette County	2,176.27

Dodgeville	Upland Hills Health	2,319.07
Durand	Chippewa Valley Hospital	4,079.93
Eagle River	Eagle River Memorial Hospital, Inc.	2,089.94
Eau Claire	Luther Hospital	2,856.90
Eau Claire	Sacred Heart Hospital	2,048.11
Edgerton	Memorial Community Hospital	4,277.41
Elkhorn	Lakeland Medical Center, Inc.	2,818.54
Fond du Lac	Agnesian HealthCare, Inc.	2,038.43
Fond Du Lac	Fond du Lac County Department of Com. Prog.	542.75
Fort Atkinson	Fort Atkinson Memorial Health Services	1,611.49
Friendship	Adams County Memorial Hospital	2,122.78
Grantsburg	Burnett Medical Center, Inc.	2,463.85
Green Bay	Bellin Memorial Hospital	3,203.79
Green Bay	Bellin Psychiatric Center	1,127.78
Green Bay	Brown County Mental Health Center	604.30
Green Bay	Libertas Treatment Center	599.69
Green Bay	St. Mary's Hospital Medical Center	2,150.08
Green Bay	St. Vincent Hospital	2,181.42
Greenfield	Kindred Hospital-Milwaukee	2,863.08
Hartford	Aurora Medical Center	1,951.60
Hayward	Hayward Area Memorial Hospital	2,499.17
Hillsboro	St. Joseph's Comm. Health Services, Inc.	3,214.87
Hudson	Hudson Hospital	3,123.36
Janesville	Mercy Health System Corporation	2,959.12
Janesville	Rock County Psychiatric Hospital	627.07
Kenosha	Aurora Medical Center - Kenosha	3,394.71
Kenosha	Children's Hospital of WI, Inc. - Kenosha	1,583.90
Kenosha	Kenosha Hospital and Medical Center	3,002.25
La Crosse	Franciscan Skemp Healthcare - La Crosse	2,472.35
La Crosse	Gundersen Lutheran Medical Center, Inc.	3,399.28
Ladysmith	Rusk Co. Memorial Hospital and Nursing Home	1,713.81
Lancaster	Grant Regional Health Center, Inc.	2,827.16

Madison	Mendota Mental Health Institute	577.84
Madison	Meriter Hospital, Inc.	2,740.11
Madison	St. Mary's Hospital Medical Center	2,785.67
Madison	University of WI Hospital and Clinics Authority	3,171.65
Manitowoc	Holy Family Memorial Medical Center	2,349.37
Marinette	Bay Area Medical Center	1,985.82
Marshfield	Norwood Health Center	662.10
Marshfield	Saint Joseph's Hospital	2,693.24
Mauston	Hess Memorial Hospital	2,500.85
Medford	Memorial Health Center, Inc.	2,079.43
Menomonee Falls	Community Memorial Hospital	2,527.08
Menomonie	Myrtle Werth Hospital-Mayo Health System	2,020.15
Mequon	St. Mary's Hospital-Ozaukee	2,626.39
Merrill	Good Samaritan Health Center	1,862.32
Milwaukee	Aurora Sinai Medical Center	3,504.31
Milwaukee	Children's Hospital of Wisconsin	4,109.72
Milwaukee	Columbia Hospital, Inc.	3,142.63
Milwaukee	Froedtert Memorial Lutheran Hospital	3,763.75
Milwaukee	Milwaukee County Mental Health Complex	658.69
Milwaukee	Sacred Heart Rehabilitation Institute	1,590.18
Milwaukee	St. Joseph's Hospital	2,870.63
Milwaukee	St. Luke's Medical Center	4,194.60
Milwaukee	St. Mary's Hospital-Milwaukee	3,038.61
Milwaukee	St. Michael Hospital	3,041.39
Monroe	The Monroe Clinic	2,821.34
Neenah	Theda Clark Medical Center	2,123.14
Neillsville	Memorial Hospital, Inc	2,546.27
New London	New London Family Medical Center	2,048.86
New Richmond	Holy Family Hospital	2,331.20
Oconomowoc	Oconomowoc Memorial Hospital	2,756.58
Oconomowoc	Rogers Memorial Hospital	845.81

Oconto	Oconto Memorial Hospital, Inc.	2,419.99
Oconto Falls	Community Memorial Hospital	2,436.47
Osceola	Osceola Medical Center	2,533.79
Oshkosh	Mercy Medical Center of Oshkosh	2,204.91
Osseo	Osseo Area Hospital and Nursing Home, Inc.	8,485.86
Park Falls	Flambeau Hospital, Inc.	2,149.84
Platteville	Southwest Health Center, Inc.	2,053.36
Portage	Divine Savior Healthcare	2,096.57
Prairie Du Chien	Prairie du Chien Memorial Hospital	2,986.91
Prairie Du Sac	Sauk Prairie Memorial Hospital	2,575.36
Racine	All Saints-St. Luke's Hospital, Inc.	1,500.18
Racine	All Saints-St. Mary's Medical Center, Inc.	2,203.06
Reedsburg	Reedsburg Area Medical Center	2,252.02
Rhineland	Saint Mary's Hospital, Inc.	2,601.07
Rice Lake	Lakeview Medical Center	1,649.24
Richland Center	The Richland Hospital, Inc.	2,376.05
Ripon	Ripon Medical Center	2,345.92
River Falls	River Falls Area Hospital	2,771.15
Shawano	Shawano Medical Center	1,945.56
Sheboygan	Sheboygan Memorial/Valley View Medical Center	2,414.85
Sheboygan	St. Nicholas Hospital	1,870.69
Shell Lake	Indianhead Medical Center Shell Lake, Inc.	1,889.70
Sparta	Franciscan Skemp Healthcare-Sparta	2,503.34
Spooner	Spooner Health System	2,063.49
St. Croix Falls	St. Croix Regional Medical Center, Inc.	2,738.80
Stanley	Victory Medical Center	2,768.09
Stevens Point	Saint Michael's Hospital	2,016.21
Stoughton	Stoughton Hospital Association	1,945.35
Sturgeon Bay	Door County Memorial Hospital	3,027.83
Superior	St. Mary's Hospital of Superior	1,959.67
Tomah	Tomah Memorial Hospital, Inc.	1,660.85

Tomahawk	Sacred Heart Hospital, Inc.	1,350.84
Two Rivers	Aurora Medical Center of Manitowoc City, Inc.	2,441.01
Viroqua	Vernon Memorial Hospital	2,196.89
Waterford	Lakeview NeuroRehab Center Midwest	1,655.79
Watertown	Watertown Memorial Hospital	2,476.15
Waukesha	Waukesha County Mental Health Center	694.85
Waukesha	Waukesha Memorial Hospital, Inc.	2,691.44
Waupaca	Riverside Medical Center	1,958.61
Waupun	Waupun Memorial Hospital	1,903.18
Wausau	North Central Health Care Facilities	694.88
Wausau	Wausau Hospital	2,602.82
Wauwatosa	Aurora Psychiatric Hospital	1,075.72
West Allis	Rogers Memorial Hospital - Milwaukee	1,674.72
West Allis	Select Specialty Hospital	2,372.35
West Allis	West Allis Memorial Hospital	3,282.94
West Bend	St. Joseph's Community Hospital	1,758.48
Whitehall	Tri-County Memorial Hospital, Inc.	2,472.95
Wild Rose	Wild Rose Community Memorial Hospital Inc.	2,077.47
Winnebago	Winnebago Mental Health Institute	457.54
Wisconsin Rapids	Riverview Hospital Association	1,934.27
Woodruff	Howard Young Medical Center, Inc.	2,509.65

Data Source: Gross Inpatient Revenue and Total Discharge Days, 2001 Wisconsin Hospital Fiscal Survey

* Average Daily Charge is the sum of Gross Inpatient Revenue and Gross Inpatient Ancillary Revenue divided by Total Discharge Days.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

39.8 LIFE EXPECTANCY TABLE

See the [Life Expectancy Table](#) at Social Security Administration site.

*This page last updated in Release Number: 09-04
Release Date: 09/09/09
Effective Date: 09/09/09*

39.9 BADGERCARE PREMIUMS

See the [BadgerCare + handbook Section 48](#) for BadgerCare Plus premiums

*This page last updated in Release Number: 09-02
Release Date: 02/23/09
Effective Date: 02/23/09*

39.10 MAPP PREMIUMS

MAPP Premiums - Income exceeds 150% of the **FPL**

MAPP PREMIUM SCHEDULE					
Sum of Adjusted Countable Unearned and Adjusted Earned Income		The premium is:	Sum of Adjusted Countable Unearned and Adjusted Earned Income		The premium is:
From	To	PREMIUM	From	To	PREMIUM
\$0	\$25.00	\$0.00	500.01	525.00	500.00
25.01	50.00	25.00	525.01	550.00	525.00
50.01	75.00	50.00	550.01	575.00	550.00
75.01	100.00	75.00	575.01	600.00	575.00
100.01	125.00	100.00	600.01	625.00	600.00
125.01	150.00	125.00	625.01	650.00	625.00

150.01	175.00	150.00	650.01	675.00	650.00
175.01	200.00	175.00	675.01	700.00	675.00
200.01	225.00	200.00	700.01	725.00	700.00
225.01	250.00	225.00	725.01	750.00	725.00
250.01	275.00	250.00	750.01	775.00	750.00
275.01	300.00	275.00	775.01	800.00	775.00
300.01	325.00	300.00	800.01	825.00	800.00
325.01	350.00	325.00	825.01	850.00	825.00
350.01	375.00	350.00	850.01	875.00	850.00
375.01	400.00	375.00	875.01	900.00	875.00
400.01	425.00	400.00	900.01	925.00	900.00
425.01	450.00	425.00	925.01	950.00	925.00
450.01	475.00	450.00	950.01	975.00	950.00
475.01	500.00	475.00	975.01	1000.00	975.00
			1000.01	1025.00	1000.00

If the subtotal from the MAPP Premium Calculation Worksheet is more than \$1,025 a month, the premium is equal to the exact whole dollar amount of the subtotal.

*This page last updated in Release Number: 08-01
Release Date: 02/01/08
Effective Date: 02/01/08*

39.11 SENIORCARE INCOME LIMITS AND PARTICIPATION LEVELS

[39.11.1 SC Income Limits Introduction](#)

[39.11.2. Level 1 : Co-Payment](#)

[39.11.3 Level 2a: Deductible](#)

[39.11.4 Level 2b: Deductible](#)

[39.11.5. Level 3: Spenddown](#)

[39.11.5.1 Level 3: FTG of One](#)

[39.11.5.2 Level 3: FTG of Two](#)

39.11.1 SC Income Limits Introduction

For applicants determined eligible, **SC** pays for a portion of covered prescription drugs (See [33.6 SC Financial Requirements](#)), depending on the person's participation level.

Effective with benefit periods starting September 1, 2003 there are four participation levels. The level of benefits an *applicant* receives depends on his or her annual *income* and, for some, on the amount they spend on covered prescription drugs during their 12-month benefit period.

The participation levels are:

1. **Level 1:** Co-Payment (Annual income is at or below 160% of the *FPL*.)
2. **Level 2a:** Deductible \$500 (Annual income is greater than 160% of the FPL and less than or equal to 200% of the FPL.)
3. **Level 2b:** Deductible \$850 (Annual income is greater than 200% of the FPL and less than or equal to 240% of the FPL.)
4. **Level 3:** Spenddown (Annual income is above 240% of the FPL.)

Note: The FPL is set annually by the Department of Health Services see 39.5 FPL Table

If the FPL changes during the eligibility determination process or before a redetermination can be completed, the new levels will be used.

SeniorCare Levels of Participation	
Income Limits*	Annual Out-of-Pocket Expense Requirements and Benefits
Level 1 Income at or below 160% of FPL At or below \$18,672 per individual or \$25,168 per couple annually.*	<ul style="list-style-type: none"> ▪ No deductible or spenddown. ▪ \$5 co-pay for each covered generic prescription drug. ▪ \$15 co-pay for each covered brand name prescription drug.
Level 2a Income above 160% and at or below 200% FPL	<ul style="list-style-type: none"> ▪ \$500 deductible per person. ▪ Pay the SeniorCare rate for drugs until the \$500 deductible is met. ▪ After \$500 deductible is met, pay a \$5 co-

<p>\$18,673 to \$23,340 per individual and \$25,169 to \$31,460 per couple annually.*</p>	<p>pay for each covered generic prescription drug and a \$15 co-pay for each covered brand name prescription drug.</p>
<p>Level 2b</p> <p>Income above 200% - and at or below 240% of FPL</p> <p>\$23,341 to \$28,008 per individual and \$31,461 to 37,752 per couple annually.</p>	<ul style="list-style-type: none"> ▪ \$850 deductible per person. ▪ Pay the SeniorCare rate for most covered drugs until the \$850 deductible is met. ▪ After \$850 deductible is met, pay a \$5 co-pay for each covered generic prescription drug and a \$15 co-pay for each covered brand name prescription drug.
<p>Level 3</p> <p>Annual income is above 240% of the FPL</p> <p>\$28,009 or higher per individual and \$37,753 or higher per couple annually.*</p>	<ul style="list-style-type: none"> ▪ Pay retail price for drugs equal to the difference between your income and \$27,577 per individual or \$37,224 per couple. This is called “spenddown.” ▪ Covered drug costs for spenddown will be tracked automatically. During the spenddown, there is no discount on drug costs. ▪ After spenddown is met, meet an \$850 deductible per person. ▪ Pay SeniorCare rate for most covered drugs until the \$850 deductible is met. ▪ After the \$850 deductible is met, pay a \$5 co-pay for each covered generic prescription drug and a \$15 co-pay for each covered brand name prescription drug.

* These income amounts are based on the 2014 federal poverty guidelines, which increase by a small amount each year.

39.11.2 Level 1: Co-Payment

SeniorCare will pay for covered prescription drugs purchased from participating pharmacies except for participant co-payments.

Level 1 participants are required to pay a \$5 co-payment for each covered generic prescription drug, and a \$15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the \$15 brand name co-pay.

If a participant has private insurance with a higher co-payment per prescription than SeniorCare, the SeniorCare co-payment rules will apply and benefits will be coordinated with the private insurance company. Providers who have questions regarding billing/benefit coordination should contact Provider Services Hotline at 1-800-947-9627.

Residents of nursing homes and community based residential facilities will have to pay the usual SeniorCare co-payment even when they are required to purchase drugs on less than a monthly basis.

39.11.3 Level 2a: Deductible

Participant has an annual deductible of \$500. Participant will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

After this deductible is met, a level 2a participant is required to pay a \$5 co-payment for each covered generic prescription drug, and a \$15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the \$15 brand name co-pay.

39.11.4 Level 2b: Deductible

Participant has an annual deductible of \$850. Participant will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

After this deductible is met, a level 2b participant is required to pay a \$5 co-payment for each covered generic prescription drug, and a \$15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the \$15 brand name co-pay.

Note: If married persons in the same *FTG* with annual income above 160% of FPL are determined non-financially eligible at different times, the deductible amount is prorated for the *spouse* who applies later. (See [33.9.3.1 FTG Changes at Level 2a and 2b](#))

39.11.5 Level 3: Spenddown

Level 3 participants must meet a spenddown. The amount of spenddown is the difference between the FTG annual income and 240% of the FPL corresponding the size of the FTG. The SeniorCare program tracks the amount spent on covered prescriptions drugs that can be applied to an applicant's spenddown.

39.11.5.1 Level 3: FTG of One

A SeniorCare participant considered as a FTG of one with gross annual income above 240% FPL pays retail prices for covered prescription drugs until those payments equal the spenddown amount.

After the spenddown has been met by purchasing drugs at regular prices the participant has an annual deductible of \$850. During the deductible period the participant will get a discount off the retail price for most covered prescription drugs during the deductible period.

After this deductible is met, he or she is required to pay a \$5 co-payment for each covered generic prescription drug, and a \$15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the \$15 brand name co-pay.

Example 1: Dorothy's annual income is \$29,009. This is \$1,000 more than 240% of the FPL for a FTG of one. Her spenddown amount for the 12-month benefit period is \$1,000. Dorothy pays the retail price for her covered prescription drugs until those payments equal the spenddown amount.

If Dorothy meets the spenddown during her benefit period, she can begin purchasing covered prescription drugs at the discounted rate. These costs are applied toward the \$850 deductible.

After this deductible is met, Dorothy purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period

39.11.5.2 Level 3: FTG of Two

Married persons considered as a FTG of two with annual income greater than 240% FPL and in which both spouses are determined non-financially eligible at the same time pay retail price for covered prescription drugs until the spenddown requirement is met.

In this case, the spenddown amount is shared, and covered prescription drugs purchased for either person in the married couple will count toward meeting the spenddown requirement, when both are eligible.

After the spenddown has been met, each spouse must meet a separate \$850 deductible requirement. Participants will get a discount off the retail price for most covered prescription drugs during the deductible period. Only the covered prescription drugs purchased for an individual spouse may count toward that spouse's deductible.

After a spouse has met his or her deductible, he or she is required to pay a \$5 co-payment for each covered generic prescription drug, and a \$15 co-payment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the \$15 brand name co-pay.

Example 2: Bob and Alice's annual income is \$39,753, which is \$2,000 more than 240% of the FPL for a FTG of two. Both spouses are eligible and, for the 12-month benefit period, their joint spenddown amount is \$2,000.

Bob and Alice pay for their covered prescription drugs at retail price until the \$2,000 spenddown is met. Covered prescription drugs purchased for either Bob or Alice will count toward the spenddown requirement.

After Bob and Alice meet the spenddown, each person has a \$850 deductible. Only covered prescription drugs purchased for Bob count toward his deductible, and only covered prescription drugs purchased for Alice count toward her deductible.

Bob meets his deductible in two months. He then purchases covered prescription drugs at the co-payment amounts for the remainder of his benefit period. Alice meets her deductible in three months. She then purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period.

If only one spouse in a married couple is determined eligible, only his or her costs count toward the spenddown. He or she pays retail price for covered prescription drugs until the spenddown requirement is met.

Example 3: Tracy and Dave's annual income is \$39,753, which is \$2,000 more than 240% of the FPL for a FTG of two. Because Tracy is 63 years old, only Dave is eligible for SeniorCare. For the 12-month benefit period Dave's spenddown amount is \$2,000.

Tracy and Dave pay for their covered prescription drugs at retail price. Only covered prescription drugs purchased for Dave count toward the spenddown requirement.

After Dave has met the \$2,000 spenddown, he has a \$850 deductible. Only covered prescription drugs purchased for Dave count toward his deductible. After Dave meets his deductible, he purchases covered prescription drugs at the co-payment amounts for the remainder of her benefit period.

*This page last updated in Release Number: 14-01
 Release Date: 05/01/14
 Effective Date: 02/01/14*

40 WORKSHEETS

40.1 WORKSHEETS TABLE OF CONTENTS

Following is a list of Medicaid worksheets. All worksheets should be copied for your use.

WORKSHEETS	
NUMBER	NAME
Wkst 01	Medicaid Non-Financial
Wkst 02	Dependent Care
Wkst 03	Medicaid Deductible
Wkst 04	Medicaid Institution Determination
Wkst 05	Medicaid Extensions (obsolete)
Wkst 06	EBD – Related Determination Worksheet
Wkst 07	Spousal Impoverishment Income Allocation
Wkst 08	Medicaid Purchase Plan (MAPP) Eligibility
Wkst 09	Medicaid Purchase Plan (MAPP) Premium Calculation
Wkst 10	Medicaid Purchase Plan (MAPP) Work Expenses
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Wkst 12	Family Care Eligibility – Non-MA Financial Determination (obsolete)
Wkst 13	FFU Income (obsolete)
Wkst 14	AFDC-Related Determination Worksheet

*This page last updated in Release Number: 14-02
Release Date: 12/18/14
Effective Date: 12/18/14*