WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
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Medicaid Eligibility Handbook Release 25-04

The information concerning the Medicaid program provided in this handbook release is published in accordance with: Titles XI and XIX of the Social Security Act; Parts 430 through 481 of Title 42 of the Code of Federal Regulations; Chapters 46 and 49 of the Wisconsin Statutes; and Chapters HA 3, DHS 2, 10 and 101 through 109 of the Wisconsin Administrative Code.3

Contents

Introduction (Ch. 1) 30
1.1 Introduction To Medicaid 30
1.1.1 Introduction 30
1.1.2 Subprograms of Medicaid 30
1.1.3 Financial Introduction 31
1.1.3.1 Assets 31
1.1.3.2 Elderly, Blind, or Disabled Fiscal Group 31
1.1.3.3 Disabled Minors 31
1.1.3.4 Income 31
1.1.4 Health Care Choice 31
1.1.5 How to Apply 32
1.2 Continuous Coverage for Qualifying Children 33
1.2.1 Continuous Coverage Period 33
1.2.2 Populations 33
1.2.3 Termination of Coverage 34
1.2.3.1 When Eligibility was Based on Incorrect Information or Agency Error 34
1.2.4 Incarceration 35
1.2.5 Emergency Services 35
1.2.6 Institutionalized Children 35
1.2.7 HCBW Medicaid 36
1.2.8 SSI Medicaid 36
1.2.9 WWWMA 36
1.2.10 Transitions Between CHIP and Medicaid 36
1.2.11 Certification Period Changes for Children in Continuous Coverage Periods 37
Applications, Renewals, and Changes (Chs. 2-3) 38
2 Applications 38
2.1 Applications Introduction 38
2.1.1 Affirmative Action and Civil Rights 38
2.2 Application Methods 40
2.3 Where to Apply 41
2.3.1 Where to Apply Introduction 41
2.3.2 Intercounty Placements 41
2.3.3 Applications Outside Wisconsin 42
2.4 Valid Application 43

2.5 Valid Signature 44
2.5.1 Valid Signature Introduction 44
2.5.2 Witnessing the Signature 46
2.5.3 Spousal Impoverishment Medicaid Signatures 46
2.5.4 Telephone Signature Requirements 46
2.5.5 Valid Signature on the Federally-Facilitated Marketplace Application 47
2.5.6 Electronic Signatures 47
2.6 Filing Date 48
2.6.1 In Person/Mail/Fax 48
2.6.2 By Telephone 48
2.6.3 By ACCESS 48
2.6.4 Low Income Subsidy Program of Medicare Savings Programs 48
2.6.5 Federally Facilitated Marketplace 48
2.7 Application Processing Period 49
2.7.1 Multiple Application Submission 49
2.8 Begin Dates 51
2.8.1 Begin Dates Introduction 51
2.8.2 Backdated Eligibility 51
2.9 Denials and Terminations 53
2.9.1 Termination 53
2.9.2 Denial 53
3 Eligibility Renewals and Redeterminations 55
3.1 Renewals 55
3.1.1 Timely Renewals 55
3.1.2 Late Renewals 55
3.1.3 Late Verifications for Renewals 57
3.1.4 Gaps in Coverage 57
3.1.5 Program Changes at Renewal 58
3.2 Administrative Renewals 59
3.2.1 Administrative Renewals Introduction 59
3.2.2 Administrative Renewal Selection Criteria 59
3.2.3 Administrative Renewal Process 59
3.3 Redeterminations for Changes 61
3.3.1 Changes in Circumstance 61
3.3.2 Member Transition to Disability 63

3.3.3 Program Changes 64
3.4 Renewal Requirements 65
3.4.1 Choice of Renewal 65
3.4.2 Signature at Renewal 65
3.4.3 Renewal Notices 65
Nonfinancial (Chs. 4 - 14) 66
4 Who is Nonfinancially Eligible for Medicaid? 66
4.1 Who is Nonfinancially Eligible for Medicaid? 66
5 Elderly, Blind, or Disabled 67
5.1 Elderly 67
5.2 Determination of Disability 68
5.2.1 Definition of Disability 68
5.2.2 Disabled Medicaid Applicants and Members Who Convert from Social Security Disability to Social Security Retirement Benefits 68
5.2.3 Katie Beckett Medicaid Members Moving to Other EBD Medicaid Programs 69
5.3 Disability Application Process 71
5.3.1 Application Form 71
5.3.2 Agency Form Processing 71
5.3.3 Release Form 72
5.3.4 Medical Report 72
5.3.5 SSI Application Date 72
5.3.6 Routine SSI Medicaid Extension 72
5.3.7 Other SSI Medicaid Extensions 73
5.4 Disability Determination Bureau Action 74
5.4.1 Disability Determination Bureau Action Introduction 74
5.4.2 Allowances 74
5.4.3 Diary Date 74
5.4.4 Denials 74
5.5 Reconsideration/Hearing 75
5.5.1 Reconsideration/Hearing Introduction 75
5.5.2 Reversed or Delayed Disability Decision 75
5.6 Medical Exam Cost 77
5.7 Redetermination 78
5.7.1 Redetermination Introduction 78
5.7.2 Members Exceeding the Substantial Gainful Activity Level 79

5.8 Conflicting Claims 80
5.9 Presumptive Disability 81
5.9.1 Presumptive Disability Introduction 81
5.9.2 Presumptive Disability Determined by the IM Agency 81
5.9.3 Presumptive Disability Determined by DDB 84
5.9.4 Deceased Applicants 84
5.9.5 Eligibility 84
5.9.6 Disability Application Denials 85
5.10 Medicaid Purchase Plan Disability 87
5.10.1 MAPP Introduction 87
5.10.2 Medicaid Applicants and Members Who Convert from Social Security Disability to Social Security Retirement 87
6 Residency 88
6.1 Residency Eligibility 88
6.1.1 Residency Eligibility Introduction 88
6.1.2 Migrant Workers 88
6.2 Intent to Reside 89
6.3 Determining Residence 90
6.3.1 Under Age 21 90
6.3.2 Age 21 and Over 90
6.4 Special Situations 91
6.4.1 State Supplementary Payment 91
6.4.2 Homeless Persons 91
6.5 Absence 92
6.5.1 Absence Introduction 92
6.5.2 Temporary Absence 92
6.6 Reserved 93
6.7 Reserved 94
6.8 Interstate Placements 95
6.8.1 Interstate Placements Introduction 95
6.8.2 Reciprocal Agreement 95
6.8.3 Disputes 96
6.9 Reserved 97
7 U.S. Citizen or Qualifying Immigrant 98
7.1 US Citizens and Nationals 98

7.1.1 U.S. Citizens and Nationals Introduction 98
7.1.2 Child Citizenship Act of 2000 98
7.1.3 Compacts of Free Association 99
7.2 Verifying U.S. Citizenship 100
7.2.1 Citizenship Verification Introduction 100
7.2.2 Reserved 101
7.2.3 U.S. Citizenship Verification Through Data Exchange 101
7.2.4 U.S. Citizenship Verification through Documentation 101
7.2.5 Agencies Paying for Documentation 108
7.2.6 Reserved 109
7.2.7 Situations which Require Special Documentation Processing 109
7.3 Immigrants 111
7.3.1 Declaration of Satisfactory Immigration Status 111
7.3.2 Verification 112
7.3.3 Immigrants Eligible for Medicaid 115
7.3.4 Public Charge 125
7.3.5 Immigration and Customs Enforcement (ICE) Reporting 125
7.3.6 Undocumented Non-Citizens 125
7.3.8 Refugee Assistance Programs 127
7.4 Reserved 129
8 Medical Support 130
8.1 Medical Support 130
8.1.1 Medical Support Introduction 130
8.1.2 Recovery of Birth Costs 130
8.1.3 Referral to Child Support Agencies 130
8.2 Medical Support/Child Support Agency Cooperation 132
8.2.1 Introduction 132
8.2.2 Exemptions from Cooperation 132
8.2.3 Failure to Cooperate 132
8.3 Claiming Good Cause 134
8.3.1 Claiming Good Cause Introduction 134
8.3.2 Notice 134
8.3.3 Good Cause Claim 134
8.3.4 Circumstances 134
8.3.5 Evidence 135

8.3.6 Investigation 136
8.3.7 Determination 137
8.3.8 Good Cause Found 137
8.3.9 Good Cause Not Found 137
8.3.10 Review 138
8.4 Cooperation Between IM & CSA 139
8.4.1 Information 139
8.4.2 Medicaid Discontinued 139
8.4.3 Fraud 139
9 Third Party Liability 140
9.1 Third Party Liability 140
9.1.1 Third Party Liability Introduction 140
9.1.2 Third Party Liability Cooperation 140
9.1.3 Third Party Liability Cooperation Requirements 140
9.1.4 Third Party Liability Good Cause Claim 140
9.1.5 Assignment Process 141
9.2 Nursing Home and Hospital Insurance 142
9.2.1 Nursing Home, Hospital, and Long-term Care Insurance Introduction 142
9.2.2 Assignment 142
9.2.3 Recovery of Payments 142
9.3 Health Insurance Risk Sharing Plan (HIRSP) 144
9.4 Health Insurance Premium Payment (HIPP) 145
9.4.1 Cost-Effective 145
9.4.2 Participation in HIPP 145
9.4.3 Cooperation 145
9.4.4 Not Cost-Effective 145
9.5 Casualty Claim Process (Subrogation) 146
9.5.1 Casualty Claims (Subrogation) Introduction 146
9.5.2 Reporting Accident or Injury Claims 146
9.6 Other Health Insurance 147
9.6.1 Other Health Insurance Introduction 147
9.6.2 Policies Not To Report 147
9.7 Reserved 148
9.8 Reserved 149
9.9 Reserved 150

10 SSN 151
10.1 SSN Requirements 151
10.1.1 Social Security Number Requirements 151
10.1.2 Social Security Number Exceptions 151
10.1.3 SSN Mismatches 151
11 Premium or Cost Share 153
11.1 Premium or Cost Share 153
12 Change Reporting 154
12.1 Change Reporting Introduction 154
13 Inmates 155
13.1 Introduction 155
13.2 Covered Services 156
13.3 Suspension Start Date 157
13.3.1 Applicants 157
13.3.2 Backdated Eligibility 157
13.3.3 Existing Members 157
13.3.4 Deductibles 157
13.4 Suspension End Date 158
13.5 Renewals 159
13.6 Change Reporting 160
13.7 Household Composition 161
13.8 Special Rules 162
13.8.1 Children Whose Parent/Caretaker is an Inmate 162
13.8.2 Pregnant Women 162
13.8.3 Huber Law 162
13.8.4 Out-of-State Inmates 163
13.8.5 Services for Youth 163
13.9 State Correctional Institutions 164
14 Reserved 167
Financial (Chs. 15 - 18) 168
15 Income 168
15.1 Income Introduction 168
15.1.1 Elderly, Blind, or Disabled Fiscal Test Group 168
15.1.2 Special Financial Rules for Disabled Children for SSI-Related Medicaid 168
15.1.3 Income 170

15.1.4 Supplemental Security Income-Related Test 170
15.1.5 Availability 170
15.1.6 Countable Income 171
15.2 Prospective Income 172
15.2.1 Prospective Budgeting 172
15.2.2 Prorating Income 172
15.2.3 Fluctuating Income 173
15.3 Exempt and Disregarded Income 174
15.3.1 Adoption Assistance 174
15.3.2 Agent Orange Settlement Fund 174
15.3.3 Combat Pay 174
15.3.4 Crime Victim Restitution Program 174
15.3.5 Disaster and Emergency Assistance 174
15.3.6 Dottie Moore Payments 174
15.3.7 Foster Care 174
15.3.8 General Income Disregard 175
15.3.9 Individual Development Account Payments 175
15.3.10 Inconsequential 175
15.3.11 Kinship Care 175
15.3.12 Life Insurance 175
15.3.13 Nutrition Benefits 175
15.3.14 Payments to Native Americans 175
15.3.15 Payments to Nazi Victims 177
15.3.16 Radiation Exposure Compensation Act 177
15.3.17 Refugee Cash Assistance 177
15.3.18 Refugee "Reception and Placement" Payments 177
15.3.19 Reimbursements 177
15.3.20 Relocation Payments 178
15.3.21 Repayments 178
15.3.22 Special Programs 179
15.3.23 Spina Bifida Child 179
15.3.24 Susan Walker Payments 179
15.3.25 Travel Tickets 179
15.3.26 VA Allowances 179
15.3.27 Wartime Relocation of Citizens 182

15.3.28 Wisconsin Works Payments 182
15.3.29 Subsidized Guardianship Payments 182
15.3.30 Certain Payment Types Related to the COVID-19 Pandemic 182
15.3.31 Cash Benefits Received in Conjunction with Medical and Social Services 183
15.3.32 Medicare Advantage Supplemental Benefits 183
15.3.33 Reserved 184
15.3.34 Federal Income Tax Refunds and Credits 184
15.3.35 Temporary COLA Disregard for Social Security Recipients 184
15.3.36 Guaranteed Income Payments 184
15.3.37 Assistance Based on Need (General Assistance) 184
15.4 Unearned Income 185
15.4.1 Income From Trusts 185
15.4.2 Sick Benefits 185
15.4.3 Unemployment Compensation 186
15.4.4 Retirement Benefits 186
15.4.6 Gifts 186
15.4.7 Land Contract 186
15.4.8 Loans, Promissory Notes, and Mortgages 187
15.4.9 Interest and Dividend Income 187
15.4.10 Social Security Benefits 188
15.4.11 Property Settlement 188
15.4.12 Lump Sum Payments 188
15.4.13 Money for School 188
15.4.14 Child Support 190
15.4.15 Profit Sharing 190
15.4.16 Income Received by Members of a Religious Order 190
15.4.17 Federal Match Grants for Refugees 191
15.4.18 Gambling Winnings 191
15.4.19 Payments to Native Americans 191
15.4.20 Alimony, Maintenance, and Other Spousal Support Payments 191
15.4.21 Reimbursement of Living Expenses 191
15.4.22 Income Allocation from Institutionalized Spouse to Community Spouse 191
15.4.23 Rental Income 191
15.4.24 REWARD Wisconsin Stipends 192
15.4.25 Certain Payment Types Related to the COVID-19 Pandemic 192

15.4.26 Virtual Currency 193
15.5 Earned Income 194
15.5.1 Income In-Kind 194
15.5.2 Contractual Income 194
15.5.3 Rental Income 195
15.5.4 Jury Duty Payments 195
15.5.5 Wage Advances 195
15.5.6 Worker's Compensation 195
15.5.7 Income Tax Refunds 195
15.5.8 Student Income 195
15.5.9 AmeriCorps 195
15.5.10 Census 195
15.5.11 Severance Pay 195
15.5.12 Income Received by Members of a Religious Order 196
15.5.13 Title V—Older Americans Act of 1965 196
15.5.14 Room and Board Income 196
15.5.15 Earned Income Tax Credit 196
15.5.16 Make Work Pay Credit 196
15.5.17 Special Tax Credit for Certain Government Retirees 196
15.5.18 Prison or Jail Job 196
15.5.19 Virtual Currency 197
15.6 Self-Employment Income 198
15.6.1 Definitions 198
15.6.2 Ways to Identify 198
15.6.3 Self-Employment Income Assets 199
15.6.4 Self-Employed Income Sources 200
15.6.5 Calculating Income Maintenance Income 201
15.6.6 Verification 204
15.6.7 Self-Employment Hours 204
15.6.8 Backdated Months 204
15.7 Income Deductions 206
15.7.1 Maintaining Home or Apartment 206
15.7.2 Special Exempt Income 206
15.7.3 Medical/Remedial Expenses 208
15.7.4 Impairment-Related Work Expenses 210

15.7.5 $65 and ½ Earned Income Deduction 211
16 Assets 212
16.1 Assets Introduction 212
16.2 Assets Availability 213
16.2.1 Assets Availability Introduction 213
16.2.2 Real Property 213
16.3 Separate and Mixed Assets 215
16.4 Accounts 216
16.4.1 Joint Accounts 216
16.4.2 Jointly Held Real Property 217
16.5 Burial Assets 218
16.5.1 Irrevocable Burial Trusts 218
16.5.2 Burial Insurance 218
16.5.3 Life Insurance-Funded Burial Contracts 219
16.5.4 Spaces 221
16.5.5 Burial Funds 221
16.5.6 Wisconsin Funeral Trust Program 223
16.6 Non-Burial Trusts 225
16.6.1 Non-Burial Trusts Introduction 225
16.6.2 Trust Principal 225
16.6.3 Revocable Trusts 225
16.6.4 Irrevocable Trusts 225
16.6.5 Special Needs Trusts 227
16.6.6 Pooled Trusts 228
16.6.7 Ho-Chunk Tribal Trusts 228
16.7 Liquid Assets 230
16.7.1 Personal Property 230
16.7.2 Loans (including Home Equity Loans), Reverse Mortgages, and Promissory Notes 231
16.7.3 U.S. Department of Housing and Urban Development Payments 232
16.7.4 Reserved 232
16.7.5 Life Insurance 232
16.7.6 Treatment Of Continuing Care Retirement Community Entrance Fees 233
16.7.7 Income Tax Refunds and Credits 234
16.7.8 Earned Income and Child Tax Credits 234
16.7.9 Vehicles (Automobiles) 234

16.7.10 Property Settlement 236
16.7.11 Lump Sums Payments 236
16.7.12 Land Contract 237
16.7.13 Mortgage 238
16.7.14 Wisconsin Higher Education Bonds 238
16.7.15 Wartime Relocation of Citizens 238
16.7.16 Agent Orange Settlement Fund 238
16.7.17 Radiation Exposure Compensation Act 238
16.7.18 Self-Support Plan Assets 239
16.7.19 Replacing and Repairing Exempt Assets 239
16.7.20 Reserved 239
16.7.21 Gifts 239
16.7.22 U.S. Savings Bonds 239
16.7.23 Indian Judgment Fund Purchases 239
16.7.24 Payments to Nazi Victims 240
16.7.25 Spina Bifida Child 240
16.7.26 Uniform Gifts/Transfers to Minors Act 240
16.7.27 Individual Development Accounts Programs 240
16.7.28 Crime Victim Restitution Program 240
16.7.29 The American Recovery and Reinvestment Act of 2009 240
16.7.30 Achieving a Better Life Experience (ABLE) Accounts 240
16.7.31 Crowdfunding Accounts 241
16.7.32 Independence Accounts 241
16.7.33 Certain Payment Types Related to the COVID-19 Pandemic 241
16.7.34 Guaranteed Income Payments 242
16.7.35 Medicare Advantage Supplemental Benefits 242
16.7.36 Medicare Set-Aside Arrangements 242
16.8 Real Property 244
16.8.1 Home/Homestead Property 244
16.9 Property Essential to Self-Support 248
16.9.1 Introduction to Property Essential to Self-Support 248
16.9.2 Business Property Excluded Regardless of Value Rate of Return 248
16.9.3 Nonbusiness Property Excluded up to $6,000 Regardless of Rate of Return 248
16.9.4 Nonbusiness Income-Producing Property Excluded up to $6,000 if it Produces at Least Six Percent Rate of Return 249

16.10 Indian Lands 250
16.11 Retirement Funds 251
16.11.1 Types of Retirement Funds 251
16.11.2 Retirement Funds as Assets 251
16.11.3 Retirement Funds as Income 253
16.12 Annuities 254
16.12.1 Annuity Introduction and Definitions 254
16.12.2 Treatment of Annuities as Assets or Income 254
16.12.3 Long-Term Care Annuity Disclosure and Remainder Beneficiary Designation Requirements 255
17 Divestment 257
17.1 Divestment Defined 257
17.1.1 Applicable Health Care Programs 257
17.1.2 Excluded Applicants and Members 258
17.2 Evaluation of Transfers for Divestment 259
17.2.1 Exemption or Disregarded Status of Income and Assets 259
17.2.2 Date of Transfer 259
17.2.3 Transfers That Are Not Divestments 261
17.2.4 Determining Fair Market Value 262
17.2.5 Institutionalized Person 262
17.2.6 Allowed Divestments 263
17.2.7 Divestments That Are Not Allowed and Result in a Penalty Period 270
17.3 Penalty Period 279
17.3.1 Penalty Period Introduction 279
17.3.2 Calculating the Penalty Period 279
17.3.3 Penalty Period Begin Date for Applicants 280
17.3.4 Penalty Period Begin Date for Members 281
17.3.5 Curing a Divestment 281
17.3.6 Divestments During a Penalty Period 282
17.3.7 Changing Divestment Penalty Periods 282
17.3.8 Both Spouses Institutionalized 282
17.4-17.17 Reserved 284
17.4 Reserved 284
17.5 Reserved 285
17.6 Reserved 286

17.7 Reserved 287
17.8 Reserved 288
17.9 Reserved 289
17.10 Reserved 290
17.11 Reserved 291
17.12 Reserved 292
17.13 Reserved 293
17.14 Reserved 294
17.15 Reserved 295
17.16 Reserved 296
17.17 Reserved 297
18 Spousal Impoverishment 298
18.1 Spousal Impoverishment Introduction 298
18.2 Reserved 299
18.3 Spousal Impoverishment Requirements 300
18.4 Spousal Impoverishment Assets 301
18.4.1 Spousal Impoverishment Assets Introduction 301
18.4.2 Asset Assessment 302
18.4.3 Calculate the Community Spouse Asset Share 302
18.4.4 Asset Test 302
18.4.5 Undue Hardship 302
18.4.6 Asset Transfer 303
18.5 Spousal Impoverishment Income 306
18.5.1 Nontrust Income 306
18.5.2 Trust Income 306
18.6 Spousal Impoverishment Income Allocation 307
18.6.1 Spousal Impoverishment Income Allocation Introduction 307
18.6.2 Community Spouse Income Allocation 307
18.6.3 Dependent Family Member Income Allowance 308
18.7 Reserved 310
18.8 Spousal Impoverishment Notices 311
18.9 Community Spouse's Medicaid Application 312
18.10 Dual Spousal Impoverishment Cases 313
Program Admin. (Chs. 19 - 23) 314
19 Access Rights and Releasing Information 314

19.1 Applicant and Member Access Rights 314
19.1.1 Introduction 314
19.1.2 Fair Hearings 314
19.1.3 Sensitive Medical Information 314
19.1.4 Access by Someone Else 314
19.2 Releasing Information 316
19.2.1 Disclosure Without Consent 316
19.2.2 Disclosure with Consent 317
19.2.3 Emergencies 317
19.2.4 Special Circumstances 317
19.2.5 Prohibited Disclosure 317
19.2.6 Data Exchanges 318
19.2.7 Documents 318
20 Verification 320
20.1 Verification Introduction 320
20.1.1 Verification Definition 320
20.1.2 Documentation 320
20.1.3 Verification Receipt Date 320
20.1.4 General Rules 320
20.2 Collateral Contacts 322
20.2.1 Third-Party Cooperation 322
20.3 Mandatory Verification Items 323
20.3.1 Mandatory Verification Items Introduction 323
20.3.2 Social Security Number 323
20.3.3 Immigration Status 324
20.3.4 Disability 324
20.3.5 Assets 324
20.3.6 Medical or Remedial Expenses 328
20.3.7 Power of Attorney, Guardianship, or Conservator 328
20.3.8 Income 329
20.3.9 Proof of Temporary Hardship for MAPP Members 333
20.3.10 Huber Law Exemption 333
20.3.11 Tribal Membership, Descent, or Eligible to Receive Indian Health Services 334
20.4 Questionable Items 335
20.4.1 Questionable Items Introduction 335

20.4.2 Tuberculosis 335
20.4.3 Farm and Self-Employment Income 335
20.5 Member Responsibility 336
20.6 Front End Verification 337
20.7 When to Verify 338
20.7.1 Application and Renewal 338
20.7.2 Changes 338
20.7.3 Date of Death Matches 338
20.8 Actions 340
20.8.1 Positive Actions 340
20.8.2 Delay 340
20.8.3 Negative Actions 340
20.9 Release of Information 342
20.10 Verification Resources 343
21 Benefits 344
21.1 Benefits Introduction 344
21.2 Full-Benefit Medicaid 345
21.3 Limited Benefit Medicaid 346
21.4 Covered Services 347
21.4.1 Covered Services Introduction 347
21.4.2 Transportation 348
21.5 Copayment 350
21.5.1 Introduction 350
21.5.2 Copay Exempt Populations 350
21.5.3 Copay Exempt Programs 350
21.5.4 Copay Exempt Services 350
21.6 HMO Enrollment 352
21.6.1 SSI HMO Enrollment 352
21.6.2 HMO Selection and Assignment 353
21.6.3 Open Enrollment and Lock-in Periods 354
21.6.4 HMO Disenrollment 354
21.6.5 Enrollment Exceptions 356
21.7 ForwardHealth Cards 358
21.7.1 ForwardHealth Cards Introduction 358
21.7.2 Homeless 359

21.7.3 Pharmacy Services Lock-in Program 359
21.7.4 Temporary Cards 359
21.7.5 Lost or Stolen Cards 359
21.8 Waiver of Medicaid Benefit Limitations 361
21.9 Third Party Coverage 362
21.10 Good Faith Claims 363
21.10.1 Definition of Good Faith Claims 363
21.10.2 Denials 363
21.10.3 Causes and Resolutions 363
21.10.4 Process 364
21.10.5 Instructions 364
21.11 Five Percent Cost Share Limit 367
21.11.1 Copay Limits for Members and Programs exempt from copays 367
21.11.2 Programs Excluded from the Five Percent Cost Share Limit 367
21.11.3 Determining the Copay Limit 367
21.11.4 Changes to the Copay Limit 369
21.11.5 Meeting the Copay Limit 370
22 Administration 371
22.1 Estate Recovery 371
22.1.1 Estate Recovery Program Definition 371
22.1.2 Recoverable Services 371
22.1.3 Nursing Home Definition 372
22.1.4 Liens 372
22.1.5 Estate Claims 376
22.1.6 Match System 381
22.1.7 Notify Members 381
22.1.8 Estate Recovery Program Contacts 382
22.1.9 Voluntary Recovery (Not Estate Recovery Program) 382
22.1.10 Incentive Payments 382
22.1.11 Other Programs 382
22.2 Overpayments 383
22.3 Interagency Case Transfer 384
22.4 Undue Hardship 385
22.4.1 Application of Policy 385
22.4.2 Undue Hardship Waiver Request Process 385

22.4.3 Valid Request 385
22.4.4 Effective Date of Approved Undue Hardship Waivers 386
22.4.5 Required Documentation 387
22.4.6 Determination Process Time Frame 388
22.4.7 Bed Hold Payments and Notifications (Divestment Only) 388
22.4.8 Fair Hearing Rights 388
22.4.9 Referrals to Adult-at-Risk Agency 389
22.5 Legal Guardians, Conservators, Power of Attorney, and Other Representatives 390
22.5.1 Authorized Representatives 390
22.5.2 Additional Responsibilities 391
22.5.3 Community Spouse as Representative 392
22.5.4 Legal Guardians and Conservators 392
22.5.5 Power of Attorney 393
22.6 Restoration of Benefits 394
22.6.1 Incorrect Member Contribution 394
23 Notices and Fair Hearings 395
23.1 Notices 395
23.1.1 Notice Requirements 395
23.1.2 Notice of Approval 395
23.1.3 Notice of Denial 395
23.1.4 Notice of Adverse Action 395
23.2 Fair Hearings 397
23.2.1 Resolution Prior to Hearing 397
23.2.2 Fair Hearing Request 397
23.2.3 Prior to the Hearing 398
23.2.4 Continued Benefits 398
23.2.5 Hearing 399
23.2.6 Time Limits 399
23.2.7 Hearing Decision 399
23.2.8 Withdrawal of Fair Hearing Request 400
23.2.9 Cost Motion 400
23.2.10 Rehearing 400
23.2.11 Judicial Appeals 401
Subprograms (Chs. 24- 38) 402
24 SSI-Related Medicaid and Deductibles 402

24.1 SSI-Related Medicaid Introduction 402
24.2 Medicaid Deductible Introduction 403
24.3 Deductible Period 404
24.4 Choosing Not to Have a Deductible 406
24.5 Calculating the Deductible 407
24.5.1 Deductible Amount 407
24.5.2 Institution Cases 407
24.5.3 Deductible Examples 408
24.6 Changes During the Deductible Period 409
24.6.1 Income or Deduction Changes 409
24.6.2 Group Size Changes 410
24.6.3 Asset Changes 410
24.6.4 Non-Financial Changes 410
24.7 Meeting the Deductible 411
24.7.1 Countable Costs 411
24.7.2 Noncountable Costs 415
24.7.3 Prepaying a Deductible 415
24.8 Order of Bill Deduction 417
24.8.1 Hospital Bills 417
24.8.2 Pregnancy Fees 417
24.9 Notice to Fiscal Agent Concerning Any Remaining Deductible 418
24.10 Late Reporting of Deductible Information 419
24.11 Reserved 420
24.12 Changes After Meeting a Deductible 421
24.12.1 Changes After Meeting a Deductible Introduction 421
24.12.2 Income Changes 421
24.12.3 Asset Changes 421
24.12.4 Non-Financial Changes 421
24.13 Death During a Deductible Period 422
24.13.1 Death During a Deductible Period Introduction 422
24.13.2 Prepaid Deductible 422
24.14 Reserved 423
25 Special Status Medicaid 424
25.1 Special Status Medicaid 424
25.1.1 Special Status Medicaid Introduction 424

25.1.2 Special Status Medicaid Income and Asset Limits 424
25.2 Disabled Adult Child 425
25.2.1 Introduction 425
25.2.2 Identifying a DAC Group 425
25.2.3 Determining the Income Disregard for DAC Group 425
25.3 503 Group 427
25.3.1 Introduction 427
25.3.2 Identifying a 503 Group 427
25.3.3 Determining the COLA Disregard for 503 Group 427
25.4 Widow/Widower Group 430
25.4.1 Introduction 430
25.4.2 Identifying a Widow/Widower Group 430
25.4.3 Determining the Income Disregard for Widow/Widower Group 430
25.5 Section 1619 Group 431
25.6 Reserved 432
25.7 Reserved 433
25.8 Reserved 434
26 Medicaid Purchase Plan 435
26.1 Introduction 435
26.2 Application 436
26.2.1 MAPP Application Introduction 436
26.2.2 Begin Month 436
26.2.3 Fiscal Test Group 436
26.3 Nonfinancial Requirements 437
26.3.1 Medicaid Purchase Plan Nonfinancial Requirements Introduction 437
26.3.2 Disability 437
26.3.3 Work Requirement 438
26.3.4 Work Requirement Exemption 438
26.3.5 Health and Employment Counseling Program 439
26.3.6 Health Insurance Premium Payment 440
26.3.7 Spousal Impoverishment 440
26.3.8 Institutionalization 440
26.3.9 Community Waivers 441
26.4 MAPP Financial Requirements 442
26.4.1 Assets 442

26.4.2 Income 444
26.5 MAPP Premiums 446
26.5.1 Calculation 446
26.5.2 Initial Premium 447
26.5.3 Ongoing Premiums 448
26.5.4 Payment Information 449
26.5.5 Late Payment of Premium 450
26.5.6 Non-Payment of Premium 451
26.5.7 Temporary MAPP Premium Waivers due to Hardship 452
26.6 Opting Out 455
26.7 Changes 456
26.7.1 MAPP Changes Introduction 456
26.7.2 Premium Changes 456
26.8 MAPP Prepaid Deductibles 457
26.9 MAPP Notices 458
26.10 Reserved 459
27 Institutional Long-Term Care 460
27.1 Institutions 460
27.1.1 Institutions Introduction 460
27.1.2 Institutions for Mental Disease 460
27.1.3 Hospitals 461
27.1.4 Minors in a Medical Institution 461
27.2 Licensing and Certification 463
27.3 Facilities Not Medicaid Certified 464
27.4 Definitions 465
27.4.1 Institutionalized Person 465
27.4.2 Community Spouse 465
27.4.3 SSI Recipient and Institutional Medicaid Application 465
27.5 Financial 466
27.5.1 ILTC Assets 466
27.5.2 ILTC Income 466
27.5.3 Divestment 466
27.5.4 Instructions for Manual Eligibility Determinations 466
27.6 Monthly Need 468
27.6.1 Intermediate and Long-Term Care Monthly Need Introduction 468

27.6.2 Hospitalized Persons 468
27.6.3 Both Spouses Institutionalized 468
27.6.4 Health Insurance 468
27.6.5 Support Payments 469
27.6.6 Fees to Guardians or Attorneys 469
27.7 Cost of Care Calculation 470
27.7.1 Introduction 470
27.7.2 Hospitalized People 470
27.7.3 Partial Months 471
27.7.4 Transfers Between Institutions 471
27.7.5 Retroactive Cost of Care 471
27.7.6 Personal Needs Allowance 472
27.7.7 Medical or Remedial Expenses and Payments for Noncovered Services 472
CARES Process 474
27.8 Nursing Home Contracts 475
27.9 Nursing Home Refunds 476
27.10 Liability Effective Dates 477
27.11 Institutions for Mental Disease 478
28 Home and Community-Based Waivers Long Term Care (HCBWLTC) 480
28.1 HCBWLTC Introduction 480
28.1.1 Adult Home and Community Based Waivers Long-Term Care Disability Policy 481
28.1.2 Family Care 481
28.1.3 Family Care Partnership 481
28.1.4 PACE 482
28.1.5 IRIS 482
28.1.6 Changing Programs 483
28.1.7 Spousal Impoverishment 483
28.2 HCBWLTC Fiscal Test Group 484
28.3 HCBWLTC Divestment 485
28.4 HCBWLTC Reserved 486
28.5 HCBWLTC Effective Date 487
28.5.1 Urgent Services 487
28.6 HCBWLTC Groups and Cost Sharing 488
28.6.1 Group A 488
28.6.2 Group B and B Plus 488

28.6.3 Cost Share Amount 488
28.6.4 Maximum Cost Share Amount 491
28.6.5 Waiver or Reduction Cost Share 491
28.7 HCBWLTC Medical Codes 492
28.8 HCBWLTC Care Review 493
28.9 HCBWLTC Community Spouse's Medicaid Application 494
28.10 Reserved 495
28.11 Reserved 496
28.12 Reserved 497
28.13 Reserved 498
28.14 Reserved 499
29 Katie Beckett Medicaid 500
29.1 Katie Beckett Medicaid 500
29.2 Katie Beckett Medicaid Renewals 501
29.2.1 Ineligible for KBM after Renewal 501
29.3 Katie Beckett Medicaid Changes in Circumstance 502
29.4 Katie Beckett Medicaid Members Turning Age 19 503
30 Tuberculosis 504
30.1 Tuberculosis Medicaid 504
30.2 Reserved 505
30.3 Reserved 506
30.4 Reserved 507
30.5 Reserved 508
30.6 Reserved 509
31 Migrant Workers 510
31.1 Migrant Workers 510
31.2 Reserved 511
31.3 Reserved 512
31.4 Reserved 513
32 Medicare Savings Programs 514
32.1 Medicare Savings Programs (MSP) 514
32.1.1 Medicare Savings Programs Introduction 514
32.1.2 Medicare Savings Programs Fiscal Test Group 515
32.1.3 Medicare Savings Programs Benefits 515
32.1.4 Low Income Subsidy Requests 515

32.1.5 Part B Enrollment Via the Medicare Savings Programs Buy-In Program 515
32.2 QMB 516
32.2.1 Introduction 516
32.2.2 Entitled to Medicare 516
32.2.3 Income Limit 517
32.3 SLMB 518
32.3.1 Introduction 518
32.3.2 Income Limit 518
32.4 SLMB+ 519
32.4.1 Introduction 519
32.4.2 Income Limit 519
32.5 QDWI 520
32.5.1 Introduction 520
32.5.2 Income Limit 520
32.6 Medicare Savings Programs Asset Limit 521
32.7 Medicare Savings Programs Begin Dates 522
32.7.1 QMB Begin Dates 522
32.8 Medicare Savings Programs Backdating 523
32.8.1 QMB Backdating 523
32.8.2 SLMB, SLMB+, QDWI Backdating 523
32.9 Medicare Savings Programs No Deductible 524
32.10 Medicare Savings Programs Renewals and Changes 525
32.10.1 QMB Renewals 525
32.10.2 QMB Changes in Circumstance 526
32.10.3 SLMB, SLMB+, QDWI Renewals 526
32.10.4 SLMB, SLMB+, QDWI Changes in Circumstance 526
32.10.5 Program Choice 527
32.11 Medicare Beneficiaries Adversely Affected 528
33 SeniorCare 529
33.1 Introduction 529
33.2 Application 530
33.2.1 SeniorCare Application Introduction 530
33.2.2 Application Processing 530
33.2.3 Signing the Application 531
33.2.4 Authorized Representative 531

33.2.5 Guardian and Power of Attorney 532
33.3 Nonfinancial Requirements 533
33.3.1 SeniorCare Nonfinancial Requirements Introduction 533
33.3.2 Enrollment Fee 535
33.3.3 Age Limitation 537
33.3.4 Other Insurance 537
33.3.5 Creditable Coverage 538
33.4 Fiscal Test Group 539
33.5 Benefit Period 540
33.5.1 SeniorCare Benefit Period Introduction 540
33.5.2 ID Cards 540
33.5.3 Eligibility Begin Date 540
33.6 Financial Requirements 542
33.6.1 Assets 542
33.6.2 Income 542
33.6.3 Gross Social Security 542
33.6.4 Gross Earnings 543
33.6.5 Interest and Dividends 543
33.6.6 Self-Employment Earnings 544
33.6.7 Gross Retirement Income 545
33.6.8 Other Income 545
33.6.9 Disregarded Income 546
33.7 Participation Levels 548
33.8 Countable Costs 549
33.8.1 SeniorCare Countable Costs Introduction 549
33.8.2 Carryover 549
33.8.3 Date of Purchase 549
33.9 Addition of a Spouse 551
33.9.1 SeniorCare Addition of a Spouse Introduction 551
33.9.2 Adding a Spouse No Change in FTG 551
33.9.3 FTG Changes 553
33.9.4 Addition of a Spouse Summary Table 555
33.10 Changes 557
33.10.1 SeniorCare Changes Introduction 557
33.10.2 Correction of Errors 558

33.10.3 Fraud 560
33.11 Re-Application 561
33.12 Early Termination 562
33.12.1 SeniorCare Early Termination 562
33.12.2 Withdrawal 562
33.13 Notice of Decision 564
33.14 Appeals 565
33.14.1 SeniorCare Appeals Introduction 565
33.14.2 Requesting a Hearing 565
33.14.3 Hearing 565
33.15 Annual Eligibility Renewal 566
33.15.1 Maintaining SeniorCare Coverage During Regularly Scheduled Renewals 566
33.16 Benefits 567
33.16.1 SeniorCare Benefits Introduction 567
33.16.2 Discount Pricing 568
33.16.3 Early Refills 568
33.16.4 Out-of-State Pharmacies 568
34 Emergency Services 569
34.1 Emergency Services 569
34.1.1 Emergency Services Eligibility Introduction 569
34.1.2 Determination of Emergency Services Eligibility 570
34.1.3 Certification of Emergency Services Eligibility 570
34.1.4 BadgerCare Plus Emergency Services 571
34.1.5 Emergency Services and Public Charge 571
35 Long Term Care Insurance Partnership (LTCIP) 572
35.1 Long Term Care Insurance Partnership (LTCIP) 572
35.1.1 LTCIP Introduction 572
35.1.2 LTCIP Asset Disregard 572
35.1.3 Verification 572
35.1.4 Examples 573
35.1.5 Process Help 574
36 Wisconsin Well Woman Medicaid 575
36.1 Introduction 575
36.2 WWWMA Enrollment 576
36.2.1 WWWMA Backdated Eligibility 576

36.2.2 WWWMA Enrollment through the Wisconsin Well Woman Program 576
36.2.3 WWWMA Enrollment for Family Planning Only Services Members 578
36.2.4 WWWMA Enrollment for BadgerCare Plus Members 578
36.3 WWWMA Nonfinancial Requirements 580
36.3.1 Introduction 580
36.3.2 Disqualifying Insurance Coverage 580
36.3.3 Non-Disqualifying Insurance Coverage 581
36.4 Financial Requirements 582
36.5 Changes 583
36.5.1 Maintaining WWWMA Coverage While Considering other Medicaid Eligibility 583
36.6 Renewals 585
36.6.1 Maintaining WWWMA Coverage During Regularly Scheduled Renewals 585
36.7 EM CAPO Contact Information 586
37 Home and Community-Based Services: Children's Long-Term Support Waiver Program 587
37.1 Children's Long-Term Support (CLTS) Waiver Program Introduction 587
37.1.1 Program Purpose 587
37.1.2 Eligibility Requirements 587
37.2 Agency Roles and Responsibilities 588
37.3 HCBW Medicaid CARES Processing for the CLTS Waiver Program 589
37.4 Cost Sharing 590
37.4.1 Group A 590
37.4.2 Group B and B Plus 590
37.4.3 Calculating a Cost Share for HCBW Members 590
37.5 CLTS Parental Payment 591
38 Reserved 592
38.1 Reserved 592
38.2 Reserved 593
38.3 Reserved 594
38.4 Reserved 595
38.5 Reserved 596
Appendix (Chs. 39-40) 597
39 Tables 597
39.1 Life Estate and Remainder Interest 597
39.2 County and Tribe Areas 600
39.2.1 Area 1 600

39.2.2 Area 2 600
39.3 AFDC-Related Income Table 604
39.4 EBD Assets and Income Tables 605
39.4.1 Elderly, Blind, or Disabled Assets and Income Table 605
39.4.2 Disabled Minors Deeming and Allowances 605
39.4.3 LTC Post-Eligibility Allowances 606
39.4.4 LTC Spousal Impoverishment Post-Eligibility Allowances and Community Spouse Asset Share 606
39.4.5 Family Care, Family Care Partnership, or PACE Group B Plus Cost Share Cap 606
39.4.6 Institutional Cost of Care Values 606
39.4.7 SSI Reference Values 607
39.5 FPL Table 608
39.6 COLA Disregard 612
39.7 Hospital Daily Rates 613
39.8 Life Expectancy Table 618
39.9 Reserved 619
39.10 Medicaid Purchase Plan Premiums before August 1, 2020 only 620
39.11 SeniorCare Income Limits and Participation Levels 621
39.11.1 SeniorCare Income Limits Introduction 621
39.11.2 Level 1: Copayment 622
39.11.3 Level 2a: Deductible 622
39.11.4 Level 2b: Deductible 622
39.11.5 Level 3: Spenddown 623
39.12 Five Percent Copay Limit Tiers 625
39.13 VA Allowance Rates 626
40 Worksheets 627
40.1 Worksheets 627
Glossary 628

Introduction (Ch. 1)

1.1 Introduction To Medicaid

1.1.1 Introduction

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

1.1.2 Subprograms of Medicaid

There are different subprograms of Medicaid:

Full-Benefit EBD Medicaid Programs

- SSI-Related Medicaid
- Medicaid Purchase Plan (MAPP)
- Katie Beckett Medicaid
- Wisconsin Well Woman Medicaid (WWWMA)
- SSI Medicaid

Full-Benefit Long-Term Care Programs

- Institutional Medicaid
- Community Waivers Programs, which include:
    - Family Care
    - Family Care Partnership
    - Program of All-Inclusive Care for the Elderly (PACE)
    - Include, Respect, I Self-Direct (IRIS)
    - Children's Long-term Support Waiver Program (CLTS)

Limited-Benefit EBD Medicaid Programs

- Medicare Savings Program:
    - Qualified Medicare Beneficiary (QMB)
    - Specified Low-Income Medicare Beneficiary (SLMB)
    - Specified Low-Income Medicare Beneficiary Plus (SLMB+)
    - Qualified Disabled and Working Individual (QDWI)
- Emergency Medicaid
- SeniorCare

A person may qualify for one or more of the subprograms listed above, and will be found eligible if they meet all the requirements for a given subprogram. Individuals who do not qualify under a subprogram listed above may be eligible for BadgerCare Plus. See the BadgerCare Plus Handbook for more information.

People eligible for federal or state SSI are categorically eligible for SSI Medicaid and receive this form of Medicaid automatically. The Social Security Administration makes determinations of SSI eligibility for SSI recipients and receipt of SSI is the only eligibility criterion for SSI Medicaid.

1.1.3 Financial Introduction

See Section 39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES for EBD asset limits. See SECTION 1.1.3.3 DISABLED MINORS to determine Medicaid eligibility for disabled minors who fail BadgerCare Plus financial tests.

1.1.3.1 Assets

The EBD fiscal group's assets must be within the appropriate categorically needy or medically needy asset limit before any member of that group can qualify for Medicaid. EBD fiscal groups that have assets in excess of the appropriate EBD asset limit are ineligible for Medicaid.

1.1.3.2 Elderly, Blind, or Disabled Fiscal Group

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

There are some exceptions to this concept. A blind or disabled minor living with his or her parents would be a one-person fiscal group. Special instructions for deeming parental income and assets to the disabled minor are described in SECTION 24.1 SSI RELATED MEDICAID INTRODUCTION.

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

An individual applying for LTC Medicaid, including institutional, HCBW, Family Care, PACE, Partnership, or IRIS would be a one-person fiscal group. If the individual is married, refer to SECTION 18.1 SPOUSAL IMPOVERISHMENT INTRODUCTION for special instructions regarding spousal impoverishment procedures.

1.1.3.3 Disabled Minors

A blind or disabled minor (or dependent 18-year-old) must have his or her Medicaid eligibility determined according to special procedures if eligible (see SECTION 15.1.2 SPECIAL FINANCIAL TESTS FOR DISABLED MINORS).

Note: *EBD Medicaid testing procedures are different from those used for HCBW Medicaid for the Children's Long-Term Support Waiver Program. (See Section 37.3 HCBW MEDICAID CARES PROCESSING FOR THE CLTS WAIVER PROGRAM.)*

1.1.3.4 Income

See SECTION 39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES for EBD income limits. See SECTION 39.5 FEDERAL POVERTY LEVEL TABLE for all other Medicaid income limits. Chapters for each type of Medicaid explain how to determine the income to be compared with the income limits.

1.1.4 Health Care Choice

Once an individual has been determined eligible for EBD Medicaid, he or she must be enrolled in EBD Medicaid even if he or she is also eligible for BadgerCare Plus, unless he or she has a change in circumstances that results in ineligibility for EBD Medicaid. The only exception to this policy is pregnant

women who are eligible for both EBD Medicaid and BadgerCare Plus. In these instances, the pregnant woman will be enrolled in BadgerCare Plus.

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

1.1.5 How to Apply

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

- ACCESS online application at access.wisconsin.gov/.
- Face-to-face interview at the agency.
- Mail-in.
- Telephone interview.

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

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1.2 Continuous Coverage for Qualifying Children

On December 29, 2022, the Consolidated Appropriations Act, 2023, was signed into law. This legislation requires that children in certain Medicaid programs and the Children's Health Insurance Program (CHIP) are provided with 12 months of continuous health care coverage, with some limited exceptions, effective January 1, 2024. Continuous coverage means that the child will not lose coverage during that time, even if the family's situation changes.

1.2.1 Continuous Coverage Period

Effective January 1, 2024, most children under age 19 enrolled in BadgerCare Plus and Medicaid programs will have 12 months of continuous coverage, starting with the date of their health care application, new certification period at renewal, or when the child otherwise becomes eligible under a qualifying group. This also applies when a new child under 19 is added to a case that already has a child with 12 months of continuous coverage.

Example 1	James applies for health care for his 13-year-old son Henry on January 17, 2024, with a three month backdate, and Henry is determined eligible as of October 1, 2023. Henry will have continuous coverage from January 1 through December 31, 2024. Even if the household has a change in circumstances during the certification period, Henry will remain eligible through December 31, 2024.

Note *Backdated months do not count toward the 12-month continuous coverage period. To qualify for a 12-month continuous coverage period, a child must be eligible for the application month and/or a following month. If a child is only eligible in a backdated month, they do not qualify for a 12-month continuous coverage period.*

Children who are already members of an applicable health care program on January 1, 2024, will have a continuous coverage period that extends to their next renewal date.

Example 2	Jill is 10 years old. She was enrolled in Medicaid in May 2023. She is still enrolled as of January 1, 2024, so she will have continuous coverage from January 1, 2024, to her renewal date of April 30, 2024. Even if the household reports a change and she goes above the program income limit, she will remain eligible through April 30, 2024.

At renewal, a child must meet the program's eligibility requirements in order to get a new 12-month period of continuous coverage.

Example 3	Gino is 16 and has been enrolled in Medicaid since May 2020. Gino's renewal is due in March 2024. Because Gino is enrolled as of January 1, 2024, he also has continuous coverage until his renewal in March 2024. At renewal, Gino no longer meets program rules, so his health care benefits end March 31, 2024. He does not qualify for a new 12-month continuous coverage period.

1.2.2 Populations

Children under age 19 in the following programs are eligible for 12 months of continuous coverage:

- BadgerCare Plus
- Supplemental Security Income (SSI) Medicaid
- SSI-Related Medicaid
- Special Status Medicaid
- Institutional Medicaid
- Home and Community Based Waiver (HCBW) Medicaid

- Family Planning Only Services (FPOS)
- Medicaid Purchase Plan (MAPP)
- Foster Care Medicaid
- Wisconsin Well Woman Medicaid
- Emergency Services Medicaid
- Tuberculosis-Related Medicaid
- Katie Beckett Medicaid
- Medicare Savings Programs

Continuous coverage does not apply to children:

- Enrolled under presumptive eligibility.
- Required to meet a deductible in order to enroll in BadgerCare Plus or Medicaid.

1.2.3 Termination of Coverage

Qualifying children under 19 will only lose health care coverage during their 12-month period for the following reasons:

- The child turns 19.
- The child is no longer a resident of Wisconsin.
- The child passes away.
- The child's citizenship or immigration status is not verified within the reasonable opportunity period.
- The child was eligible as a pregnant minor, turns 19, and their postpartum period ends.
- The child's eligibility was based on incorrect information or agency error.
- There is a voluntary request for disenrollment from BadgerCare Plus or Medicaid.

Example 4	Carlos is 17 and enrolls in Medicaid on February 1, 2024. On May 12, the household reports moving to Florida. Carlos' Medicaid ends May 31, 2024.

Example 5	Carolina applies for Medicaid for her son Javier. Javier is eligible, but verification of his citizenship is still needed. Javier is enrolled in Medicaid as of February 1, 2024, and is given a reasonable opportunity period to verify his citizenship. Javier's citizenship is not verified by the due date of May 10, 2024, so his Medicaid ends May 31, 2024.

1.2.3.1 When Eligibility was Based on Incorrect Information or Agency Error

Children whose eligibility determination at application or renewal was made based on incorrect information or agency error will have their eligibility redetermined when the error is discovered. When eligibility is redetermined, depending on the circumstances of the case, the following may happen:

- The child's existing coverage will end if they are not eligible for any category of health care based on the corrected information (see Example 6).
- A new 12-month continuous coverage period will be established if the child remains eligible for their existing or a different category of health care coverage (see Example 7).
- If the child no longer meets eligibility rules due to a change in circumstances unrelated to the corrected information (and the change causing ineligibility is not one of the reasons that a continuous coverage period may end), the child will remain enrolled until the end of their existing continuous coverage period, but will move to the benefit category that aligns with the

corrected information for the remainder of that period, and may have a new or increased premium (see Example 8).

Example 6	Maggie is 12 years old and enrolls in SSI-Related Medicaid on February 1. Maggie's continuous coverage period is set from February 1 through January 31 of the following year. On March 10, it is discovered that Maggie's eligibility determination was based on incorrect income information. When eligibility is redetermined with the corrected information, it is determined that Maggie would only be eligible by meeting a deductible. Maggie's SSI-Related Medicaid coverage ends effective April 1.

Example 7	Henry is 3 years old and enrolls in SSI-Related Medicaid on January 1. Henry's continuous coverage period is set from January 1 through December 31. On March 12, it is discovered that Henry's eligibility determination was made based on incorrect income information. Henry's eligibility is redetermined based on accurate income information, and he is now eligible for BadgerCare Plus. Henry receives a new 12-month certification period with continuous coverage starting April 1 through March 31 of the following year.

Example 8	Ethan is 10 years old and enrolls in BadgerCare Plus on July 10. His continuous coverage period is set from July 1 through June 30 of the following year. At the time of enrollment Ethan had no other health insurance coverage. Ethan obtained health insurance through his father's employer in December, which is not a reason a child's continuous coverage period can end. On January 1, it is discovered that Ethan's eligibility determination was based on incorrect income information. Ethan's eligibility is redetermined based on accurate income information and he is still under the income limit for BadgerCare Plus. Ethan is not eligible for a new 12-month certification period because at his family's income level, he would be ineligible due to health insurance crowd-out rules. However, his BadgerCare Plus will continue and he will be charged a monthly premium for the remainder of his existing continuous coverage period.

1.2.4 Incarceration

If a child becomes incarcerated and their eligibility is suspended, their continuous coverage will run in the background. If they are released from incarceration within the 12-month period, they will qualify for continuous coverage for the rest of the 12-month period.

If a child's only parent or caretaker becomes incarcerated, the child will keep their health care for the rest of the 12-month period. If the child becomes eligible on another case or if they are enrolled in Foster Care Medicaid, they will get a new 12-month period of continuous coverage (see BadgerCare Plus Handbook, SECTION 1.2.8 FOSTER CARE MEDICAID).

1.2.5 Emergency Services

An immigrant child enrolled in Emergency Services qualifies for a 12-month period of continuous coverage. Their enrollment is not limited to the period their provider indicates they require treatment of an emergency medical condition.

1.2.6 Institutionalized Children

If a child enrolled in Institutional Medicaid is discharged from a medical institution or institution for mental diseases (IMD), and they are not eligible for another category of health care, they will keep their Institutional Medicaid for the rest of the 12-month period.

1.2.7 HCBW Medicaid

If a child enrolled in HCBW Medicaid is disenrolled from their waiver services or managed care organization (for example, due to loss of functional eligibility or non-payment of cost share), and they are not eligible for another category of full-benefit health care, they will keep their HCBW Medicaid and can keep getting Medicaid card services for the rest of the 12-month continuous coverage period.

Example 9	Chen is enrolled in CLTS as of January 1, 2024. His renewal date is September 30, 2024. In April 2024, the county waiver agency reports that Chen is no longer functionally eligible for CLTS. Chen does not qualify for BadgerCare Plus or Medicaid, so he remains enrolled in HCBW Medicaid through September 30, 2024.

Note *If someone voluntarily disenrolls from HCBW services, it will be treated as a voluntary disenrollment from HCBW Medicaid and continuous coverage under HCBW Medicaid will end.*

1.2.8 SSI Medicaid

If a child getting SSI Medicaid loses their SSI cash benefits or 1619(b) eligibility, they will keep their SSI Medicaid for the rest of the 12-month continuous coverage period. Their 12-month period is based on the month their most recent enrollment in SSI Medicaid began, since SSI Medicaid does not have applications or renewals.

Example 10	Jill is enrolled in SSI Medicaid as of February 1, 2024. Her 12-month continuous coverage period is February 1, 2024, to January 31, 2025. Jill no longer qualifies for SSI cash benefits in September 2024. She will keep her SSI Medicaid through January 31, 2025.

Example 11	Abdul has been enrolled in SSI Medicaid since May 1, 2021. In July 2024, Abdul loses his SSI cash benefits. He will keep his SSI Medicaid through April 30, 2025.

Example 12	Leo was enrolled in SSI Medicaid since January 1, 2021. In August 2024, Leo loses his SSI cash benefits. He will keep his SSI Medicaid through December 31, 2024. In May 2025, Leo starts getting SSI cash benefits again and he is re-enrolled in SSI Medicaid. He gets a new 12-month continuous coverage period from May 1, 2025, to April 30, 2026.

1.2.9 WWWMA

If a child enrolled in WWWMA no longer requires treatment or gets health insurance that covers their treatment, they will keep their WWWMA for the rest of the 12-month continuous coverage period.

1.2.10 Transitions Between CHIP and Medicaid

BadgerCare Plus is funded by both Medicaid (Title 19) and CHIP (Title 21) (see SECTION 51.1 BADGERCARE PLUS CATEGORIES).

During a child's 12-month continuous coverage period, they may not move from a Medicaid-funded health care category to a CHIP-funded category unless their eligibility determination was based on incorrect information or agency error (see SECTION 1.2.3.1 WHEN ELIGIBILITY WAS BASED ON INCORRECT INFORMATION OR AGENCY ERROR).

However, they may move from a CHIP-funded category to a full-benefit Medicaid-funded category, with one exception: a child may not move from a CHIP-funded BadgerCare Plus category into a BadgerCare Plus earned income or spousal support extension. When a child moves from a CHIP-funded category to a Medicaid-funded category, they will begin a new 12-month certification period with continuous coverage.

Example 13	Max is 10 years old and enrolls in a CHIP-funded category of BadgerCare Plus on January 1. Max's continuous coverage period is set from January 1 through December 31. On March 14, Max enrolls in the Children's Long-Term Support program (CLTS) with HCBW Medicaid as his basis of eligibility. The change results in Max being moved from a CHIP-funded category of BadgerCare Plus to HCBW Medicaid. Max receives a new 12-month certification period with continuous coverage from April 1 through March 31 of the following year.

1.2.11 Certification Period Changes for Children in Continuous Coverage Periods

When an individual opens for a new health care certification period on a case, new 12-month certification periods will be established for other eligible health care members in the household, with some exceptions. See BadgerCare Plus, Section 1.2.10 Certification Period Changes for Children in Continuous Coverage Periods for more information.

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Applications, Renewals, and Changes (Chs. 2-3)

2 Applications

2.1 Applications Introduction

Anyone has the right to apply for Medicaid. However, people younger than 18 years old must have a parent, caretaker relative, or legal guardian apply for Medicaid on their behalf unless they are living independently. In situations where a legal guardian, parent, or caretaker is absent, an adult acting responsibly may apply on behalf of a person who is younger than 18 years old.

The applicant may be assisted by any person they choose in completing an application.

Anyone who expresses interest in applying should be encouraged to file an application as soon as possible (see SECTION 2.2 APPLICATION METHODS).

The income maintenance (IM) agency must provide the following documents at application or a new request for health care on an existing case:

- Notice of Assignment: Child Support, Family Support, Maintenance, and Medical Support (DCF-F-DWSP 2477) must be provided to all applicants.
- Child Support Cooperation & Good Cause notice (DCF-P-5600)- must be provided to applicants with children applying for health care who have an absent parent. The IM agency must also provide this notice to the member in situations where a parent leaves the home resulting in a child on the case now having an absent parent.

Exception: The IM agency does not need to provide these documents to applicants who apply via ACCESS since this information is included in the ACCESS application.

The IM agency must also provide these documents to anyone who requests them.

People open for non-health care program(s) who want to enroll in a health care program must sign an application or program request for health care. If they or someone else in the household is already open for a health care program, they can request another health care program without a new application or new signature.

Example 1	Tim and Carrie are married. When Tim applies for health care, he indicates that he is requesting health care for himself, but Carrie is not requesting health care. Tim is determined eligible for Medicaid. Four months later, Carrie decides that she would also like to apply for health care. Carrie does not need to submit a new application or new signature. She can contact the IM agency to request health care.

Note: *An application can be filed on behalf of a deceased person. If the application is filed within the same calendar month as the date of death or within the three months after the date of death, the application should be processed as if the applicant were alive. If the application is filed more than four months after the date of death, the application must be denied.*

2.1.1 Affirmative Action and Civil Rights

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

Notify members during intake that assistance is available to assure effective communication. This includes certified interpreters for deaf persons and translators for non-English speaking persons. See the ForwardHealth Enrollment and Benefits Handbook (P-00079).

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

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2.2 Application Methods

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

- ACCESS: access.wisconsin.gov
- Mail-in or fax using the Wisconsin Medicaid for the Elderly, Blind, or Disabled Application Packet (F-10101)
- Telephone interview
- Face-to-face interview
- Use of the paper or online application available through the Federally-Facilitated Marketplace (FFM)
- Telephone application with the FFM

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2.3 Where to Apply

2.3.1 Where to Apply Introduction

The agency (county/tribe or consortium) of the applicant's county of residence should process the individual's application.

An individual who resides in a nursing home/hospital for 30 days or more is considered a resident of the county in which the nursing home/hospital is located.

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

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

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

2.3.2 Intercounty Placements

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

A congregate care facility is a:

- Child care institution
- Group home
- Foster home.
- Nursing home
- AFH
- CBRF
- Any other like facility

The placing county may request the assistance of the receiving county in completing applications for persons who are not enrolled in Medicaid and reviews for Medicaid members. The receiving county must then forward the information to the placing county. The placing county remains responsible for determining the applicant's eligibility.

If the placing county requests assistance from the receiving county, the placing county must provide the other agency with:

- The applicant's name, age, and SSN.
- The date of placement.
- The applicant's current Medicaid status.
- The name and address of the congregate care facility in which the applicant has been placed.

- The name of the county and agency making the placement.

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

2.3.3 Applications Outside Wisconsin

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

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2.4 Valid Application

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

1. Name,
2. Address, and
3. Signature:

    a) In the Signature Section of the Medicaid application (F-10101),
    b) On the Medicaid, BadgerCare Plus, and Family Planning Only Services Registration Application (F-10129),
    c) In the Signature Section of the BadgerCare Plus Application Packet (F-10182),
    d) An electronic signature in ACCESS, **or**
    e) Telephonically.

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2.5 Valid Signature

2.5.1 Valid Signature Introduction

The applicant, their representative (see below), or the applicant's caretaker relative must sign **one** of the following (using their own signature):

- The paper application form
- The signature page of the Application Summary (by telephone, electronically, or with a handwritten signature)
- The ACCESS application with an electronic signature
- The online or paper Application for Health Coverage & Help Paying Costs from the Federally Facilitated Marketplace (FFM)

Note *When an applicant calls to complete a Request for Assistance (RFA) but does not complete a full application on the same day, a telephonic signature must be collected for the RFA. Another telephonic signature will be required when the full application is completed. However, if the RFA and full application are completed on the same day, a telephonic signature only has to be collected once, and it is valid for both the RFA and the application.*

2.5.1.1 Signatures From Representatives

The following people can sign the application with their own name on behalf of the applicant:

1. **Guardian**

   When an application is submitted with a signature of someone claiming to be the applicant's guardian, the IM agency must obtain a copy of the document that designates the signer of the application as the guardian. From the documents provided, ensure that the individual claiming to be the applicant's guardian can file an application on their behalf.

   When someone has been designated as one of the following, only the guardian, not the applicant, may sign the application or appoint an authorized representative:

- Guardian of the estate
- Guardian of the person and the estate
- Guardian of the person and the court document appointing the legal guardian of the person specifically grants the guardian the authority to enroll their ward in BadgerCare Plus, Medicaid, or public assistance programs.

   If the applicant only has a guardian of the person who has not been granted the authority to enroll their ward in BadgerCare Plus, Medicaid, or public assistance programs, the guardian of the person cannot sign the application unless the applicant appoints them as their authorized representative.

Note *The guardian of the person may ask the court to update their letters of guardianship to grant them the authority to enroll their ward in public assistance programs.*

   The applicant may appoint their guardian of the person to be their authorized representative. If the applicant has appointed their guardian of the person to be their authorized representative, the guardian may sign the application as the authorized representative.

2. **Conservator (Wis. Stat. 54.76(2))**

   A conservator is a person who is appointed by a court at an individual's request under Wis. Stat. 54.76(2) to manage the estate of the individual. When an application is submitted with a signature of someone claiming to be the applicant's conservator, a copy of the document that

designates the signer of the application as the conservator is required.

The conservator is not required to sign the application, though they are able to sign on behalf of the applicant. If an applicant has a conservator, the applicant can still sign the application on their own behalf.

3. **Authorized Representative**
   The applicant may authorize someone to represent them. An authorized representative can be an individual or an organization (see SECTION 22.5 REPRESENTATIVES). If the applicant needs to appoint an authorized representative when applying by telephone or in person, the applicant must complete the Appoint, Change, or Remove an Authorized Representative form (F-10126). When appointing an authorized representative, someone other than the authorized representative must witness the applicant's signature. If the applicant signs with a mark, two witness signatures are required.

   The authorized representative is not required to sign the application, though they are able to sign on behalf of the applicant. If an applicant has an authorized representative, the applicant can still sign the application on their own behalf.
4. **Agent with Durable Power of Attorney for Finances (Wis. Stat. ch. 244)**
   An agent with durable power of attorney for finances is a person to whom the applicant has given power of attorney authority and agrees that the authority will continue even if the applicant later becomes disabled or otherwise incapacitated. Only an agent with activated durable power of attorney for finances (may also be known as a durable power of attorney for finances and property) is considered to have power of attorney for the purpose of providing a valid signature on the application. An agent with power of attorney for health care is not considered to have power of attorney for the purpose of providing a valid signature on the application.

   When a submitted application is signed by someone claiming to be the applicant's agent with activated durable power of attorney for finances, the agency must do both of the following:

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

   Do not consider the application properly signed unless both of the above conditions are met. An individual's agent with activated durable power of attorney for finances may appoint an authorized representative for purposes of making a health care application, if authorized on the Durable Power of Attorney for Finances form.

   The Durable Power of Attorney for Finances form will specify what authority is granted. The appointment of an agent with durable power of attorney for finances does not prevent an individual from filing their own application, nor does it prevent the individual from granting authority to someone else to apply for public assistance on their behalf.
5. **A superintendent of a state mental health institute or center for the developmentally disabled**
6. **A warden or warden's designee**
   A warden or warden's designee for an inmate of a state correctional institution who is a hospital inpatient for more than 24 hours.

7. **The superintendent of a county psychiatric institution**
   The superintendent of a county psychiatric institution may sign an application for a resident of the institution provided that the county social or human services director has delegated to them (in writing) the authority to sign and witness applications for residents of the institution. Retain a copy of this written authorization. The social or human services director may end the delegation when there is reason to believe that the delegated authority is not being carried out properly.

2.5.2 Witnessing the Signature

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

An agency staff person is not required to witness the signature of a paper, online, or telephonic application.

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

2.5.3 Spousal Impoverishment Medicaid Signatures

All spousal impoverishment Medicaid applications, renewals, or changes in marital status that cause someone to be subject to spousal impoverishment rules, require the signatures of **both** the institutionalized person and the community spouse or of a person authorized to sign for them as described in SECTION 2.5.1.1 SIGNATURES FROM REPRESENTATIVES.

If the benefits are denied or terminated because the community spouse refuses to sign, disclose the value of assets, or provide required information on income or resources, the applicant or member must be sent information on the Undue Hardship Waiver process. For more information on this policy, see SECTION 22.4 UNDUE HARDSHIP and Process Help Section 11.7.

2.5.4 Telephone Signature Requirements

Telephonic signatures are valid forms of signatures for Medicaid. To collect a valid telephonic signature:

1. Create an audio recording of the following:
   a) Key information provided by the household during the telephone interview
   b) Signature statement that includes:
      i. Rights and responsibilities
      ii. Attestation to the accuracy and completeness of information provided
      iii. Attestation to the identity of individual signing the application
      iv. Release of information
2. Store the audio recording in the ECF.
3. Send the applicant or member a written summary of the information provided during the interview. Include a cover letter that outlines the applicant or member's responsibility to review the information provided and notify the agency within 10 calendar days if any errors are noted.
4. Store a copy of the written summary and cover letter in the ECF.

Note *Applications that are submitted through ACCESS or transferred from the Federally-Facilitated Marketplace are signed electronically, so an additional signature (telephone or physical) is not needed.*

2.5.5 Valid Signature on the Federally-Facilitated Marketplace Application

Agencies should accept the signature on the FFM application for all individuals on that application and create companion cases for adult children without obtaining a separate signature or application. Workers should reference the original FFM ACCESS application in case comments on the companion case. This policy is for FFM applications only. Current policies for non-FFM applications requiring an adult child to apply separately are still valid.

Because the Medicaid-specific rights and responsibilities information is not provided when a person applies for health care through the FFM, a summary must be sent to the applicant once the application is processed. No additional signature is required.

Note *Referrals from the FFM may include households with individuals whose eligibility may not be able to be determined on one case.*

2.5.6 Electronic Signatures

In general, electronic signatures are valid signatures for documents requiring applicant or member signatures. Electronic signatures may appear typed or printed and may vary depending on the software used to collect the signature. Accept the electronic signature as a valid signature and process the document accordingly.

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2.6 Filing Date

The application filing date helps determine when an applicant can start getting benefits if they meet program rules (see SECTION 2.8 BEGIN DATES).

2.6.1 In Person/Mail/Fax

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

2.6.2 By Telephone

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

2.6.3 By ACCESS

The filing date on an ACCESS application is the date the application is electronically submitted.

2.6.4 Low Income Subsidy Program of Medicare Savings Programs

Low Income Subsidy (LIS, also called Extra Help) application information sent to DHS electronically from the Social Security Administration (SSA) is considered a request for Medicare Savings Programs (MSP). The filing date for the MSP request is the filing date set by SSA for the LIS application.

Because the LIS data sent by SSA does not provide enough information to determine if the applicant is eligible for Medicaid or MSP, the LIS data is used to establish a request for assistance (RFA). The contact date is the date when DHS receives the LIS data from SSA. In order for the agency to determine if the LIS applicant is eligible for Medicaid and MSP, the applicant must submit a completed application within 30 days of the RFA contact date. If the applicant does not submit a timely application, the RFA is withdrawn automatically.

2.6.5 Federally Facilitated Marketplace

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

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2.7 Application Processing Period

All applications received by an agency must be processed and eligibility approved or denied as soon as possible. The health care application processing period is 30 days. This means that, as a rule, the agency must process the application, determine eligibility, and issue a notice of decision no later than the 30th calendar day after the date on which the application is received by the agency (or the next business day if the 30th day falls on a weekend or holiday). However, the application processing period is extended as needed to ensure the applicant has at least 20 days from the mailing date of a verification request to provide verification.

Note	*For applications submitted electronically, the "date received," for purposes of determining when the application processing period begins, may be different from the filing date (see SECTION 2.6 FILING DATE). For ACCESS and Marketplace applications, the date received is the date on which the application is delivered to the agency or the next business day if delivered weekdays after 4:30 p.m., on a weekend, or on a holiday. For MSP applications originating from LIS data sent by SSA, the date received is the contact date of the request for assistance (RFA).*

Example 1	A signed application is received on March 15. The worker processes the application on April 7 and requests verification. Verification is due on April 27 but is not received by that date. Even though April 14 is the 30th day after the filing date, the application must not be denied for lack of verification until April 27 to allow the applicant at least 20 days to provide verification.

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

For more information on application denials for failure to provide verification, see SECTION 20.7 WHEN TO VERIFY.

If an agency fails to act on an application within the 30-day application processing period, the agency must still honor the application's filing date when determining eligibility.

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

2.7.1 Multiple Application Submission

When an applicant submits more than one application within the same application filing period, the earliest received application establishes the filing date. However, the information from the latest received application must be used in the eligibility determination since that is the most current information reported by the household.

Example 1	Charlie applies for health care on June 15. Charlie moves from Superior to Green Bay on June 20. Charlie applies for health care again on June 21, because Charlie didn't know a new application was not needed. The filing date for Charlie's health care request is June 15. Some information from the June 15 application might be valid, but information from Charlie's more recent June 21 application must be used in Charlie's eligibility determination, contact details, and agency administration.

The application processing timeline is based on the established filing date from the earliest received application (see SECTION 2.7 APPLICATION PROCESSING PERIOD).

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2.8 Begin Dates

2.8.1 Begin Dates Introduction

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

1. Deductible – The date the deductible was met.
2. Person Adds – The date the person moved into the household.
3. Recent Moves – The date the member moved to Wisconsin.
   Exception: The begin date for an SSI recipient who moves to Wisconsin is the 1st of the month of the move.
4. Home and Community-Based Waivers – The program start date provided by the Managed Care Organization (MCO), IRIS Consultant Agency (ICA), or County Waiver Agency (CWA).
5. Institutionalized – The date the person entered into the nursing home or hospital.
6. QMB – The first of the month following the eligibility confirmation.
7. SeniorCare – The first of the month following the month in which all program requirements have been met.

2.8.2 Backdated Eligibility

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

The backdated eligibility should not go back further than the first of the month, three months prior to the application month. The member may be certified for any backdate month in which he or she would have been eligible had he or she applied in that month.

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

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

Example 1	Mary who is 66 years old, applied for Medicaid on April 6, and was found eligible. At the time of application, Mary did not request a backdate. In September Mary is billed for a doctor's appointment she had at the end of February. Mary can ask to have her eligibility backdated through February. She meets all non-financial and financial eligibility criteria in the months of February and March. Her worker certifies her for Medicaid for both months.

See SECTION 15.6.8 BACKDATED MONTHS for information on counting self-employment income for backdated months.

For backdating rules for Medicare Beneficiaries, see SECTION 32.8 MEDICARE SAVINGS PROGRAMS BACKDATING.

Assets

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

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2.9 Denials and Terminations

2.9.1 Termination

During the calendar month after a member's enrollment has been terminated for a reason other than not completing a renewal, Medicaid can be reopened without requiring a new application or a new signature. The certification period for the health care assistance group (AG) prior to termination will be reinstated. The person may need to provide verification if required to complete the eligibility determination.

If more than a calendar month has passed since a member's enrollment ended, the applicant must file a new application or make a new request (if another health care AG is open on the case) to reopen their Medicaid.

Example 1	Leroy is enrolled in MAPP with a renewal date of December 31. On September 3, he reports to his IM agency that he received a raise at work, which requires verification to be provided. MAPP coverage for Leroy is maintained while eligibility is pended. Leroy does not submit the required verification by the due date of September 23, so his eligibility for MAPP ends as of October 31. On November 7, Leroy contacts his IM agency to request that his health care be re-opened, and he provides the required verification of his income on November 20. Since this is within the calendar month after his MAPP ended, Leroy does not need to submit a new application or new signature. Leroy is re-enrolled in MAPP as of November 1.

Example 2	Linda is enrolled in BadgerCare Plus and her husband Leo is enrolled in MAPP with a renewal date of January 31. On September 2, she reports to her IM agency that Leo received a gift from his aunt, which increased his assets to $16,000. Leo's MAPP ends September 30 because his assets are over the MAPP program asset limit, and he is not eligible for any other form of Medicaid. On December 10, Linda contacts her IM agency to request that Leo's MAPP be reopened, as he purchased a vehicle (which is their only vehicle) and is no longer over the MAPP asset limit. It has been more than a calendar month since his MAPP ended, but because Linda is open for BadgerCare Plus, they do not need to submit a new application or new signature. Asset verification is received on December 15, and Leo's eligibility for MAPP is reinstated starting December 1.

If health care coverage ended due to failure to submit the renewal timely or provide required verification for the renewal, the person can submit the renewal and any necessary verification within three months of the renewal month to have eligibility redetermined from the eligibility end date without completing a new application (see SECTION 3.1.2 LATE RENEWALS).

2.9.2 Denial

If the person applied for health care and the IM agency denied the health care application 30 or fewer days ago, they can re-request health care without submitting a new application or a new signature. The date of the new health care request is the new filing date.

Example 1	Keisha applied for health care on August 15. The IM agency processed the application on September 8 and denied health care for Keisha. Keisha calls the IM agency on September 20 to re-request health care. The new filing date for health care is September 20. The IM agency cannot require Keisha to submit a new application or a new signature since it is within 30 days of the denial date of her application.

If an application is denied because required verification is not received by the due date, but verification is later received within 30 days of the application denial date, the IM agency must consider this as the

person re-requesting health care. In this situation, the person does not also need to contact the IM agency to directly re-request health care nor is a new signature required.

Example 2	Cameron applied for health care on April 15. The IM agency processed the application on April 20 and pended for verification of income due May 15. Verification was not received, and the application was denied. Cameron submitted the income verification to the IM agency on May 22. The IM agency considers this a re-request for health care with a new filing date of May 22. No new application or new signature is required.

If the person applied for health care and the IM agency initially denied the health care application (or the only health care eligibility on the case is an unmet deductible) more than 30 days ago, the person must submit and sign a new application in order to re-request health care, regardless of the other non-health care programs the person is enrolled in.

Example 3	James applied for health care and FoodShare on September 13. The IM agency processed the application on September 20 and denied health care for James, but approved FoodShare. James calls the IM agency on October 25 to re-request health care. James must submit a new application for health care since it is more than 30 days since the denial date of his application.

The person may need to provide verification if required to complete the eligibility determination.

Note *If someone who was determined eligible for an unmet deductible wishes to request a new deductible period, a new application is required regardless of when the previous deductible period was established and regardless of whether they or anyone else on the case is eligible for another health care program (see SECTION 24.3 DEDUCTIBLE PERIOD).*

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3 Eligibility Renewals and Redeterminations

3.1 Renewals

A renewal is the process during which all eligibility factors subject to change are reexamined and eligibility is redetermined. For members who submit their renewal timely (see SECTION 3.1.1 TIMELY RENEWALS), existing heath care coverage must be maintained until the renewal is completed.

The first required renewal for Medicaid is 12 months from the most recent certification month, except for cases with a deductible. For cases that met the deductible, the renewal date is six months from the start of the deductible period. A renewal is not scheduled for an unmet deductible unless another health care program is due for renewal.

An early renewal can only be completed at the member's request.

A child within their continuous coverage period (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN) may be adversely impacted by an early renewal (for example, they could be ineligible, or have a new or higher premium). However, the child will not lose coverage or be charged a new or higher premium during their current continuous coverage period. Other household members may be renewed early and may qualify for new 12-month certification periods.

3.1.1 Timely Renewals

Health care renewals received by the last business day of the renewal month are considered timely. When a renewal is received timely, the member's existing health care coverage must be maintained until the renewal is fully processed by the agency. This includes situations where the member no longer meets the requirements of their current health care category and the agency needs to request additional information to determine if the member is eligible for a different form of health care.

Example 1	Marta is enrolled in MAPP. July is the last month of her certification period. On July 18, a notice is sent to inform Marta that her coverage will end July 31 because she did not yet complete her renewal. Marta's renewal is submitted on July 31 during business hours. Marta's MAPP coverage is reinstated for the month of August, and she is sent a notice that she is enrolled in MAPP effective August 1 and will remain enrolled while the agency processes her renewal. On August 19, the renewal process is completed, and Marta is no longer eligible for any category of health care. Marta receives a notice that her MAPP coverage will end September 30, in accordance with notice requirements.

For QMB renewals, benefits reopen from the first of the month following when coverage ends if the eligibility redetermination is fully completed during the renewal month or the month following the renewal month. See SECTION 32.10.1 QMB RENEWALS.

Example 2	Diana is open for SSI-Related Medicaid and QMB which is due for renewal in February. She submits her renewal on February 20. Because her renewal is timely, her benefits are maintained for March. On February 22, the worker processes the renewal and requests needed verification with a due date of March 14. On March 14, verifications are received for the renewal and eligibility is determined. Diana is enrolled in a new certification period starting April 1. There is no gap in her MS or QMB enrollment.

For Katie Beckett Medicaid renewals, see SECTION 29.2 KATIE BECKETT MEDICAID RENEWALS.

3.1.2 Late Renewals

Health care renewals received within three months of the renewal month can be processed as a late renewal instead of requiring a new application. There is no requirement for prior health care benefits to be maintained for a late renewal. The three-month period that allows for late renewals and renewal-

related verifications starts the month after enrollment ended. It does not restart when a late renewal or when late verification has been submitted.

Exceptions: Late renewal policies do not apply to SeniorCare.

This policy applies to members receiving health care benefits based on a met deductible but not to members with an unmet deductible.

Late renewals are only permitted for people whose eligibility has ended due to lack of renewal and not for other reasons.

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

A late submission of an online or paper renewal form or a late renewal request by phone or in person is a valid request for health care. If verification is required to complete the renewal, the member has 20 days to provide it, even if this extends renewal processing into the fourth month after benefits closed.

Example 1	Jenny's renewal is due in January. No renewal is received by January adverse action, so a notice is sent to Jenny explaining her coverage will end effective January 31. Her renewal is later received on March 10, and Jenny requested backdated coverage for February. Jenny's income verification is due on March 30. She provides verification of February and March income by the due date and meets all other eligibility criteria for Medicaid. Her new certification period starts on February 1.

Example 2	Joni's renewal is due in January. Joni did not submit a renewal by January adverse action, so a notice is sent to Joni explaining her coverage will end effective January 31. She submits a renewal on April 25, with a backdate request to February. The renewal is processed the same day, and she is asked to provide verification of her income by May 15. If Joni provides verification of her February, March and April income on or before May 15 and meets all other eligibility criteria for Medicaid, she will be enrolled in a new certification period starting on February 1. Her next renewal will be due January 31 of the following year. If Joni submits verification after the May 15 due date, a new application is required. She can request up to three months of backdated coverage when she reapplies.

For QMB renewals benefits reopen from the first of the month following when current coverage ends, whether the renewal is completed timely in the renewal month or completed late in the month following the renewal month. See SECTION 32.10.1 QMB RENEWALS.

Example 3	Shelly has Medicaid and QMB renewals due in February. She submits her Medicaid and QMB renewal late with the necessary verifications on March 20. On March 30, the worker processes the renewal and verifications which completes the Medicaid and QMB renewal. The member is enrolled in Medicaid and QMB with a new certification period starting March 1. There is no gap in her QMB eligibility because benefits are confirmed in the month following the renewal month.

Example 4	Cindy has Medicaid and QMB renewals due in February. She submits her Medicaid and QMB renewal late with the necessary verifications on April 20, requesting a backdate for March. On April 22, the

	renewal and verifications for March and April are processed, which completes the Medicaid and QMB renewal. The member is enrolled in Medicaid with a new certification period starting March 1, and QMB with a new certification period starting May 1. There is a gap in her QMB eligibility because the redetermination was not confirmed during the renewal month or the month following the renewal month.

3.1.3 Late Verifications for Renewals

If a health care renewal is received timely but verifications are not provided with the renewal submission, the health care program open during the renewal month is maintained while awaiting verifications. If verification is not received by the verification due date, the requirement to maintain benefits ends and health care coverage ends.

If a health care renewal is received late, health care is not maintained while eligibility is being redetermined. Regardless of whether a renewal was received timely or late, if verifications are submitted anytime in the three months following the renewal month health care can reopen without a new application.

During the three months following the renewal due month, any verification that was previously provided as part of the renewal process, including AVS results, remains acceptable unless a subsequent change was reported. Only the missing verifications must be provided.

If a member has a gap in coverage, and is requesting backdated coverage, verification is required for all requested months. The member will have 20 days to provide the verification.

Example 5	Sunny's Medicaid renewal is due in January. She completes her renewal timely on January 5, and income verification is requested with a due date of January 25. Medicaid coverage is maintained for February. Sunny does not submit the requested verification by January 25, and her Medicaid eligibility ends February 28. On April 27, she submits paystubs for March 10 and March 24, and requests a backdate to March. Verification of her current income for April is requested, with a due date of May 17. On May 17, April income verification is provided. Sunny meets the eligibility criteria for Medicaid and her new certification period begins on March 1.

3.1.4 Gaps in Coverage

If a member has a gap in coverage because of a late renewal, late verifications, or both, the member may request coverage of the past months in which a gap in coverage occurred. Backdated coverage under the late renewal policy is available to all health care members who meet program rules (see SECTION 2.8.2 BACKDATED ELIGIBILITY).

If a member requests coverage for past months during a late renewal, they must provide all necessary information and verification for those months (including verification of income and assets for all months requested). A member must also pay any required premiums to become eligible for those months.

Note *QMB coverage is not retroactive. For QMB see SECTION 32.10.1 for QMB begin dates following a renewal.*

Example 6	Marge's SLMB+ renewal is due in January. No renewal is received by January adverse action. A notice of SLMB+ coverage ending January 31 is sent to Marge. She calls the agency to complete a late renewal on April 15 and requests a backdate to February. Verification is requested for February, March and April.

	The due date is May 5. If she provides verifications for each month on or before May 5 (and she meets all other eligibility criteria) her eligibility and certification period restart as of February 1.

3.1.5 Program Changes at Renewal

If health care coverage was maintained during a renewal and the member's enrollment changes to a new health care program or has a reduction in their premium, liability, or cost-share, their eligibility may need to be redetermined for the month(s) that coverage was maintained.

After a renewal is processed, if a member's enrollment changes from a limited-benefit to a full benefit health care program, the eligibility in the new program may need to be redetermined for the months that coverage was maintained and any month in which the member may be eligible for the new health care program.

After a renewal is processed, if the member becomes eligible for SLMB, SLMB+, or QDWI, their eligibility will be redetermined in the new MSP program retroactively back to the date their prior benefits were maintained. Normally, an individual cannot qualify for SLMB+ if they are enrolled in full-benefit Medicaid, but in this circumstance the overlap is allowed.

Example 7	Tom is enrolled in MAPP and receives Medicare. The only Medicare Savings Program he qualifies for financially is SLMB+, but he is not enrolled because he has full-benefit Medicaid. His health care renewal is due in February. He submits a renewal on February 3. Verification is requested with a due date of February 23. Because his renewal was received timely, his MAPP coverage is maintained for March. Verification is received on February 19 along with a report that Tom is no longer meeting the MAPP work requirement. MAPP enrollment ends as of March 31 and Tom's eligibility for SLMB+ begins on March 1.

Example 8	Matt's Institutional Medicaid is due for renewal in February. He submits a renewal on February 3. Income verification is requested with a due date of February 23. Because his renewal was received timely his Institutional Medicaid coverage and his patient liability from February are maintained for March. Verification is received on February 19 verifying an income reduction. Although Institutional Medicaid coverage was maintained through March, the income reduction was reported in February and verified timely, so his patient liability is reduced retroactively for February and March.

Eligibility must be retroactively determined in situations where health care coverage was maintained for one household member and, after the redetermination of eligibility, another household member that was previously not eligible for health care is newly eligible. Eligibility is determined back to the date the change was reported.

Example 9	John and his wife Julieta both applied for health care. Julieta was denied for being over assets for MAPP, but John opened for MAPP. John is due for renewal in February. On February 3 the renewal is submitted. Verification is requested with a due date of February 23. John's MAPP coverage is maintained for March. Verification is received on February 19. A joint asset decrease makes both John and Julieta eligible for MAPP with a new certification period starting April.1. However, because the asset reduction was reported and verified in February, Julieta's eligibility for MAPP is determined retroactively for February and March.

3.2 Administrative Renewals

3.2.1 Administrative Renewals Introduction

Based on federal requirements, health care eligibility must be redetermined once every 12 months based on information available to an agency. Agencies cannot require information from health care members during an annual renewal unless the information cannot be obtained through an electronic data exchange or the information from the electronic data exchange is not reasonably compatible with the information on file. The process of using electronic data exchanges for renewals is referred to as an administrative renewal.

If information from electronic data exchanges validated information about the member's income as currently recorded in CARES, additional information about income cannot be requested from the member at renewal. This includes member-reported information about earned income that is found to be reasonably compatible with earned income information obtained from the State Wage Information Collection Agency (SWICA) and Federal Data Services Hub (FDSH) data exchanges, as well as any information about unearned income verified through the Social Security Administration (SSA) or Unemployment Insurance Benefits (UIB) data exchanges. Unless reported otherwise, it is assumed during the administrative renewal process that household composition has not changed.

3.2.2 Administrative Renewal Selection Criteria

To be considered for an administrative renewal, a member must be due for renewal in the following month and have eligibility in one or more qualifying BadgerCare Plus, Family Planning Only Services (FPOS), or Elderly, Blind, or Disabled (EBD) Medicaid assistance groups (AGs) open, including members open with a suspended status.

Some members in a household may have their eligibility administratively renewed while other members in the household must complete a regular renewal to continue their eligibility.

A member's health care eligibility can be administratively renewed if all of the information necessary to determine the member's eligibility is on file and their income and assets can be verified through a data exchange (for example, income with a SWICA match or Equifax match through FDSH, Social Security income, Unemployment income).

A member's health care eligibility cannot be administratively renewed if they meet any of the following criteria:

- Have income on file that cannot be verified through a data exchange, such as self-employment income, in-kind income, income from trusts, and other types of countable income for Medicaid.
- Are age 14 or older and have a missing or unverified SSN.
- Are pregnant and the due date is on or before the renewal month.
- Are enrolled in Medicaid after having met a deductible.
- Are enrolled in Institutional Medicaid.
- Are enrolled in Group A Community Waiver based on 1619(b) or EBD Medicaid Eligibility.
- Are already in the process of completing a regular renewal.

3.2.3 Administrative Renewal Process

The administrative renewal process begins in the 11th month of a member's certification period. CARES determines who qualifies for an administrative renewal, verifies and updates information based on data

exchanges, tests employment income and SWICA and FDSH results for reasonable compatibility, and runs through batch eligibility (see Process Help, Section 4.7 Administrative Renewals).

3.2.3.1 Successful Administrative Renewals

Members who have a successful administrative renewal will have health care eligibility redetermined and will be certified for a new 12- month certification period and will receive a Notice of Decision.

If any members in the household can be administratively renewed, the household will be sent a letter notifying them that their eligibility has been renewed, along with a case summary (except for cases open only for Group A Community Waivers and/or QMB based on SSI eligibility). The member(s) must review the information on the case summary and report if any of the information is incorrect within 30 days of the mailing date. The member(s) can make the changes on the summary and mail or fax it to their agency, or they can report their changes through ACCESS or by phone. If all of the information on the case summary is correct, the member(s) will not need to take any other action.

If any members of the household cannot be administratively renewed, the household will be sent an eligibility renewal letter and a Pre-Printed Renewal Form (PPRF). If the household does not complete this renewal process, then only the members who were administratively renewed will continue to be eligible in the next 12-month certification period.

If a successfully administratively renewed case is open only for Group A Community Waivers and/or QMB based on SSI eligibility, the member will be sent a different administrative renewal letter that does not include a case summary. Because these members are categorically eligible based on their SSI eligibility, the letter informs them that their benefits have been renewed because they continue to receive SSI. These members will not need to review a case summary and do not need to take any other action.

3.2.3.2 Unsuccessful Administrative Renewals

Benefits may not be terminated or reduced (for example, being charged a greater premium amount) during the administrative renewal process based solely on information obtained from a data exchange. This includes information obtained from SSA, UIB, FDSH, or SWICA data exchanges. If benefits cannot be continued through the administrative renewal process, the member will be excluded from the administrative renewal process, and they will be sent an eligibility renewal letter and a Pre-Printed Renewal Form (PPRF). The member will have at least 30 days to complete, sign, and return the PPRF or to complete their renewal by phone, in-person, or through ACCESS.

3.2.3.3 Change Reporting After Administrative Renewal

Members who have a successful administrative renewal remain subject to change reporting requirements. The administrative renewal letter instructs a member to review and report any changes to the information provided in the attached case summary. In addition, members who are administratively renewed will receive a Notice of Decision that identifies program-specific change reporting requirements. Changes reported for a member who has undergone an administrative renewal should be processed under existing policy.

Changes reported as part of a renewal for another program should also be applied to health care.

3.3 Redeterminations for Changes

When a member no longer meets the eligibility requirements of their current health care program due to a change, their existing coverage must be maintained while eligibility for all other health care programs is being determined.

Example 1	Anders is enrolled in SSI-Related Medicaid and QMB. On July 13, he reports an income increase, bringing his countable income to 115% FPL, which is over the income limit for both SSI-Related Medicaid and QMB. While the income verification is requested and his eligibility for other benefits is being determined, Anders's existing benefits are maintained. On July 22, Anders is determined eligible for an unmet Medicaid deductible and SLMB. Anders' SSI-Related Medicaid and QMB end August 31, and the Medicaid deductible and SLMB begin September 1.

Example 2	Ella is enrolled in MAPP. Outside of CWW, she is also enrolled in IRIS. On November 2, she reports that she received an inheritance that puts her over the $15,000 asset limit for MAPP. Because she is enrolled in IRIS, eligibility must be determined for other health care, including Waiver Medicaid. Ella is married and spousal impoverishment policies apply to the Waiver Medicaid determination. Verification is requested for the additional financial information (and spousal signature) needed to determine if Ella is eligible for Waiver Medicaid under spousal impoverishment rules. Ella's MAPP coverage is maintained for December while eligibility for Waiver Medicaid is determined. On November 23, Ella is determined eligible for Waiver Medicaid. Ella's MAPP coverage ends December 31, and Waiver Medicaid begins January 1.

3.3.1 Changes in Circumstance

Health care eligibility must be promptly redetermined between regular renewals whenever information is received about a change in a member's circumstances that may affect their eligibility. Requests for information or verification must be limited to information related to the change. During redeterminations of eligibility due to a change in circumstances, the member must remain enrolled in their prior health care assistance group without disruption until enough information is available to determine all health care eligibility.

When an individual is enrolled in a new health care certification period on a case, new 12-month certification periods will be established for all eligible health care members in the household, with some exceptions.

New certification periods will be established for existing eligible members when an individual is enrolled in health care following a change in circumstances, person-add, new program request, or renewal. For example, new certification periods can be established when a person joins the household and is enrolled in health care, changes health care categories, or a previously ineligible person becomes eligible due to a change (for example, a reduction in income puts them under the program limit).

New certification periods will not be established for an existing member when:

- A newly added person is found ineligible.
- A new assistance group is pending.
- The member is open for time-limited benefits.
- The member is a child who is in their 12-month continuous coverage period and the change would result in a negative action or would move the child from Medicaid to CHIP.
- The existing member is ineligible based on the change in circumstances.

Example 3	Margaret and Phillip are enrolled in BadgerCare Plus as childless adults with a certification period of January 1, through December 31. On July 2, 11-year-old William joins the household and requests health care. William does not have continuous coverage from another case. William is enrolled in BadgerCare Plus with continuous coverage from July 1 through July 31 of the following year. Margaret and Phillip are now eligible for BadgerCare Plus as caretakers and will also start a new certification period from August 1 through July 31 of the following year.

Example 4	Diego and Sofia are enrolled in BadgerCare Plus and their 4-year-old daughter Gabriella is enrolled in Medicaid from February 1, through January 31. On August 8, Diego's 12-year-old daughter Isabella joins the household and requests health care. Isabella has had BadgerCare Plus on another case since January. Her BadgerCare Plus enrollment ends on the other case, and she is determined eligible on Diego's case. Isabella is enrolled in BadgerCare Plus with a new continuous coverage period from September 1, through August 31. Diego and Sofia, remain eligible for BadgerCare Plus and start a new certification period from September 1, through August 31. Gabriella remains eligible in Medicaid and starts a new certification period from September 1, through August 31.

Example 5	Bill and Carrie are enrolled in BadgerCare Plus as parents and their 12-year-old daughter Kiley is disabled and enrolled in SSI-Related Medicaid. Their certification period is January 1, through December 31. Kiley is determined to no longer be disabled on June 5. There was no other change. Kiley transitions from SSI-Related Medicaid to BadgerCare Plus with a new certification period of July 1, through June 30. A new 12-month certification period is established for Bill and Carrie from July 1, through June 30.

Example 6	Edith is enrolled in SSI-Related Medicaid from January 1, through December 31. In July, Edith gets married and requests health care for her husband, Chester. Chester is eligible and enrolled in SSI-Related Medicaid. Edith continues to be eligible. Because someone is newly opening for a health care certification period, a new 12-month certification period is established for Edith and Chester.

Example 7	Dimitri is enrolled in SSI-Related Medicaid from July 1 through June 30. In October, Dimitri gets married and requests health care for his wife, Polina. Polina is neither a US citizen nor a qualifying immigrant and is found ineligible. Dimitri's SSI-Related Medicaid certification period does not change.

3.3.1.1 Time-Limited Benefits

New certification periods will not be established for members enrolled in time-limited health care benefits, including:

- Pregnant and postpartum individuals enrolled in BadgerCare Plus,
- Continuously Eligible Newborns,
- People in a four or twelve-month BadgerCare Plus Extension, and
- People who need to meet or have met a deductible to enroll in BadgerCare Plus or Medicaid.

Example 8	Matthew and his child Lee are enrolled in BadgerCare Plus from January 1, 2025, through December 31, 2025. Lilly, Lee's mother, is enrolled in BadgerCare Plus as a pregnant individual with a renewal date of September 30, 2025. In May, their other child Silas joins the household. Lilly remains pregnant. Silas's information is verified and there is no other change. Silas is enrolled in BadgerCare Plus from May 1, 2025, through May 31, 2026. A new 12-month certification period is established for Matthew and Lee from June 1, 2025, through May 31, 2026. Lilly's certification period does not change.

However, a new time-limited health care benefit will result in other members getting a new 12-month certification period.

Example 9	Deepak, Fatima, and their son Ravi are enrolled in BadgerCare Plus from July 1, 2025, through June 30, 2026. In August 2025, Fatima's pregnancy is reported, and she moves from BadgerCare Plus as a parent to BadgerCare Plus as a pregnant individual through May 31, 2026. There are no other changes, and Deepak and Ravi remain eligible. A new 12-month certification period is established for Deepak and Ravi from September 1, 2025, through August 31, 2026.

3.3.1.2 Children in Continuous Coverage Periods

If a child would be negatively impacted or move to a CHIP category of health care because of a change, person-add, or new program request during their 12-month continuous coverage period, the child will not get a new 12-month certification period. They will remain in their current period. However, other eligible household members can get new 12-month certification periods. Households may also have different health care renewal dates. See BadgerCare Plus Handbook, Section 1.2.10 Certification Period Changes for Children in Continuous Coverage Periods for examples.

3.3.1.3 Other Health Care Programs

If an individual opens for a new certification period for Wisconsin Well Woman Medicaid, Katie Beckett Medicaid, the SeniorCare Prescription Drug Program, or benefits outside of the CARES eligibility system, new 12-month certification periods will not be established for existing members on the case.

For more information regarding changes in circumstances for Katie Beckett members, see SECTION 29.3 KATIE BECKETT MEDICAID CHANGES IN CIRCUMSTANCES.

3.3.2 Member Transition to Disability

When a member enrolled in BadgerCare Plus or other health care program not based on disability no longer meets the requirements of their current health care category due to a change in circumstances, the IM agency must determine if they qualify for Medicaid based on disability if any of the following are true:

- The member has been determined disabled.
- The member indicates they want to apply for a disability determination.
- The member is enrolled in an adult long-term care program (Family Care, Family Care Partnership, PACE, or IRIS).

Prior coverage is maintained while the Medicaid Disability Application Form, F-10112 (MADA), Authorization to Disclose Information to Disability Determination Bureau, F-14014 (ADDD), and any other necessary information (including an Asset Assessment, if appropriate) are requested. If the member is otherwise eligible for EBD Medicaid types after the MADA, ADDD, and all necessary information is collected, the prior coverage continues to be maintained while the Disability Determination Bureau (DDB) makes the determination of disability.

Example 10	Hoai is enrolled in BadgerCare Plus and IRIS. On March 20, he reports an income increase from his part-time job that puts him over the limit for BadgerCare Plus. He does not have a disability determination and is not married. Because he is enrolled in a long-term care program, BadgerCare Plus must be maintained until it is determined if Hoai is eligible for Medicaid based on disability. On March 21, a request for asset information and the MADA and ADDD are sent to Hoai. Hoai provides the requested asset information and disability application forms by the due date, and he

	meets the eligibility criteria for Medicaid Purchase Plan (MAPP) if determined disabled by the DDB. On April 10, Hoai's disability application is sent to the DDB. Hoai's BadgerCare Plus coverage (and IRIS enrollment) will be maintained until the DDB makes a decision, as long as he remains otherwise eligible for MAPP or another form of full-benefit Medicaid based on disability. A notice is sent informing Hoai that he is now subject to EBD reporting rules, and his existing coverage will be maintained while the DDB is making their decision. On July 10, the DDB returns a decision that Hoai's disability application is approved for Medicaid. His BadgerCare Plus ends on July 31 and he is enrolled in MAPP effective August 1. He remains enrolled in IRIS.

3.3.3 Program Changes

If health care coverage was maintained during a redetermination of eligibility and the member's enrollment changes to a new health care program or has a reduction in premium, liability, or cost-share for a current health care program, their eligibility may need to be redetermined for the month(s) that coverage was maintained.

After redetermination, if a member's enrollment changes from a limited-benefit to a full-benefit health care program, their eligibility in the new program may need to be redetermined for the months that coverage was maintained and in any month in which the member may be eligible for the new health care program.

After redetermination, if a member becomes eligible for SLMB, SLMB+, or QDWI, eligibility will be determined in the new MSP program retroactively back to the date their prior benefits were maintained. Normally, an individual cannot qualify for SLMB+ if they are enrolled in full-benefit Medicaid, but in this circumstance the overlap is allowed.

Example 11	Tim applied for health care on October 2. He was denied for SSI-Related Medicaid due to being over the asset limit and he opened for SLMB. On February 3, he reports a reduction in assets. Verification is requested with a due date of February 23. His SLMB coverage is maintained for March. Verification is received on February 19. His asset decrease makes him eligible for SSI-Related Medicaid with a new certification period starting April 1. However, because the asset reduction was reported in February and verified timely, his eligibility for SSI-Related Medicaid must also be tested retroactively for February and March.

Eligibility must be retroactively determined in situations where health care coverage was maintained for one household member, and, after the redetermination of eligibility, another household member that was previously not eligible for health care is newly eligible. Eligibility is determined back to the date the change was reported.

Example 12	Jim and his wife, Bonnie, both applied for health care on October 2. Bonnie was denied for being over assets for MAPP, but Jim opened for MAPP. On February 3, Jim and Bonnie report a reduction in joint assets. Verification is requested with a due date of February 23. Jim's MAPP coverage is maintained for March. Verification is received on February 19. The asset decrease makes both Jim and Bonnie eligible for MAPP on April 1. However, because the asset reduction was reported in February and verified timely, eligibility for Bonnie's MAPP must also be tested retroactively for February and March.

3.4 Renewal Requirements

3.4.1 Choice of Renewal

The member may complete a Medicaid renewal using any of the following methods:

- Face-to-face
- Telephone
- Mail-in (paper application or Pre-Printed Renewal Form (PPRF))
- ACCESS (https://access.wis.gov)

3.4.2 Signature at Renewal

The member must include a valid signature at the time of renewal. This includes either signing telephonically, electronically or providing a handwritten signature on one of the following:

- The paper application form or Pre-Printed Renewal Form (PPRF)
- The signature page of the Application Summary
- The ACCESS or FFM application form with an electronic signature

With the exception of renewals completed through the administrative renewal process, the signature requirements for renewals are the same as those for applications (see SECTION 2.5 VALID SIGNATURE).

A new authorized representative form is not required at renewal if the person signing the renewal is the authorized representative on file.

3.4.3 Renewal Notices

A Medicaid eligibility renewal letter and a Pre-Printed Renewal Form (PPRF) are generated on the second Saturday of the 11th month of the certification period. If a renewal has not been received by adverse action of the renewal month, a notice is sent informing the member that their benefits are ending at the end of the month.

If a renewal is in progress at adverse action, or if a renewal is received after adverse action but by the last business day of the renewal month, a letter is sent indicating that health care coverage will be maintained until the renewal process is completed.

See Process Help 4.3 Renewal Notices for renewal notices for manually certified health care programs.

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Nonfinancial (Chs. 4 - 14)

4 Who is Nonfinancially Eligible for Medicaid?

4.1 Who is Nonfinancially Eligible for Medicaid?

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

- Be elderly, blind, or disabled (SECTION 5.2 DETERMINATION OF DISABILITY, or SECTION 37.1.2 CHILDREN'S LONG-TERM SUPPORT (CLTS) WAIVER PROGRAM INTRODUCTION)
- Be a resident of the state of Wisconsin (see SECTION 6.1 RESIDENCY ELIGIBILITY)
- Be a U.S. citizen or Qualifying Immigrant (see SECTION 7.1 US CITIZENS AND NATIONALS)
- Cooperate with medical support liability (see SECTION 8.1 MEDICAL SUPPORT)
- Cooperate with TPL (see SECTION 9.1 THIRD PARTY LIABILITY)
- Provide SSN or apply (see SECTION 10.1 SSN REQUIREMENTS)
- Pay a premium if required (see SECTION 11.1 PREMIUM OR COST SHARE)
- Pay a community waiver/FamilyCare cost share if required (see SECTION 11.1 PREMIUM OR COST SHARE)

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5 Elderly, Blind, or Disabled

5.1 Elderly

Elderly is defined as an individual 65 years of age or older. See SECTION 4.1 WHO IS NONFINANCIALLY ELIGIBLE FOR MEDICAID?.

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5.2 Determination of Disability

5.2.1 Definition of Disability

The law defines disability for Medicaid as: "The inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." See SECTION 39.4.7 SSI REFERENCE VALUES for the current SGA limits.

One exception to this is that a MAPP disability determination does not involve the SGA test. See SECTION 26.1 MEDICAID PURCHASE PLAN INTRODUCTION for the MAPP disability definition.

Disability and blindness determinations for most EBD Medicaid programs are made by the DDB. The IM agency should submit an application for a disability determination even if the applicant/member has already applied for SSI or SSDI (see SECTION 5.3 DISABILITY APPLICATION PROCESS), except for children applying for home and community-based waivers. An application for a disability determination should only be submitted for these children at the parent's request.

Note that for some long-term care programs, eligibility is based on level of care determinations rather than on a disability determination. For example, there is no disability determination required for children to be eligible for home and community-based waivers. The appropriate level-of-care determination as established by the functional screen is used as an indicator of the child's need for services. This is also true for some adults. See SECTION 28.1 ADULT HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE INTRODUCTION and CHAPTER 37 HOME AND COMMUNITY-BASED SERVICES: THE CHILDREN'S LONG-TERM SUPPORT WAIVER PROGRAM.

5.2.2 Disabled Medicaid Applicants and Members Who Convert from Social Security Disability to Social Security Retirement Benefits

An EBD Medicaid applicant or member whose SSDI or any other disability-related Old Age, Survivors and Disability Insurance (OASDI or Title II) benefits stopped because he or she began receiving SSRE is considered to have met the disability requirement for all types of EBD Medicaid, including MAPP. A disability re-determination is not required. The member is not required to provide verification of the disability unless the worker is not able to use data exchanges or other information from SSA to confirm that the individual received disability payments immediately prior to receiving SSRE.

Example 1	Ed is an EBD Medicaid member who was determined disabled ten years ago and has been receiving SSDI since that time. Upon turning 63, his SSDI payments change to SSRE payments. The IM worker can see this change by querying SOLQ-I. By policy, Ed is considered disabled and will not be required to provide any further verification or go through a re-determination.

Example 2	Nancy was determined disabled fifteen years ago and began receiving SSDI. Two years ago, her SSDI payments converted to SSRE payments. Nancy came into the agency this year to apply for MAPP. Although she was previously unknown to CARES, the IM worker was able to research her payments through SOLQ-I and see that prior to receiving her SSRE payment, she was receiving SSDI. Nancy is considered disabled and is not required to provide any further disability verification.

Example 3	Fred was determined disabled twenty years ago. His SSDI payments recently converted to SSRE. Fred moved to Wisconsin and applied for MAPP. The worker was unable to find evidence of this conversion

	through SOLQ-I. Fred provided a statement from his "My Social Security" account that shows his SSDI payment stopped and SSRE payments began. This verification is sufficient to consider Fred disabled. He does not need to provide any further verification or go through a re-determination.

5.2.3 Katie Beckett Medicaid Members Moving to Other EBD Medicaid Programs

Katie Beckett Medicaid (KBM) is a full-benefit Medicaid program for children with disabilities who have complex health care needs and live at home (see CHAPTER 29.1 KATIE BECKETT MEDICAID). KBM workers determine eligibility for KBM. Eligibility for KBM requires a disability determination that is completed by the Bureau of Clinical Policy and Pharmacy (BCPP) rather than the Disability Determination Bureau (DDB). BCPP uses the same criteria as the Social Security Administration (SSA) and the DDB.

When a member loses eligibility for KBM for any reason other than a medical cessation of disability, the member's KBM disability determination meets the disability requirement for all categories of EBD Medicaid as long as the member submits requested information timely. The member's submission of information is timely if a health care application is submitted to IM within three months of when their KBM coverage ended. When an application is received, if the former KBM member otherwise meets all financial and non-financial requirements, they will be enrolled in an EBD Medicaid program first and then asked to submit the Medicaid-Disability Application, F-10112 (MADA), and an Authorization to Disclose Information to Disability Determination Bureau (DDB), F-14014 (ADDD). As long as all required information is provided timely and they are otherwise eligible, the former KBM member will continue to be considered to meet the disability requirement for all Medicaid programs until there is a decision on their DDB disability application. The member's eligibility will be redetermined once there is a final decision on their DDB disability application.

If the health care application is submitted more than three months after KBM coverage ends, or if the required MADA and ADDD forms and all requested information and verification are not submitted timely, the KBM disability determination will no longer satisfy the disability requirement for other Medicaid programs. The member will need a DDB disability determination to enroll or maintain their enrollment in an EBD Medicaid program or they may qualify for a health care program that does not require a disability determination, such as BadgerCare Plus.

Example 4	Carmen is 2 years old and enrolled in KBM through the end of May of this year. In February, Carmen is hospitalized and remains hospitalized in April. Despite her hospitalization for over 30 days, Carmen remains in KBM because she is still within her 12 months of continuous coverage. In late April, Carmen's parents complete a KBM renewal. Due to her hospitalization, she is no longer eligible for KBM after her continuous coverage ends. She receives a letter informing her that her KBM enrollment will end on May 31. The letter states that if she submits a health care application to the IM agency within 30 days of the letter's date, her KBM coverage will be extended until it is determined whether she is eligible for another Medicaid program. On May 5, Carmen's parents submit a health care application to the IM agency. On May 10, the IM agency processes Carmen's application and determines that she is eligible for Institutional Medicaid, and she is enrolled as of June 1. Carmen is sent a letter requesting that she submit the MADA and ADDD forms within 20 days. On May 20, Carmen's parents submit the completed MADA and ADDD forms. Carmen's Katie Beckett disability determination meets the EBD Medicaid disability requirement while she waits for a decision on her DDB application. Carmen's disability application is later approved by the DDB, and her Institutional Medicaid continues with a May renewal date.

Example 5	Tim is 15 years old and enrolled in KBM through the end of September. In July, it is determined that he no longer requires an institutional level of care, but he remains enrolled in KBM because he is still

	within his 12 months of continuous coverage. In August, Tim's parents complete a KBM renewal. Because he does not meet the institutional level of care requirement, he is no longer eligible for KBM after his continuous coverage period ends. Tim receives a letter informing him that his KBM enrollment will end on September 30. The letter states that if he submits a health care application to the IM agency within 30 days of the letter's date, his KBM coverage will be extended until it is determined whether he is eligible for another Medicaid program. In mid-September, Tim receives a notice informing him that his KBM enrollment will end on September 30. Tim's KBM enrollment ends on September 30 because he did not submit his health care application by the 30-day deadline, so his KBM coverage is not extended. On December 10, Tim's parents submit a health care application to the IM agency requesting a two-month backdate. On December 15, the application is processed, and Tim is determined non-financially and financially eligible for SSI-Related Medicaid. Tim is enrolled in SSI-Related Medicaid with a retroactive start date of October 1. On December 15, Tim is sent a letter requesting that the MADA and ADDD forms be completed and returned within 20 days. Tim's parents submit the MADA and ADDD forms on December 30. Because Tim's application was received within three months of the KBM end date and he submitted the MADA and ADDD forms timely, the KBM disability determination meets the disability criteria for all EBD Medicaid programs while he waits for a decision on his DDB application. Tim's disability application is later approved by the DDB, and his Medicaid continues with a September renewal date.

Example 6	Sam is enrolled in KBM. Sam turns 19 on August 20. Six months prior to her birthday, Sam receives a letter informing her that her enrollment in KBM will end August 31 due to turning 19. On August 1, Sam submits a health care application, MADA, and ADDD to the IM agency. At adverse action in August, Sam receives a notice informing her that her KBM enrollment will end as of August 31. On August 20, Sam's application is processed, and she is determined non-financially and financially eligible for Medicaid Purchase Plan (MAPP). Sam's KBM disability determination meets the disability requirement for MAPP while she waits for a decision on her DDB application. Sam is enrolled in MAPP beginning September 1. Her disability application is later approved by the DDB, and her Medicaid continues with an August renewal date.

Example 7	Daniel is 5 years old and enrolled in KBM through the end of June. In January, it is determined that he no longer requires an institutional level of care, but he remains enrolled in KBM because he is still within his 12 months of continuous coverage. In May, Daniel's parents complete a KBM renewal. Because he does not meet the institutional level of care requirement, he is no longer eligible for KBM after his continuous coverage period ends. Daniel receives a letter informing him that his KBM enrollment will end on June 30. The letter states that if he submits a health care application to the IM agency within 30 days of the letter's date, his KBM coverage will be extended until it is determined whether he is eligible for another Medicaid program. On June 2, Daniel's parents submit a health care application to the IM agency. On June 10, Daniel is determined eligible for SSI-Related Medicaid. Daniel is enrolled in SSI-Related Medicaid with a start date of July 1. Daniel is sent a letter requesting that the MADA and ADDD forms be completed and returned within 20 days. On June 25, Daniel's parents submit his MADA and ADDD forms. Daniel's disability application is denied by the DDB on September 1. Since Daniel no longer meets the disability requirement for EBD Medicaid programs, he is no longer eligible for SSI-Related Medicaid. If he is ineligible for any other Medicaid program, he will remain in SSI-Related Medicaid until the end of his continuous eligibility period on June 30.

5.3 Disability Application Process

5.3.1 Application Form

Give a MADA Medicaid Disability Application form, F-10112 to each person applying for Medicaid Disability. The MADA must be completed by the Medicaid applicant or his or her representative.

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

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

5.3.1.1 Claims Filed on Behalf of Deceased Applicants

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

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

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

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

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

5.3.2 Agency Form Processing

See Process Help Section 9.4 Automated Medicaid Disability Determination.

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

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

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

5.3.3 Release Form

Ask the applicant to sign a Confidential Information Release Authorization to Disclose Information to Disability Determination Bureau (DDB) form, F-14014. This is the only form DDB can accept. See Process Help Section 9.4 Automated Medicaid Disability Determination.

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

5.3.4 Medical Report

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

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

DDB will contact the IM agency for applications that are not fully completed with names and addresses and work information. See Process Help Section 9.4.5 How to Resend an Application to DDB.

5.3.5 SSI Application Date

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

An application for SSI is also an application for Medicaid.

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

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

5.3.6 Routine SSI Medicaid Extension

An SSI Medicaid member is eligible for a redetermination of Medicaid eligibility and Medicare Savings Program (MSP) when SSI is terminated. Members that are eligible for Medicare should also be tested for the Medicare Savings Program unless the member requests not to be tested for the Medicare Savings Program. The person is allowed an extra month of SSI Medicaid eligibility and MSP to allow the IM

agency to redetermine eligibility. The IM agency must fill the gap by ensuring continued Medicaid and MSP eligibility between the last date of SSI Medicaid and the date an eligibility determination for continuing Medicaid and MSP on another basis is completed (see Process Help Section 26.2 Routine SSI Medicaid Extension). Determining Medicaid and MSP eligibility should usually occur within the month after the person loses SSI.

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

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

- Death
- Leaving Wisconsin
- Incarceration
- Fleeing drug felon

Reminder: For all cases (CARES and non-CARES), even if the member does not meet Medicaid eligibility requirements for the months between when he or she lost SSI and when you are re-determining eligibility, he or she is still eligible. Do not require the member to come into the office. Ineligibility starts, following timely notice, when he or she:

- Does not return the application (the fiscal agent takes care of this), or
- Fails to respond to an information request, or
- No longer meets eligibility requirements (as of when the review or application is done).

5.3.7 Other SSI Medicaid Extensions

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

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

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5.4 Disability Determination Bureau Action

5.4.1 Disability Determination Bureau Action Introduction

DDB will attempt to process the disability determination within 90 days of the date it receives the signed application. If the DDB determines that the application needs to be medically deferred because the extent of an impairment will not be known until several months after its onset, DDB will notify the applicant in writing that additional evaluation time is necessary.

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

To check on the status of a disability case, call 608-266-1565, and DDB will connect you with the examiner assigned to the case. Direct procedural or policy questions to Heather Pearson at 608-266-6664.

5.4.2 Allowances

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

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

Claims NOT in CARES (paper claims): For claimants found disabled, DDB will send the paper file with all the evidence and SSA-831 to the IM agency for storage for future use in the redetermination process.

5.4.3 Diary Date

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

5.4.4 Denials

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

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

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

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5.5 Reconsideration/Hearing

5.5.1 Reconsideration/Hearing Introduction

Send reconsideration/hearing requests to the following address:

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

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

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

If DDB reverses the decision to an allowance:

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

Claims NOT in CARES (paper claims): For claimants found disabled, DDB will send the paper file with all the evidence and a completed SSA-831 to the IM agency for storage for future use in the redetermination process.

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

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

Claims NOT in CARES (paper claims): DDB does not send any notification to the IM agency.

If, in a fair hearing, a person is found to be disabled, and the ALJ does not specify a diary date for review, contact DDB and request a diary date to review the disability.

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

5.5.2 Reversed or Delayed Disability Decision

When a disability denial decision is reversed (approved) as a result of a reconsideration/hearing request or SSI or SSDI appeal, or when a delayed approval is granted, the individual's Medicaid eligibility must be redetermined.

The original Medicaid application filing date associated with the Medicaid Disability Application (MADA) decision (see SECTION 5.3 DISABILITY APPLICATION PROCESS) or the SSI or SSDI disability determination must be honored. A new application or signature is not required.

The individual's Medicaid eligibility must be re-evaluated for all months between the filing date (and backdated period, if backdating was requested) and the date of the DDB, SSI, or SSDI approval. For this retroactive period, the individual is only eligible for Medicaid in the months in which they met all Medicaid eligibility requirements.

Example:	Kate (47) originally applied for health care in January with a three month backdate request and was determined over income for BadgerCare Plus. She submitted a MADA, and her disability was initially denied. In May, her disability denial decision was reversed. Her disability onset date is December 15. The worker redetermines her health care eligibility as of October. Kate is ineligible for health care in October and November but eligible for EBD Medicaid for December and ongoing.

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5.6 Medical Exam Cost

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

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5.7 Redetermination

5.7.1 Redetermination Introduction

Review a DDB disability determination when any of the following are true:

1. The Disability Determination and Transmittal (SSA-831) indicates medical re-examination in item 17 of that form and the person is not currently receiving SSDI or SSI Disability Benefits.
2. The person is younger than 65 years old and no longer receives OASDI (Social Security) disability benefits. This does not include members who have converted from OASDI benefits to Social Security Retirement benefits (see SECTION 5.10.2 MEDICAID MEMBERS WHO CONVERT FROM SOCIAL SECURITY DISABILITY TO SOCIAL SECURITY RETIREMENT).
3. The medical circumstances have significantly improved (see SECTION 5.7.2 MEMBERS EXCEEDING THE SUBSTANTIAL GAINFUL ACTIVITY LEVEL).
4. The person has returned to work.

When a disability redetermination is required, the following information is required and is sent electronically to DDB:

- A signed and completed Medicaid Disability Redetermination Report (F-10114).
- A signed and completed Authorization to Disclose Information to Disability Determination Bureau (DDB) form, F-14014
- From the existing Electronic Case File (ECF), the original Disability Determination form (SSA-831), any subsequent disability determinations, and all prior medical evidence and forms.

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

- Item 9 (SSA-832) indicates the decision of (A) continuing or (B) ceased.
- Item 23B (SSA-832) indicates a medical re-examination date when necessary.

If the member's disability is found to continue, the DDB will send an approval response, which includes the SSA-832 form which is stored in the ECF for the IM agency to review.

If DDB determines that the member is no longer disabled, DDB will first send written notice to the member explaining the basis for the proposed decision and offering the right to appeal. Appeal forms are enclosed with this letter, and members are told that completed appeal forms must be mailed directly to DDB and be received within 45 days of the date on the letter. Members are also told that if a timely appeal is filed, Medicaid benefits will continue until a hearing is held and a decision is made. DDB will temporarily retain the SSA-832 in these cases.

If the member appeals the proposed cessation and DDB is able to reverse the decision to a continuance, an approval response will be sent electronically at that time and a revised SSA-832 will be stored in ECF.

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

If the member chooses not to appeal or fails to file the appeal on a timely basis, DDB will send documentation to ECF that contains the original SSA-832 following the expiration of the 45-day appeal period. DDB will add a **Medicaid Disability Cessation Case** indicator to the document to highlight these cases. See SECTION 5.7.1.1 EXAMPLE OF MEDICAID DISABILITY CESSATION CASE NOTICE TEXT for an example.

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

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

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

5.7.1.1 Example of Medicaid Disability Cessation Case Notice Text

To: _____
Medicaid Disability Cessation Case

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

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

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

5.7.2 Members Exceeding the Substantial Gainful Activity Level

A Medicaid member who loses SSDI because he or she exceeds the Substantial Gainful Activity level does not lose Medicaid coverage if one of the following is true:

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

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

5.8 Conflicting Claims

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

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

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5.9 Presumptive Disability

5.9.1 Presumptive Disability Introduction

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

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

Presumptive disability is a method for temporarily determining a disability for a person while a formal disability determination is being done by Disability Determination Bureau (DDB). Presumptive disability is determined either by DDB, or in some circumstances, the IM agency. The regular disability application process (see SECTION 5.3 DISABILITY APPLICATION PROCESS) must still be completed for persons with a presumptive disability. A presumptive disability decision stands until DDB makes its final disability determination.

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

5.9.2 Presumptive Disability Determined by the IM Agency

When an applicant or member has an urgent need for medical services attested to in writing by a medical professional and is likely to be found disabled by DDB because of an apparent impairment, the applicant or member may be certified as presumptively disabled by the IM agency. When the IM agency is making the presumptive disability decision, they should do so as quickly as possible. However, the normal 30-day application processing period applies (see SECTION 2.7 APPLICATION PROCESSING PERIOD).

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

1. The person has an urgent need for medical services (see SECTION 5.9.2.1 DEFINITION OF URGENT NEED).
2. The person has one of a certain set of impairments (see SECTION 5.9.2.2 IMPAIRMENTS).

Note *If the attending physician attests under "Urgent Need for Medical Services" that the applicant has one or more medically determinable physical or mental impairments that cause severe functional limitations and/or inability to work, and that have lasted or can be expected to last for at least 12 months or are expected to result in death, and the applicant is otherwise eligible for Medicaid, the IM worker must certify presumptive disability even if the applicant does not have one of the specific listed impairments (see SECTION 5.9.2.1 DEFINITION OF URGENT NEED).*

For purposes of presumptive disability determinations, a "medical professional" is defined as any health care provider or health care worker who is familiar with the applicant and is qualified to confirm the presence of an urgent need and the presence of one of the impairments. A medical professional may be a licensed physician, physician's assistant, nurse practitioner, licensed or registered nurse, psychologist, osteopath, podiatrist, optometrist, hospice coordinator, medical records custodian, or social worker. Some urgent need criteria specifically require a physician to make the attestation, which is noted where applicable.

If someone has an impairment but not an urgent need, the normal disability application process must be followed (see SECTION 5.3 DISABILITY APPLICATION).

5.9.2.1 Definition of Urgent Need

To be considered to have an urgent need, a person must be in one of the following situations due to a physical or mental health condition:

A. The attending physician (defined as a doctor who has completed residency and is responsible for providing care for the patient in a hospital or clinic) attests that applicant has one or more medically determinable physical or mental impairments that cause severe functional limitations and/or inability to work, and that have lasted or can be expected to last for at least 12 months or are expected to result in death.

Note *If Box A in Section I – Urgent Need for Medical Services is checked on the Medicaid Presumptive Disability form (F-10130) and the form is signed by an attending physician, the worker must certify the presumptive disability if the applicant meets all other Medicaid program rules, even if the applicant does not have any of the specific impairments listed in SECTION 5.9.2.2 IMPAIRMENTS.*

B. The applicant is a patient in a hospital or other medical institution.
C. The applicant will be admitted to a hospital or other medical institution without immediate health care treatment. For example, someone with schizophrenia who will need to be hospitalized if they do not take prescribed medication has an urgent need if such medication is not available without Medicaid coverage.
D. The applicant needs long-term care, and the nursing home will not admit the applicant until Medicaid benefits are in effect.
E. The applicant is unable to return home from a nursing home unless in-home service or equipment is available, and this cannot be obtained without Medicaid benefits.

5.9.2.2 Impairments

When an urgent need for medical services has been identified, the IM agency can certify the person as presumptively disabled if they have one of the following impairments, as attested to in writing by a medical professional.

A. Amputation of a leg at the hip
B. Total deafness
C. Total blindness
D. Bed confinement or immobility without a wheelchair, walker, or crutches due to a longstanding condition, excluding recent accident and recent surgery
E. Stroke (cerebral vascular accident) more than three months in the past and marked difficulty in walking or using a hand or arm
F. Cerebral palsy, muscular dystrophy, or muscle atrophy and marked difficulty in walking (for example, the use of braces), speaking, or coordination of the hands or arms
G. Down syndrome
H. Intellectual disability or another neurodevelopmental impairment (for example, autism spectrum disorder) with complete inability to independently perform basic self-care activities (such as toileting, eating, dressing, or bathing) (this category only pertains to persons who are at least four years old)
I. A child has not attained their first birthday and had a birth weight under 1200 grams (2 pounds, 10 ounces)
J. A child has not attained their first birthday and had a gestational age (GA) at birth and corresponding birth weight within one of the ranges below:
    1. GA of 37-40 weeks and birth weight under 2000 grams (4 pounds, 6 ounces)
    2. GA of 36 weeks and birth weight of 1875 grams (4 pounds, 2 ounces) or less

3. GA of 35 weeks and birth weight of 1700 grams (3 pounds, 12 ounces) or less
4. GA of 34 weeks and birth weight of 1500 grams (3 pounds, 5 ounces) or less
5. GA of 33 weeks and birth weight of 1325 grams (2 pounds, 15 ounces) or less
6. GA of 32 weeks and birth weight of 1250 grams (2 pounds, 12 ounces) or less

K. A physician confirms that the person has a terminal illness with a life expectancy of six months or less; or a physician or hospice official (hospice coordinator, staff nurse, social worker, or medical records custodian) confirms that the person is receiving hospice services because of a terminal illness
L. Spinal cord injury producing an inability to ambulate without the use of a walker or bilateral hand-held devices for more than two weeks
M. End stage renal disease (ESRD) requiring chronic dialysis
N. Symptomatic human immunodeficiency virus (HIV) infection or acquired immunodeficiency syndrome (AIDS)
O. Amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease

5.9.2.3 Presumptive Disability Certification Process

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

Changes in Urgent Need Prior to Presumptive Disability Medicaid Certification

Sometimes a person's medical condition improves between the date of the presumptive disability Medicaid application and the date of the presumptive disability Medicaid certification. This improvement results in the person no longer meeting the urgent need criteria at the time of the presumptive disability Medicaid eligibility determination. The most common example of this situation is that of a person who is hospitalized on the date of the presumptive disability Medicaid application but then released from the hospital prior to being certified by the IM worker for presumptive disability Medicaid eligibility. Under these circumstances, if the presumptive disability applicant no longer has an urgent need as of the date that the IM agency is making the presumptive disability Medicaid eligibility determination/certification, the presumptive disability request must be denied, and the applicant must be notified that their request for a presumptive disability eligibility determination has been denied.

Example 1	Bob is 55 years old and has been hospitalized since February 1, after suffering his second stroke in the last four months. Bob applies for Medicaid on February 7. His physician attests in writing that Bob has an urgent need (he is hospitalized) and that he has one of the impairments listed on the Medicaid Presumptive Disability (F-10130). The IM agency has requested verification of Bob's non-exempt assets and completion of the Medicaid Disability Application (MADA) (F-10112). On February 14, Bob returns the completed MADA and asset verification information to his IM agency. He also indicates that he was released from the hospital on February 11 and is recuperating at home. On February 14, the IM agency has all the necessary information to make a presumptive disability Medicaid eligibility determination. Since Bob no longer has an urgent need on that date, his request for presumptive disability Medicaid must be denied.

Regardless of whether the IM agency or DDB makes the presumptive disability determination, the Medicaid Disability Application (MADA) (F-10112) must be completed before the IM agency can certify the member based on a presumptive disability.

The following forms are required for the presumptive disability process:

- Wisconsin Medicaid for the Elderly, Blind or Disabled Application Packet (F-10101)
- Medicaid Disability Application (MADA) (F-10112)
- Medicaid Presumptive Disability (F-10130)
- Authorization to Disclose Information to Disability Determination Bureau (DDB) (F-14014)
- Appoint, Change, or Remove an Authorized Representative (F-10126A Person or F-10126B Organization) (if applicable)

Once a presumptive disability decision has been made, the IM agency must still follow the disability application process (see SECTION 5.3 DISABILITY APPLICATION PROCESS and Process Help, Section 9.4 Automated Medicaid Disability Determination). The Medicaid Disability Application (MADA) (F-10112) must be completed and sent to DDB along with the necessary copies of the Authorization to Disclose Information to Disability Determination Bureau (DDB) (F-14014).

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

5.9.3 Presumptive Disability Determined by DDB

If the applicant has an urgent need but does not have one of the listed impairments, the IM agency must ask DDB to make a presumptive disability determination.

Note *If someone has an impairment but not an urgent need, the normal disability application process must be followed (see SECTION 5.3 DISABILITY APPLICATION PROCESS).*

All the forms listed in Section 5.9.2.3 are still required when DDB is making the presumptive disability determination (see Process Help, Section 9.4 Automated Medicaid Disability Determination for more information).

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

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

5.9.4 Deceased Applicants

While a deceased person can be eligible for Medicaid in the months prior to their death, presumptive disability determinations are not allowed for persons who are deceased. Such requests for a final disability determination are processed through the regular disability process through DDB.

5.9.5 Eligibility

Medicaid coverage based on a presumptive disability determination begins on the date the person is found presumptively disabled by DDB or the IM worker. If the presumptive disability determination is made by the IM worker, Medicaid coverage should begin the date the complete Medicaid Presumptive

Disability (F-10130) form is received by the IM agency, if all other eligibility requirements are met. The effective date should not be delayed based on the date the IM worker takes action to confirm the case.

Example 1	Jane contacted her IM agency and applied for Medicaid on July 3. She reported being in urgent need of medical services due to muscular dystrophy. The IM worker determines that Jane would be eligible based on presumptive disability and requests that a medical professional complete and sign the Medicaid Presumptive Disability (F-10130) form to attest to the urgent need and impairment. Jane's physician completes and returns the form to the IM agency on July 12. The IM worker processes the verification on July 14. Jane is found presumptively disabled and eligible for Medicaid effective July 12.

Example 2	Bob is Jack's son and authorized representative. Bob applied for Medicaid on behalf of his father by telephone on June 20. He reported to the IM worker that Jack had a stroke six weeks ago and is in urgent need of medical services. The IM worker determines that Jack may be eligible based on presumptive disability but requests that a medical professional complete and sign the Medicaid Presumptive Disability (F-10130) form to attest to the urgent need and impairment. Bob also needs to verify Jack's assets. The completed Medicaid Presumptive Disability form, attesting to the impairment and urgent need, is received by the IM agency on July 2, and verification of Jack's checking account is received July 12. The IM worker processes the verification on July 15. The worker determines that Jack is presumptively disabled and eligible for Medicaid effective July 2.

Because CARES usually certifies Medicaid from the beginning of the month, the IM worker must manually complete a Medicaid/BadgerCare Plus Eligibility Certification (F-10110) form to apply the correct begin date. The form can be returned by fax to 608-221-8815 or by mail to the following address:

ForwardHealth
Eligibility Unit
P.O. Box 7636
Madison, WI 53707

Eligibility cannot be granted prior to the date the presumptive disability was determined until DDB makes a formal disability determination (when the case folder is returned to the IM agency). Once DDB does the final determination, eligibility may be backdated up to three months prior to the month of application but no earlier than the date of disability onset, provided all other eligibility requirements are met. The applicant does not need to submit a new application or signature.

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

5.9.6 Disability Application Denials

5.9.6.1 DDB Returns a Negative Presumptive Disability Decision

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

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

5.9.6.2 Ineligible for Non-Medical Reasons

If a member is determined ineligible for non-medical reasons, eligibility based on a presumptive disability may be terminated with timely notice without waiting for DDB's final disability decision. In such a case, the IM agency will notify DDB immediately that a medical determination is no longer needed.

5.9.6.3 DDB Reverses Presumptive Disability Decision Made by DDB or by the IM Agency

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

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

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5.10 Medicaid Purchase Plan Disability

5.10.1 MAPP Introduction

When a disability determination for the MAPP is required, complete the application process in SECTION 5.3 DISABILITY APPLICATION PROCESS.

Section V – Work History of the Medicaid – Disability Application (F-10112) must be completed in full detail in all MAPP disability determination requests. The Disability page in CWW should be coded to indicate whether the request is for a MAPP disability determination or both a regular Medicaid disability determination and a MAPP disability. It is advisable to have both determinations completed if an applicant may move from regular Medicaid disability to MAPP disability.

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

5.10.2 Medicaid Applicants and Members Who Convert from Social Security Disability to Social Security Retirement

An EBD Medicaid applicant or member whose SSDI or any other disability-related Old Age, Survivors and Disability Insurance (OASDI or Title II) benefits stopped because he or she began receiving SSRE is considered to have met the disability requirement for all types of EBD Medicaid, including MAPP. A disability re-determination is not required. Refer to 5.2.2 DISABLED MEDICAID APPLICANTS AND MEMBERS WHO CONVERT FROM SOCIAL SECURITY DISABILITY TO SOCIAL SECURITY RETIREMENT BENEFITS.

For more information on MAPP, see SECTION. 26.1 INTRODUCTION.

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6 Residency

6.1 Residency Eligibility

6.1.1 Residency Eligibility Introduction

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

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

   and

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

Example 1:	This is George's first day in Wisconsin. He states that he intends to reside in Wisconsin. For Medicaid purposes, George is a Wisconsin resident.

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

6.1.2 Migrant Workers

A person who meets the definition of a migrant worker (see SECTION 31.1 MIGRANT WORKERS) meets the residency requirement if they are currently present in Wisconsin. They do not have to "intend to reside" in Wisconsin. Certain migrant workers qualify for a simplified application procedure. For policies related to migrant workers, see BadgerCare Plus Handbook, Chapter 12 Migrant Workers.

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6.2 Intent to Reside

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

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

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

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

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6.3 Determining Residence

6.3.1 Under Age 21

6.3.1.1 In an Institution

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

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

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

6.3.1.2 Not in Institution

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

- Age 18 or under age 18 and emancipated from his or her parents, or married, and is:
- Living in Wisconsin with the intent to remain living in Wisconsin, or
- Living in Wisconsin and entered Wisconsin with a job commitment or to seek employment.
- Under age 18 and not emancipated from his or her parents and not married, and is:

    1. Living here temporarily, not receiving Medicaid from another state, and is a migrant farm worker or living with a family member who is a migrant farm worker.
    2. Living in another state when Wisconsin or one of its county agencies has legal custody of him or her.
    3. Living here and is an EBD Medicaid case (the person's eligibility is based on blindness or disability)

6.3.2 Age 21 and Over

6.3.2.1 In an Institution

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

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

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6.4 Special Situations

6.4.1 State Supplementary Payment

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

6.4.2 Homeless Persons

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

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6.5 Absence

6.5.1 Absence Introduction

Once established, Wisconsin residence is retained until one of the following:

- The person notifies the income maintenance agency that he or she no longer intends to reside in Wisconsin
- Another state determines the person is a resident in that state for Medicaid/Medical Assistance
- Other information is provided that indicates the person is no longer a resident

6.5.2 Temporary Absence

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

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6.6 Reserved

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6.7 Reserved

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6.8 Interstate Placements

6.8.1 Interstate Placements Introduction

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

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

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

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

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

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

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

6.8.2 Reciprocal Agreement

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

These are the states with which we have this agreement:

- Alabama
- Arkansas
- California
- Georgia
- Idaho
- Kansas
- Kentucky
- Maryland
- Minnesota
- Mississippi
- New Mexico

- N. Dakota
- Ohio
- Pennsylvania
- S. Carolina
- S. Dakota
- Texas
- Virginia
- W. Virginia

6.8.3 Disputes

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

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

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6.9 Reserved

Policy related to inmates has been moved to Chapter 13.

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7 U.S. Citizen or Qualifying Immigrant

7.1 US Citizens and Nationals

7.1.1 U.S. Citizens and Nationals Introduction

To qualify for Medicaid, persons who are otherwise eligible and declare that they are U.S. citizens or nationals must provide documentation of their citizenship, unless they are exempt or their citizenship is verified by the Social Security Administration through a data exchange.

A U.S. citizen is anyone who:

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

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

7.1.2 Child Citizenship Act of 2000

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

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

The CCA provides that foreign-born children who meet the conditions below automatically acquire U.S. citizenship on the date the conditions are met. They are not required to apply for a certificate of naturalization or citizenship to prove U.S. citizenship. These conditions are that the child:

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

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

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

4. Orphans adopted under the age of 18, who have had their adoption and immigration status approved by the USCIS, and are siblings of another adopted child who is under the age of 16. These children need not have lived with the adoptive parents for two years.

7.1.3 Compacts of Free Association

Citizens of the Compacts of Free Association are not considered U.S. citizens or nationals. The Compacts of Free Association include the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau. Citizens of the Compacts of Free Association (COFA) have a special status with the US that allows them to enter the country, work here, and acquire an SSN without obtaining an immigration status.

As of December 27, 2020, COFA citizens may be eligible for health care if they meet all other eligibility requirements. In addition, COFA citizens are not subject to the 5-year waiting period. However, COFA citizens who adjust their status and become Lawful Permanent Residents are subject to the 5-year waiting period.

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7.2 Verifying U.S. Citizenship

7.2.1 Citizenship Verification Introduction

U.S. citizenship must be verified for persons applying for or receiving Medicaid (MA), BadgerCare Plus, or FPOS benefits and who have declared that they are a U.S. citizen, unless they are exempt from this requirement (See SECTION 7.2.1.2 EXEMPT POPULATIONS). Citizenship verification for health care must first be attempted using the real-time data exchange with the Social Security Administration before requesting documentation of citizenship from applicants. (See SECTION 7.2.3 CITIZENSHIP VERIFICATION THROUGH DATA EXCHANGE). Only those who are not exempt and for whom verification was not available through a data exchange may be required to submit documentation of their citizenship (See SECTION 7.2.4 CITIZENSHIP VERIFICATION THROUGH DOCUMENTATION). Once citizenship has been verified for a person, verification may never again be required to receive health care benefits unless previously verified information becomes questionable.

7.2.1.1 Covered Programs

The U.S. citizenship verification requirement applies to all non-exempt applicants and members of the following programs:

- BadgerCare Plus (except for the Prenatal Program and Emergency Services)
- Medicaid (except for Emergency Services)
- Katie Beckett Medicaid
- Tuberculosis (TB)-related Medicaid
- Wisconsin Well Woman Medicaid (WWWMA)

If U.S. citizenship has been verified for any of these programs, U.S. citizenship is considered verified for all programs.

7.2.1.2 Exempt Populations

The following populations are exempt from the U.S. citizenship verification requirement:

- Anyone currently receiving SSDI or a Disabled Adult Child benefit (SSDC)
- Anyone who is currently receiving Supplemental Security Income (SSI) benefits
- Anyone currently receiving Medicare
- Anyone currently receiving Foster Care (Title IV-E and Non IV-E)
- Anyone currently receiving Adoption Assistance
- Anyone who has been eligible for Wisconsin Medicaid or BadgerCare Plus as a Continuously Eligible Newborn (CEN) at any time on or after July 1, 2006 (including CENs born on or after July 1, 2005)

The citizenship verification requirement does not apply to persons who are not applying for or receiving any health care benefits. This requirement also does not apply to persons who are not claiming to be a U.S. citizen.

Identity verification is only required in certain situations as part of citizenship verification. Persons not applying for or receiving any health care benefits and persons who are not claiming to be a U.S. citizen are not required to verify identity (see SECTION 7.2.4.3 EVIDENCE OF IDENTITY).

Former Supplemental Security Income and Medicare Recipients

Medicare, SSDI, and SSI recipients lose their exemption from the citizenship verification requirement when their enrollment in these programs ends.

Note: *IM workers must use data exchanges to verify receipt of SSI, SSDI, and Medicare prior to requesting verification from the applicant or member.*

7.2.2 Reserved

7.2.3 U.S. Citizenship Verification Through Data Exchange

For persons who meet the selection criteria below, a request will be sent electronically to the Social Security Administration (SSA) with the person's name, verified Social Security Number (SSN), and date of birth for comparison to SSA's data. If SSA is able to verify U.S. citizenship, no additional verification of U.S. citizenship is required.

To be selected for this data exchange, a person must:

- Be requesting health care.
- Have declared they are a U.S. citizen or national.
- Have provided an SSN.
- Not belong to an exempt population listed in SECTION 7.2.1.2 EXEMPT POPULATIONS.
- Not have already had their U.S. citizenship verified through other means.

Non-exempt Medicaid applicants who do not provide an SSN, or whose SSN cannot be verified, cannot have their U.S. citizenship verified through the data exchange. They must meet the U.S. citizenship verification requirement by providing documentation as defined in SECTION 7.2.4 CITIZENSHIP VERIFICATION THROUGH DOCUMENTATION.

7.2.4 U.S. Citizenship Verification through Documentation

For individuals who are not exempt from the U.S. citizenship verification requirement and have not had their U.S. citizenship verified by the Social Security Administration, agencies must first attempt to verify U.S. citizenship as follows:

- For applicants born in Wisconsin, attempt verification of citizenship through a birth record query.
- For applicants who had legal non-citizen status and subsequently gain U.S. citizenship, attempt verification of citizenship through SAVE.

If verification cannot be obtained through the SSA, birth record query, or SAVE, the individual must provide verification of U.S. citizenship through either stand-alone documentation of citizenship (see SECTION 7.2.4.1 STAND-ALONE DOCUMENTATION OF CITIZENSHIP) or both documentation of citizenship (see SECTION 7.2.4.2 EVIDENCE OF CITIZENSHIP) and identity (see SECTION 7.2.4.3 EVIDENCE OF IDENTITY). Whether benefits may be granted while waiting for documentation to be provided and for how long are discussed under the Reasonable Opportunity Period for Verification of Citizenship (see SECTION 7.2.4.4 REASONABLE OPPORTUNITY PERIOD FOR VERIFICATION OF CITIZENSHIP).

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

If an applicant/member contacts the agency for help with verifying citizenship, work with him or her to determine if anything on the document list in Process Help, Section 68.3 Acceptable Citizenship and Identity Documentation is readily available to the applicant/member. In certain circumstances the agency can authorize payment of documentation for an applicant/member. See SECTION 7.2.5 AGENCIES PAYING FOR DOCUMENTATION.

Agencies may accept citizenship and identity documents from an individual whose last name has changed due to marriage or divorce if the documentation matches in every way with the exception of the last name. If the different last names are found questionable, the agency may request that the individual provide an official document verifying the change such as a marriage license or divorce decree. If an individual has changed his or her first and last name, he or she must produce documentation from a court or governing agency documenting the change.

An electronic copy of documentation submitted by the applicant or member to satisfy the citizenship verification requirement must be maintained in the case record.

See Process Help, Section 68.1 Citizenship and Identity Verification, for tools that IM workers can use to assist members and applicants in meeting the citizenship verification requirement.

Once citizenship has been verified by a State or IM agency, verification may never be requested again, even after periods of ineligibility for health care benefits, unless other information is received causing past previously verified information to be questionable. This includes verification of citizenship or identity documented by a written affidavit.

7.2.4.1 Stand-Alone Documentation of U.S. Citizenship

Stand-alone documentation is a single document that verifies U.S. citizenship, such as a United States Passport. Stand-alone documentation of U.S. citizenship is the most reliable way to establish that the person is a U.S. citizen. If a person presents a stand-alone document, no other U.S. citizenship verification is required. See the chart below or Process Help, Section 68.3.2 Stand-Alone Documentation of Citizenship for a list of acceptable documents.

An applicant or member who does not provide a stand-alone document must provide documentation of both U.S. citizenship and identity (see SECTION 7.2.4.2 EVIDENCE OF CITIZENSHIP and SECTION 7.2.4.3 EVIDENCE OF IDENTITY).

Stand-Alone Document	Description/Explanation
Certificate of Naturalization	Form N-550 or N-570. Issued by the Department of Homeland Security for naturalization.
Certificate of Citizenship	Form N-560 or N-561. The Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.
A State-issued Enhanced Driver's License	A special type of driver's license identified specifically as an "Enhanced Driver's License". It requires proof of U.S. citizenship to obtain. Five states currently issue enhanced driver's licenses (Minnesota, Michigan, New York, Vermont, and Washington), but more states are expected to issue these licenses in the future. Accept an Enhanced Driver's License issued by any U.S. state. REAL IDs are not Enhanced Driver's Licenses. REAL IDs only provide documentation of identity, not citizenship.
U.S. Passport	The Department of State issues this. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. Passports issued with a limitation may only be used as proof of identity.

Tribal Identification Documents	Documentary evidence issued by a federally recognized Indian tribe, which meets all the following criteria: • Identifies the federally recognized Indian tribe that issued the document • Identifies the individual by name • Confirms the individual's membership, enrollment, or affiliation with the tribe Such Tribal identification documents include, but are not limited to: • A Tribal enrollment card; • A Certificate of Degree of Indian Blood; • A Tribal census document; and • Documents on Tribal letterhead, issued under the signature of the appropriate Tribal official A photograph is not required to be part of these documents.
SAVE Database	Using the SAVE system to verify citizenship status for non-citizens who gained U.S. citizenship.
Birth Query	A birth record query confirms a person's birth in Wisconsin.

7.2.4.2 Evidence of U.S. Citizenship

If an applicant whose U.S. citizenship has not been verified by SSA, birth query, or SAVE database is unable to provide stand-alone documentation of U.S. citizenship (see SECTION 7.2.4.1 STAND-ALONE DOCUMENTATION OF U.S. CITIZENSHIP), they must provide other documentation proving U.S. citizenship.

Any document used to establish U.S. citizenship must show either a birthplace in the U.S. or that the person is otherwise a U.S. citizen (see the chart below or Process Help, Section 68.3 Acceptable Citizenship and Identity Documentation). If an applicant is unable to provide any of the acceptable documents of U.S. citizenship, they may submit an affidavit signed by another person under penalty of perjury, who can reasonably attest to the applicant's U.S. citizenship. The affidavit must contain the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

The applicant may submit a Statement of Citizenship and/or Identity (F-10161) or another affidavit.

Applicants whose U.S. citizenship cannot be verified by SSA or through stand-alone documentation of U.S. citizenship must also provide documentation of identity (see SECTION 7.2.4.3 EVIDENCE OF IDENTITY).

Acceptable Documentation of Citizenship Only	**Description/Explanation**
Final Adoption Decree	The adoption decree must show the child's name and U.S. place of birth. Where an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
Birth Certificate	A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941),

	Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). The birth record document may be recorded (previously 'issued') by the state, commonwealth, territory, or local jurisdiction. **Note:** A Puerto Rican birth certificate used to verify U.S. citizenship of anyone applying for health care benefits must have been issued on or after July 1, 2010. Older birth certificates that were used to verify citizenship for persons when they previously applied for any IM program before October 1, 2010, are still considered valid.
U.S. birth record amended more than 5 years after person's birth	An amended U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). Must show a U.S. birthplace.
Acquired citizenship through parent(s) as outlined in the Child Citizenship Act 2000 (CCA)	An individual demonstrates that s/he has gained his/her U.S. Citizenship through the Child Citizenship Act of 2000.
US Citizen ID Card or Northern Mariana Card	U.S. Citizen ID Card The Immigration and Naturalization Service (INS) issued the I-179 and the I-197 from 1960 until 1983 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Northern Mariana Card Form I-873. Issued by INS for those born in the Northern Mariana Islands before November 4, 1986.
State or Federal census record	Must show birthplace and citizenship. Census records from 1900 through 1950 contain certain citizenship information. To secure this information, the applicant, member, or State should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Also add that the purpose is for Medicaid eligibility. This form requires a fee.
Education Document	The school record must show a U.S. birthplace and the name of the child.
Evidence of civil service employment by U.S. government	The document must show employment by the U.S. government before June 1, 1976. Persons employed with the U.S. Government prior to that date had to be U.S. citizens.
Hospital record	Extract of a hospital record on hospital letterhead established at the time of the person's birth and that indicates a U.S. place of birth. This is not a souvenir "birth certificate" issued by the hospital.
Life, health, or other insurance record	Must show a U.S. place of birth.

Medicaid Birth Claim	When the Wisconsin Medicaid program pays the costs associated with the birth of an infant who either: • Did not qualify as a CEN, or • Was a CEN, but born before July 1, 2006 The infant will be considered a U.S. citizen who has met the citizenship documentation requirement. If citizenship is not verified through a data exchange, identity documentation is still required.
Medical record (doctor, clinic, hospital)	The document must show a U.S. birthplace. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.
Official Military record of service	The document must show a U.S. birthplace.
Admission papers from nursing home, skilled nursing care facility, or other institution	The document must show a U.S. birthplace.
Other MA Program Verified Citizenship	An individual has already provided proof of citizenship while they were receiving Wisconsin Medicaid outside of CARES. For example, use this for members previously enrolled through the Katie Beckett program.
Birth Certificate Paid by IM Agency	A U.S. public birth certificate (paid for by the Income Maintenance agency) showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). The birth record document may be recorded (previously 'issued') by the state, commonwealth, territory, or local jurisdiction.
Religious Record or Baptismal Certificate	An official religious record. The document must show a US birthplace and either the date of birth or the individual's age at time the record was made.
Certification of Report of Birth	The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth.
Certification of Birth Abroad	Form FS-545. Issued by the Department of State consulates prior to November 1, 1990.
Consular Report of Birth Abroad of a US Citizen	Form FS-240. The Department of State consular office prepares and issues this. Children born outside the U.S. to U.S. military personnel usually have one of these.
Written Affidavit (Form F-10161)	If the applicant cannot produce the accepted documents verifying U.S. citizenship, a written affidavit may be used. The affidavit must: • Be signed under penalty of perjury by a person other than the applicant who can reasonably attest to the applicant's citizenship. • Include the applicant's name, date of birth, and place of U.S. birth. The affidavit doesn't need to be notarized. The "Citizenship Statement" section of the Statement of Citizenship and/or Identity form (F-10161) may be used for the affidavit.

7.2.4.3 Evidence of Identity

If an applicant whose U.S. citizenship is not verified by SSA is unable to provide stand-alone documentation of citizenship (see SECTION 7.2.4.1 STAND-ALONE DOCUMENTATION OF CITIZENSHIP), they must provide evidence of both citizenship (see SECTION 7.2.4.2 EVIDENCE OF CITIZENSHIP) and identity.

As a reminder, for health care, verification of identity must not be requested or required for:

- U.S. citizens who are exempt from the verification requirement (see SECTION 7.2.1.2 EXEMPT POPULATIONS).
- U.S. citizens whose citizenship is verified by SSA.
- U.S. citizens whose citizenship is verified by a birth query, SAVE database, or other stand-alone documentation of citizenship.
- Persons who have not declared they are U.S. citizens.
- Non-U.S. citizens.

The applicant may provide any documentation of identity listed in the chart below or Process Help, Section 68.3 Acceptable Citizenship and Identity Documentation to verify identity, provided such document has a photograph or other identifying information sufficient to establish identity such as name, age, sex, race, height, weight, eye color, or address.

In addition, the IM agency may accept proof of identity from a Federal agency or another State agency, including but not limited to a law enforcement, revenue, or corrections agency, if the agency has verified and certified the identity of the person. If the applicant does not have any documentation of identity and identity is not verified by another Federal or State agency, they may submit an affidavit, signed under penalty of perjury, by a person other than the applicant who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity, as described above. The affidavit does not have to be notarized. The applicant may submit a Statement of Citizenship and/or Identity (F-10161) or another affidavit.

Acceptable Documentation of Identity Only	**Description/Explanation**
State or Territory Driver's license	Driver's license issued by a U.S. State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight, or eye color. REAL IDs only provide documentation of identity, not citizenship. Note: Real IDs only provide documentation or identity, not citizenship.
Education Document	For children under age 19, school records providing the name and other identifying information. School records would include, but not be limited to report cards, daycare, or nursery school records.
FoodShare Identification Requirement met	Verifying the identity of the primary person is a requirement for a FoodShare application. Once this requirement is met for FoodShare, it is also met for the identity verification requirement for health care.
Identification card issued by Federal, State, or local government	Must have the same information as is included on driver license.
Institutional Care Affidavit (Form F-10175)	If the applicant cannot produce the accepted documents verifying identity, a signed Statement of Identity for Persons in Institutional

	Care Facilities (F-10175) may be used. A residential care facility administrator signs this form under penalty of perjury attesting to the identity of a disabled individual in the facility.
U.S. Military card or draft record, Military dependent's identification card, or US Coast Guard Merchant Mariner card	Must show identifying information that relates to the person named on the document.
Medical record	Doctor, clinic, or hospital records for children under age 19 only.
Motor Vehicle Data Exchange	This is a data exchange update with the Division of Motor Vehicles or when verifying an individual's identity through the DOT Driver License Status Check website.
Multiple Identity documents	An individual may provide 2 or more corroborating ID documents to verify his/her identity. Examples include marriage license, divorce decree, high school or college diploma, or an employer ID card.
Other MA Program Verified Identity	An individual has already provided proof of identity while they were receiving Wisconsin Medicaid outside of CARES. For example, use this for members previously enrolled through the Katie Beckett program.
State ID Paid by Agency	Must have the same information as is included on driver license.
School Identification card	School identification card with a photograph of the individual or other identifying information.
Written Affidavit for Children (Form F-10154)	If the applicant cannot produce the accepted documents verifying identity for children under 18 years of age, a Statement of Identity for Children Under 18 Years of Age (F-10154) is acceptable. The affidavit must be signed under penalty of perjury by a parent, guardian or caretaker relative stating the date and place of birth of the child. The affidavit does not have to be notarized.
Written Affidavit (Form F-10161)	If the applicant cannot produce the accepted documents verifying identity, a written affidavit may be used. The affidavit must: • Be signed under penalty of perjury by an individual other than the applicant, who can reasonably attest to the applicant's identity. • Contain the applicant's name, and other identifying information such as, age, sex, race, height, weight, eye color, or address. The affidavit doesn't need to be notarized. The "Identity Statement" section of the Statement of Citizenship and/or Identity form (F-10161) may be used for the affidavit.

7.2.4.4 Reasonable Opportunity Period for Verification of Citizenship

Applicants who are otherwise eligible for Medicaid or other health care benefits and are only waiting for verification of U.S. citizenship must be certified for health care benefits within the normal application processing timeframe (see SECTION 2.7 APPLICATION PROCESSING PERIOD). They can continue receiving health care benefits for which they are eligible while the IM agency waits for U.S. citizenship verification.

Applicants have 90 days after receiving a request for U.S. citizenship verification to provide the requested documentation. This 90-day period is called the reasonable opportunity period (ROP). The 90-day ROP starts on the date after the member receives the notice informing them of the need to provide U.S. citizenship verification by the end of the reasonable opportunity period. Federal regulations require that states assume a minimum five-day time frame for applicants to receive notices. For this reason, the end of the ROP must be no less than 95 days after the date on the notice, even when the member receives the notice in less than five days. If a member shows that a notice was received more than five days after the date on the notice, the deadline must be extended to 90 days after the date the member received the notice.

The 90-day ROP applies when citizenship verification is needed from a person at any time: applications, reviews, and when a person is newly requesting benefits on an existing case.

Applicants are not eligible for backdated health care benefits while pending for citizenship verification. Once citizenship verification is provided, the applicant's eligibility must then be determined for backdated health care benefits if they have been requested.

The ROP ends on the earlier of the date the agency verifies the person's citizenship or identity or on the 95th day following the date the reasonable opportunity period notice was sent (unless receipt of the notice was delayed). If the requested verification is not provided by the end of the 95 days, the worker must take action within 30 days to terminate eligibility. Extensions of the reasonable opportunity period are not allowed for verification of U.S. citizenship.

When a person is terminated from health care benefits for failure to provide verification of citizenship or identity by the end of the reasonable opportunity period, they are not eligible to have their benefits continued if they request a fair hearing. If a person later reapplies for health care benefits, they may receive another reasonable opportunity period to provide verification of citizenship or identity.

Benefits issued during a reasonable opportunity period (including benefits issued due to timely notice requirements) to a person otherwise eligible for Medicaid or BadgerCare Plus are not subject to recovery, even if the person never provides citizenship verification.

7.2.5 Agencies Paying for Documentation

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

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

Note *If a member has obtained and already paid for his or her own documentation and later asks the IM agency for reimbursement of those costs, the IM agency should not provide reimbursement.*

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

IM agencies should pay for a birth certificate or state ID card before relying on a written affidavit. If there is an opportunity to obtain a document that meets the guidelines, then that should be pursued.

However, when an applicant or member lacks any identity documentation needed to apply for a birth certificate or lacks any citizenship documentation to be able to apply for an ID card, it is appropriate to consider using a written affidavit for citizenship and/or identity.

In order to obtain birth certificates or state ID cards for applicants or members, agencies need to follow the process outlined in Process Help Section 68.2.5 Agency Documentation Requests.

7.2.6 Reserved

7.2.7 Situations which Require Special Documentation Processing

7.2.7.1 Person Add

A person being added to a case is subject to the verification requirement at the time of his or her request for benefits. If not exempt and citizenship is not verified by SSA, inform the applicant of the documentation requirement and give him or her the 95-day reasonable opportunity period to comply. Grant eligibility if the person is otherwise eligible. If documentation is not received timely, terminate Medicaid for that person only.

7.2.7.2 Reserved

7.2.7.3 Individuals without Verification and Effect on Household Eligibility

IM workers should not delay an individual household member's eligibility when awaiting another household members' citizenship or identity verification. The individual pending for citizenship or identity should be counted as part of the group when determining eligibility for other group members. See Process Help Section 68.2 Documentation and Verification Codes for processing instructions.

7.2.7.4 Child Citizenship Act of 2000

Certain foreign-born persons have derivative U.S. citizenship as a result of the Child Citizenship Act (CCA) (see SECTION 7.1.2 CHILD CITIZENSHIP ACT OF 2000).

IM workers should not request citizenship documentation for persons claiming U.S. citizenship through the CCA. In these cases, IM workers must instead verify the U.S. citizenship of one parent. The parent's U.S. citizenship is the basis for the child receiving derivative citizenship.

The parent's U.S. citizenship is considered evidence of the child's citizenship only. The child must provide another document to verify their identity (see SECTION 7.2.4.3 EVIDENCE OF IDENTITY).

7.2.7.5 Non-U.S. Citizens

IM agencies must not request or require citizenship verification from persons who have not declared that they are U.S. citizens. Non-U.S. citizens who apply for IM programs are not subject to citizenship verification policy. Documented non-U.S. citizens are subject to the verification process through Federal Data Services Hub (FDSH) and Systematic Alien Verification for Entitlements (SAVE), and undocumented non-U.S. citizens do not have any status that can be verified (see Process Help, Section 44.2.1.12 Immigrant/Refugee Verification for instructions on using FDSH and Process Help, Chapter 82 SAVE for instructions on using SAVE). Undocumented non-U.S. citizens can apply for Emergency Medicaid or BadgerCare Plus Prenatal Program and are not subject to the citizenship verification policy. They also do not have to verify their identity.

A person who had documented non-U.S.-citizen status and subsequently gained U.S. citizenship, should be verified through SAVE. The verification result from SAVE will be "individual is a US Citizen."

7.2.7.6 Persons in Institutional Care Facilities

Applicants with a disability in institutional care facilities may have their identity (if required) attested to by the facility director or administrator when nothing else is available. Use the Statement of Identity for Persons in Institutional Care Facilities (F-10175) for this purpose. A medical institution can be, but is not limited to, skilled nursing facilities, intermediate care facilities, institutes for mental disease, and hospitals.

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7.3 Immigrants

"Immigrants" refers to all people who reside in the U.S., but are not U.S. citizens or nationals. Immigrants may be eligible for Medicaid and other categories of health care benefits if they meet all eligibility requirements and, in addition, declare that they have a satisfactory immigration status (see SECTION 7.3.1 DECLARATION OF SATISFACTORY IMMIGRATION STATUS), and they are:

- "Qualified Immigrants" (see SECTION 7.3.3.1 QUALIFYING IMMIGRANTS), or
- "Lawfully Present" (see SECTION 7.3.3.2 LAWFULLY PRESENT IMMIGRANT CHILDREN, YOUNG ADULTS, AND PREGNANT PEOPLE), and
    - Are under age 19,
    - Are under age 21 and residing in an IMD, or
    - Are pregnant.

Immigrants who do not meet these additional requirements may still be eligible for the BadgerCare Plus Prenatal Program or Emergency Services.

Before health care benefits may be issued to immigrants, their immigration status must be verified with the Department of Homeland Security through the Federal Data Sources Hub or SAVE (See SECTION 7.3.2 VERIFICATION). Prior to verification of immigration status, benefits may also be issued for a temporary period under a Reasonable Opportunity Period (see SECTION 7.3.2.2 REASONABLE OPPORTUNITY PERIOD FOR VERIFICATION OF IMMIGRATION STATUS).

7.3.1 Declaration of Satisfactory Immigration Status

To qualify for health care benefits, persons who are not U.S. citizens or nationals must declare (or have an adult member of their household declare on his or her behalf) a satisfactory immigration status, except for:

- Persons applying for Emergency Services.
- Pregnant people applying for the BadgerCare Plus Prenatal Program.
- Persons who are not requesting benefits.

This declaration is normally provided as part of a signed application for health care that provides some basic information regarding the immigration status of household members. However, in some cases, a person may only indicate on his or paper or ACCESS application that he or she is not a U.S. citizen and not provide any information about his or her immigration status. In such a situation, it is not known whether the person is telling us that he or she is lawfully present in the U.S. (i.e., that they have a satisfactory immigration status) or that they are undocumented.

Federal law requires that agencies obtain a declaration of satisfactory immigration status before taking any action to verify a person's immigration status, including granting eligibility during a reasonable opportunity period (see 7.3.2.2 REASONABLE OPPORTUNITY PERIOD). To meet this declaration requirement, everyone who indicates that he or she is not a U.S. citizen or national must provide one of the following:

- His or her immigration status
- His or her immigration number (including an I-94, passport, SEVIS, or similar number)
- A signed declaration that says he or she has a satisfactory immigration status

Anyone who is required to and fails to provide immigration information or a declaration (or have an adult in the household provide it on his or her behalf) within standard verification timeframes must be denied health care benefits and must not be granted a reasonable opportunity period.

7.3.2 Verification

7.3.2.1 Verification through FDSH or SAVE

Primary verification of immigration status is done through the U.S. Citizenship and Immigration Services (USCIS) by use of the Federal Data Services Hub (FDSH) or Systematic Alien Verification for Entitlement (SAVE), an online service used to verify immigration status and naturalized/acquired U.S. citizenship. A worker processing an application can simply enter the immigrant's A-number or USCIS number and immigration document type into CWW. That information, along with demographic information of the individual, is sent in real time to the FDSH. The FDSH will immediately return verification of the immigrant's status, date of entry, and the date the status was granted if it's available from UCIS, along with other information. If the FDSH cannot provide verification of the immigration status, workers are directed to seek secondary verification though SAVE or take other action.

The verification query via the FDSH or SAVE most likely results in returning the latest date of any qualified immigration status update for an individual, not their original date of arrival. The only way to obtain an accurate date of arrival for those who do not meet an exemption category and who report a date of arrival prior to August 22, 1996, is through the secondary verification procedure. The FDSH or SAVE will describe the immigrant's current status which may have changed from the original status. In some situations, workers will need to maintain the original status in CWW (see the Additional Eligibility Information column in the table in SECTION 7.3.3.1 QUALIFYING IMMIGRANTS).

It may be necessary to complete a secondary or third level verification procedure with USCIS via SAVE, including confirming the date of arrival, in the following situations:

- The applicant does not fall into any of the categories of non-citizens who are exempt from the five-year waiting period (for example, refugees, asylees, those with military service).
- A worker has made an initial or primary verification inquiry using the SAVE database. The information from the inquiry conflicts with information on the applicant's immigration documents or what they are telling the worker.
- A non-citizen applicant tells a worker that they came to the U.S. prior to August 22, 1996. If they arrived in a legal or documented status, the worker needs to verify the date of arrival to ensure that the correct immigrant eligibility rules are being applied.
- The FDSH or SAVE returns the message "Institute Secondary Verification."
- The worker finds any questionable information in the initial verification process.
- Cuban/Haitian entrants when SAVE or the Hub indicates the need.

An Immigration Status Verifier at USCIS will research the individual's records and complete the response portion of the verification request.

Example 1	Shariff arrived as a student in June 2002. On June 5, 2006, he was granted asylum. The five-year waiting period does not apply to those granted asylum. Secondary verification via SAVE is not necessary. Shariff is eligible to be enrolled in BadgerCare Plus if he meets other financial and non-financial criteria.

Example 2	Tomas entered the U.S. on April 8, 1996, on a visitor's visa. He obtained qualified immigration status on September 22, 2003. Tomas applied for Medicaid on May 5, 2008. The worker completed primary verification and USCIS responded with the date of entry as September 22, 2003, since that was the last updated date on his status. The worker needs to confirm with the applicant that this is the original date he arrived in the U.S. Tomas explained that he arrived in 1996; therefore, the worker needs to conduct secondary verification. SAVE responds and confirms that the original date of arrival was April 8, 1996.

	Additionally, the worker needs to confirm that the applicant was continuously present (see SECTION 7.3.2.2.3 CONTINUOUS PRESENCE) between April 8, 1996, and September 22, 2003. Tomas signs a self-declaration confirming this and is found eligible. If the worker had used September 22, 2003, as the date of entry in CARES, Tomas would have been incorrectly subject to the five-year waiting period and not eligible until September 22, 2008.

See Process Help, Chapter 82 SAVE for more information.

7.3.2.2 Other Verification

Additional verifications from sources other than Federal Data Services Hub (FDSH) or SAVE are sometimes required.

7.3.2.2.1 Military Service/Connection

The following documents are considered valid verification of military service for persons who are in an immigration status subject to the five-year waiting period and who indicate that they, their spouse, or parent is in the military service or is a veteran.

- A signed statement or affidavit form from an applicant attesting to being a veteran, surviving spouse, or dependent child.
- Military records

7.3.2.2.2 Date of Arrival

To establish a date of arrival for a qualified immigrant who originally arrived as an undocumented immigrant prior to August 22, 1996, the applicant must provide at least one piece of documentation that shows their presence in the U.S. prior to August 22, 1996. The following documents are considered valid verification of presence in the U.S.:

- Pay stubs
- A letter from an employer
- Lease
- Rent receipts
- Utility bills
- School enrollment records

7.3.2.2.3 Continuous Presence

To establish continuous presence, a signed statement is required from the applicant stating they were continuously present for the period in question. The signed statement will be sufficient unless a worker believes the information is fraudulent or information received is questionable.

Signed Statement Example	I, first and last name, hereby declare that I have continuously resided in the United States between the day I arrived in the United States, date here, and the date I received qualified immigrant status, date here. I have not left the United States in that time for any single period longer than 30 days or for multiple periods totaling more than 90 days. Applicant or Authorized Representative Signature, Date

7.3.2.3 Reverification of Immigration Status

Immigration status for many members should only be verified once, unless the status for an individual is questionable or they have a Registration Status Code of 20. Even if an immigrant loses health care eligibility for a period of time, their immigration status does not need to be re-verified.

People with a Registration Status Code of 20 – Lawfully Residing are required to re-verify their immigration status at application or renewal, even if they have previously verified their immigration status.

This reverification requirement is only to be applied at the time of subsequent applications, renewals, or when an agency receives information indicating that the member may no longer be lawfully residing in the U.S. For pregnant people, the reverification is not to occur until the renewal is done to determine the person's eligibility after the end of the 60-day postpartum period.

Individuals who report they have moved from a non-qualifying to a qualifying immigration status must have their new qualifying immigration status verified. Individuals who report they have become naturalized citizens must have their U.S. citizenship verified.

See Process Help, Section 44.3.9 Immigrant/Refugee Information Page for additional information on using the FDSH or the procedures in the SAVE Manual.

7.3.2.4 Reasonable Opportunity Period for Verification of Immigration Status

Applicants who have declared that they are in a satisfactory immigration status, are otherwise eligible and are only pending for verification of immigration status must be certified for health care benefits within the normal application processing timeframe (30 days from the filing date). They are to continue receiving health care benefits for which they are eligible, while the IM agency waits for immigration status verification. Applicants who are otherwise eligible and are only pending for verification of immigration will have 90 days after receiving a request for immigration verification to provide the requested documentation. This 90-day period is called the Reasonable Opportunity Period (ROP). The 90-day ROP starts on the date after the member receives the notice informing the member of the need to provide immigration verification by the end of the reasonable opportunity period. Federal regulations require that we assume a minimum five-day time frame for applicants to receive notices. For this reason, we must set the end of the ROP no less than 95 days after the date on the notice, even when the member receives the notice in less than five days. It also means that if a member shows that a notice was received more than five days after the date on the notice, the deadline must be extended to 90 days after the date the member received the notice.

The 90-day ROP applies when immigration verification is needed from a person at any time: applications, renewals and when a person is newly requesting benefits on an existing case.

Applicants are eligible for benefits beginning with the first of the month of application or request. However, they are not eligible for backdated health care benefits while waiting for verification of their immigration status. Once verification of an eligible immigration status is provided, the applicant’s eligibility must then be determined for backdated health care benefits if they have been requested.

When requested verification is not provided by the end of the ROP, the worker must take action within 30 days to terminate eligibility, unless one of the following situations occurs where the worker is allowed to extend the reasonable opportunity period:

- The agency determines that the person is making a good faith effort to obtain any necessary documentation.
- The agency needs more time to verify the person’s status through other available electronic data sources.
- The agency needs to assist the person in obtaining documents needed to verify his or her status.

Persons whose health care benefits were terminated for failure to provide verification of immigration status by the end of the ROP are not eligible to have their benefits continued if they request a fair hearing.

A person may receive a reasonable opportunity period more than once in a lifetime:

Example 1	Vladimir is a 12-year-old lawfully present in the United States on a visa applying for health care benefits with his parents. When verification is attempted through the FDSH, the response requires a secondary verification request to SAVE. Vladimir is otherwise eligible for Medicaid and is enrolled in Medicaid and the ROP notice is sent to the family while waiting for the SAVE response. A week later, SAVE verifies the child is lawfully present in the U.S. under a Temporary Protected Status and the reasonable opportunity period ends. A year later, the case is up for renewal. Since Vladimir has a Registration Status Code of 20 – Lawfully Residing, his immigration status must be verified again. Once more, the FDSH response requires verification of the child's status through SAVE. If Vladimir is otherwise eligible for Medicaid, they will be enrolled without delay and be sent a new reasonable opportunity period notice to the family. Again, Vladimir may be eligible for up to 90 days after receiving the notice while his immigration status is being verified.

Example 2	Sasha is a 22-year-old applying for health care benefits. Information received from the FDSH indicates she is a victim of trafficking. Confirmation of her status as a victim of trafficking is needed, and she must submit a letter from the U.S. Department of Health and Human Services Office on Trafficking in Persons (HHS OTIP). She is enrolled in BadgerCare Plus and is sent the ROP notice requesting Sasha submit a letter from HHS OTIP. Sasha never submits a letter from HHS OTIP and her benefits end when the ROP expires. One year later, Sasha again applies for health care benefits. Once more, the FDSH returns the same results. Sasha is otherwise eligible for BadgerCare Plus. She must be enrolled in BadgerCare Plus without delay and sent a new ROP notice to Sasha requesting a letter from HHS OTIP. Again, Sasha is eligible for BadgerCare plus for 90 days after receiving the notice while waiting for Sasha to provide a letter from HHS OTIP.

Benefits issued during a reasonable opportunity period to a person otherwise eligible for Medicaid or BadgerCare Plus are not subject to recovery, even if the person turns out to have an immigration status that makes him or her ineligible for Medicaid or BadgerCare Plus benefits.

7.3.3 Immigrants Eligible for Medicaid

Immigrants may be eligible for Medicaid if they meet all other eligibility requirements and are either Qualifying Immigrants (see SECTION 7.3.3.1 QUALIFYING IMMIGRANTS) or are Lawfully Present (see SECTION 7.3.3.2 LAWFULLY PRESENT IMMIGRANT CHILDREN, YOUNG ADULTS, AND PREGNANT PEOPLE).

7.3.3.1 Qualifying Immigrants

Immigrants of any age meeting the criteria listed below are considered Qualifying Immigrants. Unless otherwise specified, categories of qualifying immigrants are enumerated in 8 U.S.C.§ 1641(b) and (c).

Types of Qualifying Immigrants

Short Name	Qualifying Immigrant Description	Eligible if:	Additional Eligibility Information	CWW Registration Status
Refugee	A refugee admitted under Immigration and Nationality Act (INA) Section 207. A refugee is a person who flees their country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group.	No additional criteria.	An immigrant admitted under this status may be eligible for Medicaid, without a five-year waiting period, even if their immigration status later changes.	04
Refugee-Like	An immigrant who has benefits eligibility to the same extent as refugees due to an act of Congress.	See SECTION 7.3.3.1.1 "REFUGEE-LIKE" IMMIGRANTS WHO HAVE BENEFITS ELIGIBILITY AS REFUGEES BECAUSE OF AN ACT OF CONGRESS for more information.	N/A	04
Asylee	An asylee admitted under INA Section 208. an asylee is a person who seeks asylum and is already present in the U.S. when they request permission to stay.	No additional criteria.	An immigrant admitted under this status may be eligible for Medicaid, without a five-year waiting period, even if their immigration status later changes.	05
Deportation Withheld	An immigrant whose deportation is withheld under INA Section 243(h) and such status was granted prior to April 1, 1997, or an immigrant whose removal is withheld under INA Section 241(b)(3) on or after April 1, 1997.	No additional criteria.	An immigrant admitted under this status may be eligible for Medicaid, without a five-year waiting period, even if their immigration status later changes.	15

Cuban-Haitian Entrant	Cuban-Haitian Entrants are defined as certain nationals of Cuba or Haiti who have permission to reside in the U.S. based on humanitarian considerations or under Section 501(e) of the Refugee Education Assistance Act of 1980 (REAA).	No additional criteria. See SECTION 7.3.3.1.2 CUBAN-HAITIAN ENTRANTS for more information.	The term "Cuban-Haitian Entrant" (CHE) relates to benefit eligibility rather than an immigration status. Individuals who meet the definition of a CHE may be eligible for certain public benefits.	11
Foreign Born American Indian	An American Indian born in Canada who is at least 50% American Indian by blood, as defined by §289 of the Immigration and Nationality Act or An American Indian born outside the U.S. who is a member of a federally recognized Indian tribe, as defined in 25 U.S.C. 450b(e).	No additional criteria.	N/A	18
COFA Citizen	A person who is a citizen of a country in the Compacts of Free Association (COFA) See SECTION 7.3.3.1.3 COFA for more information	No additional criteria. See SECTION 7.3.3.1.3 CITIZENS OF THE COMPACTS OF FREE ASSOCIATION COUNTRIES for more information.	N/A	22
Trafficking Victim's child, spouse, or parent	Victims of a severe form of trafficking, and their child, spouse, or parent in accordance with 107(b)(1) of the Trafficking Victims Protection Act of	See 7.3.3.1.4 VICTIMS OF TRAFFICKING for more information.	An immigrant admitted under this status may be eligible for Medicaid, without a five-year waiting period, even if their immigration status later changes.	19

Trafficking victim	2000 (P.L. 106-386). See 7.3.3.1.4 VICTIMS OF TRAFFICKING for more information.	Meet one additional criterion: 1. Have been in a qualifying immigration status for at least five years. 2. Be a child younger than 19 years old. 3. Be younger than 21 years old and reside in an institution for Mental Diseases. 4. Be pregnant. 5. Have arrived in the U.S. before August 22, 1996, and have been continuously present. 6. Have a military service/connection. 7. Be an Amerasian immigrant. 8. See SECTION 7.3.3.1.5 ADDITIONAL CRITERIA FOR CERTAIN QUALIFYING IMMIGRANTS for more information.	Be certified by the Department of Health and Human Services as victim of trafficking (applies to T1 visa holders and others).	19 - Meets one additional criterion or is certified by HHS as a victim of trafficking. Or 21- five-year waiting period applies
LPR	An immigrant lawfully admitted for permanent residence under INA 8 USC 1101 et seq		LPRs who were first refugees, asylees, Cuban or Haitian entrants, certain trafficking victims, or had their deportation withheld maintain that status for benefits eligibility purposes.	01
Parolee	An immigrant paroled into the U.S. under INA Section 212(d)(5) for at least one year		Certain parolees are treated as refugees for benefits eligibility purposes due to acts of Congress (SEE SECTION 7.3.3.1.1"REFUGEE-LIKE" IMMIGRANTS WHO HAVE BENEFITS ELIGIBILITY AS REFUGEES BECAUSE OF AN ACT OF CONGRESS). Parolees who are nationals of Cuba or Haiti may be Cuban Haitian Entrants for benefits eligibility purposes (see SECTION 7.3.3.1.2 CUBAN- HAITIAN ENTRANTS).	06

Conditional Entrant	An immigrant granted conditional entry under immigration law in effect before April 1, 1980 [INA Section 203(a)(7)].		N/A	03
Battered Immigrants	An immigrant as described at 8 U.S.C. §1641(c)(1) who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements		N/A	16
	An immigrant as described at 8 U.S.C. §1641(c)(2) whose child has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.	N/A		16
	An immigrant child as described at 8 U.S.C. §1641(c)(3) who resides with a parent who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.	N/A		16

7.3.3.1.1 “Refugee-Like” Immigrants who have Benefits Eligibility as Refugees Because of an Act of Congress

7.3.3.1.1.1 Iraqis and Afghans with Special Immigrant Status

Special Immigrants from Iraq or Afghanistan (Class of Admission Codes SI and SQ-1, 2, 3, 6, 7, and 8 and SW1, 2 and 3) are to be treated like they are refugees when determining their eligibility for Medicaid for

as long as they have this Special Immigrant status. This policy applies to these immigrants regardless of when they received this status.

Class of Admission (COA) Code	Description	CARES Alien Registration Status Code
SI1 or SQ1	Principal Applicant Afghan or Iraqi Special Immigrant	Code 04
SI2 or SQ2	Spouse of Principal Applicant Afghan or Iraqi Special Immigrant	Code 04
SI3 or SQ3	Unmarried Child under 21 Years of Age of Afghan or Iraqi Special Immigrant	Code 04
SI6 or SQ6	Principal Applicant Afghan or Iraqi Special Immigrant Principal Adjusting Status in the U.S.	Code 04
SI7 or SQ7	Spouse of Principal Applicant Afghan or Iraqi Special Immigrant Principal Applicant Adjusting status in the U.S.	Code 04
SI8 or SQ8	Unmarried Child Under 21 Years of Age of Afghan or Iraqi Special Immigrant Principal Applicant Adjusting Status in the U.S.	Code 04
SW1	Surviving Spouse or Child of an SQ1-eligible person	Code 04
SW2	Current spouse of SW1	Code 04
SW3	Unmarried child of SW1	Code 04

In addition, immigrant Afghan spouses and children of former Special Immigrants who have become United States citizens are also to be treated like they are refugees when determining their eligibility for Medicaid. This treatment is to continue for as long as they have a status of Special Immigrant Conditional Permanent Resident (SI CPR). The Class of Admission codes for SI CPRs are CQ1, CQ2, and CQ3.

7.3.3.1.1.2 Afghan Humanitarian Parolees

Afghans and persons with no nationalities who were residing in Afghanistan and subsequently paroled into the United States on July 31, 2021, through September 30, 2023, are to be treated as refugees when determining their eligibility for Medicaid.

In addition, Afghans and persons with no nationalities who were residing in Afghanistan and subsequently paroled into the United States after September 30, 2022, are to be treated as refugees when determining their eligibility for Medicaid if they are one of the following:

- The spouse or child of a person paroled on July 31, 2021, through September 30, 2023
- The parent or legal guardian of a person paroled on July 31, 2021, through September 30, 2023, who is determined to be an unaccompanied child

Afghan Humanitarian Parolees are to continue to be treated as refugees until either March 31, 2023, or the date their parole status expires, whichever is later.

The table below shows the Class of Admission Codes that are used for these groups:

Class of Admission Code	Description	CARES Alien Registration Status Code
SQ4, SQ5	Special Immigrant Parolee (SI Parolee)	Code 04
DT, OAR, OAW, PAR	Humanitarian Parolee	Code 04

7.3.3.1.1.3 Ukrainian Humanitarian Parolees

Ukrainians and persons with no nationalities who were residing in Ukraine and subsequently paroled into the United States between February 24, 2022, and September 30, 2024, are to be treated as refugees when determining their eligibility for Medicaid.

In addition, Ukrainians and persons with no nationalities who were residing in Ukraine and subsequently paroled into the United States after September 30, 2023, are to be treated as refugees when determining their eligibility for Medicaid if they are one of the following:

- The spouse or child of a person described above paroled between February 24, 2022, and September 30, 2024.
- The parent or legal guardian, or primary caregiver(s) of an unaccompanied child described above who was paroled between February 24, 2022, and September 30, 2024.

Ukrainian Humanitarian Parolees are to continue to be treated as refugees until the date their parole status expires or as long as they remain in a qualifying immigrant status.

The table below shows the Class of Admission (COA) codes that are used for these groups:

Class of Admission Code	**Description**	**CARES Alien Registration Status Code**
UHP, DT, PAR, or U4U	Humanitarian Parolee	Code 04

See Process Help, Section 82.6 SAVE Responses Mapping to CARES Immigration Status Codes Chart for detailed information including class of admission codes for Ukrainian humanitarian parolees.

7.3.3.1.2 Cuban-Haitian Entrants

The term "Cuban-Haitian Entrant" (CHE) relates to benefit eligibility rather than an immigration status. Cuban-Haitian entrants are defined as certain nationals of Cuba or Haiti who have permission to reside in the U.S. based on humanitarian considerations or under Section 501(e) of the Refugee Education Assistance Act of 1980 (REAA). CHE are qualified immigrants with no waiting period.

The following individuals meet the definition of Cuban-Haitian Entrant:

- An individual granted parole as a Cuban-Haitian Entrant (Status Pending) or any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided; or
- A national of Cuba or Haiti who is not subject to a final, non-appealable and legally enforceable removal order, and:
    - Was paroled into the United States and has not acquired any other status under the Immigration and Nationality Act; or
    - Is in removal proceedings under the Immigration and Nationality Act; or
    - Has an application for asylum pending with USCIS (U.S. Citizenship and Immigration Services).

Cuban-Haitian Entrants who later have a change in status and become Lawful Permanent Residents are not subject to the five-year waiting period as Lawful Permanent Residents.

7.3.3.1.3 Citizens of the Compacts of Free Association Countries

Citizens of Compacts of Free Association countries are not considered U.S. citizens or nationals. The Compacts of Free Association (COFA) countries include the Republic of the Marshall Islands, the

Federated States of Micronesia, and the Republic of Palau. COFA citizens have a special status with the U.S. that allows them to enter the country, work here, and acquire an SSN without obtaining an immigration status.

As of December 27, 2020, COFA citizens may be eligible for health care if they meet all other eligibility requirements. In addition, COFA citizens are not subject to the five-year waiting period. COFA citizens who have a change in their status and become Lawful Permanent Residents are not subject to the five-year waiting period.

7.3.3.1.4 Victims of Trafficking

The U.S. Department of Health and Human Services (HHS) Office on Trafficking Persons (HHS OTIP) provides adult victims of trafficking with Certification Letters which allow those whose immigration status would otherwise prevent them from being eligible to receive Medicaid to be eligible to receive benefits. The certification process typically takes only a few days after HHS is notified by DHS that a person has made a bona fide application for a T visa or has been granted a T visa or Continued Presence.

- Applicants with a victim Certification Letter from HHS OTIP qualify for benefits as a Victim of Trafficking regardless of their immigration status.
- Applicants who are victims of trafficking with COA codes: ST6 or T1 and are:
    - Under 18 at the time of application do NOT require a Certification Letter.
    - 18 or older must either have a victim Certification Letter or meet one of the additional qualifying criteria for certain qualifying immigrants (see SECTION 7.3.3.1.5 ADDITIONAL CRITERIA FOR CERTAIN QUALIFYING IMMIGRANTS)

Children, spouses, and parents of trafficking victims (COA codes: ST0, ST1, ST7, ST8, ST9, T2, T3, T4, T5, or T6) do not need a Certification Letter to be eligible for benefits.

Trafficking victims who are confirmed as eligible for Medicaid without a five-year waiting period and who later adjust their status and become Lawful Permanent Residents are not subject to the five-year waiting period as Lawful Permanent Residents.

7.3.3.1.5 Additional Criteria for Certain Qualifying Immigrants

Certain qualifying immigrants must meet one additional criterion to be eligible for full-benefit Medicaid and BadgerCare Plus. These groups include:

- Lawful permanent residents (LPR)
- People whose deportation is withheld under INA Section 243(h) and such status was granted prior to April 1, 1997, or an immigrant whose removal is withheld under INA Section 241(b)(3) on or after April 1, 1997.
- People who are paroled into the U.S. under INA Section 212(d)(5) for at least one year.
- People considered to be battered immigrants who suffered domestic abuse.

The groups listed above must meet one of the following additional criteria:

1. Have been in a qualifying immigration status for five years.
   These immigrants who arrived in the U.S. on or after August 22, 1996, are subject to a five-year waiting period to receive federal benefits (including BadgerCare Plus and Medicaid), other than emergency services. For these immigrants, the five-year waiting period is calculated beginning when they first receive their qualifying immigration status.
2. Are less than 19 years old.
3. Are less than 21 years old and reside in an Institution for Mental Diseases.

4. Are pregnant.

    - Pregnant applicants are eligible for full-benefit Medicaid and BadgerCare Plus.
    - Pregnant people will have the five-year waiting period lifted when their pregnancy is reported to the agency. The waiting period will be lifted until 60 days after the last day of pregnancy and through the end of the month in which the 60th day occurs.

5. Arrived in the U.S. before August 22, 1996, and have been continuously present. Applicants who alleged an arrival date in the U.S. before August 22, 1996, and obtained a qualified immigrant status after August 22, 1996, may be eligible to receive Medicaid. The immigrants described below, who apply for Medicaid and meet all eligibility requirements, are entitled to receive Medicaid benefits:
    - A non-citizen who:
        - Arrived in the U.S. before August 22, 1996, in a legal, but non-qualified, immigration status and
        - Had a change in their status to a qualified immigrant on or after August 22, 1996, and
        - Remained continuously present from their date of arrival in the U.S. until the date they gained qualified immigration status.
    - A non-citizen who:
        - Arrived in the U.S. before August 22, 1996, in undocumented status, or
        - Overstayed their original visa, and
        - Remained continuously present from their date of arrival in the U.S. until the date they gained qualified immigration status.

    - For those non-citizens who arrived in the U.S. before August 22, 1996, but whose continuous presence cannot be verified, the five-year waiting period applies from the date the individual obtained a qualified immigrant status.

    An individual meets the "continuous presence" test if they:

    - Did not have a single absence from the U.S. of more than 30 days, or
    - Did not have a cumulative number of absences totaling more than 90 days.

6. Have a military service/connection.

    Applicants may be eligible for BadgerCare Plus if they meet any of the following criteria related to military service:

    - Honorably discharged veterans of the U.S. Armed Forces. This is defined as persons who were honorably discharged after any of the following:
        - Serving for at least 24 months in the U.S. Armed Forces.
        - Serving for the period for which the person was called to active duty in the U.S. Armed Forces.
        - Serving less than 24 months but was discharged or released from active duty for a disability incurred or aggravated in the line of duty.
        - Serving less than 24 months but was discharged for family hardship.
        - Serving in the Philippine Commonwealth Army or as a Philippine Scout during World War II.
    - On active duty (other than active duty for training) in the U.S. Armed Forces.

- The spouse, unmarried and non-emancipated child under age 18, or surviving spouse of either an honorably discharged veteran or a person on active duty in the U.S. Armed Forces. A surviving spouse is defined as meeting all the following criteria:
    - A spouse who was married to the deceased veteran for at least one year.
    - A spouse who was married to the deceased veteran either:
        - Before the end of a 15-year time span following the end of the period of military service, or
        - For any period to the deceased veteran and a child was born of the marriage or was born before the marriage.
    - A spouse who has not remarried since the marriage to the deceased veteran.

7. Are an Amerasian immigrant.

    - Amerasian immigrants, defined under §584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988, may be eligible for BadgerCare Plus.

8. Also be considered a Cuban/Haitian Entrant.
9. Lawful permanent residents who were previously a refugee, asylee, or had their deportation withheld under INA Section 243(h).

    - Immigrants admitted under these statuses continue to be treated as refugees, asylees or immigrants who had their deportation withheld for benefits eligibility.
    - See SECTION 7.3.3.1.4 VICTIMS OF TRAFFICKING for additional details.

7.3.3.2 Lawfully Present Immigrant Children, Young Adults, and Pregnant People

Children younger than 19 years old, young adults younger than 21 years old who are residing in an IMD, and pregnant people may qualify for BadgerCare Plus or Medicaid if they are lawfully present in the U.S. under many of the immigrant and non-immigrant statuses. For those who are not in a qualifying Immigrant category, but are lawfully present, use the Registration Status Code of 20. Please see Process Help, Section 82.6 VIS SAVE Verification Responses Table for a list of SAVE Responses and the appropriate Registration Status Code in CWW to apply.

7.3.3.3 Immigrants Eligible for Other Health Care Programs

Immigrants who are not a qualifying immigrant nor lawfully present (for example, someone who is undocumented) and who apply for Medicaid and meet all eligibility requirements, except for citizenship and immigration status, are entitled to receive Medicaid Emergency Services only (see CHAPTER 34 EMERGENCY SERVICES).

Pregnant immigrants who are not a qualifying immigrant nor lawfully present and who apply for the BadgerCare Plus Prenatal Program and meet the eligibility requirements except for citizenship and immigration status, are entitled to receive BadgerCare Plus Prenatal Program benefits (see BadgerCare Plus Handbook, Chapter 41 BadgerCare Plus Prenatal Program) Emergency Services (see BadgerCare Plus Handbook, Chapter 39 Emergency Services), or both.

7.3.3.4 Impact of Immigrant Status on Household

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

7.3.4 Public Charge

Public charge determinations are part of longstanding immigration policy that can impact a non-U.S. citizen's ability to gain entry to the United States or obtain lawful permanent resident status (get a green card). A public charge is someone who the government believes is likely to rely on cash assistance or government-funded institutionalization for long-term care to survive.

Many non-U.S. citizens are exempt from public charge determinations. These include lawful permanent residents, also known as green card holders (unless they travel outside the U.S. for six months or more), asylees, refugees, special immigrant juveniles, survivors of trafficking, and other protected groups.

For non-U.S. citizens who are subject to public charge determinations, enrolling in Medicaid does not make them a public charge.

The **only** category of Medicaid-funded services considered in public charge determinations is **long-term institutionalization paid for by Medicaid**. The following institutionalization situations are not considered in public charge determinations:

- Short-term institutionalization for rehabilitative purposes
- Sporadic or intermittent periods of institutionalization, even on a recurring basis.
- Medicaid Home and Community Based Services (HCBS) is not considered in public charge determinations.

7.3.5 Immigration and Customs Enforcement (ICE) Reporting

Medicaid member information cannot be shared by Income Maintenance or Tribal Agencies for immigration enforcement purposes. Do not refer an immigrant to U.S. Immigration and Customs Enforcement. The Wisconsin Department of Health Services is required to share information with the Centers for Medicare and Medicaid Services, a federal agency within the U.S. Department of Health and Human Services.

7.3.6 Undocumented Non-Citizens

In cases in which it is known that the applicant originally arrived in the U.S. in undocumented status, do not attempt to verify his or her status with the U.S Citizenship and Immigration Services (USCIS). Undocumented immigrants do not have any official documentation regarding their date of arrival.

7.3.7 Immigration Status Chart

Please see Process Help, Section 82.6 VIS SAVE Verification Responses Table for a list of SAVE Responses and the appropriate Registration Status Code in CWW to apply.

CARES Registration Status Code	Immigration Status	Arrived Before August 22, 1996	Veteran* Arrived Before August 22, 1996	Arrived On or After August 22, 1996	Veteran* Arrived On or After August 22, 1996	Children Under 19 and Pregnant Persons; Arrived on or

						after August 22, 1996
01	Lawfully admitted for permanent residence	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009, Eligible
02	Permanent resident under color of law (PRUCOL)	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
03	Lawfully present under Section 203(a)(7)	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009, Eligible
04	Lawfully present under Section 207(c)	Eligible	Eligible	Eligible	Eligible	Eligible
05	Lawfully present under Section 208	Eligible	Eligible	Eligible	Eligible	Eligible
06	Lawfully present under Section 212(d)(5) and paroled for at least one year	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009, Eligible
07	IRCA (No longer valid)	N/A	N/A	N/A	N/A	N/A
08	Lawfully admitted - temporary	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
09	Undocumented Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
10	Illegal Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
11	Cuban/Haitian Entrant	Eligible	Eligible	Eligible	Eligible	Eligible
12	Considered a Permanent Resident by USCIS	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
13	Special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
14	Additional special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
15	Withheld deportation - Section 243(h)	Eligible	Eligible	Eligible	Eligible	Eligible

16	Battered Immigrant	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009, Eligible
17	Amerasian	Eligible	Eligible	Eligible	Eligible	Eligible
18	Foreign-Born Native American	Eligible	Eligible	Eligible	Eligible	Eligible
19	Victims of Trafficking**	Eligible	Eligible	Eligible	Eligible	Eligible
20	Lawfully Residing	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
21	Victims of Trafficking Subject to 5 Year Waiting Period	Eligible	Eligible	Ineligible for 5 years	Eligible	Eligible
22	Citizens of Compacts of Free Assoc (COFA)	Eligible	Eligible	Eligible	Eligible	Eligible

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

**Some victims of trafficking may need to provide certain verification to be exempt from the five-year waiting period. See SECTION 7.3.3.1.4 VICTIMS OF TRAFFICKING for more information.

7.3.8 Refugee Assistance Programs

The federal Office of Refugee Resettlement (ORR) provides resources for refugees, asylum seekers, and other new arrivals to the U.S. to assist with their integration into their new community. Several benefit programs overseen by the ORR and operated by the Bureau of Refugee Programs in the Department of Children and Families are discussed here.

7.3.8.1 Counting Refugee Related Income

Refugee Cash Assistance (RCA) program payments are not counted as income for Medicaid. RCA is administered by Wisconsin Works (W-2) agencies and is made available for refugees who do not qualify for W-2.

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

7.3.8.2 Refugee Medical Assistance

If refugees, asylees, and certain other immigrants apply for BadgerCare Plus or Wisconsin Medicaid and do not meet the eligibility requirements, they may be eligible for Refugee Medical Assistance (RMA). However, unlike BadgerCare Plus and Wisconsin Medicaid, Refugee Medical Assistance is a time-limited benefit and people must apply within a certain timeframe of receiving their refugee, asylee or other eligible immigration status.

RMA provides the same level of benefits as BadgerCare Plus but is funded separately.

While W-2 agencies have contractual responsibility for providing Refugee Medical Assistance, they must coordinate with income maintenance agencies to ensure eligibility for all regular BadgerCare Plus or Medicaid subprograms is tested first.

More information about this program is in the Bureau of Refugee Programs Policy Manual, Section 6 Refugee Medical Assistance.

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7.4 Reserved

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8 Medical Support

8.1 Medical Support

8.1.1 Medical Support Introduction

Medical Support refers to the obligation that a parent has to pay for his or her child's medical care, either through the provision of health insurance coverage or direct payment of medical bills. The child support agency (CSA) is responsible for establishing Medical support orders for some children receiving Medicaid who have an absent parent. The CSA is also responsible for establishing paternity and establishing medical support obligations for unpaid and ongoing medical support (including recovery of birth costs.)

8.1.2 Recovery of Birth Costs

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

8.1.3 Referral to Child Support Agencies

The income maintenance (IM) agency provides the CSA with information vital to opening medical support cases. The IM agency also supplies continuing information, which assists the CSA in providing medical support services.

For health care applications, new health care requests on existing cases, and person add requests that include minor children who have an absent parent, a referral is systematically sent to the CSA at the time health care eligibility is confirmed, with the exception of the situations listed in SECTION 8.2.2 EXEMPTIONS FROM COOPERATION. Detailed questions about absent parents (such as, name, Social Security number, date of birth, or contact information) cannot be asked during the application process for health care-only applications. The referral will still be sent to the CSA, even if the absent parent's name is unknown (see Process Help, Section 65.1 Enter Absent Parent Information).

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

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

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

1. A pregnant member who is unmarried or married and not living with their husband. However, pregnant members are not required to cooperate with the CSA during the pregnancy and for an additional 60 days after the last day of the pregnancy and through the end of the month in which the 60th day occurs. The member's eligibility for Medicaid will continue during this period, regardless of the member's cooperation.
2. A child receiving SSI only if the parent or caretaker relative requests child support services for the child. Do not sanction this parent or caretaker relative if they do not cooperate with the CSA.
3. Non-marital co-parents when paternity has not been legally established. This includes a non-marital co-parent even when both parents are in the same home.

Exception: Do not refer parents to the CSA when both parents are in the home and the father is on the child's birth certificate or the father's paternity has been legally established in another state by a court order or by a Voluntary Paternity Acknowledgement Form filed with a state agency.

4. Biological or adoptive parent(s) not living in the household.
   Exception: Do not refer to the CSA when the only reason a parent or stepparent is not in the home is because they are in the military.
5. Married biological parents in the home, but:
   a) Child was born prior to their marriage, and
   b) Paternity was not established by court action, or the birth was not legitimized after their marriage.

Do not refer people residing in domestic abuse shelters to the CSA. Once a person moves out of a domestic abuse shelter, complete the Absent Parent page in CWW so that the referral is sent to the CSA.

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8.2 Medical Support/Child Support Agency Cooperation

8.2.1 Introduction

Unless the person is exempt or has good cause for refusal to cooperate (see SECTION 8.2.2 EXEMPTIONS FROM COOPERATION and SECTION 8.3 CLAIMING GOOD CAUSE), each applicant or member who is referred, must, as a condition of eligibility, cooperate in **both** the following:

- Establishing the paternity of any child born out of wedlock for whom BadgerCare Plus or Medicaid, including Medicare Savings Programs, is requested or received
- Obtaining medical support for the applicant and for any child for whom Medicaid, including Medicare Savings Programs, is requested or received

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

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

8.2.2 Exemptions from Cooperation

The parent or caretaker relative is exempt from the requirement to cooperate and from any sanction for non-cooperation if:

1. The child under their care is eligible for benefits funded under any source other than Title 19, such as Title 21 (Separate CHIP) or General Purpose Revenue (that is, state funds). Information on children's categories funded by Separate CHIP or state funds is available in BadgerCare Plus, Section 51.1 BadgerCare Plus Categories. The CSA will monitor the child's Medicaid Eligibility funding source.
2. The child under their care is on SSI.
3. The parent or caretaker relative is one of the following:
    a) Eligible for the BadgerCare Plus Eligibility Extension.,
    b) A pregnant person, until the end of the month in which the 60th day after the termination of pregnancy occurs.
    c) Under 18 years old.
    d) Age 18 and receiving CHIP coverage under BadgerCare Plus (income is over 156% FPL).
4. Both absent parents are now living in the home with the child.
5. The absent parent is deceased.
6. Paternity has been established and the father is living in the home with the mother and child.
7. The only parent absent from the home is absent because of military service.

8.2.3 Failure to Cooperate

The CSA determines if there is non-cooperation for persons required to cooperate. The IM agency determines if good cause exists (see SECTION 8.3.7 DETERMINATION) and whether the applicant or member is exempt (see SECTION 8.2.2 EXEMPTIONS FROM COOPERATION). If there is a dispute, the CSA makes the final determination of cooperation while the IM agency makes the final determination of

exemptions or good cause. The member remains ineligible until they cooperate, establish good cause, or their cooperation is no longer required.

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

Example 1:	Mary, a disabled parent, is applying for Medicaid for her and her son, Michael. She refuses to cooperate in obtaining medical support for Michael. Mary meets all other non-financial and financial criteria for Medicaid and EBD Medicaid. Mary is not eligible for EBD Medicaid or Medicaid, because she will not cooperate in obtaining medical support for Michael. Even though Mary has not cooperated in obtaining medical support for Michael, he remains eligible for Medicaid.

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8.3 Claiming Good Cause

8.3.1 Claiming Good Cause Introduction

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

1. Specify the circumstance that is the basis for good cause, **and**
2. Corroborate the circumstance according to the evidence requirements in SECTION 8.3.5 EVIDENCE

8.3.2 Notice

At application or a new request for health care on an existing case, the income maintenance (IM) agency must provide a Child Support Cooperation & Good Cause notice (DCF-P-5600) whenever a child with an absent parent is part of the health care application or case. The Child Support Cooperation & Good Cause notice describes the right to refuse to cooperate for good cause in establishing paternity and securing medical support from the absent parent.

Exception: The agency does not need to provide this notice to applicants who apply via ACCESS since this information is included in the ACCESS application.

The agency must also provide this notice to the member in situations where a parent leaves the home, resulting in a child on the case now having an absent parent.

Applicants and members are not required to sign the Child Support Cooperation & Good Cause notice in order to be eligible for health care programs.

8.3.3 Good Cause Claim

The Good Cause Claim form (DCF-F-DWSP2019) must be provided to any health care applicant or member who requests one. It describes the circumstances that support a claim and how to document a claim.

The parent or caretaker must sign and date the Good Cause Claim form in order to initiate the claim. The income maintenance (IM) agency must send a copy of the submitted Good Cause Claim form to the parent or caretaker upon request.

The child support agency (CSA) must be informed within two business days that a good cause claim has been filled. When the CSA is informed of a good cause claim, they will immediately suspend all activities to establish paternity or secure medical support until notified of the final determination.

8.3.4 Circumstances

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

1. The parent or caretaker's cooperation is reasonably anticipated to result in physical or emotional harm to the:
    a) Child. This means that the child is so emotionally impaired, that his or her normal functioning is substantially affected, **or**
    b) Parent or Caretaker. This means the impairment is of such a nature or degree that it reduces that person's capacity to adequately care for the child.

2. At least one of the following circumstances exists and it is reasonably anticipated that proceeding to establish paternity or secure support or both would be detrimental to the child:
    a) The child was conceived as a result of incest or sexual assault, **or**
    b) A petition for the child's adoption has been filed with a court, **or**
    c) The parent or caretaker is being assisted by a public or private social agency in deciding whether or not to terminate parental rights and this has not gone on for more than three months.

8.3.5 Evidence

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

The following may be used as evidence:

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

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

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

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

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

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

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

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

When insufficient evidence has been submitted:

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

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

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

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

8.3.6 Investigation

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

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

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

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

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

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

8.3.7 Determination

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

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

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

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

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

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

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

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

8.3.8 Good Cause Found

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

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

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

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

8.3.9 Good Cause Not Found

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

1. Cooperate, **or**

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

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

8.3.10 Review

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

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

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

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

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8.4 Cooperation Between IM & CSA

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

8.4.1 Information

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

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

8.4.2 Medicaid Discontinued

The CSA is notified through CARES when Medicaid is discontinued.

8.4.3 Fraud

When the CSA has knowledge of possible fraud, they will refer the case back to the IM agency. For example, if in the process of collecting support the CSA establishes that a parent is in fact not absent, the CSA will give that information to the IM agency for appropriate action.

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9 Third Party Liability

9.1 Third Party Liability

9.1.1 Third Party Liability Introduction

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

9.1.2 Third Party Liability Cooperation

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

9.1.3 Third Party Liability Cooperation Requirements

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

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

Do not sanction the following for non-cooperation:

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

9.1.4 Third Party Liability Good Cause Claim

When good cause is claimed (see SECTION 8.3 CLAIMING GOOD CAUSE), the IM agency must review the circumstances and decide on whether it is an appropriate claim of good cause. The appropriate entry on the Medical Coverage page in CWW regarding the good cause determination must be made, and the reason for the decision must be documented in case comments.

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

9.1.5 Assignment Process

At application or a new request for health care on an existing case, the IM agency must give a Notice of Assignment: Child Support, Family Support, Maintenance, and Medical Support (DCF-F-DWSP2477, available in English and Spanish) to each applicant. Applicants and members are not required to sign this form in order to be eligible for health care programs.

Exception: The agency does not need to provide the Notice of Assignment to health care applicants who apply via ACCESS since this information is included in the ACCESS application

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9.2 Nursing Home and Hospital Insurance

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

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

1. Assign to the state of Wisconsin their rights to payments from a nursing home, hospital, or long-term care insurance policy (see SECTION 9.2.2 ASSIGNMENT).
2. Send any payments to the state of Wisconsin that they received from a nursing home, hospital, or long-term care insurance carrier while receiving Medicaid (see SECTION 9.2.3 RECOVERY OF PAYMENTS).

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

Terminate Medicaid eligibility for the individual who is not cooperating in providing TPL insurance information (see SECTION 9.1.2 TPL COOPERATION), unless they have good cause (see SECTION 9.1.4 TPL GOOD CAUSE CLAIM).

9.2.2 Assignment

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

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

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

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

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

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

9.2.3 Recovery of Payments

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

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

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

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

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9.3 Health Insurance Risk Sharing Plan (HIRSP)

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

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

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9.4 Health Insurance Premium Payment (HIPP)

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

9.4.1 Cost-Effective

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

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

9.4.2 Participation in HIPP

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

9.4.3 Cooperation

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

9.4.4 Not Cost-Effective

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

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9.5 Casualty Claim Process (Subrogation)

9.5.1 Casualty Claims (Subrogation) Introduction

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

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

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

9.5.2 Reporting Accident or Injury Claims

If members are in an accident or are injured and receive a cash award or settlement due to the accident or injury and Medicaid (including SSI enrollees) pays for part or all of the care, it must be reported. When Medicaid pays for a claim that is related to an accident, a letter is sent to the member informing him or her of the requirement to report the information.

If a member has hired an attorney or is working with an insurance agency to settle the claim, that must also be reported. If a member reports a claim, he or she must report the accident or injury case to the Casualty Recovery Unit using one of the following methods:

Mail:
WI Casualty Recovery—HMS
5615 Highpoint Dr., Suite 100
Irving, TX 75038-9984
Telephone: 877-391-7471
Fax: 469-359-4319
Email: wicasualty@hms.com

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

All other Medicaid members should report in person or phone their local agency and any HMO or MCO that may have provided services before the case is settled. Members should include the date of the accident and any insurance and attorney information.

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9.6 Other Health Insurance

9.6.1 Other Health Insurance Introduction

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

9.6.2 Policies Not To Report

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

1. HMOs for which the state pays all or part of the premium.
2. Medicare Part A or Part B premiums (entered in CWW on the Medicare page).
3. IHS is the exception to the rule that Medicaid is the payer of last resort. For Native Americans who are Medicaid members, IHS is the payer of last resort. Do not enter these policies in CARES.
4. Policies that pay benefits only for treatment of accidental injury.
5. Policies that may be described as health insurance, but which pay only weekly or monthly based on the insured's disability.
6. Limited insurance plans that pay only if there is a specific diagnosis, such as cancer policy. Report them only if the person insured has been diagnosed as having the disease he or she are insured against and if the benefits are assignable.
7. Life Insurance.
8. Other types of insurance types that do not cover medical services.

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9.7 Reserved

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9.8 Reserved

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9.9 Reserved

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10 SSN

10.1 SSN Requirements

10.1.1 Social Security Number Requirements

Medicaid applicants must provide an SSN or be willing to apply for one. Assist the applicant in applying for an SSN for any group member who does not have one. See SECTION 20.3.2 SOCIAL SECURITY NUMBER for more information on assisting an applicant with applying for an SSN. Non-applicants are not required to provide an SSN.

If an SSN application was made in good faith and the applicant cooperated fully with the application process, do not deny benefits if the SSN application was denied for reasons beyond the applicant's control. See SECTION 20.3.2 SOCIAL SECURITY NUMBER for more information on health care eligibility without a verified SSN.

An applicant does not need to provide a document or Social Security card. He or she only needs to provide a number, which is verified through data exchanges.

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

Verify the SSN only once.

10.1.2 Social Security Number Exceptions

Do not require an SSN for:

- Pre-adoptive infants living in a foster home.
- Non-qualifying immigrants applying for or receiving emergency services.
- Someone without an SSN who may only be issued one for a valid non-work reason.
- Someone who refuses to obtain an SSN because of well-established religious objections. ("Well-established religious objections" means that the applicant or member is a member of a recognized religious sect or division of the sect and that the applicant or member adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.)

A person who refuses to apply for or use a SSN due to religious beliefs must provide verification from a church elder or other officiant that doing so is against the church doctrine.

10.1.3 SSN Mismatches

Refer to Process Help, Section 44.4 Discrepancy Processing and Match Access, if the SOLQ-I process returns a mismatch record.

Inform the applicant or member if the SOLQ-I process returns a different SSN or suggests that another person is using the same SSN. If it appears that the incorrect SSN was provided by the applicant or member, ask the applicant or member to clarify the correct SSN. If it appears that another person is using the same SSN, advise the applicant or member to contact the SSA. The applicant or member may request SSA conduct an investigation. Do not provide the applicant or member with any information that would identify the person who is using the applicant or member's SSN.

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11 Premium or Cost Share

11.1 Premium or Cost Share

Nonpayment of a MAPP premium will result in nonfinancial ineligibility for an adult age 19 or older (see SECTION 26.5 MAPP PREMIUMS).

Nonpayment of a Home and Community-Based Waivers cost share will result in nonfinancial ineligibility for an adult age 19 or older (see SECTION 28.1 HCBWLTC ELIGIBILITY GROUPS AND COST SHARING).

Members under age 19 cannot lose their health care during their 12-month continuous coverage period for failure to pay a premium or cost share (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).

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12 Change Reporting

12.1 Change Reporting Introduction

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

Some changes may be reported through ACCESS.

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13 Inmates

13.1 Introduction

When a Medicaid applicant or member is an inmate, they may be eligible for suspended Medicaid. Suspension is a type of eligibility in which an inmate continues to be enrolled in Medicaid while incarcerated, and does not have to complete a new application to regain benefits when released.

An inmate is someone who resides in a public institution on an involuntary basis through operation of law enforcement authorities. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate.

The following individuals are not considered to be inmates for the purposes of Medicaid:

- A staff person voluntarily residing in a public institution is not considered an inmate.
- An individual voluntarily residing in an institution while waiting for other living arrangements to be made that are appropriate to the person's needs.
- An individual who is legally confined to his or her home by a monitoring device, such as an ankle bracelet.
- People who are on parole, probation, or have been released to the community pending trial (including those under pre-trial supervision).

A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. This includes correctional facilities operated by or under contract with a governmental unit. A public institution does not include a medical institution (see SECTION 27.1 INSTITUTIONS), a publicly operated community residence that serves no more than 16 residents, or a child care institution in which Foster Care maintenance payments are made under Title IV-E. People residing in these situations are not inmates.

Even though the following institutions may accommodate 16 or fewer residents, they are not considered to be publicly operated community residences. People residing in these institutions may be inmates if they are residing there on an involuntary basis through operation of law enforcement authorities:

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

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13.2 Covered Services

Individuals who are inmates of a public institution may be eligible for suspended SSI-related Medicaid or Wisconsin Well Woman Medicaid if they otherwise meet eligibility requirements. See CHAPTER 24 SSI RELATED MEDICAID AND DEDUCTIBLES or CHAPTER 36 WISCONSIN WELL WOMAN MEDICAID for information about these programs.

If a member of a different health care program becomes incarcerated, eligibility for that program will be terminated. However, the member will be evaluated for eligibility in a program that can be suspended.

When a member is incarcerated in a public institution, Medicaid will only cover inpatient services received while the member is outside of jail or prison for 24 hours or more.

While incarcerated, members are not eligible to enroll in an HMO.

Copay limits still apply to incarcerated members for any services they receive.

SeeSECTION 13.8.5 SERVICES FOR YOUTH for information on coverage for certain pre-release and post-release services for youth.

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13.3 Suspension Start Date

The suspension period will have a start date at the beginning of a benefit month due to notice requirements, but the restriction on covered services will begin the date the person becomes incarcerated. This means that the restriction on covered services may be effective for a date prior to the suspension start date displayed in the system. See SECTION 13.2 COVERED SERVICES.

13.3.1 Applicants

If the applicant is already incarcerated and has been since at least the beginning of the application month, their suspension will start the first of the month of application.

Example 1	Mark is incarcerated on January 17. He applies for health care on April 20, and is found eligible for suspended SSI-related Medicaid. Mark's suspension start date is April 1.

If the applicant was incarcerated after the first of the application month, the suspension will start the first of the month following the application month.

Example 2	Jane is incarcerated on April 15. She applies for health care on April 20, and is found eligible. She is certified for full-benefit SSI-related Medicaid from April 1, until April 30. Jane's suspended SSI-related Medicaid starts on May 1. However, the restriction on covered services will be effective April 15 (the date Jane became incarcerated).

13.3.2 Backdated Eligibility

If an applicant is determined eligible for a Medicaid backdate and was incarcerated during any of the backdated months, they will be enrolled in a suspended status for any backdated months in which they were incarcerated for the entire month. For any backdated months in which the person was not incarcerated for the entire month, they will open for full-benefit Medicaid.

13.3.3 Existing Members

Existing health care members who become incarcerated and are determined eligible for the health care suspension will be certified for the suspension from the first of the month after the incarceration is reported. This policy applies even when the incarceration is reported untimely. See SECTION 12.1 CHANGE REPORTING INTRODUCTION.

Example 3	Olivia is open for full-benefit SSI-related Medicaid. On December 23, Olivia reports she is incarcerated as of December 20. Olivia's SSI-related Medicaid is suspended starting January 1. However, the restriction on covered services will be effective December 20 (the date Olivia became incarcerated).

13.3.4 Deductibles

Suspended members who met a deductible before being incarcerated will maintain their existing certification period and renewal date, which is the end of the six-month deductible period.

Example 4	Jordan has a Medicaid deductible period from April 1, until September 30. He meets his deductible on May 10, and becomes eligible for full-benefit Medicaid. He is incarcerated on June 19. His suspension starts July 1, and his certification period goes to September 30. However, the restriction on covered services will be effective June 19 (the date Jordan became incarcerate).

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13.4 Suspension End Date

A member's suspension is lifted, and full-benefit Medicaid coverage starts on the first of the month in which the member is released, if the member continues to meet the eligibility criteria for Medicaid. A new application is not needed to lift the suspension and start full-benefit Medicaid.

The suspension period will have an end date at the end of a month, but the restriction on covered services will end when the person is no longer incarcerated. That means that the restriction on covered services may end on a date after the suspension end date displayed in the system. See SECTION 13.2 COVERED SERVICES.

Members can report their expected release date to their IM agency prior to their release. If the expected release date is known, the IM agency will redetermine Medicaid eligibility prior to the release to lift the suspension and start full-benefit Medicaid, if eligible, on the first of the month in which the member is released.

Example 1	Dolores is incarcerated and enrolled in suspended Medicaid. On August 25, she reports to her IM agency that her expected release date is September 20. The IM agency redetermines her eligibility. Her suspension will be lifted effective September 1. The restriction on covered services will be lifted on September 20 (the date Dolores is released)

The suspension may be lifted effective for the first of the month when the person was released from prison or jail, even if the release was reported untimely. However, this retroactive lifting may only go as far back as the beginning of the current certification period.

Example 2	Risha is incarcerated and enrolled in suspended Medicaid. Her current certification period started January 1. She was released on April 3, but she does not inform the IM agency that she has been released. She continues to be enrolled in suspended Medicaid. On July 5, she reports to the IM agency that she was released from jail on April 3. The suspension is lifted effective April 1. The restriction on covered services will be lifted on April 3 (the date Risha was released)

The member's health care certification renewal date will not change.

Example 3	Cameron is incarcerated and enrolled in suspended Medicaid. His renewal date is June 30 of the following year. Cameron is released on December 15. The suspension is lifted effective December 1. The restriction on covered services will be lifted on December 15 (the date Cameron is released). His renewal date remains June 30 of the following year.

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13.5 Renewals

Members in a health care suspension will go through the normal renewal process at the end of their certification period, including administrative renewals when applicable (see CHAPTER 3 RENEWALS). Members must complete the renewal and continue to meet program eligibility criteria in order to maintain their suspension. If the member does not complete the renewal or no longer meets program eligibility criteria, the member's suspension will end and Medicaid eligibility will be terminated.

Note: *If a member has appointed the prison or jail or an employee of the prison or jail as their authorized representative, that entity can complete the renewal on the member's behalf. See SECTION 22.5 REPRESENTATIVES.*

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13.6 Change Reporting

Existing change reporting policy applies for members in a suspension (see CHAPTER 12 CHANGE REPORTING). The exception is a suspension may be lifted effective for the first of the month when the person was released from prison or jail, even if the release was reported untimely. See SECTION 13.4 SUSPENSION END DATE.

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13.7 Household Composition

If the individual who is incarcerated belongs to a household, the person will be considered "temporarily absent" from the household and remain a countable member of the household for Medicaid during the suspension. The other household members will also remain countable within the incarcerated member's suspended assistance group. There is no limit to how long inmates can be considered temporarily absent from the Medicaid household, as long as they continue to meet program rules.

Applicants and members are responsible for determining if an individual who is incarcerated is part of their household or not. They will be able to include this information in the application and when reporting a change. IM workers should accept this information that is provided by the applicant or member. Verification of this information is not required. Members can also report changes to the household status during the incarceration period.

Example:	Quinton and Meg are married and both are enrolled in Medicaid. Quinton is the Primary Person on the case. Meg is incarcerated on January 3, 2021. Quinton reports Meg's incarceration and that she is still part of the household. Meg's suspension starts on February 1, 2021, and she continues to be on the same case as Quinton. On June 7, 2021, Quinton decides that Meg is no longer part of the household. He reports that Meg is still incarcerated but is no longer part of the same household as him. Meg is removed from the case and her suspension ends June 30, 2021. Meg must fill out a new application for herself if she wants to continue having suspended health care benefits going forward.

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13.8 Special Rules

13.8.1 Children Whose Parent/Caretaker is an Inmate

If the only parent(s) or caretaker(s) in the household are incarcerated, any children on the case open for Medicaid will remain eligible the remainder of their 12-month continuous coverage period. Eligibility for the children will end at the end of the 12-month period unless they open for health care on another case.

Example 1	Faye and her 10-year-old daughter, Chantelle, are both enrolled in health care as of January 1, 2024. Faye is enrolled in medically needy Medicaid and Chantelle is enrolled in BadgerCare Plus. On March 9, 2021, Faye is incarcerated. Faye's suspended Medicaid starts April 1, 2021. Chantelle will remain open for full-benefit BadgerCare Plus on Faye's case for the remainder of her 12-month continuous coverage period. Chantelle's BadgerCare Plus will end December 31, 2024. Chantelle could re-enroll in BadgerCare Plus as part of the household she now resides in or through another program such as Foster Care Medicaid depending on her situation.

13.8.2 Pregnant Women

Pregnant women who are incarcerated will have their eligibility determined under the BadgerCare Plus Prenatal Program (see BadgerCare Plus Eligibility Handbook, Section 41.1 BadgerCare Plus Prenatal Program).

When the pregnancy ends, BadgerCare Plus Prenatal Program members must have their health care eligibility redetermined for the next month. If determined eligible for Medicaid, the member will open for suspended Medicaid.

13.8.3 Huber Law

Some inmates may be allowed to leave jail for various reasons under the Huber Law, also known as the Huber Program. Huber Law prisoners who are released from jail to attend to the needs of their families can become eligible for full-benefit Medicaid if both the following are true:

- They intend to return to the home.
- They continue to be involved in the planning for the support and care of their minor children.

This is known as the Huber Law exemption.

Huber Law prisoners who are released for a purpose other than attending to the needs of their families are not eligible for full-benefit Medicaid. Instead, they may be eligible for suspended Medicaid.

Example 2	Shannon is incarcerated in jail. During her incarceration, her 8-year-old daughter, Jada, lives with Shannon's mother. Shannon is allowed to leave jail under the Huber Law for employment. Shannon leaves jail during the day to work and then returns to jail every night. She sends part of her paycheck to her mother to help with Jada's expenses. Even though Shannon provides financial support for Jada, she is not eligible for the Huber Law exemption because her court documents do not list attending to the needs of her family as a reason for her participation in the Huber Program.

Example 3	Dennis is incarcerated in jail. During his incarceration, his 3-year-old and 5-year-old children live with his wife, Brenda. Dennis is allowed to leave jail under the Huber Law to attend school and care for his children while Brenda is at work. Dennis is eligible for the Huber Law exemption because his court documents list attending to the needs of his family as a reason for his participation in the Huber Program.

13.8.4 Out-of-State Inmates

If a person is incarcerated in Wisconsin and then involuntarily transferred to a correctional institution in another state, the person is still considered a Wisconsin resident.

Example 4	Oscar resides in Wisconsin. He commits a crime in Wisconsin and is incarcerated in a Wisconsin Department of Corrections facility. Due to a shortage of space, Oscar is transferred to a prison in Minnesota. Oscar remains a Wisconsin resident and may be eligible for suspended Medicaid or Medicaid while he is residing in the prison in Minnesota.

If a person has committed a crime outside of Wisconsin and is incarcerated by that state in a correctional facility in that state, the person is considered to be a resident of that state and not Wisconsin.

Example 5	Connor resides in Wisconsin. He commits a crime in Illinois and is incarcerated in an Illinois correctional facility. Connor is an Illinois resident while he is residing in the facility in Illinois. He is not eligible for suspended or full-benefit Medicaid in Wisconsin since he is not a Wisconsin resident.

13.8.5 Services for Youth

Youth who are incarcerated and enrolled in suspended Medicaid can receive HealthCheck screening services and targeted case management during certain times if they are either:

- Under 21 years old.
- Under 26 years old and meet the criteria to be a Former Foster Care Youth (see BadgerCare Plus Handbook Section 11.2 Former Foster Care Youth).

These youth are eligible for HealthCheck screening services 30 days prior to their release and within one week (or as soon as practicable) after their release.

These youth are eligible for targeted case management 30 days prior to their release and at least 30 days after release.

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13.9 State Correctional Institutions

The following is the list of correctional institutions administered by the Wisconsin Department of Corrections.

Brown

Green Bay Correctional Institution (GBCI)

Chippewa

Chippewa Valley Correctional Treatment Facility (CVCTF)

Stanley Correctional Institution (SCI)

Columbia

Columbia Correctional Institution (CCI)

Crawford

Prairie du Chien Correctional Institution (PDCI)

Dane

Oakhill Correctional Institution (OCI)

Oregon Correctional Center (OCC)

Thompson Correctional Center (TCC)

Mendota Juvenile Treatment Center (MJTC)

Dodge

John Burke Correctional Center (JBCC)

Dodge Correctional Institution (DCI)

Fox Lake Correctional Institution (FLCI)

Waupun Correctional Institution (WCI)

Douglas

Gordon Correctional Center (GCC)

Fond du Lac

Taycheedah Correctional Institution (TCI)

Grant

Wisconsin Secure Program Facility (WSPF)

Jackson

Black River Correctional Center (BRCC)

Jackson Correctional Institution (JCI)

Juneau

New Lisbon Correctional Institution (NLCI)

Kenosha

Kenosha Correctional Center (KCC)

Lincoln

Copper Lake School (CLS)

Lincoln Hills School (LHS)

Milwaukee

Marshall E. Sherrer Correctional Center (MSCC)

Milwaukee Secure Detention Facility (MSDF)

Milwaukee Women's Correctional Center (MWCC)

Felmers O. Chaney Correctional Center (FCCC)

Oneida

McNaughton Correctional Center (MCC)

Outagamie

Sanger Powers Correctional Institution (SPCI)

Racine

Robert E. Ellsworth Correctional Center (RECC)

Racine Correctional Institution (RCI)

Racine Youthful Offender Correctional Facility (RYOCF)

Sturtevant Transitional Facility (STF)

St. Croix

St. Croix Correctional Center (SCCC)

Sawyer

Flambeau Correctional Center (FCC)

Sheboygan

Kettle Moraine Correctional Institution (KMCI)

Waushara

Redgranite Correctional Institution (RCI)

Winnebago

Drug Abuse Correctional Center (DACC)

Oshkosh Correctional Institution (OSCI)

Winnebago Correctional Center (WCC)

Wisconsin Resource Center (WRC)

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14 Reserved

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Financial (Chs. 15 - 18)

15 Income

15.1 Income Introduction

15.1.1 Elderly, Blind, or Disabled Fiscal Test Group

An EBD fiscal test group (FTG) usually includes the individual who is non-financially eligible for Medicaid and anyone who lives with him or her and who is legally responsible for him or her. EBD fiscal test groups are groups of one or two. Spouses who live together are in each other's FTG. This means that the income and assets of both spouses are counted when determining Medicaid eligibility for either or both spouses. The FTG size for this living arrangement is two.

There are some exceptions to this Policy:

- Blind or disabled minors (or dependent 18-year-olds): A blind or disabled minor (or dependent 18-year-old) living with his or her parents would be a one-person FTG. Special instructions for deeming parental income to the disabled minor are described in SECTION 15.1.2 SPECIAL FINANCIAL TESTS FOR DISABLED MINORS
- Children and young adults who are applying for HCBW Medicaid for enrollment into the CLTS waiver program are a one-person FTG and have eligibility determined under the policy in SECTION 37.3 HCBW MEDICAID CARES PROCESSING FOR THE CLTS WAIVER PROGRAM.
- SSI recipients: If one spouse is applying for EBD Medicaid and the other spouse is an SSI recipient, the SSI recipient spouse is not included in the applicant's FTG. For this situation, you would have a one-person FTG when determining the Medicaid eligibility of the non-SSI spouse.
- Medicaid Purchase Plan (MAPP): Children are included in the FTG of a MAPP applicant or member, so the FTG for this program could be greater than two people. See SECTION 26.2.2 FISCAL TEST GROUP for more information.

An individual applying for Long-Term Care Medicaid, including Institutional Medicaid, HCBW, Family Care, PACE, Partnership, or IRIS, would be a one-person fiscal group. If the individual is married, refer to SECTION 18.1 SPOUSAL IMPOVERISHMENT INTRODUCTION for special instructions regarding spousal impoverishment procedures.

15.1.2 Special Financial Rules for Disabled Children for SSI-Related Medicaid

Some amount of parental income may be deemed to a blind or disabled minor child or dependent 18-year-old when determining the child's financial eligibility for SSI-Related Medicaid and Medicare Savings Programs.

The blind or disabled child is a separate fiscal test group of one. The deemed parental income is added to the child's own income for the eligibility determination.

An "eligible child" in this section is defined as a minor child or dependent 18-year-old who is blind or disabled.

An "ineligible child" in this section is defined as a minor child or dependent 18-year-old who lives in the same household as the eligible child and is neither blind nor disabled.

Children who receive SSI are not counted as household members for purposes of this deeming process.

To determine how much parental income must be deemed to each eligible child:

1. Determine how much parental income to allocate to any **ineligible** children in the household. To do this, for each ineligible child, subtract the child's unearned and earned income from the **SSI-Related Deeming Amount to an Ineligible Minor**. This amount is updated annually and can be found in SECTION 39.4.2 DISABLED MINORS DEEMING AND ALLOWANCES.
2. Determine the remaining **total parental income** as follows:
    a) Subtract the ineligible child allocation amount (Step 1) from the parental unearned income. If there is not enough parental unearned income to subtract the whole amount, subtract the rest from parental earned income.
    b) If there is any remaining parental unearned income from Step 2(a), subtract the $20 general income disregard from the remaining unearned income. If there is not enough unearned income to subtract the full $20, subtract the rest of the $20 general income disregard from the parental earned income.
    c) Starting from what is left of the parental earned income, first subtract $65, and then subtract half of the remaining parental earned income.
    d) To the remaining parental earned income, add any parental unearned income remaining after steps 2(a) and (b).
3. Determine the amount of parental income that must be deemed to the eligible children by subtracting the appropriate **Parental Living Allowance** from the remaining total parental income determined in Step 2. Use the Parental Living Allowance amount for one parent if only one parent lives in the household. Use the amount for two parents if both parents (or one parent and a spouse) live in the household. The Parental Living Allowance amounts are updated annually and can be found in SECTION 39.4.2 DISABLED MINORS DEEMING AND ALLOWANCES.
4. Divide the parental deemed income equally among the eligible children.

Example 1:	Mr. and Mrs. Darwin live with their two minor children, Matthew and Jenny. Matthew is disabled and applying for Medicaid in 2022. Jenny is neither blind nor disabled. Neither child has income. Mr. and Mrs. Darwin have no unearned income and their gross earned income is $3,800 a month. In 2022, the SSI-Related Deeming Amount to an Ineligible Minor is $420 and the Parental Living Allowance for two parents is $1,261. ---------- 1. Determine amount allocated for ineligible child ($420 - $0) = $420 2. Determine total parental income: a) Start with $3,800 gross parental earned income b) Subtract $420 allocated for Jenny = $3,380 c) Subtract $20 general income disregard = $3,360 d) Subtract $65 earned income disregard = $3,295 e) Subtract half of remaining earned income = $1,647.50 3. Subtract parental living allowance for two parents ($1,261) from total parental income ($1,647.50) = $386.50 4. Divide by the number of eligible children (1) = **$386.50 deemed to Matthew**

Example 2:	Lawrence is a single parent with three minor children, Abel, Maris, and Dean. Dean is disabled and applying for Medicaid in 2022. Abel and Maris are neither blind nor disabled. None of the children have any income. Lawrence has $600 monthly unearned income and $2,050 monthly earned income.

	In 2022, the SSI-Related Deeming Amount to an Ineligible Minor is $420 and the Parental Living Allowance for one parent is $841. ---------- 1. Determine amount allocated for ineligible children ($420 - $0) + ($420 - $0) = $840 2. Determine total parental income: a) Start with $600 gross unearned income b) Subtract $840 allocated for Abel and Maris = -$240 remaining allocation c) Subtract $240 remaining allocation from gross parental earned income ($2,050) = $1,810 d) Subtract $20 general income disregard = $1,790 e) Subtract $65 earned income disregard = $1,725 f) Subtract half of remaining earned income = $862.50 3. Subtract parental living allowance for one parent ($841) from total parental income ($862.50) = $21.50 4. Divide by the number of eligible children (1) = **$21.50 deemed to Dean**

15.1.3 Income

See Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables for EBD income limits. See SECTION 39.5 FEDERAL POVERTY LEVEL TABLE for all other Medicaid income limits. Chapters for each type of Medicaid explain how to determine the income that you compare to the income limits.

See BadgerCare Plus Eligibility Handbook Section 43.2 Financial Test for TB-Related income limits.

15.1.4 Supplemental Security Income-Related Test

A fiscal group with income that does not exceed the categorically needy income limit passes the Medicaid SSI-related categorically needy income test (see SECTION 24.1 SSI-RELATED MEDICAID INTRODUCTION for more information).

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

If an EBD fiscal group fails the medically needy income test because their net income exceeds the medically needy income limit, they can still qualify for Medicaid if they can meet a Medicaid deductible. Refer to SECTION 24.2 MEDICAID DEDUCTIBLE INTRODUCTION for more information about Medicaid deductibles and to SECTION 24.5 CALCULATING THE DEDUCTIBLE for instructions on how to calculate a Medicaid deductible.

15.1.5 Availability

Available income can include **more** than a person actually receives if any of the following are true:

- A benefit payment (such as a Social Security benefit) has been reduced to recover a previous overpayment.
- Amounts are being withheld because of a garnishment or to pay a debt or other legal obligation.
- Amounts are being withheld to make another payment (such as Medicare premiums).

Available income can include **less** than a person actually receives if part of the payment is for an expense the person had in getting the payment. For example, if someone is paid for damages they

received in an accident, the medical, legal, or other expenses connected with the accident are subtracted from countable income.

If the person receives a retroactive check from a benefit program other than SSI, legal fees connected with the claim are subtracted.

Any part of taxable income used to pay personal income taxes is not subtracted, because the payment of taxes is not an expense the person has in getting the income.

Note *Applicants and members are not required to apply for cash benefits such as Social Security disability or retirement benefits, Supplemental Security Income (SSI), unemployment benefits, pensions, etc., as a condition of eligibility for Medicaid. Cash benefits that a person might potentially be eligible for that they do not actually receive must* ***not*** *be counted as income.*

15.1.6 Countable Income

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

15.1.6.1 Migrant Workers

Annualize migrant workers income (see CHAPTER 31 MIGRANT WORKERS).

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15.2 Prospective Income

15.2.1 Prospective Budgeting

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

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

Use all available data exchanges to verify income.

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

15.2.2 Prorating Income

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

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

Farm and self-employment income (see SECTION 15.6 SELF EMPLOYMENT INCOME) is either averaged or prorated.

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

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

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

Prorated Income Is an Unavailable Asset

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

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

15.2.3 Fluctuating Income

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

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15.3 Exempt and Disregarded Income

"Disregard" and "exempt" in this section mean "do not count." When calculating the total amount of income a person has received, disregard the following kinds of income:

15.3.1 Adoption Assistance

Disregard adoption assistance payments.

15.3.2 Agent Orange Settlement Fund

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

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

15.3.3 Combat Pay

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

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

Example 1	John's wife Bonnie and their daughter have an open Medicaid case. John is in the military stationed overseas, and his monthly income is $1,000. John sends his wife $1,000 every month. When John is deployed to a combat zone his pay is increased to $1,300 a month, which is deposited into a joint account. Because the $300 is combat zone pay, it is exempt income and not counted in the determination. The pre-combat pay of $1,000 is budgeted as unearned income for Medicaid.

15.3.4 Crime Victim Restitution Program

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

15.3.5 Disaster and Emergency Assistance

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

15.3.6 Dottie Moore Payments

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

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

15.3.7 Foster Care

Disregard foster care payments. Foster care payments are considered to be the income of the child or adult who is receiving foster care and these payments are exempt income for the foster care recipient. However, in some situations the foster care recipient uses these payments to pay the foster parent for his or her room and board expenses. The room and board payments that are received by the foster parent are not disregarded and should be counted as non-exempt earned income (see SECTION 15.5.15 EARNED INCOME TAX CREDIT) for the foster parent's Medicaid eligibility determination.

15.3.8 General Income Disregard

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

15.3.9 Individual Development Account Payments

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

15.3.10 Inconsequential

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

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

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

Exclude the following income that is received either infrequently or irregularly:

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

15.3.11 Kinship Care

Disregard Kinship Care payments.

15.3.12 Life Insurance

Disregard life insurance policy dividends.

15.3.13 Nutrition Benefits

Disregard benefits received from the following:

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

15.3.14 Payments to Native Americans

Disregard the following payments to Native Americans:

1. Menominee Indian Bond interest payments
2. All judgment payments to tribes through the Indian Claims Commission or Court of Claims
3. Payments under the Alaskan Native Claims Settlement Act
4. Payments under the Maine Indian Claims Settlement Fund

5. Payments under PL 93-124 to the Sisseton-Wahpeton Sioux Tribe, except individual shares over $2,000
6. Payments under PL 93-134 to the Maricopa Ak-Chin Indian Community, Navajo Tribe, Coast Indian Community of the Resighini Rancheria, Stillaguamish Tribe, Pueblo of Taos Tribe, Walker River Paiute Tribe, and White Earth Band of the Minnesota Chippewa Tribe, except individual shares over $2,000
7. Payments under PL 94-114 to the Bad River Band and Lac Courte Oreilles Band of Chippewa Indians and the Stockbridge-Munsee Indian Community of Mohicans
8. Payments under PL 96-318 to the Delaware Tribe of Kansas and of Idaho
9. Payments under PL 96-420 to the Houlton Band of Muliseet Indians, the Passamoquoddy, and Penobscot
10. For EBD Medicaid cases, under PL 98-64, disregard all Indian judgment funds held in trust by the Secretary of the Interior for an Indian tribe and distributed on an individual basis to members of the tribe. Also disregard interest and investment income from these funds
11. Payments under PL 99-346, Saginaw Chippewa Indian Tribe of Michigan
12. Payments under PL 99-377 to the Mille Lacs, Leech Lake, and White Earth, Minnesota reservations
13. Payments under PL 101-41, Puyallup Tribe of Indians Settlement Act of 1989
14. Payments under the Distribution of Judgment Funds Act of 1987 to the Cow Creek Band, Umpqua Tribe
15. Payments under the Distribution of Indian Judgment to the Crow Creek and Lower Brule Sioux except individual shares over $2,000
16. Payments under the settlement of the Cobell v. Salazar class-action trust case
17. Non-gaming tribal income from the following sources:
    a) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from one of the following:
        i. Rights of ownership or possession in any lands held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation or otherwise under the supervision of the Secretary of the Interior
        ii. Federally-protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources

    b) Distributions resulting from real property ownership interests related to natural resources and improvements:
        i. Located on or near a reservation or within the most recent boundaries of a prior federal reservation or
        ii. Resulting from the exercise of federally-protected rights relating to such real property ownership interests.

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

    This applies to eligibility determinations for all Medicaid subprograms for elderly, blind, or disabled persons except the following:
    a) SeniorCare
    b) LTC programs, such as the following:

i. Institutional Medicaid
ii. HCBW
iii. Managed LTC or IRIS

For these subprograms, which are treated differently because they are covered under a different section of federal law, count all income from Tribal Per Capita payments from gaming revenue as unearned income.

19. Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
20. Payment from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
21. Money from selling things that have cultural significance
22. Tribal general welfare payments that are based on the individual's demonstration of need, even if the source of the payment is gaming revenue
23. Payments under the Michigan Indian Claims Settlement Act (MICSA) to the Sault Ste. Marie Tribe of Chippewa Indians and the Bay Mills Indian Community

15.3.15 Payments to Nazi Victims

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

15.3.16 Radiation Exposure Compensation Act

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

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

15.3.17 Refugee Cash Assistance

Disregard cash payments from the RCA program. RCA is administered by W-2 agencies and is made available for refugees who do not qualify for W-2.

15.3.18 Refugee "Reception and Placement" Payments

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

15.3.19 Reimbursements

A reimbursement is a payment that a person receives for out-of-pocket expenses. Disregard reimbursements for expenses an AG member has incurred or paid. Do not disregard reimbursements for normal household living expenses, such as rent, clothing, or food eaten at home (see SECTION 15.4.21 REIMBURSEMENT OF LIVING EXPENSES).

The following are some examples of reimbursements you should disregard:

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

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

15.3.20 Relocation Payments

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

Disregard Experimental Housing Allowance Program payments. The program's purpose is to study housing supply. Test areas, which include Brown County, were selected throughout the U.S., and contracts were entered into prior to January 1, 1975. A sample of families was selected to receive monthly housing allowance payments.

For Medicaid applicants or members, disregard housing assistance payments received under the following acts:

- United States Housing Act of 1937
- National Housing Act
- Section 101 of the Housing and Urban Development Act of 1965
- Title V of the Housing Act of 1949
- Section 202(h) of the Housing Act of 1959

15.3.21 Repayments

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

Disregard the following repayments:

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

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

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

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

15.3.22 Special Programs

Disregard income from all of the following:

- Active Corps of Executives
- Emergency Fuel Assistance
- Foster Grandparents Program
- Governmental rent or housing subsidy, including reimbursements due to federal regulatory changes in computing HUD housing rent
- Homestead Tax Credit
- Low Income Energy Assistance Program
- Programs funded under Title V of the Older Americans Act of 1965 (see SECTION 15.5.13 TITLE V—OLDER AMERICANS ACT OF 1965), except wages or salaries, which are counted as earned income.
- Retired Senior Volunteer Program
- Service Corps of Retired Executives
- University Year for Action Program
- Volunteers in Service to America
- Wisconsin's Family Support Program (Wis. Stat. § 46.985). This program funds the unique needs of severely disabled children. They may be a vendor or a money payment.
- Senior Companion Program
- AmeriCorps State and National and AmeriCorps NCCC

15.3.23 Spina Bifida Child

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

15.3.24 Susan Walker Payments

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

15.3.25 Travel Tickets

In Medicaid cases, disregard the value of any commercial transportation ticket that the member, the member's spouse, or the member's parents (if the member is a minor) receives as a gift if it is:

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

15.3.26 VA Allowances

15.3.26.1 Aid & Attendance (A&A) and Housebound Allowances

For veterans and surviving spouses who need help with activities of daily living or are housebound due to disability, a Department of Veterans Affairs (VA) benefit may include a monetary amount referred to as an “Aid & Attendance” (A&A) or “housebound” allowance (see SECTION 39.13 VA ALLOWANCE RATES).

Disregard A&A and housebound allowances when determining eligibility for any category of Medicaid.

Disregard A&A and housebound allowances when determining the patient liability or cost share amount for Institutional Medicaid and Community Waivers. This rule does not apply to State Veterans Home residents without dependents (see Section 15.3.26.3 Patient Liability Calculation for State Veterans Home Residents Without Dependents).

Example 3	Jack is a single veteran living in his home. He receives a $2,051 monthly need-based VA pension. His VA pension includes an A&A allowance of $821 per month. The A&A allowance is disregarded for Medicaid eligibility. $2,051 VA pension - $821 A&A allowance (disregarded) _____ = $1,230 budgetable income

Example 4	Donald is a married veteran living with his spouse and two children. He is disabled (as determined by the VA) and receives VA disability compensation benefits in the amount of $1,963 per month. He does not receive A&A or housebound allowances and the VA did not consider any unreimbursed medical expenses when calculating the VA disability compensation benefit amount. The full $1,963 is budgetable income to the household.

When a single veteran or a surviving spouse without dependents is in a nursing home and enrolled in Medicaid, the VA is required to reduce the pension amount to no more than $90, except when the member is in a State Veterans Home. These reduced pensions of $90 or less are always considered A&A, so the full amount of these reduced pensions is disregarded for Medicaid eligibility as well as cost share or patient liability determinations.

Example 5	Patrick is a single veteran with no dependents who is in a nursing home and open for Institutional Medicaid. He receives a $90 monthly VA pension. The entire $90 VA pension amount is A&A and is disregarded for both his Medicaid eligibility and patient liability determinations.

15.3.26.2 Unreimbursed Medical Expenses (UME)

When the VA determines the amount of a need-based benefit payment, it may consider any unreimbursed medical expenses incurred by the beneficiary or a member of their household that exceed 5% of the VA's basic Maximum Annual Pension Rate (MAPR). These expenses are sometimes referred to as "unreimbursed" or "unusual" medical expenses (UME). The VA deducts UME from countable income when computing the VA payment, resulting in a higher monthly payment.

Disregard any portion of a VA benefit that is for UME when determining eligibility for any category of EBD Medicaid.

Disregard any portion of a VA benefit that is for UME when determining the patient liability or cost share amount for Institutional or Community Waivers Medicaid. This rule does not apply to State Veterans Home residents without dependents (SEE SECTION 15.3.26.3 PATIENT LIABILITY CALCULATION FOR STATE VETERANS HOME RESIDENTS WITHOUT DEPENDENTS).

Example 6	Allan is a veteran who resides in an assisted living facility. He receives a $1,200 monthly Social Security benefit and a monthly VA pension. His VA pension includes an A&A allowance of $883 per month. When calculating his pension amount, the VA also considered Allan's $42,000 annual ($3,500 monthly)

	assisted living fees as UME. The UME reduced his countable income (for VA purposes) to $0, resulting in a VA pension amount of $2,051 per month. The portion of the VA pension that is for A&A and UME is disregarded for Medicaid eligibility. Because Allan's $883 monthly A&A allowance plus the $3,500 monthly UME amount that the VA considered is greater than the total pension amount, the entire pension amount is for A&A and UME and must be disregarded for Medicaid eligibility. $1,200 Social Security + $2,051 VA pension - $2,051 amount of VA pension for A&A/UME (disregarded) _____ = $1,200 budgetable income

15.3.26.3 Patient Liability Calculation for State Veterans Home Residents Without Dependents

For any veteran without a spouse or dependents (or for a surviving spouse without dependents) who resides at a State Veterans Home at King, Chippewa Falls, or Union Grove:

- The portion of the VA pension that is an A&A or housebound allowance or is for UME is disregarded in the eligibility determination.
- If the member receives a VA pension in an amount less than or equal to $90, the total pension amount is exempt for the patient liability calculation.
- If the member receives a VA pension in an amount greater than $90, only $90 of the VA pension is exempt for the patient liability calculation. The portion of the VA pension that is an A&A or housebound allowance or is for UME is included when calculating patient liability.

These special patient liability rules do not apply to State Veterans Home residents who have a spouse or other dependents.

If a veteran or surviving spouse in a State Veterans Home has dependents and receives a VA benefit, for Medicaid eligibility and patient liability, disregard any amount of the VA benefit that is an A&A or housebound allowance or is for UME.

Example 7	John is a single veteran with no dependents residing at the State Veterans Home at King. His total monthly income consists of a $90 VA pension and a $55 annuity payment. The $90 VA pension is totally disregarded for his Medicaid eligibility and patient liability calculation. John's budgetable income is $55. After deducting the $55 personal needs allowance, he has a $0 patient liability.

Example 8	Scott is a single veteran with no dependents residing at the State Veterans Home at Chippewa Falls. His total monthly income consists of a $590 VA pension ($200 of which is for UME) and a $50 annuity payment. For his Medicaid eligibility determination, the $200 UME portion of his VA pension is disregarded. For his patient liability calculation, only $90 of the VA pension is disregarded. **Eligibility Calculation** $390 VA Pension ($590 gross VA pension – $200 UME) + $50 Annuity _____ $440 gross countable income **Patient Liability Calculation** $440 gross countable income + $200 UME (counted) _____ $640 adjusted gross income

	- $55 (personal needs allowance) - $90 (VA allowance) _____ $ 495 patient liability amount

Example 9	Melvin is a veteran residing at the State Veterans Home at King. He has a spouse residing in the community. His total monthly income consists of a $1,400 monthly Social Security benefit and a $410 monthly VA pension ($200 of which is for UME). The portion of the VA pension that is for UME is totally disregarded for both his Medicaid eligibility and patient liability calculation. $1,400 Social Security + $410 VA pension - $200 UME (disregarded) _____ = $1,610 budgetable income

15.3.27 Wartime Relocation of Citizens

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

15.3.28 Wisconsin Works Payments

Disregard W-2 stipends and payments, including Case Management Follow-up Plus (CMF+) payments, made directly to a member as part of his or her participation in W-2. Earnings obtained through W-2's subsidized employment programs, such as Trial Jobs or Transform Milwaukee Jobs, are countable earned income.

15.3.29 Subsidized Guardianship Payments

Disregard subsidized guardianship payments.

15.3.30 Certain Payment Types Related to the COVID-19 Pandemic

There is no uniform policy for how to count payment types related to the COVID-19 pandemic; some payment types are counted as income and some payment types are not counted as income. The criteria used to evaluate whether a payment type is counted as income include:

- The text of the federal law that authorized the payment type.
- Guidance received from federal agencies.
- Whether the payment can be considered "disaster assistance."

The payment types that do not count as income include but are not limited to:

- Federal recovery rebates (sometimes referred to as Coronavirus stimulus payments or economic impact payments) issued by the IRS in response to the federal COVID-19 public health emergency.
- Federal Pandemic Unemployment Compensation (FPUC) payments.
- Retroactive Pandemic Unemployment Assistance (PUA) payments.
- Retroactive Pandemic Emergency Unemployment Compensation (PEUC) payments.
- Retroactive Extended Benefits (EB) unemployment compensation payments.
- We're All In Small Business Grants.

- Child Care Counts supplementary payments. These payments are awarded to child care providers.
- Wisconsin Emergency Rental Assistance (WERA) payments.
- COVID-19 Funeral Assistance.
- Emergency Assistance for Rural Housing/Rural Rental Assistance.
- Homeowner Assistance Fund.
- Housing Assistance and Supporting Services Programs for Native Americans.
- Education Stabilization Fund (ESF) payments, which include payments from the following funds:
    - Elementary and Secondary School Emergency Relief (ESSER) Fund
    - Governor's Emergency Education Relief (GEER) Fund
    - Emergency Assistance to non-Public School (EANS) Fund
    - Higher Education Emergency Relief (HEER) Fund payments
- Economic relief payments paid directly from a tribal government to a tribal member using local government relief funds provided through the CARES Act.
- A Paycheck Protection Program (PPP) loan. The loan itself is not counted as income. However, if the loan is being used to pay employee wages, the wages are counted as income for the employee who receives them.

See SECTION 15.4.25 CERTAIN PAYMENT TYPES RELATED TO THE COVID-19 PANDEMIC for countable types of pandemic-related unemployment compensation benefits.

15.3.31 Cash Benefits Received in Conjunction with Medical and Social Services

The treatment of cash benefits received in conjunction with medical and social services depends on whether it is provided by a governmental or nongovernmental organization.

To be considered governmental, the program must be authorized by federal, state, or local law, statute, or ordinance to provide medical or social services. This includes entities that are under contract with a federal, state, or local government to provide services.

Disregard any cash benefits provided by a governmental medical or social services program.

Disregard cash benefits provided by a nongovernmental medical or social services organization if either of the following conditions is met:

- The cash is for approved medical or social services already received.
- The cash is only for the future purchase of medical- or social service-related items.

15.3.32 Medicare Advantage Supplemental Benefits

Disregard all Medicare Advantage supplemental benefits.

A supplemental benefit is an item or service provided by a Medicare Advantage Plan that is not covered by original Medicare.

Example 10	Mariel received a prepaid debit card from her dual eligible special needs (D-SNP) plan as a wellness benefit that she can use to purchase healthy food and over-the-counter medications. The funds on the debit card must not be counted as income or assets.

15.3.33 Reserved

15.3.34 Federal Income Tax Refunds and Credits

Federal income tax refunds (including refundable tax credits) and advance payments of any tax credits, including the Earned Income Tax Credit and the Child Tax Credit, are totally disregarded as income.

15.3.35 Temporary COLA Disregard for Social Security Recipients

The annual Cost of Living Adjustment (COLA) increase to Social Security benefits is disregarded in certain months for the following programs and categories, which have income limits that are tied to the Federal Poverty Level (FPL):

- Medically Needy SSI-Related Medicaid (including deductibles)
- Medicaid Purchase Plan (including premiums)
- Medicare Savings Programs

The disregard begins the month of the COLA increase (usually January) and ends when the new FPL amounts are in effect (usually February 1 for new applications and March 1 for ongoing cases).

Example 11	In December, Ed's Social Security payment was $875 per month. It increased to $900 in January. The current COLA disregard amount is calculated by subtracting Ed's previous Social Security payment amount from his current payment amount. Ed's current COLA disregard amount is $25, which is disregarded from January 1 until February 28. The disregard ends when the new FPL amounts go into effect on March 1.

15.3.36 Guaranteed Income Payments

A guaranteed income payment is excluded for all categories of Medicaid if both of the following apply:

- The payment itself is privately funded.
- The payment is administered by a non-profit organization.

Guaranteed income payments that are excluded include, but are not limited to, payments from the Madison Forward Fund, the Madison Forward Fund 2.0, and The Bridge Project in Milwaukee.

See SECTION 16.7.34 GUARANTEED INCOME PAYMENTS for information about asset treatment of guaranteed income payments.

15.3.37 Assistance Based on Need (General Assistance)

Income is disregarded as Assistance Based on Need, also known as General Assistance, if it is:

- Provided under a program which uses income as a factor of eligibility, and
- Funded wholly by a state (including tribes), a political subdivision of a state, or combination of such jurisdictions.

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15.4 Unearned Income

Unearned income is income that a member receives from sources other than employment. Unless it is disregarded income (see SECTION 15.3 EXEMPT AND DISREGARDED INCOME) or an income deduction (see SECTION 15.7 INCOME DEDUCTIONS), count gross unearned income in a person's income total.

When two payments from the same income source are received the same month due to mailing cycle adjustments, count each payment only for the month it is intended. Income sources commonly affected by such mailing cycle fluctuations include general assistance, other public assistance programs, SSI, and SSA benefits.

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

15.4.1 Income From Trusts

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

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

The grantor can be:

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

All payments (including interest and dividends) from a trust to the beneficiary are unearned income to the beneficiary. See SECTION 15.4.9 INTEREST AND DIVIDEND INCOME for instructions on counting interest.

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

Note *If the grantor is an institutionalized person or acting on behalf of an institutionalized person, payments from any trust, both revocable and irrevocable, that are not to or for the benefit of the institutionalized person are divestment (see SECTION 17.2 EVALUATION OF TRANSFERS FOR DIVESTMENT).*

15.4.2 Sick Benefits

Sick benefits are payments, such as income continuation, received from insurance. Cash from any insurance policy that pays a flat rate benefit to the recipient without regard to the actual charges or expenses incurred is unearned income. Examples of these types of insurance policies are per diem hospitalization or disability insurance, or cancer or dismemberment policies.

Do not count the following:

- Reimbursement for medical or social services
- Payments restricted to the future purchase of a medical or social service

15.4.3 Unemployment Compensation

Count normal UC that is received. Count UC that is intercepted to collect child support as if the UC beneficiary actually received the intercepted dollars.

15.4.4 Retirement Benefits

See SECTION 16.11 RETIREMENT FUNDS

15.4.5 General Relief and Charity

Count unrestricted General Relief and charitable payments as follows:

1. Subtract the process month's Family Allowance from the AFDC Assistance Standard (see SECTION 39.3 AFDC-RELATED INCOME TABLE) for this size fiscal group.
2. Multiply the difference by 12 to get the maximum payment you can disregard.
3. Ignore any payment that is less than the maximum.
4. Subtract from the maximum the amount of any payment that is greater than the maximum.
5. Count the remainder as unearned income.

15.4.6 Gifts

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

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

Disregard cash gifts (such as for birthdays, graduation, and Christmas) that total $60 or less for each AG member for each calendar quarter.

Funds received through a crowdfunding account, such as GoFundMe and Kickstarter, would be considered a gift and counted as unearned income in the month of receipt and as an available asset in subsequent months as long as the funds are still in the person's possession (i.e., the person did not spend it in the month of receipt).

Funds that are not accessible for a person to withdraw are an unavailable asset. Disbursements would be unearned income in the month withdrawn and an available asset in subsequent months if the funds are still in the person's possession.

15.4.7 Land Contract

Count any portion of monthly payments received that are considered interest from a land contract as unearned income. If the land contract cannot be sold because it is not considered to be negotiable, assignable, enforceable, and marketable, it cannot be considered an available asset. Count any repayments toward the principal of the loan as income. If the land contract can be sold, it is counted as an available asset, and the principal portion of the repayment remains an asset. Disregard any

repayments toward the principal of the loan as income. Deduct from the gross amount any expenses the person is required to pay by the terms of the contract.

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

Example 2	Bob receives land contract payments from Farmer Brown twice a year: one $5,000 payment in March and another $5,000 payment in September. Ten percent of that payment is interest. If Bob is applying in February, prorate the land contract payments Bob receives after he becomes eligible. In March when Bob receives a $5,000 land contract payment, divide the total countable income ($5,000 times 10 percent equals $500) by the frequency of the payments (six months) to get the budgeted income amount of $83.33 per month ($500 divided by six months equals $83.33). Begin budgeting this amount in March.

15.4.8 Loans, Promissory Notes, and Mortgages

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

1. Count the interest as unearned income in the month received.
2. Count any repayments toward the principal of the **loan**, regardless of whether it is a full payment, a partial payment, or an installment payment, as an asset but only if the **promissory note** itself is an available counted asset.
3. When the **promissory note** cannot be sold because it is not considered to be negotiable, assignable, enforceable, and marketable, it cannot be considered an available asset. Count any repayments toward the principal of the **loan** as income.
4. If an AG member receives a loan and it is available for current living expenses, count it as an asset. Do this even if there is a repayment agreement. If it is not available for current living expenses, disregard it.

15.4.9 Interest and Dividend Income

15.4.9.1 Elderly, Blind, or Disabled Interest and Dividend Income

Most interest and dividend earnings are excluded income so are not counted when determining Medicaid eligibility. See SECTION 15.4.9.1.1 EXCLUDED SOURCES OF INTEREST OR DIVIDEND INCOME for excluded sources of interest or dividend income and SECTION 15.4.9.1.2 INTEREST AND DIVIDENDS INCOME NOT EXCLUDED FOR ELDERLY, BLIND, OR DISABLED MEDICAID for interest and dividend income not excluded for EBD.

Most interest and dividend income from a resource excluded under SSI rules will be an excluded source of income for all Medicaid eligibility and post-eligibility determinations. The are, however, some exceptions (see SECTION 15.4.9.1.2 INTEREST AND DIVIDENDS INCOME NOT EXCLUDED FOR ELDERLY, BLIND, OR DISABLED MEDICAID).

15.4.9.1.1 Excluded Sources of Interest or Dividend Income

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

- Interest or dividend income from a non-exempt resource, such as savings accounts, checking accounts, stocks, or bonds
- Medicaid resources that are exempt by federal statute other than the Social Security Act:
    - Agent Orange Settlement Payments
    - Austrian Social Insurance Payments

  - Corporation for National Community Service (formerly ACTION) Programs
  - Interests of IDAs—TANF-Funded
  - IDAs—Demonstrated Project
  - Japanese-American and Aleutian Restitution Payments
  - Low Income Energy Assistance
  - Payments to Victims of Nazi Persecution
  - Netherlands WUV Payments to Victims of Persecution
  - Department of Defense Payments to Certain Persons Captured and Interned by North Vietnam
  - Radiation Exposure Compensation Trust Fund
  - Ricky Ray Hemophilia Relief Fund
  - Payments to Veterans' Children with Certain Birth Defects
- Interest and dividends that accrue to revocable and irrevocable trusts
- Interest and dividends from a life insurance policy

15.4.9.1.2 Interest and Dividends Income Not Excluded for Elderly, Blind, or Disabled Medicaid
Count the following interest and dividends income for Medicaid:

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

Count the non-excluded interest and dividend income listed above as unearned income only when both the following are true:

- It is received regularly and frequently.
- It is more than $20 a month.

15.4.10 Social Security Benefits

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

15.4.11 Property Settlement

See SECTION 16.7.10 PROPERTY SETTLEMENT.

15.4.12 Lump Sum Payments

See SECTION 16.7.11 LUMP SUMS PAYMENTS.

15.4.13 Money for School

For elderly or disabled cases, apply the disregards listed in SECTION 15.4.13.1 TOTAL DISREGARDS and SECTION 15.4.13.2 PARTIAL DISREGARDS but count all other money that is derived from any other student loan or grant not listed below. Use the Student Financial Aids Report (F-16021) to obtain the type and

amount of the student's aid package. Also, use it to inform the student financial aids office of assistance granted.

See SECTION 15.4.13.3 WORKFORCE INVESTMENT ACT for instructions on how to treat income that is earned under the WIA.

15.4.13.1 Total Disregards

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

- Supplemental Educational Opportunity Grant
- Perkins Loans (formerly National Defense Student Loans)
- Federal Direct Student Loan Program (formerly the Guaranteed Student Loan Program and the Federal Family Education Loan Program)
- Wisconsin Direct Student Loan
- Talent Incentive Program/State Student
- Incentive Grant (Talent Incentive Program or State Student Incentive Grant)
- College Work Study Program
- Basic Educational Opportunity Grants (Pell Grants)
- Wisconsin Indian Grant
- Bureau of Indian Affairs Grant
- Any other undergraduate loan or grant made or insured under any program administered by the U.S. Commissioner of Education
- Any other loans and grants obtained and used under conditions that prevent their use for current living costs
- County training program allowances granted by an IM agency

15.4.13.2 Partial Disregards

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

1. Determine the cost of tuition, fees, books, transportation essential to education or training, and day care.
2. Subtract the total in "1" from the grant, loan, scholarship, etc. total.
3. Count any remaining money as unearned income only as of when the student gets the money and over the months the money is intended to cover.

Example 3	The remaining $600 of a grant is intended to cover January through June. If it is received in: • May, count $100 in each of the income months of May and June • July, budget $0 • December, count $100 in each of the income months of January through June.

15.4.13.3 Workforce Investment Act

For both family and elderly/disabled Medicaid cases, disregard all unearned income from WIA to any adult or minor participating in WIA, including:

- "Need-based payments" paid to people as allowances to enable them to participate in a training program.
- "Compensation in lieu of wages" paid to people in "tryout employment." This is arranged when private-for-profit opportunities are not available and is generally limited to people younger than

22 years old. Ask any applicant younger than 23 years old or the local WIA staff if he or she is participating in "tryout employment." If he or she is, count this as unearned income.

- "Payments for supportive services" paid to people in training programs who are not able to pay for training-related expenses (e.g., transportation, health care, child care, meals).

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

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

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

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

15.4.14 Child Support

Count child support income as unearned income.

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

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

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

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

15.4.15 Profit Sharing

Count profit sharing income as unearned income.

15.4.16 Income Received by Members of a Religious Order

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

Count the compensation as earned income if it meets the criteria in SECTION 15.5.12 INCOME RECEIVED BY MEMBERS OF A RELIGIOUS ORDER.

15.4.17 Federal Match Grants for Refugees

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

15.4.18 Gambling Winnings

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

15.4.19 Payments to Native Americans

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

This applies to eligibility determinations for all Medicaid subprograms for elderly, blind, or disabled persons **except** SeniorCare and LTC programs such as Institutional Medicaid, Family Care, and HCBWs, including Partnership and PACE. For these subprograms, count all income from Tribal Per Capita payments from gaming revenue as unearned income.

15.4.20 Alimony, Maintenance, and Other Spousal Support Payments

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

15.4.21 Reimbursement of Living Expenses

Count reimbursements for normal living expenses, such as rent, utilities, clothing, and food eaten at home, as income. For examples of reimbursements that are not counted as income, see SECTION 15.3.19 REIMBURSEMENTS.

15.4.22 Income Allocation from Institutionalized Spouse to Community Spouse

Income allocated from an institutionalized spouse to a community spouse per SECTION 18.6 SPOUSAL IMPOVERISHMENT INCOME ALLOCATION is counted income to the community spouse if that community spouse is receiving a form of EBD Medicaid.

15.4.23 Rental Income

When a Medicaid group member reports rental income to the IRS as self-employment income, see SECTION 15.6.4 SELF-EMPLOYED INCOME SOURCES.

If he or she does not report it as self-employment income, the net rental income is counted as unearned income. Determine net rental income as follows

1. When the owner is not an occupant, net rental income is the total rent payment(s) received minus the interest portion of the mortgage payment(s) and other verifiable operational costs. If an institutionalized person has excess operational costs above the monthly rental income, carry the excess costs over into later months until they are offset completely by rental income. But do the carryover only until the end of the year in which the expenses were incurred.

   When a life estate (see SECTION 16.8.1.6 LIFE ESTATE) holder moves off the property and the property is rented, count the net rental income the holder is entitled to receive. The operational costs are the same as the costs the holder was liable for when living on the property.

a) Operational costs include ordinary and necessary expenses, such as insurance, taxes, advertising for tenants, and repairs. Repairs include such expenses as repainting, fixing gutters or floors, plastering, and replacing broken windows.
b) Capital expenditures are not deductible from gross rent. A capital expenditure is an expense for an addition or increase in the value of the property. It would include such improvements as finishing a basement, adding a room, putting up a fence, putting in new plumbing, wiring, or cabinets, or paving a driveway.

2. When the owner is an occupant (of a duplex, triplex, etc.) and lives in one of the units, determine net rental income as follows:

    a) Add together the annual interest portion of the mortgage payment and other annual verifiable operational costs common to the entire operation to get the total annual expenses.
        i. Operational costs include ordinary and necessary expenses, such as insurance, taxes, advertising for tenants, and repairs. Repairs include such expenses, such as repainting, fixing gutters or floors, plastering, and replacing broken windows.
        ii. Capital expenditures are not deductible from gross rent. A capital expenditure is an expense for an addition or increase in the value of the property. It would include such improvements as finishing a basement, adding a room, putting up a fence, putting in new plumbing, wiring, or cabinets, or paving a driveway.
    b) Divide the result in step 1 (the total annual expenses) by the total number of units to get the proportionate annual share of expenses.
    c) Multiply the amount in step 2 (the proportionate annual share of expenses) by the number of rental units (rental units means the total number of units minus the unit the owner lives in) to get the member's total annual expenses.
    d) Subtract the result in step 3 (the member's total annual expenses) from the total annual rental income to get the member's net annual rental income.
    e) Divide the result of step 4 (the member's net annual rental income) by 12 to get the member's net monthly rental income. Budget this amount.

Example 4	George owns a four unit apartment building and lives in unit 1. His annual interest paid on his mortgage for the most recent tax year is $9,765. His operational expenses, including taxes on the building, from the most recent taxes is $12,359. This totals $22,124. This amount divided by four units equals a proportionate share of $5,531. $5,531 multiplied by three rental units equals $16,593. This represents his total budgetable annual expenses. His total annual rental income equals $28,800 ($800 per unit per month). $28,800 –$16,593 _____ $12,207 $12,207 / 12 = **$1,017.25** net monthly rental income.

15.4.24 REWARD Wisconsin Stipends

Count REWARD Wisconsin stipends as income. These stipends are awarded to child care professionals.

15.4.25 Certain Payment Types Related to the COVID-19 Pandemic

There is no uniform policy for how to count payment types related to the COVID-19 pandemic; some payment types are counted as income and some payment types are not counted as income. The criteria used to evaluate whether a payment type is counted as income include:

- The text of the federal law that authorized the payment type;
- Guidance received from federal agencies; and
- Whether the payment can be considered “disaster assistance”.

The payment types that count as income **include but are not limited to:**

- Workforce Retention and Recognition Stipend Program payments. These payments are awarded to child care professionals.
- USDA Coronavirus Food Assistance Program – Direct Payments to Farmers and Ranchers.
- Child Care Counts Stabilization Payments.

See section 15.3.30 CERTAIN PAYMENT TYPES RELATED TO THE COVID-19 PANDEMIC for non-countable types of pandemic-related income.

15.4.26 Virtual Currency

Virtual currency is money that is a digital system not in U.S. dollars or other money system backed by a government. Examples may include, but are not limited to, Bitcoin, Ethereum, and Litecoin. Traditional currency, such as the U.S. dollar, is used to purchase virtual currency, and virtual currency may be sold for traditional currency. Virtual currency does not refer to Venmo or PayPal. Venmo and PayPal are payment services that facilitate the movement of funds between people or businesses; they are not currencies. Income earned via Venmo or PayPal sales would most likely fall under self-employment income policies, not virtual currency.

If virtual currency is sold, income received from the sale is counted as income. See SECTION 15.5.19 VIRTUAL CURRENCY for information about treatment of virtual currency that the applicant or member has earned through work.

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15.5 Earned Income

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

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

15.5.1 Income In-Kind

Count in-kind benefits as earned income if they meet all of the following criteria:

- Regular
- Predictable
- Received in return for a service or product

Do not count meals and lodging for armed services members.

To determine the value of in-kind benefits, use the prevailing wage (but not less than the minimum wage) in the community for the type of work the person does to earn the benefits. In order to determine the value of the in-kind benefits, the verification must include the amount of time the person does the work activity each month.

Example 1	Sue weeds her neighbor's garden about an hour a week in exchange for a hot meal. The in-kind value of this exchange is the prevailing wage, not less than minimum wage, for the weekly hour of weeding that Sue does for her neighbor. The value is not based on the value of the hot meal. Sue is not a landscape architect or a master gardener, so the prevailing wage would be minimum wage. The required verification for this in-kind income is documentation, such as a signed statement, from her neighbor that Sue weeds an hour a week for her neighbor in exchange for a hot meal.

Example 2	Roy walks his neighbor's dog a few times a month in exchange for transportation to and from his doctors' appointments. Roy tells the worker that he thinks this is worth $20 a month for the 8 hours a month he walks the dog, which would equal $2.50 an hour. The worker would ask for verification that includes how often and for how long each time Roy walks the dog in exchange for transportation to and from appointments. Since Roy is not a bonded dog walker or a professional dog trainer, the worker would enter minimum wage as a reasonable prevailing wage for this exchange.

15.5.2 Contractual Income

This provision applies primarily to teachers and other school employees.

When an employed Medicaid group member is paid under a contract, either written or verbal, rather than on an hourly or piecework basis, determine the period of the contract and then prorate the income from the contract over that period. For example, if the contract is for 18 months, prorate the contract's income over 18 months regardless of the number of installments made in paying the income. Do this even if any of the following are true:

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

15.5.3 Rental Income

When a Medicaid group member reports rental income to the IRS as self-employment income, see SECTION 15.6.4 SELF-EMPLOYED INCOME.

If the owner does not report it as self-employment income, see SECTION 15.4.23 RENTAL INCOME.

15.5.4 Jury Duty Payments

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

15.5.5 Wage Advances

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

15.5.6 Worker's Compensation

Worker's compensation is compensation for lost wages that would have been earned, except for an injury suffered during the course of employment. Count worker's compensation as unearned income. The amount of the income is the amount that the applicant or member can access. This may be the entire lump sum if distributed at once or the monthly amount available for withdrawal if the total sum was placed in a restricted account (for example, as a result of a settlement).

15.5.7 Income Tax Refunds

Effective January 1, 2010, income tax refunds are disregarded income (see SECTION 16.7.7 INCOME TAX REFUNDS).

15.5.8 Student Income

Disregard a member’s income if he or she meets any of the following criteria:

- Meets the definition of a dependent 18-year-old
- Is younger than 19 years old and is enrolled as a full-time student
- Is younger than 19 years old and is enrolled as a part-time student working less than 30 hours per week

Count the earned income of anyone younger than 19 years old who does not meet any of the criteria listed above.

15.5.9 AmeriCorps

Disregard any benefit whether cash or in-kind, including but not limited to living allowance payments, stipends, food and shelter, clothing allowance, and educational awards or payments in lieu of educational awards. Disregard any child care allowance to the extent it was used to meet child care expenses to participate in AmeriCorps. Disregard any basic health insurance policy, child care services, auxiliary aid, and services to people with disabilities and the national service.

15.5.10 Census

Disregard all wages paid by the Census Bureau for temporary employment related to the Census.

15.5.11 Severance Pay

Count severance pay as earned income in the month of receipt. Count severance pay that has been deferred at the employee’s request or through a mutual agreement with his or her employer as earned income when he or she would have received the amount had it not been deferred.

15.5.12 Income Received by Members of a Religious Order

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

15.5.13 Title V—Older Americans Act of 1965

Count only wages and salaries paid to individuals as a result of their participation in a program funded under Title V of the Older Americans Act of 1965 as earned income.

These programs include, but are not limited to:

- Green Thumb
- Experience Works
- The National Urban League
- National Senior Citizens Education and Research Center (Senior Aides)
- National Indian Council on Aging
- USDA Forest Service
- Wisconsin Senior Employment Program
- Community service employment programs, such as the Older Americans Community Service Program

Identify programs funded under the Title V of the Older Americans Act using documents provided by the member, contacts with the provider, or a local council on aging.

Do not count reimbursements (see SECTION 15.3.19 REIMBURSEMENTS).

15.5.14 Room and Board Income

Calculate the net amount by deducting one of the following from the gross amount received from each roomer and/or boarder:

- $15 roomer only
- $111 boarder only
- $126 roomer and boarder

15.5.15 Earned Income Tax Credit

Effective January 1, 2010, disregard EITC payments.

15.5.16 Make Work Pay Credit

Effective January 1, 2010, disregard actual payments made under Make Work Pay.

15.5.17 Special Tax Credit for Certain Government Retirees

Effective January 1, 2010, disregard actual payments made under the Special Tax Credit for Certain Government Retirees.

15.5.18 Prison or Jail Job

Count income that an inmate earns from a prison or jail job that pays less than minimum wage, such as jobs through Badger State Industries (BSI). This income does not need to be verified.

15.5.19 Virtual Currency

Virtual currency is money that is a digital system not in U.S. dollars or other money system backed by a government. Examples may include, but are not limited to, Bitcoin, Ethereum, and Litecoin. Traditional currency, such as the U.S. dollar, is used to purchase virtual currency, and virtual currency may be sold for traditional currency. Virtual currency does not refer to Venmo or PayPal. Venmo and PayPal are payment services that facilitate the movement of funds between people or businesses; they are not currencies. Income earned via Venmo or PayPal sales would most likely fall under self-employment income policies, not virtual currency.

Virtual currency is counted as income when it is:

- Received as payment for goods or services
- Received by an independent contractor for performing services
- Received from an employer as remuneration for services (i.e., wages)

See SECTION 15.4.26 VIRTUAL CURRENCY for information about the sale of virtual currency.

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15.6 Self-Employment Income

15.6.1 Definitions

15.6.1.1 Income

Self-employment income is income directly from one's own business rather than as an employee with a specified salary or wages from an employer.

15.6.1.2 Business

Business means an occupation, work, or trade in which a person is engaged as a means of livelihood.

15.6.1.3 Operating

A business is operating when it is ready to function in its specific purpose. The period of operation begins when the business first opens and generally continues uninterrupted up to the present. A business is operating even if there are no sales and no work is being performed. Thus a seasonal business operates in the off season unless there has been a significant change in circumstances (see SECTION 15.6.5.3 ANTICIPATED EARNINGS).

A business is not operating when it cannot function in its specific purpose. For instance, if a mechanic cannot work for four months because of an illness or injury, he or she may claim his or her business was not in operation for those months.

15.6.1.4 Income Maintenance Income

IM income is self-employment income that is counted in determining IM eligibility and benefits.

15.6.1.5 Real Property

Real property means land and most things attached to the land, such as buildings and vegetation.

15.6.1.6 Non-real Property

Non-real property means all property other than real property.

15.6.2 Ways to Identify

Identify a farm or other business according to the following criteria.

15.6.2.1 By Organization

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

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

15.6.2.2 By IRS Tax Forms

A self-employed person who earns more than $400 net income must file an end-of-year return with the IRS. A person who will owe more than $400 in taxes at the end of the year must file quarterly estimates.

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

- Form 1065 - Partnership or multi-member LLC
  - Schedule K-1 (Form 1065) -- Partner's Share of Income, Deductions, Credits, etc.
- Form 1120S - S Corporation
- Form 4562 - Depreciation & Amortization
- Form 1040 - Sole Proprietorship
  - Form 4797 - Sales of Business Property
  - Schedule C (Form 1040) - Business (non-farm)
  - Schedule E (Form 1040) - Rental and Royalty
  - Schedule F (Form 1040) - Farm Income
  - Schedule SE (Form 1040) - Social Security Self-Employment
- Other Forms
  - Schedule D (Form 1040) - Capital Gains and Losses
  - Schedule 1 (Form 1040) - Additional Income and Adjustments to Income
  - Form 1040 - U.S. Individual Income Tax Return

15.6.2.3 Employee Status

A person is an employee if he or she is under the direct "wield and control" of an employer. The employer has the right to control the method and result of the employee's service. A self-employed person earns income directly from his or her own business, and all of the following applies:

1. Does not have federal income tax and FICA payments withheld from a paycheck.

Note: *A babysitter who works in someone else's home is considered an employee of that household, even if the individual employing him or her does not withhold taxes or FICA.*

2. Does not complete a W-4 for an employer.
3. Is not covered by employer liability insurance or worker's compensation.
4. Is responsible for his or her own work schedule.

15.6.3 Self-Employment Income Assets

15.6.3.1 Business Assets

The value of property essential to self-support and used in a trade or business is excluded if the business is currently operating (see SECTION 15.6.1.3 OPERATING) for the self-support of the individual. This includes real and personal property (e.g., land, buildings, equipment, and supplies) used in a trade or business and liquid assets used as part of a trade or business.

If the property is not currently operating, it is exempt if there is a reasonable expectation it will resume operating within the next 12 months. The reasonable expectation should be based on the following information:

1. Date of last use
2. Reason property is not in current use
3. Estimated date the person expects to resume use

If the individual decides not to resume operating, the property becomes a countable asset in the month after the decision is made not to resume.

The 12-month limit should only be extended when a disabling condition prevents the person from resuming business use of the property.

15.6.3.2 Bank Accounts

The value of business bank accounts is disregarded, even if a partner or sole proprietor makes withdrawals from the account for personal use. A bank account is a business account if the individual claims that it is a business account.

15.6.3.3 Disallowed Expenses

Expenses that are allowed self-employment deductions on the IRS business tax forms are allowed expenses for Medicaid. Some specific expenses that have been identified as not allowed in the calculation of Self Employment Income on the IRS tax forms and therefore not allowed for Medicaid are:

1. Net loss carryover from previous periods,
2. Federal, State, and local income taxes,
3. Charitable donations,
4. Work-related personal expenses, such as transportation to and from work,
5. Work-related personal expenses such as pensions, employee benefit and retirement programs and/or profit sharing expenses (Business expenses for employees' pensions, benefits, retirement programs, and profit sharing expenses are allowable, but the work-related personal expenses of the employer are not), **or**
6. Principal payments on loans for the purchase price of income producing real estate, capital assets/equipment, and durable goods.

15.6.4 Self-Employed Income Sources

All self-employment income is earned income, except royalty income and some rental income.

Self-employment income is income that is reported to IRS as farm or other self-employment income or as rental or royalty income. When income is not reported to the IRS, you must judge whether or not it is self-employment income.

Self-employment income sources are:

1. **Business.** Income from operating a business.
2. **Capital Gains.** Business income from selling securities and other property is counted. Personal capital gains are not counted as income.
3. **Rental.** Rental income is rent received from properties owned or controlled. Rental income is either earned or unearned. It is earned only if the owner actively manages the property on an average of 20 or more hours per week. If rental income is not reported to the IRS, see SECTION 15.4.23 RENTAL INCOME.
4. **Royalties.** Royalty income is unearned income received for granting the use of property owned or controlled. Examples are patents, copyrighted materials, or a natural resource. The right to income is often expressed as a percentage of receipts from using the property or as an amount per unit produced.

15.6.5 Calculating Income Maintenance Income

IM income (see SECTION 15.6.1.1 INCOME) is anything you receive in cash or in-kind that you can use to meet your needs for food, clothing, and shelter by either:

1. Using IRS tax forms completed for the previous year, or
2. Anticipating earnings (see SECTION 15.6.5.3 ANTICIPATED EARNINGS)

15.6.5.1 IRS Tax Forms and Worksheets

IM workers should not complete any IRS tax forms on an applicant's or member's behalf. It is the responsibility of the applicant or member to complete IRS tax forms.

Workers should only consult IRS tax forms only if **all** of the following conditions are met:

- The business was in operation at least one full month during the previous tax year.
- The business has been in operation six or more months at the time of the application.
- The person does not claim a significant change in circumstances since the previous year.

If all three conditions are not met, use anticipated earnings (see SECTION 15.6.5.3 ANTICIPATED EARNINGS).

If you decide to use IRS tax forms, use them together with the charts in Process Help, Section 16.2 Self-Employment Income, or the self-employment income worksheets, which identify which income and expenses need to be entered onto the Self-Employment page by line on the IRS tax forms.

For each operation, select the worksheet you need (if applicable) and, using the provided tax forms and/or schedule, complete the worksheet (if applicable) and enter the income and expenses onto the Self-Employment page.

1. Sole Proprietor - Farm and Other Business
   There is no worksheet for Sole Proprietor. See Process Help, Section 16.2.2.3.2 Entering Information for a Sole Proprietorship to identify which lines need to be entered in CWW for each of the following IRS tax forms:
   a) IRS Form 4797 - Capital & Ordinary Gains
   b) IRS Schedule C (Form 1040) - Profit or Loss From Business
   c) IRS Schedule E (Form 1040) - Rental and Royalty Income
   d) IRS Schedule F (Form 1040) - Farm Income
2. Partnership (F-16036)
   a) IRS Form 1065 - Partnership Income
   b) IRS Schedule K-1 (Form 1065) - Partner's Share of Income
3. Subchapter S Corporation (F-16035)
   a) IRS Form - 1120S - Small Business Corporation Income
   b) IRS Schedule K-1 (Form 1120S - Shareholder's Share of Income

When a household has more than one self-employment operation, the losses of one may be used to offset the profits of another. Apply this offset only to those self-employment operations that produced earned income. Do not apply a loss from unearned income to a gain in earned income. Losses from self-employment cannot be used to offset other earned or unearned income.

15.6.5.2 Depreciation

Depreciation is an allowable deduction for EBD Medicaid cases.

15.6.5.3 Anticipated Earnings

If past circumstances do not represent present circumstances, workers should calculate self-employment income based on anticipated earnings. Anticipated earnings should also be used in the following situations:

- The applicant's or member's business underwent a significant change in circumstances. A significant change in circumstances is any change that can be expected to affect income over time. It is the applicant's or member's responsibility to report significant changes. The following are examples of significant changes:
    - The owner sold or closed down the business.
    - The owner sold a part of his or her business (e.g., one of two retail stores).
    - The owner is ill or injured and will be unable to operate the business for a period of time.
    - A plumber gets the contract on a new apartment complex. The job will take nine months and his or her income will increase.
    - A farmer suffers unusual crop loss due to the weather or other circumstances.
    - There is a substantial cost increase for a particular material such that there will be less profit per unit sold.
    - Sales are consistently below previous levels for an unknown reason. The relevant period may vary depending on the type of business (consider normal sales fluctuations).
- The applicant's or member's business was not in operation for at least one full month during the previous tax year.
- The applicant's or member's business was not in operation for six or more months when the person applied for or renewed benefits or reported changes.

IM workers should determine whether it is necessary to use anticipated earnings on a case-by-case basis and document the reasons for the determination in case comments.

The date of an income change is the date a worker and applicant or member agree that a significant change in circumstances occurred. IM workers must also judge whether the person's report was timely to decide if the case was overpaid or underpaid. Changes are then effective according to the normal prospective budgeting cycle. IM workers should not recover payments made before the agreed upon date.

15.6.5.3.1 Reporting Anticipated Earnings

The Self-Employment Income Report form (F-00107) (also called a SEIRF) simplifies reporting income and expenses when earnings must be anticipated. It can be used to report income for any type of business with any form of organization. However, some people, especially farm operators, may find it easier to complete the applicable IRS Form 1040 schedule when income and expense items are more complex.

For anticipated earnings to be determined, the applicant or member must complete a SEIRF for the months of operation since the significant change in circumstances occurred, not to exceed 12 months. (**Note:** The beginning of a business is a significant change in circumstances.) When requesting verification, the SEIRF forms will be prepopulated with the individual's and business' information, and will identify each individual month for which income and expenses are needed. However, he or she may complete a separate SEIRF for each month or combine the months on one SEIRF.

When a new self-employment business is reported or when a significant change in circumstance occurs, recalculate self-employment income as follows:

- When **six or more months** of actual self-employment information is available (but tax information is not available), calculate monthly average self-employment income using all the months' (at least six months, but no more than 12 months) income.

Example 2	James applies for Medicaid on November 1, 2017. He reports that he was self-employed starting in April 2017. The agency asks James to complete SEIRFs for April, May, June, July, August, September, and October so that his prospective self-employment income can be determined for his Medicaid certification period (November 2017–October 2018).

- When **two or more full months but less than six months** of actual self-employment information is available, calculate a monthly self-employment net income average using all of the actual income information. Because at least three months of income is needed, if the business has only been in operation two months, calculate the monthly self-employment net income average using the actual income information for two months, and an estimate of net income for the next month.

Example 3	Bonnie applies for Child Care and Medicaid on April 5, 2016. She reports that she was self-employed starting in January 2016. The agency asks Bonnie to complete a SEIRF for January, February, and March so that her prospective self-employment income can be determined for her Child Care and Medicaid certification period (April 2016–March 2017).

- When **at least one full month but less than two full months** of actual self-employment income information is available, calculate a monthly net income average using the actual net income received in any partial month of operation, the one full month of operation, and an estimate of net income for the next month.

Example 4	Ricardo applies for FoodShare and Medicaid on February 5. He was self-employed starting December 15. The agency asks Ricardo to complete a SEIRF for December, January, and February so that his prospective self-employment income can be calculated. The completed SEIRF includes Ricardo's actual income and expenses for December and January, and his expected income and expenses for February. The worker divides the total by three to determine an anticipated monthly average income amount. This amount would be used until Ricardo reports a significant change in self-employment or until Ricardo renews his benefits.

- When there is **less than one full month** of actual income information available, calculate a monthly net self-employment income average using the actual net income received in the partial month (since the significant change in circumstance occurred) and estimated income and expenses for the next two months.

Example 5	Jenny is a Medicaid member who has been self-employed as a hairdresser since 2012. Jenny's Medicaid certification period is December 2015 to November 2016. The worker used Jenny's 2014 tax return to establish a monthly income amount. In March 2016, Jenny reports that she has been unable to work since breaking her arm on February 17. She is not sure when she will be able to return to work, but it will not be until at least May. Jenny completes a SEIRF for February 17–February 28 (actual income since the significant change in circumstance occurred), and for March and April using a best estimate of income. The worker uses these three months (February, March, and April)

	to determine a prospective self-employment income estimate for the remainder of the certification period (through November 2016).

Use the average until the member's next renewal or if a significant change in circumstances is reported between renewals.

Use the anticipated earnings amount until the person completes an IRS tax form or reports a significant change in circumstances.

15.6.6 Verification

Self-employment income information is not available through data exchanges and therefore must be verified (see SECTION 20.3.8 INCOME).

Completed IRS tax forms (see SECTION 15.6.2.2 BY IRS TAX FORMS) are sufficient verification of farm and self-employment income. If tax forms are not available or cannot be used because of a significant change in circumstances, other documents, such as a completed and signed Self-Employment Income Report form(s) (SEIRF) or bookkeeping records, are sufficient verification.

If a Program Add request is made on a case with self-employment income, use the existing previously verified information, instead of re-verifying it, if all of the following are true:

- A recent determination was made.
- SEIRFs or bookkeeping records were used.
- No significant change has been reported by the individual.
- The business has not filed taxes in the meantime.

Note *It is not necessary to collect copies of supportive verification, such as receipts from sales and purchases. However, verification can be requested when the information given is in question (see Section 20.4.1 Questionable Items Introduction). If requesting verification, workers must document the reason for the request in case comments.*

15.6.7 Self-Employment Hours

Count the time a self-employed person puts in on business-related activities involving planning, selling, advertising, and management along with time put in on production of goods and providing of services as hours of work.

Verification of self-reported monthly hours worked is not required unless questionable (see SECTION 20.4 QUESTIONABLE ITEMS).

15.6.8 Backdated Months

Self-employment income is averaged over the number of months the business has been in operation in a tax year or anticipated based on an average of SEIRFs. It is not based on exact income for a single month, as that does not take into consideration seasonal work and fluctuating income for the business. If an individual had applied in a backdated month, eligibility would not be determined on the basis of one month of self-employment income; instead, eligibility would be based on an average of at least three months of income.

When a self-employed applicant or member requests backdated benefits for health care, workers must do the following:

1. Average self-employment income for the application month forward (to determine ongoing eligibility).
2. Determine eligibility for the backdated months as if the applicant or member had applied in the earliest backdated month requested:
    a) If income is reported via federal taxes, the tax filing year has not changed, and no significant change in circumstances has occurred, the same averaged income and expenses from the tax forms can be used for ongoing and backdated eligibility.
    b) In all other scenarios, workers must consider SEIRFs and the average to be counted if that earliest month was the application month. If estimates would have been used, but the month has passed, actual information should be provided on the SEIRFs.
3. Consider any significant changes that occurred during the backdated months that would require a new average to be calculated for the second and/or third month. If there has not been a significant change or a change in the tax filing year during the backdated months, the average calculated for the earliest month can be used throughout the backdated months.

Example 6	Maggie applied for Medicaid in June and requested backdated eligibility to March. She has been self-employed as a seamstress since February of the same year. She does not file taxes. For the application month of June, SEIRFs would be used for all available months – February, March, April, and May to budget average income for the month of June and ongoing. If she had applied in March, her income would have been averaged based on actual income for the months of February, March, and April, so SEIRFs for February, March, and April would be used for determining her eligibility for Medicaid for the backdated months of March, April, and May.

Example 7	Glenn applied for Medicaid in September and requested backdated eligibility to June. He has been self-employed as a farmer, but reported having a true significant change in circumstances in May. For the application month of September, SEIRFs would be used for all months since the significant change – May, June, July, and August to budget average income for the month of September and ongoing. If he had applied in June, his income would have been average based on actual income for the months of May, June, and July, so SEIRFs for May, June, and July would be used for determining his eligibility for Medicaid for the backdated months of June, July, and August.

Example 8	Hershel applied for Medicaid and FoodShare for himself in April and requested backdated eligibility to January. He owns a bakery and filed taxes. However, he reports that his previous year's taxes no longer reflect his earnings due to a true significant change that occurred in March. For the application month of April, SEIRFs would be used for all months since the significant change occurred in March, so Hershel's actual income for March and estimated income for April and May would be used to budget average income for the month of April and ongoing. If he had applied in January, taxes would be used as verification of his income, so his taxes can be used for determining his eligibility for Medicaid for the backdated months of January and February. However, because of the significant change in March, an average of March, April, and May SEIRFs would be used for determining his eligibility for Medicaid for the backdated month of March.

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15.7 Income Deductions

15.7.1 Maintaining Home or Apartment

If a person residing in a medical institution (see SECTION 27.1.1 INSTITUTIONS INTRODUCTION) has a home or apartment or was residing in an assisted living facility prior to institutionalization, deduct an amount from their income to allow for maintaining the home, apartment, or room at the assisted living facility that does not exceed the Institutions Home Maintenance Allowance Maximum (see SECTION 39.4.3 LTC POST-ELIGIBILITY ALLOWANCES). The amount is in addition to the $55 personal needs allowance. It should be enough for mortgage, rent, property taxes (including special assessments), home or renters' insurance, utilities (heat, water, sewer, electricity), and other incidental costs. If the member was residing at an assisted living facility prior to institutionalization, use the facility's room and board rate, up to the maximum, for the home maintenance deduction.

Make the deduction only when both the following conditions are met:

- A physician provides a statement (verbally or in writing) certifying that the person is likely to return to the home or apartment within six months.
- The person's spouse is not living in the home or apartment.

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

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

Example 1	Bob entered a nursing home in June 2013 as a private pay patient. In June 2014, he qualifies for Medicaid and is potentially eligible for the home maintenance allowance. Bob's doctor says he is expected to return home by November 2014. He is eligible for a home maintenance deduction from his income, when determining the amount of his income available for his cost of care, starting in June 2014.

Note *The home maintenance allowance may only be given for Institutional Medicaid. It does not apply to HCBW Medicaid.*

15.7.2 Special Exempt Income

Special exempt income includes:

- Income used for supporting others (see SECTION 15.7.2.1 SUPPORT PAYMENTS).
- Court-ordered attorney fees (see SECTION 15.7.2.3 FEES TO GUARDIANS OR ATTORNEYS).
- Court-ordered guardian and guardian ad litem fees (see SECTION 15.7.2.3 FEES TO GUARDIANS OR ATTORNEYS).
- Expenses associated with establishing and maintaining a guardianship (see SECTION 15.7.2.3 FEES TO GUARDIANS OR ATTORNEYS).
- Expenses associated with a self-support plan (see SECTION 15.7.2.2 SELF-SUPPORT PLAN).
- IRWE (see SECTION 15.7.4 IMPAIRMENT-RELATED WORK EXPENSES).
- Maintaining a home or apartment (see SECTION 15.7.1 MAINTAINING HOME OR APARTMENT).
- Costs associated with real property listed for sale (see SECTION 16.2 ASSETS AVAILABILITY).

For specific exemptions, see SECTION 15.3 EXEMPT AND DISREGARDED INCOME.

15.7.2.1 Support Payments

Support payments are payments that a Medicaid member makes to another person outside the FTG for the purpose of supporting and maintaining that person. Support payments are either court-ordered (see SECTION 15.7.2.1.1 COURT-ORDERED or non-court-ordered (see SECTION 15.7.2.1.2 NON-COURT-ORDERED).

Include the support payment amount as part of an institutionalized person's monthly need (see SECTION 27.6 ILTC MONTHLY NEED) and cost of care (see SECTION 27.7 ILTC COST OF CARE CALCULATION).

A person in the fiscal group who has legal responsibility for a person in a nursing home may be paying that person's patient liability. If so, deduct this amount from the group's income.

Note *Support payments are different from the community spouse income allocation (see SECTION 18.6.2 COMMUNITY SPOUSE INCOME ALLOCATION for more information).*

15.7.2.1.1 Court-Ordered

The income deduction for monthly court-ordered support expenses is the amount that the member is "obligated" to pay as stipulated in the court order. Do not allow payments for arrearages and annual R & D expenses.

Actual payments may be deducted for court-ordered lying-in costs for the costs of the birth of the child. Unlike monthly court-ordered expenses, actual payments for lying-in costs are frequently paid at various times and are usually not tied to a regular payment schedule.

Note *If the court order stipulates that the individual must pay a monthly amount toward lying-in costs, allow the court-ordered amount (obligated amount) as an income deduction. If the member is required to pay lying-in costs but no specific monthly amount is ordered, allow actual payments for lying-in costs as an income deduction.*

15.7.2.1.2 Non-Court-Ordered

Include non-court-ordered support payments only if they are paid to the following:

- Institutionalized spouse. The maximum amount that can be included is the AFDC cat needy income limit for a group size of one (see SECTION 39.3 AFDC-RELATED INCOME TABLE) minus the spouse's net income.
- Minor child who is living with a non-legally responsible relative. The maximum amount that can be included is the AFDC cat needy income limit for a group size of one plus the child's medical expenses minus the child's net income.

Do not include non-court-ordered payments if they are to one of the following:

- A spouse or minor child who receives SSI
- A spouse who is eligible for SSI but refuses to apply for it

15.7.2.2 Plan to Achieve Self-Support

A member whose eligibility is based on blindness or disability may deduct income that is received under an approved plan to achieve self-support (PASS). A PASS allows qualifying blind or disabled individuals to receive income and accumulate resources for training or purchasing equipment necessary for reaching employment goals that will lead to self-support. Where all requirements are met, income from any source, earned or unearned, is deducted and allowed to accumulate to the extent specified in the plan.

To qualify for this deduction, the member must perform in accordance with the plan. The plan must:

- Be specific, current, and in writing.
- Be approved by the Social Security Administration as verified by submission of the plan and the Social Security Administration's approval letter.
- Specify the amount to be set aside and the expected cost and time required to accomplish the objective.
- Provide for identification and segregation of goods and money accumulated and conserved.

15.7.2.3 Fees to Guardians or Attorneys

15.7.2.3.1 Disallowed Deductions

The following fees to guardians or attorneys are not allowed income deductions:

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

Exception: Deduct this third party prepayment if all the following are true:

- The third party was the county acting as guardian ad litem. A guardian ad litem is someone appointed by the court to represent the best interests of a juvenile or disabled person during a particular court proceeding.
- The prepayment was to an attorney who was not a county employee at the time the services were delivered.
- A court ordered the institutionalized person to reimburse the county's prepayment.

15.7.2.3.2 Allowed Deductions

The following fees to guardians or attorneys are allowable income deductions:

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

15.7.3 Medical/Remedial Expenses

Medical/remedial expenses are used in all the following:

- HCBW programs
- Patient liability calculations for residents of a medical institution
- Cost share and MAPP premium calculations
- Meeting a Medicaid deductible (SEE SECTION 24.7 MEETING THE DEDUCTIBLE)
- MAPP eligibility calculation if expenses are over $500 monthly (see SECTION 26.4.2.1 DEDUCTION FOR MEDICAL AND REMEDIAL EXPENSES OVER $500 for more information on this MAPP-specific deduction)

Medical Expenses

Medical expenses are anticipated, incurred expenses for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state). The expense is for diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body. These are expenses that are the responsibility of the member, and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

The following are examples of medical expenses:

- Deductibles and copayments for Medicaid, Medicare, and private health insurances
- Health insurance premiums.
- Bills for medical services that are not covered by Wisconsin Medicaid
- For purposes of meeting a Medicaid deductible, medical services received before the person became eligible for Medicaid (Past medical bills cannot be used for MAPP premium calculations.)

Medicaid overpayments, unpaid patient liabilities, and unpaid cost shares are not medical expenses. They cannot be deducted from income to lower a current or future patient liability or cost share or used to meet a deductible.

Remedial expenses

Remedial expenses are costs incurred for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. These are expenses that are the responsibility of the member and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

Some examples of remedial expenses are:

1. Case management
2. Day care
3. Housing modifications for accessibility
4. Respite care
5. Supportive home care
   Supportive Home Care is necessary assistance to help people meet their daily living needs, ensure adequate functioning in their home, and safely access their community. Services may include:

   a) Assistance with activities of daily living
   b) Attendant care
      Supervision
   c) Reporting changes in the participant's condition
   d) Assistance with medication and medical procedures which are normally self-administered
   e) The extension of therapy services, ambulation and exercise
   f) Tasks associated with routine household upkeep, including general housekeeping chores, lawn mowing, snow removal, changing storm or screen windows and other household services that are essential to the participant's safety, well-being and care at home
6. Transportation to obtain medical care. This includes but is not limited to taxi, rideshare services, bus fares, or a person's own vehicle, if approved.
7. Services recognized under Wis. Stat. § 46.27
8. Community Based Residential Facility (CBRF), Adult Family/Foster Home (AFH), Residential Care Apartment Complex (RCAC), and all other community substitute care setting program costs, not including room and board expenses, can be counted as a remedial expense only as they are incurred. CBRF, AFH, RCAC and all other community substitute care setting program costs will be

considered incurred as of the date that the member is billed for these expenses by the CBRF, AFH, RCAC or other community substitute care setting. The billing procedure used by the CBRF, AFH, RCAC or other community substitute care setting (one month in advance, bimonthly, etc.) for Medicaid residents should be the same as that which is used for its non-Medicaid residents.

a) In determining how much of a CBRF, AFH, RCAC or other community substitute care setting expense can be applied to meet a medical deductible, use the facility's breakdown of the room and board versus program costs, with the program costs to be applied to the deductible.

15.7.4 Impairment-Related Work Expenses

IRWE are expenses used to determine eligibility for Medicaid, MAPP, and premium calculations. IRWE are anticipated incurred expenses by the member (and for MAPP only, their spouse) related to the member's impairment and employment. The expense cannot be one that a similar worker without a disability would have, such as uniforms. The expense cannot be reimbursable by a legally obligated third party such as Medicaid, private insurance, or the member's employer. If an anticipated IRWE is later paid by an unanticipated source, it is still allowable for past months in which it was budgeted but not for future months.

Example 2	On March 25, Cecil was told by Harvey's Auto Repair Shop that his wheelchair accessible van required repairs to fix the specialized door ramp. Cecil received an estimate of $2,000 for the repairs. The $2,000 estimate was determined to be a standard charge for this type of repair in the community. On March 26, Cecil applied for MAPP in Milwaukee County. At this time, the anticipated expense of the van repair was deducted from Cecil's income. Cecil delayed making the repairs until May 27, when the van's wheelchair accessible door completely quit working. At that time, Cecil's friend Robin paid Harvey's Auto Repair Shop for the repairs to Cecil's van door. Cecil reported the repairs and the source of the money for the repairs to his IM worker. Cecil's IM worker should not deduct the anticipated cost of the van repairs for any subsequent eligibility and premium determinations.

Deduct any MAPP member's expenses which:

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

Bills from months prior to the months for which eligibility is being determined are not an allowable IRWE. This is true even if it is currently being paid.

Determine a standard charge for the item or service based on what is representative for the member's community. If you count an expense as an IRWE, do not also use the expense as a medical/remedial expense.

Some examples of IRWE are modified audio/visual equipment, typing aides, specialized keyboards, prostheses, reading aids, vehicle modification (plus installation, maintenance, and associated repair costs), and wheelchairs.

Do not allow the expense of getting to and from work as an IRWE, unless the expense is related to the member's disability.

Exceptions: Always count the expenses of getting to and from work and the child care expenses as an IRWE for blind individuals.

15.7.5 $65 and ½ Earned Income Deduction

The $65 and ½ earned income deduction is an EBD FTG deduction.

To calculate the $65 and ½ earned income deduction, subtract $65 from the member's monthly earned income. Divide the result by two, and add $65. This is the earned income deduction.

Example 3	Michelle has monthly income of $1,240. Her $65 and ½ earned income deduction is $1,240.00 - 65.00 _____ $1,175.00 $1,175.00/2 = $587.50 Countable Income $ 587.50 + 65.00 _____ $ 652.50 Earned Income Disregard Michelle's earned income deduction amount is $652.50.

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16 Assets

16.1 Assets Introduction

Children under the age of 19 are not subject to an asset test for any category of EBD Medicaid, including MAPP, community waivers, FamilyCare, etc.

SSI MA recipients have already had their assets verified by the Social Security Administration. Assets should not be re-verified for these individuals.

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

Example 1:	Mr. Johnson has $2,600.00 in his checking account for the month of March. This includes his Social Security check of $700.00 that was deposited into the account on March 10. His countable asset amount for March is $1,900.00.

Example 2:	Mrs. Jones has $2,400.00 in her checking account for the month of March. She receives Social Security of $1,000.00 each month. She cashed her Social Security check and used the cash to pay her bills. Because her income is not included in the checking account balance, the income should not be deducted from the checking account balance.

Add together all countable, available assets (see SECTION 16.2 ASSETS AVAILABILITY), the fiscal group owns including:

1. Joint accounts (see SECTION 16.4.1 JOINT ACCOUNTS)
2. Burial assets (see SECTION 16.5 BURIAL ASSETS)
3. Savings account
4. Checking account
5. Cash available
6. Stocks, bonds, CDs.
7. Loans (see SECTION 16.7.2 LOANS)
8. Life insurance (see SECTION 16.7.5 LIFE INSURANCE)
9. Non-burial trusts (see SECTION 16.6 NON-BURIAL TRUSTS)
10. Land contract (see SECTION 16.7.12 LAND CONTRACT)
11. Mortgage (see SECTION 16.7.13 MORTGAGE)
12. Trailer home (see SECTION 16.8.1.2 NON-MOTORIZED TRAILER HOMES)
13. Non-home real property. (see SECTION 16.8 REAL PROPERTY)
14. Some vehicles (see SECTION 16.7.9 VEHICLES (AUTOMOBILES), 18.4 SPOUSAL IMPOVERISHMENT ASSETS)

The EBD fiscal group's assets must be within the appropriate asset limit before any member of that group can qualify for Medicaid. EBD fiscal groups who have assets in excess of the appropriate asset limit are ineligible for Medicaid.

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16.2 Assets Availability

16.2.1 Assets Availability Introduction

An asset is available when:

1. It can be sold, transferred, or disposed of by the owner or the owner's representative, and
2. The owner has a legal right to the money obtained from sale of the asset, and
3. The owner has the legal ability to make the money available for support and maintenance, and
4. The asset can be made available in less than 30 days.

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

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

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

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

Note: *Employer Health Reimbursement Arrangements (HRAs) are not an available resource. DHS's Third Party Liability Unit will consider an HRA to be a potential source of payment for health care services covered by Medicaid.*

Example 1:	Sylvia has life insurance that she cannot convert to cash within 30 days. She has a letter from the insurance company stating when she will receive the money. It becomes available the day she receives the money. Enter an expected change in CWW with the date the asset is expected to be available.

Note: *An unavailable asset may still be considered when determining whether an institutionalized person has divested (see SECTION 17.2.10 UNAVAILABILITY).*

16.2.2 Real Property

Non-exempt real property (see SECTION 16.8 REAL PROPERTY) is unavailable when:

1. The person who owns the property lists it for sale with a realtor.

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

   The non-exempt real property is unavailable and minimal maintenance costs are allowed as long as the person is making a good faith effort to sell the property at current market value.

If the member refuses a fair market value offer(s) while the property is listed for sale with a realtor, the member is no longer making a good faith effort to sell the property. In this case, the property is an available asset and minimal maintenance costs will no longer be allowed.

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

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

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

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

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16.3 Separate and Mixed Assets

When a Medicaid group keeps an exempt asset in:

1. A separate account or an account with other exempt assets, exempt the exempt asset:
    a) Indefinitely, for example, most payments to Native Americans (see SECTION 15.3.14 PAYMENTS TO NATIVE AMERICANS), **or**
    b) For as long as the exemption can be applied to the asset, for example, EITC (see SECTION 16.7.8 EARNED INCOME TAX CREDIT), which is exempt for 12 months following the month of receipt.
2. An account mixed with other assets (some of which are non-exempt), exempt only the portion that is considered the exempt asset:
    a) For six months from the date the exempt asset was mixed with the non-exempt assets, **or**
    b) If the exempt asset has been prorated as income, exempt it for the period over which it is prorated.

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16.4 Accounts

16.4.1 Joint Accounts

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

Apply the following policy to accounts where the account holders have equal access to the funds.

Note: *The following policy does not apply to joint ownership of securities such as stocks and bonds. Shares of stock represent ownership in a business, and their value shifts. Absent evidence to the contrary, assume each owner owns an equal share of the value of the security. For example, two owners would each own 50% of the value. The individual's stock certificate or statement of account should indicate their ownership percentage.*

16.4.1.1 EBD Medicaid Applicant/Member EBD Co-owner

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

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

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

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

16.4.1.2 EBD Medicaid Applicant/Member Non EBD Co-owner

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

16.4.1.3 Exception to Joint Accounts policy

Do not apply Joint Accounts policies (see Section 16.4.1 Joint Accounts) to the following kinds of joint accounts:

- Accounts established for business, charitable or civic purposes.
- Trust or restricted accounts. A trust or restricted account is one in which the person named as holder of the account has no access or limited access to the funds in it.
- Special purpose accounts. A special purpose account has at least one holder acting as the power-of-attorney, guardian, or conservator for at least one of the other holders of the account.
- Convenience accounts
  The following policy applies only to joint accounts of persons who are not married to one another:

  When a person's name appears on a joint account, assume he or she is part owner of the assets in the account. Inform the member that he or she has a right to present evidence showing he or she did not deposit any assets into the account.

To show that he or she does not own or co-own any assets in the account, he or she must present all of the following:

- A signed statement explaining:
  - Who owns the funds in the joint account
  - The reason for establishing it
  - Who made the deposits to the account
- A signed corroborating statement from the co-holder of the account
- A copy of the change in the account which removes his or her name or restricts his or her access

If the co-holder is incompetent or a minor, obtain a statement from a knowledgeable third party. Then, decide whether to accept the person's statement. If you decide he or she is not a co-holder, apply the decision retroactively as well as prospectively. When no third party is available, document the reason.

16.4.2 Jointly Held Real Property

Apportion an equal share of any real property or any income derived from real property to each owner. To apportion, the equity or income must be available.

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16.5 Burial Assets

16.5.1 Irrevocable Burial Trusts

Per Wisconsin law, when a person makes a pre-need agreement with a funeral provider to purchase funeral or burial products and services (not including burial spaces), all payments made under the agreement are trust funds, including interest and dividends, until the person's death. For Medicaid purposes, Wisconsin law stipulates that such trusts may be made irrevocable as to the first $4,500 of the funds paid under the agreement. The irrevocable amount of such a trust is referred to as an irrevocable burial trust and is an exempt asset. If the total value of an otherwise irrevocable pre-need agreement with a funeral provider exceeds $4,500, the amount over $4,500 is revocable and is a countable asset. Interest and dividends, if any, are exempt only if they accrue to irrevocable burial trusts and the trust agreement specifies that they are irrevocable.

For burial trusts established in another state, all amounts that are irrevocable by the laws of that state are exempt. Any question about any state's law should be referred to corporation counsel.

Each Medicaid fiscal test group member may have one or more irrevocable burial trusts.

The following are not considered irrevocable burial trusts for Medicaid purposes. These are subject to the burial fund provisions described in SECTION 16.5.5 BURIAL FUNDS:

- A revocable pre-need agreement with a funeral provider to purchase funeral or burial products and services
- An irrevocable pre-need agreement with a funeral provider to purchase funeral or burial products and services, if the applicant or member has established a revocable trust to fund the burial agreement
- A revocable or irrevocable trust account for burial purposes, established with the applicant or member's own assets, that is not a pre-need agreement with a funeral provider

16.5.2 Burial Insurance

A burial insurance policy is a contract whose terms preclude the use of its proceeds for anything other than the payment of the insured's burial expense. It is an insurance product sold by a state-licensed insurance company and is typically funded with an annuity or life insurance policy.

The following are not burial insurance policies:

- If a policy has CSV to which the member has access, the policy is life insurance, not burial insurance.
- If a burial policy calls for any excess proceeds to be paid to a secondary beneficiary (other than the deceased person's estate), it is life insurance, not burial insurance.
- Similarly, if a policy calls for the proceeds to be paid to a private party who is expected, but not legally required, to use the funds for the burial costs of the insured, the policy is life insurance.

The ownership of the annuity or life insurance policy is irrevocably assigned by the policyholder to a funeral expense trust established by the insurance company. The trustee or trust administrator is required to pay all trust proceeds toward the policy holder's funeral expenses at the time of the policyholder's death. If a trust's proceeds exceed burial costs, the excess must revert back to the deceased person's estate.

A burial insurance policy is unavailable if both the following are true:

- It includes language that says it is irrevocable.
- It states that all of the proceeds must be used for burial expenses.

The purchase of a burial insurance policy that meets the above conditions is not a divestment because the purchaser is presumed to receive fair market value.

16.5.3 Life Insurance-Funded Burial Contracts

A life insurance-funded burial contract involves a person purchasing a life insurance policy on his or her own life and then assigning, revocably or irrevocably, either the proceeds or ownership of the policy to a third party, generally a funeral provider. The purpose of the assignment is to fund a burial contract.

Death benefits that exceed the actual costs of burial expenses must be paid to the insured's estate or the insured's beneficiary.

A burial contract that is funded with a life insurance policy must be in writing and must contain all of the following:

- Name of funeral home and the insurer.
- Statement of funeral goods and services.
- Effect of canceling or surrendering the insurance policy.
- Effect of changing the assignment of the policy proceeds.
- Nature and extent of any price guarantees for goods and services.

The assignment option (revocable or irrevocable) chosen by the customer impacts the determination of countable asset and/or divestment amount.

16.5.3.1 Irrevocable Assignment of Life Insurance-Funded Burial Contracts

An irrevocably assigned LIFBC is an unavailable asset because the member no longer owns it.

If a member has chosen irrevocable assignment of his or her LIFBC, the burial space exemption (see SECTION 16.5.4 SPACES) may apply, depending on the nature of the contract. Any portion of the contract that represents the purchase of a burial space is exempt and has no effect on the burial funds exclusion (see SECTION 16.5.5 BURIAL FUNDS).

If the face value of the burial funds portion of the contract exceeds $1,500, it offsets the burial fund exclusion described in SECTION 16.5.5 BURIAL FUNDS.

If the face value of the burial funds portion does not exceed $1,500, determine the CSV of the LIFBC at the time that it was assigned and proceed in the following order:

1. Apply the CSV to burial spaces.
2. Apply the burial fund logic described in SECTION 16.5.5 BURIAL FUNDS to any remaining CSV.
3. Apply the CSV to any itemized goods or services, not accounted for by 1. and 2. above, purchased at fair market value.
4. Any remaining CSV must be evaluated for divestment (see SECTION 17.2.7.15 REVOCABLE TRUSTS).

Example 1:	Mr. Atkins has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value of the LIFBC is $3,000. The Statement of Funeral Goods and Services shows $3,000 for the pre-arrangement of the funeral, of which $1,300 is designated for a casket and $1,700 for funeral expenses (services and cash advances for such things as flowers and the obituary). The $1,700 funeral expense portion reduces the $1,500 burial fund exclusion (see SECTION 16.5.5 BURIAL FUNDS), and so $1,500 of this LIFBC will be considered his exempt burial fund. The $1,300

	casket does not reduce the burial fund exclusion (see SECTION 16.5.5 BURIAL FUNDS) and is not a countable asset because it is a purchase of a burial space. Because the LIFBC was assigned irrevocably, determine if Mr. Atkins is receiving other goods or services at fair market value for the remaining $200 designated for funeral expenses. If he is not receiving goods or services at fair market value, the remaining $200 is evaluated for divestment (see SECTION 17.2.7.15 REVOCABLE TRUSTS).

If the face value of the LIFBC exceeds the total amount shown on the Statement of Funeral Goods and Services, determine the cash surrender value (of the LIFBC at the time that it was assigned) and apply the divestment policy (see SECTION 17.13.2 REVOCABLE TRUSTS). Any portion of an irrevocably assigned LIFBC for which no goods and services are received at fair market value is the divested amount.

Example 2:	Mr. Atkins has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value and the cash value of the LIFBC is $3,200. The Statement of Funeral Goods and Services shows $3,000 for the pre-arrangement of the funeral. A divestment in the amount of $200 occurred because the cash value of the LIFBC exceeds the expenses of the pre-arrangement of the funeral

16.5.3.2 Revocable Assignment of Life Insurance-Funded Burial Contracts

When a member has chosen revocable assignment of his or her LIFBC, use the following procedures to determine the countable asset amount.

Identify all other burial assets and life insurance policies the member may have. Use burial fund logic (see SECTION 16.5.5 BURIAL FUNDS) to determine what portion of the LIFBC is a countable asset.

The value of the burial contract is equal to the CSV of the life insurance policy. If the face value of all life insurance policies is $1,500 or less, exempt the CSV under the life insurance exclusion.

If the face value of all policies exceeds $1,500, treat the CSV of the policy according to the burial funds exclusion (see SECTION 16.5.5 BURIAL FUNDS), if applicable.

If one or more burial spaces are included in the statement of funeral goods and services, the burial space exclusion (see SECTION 16.5.4 SPACES) does not apply because the provider has not received payment and therefore no purchase of burial space(s) has been made.

Example 3:	Mrs. White has a revocably assigned LIFBC and no other burial assets or life insurance policies. The face value of the LIFBC is $3,000 and the CSV is $1,700. The total value of the LIFBC is equal to the CSV of $1,700. The burial contract designates $1,300 for a casket and $1,700 for funeral expenses. The burial space exclusion (see SECTION 16.5.4 SPACES) does not apply to Mrs. White's contract, but $1,500 of the CSV is exempt under the burial funds exclusion (see SECTION 16.5.5 BURIAL FUNDS). The remaining $200 of the CSV is a countable asset.

Example 4:	Mrs. White has a revocably assigned LIFBC. She additionally has a burial plot already paid for and a whole life insurance policy with a face value of $1,500 and CSV of $1,000. The face value of the LIFBC is $3,000, and the CSV is $1,700. The total value of the LIFBC is equal to the CSV of $1,700. The burial contract designates $1,300 for a casket and $1,700 for funeral expenses. The burial space exclusion (see SECTION 16.5.4 SPACES) does not apply to Mrs. White's contract. No portion of the CSV

	is exempt under the burial funds exclusion (see SECTION 16.5.5 BURIAL FUNDS) because the face value of her whole life insurance policy is $1,500. The burial plot is exempt, because it is paid for. The entire value of the LIFBC ($1,700) is a countable asset.

16.5.4 Spaces

Burial space exemptions apply only to EBD fiscal group members. Burial space exemptions include all the following, if they have been paid for or are included in a contract to purchase with burial insurance that meets the criteria of SECTION 16.5.2 BURIAL INSURANCE or a LIFBC that meets the criteria in SECTION 16.5.3 LIFE INSURANCE-FUNDED BURIAL CONTRACTS:

- Plots, vaults, caskets, crypts, mausoleums, urns, or other repositories customarily used for the remains of deceased persons
- Necessary and reasonable improvements upon the burial space with items such as headstones, markers, plaques
- Arrangements for opening and closing the grave site

Exempt multiple spaces of any value under the following conditions:

- The space(s) must be owned by the elderly, blind, or disabled person, that person's spouse, or, when the EBD person is a minor, by the minor's parents.
- Both a plot and a mausoleum space cannot be exempted for the same person.
- Each person may have more than one type of space.
- The space(s) must be for the use of the elderly, blind, or disabled member or one of the following:
    - Spouse.
    - Minor or adult natural, adoptive, or stepchild.
    - Brother or sister.
    - Natural or adoptive parent.
    - Spouse of any of the above.

If the burial space expenses are being paid for through burial insurance or a LIFBC for a relative with a qualifying relationship (other than the EBD person and that person's spouse), allow only those expenses listed above as exemptions. Any other goods or services purchased through the burial insurance or LIFBC would be a divestment.

Example 5:	Bob, who is 12 years old, lives with his parents and is tested for EBD Medicaid. His father owns five burial plots and spaces: the first is for Bob, the second and third are for his parents, the fourth is for his older brother, who does not live at home, and the fifth is for Bob's uncle. All the plots and spaces are exempt except for the fifth.

Example 6:	Harry is applying for HCBW. Last year he used his life insurance policy with a face value of $10,000 and a cash value of $8,000 to set up a LIFBC for his son. On the Statement of Goods and Services, $4,000 is designated for a casket, $1,000 for a vault, and $500 for the cemetery plot, for a total of $5,500 that is exempt burial space expenses. The remaining $2,500 that was put in to the LIFBC is considered divestment.

16.5.5 Burial Funds

Burial fund exemptions apply only to EBD Medicaid fiscal group members. Burial funds are funds that are set aside for burial expenses. EBD Medicaid members and their spouses may each have one burial fund.

To find the amount of a burial fund that can be exempted, add together the following:

- The face value of the person's irrevocable burial trusts (see SECTION 16.5.1 IRREVOCABLE BURIAL TRUSTS)
- The face value of all of their life insurance policies whose cash value is exempt (see SECTION 16.7.5 LIFE INSURANCE)
- The face value of their exempt burial insurance (see SECTION 16.5.2 BURIAL INSURANCE)
- The cash surrender value of revocably assigned LIFBC (see SECTION 16.5.3.2 REVOCABLE ASSIGNMENT OF LIFE INSURANCE-FUNDED BURIAL CONTRACTS)
- The burial funds portion of irrevocably assigned LIFBC (see SECTION 16.5.3.1 IRREVOCABLE ASSIGNMENT OF LIFE INSURANCE-FUNDED BURIAL CONTRACTS)

If the total value of the exemptions above is $1,500 or more, no additional burial assets are exempt.

If the total is less than $1,500, subtract the total from $1,500. The result is the amount of the person's burial fund total that is exempted.

Example 7:	Mrs. Smith, who is 74 years old, applies for EBD Medicaid. She has a $1,600 savings account designated as a burial fund, a $1,300 irrevocable burial trust, and two life insurance policies. The combined face values of the life insurance policies total $900. The irrevocable burial trust is exempt. The life insurance cash values are exempt when the total of their face values does not exceed $1,500. $1,300 Irrevocable burial trust +900 Face value life insurance _____ $2,200 The total is more than $1,500, so no portion of the burial fund (savings account) is exempt.

Example 8:	This time, Mrs. Smith, in addition to her $1,600 savings account designated as a burial fund, has a $300 irrevocable burial trust and two life insurance policies with a combined face value of $900. $ 300 Irrevocable trust + 900 Face value life insurance _____ $1,200 The total is less than $1,500, so determine what portion of Mrs. Smith's savings account can be exempted as a burial fund. $1,500 Maximum burial fund exclusion - 1,200 _____ $ 300 Mrs. Smith can exempt $300 from her savings account as a burial fund. The remaining $1,300 is an available asset.

Anyone claiming a burial fund must sign a statement identifying the fund's location, type, amount, and account number. The statement must specify the month and year in which they first intended to set the fund aside for burial.

The fund can be excluded retroactively back to the first day of the specified month, but no earlier than November 1, 1982. It loses its exemption if it is used for anything other than the person's burial.

The fund set aside for burial must be identifiable, but not necessarily segregated, from other funds.

16.5.6 Wisconsin Funeral Trust Program

The Wisconsin Funeral Trust is a single trust owned and operated by the WFDA. It was established and maintained according to the rules of the Wisconsin Department of Financial Institutions. It is available for use by all WFDA members statewide. Funds placed in the Trust will be invested in accordance with applicable state law.

WFDA has created two preneed funeral contracts: one is for a guaranteed price and the other is for a non-guaranteed price. These contracts are available to all individuals, not just those who are or may be EBD Medicaid applicants or members.

The agreement by the purchaser with the funeral home constitutes a purchase, even if revocable in whole or part. The contract nearly always includes burial spaces, which are excluded assets. The contract is not:

- An installment burial contract.
- An insurance funded burial contract.
- Divestment as the funds transferred are in exchange for equal amounts of goods and/or services.

In determining countable asset value:

1. Deduct first the amount considered as irrevocable under Wisconsin law and the Medicaid state plan (see SECTION 16.5.1) up to a maximum of $4,500.
2. Deduct next the amount equal to the value of all burial spaces purchased by the contract. Remember that "burial spaces" includes caskets and outer burial containers, vaults, liners, etc.
3. Deduct any amount that can be included in the applicant's or member's burial fund.
4. The remainder is the countable asset.

Example 9:	Total Contract Value = $6,700 Amount Designated as Irrevocable = - $4,500 $2,200 Value of Excluded Burial Spaces = - $1,300 $900 Amount of Excluded Burial Funds*= - 0 Countable Asset = **$900** * The amount of funds that may be excluded as the $1,500 "burial fund" is reduced by any amount of cash value in his or her life insurance and the amount of irrevocable burial trust. Whenever the burial contact specifies $1,500 or more as irrevocable, no funds can be excluded as "burial fund."

Example 10:	Total Contract Value = $4,200 Amount Designated as Irrevocable = - $1,300 $2,900 Value of Excluded Burial Spaces = - $1,300 $1,600

	Amount of Excluded Burial Funds* = - 200** Countable Asset = **$1,400** **This example assumes that the person has not identified another insurance or irrevocable burial funds toward his or her "burial fund." The $1,500 maximum burial fund allowance, less the $1,300 this contract makes irrevocable, leaves room for an additional $200 to be allocated to the "burial fund". Note that in Example 1, the purchaser was able to achieve a higher exemption.

16.5.6.1 Statement of Funeral Goods and Services

The U.S. FTC requires funeral directors nationwide to use a "Statement of Funeral Goods and Services" as a way of indicating to their customers what is being purchased and their charges. This form looks like the first page of the WFDA preneed funeral contract. WFDA has advised their members to complete and provide to the family a copy of the Statement of Funeral Goods and Service along with the preneed funeral contact as a service to their customers and in compliance with FTC rules.

16.5.6.2 Cash Advances

On both the WFDA preneed funeral contract and the FTC's Statement of Funeral Goods and Services is an area called "Cash Advance Items." These are expenses for services and goods not provided by the funeral home but often related to the funeral.

Usually, the funeral home asks the purchaser or family to reimburse it dollar-for-dollar equal to what was advanced. A funeral home can, however, charge additional sums for its service in making cash advances on behalf of the deceased's family. For example, a funeral home may advance a $175.00 payment for an obituary charge to the local newspaper; when billing the family, the funeral home adds a $20.00 service fee for a total of $195.00. By FTC rule, whenever the funeral home bills for more than the actual amount of the cash advance, it must identify this to the purchaser or family with a standard phrase added to the Statement of Funeral Goods and Services; the phrase is "We charge you for our services in obtaining ... " This phrase appears on the WFDA preneed agreement and comes into effect whenever the small box to the left of each line under "Cash Advance Item" is marked.

Amounts identified on a preneed agreement under "Cash Advances Items" are not disregarded and are part of the "Total Contract Value" in the asset calculations (see the formula above) for EBD Medicaid. This is true whether there is an additional charge on the cash advance item or not.

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16.6 Non-Burial Trusts

16.6.1 Non-Burial Trusts Introduction

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

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

The grantor can be:

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

If the principal of a trust includes assets of the applicant/member or spouse, and the assets of any other person or persons, apply the policies in SECTION 16.6.3 REVOCABLE TRUSTS and SECTION 16.6.4 IRREVOCABLE TRUSTS to the portion of the trust attributable to the assets of the applicant/member or spouse.

16.6.2 Trust Principal

The trust principal is the amount placed in trust by the grantor plus any trust earnings paid into the trust and left to accumulate.

16.6.3 Revocable Trusts

A Revocable Trust is a trust which can be revoked, canceled or modified by the grantor or by a court. A trust which is called irrevocable, but which will terminate if some action is taken by the grantor, is considered a revocable trust.

The trust principal of a revocable trust is an available asset.

16.6.4 Irrevocable Trusts

An irrevocable trust is a trust that cannot, in any way, be revoked by the grantor.

16.6.4.1 Trust Established With Resources of a Third Party

If the resources of someone other than the individual or their spouse (i.e., a third party),were used to form the principal of an irrevocable trust, the trust principal is not an available asset unless the terms of the trust permit the individual to require that the trustee distribute principal or income to him or her.

16.6.4.2 Trust Established With Resources of the Individual or Spouse

If the resources of the individual or the individual's spouse were used to form all or part of the principal of the trust, some or all of the trust principal and income may be considered a non-exempt asset, available to the individual. If there are any circumstances under which payment from the trust could be

made to or for the benefit of the individual at any time no matter how distant, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered non-exempt assets, available to the individual.

This treatment applies regardless of:

- The purpose for which a trust is established
- Whether the trustees have or exercise any discretion under the trust
- Any restrictions on when or whether distributions may be made from the trust
- Any restrictions on the use of distributions from the trust

Example 1:	Doug is a 65 year old Medicaid applicant. Several years ago, Doug transferred his life savings of $60,000 to an irrevocable trust, naming himself as the beneficiary. Doug's brother, Jim was appointed as the trustee. Under the terms of the trust, Jim could disburse up to $10,000 annually, from either trust principal or trust income, either directly to Doug or indirectly to provide some benefit for Doug. The trustee had sole discretion as to when and how these trust disbursements would be made, but under no circumstance could they exceed $10,000 in a 12 month period. Because the entire corpus (principal of the fund) could eventually be distributed, $60,000 would be considered an available non-exempt asset for Doug's Medicaid eligibility determination, even if the trustee decides not to make any actual disbursements.

Example 2:	Al is a 65 year old Medicaid applicant. Six years ago, Al sold his farm for $300,000 and put the entire proceeds from the sale into an irrevocable trust, naming himself as the beneficiary. Al's friend, Scott was appointed as the trustee. Under the terms of the trust, Scott could disburse any amount of trust principal or trust income, at any time, either directly to Al or indirectly to provide some benefit for Al. The trustee had sole discretion as to when and how disbursements would be made as well as the amount that could be disbursed. Therefore $300,000 would be considered an available non-exempt asset for Al's Medicaid eligibility determination, even if the trustee never makes an actual disbursement.

Example 3:	Dave is a 65 year old Medicaid applicant who won a $250,000 lottery several years ago and put the entire amount into an irrevocable trust, naming himself as the beneficiary. Dave appointed his brother Don as the trustee. Under the terms of the trust, none of the trust principal could ever be distributed to Dave during his lifetime. Don could only distribute the income that is produced by the trust to his brother Dave, and Don has sole discretion as to whether or not any income is actually distributed. The trust principal would be an unavailable asset since the terms of the trust prohibit any distribution of trust principal during Dave's lifetime. Any disbursements of trust income to Dave would be counted as income to Dave in the month of receipt. Because Don has the authority to distribute all of the income, any trust income which is not disbursed by Don, but instead remains in the trust, is considered to be an available asset.

Example 4:	In this example, use the same facts as in example 3, except that the trust requires Don to distribute fifty percent of the generated income to Dave and add the remaining fifty percent to the principal where it will accumulate without distribution. The half of the generated income that is paid to Dave would be income in the month of receipt. The other half of the income would be an unavailable asset and tested for divestment

Note *If the grantor is an institutionalized person, their spouse, or someone acting on behalf of an institutionalized person, setting up an irrevocable trust may be a divestment (see SECTION 17.2.7.16 IRREVOCABLE TRUSTS ASSIGNED OR CREATED DURING OR AFTER THE LOOK BACK PERIOD and SECTION 17.2.6 ALLOWED DIVESTMENTS).*

The policies described above regarding irrevocable trusts do not apply to Special Needs and Pooled Trusts (see SECTION 16.6.5 SPECIAL NEEDS TRUST and SECTION 16.6.6 POOLED TRUSTS). The policies described above also do not apply to irrevocable trusts created by a will (also known as testamentary trusts), unless the terms of the trust permit the individual or beneficiary to require that the trustee distribute principal or income to them.

16.6.5 Special Needs Trusts

A special needs trust is a trust established for the sole benefit of a person under age 65 who is disabled.

Trusts that meet all the following requirements are disregarded.

1. The trust contains the assets of an individual who is under the age of 65 and disabled.
2. The trust was established for the sole benefit of the disabled individual by their parent, grandparent, or legal guardian, by the disabled individual, or by a court.

Note *Special needs trusts established prior to December 13, 2016, may not be established by the disabled individual. They may only be established by the disabled individual's parent, grandparent, or legal guardian, or by a court.*

Note *In the case of a legally competent, disabled adult, a parent or grandparent may establish a seed trust using a nominal amount of their own money (for example, $10) or an empty or dry trust. After the trust is established, the disabled adult's assets can be transferred into the trust.*

3. The trust provides that, upon the death of the beneficiary, after subtracting taxes and a reasonable amount for administrative costs, Wisconsin Medicaid will receive all amounts remaining in the trust not in excess of the total amount of medical assistance paid on behalf of the beneficiary.

A trust that meets the above criteria is treated as a special needs trust for Medicaid purposes even if the trust agreement does not specifically call it a special needs trust.

A trust that does not meet the above criteria is not treated as a special needs trust for Medicaid purposes, even if it is called a special needs trust in the trust agreement. For trusts that do not meet the above criteria, availability must be determined according to the criteria in SECTION 16.6.3 REVOCABLE TRUSTS or SECTION 16.6.4 IRREVOCABLE TRUSTS.

Additions to the trust principal made directly to the special needs trust before the beneficiary reaches age 65 are disregarded. Distributions from the trust are also disregarded. These disregards continue after the beneficiary turns 65, provided they continue to be disabled.

Additions to the trust after age 65

In general, additions to the trust after the beneficiary turns 65 are not disregarded. The value of any non-excluded assets added to the trust after the beneficiary reaches age 65 is considered available to the beneficiary.

However, if the beneficiary's right to receive support payments, U.S. Military Survivor Benefit Plan payments, or payments from an annuity has been irrevocably assigned to the trust before the trust beneficiary turned 65, the payments are treated the same as payments made before the individual turned 65 and continue to qualify for the special needs trust exemption.

Interest, dividends, or other earnings of the trust after the beneficiary reaches age 65 remain excluded.

16.6.6 Pooled Trusts

A pooled trust contains the assets of many different individuals, each held in separate trust accounts and established for separate beneficiaries.

Pooled trusts that contain the assets of a disabled individual are disregarded for Medicaid purposes if they meet the following conditions:

1. The pooled trust is established and managed by a nonprofit association. Separate accounts are maintained for each beneficiary, but assets are pooled for investing and management purposes.
2. Accounts are established solely for the benefit of the disabled individual(s), and the person has had their disability determined by DDB or SSA.
3. The account in the trust is established by the disabled individual, their parent, grandparent, or legal guardian, or by a court.
4. The trust provides that, to the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, after subtracting taxes and a reasonable amount for administrative costs, Wisconsin Medicaid will receive all amounts remaining in the account not in excess of the total amount of medical assistance paid on behalf of the beneficiary.

The funds deposited in, contributions to, and distributions from the pooled trust are disregarded. The disregard continues after the person turns 65, provided they continue to be disabled.

Note *Assets that have been placed in a potential pooled trust account pending a disability determination are unavailable assets until the disability determination has been made. If the individual has been determined disabled by DDB, the pooled trust is an exempt asset as of the disability onset date. If the individual is not determined disabled, the assets are counted.*

Disregarded pooled trusts in Wisconsin include, but are not limited to:

- WisPACT Trust I
- Life Navigators Pooled Trust II
- Life Navigators Pooled Trust III

16.6.7 Ho-Chunk Tribal Trusts

The Ho-Chunk Tribe, under its tribal ordinances and in conjunction with the Indian Gaming Regulatory Act, establishes irrevocable trusts for tribal members who are minors or determined to be legally incompetent. These irrevocable trusts are funded primarily with per capita distribution payments derived from gaming revenue. DHS has determined that funds placed in these trusts, for the benefit of minors and individuals who are legally incompetent, are considered to be owned by the Ho-Chunk Tribe and not the trust beneficiary. Therefore, the irrevocable Ho-Chunk Tribal Trusts established for minors or legally incompetent tribal members are considered to be unavailable assets for the tribal member's Medicaid eligibility determination.

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16.7 Liquid Assets

16.7.1 Personal Property

16.7.1.1 Household Goods

Do not count household goods as an asset.

Household goods include both of the following:

- Items of personal property, found in or near the home, that are used on a regular basis
- Items needed by the household for maintenance, use, and occupancy of the premises as a home

Examples of household goods include, but are not limited to, the following:

- Furniture
- Appliances
- Electronic equipment, such as personal computers and television sets
- Carpets
- Cooking and eating utensils
- Dishes

Note *Items that are acquired or held because of their value or as an investment are not considered household goods (see SECTION 16.7.1.3 OTHER PERSONAL PROPERTY).*

16.7.1.2 Personal Effects

Do not count personal effects as an asset.

Personal effects are one of the following:

- Items of personal property originally worn or carried by the individual
- Articles otherwise having an intimate relation to the individual

Examples of personal effects include, but are not limited to, the following:

- Personal jewelry including wedding and engagement rings
- Personal care items
- Educational or recreational items such as books or musical instruments
- Items of cultural or religious significance to an individual, such as ceremonial attire
- Items required because of an individual's physical or mental impairment, such as prosthetic devices or wheelchairs

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Note *Items that are acquired or held because of their value or as an investment are not considered personal effects.*

16.7.1.3 Other Personal Property

Both the following are true of personal property that an individual acquires or holds because of its value or as an investment:

- It is a countable resource (asset).
- It is not considered to be a household good or personal effect.

Other personal property items include, but are not limited to, the following:

- Gems acquired or held because of their value or as an investment
- Jewelry that is not worn or held for family significance

- Collectibles acquired or held because of their value or as an investment
- Virtual currency

Example 1	Mr. Hollenback received $10,000 from an insurance settlement. Mr. Hollenback paid back creditors with $7,000 and purchased $3,000 in jewelry. Mr. Hollenback does not wear the jewelry. The IM workers must determine whether the jewelry is excluded from resources as a personal effect or is a countable resource in the form of other personal property. Mr. Hollenback's statements establish that the jewelry has no family significance and that he purchased the jewelry for its value as a means to spend down the $10,000. The IM workers correctly determines that the jewelry is not an excludable personal effect because an item purchased for its value cannot be a personal effect. The IM worker correctly determines the jewelry as a countable asset.

16.7.2 Loans (including Home Equity Loans), Reverse Mortgages, and Promissory Notes

The following information applies except as directed otherwise in SECTION 16.7.2.1 REVERSE MORTGAGE and SECTION 16.7.2.2 LOANS AND OTHER CONTRACTS EXCHANGED FOR PROMISSORY NOTES.

If an AG member receives a loan and it is available for current living expenses, count it as an asset. Do this even if there is a repayment agreement. If it is not available for current living expenses, disregard it.

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

1. Count any repayments toward the principal of the loan, whether it is a full payment, a partial payment, or an installment payment, as an asset.
2. Count any interest payment on the loan as unearned income in the month received and as an asset in the months following the month it was received.

16.7.2.1 Reverse Mortgage

A reverse mortgage loan is a loan, or an agreement to lend, that is secured by a first mortgage on the borrower's principal residence. The terms of the loan specify regular payments to the borrower. Repayment (through sale of the residence) is required at the time all the borrowers have died or when they have sold the residence or moved to a new one.

Treat reverse mortgage loan payments to the borrower as assets in the month after the month received. Do not count undisbursed funds (not yet paid to the borrower) as assets. They are considered equity in the borrower's residence.

Note *Home equity lines of credit (HELOCs) are treated like reverse mortgages. The available balance of the HELOC is not an asset. The equity value of the property that secures the HELOC is reduced by the HELOC's outstanding balance because it is secured with a lien as with a reverse mortgage.*

16.7.2.2 Loans and Other Contracts Exchanged for Promissory Notes

The current market value of a promissory note or loan made by an AG member will be assumed to be equal to the outstanding balance, and the promissory note or loan will be a countable asset in a Medicaid eligibility determination unless it cannot be sold.

An applicant who disputes the value used by the IM worker must provide credible evidence from a knowledgeable source that the note is non-negotiable or has a different current market value.

Promissory notes or loans that cannot be sold because they are not negotiable, assignable, enforceable, or otherwise marketable are considered unavailable assets (see Section 17.2.6.15 PROMISSORY NOTES, LOANS, LAND CONTRACTS, AND MORTGAGES regarding divestment policy).

16.7.3 U.S. Department of Housing and Urban Development Payments

Disregard reimbursements resulting from federal regulatory changes in computing HUD housing rent as income in the month paid and assets in the next month.

16.7.4 Reserved

16.7.5 Life Insurance

The cash surrender value (CSV) of life insurance is a countable asset. However, there is a limited exception to this rule: For a person who is aged 65 or older, blind, or disabled, the CSV of their life insurance is only counted if the total face value (FV) of all life insurance policies owned by that person exceeds $1,500.

The CSV is the amount that the insurer will pay upon cancellation of the policy before death of the insured or before maturity of the policy. The FV is the amount that is contracted for when the life insurance policy is purchased. It may be described on the policy as the "face value," "amount of insurance," "amount of this policy," "sum insured," or a similar term.

For each person who is aged 65 or older, blind, or disabled, it must be determined if the total FV of all life insurance policies owned by that individual is greater than $1,500. When the total FV is determined, the following **must not be** included:

- The FV of any insurance policy that has no CSV, such as burial insurance and most term life insurance.
- The value of any dividend additions. Dividend additions are increases in coverage purchased using dividends generated by the policy. They are often referred to as "paid-up additions" or "paid-up additional insurance."
- Additional sums payable because of special provisions or riders. Riders are modifications the policy owner adds to the life insurance policy at the time of purchase. A common example is accidental death.

If the total FV of the life insurance owned by a person who is aged 65 or older, blind, or disabled is $1,500 or less, the CSV of any life insurance policy owned by that person is an exempt asset, including the CSV of any dividend additions.

For life insurance policies that cannot be excluded under the limited exception, the CSV of the policy, including the CSV or any dividend additions, is a countable asset.

Example 3

Steve (aged 67) and Mary (aged 63) are married. Steve is applying for Medicaid. Both individuals have whole life policies in which dividends are used to purchase individual coverage on the policy ("paid-up additions").

Policy	**Owner**	**Face Value**	**Cash Surrender Value**	**Dividends**	**Riders**
Whole Life	Steve	$1,500	6,700 (including CSV of paid-up addition)	Used to purchase additional coverage on the policy	$25,000 accid death
Term life	Steve	$250,000	$0	N/A	N/A
Whole life	Mary	$5,200	$12,700 (including CSV of paid-up additions)	Used to purchase additional coverage on the policy	$15,000 accid death

	The total FV of life insurance policies owned by Steve is not greater than $1,500, so the $6,700 CSV of Steve's whole life insurance must be disregarded for his eligibility determination. The accidental death rider and Steve's term life policy are not counted when determining the total FV. Mary is under the age of 65 and is not blind or disabled. Therefore, it is not necessary to calculate the total FV of her life insurance policies because the limited exception does not apply to her assets. Her whole life insurance policy's CSV of $12,700 is a countable asset for Steve's eligibility determination unless all or part of it can be excluded under other provisions, such as a burial fund.

Example 4

Siobhan is disabled and has one life insurance policy. The dividends from her policy are deposited into a separate, interest-bearing account.

Policy	**Owner**	**Face Value**	**Cash Surrender Value**	**Dividends**
Whole life	Siobhan	$1,500	$545	Accumulated in a separate account ($1,20

The total FV life insurance policies owned by Siobhan is not greater than $1,500, so the $545 of CSV of the whole life insurance policy is not a countable asset. However, the $1,200 dividend accumulations held in a separate, available account are treated as a separate asset from life insurance.

16.7.6 Treatment Of Continuing Care Retirement Community Entrance Fees

A CCRC or Life Care Community typically provides a variety of living arrangements, from independent living through skilled nursing care. Potential residents frequently must pay substantial entrance fees and sign detailed contracts before moving to the community.

Entrance fees paid by an individual to a CCRC or Life Care Community are counted as an available non-exempt asset of the individual for Medicaid eligibility determinations when **all** of the following conditions apply:

- The person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, even in part, to pay for care if the person's other resources or income are insufficient to pay for his or her care. It is not necessary for the CCRC or Life Care Community to provide a full, lump sum refund of the entrance fee to the resident. If even a portion of the fee can be refunded or applied to pay for care as required, this condition would be met.
- The person is eligible for a refund of any remaining entrance fee when the person dies or terminates the contract and leaves the community. It is not necessary for the resident to actually receive a refund of the entrance fee or deposit. This second condition is met as long as the resident could receive a refund were the contract to be terminated or if the resident dies.
- The entrance fee does not confer an ownership interest in the CCRC or Life Care Community. An ownership interest generally means the right to possess and convey property, but that might not be an all-inclusive definition. Therefore, the resident will be required to verify whether or not he or she has an ownership interest in the CCRC or Life Care Community by presenting documentation from the facility to that effect. If the CCRC or Life Care Community confirms that the entrance fee does not confer an ownership interest to the resident, then this third condition is met.

Entrance fees that meet all three conditions described above will be counted as an available non-exempt asset for all Medicaid eligibility determinations for the elderly, blind, and disabled, regardless of whether or not the individual is requesting LTC services. An entrance fee that does not meet all three conditions described above is an unavailable asset.

For Medicaid eligibility determinations, all normal spousal impoverishment rules regarding income and asset allocations for a community spouse are applicable to married couples who reside in a CCRC or Life Care Community, when one spouse resides in the skilled nursing care section of the facility and the other spouse (the community spouse) resides in a more independent living setting. CCRC and Life Care Community contracts are required by federal law to account for spousal impoverishment income and asset allocations to a community spouse before determining the amount of resources that a resident must spend on his or her own care.

16.7.7 Income Tax Refunds and Credits

Disregard all federal income tax refunds and credits for 12 months following the month of receipt. If there is a remaining, unspent portion of the refund or credit after the 12-month disregard period has passed, count that portion as an available asset.

All state income tax refunds and credits are considered available assets starting in the month after the month of receipt.

16.7.8 Earned Income and Child Tax Credits

Disregard all EITC and Child Tax Credits, including advance payments of these credits, in the month received and for 12 months following the month of receipt.

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

16.7.9 Vehicles (Automobiles)

Vehicle refers to any registered or unregistered vehicle used for transportation. Vehicles used for transportation include, but are not limited to, cars, trucks, motorcycles, boats, and snowmobiles.

16.7.9.1 Determining Equity Value

Equity value is:

- The vehicle's wholesale value as given in a standard guide on motor vehicle values (blue book) or the value as estimated by a sales representative at a local dealership.
- Minus any encumbrances (loans or mortgages) that are recorded on the vehicle’s title as liens.

Do not increase a vehicle's value by adding the value of low mileage or other factors, such as optional equipment or apparatus for the handicapped.

Occasionally, a vehicle has more than one owner. Some of the owners may be in the FTG while others may not. To find what the FTG’s equity value in the vehicle is, do the following:

1. Find the vehicle’s wholesale value.
2. Subtract the encumbrances (loans or mortgages) that are recorded as liens on the vehicle’s title. The result is the equity value.
3. Divide the equity value by the total number of owners.
4. Add the prorated equity values of the owners who are in the FTG. The result is the FTG’s equity value in the vehicle.

16.7.9.2 When to Count, When to Exempt

Count vehicle values as follows:

- One vehicle per eligible individual or couple is excluded regardless of the value if it is used for transportation of the eligible individual or couple or a member of the eligible individual's or couple's household. Assume the vehicle is used for transportation, absent evidence to the contrary.
- When an individual owns more than one vehicle apply the exclusion as follows:
    - Apply the exclusion in the manner most advantageous to the individual.
    - Apply the total exclusion to the vehicle with the greatest equity value if the eligible individual or couple own more than one vehicle used for transportation of the eligible individual or couple or a member of the individual's or couple's household.
    - The equity value of any vehicle, other than the one wholly excluded, is a resource when it meets both of the following criteria:
        - It is owned by an eligible individual or couple
        - It can't be excluded under another provision (e.g., property essential to self-support, plan to achieve self-support, vehicles that are homes)
    - Do not apply the vehicle exclusion to the following vehicles:
        - A vehicle that has been junked
        - A vehicle that is used only for recreational purposes
- When an individual owns two or more vehicles, apply the following rules:
    - If only one vehicle is used for transportation, totally exclude the value of that vehicle.
    - If more than one vehicle is used for transportation, totally exclude the vehicle with the greatest equity value.

Example 5	George is applying for Medicaid. He has three vehicles: a car (equity value $2500), a truck (equity value $7500), and a snowmobile (equity value $750). He states that the snowmobile is used only for recreation in the winter. He uses the car and the truck interchangeably for transportation. The truck is excluded in the asset determination as it is used for transportation and has the highest equity value. While the car is also used for transportation, only one vehicle can be excluded. The equity value of the car counts in the asset determination. The equity value of the snowmobile also counts in the asset determination. Even if this was George's only vehicle, because he states that it is used for recreational purposes only, it would still be a counted asset.

For any vehicle that cannot be excluded for transportation reasons, consider excluding it under the provisions for:

- Property essential to self-support (see SECTION 16.9 PROPERTY ESSENTIAL TO SELF-SUPPORT)
- Plan to achieve self-support (see SECTION 15.7.2.2 PLAN TO ACHIEVE SELF-SUPPORT)
- Vehicles that are homes (see SECTION 16.8.1.7 VEHICLES THAT ARE HOMES)

If the vehicle does not qualify for the exclusion, count the equity value of the vehicle as a resource.

- If an individual owns a vehicle that is temporarily inoperable (e.g., needs repairs) and states that the vehicle will be repaired and used for transportation within the next 12 calendar months, exclude the total value of the vehicle until the repairs are completed. At that point, apply the rules for determining if the vehicle should be excluded.

If an individual states that the vehicle will not be repaired and used for transportation in the next 12 calendar months, count the equity value of the vehicle as a resource.

16.7.10 Property Settlement

Money received as a property settlement is always an asset regardless of whether it is paid in one payment or in installments. It is never income.

16.7.11 Lump Sums Payments

Lump sum payments (rather than recurring payments) from such sources as insurance policies, veterans benefits, sale of property, Railroad Retirement, unemployment compensation benefits, and retroactive corrective financial aid payments are counted as an asset when received.

16.7.11.1 Retroactive SS Payments

The unspent portion of retroactive SSI and RSDI benefits received on or after March 2, 2004, are excluded from resources for the nine calendar months following the month in which the individual receives the benefits.

Do not count a retroactive social security or SSI payment as an asset either in the month of receipt or nine months following the month the payment is received. A retroactive payment means it is paid later than the month in which it is due. After nine months, treat any remaining available portion as an asset.

During the nine months in which it is not counted, the unspent portion of the payment can be mingled with other funds, provided it can be distinctly and separately identified.

The unspent portion of retroactive SSI and RSDI benefits received before March 2, 2004, is excluded from resources for the six calendar months following the month in which the individual received the benefits.

16.7.11.2 Lump Sum Payments Under the Settlement of the Cobell v. Salazar Class-Action Trust Case

The unspent portion of Cobell settlement payments is excluded from resources for one year following the month in which the individual receives the payment.

While some members received class payments, others may have received payments in exchange for their ownership interest in land. This buy-out is an asset conversion that receives special treatment under the act. Exclude funds received from the sale of this land from resource counting for one year from the date of receipt. Funds retained longer than one year are countable as a resource.

Example 6	A class member receives a settlement payment (or a land buy-out payment) on October 5, 2011. Exclude this money for one year (November 2011 through October 2012). If retained, the money would be a countable resource starting November 2012.

During the year in which it is not counted, the unspent portion of these payments can be mingled with other funds, provided it can be distinctly and separately identified.

16.7.11.3 Reimbursement of Cost Share or Patient Liability Payments

To prevent the loss of eligibility due to counting a lump sum reimbursement of cost share or patient liability as an asset, the payment must be excluded as an asset in the month of its receipt, and for the next nine months. At the end of this period, any remaining available portion will be counted as an asset for purposes of determining eligibility. This time period gives members time to use these assets while also maintaining their Medicaid eligibility. This policy aligns with the treatment of lump sum payments

received by members for retroactive Social Security payments (see SECTION 16.7.11.1, RETROACTIVE SS PAYMENTS).

Example 7	Michelle is a former SSI recipient and now receives Social Security Disability Income and a surviving child benefit. She is considered a Disabled Adult Child (DAC) by the Social Security Administration. She applies for Medicaid but does not know when she stopped receiving SSI. Instead of being determined eligible for Medicaid as a DAC with no premium or cost share, she is determined eligible for Waiver Medicaid as a Group B with a cost share, which she pays each month. When her previous receipt of SSI is discovered, Michelle is owed the money that she paid towards her cost share and must be reimbursed that amount. Michelle has nine months after the month of receipt in which the reimbursed amount will not be considered an asset. If she receives the reimbursement in January, any remaining amount from the reimbursement will be counted as an asset in November.

16.7.11.4 Retroactive VA Aid and Attendance

Retroactive Aid and Attendance payments from the VA are an exempt asset through the month after the month of receipt.

Example 8	Gloria receives $5000 in retroactive VA aid and attendance as a lump sum payment in May. The amount of that payment is disregarded through June 30. Any remaining funds as of July 1 are a countable asset.

16.7.12 Land Contract

When a land contract is executed, the purchaser builds equity in the property through the payments he or she makes. The seller keeps legal title to the property until it is paid for. The seller's interest in the land contract is personal property, not real property.

The seller's legal title to the property can be sold and converted to cash for support and maintenance. To determine the value of the seller's legal interest in the land contract:

1. Find the original sale price or the fair market value (as determined by a qualified real estate appraiser). Of these two amounts, choose the one which more accurately reflects the contract's true value on the date it was originated.
2. From this amount subtract:
    a) Payments which the purchaser has already made on the principal.

Example 9	The fair market value of the land contract is $50,000. The purchaser has already paid $10,000 on the principal. $50,000 Fair Market Value -10,000 Already Paid _____ $40,000 Outstanding Balance

    b) Encumbrances on the contract (for example, a personal loan).
    c) The amount lost to a discount.

Example 10	Company ABD purchases land contracts. They have offered to buy Mr. Graham's land contract at a 10 percent discount. $40,000 Outstanding Balance - 4,000 10% _____ $36,000 Value of Mr. Graham's Interest in the Land Contract

3. The remainder, after subtracting 2. a., b., and c. from the original sale price, is the value of the seller's interest in the land contract. Count this as an available asset.

   If the land contract is not an available asset, the person must document its unavailability by showing either one of the following:

   a) The terms of the land contract prohibit its sale.
   b) No one is willing to purchase it from him or her.

   When the claim is that no one will purchase the land contract, it must be offered for sale to at least one individual or organization active in the land contract purchasing market. A written statement from the individual or organization that they will not buy it is sufficient to establish the land contract as an unavailable asset.

   Notice that if it has been offered only to an individual or organization that never purchases land contracts, it remains an available asset.

16.7.13 Mortgage

Treat any mortgage held by and owed to a member the same as a land contract.

16.7.14 Wisconsin Higher Education Bonds

The state of Wisconsin sells Wisconsin Higher Education Bonds to the public as a way to save for higher education. To determine their net value, subtract broker's fees from market value.

The bonds may be sold back to the state, under certain time restraints:

1. Before the maturity date, a portion of their value is withheld. The amount withheld equals the school's tuition and fees. Any excess goes to the person.
2. On or after the maturity date, the value is the total amount received.

The bonds may be sold on the "secondary" bond market at any time. Since they can be disposed of on the market with no time limit, they are an available asset. To determine their net value, subtract broker's fees from market value. (Verify the amounts through a broker.)

16.7.15 Wartime Relocation of Citizens

Disregard restitution paid under PL 100-383 to Japanese-Americans and Aleuts or their survivors who were interned or relocated during World War II.

16.7.16 Agent Orange Settlement Fund

Disregard payments received from the Agent Orange Settlement Fund or any other fund established in settling In Re "Agent Orange" Product Liability Litigation, M.D.L. No. 381 (E.D.N.Y.). Disregard as income in the month received and as an asset thereafter.

16.7.17 Radiation Exposure Compensation Act

Disregard payments from any program under the Radiation Exposure Act (PL 101-426) paid to persons to compensate injury or death resulting from exposure to radiation from nuclear testing ($50,000) and uranium mining ($100,000).

When the affected person is deceased, payment is made to his or her surviving spouse, children, parents, or grandparents. The federal Department of Justice reviews the claims and makes the payments.

Apply this disregard retroactively to October 15, 1990, and continue to disregard the payment for as long as it is identified separately.

16.7.18 Self-Support Plan Assets

Disregard assets set aside to carry out an approved self-support plan (see SECTION 15.7.2.2 SELF-SUPPORT PLAN). The set-aside must be segregated from other funds. Disregard interest that accumulates, provided the set-aside does not exceed the provisions of the plan.

16.7.19 Replacing and Repairing Exempt Assets

Vehicles and homes are examples of exempt assets. If an exempt asset is lost, stolen, or damaged, disregard any cash (and interest earned) or in-kind replacement received from any source to repair or replace it.

The cash or in-kind payment must be used within nine months of the date it is received. After the end of the ninth month, count as an asset leftover cash not used for the repairs or replacement.

Extend the nine-month period for up to another nine months if the person has good cause for not repairing or replacing the thing. Good cause means circumstances beyond the person's control to prevent repair or replacement. This includes not being able to contract it out. When there is good cause, count as an asset any amount not used for repairs or replacement. Begin with the month after the end of the extension.

If, during a good cause extension, the person no longer intends to replace or repair the exempt asset, count the amount for replacement or repair as an asset. Begin with the month the person reports his or her change of intent.

16.7.20 Reserved

16.7.21 Gifts

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

Treat non-cash gifts as an asset, as you would an asset of a similar type. A cash gift is income in the month of receipt. It is an asset in the months after the month of receipt. Disregard cash gifts (such as for birthdays, graduation, and Christmas) that total $60 or less, for each assistance group member, for each calendar quarter.

16.7.22 U.S. Savings Bonds

Count the cash value of a U.S. Savings Bond unless it is unavailable. A bond is unavailable only if the Medicaid group proves it tried to cash the bond and was refused.

16.7.23 Indian Judgment Fund Purchases

Disregard assets purchased with Indian judgment funds (see 10. of SECTION 15.3.14 PAYMENTS TO NATIVE AMERICANS), but do not disregard:

- Proceeds from the sale of these initial purchases.
- Subsequent purchases made with the proceeds from the sale of these initial purchases.

16.7.24 Payments to Nazi Victims

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

16.7.25 Spina Bifida Child

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

16.7.26 Uniform Gifts/Transfers to Minors Act

The Uniform Gifts to Minors Act (UGMA) and the Uniform Transfers to Minors Act (UTMA) allow property to be transferred to an adult or trust company who holds the property as custodian for the minor. UGMA/UTMA property is required by statute to be transferred to the beneficiary when they reach the age of majority (usually at the age of 18 or 21 depending on state law).

Funds held in a UGMA or UTMA custodial account are unavailable to the beneficiary.

When the beneficiary reaches the age of majority and the custodianship ends, the property becomes available to the beneficiary. It is counted as income in the month of transfer and as an asset in the following month.

16.7.27 Individual Development Accounts Programs

IDAs are restricted accounts owned by people with low incomes. The IDA program provides matching funds for buying a home, starting a business, or post-secondary education. Member savings and interest are a countable asset if the IDA was established using the Assets for Independence Act or Refugee Assistance Act funds. However, if W-2 or Community Reinvestment funds support the IDA program, the assets are exempt.

16.7.28 Crime Victim Restitution Program

Disregard any payments received from a state-established fund to aid victims of a crime. These payments are an excluded resource for nine months following the month of receipt.

16.7.29 The American Recovery and Reinvestment Act of 2009

Do not count the one-time $250 payment under the American Recovery and Reinvestment Act of 2009 as an asset either in the month of receipt or nine months following the month the payment is received.

16.7.30 Achieving a Better Life Experience (ABLE) Accounts

ABLE accounts are tax-sheltered money market savings accounts specifically designed for people with disabilities. Anyone may contribute to these accounts for the disabled beneficiary.

While Wisconsin does not offer residents a state-specific ABLE program, Wisconsin residents may open these accounts in any state where an ABLE program is offered. If an applicant or member has an ABLE account, treat the money in the account as follows:

1. Do not count the balance on the account as an asset.
2. Do not count contributions to the account from someone other than the member, any interest or dividends earned, or other appreciation in value as income.

Note	*The fact that someone uses their earned or unearned income to contribute to an ABLE account does not make the income exempt for purposes of Medicaid eligibility. Income received by the designated beneficiary and deposited into their ABLE account is still income to the designated beneficiary. For example, an applicant can have contributions automatically deducted from their paycheck and deposited into an ABLE account. In this case, the income used to make the ABLE account contribution is included in the Medicaid eligibility determination as income, even though the ABLE account is an exempt asset.*

3. Exempt all distributions from these accounts to the beneficiary, as long as they are for qualified disability expenses and are not more than the beneficiary's qualified disability expenses. "Qualified disability expenses" means any expenses related to the eligible person's blindness or disability that are incurred for the benefit of an eligible person who is the designated beneficiary. This includes the following expenses: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for oversight and monitoring, funeral and burial expenses, and other expenses consistent with the purposes of the ABLE program. Unless the applicant or member reports that a distribution was used for non-qualifying expenses, it should be assumed that the distribution was used for qualified disability expenses.
4. Disregard ABLE account distributions used for qualified disability expenses from a person's total income when calculating cost of care for long-term care and home and community-based waivers.

ABLE account funds remaining after an applicant's or member's death are subject to estate recovery.

Note	*If a third party contributes to someone else's ABLE account, and then later applies for long-term care Medicaid, the contributed funds may be considered divestment.*

16.7.31 Crowdfunding Accounts

Crowdfunding accounts, such as GoFundMe and Kickstarter, raise money from multiple people online to finance things like a new business venture, medical bills, or funeral costs. If the funds in these accounts are not accessible for the person to withdraw, the funds would be an unavailable asset. Disbursements or withdrawals would be unearned income (a gift) in the month withdrawn, and any withdrawn amount that is still available in subsequent months would be an available asset.

16.7.32 Independence Accounts

Independence account balances will be exempt assets for all Medicaid programs. Any "pre-Independence account balance" will be a counted asset. Only funds deposited in a registered Independence Account while the member is eligible for MAPP may be exempted from the asset limit. Any deposits made prior to MAPP enrollment or during periods of MAPP ineligibility are not exempt assets. Note that there are different rules for retirement/pension accounts and non-retirement/pension accounts regarding how they may be registered as Independence Accounts and when funds may be deposited. See SECTION 26.4.1.1 INDEPENDENCE ACCOUNTS for more information on these accounts.

16.7.33 Certain Payment Types Related to the COVID-19 Pandemic

There is no uniform policy for how to count payment types related to the COVID-19 pandemic; some payment types are counted as assets and some payment types are not counted as assets. The criteria used to evaluate whether a payment type is counted as an asset include:

- The text of the federal law that authorized the payment type
- Guidance received from federal agencies

- Whether the payment can be considered “disaster assistance”

The payment types that do not count as assets **include but are not limited to:**

- We’re All In Small Business Grants.
- Child Care Counts supplementary payments, which are payments awarded to child care providers.
- Wisconsin Emergency Rental Assistance (WERA) payments.
- COVID-19 Funeral Assistance.
- Emergency Assistance for Rural Housing/Rural Rental Assistance.
- Homeowner Assistance Fund payments.
- Housing Assistance and Supporting Services Programs for Native Americans payments.
- Higher Education Emergency Relief Fund (HEERF) payments.
- Retroactive Pandemic Unemployment Assistance (PUA), Pandemic Emergency Unemployment Compensation (PEUC), Federal Pandemic Unemployment Compensation (FPUC), Mixed Earner Unemployment Compensation (MEUC), Extended Benefits (EB), and Lost Wages Assistance (LWA) payments.
- Federal recovery rebates (sometimes referred to as Coronavirus stimulus payments or economic impact payments) issued by the IRS in response to the federal COVID-19 public health emergency.

16.7.34 Guaranteed Income Payments

A guaranteed income payment that is retained in the month after the month of receipt is excluded as an asset indefinitely if all of the following apply:

- The payment itself is privately funded.
- The payment is administered by a non-profit organization.
- The payment is separately identifiable (See SECTION 16.3 SEPARATE AND MIXED ASSETS).

Guaranteed income payments that can be excluded include, but are not limited to, payments from the Madison Forward Fund, the Madison Forward Fund 2.0, and the Bridge Project in Milwaukee.

See SECTION 15.3.36 GUARANTEED INCOME PAYMENTS for information about income treatment of guaranteed income payments.

16.7.35 Medicare Advantage Supplemental Benefits

Disregard all Medicare Advantage supplemental benefits.

A supplemental benefit is an item or service provided by a Medicare Advantage Plan that is not covered by original Medicare.

Example 12	Mariel received a prepaid debit card from her dual eligible special needs plan (D-SNP) plan as a wellness benefit that she can use to purchase healthy food and over-the-counter medications. The funds on the debit card must not be counted as income or assets.

16.7.36 Medicare Set-Aside Arrangements

A Workers Compensation Medicare Set-Aside Arrangement (WCMSA) or Medicare Set-Aside Arrangement (MSA) is an agreement between Medicare and the Medicare beneficiary to take a portion of a workers' compensation or other injury-related insurance settlement and set those funds aside for all future injury-related medical expenses that would normally be paid by Medicare.

Medicare set-aside arrangements are not subject to any special treatment under Medicaid rules. WCMSA/MSA funds must be evaluated to determine if they meet the Medicaid definition of an available asset (see SECTION 16.2.1 ASSETS AVAILABILITY INTRODUCTION).

Note *There may be cases in which WCMSA/MSA funds are placed into a trust that is exempt for Medicaid purposes, such as a special needs trust (see SECTION 16.6.5 SPECIAL NEEDS TRUSTS) or pooled trust (see SECTION 16.6.6 POOLED TRUSTS), in which case the WCMSA/MSA funds may be disregarded under those trust provisions.*

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16.8 Real Property

16.8.1 Home/Homestead Property

An individual's home is an excluded asset.

A home is defined as any property an individual has an ownership interest in and which serves as their primary place of residence. An individual's primary place of residence is the property they consider their principal home and to which, if absent, they intend to return. It can be real or personal property, fixed or mobile, and located on land or water.

The home can include any of the following:

- The shelter in which they reside
- The land on which the shelter is located
- Related buildings on the land

The home can include more than one lot. Land is considered part of the home as long as the lots adjoin one another and are not separated by land in which neither the individual nor their spouse has an ownership interest. Easements and public rights of way, such as utility lines and roads, do not separate other land from the home plot. For example, there are farms where the land is on both sides of a road and considered a part of the home. If land is completely separated from the home property by land in which neither the individual nor their spouse has ownership interest, it should not be considered part of the home.

16.8.1.1 Multi-unit Dwelling

When a Medicaid fiscal group member lives in one unit of a multi-unit dwelling and owns all of the units, exempt all of the units and the property they are on. Consider the whole multi-unit dwelling as the group member's home.

16.8.1.2 Non-Motorized Trailer Homes

A non-motorized trailer home is considered real property, regardless of whether or not the member owns the land that it is on. Consider the non-motorized trailer home:

1. Home property (see SECTION 16.8.1 HOME/ HOMESTEAD PROPERTY) if the member currently lives in it or had lived in it before entering an institution. If the member owns the land that the non-motorized trailer home is sitting on, consider it and any other buildings on that land as part of the homestead.
2. Non-home real property if the member does not live in it or had not lived in it prior to entering an institution.
   If the non-motorized trailer home is listed for sale, it is considered unavailable (see SECTION 16.2 ASSETS AVAILABILITY).

16.8.1.3 Exempt Home Property

Although home property is an exempt asset under the conditions described in this subsection, there are limits on divesting home property (see SECTION 17.2.7.23 HOMESTEAD PROPERTY).

Non-Institutionalized Person. For a person who is not residing in an institution, the home is exempt as long as the person resides in it, or intends to return to it. There is no time limit for an intended return. The home remains exempt even if the person rents out part of it while he or she continues to reside there.

Institutionalized Person. When a person resides in an institution, the home is exempt if one of the following conditions is met:

1. His or her spouse or dependent relative resides in the home. The dependency of the relative may be of any kind, such as financial or medical. The relative may be father, mother, daughter, son, grandson, granddaughter, in-laws, stepmother, stepfather, stepson, stepdaughter, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, stepsister, half-sister, half-brother, niece, nephew, or cousin.
2. The institutionalized person expresses his or her intent to return to the home. If he or she is able to form an intent but unable to express it, determine his or her intent through other available evidence. Other evidence includes:

    a) His or her written statements.
    b) His or her oral statements made before incapacitation. Accept reports of these statements made by family members.
    c) Accept reports of his or her intent made by an authorized representative. If there is no evidence he or she disagrees with the statement, accept the authorized representative's statement.

If he or she appears unable to form an intent but has not been judged incompetent by a court, accept a family member's statement as evidence of his or her intent.

If he or she has been judged incompetent, accept the intent statement of his or her guardian. Use the guardian's intent statement even if it differs from the member's.

If neither condition #1 nor #2 is met, the property is no longer the principal residence and becomes non-home property.

Refer to SECTION 18.4 SPOUSAL IMPOVERISHMENT ASSETS and SECTION 18.4.1 SPOUSAL IMPOVERISHMENT ASSETS INTRODUCTION for the definition of institutionalized spouse and home exemptions when Spousal Impoverishment policies apply.

16.8.1.4 Home Equity Over $750,000.00

Effective January 1, 2009, persons who apply for Medicaid coverage of long term care (LTC) services (i.e., Institutional, community waivers, Family Care, Partnership or PACE) are not eligible for LTC services if the equity interest in their home is greater than $750,000. He or she is still eligible for card services if all other eligibility requirements are met.

This restriction does not apply if a spouse, minor, or disabled child resides in the home.

The $750,000 LTC home equity limit can be waived in situations whereby the imposition of this eligibility requirement results in an "undue hardship" for the individual. When determining whether or not an undue hardship exists, follow the same undue hardship guidelines outlined in SECTION 22.4 UNDUE HARDSHIP.

This policy applies regardless of whether or not the applicant or member lists the home for sale.

The equity value of a home is the current FMV minus any encumbrance on it. An encumbrance is a legally binding debt against the home. This can be a mortgage, reverse mortgage, home equity loan, or other debt secured by the home.

Note: *Property tax assessments can be used to determine a property's FMV if both the local agency and applicant/member agree that it accurately represents the price it would sell for on the open market in that geographic area. If both parties do not agree, statements from one or more realtors could be sufficient. If the local agency requests a comparative analysis, they are required to pay for it. Regardless of what process is used, the member always has the right to appeal the agency decision if they think it is incorrect.*

Example 1:	Bob is a 66 year old bachelor, living in his own home who applies for Medicaid on February 1, 2009. His home has a FMV of $760,000 with no encumbrances. Bob meets all other Medicaid eligibility requirements and is certified for Medicaid effective February 1, 2009. In October 2009, Bob's health deteriorates and he applies for a community waiver program. That application is denied because Bob's equity interest in his home exceeds the LTC eligibility limit by $10,000. On December 15, 2009 Bob reapplies for a community waiver program and reports that on December 1, 2009, he took out a $12,000 home equity loan and used the entire loan proceeds to purchase exempt burial assets and furniture for his home. Bob's December 15, 2009 application for community waivers is approved because Bob's equity interest in his home is now $748,000, which is below the LTC eligibility limit, and he meets all other Medicaid eligibility requirements.

Example 2:	Dave is 75 years old, married and living with his wife Ruth in their home which sits on a 75 acre parcel of property. The entire property qualifies as homestead property. It has a FMV of $1,000,000 with no encumbrances. On March 5, 2009, Dave applies for Family Care. The Family Care application is approved because even though Dave's home equity value exceeds the $750,000 LTC eligibility limit, his wife resides in the home, which negates the $750,000 LTC home equity restriction.

This home equity provision applies only to individuals who apply for LTC Medicaid (i.e., nursing home, Family Care, etc.), on or after January 1, 2009. It does not apply to individuals who are current members of Medicaid LTC programs as of January 1, 2009, as long as they remain continuously eligible for LTC Medicaid after that date. A Medicaid LTC member who becomes ineligible for Medicaid LTC after January 1, 2009, for a calendar month or more, would be subject to the $750,000 home equity limit during any subsequent reapplication for Medicaid LTC programs.

16.8.1.5 Sale of Home Property

Money from the sale of real property is an asset. When the property that is sold is a homestead, disregard the proceeds if they are placed in an escrow account and used to purchase another home within three months.

16.8.1.6 Life Estate

A life estate allows an individual to gift a home or other possession but retain certain property rights for his or her lifetime. Generally a life estate provides an individual the right to possess and use a gifted property, and to make money from it. The person does not have the title to or the right to sell the property. He or she usually may not pass it on to his or her heirs as an inheritance. He or she also has the right to sell his or her interest in it. He or she is liable for all costs of the property such as taxes and repairs, unless the will (or deed) states otherwise.

When property is conveyed to one person for life (life estate holder) and to another person (the remainder man), both a life estate interest and remainder interest are created. When the life estate holder dies, the remainder man holds full and unconditional title to the property and can dispose of it as he or she wishes (fee simple). Life estate values need to be determined for divestment calculation.

Example 3:	Sidney gifted away his $100,000.00 home to his nephew Frank, but retained a $30,000.00 life estate, the divested amount is $70,000.00. The life estate interest is an unavailable asset when determining Medicaid asset eligibility for Sidney. However, the remainder interest is an available non-exempt asset for Frank, the remainder person, for Medicaid eligibility determinations.

Determine the value of the remainder interest for the date you are determining Medicaid eligibility. To do this, use the age of the life estate holder on the date that you are determining eligibility for the remainder person. Also use the property's FMV as of that same date. Then select the remainder multiplier (the one that corresponds to the age of the life estate holder) from the life estate table and multiply the FMV by that number. The result should be the value of the property's remainder interest for the remainder person as of the date that eligibility for Medicaid is being determined for that person.

To determine the value of a life estate or remainder interest:

1. In the Life Estate and Remainder Interest Table (see SECTION 39.1 LIFE ESTATE AND REMAINDER INTEREST), find the line for the person's age as of the transaction date.
2. Multiply the figure on that line in the Life Estate or Remainder column times the fair market value to determine the value of the life estate or remainder interest.

When a life estate holder moves off the property and the property is rented, follow the instructions in SECTION 15.5.3 RENTAL INCOME for counting the rental income.

If a remainder person sells the property for which a life estate is retained, the life estate holder is not entitled to any of the payments.

However, if the life estate holder gives up his or her life estate to secure the sale of the property, then the life estate holder would be entitled to some portion of the proceeds from the sale of the property. Treat money received as a result of property settlement as an asset (see SECTION 16.7.10 PROPERTY SETTLEMENT).

16.8.1.7 Vehicles that are Homes

Vehicles such as motor homes and boats are considered home property for Medicaid purposes under certain circumstances. Consider a vehicle:

- Home property if the member currently lives in it as their primary dwelling or had lived in it as their primary dwelling before entering an institution. If the member owns the land that the vehicle is sitting on, consider the land and any other buildings on that land as part of the homestead. The member does not need to own the vehicle itself for the land on which the vehicle is located to be considered home property.
- Non-home vehicle property if the member does not live in it as their primary dwelling or had not lived in it as their primary dwelling prior to entering an institution.

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16.9 Property Essential to Self-Support

16.9.1 Introduction to Property Essential to Self-Support

Certain assets deemed to be essential to an individual's means of self-support are excluded. These assets fall into three main categories:

- Property used in an established trade or business, which is excluded regardless of its value or rate of return if the business is currently operating for the self-support of the individual or their spouse, or there is a reasonable expectation it will resume operating within the next 12 months (see SECTION 15.6.3.1 BUSINESS ASSETS)
- Nonbusiness property used to produce goods or services essential to self-support, which is excluded up to $6,000
- Nonbusiness income-producing property, which is excluded up to $6,000 if it produces at least a six percent rate of return

16.9.2 Business Property Excluded Regardless of Value Rate of Return

This category includes:

- Property used in a trade or business, if the individual is actively involved in the business operation on a day-to-day basis
- Government-issued permits (such as commercial fishing permits)
- Personal property used by an individual as an employee for work or required by an employer for work

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Note: *Rental property is not considered business property unless the property owner is in the business of renting and managing properties. If a person simply owns a piece of property and is renting it to produce passive income, they are not considered to be the owner of a trade or business.*

The information reported on the Schedule E, Supplemental Income and Loss (if applicable), should be checked to determine whether the individual is actively engaged in the business. If the income is listed as Non-Passive Income, the individual is actively engaged in the business.

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

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

16.9.3 Nonbusiness Property Excluded up to $6,000 Regardless of Rate of Return

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

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

Example 1	John owns two acres of land that he uses to grow fruits and vegetables for his personal consumption. Up to $6,000 of the equity value of the property is exempt.

16.9.4 Nonbusiness Income-Producing Property Excluded up to $6,000 if it Produces at Least Six Percent Rate of Return

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

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

Example 2	James is applying for EBD Medicaid. He lives in a CBRF and is renting out his home which has an equity value of $20,000. He does not intend to return to the home. The income from the rent exceeds 6 percent of the equity value of the home, so $6,000 of the equity value is exempt. The remaining $14,000 is a counted asset.

Example 3	Joan is applying for EBD Medicaid. She lives in her home but also owns a lake cottage in northern Wisconsin. She rents the cottage during the summer months. The income from the rent does not equal 6 percent of the equity value of the cottage. The entire equity value of the cottage is a countable asset.

If the excluded portion produces less than a six percent return due to circumstances beyond the person's control (e.g., crop failure, illness), and there is reasonable expectation that it will again produce at least a six percent return, continue to consider the first $6,000 in equity as excluded.

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16.10 Indian Lands

Exclude a Native American's interest in or possession of land that is held by an individual Native American or tribe, and that can only be disposed of with the approval of other individuals, the tribe, or the federal government.

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16.11 Retirement Funds

16.11.1 Types of Retirement Funds

Retirement funds include employer-sponsored retirement plans and individually owned retirement plans.

Employer-Sponsored Retirement Plans

Employer-sponsored retirement plans include:

- 401(k) or SIMPLE 401(k).
- 403(b) Plans: For employees of public schools and certain tax-exempt organizations.
- 457(b) Plans: Deferred compensation plans available to state and local government employees.
- Thrift Savings Plans (TSPs): Similar to a 401(k) plan but only available to federal employees and military members.
- Qualified Pension Plans: Employer-sponsored pension (such as Wisconsin Retirement System's Employee Trust Fund (ETF)).
- Profit-Sharing Plans: Employer-contributed plans.

Individually Owned Retirement Plans

Individually owned retirement plans include:

- Keogh plans: For self-employed individuals.
- Individual retirement arrangements (IRAs): Types include traditional, Roth, SEP, and SIMPLE IRAs.

An IRA can be in the form of an **individual retirement account** or an **individual retirement annuity**. An individual retirement account can hold a variety of asset types, including stocks, bonds, mutual funds, annuities, CDs, and other assets. An individual retirement annuity (also called "IRA annuity") invests only in fixed or variable annuities and provides a guaranteed income stream at retirement. IRA annuities can be in accumulation or pay out status, but most often IRA annuities are annuitized at the time they are established.

IRAs cannot be jointly owned. IRAs are not transferable and have exclusive benefits for the individual who funded the IRA (or that individual's beneficiary after they die). In limited situations, a spouse can fund an IRA for their partner, but in that situation only the partner has access to the assets.

Other Funds Set Aside for Retirement

Funds that are intended for retirement but not held in an employer-sponsored or individually owned retirement plan are not considered retirement funds for purposes of Medicaid eligibility. They are evaluated based on the type of account in which the funds are held. For example, if funds being saved for retirement are held in a regular savings account, the funds are evaluated as a savings account.

16.11.2 Retirement Funds as Assets

Employer-sponsored and individually owned retirement plans must be evaluated for availability as assets.

Retirement Funds of a Medicaid Applicant or Member

In general, individually owned retirement plans (IRAs and Keoghs) are counted as available assets. The available amount is calculated as the principal, less any penalties for withdrawal. Tax withholdings are

not deducted from the available asset value. Exception: IRA annuities that are currently paying out are treated as annuities rather than retirement funds when evaluating their availability as assets (see SECTION 16.12 ANNUITIES).

Note *For long-term care cases, annuity disclosure and remainder beneficiary designation requirements apply to IRA annuities regardless of whether the annuity is evaluated as a retirement fund or as an annuity (see SECTION 16.12.3 LONG-TERM CARE ANNUITY DISCLOSURE AND REMAINDER BENEFICIARY DESIGNATION REQUIREMENTS).*

Employer-sponsored retirement plans are not counted as available assets if any of the following are true:

- The individual is currently receiving periodic payments from the plan.
- The individual is still employed and would have to quit their job to obtain the funds.
- The individual does not have access to the account's principal.

If none of the above are true and the individual has the ability to cash out their employer-sponsored retirement plan, the cash value of the plan (after any penalties but before any tax withholding) is counted as an available asset.

Retirement Funds of an Ineligible Spouse

In general, both employer-sponsored and individually owned retirement plans of an ineligible spouse (defined as a Medicaid applicant or member's spouse who is not requesting full-benefit health care) are disregarded as assets.

However, IRA annuities owned by an ineligible spouse are only considered exempt retirement funds if the annuitant is the person who funded the IRA. Otherwise, the ineligible spouse's IRA annuity must be evaluated as an annuity rather than a retirement fund when determining whether it must be counted as an asset (see SECTION 16.12 ANNUITIES).

Note *For long-term care cases, annuity disclosure and remainder beneficiary designation requirements apply regardless of whether the ineligible spouse's IRA annuity is evaluated as a retirement fund or as an annuity (see SECTION 16.12.3 LONG-TERM CARE ANNUITY DISCLOSURE AND REMAINDER BENEFICIARY DESIGNATION REQUIREMENTS).*

Conversion of Retirement Funds

Retirement funds that are cashed out or rolled over are treated as a conversion from one asset type to another.

Example 1	Carol has a 401(k) retirement plan with her employer. When she ends her employment, she cashes out her 401(k) and rolls the funds into a newly created IRA. Once the IRA is established, the funds are assessed for asset and income availability as an individually owned retirement plan.

Example 2	Jane has a 401(k) retirement plan with her employer. When she ends her employment, she cashes out her 401(k) and deposits the funds into her checking account. The funds are assessed for asset availability as part of her checking account as soon as they are deposited into the account and are no longer treated as retirement funds.

16.11.3 Retirement Funds as Income

Employer-Sponsored Retirement Plans

Regular, periodic payments from an employer-sponsored retirement plan are counted as unearned income in the month received.

Example 1	Mike receives $500 per month from his 401(k) retirement fund and deposits the funds into his checking account. The $500 per month is counted as unearned income.

Individually Owned Retirement Plans

Withdrawals and distributions from individually owned retirement funds (IRAs and Keoghs) are not counted as income. These transactions are considered a conversion from one asset type to another, similar to a withdrawal or transfer from a bank account. Exception: IRA annuities that are currently paying out are treated as annuities rather than retirement funds when evaluating their availability as income (see SECTION 16.12 ANNUITIES).

Example 2	Mike regularly withdraws $500 per month from his IRA and deposits the funds into his checking account. The $500 per month is not income. It is an asset in his checking account.

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16.12 Annuities

16.12.1 Annuity Introduction and Definitions

An annuity is a purchase contract where the purchaser (person funding the annuity) pays a lump sum or makes periodic payments to a bank or insurance company (annuity issuer) in return for an expectation of future payments.

The **annuitant** is the person entitled to the payments. An annuity may include a beneficiary clause under which, if the annuitant dies, the contracting entity converts any funds remaining in the annuity into a lump sum or periodic payments which are paid to a designated **remainder beneficiary**. Depending on the settlement option of an annuity, payments may continue for a fixed period or for as long as the annuitant or another designated beneficiary lives, creating an ongoing income stream from the previously deposited funds.

When an annuity is established, payments may be immediate or deferred. Deferred annuities are established with a funding timeframe, called an **accumulation phase**. This is a period when deposits are made into the annuity to build up its value. Immediate annuities don't have an accumulation phase because they are annuitized at the time of purchase. Typically, annuities only have cash surrender value during the accumulation phase. The **pay-out phase** (annuitization) begins at the time payments start going to the annuitant in accordance with the settlement option. The settlement option specifies the way the funds from the annuity will be paid out. It involves choosing the amount of each payment, how often payments will be made, and the length of time over which the payments will be made.

Revocable vs Irrevocable Annuities

If the terms of the annuity contract allow the fund to be surrendered, it is considered revocable.

If the terms of the annuity contract do not allow the fund to be surrendered, it is considered irrevocable.

16.12.2 Treatment of Annuities as Assets or Income

Asset Treatment of Annuities

Annuities that can be surrendered (revocable annuities) are considered available, countable assets. The countable asset value of an annuity that can be surrendered is determined as follows:

- Total deposits made to the annuity
- Plus any earnings on the deposits not previously paid out
- Minus any earlier withdrawals and any surrender costs charged for the withdrawal. Income tax withheld or tax penalties for early withdrawal are not deducted from the surrender value.

Annuities that cannot be surrendered (irrevocable annuities) are considered unavailable assets. For long-term care cases, irrevocable annuities must be evaluated for divestment (see SECTION 17.2.6.14 IRREVOCABLE ANNUITIES). An irrevocable annuity is considered an unavailable asset on the date the settlement option was made final (typically the annuitization date).

Income Treatment of Annuities

Annuity payments are counted as unearned income if the annuity is an unavailable asset.

Annuity payments are not counted as unearned income if the annuity is an available asset.

16.12.3 Long-Term Care Annuity Disclosure and Remainder Beneficiary Designation Requirements

For long-term care cases, annuities purchased or substantively changed after January 1, 2009, are subject to annuity disclosure (see SECTION 16.12.3.1 ANNUITY DISCLOSURE) and remainder beneficiary designation (see SECTION 16.12.3.2 REMAINDER BENEFICIARY DESIGNATION) requirements.

Annuities purchased prior to January 1, 2009, that have not been substantively changed since that date are not subject to LTC annuity disclosure or remainder beneficiary assignment requirements, but these annuities must still be reported and evaluated for their availability as income or assets.

The following actions are considered substantive changes:

- Additions of principal
- Elective withdrawals
- Requests to change the distribution of the annuity
- Elections to annuitize the contract
- A change in ownership
- Any other non-routine action not listed below

The following actions are not considered substantive changes:

- Routine transactions such as notification of an address change, notification of death or divorce of a remainder beneficiary, and other similar circumstances.
- Changes that occur based on terms of the annuities that existed prior to January 1, 2009, and which do not require a decision, election, or action to take effect.
- Changes beyond the control of the individual, such as a change in law, a change in the policy of the issuer, or a change in the terms based on other factors, such as the issuer's economic status.

16.12.3.1 Annuity Disclosure

For annuities purchased or substantively changed after January 1, 2009, an annuity disclosure form (Annuity Information - Disclosure, F-10192) must be completed for each annuity owned by the LTC applicant/member or their community spouse.

If the LTC applicant/member or their community spouse does not complete the annuity disclosure form, they are ineligible for Medicaid coverage of long-term care services for failure to provide requested information.

16.12.3.2 Remainder Beneficiary Designation

For annuities purchased or substantively changed after January 1, 2009, the annuity contract must name the State of Wisconsin Estate Recovery program as the remainder beneficiary in the first position, or in second position if a community spouse or minor or disabled child is named in the first position, unless it is verified that the annuity has no death benefit.

To fulfill this requirement, the annuity owner must complete and submit the Medicaid Annuity Beneficiary Designation form (F-10191) to the IM agency. The form must be completed when the annuity is disclosed even if the State of Wisconsin Estate Recovery program is already named as the appropriate remainder beneficiary on the annuity contract.

If the completed F-10191 is received by the due date, the eligibility determination must be completed and the completed F-10191 along with the Medicaid Issuer of Annuity - Notice of Obligation form (F-10190) must be sent to both the annuity issuer and the Wisconsin Medicaid Estate Recovery program.

If the LTC applicant/member or spouse fails to cooperate with naming the state as remainder beneficiary when required, a divestment penalty period will be imposed. The divested amount is the full purchase price of the annuity.

16.12.3.3 Notice of Obligation to Annuity Issuer

Once the state has been designated as the remainder beneficiary, the annuity issuer must notify the agency about any changes made to that annuity to ensure the annuitant does not change the terms of the annuity beneficiary designation at a later date. The issuer acknowledges this obligation by completing and returning the Medicaid Issuer of Annuity - Notice of Obligation form (F-10190). When the IM agency receives a completed F-10190, or any other subsequent annuity information from the annuity issuer, it must be sent to the Estate Recovery program.

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17 Divestment

17.1 Divestment Defined

Divestment is the act of transferring ownership of assets or income and receiving less than fair market value FMV in return. Applicants or members seeking Medicaid-covered long-term care services are subject to a set of special rules about transferring assets and income. Wisconsin refers to these as "divestment rules."

If someone subject to divestment rules transfers an asset and/or income and is seeking Medicaid coverage of long-term care services (see 17.1.1 Applicable Health Care Programs), the transfer must be evaluated (see 17.2 Evaluation of Transfers for Divestment). Divestment rules do not apply to the applicants or members listed in 17.1.2 Excluded Applicants and Members.

Divestment rules apply even if someone else transfers the applicant or member's assets or income. Divestments can be made by:

- An institutionalized person.
- An institutionalized person's spouse.
- A person, including a court or an administrative body, with legal authority to act in place of or on behalf of the institutionalized person or the person's spouse.
- A person, including a court or an administrative body, acting at the direction or upon the request of the institutionalized person or the person's spouse. This includes relatives, friends, volunteers, and authorized representatives.

Note: *An **Institutionalized Person** is someone who meets one of the following criteria:*

1. *Participates in a Home and Community-Based Waivers program*
2. *Has resided in a medical institution for 30 or more consecutive days for a purpose other than receiving residential substance use disorder treatment*
3. *Is likely to reside in a medical institution for 30 or more consecutive days for a purpose other than receiving residential substance use disorder treatment, as attested to by the medical institution.*

An exception to the 30-day period is that a resident of an IMD for a purpose other than receiving residential substance use disorder treatment is considered an institutionalized person until they are discharged.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days.

Example 1:	Don enters a nursing home and applies for Institutional Medicaid. Don's daughter, Stacy, donates his boat and all the money in his savings account to charity. Divestment rules apply to this transfer even though Don did not make the gift himself.

17.1.1 Applicable Health Care Programs

Divestment rules apply to long-term care services provided through the following programs:

- Adult Community Waivers programs, regardless of the member's form of Medicaid.
  - Family Care.
  - Family Care Partnership.
  - PACE.
  - IRIS programs.

- Institutional Medicaid.
- Medicaid Purchase Plan (MAPP) members.
- BadgerCare Plus for institutionalized childless adults.

Example 2:	Henry is enrolled in MAPP and moves into a skilled nursing facility. He is over the asset limit for institutional Medicaid, so he remains enrolled in MAPP, which covers his long-term care services in the nursing home. Henry sells his home and gives the money to his daughter. Even though Henry is not enrolled in institutional Medicaid, divestment rules apply to his gift because Medicaid is paying for his long-term care services.

Example 3:	Keisha is enrolled in BadgerCare Plus. She has complications from surgery that impact her motor functions. Keisha enrolls in the Family Care program to get extra services to remain in her home. Keisha's income and asset transfers are now subject to divestment rules.

17.1.2 Excluded Applicants and Members

Divestment rules do not apply to transfers made by or on behalf of:

- Children under 19 years old.
- Children under 22 years old who are enrolled in the Children's Long-term Support (CLTS) waiver program.
- A person of any age receiving residential substance use disorder (SUD) treatment in any setting, if the person is only there to receive residential SUD treatment.

Example 4:	Cedric is 22 years old, has a disability determination, and is institutionalized. He applies for institutional Medicaid and reports on his application that he gifted money to his brother. The IM agency requests more information and discovers Cedric was 17 when he gave away the money. Due to his age at the time he gave the money away, this is not a divestment.

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17.2 Evaluation of Transfers for Divestment

IM agencies evaluate information provided about a transfer to determine if it is a divestment. If a divestment occurs, the agency determines if it is allowed or if it requires a penalty period. Note: Divestment rules do not apply to the applicants or members listed in SECTION 17.1.2 EXCLUDED APPLICANTS AND MEMBERS.

The evaluation of a transfer for divestment includes:

- 17.2.1 EXEMPTION OR DISREGARDED STATUS OF INCOME AND ASSETS
- 17.2.2 DATE OF TRANSFER
- 17.2.3 TRANSFERS THAT ARE NOT DIVESTMENT
- 17.2.4 DETERMINING FAIR MARKET VALUE
- 17.2.6 ALLOWED DIVESTMENTS
- 17.2.7 DIVESTMENTS THAT ARE NOT ALLOWED THAT RESULT IN A PENALTY PERIOD

17.2.1 Exemption or Disregarded Status of Income and Assets

Transfers of exempt income and assets do not count as divestments. For the purposes of divestment, exempt and disregarded have the same meaning. This chapter uses the word exempt.

Income and assets are either exempt or nonexempt following the policies in Chapter 15 Income and Chapter 16 Assets.

- Transfers of **exempt** income and assets are **not** divestment with the exception of homestead property SECTION 17.2.7.1 TRANSFER FOR LESS THAN FAIR MARKET VALUE (see SECTION 17.2.3 TRANSFERS THAT ARE NOT DIVESTMENT).
- Transfers of **nonexempt** income and assets **are evaluated** for divestment rule applicability.

17.2.2 Date of Transfer

Any transfer of nonexempt income or nonexempt assets that occurs during the look back period (see 17.2.2.1 THE LOOK BACK PERIOD) or while a person is eligible for long-term care services must be evaluated for divestment.

The exact date of each transfer is needed to evaluate the transfer for divestment rule applicability.

For real property, such as homestead property, the date of transfer is the date the Quit Claim Deed was signed and notarized or authenticated by an attorney. The date the county Register of Deeds recorded the transfer is not the date of transfer.

17.2.2.1 The Look Back Period

Per federal law, transfers of nonexempt income or assets that occur during the 60 months (five years) prior to the month of application must be evaluated for divestment. This 60-month period is the "look back period."

17.2.2.1.1 Beginning of the Look Back Period

The first month (month one) of the look back period is the more recent of either:

- The month before the institutional Medicaid application month.
- The month before the Community Waivers program application month.

The application month is the first month all of these conditions are true:

Program	Conditions
Institutional Medicaid	The applicant is institutionalized. The applicant has applied for health care.
Community Waivers Programs	The applicant is determined to be functionally eligible. The applicant has requested one of the Community Waivers programs. The applicant is otherwise eligible for enrollment in Family Care, Family Care Partnership, PACE, or IRIS.

Example 1	Kaylee was institutionalized on March 2. She submitted a signed application for Medicaid to the agency on May 5. Her look back period begins with April as month one.

Example 2	Judas had options counseling with the ADRC and submitted a signed Medicaid application and request for Family Care on June 19. He was found functionally eligible on May 5 and was otherwise eligible for enrollment in FC through Waiver Medicaid. His look back period begins with May as month one.

17.2.2.1.2 Transfers Prior to the Look Back Period

Transfers that occur before the 60-month (five-year) look back period are not subject to divestment rules. This includes the irrevocable assignment of an asset or purchase of an annuity that has not been changed (see 17.2.3 TRANSFERS THAT ARE NOT DIVESTMENT).

17.2.2.1.3 Transfers During the Look Back Period

An applicant or member may be ineligible for long-term care services if the applicant or member, their spouse, or anyone acting on their behalf divests the applicant's or member's income or assets during the look back period. The period of long-term care ineligibility is based on the value of the divestment. Applicants must report any divestment that occurred during the look back period when they apply.

17.2.2.1.4 Transfers During the Look Back Period That Are Reported Late

Divestments that occurred during the look back period and are reported or discovered after eligibility was established must be evaluated. A divestment reported after eligibility was established doesn't result in an overpayment but may result in a penalty period. See 17.3 PENALTY PERIOD.

Example 3	Trisha is 70, institutionalized, and applies for institutional Medicaid. She reports no divestment on her application. Several years later, Trisha reports that she gave her granddaughter $10,000 four years prior to her initial institutional Medicaid application. This divestment happened during her look back period, which is now seven years ago. Because this divestment occurred during the look back period and was required to be reported in her application, the divestment must now be evaluated.

17.2.2.1.5 Transfers Made by the Community Spouse Who Later Applies for Medicaid

If a community spouse applies for Long Term Care services, any divestment that occurred during their own look back period must be evaluated. This includes allowed divestments made by the community spouse that were previously evaluated for the institutionalized person. See also 17.3.8 BOTH SPOUSES INSTITUTIONALIZED.

Example 4	Brent is an institutionalized person. Eight years after Brent was found eligible for Long Term Care services, Brent's community spouse, Sven, applied for Long Term Care services. Sven reported a gift of $15,000 to his niece six months before he applied for Long Term Care services. Because this divestment occurred over 60 months (five years) after Brent was found eligible, the divestment was allowed and

	didn't impact Brent's eligibility. See 17.2.6.3 DIVESTMENT BY THE COMMUNITY SPOUSE AFTER FIVE YEARS. This divestment must still be evaluated for Sven's Long Term Care eligibility because it occurred during Sven's look back period.

17.2.3 Transfers That Are Not Divestments

Once a transfer is determined not to be a divestment, it has no impact on eligibility.

17.2.3.1 Transfers for Fair Market Value

A transfer for fair market value (FMV) is not a divestment. See 17.2.4 DETERMINING FAIR MARKET VALUE. This includes:

- Receiving equal value in return for an asset.
- Converting an asset from one form to another of equal value.

Example 5	Tally purchases a sailboat for $12,000. He verifies the value of the sailboat to be $12,500. Because this purchase was converting a cash asset into another asset (the sailboat), purchasing and keeping the sailboat isn't a divestment. Tally's assets now count the $12,500 sailboat instead of the $12,000 in cash used to purchase the boat.

Example 6	Sterling transferred ownership of his RV to his parents. In payment, his parents signed over to Sterling the deed to their cottage. The FMV of the RV was the same as the FMV of the cottage. This transfer is not a divestment because Sterling received FMV for his transfer, and the cottage will be evaluated as a countable asset.

17.2.3.2 Transfers of Exempt Income or Assets

Income or assets determined to be exempt (except homestead property per 17.2.7.1 TRANSFER FOR LESS THAN FAIR MARKET VALUE) are not subject to divestment rules.

Example 7	Hattie is eligible for Medicaid and receiving long-term care services. She owns one car. Hattie transfers ownership of the car to her sister. Hattie buys another car, and now once again owns one car. She gives this car to her father. Because one car is an exempt asset, these transfers are not subject to divestment rules.

Assets can be permanently or temporarily exempt (see SECTION 16.7 LIQUID ASSETS). The transfer of temporarily exempt assets is not subject to divestment rules during the time they are exempt. This includes, but is not limited to, giving away funds from:

- Retroactive Social Security payments during the nine months after the payment was received.
- Patient liability or cost share refunds during the nine months after the refund was received.

Example 8	On February 15, Sri received a cost share refund of $5,000. This refund is exempt in February and remains exempt for nine months (March through November). Sri gives away the entire $5,000 to her mother and reports that gift to the IM agency. • If Sri gave the $5,000 to her mother between February 15 and November 30, the gift is not a divestment because it was exempt during that time. • If Sri gave the $5,000 to her mother December 1 or later, the gift is a divestment and must be evaluated.

17.2.3.3 Prenuptial Agreements

The act of signing a prenuptial agreement is not a divestment.

17.2.3.4 Payments to a Relative While the Institutionalized Person Received Room and Board

An institutionalized person paying a relative for room and board is not a divestment if the payments do not exceed fair market value, the institutionalized person is actually receiving room and board, and the institutionalized person provides a written lease that existed during the time they received room and board from the relative.

17.2.3.5 Ownership Returned Before Application

Returning the ownership or full value of a divested asset during the look back period is not divestment. This is because both the transfer and the return occurred before the request for Long Term Care services.

Example 9	Dan transfers ownership of his lake house (not homestead property) to his daughter, Cile, as a gift. Two years later, Dan and his daughter realize that this transfer affects his future eligibility for Medicaid, so Cile signs the lake house back over to Dan. Later that year, Dan applies for Long Term Care services. No divestment penalty period is imposed for the transfer of his lake house to his daughter because ownership was returned to him prior to his application.

17.2.4 Determining Fair Market Value

Fair market value FMV is an estimate of the price an asset has when sold on the open market. The FMV is based on the time an asset is transferred and not when the transfer is reported to or evaluated by the IM agency.

The FMV of real property can be established by:

- **Assessment**
  Property tax assessments or appraisals may document a property's FMV if both the IM agency and applicant or member agree that it accurately represents the FMV.
- **Statements from Realtors**
  Statements from one or more realtors giving the FMV.
- **Comparative Market Analysis**
  Prepared by a realtor, a Comparative Market Analysis estimates the FMV of the applicant or member's property by evaluating the recent sale prices of comparable properties. If the IM agency requests this document, the agency must pay for it.

The applicant or member has the right to file a fair hearing if they disagree with the FMV of the property determined by the IM agency.

Example 1	Paul applied for institutional Medicaid this month and reported transferring ownership of his house to a friend three years ago. Today, the house is worth $70,000, but three years ago, the value of the house was $54,000. The FMV is $54,000 for divestment purposes as that is the value Paul could have received if he had sold it three years ago.

17.2.5 Institutionalized Person

When determining whether a divestment is allowable or not, an institutionalized person is defined as someone who participates in a Home and Community-Based Waivers program **or** who resides in a medical institution. See details in SECTION 17.1 DIVESTMENT DEFINED.

17.2.6 Allowed Divestments

17.2.6.1 Transfers Made for a Purpose Other Than To Qualify for Medicaid

A divestment that occurred in the look back period or any time after does not affect eligibility if the person who divested can show that the divestment was not made with the intent to qualify for Medicaid.

The person must present evidence that shows the specific purpose and reason for making the transfer and establish that the resource was transferred for a purpose other than to qualify for Medicaid. Verbal assurances that they were not trying to become financially eligible for Medicaid are not sufficient. Take into consideration statements from physicians, insurance agents, insurance documents, and bank records that confirm the person's statements.

Any of the following circumstances are sufficient to establish that the institutionalized person or community spouse transferred resources without an intent to qualify for Medicaid. This list is not intended to be all-inclusive; in other situations, the person's intent must be evaluated on a case-by-case basis to determine whether a divestment occurred.

17.2.6.1.1 Sufficient Resources To Cover Five Years of Long-Term Care

A transfer by an institutionalized person or their spouse who, immediately after the transfer, still had sufficient financial resources (including long-term care insurance) to cover five years of long-term care is an allowed divestment and doesn't result in a penalty period.

For the average monthly nursing home cost of care in effect at the time of the transfer, see SECTION 39.4.3 LTC POST-ELIGIBILITY ALLOWANCES (view history pages for prior year amounts).This cost per month multiplied by 60 months provides the amount to compare to the income, assets, and insurance held by the individual immediately after the transfer.

Example 1	Lucius had a money market account. Lucius gave his nephew a graduation present worth $25,000. After the gift, Lucius' money market account still had enough funds to pay for more than five years of long-term care services. Two years later, Lucius suffered a traumatic brain injury and was institutionalized. Because the cost of specialized nursing home care is significantly greater than a regular nursing home, Lucius depletes his money market account and must apply for Institutional Medicaid after only two years. Because Lucius still had enough money to pay for five years of care at a regular nursing home after he gave the gift to his nephew, the gift is an allowed divestment and doesn't result in a penalty period.

Example 2	Pierce had an investment portfolio with assets that could pay for more than five years of long-term care services. Pierce paid for his granddaughter to take a trip to Europe. Immediately after the transfer, his investment portfolio still contained enough funds to pay for more than five years of long-term care services. Later, his investments plummeted in value due to the stock market. Before the stock market recovered, he entered a nursing home and quickly spent his remaining assets on his care. Pierce then applied for Medicaid to continue receiving his necessary long-term care services. Because Pierce still had enough assets to pay for his long-term care for five years immediately after he made the gift to his granddaughter, the gift is an allowed divestment and doesn't result in a penalty period even though the gift was in Pierce's look back period.

17.2.6.1.2 Sufficient Resources To Cover Long-Term Care for Remaining Life Expectancy

A transfer by an institutionalized person or their spouse is an allowed divestment and doesn't result in a penalty period if both of the following conditions are met:

- The institutionalized person's life expectancy was less than five years at the time of the transfer (see SECTION 39.8 LIFE EXPECTANCY TABLE).
- Immediately after the transfer, the institutionalized person still had sufficient resources (including long-term care insurance) to pay for their long-term care services for their remaining life expectancy

For the average monthly nursing home cost of care in effect at the time of the transfer, see SECTION 39.4.6 INSTITUTIONAL COST OF CARE VALUES (view history pages for prior year amounts). This cost per month multiplied by 60 months provides the amount to compare to the income, assets, and insurance held by the individual immediately after the transfer.

17.2.6.1.3 Unexpected Need

An unexpected need is evaluated by considering the institutionalized person's health and age at the time of the divestment. If the institutionalized person did not anticipate the need for long-term care services in the next five years and divested, it is an allowed divestment and doesn't result in a penalty period.

Example 3	Gerard had no health issues, was gainfully employed, and was 50 years old when he gave $50,000 to his daughter. Two years later, Gerard experienced a heart attack that caused him to need long-term care services for the rest of his life. When he gave the $50,000 to his daughter, Gerard was not expected to have set aside resources for five years of long-term care. This gift is an allowed divestment and doesn't result in a penalty period.

17.2.6.1.4 Pattern of Gifting

If the institutionalized person or their spouse had a pattern of gifting money, such as to family members or charities, prior to the look back period, similar divestments during the look back period are allowed and don't result in a penalty period if **both** of the following conditions are met:

- There is no gap in the years or occasions the gifts occurred.
- The total value of yearly gifts given as part of a pattern don't exceed 15% of the individual or couple's annual gross income in the year the gifts were given.

This allowed divestment is not limited to gifts made on traditional gift-giving occasions such as birthdays, graduations, and weddings. It can include a pattern of giving to assist family members with educational or vocational goals.

Example 4	Jacques is applying for long-term care. He has five grandchildren. Two of Jacques's grandchildren graduated during his look back period, and he gave them each $1,000 as graduation gifts. The amounts of those graduation gifts did not exceed 15% of his income in the years they were given. Jacques can also show that, prior to the look back period, he gave similar gifts to two of his other grandchildren when they graduated from high school. He has therefore shown that the gifts given to his grandchildren during the look back period were part of a "pattern of gifting." The gifts are an allowed divestment and don't result in a penalty period.

17.2.6.1.5 Resources Spent on Support of Dependent Relatives

The institutionalized person or their spouse's support of dependent relatives who were living with them at the time of the transfer is an allowed divestment and doesn't result in a penalty period when either of the following conditions are met:

- The institutionalized person or their spouse claims the relative as a dependent for IRS tax purposes.

- The institutionalized person or their spouse provides more than 50% of the cost of care and support for the dependent relative.

17.2.6.2 Trusts for Disabled Individuals

A trust for a disabled individual (sometimes called a third-party trust) is an irrevocable trust established solely for the benefit of:

- The grantor's disabled child (of any age)
- Any other disabled person who is under 65 years of age

The beneficiary must meet the definition of disability in SECTION 5.2.1 DEFINITION OF DISABILITY.

If the beneficiary is the grantor's disabled child, the grantor may transfer funds to the trust without penalty at any time, provided that the beneficiary continues to be disabled.

If the beneficiary is not the grantor's disabled child, the grantor may transfer funds to the trust without penalty until the beneficiary turns age 65, provided that the beneficiary continues to be disabled. Anything added to the trust after the beneficiary turns age 65 is a divestment (see SECTION 17.2.7.18 TRUSTS FOR DISABLED INDIVIDUALS ESTABLISHED OR FUNDED AFTER THE BENEFICIARY TURNS 65).

Note *Unlike special needs and pooled trusts, trusts for disabled individuals are not required to have any type of Medicaid "payback provision" that becomes effective upon the death of the beneficiary.*

Third-party trusts for disabled individuals in Wisconsin include, but are not limited to:

- WisPACT Trust II
- Life Navigators Community Trust I

A trust for disabled individuals can also be a freestanding irrevocable trust with a private trustee, as long as it meets the conditions above.

17.2.6.3 Divestment by the Community Spouse After Five Years

The transfer of assets (e.g., liquid, homestead, etc.) by a community spouse more than 60 months (five years) after the institutionalized person was determined eligible is an allowed divestment and doesn't result in a penalty period or impact eligibility for the institutionalized spouse.

Example 5	Chu is married and applied for Medicaid when he entered a nursing home. He was determined eligible for institutional Medicaid. Six years after Chu became eligible, Edith, Chu's community spouse, gave $30,000 to her nephew. This divestment is allowed and doesn't result in a penalty period.

Example 6	When Chu applied for institutional Medicaid, he and Edith owned a home together. After Chu became eligible, he transferred complete ownership of the home to Edith. When Chu had been eligible for institutional Medicaid for five years, Edith transferred the homestead property to someone else for less than fair market value. Chu's eligibility was not affected. This divestment is allowed and doesn't result in a penalty period. Edith applies for Long Term Care services two years later. Her transfer of the homestead property is in her look back period and must be evaluated by the agency for divestment.

17.2.6.4 Divorce or Separation Action

The division of property as part of a divorce or separation action is an allowed divestment and doesn't result in a penalty period.

17.2.6.5 Involuntary Loss of Property

The loss of property due to foreclosure or repossession is an allowed divestment and doesn't result in a penalty period.

17.2.6.6 Intent To Sell for Fair Market Value (FMV)

The disposal of an asset by an institutionalized person who can prove they intended to receive FMV, is an allowed divestment and doesn't result in a penalty period.

Example 7	Gary sells a boat and agrees to two payments that total the FMV of the boat. He cashes a check for the first payment, but the second payment is a bad check. Gary shows proof of the bad check and that he has been unable to recover the boat or the second payment. When Gary applies for Medicaid, this is an allowed divestment and doesn't result in a penalty period.

17.2.6.7 Undue Hardship Request Is Granted

Any divestment associated with an undue hardship waiver request that is approved by the IM agency per 22.4 UNDUE HARDSHIP, is an allowed divestment and doesn't result in a penalty period.

17.2.6.8 Transfer of Homestead Property

The transfer of homestead property by an institutionalized person or their spouse for less than FMV is an allowed divestment and doesn't result in a penalty period when the transfer is to:

- The institutionalized person's spouse.
- The institutionalized person's child if **at least one** of the following criteria is met:
    - The child is under the age of 21.
    - The child is blind or permanently and totally disabled.
    - The child resided in the institutionalized person's home for at least two years immediately before the institutionalized person either moved to a medical institution or began receiving HCBW services with a nursing-home level-of-care. The child provided care that allowed the institutionalized person to remain residing at home for the entire two years immediately before the person met institutional status (by moving to a medical institution or receiving HCBW services with a nursing-home level-of-care). The child's provision of care must be verified by a notarized statement from the institutionalized person's physician or someone else who has personal knowledge of the circumstances. A notarized statement from the child is not sufficient. The homestead transfer does not have to take place after the provision of care in order to be an allowed divestment.
- The institutionalized person's sibling if **both** of the following criteria are met:
    - The sibling resided in the institutionalized person's home for at least one year immediately before the institutionalized person either moved to a medical institution or began receiving HCBW services with a nursing-home level-of-care.
    - The sibling has a verified equity or ownership interest in the home. The equity or ownership interest must be verified by documentation such as a copy of the deed, land contract, or other documentation such as canceled checks or receipts.

17.2.6.9 Transfer of Assets to Spouse or Blind or Disabled Children

The transfer of any asset by an institutionalized person or their spouse for less than FMV is an allowed divestment and doesn't result in a penalty period when the transfer is to:

- A spouse

- A child of the institutionalized person or their spouse, regardless of the child's age, if the child is blind or permanently and totally disabled

17.2.6.10 Certain Payments to Relatives for Services Provided

Payments (or transfer of ownership of something of value) by an institutionalized person to a relative for services provided to the institutionalized person is an allowed divestment and doesn't result in a penalty period if either:

- The amount is **less** than 10 percent of the maximum Community Spouse asset share (CSAS) and meets both of the following:
  - The services directly benefited the institutionalized person.
  - The payment did not exceed reasonable compensation for the services provided.
- The amount is **greater** than 10 percent of the maximum Community Spouse asset share and meets all of the following:
  - The services directly benefited the institutionalized person.
  - The payment did not exceed reasonable compensation for the services provided.
  - The institutionalized person and the relative providing the service have a written, notarized agreement that meets all of the following:
    - Specifies the service being provided to the institutionalized person
    - Specifies the amount to be paid to the relative providing the services
    - Was notarized at the time the relative began to provide the services

Example 8	Kerry requests enrollment in Family Care on January 10. She paid her son $3,500 to remodel her bathroom the previous month. Her son installed new tile and fixtures, which directly benefited Kerry. Kerry provides verification from a local contractor who estimates he would have charged $4,000 for the same job. This amount is less than the maximum Community Spouse asset share at the time, so Kerry doesn't need a notarized agreement. Since the bathroom remodel directly benefited Kerry and she did not pay more than reasonable compensation for the service, the payment to her son is an allowed divestment and doesn't result in a penalty period.

Example 9	Rosemary enters a nursing home and applies for Medicaid on November 1. When asked if she has transferred any assets in the past 60 months, Rosemary indicates that she paid her daughter $30,000 in exchange for her daughter providing personal care for her over the past two years. Rosemary provides an estimate from a home care provider that a similar amount of care from one of their employees would have cost $32,000 for two years. This payment is above 10 percent of Rosemary's Community Spouse asset share, so Rosemary must provide a notarized agreement. Rosemary provides the IM agency with an agreement that is dated and notarized at the time her daughter began providing care. Rosemary provided the required notarized agreement and did not pay more than reasonable compensation for the service her daughter provided. The payment to her daughter is an allowed divestment and doesn't result in a penalty period.

17.2.6.11 Payments to Relatives While the Institutionalized Person Did Not Receive Room and Board

A payment for room and board made to relatives by an institutionalized person after they were institutionalized is an allowed divestment and doesn't result in a penalty period if the payment is only for the month immediately preceding the month that they entered the institution, the payment was for FMV, and the agreement is verified with a lease that existed during the time the institutionalized person received room and board from the relative.

17.2.6.12 Trusts Established by a Will

A trust established by a will is an allowed divestment and doesn't result in a penalty period.

17.2.6.13 Regulated Gambling Losses

Money lost from participating in gambling at a casino, racetrack, or other regulated gambling is an allowed divestment and doesn't result in a penalty period.

17.2.6.14 Irrevocable Annuities

An irrevocable annuity purchased, created, or substantively changed during the look back period or after eligibility is established may be an allowed divestment.

"Substantively changed" means action was taken that changes the course of payments made under an annuity or the treatment of the income or principal of an annuity. See SECTION 16.7.4.5 ANNUITY DISCLOSURE REQUIREMENT FOR LONG-TERM CARE for information about what types of transactions constitute a substantive change.

To be an allowed divestment, the annuity must name the Wisconsin Department of Health Services Estate Recovery Program as a **remainder beneficiary** (see SECTION 16.7.4.6 REMAINDER BENEFICIARY DESIGNATION REQUIREMENT FOR LONG-TERM CARE) and meet at least one of the following criteria:

1. The annuity was created through a **retirement account conversion.** This includes annuities created from funds in a Roth IRA, 408 IRA, or other employer-sponsored retirement plan.
2. The annuity is an **individual retirement** annuity, defined as follows:
    - It is considered an individual retirement annuity according to Sec. 408(b) of the Internal Revenue Code of 1986 (IRC), or
    - It is deemed IRA under a qualified employer plan according to Sec. 408(q) of the IRC.
3. The annuity was **purchased from a life insurance company or other commercial company** that sells annuities as part of its normal course of business, and meets **all** of the following criteria.
    a) **Non-assignable**
    The owner cannot transfer or sign over title, rights, or interested to a third party.
    b) **Currently issuing equal monthly payments**
    The annuity is currently issuing substantially equal monthly payments to the institutionalized person or spouse with no balloon, deferred, or graduated payments. Payment amounts may vary due to changes in interest rates.
    c) **Full payback (period certain)**
    The annuity is a period-certain annuity that returns the full principal and interest within the annuitant's life expectancy as listed in the Period Life Table.
    d) **Actuarially Sound**
    The number of months that annuity payments will be issued should be less than the number of months of the individual's life expectancy (multiply figure from the Period Life Table by 12).

Note: *Annuities that provide for indefinite "lifetime payments" may not return the full principal and interest within the member's life expectancy and are not actuarially sound.*

For irrevocable annuities that do not meet the above criteria, the divested amount is the full purchase price of the annuity.

Example 10	Rashon applies for HBCW. He had invested in a Roth IRA while he was working. He converted the IRA to an irrevocable annuity when he retired six months ago and named the Wisconsin Department of Health Services Estate Recovery Program as the beneficiary. Since the annuity meets the conditions in 17.2.6.14 IRREVOCABLE ANNUITIES, the purchase of the annuity is an allowed divestment.

Example 11	Bowen applied for institutional Medicaid on July 28. On July 18, his community spouse Yun used $126,500 of the couple's resources to purchase an irrevocable nine-year period certain immediate annuity from the XYZ Life Insurance Company. Yun is the annuitant. Yun was 74 years old on the date the annuity was purchased and had a life expectancy of 9.75 years (117 months). The annuity will issue regular monthly checks of $1,488.75 for a set period of nine years or 108 total months. The insurance company will pay out a total of $160,785 over the period of the annuity contract. The contract date of the annuity was July 18 and the first monthly payment was issued on August 18. The annuity names the Wisconsin Department of Health Services Estate Recovery Program as the beneficiary, was purchased from a life insurance company, will issue regular monthly payments, is currently issuing payments and will provide for full return of principal and interest during the community spouse's life expectancy. Therefore, since the annuity meets the conditions in 17.2.6.14 IRREVOCABLE ANNUITIES, the purchase of the annuity is an allowed divestment.

17.2.6.15 Promissory Notes, Loans, Land Contracts, and Mortgages

The purchase of a promissory note, loan, land contract, or mortgage purchased during the look back period or after eligibility is established is an allowed divestment when the terms meet all of the following criteria:

1. **Actuarially Sound**
   The repayment term must be within the lender's life expectancy as determined by the Office of the Chief Actuary of the Social Security Administration, found at the following link: https://www.ssa.gov/OACT/STATS/table4c6.html
   The date the promissory note, loan, land contract, or mortgage purchased during the look back period or after eligibility is established was signed is used to calculate the lender's life expectancy. The promissory note, loan, land contract, or mortgage purchased during the look back period or after eligibility is established is actuarially sound if, when it was purchased, the lender was expected to live long enough to receive payment in full during their lifetime.
2. **Equal Payments**
   The repayment terms must include these conditions:
   a) Repayments must be in equal amounts during the term of the loan.
   b) Deferrals of repayment are prohibited.
   c) Balloon payments are prohibited.

Note *Voluntary prepayments that exceed the required regular monthly payment amount ("paying extra") are not balloon payments.*

3. **No Cancellation**
   The terms must not allow cancellation of repayment of the balance upon the death of the lender.
4. **Originally Allowed Cancellation but Terms were Amended**
   If the promissory note, loan, land contract, or mortgage purchased during the look back period or after eligibility is established allows cancellation of repayment of the balance upon the death of the lender, the note can be amended to remove this language to avoid or cure a divestment penalty. If amended, it meets the criterion of not allowing the cancellation of repayment of the balance upon the death of the lender.

17.2.7 Divestments That Are Not Allowed and Result in a Penalty Period

This section discusses unallowable divestments that result in a penalty period (17.3 PENALTY PERIOD).

This section doesn't include all situations in which a divestment is not allowed. For situations not listed here, the member or applicant's intent must be evaluated individually to determine whether it is an unallowable divestment.

Prior to determining whether a transfer is an allowed divestment or not, the transfer must be evaluated as a divestment based on the following:

- 17.2.1 EXEMPTION OR DISREGARDED STATUS OF INCOME AND ASSETS
- 17.2.2 DATE OF TRANSFER
- 17.2.3 TRANSFERS THAT ARE NOT DIVESTMENT
- 17.2.4 DETERMINING FAIR MARKET VALUE
- 17.2.6 ALLOWED DIVESTMENTS

17.2.7.1 Transfer for Less Than Fair Market Value (FMV)

The transfer of ownership of a nonexempt asset for less than FMV is an unallowable divestment and results in a penalty period. Some examples of unallowable divestments are:

- Gifting money to others or making donations, even to non-profit organizations, when either:
  - The yearly gifted amount exceeds 15 percent of the individual or couple's annual gross income at the time the gift is transferred.
  - The pattern of gifting is not consistent because there is a gap in the pattern or occasions.
- Selling or giving away property, land, nonexempt vehicles, or other nonexempt assets for less than fair market value.
- Going on vacations and paying for someone other than the community spouse or a caretaker to accompany.
- Selling an exempt asset and then giving the money received to someone else.
- Transferring ownership of the exempt homestead property for less than fair market value except those listed in 17.2.6.8 TRANSFER OF HOMESTEAD PROPERTY.

17.2.7.2 Making an Asset Unavailable

An asset used in a way by a member or spouse that makes it unavailable and for which they don't receive FMV in return is an unallowable divestment and results in a penalty period.

Example 1	Mitch allowed his non-homestead property to be used as collateral for his son's business loan. Mitch's non-homestead property was considered a nonexempt asset. Because using it as collateral makes it unavailable, his use of this asset is an unallowable divestment and results in a penalty period.

17.2.7.3 Refusal To Claim

Refusal to take action to claim a portion of the estate of a deceased spouse or parent despite statutory entitlement to that portion is an unallowable divestment and results in a penalty period.

This includes situations in which the will of the institutionalized person's spouse precludes any inheritance for the institutionalized person. Under Wisconsin law, a person is entitled to a portion of their spouse's estate. If the institutionalized person does not contest their spouse's will in this situation, the inaction is an unallowable divestment and results in a penalty period if both:

- The value of the abandoned portion is clearly identified.

- There is certainty that a legal claim action will be successful as determined by the IM agency's Corporation Counsel. The IM agency may not consider the actions taken to avoid income or assets a divestment without this determination from the agency's Corporation Counsel.

17.2.7.4 Avoiding Receipt

The action of avoiding the receipt of income or assets a member is entitled to is an unallowable divestment and results in a penalty period. This type of divestment includes:

- Irrevocably waiving pension income.
- Disclaiming an inheritance.
- Not accepting or accessing injury settlements.
- Diverting tort settlements into a trust or similar device.
- Refusing to take legal action to obtain a court-ordered payment that is due to the institutionalized person, such as child support or alimony.

It is not divestment if the applicant or member fails to apply for cash benefits that they may be eligible for, such as Social Security or veterans' benefits.

17.2.7.5 Payments for Services Provided by the Relative

The transfer of income or assets to a relative as payment for care or services provided to the institutionalized person is an unallowable divestment and results in a penalty period unless it meets the criteria to be an allowed divestment per 17.2.6.10 CERTAIN PAYMENTS TO RELATIVES FOR SERVICES PROVIDED.

Example 2	Jennifer enters a nursing home on December 12 and applies for Medicaid. She reports she paid her daughter $7,000 in December for making dinner every night for two months. • The IM agency checks with a local meal service that reports reasonable compensation for each meal provided is $2. • $7,000 is less than 10% of the maximum Community Spouse asset share at the time, so Jennifer is not required to provide a notarized agreement. Jennifer's daughter provided 61 meals. Reasonable compensation for these meals was $122. Jennifer's payment to her daughter is an unallowable divestment and results in a penalty period. The divested amount for this payment is $6,878 ($7,000-$122).

17.2.7.6 Room and Board

The payment of room and board by an institutionalized person to a relative after the person has been institutionalized is an unallowable divestment and results in a penalty period unless it meets the criteria for an exception per 17.2.3.4 PAYMENTS TO A RELATIVE WHILE THE INSTITUTIONALIZED PERSON RECEIVED ROOM AND BOARD.

17.2.7.7 Community Spouse Divestment That Impacts the Institutionalized Person

The transfer of assets by a community spouse is a divestment and must be evaluated if the transfer occurred within five years of the institutionalized person becoming eligible for long-term care Medicaid.

Example 3	Ralph, a married man, went into the nursing home and applied for and was determined eligible for institutional Medicaid. One year after Ralph became eligible, Edith, Ralph's community spouse, gave $30,000 to a nephew. This is an unallowable divestment and results in a penalty period for Ralph because it occurred within the first five years of his eligibility.

17.2.7.8 Transfer of Income in the Month of Receipt

Income received and transferred in the month of receipt for less than FMV is an unallowable divestment and results in a penalty period.

Example 4	Monte resides in a nursing home. He receives a pension check of $3,000 on January 1. Monte signs the check over to his son on January 5 and doesn't receive anything in return. This is an unallowable divestment and results in a penalty period.

Unless there is reason to believe otherwise, assume that monthly household income was spent by the institutionalized person on normal costs of living.

17.2.7.9 Transfer of the Right To Receive Income

Transferring the right to receive nonexempt income by an applicant or member to someone else is a divestment and results in a penalty period.

When a person has transferred income or the right to receive income, the penalty period is calculated based on the total amount of income transferred.

Example 5	Donald transfers his rights to his $325,000 pension, which is paid in monthly payments of $4,500, to his daughter. This is an unallowable divestment and results in a penalty period. The worker must determine the divestment amount and penalty period. The divested amount is $325,000, not the $4,500 the daughter expects to receive each month from the pension.

17.2.7.10 Life Estate – Transferring the Property for Less Than FMV

The transfer of property originally owned by a life estate holder to a remainder person without receiving FMV is an unallowable divestment and results in a penalty period.

The divested amount is the FMV of the property at the time of the transfer minus the life estate value. To determine the life estate value, multiply the FMV of the property by the number from the 39.1 LIFE ESTATE AND REMAINDER INTEREST table corresponding to the age of the life estate holder at the time the property was transferred.

Example 6	Marion, age 83, gave her home to her son John, retaining a life estate. The FMV of the house at the time of the transfer was $87,000. Two years later, Marion applied for Long Term Care Medicaid. Since the transfer of her home occurred in the look back period, it is an unallowable divestment and results in a penalty period. The worker must determine the divestment amount and penalty period. The divestment amount is the FMV of the house at the time of transfer, minus the life estate value. To determine the life estate value, multiply $87,000 by .38642 (the number from 39.1 LIFE ESTATE AND REMAINDER INTEREST table that corresponds to Marion's age, 83, at the time of transfer). Marion is the life estate holder. John is the remainder person. The divested amount is $87,000 - $33,618.54 = $53,381.46.

17.2.7.11 Life Estate – Divestment by Joint Owners

The transfer of a life estate on a property by joint owners without receiving FMV based on their share is an unallowable divestment and results in a penalty period.

To determine the life estate value, or share, for each individual, divide the property's FMV by the number of life estate holders. Then calculate the life estate value by multiplying the individual share of the FMV by the number in 39.1 LIFE ESTATE AND REMAINDER INTEREST table corresponding to the individual's age at the time of the transfer or termination of the life estate.

Example 7	Marie and George transferred ownership of their home to their three sons and retained a life estate on the property. The FMV of the home at the time of the transfer was $140,000. At the time George was 82 and Marie was 68. One year later, George applied for Long Term Care Medicaid. This is an unallowable divestment and results in a penalty period. Since the transfer occurred in the look back period, the worker must determine the amount of the divestment and the penalty period. To calculate the total divestment, the worker must first determine the life estate values. $140,000 divided by 2 = $70,000 George's age at the time of the transfer was 82. Multiply 70,000 x .40295 (see 39.1 LIFE ESTATE AND REMAINDER INTEREST for this value.) = 28,206.50 Marie's age at the time of transfer was 68. Multiply 70,000 X .63610 = 44,527.00 The total life estate value for both Marie and George is $72,733.50. The divested amount is the FMV minus the life estate value ($140,000 - $72,733.50 = $67,266.50).

17.2.7.12 Life Estate – Termination and Payment of Less than FMV

The termination of a life estate by its holder before their death without receiving the FMV of the life estate is an unallowable divestment and results in a penalty period.

The divested amount is the life estate value at the time of termination minus the amount received by the life estate holder. To determine the life estate value, the FMV of the property is multiplied by the number corresponding to the age of the life estate holder at the time the life estate was terminated (see SECTION 39.1 LIFE ESTATE AND REMAINDER INTEREST).

Example 8	Marion, age 83, gave her home to her son John, retaining a life estate. The FMV of the house at the time of the transfer was $87,000. Two years later, Marion applied for Long Term Care Medicaid. Since the transfer of her home occurred in the look back period, it is an unallowable divestment and results in a penalty period. Marion served a divestment penalty period for this divestment. Marion is the life estate holder. John is the remainder person. John sold the home for the current FMV of $102,000, and Marion terminated the life estate. John took the proceeds from the home and bought another house. He did not pay Marion for the value of the life estate which is an unallowable divestment and results in a penalty period. The divestment amount is the life estate value at the time the life estate was terminated. To determine the life estate value, multiply $102,000 (value of the house at the time the life estate was terminated) by .33764. (The number is from the table in SECTION 39.1 LIFE ESTATE AND REMAINDER INTEREST corresponding to Marion's age, 86, at the time the life estate was terminated.) $102,000 X .33764 = $34,439.28 The divested amount is $34,439.28 (see SECTION 17.3.4 PENALTY PERIOD BEGIN DATE FOR MEMBERS).

Example 9	When James was 75 years old, he sold his home to his son Robert. The home was worth $95,000. Robert paid James $50,000 for the home and James retained a life estate. The life estate value is $49,541.55 (95,000 X .52149) (see SECTION 39.1 LIFE ESTATE AND REMAINDER INTEREST). Since James received both $50,000 from Robert and retained a life estate worth $49,541.55, the total value he

	received is more than the FMV of the home. Because the value he received is greater than the FMV of the home, it is not a divestment.

17.2.7.13 Life Estate – Divestment by the Remainder Person

The sale of property for FMV by a remainder person that gives the estate holder more than FMV for their life estate interest is an unallowable divestment and results in a penalty period for the remainder person.

Example 10	Fey is a remainder person and owns a property on which her mother holds a life estate. Fey sells the property for FMV but gives her mother $10,000 more than the amount she owes to buy out her mother's life estate. If Fey applies for Long Term Care Medicaid in less than 5 years, this $10,000 is considered an unallowable divestment and results in a penalty period for Fey.

17.2.7.14 Purchase of a Life Estate in the Home of Another Person

The purchase of a life estate interest in another individual's home is an unallowable divestment and results in a penalty period, unless the purchaser verifies that both:

- The purchaser resided in the home for a period of at least 12 consecutive months after the date of purchase as detailed in 17.2.7.14.2 Residence Requirement,
- The purchaser paid FMV for the life estate interest.

If the 12-month residence requirement is not met at the time of the application for Long Term Care Medicaid, the full purchase price of the life estate is used to determine the divested amount.

The divestment penalty remains in effect until one of the following, whichever is earlier:

- The end of the penalty period.
- The date the purchaser meets the residence requirement.

There is no pro-ration of the divestment penalty period for living in the home for part of the 12 months.

17.2.7.14.1 Couple Holds Life Estate in Another Person's Home

When a couple jointly holds a life estate in another person's home, the institutionalized person must reside in the home for 12 consecutive months, or their portion of the life estate value is an unallowable divestment and results in a penalty period. See 17.2.7.11 Life Estate - Divestment by Joint Owners for instructions on calculating the spouse's portion of the life estate value.

17.2.7.14.2 Residence Requirement

These four rules determine if a person has resided in the home for 12 consecutive months:

1. **Residence start date**
   The 12-month period of continuous residence may start immediately after the purchase or at any time after the purchase.
2. **Absence less than 30 days**
   Absences from the life estate home for less than 30 consecutive days do not affect the 12-month determination.

Example 11	Ralph purchases a life estate interest in his brother's home on January 5 and moves into that home on the same date. He goes to Florida on January 20 and returns to the home three weeks later, on February 10. January and February count as whole months of residence because Ralph's absence was less than 30 consecutive days.

3. **Voluntary absence of 30 days or more**
   Absences from the life estate home for 30 days or more for vacations, trips, or to stay elsewhere on a voluntary basis result in the 12-month period starting over.

Example 12	Vicki purchases a life estate interest in her sister's home on January 20 and moves into that home on the same date. On March 3, Vicki goes to Bermuda for a family vacation and returns on April 15. The consecutive months of residency string breaks because Vicki was absent from the home for 30 or more consecutive days because of vacation. Her 12-month residence clock is reset with April being her "new" first month of residence.

4. **Involuntary absence for 30 days or more**
   Absences from the life estate home for 30 days or more because of hospitalization or a rehabilitation stay do not count toward the 12 consecutive months.
   These types of absences do not result in the 12-month period starting over.
   The individual must continue residing in the home for the number of month(s) they were absent due to hospitalization or rehabilitation to achieve 12 total months of residence.
   When the individual lives in the home for at least one day of the month, it is considered a month of residence.

Example 13	Jim purchases a life estate interest in his cousin's home on January 20 and moves into that home on the same date. Jim resides in the home until April 10, at which time he is hospitalized. Jim remains in the hospital until August 5 and returns home. Jim then resides in the home from August 5 until December 24. To determine months of residence, the worker considers: ○ Jim's residence in the home for the months of January, February, March, and April count as four consecutive months. ○ May, June, and July are not included in the consecutive month count because Jim is absent from the home for those full calendar months. The absence from the home for those months doesn't cause the 12-month clock to restart because Jim's absence was the result of his hospitalization. ○ When Jim returns to the home on August 5, August counts as the fifth month of continuous residency. ○ Jim will meet the 12 months of continuous residency requirement in March, the fifteenth month of his ownership.

17.2.7.14.3 Life Estate FMV When Purchased From Another Person's Home
If the 12-month residence requirement is met by the time of the application for Long Term Care, the worker must also determine if the applicant paid FMV for the life estate.

The FMV of the life estate is determined using the age of the life estate holder and the property's FMV on the creation date of the life estate. Multiply the property's FMV by the life estate multiplier on the table in 39.1 LIFE ESTATE AND REMAINDER INTEREST. The result is the value of the property's life estate interest as of that date. If the applicant paid more than FMV for the life estate interest, it is an unallowable divestment and the difference (what was paid minus the fair market value) is the divested amount.

Example 14	Joyce, who is 75 years old, has $200,000 in her savings account. On February 3, she gives $200,000 to her son in exchange for a life estate interest in her son's home. The FMV of the son's home as of this transfer was $300,000. Joyce moved into her son's home on March 5 and resided there continuously for more than 12 consecutive months. Fifteen months after moving in, Joyce applies for Family Care, meeting the functional eligibility criteria and all other Medicaid eligibility requirements.

	To determine if a divestment occurred, the worker applies the following tests: 1. Residence Test: Joyce establishes that as of her application date for Community Waivers programs, she has resided in her son's home for more than 12 consecutive months. 2. FMV Test: Using the table in 39.1 LIFE ESTATE AND REMAINDER INTEREST, Joyce's life estate interest was worth $156,447 ($300,000 FMV of the home X .52149 based on Joyce's age) at the time of the purchase. Since Joyce paid $200,000 for a life estate that was worth $156,447, the divested amount is $43,553. Joyce is subject to a penalty period based on this amount.

17.2.7.15 Revocable Trusts

Any payment made from a revocable trust created with an institutionalized person's assets that is not to or for their benefit is an unallowable divestment and results in a penalty period.

Example 15	Ray created a revocable trust with his assets. That trust is considered an available asset to Ray. Ray goes on vacation and takes several friends, paying for their lodging. Because this payment was not for Ray's benefit, the payment is an unallowable divestment and results in a penalty period.

17.2.7.16 Irrevocable Trusts Assigned or Created During or After the Look Back Period

Irrevocable trusts assigned or created during or after the look back period may be unallowable divestments and result in a penalty period. Examples of this are:

- The institutionalized person created an irrevocable trust using his or her assets for some or all the trust. The divested amount is the total amount of the created trust.
- Sometimes revocable trusts contain a clause allowing them to become irrevocable later in the life of the trust. The divestment occurs on the date the trust changed from revocable to irrevocable. The divested amount is the amount in the trust on that date.

Example 16	In 1998, Benny created a revocable trust fund of $100,000 for his daughter. There was a clause in the trust stating the trust would become irrevocable if Benny became incompetent. He was determined incompetent on February 2, 2007, and the trust changed from revocable to irrevocable. Benny entered an institution and applied for Medicaid in July 2008. The trust changing from a revocable trust to an irrevocable trust is an unallowable divestment and results in a penalty period. He divested the total amount of the trust on February 2, 2007.

- The institutionalized person added funds to the irrevocable trust. The divested amount is the amount of the added funds.

17.2.7.17 Irrevocable Trusts Created Prior to the Look Back Period: Payments Made to Anyone Other Than Institutionalized Person

Any payment made from an irrevocable trust created with an institutionalized person's assets that is not to or for the benefit of them during or after the look back period is an unallowable divestment and results in a penalty period, even if the trust was created prior to the look back period.

17.2.7.18 Trusts for Disabled Individuals Established or Funded After the Beneficiary Turns 65

When a third party establishes or adds funds to a trust for the benefit of a disabled person (see SECTION 17.2.6.2 TRUSTS FOR DISABLED INDIVIDUALS), it is an unallowable divestment and results in a penalty period for the third party **unless** either of the following conditions are met:

- The beneficiary of the trust was disabled and under the age of 65 at the time of the transfer.

- The beneficiary is third party's disabled child.

The divested amount is the total amount of funds transferred to establish the trust.

17.2.7.19 Irrevocably Assigned Life Insurance Funded Burial Contracts With a Remaining Cash Surrender Value

Irrevocable life insurance funded burial contracts (LIFBC) must be evaluated as assets per 16.5.3.1 IRREVOCABLE ASSIGNMENT OF LIFE INSURANCE-FUNDED BURIAL CONTRACTS in order to evaluate for divestment. If the calculations of cash surrender value CSV have any amount left over, that amount is the divested amount. It is an unallowable divestment and results in a penalty period.

Example 17	Les has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value of the LIFBC is $3,000. The Statement of Funeral Goods and Services shows $3,000 for the pre-arrangement of the funeral, of which $1,300 is designated for a casket and $1,700 for funeral expenses (services and cash advances for such things as flowers and the obituary). The $1,700 funeral expense portion reduces the $1,500 burial fund exclusion (see 16.5.5 BURIAL FUNDS), and so $1,500 of this LIFBC is his exempt burial fund. The $1,300 casket doesn't reduce the burial fund exclusion (see 16.5.5 BURIAL FUNDS) and is not a countable asset because it is a purchase of a burial space. Because the LIFBC was assigned irrevocably, it must be determined if Les is receiving other goods or services at FMV for the remaining $200 designated for funeral expenses. If he is not receiving goods or services at fair market value, consider the remaining $200 a divestment.

17.2.7.20 Irrevocably Assigned Life Insurance Funded Burial Contracts With a Face Value That Exceeds the Statement of Funeral Goods and Services

If the face value of the LIFBC exceeds the total amount shown on the Statement of Funeral Goods and Services, the cash surrender value of the LIFBC must be determined at the time it was assigned. Any portion of an irrevocably assigned LIFBC for which no goods and services are received at FMV is the divested amount.

Example 18	Joey has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value and the cash value of the LIFBC is $3,200. The Statement of Funeral Goods and Services shows $3,000 for the pre-arrangement of the funeral. A divestment in the amount of $200 occurs because the cash value of the LIFBC exceeds the expenses of the pre-arrangement of the funeral.

17.2.7.21 Unregulated Gambling Losses

Money lost by making personal bets with friends, relatives, or from other unregulated gambling is an unallowable divestment and results in a penalty period.

17.2.7.22 Voluntary Foreclosure or Repossession

Voluntarily signing ownership of an asset over to the financial institution holding the loan rather than trying to sell the item is an unallowable divestment and results in a penalty period. This includes situations in which someone wants an alternative to foreclosure or repossession due to defaulting on the loan.

Example 19	Quince cannot pay his mortgage on his lake house. He must either sell the lake house to pay the mortgage or sign the property over to the mortgage holder to avoid foreclosure. Quince feels the amount of money he would get to keep after selling the lake house is not worth the time it would take to get it ready to sell, so he signs it over to the bank. This is an unallowable divestment and results in a penalty period.

17.2.7.23 Homestead Property

Homestead property, usually an exempt asset, is given special consideration in the Medicaid divestment policy. A divestment of homestead property is unallowable and results in a penalty period unless it meets the criteria under 17.2.6.8 TRANSFER OF HOMESTEAD PROPERTY.

17.2.7.24 Jointly Held Assets and Value of the Asset Is Transferred

The transfer during the look back period or anytime thereafter of an asset owned by an institutionalized person in common with another person is an unallowable divestment and results in a penalty period if either:

- The transfer reduces or eliminates the institutionalized person's ownership or control of the asset.
- The transfer limits the institutionalized person's right to sell or otherwise dispose of the asset.

Example 20	For many years Debra held a joint account with her daughter, Julie. On October 15, Julie withdraws $13,000 from it and purchases a certificate of deposit in her name. On December 3 of that year, Debra enters a nursing home and applies for Medicaid. The $13,000 withdrawal is an unallowable divestment and results in a penalty period.

17.2.7.25 Adding Someone as an Additional Owner of an Asset

The addition of another person’s name to the ownership of an institutionalized person’s asset is an unallowable divestment and results in a penalty period if either:

- The addition of another individual’s name limits the individual’s right to sell or otherwise dispose of the asset.
- The addition of another individual’s name requires the other individual agree to the sale or the disposal of the asset, where no such agreement was necessary before.

Example 21	John bought a piece of property with his nephew, Carl. Three months later John applied for a Community Waivers program. John explained that Carl refused to sell the property, making it unavailable and that it should not count as an asset. The purchase of the property was during the look back period and the nephew’s refusal to make it available through liquidation is a divestment. John is subject to a penalty period starting from the date he requested Long Term Care Medicaid if he was otherwise eligible.

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17.3 Penalty Period

17.3.1 Penalty Period Introduction

If an unallowable divestment occurs, the institutionalized person is ineligible for Medicaid coverage of long-term care services for a time period known as the penalty period.

The length of the penalty period is based on the value of the divestment. Once the penalty period starts, it runs uninterrupted until it expires, even if the person is no longer in a long-term care facility or "otherwise eligible" for long-term care Medicaid. If an undue hardship waiver is requested and granted, then the penalty period will be waived per 22.4 UNDUE HARDSHIP.

Penalty periods only impact someone's eligibility for LTC services and do not affect an applicant or member's eligibility for Medicaid card services (21.4.1.1 MEDICAID CARD SERVICES) when they are residing in a medical institution. An individual ineligible for Community Waivers programs due to a divestment may still be eligible for other types of Medicaid that do not cover long-term care services.

17.3.1.1 Institutions and the Penalty Period

During the penalty period, Medicaid doesn't pay the institutionalized person's daily care rate in the nursing home, although they are still eligible for Medicaid card services (see 21.4.1.1 MEDICAID CARD SERVICES).

Example 1:	Martha resides in a nursing home and applies for institutional Medicaid. Martha is ineligible for Medicaid to pay for her long-term care services in the nursing home for five months due to a divestment. She is eligible for institutional Medicaid, but Medicaid will only pay for her card services during the five-month penalty period. Once the penalty period is over, Martha's institutional Medicaid will pay for her long-term care services.

17.3.1.2 Community Waivers Programs and the Penalty Period

A person is not eligible to enroll in Community Waivers programs during a divestment penalty period. However, a person who is ineligible for Community Waivers programs due to a divestment penalty may be eligible for other programs during the penalty period. They cannot be eligible for Waivers Medicaid or Institutional Medicaid, but they can become eligible for a form of Medicaid not based on receipt of long-term care services, such as SSI-related Medicaid or MAPP, if they meet the eligibility requirements for that program.

Example 2:	Joe applies for Community Waivers programs through Waivers Medicaid and is determined ineligible for nine months due to a divestment. The IM agency determines that Joe can become eligible for SSI-Related Medicaid by meeting a deductible. Even if Joe meets the deductible and becomes eligible for Medicaid, he may not enroll in any Community Waivers programs until his nine-month divestment penalty period ends.

17.3.2 Calculating the Penalty Period

The divestment penalty period is calculated in days by dividing the divested amount by the average daily nursing home private pay rate in effect at the time of the application (see SECTION 39.4.6 INSTITUTIONAL COST OF CARE VALUES). This rate is updated annually on January 1.

Example 3:	Jeff moved to a nursing home and applied for Medicaid on February 1, 2025. One month earlier, Jeff transferred $18,500 in cash to his son, and it is determined to be a divestment that is not allowed resulting in a penalty period. At the time of application, Jeff is otherwise eligible for LTC Medicaid. Since $18,500 divided by the average daily nursing home private pay rate at the time Jeff applied ($340.99) equals 54.25 days, Jeff will have a divestment penalty period of 54 days.

For divestments that occur after long term care eligibility is established or subsequent divestments that occur when a person is already in a divestment penalty period, the additional penalty period is calculated using the average daily nursing home private pay rate in effect at the time the divestment penalty period is being determined (see SECTION 17.3.6 DIVESTMENTS DURING A PENALTY PERIOD).

17.3.2.1 Multiple Divestments During the Look Back Period

Multiple divestments that occur during the look back period must be calculated by adding the individual divestment amounts together to get the total divestment amount. The total is used to calculate the divestment penalty period.

To cure multiple divestments that occurred during the look back period, the applicant must receive the full amount of the total divestment that occurred during the look back period.

17.3.2.2 Multiple Divestments Occurring in Different Months

Multiple divestments that occur while the member is eligible for Medicaid are considered separate divestments unless they occur in the same month.

17.3.2.3 Multiple Divestments Occurring in the Same Month

Multiple divestments that occur in the same month while the member is eligible for Medicaid are added together to calculate the total amount.

17.3.3 Penalty Period Begin Date for Applicants

The penalty period for an applicant begins on the date that meets all of the following:

- The person applies for institutional Medicaid or requests one of the Community Waivers programs (Family Care, Family Care Partnership, PACE, or IRIS).
- The person enters an institution or meets the appropriate LOC and functional screen criteria.
- The person meets all other Medicaid nonfinancial and financial eligibility requirements.

An enrollment date is not required for Community Waivers programs applicants to meet the criteria.

Note: *An applicant who divests excess assets during the application period, including any backdated months, is ineligible due to excess assets until the month that they divested the assets. The divestment penalty period as well as the potential eligibility for card services begins on the date of the divestment.*

Example 4:	Jeff requested enrollment in Family Care and was determined functionally eligible on March 1. He applied for Waiver Medicaid on March 5. One month earlier, Jeff had transferred $18,500 in cash to his son, which is a divestment. At the time of application, Jeff is otherwise eligible for Waiver Medicaid. Jeff's penalty period begins on March 5, the date by which he requested Family Care, met the functional screen criteria, and applied for Waiver Medicaid.

Example 5:	Joan entered a nursing home on March 1 and applied for Medicaid on March 4. On her application, Joan reported that, in the previous month, she gave her adult daughter a $100,000 cash gift, which is a divestment. All requested verification is received on March 27, and Joan meets all other Medicaid eligibility requirements. Joan's divestment penalty period begins on March 1.

Example 6:	John applied for a Community Waivers program on April 7. He indicated on his application that he gave his adult son a $60,000 cash gift three months earlier, which is a divestment. As of April 7, John meets the community waiver functional screen criteria and all other Medicaid eligibility requirements. He doesn't have an enrollment date at this time. John's penalty period begins on April 7.

Example 7:	Jeff entered a nursing home on March 1. He applied for Medicaid on April 15 and requested that his eligibility be backdated to March 1. John meets all other Medicaid eligibility requirements in March and April. However, he reported transferring $100,000 in stocks and bonds to his brother in February, which is a divestment. John's divestment penalty period begins on March 1, which is the date he was institutionalized, applied for Medicaid LTC, and was otherwise eligible for Medicaid except for the imposition of the divestment penalty.

Example 8:	Sam entered a nursing home on October 1. He applied for Medicaid on January 3 and requested that his eligibility be backdated to October 1. He reported giving away an inheritance on November 23 which is a divestment. All necessary verification is received on January 17. Sam is denied Medicaid for being over assets in October and approved and eligible as of November 1. Sam's divestment penalty period would begin on November 23, which is the date that he was institutionalized, applied for Medicaid, and was otherwise eligible for Medicaid except for the imposition of the divestment penalty. Sam will receive Medicaid card services during his penalty period.

17.3.4 Penalty Period Begin Date for Members

An enrolled member's penalty period begins on the first of the month after they are given timely notice (see SECTION 23.1.4 TIMELY NOTICE OF ADVERSE ACTION).

Example 9:	Joe was determined eligible for institutional Medicaid effective March 1. On July 2, he sold his home and gave the proceeds to his son. Joe reported the divestment on July 12. The worker entered the divestment in CARES on July 16, which impacted Joe's institutional Medicaid effective August 1. The penalty period begins August 1, the date the worker was able to give timely notice of the penalty period. If the worker had not entered the divestment in CARES until after adverse action in July, the penalty period begin date would be September 1, the first day his LTC services could be impacted with timely notice. Joe will receive only Medicaid card services during the divestment penalty period.

17.3.5 Curing a Divestment

Curing a divestment penalty period occurs when the entire divested resource or equivalent value is returned to the individual. The individual's eligibility for LTC services must be redetermined back to the start date of the previously imposed penalty period. If they met all other eligibility requirements during the retroactive period, the individual must be certified for Medicaid-covered LTC services. The returned assets are counted as available assets at the beginning of the month they were returned.

Example 10:	Scott gave a CD to his adult son on March 10. On October 1, Scott entered a nursing home and applied for Medicaid. Based on the value of the CD that he divested to his son, Scott was ineligible for Medicaid coverage of the cost of his institutional care for 38 days. The divestment penalty period started on October 1 and ended on November 7. Scott was certified for institutional Medicaid on November 8. Scott's son had already cashed in the CD, but, on December 5, he returned the entire value in cash to Scott. Since the equivalent value of Scott's previously transferred asset was returned, Scott is now potentially eligible for institutional Medicaid services for the period of October 1 through November 7. Scott met all other eligibility requirements during that retroactive period, and he is certified for institutional Medicaid services for that same period. The cash that Scott received from his son and

	reported on December 5 is counted as an asset beginning in December. Because the value of the cash exceeds the program asset limit, it would make him ineligible for Medicaid, effective January 1, unless his assets are reduced to meet the asset limit prior to January 1.

17.3.5.1 Curing Multiple Divestments Occurring in the Look Back Period

An applicant or member can cure their divestment period penalty that resulted from multiple divestments during the look back period by showing that all the assets divested during the look back period, or amounts equal to their value, have been returned.

17.3.5.2 Curing Multiple Divestments Occurring in the Same Month

After eligibility is established, a member can cure their unallowable divestments that occurred in the same month by receiving the full amount of the divestments.

17.3.5.3 No Partial Cure

The total value of the divested amount must be given to the institutionalized person to cure the divestment. A penalty period is not recalculated based on a partial repayment.

Example 11:	Jerry divested cash to his daughter prior to applying for institutional Medicaid. He has a 373-day penalty period. His daughter returned half of the divested amount. Jerry's penalty period remains 373 days. If Jerry's daughter returned the entire amount, the divestment would be cured, and Jerry would no longer have a penalty period.

17.3.6 Divestments During a Penalty Period

Divestments that occur during the penalty period incur an additional penalty period. This calculation is based on the average daily nursing home private pay rate in effect when the additional divestment penalty period is determined. The new penalty period doesn't begin until the existing period(s) expires. The penalty periods cannot run concurrently.

Example 12:	Jeff has a penalty period that lasts until July 25. In May, he transferred a large amount of cash to friends. Based on the value of this divestment and the average daily nursing home private pay rate currently in effect, Jeff's additional divestment penalty period is 154 days. The new divestment period of 154 days begins July 26, the day after the original divestment penalty period has ended.

17.3.7 Changing Divestment Penalty Periods

There are circumstances that require updates to existing penalty periods. These include shortening a penalty period based on a fair hearing decision, curing divestment penalty periods, and other changes. See Process Help, Section 11.6.6 Changing Divestment Periods after Confirmation for information about changing divestment penalty periods.

17.3.8 Both Spouses Institutionalized

If the community spouse makes a divestment resulting in a penalty period for the institutionalized person (17.2.7.7 COMMUNITY SPOUSE DIVESTMENT THAT IMPACTS THE INSTITUTIONALIZED PERSON), split the remaining penalty period between the spouses at the time the community spouse enters an institution, applies for Medicaid, and is found otherwise eligible.

Example 13:	Joe is in a nursing home. Joe's wife, Mildred, is his community spouse. Joe inherited $84,000 and immediately transferred it to Mildred. Mildred gave it to her church. This divestment resulted in a penalty period for Joe. Now Mildred is entering the nursing home and applying for Medicaid. The time that remains on Joe's penalty period must be divided between the spouses.

The penalty period must be determined as follows:

1. Find the divested amount used to calculate the original penalty period.
2. Calculate how much of the divested amount remains to be satisfied by:
    a) Multiplying the average nursing home private pay rate used to calculate the original divestment penalty period times the number of days already served of the penalty period.
    b) Subtracting the result from the original divested amount.
3. Calculate the penalty period for the remaining divested amount by using the current average nursing home private pay rate.
4. Divide the new penalty period equally between the two spouses.

Refer to Process Help, Section 11.6.6.5 Spousal Split.

If either spouse leaves the institution or dies, add the remainder of his or her penalty period to the other spouse's penalty period.

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18 Spousal Impoverishment

18.1 Spousal Impoverishment Introduction

Spousal impoverishment is a Medicaid policy that allows persons to retain assets and income that are above the regular Medicaid financial limits. Spousal impoverishment policy applies to institutionalized persons. For purposes of spousal impoverishment, an institutionalized person means someone who:

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

Note: *An individual is not considered "institutionalized" for purposes of spousal impoverishment if he or she has resided in a medical institution for 30 or more consecutive days, is likely to reside in a medical institution for 30 or more consecutive days, or is residing in an IMD, and the sole purpose for residing in the medical institution or IMD is to receive residential substance use disorder treatment.*

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

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

As long as the community spouse is not an institutionalized person residing in an institution, his or her living arrangement can have no effect on his or her asset share (see SECTION 18.4.3. CALCULATE THE COMMUNITY SPOUSE ASSET SHARE) or income allocation (see SECTION 18.6.2 COMMUNITY SPOUSE INCOME ALLOCATION).

Example 1:	Joe is an institutionalized person living in a nursing home. His wife, Carla, is receiving HCBW services in a CBRF. Because Carla is not residing in a medical institution, Joe's eligibility is determined using Spousal Impoverishment rules.

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

See SECTION 2.5.3 SPOUSAL IMPOVERISHMENT MEDICAID SIGNATURES for application and review signature requirements.

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18.3 Spousal Impoverishment Requirements

All institutionalized persons applying for Medicaid must meet the same nonfinancial requirements. Spousal impoverishment policy introduces no changes in Medicaid nonfinancial tests.

On the financial side:

1. **Assets.** The assets of both the institutionalized person and his or her community spouse are counted in the asset test.
2. **Income.** The income limit is the same as that for non-spousal impoverishment institutionalized persons. But, after the institutionalized person becomes eligible, he or she is allowed to allocate some of his or her income back to his or her community spouse and family.

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18.4 Spousal Impoverishment Assets

18.4.1 Spousal Impoverishment Assets Introduction

Count the combined assets of the institutionalized person and his or her community spouse. (**Note:** Disregard prenuptial agreements. They have no effect on spousal impoverishment determinations.) Add together all countable, available assets (see SECTION 16.1 ASSETS INTRODUCTION) the couple owns.

Do not count the following assets:

- Homestead property. If the institutionalized person and the community spouse each own home property and meet the criteria in SECTION 16.8.1.3 EXEMPT HOME PROPERTY, exempt the institutionalized person's home but not the community spouse's home.

Example 1	One spouse is in a nursing home, the other lives in the community. They have lived apart for 10 years. The institutionalized person owns a home and intends to return. The community spouse owns a different home. The home that each spouse owns is the principal residence of that spouse. The institutionalized person's home is an exempt asset. The community spouse's home is not exempt.

- If they both own homes and the institutionalized person's home is not exempt, count the institutionalized person's home but exempt the spouse's home. Both homes cannot be exempt simultaneously.
- One vehicle, regardless of value or purpose. If the AG has more than one vehicle, completely disregard the vehicle with the highest equity value, regardless of purpose. Then, for the remaining vehicles, follow the EBD rules for vehicles (see SECTION 16.7.9 VEHICLES [AUTOMOBILES]).

Example 2	Howard is applying for benefits. Howard is in an institution and Marianne is his community spouse. They own a boat with an equity value of $10,000 and an automobile with an equity value of $7,000. Because the boat has a higher equity value, it is disregarded. The automobile does not meet the criteria for exemption and so is a counted asset; count $7,000 in the asset assessment and the asset determination.

- All assets designated for burial purposes. This includes burial assets owned by the applicant/member and/or the community spouse for a child(ren).
- Any unreasonable amount should be supported by documentation of the burial-related costs or contract.

  Do not allow applicants and members to simply state that they are setting aside an unreasonable amount of cash (e.g., $1,000,000) as their burial fund for unspecified funeral expenses. If they can document the funeral expense that they expect to incur, it can be totally exempt regardless of its cost.

  For example, ask the member to document that he or she has arranged to purchase a $100,000 casket or that a funeral home will provide them with a $75,000 funeral along with an itemized listing of the funeral goods and services that will be provided.

  This differs from EBD burial policies for non-institutionalized persons and institutionalized persons without a community spouse (see SECTION 16.5 BURIAL ASSETS).

- Household goods and personal items, regardless of their value.
- All assets not counted in determining EBD Medicaid eligibility.
- IRA and work-related retirement benefit plans or individually-owned retirement accounts, such as IRAs or Keoghs of an ineligible community spouse (see SECTION 16.7.20 RETIREMENT BENEFITS).

18.4.2 Asset Assessment

The IM agency must make an assessment of the total countable assets of the couple at one of the following, whichever is earlier:

- The beginning of the person's first continuous period of institutionalization of 30 days or more
- The date the person was first determined functionally eligible for HCBWs

Complete an asset assessment when a person applies, even if he or she had one done in the past, to get the most current asset share.

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

The IM agency should inform the person for whom an assessment is being made what documentation is required. He or she must document ownership interest in and the value of any available assets the couple had at the time of his or her first period of continuous institutionalization. The same documentation procedures are used as when an application is filed (see SECTION 20.1 VERIFICATION INTRODUCTION).

18.4.3 Calculate the Community Spouse Asset Share

The community spouse asset share is the amount of countable assets greater than $2,000 that the community spouse, the institutionalized person, or both, can possess at the time the institutionalized person applies for Medicaid.

IF the total countable assets of the couple are:	**Then the community spouse asset share is:**
$315,840 or more	$157,920
Less than $315,840 but greater than $100,000	½ of the total countable assets of the couple
$100,000 or less	$50,000

18.4.4 Asset Test

When an institutionalized person applies for Medicaid, compare the total countable assets of the couple to $2,000 plus the greater of one of the following:

- Community spouse asset share.
- An amount ordered by a court or fair hearing.

If assets at the time of application are equal to or less than this amount, the institutionalized person is eligible. If they are more, the institutionalized person is not eligible.

18.4.5 Undue Hardship

An institutionalized person will not be denied Medicaid if the IM agency determines that the ineligibility caused by excess assets creates undue hardship for him or her (see SECTION 22.4 UNDUE HARDSHIP for more information).

18.4.6 Asset Transfer

After the institutionalized person is found eligible, he or she may transfer assets to the community spouse. The maximum amount he or she can transfer is the community spouse asset share (or a greater amount ordered by a court or a fair hearing). If the community spouse already has some assets, the institutionalized person can transfer assets which, when added to the community spouse's assets, equal the community spouse asset share (or an amount ordered by a court or a fair hearing).

He or she is not allowed to transfer assets for less than fair market value to anyone other than the community spouse.

18.4.6.1 Asset Transfer Period

The institutionalized spouse must transfer the assets to the community spouse by the next regularly scheduled review (12 months). If their assets are above $2,000 on the date of the next scheduled review, they will be determined ineligible. They will remain ineligible until their assets no longer exceed the $2,000 Medicaid asset limit.

Example 3	Robert was first institutionalized September 2013. Lucinda, Robert's wife, remained in the community. The couple passed the joint asset test and Robert was determined eligible in September 2013. The couple's total combined assets were $42,000, $32,000 of which were owned solely by Robert. Robert had until the next scheduled review (August 2014) to get his total assets under the $2,000 Medicaid asset limit. By August 2014, Robert had only transferred $23,000 to Lucinda. Robert still had $9,000 in assets. Robert became ineligible September 2014 and will remain ineligible as long as his assets are over $2,000.

18.4.6.1.1 Leaves Institution or Becomes Ineligible During the 12-Month Transfer Period

If the institutionalized spouse **during** the 12-month transfer period:

1. Leaves the institution for 30 days or more **and** becomes institutionalized again, **or**
2. Becomes ineligible for Medicaid **and** then becomes eligible for Medicaid once again, **or**
3. Changes from Group B/B+ waivers to Group A waivers then becomes eligible once again for Group B/B+ waivers all within the 12-month transfer period.

The time allowed to transfer assets does not start over again.

If the individual left the institution or became ineligible during the 12-month transfer period, without regaining eligibility during the 12-month transfer period, and reapplies for long-term care **after** the 12-month transfer period has ended, he/she is eligible for a new transfer period.

Example 4	Daniel is in a nursing home, while Susan, his wife is in the community. Daniel is found eligible for Medicaid beginning March 28, 2020 (the date of institutionalization), starting the 12-month asset transfer period. In May 2020, Daniel is discharged from the nursing home and his Medicaid eligibility ends. In July 2020, Daniel returns to the nursing home. Because Daniel became institutionalized again within the 12-month transfer period, the transfer period does not start over.

Example 5	Betsy was admitted to the nursing home on April 14, 2018 and applied for Medicaid on June 6, requesting a two-month backdate. Nicholas, her husband, remains in the community. Betsy was discharged from the nursing home on May 7, 2019, the 12th month of her asset transfer period. Betsy returns to the nursing home on March 6, 2020 and reapplies for Medicaid on March 13. Because Betsy

	returned to the nursing home after her 12-month transfer period, she is allowed a new asset transfer period.

18.4.6.1.2 Change in Marital Status During the 12-Month Transfer Period

If the community spouse passes away or is no longer married to the institutionalized person, then spousal impoverishment rules no longer apply and the institutionalized person is subject to the $2,000 asset limit.

Example 6	Sue was institutionalized in July 2017 and was married to Tom, who resided in the community. Sue was eligible for Medicaid in July 2017 and had until June 2018 to get under the $2,000 asset limit. On September 20, 2017, Sue reports that Tom passed away. Because spousal impoverishment rules no longer apply for ongoing eligibility, Sue would be subjected to the $2,000 asset limit beginning November 2017.

18.4.6.2 Institutionalized Spouse Is Eligible After the 12-Month Transfer Period

18.4.6.2.1 Leaves Institution for 30 or More Days Then Is Reinstitutionalized

If the institutionalized spouse remains in the institution and Medicaid-eligible after the expiration of the 12-month transfer period but then leaves the institution for 30 days or more and subsequently becomes institutionalized once again for 30 days or more, he or she would be subject to all spousal impoverishment rules upon becoming reinstitutionalized. This includes all of the following:

- An asset assessment (see SECTION 18.4.2 ASSET ASSESSMENT) would be required for the purpose of determining the community spouse asset share.
- The couple would have to once again pass a joint asset test.
- The institutionalized spouse would receive another 12-month period to transfer all of his or her assets in excess of $2,000 to his or her community spouse.

Example 7	Peter was institutionalized and determined Medicaid eligible in March of 2002. Janice, Peter's wife, remained in the community. In February 2003, Peter's assets were below $2,000. Peter remained Medicaid eligible and institutionalized through May 2003. In June 2003, Peter left the nursing home and joined Janice in their home in the community. His Medicaid eligibility ended on June 30, 2003. In August 2003, Peter inherited $100,000. In September 2003, Peter's condition worsened and he was institutionalized again and applied for Medicaid. All spousal impoverishment rules would be applied to Peter's September 2003 application. His eligibility would be based on a joint asset test, and, if eligible, he would have 12 months to transfer assets in his name that exceed $2,000 to his wife.

18.4.6.2.2 Loses Medicaid Eligibility but Remains Institutionalized

If the institutionalized spouse remains in the institution and remains Medicaid eligible after the 12-month transfer period but subsequently becomes ineligible and remains institutionalized, spousal impoverishment asset rules would not be applicable if he or she should reapply.

If the institutionalized spouse reapplies for Medicaid, his or her asset limit would be $2,000 and the community spouse's assets would not be counted.

If eligible, the institutionalized spouse would still be allowed to allocate some of his or her income to the community spouse.

Example 8	Gregory was institutionalized in December 2007. Gregory and his wife, Marcia, who remained in the community, passed the joint asset test. Gregory was found eligible and had until November 2008 to get under the $2,000 asset limit. By November 2008, Greg had transferred enough assets to Marcia to get under the asset limit.

	In March 2009, while Gregory remained institutionalized, he refused to sign over to Medicaid a health insurance payment check. His Medicaid eligibility was discontinued March 31, 2009, for failure to cooperate with TPL requirements. Greg has never left the institution and now reapplies for Medicaid on June 3, 2009. Since Greg did not leave the institution for 30 days or more since his original Medicaid spousal impoverishment application was approved (December 2007), the assets of his community spouse are not counted when determining eligibility for the application filed June 2009. Greg's asset limit for this application is $2,000.

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18.5 Spousal Impoverishment Income

The income limit is the same as for institutionalized persons who do not have a community spouse (see Section 39.4 EBD Assets and Income Tables).

18.5.1 Nontrust Income

Count non-trust income as belonging to the person who receives the payment.

1. If the payment is received in both spouses' names, count half for each.
2. If the payment does not specify the payee, count half for each spouse.
3. If the payment is shared with others, count amounts equal to each spouse's proportionate share.

Count as income to the institutionalized spouse any income that the community spouse actually makes available to him or her, whether voluntarily or under a court order.

18.5.2 Trust Income

Follow the specific terms of the trust as to which spouse is the payee and what percentage of the income belongs to him or her. If the percentage is unspecified, consider half the payment to belong to each spouse. If any trust income goes to dependent family members, attribute it to whom it is assigned; if it is not assigned to a specific family member, divide it equally between those who receive it.

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18.6 Spousal Impoverishment Income Allocation

18.6.1 Spousal Impoverishment Income Allocation Introduction

After an institutionalized person is found eligible, they may allocate some of their income to the community spouse and any dependent family members who live with the community spouse.

Dependent family members are defined as follows:

- Children under the age of 18, of either parent
- Children of any age, of either parent, who are claimed as tax dependents under the Internal Revenue Code (IRC)
- Siblings of either the institutionalized person or the community spouse who are claimed as tax dependents under the IRC
- Parents of either the institutionalized person or the community spouse who are claimed as tax dependents under the IRC

Income that is allocated to the community spouse must be given (or made available) to the community spouse each month for it to be allowed as a post-eligibility income deduction for the institutionalized person. Income that is allocated to a dependent family member does not have to be given to the dependent family member.

Note *Income allocated to the community spouse is countable income for the community spouse if they apply for health care.*

The institutionalized person must decide how much income to allocate to their community spouse. They may allocate an amount that brings the community spouse's income up to the maximum allocation (see SECTION 18.6.2 COMMUNITY SPOUSE INCOME ALLOCATION) or they may choose to allocate a lesser amount.

Since the institutionalized person may have medical costs that are not covered by Medicaid, they may need to keep some income rather than allocating the maximum allowable amount.

Example 1	Finella is in a nursing home and open for Institutional Medicaid. Her husband Teddy lives in the community. Finella's monthly income is $500. She incurs $80 in noncovered medical expenses each month. She decides to give $365 to Teddy, keeping only her $55 personal needs allowance (see SECTION 39.4.3 LTC POST-ELIGIBILITY ALLOWANCES) and $80 to pay for her medical expenses (see SECTION 27.7.7 MEDICAL OR REMEDIAL EXPENSES AND PAYMENTS FOR NONCOVERED SERVICES). These post-eligibility income deductions and allowances reduce her nursing home patient liability amount to $0.

18.6.2 Community Spouse Income Allocation

The maximum amount of income that the institutionalized spouse can allocate to their community spouse is determined as follows:

1. Find the **Community Spouse Lower Income Allocation Limit**. This amount is updated annually and can be found in SECTION 39.4.4 LTC SPOUSAL IMPOVERISHMENT POST-ELIGIBILITY ALLOWANCES AND COMMUNITY SPOUSE ASSET SHARE.
2. Determine the **excess shelter allowance**, calculated as the community spouse's shelter expenses that are in excess of the Shelter Base Amount. The Shelter Base Amount is updated annually and can be found in SECTION 39.4.4 LTC SPOUSAL IMPOVERISHMENT POST-ELIGIBILITY ALLOWANCES AND COMMUNITY SPOUSE ASSET SHARE.

Note: *Do not grant the excess shelter allowance for HCBW cases where the institutionalized person lives together with the community spouse.*

3. Allowable shelter expenses include:
    a) Rent
    b) Mortgage principal and interest
    c) Taxes (including special assessments) and homeowner's or renter's insurance for the principal place of residence.
    d) Any required maintenance fee if the community spouse lives in a condominium or cooperative.
    e) The **standard utility allowance** established under FoodShare. See the FoodShare Wisconsin Policy Handbook, Section 8.1.3 Deductions for the current standard utility allowance amounts.

If the community spouse pays:	**Add:**
Heat and utilities	HSUA (Heating Standard Utility Allowance)
Utilities only	LUA (Limited Utility Allowance)
Telephone only	PUA (Phone Utility Allowance)

    f) If the community spouse lives in a condominium or cooperative where the maintenance fee includes utility expenses, reduce the standard utility allowance by the amount of utility expenses included in the maintenance fee.

4. Determine the lesser of:
    a) The sum of the Community Spouse Lower Income Allocation Limit (Step 1) and the excess shelter allowance (Step 2), if applicable.
    b) The Community Spouse Income Allocation Maximum. This amount is updated annually and can be found in SECTION 39.4.4 LTC SPOUSAL IMPOVERISHMENT POST-ELIGIBILITY ALLOWANCES AND COMMUNITY SPOUSE ASSET SHARE.

5. Subtract the community spouse's monthly gross income from the amount determined in Step 3. Use the EBD rules for countable income, but do not give earned income, unearned income, or work-related deductions.

The result is the maximum amount of income that the institutionalized person can give to their community spouse. They may give an amount less than this, but not more unless ordered by a fair hearing decision or a court order.

A court or fair hearing can increase the community spouse income allocation if it determines the spouse is not able to provide for his or her necessary and basic maintenance needs with the amount allocated.

18.6.3 Dependent Family Member Income Allowance

The institutionalized person can allocate a certain amount of their income to dependent family members (as defined in SECTION 18.6.1 SPOUSAL IMPOVERISHMENT INCOME ALLOCATION INTRODUCTION) who live with the community spouse.

Each dependent family member's income allowance is calculated as follows:

1. Subtract the dependent family member's actual income from the Dependent Family Member Income Allowance Standard. This amount is updated annually and can be found in SECTION 39.4.4

LTC SPOUSAL IMPOVERISHMENT POST-ELIGIBILITY ALLOWANCES AND COMMUNITY SPOUSE ASSET SHARE. Use the EBD rules for countable income, but do not give earned income, unearned income, or work-related deductions.

2. Divide the result by three.

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18.7 Reserved

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18.8 Spousal Impoverishment Notices

After the institutionalized person is determined eligible for Institutional Medicaid or HCBW Medicaid, the following notices are sent to both spouses:

1. Institutional Medicaid Income Allocation (F-10097) or Community-Based Long-Term Care Services Medicaid Income Allocation (F-10097A). This notice contains the amount of income allocated to the community spouse and the amount of the institutionalized person's cost of care contribution. This notice is must also sent any time there is a change in the allocated amount.
2. Medicaid Member Asset Allocation (F-10098). This notice specifies the amount of assets the member must transfer to the community spouse in order to retain Medicaid eligibility. It also specifies the date by which the transfer must be made.

Note: *These notices are not sent for Group A eligible Waiver cases.*

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18.9 Community Spouse's Medicaid Application

Count assets and income allocated and transferred to the community spouse by the institutionalized person when determining the community spouse's Medicaid eligibility. Beyond these, count only the assets and income belonging to the community spouse.

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18.10 Dual Spousal Impoverishment Cases

When both spouses are applying for community waivers, Family Care, or PACE/Partnership, and neither spouse resides in a medical institution, both eligibility determinations are done using spousal impoverishment policies.

The eligibility determination for both spouses is done on one case if the couple resides together.

Since income allocated to a community spouse is counted as income for that spouse, the couple should decide which spouse should allocate to the other spouse and how much to allocate.

One spouse may have more income or less expenses, so he or she could allocate to the other spouse with less income or more expenses. Each case will have to be assessed individually and the income allocation adjusted to meet the needs of the couple.

For instructions on entering income allocated paid out and allocated income received, see Process Help Section 11.5.3.1 Income Allocation in Dual Spouse Cases.

Asset Eligibility for Dual Spousal Cases

When both spouses are applying for Waivers and neither spouse resides in a medical institution, an asset assessment should be done for both spouses using the couple's combined assets. Both are tested using the Community Spouse Asset Share calculated with the asset assessment plus $2,000.

Asset Transfer Period

Both spouses have 12 months from the time of application to decrease their countable assets to less than $2,000. The assets can be transferred from one spouse to the other and used to purchase other exempt assets such as burial assets. The assets can also be used on other necessary living expenses for either spouse. Both spouses must have their countable assets below $2,000 at the next regularly scheduled renewal to remain eligible.

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Program Admin. (Chs. 19 - 23)

19 Access Rights and Releasing Information

19.1 Applicant and Member Access Rights

19.1.1 Introduction

An applicant or member has the right to see their entire case record to verify that its content is accurate with respect to their statements and that documentation of facts about them from other sources is correct.

When an applicant or member requests access to the record for reasons not related to preparation for a fair hearing, the agency does not have to show them the entire record. The agency can show the applicant or member only the parts of the record relevant to the request.

19.1.2 Fair Hearings

Agencies cannot withhold any part of the record from the applicant or member when they are preparing for a fair hearing (see SECTION 23.2.3 PRIOR TO THE HEARING).

19.1.3 Sensitive Medical Information

The Confidential Information Release Authorization to Agency (F-82009) form does not promise the medical reporting source that information won't be revealed to the person if they request to see it. In most cases, the applicant or member has direct access to the information.

Agencies may determine, in some cases, that the requested medical information is of a "sensitive" nature and that its release directly to the applicant or member may not be in their best interest. When this occurs, the agency can request that the applicant or member name, in writing, a representative. This representative may be a physician or other responsible person (for example, a clergyman or attorney). The agency will release the requested information to the representative with the instruction that they review it and inform the applicant or member of the content at the representative's discretion.

Agencies must retain the applicant or member’s authorization to release this information to their representative in the case record.

19.1.4 Access by Someone Else

An applicant or member may authorize the income maintenance (IM) agency to grant access to their case record to another person or organization. This authorized entity has the same right of access to the case record as that of the applicant or member or to the extent that the applicant or member indicates on the release of information form, if applicable.

This authorized entity can be an attorney but does not need to be an attorney. The applicant or member does not need to complete a release of information form to authorize their attorney to access their case record. The agency can request proof of the attorney's licensure if the person's statement that they are an attorney is questionable. If the entity is not an attorney, the applicant or member must complete a release of information form, such as F-02340.

Note	*A person or entity who is already known on the Medicaid case as a legal guardian, conservator, power of attorney, or authorized representative can access the case record. They do not need additional authorization to access the case record (see SECTION 22.5 LEGAL GUARDIANS, CONSERVATORS, POWER OF ATTORNEY, AND OTHER REPRESENTATIVES).*

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19.2 Releasing Information

19.2.1 Disclosure Without Consent

DHS 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.

Income Maintenance (IM) agencies may disclose information from 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 DHS programs.
6. General relief/assistance agencies.
7. State of Wisconsin DCF staff for administering W-2.
8. FSET agencies administering the FoodShare Employment and Training program.
9. Any fiscal agent of the state administering benefit payments under the BadgerCare Plus program (currently Gainwell Technologies).
10. The Social Security Administration for administering the Supplemental Security Income (SSI) benefits.
11. Local public housing authorities where the member applies for public housing or for federal rent assistance.
12. DWD, Division of Unemployment Insurance (DUI) for computer matching to Unemployment Insurance Benefit payments.
13. Job Training Partnership Act (JTPA) agencies to the extent that the information is necessary to determine JTPA program eligibility.
14. Any other federally assisted program providing cash or in-kind assistance or services directly to persons 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 FoodShare. 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.
15. US Comptroller General's Office.
16. Any official conducting an investigation, prosecution, or civil proceeding in connection with the administration of an Income Maintenance program. They must submit to the agency a written request to obtain information. The request must include the identity of the person requesting the information, their authority to request, the violation being investigated, and identify the person being investigated. Do not apply this restriction to the agency’s District Attorney or fraud investigator.
17. 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.
18. Staff of any public or private agency for the administration of the:
    a) Federal Title IV-E Foster Care program
    b) Adoption Assistance program.

No other routine disclosure from client records is approved. The applicant, member, or their legal guardian, conservator, or power of attorney must authorize all other disclosures. See CHAPTER 22.5 LEGAL GUARDIANS, CONSERVATORS, POWER OF ATTORNEY, AND OTHER REPRESENTATIVES for more information on the entities that can act on behalf of an applicant or member.

19.2.2 Disclosure with Consent

Applicants and members may authorize the disclosure of information of record about themselves to a third party in writing. Forms such as F-02340 or F-82009 may be used for this purpose. The authorization must specify the information to be disclosed, to whom it is to be disclosed, and for what period of time.

19.2.3 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. The agency must notify the applicant or member in writing within 72 hours of this disclosure.

19.2.4 Special Circumstances

19.2.4.1 Legislative Committees

Agencies cannot 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 or name any applicant or recipient.

19.2.4.2 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, CTS, FoodShare, BadgerCare Plus, and Medicaid 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.

Agencies can release information to CVC program staff about CVC applicants and recipients only when the CVC applicants and recipients have signed a release of confidential information for the CVC program. Information that can be released are about eligibility and the amount of benefits in the W-2, CTS, FoodShare, BadgerCare Plus, and Medicaid programs.

19.2.4.3 Subpoenas and Records Requests

If a court issues a subpoena for a case record or for any agency representative to testify concerning an applicant or member, the IM Agency must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

19.2.5 Prohibited Disclosure

Examples in which disclosure is prohibited are:

1. Requests from an official not connected with the agency for privileged information.
2. Requests from private persons for case information frequently related to business or personal matters, such as the collection of bills from the recipient.

3. IM agencies are not authorized to provide information about the receipt of benefits or the dollar amount of those benefits to the U.S. Citizenship and Immigration Services (USCIS), 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.

19.2.6 Data Exchanges

19.2.6.1 Data Exchanges Introduction

CWW Data Exchanges provide query access to databases that store employment, unemployment income, and Social Security and SSI income (including social security number, citizenship/identification, and Medicare verification) information.

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

19.2.6.2 Use of Data

Data exchanges can only be accessed for official program purposes. No one is permitted to browse the records in any query, even if there are no intentions to share the data.

19.2.6.3 Query Access

Agencies must take all precautions necessary to ensure that only authorized agency staff have access to the online queries.

19.2.6.4 Release of Data

Only release data received from a query to:

- The person who is the subject of the data.
- The person's attorney or other duly authorized representative who needs the data in connection with that person's fair hearing.
- Another county, state, or federal agency administering the FS, child support, SSI, BadgerCare Plus, or Medicaid programs.
- A criminal or civil authority that agrees in writing to protect the confidentiality of the data provided.

19.2.7 Documents

19.2.7.1 Date Stamping 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.

19.2.7.2 Photocopying Vital Records

Wis. Stats. §69.30 permits DHS, county, W-2, and tribal social and human service agencies to photocopy vital records for administrative use. Vital records include:

- Birth certificates
- Death certificates
- Marriage documents

- Divorce and annulment certificates
- Data related to any of the above documents

This statute exempts agencies from its restrictions if there is an administrative need for the copy and it's marked "For Administrative Use." Penalties for improperly photocopying vital records include fines and imprisonment.

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20 Verification

20.1 Verification Introduction

20.1.1 Verification Definition

Verification is part of determining eligibility. To verify means to establish the accuracy of verbal or written statements made about a group's circumstances.

If the member is applying for other programs of assistance or if you are looking for sources of verification, see the specific verification chapters for those programs in their respective handbooks.

20.1.2 Documentation

Documentation is a method by which you accomplish verification. Case comments in CWW provide documentation, including worker notes regarding collateral contacts, viewing documents, home visits, etc. Include enough data to describe the nature and source of information if follow up is needed.

20.1.3 Verification Receipt Date

The verification receipt date is the day verification is delivered to the appropriate IM agency or the next business day if verification is delivered after the agency's regularly scheduled business hours. IM agencies must stamp the receipt date on each piece of verification provided.

20.1.4 General Rules

1. Over-verification, including requiring excessive pieces of evidence for any one item or requesting verification that is not needed to determine eligibility, is prohibited. Once the accuracy of a written or verbal statement has been established, additional verification can't be required. For example, once U.S. citizenship is verified, a member or applicant never has to verify it again (see SECTION 7.2 VERIFYING U.S. CITIZENSHIP).
2. If information has already been verified, the applicant or member does not need to verify it again except in the following situations:
    a) There is reason to believe the information is fraudulent or differs from more recent information. If fraud is suspected, the IM agency will determine if a referral for fraud or for front-end verification should be made (see SECTION 20.6 FRONT END VERIFICATION).
    b) The member reported a change to information that is subject to mandatory verification rules or is questionable.
    c) At renewal, information is subject to mandatory verification rules or is questionable.
3. One particular type of verification can't be exclusively required when various types are adequate and available.
4. Verification need not be presented in person. Verification may be submitted by mail, fax, email, or another electronic device, or through an authorized representative.
5. Applicants and members must not be subject to different verification requirements solely based on race, color, national origin, age, disability, sex, religion, or migrant status when people in similar circumstances would not otherwise have the same verification requirements.

Example 1	Marie reports on her application that she is a U.S. citizen. She also reports that the primary language spoken in her home is a language other than English, and it is her preferred language. Marie's U.S. citizenship was found questionable because she has a preferred language that is not English. A request was sent to Marie to specifically submit her birth certificate in order to verify her U.S. citizenship. This action is not allowed. Verification of U.S.

	citizenship must first be attempted through data exchange or other documentation as explained in Section 7.2 Verifying U.S. Citizenship.

6. The applicant or member can't be required to sign a release form (either blanket or specialized) when the member provides required verification.
7. Verification of information that is not used to determine eligibility can't be required.
8. During verification, the applicant or member can't be harassed or have their privacy, personal dignity, or constitutional rights violated.

The applicant or member has primary responsibility for providing verification and resolving questionable information. However, the IM worker must use all available data exchanges to verify information rather than requiring the applicant to provide it, unless the information from the data source is not reasonably compatible with what the applicant or member has reported (see SECTION 20.3.8.1 REASONABLE COMPATIBILITY FOR INCOME FOR HEALTH CARE and SECTION 20.3.5.2 REASONABLE COMPATIBILITY FOR ASSETS).

IM agencies must assist the applicant or member in obtaining verification if they request help or have difficulty in obtaining it.

The best information available should be used to process the application or change within the time limit when both of the following conditions exist:

1. The applicant or member does not have the power to produce verification.
2. Information is not obtainable timely even with the IM worker's assistance.

Applicants meeting the health care program eligibility criteria based on this best available information are eligible for benefits. Even after the application or change is processed using best available information, the IM agency is required to continue in their attempts to obtain verification. When the verification is received, benefits may need to be adjusted based on the new information. The agency must explain this to the applicant or member when requesting verification.

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20.2 Collateral Contacts

Collateral contacts consist of oral confirmations of circumstances by persons other than members of the health care assistance group. A collateral contact may be made either in person or over the telephone.

20.2.1 Third-Party Cooperation

Wisconsin Stats. §49.78(11) allows DHS, consortia, county, and tribal IM agencies to request third-party cooperation from any person in Wisconsin in the verification of data. Third parties are obligated in the law to provide information within seven days of the request. No compensation to the third party is required, and the lack of compensation is not a valid reason for the third party to refuse to cooperate. The law also provides protections to third parties for providing any information requested by IM agencies otherwise allowed by law.

Note: *Failure of a third party to provide information may not result in any loss or denial of eligibility for a member or applicant.*

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20.3 Mandatory Verification Items

20.3.1 Mandatory Verification Items Introduction

The following items must be verified for Medicaid:

- SSN (see SECTION 10.1 SSN REQUIREMENTS)
- U.S. citizenship (see SECTION 7.2 VERIFYING U.S. CITIZENSHIP)
- Immigrant status (see SECTION 7.3.2 VERIFICATION)
- Disability (see SECTION 5.2 DETERMINATION OF DISABILITY)
- Income (see SECTION 15.1 INCOME INTRODUCTION)
- Assets (see SECTION 16.1 ASSETS INTRODUCTION)
- Divestment, for Medicaid long-term care programs (see CHAPTER 17 DIVESTMENT)
- Medical expenses used to meet a deductible (see SECTION 24.2 MEDICAID DEDUCTIBLE INTRODUCTION)
- Out-of-pocket medical/remedial expenses for MAPP and Institutional Medicaid patient liability and Waiver Medicaid cost share deductions (see SECTION 15.7.3 MEDICAL/REMEDIAL EXPENSES)
- Documentation for power of attorney and guardianship (see SECTION 22.5 LEGAL GUARDIANS, CONSERVATORS, POWER OF ATTORNEY, AND OTHER REPRESENTATIVES)
- Migrant worker's eligibility in another state (see SECTION 31.1 MIGRANT WORKERS)
- Institutional Medicaid patient liability home maintenance deduction (see SECTION 15.7.1 MAINTAINING HOME OR APARTMENT)
- Temporary hardship for MAPP premium waiver (see SECTION 26.5.8 TEMPORARY MAPP PREMIUM WAIVERS DUE TO HARDSHIP)
- Huber Law participation, for incarcerated individuals qualifying for the Huber Law exemption (see SECTION 13.8.3 HUBER LAW)
- Tribal membership or Native American descent (see SECTION 20.3.11 TRIBAL MEMBERSHIP, DESCENT, OR ELIGIBLE TO RECEIVE INDIAN HEALTH SERVICES)

Unless determined questionable, self-declaration is acceptable for all other items.

20.3.2 Social Security Number

Social security numbers (SSNs) must be furnished for household members requesting Medicaid unless they are exempt from the SSN requirement (see SECTION 10.1.1 SOCIAL SECURITY NUMBER REQUIREMENTS). SSNs are not required from non-applicants.

An applicant is not required to provide a document or Social Security card. They only need to provide a number, which is verified through the CARES SSN validation process.

If the SSN validation process returns a mismatch record, the member must provide the social security card or another official government document with the SSN displayed. If an applicant does not yet have an SSN, they must be willing to apply for one.

Agencies must assist any household that requests help with applying for an SSN for any applicant or member who does not have one. “Assisting the applicant” may include helping with filing the SS-5 SSN Application form, obtaining a birth certificate on behalf of the applicant, or assisting with obtaining another document needed to apply for the SSN.

Health care eligibility may not be delayed if the person is otherwise eligible for benefits and any of the following are true:

- The person has provided an SSN, even if the SSN has not yet been verified.
- The person has requested assistance with applying for an SSN.
- The person has verified that they have applied for an SSN.

In cases where an application for SSN has been filed with the Social Security Administration, an SSN must be provided by the time of the next health care renewal for the case or health care eligibility will be terminated for that person. In addition, if eligibility for another program pends for provision of an SSN and the SSN application date on file is six months or older, eligibility for health care will also pend. Members will have 20 days to provide an SSN, but if they do not, health care eligibility must be terminated.

Even when U.S. citizenship cannot be verified due to a lack of a verified SSN, health care benefits should not be delayed for lack of an SSN during the reasonable opportunity period for verification of U.S. citizenship (see SECTION 7.2.4.4 REASONABLE OPPORTUNITY PERIOD FOR VERIFICATION OF CITIZENSHIP).

20.3.2.1 Fraudulent Use of SSN

The member should be informed if the SSN validation process indicates another individual is using the same SSN. The member should contact the Social Security Administration and request they conduct an investigation. The IM worker cannot provide the member with any information that would identify the individual who is using the member's SSN.

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

- Recommend further action be taken.
- Provide the member with the information on the fraudulent action so that the member may pursue action through the legal system.

Verify the SSN only once.

20.3.3 Immigration Status

Verification of the individual's immigration status is done through the FDSH or the Systematic Alien Verification for Entitlement (SAVE) system. Women applying for BadgerCare Plus Prenatal Program (see BadgerCare Plus Handbook, Chapter 41 BadgerCare Plus Prenatal Program) and people applying for Emergency Services (see CHAPTER 34 EMERGENCY SERVICES do not have to verify their immigration status.

Applicants who are otherwise eligible and are only pending for verification of immigration status must be certified for health care benefits during the reasonable opportunity period (see SECTION 7.3.2.2 REASONABLE OPPORTUNITY PERIOD for Verification of Immigration Status.

20.3.4 Disability

Disability and blindness determinations are made by the DDB in the DHS. Items that can be used to verify disability status include, but are not limited to:

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

20.3.5 Assets

Verification of countable assets is mandatory.

Note *The value of exempt assets, such as an EBD Medicaid member's burial plot, may not be verified unless the worker has information that deems the member-reported amount to be questionable.*

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

Do not verify cash on hand.

Verify AVS liquid assets using the Asset Verification System (AVS) integrated within CARES Worker Web. If current asset information is not available through AVS, the applicant/member is required to verify their assets through other sources (for example, bank statements). Assist the applicant/member in obtaining verification if he or she has difficulty in obtaining it.

20.3.5.1 Divestment

Verify if a member or spouse has divested assets when determining eligibility for institutional Medicaid and community waivers (see SECTION 17.1 DIVESTMENT DEFINED).

20.3.5.2 Reasonable Compatibility for Assets

As defined in federal regulations, information from an electronic data source (in this case, AVS) is reasonably compatible if it results in the same eligibility outcome as self-reported information.

- If the individual reports assets that are above a given asset limit, the self-reported asset information will be used to deny or terminate health care benefits, regardless of what the outcome would be from using AVS information. Verification is not required.
- If both AVS and the self-reported information put the individual's total countable assets below a given asset limit, the two data sources are considered to be reasonably compatible and further verification may not be requested or required.
- If AVS puts the individual's total countable assets above a given asset limit, but the self-reported information puts his or her total countable assets below that same limit, the two data sources are not reasonably compatible and further verification is required as a condition of eligibility.

The reasonable compatibility test will only be applied to AVS liquid assets that have not otherwise been verified (for example, if a member submits bank statements as part of their initial application, or if the asset has been verified by another program). It can only be applied when asset information is available through the Asset Verification System.

20.3.5.2.1 Determination of Reasonable Compatibility

The reasonable compatibility test will be performed during the eligibility determination for EBD Medicaid if there is an AVS-returned amount for at least one unverified liquid asset. To determine reasonable compatibility, CARES will perform the following calculations:

Calculation	Description
1: Total Countable Assets (Self-Reported)	Sum of all the self-reported amounts for all countable assets. If the self-reported countable assets are over the asset limit, eligibility will fail right away and no reasonable compatibility test will be performed.
2: Total Countable Assets (AVS and/or Self-Reported)	Sum of the following: • All verified, countable asset amounts. • For all countable AVS assets, if an AVS amount was returned for an asset and that asset has not been verified: the higher of the AVS-returned or the unverified self-reported amounts.

	• All unverified, self-reported countable asset amounts with no AVS match, including non-AVS assets. • All countable AVS assets that were not reported.

CARES will compare the results of calculations 1 and 2 to determine reasonable compatibility.

- **If reasonably compatible**, verification of the AVS-matched asset amounts will not be requested, and eligibility will not pend for verification of these assets, even when there is a ?, Q?, WN, NV, or QV in the verification field. If otherwise eligible, the individual will receive a Notice of Decision listing the self-reported asset amounts. If eligibility is pending for other assets, a Verification Checklist will be sent.
- **If not reasonably compatible**, a Verification Checklist will be sent to the individual to request verification for all assets for which the individual has not already provided verification. If the individual does not provide the requested verification by the due date, eligibility will be denied or terminated for lack of verification.

Note *When there is an MSP request in addition to a request for EBD Medicaid, an additional, separate reasonable compatibility determination will be performed for MSP. In situations where the assets are reasonably compatible for MSP but exceed the asset limit for other programs, the individual may enroll in MSP without being required to provide further verification of assets for that program.*

If an individual is applying for health care and has also requested MAPP, the reasonable compatibility test may provide different results based on the EBD Medicaid and MAPP asset limits. Because CARES considers these two programs to be part of the same health care request, the reasonable compatibility test will be performed using the MAPP asset limits only if the individual is found ineligible for EBD Medicaid because of excess assets or failure to provide verification of assets. This means an individual can still be eligible for MAPP based on the reasonable compatibility test for assets, even if they failed to submit verification of assets as required for EBD Medicaid (see Example 2 below).

If the worker is running with dates and an AVS amount is entered for a given asset, the reasonable compatibility test will be performed as long as the eligibility month is June 2018 or later.

The following examples show various results of the reasonable compatibility test.

Example 1	Lauren applies for EBD Medicaid and reports the following asset amount, without providing verification: A. Checking account: $5 AVS returns the following information and the worker processes the information as shown: • Savings account: $200 | Match with A • Undisclosed checking account: $800 | Add as new information **Reasonable Compatibility Determination** • EBD Medicaid Asset Limit: $2,000 • 1. Total Countable Assets (Self-Reported): **$5** • 2. Total Countable Assets (AVS and/or Self-Reported): $200 + $800 = **$1,000** • Result: **Reasonably Compatible**, because the sum of both calculations is less than the asset limit. No further verification is requested from Lauren. A Notice of Decision is sent, listing only the self-reported amount.

Example 2	Mike applies for EBD Medicaid with a MAPP request and reports the following asset amounts, without providing verification: A. Checking account: $500 B. Savings account: $700 C. Savings bond" $300 (non-AVS asset) AVS returns the following information and the worker processes the information as shown: • Checking account: $800 | Match with A • Savings account: $400 | Match with B • Undisclosed checking account: $900 | Add as new information **Reasonable Compatibility Determination for EBD Medicaid** • EBD Medicaid Asset Limit: $2,000 • 1. Total Countable Assets (Self-Reported): $500 + $700 + $300 = **$1,500** • 2. Total Countable Assets (AVS and/or Self-Reported): $800 + $700 + $900 + $300 = **$2,700** • Result: **Not Reasonably Compatible**, because the sum of countable assets from data sources is above the EBD Medicaid asset limit. In this case, the $700 savings account amount is used when calculating the total countable assets based on data sources, as it is the higher of the self-reported and AVS-returned information. A Verification Checklist is sent to Mike. All self-reported assets and the undisclosed checking account returned by AVS are included in the Proof Needed section. If Mike provides verification of his assets and is found to be over the $2,000 asset limit for EBD Medicaid, CARES will then consider his MAPP eligibility without a reasonable compatibility test because all assets have been verified. If he meets all financial and non-financial rules for MAPP, his MAPP eligibility will be approved. However, if Mike provides verification of his savings bond (the non-AVS asset) but fails to verify his checking and savings accounts, CARES will consider his MAPP eligibility using a reasonable compatibility test based on the MAPP asset limit. **Reasonable Compatibility Determination for MAPP** • MAPP Asset Limit: $15,000 • Total Countable Assets (Self-Reported): $500 + $700 + $300 = **$1,500** • Total Countable Assets (AVS and/or Self-Reported): $800 + $700 + $900 + $300 = **$2,700** • Result: **Reasonably Compatible**, because the sum of countable assets from data sources is below the MAPP asset limit. No further verification is requested from Mike. A Notice of Decision is sent, listing only the self-reported amounts.

Example 3	Tasha applies for EBD Medicaid and MSP and reports the following asset amounts, without providing verification: A. Checking account: $1,000 B. Savings account: $500 AVS returns the following information and the worker processes the information as shown: • Checking account: $2,000 | Match with A • Savings account: $2,500 | Match with B **Reasonable Compatibility Determination for EBD Medicaid**

	• EBD Medicaid Asset Limit: $2,000 • 1. Total Countable Assets (Self-Reported): $1,000 + $500 = **$1,500** • 2. Total Countable Assets (AVS and/or Self-Reported): $2,000 + $2,500 = **$4,500** • Result: **Not Reasonably Compatible for EBD Medicaid** because the sum of countable assets from data sources is above the EBD Medicaid asset limit. **Reasonable Compatibility Determination for MSP** • MSP Asset Limit: $7,730 • 1. Total Countable Assets (Self-Reported): $1,000 + $500 = **$1,500** • 2. Total Countable Assets (AVS and/or Self-Reported): $2,000 + $2,500 = **$4,500** • Result: **Reasonably Compatible for MSP** because the sum of countable assets from data sources is below the MSP asset limit. A Verification Checklist is sent to the Tasha to request verification of the checking and savings account for EBD Medicaid. However, if Tasha does not return verification of these accounts, she will remain eligible for MSP.

20.3.5.2.2 Programs for Which Reasonable Compatibility Will Apply
The reasonable compatibility test will be performed as part of any eligibility determination for all EBD Medicaid programs with asset tests.

Populations not subject to an asset test (for example, children under age 19 and children who are members of the Children's Long-Term Support Waiver Program) will not have a reasonable compatibility test.

20.3.6 Medical or Remedial Expenses

Medical or remedial expenses used to meet a deductible or calculate patient liability, cost share, or premium amounts must be verified. The expense amount, any third party liability amount, and date of service must all be verified. If verification is not provided, do not include the expense to determine when a deductible has been met or in the liability, cost share, or premium calculation. Do not deny or terminate eligibility for failure to provide the requested verification.

For HCBW, Family Care, Family Care Partnership, PACE, and IRIS members, Care Managers, ADRC staff, and IRIS Consultant Agencies (ICAs) calculate medical and remedial expenses. Because care managers, ADRC staff, and ICAs already verify all medical and remedial expenses before reporting those expenses to IM, additional verification is not needed. Refer to 28.6.4.5 MEDICAL/REMEDIAL EXPENSES.

20.3.7 Power of Attorney, Guardianship, or Conservator

If the applicant or member states they have an agent with power of attorney, documentation of the power of attorney appointment is required. Only an agent with durable power of attorney for finances is considered to have power of attorney for health care programs. “Durable” means that the power of attorney continues even if the applicant or member becomes incapacitated.

If the applicant or member states they have a legal guardian, documentation of the court-ordered guardianship is required.

If the applicant or member states they have a conservator, documentation of the court-ordered conservatorship is required.

If verification is not provided, do not grant the claimed agent with power of attorney, guardian, or conservator access to case notices or follow any direction provided by that person unless they are an

authorized representative. Do not deny or terminate eligibility for failure to provide the requested verification.

20.3.8 Income

Verify all sources of nonexempt income for EBD Medicaid applicants and members. Verify income using the automated data exchanges, when current (the month for which eligibility is being determined) information is available on a specific data exchange. If current income information is not available through a data exchange, the applicant/member is required to supply verification/documentation of their earned and unearned income.

In certain cases, data exchange resources do not exist or are unavailable to IM workers for eligibility determinations. For example, data exchanges are not available for persons who do not supply their SSN or where the income reported is not part of an existing data exchange. Under these circumstances, income must be verified by the member through other sources (i.e., check stubs, award letters, etc.).

The following are examples of persons for whom a data exchange will never exist and, therefore, income verification is required at eligibility determination:

1. Ineligible persons who do not provide an SSN and whose income would be counted in the eligibility determination (Fiscal Test Group member).
2. Non-citizens without an SSN applying for emergency services. Persons whose employers do not report wages to the Department of Workforce Development (DWD) in Wisconsin, such as Wisconsin residents who work out of state and persons who work for the federal government.
3. Persons with income from sources that are never available to IM workers through a data exchange, such as self-employment income.

The applicant/member is responsible for providing verification of income that is not available through data exchange. For example, data exchanges are not available for persons who do not supply their SSN or where the income reported is not part of an existing data exchange. Under these circumstances, income must be verified by the applicant/member through other sources (i.e., check stubs, award letters, etc.).

Assist the applicant/member in obtaining verification if he or she has difficulty in obtaining it.

Do not deny eligibility if reasonable attempts to verify the income have been made. Use the best information available to process the application or change timely when the following two conditions exist:

1. The applicant/member does not have the power to produce verification, and
2. Information is not obtainable timely even with your assistance. In this situation, continue to attempt to obtain the verification. Once the verification is received, benefits may need to be adjusted based on the verified information.

Note *Accept a member's or suspended member's statement and do not require verification of income earned by an inmate from a prison or jail job that pays less than minimum wage, such as jobs through Badger State Industries (BSI). See SECTION 15.5.18 PRISON OR JAIL JOB.*

20.3.8.1 Reasonable Compatibility for Income for Health Care

This section addresses reasonable compatibility for income. Reasonable compatibility for assets can be found in SECTION 20.3.5.2 REASONABLE COMPATIBILITY FOR ASSETS.

Agencies may not request verification from health care applicants and members unless the information cannot be obtained through an electronic data source, the income is jail or prison earnings of an inmate (see SECTION 15.5.18 PRISON OR JAIL JOB), or information from the data source is not "reasonably compatible" with what the applicant has reported. Information from a data source that supports an eligibility determination based on the attested information provided by an applicant or member is considered "reasonably compatible."

The following list describes the potential scenarios and whether the scenario results in a determination of reasonable compatibility:

- If both the electronic data source and the member-reported information put the individual's total countable income below a given income threshold, the two data sources are considered to be reasonably compatible and **further verification may not be requested or required**.
- If the electronic data source puts the individual's total countable income above a given income threshold, but the member-reported information puts the individual's total countable income below that same threshold, an additional test that uses a 20% threshold occurs.
    - If the individual's total countable income using information from the electronic data source is less than or equal to 120% of the individual's total countable income using the member-reported information, the two data sources are considered to be reasonably compatible and further verification may not be requested or required.
    - If the individual's total countable income using information from the electronic data source is more than 120% of the individual's total countable income using the member-reported information, the two data sources are not reasonably compatible and further verification is required as a condition of eligibility.
- If the member reports income that is above a given threshold, the member-reported income information is used to deny or terminate health care benefits, regardless of what the outcome would be using information from the electronic data source. In this scenario, **verification is not required**.

The reasonable compatibility test is only applied to job earnings that have not otherwise been verified (for example, as part of another program's verification process). It can only be applied when earnings information is available through the State Wage Information Collection Agency (SWICA) or through Equifax from the Federal Data Services Hub (FDSH).

Unearned income (as defined in SECTION 15.4 UNEARNED INCOME) is verified as outlined in this chapter and in Process Help Chapter 44 Data Exchange. If there is an electronic data source available to use for verifying a type of unearned income, it should be used as verification for that income. If no data source is available, the applicant or member must provide verification of the unearned income. If Equifax data is available for a type of unearned income, and the Equifax amount is the same as the amount reported by the member, the unearned income must be considered verified.

Self-employment and in-kind job income are verified as outlined in SECTION 15.6.6 VERIFICATION and SECTION 15.5.1 INCOME IN-KIND and Process Help Sections 16.2 and 16.6.

20.3.8.1.1 Programs for Which Reasonable Compatibility Will Apply
The reasonable compatibility test will be performed as part of any eligibility determination for the following categories of Medicaid:

- Elderly, Blind or Disabled Medicaid (EBD MA), except deductibles

- Medicaid Purchase Plan (MAPP)
- Medicare Savings Program (QMB/SLMB/SLMB+)

20.3.8.1.2 Reasonable Compatibility Thresholds

The reasonable compatibility test will apply to each AG for which earned income is reported, has not already been verified, and for which SWICA and/or Equifax data is available. Because different AGs are subject to different income and premium thresholds, the thresholds described below will be used by population as the first step in determining whether reported information is reasonably compatible.

- EBD Categorically Needy SSI-Related MA and Medically Needy MA thresholds are based on the income limits shown in SECTION 39.4.1 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME.
- MAPP and MSP thresholds are based on the income limits shown in SECTION 39.5 FPL TABLE.
- MAPP Premium thresholds are based on 100% FPL for a group of one as shown in SECTION 39.5 FPL TABLE. and described in the table below.

If both the total countable income using information reported by the applicant or member and the total countable income using information from the electronic data source are less than the threshold, the reasonable compatibility standard is met, and no further verification is required.

If the total countable income using information reported by the applicant or member is less than the threshold and the total countable income using information from the electronic data source is greater than the threshold, a second step occurs.

In this second step, the total countable income using information from the electronic data source is compared to a threshold that is equal to 120% of the total countable income using information reported by the applicant or member. If the total countable income using information from the electronic data source is equal to or less than 120% of the total countable income using information reported by the applicant or member, the reasonable compatibility standard is met, and no further verification is required.

Reasonable Compatibility Test for MAPP Premiums		
If total gross income using the monthly earnings amount reported by the member is:	And total gross income using the monthly earnings reported by SWICA or Equifax is:	Is it reasonably compatible?
Equal to or below the MAPP premium threshold (100% of the FPL)	Equal to or below the MAPP premium threshold (100% of the FPL)	Yes. Eligibility will be based on the member-reported earnings amount, and a premium will not be owed.
Equal to or below the MAPP premium threshold (100% of the FPL)	Above the MAPP premium threshold (100% of the FPL)	The 20% threshold test occurs. If the total gross income using the monthly earnings reported by SWICA or Equifax is equal to or less than 120% of the total gross income using the monthly earnings amount reported by the member, the amounts are reasonably compatible. Eligibility will be based on the member-reported earnings amount, and a premium will not be owed.

		If the total gross income using the monthly earnings reported by SWICA or Equifax is greater than 120 % of the total gross income using the monthly earnings amount reported by the member, the amounts are not reasonably compatible. Further verification must be requested.
Above the MAPP premium threshold (100% of the FPL)	Above the MAPP premium threshold (100% of the FPL)	A reasonable compatibility test was not done. Income must be verified for the correct premium amount to be determined.
Above the MAPP premium threshold (100% of the FPL)	Equal to or below the MAPP premium threshold (100% of the FPL)	A reasonable compatibility test was not done. Income must be verified for the correct premium amount to be determined.

Because different thresholds are used for different populations, individual members of a household or a given AG may pass the reasonable compatibility test while others do not.

Example 4	Leonard is applying for EBD Medicaid. He is not married and has no children. The SSI-Related Medically Needy monthly income limit is $1,304.17. Leonard reports monthly earned income of $1,200; this is his only income, and it is below the income limit. The State Wage Information Collection Agency (SWICA) reports that Leonard's monthly earned income is $1,400. This income amount is above the income limit. Therefore, the reasonable compatibility test using the 20% threshold will be applied. The 20% threshold amount is the amount that is 20% greater than the total income that includes the earned income reported by the applicant or member. In this example, the 20% threshold amount is $1,440. The total income that includes the earned income reported by SWICA ($1,400) is less than the 20% threshold amount ($1,440). Therefore, the amounts are determined to be reasonably compatible. Leonard does not need to verify the earned income.

20.3.8.1.3 Reasonable Compatibility Test

Reasonable compatibility will first be tested based on the household's total countable income as reported to the agency or verified through other sources. This test will determine whether the member is required to provide verification of earnings.

If the member-reported earnings amount is not reasonably compatible (based on the household's total reported income), verification of earnings will be required at the same time verification is required for unearned income, self-employment, and/or tax deductions.

A second verification request will be required if the initial test leads to a determination of reasonable compatibility but the earnings are no longer reasonably compatible after other income types or deductions have been verified.

If earnings are determined to be reasonably compatible, the amount reported by the member should be used to determine eligibility and premium amounts for health care.

If the earnings are later verified (for example, because verification is required for another program), the verified earnings must be used to determine eligibility and premium amounts for health care.

See SECTION 22.2.1.2.4 ELIGIBILITY AND PREMIUM DETERMINATIONS BASED ON REASONABLE COMPATIBILITY for information about when members with eligibility or premium determinations based on income that was reasonably compatible can be subject to overpayments.

20.3.8.1.4 Use of Equifax Data for Verification of Income
If Equifax data is available for a given employment, and the Equifax amount is the same as the amount reported by the applicant or member, the earned income must be considered verified. Earned income that is verified is not subject to a reasonable compatibility test.

If the amount reported by the applicant or member is not the same as the Equifax amount, the earned income is not considered verified. The reasonable compatibility test is completed for earned income that has not otherwise been verified.

If the amount reported by the applicant or member is not reasonably compatible, the applicant or member is required to provide verification of earned income. IM agencies must assist the applicant or member in obtaining verification if they request help or tell their agency that they are having difficulty obtaining it (see SECTION 20.1.4 GENERAL RULES).

If the applicant/member and/or worker have made reasonable efforts to obtain verification and are not able to do so, then the agency should determine the income amount based on "best available" information and then document how this amount was determined.

Health care benefits cannot be denied or terminated based on earned income data received from Equifax without giving the applicant or member an opportunity to verify their reported earned income amount.

Note *The same policy applies when a member is reporting a change in earned income. If the Equifax amount is the same as the amount reported by the member, the earned income must be considered verified.*

Example 5	Anya applies for health care for herself. She is 65 years old but does not yet receive Social Security income. The only income she reports is earned income. The monthly earned income amount she reports is different than the monthly earned income amount returned by Equifax, so earned income is not considered verified and the reasonable compatibility test occurs. The earned income amount reported by Anya is not reasonably compatible, so she must provide verification of her earned income. Anya verifies that her earned income is less than 100% of the federal poverty level, so she is determined financially eligible for SSI-Related Medicaid. If the monthly earned income amount reported by Anya and the monthly earned income amount returned by Equifax had been the same, the earned income would have been considered verified, and the reasonable compatibility test would not have occurred. Eligibility would have been determined using the amount reported by Anya, and no verification would be requested.

20.3.9 Proof of Temporary Hardship for MAPP Members

Verify a temporary hardship for MAPP applicants and members who apply for a temporary MAPP premium waiver due to hardship, SECTION 26.5.8.

20.3.10 Huber Law Exemption

Applicants and members who are incarcerated but allowed to leave jail under the Huber Law can become or remain eligible for full-benefit Medicaid if the reason for the release is to return home to care for their minor children (see SECTION 13.8.3 HUBER LAW for the Huber Law exemption criteria).

To qualify for the Huber Law exemption, verification that the applicant or member is returning home to care for minor children is required.

Acceptable verification sources include:

- Agency Form
- Court Order
- City or County Records, such as from the correctional facility
- Lawyer Statement or Record
- Other Acceptable Written or Verbal Statement, such as from the court or correctional facility staff

If the verification shows that the person is only allowed to leave jail under the Huber Law for a reason other than caring for a minor child, the person is not eligible for the Huber Law exemption.

20.3.11 Tribal Membership, Descent, or Eligible to Receive Indian Health Services

Verification of tribal membership, descent from a tribal member, or eligibility to receive Indian Health Service (IHS) services is required to receive an exemption from paying Medicaid premiums and copayments (see SECTION 21.5.2 COPAY EXEMPT POPULATIONS). Verification may be done with a:

- Tribal Enrollment Card
- Written verification or a document issued by the tribe indicating tribal affiliation
- Certificate of degree of Indian blood issued by the Bureau of Indian Affairs
- Tribal census document
- Medical record card or similar documentation that specifies an individual is an Indian that is issued by an Indian health care provider
- Statement of Tribal Affiliation (F-00685)

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20.4 Questionable Items

20.4.1 Questionable Items Introduction

Information is questionable when:

1. There are inconsistencies in the group's oral or written statements.
2. There are inconsistencies between the group's claims and collateral contacts, documents, or prior records.
3. The member or his or her representative is unsure of the accuracy of his or her own statements.
4. The member has been convicted of Medicaid member fraud or has legally acknowledged his or her guilt of member fraud.
5. The member is a minor who reports that he or she is living alone. This does not apply to minors applying solely for FPOS.
6. Unclear or vague (i.e., information provided, but not clear).

20.4.2 Tuberculosis

See BadgerCare Plus Handbook, Chapter 43 Tuberculosis-Related Medicaid for appropriate verification items if information provided is questionable.

20.4.3 Farm and Self-Employment Income

See SECTION 15.6.6 VERIFICATION for appropriate verification items if information provided is questionable.

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20.5 Member Responsibility

Assist the Member

The IM worker has a responsibility to use all available data exchanges to verify information, but the member has primary responsibility for providing verification. The member must likewise resolve questionable information. Do not deny eligibility when the member does not have the ability to produce verification.

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

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

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

In this situation, seek verification later. When you have received the verification, you may need to adjust or recoup benefits based on the new information. Explain this to the member when requesting verification.

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20.6 Front End Verification

Front-End verification (FEV) is intensive verification of a case by a special unit or worker. A group should be referred for FEV only when its characteristics meet a designated profile (see Process Help Section 31.3.4 FEV/Fraud Referral vs. Claim Referral).

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20.7 When to Verify

Proof of certain information is required to determine eligibility for Medicaid. Mandatory (see SECTION 20.3 MANDATORY VERIFICATION ITEMS) and questionable (see SECTION 20.4 QUESTIONABLE ITEMS) items must be verified at application, renewal, person addition or deletion, or when there is a change in circumstance that affects eligibility or benefit level. One-time only verification items do not need to be re-verified. For changes in circumstance and timely renewals, current benefits are maintained until a redetermination of benefits is completed.

Verification means to establish the accuracy of verbal or written statements made by, or about an individual's circumstances. Case files or case comments must include documentation for any information required to be verified to determine eligibility or benefit levels.

Exception: Veterans benefits, including allowances for Aid and Attendance, Housebound, and Unusual Medical Expenses usually increase only once a year, in January. If an IM agency verifies the January veterans benefit increase, it does not have to re-verify the veteran benefit income at the time of the next scheduled eligibility renewal, which occurs later in that same year. If another change in the veterans benefit does occur between January and the next scheduled eligibility renewal, that income change will have to be verified. This exception is being adopted to reduce the verification workload for both the IM agency and Veterans Administration staff, who routinely pursue and provide veterans benefit income verification every January.

20.7.1 Application and Renewal

20.7.1.1 Application

The time period for processing an application for Medicaid is 30 days from the filing date (see SECTION 2.6 FILING DATE and SECTION 2.7 APPLICATION PROCESSING PERIOD).

Eligibility cannot be denied for failure to provide the required verification until the later of:

1. The 20th day after requesting verification.
2. The 30th day after the application filing date.

The applicant will be advised of the specific verification required and given a minimum of 20 calendar days to provide any necessary verification.

20.7.1.2 Eligibility Renewals

Eligibility must not be denied for failure to provide the required verification until the 20th day after requesting verification. Renewal verifications are accepted late if they are received anytime within the three months following the renewal month. The three-month period begins the month after eligibility ends. If verifications are required to complete a timely or late renewal, the member will have 20 days to provide it.

20.7.2 Changes

When a member reports a change that requires verification, current health care benefits are maintained while the change is being processed, including while verification is requested. The member must be notified in writing of the specific verification required and allowed a minimum of 20 days to provide it.

20.7.3 Date of Death Matches

Wisconsin Medicaid uses data exchanges with the Wisconsin Vital Records Office and the Social Security Administration (SSA) to identify when an applicant or member has died and to verify the date of death.

When date of death (DOD) information received from Vital Records exactly matches an applicant or member's SSN and other demographic information, it is considered verified, and a notice of decision is sent to the household. No refutation period is required.

When DOD information received from Vital Records matches an applicant or member's SSN but does not exactly match other demographic information, another source, such as a family member or another data exchange, must be used before the DOD can be considered verified.

When an SSA data exchange indicates that an applicant or member has died and the IM agency has not received any other information to confirm the death, the member, another family member, or the member's representative must be allowed 10 days to correct any misinformation prior to benefits being impacted. For ongoing cases, the member for whom a death match was received will still be considered to be alive and benefits for the member or others on the case will not be changed or pended during this time. The case should be pended when verifications, such as earned income, are needed. Benefit changes due to changes in eligibility will still need to be processed. However, for an application, person add, or renewal, it means allowing at least the minimum 10 days for a response before a worker confirms eligibility for the application, renewal, or person/program add.

This 10-day period is known as the "refutation period." A letter is automatically sent to the primary person requesting a response if the individual is not deceased. The response due date must be extended to a longer period to allow for mailing delays due to weekends or holidays (will follow the VCL due date logic). The refutation period may only be shortened when either:

- A member, family member, or the member's representative, confirms the date of death.
- A worker verifies a date of death through a third-party source, such as a local newspaper obituary.

At the end of the refutation period, if no response is received from the member or applicant or the household, the date of death is considered verified and eligibility for the household must be redetermined and a notice of decision issued.

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20.8 Actions

20.8.1 Positive Actions

Benefits will begin or continue when:

- The member has submitted a timely renewal which remains in progress over adverse action of the renewal month.
- The member submitted a timely renewal after adverse action but by the last business day of the renewal month.
- The member has a change in circumstance and verification is requested to determine eligibility for other forms of health care.
- The member provides requested verification within the specified time limits and is otherwise eligible.
- Requested verification is mandatory, but the member does not have the power to produce the verification and he or she is otherwise eligible. In this situation, the agency must also make an effort to obtain the verification (see SECTION 20.1.4 GENERAL RULES).

20.8.2 Delay

Applicants must be notified of a processing delay when:

- Verification is needed.
- The applicant has the power to produce the verification.
- The minimum time period allowed for producing the verification has not passed.
- Additional time is needed to produce the verification.

A notice is sent to the applicant indicating the reason for the delay, the specific verification required, and the date the verification is due.

If eligibility is maintained following a timely renewal with pending verification, a notice is generated to explain health care benefits are being maintained during the redetermination.

20.8.3 Negative Actions

Benefits will be denied or reduced when all of the following are true:

- The member has been tested for all categories of health care and is determined ineligible.
- The applicant or member has the power to produce the verification.
- The time allowed to produce the verification has passed.
- The applicant or member has been given adequate notice of the verification required.
- The requested verification is needed to determine current eligibility. Current eligibility cannot be denied for lack of verification of a past circumstance that does not affect current eligibility.
- The member is not a child in a continuous coverage period (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).

Eligibility cannot be denied or terminated for failure to verify information that the member is not responsible to obtain (see Section 20.1.4 GENERAL RULES regarding agency use of data exchanges and verification of information that is not used to determine eligibility).

Note *Eligibility cannot be denied or terminated for failure to verify medical expenses. The disallowance of unverified expenses and deductions is the only penalty to be imposed.*

Eligibility cannot be denied or terminated for failure to verify tribal member status (see SECTION 20.3.11 TRIBAL MEMBERSHIP, DESCENT, OR ELIGIBLE TO RECEIVE INDIAN HEALTH SERVICES).

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20.9 Release of Information

You need someone's written release to get information from a verification source only when the source requires it.

When a source requires a written release:

1. Explain the requirement to the member.
2. Ask the member, his or her spouse, or another appropriate adult in the household to sign the necessary release form(s). The form may be:

    a) The CARES-generated or alternate pre-printed application forms.
    b) Release to Disability Determination Bureau form (F-14014).

Deny, discontinue or reduce benefits only when:

1. No appropriate person will sign the release form, and
2. The missing verification is necessary to determine eligibility, and
3. The member is unwilling or unable to provide the verification directly, and
4. The source requires a release, and
5. The release is the only way you can obtain the verification.

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20.10 Verification Resources

Workers can verify many sources of information, such as income, Social Security, UC, and birth records, through data exchanges. See Process Help Handbook Chapter 44 Data Exchange for instructions.

Verification of some liquid assets can be obtained electronically using the Asset Verification System (AVS). For instructions on using AVS, see Process Help Section 50.4 Asset Verification System (AVS).

Verification of immigration status can be obtained through the Federal Data Services Hub (FDSH) or the SAVE system. For instructions on using the SAVE system, see Process Help Handbook Chapter 82 SAVE.

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21 Benefits

21.1 Benefits Introduction

Medicaid covers many health care services. However, limitations apply that ensure only medically necessary services are provided.

The benefit and coverage information provided here is subject to change. The most current Medicaid coverage information is included in the ForwardHealth Online Handbook at https://www.forwardhealth.wi.gov/WIPortal/Default.aspx

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21.2 Full-Benefit Medicaid

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

1. Katie Beckett Medicaid (see SECTION 29.1 KATIE BECKETT)
2. HCBWLTC (see Section 28.1 Home and Community-Based Waivers Long-term Care Introduction)
3. Institutional Medicaid (see SECTION 27.1 INSTITUTIONS)
4. BadgerCare Plus (see the BadgerCare Plus Handbook)
5. SSI-related Medicaid (categorically or medically needy)
6. Foster Care Medicaid (see the BadgerCare Plus Handbook)
7. Adoption Assistance Medicaid
8. Medicaid Met Deductibles (see SECTION 24.2 MEDICAID DEDUCTIBLE INTRODUCTION)
9. MAPP (see SECTION 26.1 MEDICAID PURCHASE PLAN INTRODUCTION)
10. WWWMA (see CHAPTER 36 WISCONSIN WELL WOMAN MEDICAID)
11. SSI-Medicaid

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21.3 Limited Benefit Medicaid

Limited benefit subprograms of Medicaid includes:

1. Medicare Savings Programs (see SECTION 32.1 MEDICARE SAVINGS PROGRAMS).
2. Emergency Services for Non-Qualifying Aliens
3. TB-Related Medicaid (see BadgerCare Plus Handbook, CHAPTER 43 TUBERCULOSIS-RELATED MEDICAID).
4. Presumptively Eligible Pregnant Women (see the BadgerCare Plus Handbook)
5. SeniorCare (see SECTION 33.1 SENIORCARE INTRODUCTION)
6. Family Planning Only Services (see the BadgerCare Plus Handbook)

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21.4 Covered Services

21.4.1 Covered Services Introduction

The benefit and coverage information provided here is subject to change. The most current Medicaid coverage information is included in the ForwardHealth Online Handbook.

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

Medicaid providers must submit a prior authorization request to the Medicaid fiscal agent before providing certain Medicaid services.

Individuals who are enrolled in Medicare (Part A and/or B) and are eligible for full-benefit Medicaid (see SECTION 21.2 FULL-BENEFIT MEDICAID), including SSI recipients, are referred to as dual eligible individuals. Effective January 1, 2006, Medicaid no longer provides prescription drug coverage for these individuals. These dual eligible individuals do not have to file an application for "Extra Help" and are deemed eligible for "Extra Help" from CMS to pay their Medicare Part D costs.

A Medicare Part D Prescription Drug Plan (PDP) card will be issued to them, and it must be used for prescription drugs instead of their ForwardHealth card.

Individuals who are enrolled in Medicare (Part A and/or B) and are Medicare Beneficiaries (see SECTION 32.1 MEDICARE SAVINGS PROGRAMS), except for QDWI, are also considered to be dual eligibles. These dual eligibles are also be deemed eligible for "Extra Help" from CMS to pay their Medicare Part D costs.

Examples of Medicaid covered services include:

1. Case management services.
2. Chiropractic services.
3. Dental services.
4. Family planning services and supplies.
5. FQHC services.
6. HealthCheck (Early and Periodic Screening, Diagnosis and Treatment & ESPDT) of people under 21 years of age.
7. Home and community-based services authorized under a waiver.
8. Home health services or nursing services if a home health agency is unavailable.
9. Hospice care.
10. Inpatient hospital services other than services in an institution for mental disease.
11. Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
    a) under 21 years of age.
    b) under 22 years of age and received services immediately before reaching age 21.
    c) 65 years of age or older.
12. Intermediate care facility services, other than services at an institution for mental disease.
13. Laboratory and X-ray services.

14. Legend drugs and over-the counter drugs listed in Wisconsin Medicaid's drug index.
15. Medical supplies and equipment.
16. Mental health and medical day treatment.
17. Mental health and psychosocial rehabilitative services, including case management services provided by the staff of a certified community support program.
18. Nurse midwife services.
19. Nursing services, including services performed by a nurse practitioner.
20. Optometric or optical services, including eyeglasses.
21. Outpatient hospital services.
22. Personal care services.
23. Physical and occupational therapy.
24. Physician services.
25. Podiatry services.
26. Prenatal care coordination for women with high-risk pregnancies.
27. Respiratory care services for ventilator-dependent individuals.
28. Rural health clinic services.
29. Skilled nursing home services other than in an institution for mental disease.
30. Speech, hearing, and language disorder services.
31. Substance abuse (alcohol and other abuse services), including residential substance use disorder treatment.
32. TB services.
33. Transportation to obtain medical care.

If you or the member have additional questions, contact Member Services at 1-800-362-3002.

21.4.1.1 Medicaid Card Services

Medicaid card services are the Medicaid-covered services included in the ForwardHealth Online Handbook at https://www.forwardhealth.wi.gov/WIPortal/Default.aspx **except** Skilled Nursing Facility or Intermediate Care Facility payments and ancillary services. These excepted services consist of the routine, day-to-day health care services that are provided to Medicaid members by a nursing home and that are reimbursed within the daily care rate. See SECTION 17.3.1 PENALTY PERIOD INTRODUCTION for information on how Divestment impacts covered services for applicants and members receiving long-term care services.

21.4.2 Transportation

Federal regulations require the Medicaid program provide transportation for members who have no other way to receive a ride to their Medicaid health care appointments. Transportation can be by ambulance, SMV, or common carrier.

21.4.2.1 Ambulance

Ambulance transportation is a covered service if it is provided by a BadgerCare Plus certified ambulance provider and the member is suffering from an illness or injury that rules out other forms of transportation and only if it is for:

1. Emergency care when immediate medical treatment or examination is needed to deal with or guard against a worsening of the person's condition.
2. Non-emergency transportation when use of any other method of transportation is contraindicated and is authorized in writing by a physician, physician assistant, nurse midwife, nurse practitioner, or registered nurse.

21.4.2.2 Specialized Medical Vehicle

An SMV is a vehicle equipped with a lift or ramp for loading wheelchairs. The driver of an SMV must meet driver requirements in accordance with Wis. Admin. Code § DHS 105.39.

SMV transportation is a covered service if provided by a BadgerCare Plus SMV enrolled provider and a health care provider has documented why the member's condition prevents him or her from using a common carrier or private vehicle.

21.4.2.3 Common Carrier

Common carrier means any mode of transportation other than an ambulance or an SMV.

21.4.2.4 Transportation Coordination

NEMT is coordinated by the DHS NEMT manager, Medical Transportation Management Inc. (MTM Inc.). As the NEMT manager, MTM Inc. arranges and pays for rides to covered Medicaid services for members who have no other way to receive a ride. Rides can include ambulance, SMV, or common carrier transportation depending on a member's medical and transportation needs. Members must schedule routine rides at least two business days before their appointment.

The NEMT manager does not coordinate transportation for the following members:

- Members residing in a nursing home. Members residing in a nursing home have their NEMT services coordinated by the nursing home.
- Members enrolled in Family Care. Members enrolled in Family Care receive NEMT services from the Family Care MCO.

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21.5 Copayment

21.5.1 Introduction

An EBD Medicaid member may be required to pay a part of the cost of a service. This payment is called a "copayment" or "copay."

21.5.2 Copay Exempt Populations

Providers are prohibited from collecting copays from the following members:

- Children under age 19 regardless of income or benefit program.
- Children in foster care, regardless of age. or
- Children in adoption assistance, regardless of age..
- American Indians or Alaskan Native Tribal members, the son or daughter of a tribal member, the grandson or granddaughter of a tribal member, or anyone otherwise eligible to receive Indian Health Services, regardless of age or income level, when they receive items and services either directly from an Indian health care provider or through referral under contract health services.
- Former Foster Care Youth
- Anyone receiving services through Express Enrollment
- Pregnant women

21.5.3 Copay Exempt Programs

Copays will not be charged for members enrolled in the following subprograms:

- Family Planning Only Services
- Institutional Medicaid (**not including** childless adults (CLAs) enrolled in BadgerCare Plus and residing in an institution)
- Katie Beckett
- Wisconsin Well Woman Medicaid

21.5.4 Copay Exempt Services

The following services do **not** require copayment:

- Case management services.
- Crisis intervention services.
- Community support program services.
- Emergency services.
- Family planning services, including sterilizations.
- HealthCheck.
- HealthCheck "Other Services."
- Home care services.
- Hospice care services.
- Immunizations.
- Independent laboratory services.
- Injections.
- Private Duty Nursing (PDN) and PDN services for ventilator-dependent members.
- Pregnancy related services.
- Preventive services with an A or B rating from the U.S. Preventive Services Task Force.
- Residential substance use disorder treatment services.
- School-based services.

- Substance abuse day treatment services.
- Surgical assistance.

Providers are required to make a reasonable effort to collect the copayment. Copayments range from $0.50 to $3.00 for each procedure or service. Providers may not refuse services to an EBD Medicaid member who fails to make a copayment.

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21.6 HMO Enrollment

In Wisconsin, health maintenance organization (HMO) refers to managed care organizations that contract with health care providers and facilities to provide services for BadgerCare Plus and the Medicaid for Elderly, Blind or Disabled programs.

The HMO Enrollment Specialist is an organization under contract with DHS to provide unbiased HMO enrollment counseling to BadgerCare Plus and SSI Medicaid members and outreach about enrollment choice options. The HMO Enrollment Specialist also assists members in making an HMO selection and responds to questions about enrollment.

Note *This section only addresses enrollment in an SSI HMO and does not cover enrollment in a BadgerCare Plus HMO or Long-Term Care Managed Care Organization (LTC MCO).*

21.6.1 SSI HMO Enrollment

SSI Medicaid and SSI-Related Medicaid are mandatory HMO enrollment programs, meaning most members are required to enroll in an HMO. However, the following persons cannot enroll in an HMO:

- Persons who are enrolled in a long-term care managed care organization (MCO)
- Persons who live in a nursing home or medical facility
- SSI Medicaid members who are under the age of 19
- Persons who are eligible for suspended benefits (see CHAPTER 13 INMATES)

Certain persons may enroll in an HMO on a voluntary basis (see SECTION 21.6.1.1 VOLUNTARY HMO ENROLLMENT) or qualify for an exemption from HMO enrollment (see SECTION 21.6.5 EXEMPTIONS).

HMO enrollment always begins the 1st of a month. The month in which enrollment begins depends on the time of the month when eligibility was established or when the member's enrollment status changed:

- If eligibility was established prior to the 10th of the month, HMO enrollment will begin the 1st of the following month.
- If eligibility was established on the 10th of the month or later, HMO enrollment will begin the 1st of the month following the next month.

Until a member's HMO enrollment has started, the member will receive their services on a fee-for-service basis, which means they can receive covered services from any Medicaid-certified provider.

If the member's enrollment status changes during the month (for example, going from being exempt from HMO enrollment to no longer being exempt), the member will be enrolled in an HMO effective the 1st of the following month.

Retroactive enrollment (backdating HMO enrollment) may be allowed in some circumstances but may also require approval from the HMO. Members who would like to request backdated enrollment should contact an HMO Enrollment Specialist at 800-291-2002. The HMO Enrollment Specialist will review retroactive enrollment backdating requests and coordinate with the HMO if necessary.

The list of medical status codes under which a member is eligible for SSI HMO enrollment can be found on the ForwardHealth Enrollment information page. This list does not differentiate between voluntary or mandatory HMO enrollment. It is only a compilation of all medical status codes that could be enrolled in an HMO.

21.6.1.1 Voluntary HMO Enrollment

Voluntary HMO enrollment means a member is not required to enroll in an HMO but can choose to enroll in an HMO if they want to. Someone is considered voluntary for SSI HMO enrollment if they meet any of the following criteria:

- The member is residing in a service area where there is only one HMO available.
- The member reports they are a Native American, American Indian, an Alaskan Native, or a member of a federally recognized tribe or has verified their tribal member status for eligibility purposes.
- The member is eligible for both Medicaid and Medicare, often referred to as a dual eligible.
- The member is eligible for benefits under MAPP. MAPP is a voluntary enrollment program.

21.6.2 HMO Selection and Assignment

Members can choose an HMO after they are found eligible for SSI Medicaid, SSI-Related Medicaid, or MAPP. Individuals who are applying for benefits online through ACCESS can indicate an HMO preference when they submit their application. Indicating a preference does not guarantee the individual will be enrolled in the HMO they selected when they submitted the application, but the preference will be taken into account when assigning the member to an HMO after they become eligible for benefits. If the member did not indicate a preference when they submitted their application, an HMO will be assigned for the individual based on any previous enrollment in an SSI HMO or based on a round-robin HMO assignment.

Enrollment in an SSI HMO is on an individual basis, meaning household members could be in different HMOs from other members of the household or their spouse. If the member was previously enrolled in an SSI HMO in the last 12 months, the member will be assigned to their previous HMO.

For members who are required to enroll in an HMO, if the member never indicated a preference to begin with, they will be assigned to an HMO and will receive an HMO enrollment packet in the mail. The enrollment packet includes a cover letter with information on their assigned HMO and start date, an SSI HMO Program Guide (P-12770) with a list of available HMOs and their service areas, an enrollment form, and instructions on how to choose or change an HMO.

Voluntary members will also receive an HMO enrollment packet but will not be assigned to an HMO. They will receive a cover letter explaining they are not required to enroll in an HMO but can choose one if they want to.

To select an HMO, check their current enrollment status, or make a change to their current enrollment, members can:

- Log in to their ACCESS account and navigate to the “Manage My HMO” tab.
- Complete and return the HMO Enrollment Choice form by mail.
- Call the HMO Enrollment Specialist by phone at 1-800-291-2002.

Members with questions about their rights as HMO members or concerns about the care they receive from the HMO may contact the HMO Ombuds. The HMO Ombuds can assist members in researching and resolving grievances or conflicts about their care.

HMO Ombuds
P.O. Box 6470
Madison, WI 53791-9823
Phone: 1-800-760-0001 (Monday through Friday from 8 a.m. to 4:30 p.m.)

The SSI Managed Care External Consumer Advocate also provides advocacy services for SSI Medicaid HMO members with a disability. Members can contact the SSI Managed Care External Consumer Advocate at 800-928-8778 from 8:30 a.m. to 5 p.m., Monday through Friday.

21.6.3 Open Enrollment and Lock-in Periods

Once a member has been assigned to an HMO, they will have a three-month open enrollment period beginning from their initial HMO enrollment date in which they can change HMOs freely. After the three-month open enrollment period, the member enters a lock-in period for nine months. During the lock-in period, they cannot change HMOs or disenroll from the HMO without a qualifying reason such as an exemption or a change to an enrollment status that does not require HMO enrollment.

Note *The open enrollment and lock-in periods do not align with the 12-month eligibility certification period.*

Example 1	Lorena applies and is found eligible for SSI-Related Medicaid on September 15 with a certification period of September 1 through August 31. She is assigned to HMO A with an enrollment start date of November 1. Her open enrollment period is from November 1 through January 31. Her lock-in period is from February 1 through November 30.

If a member is regaining HMO enrollment after more than two months of not being enrolled, the member will be assigned to their previous HMO (if they were enrolled in this HMO in the last 12 months) but will get a new open enrollment and lock-in period.

After the lock-in period has ended, the member is able to change HMOs at any time and does not need a qualifying reason to change HMOs. However, when a new HMO is selected, it will restart the open enrollment and lock-in cycle again effective with the start date of enrollment in the new HMO. If the member does not change HMOs after the lock-in period has ended, they will be reminded once every year (if they remain eligible for Medicaid under the same category of eligibility) that they can change HMOs.

Voluntary members will be subject to the open enrollment and lock-in period if they choose to enroll in an HMO. During the open enrollment period, a voluntary member may choose to disenroll from the HMO without cause and choose fee-for-service (FFS).

21.6.4 HMO Disenrollment

Members may be disenrolled from the HMO for a variety of reasons. Some disenrollments are automatic, meaning the disenrollment occurs based on changes to the member's eligibility or enrollment status. There are also voluntary disenrollments, which can be requested by the member, the member's family, or a legal guardian, and involuntary disenrollments, which are requested by the HMO.

21.6.4.1 Automatic Disenrollment

Automatic disenrollment occurs when there are changes to the member's eligibility or enrollment status that affects their HMO enrollment and typically occurs automatically once eligibility has been updated. The table below includes a list of automatic disenrollments and date on which the disenrollment is effective.

Reason for Disenrollment	Disenrollment Date
Loss of Medicaid eligibility	End of the month in which Medicaid eligibility ends.
Date of Death entered	Date of Death

Moving outside of the HMO's service area	End of the month in which the move was reported
Incarceration or Institutionalization	End of the month prior to the month incarceration or institutionalization starts and lasts more than 30 calendar days
Enrollment in a Waiver program or Long-Term Care MCO	End of the month prior to the month waiver program or LTC MCO enrollment starts

21.6.4.2 Voluntary Disenrollment

The member may disenroll from the HMO for any reason as long as they are no longer in their lock-in period.

If the member is still in the lock-in period, the member, the member's family, or the legal guardian must request disenrollment based on a qualifying reason.

Qualifying reasons for disenrollment include but are not limited to:

- A temporary loss of eligibility caused the member to miss their open enrollment period.
- The HMO does not cover the service the member seeks, due to moral or religious objections.
- The member needs related services (for example, a cesarean section and tubal ligation) to be performed at the same time, but not all related services are within the provider network and the member's primary care provider or another provider determines that the risk of receiving services separately would subject the member to unnecessary risk.
- The member is enrolled in both Medicaid and a Medicare Dual Eligible Special Needs Plan (D-SNP) and is requesting to align their Medicaid-HMO with their Medicare D-SNP.
- Other reasons, including poor quality of care, lack of access to services, or lack of access to providers experienced in dealing with the member's care needs.

Voluntary disenrollments are effective no later than the first day of the month following the month in which the disenrollment was requested.

If the SSI HMO fails to complete a required assessment and care plan during the first 90 days of enrollment and is able to demonstrate a good faith process to complete the assessment, the open enrollment period will be extended an additional 30 days.

21.6.4.3 Involuntary Disenrollment

The Department of Health Services may approve involuntary disenrollments with an effective date of the following month, if approved with the exception of a just- cause disenrollment, which may require additional review of the effective date of disenrollment based on the circumstances.

The HMO must submit a disenrollment request to the Department and include evidence attesting to the reason. The HMO must direct all members for whom an involuntary disenrollment request has been made to the HMO Enrollment Specialist for assistance and/or for choice counseling.

Involuntary disenrollments may include but are not limited to:

- **Just Cause** – A situation where enrollment would be harmful to the interests of the member or in which the HMO cannot provide the member with medically necessary services for reasons beyond the HMO's control. An HMO cannot request just- cause disenrollment because of an adverse change in the member's health status, or because of the member's utilization of

medical services, diminished capacity, or uncooperative disruptive behavior resulting from the member's special needs (except when their continued enrollment in the HMO seriously impairs the HMO's ability to furnish services to the member or other members).

- **The member is residing in a nursing home for longer than 90 days** – The member, the nursing home, or the HMO may contact the HMO enrollment specialist to disenroll the member from the HMO so nursing home services can be billed fee-for-service. Once the member is no longer residing in the nursing home, the member may be eligible for HMO enrollment.

21.6.5 Enrollment Exceptions

Members with specific needs can disenroll or opt out of HMO enrollment and receive their health care under fee-for-service if they meet the rules for an enrollment exemption. Most exemption requests must come from the member, the member's family, or legal guardian. They may need to be approved by either the HMO Enrollment Specialist, an HMO Ombuds, or state Nurse Consultant.

Exemptions will generally be effective the first day of the next month after the month in which the exemption was requested, unless otherwise specified. Exemption requests will not be backdated unless an exception is granted by the Department. The duration of the exemption may vary depending on the type of exemption. Members should be directed to the HMO Enrollment Specialist for assistance in requesting an exemption and/or choice counseling.

Note *The state Nurse Consultant provides consultation and technical assistance on topics related to health needs and complex care. The Nurse Consultant may need to make decisions on enrollment exemptions related to complex health care needs.*

Types of Enrollment Exemptions

Exemption	Description
Admission or Enrollment in the Birth to 3 Program (BadgerCare Plus only)	The head of the household or the county Birth to 3 Program may request an exemption on behalf of the child when the child is enrolled in the Birth to 3 Program. Birth to 3 Program providers are encouraged to work with the member's HMO before requesting the enrollment exemption. This exemption can be backdated up to two months from the month the request is received.
Commercial Insurance or Commercial HMO Enrollment	The member is enrolled in a commercial insurance plan or commercial HMO that limits them to a restricted private network and does not align with the SSI HMO provider network.
Continuity of Care	A one- to two- month continuity of care exemption may be granted when a member is newly enrolled or about to be enrolled in an HMO and has an upcoming appointment (within the next two months) with a provider with whom they have a previously established relationship, and that provider is not part of the HMO's network. If the member has more complex medical needs and requires an exemption longer than two months, the HMO Enrollment Specialist will refer the member to the State Nurse Consultant. In addition, a longer continuity of care exemption can be granted for a pregnant individual who wants to see a nurse midwife/practitioner of their choosing who is not part of the HMO's provider network. For a pregnant

	individual, the exemption can be applied at any time starting from the month of request through two months after the estimated due date.
Distance	This exemption may be granted for a one- to -two-month period when a member has moved out of an HMO's service area while their eligibility has not yet been updated to reflect the change in address AND the member needs immediate care in the area that is not covered by their current HMO.
HIPP Determination in progress or enrollment in the HIPP program	This exemption may be granted if the member is pending an eligibility determination for the HIPP program or is enrolled in the HIPP program, and the employer-sponsored insurance plan limits the member to a restricted provider network that does not align with the HMO's provider network.
Long Term Complex Care	The state Nursing Consultant may apply this exemption for up to 12 months for individuals who have complex needs and may need specialized care outside of a member's HMO network.
Low Birth Weight	The state Nurse Consultant may apply this exemption to newborns with a low birth weight (birth weight less than 2,500 grams or 5 lbs. 8 oz.).
Native American, American Indian, Alaskan Native or member of a federally recognized Tribe	If the member attests they are a Native American, American Indian, Alaskan Native, or a member of a federally recognized tribe, they are not required to enroll in an HMO. The member can choose to remove this exemption at any time to enroll into an HMO.
Care4Kids Extension	This exemption applies to children in BadgerCare Plus who are still receiving services under the Care4Kids 12-month extension after being discharged from out-of-home care. Care4Kids is a specialized managed care program for children in out-of-home care in Kenosha, Ozaukee, Milwaukee, Racine, Washington, and Waukesha counties.
Transplants	The member had a stem cell or bone marrow transplant or the member is receiving sickle cell disease gene therapy. Members undergoing stem cell or bone marrow transplants will be permanently exempted from HMO enrollment effective the first of the month in which the surgery is performed. Members undergoing sickle cell disease gene therapy will be permanently exempted from HMO enrollment effective the first of the month in which successful apheresis is performed. Transplant exemption requests may be made by the HMO or the member and are directed to the state Nurse Consultant.

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21.7 ForwardHealth Cards

21.7.1 ForwardHealth Cards Introduction

ForwardHealth cards are issued to Medicaid members. These cards are permanent, plastic, and display the word "ForwardHealth" on them. Members use the same ForwardHealth card each month. Monthly cards are not issued.

The cards do not display eligibility dates. Health care providers use the ID number on the front of the card to bill for services provided to the member.

Cards should not be thrown away. If a member becomes eligible again, he or she will use the same ForwardHealth card originally issued. If members have questions regarding their eligibility status, they can log into *ACCESS* or call Member Services at 1-800-362-3002.

BadgerCare Plus and Medicaid

SeniorCare

Each person in the family who is eligible for Medicaid receives his or her own card. The cards do not display eligibility dates. All Medicaid services are paid for under the Medicaid ID number on the card.

Members will know if they are eligible based on positive and negative notices sent from the IM agency. Members who receive a notice that they are no longer eligible for Medicaid should keep their ForwardHealth cards. Cards should not be thrown away. If a member becomes eligible again, he or she

will use the same ForwardHealth card originally issued. If members have questions regarding their eligibility status, they can call you or Member Services at 1-800-362-3002.

21.7.2 Homeless

Make ID cards available to homeless Medicaid members who have no fixed address or mailing address. Use your agency address or some other fixed address for delivery.

21.7.3 Pharmacy Services Lock-in Program

A program called Pharmacy Services Lock-In is available in cases of benefit misuse. Members enrolled in the Pharmacy Services Lock-In Program are assigned to one primary care provider and one pharmacy to reduce unnecessary physician and pharmacy utilization and to discourage the non-medical or excessive use of prescription drugs. The Pharmacy Services Lock-In Program applies to members in fee-for-service as well as members enrolled in Medicaid SSI HMOs and BadgerCare Plus HMOs. Members remain enrolled in the Pharmacy Services Lock-In Program for two years and are continuously monitored for their prescription drug usage. At the end of the two-year enrollment period, an assessment is made to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program.

The Pharmacy Services Lock-In Program monitors claims for pharmacy services and prescription drugs specifically. The Pharmacy Services Lock-In Program does not address other types of member fraud or misuse of benefits, such as misuse of the ForwardHealth card or excessive use of emergency room services.

If a provider suspects that a member is abusing his or her benefits or misusing his or her ForwardHealth card, providers are required to notify ForwardHealth by calling Provider Services at 800-947-9627 or by writing to:

Division of Medicaid Services
Bureau of Benefits Management
P.O. Box 309
Madison, WI 53701-0309

21.7.4 Temporary Cards

With implementation of the ForwardHealth ID card, temporary ID cards are no longer used or available for ordering from the fiscal agent.

21.7.5 Lost or Stolen Cards

If a member needs a replacement card, they or an authorized representative, can request a replacement card by:

1. Going to ACCESS.
    a) Create an ACCESS Account, then
    b) Go to your ACCESS Account Home Page and select a new ForwardHealth card (see ACCESS User Guide, Section 4.10 Get a New Card), or
2. Contacting Member Services at 1-800-362-3002.

If the member has multiple benefit ID cards, there will be a choice of which ID card to request. A new ForwardHealth card will be created the evening of the request and will be sent out the following business day.

Replacement cards are issued automatically when the card has been returned as undeliverable and the member’s address changes.

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21.8 Waiver of Medicaid Benefit Limitations

A person who is eligible for Medicaid but has been refused a specific, medically necessary Medicaid benefit by a provider can work with his or her provider to apply for a discretionary waiver or variance. The waiver or variance cannot be used to receive noncovered services. If a waiver or variance is requested, the Division of Medicaid Services would consider whether to grant the waiver or variance to allow the person to receive the benefit.

The provider of the service must request the waiver. The written request must meet all requirements detailed in Wis. Admin. Code § DHS 106.13 and should be sent to the following address:

Division of Medicaid Services
Waivers and Variances
P.O. Box 309
Madison, WI 53701-0309

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21.9 Third Party Coverage

See SECTION 9.1 THIRD PARTY LIABILITY.

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21.10 Good Faith Claims

21.10.1 Definition of Good Faith Claims

A good faith claim is a claim that has been denied by Medicaid with an eligibility-related EOB code. This occurs even though the provider verified eligibility for the dates of service billed and submitted a correct and complete claim. Providers can resubmit the claim to the fiscal agent to be processed as a good faith claim. If the eligibility file has been updated by the time the claim is resubmitted, it will be paid automatically. If the file still does not reflect eligibility for the period covered by the claim, the fiscal agent will try to resolve the eligibility discrepancy. If they are unable to resolve it from the information available, they will contact you to verify eligibility. The Good Faith Medicaid/BadgerCare Plus Certification form (F-10111) is used for this purpose. A good faith claim cannot be reimbursed until the fiscal agent member file is updated.

21.10.2 Denials

If a provider receives a claim denial for one of the following reasons on the Remittance Advice, the provider can resubmit it as a good faith claim .

R/A Report Denial Code	Reason
029	Medicaid number doesn't match recipient's last name.
172	Recipient Medicaid ID number not eligible for dates of service.
281	Recipient Medicaid ID number is incorrect. Verify and correct the Medicaid number and resubmit claim.
614	Medicaid number doesn't match recipient's first name.

21.10.3 Causes and Resolutions

Causes and a good faith claim can occur when:

1. A member presents an ID card that is invalid because:
    a) You issued a temporary ID card for a prior period or manually determined case and did not update CARES or send the fiscal agent an F-10110 (formerly DES 3070) to update the member's eligibility file. The fiscal agent will apply the dates of eligibility indicated on the card with med stat 71. A letter will be sent to you to confirm that the member is eligible for the dates on the card. The letter will include instructions on how to complete a F-10111 and the information that is needed.
    b) The provider suspects the member of misusing or abusing a Medicaid ID card (i.e., using an altered card or a card that belongs to someone else). If the provider submits a copy of the card and the fiscal agent can tell that it was altered, the fiscal agent will contact you to verify the member was eligible or forward it to the DMS for review.
2. The member's name has changed since the card was issued. The fiscal agent can usually resolve claims that are denied with code "029" and "614." If necessary, the fiscal agent will contact you to confirm the information.

With the implementation of the ForwardHealth ID cards, providers are less likely to receive one of the eligibility-related denials used for good faith claim submissions. Providers are told to verify eligibility using the variety of methods available to them through the Eligibility Verification System (EVS). When

the provider verifies the member's eligibility, they are getting the most current information available on the MMIS. Therefore, it is unlikely that they will be told the member is eligible when he or she is not.

The most likely reason a good faith situation arises is when a provider sees a temporary paper ID card issued by the agency. The provider may bill Medicaid before the eligibility is updated on MMIS, or perhaps the eligibility was never sent to MMIS. In either case, if the member presents a valid temporary Medicaid ID card for the dates of service, and the provider sends a copy of the card with the good faith claim, the fiscal agent will update the member's eligibility file with a good faith segment and pay the claim immediately.

The fiscal agent will then attempt to resolve the discrepancy from information on file or contact you to confirm eligibility and correct the eligibility segment. If the provider does not send a copy of the ID card with the claim, the fiscal agent must confirm eligibility with you before the claim can be paid.

The definition of a valid card is either a:

1. ForwardHealth card that indicates eligibility for the dates of service through the EVS.
2. A temporary paper card showing dates of eligibility.

21.10.4 Process

The fiscal agent initiates the good faith claim process by sending you a Good Faith Medicaid/BadgerCare Plus Certification form (F-10111) that they have partially completed and one or two letters, depending on what documentation of eligibility the provider included with the claim. Complete F-10111 for new members (cert. 1) or F-10110 (formerly DES 3070) for amended certifications (cert. 3). Send completed F-10111 forms to:

ForwardHealth
Good Faith Unit
P.O. Box 6215
Madison, WI 53784

Send completed F-10110 forms by fax to 608-221-8815 or by mail to:

ForwardHealth
Eligibility Unit
P.O. Box 7636
Madison, WI 53707

21.10.5 Instructions

Agency Denial

If the member identified on this Good Faith form was neither eligible nor possessed a valid ID card for the dates of service indicated in field six, place an "X" in this box. If you check "Yes" here, you must also check the reason in the field below.

Member Did Not Have ID Card After Date of Service

Place an "X" in this box if you are certain that the member did not possess a valid Medicaid ID card for the date of service. In the blank provided, enter the closing date of eligibility.

Recipient Not Eligible

Place an "X" in this box if the member was not eligible for any of the dates of service shown. If the member was eligible for some of the dates of service, follow the instructions for completing the Partial Deny box.

Record Not Found

Place an "X" in this box if the member has never been eligible for Medicaid in your agency.

Dates of Services

The fiscal agent enters the dates of service for the claim.

Partial Deny

Use this field only if the member had eligibility for some of the dates of service. Enter the "from" and "to" dates which cover the portion of the dates of service for which the member did not have eligibility.

Type of Certification

The fiscal agent will check one of these boxes:

1. Initial Certification
   The fiscal agent will place an "X" in this box when the member and Medicaid number submitted on the claim cannot be found on the eligibility master file.
2. Amended Certification
   The fiscal agent will place an "X" in this box when the member is on MMIS, but no eligibility exists for the claimed dates of service.

Agency Number

The fiscal agent will enter the three-digit code of the agency they believe may have certified the member during the dates in question.

Casehead ID Number

The fiscal agent will enter the known or suspected MMIS case number (primary person’s SSN + tie-breaker) of the member listed on the provider’s claim.

Action Date

The fiscal agent enters the date they completed the Good Faith form.

Medical Status Code

When the fiscal agent receives the provider’s claim along with a photocopy of an ID card, a hard copy response received through EVS, or a transaction log number from the Automated Voice Response (AVR), the fiscal agent compares the dates of service with the dates on the card. If the dates of service fall within the dates of eligibility for the ID number on the card, the fiscal agent enters a “71” medical

status code and pays the claim immediately. The fiscal agent then enters the eligibility dates for the entire month in which services were provided.

If the member was eligible for the entire period of certification shown on the Good Faith form (F-10111), remove the "71" medical status code and write in the correct code. Attach a F-10110 (formerly DES 3070) to add the certification period and appropriate medical status code for the time when the member was eligible for Medicaid.

Period of Certification

If the fiscal agent has entered the suspected period of certification to be added to the member master file, check it for accuracy. Then complete a F-10110 (formerly DES 3070) and enter the period of certification if the member file does not show eligibility for the time when the member was eligible or for the time covered by an ID card issued to the member.

Control Name Year of Birth

The fiscal agent will enter the suspected control name and year of birth (YOB) for the member. This control name must be the first four letters of the member's last name. The YOB is the last two digits in the member's year of birth. Both of these items must match the information currently in the member's fiscal agent file.

Current ID Number

The fiscal agent will enter the member's current Medicaid ID number.

Date of Birth

The fiscal agent completes this field only for initial certifications. Change this birth date if the date entered is incorrect. Indicate birthdate as MM/DD/CCYY.

Signature of Agency Director

Good Faith forms must have an authorized signature for initial certifications.

Worker ID

On initial certifications, enter the six-digit worker code of the certifying IM worker.

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21.11 Five Percent Cost Share Limit

Members may not pay more than five percent of their household income for monthly premiums and copays for BadgerCare Plus or Medicaid card services. This limit does not apply to deductibles, patient liability for Institutional Medicaid, or cost sharing for Home and Community-Based Waiver services.

The five percent cost share limit applies to members eligible for BadgerCare Plus, SSI Medicaid, and most EBD Medicaid programs. Members enrolled in MAPP and SeniorCare do not have a cost-sharing limit.

For members subject to the cost-sharing limit, a copay limit will be set on a monthly basis. The copay limit is based on the assistance group's income used to determine eligibility. Copays are tracked based on copays the individual has incurred, not the amount of copays actually paid.

21.11.1 Copay Limits for Members and Programs exempt from copays

Members who are in a copay exempt category (21.5.2 COPAY EXEMPT POPULATIONS) will not have a copay limit while they are copay exempt since they have no copays.

Members who are enrolled in any copay exempt subprograms (21.5.3 COPAY EXEMPT PROGRAMS) will have a copay limit of $0 as there are no copays for members enrolled in these programs.

21.11.2 Programs Excluded from the Five Percent Cost Share Limit

Members enrolled in the following subprograms will continue to be charged premiums and copays with no five percent cost share limit set based on their income:

- Medicaid Purchase Plan (MAPP)
- SeniorCare

Note: *Members who are enrolled only in Medicare Savings Programs (except for Qualified Medicare Beneficiaries (QMB)) do not receive Medicaid card services and thus do not have copays.*

21.11.3 Determining the Copay Limit

For members enrolled in a health care program that has a copay limit, copay limits will be based on the assistance group's income used to determine eligibility. Per-member copay limits will be set based on the income tiers (see SECTION 39.12 FIVE PERCENT COPAY LIMIT TIERS).

If the member is married and both spouses are enrolled in a health care program that has a copay limit (and neither spouse is exempt from copays), the copay limit will be prorated between them. If one spouse is exempt from copays (for example, due to pregnancy), the other spouse will have the full individual copay limit for their income tier.

Example 1:	Jane and Benji are married and enrolled in SSI-Related Medicaid. The assistance group has counted income which puts their household income in the 50-100% of FPL income tier for an assistance group size of two. Since both Jane and Benji are eligible and have to pay copays, the $26 copay limit for the household will be prorated between Jane and Benji. They will each have a monthly copay limit of $13.

Note: *If needed, use the following formula to determine the assistance group income FPL percentage and the appropriate tier:Assistance Group Income / (100% FPL for the group size) = Assistance Group Size % FPL.*

If spouses are enrolled in two different health care programs (and both programs have a copay limit), the copay limit for the household will be calculated based on the assistance group with **lower** income and prorated between spouses. This will prevent the spouse with lower income from paying cost sharing expenses in excess of the five percent limit.

Example 2:	Dave, his wife Debbie, and their son Derek receive health care benefits. Dave is enrolled in SSI-Related Medicaid and Debbie and Derek are enrolled in BadgerCare Plus. Due to the different income budgeting rules for SSI-Related Medicaid and BadgerCare Plus: • The countable income for SSI-Related Medicaid is 69% of the FPL for a group size of two. That puts the SSI-Related Medicaid assistance group income in the >50-100% of FPL income tier. • The countable income for BadgerCare Plus is 48% of the FPL for a group size of three. That puts the BadgerCare Plus assistance group income in the 0-50% of FPL income tier. To determine the copay limit for the household, the lower BadgerCare Plus assistance group income tier of 0-50% of FPL will be used. Debbie, Dave, and Derek each have a $0 copay limit, meaning they will not be charged any copays.

If a member who is enrolled in a health care program that has a copay limit is married to someone who is enrolled in a program that has no copay limit (MAPP or SeniorCare), the member will have the full individual copay limit for his or her income tier.

Example 3:	Sean and Sandra are a married couple. Sean is enrolled in SeniorCare and Sandra is enrolled in medically needy SSI-related MA. The countable income for Sandra's SSI-Related Medicaid assistance group is 72% of the FPL, which puts this assistance group in the >50-100% of FPL income tier. Because Sean is enrolled in a program that has no copay limit, Sandra will pay the full individual copay limit of the income tier.

For members who are eligible for both QMB and a full benefit health care program that has a copay limit, the income used to determine eligibility for the full benefit program will be used to calculate the member's copay limit.

Example 4:	Dwayne is eligible for both SSI-Related Medicaid and Medicare. He also qualifies for QMB. Under SSI-Related Medicaid, Dwayne's income is in the >50-100% of FPL tier. His copay limit is $26 per month based on his SSI-Related Medicaid eligibility. Since QMB is a limited benefit program, no copay limit will be set for QMB. If Dwayne were only eligible for QMB, his copay limit would be set based on the income used to determine his eligibility for QMB.

21.11.3.1 Determining Copay Limits for Community Waivers Group B and B Plus

For Group B and B Plus Home and Community Based Waiver members, the copay limit will be based on the member's cost share amount for Waiver services rather than the income used to determine the member's eligibility.

- If the Waiver services cost share amount is less than $27 (the full individual copay limit for the >50-100% of FPL income tier plus one dollar), the Group B or B Plus Waiver member will have the copay limit for the 0-50% of FPL income tier ($0).
- If the Waiver services cost share amount is $27 or greater, the Group B or B Plus Waiver member will have the copay limit for the >50-100% of FPL income tier ($26).

Example 7:	Marge is a Group B waiver member. Her Waiver cost share amount is $15. Because this amount is less than $27, Marge's copay limit is $0, which means that she will not be charged any copays.

Example 8:	George is a Group B waiver member. His Waiver cost share amount is $120. George's copay limit is $26 because his cost share amount is greater than $27.

If a Group B or B Plus Waiver member is married to someone who is also a Group B or B Plus Waiver member or is enrolled in another Medicaid subprogram that has a copay limit (and who is not exempt from copays), the copay limit calculated for the spouse in the lower copay limit tier will be prorated between the two spouses.

Example 9:	If Marge and George in examples 6 and 7 above were a married couple, the copay limit for the household would be based on the spouse in the lower copay limit tier (in this case, Marge). Marge and George would therefore each have a copay limit of $0.

Example 10:	Trevor and Kate are married and enrolled in different health care benefits. Trevor is eligible for SSI-Related Medicaid and his income falls in the >0-50% FPL tier. Kate is eligible for Community Waivers Group B. Her Waiver cost share amount is $65. Since Trevor's income would be in a lower FPL tier than Kate's Waiver cost share amount, Trevor and Kate would each have a copay limit of $0.

If a Group B or B Plus Waiver member is married to someone who is enrolled in a program that has no copay limit (MAPP or SeniorCare), the Waiver member will have the full individual copay limit for his or her copay limit tier.

Example 11:	Steve and Angela are a married couple. Steve is a Group B Plus Waiver member and Angela is enrolled in MAPP. Steve's Waiver cost share amount is $30, so his copay limit is based on the >50-100% of FPL income tier. Angela has no copay limit.

21.11.3.2 Determining Copay Limits for Members in SSI Medicaid

- For SSI Medicaid members, whose Medicaid eligibility is determined by the Social Security Administration (SSA) rather than income maintenance agencies, per-member copay limits will be based on the >50-100% of FPL income tier (see APPENDIX 39.12 FIVE PERCENT COPAY LIMIT TIERS).

If an SSI Medicaid member is married to someone who is enrolled in BadgerCare Plus or an EBD Medicaid subprogram that has a copay limit, each spouse's copay limit will be calculated individually and the copay limit will not be prorated between spouses.

Example 12:	Chantal and Peter are married and both are receiving health care benefits. Chantal is eligible for SSI Medicaid and Peter is eligible for SSI-Related Medicaid with income at 84% of the FPL. Chantal and Peter will each have individual copay limits as listed in APPENDIX 39.12 FIVE PERCENT COPAY LIMIT TIERS.

21.11.4 Changes to the Copay Limit

Once determined, the copay limit will remain the same from month to month unless changes are reported that affect the copay limit, such as a change in income or household composition. Members have the right to appeal their monthly copay limit.

Increases in copay limits may not be made without providing timely notice to the member. If a change results in an increase in the member's copay limit and eligibility is confirmed prior to adverse action for the month, the copay limit increase will be effective the following month. If eligibility is confirmed after adverse action, the copay limit increase will be effective two months after the month in which the change occurred.

If a change results in a decrease in the monthly copay limit, the decrease should be effective during the month in which the change occurred or, if the change was reported untimely (more than ten days after the change occurred), the month in which the change was reported, whichever is later.

21.11.5 Meeting the Copay Limit

Members are notified once they have incurred enough copays before the end of the month to meet their monthly copay limit. This notification is informational only and members may not appeal the date the copay limit was determined to have been met. Once the copay is met for a given month, it can never become "unmet" in the same month and the member will not be charged any more copays in that month.

Example 13:	Tamika is enrolled in HCBW and has a copay limit of $26 for the month of August. On August 12, interChange notifies CARES that Tamika has met her copay limit of $26. CARES issues Tamika an automated notice stating that her $26 copay limit has been met for the month of August and that she will have no copays for the remainder of the month. On August 21, Tamika has a doctor's appointment. She will have no copay for the doctor's appointment since her copay limit has already been met for the month of August. On September 1, Tamika will be responsible for copays incurred until her monthly limit is met.

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22 Administration

22.1 Estate Recovery

22.1.1 Estate Recovery Program Definition

The state seeks repayment of certain correctly paid health and LTC benefits by Medicaid members through all of the following:

- Liens against a home
- Claims against estates
- Affidavits
- Voluntary recoveries

22.1.2 Recoverable Services

Not all services provided by Medicaid are recoverable. Recoverability depends on what was provided and the member's age and residence when he or she received the benefit.

The following are the services for which ERP may seek recovery:

1. All Medicaid services received while living in a nursing home on or after October 1, 1991.
2. All Medicaid services received while institutionalized in an inpatient hospital on or after July 1, 1995.
3. Home health care services received by members age 55 or older on or after July 1, 1995, consisting of:
    a) Skilled nursing services.
    b) Home health aide services.
    c) Home health therapy and speech pathology services.
    d) Private duty nursing services.
    e) Personal care services received by members age 55 or older on or after April 1, 2000.

Example	Josie is 12 years old and is enrolled in Katie Beckett Medicaid. She receives home health care services that include skilled nursing services, home health therapy, and speech pathology. Because she was not 55 years or older when she received the home health care services, she is not subject to estate recovery.

4. All HCBW services (COP-W, CIP 1A, CIP 1B, CIP II, Brain Injury Waiver, Community Opportunities and Recovery, and Community Supported Living Arrangements) received by members age 55 or older between July 1, 1995, and July 31, 2014:
    a) Prescription/legend drugs received by waiver participants.
    b) Benefits paid associated with a waiver participant's inpatient hospital stay. These include inpatient services that are billed separately by providers and services that are noncovered hospital services.
5. Family Care services received by members age 55 or older between February 1, 2000, and July 31, 2014:
    a) Prescription/legend drugs received by waiver participants.
    b) Benefits paid associated with a waiver participant's inpatient hospital stay. This includes inpatient services that are billed separately by providers and that are non-covered hospital services.

Note: *The Non-Medicaid Family Care no longer exists as of May 1, 2003. However, ERP could recover from members who received benefits under this program prior to May 1, 2003.*

6. All Family Care Partnership HCBW services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older between March 1, 2009, and July 31, 2014.
7. All IRIS services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older before August 1, 2014.
8. All Medicaid services received by members age 55 or older participating in a LTC program on or after August 1, 2014.
   LTC programs include all HCBW programs (including COP-W, CIP 1A, CIP 1B, CIP II, Brain Injury Waiver, Community Opportunities and Recovery, Community Supported Living Arrangements, FamilyCare, FamilyCare Partnership, IRIS, and PACE). The capitation payment made to the MCO on or after August 1, 2014, will be recovered for members receiving LTC program services through managed care.
9. Costs that may be recovered through a lien are:
   a) Medicaid costs for services received on or after October 1, 1991, during a nursing home stay or services received while institutionalized in a hospital on or after July 1, 1995.
   b) Medicaid costs of all other recoverable services as listed in Items 1-5 that are received on or after April 1, 2000, by members age 55 or older as of the date of the service.

If a member's services do not meet the criteria listed above, they are not subject to estate recovery.

22.1.2.1 Medicare Savings Programs

As of January 1, 2010, payments for premiums, copayments, and deductibles for QMB and Medicare Part B for any MSP member are not recoverable through ERP.

22.1.3 Nursing Home Definition

For ERP purposes, a "nursing home" is a place that provides 24-hour services, including room and board, to three or more unrelated residents who, because of their mental or physical condition, require nursing or personal care more than seven hours a week. This includes SNF, ICF, in-patient psychiatric facilities, and Facilities for the Developmentally Disabled (FDD). A "nursing home" does not include:

1. A convent or facility owned or operated exclusively by and for members of a religious order that provides reception and care or treatment.
2. A hospice, as defined in Wis. Stat. § 50.90(1), that directly provides inpatient care.
3. Community waiver residence.
4. IMD.

22.1.4 Liens

DHS will not file a lien on:

1. Non-home property.
2. Homestead property sold by land contract.
3. Property outside Wisconsin (see SECTION 22.1.4.2 OUT-OF-STATE PROPERTY).
4. A mobile home or the land it sits on when the member does not own the land.

DHS may file a lien on:

1. A home and all property used and operated in connection with that home.

2. A mobile home and the land it sits on, when the member owns the land.
3. A home placed in a revocable trust (see SECTION 22.1.4.8 HOMES PLACED IN REVOCABLE TRUSTS).
4. Life estates created on or after August 1, 2014.

When a home is sold, DHS uses the lien to recover certain payments for Medicaid services provided as listed in SECTION 22.1.2 RECOVERABLE SERVICES. The lien's value is "open ended." The lien's value increases as the amount of recoverable Medicaid services paid accumulates.

Payment of the lien is made directly to DHS. Do not accept any payments relating to liens filed by DHS.

Contact the ERP Estate Recovery Specialist if the member's home is sold within 45 days after the Notice of Intent to File a Lien is completed.

The lien has no effect until filed.

Example 1	Aaron applies for Medicaid on March 6, 1995. He has a home and his circumstances require a lien. The IM agency sends a Notice of Intent to File a Lien on March 10, 1995. ERP staff cannot file a lien until April 24, 1995, because of the required 45 day waiting period. Aaron's legal representative sells the property on April 10, 1995. Recovery of Aaron's Medicaid payments by a lien on that property is not possible as the property was sold before a lien was filed. The IM agency contacts the ERP Lien Specialist to report on the home's sale.

22.1.4.1 Notice of Intent to File a Lien

A Notice of Intent to File a Lien (F-13038) must be sent when a Medicaid member meets all the following criteria:

1. They live in a nursing home or inpatient hospital and are required to contribute to the cost of care. (Individuals eligible under a MAGI group are not required to contribute to the cost of care and are not subject to liens on their homes.)
2. They own a home.
3. They are not expected to return to live at that home.
   Base this decision on the person's medical condition. Their physician's statement that they can reasonably be expected to return home is sufficient support for the person's claim that they will return.

   The physician's statement should include a description of the diagnosis and prognosis for the member. A form asking for a physician to merely indicate by checking a box, etc., that there is a reasonable expectation that the institutionalized individual will return home is not acceptable or sufficient. Allow the physician a reasonable amount of time to provide this information.

   When there is contradictory information (from a nursing home social worker, discharge planner, etc.) concerning the reasonable expectation of returning home, or you question the reasonableness of the statement by the member, family, guardian, power of attorney, or physician that the person will return home, consult with the ERP's Estate Recovery Specialist. Do **not** file a Notice of Intent to File a Lien until ERP staff has checked with DHS medical consultants. If ERP determines there is not a reasonable expectation, ERP will send you a letter listing the reasons for this decision. At that point, if all of the other conditions described in this section are met, file the Notice of Intent to File a Lien.
4. None of the following relatives of the member reside in the home:

   a) Spouse

b) Child who is any of the following:
   i. Under age 21
   ii. Blind
   iii. Disabled

c) Sibling, if the two following conditions apply to the sibling:
   i. They have an equity interest in the home.
   ii. They have lived in the home continuously beginning at least 12 months before the member's nursing home or hospital admission.

A copy of the completed Notice of Intent to File a Lien must be stored in the member's case file and sent to the following:

- The member or their authorized representative
- The Estate Recovery Program (ERP) office

See Process Help, Section 11.10.3.1 How to Send the Notice of Intent to File a Lien.

ERP staff delays further action until the period given to the member to request a fair hearing passes. If no hearing is requested, ERP staff will file a lien on the property with the Register of Deeds for the county in which the property is located. If a hearing is requested, a lien is not filed until approved by a hearing decision.

22.1.4.2 Out-of-State Property

If a Medicaid member has property outside Wisconsin that would be subject to a lien if located in Wisconsin, provide the same data you would provide on Wisconsin property. Do not give a Notice of Intent to File a Lien.

DHS may not file liens against out-of-state properties. However, ERP staff wants data on these cases to assist in negotiating lien agreements with other states.

22.1.4.3 Returns Home to Live or No Longer Owns the Home

If, despite expectations, the resident is discharged from the nursing home or inpatient hospital, to return home to live or if the member no longer owns the home, the lien must be released. Notify the ERP. ERP staff will release the lien.

22.1.4.4 Change in Circumstances

At review and other times, at local option, reexamine the circumstances of the member's home. If conditions change such that a lien must be filed, complete a Notice of Intent to File a Lien.

22.1.4.5 Special Cases

ERP staff applies special consideration for the following two case situations:

1. When a child (age 21 or older) of the member lives in the home, DHS is able to file a lien. It will not enforce the lien until that child moves or the home is sold if he or she:
   a) Lived in the home with the member for at least two years before the resident's admission to the nursing home or hospital, **and**
   b) Assisted the parent such that he or she helped delay the member's admission.

2. When a sibling of the member (other than a sibling described in SECTION 22.1.4.1 NOTICE OF INTENT TO FILE A LIEN) lives in the home, DHS is able to file a lien. It will not enforce the lien until that sibling moves or the home is sold if the sibling resided in the home for at least 12 months before the member's admission to the nursing home or hospital.

Alert the ERP when your member meets either of these two case situations.

22.1.4.6 Adjustment for Burial Trust

DHS may adjust the amount of its lien to allow a member to use proceeds from the sale of the home to establish or supplement a burial trust. ERP staff will review each situation individually. Refer any questions regarding lien satisfaction amounts or lien releases to the ERP staff.

22.1.4.7 Administrative Hearing: Liens

A member or his or her representative may request an administrative hearing if he or she feels the statutory requirements for imposing the lien have not been met. The IM agency attends the hearing to explain the decision to file the Notice of Intent to File a Lien. The only issue at the hearing will be whether the following requirements were satisfied:

1. The member has an ownership interest in a home.
2. The member resides in a nursing home or hospital.
3. The member cannot **reasonably** be expected to be discharged from the nursing home or hospital and return home to live.
4. None of the following lawfully reside in the home:

    a) The member's spouse.
    b) The member's child who is:
        i. Under age 21, **or**
        ii. Disabled, **or**
        iii. Blind.

    c) The member's sibling who has an ownership interest in the home and who has lived in the home continuously beginning at least 12 months before the member was admitted to the nursing home or hospital.

The request for an administrative hearing must be made in writing directly to the DHA at:

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

The request must be clearly marked "Medicaid Lien" and must be filed within 45 days of the mail date on the Notice of Intent to File a Lien. The date the written request is received by DHA is the date the hearing request is considered filed.

22.1.4.8 Homes Placed in Revocable Trusts

If a Medicaid member places his or her home in a revocable trust (see SECTION 16.1 ASSETS INTRODUCTION), he or she retains an ownership interest in the home. Complete a Notice of Intent to File a Lien if the member meets the conditions for a lien to be filed (see SECTION 22.1.4.1 NOTICE OF INTENT TO FILE A LIEN).

22.1.5 Estate Claims

DHS recovers Medicaid benefit costs from the member's estate or from the member's surviving spouse's estate

Recovery from a member's surviving spouse's estate will be limited to 50 percent of the marital property that the member had an interest in immediately prior to death.

When DHS learns of the death of a member or a member's surviving spouse, it files a claim in probate court in the amount of Medicaid recoverable benefits.

The probate court will not allow a claim on the estate to be paid if any of the following survives the member:

1. A spouse.
2. A child, if the child is:
    a) Under age 21, **or**
    b) Blind, **or**
    c) Disabled.

Do not negotiate a settlement, accept any funds, or sign any release for estate claims that have been filed by DHS. ERP staff should be notified if a claim is filed by the county against an estate for recovery of overpayments or incorrect Medicaid benefits for those 55 years of age or older or for any member who has resided in a nursing home.

Refer any questions about specific estate claims to the ERP staff.

22.1.5.1 Waiver of Estate Claim

In estates of members who die on or after April 1, 1995, an heir or beneficiary of the deceased member's estate or co-owner or beneficiary of a member's non-probate property may apply for a waiver of an estate claim filed by ERP. To be successful, the person applying for the waiver must show one of these three hardships exist:

1. The waiver applicant would become or remain eligible for AFDC, SSI, FoodShare, or Medicaid if ERP pursued the estate claim.
2. The deceased member's real property is part of the waiver applicant's business (for example, a farm) and the ERP recovery claim would affect the property and result in the waiver applicant's loss of his or her means of livelihood.
3. The waiver applicant is receiving general relief or veteran's benefits based on need under Wis. Stat. § 45.40(1m).

The waiver application must be made in writing within 45 days after the day:

1. ERP mailed its recovery claim to the probate court or its affidavit to the heir, beneficiary, or co-owner or
2. ERP mailed its notice of waiver rights, whichever is latest.

The waiver application must include these points:

1. Relationship of the waiver applicant to the deceased member.
2. The hardship under which the waiver is requested.

ERP staff must issue a written decision granting or denying the waiver request within 90 days after the waiver application is received by ERP. In determining its decision, ERP must consider all information provided to it within 60 days of its receipt of the waiver application.

22.1.5.2 Notice of Hardship Waiver Rights

ERP will provide notice of the waiver provisions to the person handling the deceased member's estate. If ERP is not able to determine who that person is, the notice will be included with the claim when ERP files it with the claim court.

The person handling the estate is then responsible for notifying the decedent's heirs and beneficiaries of the waiver provisions.

ERP will provide notice of the waiver provisions to co-owners and beneficiaries of the member's non-probate property.

22.1.5.3 Administrative Hearings: Hardship Waivers

If a waiver application is denied, the waiver applicant may request an administrative hearing. ERP staff will attend the hearing to defend their denial of the hardship waiver.

The hearing request must be made within 45 days of the date the ERP decision was mailed.

The hearing request must:

1. Be made in writing.
2. Identify the basis for contesting the ERP decision.
3. Be made to the DHA at:
   Department of Administration
   Division of Hearings and Appeals
   P.O. Box 7875
   Madison, WI 53707-7875

The date the request is received at DHA is used to determine the timeliness of the request.

ERP staff will maintain DHS' claim in the estate pending the administrative hearing decision. If collections are made and the waiver is ultimately approved, those funds will be returned.

To introduce evidence at a hearing not previously provided to DHS, the applicant must mail that evidence to DHS with a postmark at least seven working days before the hearing date.

22.1.5.4 Personal Representative's Notice

The personal representative of the estate of a Medicaid member must notify DHS that the estate is being probated (Wis. Stat. § 859.07[2]). The notification must be by certified mail and include the date by which claims against the estate must be filed.

22.1.5.5 Real Property as Part of the Estate

When a real property **is part of the estate**, ERP may file a lien equal to the Medicaid payments even if one of these persons is alive:

1. The spouse.
2. A child under age 21.
3. A disabled or blind child of any age.

Recovery through the lien will not be enforced as long as any of these persons meet the criteria and is alive.

Example 2	Mr. Arnold dies. A claim on his estate is filed and the estate includes his real property. His spouse is deceased, and he has no blind or disabled child. He has a child, age 19. This child lives outside Mr. Arnold's home. A lien is placed on the real property but cannot be enforced because the minor child is still alive. The child later turns 21. As there is then no living spouse, child under 21, or disabled or blind child, the lien can be enforced.

DHS will take a lien in full or partial settlement of an estate claim against the portion of an estate that is a home if:

1. A child, of any age of the deceased member:
    a. Resides in the member's home, **and**
    b. That child resided in that home for at least 24 months before the member entered the nursing home, hospital, or received HCBW services, **and**
    c. That child provided care that delayed the member's move to the nursing home, hospital, or his or her receipt of HCBW services.

2. A sibling of the deceased member:

    a. Resides in the member's home, **and**
    b. Resided in that home for at least 12 months before the date the member entered a nursing home, hospital, or received home and community-based services.

The lien filed in one of these two instances will be payable at the death of the child or sibling or when the property is transferred, whichever comes first.

However, if the caretaker child or sibling sells the home covered by the DHS lien and uses the sale proceeds to buy another home to be used as that child's or sibling's primary residence, then:

1. DHS will transfer the lien to the new home if the amount of the child or sibling's payment or down payment for the new home is equal to or greater than the proceeds from the original home.
2. If the down payment on the new home is less than the proceeds from the sale of the original home, DHS will recover the amount of the proceeds above the down payment, but no greater than the lien amount. If there is an amount in the lien still not satisfied, DHS will file a lien for the remaining amount on the new home.

22.1.5.6 Affidavits in Small Sum Estates

Heirs, guardians, and trustees of revocable trusts created by a deceased Medicaid member must notify ERP before transferring any of the deceased's property through a Transfer by Affidavit ($50,000 and under) (Wis. Stat. § 867.03). The heir, guardian, or trustee must send a copy of the affidavit to ERP by certified mail, return receipt requested. Examples of property include bank accounts (savings or checking); postal savings; credit union or building and loan shares; contents of safe deposit boxes; savings bonds; stocks and other securities; promissory notes and mortgages which are payable to the applicant/member and negotiable; real estate; etc.

If an heir, guardian, or trustee transfers the deceased's property, ERP will send an affidavit to the heir, guardian or trustee to recover any funds remaining after burial and estate administration costs have been paid. Funeral costs are limited to those expenses connected with the funeral service and burial. A

marker for the grave is considered a burial cost. Memorials and/or donations to churches, organizations, persons, or institutions are not considered burial costs.

ERP will also send its affidavit to the co-owners and/or beneficiaries of a member's non-probate property. Non-probate property is property that passes outside an individual's estate. This means that non-probate property does not go through probate before it is transferred to those who inherit it. Non-probate property subject to recovery includes, but is not limited to, life estates, property held in joint tenancy, life insurance proceeds, property held in revocable trusts, and property that is payable-on-death or transfer-on-death to a beneficiary.

Co-owners and beneficiaries of a member's non-probate property have the right to request a fair hearing as on the value of the member's interest in the property.

The value of the member's interest for jointly owned property is the percentage interest attributed to the member when Medicaid eligibility was determined or, if not determined at eligibility, the fractional interest the member had in the property at his or her death. For life estate interests, the value is the percentage of ownership based on the member's age at the date of death, according to the life estate tables used for Medicaid eligibility.

The value of the property is the fair market value. Fair market value is the price a willing buyer would pay to a willing seller for purchase of the property. It is the co-owners' or beneficiaries' responsibility to establish that value through a credible method like an appraisal by a licensed appraiser.

ERP staff will attend the fair hearing to present DHS' position on the value of the property.

Real property of a Medicaid member, whether non-probate or transferred by affidavit, is subject to a lien if the state's claim cannot be satisfied through other assets.

The DHS may not enforce the lien while any of the following survive:

1. Spouse,
2. Child who is:
    a) Under age 21, **or**
    b) Blind, **or**
    c) Disabled.

ERP will recover any funds that remain from a burial trust after costs have been paid.

Direct specific questions about questionable allowable costs to ERP staff.

22.1.5.7 Patient Fund Account

Nursing homes are required to notify ERP when a Medicaid member dies with money left in his or her nursing home patient fund account if he or she has no surviving spouse or minor or disabled child.

ERP will claim from the nursing home any funds remaining in the patient account after payment of funeral and burial expenses and outstanding debts from the last month of illness that are not chargeable to Medicaid.

22.1.5.8 Native Americans

Native Americans: Income, Resources and Property Exempt from Medicaid Estate Recovery

The following income, resources, and property are exempt from Medicaid estate recovery:

1. Certain income and resources (such as interests in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
2. Ownership interest in trust or non-trust property, including real property and improvements:
    a) Located on a reservation (any federally recognized Indian Tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Act and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
    b) For any federally recognized Tribe not described in (a), located within the most recent boundaries of a prior Federal reservation.
    c) Protection of non-trust property described in (a) and (b) is limited to circumstances when it passes from an Indian (as defined in section 4 of the Indian Health Care Improvement Act) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a Tribe and non-Indians, such as spouses and step-children, that their culture would nevertheless protect as family members; to a Tribe or Tribal organization; and/or to one or more Indians;
3. Income left as a remainder in an estate derived from property protected in 2 above, that was either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s), as long as the individual can clearly trace it as coming from the protected property.
4. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally-protected rights, and income either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s) derived from these sources as long as the individual can clearly trace it as coming from protected sources; and
5. Ownership interests in or usage rights to items not covered by 1-4 above that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom

Native Americans: Income, Resources and Property Not Exempt from Medicaid Estate Recovery

The following income, resources and property from the estates of Native Americans are not exempt from estate recovery:

1. Ownership interests in assets and property, both real and personal, that are not described in items 1-5 above.
2. Any income and assets left as a remainder in an estate that do not derive from protected property or sources in items 1-5.

22.1.5.9 Reparation Payments to Individuals

Government reparation payments to special populations are exempt from Medicaid estate recovery.

22.1.5.10 Voluntary Recovery (ERP)

When a member age 55 or older wishes to pay an amount to Medicaid to maintain Medicaid eligibility, prepay a Medicaid deductible, or reduce a potential claim in an estate, forward the payment to ERP. First check BVCI to make sure there is not an outstanding Medicaid claim for an overpayment since the money should be applied to an overpayment first. Voluntary payments, except for prepayment of a deductible, may only be up to the amount of Medicaid paid to date. (See SECTION 22.1.10 VOLUNTARY RECOVERY (NOT ERP) for voluntary recoveries for members under age 55.)

The check or money order should be made payable to DHS.

Mail the payment to:

Estate Recovery
313 Blettner Blvd
Madison WI
53714-2405

With the payment, include:

1. Documentation that the payment is voluntary.
2. The member's name and Medicaid ID number.
3. Name and address of the person who should receive the receipt.

These refunds will be credited to the member and will be used to offset any claim that may be filed in the member's estate.

Incentive payments of five percent will be paid to the IM agency for refunds.

Advise heirs and beneficiaries of deceased members who wish to make a voluntary refund to call ERP staff.

22.1.6 Match System

ERP maintains the Estate Recovery Database. Information you submit on the Estate Recovery Disclosure Form and data received through the SSA State Data Exchange (SDX) tape (for SSI/Medicaid members) is on the database.

The database is compared to the death record files of the DMS, Vital Records and State Registrar Section.

When a match shows a Medicaid member or his or her surviving spouse has died, a report record is produced. ERP staff checks the report against new probate proceedings listed on the Wisconsin Circuit Court Access website. This is a back up to the requirement that DHS be notified of the last date for filing claims.

22.1.7 Notify Members

A copy of the Wisconsin Medicaid Estate Recovery Program Handbook (P-13032) must be provided to every Medicaid member who is 54 1/2 years old or older or institutionalized at application, except people who are only applying for are enrolled in one of the MSPs. CARES will send this documentation

automatically. The applicant or member or their representative should read the notice of liability on the application form ("Estate Recovery"). The member acknowledges understanding of this notice when signing the application.

22.1.8 Estate Recovery Program Contacts

The ERP address is:

Estate Recovery Program Section
Division of Medicaid Services
P.O. Box 309
Madison, WI 53701-0309

For general information regarding ERP, refer members to Member Services at 1-800-362-3002.

22.1.9 Voluntary Recovery (Not Estate Recovery Program)

Accept payments from a member under age 55 made for purposes of Medicaid eligibility or prepaying a Medicaid deductible.

Instruct the member to make the payment payable to your IM agency. Report the receipt on the Community Aids Reporting System (CARS) labeled as a Medical Refund.

22.1.10 Incentive Payments

DHS will return to local agencies five percent of collections made through a lien, voluntary payments, and probated estate recoveries. DHS will pay this incentive to the last agency certifying the member for Medicaid.

The payments are discretionary. DHS will make them based on compliance with program requirements.

22.1.11 Other Programs

ERP also recovers for Community Options Program (COP), Wisconsin Chronic Disease Program (WCDP), and non-Medicaid Family Care.

Note *Non-Medicaid Family Care no longer exists as of May 1, 2003. However, ERP could recover from those who received benefits under this program prior to May 1, 2003.*

Note *The Community Options Program no longer exists as of June 30, 2018. However, ERP could recover from those who received benefits under this program prior to June 30, 2018.*

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22.2 Overpayments

An overpayment occurs when any of the following occur:

- Medicaid benefits are incorrectly paid for a person who was not eligible for them.
- A MAPP member should have paid a higher premium.
- A long-term care member did not pay as much as they should have for their nursing home patient liability or waiver cost share.

Effective April 1, 2023, DHS and IM agencies will not establish new Medicaid overpayment claims for members.

Income maintenance (IM) agencies may refer suspected fraudulent activity to the DHS Office of Inspector General (OIG), the district attorney (DA), or corporation counsel for investigation. The DA or corporation counsel may prosecute for fraud.

Note *This policy on member overpayment claims does not include provider overpayments where there is an error in a claims payment to a provider or repayments that are part of the Estate Recovery Program (see SECTION 22.1 ESTATE RECOVERY).*

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22.3 Interagency Case Transfer

A case transfer occurs when the primary person who is currently receiving benefits (or whose benefits have been closed for less than one calendar month) reports that they have moved to a different county or tribal area. The only exception to this is protective placements (see SECTION 2.3.2 INTERCOUNTY PLACEMENTS).

A case transfer does not impact the certification period(s) of the case members. A new application or renewal is not required when a case is transferred.

The agency to which the member reports the move must collect information about the changes, including the new residential address. If the agency does not have sufficient information about the changed circumstances, it must request information from the member according to the verification policy in CHAPTER 20 VERIFICATION.

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22.4 Undue Hardship

22.4.1 Application of Policy

Undue hardship may apply only when eligibility for long-term care services is denied or terminated for any of the following situations:

- A community spouse has refused to sign the application or provide required information (see SECTION 2.5.3 SPOUSAL IMPOVERISHMENT MEDICAID SIGNATURES)
- The applicant's or member's home has equity interest of more than $750,000 (see SECTION 16.8.1.4 HOME EQUITY OVER $750,000.00)
- A divestment penalty period has been imposed (see SECTION 17.2.6.7 UNDUE HARDSHIP REQUEST IS GRANTED)
- A spousal impoverishment case has excess assets (see SECTION 18.4.5 UNDUE HARDSHIP)

Undue hardship occurs if denial or termination of an applicant's or member's eligibility for coverage of long-term care services would deprive the person of any of the following:

- Medical care, which then endangers the person's health or life
- Food
- Clothing
- Shelter
- Other necessities of life

22.4.2 Undue Hardship Waiver Request Process

If an applicant or member is denied long-term care services as a result of any of the situations listed in SECTION 22.4.1 APPLICATION OF POLICY, the applicant or member must be sent the following:

- Undue hardship letter (F-10187).
- Undue Hardship Waiver Request form (F-10193).

See Process Help Section 11.7 for information on how these forms are sent. If the situation requires an IM worker to manually send these forms, the forms must be mailed the same day or, at the latest, within 24 hours after CWW or the IM worker mails the Notice of Denial of Benefits/Negative Change in Benefits (F-16001) informing the applicant or member that long-term care services will be terminated or denied.

22.4.3 Valid Request

A completed Undue Hardship Waiver Request form (F-10193) must be submitted to the IM agency. A written and signed request that fulfills the minimum request requirements listed in SECTION 22.4.5 REQUIRED DOCUMENTATION is also acceptable.

The long-term care facility in which the applicant or member is residing may also file an undue hardship request on behalf of the institutionalized person. However, the long-term care facility must have the applicant or member's, or his or her authorized representative's, power of attorney's, or legal guardian's written permission, using the Undue Hardship Waiver Request form, to file the undue hardship request.

The long-term care facility can also represent the institutionalized person in any subsequent fair hearing activity involving an undue hardship request or denial, as long as the facility has the applicant's or member's (or his or her authorized representative's, power of attorney's, or legal guardian's) written permission to do so. This can also include the facility requesting a fair hearing.

Note: *A long-term care facility could include a nursing home, CBRF, or IMD (see SECTION 27.1 INSTITUTIONS).*

22.4.4 Effective Date of Approved Undue Hardship Waivers

IM agencies are required to process any valid request for an undue hardship waiver, whether the request is submitted timely or untimely. Completed requests must be scanned into the ECF and case comments entered documenting the receipt of the undue hardship request.

22.4.4.1 Timely Request—Received Within 20 Calendar Days After Notification Is Mailed

If the valid request for an undue hardship waiver is received by the IM agency within 20 calendar days of the undue hardship letter (F-10187) mailing date, and the request is approved, the effective date of the waiver will be as follows:

- For divestment, the entire divestment penalty period will be waived.
- For all others, the effective date will be the date initial eligibility would have begun, including any requested backdated months.

Example 1:	Amy receives a notice dated February 10 that her January 20 application for HCBW Medicaid is denied and she will have a 100-day divestment penalty period beginning January 20. Amy submits an undue hardship request to the IM agency that is received on February 15. The undue hardship request is approved by the IM agency and Amy's penalty period is waived. Amy is eligible for HCBW Medicaid beginning on the enrollment date provided to the IM agency by the ADRC.

Example 2:	Chris submits an application for institutional Medicaid on April 30. He receives a notice dated May 20 that his application is denied due to his community spouse's refusal to sign the Medicaid application. He entered the nursing facility on April 5. Chris has been separated from his wife for many years, and she has refused all attempts to make contact to sign Chris's application. Chris submits an undue hardship request to the IM agency that is received on June 5. The undue hardship request is approved by the IM agency and Chris is eligible for institutional Medicaid beginning April 5.

22.4.4.2 Untimely Request—Received Later Than 20 Calendar Days After Notification Is Mailed

A request may be submitted later than 20 calendar days after the IM agency mails out the undue hardship letter (F-10187), but if approved, the hardship waiver effective date will not be earlier than the date the request is received by the agency. For divestment cases, the remaining penalty period will be waived from the date the request is received by the agency.

Example 3:	Alice applies for Institutional Medicaid on January 20. She receives a notice dated February 10 that her application is denied and that she will have a 350-day divestment penalty period beginning January 20. In June, Alice's health deteriorates and her monthly income decreases by 60 percent. Alice submits an undue hardship request to the IM agency that is received on June 25. The undue hardship request is approved by the IM agency and Alice's remaining penalty period is waived. Alice is eligible for Institutional Medicaid beginning June 25.

Example 4:	Shane applies for HCBW Medicaid on April 30. He receives a notice dated May 20 that his application is denied due to having more than $750,000 in home equity. Shane lives in his home and has other assets under the asset limit. He is functionally eligible at a nursing home level of care. Shane explores options for selling his home and moving, but the market is poor for his area, and his home has had many modifications that make it easier for Shane to live in the community with his physical disabilities but less likely for the house to sell. Shane's options for housing that meets his physical needs are limited in his community. Shane submits an undue hardship request that is received by the IM agency on June 30.

	The agency approves the undue hardship request and the effective date of June 30 is communicated to the Aging and Disability Resource Center (ADRC). Shane is eligible for HCBW Medicaid to begin with the enrollment date provided to the IM agency by the ADRC.

22.4.5 Required Documentation

An applicant or member (or his or her authorized representative, power of attorney, or legal guardian) must submit both of the following verifications of undue hardship (unless otherwise noted):

- A statement signed by the applicant or member (or his or her authorized representative) which describes the following:
  - In cases where a community spouse refuses to cooperate with the application process, documentation of all attempts to get cooperation from the community spouse,
  - In cases of divestment, whether the assets are recoverable, and if so, the attempts that were made to recover the divested assets,
  - In cases when an individual is denied due to having more than $750,000 in home equity, an explanation of why the home equity cannot be accessed
  - In cases where an individual in a spousal impoverishment case is denied due to excess assets, an explanation of why the excess assets cannot be accessed.
- Proof that an undue hardship would exist if eligibility is terminated or denied or the divestment penalty period is applied (required for all four situations to which Undue Hardship policy may apply) as follows:
- **If the applicant or member is currently institutionalized**, he or she must submit a copy of the notification from the long term care facility which states both of the following:
  - The date of involuntary discharge
  - An alternative placement location
- Or other proof that if the undue hardship waiver is not approved, the applicant or member will:
  - Not receive medical care resulting in his or hers health or life to be endangered
  - He or she will not have food, clothing, shelter, or other necessities of life.
- **If the applicant or member is applying for HCBW**, including FamilyCare, FamilyCare Partnership, PACE, or IRIS he or she must submit an estimate of the cost of the long term care services needed to meet his or her medical and remedial needs (as determined by the waivers case manager) and an estimate of costs for food, shelter, clothing, and other necessities of life.

  These two estimates must be compared to the applicant, member, or couple's income and assets. If the IM agency determines that the applicant or member does not have enough income and/or assets to pay for his or her long term care and other needs (i.e., food, shelter, etc.), consider the applicant or member's health to be endangered.

If the required documentation is **not** submitted with the request for an undue hardship waiver, send a written request for verification to the applicant or member, giving a verification due date of 20 calendar days from the date the request is mailed. If the applicant or member fails to submit the required verification within 20 calendar days after the request is mailed, deny the undue hardship waiver request and notify the applicant or member by sending a Notice of Denial of Benefits/Negative Change in Benefits (F-16001). The deadline to submit the required documentation may be extended for up to 10 calendar days if the individual communicates to the agency a need for additional time or assistance to obtain verification.

22.4.6 Determination Process Time Frame

A decision about whether to approve or deny an undue hardship waiver must be made by the IM agency within 30 calendar days after receipt of the Undue Hardship Waiver Request form (F-10193). Send the applicant or member the appropriate manual Notice of Approval of Benefits/Positive Change in Benefits (F-16015) or Notice of Denial of Benefits/Negative Change in Benefits (F-16001) based on the IM agency's decision.

If the undue hardship request is denied, the Notice of Denial of Benefits/Negative Change in Benefits (F-16001) must include the agency's reason for the denial: "You have not provided proof that the denial of long term care services will create an undue hardship for you." The applicant or member has the right to make another subsequent request if and when his or her circumstances change.

If an undue hardship waiver is approved, a new undue hardship request is not required to be completed at renewal unless there has been a change in the circumstances surrounding the original reason for the request.

22.4.7 Bed Hold Payments and Notifications (Divestment Only)

When an undue hardship waiver request is received by an IM agency from an institutionalized individual, the IM agency must inform the institution that the request was received and that a bed hold payment will be made on the client's behalf for the period of time while the IM agency is making a decision about the hardship waiver request. The period covered begins on the date a written hardship waiver request is received at the IM agency until the date the agency issues its decision on the waiver request, up to a maximum of 30 calendar days.

The IM agency must notify the institution of the agency's decision about the undue hardship waiver.

If the request for an undue hardship waiver is approved, the divestment penalty period will be waived and the need for a bed hold payment is therefore unnecessary.

If the undue hardship waiver request is denied, the IM agency must indicate the dates for which the state will make the bed hold payments.

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

See Process Help Section 11.7.2.1 for more information for a bed hold due to undue hardship.

22.4.8 Fair Hearing Rights

If the request for an undue hardship waiver is denied, the individual has the right to appeal the decision through a written request to the DHA. The individual has 45 calendar days from the date of the notice issuance to file the appeal. These same hearing rights are also applicable to the facility in which the individual resides, as long as the facility has the institutionalized individual's written permission to represent him or her in the appeal process.

22.4.9 Referrals to Adult-at-Risk Agency

If a power of attorney, legal guardian, or other authorized representative transferred the asset, the IM agency must consider making a referral to the local Adult-at-Risk agency for investigation of possible financial exploitation of an elderly, blind, or disabled individual.

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22.5 Legal Guardians, Conservators, Power of Attorney, and Other Representatives

22.5.1 Authorized Representatives

Applicants or members can appoint either an individual or an organization as authorized representative. An authorized representative can be appointed through any of the following means:

- ACCESS, when applying
- Federally Facilitated Marketplace (Note: When a Marketplace application is processed by the agency and an applicant has appointed an authorized representative in the application, the agency must honor this appointment of an authorized representative.)
- Paper form (signed in writing or electronically): Appoint, Change, or Remove an Authorized Representative (F-10126)

If an applicant or member is represented by a guardian of the person and the estate, guardian of the estate, or conservator, the guardian or conservator must appoint the authorized representative. A guardian of the person can appoint the authorized representative only if the court document appointing the legal guardian of the person includes language granting the guardian the authority to enroll the person in BadgerCare Plus, Medicaid, or public assistance programs.

If the applicant or member only has a **guardian of the person** who does not have the authority to enroll the person in Medicaid or public assistance programs, the applicant or member must appoint the guardian of the person as an authorized representative if the applicant or member would like the guardian of the person to act on their behalf. If the applicant or member has a power of attorney, the applicant or member can still appoint an authorized representative.

A valid authorized representative appointment requires all contact information of the authorized representative and the signatures of the applicant or member, the authorized representative, and a witness. If the applicant or member is signing with an "X," a valid appointment requires two witness signatures. If any of the required signatures are missing, the following three conditions apply:

- The authorized representative appointment is not valid.
- This authorized representative cannot take action on behalf of the applicant or member.
- The agency cannot disclose information about the case to the invalid authorized representative.

There can be only one authorized representative at a time on a case. There is no time limit on how long a person or organization can act as authorized representative. The appointment of the authorized representative is valid until the applicant or member notifies the agency of a change or removal in writing. Once appointed, the authorized representative has ability to act for all open programs on the case.

Organizations acting as authorized representatives must provide the name and contact information of a person from the organization. Once the organization has been appointed as the authorized representative, anyone from the organization will be able to take action on behalf of the applicant or member (not just the person who signed the form on behalf of the organization). If an organization is only changing the contact person for the organization, the member is not required to complete a new Appoint, Change or Remove Authorized Representative form if the organization is going to remain as the authorized representative.

The authorized representative should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the individual being represented. An authorized representative is limited to doing any or all of the following on behalf of the applicant or member:

- Apply for or renew benefits
- Report changes in the applicant or member's circumstances or demographic information
- Receive copies of the applicant or member's notices and other communications from the agency
- Work with the IM agency on any benefit related matters
- File grievances or appeals regarding the applicant or member's eligibility

To change an authorized representative, the member must complete and submit the Appoint, Change, or Remove an Authorized Representative form (Person F-10126A or Organization F-10126B) to their IM agency.

To remove an authorized representative, the member needs to let the agency know of the removal in writing. For example, by completing Section One of the Appoint, Change, or Remove an Authorized Representative form or submitting a signed letter indicating the removal. The member does not need to gather additional signatures from the authorized representative or a witness to complete the removal of an authorized representative. Authorized representatives can also request in writing (for example, a signed statement) to be removed if they no longer want to act as the authorized representative. If an authorized representative is requesting to be removed, a signed statement is not needed by the member. An authorized representative designation is valid on a case until a written and signed request is received for removal.

Example 1:	Penny is due for renewal of her Medicaid benefits on August 31. In July, she receives her case summary as part of the administrative renewal process. Penny's case summary lists her mom, Darlene, as her authorized representative. Penny no longer wants Darlene to be her authorized representative. Penny crosses out the authorized representative information on the case summary, signs it, and mails it to the IM agency. The IM agency receives the case summary on August 3. Based on Penny's handwritten update on the case summary, the IM agency removes Darlene as Penny's authorized representative effective on August 3.

22.5.2 Additional Responsibilities

The applicant or member can choose to appoint the person who is acting as his or her authorized representative to receive the member's ForwardHealth card and is also allowed to do the following tasks:

- Enroll the applicant or member in an HMO
- Contact Member Services or the HMO about a bill, service or other medical information, including Protected Health Information (PHI)

An authorized representative who is appointed by the member to have these additional functions is coded in CARES as a Medicaid (MA) Payee. The authorized representative and the MA Payee must be the same person, and the MA Payee cannot be an organization. If the member's authorized representative is an organization and the member wants to appoint a MA Payee, the member will need to change the authorized representative to a person and authorize that person to have the MA Payee functions.

The applicant or member can appoint their authorized representative to fulfill the additional responsibilities listed on Section 1 Part C of the Appoint, Change, or Remove an Authorized

Representative: Person form (F-10126A). The applicant or member acknowledges that they are authorizing the disclosure of PHI to the authorized representative since the authorized representative will have access to medical information such as health care services or treatments, medical bills, etc.

There is no time limit on the MA Payee designation. An applicant or member can request removal of the MA Payee in writing at any time. For example, the applicant or member can submit the Appoint, Change or Remove Authorized Representative form or write a letter indicating the MA Payee removal.

22.5.3 Community Spouse as Representative

In Spousal Impoverishment cases, when a Community Spouse cooperates with providing their signature at application and/or renewal (see SECTION 2.5.3 SPOUSAL IMPOVERISHMENT MEDICAID SIGNATURES), the Community Spouse can act on the applicant's/member's behalf without requiring the completion of the Appoint, Change, or Remove an Authorized Representative form (F-10126A). The act of signing the application/renewal allows the Community Spouse to do the following on the applicant's/member's behalf:

- Provide information for the member's application and/or renewal
- Report changes in the applicant's/member's circumstances or demographic information
- Receive copies of the applicant's/member's notices and other communication from the agency
- Work with the IM agency on any benefit related matters
- File grievances or appeals regarding the applicant's/member's eligibility

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Note: *In Spousal Impoverishment cases, the applicant or member's signature and the community spouse's signature are both required at application and renewal.*

22.5.4 Legal Guardians and Conservators

Persons or interested parties may petition a court to appoint a guardian or conservator. There are a variety of reasons that an appointment may be sought including but not limited to:

- Inability to manage finances
- Inability to manage personal health
- Inability to function safely without supervision
- Parent or guardian of minor is now deceased

Some of these appointments might be an emergency or temporary reason, or for the purposes of succession after the death of the previous guardian or conservator.

A judge grants the guardian or conservator powers based on the circumstances of the person. A guardian of the person and the estate or a guardian of the estate is considered to be the applicant or member's guardian for Medicaid purposes. A guardian of the person is the applicant's or member's legal guardian for Medicaid purposes only if the court document appointing the legal guardian of the person includes language granting them the authority to enroll the person in Medicaid or public assistance programs.

If a person or entity is one of these guardian types or the conservator, the applicant or member does not need to separately appoint them as the authorized representative. The legal guardian or conservator appointment grants them the powers that an authorized representative would have on the Medicaid case.

If the court document appointing the guardian of the person does not grant the authority to enroll the applicant or member in Medicaid public assistance programs, the applicant or member must appoint the

guardian of the person as an authorized representative if the applicant or member would like the guardian of the person to act on their behalf.

Depending on their court appointed powers, a guardian or conservator can apply for and act in the same capacity as an authorized representative for the household. It is possible the court appointed powers will give the guardian or conservator sole authority to manage the person's eligibility.

The guardian or conservator should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the person being represented. The guardian or conservator can take any action on the application or case on behalf of the applicant or member unless the guardianship or conservatorship court order limits their powers.

Applicant and member notices and other communications from the agency will be sent to the legal guardian or conservator.

See SECTION 20.3.7 POWER OF ATTORNEY, GUARDIANSHIP, OR CONSERVATOR for information on verification requirements. See SECTION 2.5 VALID SIGNATURE for information on valid application signatures by guardians or conservators.

22.5.5 Power of Attorney

A person may grant power of attorney to an agent. An agent with power of attorney may act within the scope of authority granted in the power of attorney appointment.

An agent with durable power of attorney for finances is a person to whom the applicant has given power of attorney authority and agrees that the authority will continue even if the applicant later becomes disabled or otherwise incapacitated. Only an agent with durable power of attorney for finances (may also be known as a durable power of attorney for finances and property) is considered to have power of attorney for Medicaid purposes.

If a person has an agent with durable power of attorney for finances, the applicant or member does not need to separately appoint them as an authorized representative. The durable power of attorney for finances appointment grants them the powers that an authorized representative would have on the Medicaid case.

The agent with durable power of attorney for finances should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the person being represented. The agent with durable power of attorney for finances can take any action on the application or case on behalf of the applicant or member unless the power of attorney appointment limits their powers.

See SECTION 20.3.7 POWER OF ATTORNEY, GUARDIANSHIP, OR CONSERVATOR for information on verification requirements. See SECTION 2.5 VALID SIGNATURE for information on valid application signatures by an agent with power of attorney.

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22.6 Restoration of Benefits

If it is determined that a member's benefits have been incorrectly denied or terminated, their Medicaid should be restored from the date of the incorrect denial or termination through the time period that they would have remained eligible.

If the member was incorrectly denied or terminated for BadgerCare Plus or MAPP with a premium obligation, the member should be allowed to pick the months in which they would like to receive benefits. All premiums owed for the months in which the member would like to receive benefits must be paid before the member is enrolled for those months.

If a member already paid for a Medicaid covered service, the member will need to contact their provider to bill Medicaid for services provided during that time. A Medicaid provider must refund the amount that Medicaid will reimburse for the service. The provider may choose to refund up to the full amount billed to the member, but that decision is entirely optional.

22.6.1 Incorrect Member Contribution

22.6.1.1 Premiums

If a MAPP premium is calculated in an amount that is incorrect and higher than it should have been, the excess amount must be refunded to the member when the error is discovered (see SECTION 26.5.3.3 REFUNDS and Process Help Section 25.4.3).

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23 Notices and Fair Hearings

23.1 Notices

A notice must be either mailed or sent electronically at least 10 days prior to the effective date of an adverse action, such as a termination of benefits or an increase in premium, cost share, or liability.

23.1.1 Notice Requirements

Applicants and members must be provided with written notice of:

- The decision on an application or renewal.
- Any action to extend current benefits.
- Any action to discontinue or suspend a member's benefits.
- Any action that changes the form or amount of benefits.

23.1.2 Notice of Approval

Any notice of approval of eligibility must include:

- The basis and effective date of eligibility and which individuals are eligible.
- The circumstances under which the individual must report and procedures for reporting any changes that may affect the individual's eligibility.
- If applicable, the amount of medical expenses which must be incurred to meet a deductible.
- If applicable, basic information on the level of benefits and services available based on the individual's eligibility including:
    - A description of any premiums and cost sharing required
    - An explanation of how to receive additional detailed information on benefits and financial responsibilities
    - An explanation of any right to appeal the eligibility status or level of benefits and services approved

23.1.3 Notice of Denial

Any notice of denial of eligibility for an individual or the household must include:

- The month(s) that were denied and which individuals were determined ineligible.
- The reason(s) for the denial, including citations to the law or policy that supports the action.
- An explanation of the right to a fair hearing and how to request one.

23.1.4 Notice of Adverse Action

An adverse action is a change made by an IM agency that will stop or reduce benefits or increase cost sharing. Members have the right to adequate and timely notice of an adverse action.

23.1.4.1 Adequate Notice of Adverse Action

To be "adequate," a notice of an adverse action must include the following:

- A statement describing the intended action
- The reason(s) for the intended action, including a citation to the law, regulation, rule, or policy that supports or requires the action
- An explanation of the right to a fair hearing and how to request one
- A statement on the availability of free representation

- A statement that if a hearing is requested before the action's effective date, benefits will continue until the hearing decision is made
- A statement that the member may have to repay any benefits continued during the appeal if the hearing decision isn't in their favor or they abandon or withdraw the hearing request
- The telephone number of the income maintenance agency to contact for more information

23.1.4.2 Timely Notice of Adverse Action

Notice must be provided at least **10 days** before the effective date of any intended adverse action **unless** one or more of the following circumstances apply:

- Factual information confirms a recipient or payee's death and there is no relative to take their place as primary person.
- A clear, written statement initiated and signed by the member is submitted stating they no longer wish to receive benefits.
- The member has applied for and is receiving benefits from another state.

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23.2 Fair Hearings

Applicants and members have the right to a fair hearing, timely case decisions, and accurate notices of decision. Hearings are conducted by the Wisconsin Department of Administration, Division of Hearings and Appeals (DHA) for Medicaid.

Hearings serve to:

1. Interpret the program to applicants and members who disagree with the agency's action.
2. Bring the applicant or member and the agency 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.

23.2.1 Resolution Prior to Hearing

When an applicant or member disagrees with an agency's action, the applicant or member may contact their agency to attempt to resolve the issue. This may be done through the normal modes of communication between the applicant or member and the agency, such as a phone call or in-person visit. It also may be done through an agency conference where the applicant or member meets with the worker responsible for the agency's action or other agency representatives.

This contact with the agency does not affect the applicant or member's right to a fair hearing or the time limit for requesting a fair hearing. The agency must advise the applicant or member that to have an agency conference is the applicant or member's choice and doesn't delay or replace a fair hearing. The applicant or member may request a hearing without first contacting the agency.

Note *If the applicant or member requested a fair hearing, the fair hearing process will continue unless the applicant or member voluntarily withdraws the hearing request in writing to DHA (see SECTION 23.2.8 WITHDRAWAL OF FAIR HEARING REQUEST).*

23.2.2 Fair Hearing Request

For Medicaid, the applicant, member, or representative may request a fair hearing in writing by filling out the Request for a Fair Hearing (DHS-28) form or writing a letter with the request and sending it to the DHA.

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

Fax (608) 264-9885

Email: DHAMail@wisconsin.gov

DHA will schedule a hearing upon receipt of the hearing request. DHA has jurisdiction to conduct hearings for Medicaid if the request is received by DHA within 45 days of the action effective date. DHA may dismiss a request if the action being appealed is a result of a change in federal or state law or policy

affecting a significant number of members, unless the member questions its application specific to their case. When a hearing request is dismissed, DHA will notify the applicant or member.

A hearing request from an applicant or member who plans to move from Wisconsin before a decision would normally be issued, such as a migrant worker, will be expedited so the applicant or member can receive a decision and any restored benefits before they leave the state.

A group of people may request a group hearing if individual issues of fact are not disputed, and the sole issue being appealed is a state or 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 applicant or member must be notified of the right to withdraw from a group hearing and pursue an individual hearing.

23.2.3 Prior to the Hearing

The agency must prepare for the hearing by reviewing the appropriate case records and determine the cause of the contested action. The agency must submit a detailed summary to DHA and the applicant, member, or their representative that explains the action(s) under appeal within 10 days of receiving notification of the hearing request.

The agency must also gather relevant testimonies, exhibits, and materials from the case record and other sources. This information must be submitted to DHA and the applicant, member, or their representative as early as possible prior to the hearing.

At least 10 days prior to the hearing, DHA sends a Notice of Scheduled Hearing to the applicant or member, their representative, if applicable, and the agency. This allows the applicant or member and agency 10 days to prepare for the hearing. The applicant or member may request less advance notice to expedite scheduling the hearing.

The notice states that:

- DHA will dismiss the request if the applicant, member, or any representative fails to appear without good cause.
- The name, address, and phone number of whom to notify if the applicant, member, or representative cannot attend.
- The applicant or member and any representative may examine the case record prior to the hearing. Agencies must allow the applicant, member, or representative access to their case record and the opportunity to photocopy, free of charge and at a reasonable time before the hearing, all documents they would like to introduce as an exhibit at the hearing. Questions relating to the examination of sensitive information can be directed to DHA.

23.2.4 Continued Benefits

DHA may order a member’s Medicaid benefits to continue while a decision on the hearing is pending. The IM agency must comply with DHA's initial order until otherwise notified or the member waives this continuation of benefits. The IM agency must inform members of their right to waive continued benefits.

DHA can reverse its continuance order only when the hearing was not requested prior to the action's effective date. If DHA does not order benefits reinstated and the agency believes that the member is entitled to them, the agency must notify DHA.

Once benefit continuation has begun, the IM agency must maintain those benefits until DHA orders a change or some other change in eligibility occurs.

23.2.5 Hearing

Hearings are conducted by an Administrative Law Judge (ALJ). The ALJ is an impartial official who:

- Is familiar with relevant federal and state policies and procedures.
- Was not involved in the action being contested.
- Was not the immediate supervisor of the worker who took the action.
- Does not have a personal stake or involvement in the case.

ALJs are duly appointed and qualified agents of DHA.

The ALJ's powers and duties are to:

- Administer oaths or affirmations.
- Ensure all relevant issues are considered.
- 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.
- Provide a hearing record and decision.

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

23.2.6 Time Limits

DHA must conduct the hearing and issue its decision and the IM agency must implement the decision within 90 days of the date DHA receives the hearing request.

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

When the decision is not favorable to the applicant or member, the decision notice is the final notice for the case, with the exception of overpayment notices. No further timely or adequate notice requirement applies for the issue that was appealed. Medicaid benefits will be discontinued or reduced immediately.

The DHA decision includes a description for the applicant or member of their right to rehearing, judicial review, or both. It is not necessary to request a rehearing before going to circuit court.

23.2.7 Hearing Decision

23.2.7.1 Final Decision

The ALJ will issue a final decision for most hearings. Agencies must follow a final decision for the case involved in the hearing, even if the final decision conflicts with existing policies and procedures. Agencies should continue to follow the written policies and procedures in all other cases.

23.2.7.2 Proposed Decisions

The ALJ will sometimes issue a proposed decision, such as if there are questions about Medicaid policy or if it conforms to state and federal law. All parties are able to send written comments to DHA within

15 days of receipt of the proposed decision. After the 15-day comment period, DHA will send the proposed decision and all comments received to the Secretary of the Department of Health Services. The Secretary will review the proposed decision and make the final decision. The final decision will then be communicated to all parties.

23.2.7.3 Abandoned Hearing

If the applicant, member, or representative fails to appear at the hearing without good cause, the hearing request will be dismissed. This type of dismissal is called an Abandoned Hearing. DHA will notify the applicant, member, or representative and the agency when a hearing is dismissed.

A fair hearing thought to be abandoned may be rescheduled by DHA.

23.2.8 Withdrawal of Fair Hearing Request

Only the applicant, member, or their representative may withdraw a fair hearing request for Medicaid. Applicants, members, and representatives can fill out the Voluntary Withdrawal (DHA-17) form or send a written and signed letter to DHA:

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

Fax (608) 264-9885

Email: DHAMail@wisconsin.gov

Only DHA has the authority to grant or deny a withdrawal request. DHA will notify the agency if a fair hearing request is withdrawn.

23.2.9 Cost Motion

When the applicant or member wins a hearing, their attorney may file a cost motion with DHA. A cost motion is a request for payment of attorney fees and other costs associated with the hearing.

The agency has 15 days from the filing of the cost motion to submit a written response to DHA.

The ALJ will review the 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.

23.2.10 Rehearing

An applicant or member may request a rehearing by DHA. The request must be made within 20 days of the date of the decision. DHA may grant or refuse the request. A rehearing will be held only when there has been:

- An error of law.

- An error of important fact.
- New evidence discovered which could not have been presented at the first hearing.

DHA will usually not grant a rehearing unless the error or new evidence is sufficiently important to change the decision. If DHA neither grants nor denies a rehearing request within 30 days, the request is deemed denied.

Note *Even if a rehearing is granted, the agency must continue to comply with the final decision unless and until a decision from the rehearing reverses it.*

23.2.11 Judicial Appeals

An applicant or member that disagrees with the final decision may appeal to the Circuit Court of their residence. They must do this within 30 days of the date of the decision or rehearing denial, whichever is later.

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Subprograms (Chs. 24- 38)

24 SSI-Related Medicaid and Deductibles

24.1 SSI-Related Medicaid Introduction

SSI-related Medicaid is the basic Medicaid program for individuals who are elderly, blind, or disabled and who are not receiving SSI. SSI-related individuals must meet Medicaid nonfinancial eligibility requirements (see SECTION 4.1 WHO IS NONFINANCIALLY ELIGIBLE FOR MEDICAID?). SSI-related Medicaid has the lowest income and asset limits of all EBD Medicaid programs/categories. It has two income limits which are referred to as the "categorically needy" limit and the "medically needy" limit (see SECTION 39.4.1 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES for the SSI-related categorically needy and medically needy income limits).

Categorically Needy
A fiscal test group with countable net income that does not exceed the categorically needy income limit passes the SSI-related Medicaid categorically needy income test.

Medically Needy
If a fiscal test group's countable net income exceeds the categorically needy income limit, their income is then compared to the medically needy limit of 100% FPL. If the fiscal group's countable net income is between the categorically needy limit and the medically needy limit, the group passes the Medicaid SSI-related medically needy income test.

Deductible
If a fiscal group's countable net income exceeds the medically needy income limit, they can still qualify for Medicaid by meeting a deductible, if otherwise eligible (see SECTION 24.2 MEDICAID DEDUCTIBLE INTRODUCTION and SECTION 24.5 CALCULATING THE DEDUCTIBLE).

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24.2 Medicaid Deductible Introduction

When a Medicaid applicant is ineligible for Medicaid solely because he or she has income that exceeds the Medicaid medically needy income limit, he or she can become eligible by meeting the Medicaid deductible. "Meeting the Medicaid deductible" means incurring medical costs that equal the dollar amount of the deductible.

The Medicaid deductible is the group's total excess monthly income over the 6 consecutive months of the Medicaid deductible period (See 24.3 DEDUCTIBLE PERIOD).

"Excess monthly income" is the amount which is above the group's monthly medically needy income limit.

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24.3 Deductible Period

The Medicaid deductible period is a period of six consecutive months. It is the length of time the group has for meeting the Medicaid deductible. See SECTION 5.9.5 ELIGIBILITY for an exception to the six-month deductible period for backdate periods after a formal disability determination has been made for a member certified under a presumptive disability.

The applicant can choose to begin the Medicaid deductible period as early as three months prior to the month of application and as late as the month after the month of application.

Example 1	John applies for Medicaid in July. He can choose to begin his six-month Medicaid deductible period in April, May, June, July, or August.

However, the first month of a deductible period may not be a month in which the person is ineligible for excess assets or is non-financially ineligible. The applicant may choose a six-month deductible period that includes one or more months (except for the first month) in which they are ineligible for excess assets or for a non-financial reason. Excess income is still calculated and included in the deductible amount for any months that the applicant may be ineligible due to assets or a non-financial reason. If the applicant meets the deductible, they may only be certified for Medicaid during the months when they were non-financially and asset eligible.

Example 2	Doyle applies for Medicaid in July. He has excess income in July. He wants a Medicaid deductible period that goes from April through September. In addition to having excess income in April, Doyle had $5,000 in his savings account on April 30. He cannot include April in his Medicaid deductible period. He no longer had the $5,000 on May 31, so he can begin his Medicaid deductible period in May.

Example 3	Clarice applies for Medicaid in July. She has excess income in July. She wants a Medicaid deductible period that goes from April through September. In addition to having excess income in April and May, Clarice had an inheritance of $5,000 in May. She still retained it on May 31, but no longer had the $5,000 on June 30. Her deductible period will run from April through September. However, if she meets the deductible in April, she would only be eligible through the end of April and from June 1 to September 30. If she meets the deductible in May, she would only be eligible from June 1 to September 30. Due to excess assets in May, she may not be eligible for any day in that month.

Example 4	Marion applies for Medicaid in July. She has excess income in July. She wants a Medicaid deductible period that goes from April through September. Marion was incarcerated from April 30 through May 18. She meets the deductible with a countable expense from April 10, so she should be certified from April 10 through April 29, and May 19 through September 30.

Example 5	Janet applies for Medicaid in July and requests a Medicaid deductible period from April through September. She gave birth on June 30. Janet paid the full deductible amount, so is certified from April 1 through June 30.

For backdate months, when a person had excess assets in any of the three months prior to the month of application, his or her eligibility in the backdate month is determined by whether or not they had excess assets on the last day of the month.

Example 6	Jack applies for Medicaid in July. He wants a Medicaid deductible period that goes back two months to include May and June. In May, he received a $10,000 gift. On May 29, he spent the $10,000 on a new roof. His assets were below the asset limit by the last day of the month, and he is otherwise eligible except for excess income for both backdated months, so his deductible period can begin in May.

A new deductible period can be established at any time before the current deductible has been met. The person must sign and submit a new application in order for the new deductible period to be established. A new application is required regardless of when the previous deductible period was established or if anyone in the household is eligible for another health care program such as a Medicare Savings Program.

Example 7	Jeff applies for Medicaid in January. His monthly excess income is $100. His Medicaid deductible is $600 and his deductible period is January 1 through June 30. In April, Jeff's monthly excess income decreases to $10 a month. Jeff reports the decreased income in April and now has a choice between two different deductible recalculations. He can either have the agency recalculate the original $600 deductible which would then become a $330 deductible (three months of $100 excess income and three months of $10 excess income) or, since he hasn't yet met that deductible, he can file a new application in April and establish a new deductible period of April through September with a $60 deductible obligation ($10 x 6 = $60). If Jeff hasn't already incurred any substantial medical expenses, he may want to file a new application, set a new deductible period, and be in a better position to meet a much smaller deductible (see SECTION 24.6.1 INCOME OR DEDUCTION CHANGES).

Members who have been certified for Medicaid after meeting a deductible will have to complete a renewal to establish a new deductible period. No renewal notice is sent regarding the new deductible period if the applicant did not meet the deductible for the current period.

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24.4 Choosing Not to Have a Deductible

An applicant who is ineligible for excess income in some backdate months, but has no excess income in others, does not have to choose to have a Medicaid deductible. He or she can choose to be certified in the months he or she is eligible and to accept the ineligibility of the other months where he or she has excess income.

Example 1:	Horace applies for Medicaid in July. He has no income and does not expect any income in the future. He is financially eligible in July. He also wants Medicaid eligibility for April to cover some medical expenses he had in April. In April he would have been eligible because he had no income or assets. But in May and June he had excess income of $20 each month. He has 2 choices: Choose a Medicaid deductible period of April through September. After meeting the Medicaid deductible of $40 he would be certified for Medicaid from April through September. Not choose a Medicaid deductible period. He would not have to meet a Medicaid deductible. He could be certified immediately for April and July. But he would have to forego Medicaid for May and June because of the excess income in May and June.

If the applicant has excess income in the month of application, but no excess income in the 3 months prior to the month of application, he or she does not have to include them in a deductible period. He or she can be certified for them immediately, and can begin the Medicaid deductible period with the month of application.

Example 2:	Roslyn applies for Medicaid in July. She is ineligible because she has excess income. She had no income in April, May, or June. She can be certified immediately for April, May, and June. She begins her Medicaid deductible period in July.

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24.5 Calculating the Deductible

24.5.1 Deductible Amount

To calculate the dollar amount of a Medicaid deductible for an SSI-related fiscal test group:

1. Determine the fiscal test group's total income for each month of the deductible period (see SECTION 24.3 DEDUCTIBLE PERIOD). Subtract the applicable income disregards and deductions (see SECTION 15.3 EXEMPT/DISREGARDED INCOME and SECTION 15.7 INCOME DEDUCTIONS).

   Certain income disregards and deductions allowed in other forms of Medicaid, such as the COLA and OASDI disregards for Special Status Medicaid and medical/remedial expenses for MAPP, are not deducted when calculating a deductible.
2. Compare the total countable income of each month to the SSI-related medically needy income limit (see SECTION 39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES).
   - If a given month's income is less than or equal to the medically needy limit, ignore it.
   - If a given month's income is more than the medically needy limit, find the excess income by subtracting the income limit from the net income of that month.
3. Add together the excess income of the months in the deductible period. The result is the Medicaid deductible.

24.5.2 Institution Cases

24.5.2.1 Backdating

Institutionalized and non-institutionalized persons can be eligible back to the 1st of the month, three months prior to the month of application. Even if they are ineligible in the month of application, they may still be eligible for retroactive coverage. When an institutionalized person requests retroactive Medicaid, test him or her against the nonfinancial and financial standards that are appropriate to the month being tested. For the months he or she was not institutionalized, use the EBD asset and income limits (39.4 EBD ASSETS AND INCOME TABLES). For the months he or she was institutionalized, use the institutional eligibility criteria found in 27.1 INSTITUTIONS.

24.5.2.2 Deductible

For the months in which he or she was not institutionalized, he or she may be eligible in some, but ineligible in others, due to excess income. In this situation, he or she has two choices:

1. To be certified for the months he or she is eligible, and accept the ineligibility of the other months in which he or she has excess income, or
2. To meet a deductible. The deductible period begins in the backdate month that he or she chooses, and extends six months. Calculate the deductible for the full 6-month deductible period. Calculate the deductible by comparing his or her monthly income for each of the 6 months to the SSI-related medically needy income limit, not the institutional income limit.

Expenses which can be counted against the deductible are those listed in 24.7 MEETING THE DEDUCTIBLE plus his or her cost of care (27.7 ILTC COST OF CARE CALCULATION). Expenses that cannot be counted are listed in 24.7.2 MEETING THE DEDUCTIBLE> NONCOUNTABLE COSTS.

When he or she meets the deductible, she can be certified to the end of the deductible period. At the end of the deductible period, redetermine his or her eligibility using the institutional financial tests.

24.5.3 Deductible Examples

Example 1:	Artie applies for Medicaid in July. He wants to backdate his Medicaid three months. His Medicaid deductible period is April through September. In April, May, June, and July his AG had excess income of $50 each month. His prospective excess income for August and September is $50 each month. 6 X $50 = $300. Artie's Medicaid deductible is $300.

Example 2:	Clarice applies for Medicaid in July. She wants to backdate her Medicaid to May 1. Her Medicaid deductible period is May 1 through October 31. In May and June her AG had excess income of $100 each month. In July it has excess income of $200. Its prospective excess income for August, September, and October is $200 a month. Clarice's Medicaid deductible is $1,000.

Example 3:	Myron applies for Medicaid in July. He wants to backdate Medicaid to June 1. His Medicaid deductible period is June 1 through November 30. In June his AG had excess income of $50. In July it has no excess income. Its prospective excess income for August, September, October, and November is $0. Myron's Medicaid deductible is $50.

Example 4:	Tyler applies for Medicaid in July. He wants his Medicaid to begin July 1. His Medicaid deductible period is July 1 through December 31. In July his AG has $100 excess income. Its prospective excess income for August, September, October, November, and December is $100 each month. Tyler's Medicaid deductible is $600.

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24.6 Changes During the Deductible Period

24.6.1 Income or Deduction Changes

If there are income or deduction changes during the Medicaid deductible period, that result in a decrease in the deductible amount, recalculate the Medicaid deductible amount. Beginning July 1, 2020, the deductible amount will no longer be increased when an unmet deductible assistance group has an increase in income or a decrease in deductions. Once a deductible period and deductible amount are determined and the member has been notified of his or her deductible amount, the deductible amount will never increase during the same deductible period.

At the time of initially determining a deductible period, the amount of the deductible must be determined by taking into account all changes in income, deductions and household composition known at the time the deductible is created.

To determine the amount of a decreased deductible:

1. Add together the monthly excess income of the months of the Medicaid deductible period that have already gone by.
2. Subtract the medically needy income limit from the new monthly income. This will give the excess income for the month when the income changed.
3. Using prospective net income, find the excess income of the months in the deductible period after the month when income changed.
4. Add the results of #1, #2, and #3.

Example 1:	Cicely applied for Medicaid in July. She had excess income of $20 a month. Her Medicaid deductible was $120. In November she reports a pay decrease of $10 a month. Now you must recalculate her Medicaid deductible. 1. Add together the excess income of months July through October. The result is $80. 2. Calculate her November excess income. The result is excess income of $10. 3. Prospective income for December is $10. 4. Cicely's new Medicaid deductible: $80 + $10 + $10 = $100.

If the income change results in **lower excess income** in the month of change, the applicant can choose to:

1. Recalculate the Medicaid deductible, **or**
2. Create a new deductible period.

Example 2:	Winston goes from full time to part time employment in the fourth month of his Medicaid deductible period. He still has excess income, but it is lower than in the previous three months. He can choose either to recalculate his Medicaid deductible or to have a new deductible period. If he recalculates, the resulting deductible will be lower than the previous one. His other choice is to begin a new 6-month deductible period. He may want to do this if the new deductible is even lower than the recalculated one. If he makes this choice, he will forfeit any eligibility he might have acquired in the previous deductible period if he had met the previous deductible.

If the income change results in **no excess income** the applicant has an additional choice:

1. Recalculate the deductible.
2. Create a new deductible period.
3. **Begin eligibility immediately**.

Example 3:	If Winston has no excess income in the month his income drops, and if his prospective monthly income shows no excess income, he can choose to begin eligibility immediately. In choosing this, he will forfeit the eligibility he would have had in the prior deductible period if he had met the prior deductible.

24.6.2 Group Size Changes

When the group size is different on the last day of the month from what it was on the last day of the previous month, you must recalculate the deductible if the result is a decrease in the deductible amount. Beginning July 1, 2020, the deductible amount may no longer be increased when an unmet deductible assistance group has a change in group size. Once a deductible period and deductible amount are established, the deductible amount will never increase during the same deductible period. Deductible amounts may be decreased due to changes in group size. Compare the new group's income with the new group's medically needy income limit. If there is excess monthly income, recalculate the deductible in the same way as for income changes (see SECTION 24.6.1 INCOME OR DEDUCTION CHANGES).

Example 4:	John and Sally are married and reside together. Sally is disabled and has applied for Medicaid. Sally meets all Medicaid eligibility requirements except for the fact she and her husband have excess income and would have to meet a deductible before Sally can be certified for Medicaid. The deductible period is January through June and the deductible amount is based on a 2 person fiscal test group. On March 21, John moves out of the house to go live with his brother in another state. If John is still out of the house on March 31, Sally's deductible must be recalculated using the smaller group size (one person fiscal test group) as of March 1. If after subtracting John's income the amount of excess income above the new income limit for the group of one is lower than it was for the group of 2, use the lower income and deductible amount to recalculate Sally's deductible. However, if the amount of excess income above the income limit for a group of one is higher than what it was for the group size 2, and using that amount would increase the amount of the deductible, leave the deductible amount unchanged.

24.6.3 Asset Changes

If the fiscal test group acquires new assets during the deductible period, wait until the last day of the month in which it acquired the assets. If the group has excess assets on the last day of the month, the group is not eligible for that month. Excess income may still be calculated during the dates the individual is ineligible due to assets, however the individual can only be certified for Medicaid during the dates he or she has assets below the asset limit.

24.6.4 Non-Financial Changes

If there is a change in non-financial eligibility during the deductible period excess income may still be calculated during the dates the individual is non-financially ineligible, however the individual can only be certified for Medicaid during the dates he or she is/was non-financially eligible.

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24.7 Meeting the Deductible

The fiscal test group meets the deductible by incurring medical costs that equal the dollar amount of the deductible. The countable costs are added together. When they are equal to or greater than the amount of the deductible, the group can be certified for Medicaid.

If the group has not yet met the deductible within the deductible period, it may choose to start a new deductible period that begins with a later month in the current deductible period with a new application (see SECTION 24.3 DEDUCTIBLE PERIOD).

Example 1	Stanley's deductible period is from January through June. In April Stanley incurs a large medical expense that would meet his deductible. Stanley requests to start his deductible April 1st. His new deductible period is April through September. Stanley will have to submit a new application.

If an expense was applied to a prior deductible but did not result in Medicaid certification, it can be applied to a later deductible, as long as it still meets the criteria listed in Section 24.7.1 Countable Costs below.

24.7.1 Countable Costs

To be counted toward the deductible, a medical or remedial expense must meet all of the following conditions.

1. Be an expense for a member of the applicant or member's FTG.

   Expenses may be counted if incurred for someone the member is legally responsible for if that individual could be counted in the member's FTG. The medical bill may be used even if the family member is no longer living or no longer in the current FTG.

Example 2	Sally's spouse died in April. In September, Sally requests that a medical bill incurred for her spouse be used towards her deductible. Sally is still legally responsible for the bill. The bill can be used to meet the deductible as long it did not result in a Medicaid certification in an earlier period.

2. Meet the Definition of Medical or Remedial expense as defined in SECTION 15.7.3 MEDICAL/REMEDIAL EXPENSES and SECTION 24.7.1.1 COUNTABLE EXPENSES.
3. Meet one of the following four conditions

   a) Still be owed to the medical service provider sometime during the current deductible period.

      Expenses which have been "deferred" by the provider are considered a countable cost still owed to the provider and can be used to meet a Medicaid deductible.

      i. The deferred charge should be viewed as an incurred expense that remains an unpaid obligation for the member.
      ii. If only a portion of the deferred charge was used to meet a prior deductible, any remaining balance can be used to meet future deductibles.
      iii. Many deferred charge situations involve very high costs for the services provided, it is extremely important to document in Case Comments which portion of the deferred charges are used to meet previous deductibles, and any remaining balance that can be used to meet current or future deductibles.

Example 3	From May through July Helen resided in an Institution for Mental Diseases (IMD) and incurred a $14,000 bill. As of October, Helen has not paid this bill. In October Helen's social worker, Ruth, assists Helen in applying for Medicaid. Ruth tried to help Helen meet her deductible by collecting Helen's medical bills. The "bill" for Helen's IMD stay listed $14,000 in "Deferred Charges". Ruth questioned what deferred meant. The accounts receivable person at the IMD indicated that charges for low-income people are often "deferred." "Deferred," she explained, means that the member would not be billed for the charges, but if she happens to come into a windfall of money (lottery or inheritance), they will change the status of those charges to current and try to collect the debt. Helen can use this "deferred" charge toward her deductible.

Example 4	Lestat applies for Medicaid in July. A Medicaid deductible of $700 is calculated for him. In the year prior to applying for Medicaid he had a blood transfusion. The bill for the transfusion was $800. He never paid it and still owes it to the service provider. Lestat can use the unpaid bill to meet his Medicaid deductible, but he must provide documentation to show that the charges are currently owed. The remaining $100 can be applied to the next deductible period, as long as it is still owed.

b) Paid or written off sometime during the current deductible period. Medical bills written off through bankruptcy proceedings are not allowed as a medical expense to meet a deductible.

Example 5	Frank and Estelle apply for Medicaid on March 1, requesting that their deductible period begin January 1. Their deductible for the period January 1 through June 30 is $340. In April, they had a ten-year-old medical bill of $300 written off. They can count the $300 toward the January through June deductible because it was written off during the deductible period.

c) Paid or written off sometime during the deductible period that immediately precedes and borders on the current deductible period. These bills can be used even if they were paid after the person met the deductible in the prior period.

Example 6	Jeffrey is in his second deductible period. He did not meet his deductible in the prior period, which borders on the current period. He has a bill that was written off in the prior period. He can apply this bill to his current deductible.

Example 7	Malcolm is in his second deductible period which began March 1. He did not meet his deductible in the prior deductible period, which immediately preceded the current deductible period. He has a medical bill that he paid in February of the year prior. He may not apply this toward his current deductible.

Example 8	In June, Norah met her first deductible period and was certified for Medicaid through August. After certification, and before the first deductible period ended in August, Norah paid for medical services that were not Medicaid covered services. Norah is in

	her second deductible period which began in September. Norah can apply these paid bills to the second deductible period that began in September.

d) Paid or written off sometime during the three months prior to the date of application. This expense can only be used for the first deductible period. Balances cannot be carried forward to future deductible periods.

Example 9	Sierra and Skyler apply for Medicaid on August 10, requesting that their deductible period begin on August 1. Their deductible for the period from August through January is $1500. On May 10 the couple had paid off a $2000 outstanding medical bill. They can use that expense to meet their deductible because it was paid in the three months prior to the date of their application. The remaining $500 cannot be applied to future deductible periods.

Example 10	Anna applied for Medicaid on July 25, with no request for any backdated months. Her deductible period is from July through December. She has paid her Medicare Part B premiums since she turned 65, seven years ago. She can use her Part B premium expense from the months of April, May, and June 2020 as paid medical expenses. See Process Help 19.3.4 for processing information.

Example 11	Annie applied for Medicaid on July 25, requesting a one month backdate. Her deductible period is from June through November. She has paid her Medicare Part B premiums since she turned 65, seven years ago. She can use her Part B premium expense from the months of April, May and June as paid medical expenses. See Process Help 19.3.4 for processing information.

24.7.1.1 Countable Expenses

The following are expenses that can be counted against the deductible if they meet the conditions listed in 24.7.1 COUNTABLE COSTS:

1. Medical expenses. Medical expenses are costs for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state) regardless of whether the services or goods are covered by Medicaid. Medical expenses for services or prescriptions acquired outside of the United States may be counted toward a deductible if a licensed medical practitioner or pharmacy provided the service or drug.

   Some examples of medical expenses are deductibles and co-payments for Medicaid, for Medicare, for private health insurance; and bills for medical services which are not covered by the Wisconsin Medicaid program. See SECTION 15.7.3 MEDICAL/REMEDIAL EXPENSES.

Note *ForwardHealth interChange (iC) data may be used to calculate Medicaid co-payments from the previous deductible period.*

2. Remedial expenses. Remedial expenses are costs for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition (see SECTION 15.7.3 MEDICAL/REMEDIAL EXPENSES).
3. Ambulance service and other medical transportation (21.4.2 TRANSPORTATION).
4. Medical insurance premiums paid by a member of the fiscal test group. These insurance premiums include disease specific and per diem hospital and nursing home insurance payments. This includes all Medicare premiums paid by the member. See 24.7.1. # 3 regarding premiums

paid for the three months prior to the deductible. Do not allow accidental insurance policy premiums as a countable cost.

Note *Unlike other expenses listed in this section that may not be applied toward a deductible until they are incurred, count medical insurance premiums from the first day of the deductible period, if the premium will be coming due anytime during the current deductible period. This includes all Medicare premiums owed by the member during the deductible period.*

5. Medical bills paid by a party who is not legally liable to pay them can be counted against a deductible.

   Examples of parties that pay medical bills when not legally liable include, but are not limited to: Churches, fraternal organizations, Children's Special Health Needs Unit of the Division of Public Health, Veterans Administration and the AIDS Drug Assistance Program (ADAP).
6. Medical services received at a Hill-Burton facility. The Hill-Burton Act was enacted by Congress to provide federal assistance for the construction and modernization of health care facilities. Medical facilities which receive Hill-Burton assistance must provide without charge a reasonable volume of services to persons unable to pay for those services.
7. In-kind payments. These are services or goods supplied to the provider in lieu of cash. Self declaration of the bill being satisfied is adequate verification.
8. Medical or remedial expenses that are paid or will be paid by a state, county, city or township administered program that meets the conditions detailed in 24.7.1. # 3.

   Examples include:
   a) General Assistance
   b) Community Options Program (COP)
   c) AIDS Drug Assistance Program (ADAP)

Example 12	Fred receives a medical service which will be paid by ADAP. When Fred comes in to apply for Medicaid and has to meet a deductible this medical bill that has not been paid can be used immediately because it will be paid by the state administered ADAP program.

Example 13	Sally received a medical service in January which was paid by the state administered, state funded Community Options Program in the same month. In February Sally applies for Medicaid requesting a backdate to January. Sally has excess income and must meet a deductible. Since the medical bill was paid by COP within three months of Sally's Medicaid application it can be used to meet Sally's Medicaid deductible.

9. Medical or remedial expenses that have been paid or will be paid by Indian Health Services that meet the conditions detailed in 24.7.1 # 3

Example 14	On January 1, Michael received a medical service which will be paid by Indian Health Services. When Michael applies for Medicaid on January 10 he has to meet a deductible. The bill for the January 1 medical services may be used immediately because it will be paid by the Indian Health Services program.

Example 15	Charlie received a medical service in January which was paid by Indian Health Services in the same month. In February Charlie applies for Medicaid requesting a backdate to January. Charlie has excess income and must meet a deductible. Since the bill was paid by Indian

	Health Services within three months of Charlie's Medicaid application it can be used to meet Charlie's Medicaid deductible.

10. SeniorCare Enrollment Fees

24.7.2 Noncountable Costs

Do not count the following toward the deductible:

1. Medical bills written off through bankruptcy.
2. Medical services payable or paid for by a third party who is legally liable for the bill. This includes bills that will be paid or have been paid by Medicaid, Medicare, or other Insurance.

Example 16	Medical services provided to an incarcerated person. In this case, the incarcerating authority is the legally liable third party.

3. A bill cannot be used if it has been used to meet a prior deductible. If only a portion of an unpaid bill was used to meet a prior deductible, any remaining balance that was not applied to the prior deductible, may be applied to a subsequent deductible period as long as it is still owed or meets criteria in 24.7.1 COUNTABLE COSTS.

Example 17	An applicant incurs a $300 medical bill. She applies the $300 toward her deductible even though she has not made any payments on the bill. She meets her deductible and is certified for Medicaid. Three years later she applies for Medicaid again and a deductible is calculated for her. She now pays the $300 bill. She cannot use it to meet her current deductible because she already used it to meet the prior deductible.

24.7.3 Prepaying a Deductible

Anyone can prepay a deductible for himself/herself or for someone else. It can be paid in installments or all at once. A prepaid deductible may be refunded if the member requests a refund of the prepayment **prior** to the begin date of the corresponding deductible period.

Prepayments are submitted to the local agency.

If the member is **55 or older**, prepayment checks or money orders should be made payable to: "The Department of Health Services."

The following should be included with the payment:

- Documentation that the payment is voluntary
- The member's name, and Medicaid ID number

The IM agency forwards the payment to:

ForwardHealth
Estate Recovery/Casualty Collections
313 Blettner Blvd
Madison WI
53714-2405

If the member is **under 55**, the member would make the payment payable to their IM Agency. The receipt is reported on the Community Aids Reporting System (CARS) as a Medical Refund.

24.7.3.1 Payment of Entire Deductible Amount

If the entire deductible amount is paid at any point during the deductible period, eligibility begins on the first date of the deductible period.

Example 18	Laura's deductible period is from March 1st through August 31st. The total deductible amount is $1,000. Laura submits payment of $1,000 on August 15th. Laura's Medicaid eligibility begins on March 1st.

24.7.3.2 Combination of Payment and Incurred Expenses

If the deductible is met through a combination of payment and incurred medical expenses, count the incurred medical expenses are counted first. Eligibility, by paying the remaining deductible amount, can begin no earlier than the last date of incurred medical expense within the deductible period.

Example 19	Chad's deductible period is from March 1st through August 31st. The total Medicaid deductible amount is $1,800. Chad submits a medical bill with a March 8th date of service for $800. On July 15th, he submits payment of $1,000. Chad's Medicaid eligibility begins March 8th.

24.7.3.3 Combination of Payment and Outstanding Expenses

If the deductible is met through a combination of payment and outstanding medical expenses (incurred prior to the beginning of the deductible period), eligibility begins on the first date of the deductible period.

Example 20	Roberta's deductible period is from March 1st through August 31st. The total Medicaid deductible amount is $1,500. She submits an outstanding bill from January 10th for $500. On August 15th, she submits payment of $1,000. Roberta's Medicaid eligibility begins March 1st.

24.7.3.4 Calculation Errors

If any portion of the deductible is paid and it is determined that the amount was wrong due to agency error, the amount incorrectly paid shall be refunded and reported on CARS.

24.7.3.5 Insufficient Funds

If the deductible is paid with a check that is returned for insufficient funds, the person is no longer eligible.

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24.8 Order of Bill Deduction

When applying medical bills to the deductible, start with the earliest service date. If more than one bill has the same service date, use the bill with the highest amount first, then the next highest and so on down to the lowest bill with that same service date.

24.8.1 Hospital Bills

Hospitals do not always itemize the cost of their services according to the day and time of day the patient received the services. It is difficult sometimes to know when the patient met the deductible.

For this reason, if the patient's hospital bill for one continuous stay in the hospital is equal to or above whatever the deductible was on the date of admission, count the deductible as having been met on the date of admission. Set that date as the begin date of Medicaid certification. Apply the hospital bill to the deductible first before counting any other medical costs that were incurred during the hospital stay.

Example 1:	Linda submits a $2,000 bill toward her deductible, for hospitalization from July 12th through July 14th. She also submits a physician bill for $2,500 with a date of service of July 12th. Apply the $2,000 hospital bill to the deductible first.

24.8.2 Pregnancy Fees

Many providers charge a flat fee for pregnancy related services. The single-fee includes all prenatal care, office visits, delivery, and postnatal care.

In determining whether these "global" pregnancy fees meet the deductible, treat them the same way as you would a hospital bill. If the "global" pregnancy fee is equal to or above the deductible, count the deductible as having been met as of the date an agreement was signed.

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24.9 Notice to Fiscal Agent Concerning Any Remaining Deductible

When the member receives a medical bill that is equal to or greater than the amount he or she still owes on the deductible, he or she can be certified for Medicaid. He or she must pay the part of the bill that equals the deductible. Medicaid will consider the remainder of the bill for payment.

To make sure that Medicaid does not pay what the member still owes on the deductible, send a Medicaid Remaining Deductible Update (F-10109) to the fiscal agent indicating the amount of the bill that the member owes. The fiscal agent subtracts this amount from the bill and Medicaid pays the rest.

Fill out the Medicaid Remaining Deductible Update (F-10109) only if:

A Medicaid certified provider has provided the billed services.

The person, having met the deductible, is being certified. If he or she is not being certified, Medicaid will not pay any of the bill.

The date of the bill is the date the deductible was met. Since the member is not eligible until he or she has met the deductible, he or she still owes for all bills prior to that date.

If more than one bill was incurred on the date the deductible was met, send additional Medicaid Remaining Deductible Update (F-10109) forms for any other bills for which the member would be responsible.

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24.10 Late Reporting of Deductible Information

If the client turns in late reports on income changes or medical costs, recalculate the deductible as of the date the change took place or the medical cost was incurred. See what would have been the deductible had he or she reported the changes and the medical costs as they occurred. If the medical bills would have met the deductible for any past date, begin Medicaid certification on that date.

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24.11 Reserved

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24.12 Changes After Meeting a Deductible

24.12.1 Changes After Meeting a Deductible Introduction

When the fiscal group has met the deductible, it can be certified for Medicaid to the end of the deductible period.

24.12.2 Income Changes

Income changes do not affect the group's eligibility for the remainder of the deductible period once the deductible has been met. However, workers must determine if eligibility for the deductible should have begun on an earlier date due to a reduced deductible amount and manually certify eligibility for the appropriate dates. A met deductible period may not be shortened due to any changes which would have increased the amount of the deductible.

24.12.3 Asset Changes

If the Medicaid group acquires new assets during the remainder of the deductible period, wait until the last day of the month in which it acquired the assets. If the group has excess assets on the last day of the month, discontinue Medicaid eligibility.

If the group's assets fall below the limit before the end of the met deductible period, reopen the deductible for the remainder of the original deductible period.

Example 1:	Jim has a deductible period from July through December. He meets his deductible on July 18. In August, Jim reports that he inherited $5,000 and he still has it as of August 31. His case closes for October for excess assets. On November 5, Jim reports that he spent the money and his assets are now below $2,000. Since he is still in his deductible period and no longer ineligible because of his assets, his deductible should be reopened for November 1 through December 31.

24.12.4 Non-Financial Changes

If there is a change in non-financial eligibility during the deductible period, discontinue Medicaid eligibility for those persons who have become non-financially ineligible.

The deductible period (24.3 DEDUCTIBLE PERIOD) for which excess income is calculated may include a month(s) in which, if a member had applied, he or she would have been ineligible for a non-financial reason.

If a child enters the Medicaid group, the child's name will appear on the Medicaid card for the remainder of the deductible period.

If an adult caretaker relative who is EBD or is medically verified as pregnant enters the Medicaid group, his or her name will appear on the Medicaid card for the remainder of the deductible period.

If a member loses non-financial eligibility and regains it during the same deductible period, reopen Medicaid for the dates when he or she was non-financially eligible.

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24.13 Death During a Deductible Period

24.13.1 Death During a Deductible Period Introduction

If the member dies during the deductible period, and is not already certified, look at all countable costs (see SECTION 24.7.1 COUNTABLE COSTS) prior to death. If those countable costs meet the deductible, certify the deceased person. The time period for the deductible remains six months (no prorating). All months that remain of the six-month deductible period from the point the member dies, are considered to have $0 income for a group size of 1. For a group size of 2, if the spouse passes away, the deductible amount should be recalculated for all months after the date of death with a group size of 1 and only with the surviving spouse's income. In both cases, the deductible amount must be recalculated.

If the deductible was met, met on a date after the first day of the deductible period and before the member dies, recalculate the amount of the deductible. If the new deductible amount will cause the member to meet the deductible on an earlier date, recertify the deductible using that earlier date. Eligibility will be granted from the point from which the deductible was determined to have been met through the date of death.

24.13.2 Prepaid Deductible

If the member prepays the deductible and dies after the deductible period starts, the deductible is non-refundable. If the member prepays and dies before the deductible period starts, the deductible is refundable.

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25 Special Status Medicaid

25.1 Special Status Medicaid

25.1.1 Special Status Medicaid Introduction

SSI recipients in Wisconsin are automatically enrolled in SSI Medicaid and remain eligible for SSI Medicaid as long as they continue to receive SSI. Loss of SSI payments can result in loss of Medicaid coverage.

There are special federal Medicaid continuation provisions to protect health care benefits for certain groups of former SSI recipients who receive Social Security payments. These "special status" groups are:

- Disabled adult child (DAC) group (see SECTION 25.2 DISABLED ADULT CHILD (DAC) GROUP)
- 503 group (see SECTION 25.3 503 GROUP)
- Widow/Widower group (see SECTION 25.4 WIDOW/WIDOWER GROUP)

When determining eligibility for former SSI recipients who belong to one of these special status groups, the appropriate amount of Social Security income must be disregarded, as described in the policy for each group (see sections linked above). Each group has a specific set of requirements that a person must meet to qualify for a special status income disregard. Simply losing SSI or receiving a certain type of Social Security payment does not automatically qualify someone for a special status disregard.

IM agencies are responsible for:

1. Determining whether Social Security beneficiaries who received SSI in the past qualify for special status disregards as a DAC, 503, or Widow/Widower group.
2. Calculating and applying the appropriate Social Security income disregards for these groups when applicable.

Note *Medicaid eligibility is also protected for "Section 1619" participants (see SECTION 25.5 SECTION 1619 GROUP). IM workers do not determine Medicaid eligibility for Section 1619 participants, who are automatically enrolled in SSI Medicaid.*

25.1.2 Special Status Medicaid Income and Asset Limits

Special Status Medicaid has the same income and asset limits as SSI-Related Medicaid:

- The assistance group must have countable income at or below 100% FPL after "special status" Social Security disregards.
- The assistance group must have countable assets at or below $2,000 for an unmarried person or $3,000 for a married couple.

Note	DAC and 503 groups who are eligible for Special Status Medicaid are categorically eligible for QMB (see SECTION 32.2 QMB) if they receive Medicare. Section 1619 groups who receive Medicare receive QMB benefits as part of their SSI Medicaid benefit package.

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25.2 Disabled Adult Child

25.2.1 Introduction

Section 1634(c) of the Social Security Act requires states to consider disabled adult children who lose SSI eligibility as if they were still SSI recipients for Medicaid purposes so long as they would have remained otherwise eligible for SSI benefits but for their entitlement to (or increase in) Social Security disabled child (SSDC) benefits.

SSDC is a Social Security benefit for adults aged 18 and older who have a disability that began before they reached the age of 22. It is called a "child" benefit because it is based on the Social Security earnings record of the recipient's parent (or grandparent, in some cases) who is disabled, retired, or deceased.

Note	Some people who receive SSDC and qualify for the DAC disregard may also receive Social Security benefits (such as SSDI) based on their own earnings record. If that Social Security benefit was received concurrently with SSI, then the person also qualifies as a 503 group. The portion of that Social Security payment that is attributable to COLA increases since SSI was lost must be disregarded in accordance with 503 policies (seeSECTION 25.3 503 GROUP).

25.2.2 Identifying a DAC Group

Someone qualifies as a DAC for Medicaid purposes if they meet the following criteria:

1. They currently receive a Social Security disabled child (SSDC) payment.
2. They previously received SSI (or they were a 1619 participant), but they became ineligible for SSI/1619 due to excess income when they started receiving the SSDC benefit (or increase).

25.2.3 Determining the Income Disregard for DAC Group

When eligibility is determined for someone who meets DAC criteria, the disregard amount depends on whether it was the initial SSDC payment or an increase to the SSDC payment that caused the loss of SSI.

25.2.3.1 Initial SSDC Payment Caused Loss of SSI

If the **initial** SSDC payment caused the individual to lose SSI, the disregarded amount is the gross amount of the SSDC payment. The gross amount must include any Medicare premiums being deducted from the SSDC.

Example 1	While his mother worked, Harvey received a monthly SSI payment. When his mother retired, Harvey became eligible for an SSDC payment of $1,150. The SSDC payment exceeded the SSI income limits, causing Harvey's SSI (and SSI Medicaid) eligibility to end. When Harvey applies for Medicaid, the **entire** amount of the initial SSDC payment (**$1,150**) is disregarded. Going forward, any subsequent COLA increases to his SSDC payment will be disregarded automatically as part of the annual COLA mass change.

If the **initial** SSDC payment caused the individual to lose SSI, and then the SSDC payment later increases (for example, when the parent passes away), the increase amount is counted as income and is not disregarded. All subsequent annual COLA increases are disregarded.

Example 2	While her father worked, Jane received a monthly SSI payment of $877.78. When her father passed away, Jane became eligible for an SSDC payment of $1,772 per month. The SSDC payment exceeded the SSI income limits, causing her SSI (and SSI Medicaid) eligibility to end. When Jane applies for Medicaid, the entire amount of the initial SSDC payment ($1,772) is disregarded. Two years later, Jane's SSDC payment increased to $2,025 when her brother graduated from high school and stopped

	receiving Social Security survivor benefits. A new disregard amount is not calculated due to this increase. The original SSDC payment will continue to be disregarded for the Special Status Medicaid eligibility determination. However, the increase that occurred when her brother graduated will not be disregarded. Going forward, any subsequent COLA increases to the SSDC payment will be disregarded automatically as part of the annual COLA mass change.

25.2.3.2 Increase to SSDC Payment Caused Loss of SSI

SSDC payments can increase, for example, when the parent whose earnings record the SSDC payment is based on passes away, or when another person in the family who was getting Social Security benefits (resulting in a lower SSDC payment amount due to SSA's "family maximum" rules) stops getting Social Security.

If an **increase** to the SSDC payment caused the individual to lose SSI, the disregard amount is calculated as follows:

1. Determine the gross SSDC payment amount immediately prior to the increase that caused loss of SSI.
2. Subtract that amount from the current gross SSDC payment. The gross amount must include any Medicare premiums being deducted from the SSDC.

Example 3	While his father worked, George received a monthly SSI payment. When his father retired and began receiving Social Security, George began receiving an SSDC payment of $600 per month. This caused George's SSI payment to decrease, but he remained eligible for SSI (and SSI Medicaid). Ten years later, George's father passed away and George's SSDC payment increased to $1,101, which caused George to lose SSI (and SSI Medicaid). George applies for Medicaid. The disregard amount must be determined as follows: 1. Determine through the SSA data exchange that the gross SSDC payment immediately prior to the increase that caused loss of SSI was $734 (the original $600 plus ten years of COLA increases). 2. Subtract $734 from the current gross SSDC payment amount ($1,101) to get a disregard amount of **$367**. Going forward, any subsequent COLA increases to the SSDC payment will be disregarded automatically as part of the annual COLA mass change.

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25.3 503 Group

25.3.1 Introduction

This group, named after section 503 of Public Law 94-566 extends Medicaid eligibility to certain former SSI recipients if they would be otherwise eligible for SSI benefits if all historical COLA increases to their Social Security benefits since SSI was lost were disregarded.

25.3.2 Identifying a 503 Group

Someone qualifies as a 503 group for Medicaid purposes if they meet the following criteria:

1. They currently receive some type of Social Security benefits.
2. They were previously eligible for SSI (or they were a 1619 participant) but became ineligible for SSI/1619 **for any reason**.
3. In any month since April 1977, they were eligible for SSI/1619 benefits **concurrently** with Social Security benefits.

"Concurrently" includes situations in which Social Security benefits are granted retroactively for months in which the person was also receiving SSI. It also includes situations in which SSA recovered the SSI payment because the Social Security payment covers the same period for which the person received SSI. However, "concurrently" does not include situations in which SSI eligibility is granted retroactively for a period in which the person was also receiving Social Security benefits. To be considered a 503 group, a person **must have received SSI income in the month prior to the month in which they began to receive the Social Security payment**. Sometimes SSI and Social Security payments will be received in the same month, but not always.

Example	Kathy received both SSI and Social Security Surviving Spouse (SSSS) payments for the past five years. She lost her SSI payment due to an increase in unearned income when she began receiving a pension in January of this year. While a COLA increase was not the reason she lost SSI, because the SSI and SSSS payments were received concurrently and then she lost SSI, when her Medicaid eligibility is determined, Kathy is entitled to a disregard of all COLA increases to her SSSS payments since the date SSI was lost.

25.3.3 Determining the COLA Disregard for 503 Group

To calculate the COLA disregard for 503 groups:

1. Find the gross Social Security income, which is the sum of the following:
    a) Net amount of the Social Security payment
    b) Any amount being deducted for Medicare premiums
    c) Any amount being withheld for other reasons (i.e., overpayments, garnishments)
2. In the "Month SSI Last Received" column in the table below, find the month in which the person was last eligible for and received an SSI payment.
3. Find the decimal figure that applies to that month and the year the Social Security check was received.
4. Multiply the gross Social Security income by the applicable decimal figure and round to the nearest whole dollar.

Note *Once the disregard amount is determined and applied, going forward, all subsequent COLA increases will be disregarded automatically as part of the annual COLA mass change.*

Month SSI Was Last Received	Multiply 2025 Social Security by:	Multiply 2024 Social Security by:
Jan 2024 - Dec 2024	0.024390	--
Jan 2023 - Dec 2023	0.054642	0.031008
Jan 2022 - Dec 2022	0.130305	0.108563
Jan 2021 - Dec 2021	0.178758	0.158227
Jan 2020 - Dec 2020	0.189298	0.169030
Jan 2019 - Dec 2019	0.202065	0.182116
Jan 2018 - Dec 2018	0.223798	0.204393
Jan 2017 - Dec 2017	0.239018	0.219993
Jan 2016 - Dec 2016	0.241294	0.222326
Jan 2015 - Dec 2015	0.241294	0.222326
Jan 2014 - Dec 2014	0.253976	0.235326
Jan 2013 - Dec 2013	0.265001	0.246626
Jan 2012 - Dec 2012	0.277287	0.259220
Jan 2011 - Dec 2011	0.302401	0.284961
Jan 2010 - Dec 2010	0.302401	0.284961
Jan 2009 - Dec 2009	0.302401	0.284961
Jan 2008 - Dec 2008	0.340644	0.324160
Jan 2007 - Dec 2007	0.355468	0.339355
Jan 2006 - Dec 2006	0.376058	0.360459
Jan 2005 - Dec 2005	0.400632	0.385648
Jan 2004 - Dec 2004	0.416390	0.401799
Jan 2003 - Dec 2003	0.428393	0.414103
Jan 2002 - Dec 2002	0.436285	0.422192
Jan 2001 - Dec 2001	0.450570	0.436835
Jan 2000 - Dec 2000	0.469150	0.455879
Jan 1999 - Dec 1999	0.481592	0.468632
Jan 1998 - Dec 1998	0.488245	0.475451
Jan 1997 - Dec 1997	0.498771	0.486240
Jan 1996 - Dec 1996	0.512897	0.500719
Jan 1995 - Dec 1995	0.525240	0.513371
Jan 1994 - Dec 1994	0.538172	0.526626
Jan 1993 - Dec 1993	0.549875	0.538622
Jan 1992 - Dec 1992	0.562985	0.552060
Jan 1991 - Dec 1991	0.578578	0.568042
Jan 1990 - Dec 1990	0.600169	0.590173
Jan 1989 - Dec 1989	0.618117	0.608570

Jan 1998 - Dec 1988	0.632805	0.623625
Jan 1987 - Dec 1987	0.647606	0.638796
Jan 1986 - Dec 1986	0.652128	0.643431
Jan 1985 - Dec 1985	0.662588	0.654152
Jan 1984 - Dec 1984	0.673998	0.665848
Jul 1983 - Dec 1983	0.685022	0.677148
Jul 1982 - Jun 1983	0.706724	0.699393
Jul 1981 - Jun 1982	0.736263	0.729670
Jul 1980 - Jun 1981	0.769259	0.763490
Jul 1979 - Jun 1980	0.790045	0.784796
Jul 1978 - Jun 1979	0.802859	0.797930
Apr 1977 - Jun 1978	0.813842	0.809188

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25.4 Widow/Widower Group

25.4.1 Introduction

Section 1634(d) of the Social Security Act requires states to consider certain widows, widowers, and surviving ex-spouses who lost SSI eligibility as if they were still SSI recipients for Medicaid purposes so long as they would have remained otherwise eligible for SSI benefits but for their entitlement to Social Security Widow/Widower benefits (SSDW or SSWW).

25.4.2 Identifying a Widow/Widower Group

Someone qualifies as a Widow/Widower group for Medicaid purposes if they meet the following criteria:

1. They are currently receiving a Social Security widow/widower's (SSDW or SSWW) payment.
2. They are not entitled to Medicare Part A.
3. They received an SSI benefit (or they were a 1619 participant) the month before their SSDW or SSWW benefits began, and lost SSI/1619 due to excess income when they started receiving the SSDW or SSWW payment.

Note *People who lost SSI due to receiving SSDW or SSWW payments, but who do not qualify for the Widow/Widower disregard because they receive Medicare, must be treated as a 503 group (see SECTION 25.3 503 GROUP).*

25.4.3 Determining the Income Disregard for Widow/Widower Group

When Medicaid eligibility is determined for someone who meets Widow/Widower criteria, the entire SSDW or SSWW payment is disregarded.

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25.5 Section 1619 Group

Section 1619 of the Social Security Act applies to people with disabilities who work. Medicaid is protected for 1619 participants. Both 1619(a) and 1619(b) participants are automatically enrolled in SSI Medicaid.

- The 1619(a) group includes working people with earnings at or above the substantial gainful activity (SGA) level who continue to receive a small SSI check.
- The 1619(b) group includes working people who no longer receive SSI cash benefits because they earn too much through work to qualify.

Note *If a 1619 participant loses their 1619 status (and SSI Medicaid) due to receiving Social Security benefits, they may qualify as a 503, DAC, or Widow/Widower group depending on the circumstances. When determining the special status disregard amount for a former 1619 participant who lost Medicaid eligibility due to receiving Social Security benefits, the date they lost SSI Medicaid is treated as the date they lost SSI.*

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25.6 Reserved

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25.7 Reserved

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25.8 Reserved

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26 Medicaid Purchase Plan

26.1 Introduction

MAPP is a subprogram of the Wisconsin Medicaid Program. It allows disabled people who are working or want to work to become or remain Medicaid eligible, even if employed, since there are higher income limits.

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26.2 Application

26.2.1 MAPP Application Introduction

When someone who has a disability applies for health care (see SECTION 2.1 APPLICATIONS INTRODUCTION), the request for health care is also a request for MAPP.

Eligibility for MAPP will be determined if the member is not eligible for another form of full-benefit Medicaid.

26.2.2 Begin Month

MAPP eligibility can be backdated up to three months prior to the month of application (see SECTION 2.8.2 BACKDATED ELIGIBILITY). The member may be certified for MAPP for any backdate month in which they would have been eligible for MAPP had they applied in that month. Before enrolling, the member is responsible for any premiums due (if owed) for the months in which they elect coverage, up to the current month (see SECTION 26.5.2 INITIAL PREMIUMS).

MAPP applicants can also choose to begin their eligibility:

- The month of application
- The month after the month of application
- Two months after the month of application (if processed after adverse action)

Example 1:	Jack applies for MAPP on September 30 and requests backdated coverage for June, July, and August. His application is processed on October 21. He meets all eligibility requirements as of June. Jack can choose to begin MAPP eligibility in June, July, August, September, October, November, or December.

26.2.3 Fiscal Test Group

When both members of a married couple (living together) apply for MAPP, each person must be in a separate Assistance Group (AG). Enter them in CARES on the same application. The member's spouse is a countable member of the FTG. A separate financial test is done for each spouse's AG. The married couple is entered on the same case, but they are in two separate AGs.

If a spouse of a MAPP applicant chooses not to disclose or verify assets, a case may fail for a higher Medicaid eligibility and still cascade to MAPP eligibility.

If both members of a married couple (living apart) apply for MAPP, determine eligibility as two separate cases.

Include the member's spouse and test children in the FTG. Test children include the member's minor natural or adoptive children. Do not include the member's stepchildren in the FTG. Do not count the income or assets of the test children.

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26.3 Nonfinancial Requirements

26.3.1 Medicaid Purchase Plan Nonfinancial Requirements Introduction

Members must:

- Meet general Medicaid nonfinancial requirements (see SECTION 4.1 WHO IS NONFINANCIALLY ELIGIBLE FOR MEDICAID?).
- Be at least 18 years old (there is no maximum age limit).
- Be determined disabled, presumptively disabled, or MAPP-disabled by the DDB, regardless of age (see SECTION 5.2 DETERMINATION OF DISABILITY and SECTION 5.10 MEDICAID PURCHASE PLAN DISABILITY).
- Be meeting or exempt from the work requirement (see SECTION 26.3.3 WORK REQUIREMENT and SECTION 26.3.4 WORK REQUIREMENT EXEMPTION).

26.3.2 Disability

Disability is a non-financial eligibility requirement for MAPP, even for members who are age 65 and older. DDB must certify disability (see SECTION 5.10 MEDICAID PURCHASE PLAN DISABILITY). There is no requirement that a member be a current or former SSI or SSDI beneficiary to qualify for MAPP. Earned income is not used as evidence in MAPP disability determinations.

If an applicant or member does not have a disability determination from DDB, complete the disability application process outlined in SECTION 5.3 DISABILITY APPLICATION PROCESS even if the applicant or member is age 65 or older (unless the applicant or member fits the policy on converting from SSDI to SSRE). The rest of the MAPP application must be completed at this time, and MAPP eligibility can only be pending for the disability determination before the MADA will be sent to DDB through the automated process (see Process Help Section 9.4 Automated Medicaid Disability Determination).

Applicants and Members Converting from SSDI to SSRE

An applicant or member whose SSDI or any other disability-related Old Age, Survivors and Disability Insurance (OASDI or Title II) benefits stopped because they began receiving SSRE is considered to have met the disability requirement for all types of EBD Medicaid, including MAPP. A disability re-determination is not required. The member is not required to provide verification of the disability unless the worker is not able to use data exchanges or other information from the Social Security Administration (SSA) to confirm that the individual received disability payments immediately prior to receiving SSRE.

Redeterminations

Follow the rules in SECTION 5.7 REDETERMINATION on when to review disability determination.

Members Who Have Lost Their SSDI Due to Exceeding Substantial Gainful Activity

A current MAPP member who loses SSDI because they exceed the Substantial Gainful Activity level remains MAPP-eligible until a MAPP disability determination is done by DDB. If DDB determines the individual is not disabled using the MAPP criteria, the MAPP eligibility will terminate with adverse action notice for the reason "not MAPP disabled."

Note *An 18-year-old MAPP member who does not qualify for any other full-benefit health care category cannot lose MAPP during their continuous coverage period even if they are determined no longer disabled (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).*

26.3.3 Work Requirement

To meet the work requirement, a member must engage in a work activity at least once per month or be enrolled in an HEC program (see SECTION 26.3.4 WORK REQUIREMENT EXEMPTION). Consider a member to be working whenever he or she receives something of value as compensation for his or her work activity. This includes wages or in-kind payments (see SECTION 15.5.1 INCOME IN-KIND). The exceptions are loans, gifts, awards, prizes, and reimbursement for expenses.

26.3.3.1 Self-Employment

If a member engages in a self-employment activity that generates some compensation at least once in the calendar month, the individual is employed for purposes of MAPP.

A member does not need to realize a profit from self-employment for it to be defined as work.

26.3.3.2 Contractual Employment

If a member is under contractual employment for the entire year, he or she is employed for the purposes of determining MAPP eligibility for the entire year. Do not consider members employed for any months in which they do not have a contractual employment agreement.

26.3.3.3 Employment Ending

A member has until the last day of the next calendar month to become employed again. Eligibility cannot be terminated until one full calendar month has passed since employment ended.

Example 1	Kerrie reported on March 15 that her employment ended March 5. She has until April 30 to become employed again, and her eligibility cannot be terminated due to not having employment before then.

Note *An 18-year-old MAPP member who does not qualify for any other full-benefit health care category cannot lose MAPP during their continuous coverage period even if they are no longer meeting the work requirement (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).*

26.3.3.4 Temporary Employment

If a member has signed up with a temporary service agency and is not actually working, he or she is not working for purposes of MAPP. If a member is engaged in work activity for which compensation will be received at least once in a calendar month, he or she is employed for the purposes of determining MAPP eligibility in that calendar month.

26.3.4 Work Requirement Exemption

If serious mental or physical illness or hospitalization that causes the member to be temporarily unable to work or participate in the HEC program, the work requirement can be suspended for up to six months. The IM agency may grant up to two non-consecutive work requirement exemptions (up to six months each) within any three-year period. The member must contact the IM agency to request the exemption using the Medicaid Purchase Plan (MAPP) Work Requirement Exemption (F-10127) form.

The agency may grant a work requirement exemption if the MAPP member:

- Has been enrolled in MAPP for at least six months and has paid any applicable premiums prior to the request of an exemption.
- Is expected to be able to return to work within the next six months.
- Provides a doctor's statement as proof of the mental or physical health-related hardship making them unable to work or participate in the Health and Employment Counseling program.
- Has not already been granted two exemptions in the past three years.

The MAPP member must continue to pay all applicable premiums during the work requirement exemption period or have an approved temporary premium waiver.

DHS may also grant a temporary waiver of the work requirement for good cause.

Example 1	A MAPP member who has already been granted two work requirement exemptions by the IM agency within the last three years has a car accident and will be unable to work for three months. The agency cannot grant a third exemption but can refer the request to DHS for consideration.

If a work exemption request is denied, the member has appeal rights in accordance with the Medicaid program.

In the last month of an exemption, the agency must send a notice to the member indicating the date the work requirement exemption will end and any steps the member must take to continue MAPP eligibility.

26.3.5 Health and Employment Counseling Program

Health and Employment Counseling (HEC) is a pre-employment program for MAPP members who are not employed but are looking for work. HEC participation is one way to meet the MAPP work requirement. Individuals enrolled in or applying for MAPP who are interested in HEC can call 866-278-6440 to learn more about the program.

HEC participation can occur for up to nine months with one three-month extension, for a total of 12 months.

Members can re-enroll in HEC to meet the eligibility criteria for MAPP. HEC participation is limited to twice within a five-year period, and there must be six months between any two HEC participation periods.

26.3.5.1 Health and Employment Counseling Processing

MAPP applicants or members interested in enrolling in HEC are required to complete and submit a HEC Application (F-00004). Applications may be printed from the Department of Health Services' website at: https://www.dhs.wisconsin.gov/employment-skills/hec-faq.htm. Applicants can also contact their local agency to request a HEC application be mailed to them. The applicant can complete the application on their own, with the assistance of the HEC coordinator or an advocate. IM workers are not expected to assist with completing or submitting the form for the applicant.

Once submitted, the HEC coordinator will make a final approval or disapproval decision within 10 business days. If the HEC application is approved, the HEC coordinator will send the member an approval letter and notify the IM agency. The HEC period can begin as of the first of the month:

- The approved application was submitted
- The application was approved
- After a member's existing work activity ends
- An applicant's MAPP begins

The application is not approved, the member will be informed that they have not been approved and can contact the HEC coordinator with any questions. The right to file a fair hearing will be provided on their notice of decision for MAPP eligibility.

Note *Qualifying for HEC is contingent on the member having an approved disability determination. A HEC application for an individual with a pending disability determination will be processed after a disability decision has been made by DDB. If approved, retroactive HEC participation can begin the first of the month the approved HEC application was submitted.*

26.3.5.2 Health and Employment Counseling Extension

If the HEC period is ending prior to the member meeting their employment plan goals, the member can apply to extend their HEC period by three months.

A HEC Extension Request form (F-00004A) will be sent to the member two months before their 9-month HEC period will end. To avoid any gaps in coverage, the participant should apply for an extension before the end of the seventh month of their HEC period. To be approved for an extension, the participant must request an extension before the last day of their HEC period. The HEC coordinator will make an approval or denial decision within 10 business days and the member will be mailed a decision letter.

26.3.5.3 Health and Employment Counseling Participation Changes

HEC participation will end prior to a member's 9-month or 12-month end date when:

- MAPP eligibility is terminated for a reason other than not meeting the work requirement.
- Employment or work activity is reported to the HEC coordinator and IM agency.

To notify the HEC coordinator of employment, the member needs to complete and submit the HEC Employment Report form (F-00004B). When a member enrolled in HEC notifies the IM agency that they are now employed, verification will be needed and eligibility will be redetermined.

If a member's HEC participation ends as scheduled and they are not meeting the work requirement in another way, their MAPP eligibility will be terminated with an adverse action notice.

Note *An 18-year-old MAPP member who does not qualify for any other full-benefit health care category cannot lose MAPP during their continuous coverage period even if they are determined no longer meeting the work requirement (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).*

26.3.6 Health Insurance Premium Payment

See SECTION 9.4 HEALTH INSURANCE PREMIUM PAYMENT for information about HIPP and cooperation requirements.

26.3.7 Spousal Impoverishment

There are no spousal impoverishment protections for MAPP. An institutionalized member who was determined ineligible for Medicaid using the Medicaid Institutions tests can qualify for Medicaid through MAPP. However, because only the member's assets count in determining MAPP eligibility, do not apply the spousal impoverishment provisions for assets. Similarly, because there is no post-eligibility treatment of income and instead calculate a premium using only the member's income, there is no community spouse income allocation or family member maintenance allowance for MAPP.

26.3.8 Institutionalization

Members in an institution may qualify for MAPP if they do not qualify for institutional Medicaid. If the member's monthly premium gross income exceeds 100% FPL for a group of one (see SECTION 39.5

FEDERAL POVERTY LEVEL TABLE), they are responsible to pay a monthly premium instead of a patient liability or cost share (see SECTION 27.7 COST OF CARE CALCULATION and SECTION 27.7.3 PARTIAL MONTHS).

26.3.9 Community Waivers

MAPP is a full-benefit Medicaid subprogram for community waiver participation (see SECTION 21.2 FULL-BENEFIT MEDICAID). If the member's monthly premium gross income exceeds 100% of the FPL for a group of one (see SECTION 39.5 FEDERAL POVERTY LEVEL TABLE), they are responsible to pay a monthly MAPP premium instead of a cost share.

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26.4 MAPP Financial Requirements

Follow EBD rules in Chapters 15.1 INCOME INTRODUCTION and 16.1 ASSETS INTRODUCTION to determine countable assets and income. The following are MAPP financial eligibility requirements.

26.4.1 Assets

Total countable assets of the member must be $15,000 or less. Only count the assets of the MAPP applicant for the MAPP asset eligibility test.

26.4.1.1 Independence Accounts

MAPP members can establish one or more Independence Accounts. These accounts are an exempt asset. There is no limit to the number of Independence Accounts a MAPP member may have and no restriction on what the money can be used for.

A member's deposits into an Independence Account may total no more than 50% of their gross earnings over the 12-month certification period. If the member's deposits exceed 50% of their actual gross earnings during the same 12-month certification period, a penalty is assessed (see SECTION 26.5.1.1 INDEPENDENCE ACCOUNT PENALTY). Amounts withdrawn from a MAPP Independence Account during the 12-month certification period do not affect the limit on the gross amount that may be deposited during the same period without penalty.

Example 1	The agency is processing Fred's MAPP renewal. During the previous 12-month certification period, Fred earned $5,000 from his job and received $12,000 in unearned income. During that same period, he deposited $3,000 into his Independence Account. At one point he withdrew $500 from his Independence Account to pay for car repairs. The penalty is based solely on total deposits in excess of 50% of gross earnings over the twelve-month period. Withdrawals are not counted when determining the penalty. In this example, 50% of Fred's $5,000 earned income = $2,500. The $3,000 in deposits - $2,500 = $500 penalty

Independence Account Registration

To qualify as an Independence Account, an account must be:

1. Registered with the IM Agency. To register an Independence Account, the member must submit a completed Medicaid Purchase Plan (MAPP) Independence Account Registration (F-10121) form to the IM agency. The IM agency must save a copy of the completed form in the member's case file and provide a copy to the member.
2. A separate financial account owned solely by the MAPP member (Cash, escrow accounts for a home sale, money owed, prepaid debit cards, and tax refunds may not be registered as Independence Accounts.)
3. Opened with a financial institution after MAPP eligibility is confirmed, with the following exceptions:
    a) Pension and retirement accounts
    b) Non-retirement accounts that were registered as Independence Accounts before August 1, 2020

There are different rules for retirement and non-retirement accounts regarding how they may be registered as Independence Accounts and when funds may be deposited.

Retirement Accounts

MAPP members may register their existing retirement or pension accounts as Independence Accounts. The amount that was already accumulated in the retirement or pension account before it was registered as an Independence Account is called the "Pre-Independence Account Balance." The Pre-Independence Account Balance is a countable asset. Funds may be deposited in a retirement or pension account that has been registered as an Independence Account during periods of MAPP ineligibility. However, any funds deposited during a period of MAPP ineligibility must be added to the account's Pre-Independence Account Balance and considered a countable asset.

Example 2	Sheila is approved for MAPP. She has an established retirement account through her employer that currently has a $5,000 balance. The $5,000 was a countable asset for her eligibility determination. Sheila registers the retirement account as an Independence Account with the IM agency. The money deposited into this retirement account while Sheila is a MAPP member will be considered an exempt asset as a part of an Independence Account. The $5,000 Pre-Independence Account Balance remains a countable asset.

Example 3	Tom is approved for MAPP. After he receives his Notice of Decision, he registers his existing IRA as an Independence Account. This IRA has a balance of $1,000 prior to registration as an Independence Account, so that $1,000 is a countable asset. Tom is eligible for MAPP from July to October, eligible for Medically Needy SSI-related Medicaid from November and December, and eligible for MAPP again in January. Although the amount deposited into his Independence Account in July, August, September, October, and January will be considered exempt assets when determining his eligibility for both MAPP and Medically Needy SSI-related Medicaid, any money deposited into the IRA during November and December would be added to the $1,000 Pre-Independence Account Balance and counted as an asset because Tom was not eligible for MAPP during those two months.

Non-Retirement Accounts

In order for a non-retirement account to be registered as an Independence Account, it must be opened with the financial institution after the applicant has been approved for MAPP. The amount the MAPP member opens the account with is part of the Independence Account balance and is not counted.

Example 4	Mac is approved for MAPP in October. He fills out the Independence Account form to register his existing savings account as an Independence account. The IM worker cannot approve this account as an Independence Account because it was opened and established with funds before Mac enrolled in MAPP.

Non-retirement accounts registered as Independence Accounts may only have funds deposited during months when the member is eligible for MAPP. If any funds are deposited in a non-retirement account during a period of MAPP ineligibility, the entire account balance will be considered a countable asset.

Example 5	Tom is approved for MAPP. After he receives his Notice of Decision, he opens a savings account and registers it as an Independence Account. Tom is eligible for MAPP from July to October, eligible for Medically Needy SSI-related Medicaid from November to December, and eligible for MAPP again in January. Although his Independence Account will be considered exempt when his eligibility for both MAPP and Medically Needy SSI-related Medicaid is determined, he may not deposit any money into the account during November and December because he is not eligible for MAPP during that time. If he does deposit money during those months, the Independence Account's entire balance will be considered a non-exempt asset.

For non-retirement accounts registered as Independence Accounts on or after August 1, 2020, there should be no Pre-Independence Account Balance at any time because the only deposits that are allowed into these accounts are those made while the account owner is a MAPP member.

For non-retirement accounts that were registered as Independence Accounts prior to August 1, 2020, any existing Pre-Independence Account Balance will continue to count for all Medicaid programs and the Independence Account Balance will be exempt for all Medicaid programs. However, no new funds may be deposited during months when the member is ineligible for MAPP.

For all non-retirement accounts, if new funds are deposited during months when the member is ineligible, the account loses its independence account status, and the entire asset will be counted.

26.4.1.2 Independence Account Exemption Status

If a member with an approved Independence Account loses MAPP eligibility, the exempt portion of the account (on the date eligibility ends) will remain exempt for all future application(s) for all EBD Medicaid programs.

26.4.1.3 Pension or Retirement Accounts

A member who has a pension or retirement account can designate that account as an Independence Account. The initial balance is a countable asset (see SECTION 16.7.21 RETIREMENT BENEFITS). Any dividends, interest, and deposits to the account while they are MAPP eligible are exempt from the date the Independence Account is approved. Continue to count the initial balance and any dividends, interest, and deposits to the account during periods of MAPP ineligibility as a countable asset.

26.4.2 Income

The spouse and applicant or member's net income must not exceed 250% of the FPL (See 39.5 FPL) for appropriate fiscal test group size. To determine this, do the following:

1. Determine earned income. Count the member and their spouse's income if residing together.
2. Deduct the $65 and ½ of the earned income disregard from the spouse and member's earnings (see SECTION 15.7.5 $65 AND ½ EARNED INCOME DEDUCTION).
3. Deduct the member's and spouse's IRWEs (see SECTION 15.7.4 IMPAIRMENT RELATED WORK EXPENSES (IRWE)). The result is the adjusted earned income.
4. Determine unearned income. Count the applicant or member's unearned income and their spouse's unearned income if residing together.
5. Add the adjusted earned and unearned income together.
6. Deduct $20 from the combined income.
7. Deduct special exempt income (see SECTION 15.7.2 SPECIAL EXEMPT INCOME).
8. Deduct all verified monthly out-of-pocket medical and remedial expenses incurred by a MAPP applicant or member (their spouse, if living together), if the monthly total of those expenses is above $500.
9. If a MAPP member receives Social Security payments, subtract the current COLA disregard between January 1 and the date the FPL is effective in CARES for that year (see SECTION 15.3.35 TEMPORARY COLA DISREGARD FOR SOCIAL SECURITY RECIPIENTS).
10. Subtract the disregard amount for MAPP members who are also determined to be a 503 (see SECTION 25.3 503 GROUP) or Disabled Adult Child (DAC) (see SECTION 25.2 DISABLED ADULT CHILD (DAC) GROUP).
11. Compare the result to 250% of the FPL (see SECTION 39.5 FPL TABLE). Include the member's minor dependent legal children (biological or adoptive) when determining fiscal test group size.

Include the member's dependent 18-year-old children in the fiscal test group size. Do not include the member's stepchildren.

26.4.2.1 Deduction for Medical and Remedial Expenses over $500

For MAPP only, if an applicant or member (or his or her spouse, if living together) has verified monthly out-of-pocket medical and remedial expenses that total over $500, the total amount of these expenses will be deducted from the applicant or member's and his or her spouse's income when determining whether that income is above 250% FPL in the calculation shown in 26.4.2 INCOME.

Example 7	Shelly applies for MAPP. She verifies $350 in out-of-pocket remedial expenses for herself and $200 in out-of-pocket medical expenses for her spouse that cannot be covered by MAPP or any other third party. $550 will be deducted from income as a part of Shelly's eligibility determination.

Example 8	Mary applies for MAPP. She verifies $600 in monthly out-of-pocket medical and remedial expenses, which brings her under the 250 percent of FPL income limit for MAPP. It is possible that these expenses might be covered by MAPP once Mary is eligible, but the IM worker correctly processes the application using these verified out-of-pocket expenses. One month later, Mary realizes that MAPP is now paying for $500 of these medical and remedial expenses. Mary is required to report this change in expense within 10 days. She reports that her medical expenses have dropped to $100. The IM worker enters this change, and Mary is no longer financially eligible for MAPP because the decrease in her out-of-pocket medical and remedial expenses increases her countable income. If Mary applied again using the same expenses, the IM agency would not allow the expenses because they are now known to be covered by Medicaid.

Example 9	Jim applies for MAPP. He verifies $500 in out-of-pocket medical expenses. Because the expenses are not above $500, these expenses cannot be allowed as an income deduction for the MAPP eligibility determination.

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26.5 MAPP Premiums

MAPP members with gross monthly income over 100% of the FPL will be charged a premium.

MAPP applicants with gross monthly income over 100% of the FPL must pay an initial premium to enroll in MAPP.

26.5.1 Calculation

Medicaid Purchase Plan (MAPP) premiums are calculated using only the member's income. A premium is calculated if the member's monthly Premium Gross Income exceeds 100% of the Federal Poverty Level (FPL) (see SECTION 39.5 FEDERAL POVERTY LEVEL TABLE) for a group of one.

Tribal members are not exempt from paying MAPP premiums (unlike BadgerCare Plus premiums). Federal statutes for MAPP supersede other parts of the law that exempt tribal members from premiums and copayments for services.

Eighteen-year-old MAPP members are not required to pay a premium.

To calculate monthly premium amount:

1. Determine the member's Premium Gross Income by adding together the member's monthly gross earned income and gross unearned income.
2. Determine Countable Net Income by subtracting the following deductions from the member's Premium Gross Income:
    a) The member's own verified monthly impairment-related work expenses (any amount)
    b) The member's own verified monthly out-of-pocket medical/remedial expenses (any amount)
    c) The current cost-of-living adjustment (COLA) disregard from January 1 through the date the FPL is effective in CARES for that year, if applicable
3. Determine Premium Net Income by subtracting 100% of the FPL for a group size of one from the countable net income. If this results in a negative number, change it to zero.
4. Multiply the premium net income by 3% (0.03).
5. Add the $25 Base Premium Amount and round down to the nearest whole dollar.
6. If applicable, add the Independence Account overage amount (see SECTION 26.5.1.1 INDEPENDENCE ACCOUNT PENALTY).

The result is the member's monthly premium amount.

Note	*503, Disabled Adult Child (DAC), widow or widower disregards allowed in eligibility determinations cannot be allowed in premium calculations.*

Example 1	Shannon applies for MAPP. Her Premium Gross Income is under 100% of the FPL. She has no premium.

Example 2	Michael applies for MAPP. His Premium Gross Income is 105% of the FPL. Even though his impairment-related work expenses and medical/remedial expenses decrease his Premium Net Income to $0, Michael will still have a $25 monthly MAPP premium.

Example 3	Susan is a MAPP member whose Premium Gross Income is 169% of the FPL. When her allowable deductions are taken in the premium calculation, her Countable Net Income is $1,750. Her monthly MAPP premium will be calculated as shown below: $2,200 Premium Gross Income − $300 monthly IRWE deduction − $150 monthly medical/remedial deduction ---------- $1,750 Countable Net Income − $1,304.17 (100% of the FPL) ---------- $445.83 Premium Net Income X 0.03 (3%) ---------- $13.37 +$25 Base Premium Amount ---------- $38.37 (round down to nearest whole dollar) Susan's monthly MAPP premium is $38.

26.5.1.1 Independence Account Penalty

If the member's total deposits into an Independent Account exceed 50% of the member's gross earnings, the member will be penalized using the following formula. At renewal or re-application for MAPP, look back 12 months and:

1. Take the total verified Annual Deposits minus 50% of verified annual gross earned income divided by 12 to get the monthly assessment.
2. Add this monthly assessment to the premium for the next 12 months of eligibility. CWW will only impose Independence Account penalties if the member is otherwise required to pay a premium.

Example 4	Brenda deposited $1,200 more than 50% of her actual annual gross earned income in her Independence Account. If Brenda's income exceeds 100% of the FPL (see SECTION 39.5 FEDERAL POVERTY LEVEL TABLE) and she is responsible for a monthly premium, add the monthly assessment of $100 to her monthly premium for the next 12 months. If Brenda's income is less than or equal to 100% of the FPL, do not impose a penalty.

26.5.2 Initial Premium

There are no free premium months. Before enrolling in MAPP, the applicant must pay applicable premiums for the initial benefit month and for any requested backdated months for which they are eligible and are charged a premium. Premiums must be paid up to the current month, so if eligibility is not determined until the month after application, the premium for the current month also must be paid before they can be enrolled in MAPP.

Example 5	Eric applies for MAPP on January 29, but his application is not processed until February 11. Eric was determined eligible for MAPP effective January 1 with a monthly premium of $50. Eric must pay a $50 premium for January and a $50 premium for February to open for MAPP.

Example 6	Eric applies for MAPP on January 29. Eric is requesting MAPP for February but not January. Eric is determined eligible for MAPP effective February 1. Eric does not have to pay February's premium

	before MAPP opens because it is for a future month. Eric will be enrolled in MAPP and be sent a premium statement to pay February's premium by the due date of February 10.

It is possible that an applicant owes a premium for some but not all initial months at application because their monthly premium gross income was less than 100% FPL for some of the months. For example, if the applicant requests backdated coverage, and their monthly premium gross income was under 100% FPL during the backdated months, but their monthly premium gross income is over 100% FPL in the application month, no premium is required for the backdated months and a premium is owed for the application month. The premium for the application month (or the next month if the application is being processed after the application month) must be paid before the individual can enroll in MAPP. If the premium is not paid, eligibility can be granted for any months a premium was not required but will be denied for months for which a premium was owed.

Example 7	Bernice applied for MAPP on March 10 and requested backdated eligibility for January and February. She had no income in January. She started a job in February, and her monthly premium gross income went over 100% FPL starting in March. On March 15, the worker determined that she met eligibility requirements effective January 1. Due to Bernice's income, she is not charged a premium for January or February but owes a premium beginning in March. Bernice must pay the March premium before her eligibility can be confirmed. If Bernice does not pay March's premium by the due date, she will only qualify for eligibility for the months of January and February.

The Medicaid Purchase Plan Premium Information/Payment form (F-00332) is sent to the member with the verification checklist (VCL) notifying them of the premium amount due and where to submit the premium payment (see Process Help, Section 25.3 MAPP Premium Processing for Applications and Renewals).

An applicant could change or remove their request for backdated eligibility if they are unable or do not want to pay the premiums.

Example 8	Vang applied for MAPP on October 8, with a two-month backdate request. He was determined eligible for MAPP effective August 1, with a monthly premium of $39. Vang must pay his monthly premium for August, September, and October to open for MAPP as of August 1. If Vang is unable to pay the premiums for all three benefit months at application, he can gain eligibility as of September 1 by paying the September and October premium, or as of October 1 by paying the October premium only.

26.5.3 Ongoing Premiums

Ongoing premium payments can be paid through any of the methods listed in SECTION 26.5.4.1 PAYMENT METHODS. Premiums are due on the 10th of the benefit month regardless of which payment method is chosen.

Members enrolled in ACCESS AutoPay or Electronic Funds Transfer (EFT) or Wage Withholding are mailed a monthly automatic premium payment reminder letter. This letter is mailed around the 20th of the month before the benefit month. ACCESS AutoPay payments occur on the 3rd calendar day of the benefit month. EFT and Wage Withholding payments occur on the 3rd business day of the benefit month.

Members not enrolled in ACCESS AutoPay or EFT or Wage Withholding are mailed a premium statement. The fiscal agent sends the premium statement around the 20th of the month before the benefit month.

26.5.4 Payment Information

26.5.4.1 Payment Methods

Initial premium payments required to gain MAPP eligibility can be paid:

- Online using the ACCESS website or MyACCESS app with a credit card, debit card, savings account or checking account, or
- By sending a check or money order to the fiscal agent.

This includes initial premiums at application or re-request.

For ongoing premium payments, premium statements will be sent monthly. The statement will provide the amount due and how to pay the premium.

Members have several options to pay their ongoing monthly premiums. Members can:

- Make one-time payments online using the ACCESS website or MyACCESS app with a credit card, debit card, savings account or checking account.
- Make recurring monthly payments online using the ACCESS website or MyACCESS app with a credit card, debit card, savings account or checking account. This method is called ACCESS AutoPay.
- Make recurring monthly payments via Electronic Funds Transfer (EFT) or Wage Withholding with a savings account or checking account.
- Send a check or money order to the fiscal agent.

To ensure that premium payments are properly posted by the fiscal agent, individuals may no longer pay their initial or ongoing MAPP premiums to their local or tribal IM agency. If an individual brings a premium payment to the agency, the agency must assist them with paying online or mailing their premium payment. In-person premium payments will be processed by the agency only in very limited circumstances, when the following criteria are met:

- The individual is unable to pay their premium online; and
- The individual's benefits will end before the payment, if mailed, will be processed by the fiscal agent (applicable only to ongoing members); and
- The individual has a specific and immediate medical need, where a delay in the beginning of benefits or a temporary closure of benefits will result in not being able to get a prescription, not being able to attend a medical appointment, or loss of long-term care services prior to the premium being processed.

To make recurring monthly payments via EFT, members must submit a completed Medicaid Purchase Plan Premium Member/Employer Electronic Funds Transfer form (F-13023).

To make recurring monthly payments via Wage Withholding, members must submit a completed Medicaid Purchase Plan Premium Member/Employer Electronic Funds Transfer form (F-13023) and the employer must submit the Medicaid Purchase Plan Premium Employer Wage Withholding form (F-13024).

Members who are awaiting enrollment in EFT or Wage Withholding must pay their monthly premiums using another method until they receive confirmation that their EFT or Wage Withholding enrollment is complete.

Members enrolled in ACCESS AutoPay or EFT or Wage Withholding will be mailed a monthly automatic premium payment reminder letter instead of a monthly premium statement.

26.5.4.2 Advance Payments

Premiums may not be paid in advance.

26.5.4.3 Excess Payments

The fiscal agent issues refunds if the premium was paid and is for a month in which one of the following situations occurs:

1. The individual was ineligible for MAPP.
2. The individual made an excess payment and the excess cannot be applied to the next month's premium.
3. The member requested to close MAPP and already paid the premium for a month in which they will not be open for MAPP.

The member's estate can receive a refund if he or she dies between adverse action and the beginning of the benefit month.

The fiscal agent either issues a refund or applies an excess payment to the next month's premium if a change is reported that results in no premium or a lower premium amount.

If the change is reported within 10 days of when the change occurred, the lower premium amount or $0 premium amount is effective during the month in which the change occurred. If the change is not reported within 10 days of when the change occurred, the lower premium amount or $0 premium amount is effective during the month in which it was reported. See SECTION 26.7 MAPP CHANGES for information on change reporting.

Note *When determining if a change was reported within 10 days of when the change occurred, the member's reported date of change is used. If the reported date is questionable, verification may be required.*

26.5.5 Late Payment of Premium

If a MAPP member does not pay an ongoing monthly premium by the due date, but the member pays the premium and the premium is processed in the benefit month or the next month, the member will remain enrolled in MAPP.

Example 9	Darren is enrolled in MAPP with an ongoing monthly premium of $25. His premium for August is due August 10. Darren does not pay the August premium by the due date but makes a $25 payment on August 12 via ACCESS. On August 13, ACCESS shows that his August premium is paid. Darren will remain enrolled in MAPP. In late August, Darren is mailed a premium statement for September.

Example 10	Fatima is enrolled in MAPP with an ongoing monthly premium of $43. Her premium for February is due February 10. Fatima does not pay the February premium by the due date. She will remain enrolled in MAPP through March. In late February, Fatima is mailed a premium statement for the March premium along with a cover letter that specifies the February premium is late. Fatima submits a $43 payment via ACCESS on March 5. The payment is applied to the past due February premium, and on March 6, ACCESS shows that her February premium is paid. The March premium remains unpaid. Fatima will remain enrolled in MAPP through April. In late March, Fatima is mailed a premium statement for the April premium along with a cover letter that specifies the March premium is late.

If a late payment is received and processed after the closure notice has been sent but before eligibility has ended, the member will remain enrolled in MAPP.

Example 11	Ahmed is enrolled in MAPP with an ongoing monthly premium of $51. His premium for May is due May 10. Ahmed does not pay the May premium by the due date. He will remain enrolled in MAPP through June. In late May, Ahmed is mailed a premium statement for the June premium along with a cover letter that specifies the May premium is late. As of mid-June, Ahmed has not made a payment and is mailed a notice that his MAPP eligibility will end June 30 due to not paying the May premium. Ahmed submits a $51 payment via ACCESS on June 26, and the payment is applied to the past due May premium. Because Ahmed has now paid the past due May premium, he is eligible for MAPP through the month of July. The June premium remains unpaid, and Ahmed is mailed a premium statement for the July premium along with a cover letter that specifies the June premium is late.

A payment received and processed in the month after eligibility ended is treated as a re-request and will be applied to the current month to allow the member to regain MAPP eligibility, as long as the payment covers the current month's premium in full.

Example 12	Rick is enrolled in MAPP with an ongoing monthly premium of $37. His premium for December is due December 10. As of mid-January, Rick has not made a payment and is mailed a notice that his MAPP eligibility is ending January 31. Rick's last day of MAPP coverage is January 31. Rick mails a check for $37 on February 3 that the fiscal agent receives on February 5. This payment is treated as a re-request for MAPP. The $37 payment is applied as the initial premium for February, and Rick re-opens for MAPP effective February 1.

A payment received more than a calendar month after eligibility ended will be refunded unless the individual has reapplied for MAPP or, if other health care benefits are open on the case, has re-requested MAPP.

26.5.6 Non-Payment of Premium

Payment of a premium is a condition of eligibility for MAPP. If a MAPP member does not pay an ongoing premium, the member will lose MAPP eligibility for non-payment of a premium at the end of the month following the month in which the unpaid premium was due.

Example 13	Aarav is enrolled in MAPP with an ongoing monthly premium of $30. His premium for April is due April 10. Aarav does not pay the April premium by the due date. He will continue to remain enrolled in MAPP. In late April, Aarav is mailed a premium statement for the May premium along with a cover letter that specifies the April premium is late. If Aarav does not pay the April premium, he will be sent a notice in mid-May that his MAPP eligibility will end May 31.

MAPP members that lose coverage due to non-payment of a premium are not subject to a restrictive re-enrollment period (RRP). A member whose MAPP eligibility closes due to non-payment of a premium can re-request MAPP.

If an individual loses MAPP eligibility for any reason, any past due premiums are no longer owed. An individual does not have to pay any past due premiums to reopen MAPP, but they must pay any premiums owed for the month(s) in which MAPP is being requested.

Example 14	Tatiana is enrolled in MAPP with an ongoing monthly premium of $41. Tatiana does not pay the October or November premiums, so her MAPP eligibility ends November 30. Tatiana re-requests MAPP on December 5. There is no RRP, and Tatiana does not need to pay the October or November premiums to regain MAPP eligibility. She only needs to pay an initial premium to gain eligibility for

	December. Tatiana pays the initial premium on December 6 and opens for MAPP as of December 1. Tatiana will receive a premium statement in mid-December for her premium due January 10.

If a MAPP member does not pay an ongoing premium that is owed and then has an income reduction that results in not being charged a premium before losing MAPP eligibility, the member will remain eligible for MAPP without paying any past due premiums.

Example 15	Wei is enrolled in MAPP with an ongoing monthly premium of $39. Wei does not pay the March premium by the due date. He remains enrolled in MAPP through April. On April 8, Wei reports a reduction in income that began in April; the reduction in income is verified the same day. Wei's gross monthly income is now under 100% FPL, and he no longer owes a premium for April. Since he no longer owes a premium as of April, Wei will remain eligible for MAPP for May even if he does not pay the past due March premium.

26.5.6.1 Partial Payments

Unless a temporary premium waiver is in place, members with gross monthly income over 100% of the FPL must pay their entire MAPP premium each month to maintain eligibility.

Partial payments made and processed before the last day of the month will be applied to the benefit month. If the remaining balance is not received and processed before the end of the following benefit month, the MAPP member will lose eligibility due to non-payment of premium.

Example 16	Gisele is enrolled in MAPP with an ongoing monthly premium of $35. Her premium for July is due July 10. Gisele submits a $20 payment on July 3. Although Gisele has not paid the full July premium, she will continue to remain enrolled in MAPP through August. In late July, Gisele is mailed a premium statement for the August premium along with a cover letter that specifies the July premium is late. The premium amount due for August is $35 and the past due premium amount for July is $15. Gisele does not make a premium payment in August. In mid-August, Gisele will be sent a notice that her MAPP coverage will end August 31.

26.5.7 Temporary MAPP Premium Waivers due to Hardship

MAPP applicants and members who experience a temporary hardship that makes them unable to pay their premium can apply for a temporary premium waiver. There is no limit to how many temporary premium waivers may be requested, but the temporary premium waiver cannot exceed 12 months in duration **for the same hardship reason**. Applicants and members may request the premium waiver for a backdated period of up to three months, but the premium waiver cannot exceed 12 months. If a temporary premium waiver is approved for months where a premium has already been paid, those premiums must be refunded.

To request a temporary premium waiver, MAPP applicants and members will use the Request for a Temporary Waiver of Your Medicaid Purchase Plan Premium Because of a Difficult Situation (F-02603) form. The applicant or member must describe the short-term hardship and state when it began (up to three months in the past) and its expected duration.

A qualifying temporary hardship is an unexpected, unusual expense or situation related to the member's health or ability to work, such as an injury or illness, or reduction of hours worked.

A temporary hardship may include, but is not limited to, the following, when the applicant or member:

- Has an unusual expense related to their health or ability to work. An unusual expense is an expense that is necessary for the ability of the individual to work or take care of their health that is not a regular, recurring, or planned expense. The expense cannot be anything that was used

to establish eligibility or the premium amount for the individual, as these should be regular and recurring.
- Has experienced a decrease in work hours.
- Has lost a job but remains non-financially eligible due to a medical exemption or participation in a HEC plan.
- Is the survivor of a crime, such as someone who has experienced domestic violence or sexual assault, battery, theft, and other crimes. As a result, the member has incurred extra expenses or is unable to access their funds due to the crime.
- Is experiencing temporary transportation issues, causing a decrease in the hours they can work.
- Is experiencing temporary child care issues, causing a decrease in the number of hours they can work.

Situations that do not qualify for a temporary premium waiver include, but are not limited to:

- Expenses that are not related to an applicant or member's health or ability to work.
- Inflation or other regular increase in price, such as groceries or gasoline.
- Regular, recurring expenses that can be budgeted for, like rent or utilities, that are not the result of an unexpected or unplanned change.

IM workers will be required to review temporary premium waiver requests and approve or deny them within 30 calendar days after receipt of the request.

In determining whether there is hardship, the IM worker may only consider circumstances that are documented. Hardship must be verified (see SECTION 20.1 VERIFICATION). Proof includes, but is not limited to, the following:

- Agency form
- Employer statement/paystub/taxes/Employer Verification of Earnings form (EVF-E)
- Collateral contact
- A statement from a health care or mental health provider, such as a medical doctor, psychiatrist, social worker, AODA professional, or psychologist, that identifies there is an issue and time period in which the individual cannot work.
- A receipt for the unusual health or work related expense.

Verification must be received by the due date (or the extended due date if additional time is requested) in order to process an application for a temporary waiver of premium. If verification is not received by the due date or extended due date, the request must be denied. This denial does not prevent the applicant or member from submitting another request for the same time period and being approved once verification has been received, as long as the request does not include a backdate of longer than three months prior to the month the request is received.

Example 17	On November 1, John requested a temporary waiver of premium starting August 1, but he did not provide the requested verification, so the request was denied. On December 1, John submits a new request for a temporary waiver of premium with the appropriate verification. The earliest that the waiver could be approved is September 1.

If the request for temporary waiver of premium is denied, the waiver applicant will be notified. The waiver applicant has the right to appeal the decision through a written request to the Division of Appeals (DHA). The waiver applicant has 45 calendar days from the date of the notice issuance to file the appeal.

If the request is approved, the premium waiver period will begin on one of the following:

- The first day of the month in which the temporary premium waiver request was received.
- The first day of the month after the month in which the temporary premium waiver request was received.
- The first day of the month one, two, or three months prior to the month in which the temporary premium waiver request was received, if the applicant or member stated on the request form that the temporary hardship began in the past.

Note *When processing temporary premium waiver requests received before October 2020, IM workers should remember that the premium waiver period can begin no earlier than August 1, 2020, even if the hardship began before August 1.*

Example 18	Susie requests a temporary waiver of premium on March 31. If approved, the premium waiver period could start as early as December 1 and as late as April 1, depending on the request and the verification.

The member's premium will be waived for the duration approved by the agency (up to 12 months). Temporary premium waivers that have been granted for a shorter duration than 12 months can be extended at the member's request for up to the full 12-month limit for a given hardship reason.

Example 19	Mae is a MAPP member who uses a car to get to work. Her vehicle requires an expensive fix by a mechanic. She requests a three month temporary premium waiver to help her redirect the funds toward the repairs on the car. The request is approved. When the repairs are completed, they were twice what she was quoted. She requests a three month extension of her temporary premium waiver in order to redirect those funds to the remaining repair bill. That request is approved.

Example 20	Stan is a MAPP member. He is experiencing health concerns that impact his ability to work the number of hours he typically works. While the IM worker has adjusted his premium due to the decrease in income, his doctor tells him it could be nine months before he will be back to normal work hours. He requests a temporary premium waiver and is approved. At month eight of his premium waiver, Stan's doctors inform him that they cannot approve an increase in his hours for another six months. Stan requests an extension to his temporary premium waiver. Because he has an approved nine month waiver and the maximum time a waiver can be granted for the same hardship reason is 12 months, the IM worker can only approve an additional three months to extend the waiver.

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26.6 Opting Out

If a MAPP member chooses to de-request MAPP coverage, or opt out, any time prior to the beginning of the next benefit month, MAPP eligibility will end the next possible month.

A MAPP applicant’s decision to opt out does not affect other family members' eligibility for Medicaid or Medicaid-related programs.

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26.7 Changes

26.7.1 MAPP Changes Introduction

The member must report within ten days all changes to income, household composition, allowable deductions, including medical and remedial expenses that were once out of pocket but are covered once the applicant is a MAPP member, and other non-financial changes, including loss of employment, which affect eligibility. When a change in circumstance is reported, current health care benefits must be maintained while eligibility is being redetermined.

Example 1	Nancy does not have health insurance and currently pays $550 a month for a variety of medical/remedial expenses. She applies for MAPP and is found eligible as of December 1. Once she is eligible, MAPP will cover some of her medical/remedial expenses and reduce her out of pocket medical/remedial expenses down to $50 a month in December. Because Nancy must wait until the end of December to determine the final decrease in her monthly out of pocket expenses, she must report this decrease no later than January 10th.

26.7.2 Premium Changes

Following a change, if it is determined a member has a new or increased premium, implement the premium change as of the following effective date:

- Eligibility redetermined **before** adverse action: Effective the first of the following month.
- Eligibility redetermined **after** adverse action: Effective the first of the month after the following month.

The effective date of a change that results in a reduced premium or no premium is the month of change or the month of report, whichever is later. Premium decreases must be reviewed, and eligibility redetermined when applicable, when coverage was maintained following a reported change or a timely renewal. Once eligibility is able to be redetermined, premium amounts for months with coverage maintained may need to be reduced or refunded. See SECTION 26.5.4.3 EXCESS PAYMENTS, PH 25.3.4 Change Processing, and PH 25.4.4 Changes in Premiums and Refunds.

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26.8 MAPP Prepaid Deductibles

If the client prepaid a deductible and then becomes eligible for MAPP without a premium, he or she can only get a refund of the prepayment if the deductible period has not started. Use the Community Aids Reporting System (CARS) to report the accounting.

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26.9 MAPP Notices

For manual MAPP eligibility determinations:

1. Use the Notice of Approval of Benefits/Positive Change in Benefits (F-16015) when MAPP is approved or the premium decreases.
2. Use the Notice of Denial of Benefits/Negative Change in Benefits (F-16001) when eligibility is denied or terminated or the premium increases.

Note: *The client must be given adverse action notice of any negative action (e.g. premium increase).*

Use the following notice text that is applicable to the denial reason. Use §49.472 WIS STATS as the citation for each of the reasons.

You are not eligible for the MAPP because:

1. Your assets exceed the $15,000 asset limit.
2. Your income exceeds 250% of the FPL (39.5 FPL Table) for your family size.
3. You have not paid your MAPP premium.
4. You have been determined 'not' disabled under MAPP rules by the Disability Determination Bureau.
5. You are not working.
6. You no longer meet the work or HEC participation requirement of MAPP.

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26.10 Reserved

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27 Institutional Long-Term Care

27.1 Institutions

27.1.1 Institutions Introduction

For Medicaid purposes, "institution" means medical institution. A medical institution can be, but is not limited to, skilled nursing facilities (SNF), intermediate care facilities (ICF), institutions for mental disease (IMD), and hospitals.

Medical institution means a facility that:

1. Is organized to provide medical care, including nursing and convalescent care,
2. Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards,
3. Is authorized under State law to provide medical care, and,
4. Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

27.1.2 Institutions for Mental Disease

IMDs are medical institutions that care for persons with mental illness. See the list of IMDs (27.11 INSTITUTIONS FOR MENTAL DISEASE (IMDS)).

27.1.2.1 Eligible Age

IMD residents under age 21 and over age 64 may be Medicaid eligible. Persons aged 21 through 64 are not eligible unless:

1. They are receiving residential substance use disorder treatment in the IMD; or
2. They were IMD residents immediately prior to turning age 21. If they were, they are eligible until discharge (a 21 year old can be transferred from one IMD into another and remain eligible for Medicaid) or until turning age 22, whichever comes first.

27.1.2.2 Temporary Leave

A person aged 21 through 64 who is not eligible for Medicaid can go on conditional release from an IMD or convalescent leave and become eligible for Medicaid while on leave.

1. Conditional release means a temporary release from an IMD for a trial period of residence in the community.
    a) The trial period must last no less than four days. It must be no longer than 30 days.
    b) The trial period begins after the initial three days of community residence following discharge.
    c) A person under age 22 who leaves the IMD for a trial period remains eligible as an IMD resident until he or she is unconditionally released from the IMD, or turns 22, whichever comes first.
2. For purposes of Medicaid, conditional release is permitted only once every calendar year.
3. Convalescent leave means a period of time following inpatient admission of a resident of an IMD to a general hospital for the purpose of treatment for a physical medical condition of a severity which medically contraindicates treatment of the condition in the IMD. A person under age 22

who leaves the IMD on Convalescent Leave remains eligible as an IMD resident until he or she is unconditionally released from the IMD, or turns 22, whichever comes first.

27.1.2.3 Children and Young Adults in IMD

When a child or young adult applies for Medicaid while in an IMD or after being discharged from an IMD, the IM agency must determine eligibility for Institutional Medicaid for the inpatient IMD days, regardless of the length of stay.

Young adults aged 19-20 must be enrolled in Institutional Medicaid for the inpatient IMD days only, if eligible.

Children aged 18 or younger are subject to continuous coverage requirements (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN). This means that the child, if eligible, may be enrolled in Institutional Medicaid for the inpatient IMD days plus an additional period of time for a total of 12 full months of Institutional Medicaid eligibility, even when they are no longer in the IMD. However, the child's enrollment should be changed to BadgerCare Plus or another form of Medicaid not based on institutionalization, if they are eligible.

Example 1	Jax is 15 years old and was in an IMD from March 10 through March 18, 2024. On April 1, 2024, Jax applies for Medicaid and is determined eligible for Institutional Medicaid. Jax is enrolled effective March 10. Jax is not eligible for BadgerCare Plus or any other form of full-benefit Medicaid. Jax's Medicaid coverage through Institutional Medicaid ends on March 31, 2025.

27.1.3 Hospitals

Hospitals are medical institutions that:

1. Provide 24-hour continuous nursing care,
2. Provide dietary, diagnostic, and therapeutic services, and,
3. Have a professional staff composed only of physicians and surgeons, or of physicians, surgeons and doctors of dental surgery.

A person residing in a hospital is an institutionalized person (27.4.1 INSTITUTIONALIZED PERSON) if he or she:

1. Has resided in a medical institution for 30 or more consecutive days, or
2. Is likely to reside in a medical institution for 30 or more consecutive days.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days. However, an individual is not considered "institutionalized" if he or she meets this 30-day test but is in a medical institution solely for the purpose of receiving residential substance use disorder treatment.

27.1.4 Minors in a Medical Institution

Minor children who reside (or are likely to reside) in a hospital or other medical institution for 30 or more days can be eligible for Institutional Medicaid if they are determined disabled or presumptively disabled (see SECTION 5.2 DETERMINATION OF DISABILITY and SECTION 5.9 PRESUMPTIVE DISABILITY).

For Institutional Medicaid, a blind or disabled minor is a one-person fiscal test group. Only the child's income is counted. No parental income is deemed to the institutionalized minor.

Hospitalized children under the age of 19 who have **not** been determined disabled or presumptively disabled must be tested for BadgerCare Plus with their families.

See Process Help, Section 11.2.4 Health Care Applications for Institutionalized Children for processing instructions.

Minors in a medical institution qualify for 12 months of continuous coverage. If they are discharged from a medical institution during their continuous coverage period and they do not qualify for any other form of full-benefit health care after they have been discharged, they remain eligible for Institutional Medicaid for the rest of their continuous coverage period.

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27.2 Licensing and Certification

Medical institutions (SNFs, ICFs, IMDs, hospitals) are licensed under Chapter 50, Wis. Stats. The Bureau of Quality Assurance is the licensing agency.

In order to receive Medicaid payment for the care and services they provide, medical institutions must comply with federal MA requirements. The agency that certifies their compliance is DMS.

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27.3 Facilities Not Medicaid Certified

Determine the eligibility of persons in non-certified facilities in the same way as for those in certified facilities. Medicaid will not pay cost of care for these persons, but they may still be eligible for Medicaid card services (see SECTION 21.4.1.1 MEDICAID CARD SERVICES).

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27.4 Definitions

27.4.1 Institutionalized Person

"Institutionalized person" means someone who:

1. Participates in Community Waivers, or
2. Has resided in a medical institution for 30 or more consecutive days, or
3. Is likely to reside in a medical institution for 30 or more consecutive days, as attested to by the medical institution.

An exception to the 30-day period is that a resident of an IMD is considered an institutionalized person until he or she is discharged.

The 30-day period includes situations in which the person resides in more than one medical institution during 30 or more consecutive days. However, an individual is not considered “institutionalized” if he or she meets this 30-day test but is in a medical institution solely for the purpose of receiving residential substance use disorder treatment.

27.4.2 Community Spouse

See community spouse in Glossary.

27.4.3 SSI Recipient and Institutional Medicaid Application

An SSI recipient who has resided or is likely to reside in a medical institution for 30 days or more may apply and be non-financially eligible for institutional Medicaid if the SSA will discontinue the person's SSI because of the financial effect of his or her residence in the medical institution.

An SSI recipient who has not resided or is not likely to reside in a medical institution for 30 days or more is non-financially ineligible for institutional Medicaid. The person remains Medicaid eligible through SSI.

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27.5 Financial

27.5.1 ILTC Assets

Refer to 16.1 ASSETS INTRODUCTION to determine when an asset is countable. If countable assets exceed the appropriate limit, the Medicaid applicant/member is ineligible.

Note: *Prepayment to a nursing home for the extra cost of a private room is an available asset. The applicant has the legal ability to make the prepayment available for his or her support and maintenance (16.2 ASSETS AVAILABILITY).*

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1. Unmarried member - See 39.4 EBD Assets and Income Tables or the EBT asset limits for an unmarried member
2. Married member (Spousal Impoverishment) -The assets of both the institutionalized person and his or her community spouse are counted in the initial asset test. For information about how to determine a married member's asset limit and the community spouse asset share refer to 18.4 SPOUSAL IMPOVERISHMENT ASSETS.

27.5.2 ILTC Income

Follow the policies listed in 15.1 INCOME INTRODUCTION to determine an applicant's income. The income limit is the same for non-spousal impoverishment institutionalized persons as for spousal impoverishment cases. But, for spousal impoverishment cases, after the institutionalized person becomes eligible, he or she is allowed to allocate some of his or her income back to his or her community spouse (see 18.6 SPOUSAL IMPOVERISHMENT INCOME ALLOCATION)

If income is greater than Institutions Categorically Needy Income Limit (39.4 EBD ASSETS AND INCOME TABLES) the person is ineligible for categorically needy Medicaid.

If the income is greater than need (see 27.6 ILTC MONTHLY NEED) the person is ineligible for medical needy Medicaid.

Sometimes, when both spouses are institutionalized, the income of one is greater than his or her monthly need and the income of the other is less than his or her monthly need. When this occurs, calculate the couple's combined monthly need and compare it with their combined income. If the total need is greater than the total income, and if the spouse with greater income is willing to combine it with his or her spouse's lesser income, both spouses could be eligible.

27.5.3 Divestment

See 17.1 DIVESTMENT INTRODUCTION for Divestment policies.

27.5.4 Instructions for Manual Eligibility Determinations

Use the following to determine which financial worksheet to use:

1. Medical institution (27.1 INSTITUTIONS) residents with no community spouse.
   Use the Medicaid Institution Worksheet (WORKSHEET #4).
2. Medical institution residents who have a community spouse and who became institutionalized before 09-30-89:
   Use the F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse Form and the Medicaid Institution Worksheet (WORKSHEET #4).
3. Medical institution residents who have a community spouse and who became institutionalized on or after 09-30-89:

Use the F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse form and the Spousal Impoverishment Income Allocation Worksheet (WORKSHEET #7).

4. Community waiver applicants with no community spouse:
   Use the F-20919
5. Community waiver applicants with a community spouse:
   Use the F-10095 Medicaid Asset Assessment Medical Institution/Community Waiver Resident and Community Spouse form the Medicaid Waiver Eligibility and Cost Sharing Worksheet, and the Spousal Impoverishment Income Allocation Worksheet (WORKSHEET #7).

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27.6 Monthly Need

27.6.1 Intermediate and Long-Term Care Monthly Need Introduction

Monthly need is the amount by which the institutionalized person's expenses exceed his or her income. It is computed by adding together the following monthly costs:

1. Personal needs allowance (SECTION 39.4 EBD ASSETS AND INCOME TABLES).
2. Cost of institutional care (use the private care rate of the institution where the applicant or member resides).
3. Cost of health insurance (SECTION 27.6.4 HEALTH INSURANCE).
4. Support payments (SECTION 15.7.2.1 SUPPORT PAYMENTS).
5. Out-of-pocket medical costs.
6. Work related expenses (SECTION 15.7.4 IMPAIRMENT RELATED WORK EXPENSES (IRWE)).
7. Self-support plan (SECTION 15.7.2.2 SELF-SUPPORT PLAN).
8. Expenses for establishing and maintaining a court- ordered guardianship or protective placement, including court ordered attorney or guardian fees.
9. Other medical expenses.

27.6.2 Hospitalized Persons

When you determine a hospitalized person's monthly need use the average daily charge for the hospital the person is in. See SECTION 39.7 HOSPITAL DAILY RATES. If his or her hospital is not on the list, enter $2,318.08 on Long Term Care Gatepost/ Institutions screen.

27.6.3 Both Spouses Institutionalized

If both spouses are institutionalized and one has income greater than his or her monthly need, calculate the couple's combined monthly need and compare it to their monthly income. If their combined monthly need exceeds their combined monthly income, both spouses may become eligible.

27.6.4 Health Insurance

Allow health insurance costs only if the primary person is the owner of the policy and is billed for the premium.

Do not deduct health insurance premiums for health insurance that pays for more than the cost of medical care. An insurance policy which pays for accidental injuries, does not qualify as a health insurance premium and cannot be deducted.

When a person pays premiums less often than once a month, prorate the premium to find the monthly amount. Deduct the monthly amount from the monthly income.

The accumulation of these premium amounts is an exempt asset. Exempt them for a period over which they have been prorated.

Example 1:	Mr. W. pays a health insurance premium of $600 every quarter. The monthly amount, prorated over three months, is $200. Deduct $200 from Mr. W's monthly income. Each quarter, exempt $600 of Mr. W's assets until that quarter's premium due date.

27.6.4.1 Nursing Home and Hospital Insurance

Nursing home and hospital insurance policies are indemnification policies. Indemnification policies provide benefits in a fixed amount for a confinement, such as a hospitalization, regardless of the expenses actually incurred by the insured.

Nursing home and hospital insurance policies pay a flat rate to the policy holder for each day that he or she resides in the nursing home or hospital, respectively.

Consider nursing home and hospital insurance as a type of medical insurance. Allow the premiums as a deduction in the eligibility test and post-eligibility calculation.

27.6.4.2 Assignment of Nursing Home and Hospital Insurance Payments

All members must cooperate in providing Third Party Liability (TPL) coverage and access information (see SECTION 9.2 NURSING HOME AND HOSPITAL INSURANCE). All members must sign over to the State of Wisconsin all their rights to payments from hospital or nursing home insurance (see SECTION 9.2.2 ASSIGNMENT). Terminate eligibility for any individual that will not cooperate in:

1. Providing TPL coverage and access information.
2. Turning over payments from indemnity insurance policies.

27.6.5 Support Payments

Support payments are payments which an institutionalized Medicaid member makes to another person for the purpose of supporting and maintaining that person. See SECTION 15.7.2.1 SUPPORT PAYMENTS.

27.6.6 Fees to Guardians or Attorneys

See SECTION 15.7.2.3 FEES TO GUARDIANS OR ATTORNEYS.

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27.7 Cost of Care Calculation

27.7.1 Introduction

After an institutionalized person has been determined eligible for Medicaid, his or her cost of care must be calculated. Cost of care is the amount the person will pay each month to partially offset the cost of his or her Medicaid services. It is called the patient liability amount when applied to a resident of a medical institution, including those enrolled in Family Care, Family Care Partnership, or PACE who are in or likely to be in a medical institution for 30 or more days. Institutionalized people are expected to pay their patient liability to the institution they are residing in, or to their MCO if they are enrolled in Family Care, Family Care Partnership, or PACE, as of the first day of the month.

Calculate the cost of care in the following way:

1. For a Medicaid member in a medical institution who does not have a community spouse, subtract the following from the person's monthly income:
    a) $65 and ½ earned income disregard (see SECTION 15.7.5 $65 AND ½ EARNED INCOME DEDUCTION).
    b) Monthly cost for health insurance (see SECTION 27.6.4 HEALTH INSURANCE).
    c) Support payments (see SECTION 15.7.2.1 SUPPORT PAYMENTS).
    d) Personal needs allowance (see SECTION 39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES).
    e) Home maintenance costs, if applicable (see SECTION 15.7.1 MAINTAINING HOME OR APARTMENT).
    f) Expenses for establishing and maintaining a court-ordered guardianship or protective placement, including court-ordered attorney and/or guardian fees (see SECTION 27.6.6 FEES TO GUARDIANS OR ATTORNEYS).
    g) Medical or remedial expenses (see SECTION 27.7.7 MEDICAL OR REMEDIAL EXPENSES AND PAYMENTS FOR NONCOVERED SERVICES).
2. For a Medicaid member in a medical institution who has a community spouse, follow the directions in SECTION 18.6 SPOUSAL IMPOVERISHMENT INCOME ALLOCATION.
3. For a community waivers member with or without a community spouse, follow the directions in SECTION 28.6.4 COST SHARE AMOUNT.
4. There is no cost of care for SSI recipients.
5. For a Medicaid member who was or could have been certified through a deductible before entering the institution, there is no cost of care until the deductible period ends.

Note: *503, DAC, Widow or Widower, and COLA disregards that are used in eligibility determinations for Special Status Medicaid are not used in Patient Liability Calculations.*

If the cost of care amount is equal to or more than the medical institution's Medicaid rate, the individual is responsible for the entire cost of his or her institutional care. He or she would be entitled to keep any overage without restriction. He or she would remain eligible for the Medicaid program and have no further financial obligation to the Medicaid program for that month.

27.7.2 Hospitalized People

Effective December 1, 2008, hospitalized people will be responsible for paying a patient liability. See SECTION 27.7.4 TRANSFERS BETWEEN INSTITUTIONS for information about patient liability calculations when a person transfers between a hospital and nursing home(s).

27.7.3 Partial Months

If a member is residing in an institution (see SECTION 27.1 INSTITUTIONS) and not Medicaid-eligible as of the first of the month, there is no patient liability for that month.

If a member was not institutionalized as of the first of the month or was discharged to the community prior to and including the last day of the month, there is no patient liability. However, if the member is enrolled in Family Care, Family Care Partnership, or PACE, he or she may owe a cost share to the MCO if a cost share is determined following the change in living arrangement.

Exceptions:

- There is a patient liability if the reason the person did not reside in the institution for the entire month was due to death or being on therapeutic leave.
- There is a patient liability if the reason the person was not eligible for long-term care services for the entire month is because a divestment penalty period ended in that month. Members who are institutionalized for the entire month in which their divestment penalty period ends must pay the full patient liability for that month.

27.7.3.1 Death

If the patient liability amount in the month of death is greater than the nursing home's cost of care for that month and the nursing home or entity responsible for collecting the patient liability requests it, the patient liability can be adjusted to be equal to the nursing home charges for that month (see Process Help 11.2.2.3).

27.7.3.2 Community and Nursing Home

There is no patient liability in a month in which a member moves from one of the following:

- The community into a nursing home after the first of the month.
- From a nursing home to the community before the end of the month. This includes members moving from the nursing home to the community on the last day of the month.

27.7.4 Transfers Between Institutions

Effective December 1, 2008, when an institutionalized person transfers between institutions (nursing homes, hospitals, hospices) in the same month, do not prorate the patient liability between the various institutions that he or she resided in during that month. The member will pay his or her patient liability to the institution that he or she were residing in on the first day of the month. ForwardHealth will automatically deduct the appropriate patient liability amount from the **first** nursing home, hospice, or long term inpatient hospital claim received for the member. If the amount of the patient liability exceeds the reimbursement amount of the first claim, the remaining liability amount will be deducted from the next claim(s) received for services provided in the month that patient liability is owed. Patient liability amounts deducted from claims will appear in the provider's remittance information. Nursing home, hospice, and inpatient hospital providers may have to occasionally transfer a patient liability amount that they collected from a member on the first day of a month to the appropriate provider who ultimately had the claim adjusted to reflect the required patient liability amount.

27.7.5 Retroactive Cost of Care

Occasionally a nursing home or community waivers applicant becomes retroactively eligible. This might happen, for example, when a person, having been denied eligibility, goes to a fair hearing. If the fair hearing determines the person was eligible at the time of application, the agency must retroactively

certify him or her and compute retroactive cost of care. The directions are the same as for current cost of care (see SECTION 27.7.1 INTRODUCTION).

27.7.6 Personal Needs Allowance

Deduct the personal needs allowance (see SECTION 39.4.3 LTC POST-ELIGIBILITY ALLOWANCES) for all institutionalized members in both the eligibility test and the patient liability calculation.

An institutionalized person's personal needs allowance may accumulate to where he or she may lose eligibility due to excess assets. To prevent this, he or she can spend money on personal needs or make a refund to Medicaid (see SECTION 22.1.9 VOLUNTARY RECOVERY [NOT ESTATE RECOVERY PROGRAM]).

27.7.7 Medical or Remedial Expenses and Payments for Noncovered Services

27.7.7.1 Introduction

Medicaid members in nursing homes are allowed to pay for some medically necessary noncovered services out of their patient liability. They are not required to use their personal needs allowance for these services.

Effective January 4, 2008, medical or remedial expenses an institutionalized applicant or member has incurred, is actually paying, and is legally obligated to pay are allowable expenses and are used as a need item when determining his or her eligibility for Medicaid. These actual payments are also allowed as an income deduction to reduce the cost share or patient liability amount. This includes payments for medical or remedial expenses that the institutionalized applicant or member is currently incurring as well as payments for certain previously incurred medical or remedial expenses.

Note: *This does not include any medical or remedial expenses that another person has incurred.*

In order to use the medical or remedial expense as a need item and as an income deduction in the cost share calculation, the expense must meet both the following criteria:

- The institutionalized person must be legally liable for payment of the incurred medical or remedial expense. Any portion that will be paid by a legally liable third party, such as private health insurance, Medicare, or Medicaid, cannot be allowed as a deduction.
- The institutionalized person must provide verification of the allowable expense (see SECTION 27.7.7.2 DISALLOWED EXPENSES).

Example 1:	In February, Al had a root canal performed by a dentist who is not an Medicaid provider. He is responsible for paying $600 for the procedure. Al began making payments of $100 per month on this medical bill in March. On April 1, Al became institutionalized and eligible for Medicaid. The $100 payment that Al is making on a previously incurred medical expense should be used as a need item when determining Al's institutional Medicaid eligibility. The expense should also be used as in income deduction when calculating Al's cost share obligation. The $100 payment can be used as an income deduction in the cost share calculation until it is fully paid in August. Since Al will no longer be making payments in September, the expense should be decreased to zero prior to adverse action in August.

Example 2:	In April, Edna applied for institutional Medicaid and requested a one month backdate. Her request for eligibility in March was denied because her assets exceeded program limits, but was approved effective April 1. Edna used her excess assets to make a partial payment to the nursing home for March costs, but still has an outstanding balance of $1,800. Edna agrees to make payments to the nursing home of $500 per month until the expense is paid in full. The $500 payment to the nursing home should be

	used as an income deduction when calculating her cost share for the months of April through June. In July, she will only owe $300 to the nursing home so the deduction for July should be decreased to $300 prior to adverse action in June. Edna will no longer be making payments in August, so the expense should be decreased to zero prior to adverse action in July.

Example 3:	Jack has been an institutionalized Medicaid member since January. In March, he had a tooth extracted. The procedure was performed by a dentist who is not an Medicaid provider, so it was a noncovered service. Jack contacts the agency in April to request a deduction from his cost share so that he can pay the expense. The cost of the extraction was $209. Since this was a one-time expense and his patient liability exceeds this amount, the agency enters the expense in CWW to reduce the May cost share by $209.

27.7.7.2 Disallowed Expenses

Do not allow payments that an institutionalized person is making, or requests to make, as a need item or as a cost share adjustment if the medical or remedial expense meets any of the following exception reasons:

- Remains unpaid but was previously used to meet a Medicaid deductible.
- Was incurred as the result of imposition of a divestment penalty period.
- A patient liability or cost share from a previous budget period, whether paid or unpaid, cannot be used as an incurred medical or remedial care expense in a subsequent budget period.
- Incurred medical and remedial care expenses deducted from income to determine patient liability or cost share in a month cannot be used to determine patient liability or cost share in a subsequent month.

Example 4:	On September 17, Alice was hospitalized for injuries she sustained in a fall. Alice was uninsured at the time and incurred a $2,000 hospital bill. Before leaving the hospital, she set up a payment agreement to pay $100 per month until the debt was paid. Alice used the outstanding expense to satisfy a deductible in the amount of $1,800 and was determined Medicaid-eligible from September through February. In May, Alice was determined to be functionally eligible for HCBWs and was determined eligible for Medicaid under Group B waiver rules. Without a medical or remedial expense, Alice's cost share would be $100. Alice's care manager verified that Alice still owes $1,200, but only $200 of the expense is allowable because $1,800 was already used to satisfy a deductible. Her care manager will include the $100 payment in the medical or remedial expense amount submitted to the IM worker for determining her cost share, but will reevaluate Alice's medical or remedial expense amount in two months.

Example 5:	On August 1, Alice moved to a nursing home. Her eligibility for HCBWs ended and she was determined eligible for Nursing Home Medicaid beginning August 1. She is still making the $100 payments to the hospital, and has an outstanding balance of $900. However, Alice used $1,800 to meet a deductible and already received a deduction of $200 from her community waiver cost share. The payment cannot be used as a medical expense deduction from her income when calculating the monthly patient liability.

Example 6:	In January, Lyle was institutionalized and applied for Medicaid. Due to a previous divestment, Lyle has a three-month divestment penalty period, beginning in December. During this three-month period, Medicaid will not cover the cost of Lyle's institutional care, but will only cover his card services. In March, the divestment penalty period expired, and Lyle is eligible for Medicaid payment of his institutional cost share. He would like to use $2,000 of his monthly income to pay for the nursing home bills that he incurred in January and February and deduct this amount from his cost share. The request to allow an adjustment in Lyle's cost share must be denied because the medical expense that he wants deducted from his income is to pay for the cost of institutional care incurred during a prior Medicaid divestment penalty period.

- The expense is unverified.

CARES Process

Enter allowable expenses on the Medical Expense Page for Institutional and Group B Waivers cases. See Process Help Section 18.2 Medical Expenses.

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27.8 Nursing Home Contracts

Certain nursing home contract provisions require prospective residents to be on private pay status for a period of time, usually 12 to 18 months, before applying for Medicaid (Medicaid).

In essence, this requires the prospective resident waive the right to apply for Medicaid for a period of time as a precondition to admittance. The prospective residents, who are typically on a higher private pay status at the time, would generally qualify for Medicaid before the contract provision expires.

Nursing homes must honor residents' rights guaranteed by HSS 132.31, Wis. Admin. Code, in order to participate in the Medicaid program. The standards must be enforced as a condition of federal funding. They apply to all residents in a Medicaid certified nursing home, both Medicaid and private pay, as a condition of participation in the Medicaid program.

A resident can be involuntarily discharged or transferred essentially only for:

1. medical reasons,
2. his or her welfare or that of other patients, **or**
3. nonpayment.

Changing status from private pay to Medicaid and any corresponding loss of revenue to the nursing home are not to be considered nonpayment.

Thus, contract provisions prohibiting a person from applying for Medicaid by requiring a certain length of stay as a private pay resident can't be enforced by threats of discharge.

DHS has notified all Wisconsin nursing home providers that:

1. violations of private pay duration of stay contract provisions aren't grounds for discharge, **and**
2. they must notify all present and prospective residents of this.

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27.9 Nursing Home Refunds

When an institutionalized person becomes eligible for Medicaid, he or she is certified with a begin date of the first of the month in which he or she became eligible. If he or she prepaid his or her patient liability for that month, the member may ask the nursing home to send the bill to Wisconsin Medicaid and ask that he or she be reimbursed for the month.

Treat the refund as a reimbursement in the month it is received. (15.3.19 REIMBURSEMENTS) Do not count it as income in the month it is received. Beginning with the month following the month of receipt, count any amount he or she keeps as an available asset. He or she can avoid having the reimbursement counted as an available asset by doing any of the following:

1. Transfer it for fair market value for an exempt asset.
2. Transfer it to his or her spouse.
3. Refund it to the Medicaid program in an amount equal to what Medicaid has already paid for his or her care up to the date of the reimbursement.

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27.10 Liability Effective Dates

Income changes which are reported timely and result in an increased patient liability or cost share have the following effective dates:

- Eligibility redetermined **before** adverse action: Effective the first of the following month.
- Eligibility redetermined **after** adverse action: Effective the first of the month after the following month.

Do not complete F-10110 (formerly DES 3070) for retroactive patient liability or cost share increases since the member must receive timely notice. This includes scenarios in which a member is switching from a patient liability to a cost share or from a cost share to a patient liability.

Decreases in patient liability or cost share are always effective the first of the month in which the decrease in income occurs or the decrease is reported, whichever is later.

Liability changes must be reviewed when coverage was maintained following a reported change or a timely renewal. Once eligibility is able to be redetermined, liability amounts for months with coverage maintained may need to be reduced. See PH 11.11.1.2 Restoration of Benefits for Institutional Medicaid.

Note *If an Administrative Law Judge or court orders a decreased liability or cost share, the agency must follow the court order and apply changes retroactively as stated in the court order.*

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27.11 Institutions for Mental Disease

An institution for mental diseases (IMD) is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.

Some IMDS provide residential substance use disorder (SUD) treatment. Special eligibility rules apply to IMD residents receiving residential SUD treatment (see SECTION 27.1.2 INSTITUTIONS FOR MENTAL DISEASE and SECTION 27.4.1 INSTITUTIONALIZED PERSON). The IMDs that provide residential SUD treatment are specified below.

Note *Because the number of beds and whether a facility provides SUD treatment are subject to change, this list may not always be up-to-date. When in doubt, contact the facility to determine if it is considered an IMD or provides residential SUD treatment.*

Brown

Bellin Psychiatric Center, Green Bay

Willow Creek Behavioral Health, Green Bay

Dane

5 Door Recovery/Hope Haven/Rebos United, Madison (provides residential SUD treatment)

Acadia Psychiatric Hospital, Madison

Mendota Mental Health Institute, Madison

Miramont Behavioral Health, Middleton

Eau Claire

Lutheran Social Services – Affinity House, Eau Claire (provides residential SUD treatment)

Lutheran Social Services – Fahrman Center, Eau Claire (provides residential SUD treatment)

Milwaukee

Aurora Psychiatric Hospital, Milwaukee

Genesis Behavioral Services Inc. – Jeanetta Robinson House, Milwaukee (provides residential SUD treatment)

Granite Hills Hospital, West Allis

Matt Talbot Recovery Services, Milwaukee (provides residential SUD treatment)

Rogers Memorial Hospital Inc., Brown Deer

Rogers Memorial Hospital Inc., Milwaukee

Oneida

Options Counseling Services, LLC, Rhinelander (provides residential SUD treatment)

Trempealeau

Trempealeau County Health Care Center IMD, Whitehall - license # 2961

Note: *The Trempealeau County Health Care Center is a multi-purpose complex that includes facilities that are not IMDs. To make a correct Medicaid eligibility determination for the residents of this complex, identify the type of facility the Medicaid applicant or member is in.*

Trempealeau County IMD, Whitehall - license # 5001

Washington

Exodus Transitional Care Facility, Kewaskum (provides residential SUD treatment)

Waukesha

Lutheran Social Services – Aspen Center, Waukesha (provides residential SUD treatment)

Rogers Memorial Hospital Inc., Oconomowoc

Winnebago

Winnebago Mental Health Institute, Winnebago

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

28.1 HCBWLTC Introduction

Medicaid-eligible adults who meet the LOC requirements can receive their LTC services through enrollment in an MCO or through the fee-for-service program IRIS.

Managed LTC programs include:

- Family Care
- Family Care Partnership
- PACE

Medicaid Eligibility

Community waivers enable elderly, blind, or disabled people to live in community settings rather than in state institutions or nursing homes. They allow Medicaid to pay for services and supports permitting a person to remain in a community setting that normally are not covered by Medicaid. These programs include Family Care, Family Care Partnership, PACE, and IRIS.

IM workers are responsible for determining Medicaid eligibility as well as cost share amounts, if applicable. ADRC staff and IRIS consultants are responsible for determining the person's eligibility for enrollment in the specific community waiver program.

If a member disenrolls from the managed LTC program for any reason and does not enroll in IRIS or a managed LTC program, their Medicaid eligibility must be tested under non-HCBW rules. Eligibility for HCBW would end following adverse action logic once the IM worker has been notified by the ADRC that the member has disenrolled from the managed LTC program or IRIS.

If an 18-year-old is disenrolled from their managed LTC program during their 12-month continuous coverage period, and they are not eligible for another category of full-benefit health care, they will keep their HCBW Medicaid and can keep getting Medicaid card services for the rest of the 12-month continuous coverage period. However, a voluntary disenrollment will be treated as a voluntary disenrollment from HCBW Medicaid and continuous coverage under HCBW Medicaid will end (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).

Managed Long-Term Care of IRIS Enrollment

Enrollment in managed LTC or IRIS is completed by the ADRC. The ADRC will submit the following information to IM workers:

- ADRC Referral to Income Maintenance for Managed Long-Term Care Services, F-02053, which lists the anticipated program start date for HCBW
- Medicaid application, if the ADRC is assisting the applicant with the Medicaid application process or establishing a Medicaid filing date
- Functional Screen Eligibility Results page
- Medical and Remedial Expenses: checklist For Medicaid Long-Term Care Waiver Programs, F-00295, or other communication of the total expenses

- Housing expenses and any other verification items the ADRC has received from the applicant to support the Medicaid application
- Estate Recovery Program (ERP) Disclosure, F-13039, if completed by the ADRC
- Declaration Regarding Transfer of Resources Long-Term Care Medicaid Waiver Program and/or Community Options Program, F-20919D, if any potential divestment was reported to the ADRC
- Disenrollment from the managed LTC program or IRIS, if applicable

28.1.1 Adult Home and Community Based Waivers Long-Term Care Disability Policy

To be eligible for EBD Medicaid or LTC Medicaid, a person must be elderly, blind, or disabled.

Adults over age 18 and younger than 65 years old must have a disability determination unless the person is eligible for BadgerCare Plus, WWWMA, Foster Care, or Adoption Assistance. If a person later loses eligibility for that program and must be tested for EBD Medicaid or LTC Medicaid, he or she must then be elderly, blind, or disabled to remain enrolled in Family Care, Family Care Partnership, PACE, or IRIS.

A disability finding made prior to the person's 18th birthday, which remains in effect on the person's 18th birthday, will be considered to meet the disability requirements for managed LTC or IRIS until the first of the following:

- An adult disability determination can be completed
- The child disability determination was redetermined and the child was found to no longer be disabled.

Managed LTC or IRIS eligibility will not be denied solely because the disability determination in effect at application was made prior to applicant's 18th birthday.

This policy applies to child disability determinations made by the Bureau of Clinical Policy and Pharmacy (BCPP) for Katie Beckett members. See SECTION 5.2.3 KATIE BECKETT MEDICAID MEMBERS MOVING TO OTHER EBD MEDICAID PROGRAMS.

28.1.2 Family Care

Family Care is a managed long-term care program for adults with disabilities and frail elders.

To enroll in Family Care the individual must meet the following criteria:

- Be 18 years of age or older.
- Meet financial and non-financial eligibility criteria for:
    - A full benefit category of EBD Medicaid, including Long Term Care Medicaid (see 28.1.1 DISABILITY POLICY),
    - BadgerCare Plus (BCP),
    - WWWMA,
    - Adoption Assistance (AA), or
    - Foster Care Medicaid; and
- Meet the nursing home or non-nursing home functional level of care.

28.1.3 Family Care Partnership

The Family Care Partnership program is a managed long-term care program integrating health and long-term support services for adults with disabilities and frail elders.

To participate in the Family Care Partnership program the individual must meet the following criteria:

- Be 18 years of age or older,
- Meet financial and non-financial eligibility criteria for:
    - A full benefit category of EBD Medicaid, including Long Term Care Medicaid (see 28.1.1 DISABILITY POLICY),
    - BadgerCare Plus (BCP) Standard Plan,
    - WWWMA,
    - Adoption Assistance (AA), or
    - Foster Care Medicaid; and
- Meet the nursing home functional level of care.

28.1.4 PACE

PACE is a program that provides comprehensive community-based services, including both acute and chronic care for frail elderly individuals. Most services are provided in a day health center, and members must receive medical services from a PACE physician. PACE is only available in select counties.

To enroll in PACE, the individual must meet the following criteria:

- Be 55 years of age or older,
- Meet the nursing home functional level of care,
- Reside in a county that offers PACE.

PACE participants who are not eligible for Medicaid will pay a premium to the PACE organization. If the PACE Participant is eligible for Medicaid, the participant is subject to the requirements in this chapter, including cost sharing.

28.1.5 IRIS

IRIS (Include, Respect, I Self-Direct) is a fee-for-service long-term care support program available to individuals who meet the functional and financial eligibility requirements. IRIS participants receive a budget amount that is calculated based on the results of their long-term care functional screen that can be used to purchase long-term care supports and services related to the participant's needs.

To participate in the IRIS program, individuals must meet the following criteria:

- Be 18 years of age or older;
- Meet the nursing home level of care;
- Meet the financial and non-financial eligibility criteria for one of the following:
    - A full-benefit category of EBD Medicaid, including Long-Term Care Medicaid
    - BadgerCare Plus
    - WWWMA
    - Adoption Assistance
    - Foster Care Medicaid; and
- Reside in an IRIS eligible living setting:
    - Individual's own home or apartment;
    - 1-2 or 3-4 bed Adult Family Home (AFH);
    - Residential Apartment Care Complex (RCAC).

28.1.6 Changing Programs

Individuals who want to change long-term care programs must complete this request through their Aging and Disability Resource Center (ADRC).

28.1.7 Spousal Impoverishment

Spousal impoverishment policy applies to group B and B Plus waiver participants with a community spouse (see SECTION 26.3.7 SPOUSAL IMPOVERISHMENT).

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28.2 HCBWLTC Fiscal Test Group

Form the fiscal test group as follows:

1. Single person = a fiscal test group of one.
2. Married couple, when one spouse is applying for community waivers, and the other is a community spouse. This is a spousal impoverishment situation. Combine the assets (18.4.3 CALCULATE THE COMMUNITY SPOUSE ASSET SHARE) and apply the spousal impoverishment asset test (18.4.4 ASSET TEST). The income limit is the same as for institutionalized persons who do not have a community spouse.
3. Married couple, both applying for HCBW, are in two separate fiscal test groups. Spousal impoverishment policies may apply.

Example 1:	Cathy and Bob, a married couple, are both applying for community waivers. Both are each other's community spouse. Combine the assets and apply the spousal impoverishment asset test. Calculate asset shares and asset limits for each. Cathy and Bob each have one year to spend assets down to $2,000, based on their individual application dates.

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28.3 HCBWLTC Divestment

IM determines divestment for adult home and community-based waivers applicants. For Group A applicants, the care manager completes F-20919D for IM to investigate and determine divestment. See 17.1 DIVESTMENT INTRODUCTION.

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28.4 HCBWLTC Reserved

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28.5 HCBWLTC Effective Date

The begin date of waiver eligibility is the program start date submitted to the IM agency by the care manager or the ADRC.

28.5.1 Urgent Services

Applicants who have been determined functionally eligible for Family Care or Family Care Partnership may receive services from the MCO while Medicaid financial eligibility is being determined if they have been determined by the ADRC to be in need of urgent services. See Process Help Section 11.3.4 Urgent Services for more information on how to process these requests.

The effective date of enrollment into Family Care or Family Care Partnership shall be no earlier than the date the Urgent Services Agreement is signed and the Medicaid application is submitted.

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28.6 HCBWLTC Groups and Cost Sharing

28.6.1 Group A

Group A members are waiver functionally eligible and Medicaid eligible via any full-benefit Medicaid subprogram **other than HCBW Medicaid**.

- Group A members may be eligible for any of the full-benefit Medicaid programs, as listed in SECTION 21.2 FULL-BENEFIT MEDICAID, including those eligible for Special Status MA (see SECTION 25.1 SPECIAL STATUS MEDICAID).
- Group A does not include someone solely eligible for any of the limited benefit Medicaid subprograms listed in SECTION 21.3 LIMITED BENEFIT MEDICAID.

Group A members do not have a cost share.

Members who have met a deductible are eligible for community waivers as a Group A. The member remains eligible as a Group A until the end of the deductible period. At the next review the member will be able to make a choice between meeting the deductible to receive Medicaid (remaining a Group A) or becoming eligible for community waivers as a Group B or B Plus with a potential cost share.

Group A members are financially eligible with no cost share. They are only subject to the asset limit and any premiums associated with the full-benefit Medicaid source, if applicable. For example, if the member's Medicaid source is MAPP, s/he would be subject to the MAPP asset limit and premium calculated. If the member's Medicaid source is BadgerCare Plus, the member would not have an asset limit, but may still have a premium calculated.

Note *Group A members do not have an asset limit if they are Group A eligible via BadgerCare Plus, Adoption Assistance Medicaid, Foster Care Medicaid, Katie Beckett Medicaid, or Wisconsin Well Woman Medicaid since these programs do not have an asset test. All Group A members, including those who are eligible for Group A through BadgerCare Plus eligibility, are subject to the divestment policy described in CHAPTER 17 DIVESTMENT.*

28.6.2 Group B and B Plus

Group B members are defined as those not in Group A, but who have gross income at or below the nursing home institutions categorically needy income limit (see SECTION 39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES).

Group B Plus members are defined as those not in Group A, who have gross income above the nursing home institutions categorically needy income limit, but whose income does not exceed the cost of the appropriate institutional care by more than the medically needy income limit (see SECTION 39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES).

28.6.3 Cost Share Amount

The cost share amount is the monthly amount Group B and B Plus members must pay toward the cost of their waiver services. The cost share amount is calculated in CARES by applying the cost share deductions to Group B and B Plus members' gross income. For former SSI members who are not eligible for Special Status Medicaid (SECTION 25.1 SPECIAL STATUS MEDICAID INTRODUCTION) special status disregards are not used in the Cost Share calculation. Members who owe a cost share must pay one in the month that they enroll in a community waiver program, even if they only receive services for part of a month. If the member changes from one MCO to another MCO in the same month after paying a cost share to the original MCO, they do not owe a cost share to the new MCO that month.

Family Care, Family Care Partnership, or PACE members institutionalized in a medical institution pay a patient liability calculated according to CHAPTER 27 INSTITUTIONAL LONG-TERM CARE rather than cost share under this section.

Cost Share or Patient Liability Effective Dates

Income changes which are reported timely and result in an increased patient liability or cost share have the following effective dates:

- Eligibility redetermined **before** adverse action: Effective the first of the following month.
- Eligibility redetermined **after** adverse action: Effective the first of the month after the following month.

Decreases in patient liability or cost share are always effective the first of the month in which the decrease occurs or the decrease is reported, whichever is later.

Cost share changes must be reviewed when coverage was maintained following a reported change or a timely renewal. Once eligibility is able to be redetermined, cost share amounts for months with coverage maintained may need to be reduced. See PH 11.11.1.1 Restoration of Benefits for Waivers (Refunding Cost Share).

28.6.3.1 Personal Maintenance Allowance

A personal maintenance allowance for room, board, and personal expenses must be deducted from income when calculating cost share.

The personal maintenance allowance is calculated as the total of the following, but must not exceed the Community Waivers Personal Maintenance Allowance Maximum (see SECTION 39.4.3 LTC POST-ELIGIBILITY ALLOWANCES):

1. Community Waivers Basic Needs Allowance (see SECTION 39.4.3 LTC POST-ELIGIBILITY ALLOWANCES)
2. Sixty-five dollars and ½ earned income deduction (see SECTION 15.7.5 $65 AND ½ EARNED INCOME DEDUCTION)
3. Special housing amount equal to monthly housing costs over $350. If the waiver applicant's housing costs are over $350, add together the following costs and subtract $350 to get the special housing amount:

    a) Rent.
    b) Home or renter's insurance.
    c) Mortgage.
    d) Property tax (including special assessments).
    e) Utilities (heat, water, sewer, electricity).
    f) Room amount for members in a CBRF, Residential Care Apartment Complex, or Adult Family Home. The case manager determines and provides this amount.

    Waiver participants under age 18 do not qualify for the special housing amount deduction.

If two spouses who are both waiver participants live together (or they have separate rooms in a substitute care facility, but there is only one room and board contract) the special housing amount deduction is allocated between them in the way that results in the lowest total cost share for the couple.

Example 1	Jennifer and Markus are married and live together. Both are waiver participants. Their total housing costs are $1,600. The special housing amount is calculated as $1600 − $350 = $1250. Before deducting the special housing amount, Jennifer has a cost share of $800 and Markus has a cost share of $500. To get the lowest total cost share for the couple, $500 of the special housing amount is allocated to Markus, reducing his cost share to $0. The remaining $750 of the special housing amount is allocated to Jennifer, reducing her cost share to $50.

Example 2	Dan and Allison are married and live together. Both are waiver participants. Their total housing costs are $1,075. The special housing amount is calculated as $1,075 − $350 = $725. Before deducting the special housing amount, Dan has a cost share of $1,200. Allison is eligible for Group A waivers with no cost share. To get the lowest total cost share for the couple, the full $725 special housing amount is allocated to Dan, reducing his cost share to $475.

If two spouses who are both waiver participants have separate living arrangements (e.g., they reside in two different substitute care facilities, or they reside in the same substitute care facility but each has a private room and a separate room and board contract) a separate special housing amount is calculated for each based on their individual housing costs.

If the total of 1, 2, and 3 above is greater than the Community Waivers Personal Maintenance Allowance Maximum, the maximum amount is used. See SECTION 39.4.3 LTC POST-ELIGIBILITY ALLOWANCES for the current Community Waivers Personal Maintenance Allowance Maximum.

28.6.3.2 Family Maintenance Allowance

A family maintenance allowance, an amount to be used for the support of the applicant's family members, should only be deducted from income when calculating cost share in certain cases. The family maintenance allowance may not be used for a deduction when spousal impoverishment policies apply or if the member is a disabled child. For spousal cases, the institutionalized person can allocate income to the community spouse and children in the home, see SECTION 18.6 SPOUSAL IMPOVERISHMENT INCOME ALLOCATION.

28.6.3.2.1 Family Maintenance Allowance Calculation - Minor Child

When the waiver participant has one or more children under the age of 18 who do **not** live with a community spouse, an allowance for those children is calculated as follows:

1. Determine the total gross monthly income of the member's children under age 18 who are not living with a community spouse. No exclusions, disregards, or deductions apply.
2. Subtract the minor children's total gross income from 100% the FPL for a family size equal to the number of minor children not living with a community spouse to get the family maintenance allowance. If the children's total gross income exceeds 100% FPL, no family maintenance allowance is deducted.

28.6.3.2.2 Family Maintenance Allowance Calculation - EBD-Related

If there are no minor children in the home, and spousal impoverishment policies do not apply, calculate the following:

1. Spouse's gross earned income.
2. -$65 and ½ of total gross earned income (see Section 15.7.5 $65 AND ½ EARNED INCOME DEDUCTION).
3. =_____.
4. +Spouse's total unearned income.

5. =_____ (3)+(4).
6. -$20 disregard .
7. =_____(6)-(5).
8. _____Enter the Non-Spousal-Impoverishment Family Maintenance Allowance Maximum (see SECTION 39.4.3 LTC POST-ELIGIBILITY ALLOWANCES).

If (7) is greater than (8), there is no family maintenance allowance. If (7) is less than (8), the family maintenance allowance is the difference between (7) and (8).

28.6.3.3 Special Exempt Income

Special exempt income (see SECTION 15.7.2 SPECIAL EXEMPT INCOME) must be deducted from income when calculating cost share.

28.6.3.4 Health Insurance

All health and dental insurance premiums covering the waiver person and for which he or she is responsible and pays a premium must be deducted from income when calculating cost share. This includes any Medicare Premium obligation including Medicare Part D. See SECTION 9.6.2 POLICIES NOT TO REPORT for a list of insurance types for which premium deductions are not allowed.

If the waiver participant is part of a covered group but not responsible for the premium, find his or her proportionate share by dividing the premium by the number of people covered. If both members of a couple apply, but only one pays the premium, divide the premium equally. Prorate premiums over the months payment covers.

Example 8	Sally pays a $600 premium quarterly for her Medicare supplement policy. Six hundred dollars divided by three equals $200. Enter $200 as her monthly health insurance premium payment on the Medical Coverage page.

28.6.3.5 Medical/Remedial Expenses

The dollar amount of the applicant's medical and remedial expenses, as reported by the MCO care manager, ICA, or ADRC, must be deducted from income when calculating cost share. See SECTION 15.7.3 MEDICAL/REMEDIAL EXPENSES and SECTION 20.3.6 MEDICAL OR REMEDIAL EXPENSES.

Note *Care managers should refer to the limitations associated with allowable medical or remedial expenses that are described in SECTION 27.7.7 MEDICAL OR REMEDIAL EXPENSES AND PAYMENTS FOR NON-COVERED SERVICES.*

28.6.4 Maximum Cost Share Amount

For Family Care, Family Care Partnership, and PACE, see SECTION 39.4.5 FAMILY CARE, FAMILY CARE PARTNERSHIP, OR PACE GROUP B PLUS COST SHARE CAP for maximum cost share amount.

28.6.5 Waiver or Reduction Cost Share

Family Care, Family Care Partnership, or PACE members may request a waiver or reduction of their cost share from the Department. Members indicating that they are having difficulty paying cost share should be informed of this right, directed to complete the Application for Reduction of Cost Share form (F-01827), and referred to the Bureau of Adult Programs and Policy (1-855-885-0287).

28.7 HCBWLTC Medical Codes

See the Process Help Section 81.5 Med Stat Code Chart for Community Waiver medical status codes. These are not the same codes as nursing home medical status codes. A medically needy Medicaid member could be eligible as a categorically needy waiver member (Group B), thus requiring a change in the medical status code from medically needy to categorically needy.

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28.8 HCBWLTC Care Review

IM reviews financial eligibility annually. The care manager reviews level of care eligibility annually. Eligibility should not be discontinued if the care manager has not yet made the level of care review.

The care manager informs the IM agency if the person is no longer level of care eligible. IM must notify the care manager if the person is no longer Medicaid eligible.

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28.9 HCBWLTC Community Spouse's Medicaid Application

When a community waivers person and his or her community spouse are both applying for Medicaid, they are one case, but separate AGs.

Both spouses are in the non-waiver spouse's fiscal test group (FTG). Since the waiver spouse is in the FTG, disregard any income that may have been allocated by the waiver spouse to the community spouse.

The waiver spouse is a FTG of one. CARES creates the separate FTG's and AG's.

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28.10 Reserved

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28.13 Reserved

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28.14 Reserved

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29 Katie Beckett Medicaid

29.1 Katie Beckett Medicaid

Katie Beckett Medicaid (KBM) is a special eligibility pathway for children under 19 who have certain health care needs and live at home. Katie Beckett provides Medicaid health care coverage for children who qualify. Katie Beckett Medicaid does not deem assets and income from parents or legal guardians.

To qualify for Katie Beckett Medicaid, a child must:

- Be under age 19.
- Meet the Social Security Administration's definition of "disabled."
- Be a U.S. citizen or qualifying immigrant.
- Be a Wisconsin resident.
- Live at home, in a foster care setting, or in another eligible community-based setting.
- Require the kind of care typically provided by a hospital, SNF, ICF, or long-term care facility.
- Be able to receive safe and appropriate care at home.
- Have income below the Institutions Categorically Needy income limit (see SECTION 39.4.1 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLE). The only income used in this calculation is the child's income. There is no asset test for children.
- Not require care at home that would cost more than the care they would receive in a long-term care facility covered by Medicaid.

Members enrolled in Katie Beckett Medicaid are only subject to estate recovery when they have resided in a hospital or nursing home for 30 or more continuous days. Only the child's estate (not the parent's or legal guardian's) is subject to estate recovery requirements. See SECTION 22.1 ESTATE RECOVERY for the criteria used to determine whether services are recoverable.

Families may contact Katie Beckett Medicaid Central Office by:

- Calling 888-786-3246.
- Emailing DHSKatieBeckett@dhs.wisconsin.gov.
- Faxing information to 888-786-3261.
- Writing to the following address:

  Wisconsin Department of Health Services
  DMS/Bureau of Children's Services
  201 E. Washington Ave. Room C300
  Madison, WI 53703

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29.2 Katie Beckett Medicaid Renewals

KBM certification periods are 12 months, and eligibility is maintained under continuous coverage policies until the end of the KBM certification period.

When a timely KBM renewal is submitted, a member's existing health care coverage must be maintained while their renewal is being processed. A timely renewal is one received during the renewal month, including renewals received after adverse action but by the last business day of the renewal month.

Members whose eligibility cannot be administratively renewed, and who do not submit their renewal by adverse action of the renewal month, will be notified that their coverage is ending at the end of the renewal month. They will be sent a notice of decision explaining that they are being disenrolled for failure to complete their renewal.

If the member's renewal is received after adverse action but by the end of the renewal month, their current coverage will be reinstated and maintained until the renewal is processed. The member will be notified of the reinstatement.

29.2.1 Ineligible for KBM after Renewal

At renewal, if the member still does not meet KBM requirements due the change in circumstance during their certification period they will be notified that they no longer qualify for KBM, and that additional information is needed to determine if they are eligible for a different form of Medicaid. The notice explains how to apply for health care with the IM agency and informs the member that, if their application is received by the due date (30 days from the date the notice was sent), they will keep their current coverage until the application is processed.

KBM coverage will be maintained for at least 30 days from the date the letter is sent to give the member time to apply. If the IM agency receives an application by the due date, KBM coverage will continue until the IM agency finishes processing the application. See SECTION 5.2.3 KATIE BECKETT MEDICAID MEMBERS MOVING TO OTHER EBD MEDICAID PROGRAMS, regarding disability transition when KBM coverage is ending.

If the IM agency does not receive an application by the due date, KBM coverage will end with timely notice. Applications received after the due date will be processed in accordance with normal application policies.

Example 1	Tina is 12 years old and enrolled in KBM. In March, her father reports that Tina is hospitalized and is expected to remain in the hospital for several months. While KBM requires members to be living in a home or community setting (rather than a medical institution), Tina remains enrolled in KBM for the remainder of her 12-month continuous coverage period, which ends in August. On August 3, the KBM worker processes Tina's renewal. Tina is still living in a medical institution, and therefore no longer qualifies for KBM. On August 4, a letter is sent to the household informing them that Tina no longer qualifies for KBM, but if she applies for health care and the application is received by September 3, her current coverage will continue until the application is processed. Tina's father applies by phone on August 10. On August 20, the IM worker determines Tina is eligible for Institutional Medicaid starting on October 1. Her KBM ends on September 30.

29.3 Katie Beckett Medicaid Changes in Circumstance

When a KBM member experiences a change in circumstances and no longer meets program requirements (for example, they become institutionalized or no longer meet medical criteria), they remain enrolled in KBM until the end of their continuous coverage period.

At renewal, if the member still does not meet KBM requirements due the change in circumstance, a process begins to request the member apply for other health care types with IM. See MEH SECTION 29.2.1 INELIGIBLE FOR KBM AFTER RENEWAL.

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29.4 Katie Beckett Medicaid Members Turning Age 19

Members are no longer eligible for KBM once they turn 19, and 19-year-olds are ineligible for continuous coverage (see MEDICAID ELIGIBILITY HANDBOOK SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN). Members receive two notices in advance of turning 19 informing them that their KBM enrollment will end when they turn 19 and recommending that they submit a health care application.

If a member submits a health care application within three months of their KBM enrollment ending, provides any requested documentation on time, and meets all non-financial and financial requirements, the member's KBM disability determination will satisfy the disability requirement for all EBD Medicaid programs while the member completes the required DDB disability application and waits for a decision on their DDB disability application. See SECTION 5.2.3 KATIE BECKETT MEDICAID MEMBERS MOVING TO OTHER EBD MEDICAID PROGRAMS.

Example 1	Sam is enrolled in KBM. Sam turns 19 on August 20. Six months prior to her birthday, Sam receives a letter informing her that her enrollment in KBM will end August 31 due to turning 19. On August 1, Sam submits a health care application, MADA, and ADDD to the IM agency. At adverse action in August, Sam receives a notice informing her that her KBM enrollment will end as of August 31. On August 20, Sam's application is processed, and she is determined non-financially and financially eligible for Medicaid Purchase Plan (MAPP). Sam's KBM disability determination meets the disability requirement for MAPP while she waits for a decision on her DDB application. Sam is enrolled in MAPP beginning September 1. Her disability application is later approved by the DDB, and her Medicaid continues with an August renewal date.

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30 Tuberculosis

30.1 Tuberculosis Medicaid

For information on Tuberculosis Medicaid, please see BadgerCare Plus Handbook, CHAPTER 43 TUBERCULOSIS-RELATED MEDICAID.

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31 Migrant Workers

31.1 Migrant Workers

A “migrant worker” is a person who temporarily leaves their principal place of residence outside Wisconsin and comes to Wisconsin for not more than 10 months per year in order to accept seasonal employment in the planting, cultivating, raising, harvesting, handling, drying, packing, packaging, processing, freezing, grading, or storing of any agricultural or horticultural commodity in its unmanufactured state.

“Migrant worker” does not include any of the following:

- A person who is only employed by a Wisconsin resident, and the employer or the employer’s spouse is the person’s child, parent, grandchild, grandparent, brother, sister, aunt, uncle, niece, or nephew.
- A student who is enrolled (or has been enrolled during the past six months) in any school, college, or university, unless the student is a member of a household that contains a migrant worker.

Certain migrant workers and their families qualify for a simplified application procedure when applying for BadgerCare Plus or Medicaid in Wisconsin. For policies related to migrant workers, see BadgerCare Plus Handbook, Chapter 12 Migrant Workers.

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32 Medicare Savings Programs

32.1 Medicare Savings Programs (MSP)

32.1.1 Medicare Savings Programs Introduction

Medicare is the health insurance program administered by the Centers for Medicare & Medicaid Services for people 65 years old or older, people determined disabled for two years or more, or people with end-stage renal disease (permanent kidney failure requiring dialysis or transplant) or amyotrophic lateral sclerosis (ALS). People who receive Medicare are referred to as Medicare beneficiaries.

Medicare is divided into four main types of health coverage:

- Hospitalization insurance (Part A), which pays hospital bills and certain skilled nursing facility, home health care, and hospice expenses
- Medical insurance (Part B), which pays doctor bills and certain other charges
- Medicare Advantage (Part C), which allows private health insurance companies to provide Medicare benefits
- Drug insurance (Part D), which pays for prescription drug charges

Medicare beneficiaries who are eligible for Medicare only due to end stage renal disease (ESRD) lose Medicare coverage 36 months after a kidney transplant. Beneficiaries who meet certain criteria, including not having any other health insurance coverage that covers immunosuppressive drugs, are able to qualify for continuous Medicare-covered immunosuppressive drugs through the Medicare Part B Immunosuppressive Drug (Part B-ID) benefit. The Part B-ID benefit covers only immunosuppressive drugs and no other items or services.

Medicare charges monthly premiums, and Medicare beneficiaries are responsible for deductibles and coinsurance payments to providers. These out-of-pocket charges are generally referred to as Medicare cost-sharing.

Wisconsin Medicaid may pay some or all of the member's Medicare cost-sharing for certain Medicare beneficiaries participating in the following programs:

- QMB
- SLMB
- SLMB+
- QDWI

These programs are called Medicare Savings Programs (MSP). They may also be referred to as Medicare Premium Assistance or Medicare Buy-In programs.

A request for health care is also considered a request for MSP, unless the member specifically states otherwise. Any Medicaid applicant or member who has or becomes eligible for Medicare should have their eligibility determined for MSP without requiring an additional request.

When determining eligibility for MSP, the same rules for determining financial eligibility for Medicaid are used with the exception of using the MSP asset limits in SECTION 32.6 MEDICARE SAVINGS PROGRAMS ASSET LIMITS and the MSP income limits in SECTION 39.5 FEDERAL POVERTY LEVEL TABLE. Nonfinancial eligibility is available as follows:

- For QMB (see SECTION 32.2 QUALIFIED MEDICARE BENEFICIARY)

- For SLMB (see SECTION 32.3 SPECIFIED LOW-INCOME MEDICARE BENEFICIARY)
- For SLMB+ (see SECTION 32.4 SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PLUS)
- For QDWI (see SECTION 32.5 QUALIFIED DISABLED AND WORKING INDIVIDUAL)

QMB members will receive a ForwardHealth card even if the member is not eligible for any other subprograms of Medicaid since Medicaid pays the Medicare copayments and deductibles for members enrolled in QMB.

32.1.2 Medicare Savings Programs Fiscal Test Group

The FTG size is two when a couple is living together in the community, unless one of the spouses is an SSI recipient. If one spouse is applying for MSP and the other spouse is an SSI recipient, the SSI recipient spouse is not included in the other spouse's FTG. If both spouses are living in the same nursing home, each person is an individual FTG.

32.1.3 Medicare Savings Programs Benefits

- QMB: Medicaid pays Medicare Part A, B, and B-ID premiums and Medicare deductibles, copayments, and coinsurance.
- SLMB: Medicaid pays Medicare Part B and B-ID premiums.
- SLMB+: Medicaid pays Medicare Part B and B-ID premiums.
- QDWI: Medicaid pays Medicare Part A premiums.

32.1.4 Low Income Subsidy Requests

See SECTION 2.6.4 LOW INCOME SUBSIDY PROGRAM OF MEDICARE SAVINGS PROGRAMS for information on LIS Requests for MSP.

32.1.5 Part B Enrollment Via the Medicare Savings Programs Buy-In Program

Members who are receiving Medicare Part A coverage, but who previously chose not to enroll in Part B, may be eligible to enroll in Part B outside of their usual enrollment periods via the MSP process with the state. See Process Help Section 61.2.1.3 Part B Enrollment Via MSP.

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32.2 QMB

32.2.1 Introduction

To be eligible for Qualified Medicare Beneficiary (QMB) benefits, the person must:

1. Meet non-financial Medicaid requirements
2. Be entitled to Medicare Part A or Part B-ID (as defined in SECTION 32.2.2 ENTITLED TO MEDICARE).

The following Medicaid members are categorically eligible for QMB:

- People who are receiving or are eligible to receive SSI Medicaid
- People who are eligible for Special Status Medicaid as a 503 or Disabled Adult Child (DAC)

Example 1	Kate receives Social Security Disabled Child DAC benefits from Social Security. Due to other unearned income, Kate is not eligible for Special Status Medicaid as a DAC. Therefore, she is not categorically eligible for QMB even though she receives a DAC payment.

32.2.2 Entitled to Medicare

A person is "entitled" to Medicare Part A or Part B-ID if they meet one of the following conditions:

1. They do not have to pay a premium for Medicare Part A and are enrolled in Medicare Part A as of the QMB determination.

Example 1	Mrs. Smith applies for QMB benefits August 15. She has a Medicare card with a Part A begin date of June 1. Since Medicare will pay for Part A services as of June 1, she is "entitled" to Part A at the time of the QMB determination.

2. They must pay a monthly premium to receive Medicare Part A and meet one of the following conditions:
   a) They are a Medicaid member and have been enrolled in Medicare sometime in the past. In this case, the state will attempt to enroll them in Medicare Part A. QMB eligibility cannot begin prior to the Part A begin date.

Example 2	Eleanor's Part A lapsed because she did not work enough quarters for free enrollment, and she could no longer afford the premiums. When she becomes eligible for Medicaid, the state will begin paying her Medicare premiums.

   b) They are a Medicaid member or a QMB or Specified Low-Income Medicare Beneficiary (SLMB) applicant and have never been enrolled in Medicare Part A. In this case, they must apply at the local Social Security Administration (SSA) office for Part A Medicare eligibility. The SSA office will add comments to the "Remarks" section of the application and provide a screen shot that can serve as proof of conditional Part A enrollment provided the applicant is found eligible for QMB or SLMB. SSA will provide the Part A begin date. QMB or SLMB eligibility cannot begin prior to the Part A begin date. The earliest QMB can begin is the month after the month of application.

Note: *For purposes of QMB or SLMB, a person can request conditional enrollment in Medicare Part A at their local SSA office at any time. They do not have to wait for the general enrollment period.*

Example 3	Pearl was never enrolled in the federal Medicare system. She applies for QMB. Before she can become QMB eligible she must obtain proof of conditional eligibility for Medicare Part A. She goes to the SSA office and is conditionally determined eligible

	for Part A effective June 1. She applies for QMB at the IM Agency on May 1. She becomes QMB eligible as of June 1.

3. They are enrolled in Medicare Part B Immunosuppressive Drug (Part B-ID).

32.2.3 Income Limit

The QMB income limit is 100% of the FPL (see SECTION 39.5 FPL TABLE).

The method of counting income is based on the SSI method, not on the spousal impoverishment method (see SECTION 28.1 ADULT HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE INTRODUCTION). Calculate QMB net income as follows:

$ Earned income (see SECTION 15.5 EARNED INCOME)
- $65 and ½ earned income deduction (see SECTION 15.7.5 $65 AND ½ EARNED INCOME DEDUCTION)
+ Unearned income (Social Security income, etc.) (see SECTION 15.4 UNEARNED INCOME)
- Special exempt income (see SECTION 15.7.2 SPECIAL EXEMPT INCOME)
- $20 standard deduction
= Net income used to determine QMB eligibility

When counting Social Security income, use the gross Social Security income. Gross Social Security income:

1. Of a self-payer = the Social Security check amount + Medicare premiums he or she has paid.
2. Of someone for whom the state is paying the premiums = the Social Security check amount.

The COLA increase is disregarded for the current year until the month after the new federal poverty limits become effective.

Example 1	Al is a QMB member. He has income of 99% of the FPL. In January, a COLA increase of $15.00 increases Al's income above 100% of the FPL. The COLA increase is disregarded in any determination of Al's continuing QMB eligibility. On April 1, new QMB income limits are published. Redetermine Al's QMB eligibility in May using the new QMB income limits. At this redetermination, the January COLA increase is applied.

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32.3 SLMB

32.3.1 Introduction

To be eligible for Specified Low-Income Medicare Beneficiary (SLMB) benefits, the person must:

1. Meet non-financial Medicaid requirements.
2. Be receiving Medicare Part A or Part B Immunosuppressive Drug (Part B-ID).

32.3.2 Income Limit

The SLMB income limit is at least 100% of the FPL, but less than 120% (see SECTION 39.5 FPL TABLE).

Calculate SLMB net income in the same way as QMB net income. The annual COLA increase is temporarily disregarded until the new income limits take effect (see SECTION 32.2.3 INCOME LIMIT).

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32.4 SLMB+

32.4.1 Introduction

To be eligible for Specified Low-Income Medicare Beneficiary Plus (SLMB+) benefits, the person must:

1. Meet nonfinancial Medicaid requirements.
2. Be receiving Medicare Part A or Part B Immunosuppressive Drug (Part B-ID).
3. Not be enrolled in full-benefit Medicaid (such as SSI Medicaid, Community Waivers, and BadgerCare Plus), Family Planning Only Services, or Tuberculosis Only Related Services. A person with an unmet deductible should be considered ineligible for Medicaid until they meet the deductible

32.4.2 Income Limit

SLMB+ income must be at least 120% of the FPL, but less than 135% (see SECTION 39.5 FEDERAL POVERTY LEVEL TABLE).

Calculate SLMB+ net income in the same way as QMB net income. The annual COLA increase is temporarily disregarded until the new income limits take effect (see SECTION 32.2.3 INCOME LIMIT).

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32.5 QDWI

32.5.1 Introduction

A QDWI is a person who:

- Is under age 65 and has lost premium-free Medicare Part A as a result of returning to work.
- Is not otherwise eligible for Medicaid, including but not limited to EBD Medicaid programs, Community Waivers, and BadgerCare Plus. (Consider a person with an unmet deductible ineligible for Medicaid until he or she meets the deductible.)
- Continues to be disabled.
- Meets the QDWI income limit (see Section 32.5.2 Income Limit) and asset limit (see SECTION 32.6 MEDICARE SAVINGS PROGRAMS ASSET LIMITS).

32.5.2 Income Limit

The QDWI income limit is 200% of the FPL (see SECTION 39.5 FPL TABLE).

Calculate QDWI net income in the same way as QMB net income. The annual COLA increase is temporarily disregarded until the new income limits take effect (See SECTION 32.2.3 INCOME LIMIT).

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32.6 Medicare Savings Programs Asset Limit

See 39.4 EBD ASSETS AND INCOME TABLES for MSP asset limits.

Divestment of assets has no effect on QMB, SLMB, SLMB+, or QDWI eligibility. Estate Recovery does not recover MSP benefits.

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32.7 Medicare Savings Programs Begin Dates

32.7.1 QMB Begin Dates

For initial eligibility, QMB benefits begin on the first of the month after the month in which the person is determined to be eligible, and the case is confirmed in CARES.

Example 1	Henry has been in the same nursing home since 2013. He applied for Medicaid on January 23, 2017, and also requested QMB. His application was processed and confirmed for both programs on January 23, 2017, and he was determined eligible for both. His Medicaid begin date is January 1, 2017. His QMB begin date is February 1, 2017.

32.7.2 SLMB, SLMB+, QDWI Begin Dates

SLMB, SLMB+, and QDWI benefits begin the first day of the month in which the valid application is submitted and all eligibility requirements are met. Eligibility for these programs may be backdated to the first of the month, up to three calendar months prior to the month of application (see SECTION 32.8.2 SLMB, SLMB+, AND QDWI BACKDATING).

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32.8 Medicare Savings Programs Backdating

32.8.1 QMB Backdating

Occasionally, the benefits of a person who is eligible for QMB do not correctly begin on the first of the following month. This can occur if:

- The eligibility process was not completed within 30 days.
- Certification of eligibility was not completed.
- A fair hearing decision has ordered backdated QMB benefits.

See Process Help Section 61.2.2 for instructions for QMB backdating.

For renewals, see MEH SECTION 32.10.1 QMB RENEWALS for information for QMB begin dates following a renewal.

32.8.2 SLMB, SLMB+, QDWI Backdating

Benefits can be backdated for up to three months prior to the month of application, or within three months of a late renewal (see MEH SECTION 3.1.2 LATE RENEWALS). Use the backdating guidelines in SECTION 2.8.2 BACKDATED ELIGIBILITY.

A person cannot receive backdated SLMB, SLMB+, or QDWI benefits for months in which he or she would have been income-eligible for QMB.

Example 1	Henry applied for MSP on June 15. He also requested a three-month backdate. His income for June was under the QMB income limit (100% of the FPL). He was determined eligible for QMB for ongoing months. His backdated eligibility was denied because his income in each of the backdated months of March, April, and May was under the QMB income limit (100% of the FPL). Since he would have been QMB eligible in the backdate period, he cannot receive backdated SLMB or SLMB+ benefits.

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32.9 Medicare Savings Programs No Deductible

There is no deductible in MSP (see SECTION 24.2 MEDICAID DEDUCTIBLE INTRODUCTION). If a person's income is above the appropriate income limit, he or she cannot qualify for an MSP.

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32.10 Medicare Savings Programs Renewals and Changes

MSP certification periods are 12 months. The first required renewal is 12 months from the most recent certification month.

32.10.1 QMB Renewals

QMB benefits begin on the first of the month following the renewal due month, if the renewal is confirmed during the renewal month or the month following the renewal month.

While a timely QMB renewal is being processed, the benefit is maintained until the redetermination is completed. (See MEH 3.1.1 TIMELY RENEWALS). When a timely renewal is pended, and verification to complete the renewal is also received timely and the member remains eligible for QMB, the new certification period should align with the extended month(s) of eligibility and there should be no gap in coverage.

Example 1	Diamond's Medicaid and QMB are due for renewal in February. She submits a renewal on February 20. Because a timely renewal is initiated, Medicaid and QMB coverage are maintained through March while the renewal is being processed. Verification of assets is requested and received on March 3 to complete her QMB renewal. Her new certification period begins April 1. There is no gap in her QMB eligibility.

If timely verification is received and the member is no longer eligible, or if verification is not received, MSP eligibility ends based on the following:

- Eligibility redetermined **before** adverse action, closure is effective the first of the following month.
- Eligibility redetermined **after** adverse action, closure is effective the first of the month after the following month.

Example 2	Susan's Medicaid and QMB are due for renewal in February. She submits a renewal on February 3. Verification of assets is requested with a due date of February 23. Because her renewal is received timely, health care benefits are maintained for March. Verification is received and processed on February 23, and she is no longer eligible for QMB. QMB coverage ends effective April 1.

For late QMB renewals that have all needed verification processed in the month following the renewal due month, there should be no gap in coverage.

Example 3	Meghan's Medicaid and QMB are due for renewal in February. She submits a late renewal on March 3. Because her renewal is received late, health care benefits are not maintained. Verification of assets is requested with a due date of March 23. Verification is received on March 19. Her new certification period for Medicaid and QMB begins March 1. There is no gap in her QMB eligibility because the renewal was confirmed in the month following the renewal due month.

For late renewals with needed verification processed in the second or third month following the renewal due month, there will be a gap in QMB coverage.

Example 4	Eve's Medicaid and QMB are due for renewal in February. She submits a renewal on April 3. Because her renewal is received late, health care benefits are not maintained. Verification of assets is requested with a due date of April 23. Verification of assets for March and April are received on April 19. Her new certification period for Medicaid begins March 1 and QMB begins May 1. There is a gap in her QMB eligibility because the renewal was not confirmed in the renewal due month or the month following the renewal due month.

32.10.2 QMB Changes in Circumstance

While a change in circumstance is being processed, QMB benefits are maintained until the redetermination is completed.

If timely verification is received and all other eligibility requirements are met, there should be no gap in coverage, even if the member changes MSP categories.

If timely verification is received and the member is no longer eligible, or if verification is not received, MSP eligibility ends based on the following:

- Eligibility redetermined **before** adverse action, closure is effective the first of the following month.
- Eligibility redetermined **after** adverse action, closure is effective the first of the month after the following month.

32.10.3 SLMB, SLMB+, QDWI Renewals

While a timely SLMB, SLMB+, or QDWI renewal is being processed, the benefit is maintained until the redetermination is completed. See MEH 3.1.1 TIMELY RENEWALS.

If timely verification is received and all other eligibility requirements are met, there should be no gap in coverage, even if the member changes MSP categories.

Example 5	Donald's MAPP and SLMB are due for renewal in February. He submits a renewal on February 20. Because a timely renewal is initiated, MAPP and SLMB coverage are maintained through March while the renewal is being processed. Verification of assets is requested and received on March 3 to complete his MAPP and SLMB renewal. His new certification period begins April 1. There is no gap in his SLMB eligibility.

If timely verification is received and the member is no longer eligible, or if verification is not received, MSP eligibility ends based on the following:

- Eligibility redetermined **before** adverse action: closure is effective the first of the following month.
- Eligibility redetermined **after** adverse action: closure is effective the first of the month after the following month.

Example 6	Jay's MAPP and SLMB are due for renewal in February. He submits a renewal on February 3. Because his renewal is received timely, health care benefits are maintained for March. Verification of assets is requested with a due date of February 23. Benefits are maintained for March. Verification is received and processed on February 23, and he is no longer eligible for SLMB. The effective date of the SLMB termination is April 1.

32.10.4 SLMB, SLMB+, QDWI Changes in Circumstance

While a change is circumstance is being processed, SLMB, SLMB+, or QDWI benefits are maintained until the redetermination is completed.

If timely verification is received and all other eligibility requirements are met, there should be no gap in MSP coverage, even if the member changes MSP categories.

If timely verification is received and the member is no longer eligible, or if verification is not received, MSP eligibility ends based on the following:

- Eligibility redetermined **before** adverse action, closure is effective the first of the following month.
- Eligibility redetermined **after** adverse action, closure is effective the first of the month after the following month.

32.10.5 Program Choice

While a renewal or a change in circumstance is being processed, the benefits that were open during the month of the change are maintained into the following month until the redetermination is completed. If a member receives full-benefit Medicaid that is maintained while a renewal or change is being processed, but is determined no longer eligible for full-benefit Medicaid (but is eligible for SLMB+), SLMB+ eligibility must be determined for the months when full-benefit coverage was maintained. See MEH SECTION 3.1.5 PROGRAM CHANGES AT RENEWAL and MEH SECTION 3.3.3 PROGRAM CHANGES.

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32.11 Medicare Beneficiaries Adversely Affected

When a member is found eligible for one of the MSP programs and the state pays their Part B premium, they can no longer use the premium payment as an expense. This may result in the member experiencing a reduction in benefits (for example, FoodShare may decrease) or an increase in a premium, cost share, or patient liability (for themselves or a community spouse). Additionally, members eligible for SLMB+ cannot have any other form of Medicaid.

When a person would be adversely affected, they may choose to opt out of MSP eligibility. If their MSP eligibility is SLMB+ and they have other Medicaid benefits, they will need to choose between either losing their full-benefit Medicaid coverage and keeping free Medicare Part B enrollment (through SLMB+) or losing free Medicare Part B enrollment and keeping their full-benefit Medicaid coverage (see Process Help, Section 61.4 Manual Updates to MSP on ForwardHealth interChange).

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33 SeniorCare

33.1 Introduction

SeniorCare is a prescription drug assistance program for Wisconsin residents who are 65 years of age or older and meet the program's enrollment requirements.

SeniorCare is administered by DHS, through EM CAPO. IM consortia and tribal agencies are not responsible for determining eligibility for SeniorCare, but may need to coordinate with workers in the EM CAPO for mixed cases. Mixed cases include people eligible for SeniorCare and:

1. FoodShare, or
2. A Medicare Savings Program, or
3. An unmet Medicaid deductible, or
4. Child care assistance, or
5. Are participating in a Department of Workforce Development (DWD) employment program, such as W-2.

Although SeniorCare is a subprogram of Medicaid, only the portions of the handbook that are referenced in Chapter 33 SeniorCare apply to SeniorCare policy.

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33.2 Application

33.2.1 SeniorCare Application Introduction

An individual interested in participating in SeniorCare must complete a SeniorCare Application form (F-10076). Applications may be printed from the Department of Health Services' SeniorCare web site at: https://www.dhs.wisconsin.gov/seniorcare/apply.htm. Local Aging and Disability Resource Centers may also have copies of the SeniorCare application. If the applicant is unsure where to obtain an application or wants to have one mailed to him/her, he or she should call 1-800- 657-2038 (TTY and translation services are available).

A $30 enrollment fee per person is required as a condition of eligibility. If the enrollment fee is not sent with the application, the eligibility begin date could be delayed (See SECTION 33.3.2 ENROLLMENT FEE).

SeniorCare applications should be mailed to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Note: *For benefit renewal requirements, see SECTION 33.15 ANNUAL ELIGIBILITY RENEWAL.*

33.2.2 Application Processing

A valid application for SeniorCare is a SeniorCare Application form (F-10076) with the applicant's:

1. Name, **and**
2. Address, **and**
3. Signature (see 33.2.3 SIGNING THE APPLICATION) in Section V. Applications that are not signed in Section V of F-10076) will be returned to the applicant.

However, non-financial (see SECTION 33.3 NONFINANCIAL REQUIREMENTS) and income (33.6 FINANCIAL REQUIREMENTS) information is needed to determine eligibility.

"General Delivery" may be used for a mailing address but cannot be used as a residence address.

The presence of a signature on a SeniorCare application indicates intent to apply. When a signed application is received without an enrollment fee, the department will send an enrollment fee request notice to the applicant(s). An application will not be approved until an enrollment fee is received.

When an application is received with an enrollment fee(s) where the applicant(s) has answered "No" to the question "Are you Requesting SeniorCare?", the department will assume that there is a request for at least one person. When an application is received without the enrollment fee where the applicant's answer to the question is "No", the department will follow up with the applicant(s) to determine his or her intent.

The date a valid application is received by the SeniorCare program is the application filing date. Eligibility for SeniorCare will be determined as soon as possible, but not later than 30 days from the date a valid application is received.

A delay in processing the application may occur if there is a delay in obtaining information or in receipt of the enrollment fee necessary for determining eligibility. If a delay occurs, the applicant will be notified

in writing that there is a delay in processing the application. The notice will specify the reason for the delay and inform the applicant of his or her right to appeal the delay.

If the initial application is denied and the applicant wishes to reapply, he or she should check the "New Application" box on the application form. "Reapplication" refers to current members who are requesting establishment of a new benefit period due to a change in circumstances.

33.2.3 Signing the Application

The applicant must sign the application form in Section V of F-10076 (Section VI of the 07/02 version of F-10076) with his or her signature, a mark or an "X", unless one of the following signs for him or her:

1. A guardian of the estate, a guardian of the person and the estate, or a guardian in general.
2. An authorized representative.
3. A power of attorney/durable power of attorney. (Health Care Power of Attorney is not accepted as proof of authority.)

33.2.3.1 Witnessing the Signature

If a SeniorCare applicant signs the application form in Section V of F-10076 with a mark or an "X", the signature must be witnessed by two individuals. (Section VI of the 07/02 version of F-10076).

33.2.4 Authorized Representative

An authorized representative may act on behalf of the SeniorCare member at application and/or renewals, and is authorized to provide information and any documentation that is necessary to establish SeniorCare eligibility.

A SeniorCare applicant or member may appoint an individual or an organization as an authorized representative by completing the SeniorCare Authorized Representative form (F-10080).

There can be only one authorized representative at a time for a SeniorCare. There is no time limit on how long a person or organization can act as authorized representative. The appointment of the authorized representative is valid until the applicant or member notifies the agency of a change or removal in writing. SeniorCare authorized representatives can only act on the individual's behalf for SeniorCare.

Organizations acting as authorized representatives must provide the name and contact information of a person from the organization. Once the organization has been appointed as the authorized representative, anyone from the organization will be able to take action on behalf of the applicant or member (not just the person who signed the form on behalf of the organization). If an organization is only changing the contact person for the organization, the member is not required to complete a new SeniorCare Authorization of Representative form if the organization is going to remain as the authorized representative.

The authorized representative should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the individual being represented. An authorized representative is limited to doing any or all of the following on behalf of the applicant or member:

- Apply for or renew SeniorCare benefits
- Report changes in the SeniorCare applicant or member's circumstances or demographic information

- Receive copies of the applicant or member's notices and other communications from the SeniorCare program
- Work with the SeniorCare program on any benefit related matters
- File grievances or appeals regarding the applicant or member's SeniorCare eligibility

To change an authorized representative, the member must complete and submit the SeniorCare Authorization of Representative form to the SeniorCare program.

To remove an authorized representative, the member needs to let the SeniorCare program know of the removal in writing. The member does not need to gather additional signatures from the authorized representative or a witness to complete the removal of an authorized representative. Authorized representatives can also request in writing (for example, a signed statement) to be removed if they no longer want to act as the authorized representative. If an authorized representative is requesting to be removed, a signed statement is not needed by the member. An authorized representative designation is valid on a case until a written and signed request is received for removal.

33.2.5 Guardian and Power of Attorney

If a SeniorCare applicant or member is represented by a legal guardian of the person and the estate, legal guardian of the estate, legal guardian in general, or conservator, the legal guardian or conservator must appoint the authorized representative. If the SeniorCare applicant or member only has a legal guardian of the person, the applicant or member must appoint the legal guardian of the person as an authorized representative if the member or member would like the legal guardian of the person to act on their behalf. If the applicant or member has an agent with power of attorney, the applicant or member can still appoint an authorized representative.

Copies of guardianship or POA documentation must be submitted to the SeniorCare Program before information about the applicant or member can be released to the guardian or POA, unless the POA is the authorized representative. The SeniorCare Authorization of Representative form (F-10080) will be accepted in lieu of the POA papers.

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33.3 Nonfinancial Requirements

33.3.1 SeniorCare Nonfinancial Requirements Introduction

To be non-financially eligible for SeniorCare, an applicant must:

1. Be at least 65 years of age.
2. Be a Wisconsin resident. A Wisconsin resident is an individual who meets at least one of the following criteria: A SeniorCare member may temporarily live outside the state of Wisconsin, as long as they maintain permanent residency in Wisconsin. Residency in a Wisconsin nursing home or an assisted living facility will meet this requirement. There is also not a specific period of time the applicant must be a Wisconsin resident before applying for SeniorCare.
    a) Has a permanent residence in Wisconsin
    b) Is considered a Wisconsin resident for tax purposes
    c) Is a registered voter in Wisconsin
3. Be a U.S. citizen or have qualifying immigrant status. (see Section SECTION 7.1 US CITIZENS AND NATIONALS). An applicant who is a not a U.S. citizen will need to have a qualifying immigrant status to be eligible for SeniorCare (see SECTION 7.3 IMMIGRANTS). The applicant will need to provide his or her immigration registration number. Verification of the applicant's immigration status will be made through the U.S. Citizenship and Immigration Services' Systematic Alien Verification for Entitlements (SAVE) program. In some cases, the individual may need to provide an official government document. For example, if the applicant's immigration status cannot be verified through SAVE or there are discrepancies between reported and verified data, supporting legal documentation must be provided by the applicant.

    If current SSDI, SSI, Medicare, Foster Care, or Adoption Assistance benefits have been verified, the applicant is exempt from documenting their citizenship (see SECTION 7.2 DOCUMENTING CITIZENSHIP AND IDENTITY).
4. Provide an SSN or be willing to apply for one, unless they are exempt from the SSN requirement (see SECTION 10.1.1 SOCIAL SECURITY NUMBER REQUIREMENTS).

    SeniorCare applicants only need to provide a number, which is verified through the data exchange with Social Security. If the SSN validation process returns a mismatch record, then the applicant must provide the Social Security card or another official government document with the SSN displayed. If an applicant does not yet have a SSN, they must be willing to apply for one.

    If an applicant requires assistance in obtaining a SSN, the SeniorCare Program will assist him or her in applying for one. "Assisting the applicant" may include helping with filing the SS-5 SSN Application form, obtaining a birth certificate on behalf of the applicant, or assisting with obtaining another document needed to apply for the SSN.

    SeniorCare applications without the SSN or with an incorrect SSN will not be returned. Applicants will be contacted and given an opportunity to provide a valid SSN or apply for one. The SeniorCare program will honor the original application date for individuals who initially provide an incorrect SSN or who need assistance in applying.

    If the individual is not willing to provide or apply for an SSN or the proof of application is not received within 30 days of application for the SeniorCare application date, eligibility will be denied and any enrollment fee received will be refunded. The individual can reapply once they

are willing to provide or apply for an SSN. The eligibility begin date will be based on the new application receipt date.

The member should be informed if the SSN validation process indicates another individual is using the same SSN. The member should contact the Social Security Administration and request they conduct an investigation. The IM worker cannot provide the member with any information that would identify the individual who is using the member's SSN.

If the Social Security Administration finds that the SSN has been used fraudulently it may: Verify the SSN only once.

a) Recommend further action be taken
and/or
b) Provide the member with the information on the fraudulent action so that the member may pursue action through the legal system.

5. Not be a full-benefit Medicaid member (see SECTION 21.2 FULL-BENEFIT MEDICAID). This includes members who are covered by BadgerCare Plus (see the BadgerCare Plus Handbook).

Individuals are not considered Medicaid members for SeniorCare if they have an unmet Medicaid deductible (see SECTION 24.2 MEDICAID DEDUCTIBLE INTRODUCTION) or receive one of the following:

a) Medicare Savings Program (see SECTION 32.1 MEDICARE SAVINGS PROGRAMS).
b) Tuberculosis (TB) Related Medicaid
c) Family Planning Only Services

6. Not be an inmate of a public institution. An inmate is someone who resides in a public institution on an involuntary basis through operation of law enforcement authorities. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate.

The following individuals are not considered to be inmates for the purposes of SeniorCare:

a) A staff person voluntarily residing in a public institution is not considered an inmate.
b) An individual voluntarily residing in an institution while waiting for other living arrangements to be made that are appropriate to the person's needs.
c) An individual who is legally confined to his or her home by a monitoring device, such as an ankle bracelet.
d) People who are on parole, probation, or have been released to the community pending trial (including those under pre-trial supervision).

A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. This includes correctional facilities operated by or under contract with a governmental unit. A public institution does not include a medical institution (see SECTION 27.1 INSTITUTIONS), a publicly operated community residence that serves no more than 16 residents, or a child care institution in which Foster Care maintenance payments are made under Title IV-E. People residing in these situations are not inmates.

Even though the following institutions may accommodate 16 or fewer residents, they are not considered to be publicly operated community residences. People residing in these institutions

may be inmates if they are residing there on an involuntary basis through operation of law enforcement authorities:

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

Some inmates may be allowed to leave jail for various reasons under the Huber Law, also known as the Huber Program. Huber Law prisoners who are released from jail to attend to the needs of their families can become eligible for SeniorCare if both the following are true:

a) They intended to return to the home.
b) They continue to be involved in the planning for the support and care of their minor children.

Huber Law prisoners who are released for a purpose other than attending to the needs of their families are not eligible for SeniorCare.

7. Cooperate with providing information and/or verification necessary to determine eligibility (see CHAPTER 20 VERIFICATION) and for quality assurance purposes.

   If a person requires assistance in obtaining the required verification, the SeniorCare program will assist him or her.

   If a person is not able to produce the required verification and the SeniorCare program is not able to produce the required verification, the SeniorCare program may not deny assistance.

   If a person is able to produce required verification but refuses or fails to do so, the application will be denied.

33.3.2 Enrollment Fee

In addition to the non-financial requirements listed above, each applicant must pay a $30 annual enrollment fee. The enrollment fee must be paid prior to eligibility confirmation. When a member reapplies for a new benefit period, a new enrollment fee is required.

When a SeniorCare enrollment fee check is returned for non-sufficient funds, the applicant or member is mailed a letter and provided twenty calendar days to submit a replacement check. If a replacement check is not received then eligibility is denied or terminated.

33.3.2.1 Refunds

No Application Received

If EM CAPO receives an enrollment fee without an application, a manual notice and application will be sent, if possible, to the individual from whom the enrollment fee was received. If a SeniorCare application is not received by EM CAPO within 45 days of the receipt of the enrollment fee, a refund will be processed at the request of the person who submitted the enrollment fee.

Application Denied

Anytime an application for SeniorCare is denied, a refund of the paid enrollment fee is automatically issued. A refund may be requested prior to eligibility being confirmed or within specified timelines outlined below.

Opt Out

In all opt-out cases, a refund will be issued only if the request to withdraw from the SeniorCare program is received by the later of:

- Ten days following issuance of the eligibility notice, or
- 30 days from the application filing date.

The date by which a request for refund must be received will be printed on the initial eligibility determination notice. Filing of a hearing request will not delay these deadlines for refunds.

Refunds are based on individual participation. A SeniorCare member may receive an enrollment fee refund if he or she received an initial eligibility notification, but has not received any SeniorCare prescription drug benefits or services and requests to withdraw from the program (see SECTION 33.12.2 WITHDRAWAL).

SeniorCare prescription drug benefits include use of the SeniorCare card to receive discounted drug prices in levels 1, 2a, and 2b. A refund may be issued if such charges are reversed by the pharmacy.

Use of the SeniorCare card at Level 3 where a spenddown has not been met constitutes receipt of SeniorCare prescription drug services. A refund of the enrollment fee may be issued if such claims are reversed by the pharmacy.

Example 1:	Julie is a SeniorCare member at Level 2b. Julie's SeniorCare application filing date was October 26th, and her benefit period began November 1st. On November 15th, Julie calls the SeniorCare Customer Service hotline to withdraw from the SeniorCare program and request a refund of her $30 enrollment fee. Julie used her SeniorCare card on November 10th, when she purchased a prescription. Although Julie requested a refund within 30 days of her application filing date, she is not entitled to a refund, because she received her prescription at a discounted cost by using her SeniorCare card.

Example 2:	Mike is a Level 3 SeniorCare member. Mike's SeniorCare application filing date was October 28th and his benefit period began November 1st. On November 20th, Mike requests to withdraw from the SeniorCare program and that his $30 enrollment fee be refunded to him. Mike used his SeniorCare card on November 18th, when he purchased a prescription; however, he had not met his Level 3 spenddown, so he did not receive a discounted price for his prescription. Mike is entitled to a refund of his enrollment fee if the pharmacy reverses this prescription claim. He made the refund request within 30 days of his application filing date and he has not received any SeniorCare prescription drug benefits or services. If the claims are not reversed, Mike is not entitled to a refund.

33.3.2.2 Refunds to Deceased Members

A refund may also be requested by the family member of a deceased member when all the following criteria are met:

1. He or she received an eligibility notification, and
2. Death occurs prior to the start of or within 30 days of the beginning of the SeniorCare benefit period, and
3. The request is made within 45 days of the date of death; and

4. He or she had not received any SeniorCare prescription drug benefits or services.

Example 3:	Henry was a SeniorCare member at Level 1 whose benefit period began December 1st. Henry passed away on December 4th. His daughter reported Henry's death to the SeniorCare program on December 10th, and requested a refund of his $30 enrollment fee. Henry's SeniorCare card had been used on December 1st to purchase a prescription; however, the pharmacy had reversed those charges on December 5th, since Henry's prescription had not been picked up. The $30 enrollment fee should be refunded in this case since Henry did not receive any SeniorCare prescription drug benefits or services.

Note: *If all of the above conditions are met, a refund will be issued even if the death is reported beyond the refund deadline date.*

33.3.2.3 Opt-In

Once the opt-out of eligibility is confirmed, the participant will have 30-days to contact the EM CAPO if he or she chooses to "opt in" to the program. He or she would need to send another enrollment fee if the original enrollment fee has been refunded. A new application is not required to opt in.

A participant who decides after the 30-day period that he or she wants to rejoin the program will need to complete a new application and submit the enrollment fee.

33.3.3 Age Limitation

SeniorCare is for people who are 65 years of age or older. The earliest SeniorCare eligibility can begin is the month after an applicant's 65th birthday.

A single applicant should apply for SeniorCare no sooner than the calendar month of his or her 65th birthday.

When a couple applies where one spouse is 65 or older and the other is under 65 at the time of application, only the spouse that is 65 or older can be determined eligible. If both apply, the younger spouse would be denied SeniorCare unless they are turning 65 within the current or next calendar month. If the younger spouse will turn 65 within the 12-month enrollment period, they will receive a notice pending their eligibility for the enrollment fee approximately one month prior to their 65th birthday.

33.3.4 Other Insurance

Except for people enrolled in full-benefit Medicaid, applicants who have prescription drug coverage under other health insurance plans, including Medicare Parts B and D, may enroll in SeniorCare. SeniorCare is the payer of last resort except for state-funded-only programs, such as WCDP.

SeniorCare will coordinate benefit coverage with all other health insurance coverage. SeniorCare may also coordinate benefits with pharmacies that accept discount cards. Questions about individual health insurance coverage should be directed to the health insurance company. Questions regarding insurance carriers should be directed to:

Office of Commissioner of Insurance
Bureau of Market Regulation
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517

33.3.5 Creditable Coverage

Wisconsin's SeniorCare prescription drug assistance program is considered to be creditable prescription drug coverage. This means SeniorCare meets or exceeds the standard Medicare Part D plan. If an individual chooses to enroll in SeniorCare instead of Medicare Part D, they will not have a penalty for Medicare Part D.

If an individual is enrolled in SeniorCare, they can keep SeniorCare and not pay extra if they decide to enroll in Medicare Part D later. However, if their SeniorCare coverage ends and they do not enroll in a Medicare Part D plan right away, they may have to pay more to enroll in Medicare Part D at a later date.

If an individual goes without creditable prescription drug coverage for 63 days or longer, their monthly premium for Medicare Part D will go up at least one percent for each month they did not have creditable coverage. For example, if they go nine months without coverage, their premium will always be at least nine percent higher that if they had enrolled in Medicare Part D right away.

If individuals enroll in a Medicare Part D plan, their coverage will typically begin about a month after they enroll. If they need help paying for their prescription drugs and they are enrolled in SeniorCare, they may choose to remain enrolled in SeniorCare until their Medicare Part D coverage begins.

If an individual does not enroll in a Medicare Part D plan when they are eligible, they may have to wait until the next enrollment period before they can enroll. The enrollment period is from October 15 through December 7 each year, and coverage begins January 1.

Individuals with limited income and resources may be able to get extra help paying premiums, deductibles, and copayments for Medicare Part D. They can apply or get more information about Extra Help, also called the Low Income Subsidy, by calling the Social Security Administration at 800-722-1213 or visiting www.socialsecurity.gov/extrahelp.

If applicants have questions about SeniorCare and Medicare Part D, or need help choosing which prescription drug plan is best for them, they should be referred to a benefits specialist at their local aging and disability resource center (ADRC) or the Wisconsin Medigap Part D and Prescription Drug Helpline at 1-855-677-2783.

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33.4 Fiscal Test Group

The FTG consists solely of an applicant, unless the applicant is married and resides with his or her spouse.

If the applicant is married and resides with his or her spouse, the FTG consists of both the applicant and his or her spouse. An applicant is considered to be residing with his or her spouse if the permanent residence of the spouse is the same as that of the applicant.

Exceptions: The FTG consists only of the applicant if:

1. One spouse is institutionalized and is expected to be out of the home for 30 or more days, **or**
2. The applicant's spouse is a SSI recipient, **or**
3. The applicants are married but are living separately, **or**
4. Both spouses are living in a nursing home.

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33.5 Benefit Period

33.5.1 SeniorCare Benefit Period Introduction

The benefit period for SeniorCare is 12 consecutive months. The benefit period and eligibility remain intact unless the member:

1. Moves out of state,
2. Reapplies (33.11 RE-APPLICATION),
3. Requests to withdraw from the program (33.12 EARLY TERMINATION),
4. Dies, **or**
5. Becomes an inmate of a public institution.

Once eligibility has been established, any changes in income will not be considered until the next renewal, unless the individual reapplies for a new benefit period.

33.5.2 ID Cards

When an applicant is found eligible for SeniorCare, he or she is mailed a plastic SeniorCare ID card and information about how to use it. SeniorCare members who renew their eligibility will continue to use their original card.

SeniorCare members must present their SeniorCare card to their pharmacy provider. The card does not show enrollment dates. The pharmacy provider will verify the member's enrollment at each visit.

If SeniorCare members have questions regarding their eligibility status or need a replacement SeniorCare card, they should call the SeniorCare Customer Service hotline at 1-800-657-2038.

33.5.3 Eligibility Begin Date

SeniorCare eligibility begins on the first day of the month following the month in which all eligibility requirements have been met. This includes receipt of a completed application and enrollment fee.

Exception: SeniorCare eligibility begins the day after Medicaid eligibility ends if a SeniorCare application is submitted prior to the Medicaid termination date and all eligibility requirements are met.

Example 1:	Carol applies for SeniorCare on September 19th and meets all eligibility requirements. Her application is processed on October 10th, and eligibility is confirmed the same day. Carol's benefit period is from October 1st through September 30th.

Example 2:	William applied for SeniorCare on September 19th but did not submit the enrollment fee with his application. His eligibility pends and a notice is issued. William submits the fee on October 1st and eligibility is confirmed the same day. William's benefit period is from November 1st through October 31st.

Example 3:	Mary is notified that Medicaid eligibility will end on November 30th because her assets exceed the program limit. She applied for SeniorCare on November 29th and will meet all SeniorCare eligibility requirements on December 1st (when she is no longer a full-benefit Medicaid member). Mary's benefit period is from December 1st through November 30th.

Note: *If a gap in coverage of not more than one month occurs due to an agency error, eligibility for a new 12 month benefit period begins the first of the month the completed application is received and all eligibility requirements are met, including payment of the annual enrollment fee.*

Example 4:	Harold's Renewal Application was mailed to him on December 13th to be completed for his new benefit period that would begin February 1st. The Renewal Application was mailed to the last known address in CARES which belonged to Harold's wife Mary who was in a nursing home. Mary passed away on May 2nd of this year and although the IM worker ended her Medicaid eligibility, the case address was not updated in CARES. Harold has not moved, so he was not required to report a change of address to the SeniorCare program. Due to the incorrect address, Harold did not receive the Renewal Application form to complete until late in January. The completed Renewal Application was received by the SeniorCare program on February 10th, along with a letter explaining why it was late. Harold's new SeniorCare benefit period is February 1st through January 31st, since the one month gap in coverage was due to an agency error.

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33.6 Financial Requirements

33.6.1 Assets

There is no asset test for SeniorCare. In general, cash that is received as a result of converting an asset from one form to another is not income. This includes withdrawals from savings and/or checking accounts, CDs, or money market accounts. However, special provisions apply to retirement benefits (see SECTION 33.6.7 GROSS RETIREMENT INCOME) and Cobell buy-out payments (see SECTION 16.7.11.2 LUMP SUM PAYMENTS UNDER THE SETTLEMENT OF THE COBELL V. SALAZAR CLASS-ACTION TRUST CASE). Income generated from any assets that the SeniorCare participant may have is considered budgetable income and must be reported on the application or renewal application.

Example 1	Eric has a savings account with $5,000 in it. Eric's savings account is considered an asset, but the interest that he anticipates earning is countable income. Eric anticipates withdrawing $1,000 from his savings account during the coming year. This amount does not count as income. It is an asset that has been converted to cash. Only the interest Eric anticipates receiving from the savings account is countable income. Any withdrawals from his savings account are considered the conversion of an asset and are not counted as income.

33.6.2 Income

Income for SeniorCare is based on what the FTG expects to receive in the next 12 month period, beginning with the month of application. The incomes for the applicant and his or her spouse are counted together if they live together. Applicants can use the previous year's information from tax returns or other sources as a guide when estimating what to report on their application. Applicants are asked to round income amounts to the nearest whole dollar when entering their good faith estimates on their SeniorCare application or renewal application.

Social Security income will always be verified. For all other income types, if reported amounts seem unreasonable or questionable, further verification may be obtained from the applicant or other available sources, such as a data exchange.

The income of a spouse who is in the SeniorCare FTG is included in the estimate of the annual, budgetable income even if he or she does not apply or is nonfinancially ineligible. However, the spouse's income is not counted if one of the exceptions noted in SECTION 33.4 FISCAL TEST GROUP APPLIES.

Annual income is determined prospectively from the month of application through the next 12 calendar months. Income exempted for Medicaid eligibility is also exempted for SeniorCare (see SECTION 15.3 EXEMPT AND DISREGARDED INCOME), including EITC and income tax refunds (see SECTION 15.5.7 INCOME TAX REFUNDS).

Budgetable income consists of projected gross annual income, except for self-employment income, which uses net income (see SECTION 33.6.6 SELF-EMPLOYMENT EARNINGS).

In the following income related sections, policy is defined according to the categories on the SeniorCare Application form, F-10076. All income listed in the following sections should be prospectively budgeted for a 12-month period beginning with the month of application.

33.6.3 Gross Social Security

When calculating anticipated gross annual Social Security income, add any deductions for Medicare Part B or D and court-ordered guardianship fees, alimony, and/or child support must be added to the net payment amount.

Exception: If a SeniorCare applicant is receiving Medicare premium assistance (see SECTION 32.1 MEDICARE SAVINGS PROGRAMS), his or her monthly payment already includes the Medicare Part B premium.

The applicant should contact the SSA at 1-800-772-1213 if he or she does not know his or her Medicare premium amount.

When the applicant is a surviving spouse receiving benefits under his or her spouse's Social Security number, the amount should be considered the applicant's income and reported under the applicant's income column of the application.

Social Security income is verified through the Social Security Administration data exchange.

33.6.4 Gross Earnings

Budgetable gross earnings consist of all gross earned income, except for self-employment income, which uses net income (see SECTION 33.6.6 SELF-EMPLOYMENT EARNINGS). Gross earnings include the following:

- AmeriCorps (see SECTION 15.5.9 AMERICORPS)
- Contractual income (see SECTION 15.5.2 CONTRACTUAL INCOME)
- Income in-kind (see SECTION 15.5.1 INCOME IN-KIND)
- Income received by members of a religious order (see SECTION 15.4.16 INCOME RECEIVED BY MEMBERS OF A RELIGIOUS ORDER and SECTION 15.5.12 INCOME RECEIVED BY MEMBERS OF A RELIGIOUS ORDER)
- Jury duty payments (see SECTION 15.5.4 JURY DUTY PAYMENTS)
- Salary
- Severance pay (see SECTION 15.5.11 SEVERANCE PAY)
- Wage advances (see SECTION 15.5.5 WAGE ADVANCES)
- Wages
- Wages and salaries received from a program funded under Title V—Older Americans Act of 1965 (see SECTION 15.5.13 TITLE V—OLDER AMERICANS ACT OF 1965)
- Worker's compensation (see SECTION 15.5.6 WORKER'S COMPENSATION)
- Respite care payment for services

33.6.5 Interest and Dividends

The SeniorCare applicant must report the estimated gross amount of all interest and dividends that they expect to receive in the next 12 months, beginning with the month of application. Sources of interest and dividends include, but are not limited to, the following:

- Bonds
- CDs
- Checking accounts
- Money market accounts
- Savings accounts
- Stocks
- Capital gains (see SECTION 33.6.5.1 CAPITAL GAINS)
- Trusts (see SECTION 33.6.5.2 TRUSTS)
- Annuities
- Land contracts (see SECTION 15.4.7 LAND CONTRACT)
- Loans (see SECTION 15.4.8 LOANS, PROMISSORY NOTES, AND MORTGAGES)

Payments do not need to be directly received. If they are rolled back into the asset, they still must be reported.

Irrevocable interest that a SeniorCare applicant receives for an irrevocable burial trust is not budgetable income.

Note *Unlike Medicaid, income that is received irregularly and infrequently and is under $20 per month should be reported as budgetable income for SeniorCare applicants.*

33.6.5.1 Capital Gains

Budgetable income consists of all anticipated capital gains that would be reportable as capital gains to the IRS for tax purposes. All anticipated losses should be subtracted from the gross capital gains amount, and the net capital gain amount should be reported if it is greater than zero. Negative amounts should not be reported and will not be used to offset other types of income.

The principal or initial investment in the capital asset that the person receives in cash when he or she sells the asset is not considered income. That portion is considered a conversion of an asset from one form to another.

33.6.5.2 Trusts

All anticipated payments (including interest, dividends, and withdrawals from principal) from a trust to the applicant are counted as income.

Irrevocable interest that a SeniorCare applicant receives for an irrevocable burial trust is not budgetable income.

Note *Unlike Medicaid, withdrawals from principal are counted for SeniorCare as income in the month received.*

33.6.5.3 Joint Savings

Each person who is a holder in a joint savings account is assigned an equal share of the interest earned. The applicant or applicant's spouse should report only his or her share of the interest.

If the applicant and his or her spouse are not living together and hold a joint savings account, the applicant should only report his or her share of the interest

33.6.6 Self-Employment Earnings

SeniorCare will budget net self-employment income, which is calculated by deducting allowable business expenses, losses, and depreciation from gross self-employment income (see SECTION 15.6 SELF-EMPLOYMENT INCOME).

If the net self-employment earnings are anticipated to be a loss, the amount should be reported as zero.

Negative amounts should not be reported. Any reported losses will be budgeted as zero and will not be used to offset other income.

33.6.6.1 Rental Income

If rental income is reported to the IRS as self-employment income and is subject to the federal self-employment tax for rental income (usually real estate agents or individuals in a business where extensive services are provided to the renters), depreciation should also be deducted from the gross rental income. Refer to SECTION 15.6.4 SELF-EMPLOYED INCOME SOURCES for more information about rental income for self-employed members.

Refer to SECTION 33.6.8.3 RENTAL INCOME if rental income is not reported as self-employment income.

33.6.7 Gross Retirement Income

Examples of retirement income that should be counted for SeniorCare include:

- Veterans retirement benefits
- Railroad Retirement Board benefits
- The taxable portion of IRAs, annuities, work-related retirement plans, and pensions

Retirement benefits include work-related plans for providing income when employment ends (e.g., pension, disability, or retirement plans administered by an employer or union). Other examples are funds held in an IRA and plans for self-employed individuals, sometimes referred to as Keogh plans.

The funds in retirement accounts, including IRAs, Keogh plans, etc., are assets and are therefore not counted for SeniorCare. However, periodic payments, withdrawals, and distributions the individual expects to receive from their retirement account or annuity in the next 12 months are counted as income. The only exception is when the individual has never previously made withdrawals from the account and he or she withdraws the full amount at one time. This is not considered a periodic payment and is not countable income.

Note *Rolling over an IRA (transferring the funds from one IRA to another) is the conversion of an asset from one form to another. Any potential income from an IRA rollover is countable income for SeniorCare.*

Example 2	Mike owns a $2,000 IRA and plans to withdraw all of it this year. Mike has not withdrawn any money from this IRA in the past. If Mike withdraws the full $2,000 at one time, the $2,000 continues to be considered an asset. This is a conversion from one form of an asset to another. If Mike were planning to make a one-time withdrawal of $1,000 from the $2,000 IRA in the next 12 months, the $1,000 would be considered income. He should report this income on his SeniorCare application and it should be budgeted. If Mike were planning to withdraw $100 monthly from his IRA in the next 12 months, the $100 he plans to receive monthly from the IRA is counted as income. He should report this income on his SeniorCare application and it should be budgeted.

33.6.8 Other Income

Examples of other income are:

- Allocated income from a spouse who is a Medicaid member (see SECTION 33.6.8.1 ALLOCATED INCOME FROM A MEDICAID MEMBER SPOUSE)
- Child support (see SECTION 15.4.14 CHILD SUPPORT)
- Federal farm subsidy (see SECTION 33.6.8.2 FARM SUBSIDY)
- Gifts (see SECTION 15.4.6 GIFTS)
- Profit sharing (see SECTION 15.4.15 PROFIT SHARING),
- Sick/disability benefits (see SECTION 15.4.2 SICK BENEFITS)
- Rental income (see SECTION 33.6.8.3 RENTAL INCOME)
- Unemployment compensation (see SECTION 15.4.3 UNEMPLOYMENT COMPENSATION)
- Veterans disability payments (see SECTION 33.6.8.4 VETERANS DISABILITY)

33.6.8.1 Allocated Income From a Medicaid Member Spouse

A SeniorCare applicant whose spouse is a Medicaid member living outside the home (e.g., in a nursing home) must report the spousal income allocation amount (see SECTION 18.6 SPOUSAL IMPOVERISHMENT INCOME ALLOCATION) as income.

Example 3	Betty is a Medicaid member and in a nursing home. She is allowed to allocate up to $1,000 to her spouse, Carl, according to the notice she receives. Betty only actually has $650 available, and of that, $55 is set aside as her personal needs allowance. The $595 per month that she allocates to Carl would be counted as unearned income for Carl. He would report $7,140 as "Other Income" on his SeniorCare application.

A SeniorCare applicant whose spouse is a Medicaid member living in the home (e.g., a community waivers participant) should not report income that is allocated to him or her. The allocated amount must be included in the income estimate for the Medicaid member spouse because he or she is living in the home.

33.6.8.2 Farm Subsidy

A SeniorCare applicant must report anticipated farm subsidy payments. A SeniorCare applicant must also report payments from CREP, a program where the landowner is paid to install conservation practices for a period of 10–15 years.

33.6.8.3 Rental Income

All expected rental income will be budgeted for SeniorCare. Annual operating expenses should be deducted from the annual amount of gross rental income. Operating expenses include ordinary and necessary expenses, such as insurance, utilities, taxes, advertising for tenants, and repairs. Repairs include expenses, such as repainting, fixing gutters or floors, plastering, and replacing broken windows.

Refer to SECTION 33.6.6.1 RENTAL INCOME if rental income is reported to the IRS as self-employment income.

33.6.8.4 Veterans Benefits

Veterans benefit payments should be reported as income.

Don't count as income any portion of a veterans benefit that is an aid & attendance (A&A) or housebound allowance or is intended to help the beneficiary pay for their unreimbursed medical expenses (see SECTION 15.3.26 VA ALLOWANCES).

An applicant should check with the Department of Veterans Affairs (VA) at 1-800-827-1000 to determine what (if any) amount of their veterans benefit is considered an A&A or housebound allowance or is for unreimbursed medical expenses.

Reimbursement from the VA for medical costs does not count as income.

33.6.9 Disregarded Income

The applicant should not report income anticipated from any of the following:

- Active Corps of Executives (see SECTION 15.3.22 SPECIAL PROGRAMS)
- Adoption assistance payments (see SECTION 15.3.1 ADOPTION ASSISTANCE)
- Agent Orange Settlement Fund payments (see SECTION 15.3.2 AGENT ORANGE SETTLEMENT FUND)
- Disaster and emergency assistance payments made by federal, state, county, and local agencies or other disaster assistance agencies (see SECTION 15.3.5 DISASTER AND EMERGENCY ASSISTANCE)

- Earned Income Tax Credit (see SECTION 16.7.8 EARNED INCOME TAX CREDIT)
- Earnings of a census enumerator (see SECTION 15.3.22 SPECIAL PROGRAMS)
- Emergency Fuel Assistance payments (see SECTION 15.3.22 SPECIAL PROGRAMS)
- Foster care payments (see SECTION 15.3.7 FOSTER CARE)
- Foster Grandparents Program (see SECTION 15.3.22 SPECIAL PROGRAMS)
- Governmental rent or housing subsidies (see SECTION 15.3.22 SPECIAL PROGRAMS)
- Homestead Tax Credit (see SECTION 15.3.22 SPECIAL PROGRAMS)
- Income tax refunds (both state and federal) (see SECTION 16.7.7 INCOME TAX REFUNDS)
- Individual Development Account payments (see SECTION 15.3.9 INDIVIDUAL DEVELOPMENT ACCOUNT PAYMENTS)
- Kinship Care payments (see SECTION 15.3.11 KINSHIP CARE)
- Low-Income Energy Assistance Program (see SECTION 15.3.22 SPECIAL PROGRAMS)
- Older American Community Service Program (except for wages or salaries that are counted) (see SECTION 15.3.22 SPECIAL PROGRAMS)
- Payments made to individuals because of their status as victims of Nazi persecution (see SECTION 15.3.15 PAYMENTS TO NAZI VICTIMS)
- Payments received from the class action settlement of Susan Walker vs. Bayer Corporation. These payments are to hemophiliacs who contracted the HIV virus from contaminated blood products (see SECTION 15.3.24 SUSAN WALKER PAYMENTS).
- Penalty payments made when the state does not correctly process child support refunds
- Radiation Exposure Act program payments made to compensate injury or death due to radiation from nuclear testing and uranium mining (see SECTION 15.3.16 RADIATION EXPOSURE COMPENSATION ACT)
- Reimbursement from private insurance company for medical, LTC, or dependent care expenses (see SECTION 15.3.19 REIMBURSEMENTS)
- Restitution payments to individual Japanese-Americans (or their survivors) and Aleuts who were interned or relocated during World War II (see SECTION 15.3.27 WARTIME RELOCATION OF CITIZENS).
- Retired Senior Volunteer Program (see SECTION 15.3.22 SPECIAL PROGRAMS)
- Reverse mortgage payments (see SECTION 16.7.2.1 REVERSE MORTGAGE)
- Service Corps of Retired Executives (see SECTION 15.3.22 SPECIAL PROGRAMS)
- University Year for Action Program (see SECTION 15.3.22 SPECIAL PROGRAMS)
- Volunteers in Service to America (see SECTION 15.3.22 SPECIAL PROGRAMS)
- W-2 payments for transitional jobs and community service jobs (see SECTION 15.3.28 WISCONSIN WORKS PAYMENTS)
- Wisconsin's Family Support Program (see SECTION 15.3.22 SPECIAL PROGRAMS)
- Payments from Indian Health Services (Note: Payments to Native Americans listed in SECTION 15.3.14 PAYMENTS TO NATIVE AMERICANS must be counted.)

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33.7 Participation Levels

See 39.11 SENIORCARE INCOME LIMITS.

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33.8 Countable Costs

33.8.1 SeniorCare Countable Costs Introduction

In order for the prescription drug purchase to count towards meeting a spenddown or deductible, it must be:

1. Prescribed for the eligible SeniorCare member,
2. Purchased during the benefit period, and
3. Covered by the SeniorCare program (see SECTION 33.6 FINANCIAL REQUIREMENTS).

All covered prescription drug costs the member incurs will be tracked, and the SeniorCare Program will coordinate coverage with other insurance companies if the member has other coverage. If the prescription is covered by other insurance, only the portion not paid by other insurance is applied toward the spenddown or deductible.

When a member's out-of-pocket expense requirements are met for a deductible or spenddown, participating pharmacies will be informed.

33.8.2 Carryover

There is no carryover of prescription costs from one benefit period to the next. There are two instances, within a benefit period, when carryover covered prescription amounts are applied.

1. When the covered prescription cost exceeds the remaining deductible amount, SeniorCare pays the difference.

Example 1:	Jeff earns between 160% and 200% of the FPL for a FTG size of one (39.11 SENIORCARE INCOME LIMITS AND PARTICIPATION LEVELS). He is eligible for SeniorCare and has a $500 deductible. In three months, Jeff has a remaining deductible amount of $30. During the fourth month of his benefit period, with a $30 remaining deductible, Jeff purchases a covered prescription drug that costs $100. The pharmacist informs him that he owes $30 of the $100 prescription drug cost. He has met his deductible. The remaining $70 will be paid by SeniorCare. For the next prescriptions that Jeff has filled during his benefit period, he will pay only co-payment amounts.

2. When the cost of a covered prescription drug is applied toward meeting the spenddown and the amount exceeds the remaining spenddown amount, the excess will be applied toward the deductible.

Example 2:	Rachel's income is $1,800 more than 240% of the FPL for a FTG of one (see SECTION 39.11 SENIORCARE INCOME LIMITS AND PARTICIPATION LEVELS). Her spenddown amount for the 12-month benefit period is $1,800. In four months, Rachel has incurred all but $50 of her spenddown amount by purchasing covered prescription drugs at retail price. During the fifth month of her benefit period when she has $50 of her spenddown left, Rachel purchases a covered prescription drug that costs $100. Rachel pays the full $100. Of the $100, $50 is applied to her spenddown, and $50 is applied to her deductible. She now has satisfied the spenddown, and the remaining deductible amount is $800.

33.8.3 Date of Purchase

A prescription is considered purchased on the date the prescription is filled. For the drug purchase to count toward either the spenddown or the deductible, the prescription must have been purchased during the benefit period.

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33.9 Addition of a Spouse

33.9.1 SeniorCare Addition of a Spouse Introduction

The following exceptions apply when one spouse (hereafter referred to as Spouse 2) is determined eligible after the participating spouse's (hereafter referred to as Spouse 1) benefit period has begun.

In all of these situations, Spouse 1's eligibility and benefit period does not change, unless he or she chooses to reapply (see SECTION 33.11 RE-APPLICATION).

If Spouse 2 becomes eligible after Spouse 1's benefit period has begun, Spouse 2's benefit period ends on the same date that Spouse 1's benefit period ends.

The participation level for Spouse 2 depends on whether:

1. Spouse 2 was married and living with Spouse 1 at the time of Spouse 1's application (see SECTION 33.9.2 ADDING A SPOUSE NO CHANGE IN FTG).
    a) If Spouse 1's eligibility was determined at level 2a or 2b, then refer to 33.9.2 ADDING A SPOUSE NO CHANGE IN FTG.
    b) If Spouse 1's eligibility was determined at level 3 then refer to SECTION 33.9.2.2 ADDING A SPOUSE, NO FTG CHANGE, AT LEVEL 3. Refer to the applicable policy depending on whether or not the spenddown has been met as follows:
        i. Met spenddown (SEE SECTION 33.9.2.2.1 UNMET SPENDDOWN)
        ii. Unmet spend (SEE SECTION 33.9.2.2.2 MET SPENDDOWN)

Or

2. Spouse 2 was not included in the FTG (e.g., single or not living with Spouse 1) at the time of Spouse 1's application. (see Section 33.9.3 FTG CHANGES), but they are now residing together.
    a) If spouse 1's eligibility was determined at level at level 2a or 2b, refer to SECTION 33.9.3.1 FTG CHANGES AT LEVEL 2A AND 2B)
    b) If spouse 1's eligibility was determined at level 3, refer to SECTION 33.9.3.2 FTG CHANGES AT LEVEL 3

See 33.9.4 ADDITION OF A SPOUSE SUMMARY TABLE

33.9.2 Adding a Spouse No Change in FTG

If Spouse 2' s participation level is determined after Spouse 1's and Spouse 2 was included in the original FTG (married and living with Spouse 1 at the time of Spouse 1's application) the participation level for Spouse 2 is determined based on annual income information provided on Spouse 1's application.

Example 1:	Tyler and Anne are married and live together. Tyler has significant prescription drug expenses and applies for SeniorCare. Anne takes no prescription drugs and does not request SeniorCare when Tyler applies in March. Tyler's participation level is based on a FTG of two. Tyler is found eligible, and his benefit period begins April 1st. In September, Anne is diagnosed with a health problem and begins taking prescription drugs. She applies for SeniorCare on September 15th. The same income information provided in March is used to determine Anne's eligibility, even though Tyler has since obtained a part-time job and has additional income. Anne's benefit period is from October 1st through March 31st so her benefit period ends at the same time as Tyler's. They will report the income from Tyler's part-time job when their SeniorCare eligibility is reviewed in March.

33.9.2.1 Adding A Spouse, No FTG Change, At Levels 2a and 2b

Spouse 2's deductible is prorated if the couple's gross annual income is between 160% and 240% of the FPL, and Spouse 2 becomes SeniorCare eligible after Spouse 1's benefit period has begun. To prorate the deductible, multiply the required deductible amount ($500 or $850) by the number of months in Spouse 2's benefit period and divide by 12.

Example 2:	Mary and Jim apply for SeniorCare in January. They have an annual income between 160% and 200% of the FPL for a FTG of two (see SECTION 39.11 SENIORCARE INCOME LIMITS AND PARTICIPATION LEVELS). Their income places them in Level 2a with a $500 deductible. Jim is determined eligible for SeniorCare, but Mary's eligibility for SeniorCare is denied because she is 64. Mary is refunded her enrollment fee. Jim's 12-month benefit period begins February 1st. Jim has a $500 deductible. In June, Mary will turn 65. At adverse action in the month of May, CARES will process this case through batch. At that time, the application status is updated if the applicant who is turning 65 is: 1. In an open SeniorCare case, **and** 2. The individual has requested SeniorCare. A letter is sent to Mary notifying her that if she still wishes to participate in SeniorCare, she must submit her $30 annual enrollment fee. If Mary's enrollment fee is received before July 1st, she will be determined eligible beginning July 1st. Because Mary paid her enrollment fee on July 5th, Mary's benefit period begins August 1st, and ends January 31st, when Jim's benefit period ends. Mary's deductible is prorated. Since there are six months in her benefit period, $500 is multiplied by six and the total is divided by 12. $500 x 6=$3,000/12=$250 Mary's deductible is $250. Once Mary meets the $250 deductible by purchasing covered prescription drugs, she is eligible to purchase covered prescription drugs at the co-payment amounts through the remainder of her benefit period. Jim's eligibility and benefit period are not affected. If the couple's income were between 200% and 240% of the FPL, the example would be the same except that the $500 deductible would be $850.

33.9.2.2 Adding A Spouse, No FTG Change, At level 3

If the couple's income is greater than 240% of the FPL and Spouse 2 becomes eligible after Spouse 1's benefit period has begun, the procedure differs according to whether the spenddown has been met at the time Spouse 2's eligibility begins.

33.9.2.2.1 Unmet Spenddown

When Spouse 2 is added before Spouse 1 has met the spenddown, covered prescription drug purchases of both spouses will count toward the remaining spenddown requirement.

After the spenddown has been met, both spouses begin to participate at Level 2b, and each will have a deductible requirement. The deductible for Spouse 1 is $850. The deductible for Spouse 2 is prorated (33.9.3.1 FTG CHANGES AT LEVEL 2A AND 2B).

Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After a spouse has met his or her deductible, he or she purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period.

Example 3:	Reginald and Elizabeth's joint income is $3,000 more than 240% of the FPL for a FTG of two. Elizabeth applies in December and is determined eligible for SeniorCare effective January 1. Only Elizabeth's covered prescription drug costs are applied toward the spenddown. In March, Reginald turns 65 and is determined eligible for SeniorCare beginning April 1. His benefit period ends December 31, when Elizabeth's ends. Since Elizabeth has not yet met the spenddown when Reginald's eligibility begins, both spouses' covered prescription expenses are applied toward the remaining spenddown amount, beginning April 1. In June, Elizabeth and Reginald meet the spenddown. Elizabeth has a $850 deductible, but Reginald's deductible is prorated. Since there are nine months in his benefit period, $850 is multiplied by nine and the total is divided by 12. $850 x 9 = $7,650/12 = $638 Reginald's deductible is $638. Once Reginald meets the $638 deductible, he purchases covered prescription drugs at the copayment amounts through the remainder of his benefit period. Once Elizabeth meets her $850 deductible, she purchases covered prescription drugs at the copayment amounts through the remainder of the benefit period.

33.9.2.2.2 Met Spenddown

When a second spouse is added after the spenddown has been met, the eligibility and benefit period for Spouse 1 is not affected.

If Spouse 2's income was included in Spouse 1's determination and the spenddown has been met, the deductible for Spouse 2 is prorated (33.9.2.1). Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After a spouse has met his or her deductible, he or she purchases covered prescription drugs at the co-payment amounts for the remainder of the benefit period.

Example 4:	Bob and Bernice's joint income is $1,000 more than 240% of the FPL for a FTG of two. Bernice applies in December and is determined eligible for SeniorCare effective January 1. Bob does not apply because he is not yet 65 years old. Only Bernice's covered prescription drug costs are applied toward the spenddown amount of $1,000. Bernice meets the spenddown requirement in April. She then begins purchasing covered prescription drugs that count toward her $850 deductible. In June, she has $100 left before she will meet her deductible. In May, Bob turns 65 and is determined eligible for SeniorCare. His eligibility begin date is June 1. His benefit period ends December 31, when Bernice's ends. Since Bernice has already met the spenddown requirement, Bob will begin participating at Level 2b. His deductible will be prorated. Since there are seven months in his benefit period, $850 is multiplied by seven and the total is divided by 12. $850 x 7 = $5,950/12 = $496 Bob's deductible is $496. After he meets the $496 deductible by purchasing covered prescription drugs, he purchases covered prescription drugs at copayment amounts for the remainder of his benefit period. Bernice's eligibility and benefit period are not affected. Once she meets her deductible by purchasing another $100 in covered prescription drugs, she purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period.

33.9.3 FTG Changes

When a married SeniorCare participant applies after Spouse 1's benefit period has begun, and Spouse 2 was not included in the FTG when the participation level for Spouse 1 was determined:

1. The gross annual income test for Spouse 2 is based on a FTG of two, **and**

2. Gross annual income for Spouse 2 is determined prospectively beginning with the month Spouse 2's request is received, **and**
3. The eligibility and benefit period for Spouse 1 is not affected, unless he or she chooses to reapply.

Example 5:	Jim is a SeniorCare participant from September through August. Because he was not married and living with a spouse when he applied, Jim's benefit level was based on a FTG of one. In January, Jim marries Helen. Helen applies for SeniorCare in February. Jim's eligibility is not redetermined when Helen applies. Helen's participation level is determined based on a FTG of two. Income is estimated for Helen prospectively for the 12-month period beginning in February. Helen's benefit period begins in March, if she met all eligibility requirements in February. Helen's benefit period ends in August, when Jim's benefit period ends.

33.9.3.1 FTG Changes at Level 2a and 2b

Spouse's 2 deductible is prorated (33.9.3.1 FTG CHANGES AT LEVEL 2A AND 2B) when income for Spouse 2, based on a FTG of two, is determined to be above 160% but less than or equal to 240% of the FPL and Spouse 2 is added to the case after Spouse 1's benefit period has begun.

Example 6:	Will is married, but he and his wife Grace were separated at the time he applied for SeniorCare. Will applies for SeniorCare in October. Will's benefit level is based on a FTG of one, using only his income. Will's gross annual income is less than 160% of the FPL for a FTG of one. Will is determined to be SeniorCare eligible at Level 1 beginning November 1. His 12-month benefit period ends the following October. Will does not pay a deductible or spenddown. He purchases covered prescription drugs at the copayment amounts. Grace returns home in January. She applies for SeniorCare in February and is determined eligible beginning March 1. Grace's benefit level is determined based on a FTG of two. Their joint income is between 200% and 240% of the FPL for a FTG of two. Her benefit period ends October 31st, when Will's benefit period ends. Since there are eight months in her benefit period, Grace's deductible amount is prorated. The deductible amount of $850 is multiplied by eight and then divided by 12. $850 x 8=$6,800/12=$567 Grace's deductible amount is $567. After she has met her deductible, she purchases covered prescription drugs at the copayment amounts for the remainder of the benefit period. Will's eligibility and benefit period are not affected.

33.9.3.2 FTG Changes At Level 3

Spouse 2's spenddown is prorated only if:

1. The income for Spouse 2, based on a FTG of two, is determined to be above 240% of the FPL, **and**
2. Spouse 2 becomes eligible after Spouse 1's benefit period has begun, **and**
3. Spouse 2 was not included in the FTG when the participation level for Spouse # 1 was determined.

To prorate Spouse 2's spenddown, multiply the amount of income exceeding 240% FPL by the number of months of Spouse 2's benefit period and divide by 12. The result is equal to the prorated spenddown amount of Spouse 2. Only covered prescription drug costs of Spouse 2 count toward the prorated spenddown.

After the spenddown has been met, the deductible for Spouse 2 is prorated (33.9.3.1 FTG CHANGES AT LEVEL 2A AND 2B). Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After the deductible is met, he or she purchases covered remainder of the benefit period.

Example 7:	Tim is married, but his wife Marsha was institutionalized at the time he applied for SeniorCare. Marsha was expected to be out of the home for five months. Tim applies for SeniorCare in May. Tim's benefit level is based on a FTG of one. Tim's gross annual income is less than 160% of the FPL for a FTG of one. Tim is determined to be SeniorCare eligible beginning June 1. His 12-month benefit period ends the following May. Tim does not pay a deductible or spenddown. He purchases covered prescription drugs at the copayment amounts. Tim's wife Marsha returns home in November. She applies for SeniorCare in November and is determined eligible beginning December 1. Marsha's participation level is determined based on a FTG of two. Their joint income is $1,000 above 240% of the FPL for a FTG of two. Her benefit period ends May 31, when Tim's benefit period ends. Since there are six months in her benefit period, Marsha's spenddown amount is prorated. The spenddown amount of $1,000 is multiplied by six and then divided by 12. $1,000 x 6=$6,000/12=$500 Marsha's spenddown amount is $500. After she has met her spenddown, she then has a prorated deductible. Since there are six months in her benefit period, $850 is multiplied by six and then divided by 12. $850x 6=$5,100/12=$425 Marsha pays for covered prescription drugs until she has met the $425 deductible. After Marsha has met the deductible, she purchases covered prescription drugs at the copayment amounts for the remainder of benefit period. Tim's eligibility and benefit period are not affected.

33.9.4 Addition of a Spouse Summary Table

The following table assumes that Spouse 1 and Spouse 2 do not apply for SeniorCare at the same time.

	SPOUSE 1's Eligibility	**SPOUSE 2's Eligibility**
Benefit Period: **Begin Date**	First of month following receipt of a valid application and enrollment fee.	First of month following receipt of a valid application and enrollment fee. Will be later than Spouse 1's begin date.
Benefit Period: **End Date**	End of twelfth month of eligibility unless terminated early.	Same end date as Spouse 1 regardless of when Spouse 2 applies.
Participation Level: **Married at time of Spouse 1's application**	FTG of two. Participation Level determined based on annual income of both spouses.	FTG of two. Participation Level determined based on annual income from Spouse 1's application. Eligibility results will be the same as Spouse 1.
Participation Level: **Single or not living together at time of Spouse 1's application.**	Gross annual income test based on a FTG of one. When adding a new spouse, Spouse 1 does not need to reapply until the end of the twelve-month benefit period	Gross annual income test based on a FTG of two. Participation Level determined based on annual income of both spouses. Participation Level may be different than Spouse 1's. Spouse 2 must estimate income at the time he or she applies. Spouse 1's income remains the same.

	unless he or she chooses to do so.	
Deductible:	Has a $500/$850 deductible based on Participation Level.	Required deductible is prorated based on number of months of eligibility and amount of deductible.
Spenddown: **Unmet** **Original FTG of 2**	Covered prescription drugs of Spouse 1 used to meet spenddown until Spouse 2 is added. Once spenddown is met, Spouse 1 has a deductible of $850.	Projected income from Spouse 1's application will be used to determine Spouse 2's eligibility. Covered prescription drugs of both spouses are used to meet the spenddown. Once spenddown is met, Spouse 2 has a prorated deductible.
Spenddown: **Met** **Original FTG of 2**	No change in spenddown for Spouse 1.	No new spenddown when Spouse 2 is added. Spouse 2 has a prorated deductible.
Spenddown: **Unmet** **Original FTG of 1**	No change in spenddown for Spouse 1.	Spouse 2 has a prorated spenddown and deductible.
Spenddown: **Met** **Original FTG of 1**	No change in spenddown for Spouse 1.	Spouse 2 has a prorated spenddown and deductible.

Note *If Spouse 1's eligibility is terminated prior to Spouse 2's request, a new application is required for a new 12-month benefit period.*

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33.10 Changes

33.10.1 SeniorCare Changes Introduction

The following changes must be reported to the SeniorCare program within 10 days:

1. Address (including a change in mailing address or permanent residency outside of Wisconsin).
2. Household Composition (including marriage, divorce, separation, or someone moving to a nursing home or other medical facility).
3. Death.

Changes may be reported by phone to the SeniorCare Customer Service hotline at 1-800-657-2038.

Changes may also be reported by writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Members are asked to include an SSN or case number on any written correspondence.

If an individual reports any changes before the case has been confirmed in CARES, the new information will be used in his or her SeniorCare eligibility determination.

Changes reported after the case has been confirmed in CARES will be applied to the member's SeniorCare benefits as follows:

1. Address change:
    a) Reports of address changes within Wisconsin will result in SeniorCare notices being sent to the new address. SeniorCare benefit levels will not change for the current benefit period.
    b) Address changes that result in termination of Wisconsin residency result in discontinuation of SeniorCare benefits. The member will be provided with at least 10 days notice before the effective date of an adverse action

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Note: *Reporting an out-of-state address does not necessarily signify that an applicant is not a Wisconsin resident (see SECTION 33.3 SENIORCARE NONFINANCIAL REQUIREMENTS).*

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2. Death
    If a member passes away, their SeniorCare eligibility will end as of the notice date.
    If a member's spouse dies, the member will remain eligible at the same benefit level through the current SeniorCare benefit period. The member may wish to re-apply to establish a new benefit level if the spouse's death will result in a reduction in income.
3. Change in household composition
    If a member experiences a change in household composition, the SeniorCare benefit level will not change through the remainder of the SeniorCare benefit period. The member may wish to re-apply to establish a new benefit level if the change in household composition will result in a better level of participation.
4. Inmate of a Public Institution (see SECTION 33.3.1 SENIORCARE NONFINANCIAL REQUIREMENTS INTRODUCTION, NUMBER 6).
    If a member becomes an inmate of a public institution, their SeniorCare eligibility will end as of the notice date.

If a member's spouse is an inmate of a public institution the member benefit level will remain eligible as the same benefit level through the current SeniorCare benefit period. The member may wish to re-apply to establish a new benefit level if the spouse's incarceration will result in a better level of participation.

5. Change in Circumstance

   If an applicant needs to correct their application, or has a change in circumstances during the application processing period, they may need to report this information before their eligibility is determined in order to have the change impact their SeniorCare eligibility and participation level.

   Depending on the nature of a client-reported error or agency-discovered error, a member's eligibility will be redetermined (see SECTION 33.10.2 CORRECTION OF ERRORS). The member will be provided with at least 10 days notice before the effective date of an adverse action.

   If the case has already been confirmed in CARES, and the individual reports a change in circumstances since they applied (for example, a job loss), eligibility will not be redetermined. The applicant may opt out and reapply if they so desire.

Example 1:	Sally and Fred are husband and wife and applied for SeniorCare in July. Both Sally and Fred were found eligible at Level 2a with a deductible for August. In September, Fred loses his job. He reports the change to the SeniorCare program. This change will not affect Sally or Fred's SeniorCare benefits, because Fred reported the change after his case had been confirmed in CARES. If Fred had reported the change prior to his case being confirmed in CARES, the change would have been applied to Sally and Fred's eligibility determination, and they would have paid the co-payment amounts for prescription drugs. If Fred and Sally wish, they may request to file a reapplication (see SECTION 33.11 RE-APPLICATION) and submit enrollment fees to have their eligibility redetermined and change their benefit level. Without the income from Fred's job, Sally and Fred would be able to purchase prescription drugs at the co-payment level, if a reapplication is filed.

33.10.2 Correction of Errors

All errors made on the SeniorCare Application (F -10076) must be reported by the member or his or her Authorized Representative, POA, or Guardian to the SeniorCare Customer Services hotline at 1-800-657-2038 (TTY and translation services are available) or in writing to:

SeniorCare
P.O. Box 671
Madison, WI 53716-0710

An error may include, but is not limited to:

1. Doubling of income (for example, totaling income on the application incorrectly).
2. Incorrect entries (for example, income amounts are off by a factor of 100 due to the lack of decimal point).
3. Application processing errors.

An applicant who wishes to report a change in circumstances from what was on his or her submitted application may do so, but to impact eligibility, this change should be reported prior to eligibility being confirmed in CARES (see SECTION 33.10.1 #5 CHANGE IN CIRCUMSTANCE).

If a member has been found eligible for either an incorrect SeniorCare benefit level or spenddown amount due to an error, action will be taken to correct the mistake. The effective date of the correction is based on whether the error is determined to be due to agency error or Applicant/Member error, as follows.

33.10.2.1 Agency Error

Agency errors for SeniorCare will be determined on a case by case basis. If the error resulted in an overpayment, past benefits are not recoverable. If the error resulted in an underpayment, corrected benefits will be restored back to initial eligibility date of the current benefit period.

33.10.2.2 Applicant or Member Error

If an applicant or member error resulted in an overpayment, benefit recovery will be pursued, and the correction is processed with an effective date based on adverse action notice. The member will be provided with at least 10 days notice before the effective date of an adverse action.

If the error resulted in an underpayment and he or she reported the error within 45 days of the mail date of the notice of decision, corrected benefits should be restored back to the initial eligibility date of the benefit period. If the error is not reported within 45 days of the notice of decision mail date, the effective date of the correction is the first of the month in which the error is reported.

Example 2:	In August, Charlie lost this job at the Burger Palace. In September, Charlie applied for SeniorCare. In his application, Charlie erroneously reported income of $1150 per month from the Burger Palace job. Charlie's notice of decision had a mail date of October 1, and stated that Charlie had a $1500 spenddown. Depending on when Charlie reports this error, his benefits may be corrected back to the eligibility begin date or the first month in which the error was reported (see SECTION 33.10.2 CORRECTION OF ERRORS). If he reported the error by November 15, within the first 45 days after the notice of decision mail date, his benefits would be corrected back to the original effective date. If he reported the error November 16 or later (more than 45 days after the notice of decision mail date), the benefit level change would be made effective the first of the month in which the error was reported.

Example 3:	Eric applied for SeniorCare in July and was determined eligible at level 1 effective August 1. Prior to applying for SeniorCare, Eric got a part-time job that had begun in June. When Eric applied for SeniorCare, he neglected to report his anticipated part-time earnings on the SeniorCare application. Eric receives his notice of decision, dated August 8. The notice informs him that he is eligible at level 1. Eric reviews the income used in his eligibility determination that is printed in the notice and realizes that he forgot to report the earnings from his part-time job. He calls the SeniorCare Customer Service hotline on August 21 to report his error. Eric indicates that he is working 10 hours per week and earns $10 per hour. He plans to keep the job as long as possible. He estimates that his earnings will be $5,200 for his 12-month benefit period. The only other income that Eric receives is Social Security. His earnings in addition to the annual Social Security income move him from level 1 to level 2b. Since the income correction will result in a negative impact on his eligibility, the effective date of the corrective benefit is October 1, providing Eric with a 10-day notice of the negative action in his case. Prior to reporting this mistake, Eric had purchased several prescriptions at the copayment levels with his SeniorCare card. Since the correction resulted in Eric's eligibility at level 2b, he must now meet an $850 deductible between October 1 and July 31 (the end of his 12-month benefit period). SeniorCare will have overpaid Eric's benefits and could seek recovery of the overpaid amount.

33.10.3 Fraud

Fraud is defined as intentionally getting or helping another person get benefits to which he or she is not entitled. Penalties for fraud include a fine of up to $10,000, imprisonment up to one year, or both, and suspension from the SeniorCare program.

Fraudulent acts include:

1. Intent to provide misleading, fraudulent, omitted, or incomplete information on the SeniorCare application;
2. Not reporting an event that knowingly affects initial or continued eligibility for SeniorCare;
3. Applying for SeniorCare on behalf of another person and use of any part of the benefit for oneself;
4. Allowing another person to use someone else's card to get prescription drugs.

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33.11 Re-Application

SeniorCare participants may request to establish a new SeniorCare benefit period at any time. However, it is not beneficial for a SeniorCare participant to reapply unless he or she will experience a reduction in gross annual income. The reduction in annual income may occur for reasons varying from loss of income to household composition changes. This could result in SeniorCare eligibility at a lower income level resulting in a reduction/elimination of spenddown or deductible.

Such a change may result from divorce, marriage, institutionalization or death of a spouse, or any other change that results in a significant decrease in income.

To reapply, participants must submit a new application form and pay a $30 enrollment fee per person. Eligibility will be redetermined for a new 12-month period (within 30 days) after a complete application is received.

When eligibility for a new benefit period is determined, the participant's previous benefit period is terminated, and he or she is not allowed to restart the previous benefit period. Any expenses applied to the previous benefit period will not be applied to the new benefit period.

Eligibility for a new benefit period begins on the first day of the month after a complete application is received and all eligibility requirements are met.

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33.12 Early Termination

33.12.1 SeniorCare Early Termination

SeniorCare eligibility is terminated prior to the end of the established benefit period if:

1. A member no longer meets non-financial eligibility requirements, or
2. S/he requests to withdraw from the program, or
3. S/he requests to establish a new benefit period and eligibility for the new benefit period is confirmed (see SECTION 33.11 RE-APPLICATION).

When SeniorCare eligibility has been terminated prior to the end of the established benefit period and the SeniorCare Program is notified that all eligibility requirements are again satisfied, within one calendar month of SeniorCare eligibility termination, the benefit period is restored.

Exception: SeniorCare members who lose SeniorCare eligibility solely due to receipt of Medicaid benefits do not have their benefit period terminated; however, they are not eligible for SeniorCare benefits or services for the calendar months that they receive Medicaid benefits.

If Medicaid eligibility ends prior to the end of the SeniorCare benefit period, and the member is still SeniorCare eligible, SeniorCare eligibility automatically resumes.

Example 1:	Amy applies for SeniorCare on October 4th and is determined eligible effective November 1st. In December she applies for Medicaid and is determined eligible, effective December 1st. Amy is not eligible for SeniorCare benefits or services while she is receiving Medicaid. In January, Amy inherits $5,000 and is notified that her Medicaid eligibility ends January 31st, because her assets exceed the limit. Amy still meets SeniorCare eligibility requirements, so SeniorCare eligibility will resume from February 1st through October 31st.

See SECTION 33.15 ANNUAL ELIGIBILITY REVIEW for termination as it applies to the need for an annual review.

33.12.2 Withdrawal

Applicants or participants may withdraw from the SeniorCare Program at any time. To withdraw by phone, call the SeniorCare Customer Service Hotline at 1-800-657-2038.

A request to withdraw can be made in writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

A SeniorCare participant is eligible for an enrollment fee refund only if he or she meets the requirements listed in 33.3.2.1 REFUNDS.

If an applicant chooses to withdraw his or her application prior to eligibility confirmation, he or she will get a refund. If he or she later wishes to “opt in”, he or she will have to re-apply. To re-apply, a new application and enrollment fee are required.

Once eligible, if a participant chooses to “opt-out” and SeniorCare receives the request to withdraw within the timeframe for obtaining a refund, he or she will get a refund of the original enrollment fee. If, within thirty calendar days of opting out, the participant requests to opt in, he or she would need to

send in another enrollment fee but would not have to send in another application form. Eligibility will be restored back to the beginning of his or her benefit period, once the fee is received and processed.

The enrollment fee must be received by the deadline identified in the CARES notice to comply with the administrative rule requirement that he or she meets eligibility requirements. If within thirty calendar days of opting out he or she does not contact SeniorCare and SeniorCare does not receive the enrollment fee, he or she will have to submit a new application and another $30 enrollment fee if he or she wants to come back into the program.

If the participant chooses to opt-out and does not do so within the timeframe for obtaining a refund, he or she will not get a refund. Customer Service should counsel the participant that he or she will not be getting a refund, and he or she can keep his or her case open in the event his or her circumstances change and he or she wants to use the SeniorCare benefit in the next 12 months.

If the participant still opts out, but contacts SeniorCare within thirty calendar days of opting out to request to opt in, the original enrollment fee that had not been refunded will be applied. He or she will not have to send in another application form. The person will be made eligible back to their original eligibility begin date for that benefit period. This requires a manual work-around because the system will require another $30 enrollment fee to be credited for CARES to process correctly.

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33.13 Notice of Decision

A written notice is sent to the applicant indicating SeniorCare certification, benefit reduction, denial, or termination.

The initial notice of decision will provide information regarding total income used for determining the participation level. It will also provide the member with information regarding spenddown, deductible and co-payment amounts.

For reductions, denials, or terminations, the notice contains reasons for the action, with any supporting regulations. It also specifies fair hearing rights and the circumstances under which SeniorCare benefits will be continued if a hearing is requested.

SeniorCare members will be notified of an adverse action at least 10 days prior to the effective date of the adverse action, except under certain circumstances.

Timely notice requirements do not apply when:

1. A prescription drug billing must be reversed due to an incorrect billing, and that reversal results in a benefit or service change.
2. A member chooses to withdraw from the program.
3. A member requests to establish a new benefit period and eligibility for the previous benefit period is terminated (see SECTION 33.11 RE-APPLICATION).
4. A person is an inmate of a public institution.
5. A member passes away.

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33.14 Appeals

33.14.1 SeniorCare Appeals Introduction

SeniorCare applicants, participants or representatives may file an appeal by writing to the Division of Hearings and Appeals (DHA) when one of the following occurs and the action is not the result of a general program policy change:

1. An application is denied, or the person is denied the right to apply.
2. An application is not acted upon within thirty calendar days.
3. A participant believes that the benefits he or she received, or the initial eligibility date of program benefits were not properly determined.
4. Program benefits are reduced, discontinued, suspended, or terminated.

An appeal may result in a hearing.

33.14.2 Requesting a Hearing

The SeniorCare applicant or participant, or his or her representative, may request a hearing. The request for a hearing must be made in writing to the DHA within 45 days from the effective date of the adverse action .

Benefits will be continued only if the participant requests a hearing prior to the effective date of the adverse action.

Hearings may be requested by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
PO Box 7875
Madison, WI 53707-7875

33.14.3 Hearing

The hearing will be held at a location determined by the DHA.

Hearings will be:

1. Held at a time reasonably convenient to the petitioner, department or agency staff and the administrative law judge.
2. Reasonably accessible to the petitioner.
3. Held on department or agency premises, subject to the judgement of the administrative law judge.
4. Accessible to those in need of accommodations for a disability or translation. For information about an accommodation for a disability or translation for a hearing, call 1-608-266-3096.

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33.15 Annual Eligibility Renewal

An annual eligibility review is required for each participant by the end of the current 12 month benefit period to prevent a gap in coverage.

Members are mailed a preprinted Renewal Application and instructions approximately six weeks prior to the end of their current benefit period. The Renewal Application is preprinted with the information currently on file for the member. Members are required to review the information for accuracy, make any necessary changes, answer any questions, and return the signed form with their enrollment fee.

Eligibility for a new benefit period begins on the first day of the month immediately following the end of the previous benefit period when:

1. A valid pre-printed Renewal Application or new application form (F-10076) is received by the end of the current benefit period, and
2. All eligibility requirements are met, including payment of the $30 annual enrollment fee per person.

Note: *For the definition of "valid," see SECTION 3.2.2 APPLICATION PROCESSING.*

33.15.1 Maintaining SeniorCare Coverage During Regularly Scheduled Renewals

When a timely renewal is submitted, a SeniorCare member's health care coverage must be maintained while their renewal is being processed. A timely renewal is one received during the renewal month, including renewals received after adverse action but on or before the last business day of the renewal month.

Members whose eligibility cannot be administratively renewed, and who do not submit their renewal by adverse action of the renewal month, will be notified that their coverage is ending at the end of the renewal month. They will be sent a notice of decision explaining that they are being disenrolled for failure to complete their renewal, in accordance with timely notice requirements.

However, if the member's renewal is received after adverse action but by the end of the renewal month during business hours, their current coverage will be reinstated for the following month and will be maintained until the renewal is processed. The member will be notified of the reinstatement.

Example 1	Anne and Horace are a married couple enrolled in SeniorCare. January is the last month of their certification period, and their renewal is due on January 12. They do not submit the renewal by the due date. On January 17, a notice is sent to inform them that their SeniorCare coverage will end January 31 because they did not complete their renewal. Their renewal is received on January 31 during business hours. Anne and Horace's SeniorCare coverage is reinstated for the month of February, and they are sent a notice that they are enrolled in SeniorCare effective February 1 and will remain enrolled while their renewal is being processed. On February 9, EMCAPO finishes processing the renewal and Anne and Horace remain eligible for SeniorCare. A new 12-month certification period is established beginning on March 1.

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33.16 Benefits

33.16.1 SeniorCare Benefits Introduction

For all of the participation levels, SeniorCare allows the following:

1. The generic form of any covered prescription drug, unless the medical practitioner writes on the prescription that the brand name form of the covered prescription drug is medically necessary.
2. Insulins are the only general category of over-the-counter drugs that are covered.
3. For levels 1 and 2a all prescription drugs covered by Medicaid. Some limitations apply to prescription drug coverage for levels 2b and 3 if a rebate agreement has not been signed by the drug manufacturer.
4. Chemotherapy drugs that are FDA approved and the manufacturer has signed a rebate agreement.
5. Certain vaccines. For a list of covered vaccines, see SeniorCare Vaccines.

Most prescriptions are limited to a 34-day supply of medication. There are a few classes of medications that are allowed to be filled as a three-month supply. Members should work with their pharmacist and prescriber to determine whether it is clinically appropriate to dispense a three-month supply. The co-payment amount is not affected by the number of days in the supply.

Note *Some drugs require prior approval from the SeniorCare program, called prior authorization.*

Note *The member should contact his or her provider to verify that SeniorCare covers a specific drug.*

SeniorCare does not cover the following:

1. Prescription drugs administered in a physician's office.
2. Prescription drugs that are experimental or are for a cosmetic and not a medical purpose.
3. Over-the-counter drugs such as vitamins and aspirin, even with a prescription.
4. Prescription drugs for which authorization has been denied.
5. Prescription drugs from manufacturers who have not signed the appropriate rebate agreement;
    a) Prescription drugs for members in levels 1 and 2a are limited to drugs from manufacturers who have signed a federal rebate agreement.
    b) Prescription drugs for members in levels 2b and 3 are limited to drugs from manufacturers who have signed a SeniorCare rebate agreement with the state of Wisconsin.
6. Drugs that have not been dispensed from a pharmacy.

If a member chooses to purchase a prescription that is not covered under SeniorCare, they are responsible for the cost at the pharmacy's retail price and it will not count towards their spenddown and/or deductible.

SeniorCare provides medication therapy management (MTM) services. The MTM services are provided by the pharmacist to answer the member's questions about the drugs they get. The goal of MTM services is to help the member understand more about the drugs they take, make sure they are taking their drugs properly, and make sure they are only taking drugs they need.

33.16.2 Discount Pricing

The discount for a particular drug during the deductible period will be the same at every pharmacy. During the deductible period, the pharmacy must use the SeniorCare allowed price.

Exception: If a pharmacy's usual and customary charge is less than the SeniorCare allowed amount, then the participant would be charged the usual and customary charge and this amount will apply to SeniorCare spenddown and/or deductible.

33.16.3 Early Refills

When the participant is temporarily leaving the state and the supply on his or her prescriptions is insufficient, he or she will need to make arrangements with the pharmacist to have any additional refills mailed or have someone else pick-up the refill. Postage costs are not covered by SeniorCare, nor do they count toward the deductible and/or spenddown. Requests for early refills will be denied.

33.16.4 Out-of-State Pharmacies

In an emergency, a participant can get a prescription filled out of state and have it count toward SeniorCare as long as the participant is within the US, Canada, or Mexico and the pharmacy completes the necessary forms.

Out-of-state pharmacies should contact 1-800-947-9627 to file a claim for reimbursement. Non-emergency prescriptions will be covered only when prior authorization has been granted.

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34 Emergency Services

34.1 Emergency Services

34.1.1 Emergency Services Eligibility Introduction

Emergency Services Medicaid is a limited benefit for immigrants who do not qualify for other forms of Medicaid because of their immigration status.

An immigrant who is ineligible for Medicaid because of their immigration status is eligible for Emergency Services Medicaid coverage if they:

- Have a qualifying emergency medical condition.
- Meet all the eligibility requirements of any Medicaid category under the state plan except
    - U.S. citizenship or qualifying immigrant status.
    - Having or applying for an SSN.

See BadgerCare Plus Handbook, SECTION 39.1 EMERGENCY SERVICES INTRODUCTION for information about Emergency Services for non-qualifying immigrants who are not elderly, blind, or disabled.

An inmate who is a non-qualifying immigrant may be eligible for Emergency Services for the dates they are hospitalized as an inpatient for emergency treatment as long as they meet the rest of the eligibility criteria for Emergency Services.

A person can be eligible for Emergency Services for an emergency that occurred within the three months prior to the application month as long as the person met the eligibility requirements for Emergency Services during the month(s) in which the emergency occurred.

Emergency Services only covers medical services needed for the treatment of an emergency medical condition. Services related to organ transplant procedure are not covered by Emergency Services.

An emergency means a medical condition (including labor and delivery) that shows acute symptoms of sufficient severity (including severe pain) such that the lack of immediate Medicaid could result in one or more of the following:

1. Serious jeopardy to the patient's health.
2. Serious impairment to bodily functions.
3. Serious dysfunction of a bodily organ or part.

All labor and delivery services are emergency services and are covered under Emergency Services for eligible non-qualifying immigrants.

The IM agency does not determine if an emergency condition is eligible for Emergency Services coverage.

The medical provider submits claims for emergency medical services to the fiscal agent. It determines if a condition is an emergency medical condition covered by Emergency Services.

A U.S. citizen is not eligible for Medicaid Emergency Services even when they cannot produce citizenship and/or identity verification.

Example 1	Jill applies for Medicaid, declares U.S. citizenship, and is asked to provide documents proving her citizenship and identity. She has a driver license to prove identity but does not have anything to prove her citizenship. Since Emergency Services Medicaid does not require proof of citizenship and identity as an eligibility requirement, she then asks to be considered for this program. However, the IM worker cannot process Emergency Services Medicaid eligibility for persons declaring to be U.S. citizens. Emergency Services Medicaid is reserved for non-qualifying non-citizens.

34.1.2 Determination of Emergency Services Eligibility

Certification of Emergency Services is not done by CARES and must be done manually. Emergency Services coverage lasts from the time of the first treatment for the emergency until the condition is no longer an emergency for adults or the end of a 12-month period for children under age 19.

Local agencies do not determine if an emergency exists. Local agency responsibility is to determine if the non-qualifying immigrant meets all other eligibility requirements during the dates of service and to certify if they are eligible for Emergency Services.

If a non-qualifying immigrant provides a Certification of Emergency for Non-U.S. Citizens form (F-01162) at the time of application, determine their eligibility for Emergency Services for the dates of the emergency indicated on the form (unless a child under age 19). If a non-qualifying immigrant does not have the form at the time of application, ask them for the dates that they received emergency services. The F-01162 is not required to certify Emergency Services eligibility.

Persons applying for Emergency Services have the same rights and responsibilities as persons applying for regular Medicaid. They must meet the eligibility requirements for their type of Medicaid, such as being elderly, blind, or disabled,* and provide required verifications. The IM agency must provide a manual positive or negative notice regarding the applicant's eligibility. Positive notices must provide the dates of eligibility for Emergency Services. Negative notices must provide the reason(s) for the denial or termination.

*If a non-qualifying immigrant would only qualify for Medicaid if they were disabled, the normal disability determination procedures (including presumptive disability) are followed before Emergency Services eligibility is certified.

Note *Emergency Services has the same policies on referrals to child support agencies (CSA) and cooperation as Medicaid (see CHAPTER 8 MEDICAL SUPPORT).*

34.1.2.1 Medicaid Deductible

Individuals may become eligible for Emergency Services by meeting the Medicaid deductible. If, on the date they apply, they are otherwise eligible except for excess income, normal deductible policies (see SECTION 24.2 MEDICAID DEDUCTIBLE INTRODUCTION) are applicable.

34.1.3 Certification of Emergency Services Eligibility

Individuals enrolled in Emergency Services will be eligible until:

- For adults age 19 and older, the last day of the emergency.
- For children under age 19, the end of a 12-month period.
- For a child who is turning 19 in the next 12-month period, the last day of the emergency or the last day or the month the child turns 19, whichever is later.

For adults age 19 and older, if the last day of the emergency is not known, they are eligible through the last day of the month in which the emergency is expected to end.

For information on manually processing applications, see Process Help, Section 9.3 Health Care (BC+ and MA) Emergency Services Manual Application Processing. For information on manually processing renewals for members who have an ongoing emergency condition, see Process Help, Section 26.1 Manual Renewal Report.

A person eligible for Emergency Services will not receive a ForwardHealth card because Emergency Services eligibility typically ends when the emergency ends.

34.1.4 BadgerCare Plus Emergency Services

For Emergency Services for children, parents, caretakers, and pregnant women, see the BadgerCare Plus Handbook Chapter 39.1 Emergency Services and Chapter 41.1 BadgerCare Plus Prenatal Program.

34.1.5 Emergency Services and Public Charge

Emergency Services is not considered in public charge determinations (see SECTION 7.3.4 PUBLIC CHARGE).

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35 Long Term Care Insurance Partnership (LTCIP)

35.1 Long Term Care Insurance Partnership (LTCIP)

35.1.1 LTCIP Introduction

The Wisconsin Long-Term Care Insurance Partnership (LTCIP) is a joint effort between the federal Medicaid Program, long-term care insurers, and the Wisconsin Department of Health Services (DHS) and Office of the Commissioner of Insurance (OCI). The program's main purpose is to provide an incentive for people to plan for meeting their future long-term care needs, whether in a community-based setting such as their own home, or in a nursing home.

35.1.2 LTCIP Asset Disregard

The LTCIP allows a person with a qualified long-term care insurance policy to have assets disregarded in the Medicaid eligibility determination, while at the same time protecting those assets from Medicaid estate recovery. Under the LTCIP, assets are disregarded when determining eligibility for EBD Medicaid programs, or any of the programs for Medicare beneficiaries (i.e., QMB, SLMB, SLMB+, QDWI), up to the total amount of long-term care services paid by the qualified WI LTCIP policy on or after January 1, 2009. The amount paid out by the qualified LTCIP policy on or after January 1, 2009 is not counted toward the WI Medicaid asset limit, nor is it recoverable under the estate recovery program.

Maximum Disregard

The maximum amount that can be disregarded for the purpose of Medicaid eligibility, or protected from estate recovery, is the verified amount of benefits paid out by the qualified WI LTCIP policy on or after January 1, 2009.

The disregarded asset amount is still counted in the Asset Assessment when determining the Community Spouse Asset Share (CSAS) in a Spousal Impoverishment case. However, the disregarded asset amount is not counted in the individual's eligibility determination.

The disregarded amount is exempt from divestment policies, i.e., transferring assets for less than fair market value up to the LTCIP payout amount will not result in a divestment penalty. However, a divestment may result in a reduction or elimination of the Medicaid eligibility and estate recovery protections under the LTCIP. See 35.1.3.3 for more information regarding the disregard.

35.1.3 Verification

Verify the following items as described.

35.1.3.1 Verification of the Qualified LTCIP Policy

A "qualified LTCIP policy" must meet all relevant requirements of federal and state law. Qualified LTCIP policies are certified by the Wisconsin Office of the Commissioner of Insurance (OCI).

OCI certification of the policy must be verified by assuring that the policy is in the "Long-Term Care Insurance Partnership Program (LTCIP)" section of the Long-Term Care page on the OCI website.

35.1.3.2 Reciprocity Standards

Participation in Wisconsin's LTCIP program is allowed for individuals who purchased qualified policies in any state that is subject to the LTCIP reciprocity standards as documented in that state's Medicaid State Plan. Such states are referred to as "Participating States." Information regarding reciprocity states can

be found at: http://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php#approved

If the policy was issued by a Participating Reciprocity State:

1. Apply the policies specified at 35.1.2 LTCIP ASSET DISREGARD.
2. Apply the policies specified in this subsection, 35.1.3 VERIFICATION.

If the policy was not issued by a Participating State, the individual is not eligible to participate in Wisconsin's LTCIP program. The LTCIP asset disregards and estate recovery offsets do not apply to such individuals.

35.1.3.3 Verification of Benefits Paid

In addition, the amount paid out by a qualified LTCIP policy must be verified before it can be disregarded for Medicaid eligibility or estate recovery purposes. The qualified LTCIP policy carrier must document the amount paid for benefits on or after January 1, 2009 using the appropriate OCI approved form (OCI 26-114) and provide verification of the payout amount upon request. Only benefits paid on or after January 1, 2009 may be disregarded when determining eligibility for Medicaid programs.

35.1.4 Examples

Example 1:	Ruth is a resident of a medical care facility. She has no spouse. Her qualified $90,000 LTCIP policy has been paying for her care. When Ruth applies for WI Medicaid payment of long-term care services, she verifies that her qualified LTCIP policy has paid out $80,000 in policy benefits since January 1, 2009. Ruth owns the following non-exempt assets: • $5,000 savings account • $6,000 checking account • $70,000 equity value in non-homestead property The worker determines that Ruth's total non-exempt assets equal $81,000 ($5,000 + $6,000 + $70,000). Her WI Medicaid asset limit is $2,000; however, because $80,000 has been paid out by Ruth's qualified WI LTCIP policy, an additional $80,000 in non-exempt assets is disregarded. Ruth passes the asset test for WI Medicaid because we disregard $80,000 of her assets. The remaining non-exempt assets are less than $2,000. If Ruth were to pass away at this point, $80,000 of her assets would be protected from estate recovery.

Example 2:	A year later, Ruth's eligibility for WI Medicaid is reviewed. At that time, she verifies that she has exhausted her qualified LTCIP policy benefit, which has paid out the full $90,000 since January 1, 2009. Ruth owns the following non-exempt assets: • $4,000 savings account • $7,000 checking account • $80,000 equity value in non-homestead property The worker determines that Ruth's total non-exempt assets equal $91,000 ($4,000 + $7,000 + $80,000). Her WI Medicaid asset limit is $2,000; however, because $90,000 has been paid out by Ruth's qualified LTCIP policy, an additional $90,000 in non-exempt assets is disregarded. Ruth continues to qualify for WI Medicaid because we disregard $90,000 of her assets. The remaining non-exempt assets are less than $2,000. If Ruth were to pass away, $90,000 of her assets would be protected from estate recovery.

Example 3:	Edith is applying for Family Care. She and her spouse reside in their home and have $100,000 in non-exempt assets. Her qualified $80,000 LTCIP policy has been paying for long-term care she has received in her home and is now exhausted. When Edith applies for Family Care, she verifies that her LTCIP policy has paid out $80,000 in benefits since January 1, 2009. Because this is a Spousal Impoverishment case, an Asset Assessment (AA) must be done to establish the Community Spouse Asset Share. The total $100,000 is used in the AA and the CSAS is set at $50,000. Edith's asset limit of $2,000 is added to the CSAS when determining her eligibility. Since $80,000 of her assets can be disregarded, the remaining non-exempt assets are $20,000 which is less than the $52,000 limit. Prior to her first review (12 months) Edith must transfer, to her spouse, any of her assets that exceed $82,000 (the LTCIP policy pay out amount plus the regular WI Medicaid asset limit of $2,000) to remain eligible.

Example 4:	Emma had been residing in a nursing home and had been eligible for Institutional Medicaid for the past 2 years. Her qualified $90,000 LTCIP policy had been paying for a portion of her care. As of her last WI Medicaid review, the policy had paid out $70,000 since January 1, 2009, an amount disregarded in determining her continued Medicaid eligibility. Ten months after her last review, Emma died. Emma's representatives verify that, during those ten months, her qualified LTCIP policy paid out an additional $10,000 toward her long-term care. Emma's estate can protect a total of $80,000 (i.e., the total amount paid out by the qualified policy) from estate recovery.

Example 5:	Joe has a $100,000 home and $100,000 in non-exempt liquid assets. He needs home care and his qualified LTCIP policy begins paying out. By the time Joe applies for Medicaid, his LTCIP policy has paid out $100,000. Joe can have up to $102,000 in assets ($2,000 limit plus $100,000 disregarded) and still be eligible for Medicaid. His home is an exempt asset and his non exempt assets are less than $102,000 so he qualifies for Family Care. Over the next few months, Joe decides to give $100,000 to his son. At his annual review, he reports that he has done so, but because he has given away no more than the LTCIP protected asset amount (i.e., the LTCIP payout amount of $100,000), there is no divestment penalty. However, because he has divested the entire payout amount, he can no longer take advantage of the LTCIP protections with regard to his Medicaid eligibility. That means, when he's tested for Family Care, he must have assets below $2,000 to remain eligible (instead of $102,000). Also, because he already gave away the entire LTCIP protected amount during his lifetime, that amount will not be protected from estate recovery.

35.1.5 Process Help

Until CARES can be updated to accommodate this policy change, the amount of assets that are disregarded under this policy should be designated as 'unavailable' in CARES. When processing an Asset Assessment (AA) the whole asset amount should be counted as available. Once the AA is completed, update the availability question to indicate the amount paid out by the LTCIP is unavailable. Be sure to document in Case Comments why the asset is being treated as unavailable. The documentation provided for verification of the LTCIP policy and pay out should be scanned into the ECF under the Asset Information subfolder.

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36 Wisconsin Well Woman Medicaid

36.1 Introduction

Wisconsin Well Woman Medicaid (WWWMA) is a full-benefit Medicaid plan. It covers people under age 65 who have been diagnosed with and need treatment for breast or cervical cancer or certain precancerous conditions of the breast or cervix.

WWWMA is a fee-for-service Medicaid program. Members are not enrolled in an HMO.

A person must be enrolled in one of the following entry programs before they can initially enroll in WWWMA:

- Wisconsin Well Woman Program (WWWP)
- Family Planning Only Services (FPOS)
- BadgerCare Plus

Note *Temporary enrollment (also known as presumptive eligibility) in FPOS or BadgerCare Plus does not meet this entry program requirement for WWWMA eligibility.*

The individual must also meet all requirements in SECTION 36.3.1 INTRODUCTION.

Once the person is enrolled in WWWMA, they do not have to reapply for any of the above programs, as they will have full-benefit Medicaid coverage through WWWMA.

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36.2 WWWMA Enrollment

WWWMA is administered by DHS DMS Enrollment Management Central Application Processing Operation (EM CAPO). EM CAPO handles all WWWMA applications and renewals. Any applications received in local IM or tribal agencies should be faxed to the EM CAPO at 608-267-3381 immediately upon receipt to prevent any delay in eligibility determination or treatment for the applicant.

The standard Medicaid application form is not used to enroll in WWWMA. To apply for WWWMA, the applicant must complete the Wisconsin Well Woman Medicaid Application and Renewal form (F-10075) and submit it following the instructions on the form. The applicant may apply for WWWMA at any time after the screening and diagnosis of breast or cervical cancer or certain precancerous condition of the breast or cervix.

The filing date of a WWWMA application is the day a signed, valid application is received by EM CAPO. See SECTION 2.4 VALID APPLICATION.

WWWMA eligibility begins the first day of the month in which the valid application is submitted and all eligibility requirements are met.

Example 1	Maria is diagnosed with cervical cancer on December 16. She applies for WWWMA on December 17. She does not request backdated coverage. Maria is determined eligible for WWWMA. Her WWWMA enrollment starts on December 1.

36.2.1 WWWMA Backdated Eligibility

All applicants may have their WWWMA eligibility backdated to the first of the month, up to three months prior to the month of application. Eligibility may not be backdated earlier than the first of the month of the date of diagnosis.

The applicant may be certified for any backdate month in which they would have been eligible had they applied in that month.

Example 2	Yura is diagnosed with a precancerous condition of the breast on October 25. She applies for WWWMA on December 5. She requests three months of backdated coverage (September, October, November). Yura is determined eligible for WWWMA. Her WWWMA enrollment starts on October 1 since that is the first of the month of her diagnosis date. She is not eligible for WWWMA in September since that month was before her diagnosis.

36.2.2 WWWMA Enrollment through the Wisconsin Well Woman Program

The Wisconsin Well Woman Program (WWWP) is administered by the DHS Division of Public Health (DPH). WWWP provides eligible persons with breast and cervical cancer screenings, referrals, education, and outreach.

In addition to the requirements in SECTION 36.3 WWWMA NONFINANCIAL REQUIREMENTS and SECTION 36.4 WWWMA FINANCIAL REQUIREMENTS, a WWWP client must have a health screening through WWWP, be diagnosed, and need treatment for breast or cervical cancer or a precancerous condition of the breast or cervix to be eligible for WWWMA.

WWWP coordinating agencies enroll persons in WWWP and may assist them with completing the WWWMA application. They also coordinate the WWWP, client's referral to a health care provider for breast and cervical cancer screening.

36.2.2.1 WWWP Process for Assisting with WWWMA Application

1. The WWWP coordinating agency will complete the F-44818 with the assistance of the applicant prior to the applicant's health care screening. The F-44818 enrolls the person in WWWP. Their WWWP eligibility will be in interChange under medical status code "CS."
2. The WWWP client will receive a breast and cervical cancer screening from a WWWP provider.
3. If the WWWP client is diagnosed with breast or cervical cancer or a precancerous condition of the breast or cervix and wants to apply for WWWMA, they will complete Part A - Applicant/Member Information in the Wisconsin Well Woman Medicaid Application and Renewal form (F-10075).They will sign and date the application,
4. The WWWP provider will complete Part-B Diagnosing or Recertifying Provider in the F-10075 recording the diagnosis and indicating that treatment is required. The provider will sign and date the F-10075. The applicant and provider signature dates do not have to be the same date.
5. **If doing a temporary enrollment determination:** The provider will fill in the begin and end dates of the temporary enrollment for WWWMA in Part C – Temporary Enrollment / Presumptive Eligibility on the F-10075. The begin date is the date of diagnosis. The end date is the last day of the month following the month of diagnosis. See SECTION 36.2.2.2 TEMPORARY ENROLLMENT (TE) AVAILABLE ONLY TO PERSONS ENROLLING THROUGH WWWP.
6. The provider will forward a copy of the F-10075 to the WWWP coordinating agency.
7. The WWWP coordinating agency will provide the member with a copy of the signed F-10075 and F-44818 forms.
8. **If doing a temporary enrollment determination:** The WWWP coordinating agency will check to be sure correct temporary eligibility dates are entered on the F-10075 and explain that the client's temporary enrollment for WWWMA will end on the last day of the following calendar month. The WWWP coordinating agency will fax a copy of the completed F-10075 to the fiscal agent at 608-221-8815 within five days of the diagnosis date. The fiscal agent will enter the temporary enrollment in ForwardHealth.
9. The WWWP coordinating agency or the member will fax, mail, or scan and email the F-44818 and the F-10075 to EM CAPO. EM CAPO will process the application and determine eligibility for a 12-month certification period for WWWMA.

36.2.2.2 Temporary Enrollment (TE) Available Only to Persons Enrolling through WWWP

Temporary Enrollment (TE), also known as Presumptive Eligibility (PE), is a streamlined eligibility determination for temporary enrollment in Wisconsin Well Woman Medicaid (WWWMA). It allows eligible applicants immediate access to cancer treatment for a short period until an application for ongoing coverage is completed and processed. TE is only available to persons who are enrolling through the Wisconsin Well Woman Program (WWWP).

WWWP coordinating agencies perform the eligibility determination for TE in WWWMA by completing the Wisconsin Well Woman Medicaid Application and Renewal form (F-10075), including the TE/PE section. See SECTION 36.2.2.1 WWWP PROCESS FOR ASSISTING WITH WWWMA APPLICATION.

TE enrollment in WWWMA is processed by the fiscal agent. When the fiscal agent receives the F-10075 from the WWWP coordinating agency, they will enter the temporary enrollment data in ForwardHealth interChange (with a medical status code of "CB") and send the member a ForwardHealth card with the temporary enrollment dates activated on the card. If the member had a previous ForwardHealth card, it will be reactivated. Until the ForwardHealth card arrives or is reactivated, the new WWWMA member may receive services by presenting both of the following completed forms to any Medicaid provider:

1. WWWP Enrollment Form (F-44818)
2. WWWMA Application and Renewal Form (F-10075)

An applicant may only be temporarily enrolled once in a rolling 12-month period.TE in WWWMA begins on the date the person is found temporarily eligible. TE does not go back to the first of the month. TE in WWWMA ends the last day of the following calendar month.A person can only be eligible for a new TE period if a new cancer diagnosis was established and only if it has been at least 12 months since the first day of their last TE period.

Note	*If the member applies during their TE certification period and the EM CAPO is not able to process their application within the 30-day processing time frame, the EM CAPO will extend the members' eligibility for an additional 30 days from the last day of their Wisconsin Well Woman Medicaid TE with a medical status of "CB." Submit an F-10110 to extend the Well Woman Medicaid TE for an additional calendar month.*

Example 3	Jamie is diagnosed with breast cancer on February 18. On that same day, her provider completes the Wisconsin Well Woman Medicaid Application and Renewal form (F-10075), including the TE/PE section, and finds her eligible for TE for WWWMA. Jamie is eligible for TE for WWWMA from February 18 through March 31.

To continue receiving WWWMA, the member or the WWWP coordinating agency must submit an F-10075 to the EM CAPO. See SECTION 36.2.2.1 WWWP PROCESS FOR ASSISTING WITH WWWMA APPLICATION. If the member does not apply, their WWWMA benefits will end at the end of the month following the month of diagnosis.

36.2.3 WWWMA Enrollment for Family Planning Only Services Members

In addition to the requirements in SECTION 36.3 WWWMA NONFINANCIAL REQUIREMENTS and SECTION 36.4 WWWMA FINANCIAL REQUIREMENTS, a person enrolled in FPOS who meets **one** of the following criteria, may be eligible for WWWMA:

- Are screened for, and diagnosed with, breast or cervical cancer or a precancerous condition of the breast or cervix
- Receive a clinical exam through a FPOS provider and through follow up medical testing
    - Are found to be in need of treatment for breast or cervical cancer or precancerous condition of the breast or cervix **and**
    - Do not have major medical insurance or other insurance that would cover their cancer treatment.

A Wisconsin Well Woman Medicaid Application and Renewal form (F-10075) submitted by a Family Planning Only Services (FPOS) member or their representative is a request to enroll in WWWMA and disenroll from FPOS. Individuals who are enrolled in FPOS and meet the criteria in SECTION 36.2.4 ENROLLMENT FOR FAMILY PLANNING ONLY SERVICES MEMBERS may be eligible for WWWMA. See Process Help 9.1.2 WWWMA Application for information on processing WWWMA applications.

36.2.4 WWWMA Enrollment for BadgerCare Plus Members

In addition to the requirements in SECTION 36.3 WWWMA NONFINANCIAL REQUIREMENTS and SECTION 36.4 WWWMA FINANCIAL REQUIREMENTS, a person enrolled in BadgerCare Plus who meets **one** of the following criteria, may be eligible for WWWMA:

- Are screened for, and diagnosed with, breast or cervical cancer or a precancerous condition of the breast or cervix
- Receive a clinical exam through a BadgerCare Plus provider and through follow up medical testing
    - Are found to be in need of treatment for breast or cervical cancer or precancerous condition of the breast or cervix **and**
    - Do not have major medical insurance or other insurance that would cover their cancer treatment.

The person's enrollment in BadgerCare Plus must end prior to their enrollment in WWWMA. The person must contact their income maintenance agency to disenroll from BadgerCare Plus. EM CAPO does not manage BadgerCare Plus enrollment. See Process Help 9.1.2 WWWMA Application for information on processing WWWMA applications.

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36.3 WWWMA Nonfinancial Requirements

36.3.1 Introduction

To be eligible for WWWMA, a person must meet the following nonfinancial requirements:

1. Live in Wisconsin.
2. Be a U.S. citizen or qualifying immigrant. See CHAPTER 7 U.S. CITIZEN OR QUALIFYING IMMIGRANT.
3. Be under age 65.
4. Have been screened for breast or cervical cancer by the Well Woman Program, or enrolled in Family Planning Only Services or BadgerCare Plus.

Note *If BadgerCare Plus is the person's entry program for WWWMA, the person's enrollment in BadgerCare Plus must end prior to their enrollment in WWWMA.*

Example	Shanice is enrolled in BadgerCare Plus. Her BadgerCare Plus is ending on November 30. Shanice is screened for and diagnosed with breast cancer. She applies for WWWMA on November 10. She is not eligible for WWWMA for the month of November because she is enrolled in BadgerCare Plus. Her enrollment in WWWMA starts on December 1.

5. Be diagnosed for breast or cervical cancer, or certain precancerous conditions of the breast or cervix, as identified by the clinical screener.
6. Require treatment for the breast or cervical cancer, or precancerous conditions of the breast or cervix, as identified by the clinical screener.
7. Not enrolled in another full-benefit Medicaid program or BadgerCare Plus.
8. Meet the insurance coverage requirements listed below in SECTION 36.3.2 DISQUALIFYING INSURANCE COVERAGE.

36.3.2 Disqualifying Insurance Coverage

A person is ineligible for WWWMA if they are currently enrolled in any of the following:

- Group health plans that cover treatment for their breast or cervical cancer or precancerous condition of the breast or cervix
- Full benefit health insurance that covers treatment for their breast or cervical cancer or precancerous condition of the breast or cervix
- Medicare Part A
- Medicare Part B
- BadgerCare Plus without a premium or any other category of full benefit Medicaid that covers their treatment for breast or cervical cancer or precancerous condition of the breast or cervix

Note *A person who must meet a deductible to be enrolled in BadgerCare Plus or Medicaid but has not yet met the deductible is not considered to be enrolled in BadgerCare Plus or Medicaid. This person may be eligible for WWWMA if they meet all other eligibility requirements.*

- Veteran's benefits/TRICARE that cover treatment for their breast or cervical cancer or precancerous condition of the breast or cervix
- Federal employee health plans
- Peace Corps health plans
- Other full-benefit private or public health care plans that provide cancer treatment as determined by their health care team

Except for BadgerCare Plus or Medicaid, a person is ineligible for WWWMA if they are enrolled in any of these health care plans and have not yet met a deductible for the plan.

Health insurance coverage information is collected at application and renewal. Health insurance coverage information available to Wisconsin Medicaid from third party liability sources may also be used to identify if a person has current coverage.

36.3.3 Non-Disqualifying Insurance Coverage

1. The following health care benefits do not disqualify an applicant or member from WWWMA:
    a) Coverage only for accident or disability income insurance, or any combination thereof,
    b) Liability insurance including general liability insurance and automobile liability insurance,
    c) Workers' compensation or similar insurance, credit-only insurance,
    d) Coverage for on-site medical clinics,
    e) Other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits,
    f) Indian Health Services,
    g) Non-coverage of cancer treatment due to waiting period, **or**
    h) Non-coverage of breast or cervical cancer treatment due to exclusion (max out) of cancer treatment in the policy.
2. Separate health insurance benefits that are not considered health insurance if offered separately are:
    a) Limited scope dental or vision benefits, **or**
    b) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof.
3. Independent uncoordinated benefits are not considered health care insurance if offered as independent and/or uncoordinated benefits (for example, coverage only for specified disease or illness, hospital indemnity or other fixed indemnity insurance).
4. Separate insurance policies are not considered health insurance if offered as a separate insurance (Wrap Around) policy:
    a) Coverage supplemental to military insurance (ex., TRICARE wrap around), **or**
    b) Similar "wrap around" supplemental coverage under a group health plan.
5. Creditable coverage plans that do not cover treatment for the breast or cervical cancer due to a waiting period, exclusion or carve out restrictions.

Note *Current coverage under Medicare Parts A or B will disqualify an applicant or member from WWWMA eligibility.*

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36.4 Financial Requirements

Because enrollment in Wisconsin Well Woman Medicaid (WWWMA) is dependent on financial eligibility for one of the entry programs listed in SECTION 36.1 WWWMA INTRODUCTION, there are no income or asset tests specifically for WWWMA.Financial eligibility is determined through the Wisconsin Well Woman Program (WWWP), Family Planning Only Services (FPOS), or BadgerCare Plus enrollment process.

For information on BadgerCare Plus financial requirements, see BadgerCare Plus Handbook, Section 16 Income, Section 17 Deductibles, Section 18 BadgerCare Plus Extensions, and Section 19 Premiums. For information on FPOS financial requirements, see BadgerCare Plus Handbook, Section 40 Family Planning Only Services (FPOS).

Once a person is enrolled in WWWMA, they may not be financially tested as a condition of their continuing eligibility in WWWMA.

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36.5 Changes

Wisconsin Well Woman Medicaid (WWWMA) members are required to report to EM CAPO within 10 days of occurrence changes that would affect their eligibility. This includes:

1. Turning 65 years old.
2. Change in address or phone number, including if the member is incarcerated in or released from jail or prison.
3. No longer needing treatment for breast or cervical cancer.
4. Obtaining health insurance that covers their treatment for breast or cervical cancer.
5. Obtaining Medicare Part A, Part B, or both.

Note *If a child under age 19 enrolled in WWWMA no longer requires treatment or gets health insurance that covers their treatment, they will not be disenrolled during their continuous coverage period (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).*

36.5.1 Maintaining WWWMA Coverage While Considering other Medicaid Eligibility

When a WWWMA member no longer meets program requirements due to a change in circumstances, all other potential health care eligibility must be considered before coverage under WWWMA ends. Because EMCAPO workers do not determine eligibility for other forms of full-benefit health care, the redetermination must be completed by the IM agency. Depending on the circumstances of the case, additional information may be needed for the agency to determine if the member qualifies for another form of Medicaid or BadgerCare Plus.

When a WWWMA member experiences a change in circumstances and no longer meets program requirements, they will be sent a notice that they no longer qualify for WWWMA, and additional information is required to determine if they qualify for a different form of Medicaid.

- For members losing WWWMA due to turning 65, the notice will be sent to the member on the Saturday after adverse action of the month before they turn 65.
- For members losing WWWMA for another reason (such as no longer meeting medical criteria), the notice will be sent when the reported change in circumstances is processed by EM CAPO.

The notice explains how to apply for health care with the IM agency and informs the member that, if their application is received by the due date (30 days from the date the notice was sent), they will keep their current coverage until the application is processed.

WWWMA coverage will be maintained for at least 30 days from the date the letter is sent to give the member time to apply. If the IM agency receives an application by the due date, WWWMA coverage will continue until the IM agency finishes processing the application. If the IM agency does not receive an application by the due date, WWWMA coverage will end with timely notice. Applications received after the due date will be processed in accordance with normal application policies.

Example 1	Samira is enrolled in WWWMA. She will be turning 65 on April 22. On March 22, she is sent a notice informing her that she will no longer be eligible for WWWMA after she turns 65, but if she applies for health care and the application is received by April 21, her current WWWMA coverage will continue until the application is processed. Samira's application is received on April 20. The IM worker processes the application and determines Samira is eligible for SLMB+. Her WWWMA ends on June 1, in accordance with timely notice requirements.

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36.6 Renewals

Renewals are required every 12 months. To renew WWWMA, the member must submit an updated Wisconsin Well Woman Medicaid Application and Renewal (F-10075) or the Well Woman Renewal Form (WWRF) that is sent to them approximately 45 days before their renewal date. Enrollment in WWWP, FPOS, or BadgerCare Plus is not a requirement when completing a WWWMA renewal.

WWWMA renewals received within three months of the renewal month can be processed as a late renewal instead of requiring a new application. If a member has a gap in coverage because of a late renewal, they may request coverage of the past months in which the gap occurred. See SECTION 3.1.2 LATE RENEWALS for more information.

Example 1	Jenny's renewal is due on January 31. She faxes her WWWMA renewal to EM CAPO on March 10. EM CAPO processes the renewal on the same day, and verification is requested. The verification is due on March 30. Jenny submits the verification March 30, and EM CAPO determines she meets the WWWMA eligibility criteria. Her new WWWMA certification period begins on March 1. Her next renewal date is February 28 of the following year.

Example 2	LaVonne's renewal is due on January 31. She faxes her WWWMA renewal to EM CAPO on March 10. EM CAPO processes the renewal on the same day, and verification is requested. The verification is due on March 30. LaVonne submits the verification on May 20, after the verification due date, She will need to reapply for WWWMA.

36.6.1 Maintaining WWWMA Coverage During Regularly Scheduled Renewals

When a timely renewal is submitted, a WWWMA member's health care coverage must be maintained while their renewal is being processed. A timely renewal is one received during the renewal month, including renewals received after adverse action but on or before the last business day of the renewal month.

Members whose eligibility cannot be administratively renewed, and who do not submit their renewal by adverse action of the renewal month, will be notified that their coverage is ending at the end of the renewal month. They will be sent a notice of decision explaining that they are being disenrolled for failure to complete their renewal, in accordance with timely notice requirements.

If the member's renewal is received after adverse action but by the end of the renewal month during business hours, their current coverage will be reinstated for the following month and will be maintained until the renewal is processed. The member will be notified of the reinstatement.

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36.7 EM CAPO Contact Information

WWWMA applicants and members can contact EM CAPO at:

Email: DHSEMCAPO@dhs.wisconsin.gov

Phone: 877-246-2276 or 608-266-6740

Fax: 608-267-3381

Mail: WI DHS – EM CAPO
1 W. Wilson St.
PO Box 309
Madison, WI 53701

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37 Home and Community-Based Services: Children's Long-Term Support Waiver Program

37.1 Children's Long-Term Support (CLTS) Waiver Program Introduction

37.1.1 Program Purpose

Children's Long-Term Support (CLTS) is a Medicaid Home and Community-Based Waiver Program that enables children and youth with disabilities to live at home and participate in family and community life rather than reside in an institution or nursing home. The waiver program allows Medicaid to pay for supports and services that normally are not covered by Medicaid.

The CLTS Waiver Program serves eligible children and youth in the following three target groups:

- Developmental disabilities
- Physical disabilities
- Severe emotional disturbance or mental health disabilities

37.1.2 Eligibility Requirements

To be eligible for the CLTS Waiver Program, an individual must meet all of the following:

- Be under 22 years old
- Meet an institutional level of care, as determined by the CLTS Functional Screen
- Meet nonfinancial and financial eligibility criteria for a full-benefit category of Medicaid (see SECTION 21.2 FULL-BENEFIT MEDICAID)
- Reside in a setting allowed by CLTS Waiver policy

A disability determination is not required for the CLTS Waiver Program.

Children in the CLTS Waiver Program qualify for 12 months of continuous Medicaid coverage. If they are disenrolled from CLTS waiver services (for example, because they lose their functional eligibility) during the continuous coverage period and they do not qualify for any other form of full-benefit health care, they will keep their HCBW Medicaid and can keep getting Medicaid card services for the rest of their continuous coverage period. If they voluntarily disenroll from CLTS, it will be treated as a voluntary disenrollment from Waiver Medicaid.

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37.2 Agency Roles and Responsibilities

County waiver agencies (CWAs) complete the level of care assessment and determine eligibility for the CLTS Waiver Program. Being enrolled in any form of full-benefit Medicaid (see SECTION 21.2 FULL-BENEFIT MEDICAID) is a prerequisite for participation in the CLTS Waiver Program. If the child is eligible for a type of non-CARES Medicaid such as Foster Care Medicaid, Adoption Assistance Medicaid, SSI Medicaid, or Katie Beckett Medicaid, the child is not referred to IM.

CLTS Waiver Program applicants and participants who are not open for a type of non-CARES Medicaid must complete a health care application, and they must first be tested for eligibility using HCBW rules (see SECTION 37.3 HCBW CARES PROCESSING FOR THE CHILDREN'S LONG-TERM SUPPORT WAIVER PROGRAM). If an applicant or participant is ineligible for HCBW, he or she must then be tested for BadgerCare Plus.

When a CLTS waiver applicant or participant is determined to be ineligible for a CARES form of Medicaid, the IM agency sends notice of Medicaid ineligibility to the member. Additionally, IM must notify the CLTS case manager if an applicant or member is not eligible for a CARES Medicaid source.

When an applicant or participant is determined to be ineligible for the CLTS Waiver Program, the CWA sends notice regarding the waiver program to the family. The CWA must also inform the IM agency if an HCBW member is no longer functionally eligible (that is, they no longer meet an institutional level of care).

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37.3 HCBW Medicaid CARES Processing for the CLTS Waiver Program

When a child who is functionally eligible for the CLTS program is referred to IM, he or she must first be tested for eligibility using HCBW rules. To be eligible for HCBW Medicaid, the child must be both Medicaid-eligible and functionally eligible. To determine eligibility for HCBW, only the child's income is counted. Effective 10/01/09, assets are no longer counted for disabled or institutionalized children. Since assets are disregarded, there can be no divestment in a HCBW Medicaid case for a child.

If an applicant or participant is ineligible for HCBW, he or she must then be tested for BadgerCare Plus.

If the CLTS applicant is the only household member applying for healthcare, the packet provided by the CWA is all that is required to be submitted. When the CWA submits the signed F-10129 to the IM agency, the primary person is required to provide a second signature. The primary person can choose to call the IM agency to provide a telephonic signature or mail a signed Application Summary (see 2.5.1 VALID SIGNATURE INTRODUCTION).

Individuals can be eligible for the CLTS Waiver Program and HCBW Medicaid through age 21. When a CLTS Waiver Program applicant or member reaches 18 years old and their source of Medicaid is HCBW, they must apply for HCBW Medicaid as the primary person. Federal and state privacy and confidentiality protections prevent the parents of adults from automatically having access to protected information; therefore, these young adults must apply separately from their parents.

See Process Help Section 11.4 Home and Community-Based Waiver Medicaid for Children's Long-Term Support for processing instructions.

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37.4 Cost Sharing

37.4.1 Group A

Group A members are Medicaid eligible via SSI (including SSI-E Supplement and 1619a and 1619b) or a full-benefit Medicaid subprogram (see SECTION 21.2 FULL-BENEFIT MEDICAID) other than HCBW Medicaid.

Members who have met a deductible are eligible for community waivers as Group A. The member remains eligible as Group A until the end of the deductible period. At the next review the member will be able to make a choice between meeting the deductible to receive Medicaid (remaining a Group A) or becoming eligible for community waivers as Group B or B Plus with a potential cost share.

Individuals eligible as Group A have no CARES cost share obligation.

37.4.2 Group B and B Plus

Group B members are defined as those not in Group A, but who have gross income at or below the nursing home institutions categorically needy income limit (see SECTION 39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES).

Group B Plus members are defined as those not in Group A, who have gross income above the nursing home institutions categorically needy income limit, but whose income does not exceed the cost of the appropriate institutional care by more than the medically needy income limit (see SECTION 39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES).

Group B and B Plus members do have a cost share, including CLTS participants who are enrolled in HCBW Medicaid.

37.4.3 Calculating a Cost Share for HCBW Members

Cost sharing is the monthly amount a HCBW member may have to contribute to the cost of their waiver services. Only the income of the member is counted when calculating the cost share.

CWA staff submits the Medicaid Waiver Eligibility and Cost Sharing Worksheet, F-20919 to IM at application or review when an individual needs a CARES source of Medicaid. The cost share amount for HCBW Medicaid is calculated in CARES following the process outlined in SECTION 28.6.4 COST SHARE AMOUNT.

Note: *Not all deductions apply to CLTS participants who are under age 18. Do not apply the special housing amount or the family maintenance allowance to minors. If the CLTS participant is married, spousal impoverishment policies do apply.*

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37.5 CLTS Parental Payment

Following the procedures of the Uniform Fee System (Wis. Admin. Code ch. DHS 1), CWA staff determines if the parent(s) must contribute toward the CLTS supports and services their child receives. The Parental Payment Fee is calculated separately from an HCBW cost share by the CLTS case manager.

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38 Reserved

38.1 Reserved

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38.4 Reserved

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38.5 Reserved

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Appendix (Chs. 39-40)

39 Tables

39.1 Life Estate and Remainder Interest

AGE	LIFE ESTATE	REMAINDER	AGE	LIFE ESTATE	REMAINDER
0	.97188	.02812	42	.90457	.09543
1	.98988	.01012	43	.89855	.10145
2	.99017	.00983	44	.89221	.10779
3	.99008	.00992	45	.88558	.11442
4	.98981	.01019	46	.87863	.12137
5	.98938	.01062	47	.87137	.12863
6	.98884	.01116	48	.86374	.13626
7	.98822	.01178	49	.85578	.14422
8	.98748	.01252	50	.84743	.15257
9	.98663	.01337	51	.83674	.16126
10	.98565	.01435	52	.82969	.17031
11	.98453	.01547	53	.82028	.17972
12	.98329	.01671	54	.81054	.18946
13	.98198	.01802	55	.80046	.19954
14	.98066	.01934	56	.79006	.20994
15	.97937	.02063	57	.77931	.22068
16	.97815	.02185	58	.76822	.23178
17	.97700	.02300	59	.75675	.24325
18	.97590	.02410	60	.74491	.25509
19	.97480	.02520	61	.73267	.26733
20	.97365	.02635	62	.72002	.27998
21	.97245	.02755	63	.70696	.29304
22	.97120	.02880	64	.69352	.30648
23	.96986	.03014	65	.67970	.32030

24	.96841	.03159	66	.66551	.33449
25	.96678	.03322	67	.65098	.34902
26	.96495	.03505	68	.63610	.36390
27	.96290	.03710	69	.62086	.37914
28	.96062	.03938	70	.60522	.39478
29	.95813	.04187	71	.58914	.41086
30	.95543	.04457	72	.57261	.42739
31	.95254	.04746	73	.55571	.44429
32	.94942	.05058	74	.53862	.46138
33	.94608	.05392	75	.52149	.47851
34	.94250	.05750	76	.50441	.49559
35	.93868	.06132	77	.48742	.51258
36	.93460	.06540	78	.47049	.52951
37	.93026	.06974	79	.45357	.54643
38	.92567	.07433	80	.43659	.56341
39	.92083	.07917	81	.41967	.58033
40	.91571	.08429	82	.40295	.59705
41	.91030	.08970	83	.38642	.61358

AGE	LIFE ESTATE	REMAINDER	AGE	LIFE ESTATE	REMAINDER
84	.36998	.63002	99	.20486	.79514
85	.35359	.64641	100	.19975	.80025
86	.33764	.66236	101	.19532	.80468
87	.32262	.67738	102	.19054	.80946
88	.30859	.69141	103	.18437	.81563
89	.29526	.70474	104	.17856	.82144
90	.28221	.71779	105	.16962	.83038
91	.26955	.73045	106	.15488	.84512
92	.25771	.74229	107	.13409	.86591
93	.24692	.75308	108	.10068	.89932

94 95	.23728 .22887	.76272 .77113	109	.04545	.95455
96 97 98	.22181 .21550 .21000	.77819 .78450 .79000			

The source of the Life Estate & Remainder Interest Table is 26 CFR 20.2031 (49 Federal Register, Vol. 49, No. 93, May 11, 1984). The version of the table published here is from the Social Security Administration's Policy & Operations Manual Series (POMS), Section 01140.120.

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39.2 County and Tribe Areas

Use this list to determine which column to use in the AFDC-related categorically needy income test. If a municipality is in 2 counties, use the area for the county in which the Medicaid fiscal group resides. If a pregnant woman is in a maternity home, use the area in which the home is located, even though the county of residence making the payment is in the other area. For example, if her county of residence is Vilas (Area 2) and she is in a maternity home in Milwaukee (Area 1), Vilas county pays at the Area 1 rate.

39.2.1 Area 1

Brown	Kenosha	Outagamie	Sheboygan
Dane	La Crosse	Ozaukee	Washington
Dodge	Marathon	Racine	Waukesha
Dunn	Manitowoc	Rock	Winnebago
Eau Claire	Milwaukee	St. Croix	Winnebago Tribe*
Fond du Lac			

39.2.2 Area 2

Adams

Ashland

Bad River

Barron

Bayfield

Buffalo

Calumet

Chippewa

Clark

Columbia

Crawford

Door

Douglas

Florence

Forest

Green

Green Lake

Grant

Iowa

Iron

Jackson

Jefferson

Juneau

Kewaunee

Lafayette

Langlade

Lincoln

Marinette

Marquette

Menominee

Monroe

Oconto

Oneida

Pepin

Pierce

Polk

Portage

Price

Richland

Rusk

Sauk

Sawyer

Shawano

Taylor

Trempeleau

Vernon

Vilas

Walworth

Washburn

Waupaca

Waushara

Lac Courte Oreilles

Lac du Flambeau

Menominee Tribe

Mole Lake

Potawatomi

Red Cliff

St.Croix Tribe

Stockbridge -Munsee

Winnebago Tribe

*Only if residing on tax-free land in La Crosse or Marathon County. All other locations are Area 2.

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39.3 AFDC-Related Income Table

Group Size	**Categorically Needy**		**Medically Needy**
	Area I	Area II	
1	$311	$301	$591.67
2	$550	$533	$591.67
3	$647	$626	$689.33
4	$772	$749	$822.67
5	$886	$861	$944.00
6	$958	$929	$1,021.33
7	$1,037	$1,007	$1,105.33
8	$1,099	$1,068	$1,172.00
9	$1,151	$1,117	$1,226.67
10	$1,179	$1,143	$1,257.33
11	$1,204	$1,168	$1,284.00
12	$1,229	$1,193	$1,310.67
13	$1,254	$1,218	$1,337.33
14	$1,279	$1,243	$1,364.00
15	$1,304	$1,268	$1,390.67
16	$1,329	$1,293	$1,417.33
17	$1,354	$1,318	$1,444.00
18	$1,379	$1,343	$1,470.67
+	+25 each person above 18	+25 each person above 18	+26.67 each person above 18

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39.4 EBD Assets and Income Tables

39.4.1 Elderly, Blind, or Disabled Assets and Income Table

Category	Limit	Group Size 1	Group Size 2	Effective	Updated Annually?
SSI-Related Categorically Needy	Asset	$2,000.00	$3,000.00	1/1/1989	No
	Income	$1,050.78	$1,582.05	1/1/2025	Yes
SSI-Related Medically Needy	Asset	$2,000.00	$3,000.00	1/1/1989	No
	Income	$1,304.17	$1,762.50	2/1/2025	Yes
MAPP	Asset	$15,000.00	N/A	3/1/2000	No
	Income	Less than 250% FPL (see SECTION 39.5 FPL TABLE)		2/1/2025	Yes
Institutions Categorically Needy	Income	$2,901.00	N/A	1/1/2025	Yes
Group B Community Waivers	Income	$2,901.00	N/A	1/1/2025	Yes
QMB	Asset	$9,660.00	$14,470.00	1/1/2025	Yes
	Income	At or below 100% FPL (see SECTION 39.5 FPL TABLE)		2/1/2025	Yes
SLMB	Asset	$9,660.00	$14,470.00	1/1/2025	Yes
	Income	At least 100% FPL but less than 120% FPL (see SECTION 39.5 FPL TABLE)		2/1/2025	Yes
SLMB+	Asset	$9,660.00	$14,470.00	1/1/2025	Yes
	Income	At least 120% FPL but less than 135% FPL (see SECTION 39.5 FPL TABLE)		2/1/2025	Yes
QDWI	Asset	$4,000.00	$6,000.00	7/1/1990	No
	Income	$2,608.34	$3,525.00	2/1/2025	Yes

39.4.2 Disabled Minors Deeming and Allowances

Item	Amount	Effective	Updated Annually?
SSI-Related Deeming Amount to an Ineligible Minor	$483.00	1/1/2025	Yes
Parental living allowance - 1 Parent	$967.00	1/1/2025	Yes
Parental living allowance - 2 Parents	$1,450.00	1/1/2025	Yes

39.4.3 LTC Post-Eligibility Allowances

Item	Amount	Effective	Updated Annually?
Institutions Personal Needs Allowance	$55.00	7/1/2024	No
Institutions Home Maintenance Allowance Maximum	$1,146.77	1/1/2025	Yes
Non-Spousal-Impoverishment Family Maintenance Allowance Maximum	$1,146.77	1/1/2025	Yes
Community Waivers Basic Needs Allowance	$1,147.00	1/1/2025	Yes
Community Waivers Personal Maintenance Allowance Maximum	$2,901.00	1/1/2025	Yes

39.4.4 LTC Spousal Impoverishment Post-Eligibility Allowances and Community Spouse Asset Share

Description	Amount	Effective	Updated Annually?
Community Spouse Lower Income Allocation Limit	$3,525.00	7/1/2025	Yes
Shelter Base Amount	$1,057.50	7/1/2025	Yes
Community Spouse Income Allocation Maximum	$3,948.00	1/1/2025	Yes
Dependent Family Member Income Allowance Maximum	$881.25	7/1/2025	Yes
Dependent Family Member Income Allowance Standard	$2,643.75	7/1/2025	Yes
Community Spouse Asset Share (CSAS) Maximum	$157,920	1/1/2025	Yes

39.4.5 Family Care, Family Care Partnership, or PACE Group B Plus Cost Share Cap

Item	Amount	Effective	Updated Annually?
Cost Share Cap for Group B Plus Family Care, Family Care Partnership, or PACE	$3,855.56	1/1/2025	Yes

39.4.6 Institutional Cost of Care Values

Item	Amount	Effective	Updated Annually?
Daily Average Private Pay Nursing Home Rate	$340.99	1/1/2025	Yes
Monthly Average Private Pay Nursing Home Rate	$10,371.78	1/1/2025	Yes
Monthly Rate for State Centers for Persons with Developmental Disabilities	$42,286.56	1/1/2025	Yes

39.4.7 SSI Reference Values

Item	Group Size 1	Group Size 2	Effective	Updated Annually?
Federal SSI Payment Level	$967.00	$1,450.00	1/1/2025	Yes
State Supplementary Payment (SSP)	$83.78	$132.05	1994	No
SSI E Supplement	$95.99	$345.36	1994	No
Substantial Gainful Activity Threshold for Non-Blind Disabled Individuals	$1,620.00	N/A	1/1/2025	Yes
Substantial Gainful Activity Threshold for Blind Individuals	$2,700.00	N/A	1/1/2025	Yes

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39.5 FPL Table

Group Size	Annual FPL	100% FPL	120% FPL	133% FPL	135% FPL	150% FPL	156% FPL	160% FPL	185% FPL	191% FPL	200% FPL	201% FPL	240% FPL	250% FPL	300% FPL	306% FPL
1	$15,650.00	$1,304.17	$1,565.00	$1,734.55	$1,760.63	$1,956.26	$2,034.51	$2,086.67	$2,412.71	$2,490.96	$2,608.34	$2,621.38	$3,130.01	$3,260.43	$3,912.51	$3,990.76
2	$21,150.00	$1,762.50	$2,115.00	$2,344.13	$2,379.38	$2,643.75	$2,749.50	$2,820.00	$3,260.63	$3,366.38	$3,525.00	$3,542.63	$4,230.00	$4,406.25	$5,287.50	$5,393.25
3	$26,650.00	$2,220.83	$2,665.00	$2,953.70	$2,998.12	$3,331.25	$3,464.49	$3,553.33	$4,108.54	$4,241.79	$4,441.66	$4,463.87	$5,329.99	$5,552.08	$6,662.49	$6,795.74
4	$32,150.00	$2,679.17	$3,215.00	$3,563.30	$3,616.88	$4,018.76	$4,179.51	$4,286.67	$4,956.46	$5,117.21	$5,358.34	$5,385.13	$6,430.01	$6,697.93	$8,037.51	$8,198.26
5	$37,650.00	$3,137.50	$3,765.00	$4,172.88	$4,235.63	$4,706.25	$4,894.50	$5,020.00	$5,804.38	$5,992.63	$6,275.00	$6,306.38	$7,530.00	$7,843.75	$9,412.50	$9,600.75
6	$43,150.00	$3,595.83	$4,315.00	$4,782.45	$4,854.37	$5,393.75	$5,609.49	$5,753.33	$6,652.29	$6,868.04	$7,191.66	$7,227.62	$8,629.99	$8,989.58	$10,787.49	$11,003.24
7	$48,650.00	$4,054.17	$4,865.00	$5,392.05	$5,473.13	$6,081.26	$6,324.51	$6,486.67	$7,500.21	$7,743.46	$8,108.34	$8,148.88	$9,730.01	$10,135.43	$12,162.51	$12,405.76
8	$54,150.00	$4,512.50	$5,415.00	$6,001.63	$6,091.88	$6,768.75	$7,039.50	$7,220.00	$8,348.13	$8,618.88	$9,025.00	$9,070.13	$10,830.00	$11,281.25	$13,537.50	$13,808.25
9	$59,650.00	$4,970.83	$5,965.00	$6,611.20	$6,710.62	$7,456.25	$7,754.49	$7,953.33	$9,196.04	$9,494.29	$9,941.66	$9,991.37	$11,929.99	$12,427.08	$14,912.49	$15,210.74
10	$65,150.00	$5,429.17	$6,515.00	$7,220.80	$7,329.38	$8,143.76	$8,469.51	$8,686.67	$10,043.96	$10,369.71	$10,858.34	$10,912.63	$13,030.01	$13,572.93	$16,287.51	$16,613.26
11	$70,650.00	$5,887.50	$7,065.00	$7,830.38	$7,948.13	$8,831.25	$9,184.50	$9,420.00	$10,891.88	$11,245.13	$11,775.00	$11,833.88	$14,130.00	$14,718.75	$17,662.50	$18,015.75
12	$76,150.00	$6,345.83	$7,615.00	$8,439.95	$8,566.87	$9,518.75	$9,899.49	$10,153.33	$11,739.79	$12,120.54	$12,691.66	$12,755.12	$15,229.99	$15,864.58	$19,037.49	$19,418.24
13	$81,650.00	$6,804.17	$8,165.00	$9,049.55	$9,185.63	$10,206.26	$10,614.51	$10,886.67	$12,587.71	$12,995.96	$13,608.34	$13,676.38	$16,330.01	$17,010.43	$20,412.51	$20,820.76

14	$87,150.00	$7,262.50	$8,715.00	$9,659.13	$9,804.38	$10,893.75	$11,329.50	$11,620.00	$13,435.63	$13,871.38	$14,525.00	$14,597.63	$17,430.00	$18,156.25	$21,787.50	$22,223.25
15	$92,650.00	$7,720.83	$9,265.00	$10,268.70	$10,423.12	$11,581.25	$12,044.49	$12,353.33	$14,283.54	$14,746.79	$15,441.66	$15,518.87	$18,529.99	$19,302.08	$23,162.49	$23,625.75
16	$98,150.00	$8,179.17	$9,815.00	$10,878.30	$11,041.88	$12,268.76	$12,759.51	$13,086.67	$15,131.46	$15,622.21	$16,358.34	$16,440.13	$19,630.01	$20,447.93	$24,537.51	$25,028.26
17	$103,650.00	$8,637.50	$10,365.00	$11,487.88	$11,660.63	$12,956.25	$13,474.50	$13,820.00	$15,979.38	$16,497.63	$17,275.00	$17,361.38	$20,730.00	$21,593.75	$25,912.50	$26,430.75
18	$109,150.00	$9,095.83	$10,915.00	$12,097.45	$12,279.37	$13,643.75	$14,189.49	$14,553.33	$16,827.29	$17,373.04	$18,191.66	$18,282.62	$21,829.99	$22,739.58	$27,287.49	$27,833.24
19	$114,650.00	$9,554.17	$11,465.00	$12,707.05	$12,898.13	$14,331.26	$14,904.51	$15,286.67	$17,675.21	$18,248.46	$19,108.34	$19,203.88	$22,930.01	$23,885.43	$28,662.51	$29,235.76
20	$120,150.00	$10,012.50	$12,015.00	$13,316.63	$13,516.88	$15,018.75	$15,619.50	$16,020.00	$18,523.13	$19,123.88	$20,025.00	$20,125.13	$24,030.00	$25,031.25	$30,037.50	$30,638.25
21	$125,650.00	$10,470.83	$12,565.00	$13,926.20	$14,135.62	$15,706.25	$16,334.49	$16,753.33	$19,371.04	$19,999.29	$20,941.66	$21,046.37	$25,129.99	$26,177.08	$31,412.49	$32,040.74
22	$131,150.00	$10,929.17	$13,115.00	$14,535.80	$14,754.38	$16,393.76	$17,049.51	$17,486.67	$20,218.96	$20,874.71	$21,858.34	$21,967.63	$26,230.01	$27,322.93	$32,787.51	$33,443.26
23	$136,650.00	$11,387.50	$13,665.00	$15,145.38	$15,373.13	$17,081.25	$17,764.50	$18,220.00	$21,066.88	$21,750.13	$22,775.00	$22,888.88	$27,330.00	$28,468.75	$34,162.50	$34,845.75
24	$142,150.00	$11,845.83	$14,215.00	$15,754.95	$15,991.87	$17,768.75	$18,479.49	$18,953.33	$21,914.79	$22,625.54	$23,691.66	$23,810.12	$28,429.99	$29,614.58	$35,537.49	$36,248.24
each additional person	$5,500.00	$458.33	$550.00	$609.58	$618.75	$687.50	$714.99	$733.33	$847.91	$875.41	$916.66	$921.24	$1,099.99	$1,145.83	$1,374.99	$1,402.49
		QMB BC+ Extensi	SLMB	BC+ adult	QI-1 (SLMB+)		MAGI/ BC+ Limit	Senior Care tier	BC+ EE for kids	MAGI/ BC+ limit	QDWI & lower	MAGI/ BC+ kids	Senior Care tier	MAPP	BC+ pregnant	MAGI/ BC+ pregna

		ons trigger limit BC+ Adults limit MAPP premium limit		premium limit			for kids 6-18 subject to access / backdate / EE	one limit	ages 1-5	for kids 1-5 subject to access / backdate / EE	SI Inc Alloc BC+ kids premiums BC+ adults limit	premiums	three limit		women kids limit	nt women kids limit

Annual figures for SeniorCare	$25,040.00	$30,300.00	$37,560.00
	$33,840.00	$42,300.00	$50,760.00

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39.6 COLA Disregard

See SECTION 25.3.3 DETERMINING THE COLA DISREGARD FOR 503 GROUPS.

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39.7 Hospital Daily Rates

>City	Hospital Name	Average IP Daily Charge Based on Gross Inpatient Revenue*
Amery	Amery Regional Medical Center	2,089.80
Antigo	Langlade Memorial Hospital	2,138.75
Appleton	Appleton Medical Center	2,619.86
Appleton	St. Elizabeth Hospital	2,116.37
Arcadia	Franciscan Skemp Healthcare-Arcadia	3,092.15
Ashland	Memorial Medical Center, Inc.	1,482.73
Baldwin	Baldwin Area Medical Center, Inc.	2,533.16
Baraboo	St. Clare Hospital and Health Services	2,179.26
Barron	Barron Medical Center, Mayo Health System	1,954.05
Beaver Dam	Beaver Dam Community Hospitals, Inc.	2,668.64
Beloit	Beloit Memorial Hospital, Inc.	2,372.91
Berlin	Berlin Memorial Hospital	2,281.50
Black River Falls	Black River Memorial Hospital	2,008.27
Bloomer	Bloomer Medical Center, Mayo Health System, Inc.	2,650.71
Boscobel	Boscobel Area Health Care	2,223.16
Brookfield	Elmbrook Memorial Hospital	2,939.91
Burlington	Memorial Hospital Corporation of Burlington	3,388.85
Chilton	Calumet Medical Center, Inc.	2,275.09
Chippewa Falls	St. Joseph's Hospital	1,328.26
Columbus	Columbus Community Hospital, Inc.	2,189.11
Cumberland	Cumberland Memorial Hospital and ECU	1,401.31
Darlington	Memorial Hospital of Lafayette County	2,176.27
Dodgeville	Upland Hills Health	2,319.07
Durand	Chippewa Valley Hospital	4,079.93
Eagle River	Eagle River Memorial Hospital, Inc.	2,089.94
Eau Claire	Luther Hospital	2,856.90
Eau Claire	Sacred Heart Hospital	2,048.11
Edgerton	Memorial Community Hospital	4,277.41
Elkhorn	Lakeland Medical Center, Inc.	2,818.54
Fond du Lac	Agnesian HealthCare, Inc.	2,038.43

Fond Du Lac	Fond du Lac County Department of Com. Prog.	542.75
Fort Atkinson	Fort Atkinson Memorial Health Services	1,611.49
Friendship	Adams County Memorial Hospital	2,122.78
Grantsburg	Burnett Medical Center, Inc.	2,463.85
Green Bay	Bellin Memorial Hospital	3,203.79
Green Bay	Bellin Psychiatric Center	1,127.78
Green Bay	Brown County Mental Health Center	604.30
Green Bay	Libertas Treatment Center	599.69
Green Bay	St. Mary's Hospital Medical Center	2,150.08
Green Bay	St. Vincent Hospital	2,181.42
Greenfield	Kindred Hospital-Milwaukee	2,863.08
Hartford	Aurora Medical Center	1,951.60
Hayward	Hayward Area Memorial Hospital	2,499.17
Hillsboro	St. Joseph's Comm. Health Services, Inc.	3,214.87
Hudson	Hudson Hospital	3,123.36
Janesville	Mercy Health System Corporation	2,959.12
Janesville	Rock County Psychiatric Hospital	627.07
Kenosha	Aurora Medical Center - Kenosha	3,394.71
Kenosha	Children's Hospital of WI, Inc. - Kenosha	1,583.90
Kenosha	Kenosha Hospital and Medical Center	3,002.25
La Crosse	Franciscan Skemp Healthcare - La Crosse	2,472.35
La Crosse	Gundersen Lutheran Medical Center, Inc.	3,399.28
Ladysmith	Rusk Co. Memorial Hospital and Nursing Home	1,713.81
Lancaster	Grant Regional Health Center, Inc.	2,827.16
Madison	Mendota Mental Health Institute	577.84
Madison	Meriter Hospital, Inc.	2,740.11
Madison	St. Mary’s Hospital Medical Center	2,785.67
Madison	University of WI Hospital and Clinics Authority	3,171.65
Manitowoc	Holy Family Memorial Medical Center	2,349.37
Marinette	Bay Area Medical Center	1,985.82
Marshfield	Norwood Health Center	662.10
Marshfield	Saint Joseph's Hospital	2,693.24
Mauston	Hess Memorial Hospital	2,500.85

Medford	Memorial Health Center, Inc.	2,079.43
Menomonee Falls	Community Memorial Hospital	2,527.08
Menomonie	Myrtle Werth Hospital-Mayo Health System	2,020.15
Mequon	St. Mary's Hospital-Ozaukee	2,626.39
Merrill	Good Samaritan Health Center	1,862.32
Milwaukee	Aurora Sinai Medical Center	3,504.31
Milwaukee	Children's Hospital of Wisconsin	4,109.72
Milwaukee	Columbia Hospital, Inc.	3,142.63
Milwaukee	Froedtert Memorial Lutheran Hospital	3,763.75
Milwaukee	Milwaukee County Mental Health Complex	658.69
Milwaukee	Sacred Heart Rehabilitation Institute	1,590.18
Milwaukee	St. Joseph's Hospital	2,870.63
Milwaukee	St. Luke's Medical Center	4,194.60
Milwaukee	St. Mary's Hospital-Milwaukee	3,038.61
Milwaukee	St. Michael Hospital	3,041.39
Monroe	The Monroe Clinic	2,821.34
Neenah	Theda Clark Medical Center	2,123.14
Neillsville	Memorial Hospital, Inc	2,546.27
New London	New London Family Medical Center	2,048.86
New Richmond	Holy Family Hospital	2,331.20
Oconomowoc	Oconomowoc Memorial Hospital	2,756.58
Oconomowoc	Rogers Memorial Hospital	845.81
Oconto	Oconto Memorial Hospital, Inc.	2,419.99
Oconto Falls	Community Memorial Hospital	2,436.47
Osceola	Osceola Medical Center	2,533.79
Oshkosh	Mercy Medical Center of Oshkosh	2,204.91
Osseo	Osseo Area Hospital and Nursing Home, Inc.	8,485.86
Park Falls	Flambeau Hospital, Inc.	2,149.84
Platteville	Southwest Health Center, Inc.	2,053.36
Portage	Divine Savior Healthcare	2,096.57
Prairie Du Chien	Prairie du Chien Memorial Hospital	2,986.91
Prairie Du Sac	Sauk Prairie Memorial Hospital	2,575.36
Racine	All Saints-St. Luke's Hospital, Inc.	1,500.18

Racine	All Saints-St. Mary's Medical Center, Inc.	2,203.06
Reedsburg	Reedsburg Area Medical Center	2,252.02
Rhinelander	Saint Mary's Hospital, Inc.	2,601.07
Rice Lake	Lakeview Medical Center	1,649.24
Richland Center	The Richland Hospital, Inc.	2,376.05
Ripon	Ripon Medical Center	2,345.92
River Falls	River Falls Area Hospital	2,771.15
Shawano	Shawano Medical Center	1,945.56
Sheboygan	Sheboygan Memorial/Valley View Medical Center	2,414.85
Sheboygan	St. Nicholas Hospital	1,870.69
Shell Lake	Indianhead Medical Center Shell Lake, Inc.	1,889.70
Sparta	Franciscan Skemp Healthcare-Sparta	2,503.34
Spooner	Spooner Health System	2,063.49
St. Croix Falls	St. Croix Regional Medical Center, Inc.	2,738.80
Stanley	Victory Medical Center	2,768.09
Stevens Point	Saint Michael's Hospital	2,016.21
Stoughton	Stoughton Hospital Association	1,945.35
Sturgeon Bay	Door County Memorial Hospital	3,027.83
Superior	St. Mary's Hospital of Superior	1,959.67
Tomah	Tomah Memorial Hospital, Inc.	1,660.85
Tomahawk	Sacred Heart Hospital, Inc.	1,350.84
Two Rivers	Aurora Medical Center of Manitowoc City, Inc.	2,441.01
Viroqua	Vernon Memorial Hospital	2,196.89
Waterford	Lakeview NeuroRehab Center Midwest	1,655.79
Watertown	Watertown Memorial Hospital	2,476.15
Waukesha	Waukesha County Mental Health Center	694.85
Waukesha	Waukesha Memorial Hospital, Inc.	2,691.44
Waupaca	Riverside Medical Center	1,958.61
Waupun	Waupun Memorial Hospital	1,903.18
Wausau	North Central Health Care Facilities	694.88
Wausau	Wausau Hospital	2,602.82
Wauwatosa	Aurora Psychiatric Hospital	1,075.72
West Allis	Rogers Memorial Hospital - Milwaukee	1,674.72

West Allis	Select Specialty Hospital	2,372.35
West Allis	West Allis Memorial Hospital	3,282.94
West Bend	St. Joseph's Community Hospital	1,758.48
Whitehall	Tri-County Memorial Hospital, Inc.	2,472.95
Wild Rose	Wild Rose Community Memorial Hospital Inc.	2,077.47
Winnebago	Winnebago Mental Health Institute	457.54
Wisconsin Rapids	Riverview Hospital Association	1,934.27
Woodruff	Howard Young Medical Center, Inc.	2,509.65

Data Source: Gross Inpatient Revenue and Total Discharge Days, 2001 Wisconsin Hospital Fiscal Survey

* Average Daily Charge is the sum of Gross Inpatient Revenue and Gross Inpatient Ancillary Revenue divided by Total Discharge Days.

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39.8 Life Expectancy Table

See the Life Expectancy Table at Social Security Administration site.

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39.9 Reserved

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39.10 Medicaid Purchase Plan Premiums before August 1, 2020 only

The following are MAPP premiums for months of eligibility **up to and including July 2020** for members whose gross monthly income equals or exceeds 150 percent of the FPL for the appropriate fiscal test group size.

For MAPP premiums for months of eligibility starting August 1, 2020 please reference SECTION 26.5 MAPP PREMIUMS.

MAPP PREMIUM SCHEDULE prior to August 1, 2020					
Sum of Adjusted Countable Unearned and Adjusted Earned Income		The premium is:	Sum of Adjusted Countable Unearned and Adjusted Earned Income		The premium is:
From	To	PREMIUM	From	To	PREMIUM
$0	$25.00	$0.00	500.01	525.00	500.00
25.01	50.00	25.00	525.01	550.00	525.00
50.01	75.00	50.00	550.01	575.00	550.00
75.01	100.00	75.00	575.01	600.00	575.00
100.01	125.00	100.00	600.01	625.00	600.00
125.01	150.00	125.00	625.01	650.00	625.00
150.01	175.00	150.00	650.01	675.00	650.00
175.01	200.00	175.00	675.01	700.00	675.00
200.01	225.00	200.00	700.01	725.00	700.00
225.01	250.00	225.00	725.01	750.00	725.00
250.01	275.00	250.00	750.01	775.00	750.00
275.01	300.00	275.00	775.01	800.00	775.00
300.01	325.00	300.00	800.01	825.00	800.00
325.01	350.00	325.00	825.01	850.00	825.00
350.01	375.00	350.00	850.01	875.00	850.00
375.01	400.00	375.00	875.01	900.00	875.00
400.01	425.00	400.00	900.01	925.00	900.00
425.01	450.00	425.00	925.01	950.00	925.00
450.01	475.00	450.00	950.01	975.00	950.00
475.01	500.00	475.00	975.01	1000.00	975.00
			1000.01	1025.00	1000.00

If the subtotal from the MAPP Premium Calculation Worksheet is more than $1,025 a month, the premium is equal to the exact whole dollar amount of the subtotal.

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39.11 SeniorCare Income Limits and Participation Levels

39.11.1 SeniorCare Income Limits Introduction

For applicants determined eligible, SeniorCare pays for a portion of covered prescription drugs, depending on the person's participation level.

Effective with benefit periods starting September 1, 2003, there are four participation levels. The level of benefits an applicant receives depends on their annual income and, for some, on the amount they spend on covered prescription drugs during their 12-month benefit period.

The participation levels are:

- **Level 1:** Co-Payment (Annual income is at or below 160% of the Federal Poverty Level (FPL).)
- **Level 2a:** Deductible $500 (Annual income is greater than 160% of the FPL and less than or equal to 200% of the FPL.)
- **Level 2b:** Deductible $850 (Annual income is greater than 200% of the FPL and less than or equal to 240% of the FPL.)
- **Level 3:** Spenddown (Annual income is above 240% of the FPL.)

Note *The FPL may be adjusted annually (see SECTION 39.5 FPL TABLE for current FPLs). If the FPL changes during the eligibility determination process or before a redetermination can be completed, the new levels will be used.*

SeniorCare Levels of Participation	
Income Limits*	**Annual Out-of-Pocket Expense Requirements and Benefits**
Level 1 **Income at or below 160% of FPL** At or below $25,040 per individual or $33,840 per couple annually.*	• No deductible or spenddown. • $5 co-pay for each covered generic prescription drug. • $15 co-pay for each covered brand name prescription drug.
Level 2a **Income above 160% and at or below 200% FPL** $25,041 to $31,300 per individual and $33,841 to $42,300 per couple annually.*	• $500 deductible per person. • Pay the SeniorCare rate for drugs until the $500 deductible is met. • After $500 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 2b **Income above 200% and at or below 240% of FPL** $31,301 to $37,560 per individual and $42,301 to $50,760 per couple annually.	• $850 deductible per person. • Pay the SeniorCare rate for most covered drugs until the $850 deductible is met. • After $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 3 **Annual income is above 240% of the FPL**	• Pay retail price for drugs equal to the difference between the member's income and $37,560 per individual or $50,760 per couple. This is called "spenddown."

$37,561 or higher per individual and $50,761 or higher per couple annually.*	• Covered drug costs for spenddown will be tracked automatically. During the spenddown, there is no discount on drug costs. • After spenddown is met, meet an $850 deductible per person. • Pay SeniorCare rate for most covered drugs until the $850 deductible is met. • After the $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.

* These income amounts are based on the 2025 federal poverty guidelines, which typically increase by a small amount each year.

39.11.2 Level 1: Copayment

SeniorCare will pay for covered prescription drugs purchased from participating pharmacies except for participant copayments.

Level 1 participants are required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name copay.

If a participant has private insurance with a higher copayment per prescription than SeniorCare, the SeniorCare copayment rules will apply, and benefits will be coordinated with the private insurance company. Providers who have questions regarding billing/benefit coordination should contact Provider Services at 1-800-947-9627.

Residents of nursing homes and community-based residential facilities will have to pay the usual SeniorCare copayment even when they are required to purchase drugs on less than a monthly basis.

39.11.3 Level 2a: Deductible

Level 2a participants have an annual deductible of $500. The participant will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

After this deductible is met, a level 2a participant is required to pay a $5 copayment for each covered generic prescription drug and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name copay.

39.11.4 Level 2b: Deductible

Level 2b participants have an annual deductible of $850. The participant will get a discount off the retail price for most covered prescription drugs during the deductible period. The discount amount depends on the particular drug prescribed.

After this deductible is met, a level 2b participant is required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name copay.

Note: *If married persons in the same FTG with annual income above 160% of FPL are determined non-financially eligible at different times, the deductible amount is prorated for the spouse who applies later (see SECTION 33.9.3.1 FTG CHANGES AT LEVEL 2A AND 2B)*

39.11.5 Level 3: Spenddown

Level 3 participants must meet a spenddown. The amount of spenddown is the difference between the FTG annual income and 240% of the FPL corresponding to the size of the FTG. The SeniorCare program tracks the amount spent on covered prescriptions drugs that can be applied to an applicant's spenddown.

39.11.5.1 Level 3: Fiscal Test Group of One

A SeniorCare participant considered as a FTG of one with gross annual income above 240% FPL pays retail prices for covered prescription drugs until those payments equal the spenddown amount.

After the spenddown has been met by purchasing drugs at regular prices the participant has an annual deductible of $850. During the deductible period the participant will get a discount off the retail price for most covered prescription drugs during the deductible period.

After this deductible is met, they are required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name copay.

Example 1:	Dorothy's annual income is $38,560. This is $1,000 more than 240% of the FPL for a FTG of one. Her spenddown amount for the 12-month benefit period is $1,000. Dorothy pays the retail price for her covered prescription drugs until those payments equal the spenddown amount. If Dorothy meets the spenddown during her benefit period, she can begin purchasing covered prescription drugs at the discounted rate. These costs are applied toward the $850 deductible. After this deductible is met, Dorothy purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period.

39.11.5.2 Level 3: Fiscal Test Group of Two

Married persons considered as a FTG of two with annual income greater than 240% FPL and in which both spouses are determined non-financially eligible at the same time pay retail price for covered prescription drugs until the spenddown requirement is met. In this case, the spenddown amount is shared, and covered prescription drugs purchased for either person in the married couple will count toward meeting the spenddown requirement, when both are eligible.

After the spenddown has been met, each spouse must meet a separate $850 deductible requirement. Participants will get a discount off the retail price for most covered prescription drugs during the deductible period. Only the covered prescription drugs purchased for an individual spouse may count toward that spouse's deductible.

After a spouse has met his or her deductible, he or she is required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name copay.

Example 2:	Bob and Alice's annual income is $52,760, which is $2,000 more than 240% of the FPL for a FTG of two. Both spouses are eligible and, for the 12-month benefit period, their joint spenddown amount is $2,000. Bob and Alice pay for their covered prescription drugs at retail price until the $2,000 spenddown is met. Covered prescription drugs purchased for either Bob or Alice will count toward the spenddown requirement. After Bob and Alice meet the spenddown, each person has a $850 deductible. Only covered prescription drugs purchased for Bob count toward his deductible, and only covered prescription drugs purchased for Alice count toward her deductible. Bob meets his deductible in two months. He then purchases covered prescription drugs at the copayment amounts for the remainder of his benefit period. Alice meets her deductible in three months. She then purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period.

If only one spouse in a married couple is determined eligible, only that spouse's costs count toward the spenddown. They pay retail price for covered prescription drugs until the spenddown requirement is met.

Example 3:	Tracy and Dave's annual income is $52,760, which is $2,000 more than 240% of the FPL for a FTG of two. Because Tracy is 63 years old, only Dave is eligible for SeniorCare. For the 12-month benefit period Dave's spenddown amount is $2,000. Tracy and Dave pay for their covered prescription drugs at retail price. Only covered prescription drugs purchased for Dave count toward the spenddown requirement. After Dave has met the $2,000 spenddown, he has a $850 deductible. Only covered prescription drugs purchased for Dave count toward his deductible. After Dave meets his deductible, he purchases covered prescription drugs at the copayment amounts for the remainder of his benefit period.

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39.12 Five Percent Copay Limit Tiers

2025 Per-Member Copay Limits											
	Assistance Group Income Tier as Percentage of the Federal Poverty Level										
Status	0-50%	>50-100%	>100-150%	>150-200%	>200-250%	>250-300%	>300-350%	>350-400%	>400-450%	>450-500%	>500%
Individual	$0	$26	$53	$79	$106	$132	$159	$186	$212	$239	$265
Prorated (split between counted spouses)	$0	$13	$26.50	$39.50	$53	$66	$79.50	$93	$106	$119.50	$132.50

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39.13 VA Allowance Rates

The chart below can be used to identify the value of the exempt portion of a VA payment if both the VA benefit type is known and the payment indicates the member is eligible for A&A or housebound allowance, but does not list an amount for the allowance.

The following rates are effective December 1, 2024 – November 31, 2025.

VA INCOME TYPE	AID & ATTENDANCE AMOUNT	HOUSEBOUND ALLOWANCE AMOUNT
Veteran's pension (see note)	up to $945	up to $314
Surviving spouse pension (see note)	up to $567	up to $211
Veteran's disability compensation	Benefit could include A&A for the spouse. Amount depends on veteran's disability rating.	N/A
Surviving spouse dependency and indemnity compensation (DIC)	$409.53	$191.85
Surviving parent DIC	$445	N/A

Note *For VA pensions, which are based on need, the A&A or housebound allowance amounts given above or the monthly unreimbursed medical expense (UME) amount shown on the award letter could be greater than the monthly VA pension amount. In this situation, disregard the entire pension.*

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40 Worksheets

40.1 Worksheets

The following is a list of Medicaid financial worksheets.

Worksheet	Form Number	Name
3	F-01298	Medicaid Deductible Worksheet
4	F-01297	Medicaid Institution Determination Worksheet
6	F-01305	Supplemental Security Income-Related Determination
7	F-01306	Spousal Impoverishment Income Allocation Worksheet
8	F-01307	Medicaid Purchase Plan (MAPP) Eligibility Worksheet (as of 8/1/2020) Click here for old version (prior to 8/1/2020)
9	F-01316	Medicaid Purchase Plan (MAPP) Premium Calculation Worksheet (as of 8/1/2020) Click here for old version (prior to 8/1/2020)
10	F-01317	Medicaid Purchase Plan (MAPP) Impairment Related Work Expenses (IRWE) Worksheet
11	F-01318	Medicaid Purchase Plan (MAPP) Medicaid and Remedial Expenses (MRE) Worksheet

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Glossary

1619a

Provisions of the Social Security Act which allow certain employed people who would otherwise be ineligible to retain SSI status. The Social Security Administration certifies people for 1619(a) and 1619(b) eligibility. People with 1619(a) or 1619(b) status retain their MA eligibility under the SSI related category if they received MA the month before certification for 1619(a) or 1619(b).1

1619b

Provisions of the Social Security Act which allow certain employed people who would otherwise be ineligible to retain SSI status. The Social Security Administration certifies people for 1619(a) and 1619(b) eligibility. People with 1619(a) or 1619(b) status retain their MA eligibility under the SSI related category if they received MA the month before certification for 1619(a) or 1619(b).

ABLE

Achieving a Better Life Experience

ADRC

Aging and Disability Resource Center

adult

An adult is anyone age 18 or older.

adverse action

Adverse action is another name for cutoff. Adverse action is a batch job that is run in CARES approximately 13 calendar days prior to the end of the month. It is run at this time to allow 10 days for negative notices to be sent as a result of any benefit reduction, denial, or closure.

AFDC

Aid to Families with Dependent Children

AFH

Adult Family Home

AG

assistance group

ALJ

Administrative Law Judge

Annuitant

Annuitant means the person(s) entitled to payments from an annuity.

Annuitized

Annuitized means that an annuity account or fund has become irrevocable and is issuing annuity payments in accordance with the annuity contract. When a resource is annuitized, it is converted from a resource to a stream of income.

Annuity

An annuity conveys a right to receive fixed, periodic payments, either for life or for a term of months or years.

applicant

A person who has submitted a request for coverage for whom no decision has been made regarding eligibility

Arrearages

Payments of child support which were due for a prior period.

authorized representative

A person or organization authorized to act on a client's behalf. An authorized representative may be designated by the client and may exercise all the rights and responsibilities of a client.

AVS

Asset Verification System

balloon payments

When a promissory note is structured such that only interest is paid until the maturity of the note, and the principal is due at the end of the note, the last payment is a balloon payment.

Beneficiary

Beneficiary means the person(s) entitled to any remaining pay-out of an annuity upon the death of the annuitant.

CARES

This system supports the income maintenance operations for DHS and DCF. CARES is used to determine eligibility, issue benefits, track premium payments, and manage support for BadgerCare Plus, EBD Medicaid, W-2, Child Care, and Work Programs.

CBRF

community-based residential facility. A place in which five or more unrelated adults live and where they receive care, treatment, or services, but not nursing care on any permanent basis, in addition to board and room

CCRC

Continuing Care Retirement Community

CD

certificate of deposit

CFAS

Citizens of the Compact of Free Association States

CIP

Community Integration Program

CLTS

Children's Long-Term Support

CMO

Care Management Organization

CMS

Centers for Medicare and Medicaid Services. It administers the Medicare program and works in partnership with states to administer Medicaid and other programs. Formerly known as HCFA.

COLA

cost-of-living adjustment. An increase in income to compensate for inflation.

community spouse

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

COP-W

Community Options Program Waiver

Copay

Copayment. A fixed amount a person is required to pay for each episode of a particular treatment, medical supply, or equipment. For example, a policy might require a $5 copayment for each prescription while the insurance pays the remainder.

Corpus

(Re: trusts) Income and/or assets that form the main body of a trust. Assets or income in the trust corpus may be available to a person but the person no longer owns them. Also known as the trust principal.

countable assets

non-exempt and available assets

CREP

Conservation Reserve Enhancement Program

CSA

Child Support Agency

CSP

Community Support Program

CSV

Cash surrender value. The cash amount payable to a life insurance policy owner in the event of termination or cancellation of the policy before its maturity or the insured event.

Cutoff

Cutoff is another name for Adverse Action. Adverse Action is a batch job that is run in CARES approximately 13 calendar days prior to the end of the month. It is run at this time to allow 10 days for negative notices to be sent as a result of any benefit reduction, denial, or closure.

CWW

CARES Worker Web

DAC

Disabled Adult Child

DACA

Deferred Action for Childhood Arrivals

DDB

Disability Determination Bureau

deed

Legal document which conveys ownership of property between parties.

dependent 18-year-old

Anyone age 18 is a dependent 18 year-old if he or she is classified as a full-time student in high school or in the equivalent level of vocational or technical training and reasonably expected to complete the program before age 19 or carrying sufficient credits to be reasonably expected to graduate or get a GED before reaching age 19. If he or she is, for example, carrying only 3 credits, but only needs 3 credits to graduate, he or she is a full-time student.

DHA

Division of Hearings and Appeals

DHS

Department of Health Services

disability

The law defines disability for Medicaid as "The inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."

disregard

An amount not counted when determining a person's total net income.

DMS

Division of Medicaid Services

DOC

Department of Corrections

EBD

Elderly, Blind, or Disabled

ECF

Electronic Case File

EFT

electronic funds transfer

EITC

Earned Income Tax Credit

elderly

Anyone 65 years old or older

EM CAPO

Enrollment Management Central Application Processing Operation

EOB

Explanation of Benefits

EPP

Error Prone Profile

ERP

Estate Recovery Program

EVHI

Employer Verification of Health Insurance

Exempt asset

An asset that is not considered in the eligibility determination; the asset is considered excluded or disregarded in the asset determination

Face Value

The face value of a life insurance policy is the policy's death benefit (the amount paid out at the death of the insured) at the time a life insurance policy is purchased.

fair market value

The price an item would sell for on the open market in a local geographic area

FDSH

Federal Data Services Hub

fee-for-service

A method of payment for health services. The medical provider bills the Medicaid fiscal agent rather than an HMO for specific individual services.

FEMA

Federal Emergency Management Agency

FFM

Federally-Facilitated Marketplace

FMV

Fair Market Value. The price for which an item would sell on the open market in a local geographic area.

Foster Care

Care given to a children or adults including emergency, interim, or permanent care that cannot be furnished by their parent or legal guardian in their home. Foster care can be federally funded by Title IV-E of the Social Security Act or it can be state-funded.

FPL

Federal Poverty Level

FPOS

Family Planning Only Services

FQHC

Federally Qualified Health Center

FTC

Federal Trade Commission

FTG

fiscal test group

functionally eligible

Have a level of care need that is typically provided in an institutional setting such as a hospital, a nursing home, or an institution for people with developmental disabilities as determined by the Adult Long-term Care Functional Screen or the Children's Long-Term Support Functional Screen.

HCBS

Home and Community-Based Services

HCBW

Home and Community-Based Waiver

HCBWLTC

Home and Community-Based Waivers Long-term Care

HEC

Health and Employment Counseling

HIPAA

Health Insurance Portability and Accountability Act. A federal law passed in 1996 that protects health insurance coverage for workers and their families when they change or lose their jobs. Title II Administration Simplification provides national uniformity of transaction coding and national identifiers for providers. Data privacy is included in Title II.

HIPP

Health Insurance Premium Payment

HIRSP

Health Insurance Risk Sharing Plan

homestead

A place of abode and the lands used or operated in connection with it. Homestead property may have more than one building or house on it.

HUD

U.S. Department of Housing and Urban Development

ICF

Intermediate Care Facility

IDA

Individual Development Account

IEVS

Income and Eligibility Verification System. A set of data exchanges with other state and federal sources used to verify income and assets of Medicaid applicants and recipients.

IHS

Indian Health Service

IM

income maintenance

IMD

Institution for Mental Disease

INS

Immigration and Naturalization Service

IRA

Individual Retirement Account

IRC

Internal Revenue Code

IRIS

Include, Respect, I Self-Direct. A Medicaid waiver program.

IRS

Internal Revenue Service

IRWE

Impairment-Related Work Expenses

IV-D Agency

A state, county, or private agency that is responsible for establishing paternity and collecting child support and medical support according to Title IV-D of the Social Security Act.

LCA

Local Coordinating Agencies for the Wisconsin Well Woman Medicaid Program.

lien

A legal claim against property for the satisfaction of a debt. The lien is paid off at the time the property is sold.

LIFBC

Life Insurance-Funded Burial Contract

LIS

Low Income Subsidy of Medicare Part D. This is also called "Extra Help" by the SSA. It helps people with limited resources pay for a portion of Part D costs.

LLC

limited liability company

LOC

level of care. Used in the Family Care, PACE, Family Care Partnership, IRIS, and Home and Community-Based Waiver programs.

LTC

long-term care

MADA

Medicaid — Disability Application

MAGI

Modified Adjusted Gross Income

managed care

A health care delivery system under which enrollees receive most medical services through a health plan or network of providers which coordinates the services provided. DHS pays a fixed rate in advance for each enrollee.

MAPP

Medicaid Purchase Plan

MCO

Managed Care Organization

member

A recipient of Medicaid; formerly referred to as a "client."

minor

A minor is a person less than age 18.

Minor Parent

A minor parent is a minor who: 1. Is not the primary person. 2. Is living in a household where the primary person is his or her LRR caretaker. 3. Has his or her own child under his or her care.

MPA

Medicare Premium Assistance. This term is obsolete. See MSP.

MSP

Medicare Savings Programs. Assistance to help pay coinsurance, premiums, and deductibles for Medicare beneficiaries who are also one of these types of Medicaid recipients: QMB, SLMB, SLMB+, or QDWI. This has also been called "Medicare buyin," "buy in," or "Medicare Premium Assistance (MPA)." DHS is using the term "MSP" to refer to this type of assistance.

NEMT

Non-emergency medical transportation. A public transportation and shared ride service for eligible BadgerCare Plus and Medicaid members.

NLRR Child

A non-legally responsible relative (NLRR) child has no relatives in the household who are legally responsible for him or her. He or she meets these two conditions: he or she does not have a parent in the household and the primary person, the primary person's spouse, or a nonmarital parent is his or her caretaker.

OASDI

Old Age, Survivors, and Disability Insurance Program. Old-Age, Survivors, and Disability Insurance Program payments, known as “Social Security” by the Social Security Administration (SSA) include SSA Retirement, Disability, Survivors benefits, and any other benefits covered in Title II of the Social Security Act.

PACE

Program of All-Inclusive Care for the Elderly

PPRF

Pre-Printed Renewal Form

Public Institution

A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term“public institution” does not include a medical institution (5.8.1), a publicly operated community residence that serves no more than 16 residents, or a child care institution which foster care maintenance payments are made under Title IV-E.

QDWI

Qualified Disabled and Working Individual

QMB

Qualified Medicare Beneficiary

RCA

Refugee Cash Assistance

real property

Real property is land and most things attached to the land, such as buildings and vegetation.

Revocable Trust

Allows the trustor to dissolve the trust. If the trust provides that the trust can be modified or terminated by a court, it is considered to be a revocable trust since the grantor or his or her representative can petition the court to terminate the trust.

RFA

Request for Assistance

ROP

reasonable opportunity period

RRP

restrictive re-enrollment period

RRV

Renewal and Redetermination Verification

RSDI

Retirement Survivors Disability Insurance

SAVE

Systematic Alien Verification for Entitlements

SGA

substantial gainful activity

SLMB

Specified Low-Income Medicare Beneficiary

SLMB+

Specified Low-Income Medicare Beneficiary Plus

SMCP

Special Managed Care Program

SMRF

Six-Month Report form

SMV

specialized medical vehicle

SNF

Skilled Nursing Facility

Sole Proprietor

A person who is the sole owner of an unincorporated self-employment business.

SOLQ-I

State Online Query Internet

spousal impoverishment

"Spousal Impoverishment Protection" refers to special financial provisions in Medicaid law regarding income and assets that affect certain married couples receiving or applying for nursing home or community waiver services.

spouse

A spouse is that person recognized by Wisconsin law as another person's legal husband or wife. Wisconsin does not recognize common law marriage.

SSA

Social Security Administration. A federal agency which administers the SSI, OASDI, and Medicare programs.

SSDI

Social Security Disability Insurance. A benefit to disabled or blind individuals who have contributed to the Federal Insurance Contribution Act (FICA).

SSI

Supplemental Security Income. A program based on financial need operated by the Social Security Administration that provides monthly income to low income people who are age 65 or older, blind, or disabled.

SSI-E

Supplemental Security Income Exceptional Expense

SSN

Social Security number

SSP

State Supplementary Payment

Subsidized Guardianship

A long-term placement option for children in out-of-home care. Caretakers willing to become permanent legal guardians for children in out-of-home care receive monthly subsidized guardianship payments, similar to foster care payments.

SWICA

State Wage Information Collection Agency

TB

Tuberculosis

TPL

Third Party Liability. The obligation a third party (not Wisconsin Medicaid or the Medicaid member) has to pay the bills for a Medicaid member's medical services.

UC

Unemployment Compensation

UIB

Unemployment Insurance Benefits

USCIS

U.S. Citizenship and Immigration Services. The federal agency responsible for immigration and citizenship. This agency was formerly known as Immigration and Naturalization Service (INS).

USDA

U.S. Department of Agriculture

VA

U.S. Department of Veterans Affairs

W-2

Wisconsin Works

WCDP

Wisconsin Chronic Disease Program

WFDA

Wisconsin Funeral Directors Association

WIA

Workforce Investment Act

Workers' Compensation

A state program providing payments and reimbursement of medical expenses for people injured on the job.

WPP

Wisconsin Partnership Program. Now called Family Care Partnership.

WWWMA

Wisconsin Well Woman Medicaid

WWWP

The Wisconsin Well Woman Program