Income Maintenance Manual (IMM)
Release10-01 03/16/10

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GENERAL ADMIN REQUIREMENTS (1-6)

1 GENERAL REQUIREMENTS

1.1 STANDARDS FOR OFFICE SPACE AND FACILITIES

1.1.1 Introduction
1.1.2 Administering The Standards
1.1.3 Measurement
1.1.4 Standards
1.1.5 Reception Areas
1.1.6 Circulation and Workflow
1.1.7 Access to Handicapped
1.1.8 Environmental Factors
1.1.9 Heating, Ventilation, and Air Conditioning
1.1.10 Reimbursable Costs

1.1.1 Introduction

Federal Regulations (45 CFR 205.170) require that *DHS* establish and maintain standards for office space, equipment, and facilities that adequately and effectively meet staff program needs.

In supervising the administration of the FoodShare and Medicaid programs, DHS must assure there is adequate space designed for the specialized functions in serving clients. The kind of office space, equipment, and facilities directly affect the quality of administration of these programs and staff effectiveness in providing services.

These standards are a minimum and not necessarily what may be desirable for the most efficient and effective operation of an agency.

1.1.2 Administering The Standards

All agency offices providing Medicaid and/or FoodShare must be:

1. Well marked and clearly identifiable in the community as a public service.
2. Reasonably accessible to the client in relation to number, location, and transportation.
3. Adequate in size and adapted to current agency needs. Safeguards to the health, comfort, and safety of the client, staff, and general public include clean, well-lighted reception and work areas maintained at comfortable temperatures. Drinking fountains and adequately supplied public restrooms must be readily accessible.
4. Adequate in space assignment in relation to work flow and function, which promotes prompt and efficient service to the public.

Comfortable reception and waiting room facilities must be provided. There must be direct accessibility to the reception desk from the main entrance to the office.

Arrange space to assure privacy for client interviews, supervisory purposes, and general meetings, conferences, and training.

Locate records and files appropriately to work flow and function.

Give special consideration to waiting rooms, hallways, stairs, elevators play space for children and restrooms to accommodate the needs of children, the elderly, and the physically handicapped.

5. Adequately furnished and equipped for staff to perform their duties efficiently and to meet the needs of the client population.
6. Maintained (building, interior, exterior and surrounding grounds) in keeping with safeguards to health, comfort, and safety).

DHS evaluates compliance with these standards through:

1. Required reports
2. Regional office review
3. Administrative reviews
4. Special studies

DES and its regional offices will provide consultation regarding compliance with these standards. Action must be taken to improve office space, equipment, and facilities when the standards are not met.

Make the office as attractive as possible, whereby cleanliness, lighting, color, and furnishings enhance the overall appearance and promote community respect for the public office, efficient work flow, client dignity and privacy, and staff morale and productivity. Give attention to transportation facilities to and from the office, including parking facilities for both clients and staff.

1.1.3 Measurement

Net assignment area means that portion of the gross area which is assigned, or available for assignment, including space which is available jointly to the various occupants of a building. Net assignment includes space provided for the operation and maintenance of the building.

Compute net assignable area by measuring from the normal inside finish of the exterior walls to the office side of corridor walls or other permanent partitions. Adjust for columns, projections, and alcoves which are necessary to the building.

Deviation of up to 25% from the standards may be considered due to unique agency space requirements: the, placement of stairways, windows, doors, appurtenances caused by structural features, lighting, electrical outlets, air conditioning and/or heat outlets; and configuration of existing structures.

Light, airy, and attractive open areas with wide primary and secondary aisles provide efficient and effective arrangement of clerical staff if allowances are made for 80 square feet for each legal size file cabinet or 6 square feet for each letter size cabinet. This allows space for opening file drawers when facing a secondary aisle. This space should also include the actual square feet needed for work tables, various machines, and supply cabinets if there's no supply room.

The objectives of space standards are to improve agency operations by promoting effective use of space. Subject to the 25% variation, the following minimum office space standards apply:

Functional Position	Unit Work Areas Minimum Square Feet
Director	140
Deputy or Assistant Director	100
Subordinate Administrators	80
Office Supervisors	80

Square Footage Based on Number of Employees in a Room

	1- 4 Employees	Each Added Employee
Social Workers, Analysts, Examiners, Accountants, & other Professional workers.	80	60
Clerks, Typists, Stenos, and Office Machine Operators	70	50

The unit work area is the specific area that an employe requires on a full-time basis to perform his/ her functions. It includes normal circulation and space for general items such as a desk, chair, book-case, and wastebasket. It doesn't include reception or conference space, primary circulations, file areas, supply roans, libraries and machine rooms.

1.1.4 Standards

Optimum needs also include an adequate, well ventilated room for board meetings, staff meetings, training sessions, and space for an agency library.

The following factors affect good office layout.

1. A large open area with moveable partitions may be more efficient than dividing the same space into smaller rooms, because open area:
    a. Provides maximum flexibility for changing operations.
    b. Makes control and communication easier.
    c. Provides better light and ventilation.
    d. Reduces space requirements.
    e. Makes a better flow of work possible.
2. Supervisors who are working with their employees, rather than planning for them, should generally be in the same room as their staff.
3. Layouts should be arranged so that employees within a unit doing the same type of work are in the same roan. Units of an office having interrelationships should be near each other.
4. Employees having frequent public contacts should be located near entrances to the office.
5. Employees doing confidential work or tasks requiring quiet concentration should be located away from entrances.
6. Consider interview cubicles. These need only be large enough for an interviewer, those to be inter-viewed (usually 2 to 4 persons), a small desk or table, and comfortable chairs. The partition should provide privacy for client interviews with acoustical treatment on the walls, if necessary.
7. If employees are out of their office most of the workday, consider assigning 2 or more employees to a desk. This is effective only if the hours these staff report to the office can be staggered. Otherwise consider 50-inch desks or common work tables, with single drawers in file cabinets assigned for the storage of each employee's work papers and supplies.
8. Strategically placed conference or interview rooms may be used in place of private offices as needed for privacy.
9. In preparing new or revising old space plans, it is desirable to provide a small conference room adjoining the office of the official who has a number of conferences rather than furnishing a large office equipped for conference purposes. A separate conference roan permits its use by other groups, and as a training room.
10. For employees who need visual privacy only, consider using "bank-type" partitions. These are low (54" to 68") partitions that afford a high degree of privacy without affecting lighting, air circulation, or air conditioning systems. An area as small as 8' x 8' can contain a desk, chair, visitor's chair, and a file or bookcase.

1.1.5 Reception Areas

Provide a well marked, attractive and comfortable reception area that is well ventilated and large enough to accommodate the normal flow of clients and visitors. Interesting reading material available in the reception area also adds to the comfort of those who are waiting. Ready access to rest rooms and drinking fountains is an important consideration, too.

In establishing reception areas, consider:

1. Average number of clients received daily.
2. Logical person(s) or positions) to receive visitors.
3. Need for writing tables, magazine rack, coat rack, children's play area, wheelchair maneuvering space, and maximum seating space.

1.1.6 Circulation and Workflow

Primary aisles should generally be 44" to 66" wide; secondary aisles, 36". Within agency space, corridors or aisles should be accessible from both sides. Corridors shouldn't be duplicated in adjacent spaces.

Be safety conscious. Don't obstruct exits, corridors, or stairways. Comply with safety codes pertaining to aisles and exits.

1.1.7 Access to Handicapped

Ramps in addition to or in place of stairs at an entrance to the building removes one architectural barrier for the physically handicapped. First floor location of the agency, if the building doesn't have elevators, removes another.

1.1.8 Environmental Factors

Arrange desks so employees and clients do not face the outdoor light. Typist's desks should be arranged so the typist doesn't face the light while typing or working on materials. Reception areas should be similarly arranged to prevent bright sun-light from striking client's faces. If a large room has windows on most or all sides, face chairs and desks in the direction which gives the least direct light and glare. Provide clients a place to hang winter clothing.

1.1.9 Heating, Ventilation, and Air Conditioning

Standards for heating, lighting and air conditioning must necessarily be flexible. However, attempt to provide:

Temperature	68-72 degrees
Relative Humidity	40 - 60%
Air Motion	10 air changes/hour

1.1.10 Reimbursable Costs

For reimbursable costs and reporting requirements for office space, facilities and equipment see the Section HIVA (Accounting) Manual, Chapter I.

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1.2 HANDBOOKS AND MANUALS

All Handbooks and Manuals used by Eligibility Management workers are online and can be found on the Eligibility Management (EM) homepage in the Handbooks and Manuals section.

All EM Handbooks have the same look and feel.

See a demo in Flash that explains how the handbooks are set up..

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1.3 MINIMUM POSTING REQUIREMENTS

Currently the only poster required by FNS to be posted in agency offices is "And Justice For All", PHC 09004. This poster can be ordered from *DHS*.

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1.4 BILINGUAL SERVICES

1.4.1 Pamphlets
1.4.2 Interpretation
1.4.3 FoodShare Civil Rights Compliance

1.4.1 Pamphlets

Display and make available to all persons at each office the various state and USDA publications (pamphlets, informational flyers, posters, and other materials) which inform and advise, in both English and Spanish, of benefits and eligibility requirements.

Provide the Spanish version of the Application for Financial/Medical Assistance and/or Food Stamps (*CAF*) to anyone requesting it.

1.4.2 Interpretation

Provide for bilingual interpretation when:

1. Your office makes eligibility decisions for a service area containing approximately 100 single language, low-income households that speak the same non-English language.

   By single language minority, we mean a household which speaks the same non-English language and doesn't contain an adult fluent in English as a second language.

2. Your agency's county or tribal area has a total of less than 100 low-income households, if a majority of those households speak the same non-English language.

3. Your agency's county or tribal area has a seasonal influx of migrant farm workers when the area meets or exceeds the requirements in either #1 or #2, above

Provide bilingual interpretation through paid agency staff or by contractually purchased services with non-agency personnel when you annually receive 100 or more applications for assistance from non-English speaking households.

If you receive less than 100 such applications annually, you may use volunteer interpreters. However, do not use the volunteer to conduct the application interview or to approve an application. S/he may pro-vide program information, pre-screening activities, secure needed verification and assist the applicant to complete the application process. Don't use minors as interpreters.

1.4.3 FoodShare Civil Rights Compliance

The Code of Federal Regulations dealing with civil rights require: "local certifying agencies advise local minority group organizations, in writing, that the Food Stamp Program is available to all eligible households without regard to race, color, religious creed, national origin, or political beliefs. Local agencies must contact minority group organizations once every fiscal year. If there are no minority group organizations in the project area, the local agency must contact prominent minority leaders, ministers, teachers, and other community spokesman in the project area."

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1.5 RECORD RETENTION

1.5.1 Paper Case Records Retention
1.5.2 Electronic Case File (ECF) and Retention Policy
1.5.3 Date Stamping on Documents

1.5.1 Paper Case Records Retention Policy

Agencies must retain paper case documents for three years after the case closes if the documents are not scanned. However, paper case documents must be

retained for longer than three years if any litigation, claim, or audit is unresolved. In these cases, do not purge the case until three years from when the issue(s) have been resolved. The terms “litigation,” “claim,” and “audit” include but are not limited to lawsuits, fair hearings, *Intentional Program Violation (IPV)* claims, federal or state Quality Control (QC) audits, Legislative Audit Bureau (LAB) audits, etc.

On occasion, Disability Determination Bureau (DDB) documents in the red folder may belong to a *CARES* case that has been closed for three or more years, but still open at the DDB. Do not purge or destroy the red DDB folder documents unless the documents have been scanned. DDB staff may ask for the documents for a DDB review at a later date, even if the CARES/CWW case has been closed for three or more years.

1.5.2 Electronic Case File (ECF) and Retention Policy

Digital versions of case records are as valid as paper copies. Agencies are not required to retain paper copies if the document has been scanned in the ECF (Electronic Case File) or another scanning system. See the ECF Handbook for more information on the ECF and scanning. However, agencies may retain paper documents as long as they want. There is no mandate to purge paper documents after a certain period of time. All new IM case documents must be scanned within 30 days after receipt.

Documents scanned and stored in the ECF are backed up regularly and stored off site. Documents stored in the ECF may be printed or copied digitally if necessary. However, there is no need to print or scan CARES screens or data exchange information.

At some point, documents will be purged based on storage space, case closure dates, and other considerations. However, documents in the ECF will not be purged until at least the minimum document retention time period has lapsed.

Paper documents that are scanned and stored in the ECF may be destroyed at any time. This includes copies of birth certificates, Social Security cards, marriage certificates, etc. Original documents must be returned to the owner. If your agency is unable to return original documents (such as check stubs, birth certificates, or SSN cards) to recipients, do not destroy the originals. Keep them in the paper case folder until they can be returned. Otherwise, store them with other discontinued records in your agency. Documents that are turned in and are not expected to be returned (i.e. photocopies) can be destroyed after scanning in the ECF.

After scanning, *DHS* recommends storing the paper documents for at least a week in case a scanner operator error is discovered. If that happens, the document should be rescanned. Note that some documents are restricted and

can only be viewed by the immediate caseworker and his/her supervisor. So, if documents appear to be missing, check to make sure the case is not restricted and the documents not visible before rescanning.

Many CARES cases open and close several times. For documents that have not been scanned, apply the three-year retention rule to each eligibility period.

Example 1: Case A received FoodShare from January 1, 2003 to March 31, 2003. Later, Case A received FoodShare from August 1, 2005 to October 31, 2005. None of the documents were scanned in the ECF. Since three years has passed from the first eligibility period, those documents may be destroyed, but are not required to be destroyed. Documents from the second eligibility period must not be destroyed since three years have not passed since the case closed.

Permanent verification items such as Social Security cards, marriage, death, and birth certificates should have been brought forward to the new case file and thus, should not be destroyed. If at any time these case files are scanned, they may be destroyed and any originals must be returned to the owner.

1.5.3 Date Stamping on Documents

All paper documents received by an agency must have the received date on the face or first page of each document. If you do not have a date stamp, write out the date the document was received on the front of the document prior to scanning.

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1.6 MONITORING FOODSHARE (FS) ALTERNATE LIVING ARRANGEMENTS

1.6.1 Introduction
1.6.2 Drug and Alcohol Treatment Centers
1.6.3 Other Facilities

1.6.1 Introduction

Each ES agency is responsible for monitoring alternate living facilities.

They are:
1. Drug and alcohol treatment centers.
2. Homeless shelters.
3. Group living arrangements.
4. Shelters for battered women & children.

1.6.2 Drug and Alcohol Treatment Centers

Monthly Report
The Division of Community Services (DCS), Office of Alcohol & Other Drug Abuse, requires each treatment center to report monthly to the local ES agency. This report must include:

1. The name of each current FS recipient resident.
2. A statement signed by a responsible center official attesting to the list's validity.

Keep the monthly list on file until further direction from DES.

On-Site Visits
On a periodic and random basis, visit each participating center to assure that the list is accurate. Visit each center at least once each year.

The ES agency director, or his/her designee, will assign an agency staff person the responsibility to do this review. File documentation of this assignment in the file with the centers' monthly lists.

During the on-site visit, inspect the billing record for each FS recipient to ensure the recipient was involved in the center's program.

1.6.3 Other Facilities

Monthly Report
If the FS alternate living arrangement is not an alcohol or drug treatment center, require it to report to you annually:

1. The names of all current FS recipient residents.
2. A statement signed by a responsible facility official attesting to the validity of the list.

You may require this report more often, if you wish. Retain these lists until further direction from DES.

On-Site Visits

At least once each year, visit each facility and verify the accuracy of the facility's report. Ensure that each person listed was/is residing in the living arrangement as reported. You may visit the facility more often if you choose.

The FS agency director, or his/her designee, will assign an agency staff person the responsibility to perform this review. File written. documentation of this assignment in the file with the facility's monthly lists.

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2 QUALITY ASSURANCE

2.1 QUALITY ASSURANCE INTRODUCTION

The Division of Health Care Access and Accountability (DHCAA), in administering the FS and MA programs performs, quality assurance activities including:

1. Establishing agency performance standards. (2.3 Performance Standards and Corrective Actions)

2. Quality Assurance review of active and negative FS and MA cases. (2.4 Wisconsin Quality Assurance Review of Cases)

3. Assessment of liquidated damages for uncorrected Quality Assurance (QA) errors for both MA and FS. (see 2.6 Uncorrected QA Error)

4. Assessment of Agency Preventable Error *(APE)* in the FS program. (see 2.5 MA Error Findings and FS APE Assessment Penalty)

The policies described in this section refer only to State QA initiatives. Federal QC review rules and penalties for FS and MA are not described in this section.

2.1.1 Purpose

DHCAA's purpose in setting agency performance standards, performing QA reviews, requiring corrective action, and FS *APE* assessments and liquidated damages is to:

1. Ensure DHCAA meets its responsibility to the public for the proper administration of the programs it supervises. In other words ensuring that the right people get the right benefits at the right time.
2. Avoid federal sanctions by reducing the statewide FS and MA error rates.
3. Adhere to state and federal laws.

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2.2 DEFINITIONS

2.2.1 Fiscal Sanction
2.2.2 Quality Assurance "QA" Error
2.2.3 Agency Preventable Error (APE)
2.2.4 Agency Preventable Error (APE) Assessment
2.2.5 Liquidated Damages for Uncorrected QA Error
2.2.6 Corrective Action

2.2.1 Fiscal Sanction

A fiscal sanction is an adjustment made by DHCAA to an IM agency's administrative reimbursement when the IM agency does not meet state standards or requirements.

2.2.2 Quality Assurance "QA" Error

A QA ”Quality Assurance” error is a FS or MA error identified through the state’s QA review process (2.4 Wisconsin Quality Assurance Review of Cases) that results in an underpayment or overpayment of benefits.

2.2.3 Agency Preventable Error (APE)

An agency preventable error is a FS QA error that is determined, through the state’s quality assurance review process (2.4 Wisconsin Quality Assurance Review of Cases , to be a local agency-caused error. This is a preventable error that occurred because the local worker failed to take appropriate action on the case.

2.2.4 Agency Preventable Error (APE) Assessment

An ”*APE* Assessment” is an adjustment made by DHCAA to a IM agency’s administrative reimbursement for each inaccurately issued FS benefit that could have been prevented by the IM agency.

2.2.5 Liquidated Damages for Uncorrected QA Error

Liquidated Damages are adjustments made by DHCAA to an IM agency's administrative reimbursement for an uncorrected FS and MA QA error identified through FoodShare Quality Assurance (FSQA), Medicaid Eligibility Quality Control (MEQC), and Payment Error Rate Measurement (PERM) review projects.

IM agencies may be subject to liquidated damages when QA errors are not corrected within 30 days from either:

1. The date of notification of the error,

   or

2. If an error is refuted, the date on the DHCAA notice to sustain any or all findings.

2.2.6 Corrective Action

Corrective Action are those activities and process changes that much be completed by the IM agency which DHCAA deems necessary to remedy noncompliance with DHCAA program requirements. Corrective Action is detailed and agreed to in Section XX of Appendix AL of the "2006 State and County Contract Covering Social Services and Community Programs".

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2.3 PERFORMANCE STANDARDS AND CORRECTIVE ACTION

2.3.1 Performance Standards
2.3.1.1 Timely Case Processing
2.3.1.2 Second Party Reviews
2.3.2 Failure to Comply with DHCAA Requirements
2.3.3 Agency Failure to Submit or Implement Corrective Action Plan

2.3.1 Performance Standards

IM agencies are required to follow specific case processing (2.3.1.1 Timely Case Processing) and second party review (2.3.1.2 Second Party Reviews) requirements as agreed to in Section XII of Appendix AL of the "2006 State and County Contract Covering Social Services and Community Programs."

2.3.1.1 Timely Case Processing

All FS and MA applications that do not involve a disability determination must be processed within 30 days.

Expedited FoodShare benefits must be received within seven days.

If the IM agency does not meet a 95% standard for timely application processing, the DHCAA may require a corrective action plan.

Note: Community waiver processing (including Family Care, Pace and Partnership functional screen and development of a care plan) are not subject to the 95% standard for timely application processing.

2.3.1.2 Second Party Reviews

The IM agency must complete 100% of the MA and FS Second Party Reviews as required by DHCAA. If the agency does not complete 100% of the second party reviews DHCAA may require a corrective action. See the Income Maintenance Quality Assurance Second Party Review Manual for more information on Second Party Reviews.

2.3.2 Failure to Comply With DHCAA Requirements

Agencies not complying with DHCAA program regulations will receive written notification of a failure to comply with DHCAA requirements.

Within five business days of receipt of notification of failure to meet performance expectations, the IM agency must submit to DHCAA, for approval, a corrective action plan to address the deficiency. The corrective action plan must be submitted to:

1. The *DHS* Regional Office Area Administrator,

   and

2. The Contract Administrator for the State and County Contract,

   and

3. The Director of the Bureau of Enrollment Management (BEM),
   Division of Health Care Access and Accountability,
   Wisconsin Department of Health and Family Services,
   1 West Wilson Street
   Madison, WI 53702

2.3.3 Agency Failure to Submit or Implement Corrective Action Plan

An agency will be subject to an administrative payment adjustment as detailed in section 3.05 of the "2006 State and County Contract Covering Social Services and Community Programs" if the IM agency does not:

- Submit an approvable Corrective Action plan within five business days,

  or

- Implement a Corrective Action plan within ten business days of approval of the Corrective Action plan by DHCAA,

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2.4 STATE QUALITY ASSURANCE PROCESS

2.4.1 Quality Assurance Office Locations
2.4.2 Quality Assurance Sample Selection
2.4.2.1 FS Sample Selection
2.4.2.1.1 Active FS Reviews
2.4.2.1.2 Negative FS Reviews
2.4.2.2 MA Sample Selection
2.4.2.2.1 Active MA Reviews
2.4.2.2.2 Negative MA Reviews

2.4.3 How Error Rates are Determined
2.4.3.1 FS Error Rate
2.4.3.2 MA Error Rate

For active cases, the QA review process determines:

1. If a household is eligible for MA or FS.
2. If a household received the correct FS allotment or MA (including cost sharing contribution) benefits in the review month by verifying eligibility information such as:
    - Non-financial information (citizenship, state residency, age, etc.)
    - *Income*,
    - Assets,
    - Household size,
    - Expenses

Errors are referred to local agencies for corrective action.

Agencies have 30 days from the notification of an error determination to take the appropriate corrective action.

The QA specialist determines if the household is eligible for FS or MA and if the correct FS allotment or MA eligibility was determined in the review month.

If the agency disagrees with the QA determination, the agency has 10 days to refute that determination.

Note: QA data is used to determine the type of corrective action needed to improve program administration.

2.4.1 Quality Assurance Office Locations

Central Office

1 West Wilson Street
Room 1050
P.O. Box 309
Madison, WI 53707-0309
Fax # (608) 261- 6758

Field Offices

- Rhinelander Field Office
  1853 N. Stevens St.
  P.O. Box 697
  Rhinelander, WI 54501
  Fax # (715) 365-2705

- Fond du Lac Field Office
  74 S. Main St.
  Suite 205 Fond du Lac, 54935
  Fax # (920) 929- 2785

- Eau Claire Field Office
  610 Gibson St.
  Ste. 3
  Eau Claire, WI 549701-3687
  Fax # (715) 836-2516

- Milwaukee Field Office
  819 North 6th St.
  6th Floor
  Room 609C
  Milwaukee, WI 53203-1606
  Fax # (414) 227-3901

Field Offices are located in Eau Claire, Rhinelander, Green Bay, Fond du Lac, Milwaukee and Madison.

2.4.2 Quality Assurance Sample Selection

2.4.2.1 FS Sample Selection

Wisconsin samples approximately 1,200 active and 800 negative FS cases per year. Separate error rates are computed for active and negative reviews.

2.4.2.1.1 Active FS Reviews

The 1,200 active reviews are cases that received a FS allotment for the QA sample month.

2.4.2.1.2 Negative FS Reviews

Negative reviews are cases that were either denied FS in the sample month or were terminated from FS participation for the sample month.

2.4.2.2 MA Sample Selection

To meet federal requirements for Medicaid Eligibility Quality Control (MEQC), Wisconsin presently conducts special studies that focus on a specific group of MA recipients or a specific aspect of the program.

Every third year, the Centers for Medicare and Medicaid Services (CMS) requires states to conduct claims-based PERM reviews using prescribed methodologies.

In the interim years, states have the flexibility to conduct other Medicaid (MA) quality assurance projects. For 2006, Wisconsin intends to conduct a minimum of 20 MA eligibility reviews per agency.

2.4.2.2.1 Active MA Reviews

Active case reviews are cases that received MA benefits for the assigned sample month. These cases are reviewed to determine if the eligibility and cost share were correctly determined. (e.g. patient liability, cost share, premium, deductible).

2.4.2.2.2 Negative MA Reviews

Negative case reviews are cases with terminations and denials of MA benefits. The reviews determine if the agency properly notified the applicant/recipient of verification requirements and allowed at least 10 days (or balance of 30 day application period) before negative action was taken.

2.4.3 How Error Rates are Determined

2.4.3.1 FS Error Rate

The active FS error rate is the percentage of FS benefits issued in error in the QA sample.

The negative FS error rate is the percentage of negative reviews found to have been either denied or terminated incorrectly.

2.4.3.2 MA Error Rate

The active MA error rate is the percentage of MA payments in the QA sample made in error.

Overpayment and underpayment rate are calculated separately.

The negative MA error rate is the percentage of reviews found to have been denied or terminated incorrectly divided by the total number of reviews in the sample.

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2.5 MA ERROR FINDINGS AND FS APE ASSESSMENT

2.5.1 FS APE Assessments
2.5.1.1 FS APE Assessment Amount
2.5.1.2 Exceptions to the FS APE Assessments
2.5.2. Agency notification of MA and FS Error Findings and Potential FS APE Assessment
2.5.3 DHCAA Response to Refutation of Appeal
2.5.4 Documentation of Correction Action
2.5.4.1 FS Overissuance
2.5.4.2 FS Underissuance
2.5.4.3 Recoupment/Supplement Different Than QA Error

DHCAA will inform the IM agency that a MA or FS error was detected through the QC process. The IM agency is notified of a potential FS *APE* assessment when:

1. A QA error is discovered through the quality assurance process (excluding errors discovered by the federal QC staff)

   and

2. The error results in an incorrect FS benefit payment,

   and

3. The error was preventable and caused by an IM agency.

2.5.1 FS APE Assessments

DHCAA will be keeping a running tally of potential FS APE assessments for each agency. In cases with errors attributable to more than one source, the IM agency will be accountable only if the agency preventable error caused the highest dollar error.

2.5.1.1 FS APE Assessment Amount

The APE assessment amount is detailed in Section XXII of Appendix AL of the "2006 State and County Contract Covering Social Services and Community Programs".

2.5.1.2 Exceptions to the FS APE Assessments

DHCAA will not consider the error to be "agency preventable" when:

1. The error is caused by the *CARES* system, unless the agency was given written instructions by DHCAA to overcome the system's error.

2. A review by the federal FS QC staff identifies an error.

3. The error is inadvertently or intentionally caused by a client.

4. The error is found as part of DHCAA's technical assistance activity and the agency makes the correction.

5. The state isn't sanctioned by FNS.

2.5.2. Agency notification of MA and FS Error Findings and Potential FS APE Assessment

DHCAA QA staff will notify the agency of MA and/or FS error findings and when a potential FS APE Assessment exists. The DHCAA notification of the QA error will include a (FS) or "Report of Quality Assurance Review of Active Case" and the amount of the potential FS APE assessment.

Along with the "Report of Quality Assurance Review of Active Case" (FS) or Medicaid error letter, DHCAA will also send the local agency a form entitled "Agency Position on the State Quality Assurance FoodShare Finding" (F-16050) or "Agency Position on the State Quality Assurance (MA) Finding (F-10172). The

IM agency should use this form to:

1. Agree with the QA FS or MA error findings (and FS APE assessment, when applicable).

   If the agency agrees with the QA error findings and the FS APE assessment, no further notice will be sent. The FS APE assessment amount will be added to the total of potential FS APE assessments for the agency.

   The agency is strongly encouraged to indicate on the ”Agency Position on the State Quality Assurance Finding” form what caused the QA error, including any comments or suggestions for error avoidance.

   The agency has 30 calendar days to correct the case from the date that the original notification of the QA findings was received. The agency must submit documentation that corrective action was taken.

2. Agree with the QA error finding, but appeal the FS APE assessment.

   If the agency agrees with the QA error finding but disagrees with the FS APE assessment, the agency must respond within 10 days of receipt of the QA error finding and potential FS APE assessment. The appeal must detail why the FS APE assessment is incorrectly applied and provide all relevant documentation to prove that the agency could not have prevented the error. The agency should return the original ”Agency Position on the State Quality Assurance Finding” form with any documentation to DHCAA's address listed on bottom of the form. Retain a copy in the case record.

   The agency has 30 calendar days to correct the case from the date that the agency received the original notification of the QC finding, even if the FS APE assessment is appealed.

3. Refute the QA error findings.

   When the agency disagrees with the QA error findings the agency must, within 10 days of the agency's receipt of the QA error finding:

   - Return the "Agency Position on the State Quality Assurance Finding",
   - Provide in detail why the agency's determination(s) is correct,

     and

   - Include any relevant documentation to support the agency position.

If the agency refutes the QA findings and DHCAA upholds the error findings, the agency has 30 calendar days to complete the required corrective actions from the date that the agency received notification of the refutation decision.

Return the original "Agency Position on the State Quality Assurance Finding form" with any documentation to DHCAA. The address is on the bottom of the form. Retain a copy in the case record.

If the agency refutes the QA findings, the notice of any adjustments to the agency's FS APE assessment will be sent after the appeal is completed.

The APE assessment may be:

- withdrawn

  or

- any or all of the APE assessment may be upheld.

The amount of any upheld assessment will be added to the total of potential FS APE assessments for the agency.

2.5.3 DHCAA Response to Refutation of Appeal

Within 20 calendar days of receipt of a refutation of the QA error findings or appeal of FS APE assessment, DHCAA will:

1. Uphold, dismiss or amend the QA error finding and notify the agency of the decision.

2. Uphold or dismiss the APE assessment and notify the agency of any adjustment to the amount of the potential FS APE assessment.

The assessment may be withdrawn or any or all of the assessed amount may be upheld. The amount of any upheld assessment will be added to the total of potential FS APE assessments for the agency.

2.5.4 Documentation of Correction Action

2.5.4.1 FS Overissuance

For cases with a FS overissuance, a copy of the CARES Benefit Recovery Claims by Assistance Group (BVCA) screen will constitute adequate documentation of correction.

Send a copy of the BVCA screen with a copy of the Report of Quality Assurance

Review of Active Case to Quality Assurance Central Office Madison. (See 2.4.1 Quality Assurance Office Locations)

2.5.4.2 FS Underissuance

For cases with a FS underissuance, a copy of the CARES FoodShare Issuance History Details (IQFD) screen will constitute adequate documentation of correction.

Send a copy of the IQFD screen with a copy of the Report of Quality Assurance Review of Active Case to Quality Assurance Central Office Madison. (See 2.4.1 Quality Assurance Office Locations)

2.5.4.3 Recoupment/Supplement Different Than QA Error

If the recoupment or supplement amount is different from the amount of the QA error, the agency should provide a copy of the worksheet or an explanation to show how the amount was changed. All FS errors are recoverable only client errors are recoverable for MA.

Program specific policies can be found in the FoodShare handbook (7.3.2) and Medicaid Eligibility Handbook 22.2 Corrective Action.

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2.6 LIQUIDATED DAMAGES AND UNCORRECTED QA ERROR

2.6.1 Notice of Error
2.6.1.1 Correcting Agency Error
2.6.2 Liquidated Damages
2.6.2.1 Error in Benefits
2.6.2.1.1 Overpayments
2.6.2.1.2 Underpayments
2.6.2.2 Liquidated Damages for Failure to Provide Records
2.6.2.3 Liquidated Damages For Incomplete Records
2.6.2.4 Good Cause Reasons For Non-compliance With Records Requests

2.6.1 Notice of Error

The Department provides written notification (including electronic mail) to the individual identified by the IM agency as the quality assurance contact when agency errors are identified. Errors may be identified through the FoodShare Quality Assurance (FSQA) Review, Medicaid Eligibility Quality Control (MEQC) Review, and Payment Error Rate Measurement (PERM) Review. The IM agency has 30 calendar days from receipt of written notification to correct the error or provide the Department with a good faith refutation of why the corrective action cannot be taken in 30 days.

2.6.1.1 Correcting Agency Error

Agency action to correct an error identified in the QA process may include:

1. Termination of benefits,
2. Restoration of benefits,
3. Claims establishment, and/or
4. Adjustment in the level of benefits/eligibility (e.g. allotment, cost sharing, premium).

2.6.2 Liquidated Damages

The Department will assess liquidated damages for errors identified through the FoodShare Quality Assurance (FSQA) Review, Medicaid Eligibility Quality Control (MEQC) Review, and Payment Error Rate Measurement (PERM) Review. Liquidated Damages will be assessed when:

1. The IM agency fails to correct a QA error within 30 days from the date of notification of the error.

   and

2. the Department provided verification to support the error finding to the agency.

2.6.2.1 Error in Benefits

When the Department identifies an error in benefits, the IM agency will have 30 calendar days from the receipt of written notification of the error from the Department to correct the error or provide the Department with a good faith refutation of the corrective action needed.

When an error in benefits is not corrected within thirty calendar days and the Department provided verification to the agency, liquidated damages will be assessed in the amount of $250 per case.

For each additional 30 days the IM agency fails to correct the case specific error, liquidated damages will be assessed in the amount of $250 per case. If the Department takes action to correct the IM case specific error, additional liquidated damages will be assessed in the amount of $250 per case.

2.6.2.1.1 Overpayments

When the Department identifies an overpayment which requires claims establishment, the IM Agency will have 30 calendar days from receipt of notification of the error from the Department to calculate the overpayment and establish a claim.

If the overpayment claim is not established within 30 calendar days, liquidated damages will be assessed in the amount of $250 per case.

For each additional 30 days the agency fails to calculate the overpayment and establish a claim, liquidated damages will be assessed in the amount of $250 per case.

If the Department takes action to calculate the overpayment and establish the claim, additional liquidated damages will be assessed in the amount of $250 per case.

2.6.2.1.2 Underpayments

When the Department identifies an underpayment which requires restoration of benefits, the IM Agency will have 30 calendar days from receipt of notification of the error from the Department to restore benefits.

If the restoration is not established within 30 calendar days, liquidated damages will be assessed in the amount of $250 per case.

For each additional 30 days the agency fails to calculate the restoration, liquidated damages will be assessed in the amount of $250 per case.

If the Department takes action to calculate the restoration, additional liquidated damages will be assessed in the amount of $250 per case.

2.6.2.2 Liquidated Damages for Failure to Provide Records

The Department will notify the IM agency of records requests in writing (including electronic mail). Requests will be directed to the individuals the IM agency has identified as their quality assurance and file coordinators.

Upon request, the IM Agency must make records available to the Department for inspection within ten business days from the date of notice from the Department. The IM Agency must provide the requested information in a form and manner prescribed by the Department, using the *CARES* system and other systems designated by the Department. This requirement applies to both paper and electronic records.

The IM Agency must transfer to the Department any original or copy of records that the Department requests.

Failure to provide requested records within ten business days may result in an assessment of liquidated damages in the amount of $250 for each record requested that is not transferred timely.

2.6.2.3 Liquidated Damages For Incomplete Records

To be considered a complete record, an IM case record must contain a signed application or review form and the verification and documentation required by program policy in the eligibility determination.

The IM Agency must also comply with the schedules for record retention in accordance with the Department's policies and procedures and state and federal law.

An assessment of liquidated damages in the amount of $250 may result if an agency, upon Department request, provides an incomplete file that:

- Does not contain any documentation (required by program policy) that is relevant to the eligibility determination under review; or

- Only contains information generated or obtained by the Department. Information generated or obtained by the Department includes unsigned CARES combined application forms (*CAF*) and electronic verification forms for earnings or health insurance information.

2.6.2.4 Good Cause Reasons For Non-compliance With Records Requests

Liquidated damages will not be assessed if the Department is notified within ten days of request that a record is unavailable because of a natural disaster or catastrophic incident such as flood or fire, or because the Department's carrier was unable to pick up or deliver records timely. Similarly, liquidated damages will not be assessed if an electronic record is unavailable due to Department systems failures.

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2.7 FISCAL SANCTION

2.7.1 Fiscal Sanction Introduction
2.7.2 Process
2.7.3 Refutation

2.7.1 Fiscal Sanction Introduction

The Department may implement fiscal sanctions for policy or procedural non-compliance. Liquidated damages may be assessed even if the noncompliance does not result in incorrect benefits.

Before assessing a fiscal sanction, DHCAA will consider if:

1. The agency has submitted a corrective action plan to address non-compliance with provisions of the "2007 State and County Contract Covering Social Services and Community Programs".
2. The agency has implemented an approved corrective action plan within 10 business days of approval.

2.7.2 Process

The Director of the county/tribal human services department will receive written notification from the Department of any pending adjustments to his/her agency's IM expense reimbursements. Notification of pending adjustments will be provided on a quarterly basis, beginning in 2007. The Director will also be provided with specific information about:

- Any agency records that were not provided or were provided more than ten business days after notification from *DHS*;
- Any agency records that only contained information generated or obtained by the Department;
- Any agency records that do not contain any documentation (required by program policy) that is relevant to the eligibility determination under review;
- Any untimely case specific corrective actions and/or corrective actions taken by the Department; and
- The date when the adjustment is scheduled to occur.

2.7.3 Refutation

IM agencies may refute any aspect of the contract covering the administration of IM programs by following the procedure outlined in section XXI (Dispute) of the "2007 State and County Contract Covering Social Services and Community Programs."

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3 FAIR HEARINGS

3.1 FAIR HEARINGS INTRODUCTION

3.1.1 Introduction
3.1.2 Agency Conference
3.1.3 FS Cases Agency Conference

3.1.1 Introduction

When an applicant or member disagrees with an agency's action (on his/her request for benefits, amount of benefits, overpayment or termination), an agreement is often reached through an adjustment of the benefit or explanation of the program rules by the agency. (See 3.1.2 Agency Conference) However,

if no agreement is reached, the applicant/member may request an administrative review by the Division of Hearings and Appeals (*DHA*) through the fair hearing process [§49.45 (5) and Ch HA 3, WI. Admin Code.]

Hearings are conducted by DHA for BC+, MA (and all MA subprograms), CTS, FS, RAP, CC, and SeniorCare applicants/recipients and for CC providers. Administrative Disqualification Hearings (ADH) are also conducted by DHA, but only at agency request. (See 3.10.1 Rehearing by DHA for more information on Administrative Disqualification Hearings.)

Hearings serve to:

1. Interpret the program to dissatisfied clients.

2. Bring the applicant/member, the agency and state authorities into discussion for a better understanding of problems.

3. Resolve factual disputes.

4. Clarify policies and their application in relation to laws and regulations.

5. Review policies in program administration and reveal those which require clarification or revision.

6. Promptly remedy unfair treatment, mistaken or arbitrary action and negligence.

The hearing process isn't intended to be a substitute for responsible administration. Neither good nor bad administration is necessarily reflected in the number of hearings involving any one agency. For example, an applicant/member may request a hearing as a protest against a requirement which isn't within the agency's power to adjust.

Note: Individuals who believe that an agency decision regarding any component of W-2 (e.g. employment positions, Job Access Loans, Learnfare, Emergency Assistance) is incorrect may request a Fact Finding review by the W-2 agency. (See 3.8 W-2 Fact Finding for more information on the W-2 Fact Finding process.)

3.1.2 Agency Conference

An Agency Conference is a meeting between the client/CC provider and agency representatives to:

1. Resolve the matter at issue,
2. Explain the proposed action or inaction,

3. Permit the client and any representative to present information about the hearing request and to request information from the agency.

Offer the client an agency conference at his/her request.

A conference does not affect the client's right to a hearing or the time limit for completing a hearing. Advise the client that to have a conference is his/her choice and doesn't delay or replace the hearing. A hearing may be requested and held without a conference. The worker responsible for the agency's action may attend the conference.

The supervisor and/ or the agency director or designee and the client/CC provider and/or representative must attend the conference.

The conference may lead to the informal resolution of the dispute. However, a hearing must still be held if one was requested, unless the client voluntarily withdraws the hearing request in writing to DHA.

3.1.3 FS Cases Agency Conference

In FS cases, offer an agency conference to any household wishing to contest a denial of expedited service. Schedule the conference within 2 working days of the request, unless the household wants it scheduled later or states it doesn't want a conference.

The conference may lead to the informal resolution of the dispute. However, a hearing must still be held if one was requested, unless the client voluntarily withdraws the hearing request in writing to DHA

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3.2 ADVERSE ACTION AND APPEAL RIGHTS

3.2.1 AA and Appeal Rights Introduction
3.2.2 Adequate Notice
3.2.3 Timely Notice
3.2.4 No Advance Notice

3.2.1 AA and Appeal Rights Introduction

Each client has the right to adequate and timely notice of adverse action. Inform each client of his/her hearing rights and the hearing procedures as part of the adverse action notice.

The IM agency must provide, at no cost to the client, bilingual staff or interpreters who speak the appropriate language to assist the client in the appeal process. *DHA* provides translators/interpreters to clients that contact DHA directly.

3.2.2 Adequate Notice

Mail or give the client written notice of any action affecting eligibility or receipt of benefits. Use the *CARES*-generated Notice of Decision whenever possible. Use a Positive Notice F-16015 or Negative Notice F-16001 only if a CARES generated notice is not available. The notice must include:

1. A statement describing the intended action.
2. The reason(s) for the intended action, including a citation to the law, regulation, rule or policy that supports or requires the action.
3. An explanation of the right to an agency conference and/or a hearing and how to request one.
4. The client's rights and responsibilities in the hearing process.
5. A statement on the availability of free representation.
6. A statement that; if a hearing is requested before the action's effective date, benefits will continue until the hearing decision is made. This statement is not required for CC recipients and providers.

See 3.6.1.1 MA Continued Benefits for further instructions about continuance of benefits.

7. A statement that the client may have to repay any benefits continued during the appeal, if the hearing decision isn't in the client's favor or s/he abandons or withdraws the hearing request.
   This statement is not required for CC recipients and providers

8. The telephone number and, when possible, the name of an agency staff person to contact for more information.

3.2.3 Timely Notice

Provide adequate notice at least **10** days before the effective date of any intended adverse action. The length of the notice depends on the circumstances of the action and case.

In no case is notice timely, if provided after the action's effective date.

When exceptional circumstances exist, as detailed below, notice will be timely if provided less than 10 days before the intended action's effective date.

3.2.4 No Advance Notice

Timely notice is not required, if one of the following occurs.

1. Factual information confirms a recipient or payee's death and there's no relative to take his/her place as primary person.

   In FS cases, confirm the death of all group members before using this exception. If a group member remains alive, don't apply this exception; you must provide adequate notice.

2. A clear, written statement initiated and signed by the client is submitted stating s/he no longer wishes to receive benefits.

3. The client provides information that requires adverse action and s/he voluntarily states, in writing, that s/he knows that this will be the result.

4. The client has been admitted or committed to an institution which makes the client ineligible for Medicaid (MEH 6.9 Inmates) or FS benefits (FSH 3.2.1.4 Institution)

5. The client's whereabouts are unknown and the post office returns mail directed to him/her with no forwarding address.

6. The client has applied for and is receiving benefits from another jurisdiction.

7. The client's physician prescribes a change in the level of nursing home care.

8. A child is voluntarily placed in a foster home by his/her legal guardian or is removed from his/her home by a court order.

9. State or Federal law requires a benefit adjustment for all, or a significant portion of FS and/or MA cases . This circumstance is usually referred to as a "mass change".

10. In FS, the FS group's allotment varies from month to month within the eligibility period and the group was notified in writing (by a Positive Notice or CARES-generated notice) at the beginning of certification of the actual allotment amounts they would receive.

11. In FS, the FS group:

    a. Applied for other assistance and FS; **and**,
    b. Has begun receiving FS; **and**,
    c. The group was provided with a notice when the group was found FS eligible that the FS allotment would be reduced if, and when, the other assistance began.

12. A FS group member is disqualified for intentional program violation (IPV), or the allotment of the remaining FS group is reduced or discontinued because of the IPV.

13. Verification was postponed in a group's expedited FS application, and later verification requires reduced or discontinued benefits. The group already received a notice stating that the allotment would be reduced or terminated if verification required such an action.

14. A FS group failed to make cash repayment of a fraud claim and is converted from cash repayment to benefit reduction.

15. A resident of a drug or alcoholic treatment center or group living arrangement (FSH, 3.2.1) loses FS eligibility because:

    a. The facility lost its certification from the appropriate authority, or

    b. Its authorized representative status is suspended because it is approved by USDA/FCS as an FS retailer.

16. In SeniorCare, a prescription drug billing must be reversed due to an incorrect billing, and that reversal results in a benefit or service change.

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3.3 FAIR HEARING REQUEST

3.3.1 BC+, MA, FS, RAP Hearing Requests
3.3.2 Expedited Request
3.3.3 Group Requests For Hearings
3.3.4 Child Care Fair Hearing Requests
3.3.4.1 Child Care Providers Requests For Fair Hearings
3.3.4.2 Actions That May Be Appealed By Child Care Providers
3.3.4.3 Child Care Participant Requests For Fair Hearings
3.3.5 SeniorCare Participant Fair Hearing Requests

The client or his/her representatives for BC+, MA, FS and Refugee Assistance Program (RAP) may request a hearing orally or in writing. When a request is made orally, put it in writing immediately. If it's made in person, have the client sign it. Forward all hearing requests to *DHA*. DHA will schedule a hearing upon receipt of the hearing request.

Client's should use the Request for Hearing form. S/he should send it to the Wisconsin Department of Administration, Division of Hearings and Appeals.

NOTE: Fair hearing requests must be made in writing for:

1. Child Care participants and providers (3.3.4).

2. SeniorCare participants (3.3.5).

DHA's mailing address is:

Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

FAX (608) 264-9885

Email: DHAMail@wisconsin.gov

If the request is received by the agency, promptly forward it to DHA at the above address.

3.3.1 BC+, MA, FS, RAP Hearing Requests

DHA has jurisdiction to conduct hearings for :

- BC+, MA, and RAP when the hearing request is received by DHA within 45 days of the action effective date.
- FoodShare when DHA receives the hearing request within 90 days of the notice of decision that the food unit is contesting. Hearing requests can be made at anytime to appeal the amount of FoodShare benefits received.

  DHA must also accept a hearing request on an agency denial of a request for restoration of FoodShare benefits. DHA must do this even when the action causing the loss occurred more than 90 days prior to the hearing request. However, if the agency denied such a request more than a year ago, that action isn't grounds for a hearing.

Note: A hearing must be held to determine if or when a client received the notice of adverse action even if the agency, whose action is being appealed, believes that a request wasn't timely.

3.3.1.1 Hearing Requests Denied

DHA may dismiss a request at the hearing if:

1. The action (except in FS) is a result of a change in federal or state law or policy affecting a significant number of clients unless a client questions its application specific to his/her case.
2. MA eligibility depends on IV-E or *SSI* eligibility, and IV-E or SSI was properly denied.

When a hearing request is dismissed, DHA will notify the client.

3.3.2 Expedited Request

Expedite any hearing request from a client who plans to move from the hearing officer's jurisdiction (e.g., migrant worker) before a decision would normally be issued. If necessary, process the request faster than other requests so the client can receive a decision and any restored benefits before s/he leaves your area**.**

3.3.3 Group Requests For Hearings

A group of individuals may request a group hearing if individual issues of fact aren't disputed and the sole issue being appealed is a state, federal law, or policy.

DHA may also consolidate several hearings on the same topic into one, but only on questions of policy.

Procedures for group hearings are the same as in individual hearings.

Each client must be notified of the right to withdraw from a group hearing and pursue an individual hearing.

3.3.4 Child Care Fair Hearing Requests

3.3.4.1 Child Care Providers Requests For Fair Hearings

Child Care Providers must submit a written request for a Fair Hearing, within 30 days from:

- The date on the notice, **or**
- The effective date on the decision announced in the notice, whichever is later.

The request for Fair Hearing must either be made by the Child Care provider or someone designated by the Child Care Provider who has legal authority.

3.3.4.2 Actions That May Be Appealed By Child Care Providers

Child Care providers may request a fair hearing for any of the following actions:

1. Refusal to issue new Child Care authorizations or the revocation of existing Child Care authorizations for one of the following reasons:

    - False attendance reporting,
    - Refusal to provide attendance documentation,
    - Submission of false provider prices, or

- Failure to correct, or untimely correction of, a regulation violation.

2. Refusal to issue payment to a provider.

3. Determination of the provider's issuance amount (this does not include the authorization amount);

4. Collection of an overpayment.

The right to appeal the collection of an overpayment is limited to only one hearing request, per overpayment claim, and is limited to:

- Determination of the overpayment amount (at the time of the overpayment determination and/or during the collection process)
- Determination of the overpayment amount still owed during the collection process
- Decision to recoup overpayment by means of certification to the Wisconsin Department of Revenue (recoupment from Wisconsin income tax returns.)

Any subsequent appeal requests must be limited to questions of prior payment of debt that the agency or DWD is proceeding against, or mistaken identity of the debtor.

3.3.4.3 Child Care Participant Requests For Fair Hearings

Child Care participant requests for a fair hearing must be received within 45 days after the date of the notice, or the effective date of the action, whichever is later.

3.3.5 SeniorCare Participant Fair Hearing Requests

SC applicants, participants or representatives must file a Fair Hearing Request in writing to DHA. The request for a hearing must be made in writing to the DHA within 45 days from the effective date of the adverse action.

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3.4 FAIR HEARING SCHEDULED

3.4 1 Rescheduling A Hearing
3.4.2. Withdrawal Of Hearing Request
3.4.3 Agency Notification Of Withdrawn or Rescheduled Hearings

The agency whose action is being appealed will receive, by fax or e-mail, a hearing calendar/notice from *DHA*, at least 10 days before the hearing is to be held.

The hearing/calendar notice lists the hearing date and cases to be heard.

The calendar will include:
1. Claimant's name,
2. Case number,
3. Hearing time, and
4. Program of assistance.

3.4 1 Rescheduling A Hearing

The hearing time, date and place are arranged so that they are accessible to the client. Have the client contact DHA if s/he wants to reschedule a hearing. DHA will reschedule a hearing if it finds that the client has good cause. Only DHA can reschedule a hearing. The time limit for a hearing decision may be extended for as many days as the hearing is rescheduled.

3.4.2. Withdrawal Of Hearing Request

Only a client or his/her chosen representative may withdraw a hearing request. Clients who wish to withdraw a hearing request may use the Voluntary Withdrawal form.

Only DHA has the authority to grant or deny a withdrawal request. Have the client contact DHA if s/he wants to withdraw the request.

A verbal request for withdrawal must be followed by a signed written request. If the form is sent to the IM/W-2 agency it should be forwarded to DHA at:

Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

FAX: 608-264-9885

e-mail: DHAMail@wisconsin.gov

3.4.3 Agency Notification Of Withdrawn or Rescheduled Hearings

When hearings scheduled by DHA's Madison, Milwaukee or Eau Claire offices are withdrawn or rescheduled, DHA notifies the agency via fax or e-mail no later than the next workday. In order to receive these notices, agencies must :

1. Establish an internal process that ensures the fax or e-mail gets to the correct person quickly. If a specific agency contact is designated, advise DHA of this. DHA will then address the fax or e-mail to his/her attention.
2. Ensure someone is responsible for notifying other agency staff, witnesses, corporation counsel, work program office, etc., of the rescheduled or withdrawn hearing.

If DHA receives a withdrawal of an appeal which hasn't yet been scheduled for hearing, no notice is sent to the agency since the order itself is issued within a short time.

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3.5 CLIENT FAIR HEARING NOTICE & RIGHTS

3.5.1 Client Fair Hearing Notice & Rights Introduction
3.5.2 Client Examination Of Documents
3.5.3 Another Client's Record

3.5.1 Client Fair Hearing Notice & Rights Introduction

At least 10 days prior to the hearing, *DHA* sends to the client and any representative a Notice of Scheduled Hearing. This allows the client 10 days to prepare for the hearing. The client may request less advance notice to expedite scheduling the hearing.

The notice states:

1. DHA will dismiss the request if the client or any representative fails to appear without good cause,
2. The name, address, and phone number of whom to notify if the client can't attend, **and**
3. The client and any representative may examine the case record prior to the hearing (See 3.5.2 Client Examination Of Documents)

Friends and relatives of the client may also attend if s/he chooses. However, the hearing officer has the authority to limit the number of persons in attendance.

3.5.2 Client Examination Of Documents

The client and anyone representing him/her has the right to examine the case record. If the representative is not an attorney, the client's written and signed authorization is required.

The client also has the right to photocopy, free of charge, all documents s/he would like to introduce as an exhibit at the hearing. The IM agency must provide the client an opportunity to photocopy at a reasonable time before the hearing and/or on the hearing date.

Questions relating to client examination of "sensitive" information should be directed to the Division of Hearings and Appeals. See 3.11 DHA Directory.

If the agency plans to use "sensitive" material at the hearing, the client, has a right to examine the material prior to the hearing.

3.5.3 Another Client's Record

Under some circumstances, agencies may use one recipient's confidential file in another recipient's fair hearing to provide a fact or to question the credibility of a witness' credibility.

In these situations, the hearing officer reviews the confidential file alone to determine if the information is relevant and material to the fair hearing. If the officer finds the file relevant and material to the fair hearing, the agency may inspect the relevant records and move them into evidence, subject to objections.

The hearing officer will inform both the agency and the recipient that the information from the confidential file may only be used for this particular fair hearing and that any other use of the information from the confidential file may result in a fine and/or jail time. (§ 49.83, Wis. Stats.)

The hearing officer should determine if the confidential file is relevant, prior to a fair hearing. If determined relevant at the hearing, the hearing may have to be postponed in order to provide the recipient with an adequate opportunity to review the evidence contained in the records.

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3.6 AGENCY HEARING PREPARATION

3.6.1 Continued Benefits
3.6.1.1 MA Continued Benefits
3.6.1.2 FS Continued Benefits
3.6.1.3 Continued SC Benefits
3.6.2 Changes Reported After Hearing Request
3.6.3 Agency Hearing Preparation Requirements - Review The Case
3.6.4 Gather Facts
3.6.5 Prepare Statement Of Agency Action
3.6.6 Agency Representation At Fair Hearings

Upon receipt of a the Notice of Fair Hearing Request, agencies must:

1. Immediately acknowledge receipt of the hearing request by sending an e-mail to DHAMail@wisconsin.gov. (SC acknowledgement of the Notice of Fair Hearing Request does not require an e-mail to *DHA*.)
2. Enter receipt of the hearing request in the client's case comments.

3.6.1 Continued Benefits

If an appeal is based only upon a lack of timely notice and benefits are ordered to be continued pending the hearing decision: Immediately issue adequate and timely notice (3.2.3 Timely Notice) for the next possible benefit period and take action based on adverse action logic.

3.6.1.1 MA Continued Benefits

Although DHA informs the agency if benefits must be continued while a decision on the hearing is pending, do not wait for DHA's direction before continuing benefits.

- If DHA orders benefits continued, do so unless the client waives continuation. Otherwise, DHA can reverse its continuance order only when the hearing wasn't requested prior to the action's effective date. If benefits were ordered continued on a request made after the appropriate date, notify DHA. DHA will make any correction they can.

- If DHA doesn't order benefits reinstated and the agency believes that the client is entitled to them, notify DHA.

In either event, the IM agency must comply with DHA's initial order until otherwise notified.

Once benefit continuation has begun, maintain those benefits until DHA orders a change or some other change in eligibility occurs. Continue or reinstate any benefits (except FS) described in the adverse action notice if the client requests a hearing before the action's effective date.

Inform each client of his/her right to waive continued benefits. If s/he doesn't do this, continue them until the hearing decision is rendered. If someone never receives a notice and requests a hearing after the effective date, do not continue benefits.

3.6.1.2 FS Continued Benefits

Continue or reinstate FS benefits, if the request is received prior to the effective date of adverse action.

Once FS benefits are continued or reinstated, do not reduce or discontinue benefits before the final hearing decision is received unless:

1. The **certification period** expires. The household may reapply and be found eligible for a new period with benefits calculated as if the hearing wasn't pending.

2. The hearing officer issues a preliminary decision, in writing, at the hearing that:

    a. The sole issue is one of law or regulation, or

    b. The household's claim that the agency improperly computed benefits or misinterpreted or misapplied such law or regulation is invalid.

3. A change affecting the household's eligibility or benefits occurs while the hearing decision is pending and the household fails to request a hearing after the subsequent notice of adverse action.

4. A mass change affecting the household's eligibility or benefits occurs while the hearing is pending.

3.6.1.3 Continued SC Benefits

Continue SC benefits only if the participant requests a fair hearing prior to the effective date of the adverse action.

3.6.2 Changes Reported After Hearing Request

After a hearing has been requested, continue to act on reported client changes in a timely manner and correctly adjust benefits.

3.6.3 Agency Hearing Preparation Requirements- Review The Case

After a hearing has been requested, review agency records and determine if the contested action was caused by:

1. A misunderstanding,
2. An incomplete eligibility determination, or
3. A misinterpretation of policy or procedure.

If, upon review, gaps are found in pertinent information or collateral facts, the agency may reopen negotiations with the client. If the client is satisfied, s/he can withdraw the hearing request. See 3.4.2 Withdrawal of Hearing Request.

3.6.4 Gather Facts

The agency should be prepared to introduce at the hearing any testimony, exhibit and material from the case record and other sources pertinent to an equitable decision. Include all information and material up to the time of the action being appealed. To do this, the agency's representative must:

1. Define the issues.

2. Review the facts at issue and become familiar with the case as a whole. If more than one program is involved, at least one person should be familiar with the policies and procedures of the programs that relate to the case.

3. Ensure that the case record is complete and all necessary documents are present, appropriate, complete and in chronological order.

   Thoroughly document events pertaining to the issue being appealed with the date, place, and identity of any person involved. Dates of phone calls, name of the person taking them, dates of letters, etc., should be recorded. The agency representative is responsible for documenting all eligibility requirements.

4. Ensure all necessary witnesses are present. DHA will issue subpoenas upon agency request.

5. Read pertinent handbook and manual instructions.

6. Prepare a proposed recovery schedule for the amount of continued benefits.

7. If the decision under dispute was an FSET determination made by a W-2 agency, the county agency is responsible for either:

   a. Coordinating with the W-2 agency to ensure that the W-2 agency will have a representative at the review, or

b. Coordinating with the W-2 agency in gathering the information and documentation necessary in order for the county to present the decision made by the W-2 agency.

3.6.4.1 Testimony & Evidence

If a recipient will be represented by an attorney at the hearing, the agency may wish to consult with its corporation counsel.

If direct testimony is available, hearsay evidence that is not within a "hearsay exception" may be prohibited in the hearing (§ 908.04, Wis. Stats.). Subpoena witnesses, if necessary

3.6.5 Prepare Statement Of Agency Action

The agency is requested to prepare a statement explaining its action in the matter being appealed in the Notification of Hearing Request. The statement of agency action should detail the reason for the appeal and the policy followed in the agency action.

Within 10 days of the date on the Notification of Hearing Request, send the statement of agency action to:

1. DHA, **and**
2. The client and his/her representative, **and**
   The prehearing examiner(s), if listed in the fair hearing notice.

If you believe a misunderstanding still exists, continue to work out a satisfactory adjustment with the client. (3.6.1 Continued Benefits) If the client is satisfied s/he can withdraw the hearing request. Notify DHA if the hearing request is withdrawn.

3.6.6 Agency Representation At Fair Hearings

Failure of the agency to provide representation at the DHA Fair Hearing may result in the participant or provider winning his/her appeal, even when the decision made by the agency had merit. The DHA may subpoena county workers as a means of ensuring their attendance.

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3.7 DHA FAIR HEARINGS

3.7.1 DHA Fair Hearings Introduction
3.7.2 Time Limits For MA and RAP
3.7.3 Time Limits For FS Cases

3.7.1 DHA Fair Hearings Introduction

Hearings are conducted by an impartial official who:

1. Is familiar with relevant federal and state policies and procedures,
2. Wasn't involved in the action being contested,
3. Wasn't the immediate supervisor of the worker who took the action, **and**
4. Doesn't have a personal stake or involvement in the case.

The hearing officer is a duly appointed and qualified agent of *DHA*.

The Hearing Officer's powers and duties are to:

1. Administer oaths or affirmations,
2. Ensure all relevant issues are considered,
3. Request, receive and place in the record all evidence necessary to decide the issue.
   Regulate the hearing's conduct and course consistent with due process to ensure an orderly hearing.
4. Provide a hearing record and recommendation for a final decision (3.9.2 Final Decisions) by the hearing authority. If the hearing officer is also the

hearing authority, s/he renders a decision in the name of *DHS* or DWD, **and**

5. Order, when necessary, an independent medical assessment or professional evaluation from a source mutually satisfactory to the client and agency. DHS will pay for the evaluation.

3.7.2 Time Limits For MA and RAP

In BC+, MA, CC and RAP cases, DHA must conduct the hearing and issue its decision, **and** the county or tribal agency must implement the decision within **90** days of the date of receipt of the hearing request.

3.7.3 Time Limits For FS Cases

For FS cases, DHA must conduct the hearing and issue a decision within **60** days of receiving a request for a hearing. The agency has **10** days from the decision's date to implement it.

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3.8 W-2 FACT FINDING PROCESS

3.8.1 W-2 Fact Finding Process Introduction
3.8.2 Fact Finding Review Process

3.8.1 W-2 Fact Finding Process Introduction

W-2 provides a fact finding review to resolve disputes for applicants/participants who believe the W-2 agency made an incorrect decision regarding any component of W-2 (including all services and Emergency Assistance.) W-2 cases do not receive continued benefits pending the fact finding decision.

The fact finding review is a meeting to help resolve issues regarding the W-2 agency's decision. An impartial reviewer, called the fact finder, will:

1. Meet with both the applicant/participant and his/her representative and an agency representative;
2. Listen to each side,
3. Review the information, and
4. Give a written decision based on state laws and W-2 policies.

The applicant/participant may choose a representative to attend the fact finding review.

The fact finder will issue a written decision within five (5) working days from the date of the fact finding review.

Note: If a recipient/applicant disagrees with a Notice of Decision regarding Child Care Assistance, FoodShare or Medicaid benefits, a separate request for a Fair Hearing must be filed with the Department of Administration, Division of Hearings and Appeals (*DHA*). (See 3.3)

3.8.2 Fact Finding Review Process

Requests for W-2 fact finding reviews must be made in writing. The fact finding review must be scheduled within eight days of receiving the request.

Deny a fact finding request if any of the following occurs:

1. The request for a fact finding review is not received within the 45 day timeline,
2. The request is withdrawn in writing, or
3. The applicant/participant or representative fails to appear in person at the scheduled fact finding review without good cause.

If there is disagreement with the W-2 agency's fact finding decision, a second level Departmental Review may be requested by writing to the Department of Administration, Division of Hearings and Appeals (DHA). The written request must include a copy of the fact finding decision, the tape of the fact finding meeting, and be received by DHA within 21 days from the Fact Finding Notice of Decision date. The W-2 agency fact finding review must be completed to request a Departmental Review.

For more information on the W-2 Fact Finding and Departmental Review policy, see the W-2 Manual, Chapter 19.

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3.9 FAIR HEARING DECISION AND CLIENT/ AGENCY LIABILITY

3.9.1 Abandoned Hearing
3.9.2 Final Decisions
- 3.9.2.1 Final Decisions Favorable To The Client For Programs Other Than FS
- 3.9.2.2 FS Final Decisions Favorable To The Client
- 3.9.2.3 Final Decisions Not Favorable To Client For Programs Other Than FS
- 3.9.2.4 Final Decisions Not favorable To The Client FS Cases

3.9.3 Proposed Decisions

3.9.4 Recoupment
3.9.5 Agencies Sanctions
3.9.6 Cost Motion

3.9.1 Abandoned Hearing

If the client or his/her representative fails to appear without good cause, the hearing request will be dismissed. This type of dismissal is usually considered an "abandoned hearing". *DHA* will notify the client and the agency when a hearing is dismissed.

A fair hearing thought to be abandoned may be re-scheduled.

3.9.2 Final Decisions

The final decision is based on the hearing record. It contains:

1. A statement of the issue involved.
2. The facts presented in the hearing.
3. The conclusions and applicable law.
4. The order.

Agencies **must** follow a final decision for a particular case. If *DHS*/DWD finds that a final decision conflicts with existing policies and procedures DHS/DWD may issue a statewide directive changing program operations. Until DHS/DWD makes such a declaration, continue to follow DHS/DWD's written policies and procedures in all other cases. However, DHA must and will issue future decisions that follow the final decision.

The exclusive records for a final decision consists of:

- Verbatim transcript or the ALJ's recording of testimony,

  or

- An official report containing the substance of what transpired at the hearing,

  and

- All papers, requests and exhibits filed in the proceeding.

The record is available for copying and inspection by the client or any representative at any reasonable time. All hearing records and decisions are available for public inspection and copying, so long as client identity is safeguarded.

After the decision is signed, DHA will mail a certified copy to the client, his/her attorney,and agency.

When the decision orders your county or tribal treasurer or other check issuing authority to make a payment, DHA also mails a copy of the decision to him/ her. When the decision orders payment for a specific medical benefit, DHA mails a copy of the decision to the insurance carrier.

3.9.2.1 Final Decisions Favorable To The Client For Programs Other Than FS

When a decision is favorable to the client, the agency must carry out the decision's orders within 10 days of the order or 90 days of the hearing request, whichever comes first.

Document implementation of the decision in the case comments.

3.9.2.2 FS Final Decisions Favorable To The Client

In FS, if the decision is favorable to the client, and the original action was a:

1. Denial, carry out the decision within 10 days.

2. Reduction, and benefits weren't continued, carry out the decision within 10 days.

3. Reduction, and benefits were continued, continue them.

Try to make retroactive FS allotments ("restored") to a client who is moving from your jurisdiction, before the FS group leaves.

Document your actions in the case comments.

3.9.2.3 Final Decisions Not Favorable To Client For Programs Other Than FS

When the decision isn't favorable to the client, the decision notice is the final notice for the case, with exception to overpayment notices. No further timely and/or adequate notice requirement applies. Discontinue or reduce benefits immediately.

The DHA decision includes a description for the client of his/her right to rehearing and/or judicial review. It is not necessary to request a rehearing before going to circuit court.

Documentation procedures are as follows:

1. Sign and return the Certification of Administrative Action to DHA.

2. Document the administrative action in the case comments.

3.9.2.4 Final Decisions Not favorable To The Client FS Cases

In FS cases,

1. If the action being appealed was a denial, then the decision is the final action.

   or

2. If the action being appealed was the reduction or discontinuance and benefits were ordered continued, then carry out the order by the next issuance period.

Document the administrative action in the case comments.

3.9.3 Proposed Decisions

DHA reviews each hearing decision to determine if it conforms with established DHS and DWD policy and whether DHS and DWD policies conform to Wisconsin and federal law. If not, the hearing decision will be issued as a "Proposed" decision.

When DHA issues a proposed decision, a copy of the decision is sent to the client and the local agency. The proposed decision includes instructions to the agency that the decision is proposed and should not be acted upon. The agency and the client/representative are also instructed to send written comments or objections to the decision to DHA within 15 days of receipt of the proposed decision. Upon request, DHA may extend the deadline for written comments.

After the 15 day comment period has ended, DHA will send the proposed decision and all comments or objections to DHS/DWD. The Secretary of DHS/DWD will review the proposed decision and make the final decision for the case. The Secretary's final decision can be to agree or reverse the proposed decision and/or change, amend current policy. The final decision made by the Secretary will then communicated by DHA to the client and agency.

The final decision must be implemented by the agency for the case that was appealed in the hearing. If the final decision ruled current department policy to be incorrect, the agency must continue to follow the current policy in all other cases until the department changes that policy.

3.9.4 Recoupment

If an agency's adverse action is upheld, or the fair hearing is withdrawn or is abandoned, then recoup any overpayments caused by benefits having been continued.

3.9.5 Agencies Sanctions

Agency failure to follow hearing orders and failure to follow required documentation procedures are subject to a fiscal sanction. This disallowance is $250 a day for each day the agency fails to implement an order beyond the date established by the order. (See 2.7 Fiscal Sanction for additional information on fiscal sanctions.)

3.9.6 Cost Motion

When the client wins a hearing, his/her attorney may file a "cost motion" with DHA, in which s/he requests payment of attorney fees and other costs associated with the hearing.

The agency has 15 days from the filing of the client's motion to submit a written response to DHA. If the agency is not copied on the client's motion, the 15 days begin only when the agency is copied on the motion request.

The agency's response to the client motion should state the specific reasons why the agency's position at the hearing was reasonable or "substantially justified". "Substantially justified" means having a reasonable basis in law or fact. For example, if the client introduced evidence at the hearing that the agency was previously unaware of, and which would have made a difference had the agency known about it, the agency should indicate this in the response. The key point is to state specifically why the agency position was "substantially justified" (that is, "reasonable").

If the agency response includes facts not in the hearing records, the agency should submit them in the form of an affidavit.

The hearing officer will review the client's cost motion and agency response to DHA and decide if:

- The agency's position at the hearing was **not** "substantially justified" and costs associated with the cost motion must be paid from state funds.

- The agency was "substantially justified" or special circumstances exist which would make the award of the cost motion unjust.

- The costs motion was frivolous (that is, submitted in bad faith) for the purpose of harassing or maliciously injuring the state agency, the hearing officer may award costs to the state agency. The agency should include

facts relating to harassment in its response to DHA if such conduct occurred.

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3.10 REHEARING BY DHA AND JUDICIAL APPEALS

3.10.1 Rehearing by DHA and Judicial Appeals Introduction
3.10.2 Judicial Appeals

3.10.1 Rehearing by DHA and Judicial Appeals Introduction

DHS/DWD or a client/representative may request a rehearing by *DHA*. The request must be made within 20 days of the date of decision. DHA may grant or refuse the request.

Note: Even if a re-hearing is granted, the final decision must be complied with, until a decision from the rehearing reverses it.

A rehearing will be held only when there has been:

1. An error of law; or,
2. An error of important fact; or,

3. New evidence discovered which could not have been presented at the first hearing.

DHA will usually not grant a re-hearing unless the error or new evidence is sufficiently important to change the decision. If DHA neither grants or denies a rehearing request within 30 days, the request is deemed denied.

The agency is not required to assist the client in preparing his/her petition for rehearing.

3.10.2 Judicial Appeals

A client dissatisfied with a hearing decision may appeal to the Circuit Court of his/her residence. S/he must do this within 30 days, of the date, of the hearing decision or rehearing denial, whichever is later.

The client's petition for review to the Clerk of Court must include:

1. The issue being appealed, **and**
2. How s/he is aggrieved by the decision,**and**,
3. The request ("prayer") for relief s/he desires.

A copy of the petition will be served on DHFS/DWD with notice to the Wisconsin Attorney General's Office.

The agency is not required to assist the client in preparing an appeal of this sort.

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3.11 DIVISION OF HEARINGS AND APPEALS (DHA) DIRECTORY

Staff
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Assistant Administrator: Kenneth Adler
Legal Secretary Supervisor: Joan Alt

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5005 University Avenue
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4 FORMS AND PUBLICATIONS

4.1 FORMS AND PUBLICATIONS INTRODUCTION

The Department of Health Services (*DHS*) and Department of Workforce Development (DWD) create the forms and publications used in the administration of its programs.

A form is a document, notice or worksheet that a worker uses to process cases. A publication is a brochure, fact sheet or a participant handbook used to describe a program.

DHS administers Caretaker Supplement, Family Care, Family Planning Waiver Program, FoodShare, Medicaid/BadgerCare Plus, SeniorCare and the Wisconsin Funeral and Cemetery Aids Program.

DWD administers all W-2 and related work programs, including FoodShare Employment and Training, Wisconsin Shares (Child Care Assistance) and Emergency Assistance.

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4.2 CURRENT VERSIONS

To assure that the current version of a form or publication is being used, it is recommended that agencies order only a 3 to 4 month supply. Internet based forms/publications should be downloaded and printed as needed.

The most up-to-date versions of forms/publications will be available first on the internet.

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4.3 INTERNET FORMS/PUBLICATIONS

4.3.1 Accessing Internet Forms/Publications
4.3.2 Translated Forms/Publications
4.3.3 Internet Search Tips

In an effort to save the cost of printing, storing and mailing forms/publications, *DHS* is no longer printing forms/publications that are used infrequently but expects workers to download what they need from the internet, when appropriate. This will also ensure that the most current version of the form/publication is being used.

Most DHS forms/publications are published on the internet for downloading. If a form is marked ”PDF-Fillable”, it can be filled in online and then printed. The only requirement to view and print a PDF form or publication is the installation of the Adobe Acrobat Reader ® 3.0 or higher software. If you do not have Adobe Acrobat Reader® on your computer, consult with your agency’s information systems coordinator for the recommended installation on your computer(s).

All forms/publications required to be handed out at application and review will be available in printed format. See the 4.5 Ordering Forms/Publications section for information on ordering forms and publications.

4.3.1 Accessing Internet Forms/Publications

DHS/Forms

DHS has designed the Eligibility Management (EM) and *Income* Maintenance Forms (IM) web sites to meet the needs of the IM worker.

EM - The EM Page serves as a starting point to commonly used web sites. This page has links to all IM forms and publications. The EM web site is located at http://dhs.wisconsin.gov/em/index.htm .

Clicking on ”Open All Menus” or ”Close All Menus” will allow you to view the EM page in two different views.

1. Open All Menus view will show all links associated with each subject heading.
2. Close All Menus view will close all links and show only the subject headings. In this view, you can click on the subject heading to show only the links for that heading.

If you need help on the EM page, click on the link ”Need HELP with this page?”

IM Forms – The IM Forms page provides links to IM forms not publications. The IM forms page is located at http://dhs.wisconsin.gov/em/forms/imforms.htm. The IM Forms page sorts forms in the following categories:

- All IM Forms
- Medicaid
- BadgerCare Plus
- Family Planning Services
- Family Care
- Well Woman Medicaid
- SeniorCare.

A second sort allows a user to look for a form by:

- Form Number
- Title
- Language
- Form Type

The IM Forms page has links at the bottom of the page for:

- Caretaker Supplement (CTS) Forms
- Estate Recovery Forms
- Other DHS forms that are not in DHCAA (Division of Health Care Access and Accountability
- Other Shared Forms (Forms that are shared by DHS and DWD.)

- Department of Workforce Development (DWD) Forms

DHS Publications

You can access DHS publications through the EM page or at the individual program site. From the EM page, click on ”Publications”. This will give the links to the individual program site. Or, you can access publications at the following links:

ACCESS: http://dhs.wisconsin.gov/em/access/publications.htm

BadgerCare Plus http://dhs.wisconsin.gov/em/customerHelp/badgercare.htm

FoodShare http://dhs.wisconsin.gov/FoodShare/fsforms-pubs.htm

Medicaid http://dhs.wisconsin.gov/medicaid/publications.htm

SeniorCare http://dhs.wisconsin.gov/seniorCare/information.htm

SSI/CTS http://dhs.wisconsin.gov/ssi/publications_1.htm

DWD Forms

All DWD forms are located in an electronic forms repository. Some forms in the repository can be accessed via the Internet Forms Repository, while DWD internal forms are located in a secured area called the Extranet. While it is the goal of DWD to house all forms in the Internet Forms Repository, forms may be found in either place. Individuals wishing to access the Extranet will need a user ID and password. Refer to Operations Memo 98-48, for information on obtaining a user ID.

All DWD forms can be accessed via the DWD workweb (http://workweb.dwd.state.wi.us) under Forms/Records on the left side of the screen. Those forms stored in the Internet Forms Repository can also be accessed via http://dwd.wisconsin.gov/dwd/forms/.

Questions regarding DWD forms can be directed to:

Department of Workforce Development
Division of Workforce Solutions
Attention: DWS Forms Officer
P.O. Box 7972
Madison, WI 53707-7972

Phone number: 608-266-8002
E-mail: **jeannie.holtan@dwd.state.wi.us**

4.3.2 Translated Forms/Publications

Many forms/publications are available in languages other than English. The most common languages are Hmong, Russian and Spanish.

DHS identifies the language of translated forms and publications with one letter added to the end of the English form or publication number. For example: H = Hmong, R = Russian, etc. A form number with an ”A” at the end, identifies this as the instructions for that form.

Translated forms/publications are available for downloading from the DHS or DWD web sites as needed.

4.3.3 Internet Search Tips

DHS

1. If you are certain you know a document is a form or a publication, go to the specific form or publications page for the program. Visually search the list by the form name.
2. If you are unsure of the document name or whether it’s a form or a publication, go to the page that lists all IM forms and publications. Internet Explorer has a search function that you can use on any web page. Go to Edit, in the toolbar, choose Find (on this page), and enter the document name, number, or a part of the document name or number. Your search result will be highlighted. If the result is not the document you want, click on Find Next to go to the next search result. If you do not find what you want, refine your search.
3. An alternate search method is to go to the DHS main web page at http://dhs.wisconsin.gov/ , enter the form name or number in the search field and click on ”Go.” This search engine searches all web pages and documents on the DHS site, so results may vary.

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4.4 REQUIRED FORMS AND PUBLICATIONS

4.4.1 Table of Forms And Publications
4.4.2 FNS Required Signage

4.4.1 Table of Forms And Publications

The table below outlines the forms/publications required to be given to applicants/recipients at application or recertification. These forms/publications are available in printed format from *DHS* or DWD.

Scenario	Program	Form/Publication
Client Registration	FS MA BC+	• A guide to Applying for Wisconsin's Health and Nutrition Programs (P-16091)
Intake Interview (new application)	FS	• Addendum to the *CAF*. This is a *CARES* generated form, if not available through CARES the DWSP-2438-1 should be used. • Change Report form (F-16066 or F-16006) • QUEST Card and PIN Responsibility Statement, (F-16007)
	MA BC+	• Addendum to the CAF. This is a CARES generated form, if not available through CARES the DWSP-2438-1 should be used. • Medicaid Change Report, (F-10137) or • BadgerCare Plus Change Report, (F-10183) • Provide a Notice of Assignment: Child Support, Family Support, Maintenance and Medical Support form (DWSP-2477) Good Cause Claim form (DWSP-2019) to each applicant applying with children or to anyone that requests either of these. • Good Cause Notice, (DWSP-

		2018)
Recertification (review)	FS	• Addendum to the CAF. This is a CARES generated form, if not available through CARES the DWSP-2438-1 should be used. • Change Report form (F-16066 or F-16006)
	MA BC+	• Addendum to the CAF. This is a CARES generated form, if not available through CARES the DWSP-2378-1 should be used. • Change Report form, (F-10137)
Another program of assistance is open, request is made for FS	FS	• FS Application Registration, (F-16019A) (Applicant keeps Important Information section) • Addendum to the CAF. This is a CARES generated form, if not available through CARES the DWSP-2378-1 should be used. • Change Report form, (F-16066 or F-16006) • QUEST Card and PIN Responsibility Statement, F-16007
Another program of assistance is open, request is made for MA	MA BC+	• Addendum to the CAF. This is a CARES generated form, if not available through CARES the DWSP-2438-1 should be used. • Change Report form, F-10137 • Notice of Assignment, DWSP-2477 • Good Cause Notice, DWSP-2018
Adding a child to an open case or parent leaves the home (resulting in a new referral to the Child Support Agency)	FS	
	MA BC+	• Notice of Assignment, DWSP-2477 • Good Cause Notice, DWSP-2018

4.4.2 FNS Required Signage

Currently the only poster required by FNS to be posted in agency offices is "And Justice For All", PHC 09004. This poster can be ordered from DHS.

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4.5 ORDERING FORMS AND PUBLICATIONS

The first three to four letters (prefix) of the form/publication will help you to identify where a request should be sent. If the forms/publications has the prefixes F-, P-, DDE or DDES your request should be sent to *DHS*.

There are several methods to order forms/publications that are available in paper format.

When ordering forms/publications via email, fax or telephone, please provide:

1. The form number, form name and quantity needed.
2. The agency name and the address to which the forms/publications should be sent. This must be a physical street address as forms/publications are sent via UPS.
3. Your name, telephone number and email address. This information is needed in case there are questions regarding your order.

DHS

To order DHS forms/publications, you can contact the Division of Health Care Access and Accountability Forms Manager by mail, telephone, fax or email.

Division of Health Care Access and Accountability
Attn: Forms Manager
P.O. Box 309
Madison, WI 53701-0309

Telephone: (608) 261-4954

Fax: (608) 266-1096

Email: steve.bowe@wisconsin.gov

You can also order online at
http://dhs.wisconsin.gov/forms/PrintFormsOnline.htm

For more information on ordering forms/publications from DHS, go to
http://dhs.wisconsin.gov/forms/paperfpc.htm.

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4.6 CUSTOMIZING FORMS AND PUBLICATIONS

Agencies may not change state designed and required forms or publications. Optional forms such as "What to Bring With You" may only be altered to include the agency specific information such as letterhead and a contact name and number. Agencies may not substitute their own application or other forms, unless approved by *DHS*. To request approval for a local agency form, contact – Carol Cole by email at carol.cole@wisconsin.gov or (608) 261-6860.

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4.7 DHS FORMS COORDINATORS

DHS communicates with agencies via Forms Coordinators when new or revised forms/publications are published and when old ones are obsolete. DHS maintains many email listservs to communicate with agency coordinators.

To add or remove someone from the Forms Coordinator listserv, see
http://dhs.wisconsin.gov/em/policy-notification/signup.htm

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4.8 NON DHS AND DWD FORMS

DHS provides links to non-DHS forms such as the fair hearing requests form and Immigration (SAVE) forms. You can access these forms from the EM page at http://dhs.wisconsin.gov/em/index.htm. To view the forms links, click on the Forms heading to open all links.

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4.9 DHS/DWD FORMS AND PUBLICATIONS LIST

To view the complete listings of current *DHS* forms and publications and a description of how they are made available to you, use the links described below.

- DHS IM Forms http://dhs.wisconsin.gov/em/forms/imforms.htm
- DHS and DWD/DCF forms and publications that are shared for all programs of assistance. (Shared Forms)
- DHS Medicaid Publications
- DHS FoodShare Publications

For information on the Electronic Case File (ECF) codes see the ECF handbook at http://www.emhandbooks.wi.gov/ecf/.

For information on Document (Record) Retention, see 1.5 Record Retention.

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5-6 RESERVED

RESERVED

APPLICATIONS (7)

7.1 APPLICATIONS

All policies regarding applications are found in the handbook for each program. See these handbook sections for Application policies:

FoodShare Handbook section 2.1,
Medicaid Eligibility Handbook section 2.1
BadgerCare Plus Handbook sections 25.1.
Child Care Manual section 1.3.0
W-2 Manual 2.1.0

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REVIEWS (8)

8.1 REVIEWS

All polices regarding reviews are found in the handbook for each program. See these handbook sections for Review policies:

FoodShare Handbook section 2.2,
Medicaid Eligibility Handbook section 3.1
BadgerCare Plus Handbook sections 26.1.
Child Care Manual section 1.13.13
W-2 Manual

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VERIFICATION (9)

9.1 VERIFICATION

9.1.1 Verification Introduction
9.1.1.1 Validation
9.1.1.2 Documentation
9.1.2 Verification Policy For Programs
9.1.3 General Rules
9.1.3.1 Discrimination
9.1.3.2 Fair Treatment
9.1.3.3 Client Responsibility
9.1.3.4 Assist The Client
9.1.3.5 Third Party Cooperation
9.1.4 Verification And The Electronic Case File (ECF)

9.1.1 Verification Introduction

Verification is part of determining both eligibility and payment/allotment amount. To verify means to establish the accuracy of verbal or written statements made by, or about, a group's circumstances.

Validation and documentation are the 2 methods by which you accomplish verification.

9.1.1.1 Validation

To validate means to put an original or copy of a piece of evidence in the case record.

Some examples of validation include: photocopy of a person's birth certificate; an IEVS match report; a SAVE query response; a birth record query printout. When you validate, note in *CARES* the item verified by the evidence and add a case comment that you filed the document. If your agency doesn't have a standard file format, give the document's location in the record.

Example 1: Following is a validating notation made by a worker with the initials "RJS" on March 14, 1998. "Sally Ann White, DOB 6/14/88, State of WI birth certificate #148-83-2537, copy attached 3/14/98. See lower right side of case record for copy. RJS--3/14/98"

1991 Wisconsin Act 269 modified §69.30 Wis. Stats. to permit DES, county, and tribal social and human service agencies to photocopy vital records for administrative use. 1997 Wisconsin Act 27 further amended this provision to include W-2 agencies.

Vital records include:

1. Birth certificates
2. Death certificates
3. Marriage documents
4. Divorce and annulment certificates
5. Data related to any of the above documents

The statute exempts you from its restrictions if you have an administrative need for the copy and you mark the copy "For Administrative Use".
Penalties for improperly photocopying vital records include fines and imprisonment.

9.1.1.2 Documentation

One meaning of "documentation" is synonymous with "verification" (presentation of a document so as to verify. However, in these instructions, we mean your actions creating a document in the case record.

When you add notations to the record, and have no original or copy, you are documenting. Your notes will report what happened in collateral contacts, your observations of documents or home visits, or an explanation of oral conversations.

Documentation provides the new ES or W-2 worker, when the case is transferred, sufficient data to begin managing the case.

Used properly, documentation helps to reduce errors by providing understanding of and accountability for case actions.

Include enough data to describe the nature and source of the information should any follow-up be required. Initial and date your note.

Example 2: The ESS sees the applicant's Social Security Number card. Instead of making a photocopy (validation) of it for the record, the ESS notes in the record that the SSN was verified by viewing the card. The ESS dates and initials the note.

Example 3: Documentation of an insurance policy may look like this:"Sally Ann White, DOB = 06/14/53, Metropolitan Ins. Co. New York, NY. Term Life Ins. policy #148-83-2537 issued 06/12/61 for $1,000. No cash value. Policy seen on 03/14/87 by RJS."

9.1.2 Verification Policy For Programs

All policy regarding verification is found in the handbook for each program. See these handbook sections for verification policies:

FoodShare Handbook section 1.2,
Medicaid Eligibility Handbook section 20
BadgerCare Plus Handbook sections 9

9.1.3 General Rules

- Only verify those items required to determine eligibility and benefits.

Example 4: Verification of ownership of a junk vehicle is not required unless the group's assets are near the asset limit.

- Don't require verification not needed by the program for which you're testing.

Example 5: Although *SSI*-related MA requires verification of shelter expenses for categorically needy eligibility, W-2 never requires shelter expense verification. Do not require shelter expense verification for W-2.

- Do not verify an item that is not a required verification or is not documented as questionable.
- Avoid over verification. Requiring excessive pieces of evidence for any one item is over verification. If you have all the verification you need, don't continue to require added verification.

Example 6: If you have check stubs from a client's employer, don't also require the employer to report the same data

Example7: If you have a newborn's birth certificate that includes sufficient data, do not also require a hospital bracelet.

- Do not verify information already verified unless you believe the information is fraudulent or differs from more recent information. If you suspect fraud exists, determine if you should make a referral for fraud (II-D) or for front-end verification (I-E).
- Do not exclusively require a particular type of verification when various types are possible.

Example 8: Do not require a lease as the only acceptable item to verify shelter expense.

9.1.3.1 Discrimination

Don't target special groups, such as migrants, for a special verification requirement.
Don't target persons on the basis of race, religion or national origin for a special verification requirement.

9.1.3.2 Fair Treatment

Do not harass the client or violate the applicant or recipient's privacy, personal dignity, or constitutional rights. Respect personal rights.

You may make collateral contacts and home visits. Do not enter an applicant's or recipient's home without permission or under false pretenses. To do so violates legal rights and human decency.

9.1.3.3 Client Responsibility

The client has primary responsibility for providing verification. Responsibility likewise resolve questionable information. Accept anything reasonable from the client and decide if it verifies the client's statement.

Do not deny eligibility when the client does not have the ability to produce verification.

9.1.3.4 Assist The Client

Assist the client in obtaining verification if s/he has difficulty in obtaining it.
The client: (1) may not have the power to produce verification,and (2) it may not be obtainable timely even with your assistance. When these 2 conditions exist, except when restricted, use the best information available to process the application or change within the time limit and issue any benefits. Seek verification later.

When you have received the verification, you may need to adjust (recoup or supplement) benefits based on the new information. Explain this to the client when requesting verification.

Some deductions and allowances require verification before you may include them in the eligibility or benefit calculation. See the respective handbook for direction.

Example 9: In FS, you must verify some utility expenses before the expense can be allowed. If the expense is not verified, do not use the expense in your calculations.

9.1.3.5 Third Party Cooperation

Wisconsin Stats. 46.25(2m) authorizes *DHS*, county, and tribal agencies to request third party cooperation from any person in Wisconsin in the verification of data for Medicaid and FoodShare. Cooperation of the 3rd party is required within 7 days of your request.

The statute does not provide for compensation to any third party. Nor does it permit the third party to refuse verification because there is no compensation.

9.1.4 Verification And The Electronic Case File (ECF)

1. Beginning January 1, 2007, all cases requested by the State for QA purposes or for any other reason (i.e. second party review by PAC, client complaint, cases in the FS and Medicaid negative QC samples, PARIS, etc.) must be scanned into the ECF, in its entirety, as outlined in the ECF handbook within ten (10) business days of the request.

   This action is in lieu of pulling, copying and shipping the case file to the requesting state agency. Missing case files can lead to liquidated damages as outlined in the IM contract and in Administrators Memo 06-01 regarding local agency compliance with DHS requests for records and case-specific corrective action.

2. All IM agencies will scan application, review and change documentation as well as any case transfers (to minimize impact on the clients) into the ECF beginning January 1, 2007.

3. All ongoing or day-to-day scanning will be maintained and kept current so all electronic case files are current to within 30 calendar days of the reported/required case action having been performed in CARES. However, the 30 calendar days refer to day-to-day operations. If a file is requested from the department (or its designee), it must still be completed and scanned within ten (10) business days of the request.

See the Electronic Case File (ECF) Handbook for more information on the ECF.

See section 1.5 Record Retention for rules regarding when verificaion documents may be destroyed.

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CONFIDENTIALITY AND SECURITY (10)

10.1 LIMITATION ON GIVING INFORMATION

Except as stated below, no one may, for any purpose not connected with program administration, use or disclose information concerning applicants for, or current or former recipients of:

1. General Assistance (GA).
2. Aid to Families with Dependent Children (AFDC).
3. Child Support and Paternity Services.
4. State Supplemental Payment (SSP) to Supplemental Security *Income* (*SSI*).
5. Medical Assistance (MA).
6. Food Stamps (FS).
7. Wisconsin Works (W-2)
8. Other programs listed in the state and county contract for administering economic assistance programs.

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10.2 MONTHLY REPORT

10.2.1 Monthly Report Introduction
10.2.2 Request
10.2.3 Record Keeping
10.2.4 Notification

10.2.1 Monthly Report Introduction

Each agency administering Wisconsin Works (W-2) must maintain a monthly report listing all persons receiving W-2. For those listed, the report must contain:

1. Name.
2. Amount of W-2 paid during the preceding month.

Do not include participant addresses on this report.

Nothing in this report may disclose any information about adoption, foster care or treatment foster homes.

Keep this report open to public inspection during regular office hours.

You may destroy the previous version of this report when you receive a newer version.

It is unlawful to use any information obtained through access to this report for political or commercial purposes. §49.32(9)(c) and §49.83 Wis. Stats, provide penalties for misuse of this information.

You may generate a version of this report for your agency from the *CARES* EOS report subsystem.

10.2.2 Request

Anyone, except public officers, seeking permission to inspect this report must complete and sign a Request for Permission to Inspect Monthly W-2 Report.

Approve requests for inspection when the reason is for public, educational, organizational, governmental, or research purposes. You may withhold inspection for up to 5 working days when the request to inspect is for some other purpose. When you do withhold inspection permission, attempt to notify all participants on the list before granting permission; however, you may not extend the withholding beyond the 5 working-day period.

10.2.3 Record Keeping

Agencies must maintain a log of all requests to inspect this record. In each instance, record this information about the person making the request:

1. Name
2. Address
3. Employer
4. Telephone number
5.

Refuse the request when the person refuses to provide you with any of these items.

10.2.4 Notification

Within 7 days after any inspection of the report or at the next regularly scheduled communication with the person, whichever is earlier, notify each person named in the report:

1. That an inspection was requested and made; and,
2. The name and address of the person who inspected the report.

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10.3 DISCLOSURE WITHOUT CONSENT

10.3.1 Introduction
10.3.2 Emergencies

10.3.1 Introduction

DHS, DWD, DCF and its contractees may disclose information from the agency record to other programs routinely and without the person's consent for a purpose compatible with the data's collection.

See 11.2 Credit Bureau Reports for instructions for the release of credit bureau report data. I
The custodian of the ES and/or W-2 record may disclose information from 1 that record to the following compatible agencies:

1. County child support agencies.
2. County departments of social or human services.
3. DHS-contracted county, tribal, and private W-2 agencies.
4. Weatherization agencies under contract with the Wisconsin Department of Administration (DOA) providing weatherization services to low income persons.
5. Tribal agencies administering DES programs.
6. General relief/assistance agencies.
7. Wisconsin DCF staff for administering W-2 and/or FS work participation requirements.
8. Any fiscal agent of the state administering benefit payments under the MA program (currently EDS- Federal Corporation).
9. Any agent of the DHS administering the "Health Check" program.
10. The Social Security Administration for administering the Supplemental Security *Income* (*SSI*) benefits (5.7.0).
11. DHS's Division of Health (DOH), Bureau of Disability Determination (BDD) for adjudicating disability for MA applications.

12. Local public housing authorities where the DES program client applies for public housing or for federal rent assistance.
13. DWD, Division of Unemployment Insurance (DUI) for computer matching to Unemployment Insurance Benefit payments.
14. Job Training Partnership Act (JTPA) agencies to the extent that the information is necessary to determine JTPA program eligibility. This includes the amount of the W-2 payment.
15. Any other federally assisted program providing cash or in-kind assistance or services directly to individuals on the basis of need. Federally assisted school food service programs are included in this category. Families may apply for free or reduced meals in that program. Do not provide a school or school district with a list of students receiving W-2 or FS. However, if the school requests you to confirm the recipient status of a child or a list of children who have applied for free or reduced meals, provide the confirmation.
16. US Comptroller General's Office.
17. Any official conducting an investigation prosecution or civil proceeding in connection with the administration of an economic assistance program. S/he must submit to you a written request to obtain information. The request must include the identity of the person requesting the information, his/her authority to request, the violation being (continued) investigated, and identify the person being investigated. Do not apply this restriction to your District Attorney or fraud investigator.
18. Persons directly connected with the administration or enforcement of the programs which are required to participate in the state income and eligibility verification system (IEVS), to the extent that the information is used to establish or verify eligibility or benefit amounts under those programs.
19. Staff of any public or private agency for the administration of the:
    a. Federal Title IV-E Foster Care program
    b. Adoption Assistance program.
20. Staff of any public or private agency for the administration of Wisconsin's Welfare-to-Work program.
21. Staff of the Wisconsin Legislative Audit Bureau (LAB) for the administration of the W-2 program [§ 49.143(5)(d), Wis. Stats].

No other routine disclosure from client records- is approved. The client or guardian must authorize all other disclosures.

10.3.2 Emergencies

Other circumstances may arise when disclosure must be given without consent because a person's health or safety is in imminent danger. When there's reason to believe a health or safety emergency exists, the agency director (or designee) may authorize disclosure. Notify the client in writing within 72 hours of this disclosure.

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10.4 DISCLOSURE WITH CONSENT

A client may authorize the disclosure of information of record about him/ herself to a third party. Require the client or guardian's written authorization. The Confidential Information Release Authorization and Confidential Information Release Authorization to Agency may be used for this purpose . Give a copy of the authorization to the agency that collected the information. The authorization must specify the information to be disclosed, to whom it is to be disclosed, and for what period of time.

See 11.2 Credit Bureau Reports for instructions for the release of credit bureau report data. Neither *DHS* nor the contract agency must inform the client of a disclosure made as a result of the client's authorization.

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10.5 SPECIAL CIRCUMSTANCES

10.5.1 Legislative Committees
10.5.2 Employers Tax Credit Claims
10.5.3 IRS Dependent Verification
10.5.4 Crime Victim's Compensation Program
10.5.5 Law Enforcement
    10.5.5.1 Warrant Notification
10.5.6 IEVS Data
10.5.7 Supplemental Security Income
10.5.8 Addresses
    10.5.8.1 Release Permitted

10.5.8.2 Release Prohibited
10.5.8.3 Record Keeping

10.5.1 Legislative Committees

Except as provided under §49.35(1)(bm) and §49.83, Wis. Stats. (1.0.0), don't disclose information for the broad investigatory purposes of legislative committees . Federal legislation prohibits disclosure to any committee or Committees legislative body (federal, state, or local) of any information that identifies by address and/or name any applicant or recipient.

10.5.2 Employers Tax Credit Claims

Several federal laws have provided tax incentives to employers to promote hiring W-2 participants. The Targeted Jobs Tax Credit (TJTC), Work Opportunity Tax Credit (WOTC) and the Welfare-to-Work Tax Credit (VVWTC) are past and current examples.

To claim a tax credit, an employer must initiate a certification form attesting to the Internal Revenue Service (IRS) that the employee was an AFDC recipient or W-2 participant and otherwise met the qualifying criteria. Some FS recipients also may qualify, depending on the specific tax credit.

Employers may get the form (IRS Form 8850) from DWD Job Service Offices and the IRS.

Assist the employer and/or recipient/participant in completing this form. The 8850 form is to be completed on or before the date of the job offer.

If the recipient/participant is unaware that this form has been completed, notify him/her of your actions.

Keep a copy of the IRS 8850 in your case file.

10.5.3 IRS Dependent Verification

The Federal Tax Reform Act of 1986 requires a taxpayer to report the Social Security Number (SSN) for anyone claimed as his/her dependent who is age 5 or older. IRS may request of you verification that a person claimed to be a dependent and the claimed SSN match your records. Provide IRS with the minimal data from your record or *CARES* needed to provide them the requested verification of relationship and SSN.

10.5.4 Crime Victim's Compensation Program

The Crime Victim's Compensation (CVC) Program is administered by the Wisconsin Department of Justice (DOJ), Crime Victims Services. Its intent is to provide financial support to victims of crime within Wisconsin.

DOJ is required to determine a person's W-2, FS, and/or MA eligibility status and benefit amount before it may dispose of someone's application for CVC. As part of the application process for CVC, the applicant must sign an authorization of release of confidential information.

Release information to CVC program staff about CVC applicants and recipients. Information you are to release concerns eligibility and amount of benefits in the W-2, FS, and MA programs.

This instruction is based upon an agreement between DVVD and DOJ that J DOJ will maintain in its CVC file the authorization release and that you will be provided with a copy upon your request to CVC staff.

This instruction does not include the release of General Assistance data. The local General Assistance agency may determine its own policy regarding the release of its information to CVC.

10.5.5 Law Enforcement

§49.32(10)(a), Wis. Stats., permits you to provide the current address of an FS recipient or W-2 participant to a law enforcement officer when the officer meets all of these conditions:

1. Provides you, in writing, the name of the recipient or participant, and
2. Demonstrates, in writing, to your satisfaction, that the recipient or participant Is a fugitive felon under 42 USC 608(a)(9);and,
    a. Is violating a condition of probation or parole imposed under state or federal law; **or**,
    b. Has information that is necessary for the officer to conduct the official duties of that officer.
3. The location or apprehension of the felon is within the official duties of the officer.
4. The officer is making the request in the proper exercise of his/her duties.

Seek the advice of your legal counsel if you question the appropriateness of a request of this sort.

10.5.5.1 Warrant Notification

If a law enforcement officer believes, on reasonable ground, that a warrant has been issued and is outstanding for the arrest of a W-2 participant, s/he may request that a law enforcement officer be notified when the participant appears to

obtain his/her W-2 payments/ benefits. The W-2 agency staff may cooperate with this request and alert the officer when the W-2 participant appears.

Seek the advice of your legal counsel if you question the appropriateness of a request of this sort. Reference is to §49.32(10)(b) Wis. Stats.

10.5.6 IEVS Data

Protect all data provided and obtained through the *Income* and Eligibility Verification System (IEVS) (I-D). IEVS matches are done in the CARES Data Exchange subsystem; see CARES Guide, Chapter X.

10.5.7 Supplemental Security Income

When an AFDC or W-2 recipient or former recipient is found eligible for *SSI*, Security Income Social Security Administration staff may contact the ES agency (see 3.0.0, #10). *SSA* will request verification of payment amount(s) and the closure date. Provide the requested data.

SSA may request this data from you and accept your response by telephone. Some SSA staff also have access to CARES and may determine the information they need from direct CARES query. If there is a discrepancy, SSA may request, in writing, that you provide this data in writing.

10.5.8 Addresses

Provide the current address of a General Assistance (GA) recipient or W-2 participant only under allowed circumstances [§49.32(10m) Wis. Stats.].

10.5.8.1 Release Permitted

Release the current address of a GA recipient or W-2 participant when requested by a person, that person's attorney or an employee or agent of that attorney. The reason for the request must be that the person must be a party to a legal action or proceeding in which the recipient/participant is a party or a witness. However, if the action or proceeding is one listed in 5.8.2, do not provide the address.

Notice and Delay
Within 7 days after an address has been requested, provide a written notice to each recipient/participant whose address is requested. In this notice, include:

1. The date the request was made
2. The name and address of the person making the request
3. The reason the address was requested
4. A statement that the address will be released no sooner than 21 days after the date the request was made.

Do not provide a current address before 21 days after the request is formally made.

Request
Require the person requesting an address to verify:
1. His/her identity
2. His/her participation as a party in the legal action or proceeding.
3. The recipient's or participant's participation as a party or witness in the legal action or proceeding.

To meet the verification requirement in items 2 and 3, require a copy of the pleading or a copy of the subpoena for the witness.

Require the person making the address request to sign a statement setting forth his/her name, address, the reason(s) for making the request and indicating that s/he understands the limitations on the use of the address data and the penalties for misuse.

Penalties
Wisconsin law sets penalties both for misuse of address data and for falsely securing an address. The penalties are specified in §49.83 Wis: Stats.
No person may use an address for:
1. A purpose not connected with the legal action or proceeding to which the person requesting the address is a party.
2. Political or commercial use. No person may request an address using a false name.

10.5.8.2 Release Prohibited

Do not provide an address when the person making the request is a defendant in an action begun by the recipient/participant under one of these Wisconsin statutes:
1. 813.12: Domestic restraining orders and injunctions.
2. 813.122: Child abuse restraining orders and injunctions.
3. 813.123: Vulnerable adult restraining orders and injunctions.
4. 813.125: Harassment restraining orders and injunctions.
5. 813.127: Combined actions; domestic abuse, child abuse, and harassment.

10.5.8.3 Record Keeping

The agency is required to keep a record of all requests made, whether allowed or rejected, for GA recipient or W-2 participant addresses.

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10.6 PROHIBITED DISCLOSURE

Examples in which disclosure is prohibited are:

1. Request of an official not connected with the agency for privileged information.
2. Request of private individuals for case information frequently related to business or personal matters, such as the collection of bills from the recipient.
3. Except as necessary to administer W-2, a W-2 agency is not to share any information it receives regarding victims of domestic abuse. Keep all such information confidential.
4. ES and W-2 agencies are not authorized to provide information about the receipt of benefits or the dollar amount of those benefits to the Immigration & Naturalization Service (INS), the U.S. State Department, or immigration judges unless that information will assist Wisconsin in collecting outstanding debts. Even if the request is for documentation of the amount of benefits received, this information is not to be released as the disclosure is not directly connected to the administration of the program about which information is requested.
5. Those listed in 10.5.8 Addresses
6. Addresses (10.5.8.2 Release Prohibited).

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10.7 MAILINGS WITH W-2 PAYMENTS

10.7.1 Introduction
10.7.2 Guidelines For Request Submission
10.7.3 Costs

10.7.1 Introduction

DHS will mail information with monthly W-2 payments at the request of a state agency or local ES or W-2 agency if certain conditions are met. DHS will decide on the approval of requests made by state agencies.

The W-2 agency is responsible for approving the appropriateness of the materials which it is requests or is requested to have included with its payments.

Don't approve or request distribution of materials:

1. For political purposes; or,
2. For commercial purposes; or,
3. About highly controversial social issues.

Material concerning the health and welfare of adults and/or children is acceptable.

Screen all materials for accuracy, readability, and educational value.

The Code of Federal Regulations [42 CFR 205.50 (4)] requires all materials sent or distributed to applicants, recipients, or medical vendors be directly related to the administration of the program and without political implications. This includes material enclosed in envelopes containing W-2 payments.

Specifically excluded from mailing or distribution are materials such as "holiday greetings", general public announcements, voting information, and alien registration notices.

Not prohibited from distribution are materials in the immediate interest of the health and welfare of applicants and recipients. Examples are announcements of free medical examinations, availability of surplus food, and consumer protection information.

Include only the names of persons directly connected with the administration of the program in material distributed to applicants, recipients, and vendors. Identify such persons only by their official capacity with the state or local agency.

10.7.2 Guidelines For Request Submission

Inserts will be mailed to all W-2 participants within the W-2 agency's service n area. Distribution to only a part of the caseload isn't possible.

Submit your requests so they are received in the DCF by the 10th day of the month in which you wish the mailing made.

Final printed copies of the documents to be distributed must be received by DCF no later than the 15th day of the distribution month.

Example 1: If an insert is to go with the June payment (distributed in May), the Output Unit must have the request/approval by the 10th of May and the stuffers by May 15th.

When sending a large volume of stuffers to be distributed, protect them from bending or folding.

The W-2 agency is responsible for approval of any stuffers it requests on its own or another agency's behalf.
The material to be sent must:

1. Include the name and appropriate logo, if used, of the local agency requesting the mailing.
2. Include the date of the mailing as well. This may be only the month and year if you wish.
3. Be printed by the requesting agency on 20 # sulphite bond paper.
4. Have a finished size of 3'A inches by 7 inches.
5. All the inserts must be the same size and trimmed cleanly (no rough edges). -
6. Whenever possible, multiple notices should be printed on the same sheet..
7. Not exceed a total of 5 inserts per payment.
8. Be no more than 2 folds. All folds must be a "Z" fold.
9. Be in sufficient numbers to satisfy the distribution request.

If more than 5 inserts are scheduled, BWI inserts will have priority. Requesting agencies will be notified of unavailability to mail their insert that specific month.

If you have questions or wish consultation about this process, contact Ken Kluever, Supervisor, *CARES* Output Unit, at (608) 266-9545.

Submit your requests to:
DWD/ASD/BITS/Mailroom
Attention: CARES Output Unit PO Box 7935
Madison, WI 53707-7935

10.7.3 Costs

The requesting W-2 agency or the agency on behalf of which the W-2 agency is requesting the distribution is responsible for all printing costs of the stuffer.

The requesting agency will be billed for extra postage expenses if the cost of postage exceeds the normal benefit distribution amount. The weight of the regular payment is approximately 1/4 ounce. An estimate of probable billing cost can be determined by figuring the cost of the weight beyond this regular weight.

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10.8 UI QUERY

10.8.1 Introduction
10.8.2 Use of Data
10.8.3 Query Access
10.8.4 Data Storage
10.8.5 Release of Data

10.8.1 Introduction

CARES Data Exchange subsystem provides a query to the DWD Division of Unemployment Insurance data base (CARES Guide, Chapter X).

The rules of confidentiality apply to all data obtained from the query. In addition, because of the sensitive nature of the data available, *DHS* and DUI have established rules for accessing the data as well as release of data obtained from the query.

10.8.2 Use of Data

Use the data you retrieve by this query only to the extent necessary to administer DHS programs. That is, use it for work-related activities only.

Do not "browse" the wage and benefit records in the query, even if you don't intend sharing the data you find. Your improper use of the query may be subject to provisions of Chapter 108 Wis. Stats. and §49.83, Wis. Stats.

10.8.3 Query Access

Take all precautions necessary to ensure that only authorized agency staff have access to the on-line wage and benefit data in the UI query.

10.8.4 Data Storage

Store all wage and benefit data from a UI query in a place physically secure 1 from access by unauthorized persons.

10.8.5 Release of Data

You may release data gotten from a UI query only to:

1. The person who is the subject of the data.
2. The person's attorney or other duly authorized representative who needs the data in connection with that person's fair hearing.
3. Another county, state, or federal agency administering the FS, W-2, Temporary Assistance to Needy Families (TANF), MA, or Child Support programs. In Wisconsin, TANF-funded programs include W-2, Kinship Care, and the *SSI* Caretaker Supplement.

   States have differing names for their TANF programs. When you receive a query from another state for a program other than FS, MA, or Child Support, ask if that program is that state's TANF program before you release the information.
5. A criminal or civil authority that agrees in writing to protect the confidentiality of the data you provide.

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10.9 CLIENT ACCESS RIGHTS

10.9.1 Introduction

10.9.2 Fair Hearings
10.9.3 Sensitive Medical Information
10.9.4 Access By Representative

10.9.1 Introduction

A client has the right to see his/her entire case record to verify that its content is accurate with respect to his/her statements and that documentation of facts about him/her from other sources is correct.

When a client requests access to the record for reasons not related to preparation for a fair hearing or W-2 fact finding, you don't have to show the client the entire record. Ask the client what part s/he wants to review, and, if practical, show him/her only that portion of the record.

10.9.2 Fair Hearings

Don't withhold any part of the record from the client when, s/he is preparing for a fair hearing or W-2 fact finding.

10.9.3 Sensitive Medical Information

The Confidential Information Release Authorization to Agency form does not promise the medical reporting source that information won't be revealed to the client if s/he requests to see it. In most cases, the client has direct access to the information.

You may determine, in some cases, that the requested medical information is of a "sensitive" nature and that its release directly to the client may not be in his/her best interest. When this occurs, request the client to name, in writing, a representative. This representative may be a physician or other responsible person (e.g., a clergyman or attorney). Release the requested information to the representative with the instruction that s/he review it and inform the client of the content at the representative's discretion.

Retain the client's authorization to release this information to his/her representative in the case record.

10.9.4 Access By Representative

A client may authorize a representative, either an attorney or non-attorney, to act on his/her behalf in gaining access to the client's case record. The right of access by the representative is the same as that of the client's and is unrelated to any pending fair hearing.

When a non-attorney is to act for the client, require a signed authorization from the client.

When the person is an authorized representative who signed the application (I-A), the condition of a written authorization is already met.

An attorney doesn't need the client's written authorization. Where you have reason to doubt a representative's statement that s/he is an attorney, you may request proof of his/her licensure.

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PUBLIC ASSISTANCE FRAUD (11-13)

11 FRAUD PROGRAM OVERVIEW

11.1 PUBLIC ASSISTANCE FRAUD PROGRAM

11.1.1 Introduction
11.1.1.1 Structure
11.1.1.2 Annual Fraud Plan
11.1.1.2.1 Plan Requirements
11.1.1.2.2 Model Program
11.1.1.3 Legal Basis
11.1.1.4 Notifying Client
11.1.1.5 Definitions
11.1.1.6 Public Assistance Fraud Unit/Prevention Contacts
11.1.1.7 Public Assistance Collections Unit (PACU)

11.1.1 Introduction

The Public Assistance *Fraud* Program is based on Chapter 49 of the Wisconsin Statutes. The Chapter 49 Fraud Program has been administered in all geographic areas of the state since January 1, 1998. The program consists of fraud prevention, fraud investigation, and fraud overpayment collection activities.

As part of the responsibilities for ensuring the integrity of the benefit programs they administer, both Wisconsin Works (W-2) and *Income* Maintenance (IM) agencies must operate fraud prevention programs to identify and prevent fraud or error from occurring in their programs. The agency determining eligibility for a particular benefit program is responsible for fraud prevention activities in that program.

Agencies must differentiate between the:

1. Routine verification for eligibility determination conducted on all applications and re-determinations detailed in the Medicaid Eligibility Handbook, FoodShare Handbook, W-2 Manual and the Child Care Manual.
2. The selection of items for referral to fraud prevention activities. (12.1 Prevention) , **and**
3. The selection of cases for referral to fraud investigation. 13.1 Identifying Suspected Fraud

These are three different types of activities. Policies, guidelines and procedures must be established for each activity. See Chapters 12.1 Prevention and 13.1 Identifying Suspected Fraud. Separation of these activities is also necessary for

proper funding. See the 2005 CARS Consolidated/County HS/IM Programs Manual for additional information on proper reporting of these activities.

11.1.1.1 Structure

The W-2, IM, and tribal agencies administering public assistance programs are responsible for operating early fraud detection and prevention programs and for initiating claims and collections of fraudulent overpayments. These agencies are also responsible for determining which cases shall be referred to the agency's fraud investigation unit, the Department of Administration's Division of Hearings and Appeals for administrative disqualification hearings, and the local District Attorney's Office for prosecution.

Note: In Milwaukee County, the administration of W-2 is subdivided into multiple geographic service areas. Also, some multiple counties may be served by a W-2 agency consortium which acts as a single W-2 agency. All investigative service providers must interact with the appropriate W-2 agency and IM agency for a fraud investigation.

11.1.1.2 Fraud Plan

Each agency participating in the Chapter 49 Public Assistance Fraud Program, must complete and submit to the Department of Health Services, (*DHS*) Public Assistance Fraud Unit, a ""fraud plan" based on a model fraud plan issued by DHS. County and tribal IM agencies must submit their fraud plan within 30 days of the effective date of contract award. W-2 agencies must submit their fraud plan to the DWS W-2 Contract Administrator within 30 days from signing their W-2 contract. The DWS W-2 Contract Administrator will promptly forward the plan to the DHS Public Assistance Fraud Unit for review. The fraud plan must include a listing of its administrative responsibilities, program responsibilities, a budget, a description of the fraud program's structure, an organization chart, and position descriptions for the staff positions identified on the organizational chart.

11.1.1.2.1 Plan Requirements

The requirements of the fraud plan are to:

1. Develop written policy and procedures for the operation of fraud prevention and fraud investigation components of the Fraud Program, including the selection process for identifying which cases are eligible for referral for Front End Verification (*FEV*) and fraud investigation.
2. Periodically validate the selection process to ensure that the cases selected are error-prone.
3. Meet the fraud standard target of a 30% success rate for cases referred to FEV and 50% success rate for cases referred for fraud investigations.
4. Ensure that any private individual and/or company that contracts with the agency to provide investigative services meets the Wisconsin Department of Regulation and Licensing requirements for private detectives.

5. Ensure that any service provider acting as the investigative service provider complies with the federal requirement to identify itself as representing the W-2/IM agency.
6. Maintain adequate audit documentation to support administrative cost claims.
7. Comply with all applicable state and federal program standards and fraud related corrective action plans incorporated into the W-2/IM contracts, Income Maintenance Manual (IMM), W-2 Manual, DHS/DWD Operation and Administrator's memos, and supporting program handbooks.
8. Comply with all affirmative action, equal employment opportunity, and civil rights requirements referred to in the W-2/IM contracts. Tribal agencies are exempt from this requirement.

11.1.1.2.2 Model Program

DHS/DWD recommends local agencies use the model fraud plan prepared by DHS as a model for their local fraud prevention programs. (Attachments A,B,C,D of DHS Administrator's Memo 05-04) Local agencies have discretion to design their own prevention programs to meet local circumstances. All fraud prevention programs must meet the fraud plan requirements of 11.1.1.2.1.

11.1.1.3. Legal Basis

State Statute 49.197 (1m) enables the Department of the Health Services to establish a program to investigate suspected fraudulent activity on the part of recipients of Aid to Families with Dependent Children, Medicaid, FoodShare, W-2 and CC programs.

§49.795, §49.141 (W-2), §49.49 and §49.95 provide penalties for willfully making false representations related to acceptance of benefits and other acts interfering with proper program administration.

The fraud provisions in §49.95 apply to any action by a person to help an applicant or recipient obtain public assistance wrongfully. Wisconsin Statute §49.95(6) requires applicants and recipients to report to the applicable IM agency or W-2 agency, within 10 days, any and all changes in their income and/or assets. FoodShare recipients who qualify for reduced reporting requirements are subject to less restrictive reporting criteria for most changes. (FS 5.1.1).

The Food Stamp (FS) Act and the US Department of Agriculture's (USDA) federal regulations provide additional basis for penalties in the FoodShare program.

"The department shall establish a program to investigate suspected fraudulent activity on the part of recipients of Aid to Families with Dependent Children under s.49.19, on the part of participants in the Wisconsin Works Program under ss.

49.141 to 49.161, and, if the Department of Health Services contracts with the department under sub. (5), on the part of recipients of Medicaid under subch. IV and food stamp benefits under the Food Stamp Program under 7 USC 2011 to 2036."

11.1.1.4 Notifying Client

Notify applicants and recipients of the fraud provisions by explaining the purpose and nature of public assistance and the intent and purpose of fraud provisions and penalties. In addition, point out the fraud related sections of:

1. W-2 and CC application (DES- 2471).
2. Medicaid Family and EBD Applications DWSW 2378-1.
3. FoodShare Program Application F-16019A (*EBT* Card and PIN Responsibility Statement).
4. The FoodShare Eligibility and Benefits brochure.
5. The Medicaid Eligibility and Benefits Booklet.

11.1.1.5 Definitions

Benefits-

"Benefits" include AFDC benefits, W-2 payments, FS allotments, MA benefits, CC benefits and other services or assistance provided to a person or group because the person or group was found eligible for the benefit.

Bureau of Eligibility Management

The agency within the Department of Health Services (DHS), Division of Health Care Access and Accountability (DHCAA), which is responsible for administering the statewide FoodShare and Medicaid programs. This agency also is responsible for administering the statewide fraud prevention and fraud investigation program for the FoodShare, Medicaid, W-2 and Child Care programs.

CARES-

CARES : The acronym used to identify the "Client Assistance for Re-employment and Economic Support" system, which is Wisconsin's automated eligibility determination, benefit calculation and management system for the AFDC, W-2, FoodShare, and Medicaid programs.

Chapter 49

That portion of Wisconsin Statutes, which pertains to the public assistance programs.

County Agency:

The county under contract with the DHS to administer IM programs including Medicaid, FoodShare, Caretaker Supplement (CTS).

Coupon:

Any coupon, stamp, access device authorization card, cash or check, including an electronic benefit transfer card or personal identification card or type of certification provided under 7 CFR 271, subchapter C, for the purchase of eligible food.

Department:

For the purposes of this document, the "department" indicates the Department of Health Services (DHS). The Department of Workforce Development (DWD) contracts with DHS for it to administer and supervise fraud program activities for the W-2 and child care programs.

EBT:

The acronym for Electronic Benefit Transfer, which is an electronic system that allows a recipient online access to his/her FoodShare benefits through the use of a POS or point of sale device at an FNS authorized retailer, authorizing the electronic payment of federal funds to the retailer for the approved purchase of eligible food items. (In Wisconsin EBT food stamp benefits are administered through the *QUEST card*.)

Error-Prone Profile:

Characteristics identified by a local agency as common to cases that indicate a need for front end verification (FEV).

Financial and Employment Planner (FEP):

The FEP is a case manager employed by or contracting with a W-2 agency and who provides: (1) W-2 eligibility determinations, job readiness screening, employability planning; (2) financial and employment case management services; and (3) makes referral to other public or private assistance programs or resources.

FoodShare Program

The Wisconsin Food Stamp Program was renamed Wisconsin FoodShare on October 16, 2004.

Fraud:

Making false statements, suppressing facts, or giving information which misrepresents true circumstances in order to become eligible or remain eligible for benefits under Chapter 49, Wis. Stats.

Fraud/FEV Gatekeeper

An employee, supervisor, or contracted person designated by a local W-2 or IM agency to review, track, monitor, and approve all FEV and Fraud referrals for the agency.

Fraud Investigation Tracking Screens (FITS):

The screens in the CARES Benefit Recovery Subsystem on which local agencies are required to enter data on FEV and fraud investigation activities, costs and investigation results (See CARES Guide, Section 1, Chapter 10.7 for screen illustrations and data field descriptions).

CARES screen BVIR must be used to initiate a Front-end verification (FEV referral) or a fraud investigation referral. CARES screen BVIT must be used by local agencies to approve or deny FEV or Fraud investigation rifflers for investigation activities that may be funded by the fraud program. CARES screens BVIR, BVIT and BVPI are the primary FITS screens.

Fraud Investigation Referral:

A formal request issued through fraud referral documents from CARES (screens BVIR and BVIT) with supporting documentation in accordance with DWD and DHS requirements. A fraud referral is issued by a W-2, county, or *tribal agency* or the Department of Health Services to a fraud investigator. A fraud referral directs the fraud investigator to conduct an investigation where there is adequate documented information to suspect a program violation occurred. A clear statement of the possible/potential violation must be included in the request to allow the investigator to conduct a fact finding to verify the allegation or determine willful intent to defraud.

Fraud Period:

The time span during which suspected intentional program violations occurred.

Front-End Verification (FEV):

Front-End Verification (FEV) is a process of intense scrutiny of cases that exhibit characteristics of potential program violation. This process verifies the accuracy of specific information about a client at case application, review or reported change.

Front-end Verification (FEV) Referral:

A formal request issued through an FEV referral document from CARES BVIR and BVIT with supporting documentation in accordance with DWD and DHS requirements. An FEV referral is authorized on CARES BVIT by an agency's Fraud/FEV Gatekeeper for the FEV investigator to conduct an in-depth verification of specific error-prone characteristics related to a case, generally, at application, review or a change report.

Income Maintenance Program:

A term in used in reference to the public assistance programs which include Medicaid, FoodShare, and CTS.

Income Maintenance (IM) Worker

A person employed by a county, or a governing body of a federally recognized American Indian tribe whose duties include determinations or re-determinations of income maintenance program eligibility.

Intentional Program Violation (IPV):

a. *Intentional Program Violation (IPV)*

   An IPV is a finding by Administrative hearing, Court hearing, or signed agreement that a member of a W-2 assistance group intentionally made false or misleading statements, misrepresented, concealed, or withheld facts that resulted in a W-2, Job Access Loan, and/or Child Care benefit overpayment. (Wisconsin Statue 49. Three separate IPV findings results in permanent W-2 program ineligibility.

b. Intentional Program Violation [7 CFR 273.16 (c) FoodShare Program

   (1) Making a false or misleading statement, misrepresenting, concealing or withholding facts, for the purpose of obtaining benefits for which one is not entitled.

   (2) Improper use, presentation, transfer, acquisition, receipt, or possession of FoodShare benefits.

QUEST CARD:

QUEST is Wisconsin's name for its EBT card. (See EBT).

***SSA*:**

Social Security Administration.

***SSI*: Supplemental Security Income**.

This is a needs-tested program administered by SSA providing cash and/or medical benefits to persons who are blind, disabled, or elderly (65 or more years old).

Tribal Agency:

A Tribal Agency is a tribal governing body under contract with DHS to administer the IM programs.

***Trafficking*:**

Buying or selling FoodShare benefits in exchange for items other than eligible food. [7 CFR 271.2]

Wisconsin Works (W-2):

Wisconsin's Temporary Assistance to Needy Families (TANF) block grant program providing assistance to low income families to gain or maintain employment. W-2 is the program replacing Wisconsin's Aid to Families with Dependent Children (AFDC). See §49.141 to §49.161, Wis. Stats.

W-2 Agency:

County agency, tribal governing body, private agency or a public or a private consortium contracted by DWD to administer the Wisconsin Works (W-2) program.

Wisconsin SHARES:

Wisconsin SHARES is Wisconsin's child care subsidy program that provides assistance to low-income families in need of child care services to enable the recipient to work and/or participate in work activities as assigned by the W-2 agency. See **Wisconsin Statutes S.49.155**.

11.1.1.6 Public Assistance Fraud Unit/Prevention Contacts

The Public Assistance Fraud Unit is a part of the Bureau of Eligibility Management/Division of Health Care Financing in the Department of Health Services (DHS).

Contact Public Assistance Fraud Unit Staff at:

1. **Physical Address**
   Room 365
   1 West Wilson,
   Madison, WI

2. **Mail Address**
   Division of Health Care Financing
   Bureau of Eligibility Management
   Public Assistance Fraud Unit
   P.O. Box 309
   Madison, WI 53701- 309

3. **FAX:**
   608-261-6861

For information regarding general fraud program policy and procedures and inquiries about potential fraud issues relating to the FoodShare, Medicaid, W-2 and Child Care programs, contact the following individuals:

Barry Chase
Fraud Program Analyst
Department of Health Services
Phone: 608-266-1849
Email: Barry.Chase@wisconsin.gov

For reporting specific suspected recipient misuse of his/her MA card, send the recipient's name, card number, address, a summary of the information, and any supportive documentation to:

Lockin Program
Bureau of Enrollment Management
Division of Health Care Access and Accountability
PO Box 309
Madison, WI 53701

or

Call the MA Complaint Hot Line: (608) 267-2521

If appropriate, the Division of Health Care Access and Accountability will issue a restricted card.

11.1.1.7 Public Assistance Collections Unit (PACU)

Questions related to the Public Assistance Collections Unit (PACU) should be directed to:

Fay Simonini
Collections Supervisor
Department of Workforce Development
Phone: 608-267-2187

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11.2 CREDIT BUREAU REPORTS

11.2.1 Requests For Data
11.2.2 Release of Data

11.2.1 Requests For Data

Request credit bureau reports only for:

1. Applicants for or current recipients of assistance.
2. Former recipients you are investigating for fraud or intentional program violation.

Do NOT request credit bureau reports for anyone not meeting 1 of these criteria.

The Release of Information contained on the application form is a notice to the applicant/recipient that a credit check may be requested.

11.2.2 Release of Data

Special rules govern the release of credit bureau-provided data.

1. Consider all such data confidential.
2. Do not release the data (even to the applicant, recipient, or former recipient) for any purpose not directly part of an eligibility determination or investigation.

An applicant, recipient or former recipient may obtain data from his/her credit bureau files directly from the credit bureau.

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12 FRAUD PREVENTION/ FRONT END VERIFICATION

12.1 FRAUD PREVENTION

12.1.1 Fraud Prevention Plan
12.1.2 Model Program Fraud Plan
12.1.3 Program Resource

The *fraud* prevention program involves a process of intense scrutiny of specific elements or circumstances of individual cases that exhibit evidence or characteristics of potential program violation. Prevention actions are intended to prevent issuance of incorrect benefits and involves more in-depth verification than the routine verification used for program eligibility determination.

The primary goal of the prevention program activities is to insure accurate benefit issuance, not to accomplish criminal prosecution. The results of the prevention activities are used in determining benefit eligibility and to help in determining the need for further fraud control actions.

12.1.1 Fraud Prevention Plan

The fraud prevention program is a component of the general fraud program operating in every county and tribal geographic area of the state. *DHS* requires each county and tribal IM agency to submit an annual fraud plan that includes their prevention program. DWD W-2 contracts require W-2 agencies to submit a fraud plan within 30 days of the signing of the W-2 contract.

12.1.2 Model Program Fraud Plan

DHS annually provides a model Public Assistance fraud plan to all IM/W-2 agencies. DHS recommends that all local agencies use the model fraud plan as a guide for their local fraud prevention programs. W-2 contracts indicate major components of what W-2 agency fraud prevention plans should address. W-2 contracts refer to DHS IMM fraud materials and requires W-2 agencies to submit their fraud prevention and detection plan to the DWS W-2 Contract Administrator for review within 30 days the signing of the W-2 contract. The DWS W-2 Contract Administrator will promptly forward each plan to the DHS fraud unit.

12.1.3 Program Resource

DHS and DWD support fraud and fraud prevention. Program responsibility for fraud and fraud prevention rests with the Bureau of Eligibility Management/Division of Health Care Access and Accountability in the Department of Health and Family Services. See Section 11.1.1.6 for public assistance fraud contacts.

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12.2 FRONT END VERIFICATION (FEV)

Front end-verification (*FEV*) is one method of preventing *fraud*. FEV is a process of intense scrutiny of cases that exhibit characteristics of potential program violations or errors. When a case is referred by a case worker to a local agency or local agency contracted FEV Specialist or Investigator, s/he performs a more in-depth verification than the routine verification for eligibility determination.

FEV focuses on particular elements or circumstances of a specific case. The FEV Specialist or Investigator confirms or verifies the accuracy of information provided by the client at application, review, or change. S/he provides the results of the FEV to the IM and/or W-2 staff for use in verifying eligibility for program services or for fraud investigation referral when applicable.

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12.3 FEV CASE APPLICATION

12.3.1 FEV Case Application Introduction
12.3.2 Benefit Delay Prohibited

12.3.1 FEV Case Application Introduction

FEV should not be routinely required on all new case applications, reviews, or changes. Cases referred for FEV must exhibit characteristics of a potential program error prone profile (12.4 FEV Error Prone Profile).

Local IM and W-2 agencies must establish an error-prone profile for all intake staff and program eligibility workers to use to determine if a case meets criteria for an FEV referral. Measure all cases against the error-prone profile in a

consistent manner to avoid biased selection for FEV. Intake staff and program eligibility workers should refer a case for FEV when it meets the error-prone profile.

12.3.2 Benefit Delay Prohibited

Do not delay issuance of program benefits if a case is referred for FEV. Program benefit processing deadlines must be observed even if the FEV results have not been received. Benefit recoupment can be completed at a later date, if an overpayment is established.

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12.4 FEV ERROR-PRONE PROFILE

12.4.1 Characteristics for an Error-Prone Profile
12.4.1.1 Residence
12.4.1.2 Household Composition
12.4.1.3 Assets

12.4.1.4 Earned Income
12.4.1.5 Unearned Income
12.4.1.6 General Criteria

An error-prone case profile is a list of characteristics recognized by the local agency as common to error cases. Cases showing these characteristics or meeting the error-prone profile are referred for *FEV*.

Profiles allow a local agency to allocate administrative and investigative resources to those cases according to their potential for error.

The agency's Error Prone Profile characteristics should be evaluated regularly to determine if they are actually identifying errors. The recommended target is that 30% of those cases referred to FEV would result in a referral to the *Fraud* Investigator. If an agency, does not meet the 30% target, the agency should remove characteristics that are not error prone and consider adding other characteristics that the agency believes may be error-prone, as appropriate.

The criteria must accommodate situations applicable to the specific agency. One method of creating the profile is to use QC reports on cases in which either client error or potential fraud was identified by workers. Another would be a review of cases referred for fraud investigation where fraud or error was found by formal investigation. By examining actual fraud cases, it's possible to determine types of situations that resulted in error. It's also possible to discover from these cases a pattern of clues or signs of potential fraud. Second party review findings provide another source of information.

Some simple possible "case flagging" examples,

- Are there questions left blank on the application form?
- Is there unusual movement of people into and out of the household?
- Do household expenses exceed total household *income*?

Because error-prone profile criteria are likely to change over time, review the criteria annually as part of your fraud plan. Economic condition changes in your area may influence the criteria. FEV activities may prove that some characteristics originally thought to show potential errors are irrelevant and not cost effective to pursue.

The following are characteristics that may not be used when developing an error prone profile.

Race, color, national origin, ethnic background, sexual orientation, religion, age, political belief, disability, association with a person with a disability or marital status. Federal regulations specifically prohibit error-prone profiles from targeting migrant farm workers or Native Americans.

12.4.1 Characteristics for an Error-Prone Profile

Following are some examples of ”high risk” or relevant characteristics that may be helpful in developing an error-prone profile. Some items are not applicable for all programs.

12.4.1.1 Residence

Error prone residence indicators include:

1. Conflicting documentation or verification differing from that reported by the applicant or recipient.

2. Recent arrival (within the prior three months) in your county/tribal area. (You must exclude migrant farm workers, the homeless and residents of shelters from those targeted for FEV.)

3. Highly mobile families who rarely stay in one location for more than two or three months. (except for migrant farm workers).

12.4.1.2 Household Composition

Error prone indicators for household composition include:

1. Employable household members listed on the application, and then later reported to have moved.

2. Collateral contact statement is inconsistent with the client’s statement of household size.

3. Landlord's address is same as clients, but landlord is not included as a household member.

4. Landlord is the absent parent, male/female friend, or ex-spouse.

5. An unmarried client gives birth to a baby who is given the same last name as a male friend, but client claims male friend does not live with her.

6. Client reports someone else pays the rent for several months, but that person is not listed in the home.

7. Household reports large increases or decreases in household size or a frequently fluctuating household size.

12.4.1.3 Assets

Error prone indicators for assets include:

1. Client reports no assets or resources on the application, but has no unpaid bills.
2. Client reports no vehicle but has no reasonable explanation of his/her transportation method (if s/he lives remote from public transportation.)
3. Applicant claims no income for an extended period of time but offers no satisfactory explanation of how s/he met needs before applying.
4. Information provided by the client shows a substantial reduction in assets just prior to application for assistance.
5. Reported assets are very near or equal to the asset limits.

12.4.1.4 Earned Income

Error prone indicators for earned income include:

1. Reported income is different than IRS records or state tax forms.
2. Client's expenses are being met, although client's reported income is not enough to satisfy the obligations.
3. Self-employment income reported to have stopped (potential business assets available).
4. Client reports zero income but states someone else paying the bills.
5. Household that has a wage earner who becomes unemployed, and reports no UI, or reports UI has stopped but employment has not resumed.
6. Household that has child(ren) age 16 or over who are not in school or employed.
7. A FoodShare applicant reports zero income, does not request further assistance such as W-2, and is unable to clarify how needs are being met (possible unreported source of income).

12.4.1.5 Unearned Income

Error prone indicators for unearned income include:

1. Household with all members 65 or older that does not report *SSA*, *SSI*, VA, or other pensions may have income-producing assets.

2. Household member claims disability but does not report SSI, SSA, or worker's compensation.

12.4.1.6 General Criteria

General error-prone criteria include:

1. The client has provided contradictory information or made statements inconsistent with information provided by her/him during a previous contact, in the application form, or in a recent Six Month Review Form

(SMRF) or review.

2. Case was previously closed for loss of contact or failure to provide essential information.

3. Case in which fraud was previously alleged or committed.

4. Case in which information provided by applicant is incomplete or not clear.

5. The case previously was referred for FEV which resulted in either denial or reduction of benefits.

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12.5 FEV REFERRAL STEPS

IM and/or W-2 staff must initiate the *FEV* referral in *CARES* on the BVIR screen. Specific information about the referral should be documented on the BVCC comment screen after the BVIR referral screen is processed.

The steps IM or W-2 agency staff must take to initiate and process an FEV referral are as follows:

1. Conduct the interview and compare the case characteristics to the error-prone profile.
2. Specify the error-prone reason(s) of concern and refer the case using the BVIR investigation referral screen in CARES, to the agency's *fraud* or FEV gatekeeper, who may be an ES Supervisor or a designated FEV/fraud program specialist**.**
3. Provide specific information regarding the referral on screen BVCC.
4. Approve or deny the case after receiving the results of FEV prior to the final eligibility determination, the applicant will be contacted and given an

opportunity to resolve discrepancies between the information s/he provided and the information obtained through FEV.

5. Determine and coordinate any benefit savings resulting from FEV and provide them to the person responsible for reporting on the BVIT and BVPI screens on CARES.

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12.6 FEV SPECIALIST FUNCTIONS

12.6.1 Confidentiality
12.6.1.1 Personal Rights
12.6.2 Sources for FEV
12.6.2.1 Residence and Household Composition Information by Field Verification
12.6.2.2 Information by Collateral Contacts
12.6.2.3 Information by Surveillance
12.6.2.4 Vehicles & Assets Information
12.6.2.5 Income Information

FEV specialist functions can be performed by a part-time or full time agency employee or a contracted service provider. An agency should have a single FEV specialist and a back up, unless the workload warrants more than one position performing this function. The FEV specialist does not approve or deny a group's eligibility or issue benefits.

The FEV specialist typically will:

1. Verify that a case meets the criteria for FEV referral. If the referral does not appear to meet the agency's error-prone profile criteria, the FEV specialist should discuss the reason for the referral with the agency's Gatekeeper before proceeding
2. Determine which FEV activities are appropriate for the referred case.
3. Estimate the approximate time needed to perform FEV activities. When possible, complete FEV activities prior to issuance of benefits. (See Note below with processing timelines.)
4. Perform activities to verify the information that prompted the referral.
5. Report (in writing) the results of the FEV to the agency Gatekeeper, who will approve the report and forward its findings to the eligibility worker and/or the W-2 agency supervisor who performs the case management functions.

6. If the FEV results show a possible prior fraudulent overpayment, include that information in the written report. The Gatekeeper should record that information on the BVCC screen linked to the BVIR, BVIT and BVPI screens.

NOTE: Case workers are required to follow processing requirements for cases that have been referred to FEV including:

- Expedited FS criteria and
- 30-day limit for processing applications

CARES allows 30 calendar days for a timely completion date to be recorded on the BVIT screen for an FEV investigation. If an FEV investigation is expected to exceed 30 days, the agency's Gatekeeper should record an Extension Due Date on the BVIT screen and provide an explanation on the BVCC screen.

12.6.1 Confidentiality

Do not divulge information about the client or investigations for any purpose not connected with the **direct administration** of the benefit programs. Penalties for unauthorized release of an applicant or recipient's information may include a fine of $25 to $500 or imprisonment of 10 days to more than one year or both. (§49.83, Wis. Stats)

12.6.1.1 Personal Rights

As detailed in Wis. Stat. §49.81, *DHS*, DWD and all public assistance and relief granting agencies are required to respect the following rights of recipients of public assistance.

1. The right to be treated with respect.
2. The right to confidentiality of agency records and files.

NOTE: Federal law allows for the use of records:

a. To locate a person, or the assets of a person:

- who failed to file tax returns, or
- who underreported taxable *income* or
- who is a delinquent taxpayer,

b. For identifying fraudulent tax returns or

c. Providing information for tax-related prosecutions, or

d. Auditing or accounting purposes to the extent permitted under federal law.

3. The right to access to agency records and files relating to the applicant/recipient's case, except that the agency may withhold information obtained under a promise of confidentiality made to the provider of the information.

4. The right to a speedy determination of eligibility for public assistance, to notice of any proposed change in such eligibility, and, in the case of assistance, to a speedy appeal.

The method used to verify information when determining eligibility must not violate the client's rights, privacy or personnel dignity. (Grandberry v. Schmidt).

12.6.2 Sources for FEV

Following are some suggested resources which should provide FEV related information. Agencies are not limited to using only these sources. Select the most appropriate resources and procedures.

12.6.2.1 Residence and Household Composition Information by Field Verification

Field verification is a visit to an assistance group's residence to verify factors affecting eligibility for program benefits. Field verification should only be attempted when other attempts at verification have failed and the assistance group has been provided advance notice of visit.

When documentary evidence is insufficient to determine eligibility or a case fits the error prone profile a visit to the assistance group’s residence may be appropriate.

Generally, field verification involves residency or household composition. Field Verification can only be conducted when:

1. Clients are given advance notice of the date of the visit; and,

2. Documentary evidence cannot be obtained or is insufficient to make a final determination of eligibility or benefit level.

If field verification must be conducted and the advance notice of the date is given, inform the client of the information in question. Document issuance of the notice in the IM and/or W-2 record or BVCC screen for the referral, or both.

Do not conduct field verifications earlier than 8 a.m. or later than 8 p.m. DHS and DWD recommend field verification visits take place during normal business hours unless there are special circumstances. Document any special circumstances in the FEV Specialist's or Investigator's report. Examples of special circumstances are:

1. It is necessary to accommodate the client's work schedule.

2. The FEV Specialist/Investigator has made 2 unsuccessful attempts to contact the client at their residence between the hours of 8 am to 8 pm.

Conducting the Field Verification

1. At the residence, identify yourself to the client and explain the reason for your visit.
2. Request identification (Social Security card, driver's license, state ID, etc.) from the client.
3. Treat the client(s) and all other persons in the household with respect. Do not coerce them.
4. Ask permission to enter the residence. Do not attempt to enter if the client refuses to give consent. You may inform the client that refusal may delay issuance of benefits but you may not tell the client that there will be automatic denial of the case.
5. Inform the person who gave consent for you to enter the residence that s/he may withdraw that consent at any time. Anything in plain view that is pertinent to determining proper benefits may be included in the written FEV report.
6. You may ask to see areas of the residence. Do not demand access, or inspect closets, cabinets, attics, basements, garages, etc. without the resident's consent.

12.6.2.2 Information by Collateral Contacts

A collateral contact is an oral or written confirmation of a household's circumstances by a person outside the household.

A collateral contact is an oral confirmation of a household's circumstances by a person outside the household.

Do NOT contact individuals not designated as collateral contacts by the household unless:

a. The household fails to designate a collateral contact or designates one which is unacceptable to the agency; and,

b. Documentary evidence cannot be obtained or is insufficient to make a firm determination of eligibility or benefit level.

Examples of acceptable collateral contacts may include employers, landlords, social service agencies, migrant service agencies, and neighbors of the household who can be expected to provide accurate third-party verification.

12.6.2.3 Information by Surveillance

You may use legal surveillance in completing an FEV investigation of residence or household composition.

12.6.2.4 Vehicles & Assets Information

Examples of sources to verify vehicles and assets include:

1. Department of Transportation.
2. Register of Deeds for mortgage or debt information.
3. Credit bureaus.
4. Banking and other financial institutions.
5. Auto appraisers for collector vehicles.

12.6.2.5 Income Information

Examples of sources to verify income include:

1. State wage matches.
2. Contact with employer.
3. State and federal tax information.
4. Child support records.
5. Social Security Administration.
6. Financial institutions.

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13 FRAUD AND INTENTIONAL PROGRAM VIOLATION

13.1 IDENTIFYING SUSPECTED FRAUD/INTENTIONAL PROGRAM VIOLATION (IPV)

13.1.1 Elements of Fraud or Intentional Program Violation
13.1.2 Personal Rights
13.1.3 Recipient Fraud
13.1.4 Provider/Vendor
13.1.5 Identifying Potential Fraud
13.1.6 Reporting Potential Recipient FoodShare Trafficking

This section provides information on identifying potential *fraud*/IPV elements and defines different types of fraudulent activity.

13.1.1 Elements of Fraud or Intentional Program Violation (IPV)

The intent and mental competence of the client are important elements in identifying suspected fraud. For example, misrepresentation with intent to defraud is probably present when a client reports being unemployed during a given period when in fact s/he received earnings from employment in the period identified. A misstatement due to the client's misunderstanding of what constitutes *income* may not be fraud.

Examples of critical indicators of fraud/IPV are:

1. Reluctance or refusal to provide needed information about income, resources, or relevant eligibility factors.
2. Failure to report a change in circumstances that would affect eligibility.
3. Committing any act in violation of a benefit program, State statute or program regulation.

13.1.2 Personal Rights

When investigating potential fraudulent activities adhere to the Public Assistance Recipients' Bill of Rights detailed in 12.6.1

13.1.3 Recipient Fraud

Examples of recipient fraud include:

1. Collusion with a provider of benefit services to receive undue benefits/ payments (for example, childcare, subsidized jobs, health care).

2. Concealing income or assets by failure to report ownership or acquisition such as:

    a. Unreported income from jobs or from Unemployment Compensation, Social Security Benefits, Workers Compensation.

    b. Unreported assets or resources such as vehicles, savings accounts, etc.

c. Disposing of substantial assets without informing the agency.

d. Concealing circumstances or a change in circumstances which, if made known to the IM or W-2 agency, would have resulted in a decrease or discontinuance of the payment or other benefits.

For example, failure to report a change in family composition, such as the return of the absent parent to the home or the departure of an eligible member from the home.

5. Misrepresenting the number and relationship of members of the family unit.

6. Misuse of the lost, stolen or destroyed benefits process.

7. *Trafficking* or fraudulent use of FoodShare benefits.

8. Misrepresenting identity or residence for the purposes of receiving FS or W-2 benefits from one or more agencies simultaneously. See W-2 Manual 11.4.1 and FSHB Appendix 6.1.3 for a detailed description of the violation.

13.1.4 Provider/Vendor

Provider and vendor fraud can occur in collusion with a participant or independently. Agency staff should be familiar with program regulations and be alert to actions that could be an indication of possible provider fraud. When appropriate, refer these allegations for investigation per guidelines found in (See 13.4 Conducting Vendor/Provider Fraud Investigations).

Examples of provider fraud include but are not limited to:

1. Claiming compensation for program services that were not provided. (Child Care, Health Care, trial jobs, training etc.)

2. Receiving kickbacks, bribes or rebates.

   Examples of kickbacks, rebates or bribes include but are not limited to:

   a. A child care provider paying a client a portion of the child care fees as an inducement to the client to place his/her children in the provider's care.

   b. A child care provider returning a portion of his/her fees to a W-2 worker for referring clients to the provider.

   c. A child care provider paying a portion of chid care fees claimed to a W-2 caseworker as a reward the worker for overlooking excessive hours claimed or unreported absences of children.

   d. A W-2 worker receiving a fee from a client to approve false job activities reports.

   e. A W-2 worker receiving payment from an employer for directing clients to the employer or for approving excessive hourly wage reports.

   f. A transportation provider paying a W-2 worker a portion of transportation expense payments to approve excessive transportation expense claims.

3. Assisting applicants to make false claims to obtain benefits for themselves.

13.1.5 Identifying Potential Fraud

Potential fraud may be identified by many sources, including:

1. *Financial and Employment Planner (FEP)*, IM staff, and other agency personnel.
2. Complaints from general public.
3. Periodic audits of suspected providers.
4. Use of computer databases.

a. *CARES*

b. DWD files, including wage and employer information for anyone with an employer in the state (e.g. New Hire).

c. Federal agencies.

- Social Security benefits.
- Wage information.
- IRS interest income from savings.
- Unemployment benefits from other states.
- Interstate Data Exchanges.
- Interstate Matches.

d. *EBT* transaction data

5. USDA Food & Nutrition Services (FNS) personnel.

13.1.6 Reporting Potential Recipient FoodShare Trafficking

When a local agency has information that a FoodShare program client is engaged in trafficking or fraudulent use of FoodShare benefits, the local agency should forward this information in writing to *DHS*. DHS will coordinate with FNS to ensure that no further action will take place that will jeopardize an investigation that might be in progress by FNS.

1. If no contact with a client by the local agency has yet occurred regarding the alleged fraudulent activity, no contact will be initiated.

2. If contact has occurred by the local agency regarding the alleged fraudulent activity, further activity will cease until authorization from FNS is received.

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13.2 REFERRALS FOR FRAUD INVESTIGATION

13.2.1 Selection Criteria for Fraud Investigation
13.2.2 Timely Fraud Referral and CARES Entry
13.2.2.1 Worker-Initiated
13.2.2.2 Gatekeeper Review
13.2.3 Referral Documentation for a Fraud Investigation
13.2.4 CARES Fraud Screen Required Tracking
13.2.5 Agency Disposition of Fraud Investigation

Agency staff must differentiate between the selection of cases and activities used for referral to *fraud* investigation (13.1 Identifying Suspected Fraud), and the selection of cases and activities used in the fraud prevention/*FEV* program (12.1 Prevention). A clear separation of these activities is necessary for establishing effective procedures for selecting cases for referral.

13.2.1 Selection Criteria for Fraud Investigation

The primary purpose of a fraud investigation is to determine the correctness of an allegation that a recipient of a public assistance benefit **intended** to misrepresent his or her eligibility criteria or committed any act that constitutes an intentional program violation (IPV). A careful examination of a case record by the agency administrating the program is essential in determining whether it should be referred to the fraud investigation unit.

A fraud investigation referral should not be used in every case with questionable circumstances that pertain to an eligibility determination or verification. Early detection and/or fraud prevention activities are the responsibility of the local agency administering the program.

In most suspected fraud cases referred to an investigator by an IM or W-2 agency:

1. A benefit overpayment is suspected and the agency has reason to believe the overpayment is the result of misrepresentation of program eligibility requirements. The misrepresentation of program eligibility or fraudulent activity may be the result of:

    a. False or misleading statements of circumstances.

b. Failure to report a change in circumstances.
c. Concealed or withheld facts.
d. Violation of a program regulation or State statute relating to program benefits.

2. The benefit(s) would not have been provided but for the false representation.
3. The conduct of the benefit recipient indicates the misrepresentation or fraudulent use of the benefit was done with knowledge and intent.

13.2.2 Timely Fraud Referral and *CARES* Entry

Agencies are responsible for timely referral of participants receiving payment or services for investigation when fraud is suspected.

Agencies are responsible for properly reporting all investigation referrals in a timely manner on the *Fraud* Investigation Tracking Screens (FITS) on CARES. The initial referral must be entered on the BVIR screen on CARES.

13.2.2.1 Worker-Initiated

A case worker initiates a fraud referral on CARES screen BVIR. The agency's Gatekeeper approves or denies the investigation referral on CARES screen BVIT.

13.2.2.2 Gatekeeper Review

1. The gatekeeper makes an assessment as to whether the case meets the agency's fraud program referral criteria. A general guideline would be to not refer cases where the overpayment amount is expected to be less than the cost of investigation. Aggravating circumstances, such as multiple violations or multiple violators, are acceptable exceptions.

2. The fraud Gatekeeper approves or denies the investigation referral on the BVIT screen in CARES.

13.2.3 Referral Documentation for a Fraud Investigation

The fraud referral should contain all relevant data the agency has on the case to help the fraud investigator.

Including but not limited to:

1. A statement of the fraud allegation.

2. The original application for assistance of the suspect including:

    a. The source and amount of any income .

b. An evaluation of the recipient's resources or assets.

3. Any Notice of Responsibility or program violation warnings given to and/or signed by the recipient at any time prior to or during the fraud period.

4. Identification of all related public benefit programs the recipient is receiving.

5. All eligibility review information within the fraud period.

6. A statement of the estimated overpayment amount and suspected fraud period.

7. CARES-generated information identifying the recipient and benefit issuance history paid to the recipient during the alleged fraud period.

8. A list of all workers involved with the recipient in the case.

9. A statement from the referring agency indicating the case file has been reviewed by the agency and reveals the recipient had failed to report required changes.

13.2.4 CARES Fraud Screen Required Tracking

All fraud investigation cases are tracked on the CARES Benefit Recovery subsystem on screens BVIR, BVIT, and BVPI. Specific information documenting circumstances surrounding the referral should be entered on the BVCC screens that attach to BVIR, BVIT and BVPI screens. These screens are collectively called the Fraud Investigation Tracking Screens (FITS): (See CARES Guide, Section 1, Chapter 10.7)

All investigation information is entered into CARES by the referral agency including; (information generated on screens BVIR and BVIT)

1. Name of primary person.
2. SSN of Primary Person.
3. Benefit programs involved and period of overpayment.
4. Identity of referring agency, worker, and investigation agency.
5. Investigation decision date.
6. Investigation completion date.

When the fraud investigation report is returned to the referral agency, the local agency is responsible for accepting the investigation report and closing the investigation referral.

The agency fraud Gatekeeper or other designated worker must enter the investigation costs and investigation completion date on the BVIT screen.

The investigation referral continues to be tracked in the FITS/BVPI screens until final case disposition is determined by the Gatekeeper or other designated staff. The referral agency Gatekeeper or designated staff should document the investigation disposition for each program in the BVPI screen for the respective programs. Explanatory information should be recorded on the BVCC screens.

13.2.5 Agency Disposition of Fraud Investigation

Based on the fraud investigation findings, the referral agency is responsible for initiating the processes for prosecution of fraud cases and calculating and collecting fraudulent overpayments verified by the investigation.

When the investigation finds that a person committed an alleged intentional program violation (IPV), the agency must decide whether to refer the case to:

1. District Attorney (DA) for prosecution (13.5 Referral For Prosecution);
   or
2. Administrative Disqualification Hearing (ADH) (13.10 Administrative Penalties),
   or
3. Make no referral for IPV/fraud determination.

The reason for not referring the case for IPV determination must be recorded on CARES screen BVPI with an appropriate code such as "insufficient overpayment", "can not find individual", etc.

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13.3 CONDUCTING RECIPIENT FRAUD INVESTIGATION

13.3.1 Confidentiality
13.3.2 Basic Fraud Investigative Plan
13.3.3 Investigator's Report Case Documentation
13.3.4 Timeliness of Investigator's Report
13.3.5 Satisfactory Completed Investigation
13.3.6 Corrective Action Plan for Investigation Deficiencies

Each agency should request the local DA establish specific criteria for referring public assistance cases for prosecution. The fraud investigator should then develop a work plan for case investigations to produce documentation according to those guidelines.

13.3.1 Confidentiality

Respect client's rights as detailed in 12.6 FEV Specialist

13.3.2 Basic Fraud Investigative Plan

Using a checklist format, the fraud investigator must document the alleged facts from the complaint to be investigated.

1. Review the allegations contained in the complaint/investigation referral.
2. Formulate the plan objective. (Investigate to find evidence to substantiate the allegations of intentional program violation. Is there a provable violation of Chapter 49 of Wis. Statutes?).
3. Review the recipient's case record and supporting referral documentation as provided. Determine what was the original basis of eligibility and if the record contains any notice to the program agency that the original circumstances changed.
4. Conduct case driven resource search. (Depending on the program and eligibility requirements, information resources can vary. For example,

check with the school for a child living in a household, or check with an employer for unreported work income , or check service provider records for appropriate payment documentation).

5. Conduct a personal search for witnesses such as neighbors or others and conduct interviews to obtain relevant information.
6. Review the results of the investigation and confirm or redetermine the tentative fraud period specified on the BVIR referral screen.
7. Interview the recipient's caseworker(s) assigned during the fraud period. Determine if the recipient told them of a change in eligibility circumstances or what routine procedures would have been followed by the worker including documents generated for the case record. Establish if the worker(s) can identify the recipient.
8. Attempt to interview the suspect/recipient regarding the allegations of complaint. Inform the suspect/recipients of their rights to say nothing and to refuse contact with the investigator. However, the agency must give the individual opportunity to respond to the fraud allegation. Ask the current caseworker to be present.
9. If complaint is substantiated, obtain certified/ notarized copies of appropriate documents to be used as evidence.
10. Return the satisfactory completed investigation report to the referring agency.

13.3.3 Investigator's Report Case Documentation

The investigator must give the referral agency a written investigation report for each completed investigation. The report must document information in a logical sequence that incorporates who, what, when, where, why, and how in the body and substance of the investigative findings; it must address the specific allegation findings requested in the referral from the requesting agency.

The investigation report must contain the:

1. Identification of the client/contact person and verification of identity provided (for example, photo ID, driver's license).
2. Relationship of the contact person to the client.
3. Written interview(s) with the contact person documenting all relevant information.
4. Summary of the Investigator's findings.

Completed investigations must contain a summary conclusion with a recommendation to the referral agency to do one of the following:

1. Proceed with a case for administrative disposition.
2. Proceed with a case that meets the criteria for prosecution established by the local District Attorney's office and recommend adjudication of the

case. Apart from the adjudication process, note that the case may be subject to administrative sanction, recoupment and/or repayment.
3. Take no action to establish an IPV because the fraud allegation was not substantiated.

The referring agency should require the investigation report to address the minimum criteria specified by the District Attorney's guidelines for prosecution of public assistance fraud, if the DA has provided such guidelines.

13.3.4 Timeliness of Investigator's Report

The fraud investigator's final report should be delivered to the referral agency within 90 days of the fraud referral date listed on the BVIT screen.

Investigations that exceed this 90-calendar day time frame will be out of compliance unless additional time is requested and approved. For such cases the investigator should request in writing an extension from the referral agency. The extension request should state the reason for the delay. The extension request must be reviewed and returned to the investigating service provider indicating approval or denial. Requests must be submitted in writing for approval by the 80th calendar day following the date of the investigation referral by the referring agency. The referral agency must enter the end date for the extension period in the appropriate field on the BVIT screen on *CARES*.

13.3.5 Satisfactory Completed Investigation

A satisfactorily completed investigation is determined by, but not limited to, these factors:

1. Investigation report and findings address all issues of the fraud referral allegations.
2. Documentation of all essential investigation elements is adequate.
3. Factual and accurately reported data is provided.
4. Timeliness criteria are met (completion in 90 calendar days or within the agreed extended time frame).

If the referral agency determines that any of these factors are lacking, the report may be found unsatisfactory and referred back to the investigation service provider for corrective action.

The investigation service provider may exercise the option to bring any unresolved matter concerning reports or any issue related to performance to the attention of the *DHS* for resolution.

13.3.6 Corrective Action Plan for Investigation Deficiencies

When the referring agency or DHS notifies the investigation service provider in writing that its investigation report failed to meet requirements detailed in (13.3.2, 13.3.3, 13.3.4, 13.3.5), the investigation service provider must present the referring agency or DHS with a corrective action plan within 5 business days that will include:

1. Specific description and identification of the deficiency.

2. For each deficiency:

a. An outline of corrective actions to be taken.
b. Description of expected outcomes of each action.
c. A target date for implementing the action plan.
d. A date by which deficiency will be corrected.

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13.4 VENDOR / PROVIDER FRAUD INVESTIGATIONS

13.4.1 W-2 Provider/Vendor Fraud
13.4.1.1 W-2 Vendor/Provider Fraud Investigation Procedures
13.4.2 MA Provider Fraud
13.4.2.1 MA Provider Fraud Reporting
13.4.3 FoodShare Retailer Fraud/Trafficking
13.4.4 State Law Enforcement Board Investigations

Possible provider/vendor *fraud* may be identified by many sources, including:

1. *Financial and Employment Planner (FEP)*, IM staff, and other agency personnel.
2. Complaints from general public.
3. Periodic audits of suspected providers.
4. Use of computer databases.

a. *CARES*

b. DWD files, including wage and employer information for anyone with an employer in the state.

c. Federal agencies.

- Social Security benefits.
- Wage information.
- IRS interest *income* from savings.
- Unemployment benefits from other states.
- Interstate Data Exchanges.
- Match Wisconsin benefit recipients caseload against other states.

d. *EBT* transaction data

Documents are the essential source of evidence in vendor/provider fraud cases. Audits of the vendor/provider records, as provided by state statute and contract, are a common basis of a fraud investigation referral. However, vendor/provider fraud can also be reported as noted below.

13.4.1 W-2 Provider-Vendor Fraud

The W-2 agency and the State have the ability to pursue a civil or criminal action against any entity that receives funds to which it was not entitled. The W-2 agency contracts are specific regarding the responsibility of each W-2 agency to monitor its subcontractors and recover any overpaid amounts that resulted for any reason.

The following conduct by vendors/providers of the W-2 program are prohibited/fraudulent (§49.141, Wis. Stats.)

1. Knowingly and willfully making or causing to be made any false statement or representation of a material fact in any application for any benefit or payment.

2. Having knowledge of the occurrence of any event affecting the initial or continued eligibility for a benefit or payment under the W-2 program and concealing or failing to disclose that event with fraudulent intent to secure a benefit or payment under Wisconsin Works either in a greater amount or

quantity than is due or when no such benefit or payment is authorized.

3. Soliciting or receiving kickbacks, cash or other forms of compensation, for referring an individual or individuals arranging or furnishing an item or service for which payment is received under the W-2 program

This provision does not include an amount paid by an employer to an employee who has a bona fide employment relationship with the employer for employment in the provision of covered items or services.

4. W-2 providers/vendors may not knowingly charge a W-2 recipient for services provided under W-2 nor can they charge a W-2 recipient for non-W-2 services without first notifying the recipient of potential charges.

13.4.1.1 W-2 Vendor/Provider Fraud Investigation Reporting

Report W-2 program vendor/provider fraud to the W-2 program contacts noted in 11.1 Public Assistance Fraud and/or to the local W-2 agency management, if appropriate.

13.4.2 MA Provider Fraud

The following activities conducted by providers or vendors of the Medicaid program are considered fraudulent per Wis. Stat. §49.49(1) (a):

1. Intentionally making or causing to be made a false statement or representation of fact in an application for a benefit or payment.

2. Intentionally making or causing 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. Soliciting or receiving kickbacks, cash or other forms of compensation, for referring an individual or individuals or arranging or furnishing an item or service for which payment is received under the MA program.

5. MA providers/vendors may not knowingly impose upon a recipient charges in addition to payments received for services under Medicaid or knowingly impose direct charges upon a recipient in lieu of obtaining payment under Medicaid unless benefits or services are not provided under W2 and the recipient is advised of this fact prior to receiving the service.

13.4.2.1 MA Provider Fraud Reporting

If circumstances reveal a potentially fraudulent MA case involving a recipient and/or provider, compile the necessary data about MA claims paid to the recipient and provider and refer the case to the Department of Health and Family Services (*DHS*) at:

Division of Health Care Financing
Bureau of Health Care Program Integrity (BHCPI)
PO Box 309
Madison, WI 53701
Telephone: (608) 266-5540
Fax: (608) 266-1096

The Wisconsin Department of Justice prosecutes vendor/provider criminal violations of MA laws (State Stat. §49.495). The designated unit within the Department of Justice is:

Medicaid *Fraud* Control
Wisconsin Department of Justice
P.O. Box 7857
Madison, WI 53707-7857

Phone # (608) 266-1221

13.4.3 FoodShare Retailer Fraud/Trafficking and Reporting

A FoodShare retailer is a store authorized by FNS to sell food products in exchange for FoodShare benefits using the Wisconsin *Quest Card*.

Examples of FoodShare retailer fraud include but are not limited to:

1. Redeeming more FoodShare benefits than the value of food sales.
2. Selling ineligible items;
3. Accepting FoodShare benefits in payment for food sold to a FoodShare household on credit;
4. Buying or selling FoodShare benefits,

Use the toll-free hotline [(800) 424-9121] to report fraud, waste, or abuse committed by a FoodShare retailer to receive and redeem FoodShare benefits.

13.4.4 State Law Enforcement Bureau Program

When there is an identified problem of FoodShare *trafficking*, the State Law Enforcement Bureau (SLEB) program provides funding for 50% of administrative costs, as well as QUEST CARDS to local law enforcement agencies to conduct FoodShare trafficking investigations. Contact the State SLEB Manager [(608)

266-9246] to determine if there is a SLEB investigation agency in your county or for information concerning the SLEB program.

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13.5 REFERRAL TO PROSECUTION

13.5.1 Referral Criteria
- 13.5.1.1 Local Agreements
- 13.5.1.2 Referral Content Recommendations for Agencies Without Local Agreements

13.5.2 Referral Letter to DA
13.5.3 Prosecution Timeliness
13.5.4 Pre-Charge Diversion
13.5.5 Pre-Trial Agreement
13.5.6 Deferred Prosecution Agreement
13.5.7 Disqualification Consent Agreement
13.5.8 Court Decision/ Court Order
13.5.9 Court Order Disqualification/IPV Reporting in CARES

When the agency director (or designee) decides the case meets the criteria for prosecution, refer the case to the District Attorney.

13.5.1 Referral Criteria

The referral agency is responsible for initiating the process for prosecution of *fraud* and the collection of fraudulent overpayments. The agency will determine if a case should be referred for prosecution based on whether or not the:

1. Completed investigation report supports the allegation of fraud.
2. Investigation was completed in a timely manner.
3. Case meets the local agency's policy and cost effective criteria.
4. Case meets the local DA's prosecution criteria.
5. Investigation Service Provider recommends prosecution or not.

The agency administrating the benefit is responsible for addressing the guidelines specified by the District Attorney.

Additional investigation documentation may be necessary for the final case disposition depending on the disposition type (trial vs. pre-trial diversion) and special case circumstances.

13.5.1.1 Local Agreements

Agencies responsible for administering public assistance programs are strongly encouraged to develop memoranda of understanding (MOU) or other written agreements with their local District Attorney's Office to establish the conditions under which a referral for prosecution will be made.

The MOU or other written agreement with the District Attorney's Office should contain selection criteria including documentation and any other requirements (e.g. the format) for making a satisfactory referral to prosecution.

13.5.1.2 Referral Content Recommendations for Agencies Without Local Agreements

The following materials are recommended by the Wisconsin District Attorney's Association, et. al, for making a satisfactory referral to prosecution.

1. Documentation that the recipient signed the application/review form.
2. Documentation of sources and amounts of income and assets.
3. Documentation of relevant changes in the case circumstances.
4. Documentation that the recipient received more program benefits than s/he was entitled to.
5. Calculation of the amount of all overpayments subject to prosecution.
6. A written summary of an interview or an attempted interview with the recipient or the recipient's signed statement regarding the allegations.
7. The IM/W-2 agency's recommendation regarding restitution, including possible repayment by recoupment from on-going financial assistance benefits in accordance with IM/W-2 policy.
8. A copy of the investigation report with a prosecution recommendation from the investigative service.

13.5.2 Referral Letter to DA

After the agency director (or designee) reviews the investigation report and determines the case qualifies for prosecution, refer the case with a letter of referral to the District Attorney. (File an agency copy in the case record.) Include in your letter to the DA:

1. A synopsis of the fraudulent activity.
2. The investigation's summary supporting the allegation.
3. A list of supporting documentation.
4. All information obtained in the investigation.
5. Full overpayment amount and appropriate program penalties.

Note: If the fraudulent activity involved the FoodShare program, include with your referral to the DA a request that the DA's office recommend to the court that a disqualification penalty, as provided in §49.795 (8)(d), (e), (f), Wis. Stats., be imposed in addition to any other civil or criminal fraud penalties.

13.5.3 Prosecution Timeliness

Time limitations on initial determinations by the DA's Office are desired to ensure that referrals are dealt with timely and appropriately by the criminal justice system and/or the program administrative process. It is recommended that memoranda of understanding include prosecution time lines. Here is an example suggested for the MOU:

1. Within 60 days after a fraud referral by the IM/W-2 agency or its designee is sent or made to the District Attorney's Office for prosecution the DA's Office shall review the referral and do one of the following:

    a. Determine that the referral meets the criteria for prosecution, established by the DA's Office and initiate the process established by that office.

-or-

    b. Notify the W-2 agency that insufficient information is provided for the DA's Office to determine whether its criteria for prosecution are met and request the specific information needed to make that determination.

-or-

    c. Return the referral to the W-2 agency for administrative disposition with the determination that it does not meet the criteria established by the DA's Office for pursuing criminal prosecution.

-or-

    d. Return the referral to the IM/W-2 agency with notation of the DA Office's discretionary decision not to pursue prosecution and why.

2. The District Attorney's Office will send a written disposition of each prosecution referral to the IM/W-2 agency within 10 working days after completion of the case. The written disposition will include the following information:

    a. The conviction and sentence ordered or approved by the court.
    b. The disqualification action ordered by the court.
    c. The amount of overpayment charged by the District Attorney .
    d. The amount of overpayment read into the court decision, in addition to the amount charged.

13.5.4 Pre-Charge Diversion Agreement

The Pre-Charge diversion agreement is an alternative for anyone referred to the DA for an alleged IPV. It permits recovery of over issued benefits from the group member without the stigma of actual court prosecution. The referral agency should have an agreement with its local DA that provides for at least a 10 day advance written notification to the individual of the consequences of signing the consent agreement.

The pre-charge diversion agreement can be used at the point in the legal process prior to the DA filing criminal charges with the court of jurisdiction. The Pre-Charge Diversion Agreement is a contract between the person who admits to committing an IPV and the DA. The Agreement includes:

1. A statement by the person that s/he did commit an IPV,
   An agreement that s/he will make full restitution of all benefit over issuance resulting from the IPV,
2. An agreement to waive his/her right to an administrative disqualification hearing and agree to the appropriate program disqualification penalties, **and**
3. An optional agreement that s/he will pay associated costs, assessed costs and any additional penalties.

The offender makes restitution payments directly the IM/W-2 agency, unless other arrangements are incorporated into the Agreement.

13.5.5 Pre-trial Agreement

The Pre-Trial diversion agreement is similar to the Pre-Charge agreement in that it is a contract between the person who admits to committing an IPV and the DA and it includes the same stipulations listed in 13.5.4, "Pre-Charge Diversion Agreement." It is usually initiated after criminal charges have been filed with the

court of jurisdiction. The agreement or contract requires the judge's signature.

The Pre-Trial diversion agreement can be used at any point in the legal process that the DA or court wishes, including after the entry of a guilty or no contest plea by the defendant.

13.5.6 Deferred Prosecution Agreement

A Deferred Prosecution Agreement does not affect DWD or *DHS* rights as a creditor to collect overpayments. It merely provides that no further prosecution of the client will occur if the client performs certain community service activities. The local agency should recover the overpayment as it has calculated it and is not limited by the deferred prosecution agreement regarding collections. The 10 day notification guidance in Section 13.5.4 also applies to a deferred prosecution agreement.

13.5.7 Disqualification Consent Agreement

If a client's case has been referred to the District Attorney for prosecution for civil or criminal misrepresentation or *Fraud* in W-2, CC and/or FoodShare, the client may defer prosecution by signing a Disqualification Consent Agreement (F-16025). By signing this agreement the client agrees to the penalties listed on the Form HCF 16025, even though the client has not been found guilty through court proceedings.

If the client signing the Disqualification consent agreement is not the head of the household, the head of the household must also sign this form in the line provided.

13.5.8 Court Decision/ Court Order

When a court decides a recipient has committed fraud:

1. Continue the direct, provider or vendor payment if program eligibility continues.
2. Recover the overpayment in accordance with the amount and method detailed in 10.3.2 of the W-2 manual, MEH 22.2.2 Overpayment Calculation, and 7.3.2 of FSH, and Chapter 5 of the Benefit Recovery Manual for CC.
3. Immediately enter the FS IPV on the AIIP screen on *CARES*. This initiates the appropriate sanction period on CARES.
4. If a court’s determination that someone was guilty of an IPV is later overturned or reversed by a superior court, immediately end the disqualification period. Restore any benefits denied in the original IPV disqualification.

5. If a court does not impose a disqualification period for someone it finds has committed intentional program violation, initiate a disqualification period according to 13.5.8, unless contrary to court order.
6. Generally, a court order for restitution affects only the fraudulent overpayment amount. This order does not affect a local agency's obligation to recover all benefit overpayments under state and federal law. The basic obligation exists to recover all incorrectly paid amounts.

13.5.9 Court Order Disqualification/IPV Reporting in CARES

When a FS IPV has been determined by a court order, pre-charge agreement, disqualification consent agreement or a pre-trial agreement, enter the IPV information immediately into CARES on screen AIIP to help ensure that the FS disqualification period begins within 45 days of the date of determination. Enter the FS IPV in CARES within 10 days of the date of the IPV determination. See the CARES Guide Section 1 Chapter 10.7 for further direction.

CARES will automatically calculate the disqualification period for a FS IPV when CARES Screen AIIP is used. However if the court specifies a disqualification period different from the default disqualification periods in CARES, override the default period with the court ordered sanction period.

W-2 and MA do not have screens similar to AIIP that automatically calculate the disqualification period. This procedure must be done manually by the caseworker. However, entering IPV and other information on fraud investigation tracking screens (e.g. BVIR, BVIT, BVIT, BVPI, BVCC) for W-2 and MA is necessary for Fraud program data collection and funding allocations.

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13.6 ADMINISTRATIVE COST REIMBURSEMENT

DHS will reimburse local *Income* Maintenance agencies for their actual cost of *fraud* activities or allowable costs up to the funding allocations for *Fraud* Prevention and Fraud Investigation Services. The funding allocations are established by contract and identified in the Fraud Plan Budget. Additional federal matching dollars, in excess of the allocated amounts, are available for FoodShare and Medicaid fraud activities with county participation. No matching dollars are available under the Temporary Assistance for Needy Families (TANF) program for W-2 and Child Care.

Funding has been included in the W-2 administrative budget of all W-2 agencies to conduct fraud prevention and overpayment collection. The W-2 contract requires the operation of a fraud prevention and overpayment collection program. The amount of funds to operate prevention and collection programs is at the discretion of W -2 agencies. However, the W-2 agency is expected to allocate sufficient funds to achieve the goals of the fraud prevention and collections program.

To receive reimbursement for fraud investigation administrative costs, the investigative agency must perform a satisfactory investigation. A satisfactory completed investigation is defined in 13.3.5.

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13.7 FRAUDULENT BENEFIT RECOVERY

Fraud overpayments are those benefit overpayments determined as a result of an IPV finding by:

1. A court of jurisdiction.
2. An administrative disqualification hearing (ADH) or a signed ADH waiver agreement by the accused recipient and the head of household (if not the accused) waiving the right to an ADH.
3. A signed pre-charge agreement (Section 13.5.4), pre-trial agreement (Section 13.5.5), or deferred prosecution agreement (Section 13.5.6).

The referral agency may recover only the amount incorrectly paid to the recipient for the public assistance programs they manage. However, if fraud is suspected in more than one public assistance program, the referral agency initiating the fraud investigation will ensure that the fraud investigator will review all affected program violations. To accomplish this, the agency should take actions to alert case workers from other affected programs so recovery of all program benefit overpayments can be made.

13.7.1 *CARES* and CRES Fraud Overpayment Recovery Actions

Entering disqualification information in CARES screens will generate an automatic overpayment collection notice through the CARES benefit recovery system. If the first overpayment notice doesn't bring about repayment, CARES will automatically generate a total of three notices over a preset time period. If no response information is entered in CARES, the collection issue will be automatically referred to the State Central Recovery Enhanced System (CRES) which will continue collection actions. Questions on the State CRES collection system operation can be referred to 1(800) 943-9499.

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13.8 LOCAL AGENCY RETENTION PORTION OF CLAIMS

13.8.1 Introduction
13.8.2 Fraud Program Payment Procedures

13.8.1 Introduction

Federal FS regulation CFR 273.18(a)(ii) and 273.18(c)(2) authorizes the establishment of claims against a household for the value of FS benefits when an IPV for *trafficking* is established. Local agencies may establish a claim on the amount of FS benefits determined to have been trafficked during the IPV determination process. Local agencies can retain 15% of the amount of these claims that are recovered.

Local Agencies may retain 15% of the amount of an overpayment the state is authorized to retain for FS overissuance claims recovered under State Stat. §49.793(2),, and 15% for MA under State Stat. §49.497(2).

Agencies may retain 15% of money collected from benefit overpayments distributed under(Wis. Stats §49.19 *AFDC) Wis Stats §49.49, Medicaid.

> **Note**: Local Agencies may not retain 15% of the amount of an overpayment if the overpayment was the result of state, county or tribal governing body error.

13.8.2 Fraud Program Payment Procedures

See *DHS* Accounting Manual for reporting procedures necessary for agencies to retain payments recovered.

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13.9 FAIR HEARINGS, APPEAL, AND BENEFIT RECOVERY

13.9.1 Introduction
13.9.2 W-2 Fact Finding Appeal and Benefit Recovery

13.9.1 Introduction

The recipient may request a fair hearing concerning the IM agency's determination of ineligibility and/or calculation of the amount of FS and MA benefits improperly paid. If a hearing is requested, suspend all recovery actions until a decision is rendered in that appeal.

If benefits are continued while a decision on the fair hearing is pending, add those payment amounts to the collection total:

1. If the hearing decision is not favorable to the recipient; and,
2. The recipient wasn't otherwise eligible for these benefits at the time the benefit/services were provided.

13.9.2 W-2 Fact Finding Appeal and Benefit Recovery

In accordance with Wisconsin Statute §49.152, the W-2 process provides a two level appeal process, a W-2 agency fact finding and a state agency review process that fulfills the requirement under PRWORA (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) (PL 104-193). For detailed guidance on the two level appeal process, refer to the fact finding process described in Chapter 19 of the W-2 Program Manual.

If W-2 payments were affected and the Fact Finding Review restores the W-2 payment, a retroactive adjustment may need to be made to the date that benefit payments were improperly calculated, reduced, or terminated. However, the payment must be based on completed participation. See Chapter 19 of the W-2 manual for more information.

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13.10 ADMINISTRATIVE PENALTIES

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An administrative disqualification hearing (ADH) is the administrative process for determining an intentional program violation (IPV) in the AFDC, W-2, and FS programs.

13.10.1 When to use an Administrative Disqualification Hearing (ADH)

A referral agency may request an ADH when there is sufficient documentary evidence that a person or group has intentionally violated the program requirements. An ADH may be initiated regardless of the individual's current eligibility for the W-2 and/or FS Program.

Consider initiating an ADH when at least one of these conditions is met:
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1. The facts of the case don't warrant criminal prosecution.
2. The case does not meet the local prosecution referral criteria.
3. The DA declines to prosecute the referred individual.
4. The same person was previously referred for prosecution but no action was taken (within a reasonable period of time) and the referral was formally withdrawn.

13.10.2 ADH Relationship to Fair Hearing

An ADH, like a fair hearing is held by the Department of Administration (DOA), Division of Hearings and Appeals (*DHA*). An ADH differs from a fair hearing in these ways:

1. The referral agency, not the accused individual, requests the hearing.
2. A representative of the agency will present the evidence supporting the request for the ADH and the alleged IPV.
3. There is no time limit within which an ADH must be requested.
4. The timely notice (Notice of Administrative Disqualification Hearing) is measured from the date of the hearing.

13.10.3 ADH Required Evidence

The evidence for a finding of IPV in an ADH is the same as for determining an issue in a fair hearing. The level of proof for the evidence in both hearings must be "clear and convincing."

"Clear and convincing" means:

1. Explicit in detail;

2. So clear as to leave no substantial doubt;

3. Sufficiently strong to demand the unhesitating assent of every reasonable mind; or

4. Provides reasonable certainty of issues and findings.

13.10.4 Combined ADH Hearing

An ADH to determine an IPV in all benefit programs can be combined into a single ADH if the alleged IPV results from the same eligibility factors.

If the AG requests a fair hearing for current case actions the Fair Hearings and the ADH may be combined. The time limits for ADH take precedence when a fair hearing is combined with an ADH. The AG may waive the 30 day notice. In spite of differences between them, a FS or MA Fair Hearing and an ADH, they may be combined into a single hearing if:

1. The factual issues arise out of the same, or related circumstances; and,
2. The AG head of household and/or the individual accused of committing the IPV are given prior notice that the hearings will be combined.

Note: A W-2 fact finding review by DHA cannot be combined with an ADH or fair hearing.

13.10.5 Administrative Disqualification Hearing Notice

The referral agency must provide a written notice to the individual alleged to have committed the program violation at least 30 days prior to the date of the disqualification hearing.

To determine when the hearing will be held,

1. Call the Department of Administration, Division of Hearings and Appeals, telephone (608) 267-4587 and ask for the name and phone number of the Administrative Hearing Officer for your agency to contact.
2. Contact the Hearing Officer and request the dates s/he will be in the area.
3. Based on the 30 day advanced notice the agency provide the client with the date and time of the Administrative Disqualification Hearing.

If the case is currently open and the *fraud* investigation report causes the IM/W-2 Agency to take negative action toward the case, the agency may send the Administrative Disqualification Hearing Notice (F-16038) with the Negative Notice of Decision.

The written Administrative Disqualification Hearing Notice shall include the following items:

1. Date, time and location of the hearing.

2. Allegation(s) against the individual, including a statement that the agency believes benefits were received by the accused individual (or that the individual attempted to receive benefits) by intentionally violating a benefit program rule.

3. A summary of the evidence, along with appropriate documentation, supporting the allegation(s) of an IPV, including:

    a. The period of time or date(s) during which an overpayment was received or benefits misused.
    b. The amount of the overpayment or amount of misused benefits involved.
    c. A statement informing the individual of his/her right to examine the evidence and instructions on how and where the evidence can be examined.

4. A warning that the individual's failure to appear at the ADH without good cause will result in a decision by the hearing officer based solely on the information provided by the local agency at the hearing;

5. A statement that the individual may request a postponement of the hearing provided that such request is made to the Department of Administration, Division of Hearings and Appeals (DHA) at least 10 days in advance of the scheduled hearing, with the following restrictions. The hearing shall not be postponed for more than a total of 30 days.

6. A statement that the individual will have 10 days from the date of the scheduled hearing to present to the Division of Hearings and Appeals (DHA) good cause for failure to appear in order to receive a new hearing.

7. A description of the penalties that can result from a determination that the individual has committed an intentional program violation and a statement of which penalty is applicable to the individual.

8. A statement that the hearing does not preclude the District Attorney from prosecuting the individual for an intentional program violation in a civil or criminal court action, or from the agency collecting an overpayment.

9. A statement that the individual and remaining members of the Assistance Group will be responsible for repayment of the overpayment.

10. A listing of individuals or organizations that provide free legal representation to individuals alleged to have committed intentional program violations.

11. A statement that the accused individual and the head of household for the AG may sign an attached waiver agreement to waive his/her rights to appear at an ADH.

12. A statement of the accused individual's right to remain silent concerning the charge(s) and that anything said or signed by the individual concerning the charge(s) may be used against him or her in a court of law.

13. A telephone number and, if possible, the name of the person to contact for additional information.

13.10.5.1 Mailing Notice of ADH

All hearings are scheduled by the Division of Hearings and Appeals (DHA). A Notice of Administrative Disqualification Hearing should be sent to the accused individual by the referral agency so that it is received 30 days prior to the date for which the hearing is scheduled. The notice should be mailed using certified mail, restricted delivery, return receipt requested. Proof of mailing should be kept in the case record. Send a Waiver of Administrative Disqualification Hearing Agreement (F-16039) with the Administrative Disqualification Hearing Notice in case the individual decides to waive hearing attendance and accept the findings. A copy of the Notice of ADH should also be sent to DHA.

For FS-only cases, the agency has the option to mail the advance notice by first class mail or by certified mail return receipt. If the notice is sent by first class mail and is undeliverable, the ADH may still be held.

13.10.6 Waiver of Administrative Disqualification Hearing

The Administrative Disqualification Hearing Notice (F-16038) must include a statement that s/he and the head of household (if different than the accused) may waive the right to appear at an ADH. Send a copy of the Waiver of Administrative Disqualification Hearing Agreement (F-16039) with the Notice of ADH Hearing

The Waiver Agreement of Administrative Disqualification Hearing must include:

1. The date that the signed waiver must be received by the agency.
2. A signature block for the accused individual.
3. A statement that the head of household must also sign the waiver if the accused individual is not the head of household.
4. A signature block for the head of household.

5. A statement of the accused individual's right to remain silent concerning the charge(s) and that anything said or signed by the individual concerning the charge(s) may be used against him or her in a court of law.
6. The fact that waiver of the individual's right to appear at a disqualification hearing will result in a disqualification penalty and a reduction in the assistance payment for the appropriate period even if the accused individual does not admit to the facts as presented by the agency.
7. An opportunity for the accused individual to specify whether or not he or she admits to the facts as presented by the agency.
8. A statement of the fact that the remaining adult members of the household or AG, if any, will be responsible for repayment of the resulting AFDC, W-2 and/or FoodShare claim amount.

13.10.7 *CARES* ADH Disqualification Reporting

When the accused individual waives his or her right to appear at a disqualification hearing, the disqualification and appropriate reduction of assistance shall result regardless of whether this individual admits or denies the charges. Designated agency staff shall immediately enter on CARES FIT screens BVPI and BVCC the ADH waiver agreement or ADH determination information.

For FS disqualifications, also enter the information on screen AIIP. CARES will calculate the appropriate disqualification period and impose that disqualification within 45 days from the date of the IPV determination that is entered on the AIIP screen in CARES.

13.10.8 Administrative Disqualification Hearing

The ADH is scheduled by the Department of Administration, Division of Hearings and Appeals (DHA). The ADH will be presided over by a hearing officer from the Department of Administration, Division of Hearings and Appeals.

13.10.8.1 ADH Client Rights and Privileged Information

The accused individual, or his/her representative must be given adequate opportunity to:

1. Examine the contents of his/her case file, and all documents and records to be used by the agency at the hearing, at a reasonable time before the date of the hearing, and during the hearing; and to receive a copy of material pertinent to the case from the file at no charge.
2. Present his/her case for him/herself or with the aid of a representative;
3. Bring witnesses;
4. Submit evidence to establish all pertinent facts and circumstances;
5. Advance any arguments without undue influence; and

6. Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

Also, keep in mind the privileged information provisions of §905.15, Wis. Stats. Employees of IM/W-2 agencies who are authorized to have access to federal tax return information in performance of their job duties cannot disclose the federal tax information.

13.10.8.2 ADH Burden of Proof

A representative of the agency must attend the ADH to submit clear and convincing evidence to prove the allegations of Intentional Program Violation against the accused AG member.

Even if the accused AG member or his/her representative fails to attend the ADH, the agency must present clear and convincing evidence that the accused AG member committed an Intentional Program Violation in order for the Hearing Officer to determine that an IPV was committed.

The burden of producing evidence is on the agency.

13.10.8.3 Selecting and Presenting ADH Evidence

The agency must determine the essential facts in a case. This is best done by asking, "What facts need to be shown in order to prove the case?"

1. Review program policy to determine what is required.
2. Analyze the case to see if there are any other facts that must be established.
3. Obtain the best evidence to prove each fact.

The agency's evidence on each and every essential fact must meet the test of clear and convincing. The burden of proof is placed only on the agency; the client has no burden of proof that has to be met. If the agency fails to meet the level of clear and convincing proof on each and every fact, the hearing officer is likely to rule against the agency.

Also, remember to present evidence chronologically, clearly, and concisely.

13.10.9 ADH Decision

Decisions made by the hearing officer shall be based exclusively on evidence and other material introduced at the hearing. The transcript or recording of testimony, exhibits, or official reports introduced at the hearing, together with all papers and requests filed in the proceeding, and the decision of the hearing office shall be made available to the individual or to his or her representative at a reasonable time and place.

Decisions made by the hearing officer will:

1. Include a decision summarizing the facts and identifying the regulations supporting the decision.
2. Be made within 90 days of the date of the Notice of Administrative Disqualification Hearing.

13.10.10 Notice of ADH Disqualification Findings

If the ADH hearing officer finds that the accused individual committed an IPV, the agency will enter the IPV and any related benefit recovery information in CARES as soon as possible following the determination. CARES will help to generate the necessary written program notices to the primary case contact prior to disqualification. The agency will ensure that disqualification notices inform the case contact of the negative decision and the reason for the decision.

In addition, for non W-2 programs the notice shall inform the individual of the period of disqualification (which shall begin no later than the first day of the second month which follows the date of notice), and the amount of benefits the assistance group will receive during the disqualification period.

Designated agency staff shall immediately enter on CARES FIT screens BVPI and BVCC the IPV or court order information.

For FS disqualifications, also enter the information on screen AIIP. CARES will calculate the appropriate disqualification period and impose that disqualification within 45 days from the date of the IPV determination that is entered on the AIIP screen in CARES.

13.10.11 Consent Agreement Disqualification Notice

A person referred to the county District Attorney's Office to be prosecuted for committing a W-2, or FS IPV may be disqualified from W-2 or FS after signing a consent agreement. The consent agreement typically may be a "Deferred Prosecution Agreement", (13.5.4) "Pre-trial Agreement" (13.5.5), "Pre-charge Agreement" (13.5.6).

A copy of the consent agreement should be given or sent to the individual by the DA's office at least 10 days prior to any face-to-face meeting between the individual and the DA's office. The written notice should include the following:

1. A statement for the accused individual to sign stating that he or she understands the consequences of signing the agreement, along with a statement that the head of household must also sign the agreement if the accused individual is not the head of household;

2. A statement that signing the agreement will result in a reduction in benefits and/or FoodShare allotments for the appropriate period(s); and

3. A statement of the disqualification period(s) that will be imposed as a result of the accused individual signing the agreement.

13.10.12 FoodShare Penalties

A person who, on the basis of a plea of guilty or no contest or otherwise, is found to have committed a FoodShare *intentional program violation (IPV)* by an ADH or by a State or Federal court, or a consent agreement will be treated in the following manner:

1. Any resources and income of the disqualified individual will be considered available to the assistance unit. Disqualify only the person found guilty of the FS IPV. Other members of the group may continue to be eligible.

   The individual will be ineligible for FoodShare benefits for:

a. 12 months with the first offense
b. 24 months upon the second offense.
c. Permanently upon the third offense.

2. Any period for which a disqualification penalty is imposed shall remain in effect unless the finding upon which the penalty was based is subsequently reversed by a court, but in no event shall the duration of the period for which such penalty is imposed be subject to review.

3. A disqualification penalty imposed by one county/tribal agency must be used to determine the appropriate disqualification penalty for the individual by another county/*tribal agency*. Where an individual with a prior violation(s) moves from one state to another and has been found to have committed an intentional program violation(s), the local agency may impose the penalty based on the number of such violations committed in other states.

4. The disqualification penalties shall be in addition to, and cannot be substituted for, any other sanctions or penalties which may be imposed by law for the same offenses.

5. The agency must provide all applicants with a written notice of the disqualification penalties for fraud at the time of application.

6. Disqualify only the person who was found to have committed the IPV or who signed the waiver and, not the entire household for FoodShare.

13.10.13 CARES FoodShare Penalties Reporting

Enter the IPV information into CARES, which will then provide a written notice to the individual specifying the period of disqualification (which begins no later than the first day of the second month following the date of notice), and the amount of benefits the group will receive during the disqualification period. See Section 13.5.9 for additional CARES processing information.

If the court specifies the date for initiating the disqualification period, the agency shall enter the court ordered date into CARES to override the system's default calculations regarding the disqualification period.

With respect to imposing FS disqualifications, CARES will impose the disqualification period within 45 days of the IPV decision or as ordered by the court.

Along with the Notice of Disqualification, CARES will automatically send an agreement letter for restitution that will provide the following:

1. The amount owed.
2. The reason for the claim.
3. The period of time the claim covers.
4. The amount of any offsetting you did that reduced the claim.
5. The types and terms of each restitution schedule you offer the group.
6. The date by which the group must report its restitution choice to you.
7. A statement that the group's failure or refusal to make a restitution choice will result in your collection by a reduction of their benefits.
8. An area for the group to indicate its choice of restitution schedule with an area for a representative signature.
9. The group's right to a fair hearing if the individual disagrees with the claim amount.
10. A statement that the group may request re-negotiation of its chosen restitution schedule if its' financial circumstances change.

CARES also uses the data entered for FS IPV's through a data exchange system to update the national Disqualified Recipient System maintained by USDA's Food and Nutrition Service (FNS).

13.10.14 W-2 Penalties

In addition to a 10 year suspension noted in Section 13.10.15 below, Wis. Stats §49.151(2) provides guidance on W-2 IPV. W-2 agencies may permanently deny

W-2 benefits to individuals determined through court or administrative hearings to have committed an IPV on three separate occasions. After 3 separate findings, the W-2 agency may also permanently deny payments to the entire assistance group. There is no "child-only" grant provision under W-2 for children of adults found guilty of IPV.

Previous AFDC Disqualification and IPV's do not carry over into the W-2 program as W-2 disqualifications or IPVs. However, W-2 benefit payments could possibly be affected due to previous AFDC overpayments, depending on agreements or other legal actions where the participant provides consent.

13.10.15 Certain Convictions On Or After 10/14/97

Suspend a person from participation in W-2 and/or FS for a period of 10 years if that person is convicted of fraudulently misrepresenting his/her identity or residence for the purpose of receiving FS or TANF (W-2) from one or more states simultaneously.

1. The conviction must be on or after 10/14/97 in a federal or state court.
2. The violation of which the person is convicted must be misrepresentation, misstatement, or knowingly or willfully making a false statement or representation of material fact, or having knowledge of such an occurrence and concealing or failing to disclose that knowledge, with respect to a person's identity or place of residence for the purpose of receiving simultaneously from Wisconsin and at least one other state benefits under any of these programs:

    a. TANF block grant
    b. Medicaid
    c. FoodShare
    d. Supplemental Security *Income* (*SSI*)

See the W-2 Manual, 11.4.1, and the FSHB 3.14.1.2, for a more detailed description of this violation. This 10 year disqualification for W-2 is entered in CARES and counted as an IPV towards the three IPVs used for permanent disqualification from W-2 participation eligibility.

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DIRECTORY OF IM AGENCIES (14)

14.1 DIRECTORY OF INCOME MAINTENANCE AGENCIES

For the latest directory of the *Income* Maintenance Agencies please see http://dhs.wisconsin.gov/em/imagencies/index.htm

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