WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
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BadgerCare Plus Handbook Release 26-03

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

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1.1 Introduction to BadgerCare Plus

1.1.1 Overview

BadgerCare Plus is a state and federal program that provides health coverage for low-income Wisconsin residents. To be eligible for BadgerCare Plus, a person must meet certain non-financial and financial requirements.

Depending on their age, income, and other criteria, BadgerCare Plus members have their benefits funded by either the Medicaid program or Children's Health Insurance Program (CHIP).

Note *BadgerCare Plus replaced Aid to Families with Dependent Children-Medicaid (AFDC-Medicaid), Healthy Start, and BadgerCare.*

1.1.2 BadgerCare Plus Coverage Groups

Populations eligible for BadgerCare Plus include:

- Children younger than 19 years old
- Pregnant persons
- Parents and caretakers of children younger than 18 years old and dependent 18-year-olds
- Parents and caretaker relatives whose children have been removed from the home and placed in out-of-home care
- Former Foster Care Youth younger than 26 years old who were in out-of-home care when they turned 18
- Adults ages 19–64 who are not receiving Medicare, except Medicare Part B Immunosuppressive Drug Benefit (Part B-ID), and do not have dependent children

For information on income limits, see SECTION 16.1 INCOME and SECTION 50.1 FEDERAL POVERTY LEVEL TABLE.

All BadgerCare Plus members receive coverage under the Standard Plan. See CHAPTER 38 COVERED SERVICES for information on covered services.

BadgerCare Plus is funded by Medicaid and CHIP. CHIP, which is also known as State Children's Health Insurance Program (SCHIP) or Title 21, is primarily a program covering low-income children's health care needs. In Wisconsin, these low-income children include children with incomes above the Medicaid income limits up to 306% of the Federal Poverty Level (FPL). Children eligible for CHIP are covered under BadgerCare Plus. CHIP also covers pregnant persons who are enrolled in the BadgerCare Plus Prenatal Program.

Note *Receipt of Medicare Part B-ID has no effect on an individual's eligibility for BadgerCare Plus. This is a limited benefit that covers only immunosuppressive drugs. It is only available to beneficiaries who don't have comprehensive health coverage which pays for their immunosuppressive drugs, so if a member is enrolled in BadgerCare Plus, it is up to the member to disenroll from Medicare Part B-ID by contacting the Social Security Administration (SSA).*

1.1.3 Limited Coverage Health Care Plans

BadgerCare Plus also has several limited coverage health care plans. These include:

- **Family Planning Only Services**. People of childbearing or reproductive age may be eligible for limited benefits under the Family Planning Only Services Program.

- **BadgerCare Plus Prenatal Program**. Documented and undocumented immigrants who are pregnant and ineligible for BadgerCare Plus solely due to their immigration status may be eligible for the BadgerCare Plus Prenatal Program.
- **BadgerCare Plus Emergency Services**. Documented and undocumented immigrants who are children, pregnant women, parents, or caretakers and who are ineligible for BadgerCare Plus solely due to their immigration status may be eligible for coverage for BadgerCare Plus Emergency Services.
- **Tuberculosis (TB)-Related Medicaid**. People infected with TB who are not eligible for any other category of full-benefit BadgerCare Plus or Medicaid may be eligible for limited benefits for the treatment of TB.

1.1.4 Wisconsin Medicaid

Medicaid is a state and federal program that provides health coverage for Wisconsin residents who are elderly, blind, or disabled. In addition to this, Medicaid funds the benefits of most adults and children enrolled in BadgerCare Plus.

Medicaid is also known as Medical Assistance, MA, and Title 19.

1.1.4.1 Medicaid Programs

The following are different subprograms of Medicaid:

- Home and Community Based Waivers Long-Term Care and IRIS
- Institutional Long-Term Care Medicaid
- Katie Beckett
- Managed long-term care programs (Family Care, Family Care Partnership, Program of All-Inclusive Care for the Elderly (PACE))
- Medicaid Purchase Plan (MAPP)
- Supplemental Security Income (SSI) Medicaid
- SSI-related Medicaid
- Wisconsin Well Woman Medicaid
- Emergency Services for Non-Qualifying Immigrants (limited benefit)
- Medicare Savings Programs (limited benefit):
    - Qualified Medicare Beneficiary (QMB)
    - Specified Low-Income Medicare Beneficiary (SLMB)
    - Specified Low-Income Medicare Beneficiary Plus (SLMB+)
    - Qualified Disabled and Working Individual (QDWI)
- SeniorCare (limited benefit)

1.1.5 Health Care Choice

It is possible for individuals to qualify for both BadgerCare Plus and Elderly, Blind, or Disabled (EBD) Medicaid based on financial and non-financial eligibility criteria (see CHAPTER 49 HEALTH CARE CHOICE).

1.1.6 Ways to Apply

A person can apply for BadgerCare Plus:

- Online using ACCESS
- By phone by calling the income maintenance (IM) consortium or tribal agency
- In-person at the IM consortium or tribal agency

- By mail using a paper application

A person can also apply through the Federally-Facilitated Marketplace (FFM).

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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 period, 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 month 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	Jane applies for health care for her and her son Sam on January 17, 2024, with a three month backdate, and they are determined eligible for BadgerCare Plus as of October 1, 2023. Sam will have continuous coverage from January 1 through December 31, 2024. If the household has a change in circumstances during the certification period, Jane may lose coverage, but Sam 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	Juan, age 17, was enrolled in BadgerCare Plus in May 2023. He is still enrolled as of January 1, 2024, so he will have continuous coverage from January 1, 2024, to his renewal date of April 30, 2024. Even if the household reports a change and the household's income goes above the program income limit, he 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's household income is over 306% of the federal poverty level. He 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's immigration status changes and they are no longer in an eligible immigration status or designation (see SECTION 1.2.5 EMERGENCY SERVICES).
- 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	Allison is 17 and enrolls in BadgerCare Plus February 1. On May 12, her household reports moving to Florida. Allison's BadgerCare Plus ends May 31.
Example 5	Margaret applies for BadgerCare Plus for her son Ricardo. Ricardo is eligible, but verification of his citizenship is still needed. Ricardo is enrolled in BadgerCare Plus as of February 1, and is given a reasonable opportunity period to verify his citizenship. Ricardo's citizenship is not verified by the due date of May 10, so his BadgerCare Plus ends May 31.

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 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 BadgerCare Plus 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 BadgerCare Plus coverage ends effective April 1.
Example 7	Henry is 3 years old and enrolls in BadgerCare Plus on January 1, with no monthly premium. 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 with a premium. 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 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.

Children in Medicaid or a Medicaid-funded category of BadgerCare Plus enrolled in 12-month continuous coverage periods who are no longer in an eligible immigration status or designation must be transitioned to Emergency Services for the remainder of their certification period. These members are not required to have experienced or be experiencing a life-threatening condition to be certified for

Emergency Services for the remainder of their 12-month continuous coverage period. Once the child is enrolled in Emergency Services, Medicaid will only cover claims related to medical emergencies.

Children enrolled in a Children's Health Insurance Program (CHIP) funded category of BadgerCare Plus cannot be transitioned to Emergency Services unless they simultaneously experience a change that makes them eligible in a Medicaid-funded category of BadgerCare Plus, such as a reduction in household income. When a child experiences these changes simultaneously, they begin a new 12-month certification period with continuous coverage in BadgerCare Plus Emergency Services. If a child is no longer in an eligible immigration status or designation and they do not have a change that makes them eligible for Medicaid, their BadgerCare Plus eligibility will end.

Example 9	Tania is 12 years old and enrolls in BadgerCare Plus on February 1. She is verified as a non-citizen who is lawfully present in the United States with Temporary Protected Status (TPS). Her household income is 125% of the FPL. Tania's continuous coverage period is set from February 1 through January 31 of the following year. On June 10, information from CMS requires the agency to verify Tania's status. The information available on the case is submitted to SAVE. SAVE does not verify Tania's immigration status or designation. Tania is sent a notice requesting verification of her immigration status and is placed in a Reasonable Opportunity Period (ROP). Requested information is not returned. Tania's BadgerCare Plus full benefit coverage ends in accordance with ROP requirements and with timely notice. Tania is certified for BadgerCare Plus Emergency Services through January 31.
Example 10	Henrik is 10 years old and enrolls in BadgerCare Plus on September 1. Henrik is verified as a non-citizen who is lawfully present in the United States with a pending asylum application. His household income is 175% of the FPL. Henrik's continuous coverage period is set from September 1 through August 31 of the following year. On January 12, information from CMS requires the agency to verify Henrik's status. The information available on the case is submitted to SAVE. SAVE verifies Henrik is not currently in an eligible immigration status or designation. Henrik's BadgerCare Plus full benefit coverage ends with timely notice. Henrik cannot be certified for BadgerCare Plus Emergency Services because he is over the BadgerCare Plus Emergency Services income limit.

1.2.6 Premiums

A child can have a new premium obligation at application or renewal but cannot have a new premium once their 12-month continuous coverage period starts. Existing premiums for an individual child cannot increase during their 12-month continuous coverage period, but they may be reduced if applicable. If the premium is lowered, that new amount becomes their premium cap for the rest of the 12-month period.

Note	*The restriction against new or increased premiums during an established continuous coverage period does not apply if the child's eligibility determination at application or renewal was based on incorrect information or agency error (see SECTION 1.2.3.1 WHEN ELIGIBILITY WAS BASED ON INCORRECT INFORMATION OR AGENCY ERROR).*

Example 11	Kiley and Korbin are enrolled in BadgerCare Plus as of July 1, 2024. They each owe a $20 premium, for a total household premium of $40. Their individual premiums of $20 cannot increase during their 12-month period. The household has a reduction in income in December 2024, and their premiums lower to $10 each. Their premiums now cannot go above $10 for the rest of the 12-month period. If the household has an increase in income at any point in their remaining certification period, their premiums will not increase.

Example 12	Ryan is enrolled in BadgerCare Plus with no premium. Ryan's continuous coverage period ends on October 31, 2024. In July, his family reports an increase in income that would result in a $20 premium for Ryan. This premium will only take place in the new certification period, starting on November 1, 2024.

Note *While an individual child's premium cannot increase during their 12-month continuous coverage period, there may be instances where the household's total premium amount does increase, like when another child is added to the household and that new child owes a premium.*

Example 13	Emily is enrolled in BadgerCare Plus as of June 1, 2024 with a premium of $20 for a total household premium of $20. The household reports another child, Kwan, has joined the household and he is added to the case. Kwan has a premium of $20, which would bring the new household premium to $40

1.2.7 Extensions

If a child's household has an increase in income that qualifies the parents for an earned income or spousal support extension, the child will stay in their current BadgerCare Plus assistance group while their parent(s) go into the extension.

1.2.8 Foster Care Medicaid

If a child under age 19 leaves their placement or agreement, they keep Foster Care Medicaid for the remainder of their 12-month continuous coverage period, or, for at least three months after their placement or agreement end-month, whichever is later.

Example 14	Trey enrolled in Foster Care Medicaid on February 11. His placement ends July 28. Trey keeps his Foster Care Medicaid until January 31 of the following year, which is the remainder of the 12-month period.
Example 15	Sally enrolled in Foster Care Medicaid on January 12. Her placement ends November 13. Sally keeps her Foster Care Medicaid until February 28 of the following year. She has three months of Foster Care Medicaid coverage beyond the month her placement ended.

1.2.9 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, a child may move from a CHIP-funded category of BadgerCare Plus to a full-benefit Medicaid program, 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 16	Max is 10 years old and enrolls in a CHIP-funded category of BadgerCare Plus on January 1. The household's reported income at the time of enrollment is 175% of the FPL. Max's continuous coverage period is set from January 1 through December 31. On March 14, the household reports an income reduction. The new reported income is 110% of the FPL. The reduction in income results in Max being moved from a CHIP-funded category of BadgerCare Plus to a Medicaid-funded category of BadgerCare

	Plus. Max receives a new 12-month certification period with continuous coverage from April 1 through March 31 of the following year.

1.2.10 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.

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 certification period. However, other household members can get new 12-month certification periods. Households may also have different health care renewal dates.

Example 17	Mary's 10-year-old son Tom is enrolled in BadgerCare Plus with a $10 premium because Mary's income is at 210% FPL. Tom's continuous coverage period is July 1, 2024, through June 30, 2025. On December 4, 2024, Tom moves to his father Jack's household. Jack requests health care for himself and Tom. Jack is denied due to excess income. Tom would also be ineligible due to Jack's income being over 306% FPL. However, since Tom has an already established continuous coverage period from his mother's case, Tom is enrolled in BadgerCare Plus on Jack's case at 210% FPL for the remainder of his continuous coverage period, through June 30, 2025. Jack will be charged the $10 monthly premium for Tom's coverage once Tom is enrolled on Jack's case.

Example 18	LaTanya's 11-year-old son Tucker is enrolled in BadgerCare Plus with a $30 premium from January 1, 2025, through December 31, 2025. On February 7, 2025, LaTanya's 8-year-old son Trey joins the household and requests health care. Trey has continuous coverage under BadgerCare Plus without a premium from his father's case through June 30, 2025. Trey is determined eligible on LaTanya's case and would normally have a premium based on the income and group size of LaTanya's case. Trey will be enrolled in BadgerCare Plus without a premium for the remainder of his continuous coverage period from his father's case, through June 30, 2025. Tucker's premium reduces from $30 to $10 with the increased group size, and he gets a new 12-month certification period from March 1, 2025, through February 28, 2026. While Trey has a renewal date of June 30, 2025, Tucker has a renewal date of February 28, 2026. If a renewal is completed for Trey in June 2025, and Trey and Tucker are both determined eligible without adverse impact, their certification periods may align.

2.1 BadgerCare Plus Nonfinancial Requirements

Wisconsin residents in the following coverage groups may be non-financially eligible for BadgerCare Plus:

- Children younger than 19 years old
- Pregnant persons
- Parents and caretakers of children younger than 18 years old and dependent 18-year-olds
- Parents and caretaker relatives whose children have been removed from the home and placed in out-of-home care
- Former Foster Care Youth younger than 26 years old who were in out-of-home care when they turned 18
- Adults ages 19-64 who are not receiving Medicare, except Medicare Part B Immunosuppressive Drug Benefit (Part B-ID), and who do not have dependent children who reside with them at least 40% of the time.

To be eligible for BadgerCare Plus, a person must meet the following criteria:

- Be a Wisconsin resident (see CHAPTER 3 RESIDENCE)
- Be a U.S. citizen or qualified immigrant (see CHAPTER 4 CITIZEN AND IMMIGRATION STATUS)

Note *A non-qualifying immigrant receiving BadgerCare Plus Emergency Services (see SECTION 39.1 EMERGENCY SERVICES INTRODUCTION) or a BadgerCare Plus Prenatal Program applicant (see CHAPTER 41 BADGERCARE PLUS PRENATAL PROGRAM) is not required to be a U.S. citizen or qualified immigrant.*

- Provide documentation of citizenship and identity or of immigration status (see SECTION 4.1 U.S. CITIZENS AND NATIONALS)
- Cooperate with establishing medical support and Third Party Liability (TPL) (see CHAPTER 5 MEDICAL SUPPORT AND THIRD PARTY LIABILITY)
- Sign over to the state their rights to payments from a third party for medical expenses (see SECTION 5.2 MEDICAL SUPPORT/CSA COOPERATION)
- Meet BadgerCare Plus Social Security Number (SSN) requirements (see CHAPTER 6 SOCIAL SECURITY REQUIREMENTS)
- Cooperate with verification requests when information is mandatory or deemed questionable (see CHAPTER 9 VERIFICATION)
- Meet health insurance coverage requirements (see CHAPTER 7.1 HEALTH INSURANCE CONDITIONS OF ELIGIBILITY)

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2.2 Coverage Group Definitions

The following are the relationships and legal responsibility that determine who is in the BadgerCare Plus coverage groups:

2.2.1 Parents

A parent may be:

- Biological, legally adoptive, or a stepparent.
- Of any age.

There can be more than one parent of a certain gender in a household.

To be considered a parent of a child younger than 19 years old for BadgerCare Plus purposes, the child must be under the care of that person at least 40% of the time. For example, in families where parents are divorced, if the child does not live with a parent at least 40% of the time, that parent would have their eligibility considered under the Childless Adults coverage group, rather than the parents or caretakers coverage group.

Note *A child younger than 19 years old residing with a parent may not apply separately from their parent. In addition, the parent must apply as the primary person for the case unless the child filing the application is 18 years old.*

2.2.1.1 Parentage

When a woman is married to a man at the time that she gives birth, her husband is considered the legal father of the child unless a court later determines that someone else is the father.

A same-sex partner or spouse added to the child's birth certificate through a court process is considered to be a legal parent of the child.

If the parents of the child are not married at the time of the child's birth, paternity must be established in order to determine the parental relationship for the father. For unwed parents, paternity is legally established by a court order, a Voluntary Paternity Acknowledgment (VPA) form (F-05024) filed with the state Vital Records office, or through the administrative paternity process, in which genetic testing establishes the man as the father and paternity is entered in the Kids Information & Data System (KIDS) by the Child Support Agency (CSA). When paternity is established using any of these methods, the father's name is added to the birth certificate. A father's name on a birth certificate is evidence that paternity has been established.

The following designations for a father are used in CARES. See the accompanying definitions to determine which designation is appropriate for a case.

1. Claimed father
   A claimed father is someone claiming to be the father of a child but has not had his paternity established or had a paternity action initiated. A claimed father is not the father for BadgerCare Plus or Medicaid eligibility purposes. The child should be referred to the CSA so that steps to establish paternity can be taken.

2. Acknowledged father
   An acknowledged father is a temporary status used when someone is claiming to be the father of a child and claims to have had paternity established or has initiated a paternity action. An acknowledged father is not listed on the child's birth certificate but fits one of the following criteria:

   a. The father has filed a VPA, but the Wisconsin Vital Records office has not yet finished processing it.
   b. A paternity action (adjudication) has been initiated, but the courts have not yet finalized it.

   An acknowledged father is considered to be a parent for BadgerCare Plus and Medicaid eligibility purposes. However, because there is still no evidence of a formal adjudication, the

child should be referred to the CSA so that steps to establish paternity may be taken. Once paternity is established, the father is considered the legal/adjudicated father.

3. Legal/adjudicated father

   A father who has had his paternity legally established is the legal/adjudicated father. A legal/adjudicated father is one who fits one of the following criteria:

   a. The father's name appears on a birth certificate for a child.
   b. The father provides a copy of the court adjudication or similar proof of a VPA being filed with another state.

2.2.1.2 Joint Placement

When the biological or adoptive parents of a child do not live together and have joint placement arrangements for the child (through a mutually agreed upon arrangement or court order), only one parent can be determined eligible at a time unless there is reasonably equivalent placement. Reasonably equivalent placement means that the child is residing with each parent at least 40% of the time during a month.

If the child is not residing with each parent at least 40% of the time, only the parent with the greater percentage of the placement time may apply on behalf of the child or the child and their self as the parent of that child.

If only one parent of a child is applying for BadgerCare Plus and that parent is claiming to have placement of the child for at least 40% of the time, this declaration is accepted unless it is questionable.

In situations where both parents are applying for BadgerCare Plus separately and each parent claims the child is residing with them, the following information must be considered when determining on which case the child will receive BadgerCare Plus benefits if eligible:

1. If both parents agree that they have a reasonably equivalent placement arrangement and agree on which parent's case they want the child to receive BadgerCare Plus benefits on, the parents can indicate this decision to their agency.
2. If either parent disputes that the placement arrangement is reasonably equivalent, the eligibility worker must determine the monthly percentage of the physical placement based on the court order. If the court order does not show reasonably equivalent placement, the child is considered to be residing with the parent they are physically residing with during the month in question. The other parent may not be considered the caretaker relative of this child when determining that other parent's eligibility for BadgerCare Plus.
3. If the parents cannot agree on which case the child will receive benefits, the child will be issued benefits, if eligible, through the case of the household whose income is at the lower FPL level.

In determining eligibility for the parents with equivalent placement, the child is considered to be residing in both of their homes. That means the child will be included in the group size for both cases and the child's income will also be counted in both cases (see SECTION 2.3 MODIFIED ADJUSTED GROSS INCOME TEST GROUPS and SECTION 2.8 MODIFIED ADJUSTED GROSS INCOME COUNTING RULES).

If reasonably equivalent placement exists (as described above) and both parents apply for BadgerCare Plus for the child and the child has access to health insurance where an employer pays 80% or more of the monthly premium in one home but not the other, the child shall remain eligible for BadgerCare Plus

on the case with the parent who does not have access to health insurance for which the employer pays 80% or more.

Example 1	Johnny, age 10, lives 50% of the time with his mom and 50% of the time with his dad. Both Johnny's dad and mom have applied for BadgerCare Plus. Mom is employed but does not have access to health insurance coverage through her employer. Dad is employed and does have access to a family health insurance where his employer pays 81% of the monthly premium. Johnny can remain eligible on his mom's case.

If reasonably equivalent joint placement exists and both parents apply for BadgerCare Plus for the child and the income of either case requires that a premium be paid as condition of the child's BadgerCare Plus eligibility, then the parents can choose in which case the child will receive BadgerCare Plus coverage. A premium requirement in one case does not preclude eligibility in the other parent's case where no premium for the child would be owed.

Example 2	Billy, age eight, lives 40% of the time with his dad and 60% of the time with his mom. Both parents are applying for BadgerCare Plus. In his mother's case, the family income is 220% FPL and in his dad's case, the family income is 180% FPL. Billy's parents decide that Billy will be receiving his BadgerCare Plus coverage through Dad's case.

If joint placement exists with a parent who lives in another state, the child must be with the Wisconsin parent at least 50% of the time in a month to qualify for BadgerCare Plus.

2.2.1.3 Dependent 18-Year-Old

When an adult is eligible as a parent or caretaker because they are caring for an 18-year-old child and that child is the only child in the home, the child must meet both the following conditions for the parent or caretaker to be eligible for BadgerCare Plus as a parent or caretaker of a dependent 18-year-old:

- Be enrolled in high school
- Be expected to graduate high school before turning 19.

The child does not need to be enrolled full time in high school in order to meet this definition of a dependent child.

The 18-year-old remains eligible as a child until they turn 19, regardless of school enrollment or expected date of graduation.

2.2.2 Caretaker Relative

A relative who cares for a child and the relative's spouse can be eligible for BadgerCare Plus as caretaker relatives. To be considered a caretaker relative of a child in the home, a person must first have a qualifying relationship to the child (under age 19) and the child must also be under the care of that relative. The relative may or may not be legally responsible for the child.

Any of the following is a qualifying relationship for a caretaker relative:

- Stepparent (when the parent is deceased or divorced/separated from the stepparent)
- Biological full or half sibling, legally adopted, or stepsibling

  Grandparent, aunt or uncle, first cousin, nephew or niece, or any preceding generation denoted by the prefix grand-, great-, or great-great (including those through adoption)

Note *"First cousin" includes a first cousin from a different generation, such as a first cousin once removed (that is, the relative is taking care of their first cousin's child).*

- Spouse of any of the above and the spouse of a child's parent, even after the marriage ends by death, divorce, or separation

Annulment of a marriage removes all relationships established by the marriage except parent.

A spouse is that person recognized by Wisconsin law as another person's legal spouse. Wisconsin does not recognize common law marriage.

Being "under the care" means the caretaker relative exercises primary responsibility for the child's care and control, including making plans for them. Once a child marries, they can no longer be considered under the care of a caretaker relative.

In cases where a child resides with both a non-parent relative and a parent, the parent is considered to have legal custody of the child, unless legal custody has been given by a court to the relative. When legal custody has been given by a court to the relative, the relative is considered a caretaker relative for BadgerCare Plus.

A child under age 19 residing with a caretaker relative may not apply as the primary person for the relative's benefits.

Note

For both a caretaker relative and a child to be included in one case, the caretaker relative must apply for BadgerCare Plus.

2.2.3 Child Welfare Parents and Caretakers

Most parents and caretakers whose children have been placed in out-of-home care continue to have their eligibility for BadgerCare Plus determined under the parent/caretaker relative category, as the child is considered temporarily absent. See SECTION 10.1 ELIGIBILITY FOR PARENT OR CARETAKER RELATIVE WHEN CHILD IS REMOVED FROM THEIR CARE for more information.

2.2.4 Pregnant Woman

A pregnant woman is nonfinancially eligible for BadgerCare Plus. Marital status has no effect on her nonfinancial eligibility. If she is a pregnant minor, she does not have to be under the care of or related to the caretaker to be eligible for BadgerCare Plus.

If there is a pregnant woman in the group, include the number of expected babies in the group size. Verification of the number of expected babies is not required unless questionable. If the number of babies is unknown, add one to the group size.

2.2.5 Former Foster Care Youth

Former Foster Care Youth (FFCY) is a special status of BadgerCare Plus eligibility. This eligibility is available to qualifying youth under age 26, who were in out-of-home care, court-ordered Kinship Care, long-term Kinship Care, or a Subsidized Guardianship agreement on the date of their 18th birthday. Qualifying individuals are categorically eligible for BadgerCare Plus. There is no financial test or income limit. This includes individuals who were in a qualifying placement or agreement in any state when they turned 18. See SECTION 11.2 FORMER FOSTER CARE YOUTH for detailed eligibility criteria for Former Foster Care Youth.

2.2.6 Child

A child younger than 19 years old is nonfinancially eligible for BadgerCare Plus. Marital status and school enrollment status have no effect on their nonfinancial eligibility. The child does not have to be under the care of or related to the caretaker to be eligible for BadgerCare Plus.

Note	*A child younger than 19 years old residing with a caretaker relative may not apply as the primary person for the relative's benefits. For both a caretaker relative and a child to be included in one case, the caretaker relative must apply for BadgerCare Plus. A child younger than 19 years old residing with a parent may not apply separately from their parent. In addition, the parent must apply as the primary person for the case, unless the child filing the application is age 18. People older than 19 years old must always apply separately from their parents or caretakers, irrespective of their living arrangement or tax dependency.*

A child who has not been determined disabled must have their eligibility determined under BadgerCare Plus, not Medicaid for Elderly, Blind, or Disabled individuals (EBD Medicaid), even if the child has resided in an institution for 30 or more days.

2.2.7 Childless Adults

A childless adult is a person 19 to 64 years old who meets both of the following criteria:

- Is not receiving Medicare, except Medicare Part B Immunosuppressive Drug Benefit (Part B-ID).
- Does not have any dependent children younger than 19 years old who reside with them at least 40% of the time.

Marital status has no effect on a person being a childless adult.

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2.3 Modified Adjusted Gross Income Test Groups

BadgerCare Plus eligibility determinations use Modified Adjusted Gross Income (MAGI) rules. MAGI rules are based on the concept of a person's tax household, not necessarily on the physical household or family relationships.

2.3.1 Forming the Test Group Using Modified Adjusted Gross Income Tax Filing Rules

All MAGI groups are based on a "target" person. Each person who can become eligible for BadgerCare Plus on the application will be a target during the eligibility determination for a case.

2.3.1.1 Tax Filers

If the person is a tax filer and is not being claimed as a dependent by anyone else, then the person's MAGI group consists of the tax filer, the tax filer's spouse, and any dependents the tax filer is claiming.

If there is a pregnant woman in the group, include the number of expected babies in the group size. Verification of the number of expected babies is not required unless questionable. If the number of babies is unknown, add one to the group size.

In general, a person cannot be claimed as a tax dependent unless that person is a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico.

Note *IM agencies are not required to know tax rules and can accept self-attestation from applicants and members about their tax dependents, unless it is questionable.*

Whether someone is a tax filer or is a dependent of a tax filer is based on what the person plans to do for the current calendar year's taxes, and not on what they are required to do based on IRS tax law. For example, many people file taxes even though they are under the filing threshold because they want to receive their full tax refund or to qualify for the Earned Income Tax Credit. If a member reports that they plan to file taxes, the member will be treated as a tax filer in the test group, even if the member is below the threshold for being required to file.

Out-of-the-Home Tax Dependents

A tax filer is able to claim individuals who live outside of their home as their tax dependents. Common examples include college students and other adult children, elderly parents, or siblings who do not live with the filer(s). Tax filers can also claim a deceased child as their tax dependent in the year that the child has died. In these instances, the deceased child would be included in the tax filer's group size, though the child would not be eligible for benefits on that application.

Deceased Co-Filers

It is possible for a person to file their taxes jointly with a deceased spouse for the taxable year in which the spouse died. As of February 1, 2014, the deceased co-filer should be added to assistance groups according to MAGI rules for adding the jointly filing spouse of a tax filer.

Household Members in the Military

Deployed military members are still considered part of a tax household. Under MAGI rules, the military member's taxable income will count in the household and they will also be included in the household's group size, as appropriate. If a household member is absent due to military activity, they may be included in the group size but will not be eligible for assistance on this case.

Married Couples

Married individuals who are living together are always included in each other's group size, even if they are filing taxes separately. If a married couple is living apart but filing jointly, the couple is included in each other's group size. If the married couple is living apart and filing taxes separately, or are not planning to file taxes, do not include them in each other's group size.

2.3.1.2 Tax Dependents

In general, a tax dependent's household will be the same as their tax filer's household, even if the tax dependent is also a tax filer.

However, if any of the following situations apply, then the tax dependent's eligibility is based on MAGI relationship rules:

- The individual is being claimed as a dependent by a parent outside of the home (a non-custodial parent is defined as a parent who is living apart from the parent applying for benefits for the child)
- The individual is being claimed as a dependent by someone who is not their parent
- The individual lives with both parents and their parents are not married filing jointly

2.3.2 Forming the Test Group Using Modified Adjusted Gross Income Relationship Rules

Individuals who meet one of the exceptions to the MAGI tax filing rules or who are not tax filers or tax dependents will have their eligibility determined using MAGI relationship rules.

Under relationship rules, only include individuals who are living in the home with the target. If the target individual is under 19, then the target's group includes the target's parents, the target's spouse, the target's siblings under age 19 (including step and half siblings), and the target's children.

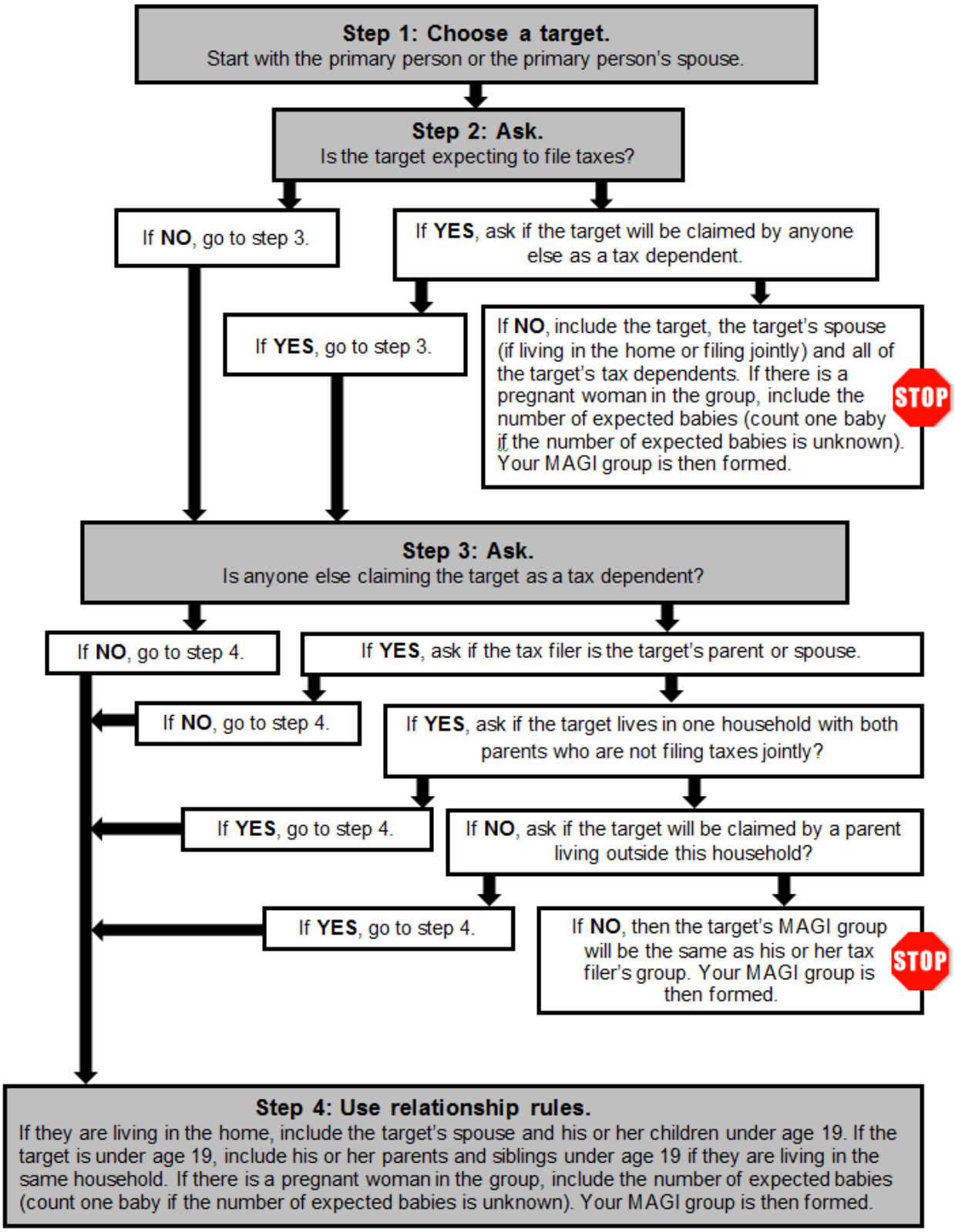
If the target individual is over age 19, the target's group includes the target's spouse and the target's children under age 19.

If there is a pregnant woman in the group, include the number of expected babies in the group size. Verification of the number of expected babies is not required unless questionable. If the number of babies is unknown, add one to the group size.

2.3.3 Modified Adjusted Gross Income Flowchart

The following flowchart may assist workers in forming groups under MAGI rules.

Four Steps to Forming a BadgerCare Plus MAGI Group



2.3.4 Former Foster Care Youth Test Group

If the primary person is a Former Foster Care Youth and younger than 26 years old, then the BadgerCare Plus test group will include the youth and their spouse if the spouse is also a Former Foster Care Youth. MAGI tax filing rules and relationship rules do not apply to Former Foster Care Youth when determining the youth's test group.

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2.4 BadgerCare Plus Household

"Living in the household" means all individuals residing in or temporarily absent (see SECTION 3.5.1 TEMPORARY ABSENCE) from the same residence. This includes:

- People living in the home in a community residential confinement program. DOC electronically monitors them.

- Huber law prisoners who are released from jail to attend to the needs of their families. The Huber law prisoner may be the caretaker relative in the household if both of the following are true:
    - The prisoner intends to return to the home.
    - The prisoner continues to be involved in the planning of the support and care of the minor children.

  See SECTION 45.8.4 HUBER LAW.

- Individuals who are incarcerated but reported as part of the household (see SECTION 45.7 HOUSEHOLD COMPOSITION).

2.4.1 Not Living in the Household

Individuals who are incarcerated are not considered to be living in the household if the applicant or member reports they are not part of the household.

2.4.2 Temporary Absence

A child and that child's parent or caretaker relative can be in the same BadgerCare Plus test group even when not living together if either is temporarily absent, provided they meet at least one of the following conditions:

1. The continuous absence is expected to be for no more than six months and the parent or caretaker relative continues to exercise responsibility for the care and control of the child.
2. The child was removed from the home by a child welfare agency and the parents meet the requirements listed in SECTION 10.1 ELIGIBILITY FOR PARENT OR CARETAKER RELATIVE WHEN CHILD IS REMOVED FROM THEIR CARE.
3. Either the child or the parent is out of the home and receiving residential substance use disorder treatment.

Condition 2 or 3 don't have a time limit. In addition, they do not require the caretaker relative to continue to exercise responsibility for the care and control of the child during these absences, except as described in SECTION 10.1 ELIGIBILITY FOR PARENT OR CARETAKER RELATIVE WHEN CHILD IS REMOVED FROM THEIR CARE and SECTION 10.2 ELIGIBILITY FOR CHILD WELFARE CARETAKERS..

The following children are not considered temporarily absent:

- Children who are in an institution for 30 or more days (unless they were placed there by a child welfare agency).
- Children who are in an IMD (unless they were placed there by a child welfare agency).

Note *Children in the above situations are considered temporarily absent if they are receiving residential substance use disorder treatment.*

2.4.3 Students

When a child younger than 19 years old who is a student living away from their parent's home applies for BadgerCare Plus, the child and their family can determine whether the student will be on their own case or a temporarily absent individual included in their parent's case.

Students older than 19 years old will need to apply for BadgerCare Plus with their own application.

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2.5 BadgerCare Plus Assistance Groups

Because of different BadgerCare Plus eligibility requirements, people within the BadgerCare Plus test group are placed into various BadgerCare Plus assistance groups.

Every BadgerCare Plus assistance group will have one potentially eligible member. Besides these potentially eligible members, other people may be designated as a person who is counted in the group and whose income may be counted when determining financial eligibility. Some people on the application will not be considered at all when determining eligibility. Placement in BadgerCare Plus assistance groups is dependent on age, tax filing relationships, and family relationships to the individual(s) whose eligibility is being determined.

The following are BadgerCare Plus assistance groups:

Assistance Group	Description
MAGY	Former Foster Care Youth
MAGP	Pregnant women, including those who are eligible for the BadgerCare Plus Prenatal Program and those who become eligible after meeting a deductible
MAGB	Continuously Eligible Newborns

MAGM	Adults in Earned Income and Spousal Support extensions
MAGN	Persons who are caretakers relatives, or the spouses of caretakers relatives in the home, including Child Welfare caretakers
MAGL	Children living with non-legally responsible relatives
MAGC	Children under age 19, living alone or with a parent or parents
MAGA	Persons age 19 or older who are parents, or stepparents of a child in the home, including Child Welfare parents
MAGD	Children who are eligible through meeting a deductible
MAGE	Children and Adults in Earned Income and Spousal Support extensions
MAGS	Childless adults

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2.6 Participation Status Codes

The participation status code for each individual in the BadgerCare Plus assistance group indicates whether the individual is eligible, counted or excluded in that assistance group.

Status Code		**Description**	**Include in the Group Size?**
CA	Counted Adult	Ineligible for BadgerCare Plus in this AG	Yes
CC	Counted Child	Ineligible for BadgerCare Plus in this AG	Yes
EA	Eligible Adult	Non-financially eligible in this BadgerCare Plus AG	Yes
EC	Eligible Child	Non-financially eligible in this BadgerCare Plus AG	Yes
XA	Excluded Adult	Ineligible for BadgerCare Plus in this AG	No
XC	Excluded Child	Ineligible for BadgerCare Plus in this AG	No

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2.7 Group Examples

Example 1

Temperance (36) and Seeley (40) are married parents and are not filing taxes. They have one daughter, Christine (1).

Person	BC+ Category	Temperance	Seeley	Christine
Temperance	MAGA	EA	CA	CC
Seeley	MAGA	CA	EA	CC
Christine	MAGC	CA	CA	EC

Example 2

Mr. and Mrs. Bennett are married parents filing taxes separately but living together. They have two daughters, Jane (18) and Elizabeth (17). Jane's husband, Charles (20) also lives with them. Mr. Bennett is claiming Jane, Elizabeth, and Charles as his tax dependents.

Person	BC+ Category	Mr. Bennett	Mrs. Bennett	Jane	Elizabeth	Charles
Mr. Bennett	MAGA	EA	CA	CC	CC	CA
Mrs. Bennett	MAGA	CA	EA	XC	XC	XA
Jane	MAGC	CA	CA	EC	CC	CA
Elizabeth	MAGC	CA	CA	CC	EC	XA
Charles	MAGS	XA	XA	CC	XC	EA

Example 3

Evie (29) and Derrick (32) are divorced parents. Their son, Neal (8), lives with Evie 80% of the time and 20% of the time with Derrick. Per their divorce agreement, this is Derrick's year to claim Neal as his tax dependent. Evie also files taxes. Evie is pregnant with her second child. Evie, Derrick, and Neal are all applying for health care. Evie and Neal will be on their own application. Derrick will have to apply on a separate application.

Person	BC+ Category	Evie	Derrick	Neal

Evie	MAGA	EA (+1)	-	XC
Derrick	MAGS	-	EA	CC
Neal	MAGC	CA (+1)	-	EC

Example 4

Same as above, except Neal lives 60% of the time with Evie and 40% of the time with Derrick, and neither Evie nor Derrick file taxes.

Person	**BC+ Category**	**Evie**	**Derrick**	**Neal**
Evie	MAGA	EA (+1)	-	CC
Derrick	MAGA	-	EA	CC
Neal	MAGC	CA (+1)	-	EC

Example 5

George (50) and Lucille (40) are married tax filers and are filing jointly. They have three tax dependents: Michael (14), Lindsay (14), and Buster (6). Buster is Lucille's nephew who George and Lucille care for. Michael and Lindsay are George and Lucille's children. George and Lucille also care for George's nephew Tobias (17) but will not claim him as a tax dependent. All six individuals are requesting health care.

Person	**BC+ Category**	**George**	**Lucille**	**Michael**	**Lindsay**	**Buster**	**Tobias**
George	MAGA	EA	CA	CC	CC	CC	XC
Lucille	MAGA	CA	EA	CC	CC	CC	XC
Michael	MAGC	CA	CA	EC	CC	CC	XC
Lindsay	MAGC	CA	CA	CC	EC	CC	XC
Buster	MAGL	XA	XA	XC	XC	EC	XC
Tobias	MAGL	XA	XA	XC	XC	XC	CC

Example 6

Danny (45) and Vicki (40) are non-married co-parents. They submit a BadgerCare Plus application for themselves, Danny's daughter DJ (22), Vicki's daughter Stephanie (13) Danny and Vicki's daughter, Michelle (10) and Danny's brother, Uncle Jesse (40). Danny claims DJ and Jesse as his tax dependents, while Vicki claims Stephanie and Michelle as her tax dependents.

Person	BC+ Category	Danny	Vicki	DJ	Stephanie	Michelle	Jesse
Danny	MAGA	EA	XA	CA	XC	XC	CA
Vicki	MAGA	XA	EA	XA	CC	CC	XA
DJ	MAGS	CA	XA	EA	XC	XC	CA
Stephanie	MAGC	XA	CA	XA	EC	CC	XA
Michelle	MAGC	CA	CA	XA	CC	EC	XA
Jesse	MAGS	XA	XA	XA	XC	XC	EA

Uncle Jesse and DJ will need to file their own applications.

Example 7

Emily is a 52-year-old grandmother who cares for her daughter, Lorelai (18) and her granddaughter, Rory (2). Emily is the primary caretaker of Rory. Lorelai has graduated high school. Nobody files taxes.

Person	BC+ Category	Emily	Lorelai	Rory
Emily	MAGN	EA	XC	XC
Lorelai	MAGC	CA	EC	CC
Rory	MAGC	XA	CC	EC

Example 8

Same example as example 7, except Emily is claiming Lorelai and Rory as her tax dependents.

Person	BC+ Category	Emily	Lorelai	Rory

Emily	MAGN	EA	CC	CC
Lorelai	MAGC	CA	EC	CC
Rory	MAGC	XA	CC	EC

Example 9

Merida is 18 years old. She lives with her parents, Elinor and Fergus. Merida is filing taxes for herself. She is not claimed as a tax dependent by anyone. Elinor and Fergus are filing taxes as married, filing jointly. They are not claiming any tax dependents.

Person	BC+ Category	Merida	Elinor	Fergus
Merida	MAGC	EC	XA	XA
Elinor	MAGA	XC	EA	CA
Fergus	MAGA	XC	CA	EA

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2.8 Modified Adjusted Gross Income Counting Rules

Within each Modified Adjusted Gross Income (MAGI) assistance group, all counted and eligible individuals' countable income is budgeted with one exception: if a group member is a child or tax dependent of a counted or eligible member within the same assistance group, the child's or tax dependent's income is only counted if they are "expected to be required" to file a tax return for the current year. If the tax dependent or child chooses to file a tax return when they are not required to, their income will not be counted. Tax dependents' and children's income is only counted when they are "expected to be required" to file a tax return.

Note *If a child or tax dependent is the only person in the MAGI group, they would not have a parent or tax filer eligible or counted in that group. As a result, the child's or tax dependent's income will always be counted, regardless of whether or not they are expected to be required to file taxes. Children in the care of a Non-legally Responsible Relative (NLRR) are an example of children who are the only counted or eligible people in a MAGI group.*

Tax dependents are only required to file a tax return if they have more income than the filing thresholds set by the IRS each year. If the child or tax dependent of another member in the same assistance group

expects to have less annual taxable income than the amounts below, their income is not included in the eligibility determination for the assistance group.

The following amounts are effective January 1, 2026:

- $1,350 per year in taxable unearned income*
- $16,100 per year in taxable earned income

*For expected unearned income, do not count Child Support, Social Security, Supplemental Security Income (SSI), Workers' Compensation, Veteran's Benefits, money from another person, or educational aid.

These income counting rules apply regardless of whether the assistance group was formed based on MAGI Tax Filing Rules or MAGI Relationship Rules.

The income of household members who are currently out of the home due to military activity will still be counted according to MAGI rules, even though the person will not be eligible on the case.

Example 1	Jack and Jill are married and will be filing a joint tax return. They have two children, Mickey (16) and Minnie (12), whom they will claim as tax dependents. Minnie has no income, but Mickey works at McDonald's earning approximately $100 per month. Mickey's annual earned income is expected to be $1,200; he is not expected to be required to file a tax return at the end of the year. Mickey's income is not counted.

Example 2	Daisy plans to file taxes this year. She has one tax dependent, her son Donald (16), who works part-time at a grocery store. He earns $1,400 per month; with an annual income of $16,800. Based on this income, Donald will be expected to be required to file a tax return. Donald's income is counted.

Example 3	Kelly and Zack are non-married co-parents and have two children, Jessie (17) and Albert (14). Albert mows lawns in the summer and makes around $300 for the year. The only other income in the household is Zack's unemployment payment in the amount of $400 per month ($4,800 per year). Kelly and Zack do not plan to file taxes. Albert is not expected to be required to file taxes. The assistance groups for this case will be based on non-MAGI relationship rules since there is no tax filer in the household. Zack's UI payment will be counted, but Albert's self-employment income is not counted because he is not expected to be required to file.

Example 4	Michael (16) and his sister Janet (17) live with their aunt Barb and her two children. Barb applies for BadgerCare Plus for herself, her two children, and her niece and nephew. Barb states she plans to file taxes and will be claiming Michael, Janet, and her two children as tax dependents. Barb is self-employed earning about $800 per month. Michael is working part-time at Dairy Queen earning approximately $150 per month. Michael is not expected to be required to file taxes. Janet works part-time at Copps and makes $1,400 per month. She will be expected to be required to file taxes. *Outcome for Barb* Barb's assistance group will consist of herself and all four children since she will be claiming them as tax dependents. Michael's income will not be counted in Barb's assistance group because he is not expected to be required to file taxes, but Janet's income will be counted in Barb's group because Janet is expected to be required to file taxes. Barb's children's assistance groups will be the same as Barb's assistance group.

	Outcome for Michael and Janet Michael and Janet will both have an assistance group of two (MAGL) since they are siblings being claimed as tax dependents by someone living in the home who is not their parent. Michael and Janet's groups are built using MAGI relationship rules. All of Michael's and Janet's earned income will be countable when determining their eligibility because they are not the children or tax dependents of someone in their group.

Example 5	Joe is married to Deanna, and they have a son Beau who is three years old. They file taxes jointly and claim Beau as a dependent. Deanna and Joe are both working and will be required to file taxes. Deanna is also in the military. Joe applies for BadgerCare Plus for himself and Beau while Deanna is deployed overseas. Even though Deanna will not be eligible, she will be a counted adult, and her income will be counted in the BadgerCare Plus determinations for Joe and Beau.

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3.1 Residency Eligibility

3.1.1 Residency Eligibility Introduction

A person must be a Wisconsin resident to be eligible for BadgerCare Plus and must meet both of the following conditions:

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 3.5 ABSENCE FROM WISCONSIN), 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.
2. Express intent to reside in Wisconsin (see SECTION 3.2 INTENT TO RESIDE). An individual can 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, regardless of whether they are employed at the time of application.

Example 1	John, a student from Wisconsin who is attending college in Minnesota, can apply for BadgerCare Plus as a Wisconsin resident.

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

Example 3	This is George's first day in Wisconsin. He states that he intends to reside in Wisconsin. For BadgerCare Plus purposes, George is a Wisconsin resident.

3.1.2 Migrant Workers

A person who meets the definition of a migrant worker (see SECTION 12.1 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 (see SECTION 12.4.2 SIMPLIFIED APPLICATION PROCEDURE FOR MIGRANT WORKERS).

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3.2 Intent to Reside

Intent to reside means a person intends that Wisconsin is and will remain their state of residence. 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 any of the following is true:

- They are judged legally incompetent by a court of record.
- Their I.Q. is 49 or less or they have a mental age of seven or less, based on tests acceptable to Wisconsin's Department of Health Services (DHS).
- They are incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by Wisconsin in the field of developmental disability.

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 Wisconsin, nor does it require an intent to reside at a fixed address.

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3.3 Determining State Residency

For individuals receiving Medicaid based on receipt of Title IV-E assistance or individuals receiving State SSI, see SECTION 3.4 SPECIAL SITUATIONS.

For individuals living in Wisconsin as a migrant worker or living with a family member who is a migrant farm worker, see SECTION 3.1.2 MIGRANT WORKERS.

For individuals placed in Wisconsin by another state that has legal custody, see Medicaid Eligibility Handbook, Section 6.8 Interstate Placements.

For all other applicants and members, use the following subsections to determine state residency.

3.3.1 Under Age 21

Not in an Institution

A person under age 21 and not residing in an institution is a Wisconsin resident if they are any of the following:

- A person under age 18, not emancipated from their parents, not married, are living in Wisconsin, and any of the following are true:

- They are living in another state when Wisconsin or one of its county agencies has legal custody of them.
- They are living in Wisconsin and are eligible based on blindness or disability.
- They are living in another state when their parent is a resident of Wisconsin, has legal custody of them, and they intend to reside with this parent.

Example 1	Alicia is a Wisconsin resident and intends to remain living in Wisconsin. She gives birth to her son, Max, at a hospital in Minnesota. Due to medical complications, Max is a patient in the hospital for three weeks immediately after his birth. Even though Max has not physically been in Wisconsin after his birth, he is a resident of Wisconsin. He is a resident because his parent, Alicia, has legal custody of Max, and Max will reside with her in Wisconsin once he is discharged from the hospital.

- A person age 18 through 20 or under age 18, emancipated from their parents or married, and either of the following is true:
  - They are living in Wisconsin with the intent to remain living in Wisconsin.
  - They are living in Wisconsin and entered Wisconsin with a job commitment or to seek employment.

In an Institution

The residence of an institutionalized person under age 21 is the state in which a parent or legal guardian indicates the institutionalized person is present and intends to stay. This is true whether their parent or legal guardian lives in Wisconsin or not.

If the parents have abandoned them and no legal guardian has been appointed, their residence is the state in which the institution is located, as long as the person requesting health care on their behalf resides in the same state.

If they are married, their residence is the institution's state.

3.3.2 Age 21 and Over

Not in an Institution

An individual age 21 or over who is not in an institution is a Wisconsin resident if either of the following is true:

- They are living in Wisconsin with the intent to remain living in Wisconsin.
- They are living in Wisconsin and entered Wisconsin with a job commitment or to seek employment.

If they are incapable of expressing intent, an individual is a resident if they are living in Wisconsin.

In an Institution

The residence of an institutionalized individual, aged 21 or over, capable of indicating intent, is the state in which they are residing with the intent to remain.

If they became incapable of indicating intent before age 21, their residency is determined in the same way as an institutionalized person under age 21.

If they became incapable of indicating intent at age 21 or older, their residence is Wisconsin.

For all others, the person is a Wisconsin resident if they intend to reside in Wisconsin.

3.4 Special Situations

3.4.1 State Supplementary Payment

The State Supplementary Payment (SSP) is the portion of an SSI payment paid by a state, not by the federal government. A person receiving SSP payments is a resident of the state making the SSP payment.

3.4.2 Foster Care Medicaid

Any child placed in or receiving out-of-home care (also known as foster care), court-ordered Kinship Care, Long-Term Kinship Care, Subsidized Guardianship or Adoption Assistance is eligible for Foster Care Medicaid in Wisconsin.

3.4.2.1 IV-E Children

Federal financial participation is available under Title IV-E of the Social Security Act to pay for all or part of a child's out-of-home care (also known as foster care), court-ordered Kinship Care, Long-Term Kinship Care, Subsidized Guardianship or Adoption Assistance. Title IV-E eligible children are categorically eligible for Foster Care Medicaid in the state where they reside.

3.4.2.2 Non-IV-E Foster Children

Wisconsin certifies Foster Care Medicaid eligibility for non IV-E foster children living in Wisconsin and other states when Wisconsin or one of its county/tribal agencies has legal custody of the child or when the Adoption Assistance or Subsidized Guardianship agreement was established in the State of Wisconsin.

Non-IV-E foster children are eligible for Foster Care Medicaid.

3.4.3 Homeless Persons

A homeless person living in Wisconsin meets the residency requirement by being physically present in Wisconsin. See SECTION 38.5.3 HOMELESS for information on mailing addresses for ForwardHealth cards.

3.5 Absence from Wisconsin

3.5.1 Absence Introduction

Once established, Wisconsin residency is retained until any of the following occurs:

- The person notifies the IM agency that they no longer intend 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.

3.5.2 Temporary Absence

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

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3.6 Reserved

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4.1 U.S. Citizens and Nationals

To qualify for BadgerCare Plus, 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 person is a U.S. citizen if any of the following is true:

- 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 person is a U.S. national if they were 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.

4.1.1 Child Citizenship Act

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

- 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
- Certain children born out of wedlock to a mother who naturalizes

The CCA provides that foreign-born children who meet all of 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 1 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 the children meet all the above conditions and any of the following:

- **Adopted under the age of 16** and has been in the legal custody of and has resided with the adopting parent or parents for at least two years.
- **Adopted while under the age of 18** and has been in the legal custody of and has resided with the adopting parent or parents for at least two years and is a sibling of another adopted child who is under 16.
- **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.
- **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.

4.1.2 Citizens of the Compacts of Free Association Countries

Citizens of the Compacts of Free Association countries are not considered U.S. citizens or nationals. The Compacts of Free Association countries include the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau. Citizens of the Compact of Free Association (COFA) countries 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. However, COFA citizens who adjust their status and become Lawful Permanent Residents are subject to the five-year waiting period.

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4.2 Verifying U.S. Citizenship

U.S. citizenship must be verified for persons applying for or receiving Medicaid (MA), BadgerCare Plus, or Family Planning Only Services (FPOS) benefits and who have declared that they are a U.S. citizen, unless they are exempt from this requirement (see SECTION 4.2.2 EXEMPT POPULATIONS). Citizenship verification for health care must first be attempted using the real-time data exchanges with the Social Security Administration, birth record query, and Systematic Alien Verification for Entitlements (SAVE) before requesting documentation of citizenship from applicants (see SECTION 4.2.3 U.S. CITIZENSHIP VERIFICATION THROUGH THE SOCIAL SECURITY ADMINISTRATION (SSA) 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 4.2.4 OTHER METHODS OF CITIZENSHIP VERIFICATION). 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.

4.2.1 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.

Presumptive Eligibility/Temporary Enrollment

Qualified providers who conduct BadgerCare Plus presumptive eligibility determinations may not verify the citizenship of persons seeking eligibility through presumptive eligibility. Persons determined eligible for BadgerCare Plus through presumptive eligibility are not subject to the citizenship verification requirement until they file an application online or with the Income Maintenance agency.

4.2.2 Exempt Populations

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

- Anyone who receives or previously received Social Security Disability Insurance (SSDI), Disabled Adult Child benefit (SSDC), or Disabled Widow(er)'s Benefits
- Anyone who receives or previously received Supplemental Security Income (SSI) benefits
- Anyone entitled to or enrolled in Medicare
- Anyone who receives Foster Care Medicaid (FSTMA), which includes Adoption Assistance, or previously received Title IV-E FSTMA
- 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)
- Anyone 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 4.2.4.3 EVIDENCE OF IDENTITY).

Data exchanges must be used to verify current or previous receipt of SSI, SSDI, SSDC, FSTMA, and Medicare prior to requesting verification from the recipient.

4.2.3 U.S. Citizenship Verification through the Social Security Administration (SSA) Data Exchange

For individuals who meet the selection criteria below, a request is sent electronically to the SSA with the person's name, verified Social Security Number (SSN), and date of birth for comparison to the SSA's data. If the SSA verifies citizenship, no additional verification of 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 4.2.2 EXEMPT POPULATIONS.
- Not have already had their U.S. citizenship verified through other means.

Non-exempt BadgerCare Plus applicants or members who do not provide an SSN, or whose SSN cannot be verified, cannot have their citizenship verified through the data exchange. They must meet the citizenship verification requirement by having their citizenship verified through a birth record query, SAVE, or by providing documentation as defined in SECTION 4.2.4 OTHER METHODS OF CITIZENSHIP VERIFICATION.

4.2.4 Other Methods of Citizenship Verification

For individuals who are not exempt from the citizenship verification requirement and have not had their citizenship verified by the Social Security Administration, agencies must first attempt to verify an individual'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 citizenship through either stand-alone documentation of citizenship (see SECTION 4.2.4.1 STAND-ALONE DOCUMENTATION OF CITIZENSHIP) or both documentation of citizenship (see SECTION 4.2.4.2 EVIDENCE OF CITIZENSHIP) and identity (see SECTION 4.2.4.3 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 4.2.4.4 REASONABLE OPPORTUNITY PERIOD FOR VERIFICATION OF CITIZENSHIP).

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

If an applicant or member contacts the agency for help with verifying citizenship, work with them to determine if anything on the document list in Process Help, Section 19.3.5.3 Automatically Populated Verification Codes and Acceptable Citizenship and Identity Documentation is readily available to the applicant or member. In certain circumstances the agency can authorize payment for obtaining documentation for an applicant or member (see SECTION 4.2.5 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 their first and last name, they 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 19.3.5 Citizenship and Identity Verification, for tools that IM workers can use to assist applicants and members 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.

4.2.4.1 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 citizenship verification is required. See the chart below or Process Help, Section 19.3.5.3.3 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 4.2.4.2 EVIDENCE OF CITIZENSHIP and SECTION 4.2.4.3 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. Note: 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: 1. Identifies the federally recognized Indian tribe that issued the document 2. Identifies the individual by name

	3. 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 • 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.

4.2.4.2 Evidence of U.S. Citizenship

If an applicant whose U.S. citizenship has not been verified by SSA, birth query, or through the SAVE database, is unable to provide stand-alone documentation of U.S. citizenship (see SECTION 4.2.4.1 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 19.3.5.3.4 Documentation of Citizenship Only).

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) form or another affidavit.

Applicants whose U.S. citizenship cannot be verified by SSA or through stand-alone documentation of citizenship must also provide documentation of identity (see SECTION 4.2.4.3 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. If 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, 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 five 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, 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).
Acquired citizenship through parent(s) as outlined in the Child Citizenship Act of 2000 (CCA)	An individual demonstrates that they have gained their U.S. citizenship through the Child Citizenship Act of 2000.
U.S. 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, • 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, 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 U.S. 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 U.S. 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.

4.2.4.3 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 4.2.4.1 STAND-ALONE DOCUMENTATION OF U.S. CITIZENSHIP), they must provide evidence of both citizenship (see SECTION 4.2.4.2 EVIDENCE OF CITIZENSHIP) and identity.

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

- U.S. citizens who are exempt from the verification requirement (see SECTION 4.2.2 EXEMPT POPULATIONS).
- U.S. citizens whose citizenship is verified by SSA, birth query, through the SAVE database, or other stand-alone documentation of citizenship.
- People who have not declared they are U.S. citizens.
- Non-U.S. citizens.

To provide separate verification of identity, the applicant must provide documentation to establish identity, provided such documentation includes a photograph or other identifying information sufficient to establish identity (such as, name, age, sex, race, height, weight, eye color, or address) (see the chart below or Process Help, Section 19.3.5.3.5 Documentation of Identity Only).

In addition, IM agencies 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) form 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. Note: REAL IDs only provide documentation of 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 U.S. 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 two or more corroborating ID documents to verify their 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.
Statement of Identity for Children Under 18 Years of Age **(Form F-10154)**	If the applicant cannot produce the accepted documents verifying identity for children under 18 years of age, a completed F-10154 is acceptable documentation of identity. The form 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 form doesn't need 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 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 (F-10161) may be used for the affidavit.

4.2.4.4 Reasonable Opportunity Period for Verification of Citizenship

Applicants who are otherwise eligible for BadgerCare Plus or other health care benefits and are only pending for verification of citizenship (and identity when needed) must be certified for health care

benefits within the normal application processing timeframe (30 days from the filing date). They are able to continue receiving health care benefits for which they are eligible, while the IM agency waits for citizenship verification. Applicants have 90 days after receiving a request for 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 citizenship verification by the end of the reasonable opportunity period. Federal regulations require that a minimum five days' time frame be allotted for applicants to receive notices. For this reason, the end of the ROP must be set 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 BadgerCare Plus are not subject to recovery, even if the person never provides citizenship verification.

4.2.5 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
- Requests financial assistance

Note *If a member has obtained and already paid for their 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 must follow the process outlined in Process Help, Section 19.3.5.6 Agency Documentation Requests.

4.2.6 Reserved

4.2.7 Situations Which Require Special Documentation Processing

4.2.7.1 Person Add

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

4.2.7.2 Presumptive Eligibility/Express Enrollment (EE)

Qualified providers who conduct BadgerCare Plus presumptive eligibility/express enrollment determinations must not apply the citizenship and identification documentation requirement to persons seeking presumptive eligibility. Persons determined presumptively eligible for BadgerCare Plus are not subject to the documentation requirement until they file a formal application with the local Income Maintenance agency.

4.2.7.3 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/identity should be counted as part of the group when determining eligibility for other group members. See Process Help, Section 19.3.5 Citizenship and Identity Verification, for processing instructions.

4.2.7.4 Child Citizenship Act

Certain foreign-born individuals have derivative U.S. citizenship as a result of the Child Citizenship Act (CCA) (see SECTION 4.1.1. CHILD CITIZENSHIP ACT).

IM workers should not request citizenship documentation for persons claiming U.S. citizenship through the CCA. In these cases, IM workers must instead verify 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 4.2.4.3 EVIDENCE OF IDENTITY).

4.2.7.5 Non-U.S. Citizens

IM agencies must not request or require citizenship or identity documentation 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 the 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 19.2.1.12 Immigrant/Refugee Verification for instructions on using FDSH and Process Help, Chapter 24.24 SAVE Introduction 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.

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."

4.2.7.6 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 (SNF), intermediate care facilities, Institutes of Mental Disease (IMD), and hospitals.

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4.3 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 BadgerCare Plus 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 4.3.1 DECLARATION OF SATISFACTORY IMMIGRATION STATUS), and
    - Are "Qualified Immigrants" (see SECTION 4.3.3.1 QUALIFYING IMMIGRANTS), or
    - Are "Lawfully Present" (see SECTION 4.3.3.2 NON-CITIZEN LAWFULLY PRESENT 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 4.3.2 VERIFICATION). Prior to verification of immigration status, benefits may also be issued for a temporary period under a Reasonable Opportunity Period (see SECTION 4.3.2.2 REASONABLE OPPORTUNITY PERIOD FOR VERIFICATION OF IMMIGRATION STATUS).

4.3.1 Declaration of Satisfactory Immigration Status

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

- Persons applying for Emergency Services.

- Pregnant women 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 their paper or ACCESS application that they are not a U.S. citizen and not provide any information about their immigration status. In such a situation, it is not known whether the person is stating that they are lawfully present in the U.S. (that is, 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 SECTION 4.3.2.2 REASONABLE OPPORTUNITY PERIOD FOR VERIFICATION OF IMMIGRATION STATUS). To meet this declaration requirement, everyone who indicates that they are not a U.S. citizen or national must provide one of the following:

- Their immigration status
- Their immigration number (including an I-94, passport, SEVIS, or similar number)
- A signed declaration that says they have 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 their behalf) within standard verification timeframes must be denied health care benefits and must not be granted a reasonable opportunity period.

4.3.2 Verification

4.3.2.1 Verification through FDSH or SAVE

Primary verification of immigration status is done through U.S. Citizenship and Immigration Services (USCIS) by use of the Federal Data Services Hub (FDSH) or Systematic Alien Verification for Entitlements (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 the USCIS, 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 Additional Eligibility Information column in the table in SECTION 4.3.3.1 QUALIFYING IMMIGRANTS).

It may be necessary to complete a secondary or third level verification procedure with the 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 4.3.2.2.3 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 24.24 SAVE Introduction for more information.

4.3.2.2 Other Verification

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

4.3.2.2.1 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

4.3.2.2.2 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

4.3.2.2.3 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 and Date

4.3.2.3 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 of 20 - Non-Citizen Lawfully Present in the U.S. Even if an immigrant loses health care eligibility for a period, their immigration status does not need to be re-verified.

When a non-citizen is no longer eligible for BadgerCare Plus due to their immigration status, their status may be reverified to ascertain if they have had a change in status through which they may be eligible for benefits.

People with a Registration Status Code of 20 – Non-Citizen Lawfully Present in the U.S. 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 12-month 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 19.3.9 Immigrant/Refugee Information Page for additional information on using the FDSH or the procedures in the SAVE Manual.

4.3.2.4 Reasonable Opportunity Period for Verification of Immigration Status

Applicants who have declared that they are in a satisfactory immigration status (and are only pending for verification of immigration status) are otherwise eligible and 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 status have 90 days after receiving a request for immigration status 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 status verification by the end of the reasonable opportunity period. Federal regulations require that a minimum of five days be allotted for applicants to receive notices. For this reason, the end of the ROP must be set 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 status verification is needed from a person at any time: applications, renewals, immigration status changes, 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 their 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 BadgerCare Plus and is enrolled in BadgerCare Plus 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 – Non-Citizen Lawfully Present in the U.S. 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 BadgerCare Plus, 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 requesting a letter from HSS 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 BadgerCare Plus are not subject to recovery, even if the person turns out to have an immigration status that makes them ineligible for BadgerCare Plus benefits.

4.3.3 Immigrants Eligible for BadgerCare Plus

Immigrants may be eligible for BadgerCare Plus if they meet all other eligibility requirements and are either Qualifying Immigrants (see SECTION 4.3.3.1 QUALIFYING IMMIGRANTS) or are Lawfully Present (see SECTION 4.3.3.2 NON-CITIZEN LAWFULLY PRESENT CHILDREN, YOUNG ADULTS, AND PREGNANT PEOPLE).

4.3.3.1 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	No additional criteria.	An immigrant admitted under this status may be eligible for BadgerCare Plus, without a five-year waiting period, even if their	04

	to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group.		immigration status later changes.	
Refugee-Like including Special Immigrant Visa Holders	An immigrant who qualifies for benefits to the same extent as a refugee due to an act of Congress	See SECTION 4.3.3.1.1 REFUGEE-LIKE IMMIGRANTS WHO HAVE BENEFIT 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 BadgerCare Plus, without a five-year waiting period, even if their immigration status later changes.	05
Person Granted Withholding of Removal	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 BadgerCare Plus, 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 4.3.3.1.2 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 Member of a Tribal Nation	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.	An immigrant admitted under this status may be eligible for BadgerCare Plus, without a five-year waiting period, even if their immigration status later changes.	18
COFA Migrant	A person who is a citizen of a country in the Compacts of Free Association (COFA).	No additional criteria. See SECTION 4.3.3.1.3 CITIZENS OF THE COMPACTS OF FREE ASSOCIATION COUNTRIES for more information.	An immigrant admitted under this status may be eligible for BadgerCare Plus, without a five-year waiting period, even if their immigration status later changes.	22

Trafficking Victim or their Family	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 2000 (P.L. 106-386).	See SECTION 4.3.3.1.4 VICTIMS OF TRAFFICKING for more information.	An immigrant admitted under this status may be eligible for BadgerCare Plus, without a five-year waiting period, even if their immigration status later changes.	19
Trafficking Victim		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. SEE SECTION 4.3.3.1.5 ADDITIONAL CRITERIA FOR CERTAIN QUALIFYING IMMIGRANTS for more information.	Be certified by the Department of Health and Human Services (HHS) as a 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.
Lawful Permanent Resident	An immigrant lawfully admitted for permanent residence under INA 8 USC 1101 et seq.		N/A	01 - Five-year waiting period applies. Or 23 - Five-year waiting period does not apply.
Person Paroled for at Least One Year	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 benefit eligibility purposes due to acts of Congress	06

			(SEE SECTION 4.3.3.1.1 REFUGEE-LIKE IMMIGRANTS WHO HAVE BENEFIT ELIGIBILITY AS REFUGEES BECAUSE OF AN ACT OF CONGRESS). Parolees who are nationals of Cuba or Haiti may be Cuban/Haitian Entrants for benefit eligibility purposes (SEE SECTION 4.3.3.1.2 CUBAN/HAITIAN ENTRANTS).	
Conditional Entrant	An immigrant granted conditional entry under immigration law in effect before April 1, 1980 [INA Section 203(a)(7)].		N/A	03
VAWA Self-Petitioner	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	N/A		16

	extreme cruelty in the U.S. and meets certain other requirements.			
	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

4.3.3.1.1 "Refugee-Like" Immigrants who have Benefit Eligibility as Refugees Because of an Act of Congress

4.3.3.1.1.1 Iraqis and Afghans with Special Immigrant Status

Special Immigrants from Iraq or Afghanistan (Class of Admission (COA) 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 BadgerCare Plus 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 BadgerCare Plus. 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 (COA) codes for SI CPRs are CQ1, CQ2, and CQ3.

4.3.3.1.1.2 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 BadgerCare Plus.

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 BadgerCare Plus 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 (COA) Codes that are used for these groups:

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

4.3.3.1.1.3 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 BadgerCare Plus.

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 BadgerCare Plus 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 (COA) Code	Description	CARES Alien Registration Status Code
UHP, DT, PAR, or U4U	Humanitarian Parolee	Code 04

See Process Help, Section 24.27 SAVE Responses Mapping to CARES Immigration Status Codes Chart for detailed information including Class of Admission (COA) codes for Ukrainian humanitarian parolees.

4.3.3.1.2 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). CHEs 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 5-year waiting period as Lawful Permanent Residents.

4.3.3.1.3 Citizens of the Compacts of Free Association Countries

Citizens of the Compacts of Free Association (COFA) countries are not considered U.S. citizens or nationals. The Compacts of Free Association countries include the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau. COFA migrants 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 migrants may be eligible for health care if they meet all other eligibility requirements. In addition, COFA migrants are not subject to the five-year waiting period. COFA migrants who have a change in their status and become Lawful Permanent Residents (LPRs) are not subject to the five-year waiting period.

4.3.3.1.4 Victims of Trafficking

The U.S. Department of Health and Human Services Office on Trafficking in 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 BadgerCare Plus to be eligible to receive benefits. The certification process typically takes a few days after HHS is notified by the U.S. Department of Homeland Security 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 the HHS OTIP qualify for benefits as a Victim of Trafficking regardless of their immigration status.
- Applicants who are victims of trafficking with class of admission (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 4.3.3.1.5 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 meet additional criteria described in SECTION 4.3.3.1.5 ADDITIONAL CRITERIA FOR CERTAIN QUALIFYING IMMIGRANTS or were certified by HHS as a victim of trafficking and who later have a change in their status and become Lawful Permanent Residents are not subject to the five-year waiting period as Lawful Permanent Residents.

4.3.3.1.5 Additional Criteria for Certain Qualifying Immigrants

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

- Lawful permanent residents (LPR)
- People who are paroled into the U.S. under INA Section 212(d)(5) for at least one year.
- People considered to be VAWA self-petitioners 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. 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 BadgerCare Plus.
- Pregnant people have the 5-year waiting period lifted when their pregnancy is reported to the agency. The waiting period is lifted until 12 months after the last day of pregnancy and through the end of the month in which the 12th month 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 legal qualified immigrant status after August 22, 1996, may be eligible to receive BadgerCare Plus. The immigrants described below, who apply for BadgerCare Plus and meet all eligibility requirements, are entitled to receive BadgerCare Plus 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 (making them 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 immigration 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 (LPRs) who were previously a refugee, asylee, COFA migrant, Foreign-Born Member of a Tribal Nation or had their removal withheld are not required to have been in a qualifying immigration status for five years.

See SECTION 4.3.3.1.4 VICTIMS OF TRAFFICKING for specific policy regarding Victims of Trafficking.

4.3.3.2 Non-Citizen Lawfully Present Children, Young Adults, and Pregnant People

Children younger than 19 years old, young adults younger than 21 years old who are residing in an Institute for Mental Diseases (IMD), and pregnant people may qualify for BadgerCare Plus if they are lawfully present in the U.S. under many of the immigrant and nonimmigrant statuses. For those who are not in a qualifying Immigrant category, but are lawfully present, use the Registration Status Code of 20 (see Process Help, Section 24.27 SAVE Responses Mapping to CARES Immigration Status Codes Chart for a list of SAVE Responses and the appropriate Registration Status Code in CWW to apply).

4.3.3.3 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 BadgerCare Plus and meet all eligibility requirements except for citizenship and immigration status may be entitled to receive BadgerCare Plus Emergency Services only (see CHAPTER 39 EMERGENCY SERVICES).

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

4.3.3.4 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 BadgerCare Plus Group. The citizen spouse or child of an ineligible immigrant may still be eligible even though the immigrant is not.

4.3.4 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 U.S or obtain lawful permanent resident (LPR) 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 LPRs, 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 BadgerCare Plus does **not** make them a public charge.

The **only** category of BadgerCare Plus 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.

No services provided under the Children's Health Insurance Program (CHIP) are considered in public charge determinations.

4.3.5 Immigration Customs Enforcement (ICE) Reporting

BadgerCare Plus 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.

4.3.6 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 their status with the U.S. Citizenship and Immigration Services (USCIS). Undocumented immigrants do not have any official documentation regarding their date of arrival.

4.3.7 Immigration Status Chart

See Process Help, Section 24.27 SAVE Responses Mapping to CARES Immigration Status Codes Chart for a list of Systematic Alien Verification for Entitlement (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 age 19 and pregnant people; Arrived on or after August 22, 1996

01	Lawful Permanent Resident - Five-year wait	Eligible	Eligible	Ineligible for five years	Eligible	Effective October 1, 2009, Eligible
02	Permanent resident under color of law	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
03	Conditional Entrant	Eligible	Eligible	Ineligible for five years	Eligible	Effective October 1, 2009, Eligible
04	Refugee or Special Immigrant Visa Holder	Eligible	Eligible	Eligible	Eligible	Eligible
05	Asylee	Eligible	Eligible	Eligible	Eligible	Eligible
06	Person Paroled for at Least One Year	Eligible	Eligible	Ineligible for five years	Eligible	Effective October 1, 2009, Eligible
07	Worker Authorized Through IRCA	N/A	N/A	N/A	N/A	N/A
08	Temporarily Lawfully Admitted Person	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
09	Undocumented Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
10	Undocumented Individual	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
11	Cuban/Haitian Entrant	Eligible	Eligible	Eligible	Eligible	Eligible
12	Conditional Permanent Resident	Ineligible	Ineligible	Ineligible	Ineligible	Eligible

13	Special Agricultural Worker	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
14	Additional Special Agricultural Worker	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
15	Person Granted Withholding of Removal	Eligible	Eligible	Eligible	Eligible	Eligible
16	VAWA Self-Petitioner	Eligible	Eligible	Ineligible for five years	Eligible	Effective October 1, 2009, Eligible
17	Amerasian	Eligible	Eligible	Eligible	Eligible	Eligible
18	Foreign-Born Member of a Tribal Nation	Eligible	Eligible	Eligible	Eligible	Eligible
19	Trafficking Victim or their Family**	Eligible	Eligible	Eligible	Eligible	Eligible
20	Non-Citizen Lawfully Present in the U.S.	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
21	Trafficking Victim with T-1 Visa	Eligible	Eligible	Ineligible for five years	Eligible	Eligible
22	Compact of Free Association Migrant	Eligible	Eligible	Eligible	Eligible	Eligible
23	Lawful Permanent Resident	Eligible	Eligible	Eligible	Eligible	Eligible

* "Veteran" includes certain veterans and active-duty service members, 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 4.3.3.1.4 VICTIMS OF TRAFFICKING).

4.3.8 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.

4.3.8.1 Counting Refugee-Related Income

Refugee Cash Assistance Program payments are not counted as income for BadgerCare Plus. Refugee Cash Assistance is administered by W-2 agencies and is made available for refugees who do not qualify for W-2.

Refugee "Reception and Placement" payments are not counted as income for BadgerCare Plus. Reception and Placement payments are 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.

4.3.8.2 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. 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 is determined for all other BadgerCare Plus or Medicaid subprograms first.

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

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5.1 Medical Support

Medical support refers to the obligation that a parent has to pay for their child's medical care, either through the provision of health insurance coverage or direct payment of medical bills. The CSA is responsible for establishing medical support orders for some children receiving BadgerCare Plus 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.)

5.1.1 Recovery of Birth Costs

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

5.1.2 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 5.2.2 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 10.2.1 Enter Absent Parent Information).

Note *A Referral to Child Support form (DCF-F-DWSP3080) only needs to be completed when the Absent Parent page cannot be completed in CWW.*

While IM agencies refer individuals receiving BadgerCare Plus to the CSA, the CSA determines which cases receive child support services. Not all BadgerCare Plus members qualify for free child support services and not all members are required to cooperate with the CSAs.

The following individuals (including minors) for whom BadgerCare Plus is requested or being received, must be referred to the local CSA with the exceptions noted below:

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 or the 12-month postpartum period (see SECTION 8.1 PREGNANT MEMBERS). The member's eligibility for BadgerCare Plus will continue during this period, regardless of the member's cooperation.
    a. **Exception**: Pregnant members receiving the BadgerCare Plus Prenatal Benefit should not be referred to a CSA.
2. A child receiving SSI. Parents or caretaker relatives are not sanctioned if they do not cooperate with the CSA.
3. Non-marital co-parents when paternity has not been legally established, even when both parents are in the home.
    a. **Exception**: Referrals are not made 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 Acknowledgment Form filed with a state agency.
4. Biological or adoptive parent(s) not living in the household.
    a. **Exception**: Referrals are not made 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. The child was born prior to their marriage, and
    b. Paternity was not established by court action or established after their marriage.

Referrals for the following individuals are not made to the local CSA:

- Former Foster Care Youth, unless the youth is also a parent of an eligible child in the household.
- People residing in domestic abuse shelters. The referral is sent to the CSA after the person moves out of the domestic abuse shelter.

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5.2 Medical Support/Child Support Agency Cooperation

5.2.1 Introduction

Unless the person is exempt or has good cause for refusal to cooperate (see SECTION 5.2.2 EXEMPTIONS FROM COOPERATION and SECTION 5.3 CLAIMING GOOD CAUSE), each member that is referred must, as a condition of eligibility, cooperate in both of 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 member and for any child for whom BadgerCare Plus is requested or received

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

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

5.2.2 Exemptions from Cooperation

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

- 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 SECTION 51.1 BADGERCARE PLUS CATEGORIES. The CSA will monitor the child's BadgerCare Plus funding source.
- The child under their care receives SSI.
- The parent or caretaker relative is one of the following:
    - Eligible for the BadgerCare Plus Extension.
    - A pregnant person, until the end of the 12-month postpartum period.
    - Under 18 years old.
    - Aged 18 and receiving CHIP coverage under BadgerCare Plus (income is over 156% FPL).
- Both absent parents are now living in the home with the child.
- The absent parent is deceased.
- Paternity has been established and the father is living in the home with the mother and child.
- The only parent absent from the home is absent because of military service.

5.2.3 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 5.3.7 DETERMINATION) and whether the applicant or member is exempt (see SECTION 5.2.2 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 may not be sanctioned.*

Example 1	Mary, a disabled parent, is applying for BadgerCare Plus 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 BadgerCare Plus and EBD Medicaid. Mary is not eligible for EBD Medicaid or BadgerCare Plus 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 BadgerCare Plus.

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5.3 Claiming Good Cause

5.3.1 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. They must do the following:

- Specify the circumstance that is the basis for good cause.
- Corroborate the circumstance according to the evidence requirements in SECTION 5.3.5 EVIDENCE.

5.3.2 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 notice to applicants who apply via ACCESS since this information is included in the ACCESS application.

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.

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

5.3.3 Good Cause Claim

The Good Cause Claim form (DCF-F-DWSP 2019) 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 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 filed. When the CSA is informed of a claim, they will immediately suspend all activities to establish paternity or secure medical support until notified of the final determination.

5.3.4 Circumstances

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

- The parent or caretaker's cooperation is reasonably anticipated to result in physical or emotional harm to one of the following:
    - Child. This means that the child is so emotionally impaired, that their normal functioning is substantially affected.
    - 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.
- 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:
    - The child was conceived as a result of incest or sexual assault.
    - A petition for the child's adoption has been filed with a court.
    - 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.

5.3.5 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:

- 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.
- Court documents or other records that indicate that a petition for the adoption of the child has been filed with a court.
- Court, medical, criminal, child protective services, social services, psychological school, or law enforcement records that indicate the alleged father or absent parent might inflict physical or emotional harm on the member or the child.

- Medical records that give the emotional health history and present emotional health status of the member or the child.
- A written statement from a mental health professional indicating a diagnosis of or prognosis on the emotional health of the member or the child.
- 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.
- A sworn statement from someone other than the member with knowledge of the circumstance on which the claim is based.
- Authorization card or other proof from Safe at Home confirming the person's status as a program participant in the Safe at Home program. Safe at Home can be contacted by calling 608-266-6613 or emailing **Error! Hyperlink reference not valid.**.
- 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 all of the following:

- Person's present emotional state
- Person's emotional health history
- Intensity and probable duration of the emotional impairment
- Degree of cooperation required
- 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 them to a mental health professional for a report relating to the claim.

When a claim is based on their 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.
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 10 days from the notification date, good cause will not be found and that they may first:

- Withdraw the claim and cooperate, or
- Exclude allowable individuals, or
- Request a hearing, or
- Withdraw the application or request that the case be closed.

If no option above has been taken when the 10 days have expired, the IM worker will deny BadgerCare Plus to the applicant or disenroll the member from BadgerCare Plus. The sanctions remain in effect until there is cooperation or until it is no longer required.

5.3.6 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 satisfies the worker that they have 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 the agency's intention. Once notified, the parent or caretaker has 10 days from the notification date to do one of the following:

- Present additional supporting or corroborative evidence of information so that contact is unnecessary.
- Exclude allowable individuals.
- Withdraw the application or request that the case be closed.
- Request a hearing.

If the 10 days have expired and no option has been taken, the IM agency will deny BadgerCare Plus to the applicant, and the sanctions shall remain in effect until there is cooperation or until it is no longer an issue.

5.3.7 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:

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

The good cause determination and all evidence submitted should be 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 BadgerCare Plus pending the determination.

If a fair hearing is requested on a good cause determination, BadgerCare Plus 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 worker must notify the applicant or member in writing of the final determination and of the right to a fair hearing and send the CSA a copy. The CSA may also participate in any fair hearing.

5.3.8 Good Cause Found

When good cause is granted, the IM worker 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 their participation.
2. The person has 10 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 10 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.

5.3.9 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 the parent or caretaker has 10 days from the notification date to do one of the following:

- Cooperate.
- Exclude allowable individuals.
- Request a hearing.
- Withdraw the application.
- Request that the case be closed.

If the 10 days have expired, no option has been taken, and the member is in non-cooperation status, the IM agency must terminate the member’s BadgerCare Plus eligibility. Sanctions remain in effect until there is cooperation or it is no longer an issue. The IM agency will continue to refer the case to the CSA.

5.3.10 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 at redetermination and when there is new evidence.

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 they have 10 days from the notification date to do one of the following:

- Cooperate.
- Exclude allowable individuals.
- Request that the case be closed.
- Request a hearing.

If the 10 days have expired and no option has been taken, the IM agency must deny the individual's BadgerCare Plus eligibility. The sanctions remain in effect until there is cooperation or until it is no longer an issue.

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5.4 Cooperation Between IM & CSA

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

5.4.1 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.

5.4.2 BadgerCare Plus Discontinued

The CSA is notified through CARES when BadgerCare Plus is discontinued.

5.4.3 Failure to Cooperate

The CSA will determine if non-cooperation occurs. KIDS notifies CARES when an individual refuses or fails to cooperate. The IM Agency must then review eligibility.

5.4.4 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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5.5 Third Party Liability

Third Party Liability (TPL) refers to the obligation that a third party (not Wisconsin BadgerCare Plus program or the BadgerCare Plus member), has to pay the bills for a BadgerCare Plus member's medical services. BadgerCare Plus is the payer of last resort for the cost of medical care. This means that if a BadgerCare Plus member also has coverage under a private health insurance plan, that plan is to be billed first for any medical services. BadgerCare Plus then pays any amount remaining after the private insurer has paid what they owe, up to the BadgerCare Plus reimbursement rate. Another common example of third-party liability is when someone receives an insurance settlement resulting from an

accident. If BadgerCare Plus paid for any medical services resulting from that accident, the BadgerCare Plus 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.

5.5.1 TPL Cooperation

All BadgerCare Plus 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 BadgerCare Plus is received. In addition, BadgerCare Plus 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.

5.5.2 TPL Cooperation Requirements

The BadgerCare Plus member must cooperate in providing TPL information unless they are 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 BadgerCare Plus, the adult is ineligible until they cooperate.

The following individuals are not sanctioned for non-cooperation:

1. Minors, including minor caretaker relatives.
2. A parent or caretaker relative requesting child support services for a child receiving SSI.
3. Pregnant BadgerCare Plus members are not sanctioned during the pregnancy or the 12-month postpartum period if the TPL source is from the absent parent.

5.5.3 TPL Good Cause Claim

When good cause is claimed (see SECTION 5.3 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.

5.5.4 Assignment Process

At application or a new request for health care on an existing case, the IM agency must provide 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 IM 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.

5.6 Casualty Claim Process (Subrogation)

Casualty claims are those claims for BadgerCare Plus 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 BadgerCare Plus 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.

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

5.6.1 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 them 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, they 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

More information can be found at www.wicasualty.com/wi/index.htm.

Note *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 via phone their local agency and any HMO or MCO that may have provided services before the case is settled. Members should include the date of the accident and any insurance/attorney information.

5.7 Other Health Insurance

The IM Agency should collect insurance coverage information on both the custodial and absent parents and caretakers 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.

5.7.1 Policies Not to Report

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

1. HMOs for which the State pays all or part of the premium.
2. Health Insurance Risk Sharing Plans (HIRSP).
3. Medicare (enter in CWW on the Medicare Page).
4. Indian Health Service (IHS). IHS is the exception to the rule that Medicaid is the payer of last resort. For Native Americans who are Medicaid clients, IHS is the payer of last resort. Do not enter these policies on CARES.
5. Policies that pay benefits only for treatment of accidental injury.
6. Policies that may be described as health insurance, but which pay only weekly or monthly based on the insured's disability.
7. 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 they are insured against and if the benefits are assignable.
8. Life Insurance.
9. Other types of insurance types that do not cover medical services.

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6.1 SSN Requirements

6.1.1 Overview of Social Security Number Requirements

BadgerCare Plus 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 9.9.1 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 9.9.1 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. They only need 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.

6.1.2 Social Security Number Exceptions

Do not require an SSN for:

- Continuously eligible newborns.
- Pre-adoptive infants living in a foster home.
- Non-qualifying immigrants applying for or receiving emergency services or BadgerCare Plus Prenatal benefits.
- Someone without an SSN who may only be issued one for a valid non-work reason.
- Tax dependents or tax filers living outside the home.
- 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 an SSN due to religious beliefs must provide verification from a church elder or other officiant that doing so is against the church doctrine.

6.1.3 Social Security Number Mismatches

Refer to Process Help, Section 19.4 Discrepancy Processing, 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 an 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 SSA. The applicant or member may request that 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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7.1 Health Insurance Conditions of Eligibility

To prevent the crowd out of private insurance, BadgerCare Plus benefits may be denied or terminated for groups who have certain current health insurance coverage.

The following groups are subject to current health insurance coverage policies:

- Children ages one through five with household incomes over 191% of the FPL
- Children ages six through 18 with household incomes over 156% of the FPL

Note *If a child qualifies for continuous coverage, their benefits cannot be terminated during the 12-month continuous coverage period because of health insurance coverage. Their benefits can only be denied or terminated during application or renewal.*

- Pregnant persons eligible under the BadgerCare Plus Prenatal Program at any income level

The following groups are exempt from the policies related to current health insurance coverage:

- Infants younger than one year old
- Children younger than 19 years old who are in a continuous coverage period
- Children younger than 19 years old who have met a deductible (exempt only during the deductible period)
- Children who are in an extension
- Children ages one through five with household income at or below 191% of the FPL
- Children ages six to 18 with household income at or below 156% of the FPL
- Former Foster Care Youth
- Pregnant persons and pregnant minors, other than those in the BadgerCare Plus Prenatal Program
- All adults 19 years old or older

Childless adults are not eligible for BadgerCare Plus if they are enrolled in any part of Medicare except Medicare Part B Immunosuppressive Drug Benefit (Part B-ID).

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7.2 Reserved

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7.3 Reserved

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7.4 Current Health Insurance Coverage

7.4.1 The Current Coverage Test for Children

The Current Coverage Test policy applies to non-exempt children (see SECTION 7.1 HEALTH INSURANCE CONDITIONS OF ELIGIBILITY). These children who currently have individual or family health insurance coverage through an employed family member currently living in the household and who meets the following criteria are not eligible for BadgerCare Plus:

1. The child is not exempt from access and coverage policies (see SECTION 7.1 HEALTH INSURANCE CONDITIONS OF ELIGIBILITY); and
2. Coverage is provided by an employer; and the employer pays at least 80% of the premium or
3. Coverage is available under the state of Wisconsin employee health plan (regardless of plan type or premium amount contributed by state or local government), and
4. The insurance covers services provided in a service area that is within a reasonable driving distance from the person's residence.

Example 1	Dave applies for BadgerCare Plus in March for his family. The children's income exceeds 191% of the FPL. Dave is currently covered by family health insurance through his employer and the employer pays

	80% of the premium. His children are not eligible for BadgerCare Plus because they are currently covered.

Children under 19 years of age who are ineligible for BadgerCare Plus due to current coverage can become eligible by meeting a deductible (see CHAPTER 17 DEDUCTIBLES).

7.4.2 Current Coverage Test for BadgerCare Plus Prenatal Program

Pregnant people who are otherwise eligible only for the BadgerCare Plus Prenatal Program are not eligible for the BadgerCare Plus Prenatal Program if they are currently covered by any health insurance plan which qualifies as minimum essential coverage as defined at 26 USC § 5000A(f)(1). The plan does not have to be employer-sponsored, but the insurance must cover services provided in a service area that is within a reasonable driving distance from the person's residence.

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7.5 Reserved

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7.6 Reserved

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7.7 Health Insurance Premium Payment

7.7.1 Introduction

Wisconsin's HIPP program helps BadgerCare Plus families pay the employee contribution of their employer sponsored insurance. The HIPP program pays the family's share of the monthly premium, co-insurance, and deductibles associated with the family health plan along with any BadgerCare covered services not included in the family health plan through fee-for-service (wrap around).

HIPP will be considered for the following BadgerCare Plus members when it is cost effective to do so:

- Children
- Pregnant Women
- Parents and Caretakers

HIPP is not available for childless adults.

In addition to families with employer sponsored health insurance plans, the following BadgerCare Plus families may also be considered for HIPP:

- Farm and other self-employed families
- Members with self-funded insurance plans

Access to HIPP coverage will be allowed even if single or "plus one" coverage is the only coverage offered by an employer.

Minimum employer contribution requirements will be eliminated, and employer-sponsored insurance (ESI) will be based solely on cost effectiveness.

7.7.2 Cost Effectiveness

The HIPP Unit of the fiscal agent determines if it is cost effective to buy the employer's insurance rather than enroll the individual in BadgerCare Plus.

The HIPP Unit will identify the cost of wrapping around the Medicaid services with the employer-sponsored plan and then determine cost effectiveness of buy-in on that calculation of cost comparability.

This determination will be done on a per person basis. Thus, in any given BadgerCare Plus group, it may be cost effective to enroll all BadgerCare Plus members or only specific members. For example: it may be cost effective to enroll an adult in HIPP but to keep the children in BadgerCare Plus.

7.7.3 Participation in HIPP

Members participating in HIPP are enrolled in BadgerCare Plus as a secondary insurance. If the employer's health insurance does not cover a service that BadgerCare Plus covers, BadgerCare Plus will cover the cost.

7.7.4 Cooperation

Parents may not be sanctioned for failing to cooperate with the HIPP program. This policy applies to both current members and new applicants.

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7.8 Reserved

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8.1 Pregnant Members

> ***Note*** *This chapter does not apply to pregnant members in the BadgerCare Plus Prenatal Program.*

A pregnant member who is enrolled in BadgerCare Plus stays eligible for both:

- The duration of the pregnancy.
- The postpartum period, which concludes at the end of the month 12 months after the end of the pregnancy.

The application does not need to be submitted prior to the end of the pregnancy, but the person must be eligible for BadgerCare Plus or Medicaid for one or more months in which they were pregnant in order for the member to remain enrolled as a pregnant member for the postpartum period. An application for Express Enrollment does not meet this application test.

Example 1	Laverne's pregnancy ended in September. She applies for BadgerCare Plus in October, and she requests one month of backdated eligibility. She is found eligible for BadgerCare Plus starting September 1. Since she was eligible for BadgerCare Plus during at least one month in which she was pregnant, she is eligible for the 12-month postpartum period.

A pregnant member with income over 306% of the Federal Poverty Level (FPL) at the time of application when eligibility is first determined can become eligible for BadgerCare Plus by meeting a deductible (see SECTION 17.2 PREGNANT MEMBERS).

There are no premiums for pregnant members.

All pregnant members, except those eligible under the BadgerCare Plus Prenatal Program, may have their eligibility backdated according to backdating policy (see SECTION 25.8.2 BACKDATED ELIGIBILITY). If a person is determined to be eligible as a pregnant member for a backdated month, they remain eligible, even if they are over the income limit for any subsequent months, as long as they are still pregnant.

Example 2	Barb is pregnant and applied for BadgerCare Plus in December with a two-month backdate request. Barb is due in March. Her income was below 306% of the FPL for October, but over 306% for November, December, and ongoing. She met all of the other eligibility criteria. Since she was determined eligible as a pregnant member for the month of October, the subsequent increase in her income is ignored and she remains eligible for BadgerCare Plus through the 12th month after the end of the pregnancy.

Pregnant Children

When a pregnancy is reported for a child under age 19 on a case, they will have continuous coverage through at least the end of the 12-month postpartum period or the end of their 12-month continuous coverage period, whichever is later.

Example 3	Marita and her 16-year-old daughter Lupita have been enrolled in BadgerCare Plus since January 2026. In April 2026, they report that Lupita is pregnant with a due date of January 25, 2027. Lupita moves from BadgerCare Plus eligibility as a child to eligibility as a pregnant member effective May 1, 2026. Lupita's continuous coverage end date is updated to January 31, 2028, the end of the postpartum period. In December 2026, Marita completes a renewal and has a new certification period established from January 1, 2027, to December 31, 2027. Lupita delivers a baby January 13, 2027. The baby is enrolled in BadgerCare Plus as a continuously eligible newborn through January 31, 2028. Lupita remains enrolled in BadgerCare Plus as a pregnant member until the end of the postpartum period on January 31, 2028.

If a child under age 19 applies as a pregnant minor on their own case, and they are initially enrolled in BadgerCare Plus as a pregnant member, they will get their 12-month continuous coverage period as a pregnant member. If their 12-month postpartum coverage period ends before the 12-month continuous coverage period ends, the member will be tested for other benefits (for example, they may transition to coverage as a child or a parent/caretaker), but if they do not qualify for another category of health care, they will remain enrolled in BadgerCare Plus as a pregnant member for the rest of their 12-month continuous coverage period for children.

Example 4	Jordan is 17, pregnant, lives on their own, and is not claimed as a tax dependent. Jordan's pregnancy ended in March 2027. Jordan applied for BadgerCare Plus in May 2027 and requested two months of backdated coverage. Jordan is determined eligible for BadgerCare Plus as a pregnant member starting March 1, 2027. Jordan's postpartum coverage ends March 31, 2028. Because they are under age 19 and are applying on their own case, their 12-month continuous coverage period as a child lasts from May 1, 2027 to April 30, 2028. When Jordan's postpartum coverage ends March 31, 2028, they can transition

	to other benefits if they meet program rules, but otherwise, they will remain enrolled in BadgerCare Plus as a pregnant member through April 30, 2028.

If the pregnant child turns 19 during the pregnancy or postpartum period, they remain entitled to their continuous coverage as a pregnant member.

Example 5	Lynn and her children, Bailey and Taylor, are open for BadgerCare Plus. A pregnancy is reported for Taylor, and they are transitioned to BadgerCare Plus for a pregnant member as of September 2026. The pregnancy ends due to miscarriage on December 5, 2026. Taylor turns 19 on January 2, 2027. They remain eligible for BadgerCare Plus as a pregnant member for the rest of the 12-month postpartum period until December 31, 2027.

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8.2 Continuously Eligible Newborns

Newborn children are automatically eligible for BadgerCare Plus as Continuously Eligible Newborns (CEN) from the date of birth through the end of the month in which they turn one year old if both the following are true:

1. They are younger than 13 months old.
2. The mother who gave birth was determined eligible in the state of Wisconsin for the month of the birth for one of the following programs:
    a. BadgerCare Plus
    b. Other full-benefit Medicaid (see Medicaid Eligibility Handbook, Section 21.2 Full-Benefit Medicaid)
    c. Emergency Services BadgerCare Plus
    d. Emergency Services Medicaid (see Medicaid Eligibility Handbook, Section 34.1 Emergency Services)
    e. BadgerCare Plus Prenatal Program as a nonqualifying immigrant

There is no income or resource test for these children while they are eligible under CEN status; therefore, they are not required to provide any income tax filing information for their BadgerCare Plus eligibility to be determined.

Note *Children born to incarcerated mothers who are eligible for the BadgerCare Plus Prenatal Program (and not eligible for any other type of BadgerCare Plus or Medicaid) on the date of the child's birth are not eligible as CENs.*

A child qualifies as a CEN if they are born to a mother whose eligibility for one of the programs listed above was determined either prior to the date of delivery or retroactively to cover the date of delivery.

Example 1	Sasha gave birth on April 15. On June 15, she applied for BadgerCare Plus. Her eligibility was backdated to March 15. Her infant son is eligible as a CEN from April 15 through April 30 of the following year, the end of the month in which he turns one year old.

The newborn child does not receive this automatic eligibility as a CEN if the mother who gave birth was temporarily enrolled in BadgerCare Plus (see CHAPTER 32 PRESUMPTIVE ELIGIBILITY).

A newborn is not required to reside with the mother who gave birth to be eligible as a CEN. This is true even if the newborn is being placed in foster care, adoption, or is residing with a caretaker relative. A

CEN who no longer resides with the mother who gave birth but still resides in Wisconsin should remain eligible as a CEN through the end of the month in which they turn one year old.

Anyone who has ever been eligible as a CEN under Wisconsin Medicaid or BadgerCare Plus is exempt from the citizenship and identity documentation requirements.

CENs do not have to pay premiums and are not subject to health insurance coverage requirements.

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9.1 Verification

Proof of certain information is required to determine eligibility for BadgerCare Plus. Mandatory (see SECTION 9.9 MANDATORY VERIFICATION ITEMS) and questionable (see SECTION 9.10 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.

9.1.1 Verification Definition

Verification is part of determining eligibility. To verify means to establish the accuracy of verbal or written statements made by or about an individual's or group's circumstances.

If the member is applying for other programs of assistance, see the verification chapters of those program handbooks.

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9.2 Application

The time period for processing an application for BadgerCare Plus is 30 days from the filing date (see SECTION 25.6 FILING DATE and SECTION 25.7 APPLICATION PROCESSING TIME FRAME)

Eligibility cannot be denied for failure to provide the required verification until the later of:

- 20th day after requesting verification.
- 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.

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9.3 Eligibility Renewals

Eligibility must not be denied for failure to provide 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.

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9.4 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.

9.4.1 Date of Death Matches

BadgerCare Plus 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 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 applicant or member, a family member, or the applicant or 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, person/program add, or renewal.

This 10-day period is known as the "refutation period." A letter is automatically sent to the primary person requesting a response if the person is not deceased. The response due date will be extended to a longer period to allow for mailing delays due to weekends or holidays (will follow the verification checklist (VCL) due date logic). The refutation period may only be shortened when either:

- A member, family member, or their representative, confirms the DOD
- A worker verifies a DOD 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 applicant or member or the household, the DOD is considered verified, eligibility for the household must be redetermined, and a notice of decision issued.

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9.5 Documentation

Documentation includes storing received information in the case record. Documentation also includes adding case comments. For collateral contact or any other information that cannot be stored in the case record, case comments must describe the nature and source of information if follow up is needed. Documentation must explain current eligibility, ineligibility, benefit level, and coverage group changes.

All documentation must be in sufficient detail to permit a reviewer to determine the reasonableness and accuracy of the determination.

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9.6 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.

9.6.1 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 may not result in any loss or denial of eligibility for a member or applicant.*

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9.7 Release of Information

Someone's written release to get information from a verification source is needed only when the source requires it.

When a source requires a written release:

1. The requirement must be explained to the member.
2. The individual, their spouse, or another appropriate adult in the household must sign the necessary release form(s). The forms that may be used are CARES-generated or alternate pre-printed application forms.

Benefits should be denied, discontinued or reduced only when:

1. The missing verification is necessary to determine eligibility, and
2. The individual is unwilling or unable to provide the verification directly, and

3. The source requires a release, and
4. The individual, their spouse, or another appropriate adult in the household refuses to sign the release, and
5. The release is the only way the verification can be obtained.

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9.8 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 4.2 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 determines if a referral for fraud or for front-end verification should be made (see SECTION 9.10 QUESTIONABLE ITEMS).
    b. The member reported a change to information that is subject to mandatory verification rules or is questionable.
    c. At renewal, if 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 may be submitted in person, by mail, fax, e-mail, or electronically through ACCESS or the MyACCESS mobile app. Verification is not required to be presented in person.
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 preferred language has no impact on the verification policy for U.S. citizenship. Verification of U.S. citizenship is attempted using the same methods used for all applicants that report U.S. citizenship, which is explained in SECTION 4.2 VERIFYING U.S. CITIZENSHIP.

6. The applicant or member can't be required to sign a release form (either blanket or specialized) when the applicant or member provides required verification.
7. Verification of information that is not used to determine eligibility cannot be required.
8. During verification, the applicant or member can't be harassed or have their privacy, personal dignity, or constitutional rights violated.
9. A one-time 10-day extension to the verification due date can be provided for the following reasons:
    a. The applicant or member requests additional time to provide the requested verification.
    b. The verification submitted by the applicant or member is incomplete or unreadable.

Note *When it is later determined a verification request was incorrect or incomplete, or when it is determined a verification request was not sent due to error, the applicant or member must be given a minimum of 20 calendar days to provide the verification.*

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 9.12 REASONABLE COMPATIBILITY FOR HEALTH CARE).

Note *Applicants and members do not have primary responsibility to provide verification of Child Welfare parent cooperation (see SECTION 10.1 ELIGIBILITY FOR PARENT OR CARETAKER RELATIVE WHEN CHILD IS REMOVED FROM THEIR CARE), or former Foster Care status (see SECTION 11.2 FORMER FOSTER CARE YOUTH).*

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 is 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 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 are redetermined based on the new information.

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9.9 Mandatory Verification Items

Verification is mandatory for certain items to determine eligibility. Unless determined questionable, self-declaration is acceptable for all other items.

The following items are mandatory, and must be verified for BadgerCare Plus:

- SSN (see SECTION 6.1 SSN REQUIREMENTS)
- Citizenship, but only for certain applicants who declare they are U.S. citizens (see SECTION 4.2 VERIFYING U.S. CITIZENSHIP)
- Identity, but only for certain applicants whose U.S. citizenship is not verified by the SSA and are unable to provide stand-alone documentation of citizenship (see SECTION 4.2.4.3 EVIDENCE OF IDENTITY)
- Immigrant status (see SECTION 4.3.2 VERIFICATION)
- Medical expenses used to meet a deductible (see SECTION 17.4 MEETING THE DEDUCTIBLE)
- Documentation for Power of Attorney and Guardianship (see SECTION 9.9.5 POWER OF ATTORNEY, GUARDIANSHIP, OR CONSERVATOR)
- Migrant worker’s eligibility in another state (see SECTION 12.4.2 SIMPLIFIED APPLICATION PROCEDURE FOR MIGRANT WORKERS)
- Income (see CHAPTER 16 INCOME)

- Health insurance coverage (see SECTION 7.4 CURRENT HEALTH INSURANCE COVERAGE)
- Parent or caretaker relative cooperation with child welfare reunification plan (see SECTION 9.9.11.1 CHILD WELFARE CARETAKERS AND PARENTS)
- Former Foster Care Youth status (see SECTION 9.9.11.3 FORMER FOSTER CARE YOUTH)
- Tribal membership or Native American descent (see SECTION 9.9.8 TRIBAL MEMBERSHIP, DESCENT, OR ELIGIBLE TO RECEIVE INDIAN HEALTH SERVICES)
- Pre-tax deductions (see SECTION 16.3.2 PRE-TAX DEDUCTIONS)
- MAGI tax deductions (see SECTION 16.3.3 TAX DEDUCTIONS)
- Huber Law participation, for incarcerated individuals qualifying for the Huber Law exemption (see SECTION 45.8.3 HUBER LAW)

9.9.1 Social Security Number

Social security numbers (SSNs) must be furnished for household members requesting BadgerCare Plus unless they are exempt from the SSN requirement (see SECTION 6.1.1 SOCIAL SECURITY NUMBER REQUIREMENTS). SSNs are not required from non-applicants, including outside of the home tax dependents and co-filers.

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 individual. 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 4.2.4.4 REASONABLE OPPORTUNITY PERIOD FOR VERIFICATION OF CITIZENSHIP).

9.9.1.1 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:

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

Verify the SSN only once.

9.9.1.2 Newborns

A parent of a newborn may begin an SSN application on the newborn's behalf while still in the hospital.

Do not require an SSN to be furnished or applied for on behalf of a newborn determined continuously eligible (see SECTION 8.2 CONTINUOUSLY ELIGIBLE NEWBORNS) for BadgerCare Plus. Accept the parent's statement about the existence and residence of the newborn.

9.9.1.3 BadgerCare Plus Emergency Services

Do not require or verify SSNs of people applying for BadgerCare Plus Emergency Services only (see CHAPTER 39 EMERGENCY SERVICES).

9.9.1.4 BadgerCare Plus Prenatal Program

Do not require or verify SSNs of people applying for the BadgerCare Plus Prenatal Program (see SECTION 41.1 BADGERCARE PLUS PRENATAL PROGRAM).

9.9.2 Immigrant 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 CHAPTER 41 BADGER CARE PLUS PRENATAL PROGRAM) and people applying for Emergency Services (see CHAPTER 39 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 4.3.2.2 REASONABLE OPPORTUNITY PERIOD FOR VERIFICATION OF IMMIGRATION STATUS).

9.9.3 Pregnancy

Verification is not required for pregnancy unless the worker has information that contradicts the applicant or member's statement.

If pregnancy information is questionable, acceptable verification sources are:

- Physician's statement
- Physician assistant's statement
- Licensed nurse practitioner's statement
- A written statement from a registered nurse working:
    - In a Healthy Birth Identification of Pregnancy Project (EDP)
    - In a Publicly funded family planning project

- As a Certified Nurse Midwife

Note *If pregnancy must be verified, the BadgerCare Plus temporary enrollment card cannot be used as a source of verification, as pregnancy will not be verified for Temporary Enrollment for Pregnant Women (see CHAPTER 32 PRESUMPTIVE ELIGIBILITY).*

9.9.4 Medical Expenses

Medical expenses used to meet a deductible 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. Do not deny or terminate eligibility for failure to provide the requested verification.

9.9.5 Power of Attorney, Guardianship, Conservator, or Patient's Representative

If the applicant or member has a financial 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 Medicaid. A “durable” designation means that the power of attorney continues even if the applicant or member becomes incapacitated.

If the applicant or member has a legal guardian, documentation of the court-ordered guardianship is required.

If the applicant or member has a conservator, documentation of the court-ordered conservatorship is required.

If the applicant or member has a patient's representative, documentation of the patient's representative appointment is required.

If verification is not provided, the claimed agent with power of attorney, guardian, conservator, or patient's representative cannot be granted access to case information or notices or act on behalf of the applicant or member unless they are an authorized representative.

9.9.6 Income

Verification of any type of countable income is required for all members with the exception of expected annual income for eligibility determinations using gap filling rules and certain earnings of prison or jail inmates (see SECTION 9.9.6.1 PRISON OR JAIL JOB). Even though verification of expected annual income is not required, the reported expected annual income must be validated by the agency using all available information (see SECTION 16.9 GAP FILLING).

Income must only be verified using electronic data sources, except when the information cannot be obtained through an electronic data source or information from the data source is not reasonably compatible with what the applicant or member has reported (see SECTION 9.12 REASONABLE COMPATIBILITY FOR HEALTH CARE).

9.9.6.1 Prison or Jail Job

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 16.4.1 SPECIALLY TREATED WAGES, #7 PRISON OR JAIL JOB).

This policy does not apply to work release jobs or other employment an inmate has that pays minimum wage or more. Income from those jobs should be verified and counted according to regular income verification policy.

9.9.6.2 Live-In Care Providers

If an applicant or member claims to be a live-in care provider with tax-exempt income, workers must provide the applicant or member with a Verifying Tax-Exempt Income for Live-in Care Providers form (F-02193) and ask them to complete it to attest to meeting the criteria that makes this income exempt. If there is a reason to question some or all of the information provided on the form, workers may seek additional verification.

9.9.7 Verification of Employer-Sponsored Health Insurance

Verification of current health insurance coverage is required at the following times, unless the individual has already verified health insurance coverage with the same employer within the last 12 months:

1. BadgerCare Plus Application and Renewal
2. Person Add - if adult (age 18 or over) is employed and part of the BadgerCare Plus test group
3. When an adult (age 18 or over) in the BadgerCare Plus test group gets a new job
4. When a change is processed causing total household income to exceed the following FPL thresholds:

    a. Children ages one through five (up to age six), 191% of the FPL
    b. Children ages six to 18, 156% of the FPL

9.9.7.1 Employer Verification of Health Insurance Database

Applicants must report when they are enrolled in other health insurance coverage, but it is not the applicant or member's responsibility to provide the details needed to verify whether or not employer sponsored health insurance meets the criteria in SECTION 7.4 CURRENT HEALTH INSURANCE COVERAGE. For the majority of applicants and members the EVHI database will be used to verify health insurance coverage details. Information gathered from employers is stored in the database. The verification will be returned based on the employer details entered on the employment page. It is critical for Income Maintenance workers to enter the correct FEIN number and all other employment details for each employment sequence so that all employers are correctly identified in the EVHI database.

If the details of the applicant or member's employment are not complete, the applicant or member will be sent a letter from the state requesting more information.

If the employer has not provided information about the health insurance they offer to their employees, a request will be sent from the State to the employer requesting that the information be provided.

BadgerCare Plus will not be terminated or denied due to an employer failure to respond to a request for verification of health insurance coverage. If BadgerCare Plus eligibility begins and an employer later responds to the verification request indicating that the person has current health insurance coverage, BadgerCare Plus eligibility will be terminated with adequate notice of adverse action, except for a child under a continuous coverage period. There will be no overpayment liability for the applicant.

9.9.7.2 Other Forms of Health Insurance Verification

Other types of verification can be used to document current employer sponsored health insurance coverage. Agencies may use other contacts with employers to complete the verification process if needed. Other forms of verification include:

- EVF-H form
- Employer statement
- Collateral Contact with the employer

9.9.8 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 in order to receive an exemption from paying BadgerCare Plus premiums and copayments (see SECTION 38.2.2 COPAY EXEMPT POPULATIONS). Acceptable verification sources include:

- Tribal Enrollment Card
- Written verification or 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) issued by an Indian health care provider that specifies an individual is an Indian
- Statement of Tribal Affiliation (F-00685)

If verification is not provided, do not indicate in CARES that the person is a Tribal member. Do not deny or terminate eligibility for failure to provide the requested verification.

9.9.9 Pretax Deductions

People whose eligibility is determined using MAGI rules can claim pretax deductions to determine their MAGI taxable income. To claim a pretax deduction, verification of the amount and deduction type is required. Verification sources such as pay stubs received during the last 30 days or other documentation from a person's employer can serve as acceptable documentation. See SECTION 16.3.2 PRETAX DEDUCTIONS for a list of pretax deductions.

If verification is not provided, the deductions will not be used when determining eligibility. Eligibility will not be denied or terminated for failure to provide the requested verification.

9.9.10 MAGI Tax Deductions

People whose eligibility is determined using MAGI rules can claim certain tax deductions from the IRS 1040 Form, regardless of whether or not they file taxes (see SECTION 16.3.3 TAX DEDUCTIONS). People who claim such deductions must provide verification that the expense is or was incurred. Verification could include:

- Receipts
- Bank statements
- Pay stubs
- Previous years' tax forms

If verification is not provided, do not include the deductions when determining eligibility. Do not deny or terminate eligibility for failure to provide the requested verification.

9.9.11 Foster Care Medicaid and FFCY BadgerCare Plus

Foster Care Medicaid enrollment data and information about placements and agreements required for agencies to make eligibility determinations for Medicaid or BadgerCare Plus, is available from the electronic Wisconsin Statewide Automated Child Welfare Information System (eWiSACWIS) data exchange. Information received through this data exchange is verified upon receipt and includes:

- SSN
- Individual demographic information, including Tribal affiliation
- Placement/agreement types, including Title IV-E funding if any
- Placement/agreement start and end dates
- Discharge reasons and dates
- Foster Care Medicaid start and end dates
- Parent or caretaker relative cooperation with reunification plan
- FFCY placement type on 18th birthday (available for most youth in WI placements)

The agency must use information in the eWiSACWIS data exchange to determine or redetermine health care eligibility. Limited information may need to be requested from the family or youth.

Note *Any individual who receives or previously received Title IV-E Foster Care Medicaid types, including Adoption Assistance, is exempt from verifying U.S. Citizenship.*

9.9.11.1 Child Welfare Caretakers and Parents

A parent or caretaker relative's health care eligibility is impacted by whether they cooperate with their child's reunification plan.

Assume the parent/caretaker are cooperating with reunification unless there is information in the eWiSACWIS data exchange or from the child welfare agency that verifies non-cooperation.

Note *Reunification will not be a goal for the following placement types: Adoption Assistance, Subsidized Guardianship, Private Preadoption, or Long-Term Kinship Care.*

9.9.11.2 Children or Youth in Out-of-Home-Care (Foster Care)

For most children and youth in Foster Care, the eWiSACWIS data exchange provides verification of the child or youth's SSN, demographic information, placement or agreement start and end dates, placement or agreement types, and discharge reasons.

9.9.11.3 Former Foster Care Youth

Verification of a person’s status as a Former Foster Care Youth (FFCY) is required only once.

FFCY status is verified using information available in the eWiSACWIS data exchange. For anyone without information available in the data exchange, including a youth from another state, FFCY status is requested from the child welfare agency using the BadgerCare Plus Former Foster Care Youth form (F-10184). It is **not** the youth's responsibility to verify their status. If the child welfare agency does not provide verification by the due date, the agency must accept the youth's statement as the best available information that they are a FFCY.

Additional verification of FFCY status is not required even if the person becomes ineligible for BadgerCare Plus at some point and later reapplies.

Income and asset information is not required to determine eligibility for FFCY BadgerCare Plus. However, if the youth is included in other assistance groups, their financial information may be needed to determine eligibility for other group members.

9.9.12 Gross vs Taxable Portion of Pension

If the gross amount of pension and annuity income has been verified, but the taxable amount has not, the gross amount must be used in the BadgerCare Plus or FPOS budget calculation. The individual's benefits will not be terminated or denied due to failure to verify the taxable amount. If neither the gross nor the taxable amount is verified, the individual's benefits will be terminated or denied due to lack of verification.

9.9.13 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 BadgerCare Plus if the reason for the release is to return home to care for their minor children (see SECTION 45.8.4 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, they are not eligible for the Huber Law exemption.

9.9.14 Student Financial Aids

Verification of grants, scholarships, and fellowships counted as income is required. Verification of expenses, including tuition, required books, supplies, or equipment, or mandatory fees, that can be used to offset these counted income types is also required. See SECTION 16.5 #16 STUDENT FINANCIAL AIDS.

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9.10 Questionable Items

Information is questionable for BadgerCare Plus 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 their representative is unsure of the accuracy of their own statements.
4. The member has been convicted of Medicaid or BadgerCare Plus fraud or has legally acknowledged their guilt of member fraud.
5. The member is a minor who reports that they are living alone. This does not apply to minors applying solely for Family Planning Services.
6. The information provided is unclear or vague.
7. CWW determines the case meets an automated EPP.

9.10.1 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 21.1.3 Making a Referral for Investigation).

9.10.2 Error Prone Profile

The EPP functionality in CWW (see Process Help, Chapter 18.27 Error Prone Profile (EPP)) identifies error prone cases at application and renewal and tracks the resolution of identified potential errors. Once an EPP has been detected, affected programs cannot be confirmed until the EPP is resolved or deferred.

EPP identifies three types of potential errors:

- Questionable Income and/or Expenses
- Unresolved Discrepancies
- IPV/Overpayment History

9.10.2.1 Questionable Income and/or Expenses

Cases may be identified and tracked by EPP as having questionable income or expenses based on either of the following conditions:

- Expenses exceed income.
- Total income has remained the same for an extended period of time.

9.10.2.2 Unresolved Discrepancies

Cases may be identified and tracked by EPP as having unresolved discrepancies if they have inaccurate or unreported income based on the presence of unresolved SWICA, UIB, SOLQ-I, or Prisoner Match discrepancies.

9.10.2.3 Intentional Program Violation or Overpayment History

Cases may be identified and tracked by EPP if they include members who have a history of IPVs or overpayments.

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9.11 Processing Timeframe

9.11.1 Verification Receipt Date

The verification receipt date is the day verification is submitted to the appropriate IM agency or the next business day if verification is submitted after the agency's regularly scheduled business hours.

IM agencies must stamp the receipt date on each piece of verification submitted.

9.11.2 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 they are otherwise eligible. In this situation, the agency must also make an effort to obtain the verification (see SECTION 9.8 GENERAL RULES).

9.11.3 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 maintained during the redetermination.

9.11.4 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 required 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).

Note	*Eligibility cannot be denied or terminated for failure to verify information that the member is not responsible to obtain, such as employer-sponsored health insurance (see SECTION 9.9.7 VERIFICATION OF EMPLOYER-SPONSORED HEALTH INSURANCE), Child Welfare parent cooperation (see SECTION 10.1 ELIGIBILITY FOR PARENT OR CARETAKER RELATIVE OF CHILD REMOVED FROM HOME), and former Foster Care status (see SECTION 11.2 FORMER FOSTER CARE YOUTH).* *Eligibility cannot be denied or terminated for failure to verify medical expenses (see SECTION 9.9.4 MEDICAL EXPENSES) and deductions (see SECTION 9.9.9 PRETAX DEDUCTIONS and SECTION 9.9.10 MAGI TAX DEDUCTIONS). 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 9.9.8 TRIBAL MEMBERSHIP, DESCENT, OR ELIGIBLE TO RECEIVE INDIAN HEALTH SERVICES)*

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9.12 Reasonable Compatibility for Health Care

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 9.9.6.1 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 16.5 OTHER INCOME) is verified as outlined in this chapter and in Process Help, Chapter 19.1 Data Exchange General Information. 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 Process Help, Section 11.2 Self-Employment Income, Process Help, Section 11.7 In-Kind and Volunteer Hours, and SECTION 16.4.3 SELF-EMPLOYMENT INCOME.

9.12.1 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 BadgerCare Plus:

- BadgerCare Plus based on MAGI rules, with the exception of deductibles
- Family Planning Only Services (FPOS) based on MAGI rules

Populations not subject to an income test (for example, Former Foster Care Youth) will not have a reasonable compatibility test.

9.12.2 Reasonable Compatibility Thresholds

The reasonable compatibility test will apply to each assistance group (AG) for which earned income is reported, has not already been verified, and for which SWICA or Equifax data is available. Because different AGs are subject to different income thresholds, the following thresholds will be used by population as the first step in determining whether reported information is reasonably compatible. In some cases, the threshold will be an FPL percent, while in others it will be a fixed dollar amount.

Population	**Threshold(s)**
Adults (MAGS, MAGA and MAGN)	100% FPL
Children – under age 1	306% FPL
Children – ages 1 through 5	191% FPL Premium thresholds (unless the child is exempt): 201, 231, 241, 251, 261, 271, 281, 291, and 301% FPL 306% FPL
Children – ages 6 through 18	133% FPL 156% FPL Premium thresholds (unless the child is exempt):

	201, 231, 241, 251, 261, 271, 281, 291, and 301% FPL 306% FPL
Pregnant women	306% FPL
FPOS	306% FPL

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 equal to or 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 equal to or 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.

For populations with multiple thresholds, the lowest threshold that is higher than the reported income is used.

Note *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 1	Marty and Jen have two sons, Alex (age 9) and Warren (age 4). They apply for BadgerCare Plus and report that Marty has earnings of $5,200 per month. Equifax data is not available. SWICA reports that Marty has earnings of $5,475 per month. For a group size of four, the reported household income is 189% FPL, while the household income based on SWICA data is 199% FPL. As parents, Marty and Jen are ineligible for BadgerCare Plus based on their reported income of 189% FPL. Each child is subject to a reasonable compatibility test based on the next highest relevant threshold for his age group. For Alex, the reasonable compatibility threshold is 201% FPL. The household's income based on both the reported income and SWICA is below this threshold, so the reasonable compatibility standard is met, and no further verification is required for Alex. For Warren, the reasonable compatibility threshold is 191% FPL (the threshold for T19 vs. T21 funding of BadgerCare Plus benefits). The household's income based on reported income is below this threshold, while the household's income based on SWICA is above this threshold. Therefore, the 20% threshold test is applied. The 20% threshold is $6,240 (the reported income of $5,200 multiplied by 120%, or 1.2). The income based on SWICA data ($5,475) is less than the 20% threshold ($6,240), so the reasonable compatibility standard is met, and no further verification is required for Warren.

9.12.3 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 received during the last 30 days will be required at the same time verification is required for unearned income, self-employment, 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.

Note	*For simplicity, the examples below include households with earned income as the only source of income. It is important to remember that reasonable compatibility is based on the individual's total countable income, not just their earned income amount.*

Example 1	Joe is a single childless adult with an income limit of $1,330 for BadgerCare Plus. He reports that his earnings are $500 per month. Equifax is not available for his employment. SWICA reports that his quarterly earnings are $2,700, for a monthly amount of $830.77. Because his income is below the income threshold using either amount, his reported information is considered reasonably compatible with the SWICA reported income, and the agency must use the $500 amount he reported without requesting additional verification.

Example 2	Lon is a single childless adult with an income limit of $1,330 for BadgerCare Plus. He reports that his earnings are $900 per month. Equifax reports that he is paid twice a month at $675 per paycheck, for a monthly amount of $1,350. Lon's reported income is below the income threshold and the Equifax reported income is above the income threshold, so the 20% threshold test is applied. The income reported by Equifax ($1,350) is greater than the 20% threshold amount (120% of $900, or $1,080). Therefore, his reported information is not considered to be reasonably compatible, and the agency must request additional verification.

Example 3	Melanie is a single childless adult with an income limit of $1,330 for BadgerCare Plus. She reports that her earnings are $1,400 per month. CARES will base the denial on this reported income amount, regardless of the income amount from SWICA or Equifax.

Example 4	Michelle applies for BadgerCare Plus for herself and her two children. She reports that she started a job last month and is earning $1,400 per month. Because the job is new, neither SWICA nor Equifax data is available. Since these data exchanges are not available, the reasonable compatibility test will not be

	performed, and Michelle will be required to verify her earnings using paystubs received during the last 30 days, an EVF-E form, or other documentation.

Example 5	Katie is a single childless adult with an income limit of $1,330 for BadgerCare Plus. She applies for FoodShare and BadgerCare Plus. She reports that her earnings are $1,200 per month. Equifax data is not available. SWICA reports that her quarterly earnings are $4,000, for a monthly amount of $1,230.77. Because she is eligible for BadgerCare Plus using either amount, her reported information is considered reasonably compatible. The agency must use her reported income for BadgerCare Plus, and based on this amount, she would be made eligible for BadgerCare Plus. Her FoodShare eligibility, however, will pend for verification of her earnings. If she returns her paystubs and they show income of $1,400 per month, this information will replace the member-reported information and her health care benefits would be terminated. If she failed to provide the requested verification, her FoodShare benefits would be denied but she would continue to remain eligible for BadgerCare Plus.

9.12.4 Determining a Data Exchange-Based Income Amount for the Reasonable Compatibility Test

The following rules will be used to determine the data exchange information that will be used for the reasonable compatibility test:

- If Equifax data is available for a given employment, CWW will apply a reasonable compatibility test for health care using the member-reported information and the data available from Equifax.
- If data from both Equifax and SWICA are available, only Equifax data will be used in the reasonable compatibility test.
- If Equifax data is not available, the system will use SWICA data if it is available as the basis of the reasonable compatibility test.

If SWICA data is used, CARES will divide the most recent quarterly SWICA wages by 13 and multiply by four to determine a monthly amount for use in the test.

If Equifax data is used, the following rules will determine the monthly amount for use in the test:

- For months for which the system is able to confirm that all paycheck information has been received from Equifax, the actual income amount reported by Equifax for that month will be used.
- For months for which the system cannot confirm that all paycheck information has been received, the system will base the monthly amount on the most recent paycheck.
    - If the member is paid weekly, the most recent paycheck will be multiplied by four.
    - If the member is paid biweekly or semi-monthly, the most recent paycheck will be multiplied by two.
    - If the member is paid monthly, the most recent paycheck amount will be used.

9.12.5 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 9.8 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 1	Anya applies for health care for herself. 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 BadgerCare Plus. 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.

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10.1 Eligibility for Parent or Caretaker Relative When Child is Removed from Their Care

Qualifying parents and caretaker relatives (see SECTION 2.2.2 CARETAKER RELATIVE) of children who have been temporarily removed from their home and are in the care of the child welfare system may be eligible for BadgerCare Plus benefits. If they cooperate with a permanency plan under authority of Wis. Stat. § 48.38 or 938.38, and the goal of the permanency plan is reunification, they may be eligible under the parent/caretaker relative category. Cooperation is always presumed, unless there is information to the contrary, or the placement type is one where reunification is never a goal. If the parent or caretaker relative meets these criteria, the child is considered temporarily absent. In these situations, the child may not always be included in their MAGI group (see SECTION 2.2 COVERAGE GROUP DEFINITIONS).

Note *Children are not considered to be in the care of the child welfare system if they are an inmate in a public institution, such as a Type 1 Juvenile Correctional Institution.*

The following chart explains the effect of placement type and reunification on the parent or caretaker relative's BadgerCare Plus eligibility:

Type of Placement/Agreement or Service	Parents (MAGA) and caretaker relatives (MAGN) with all children removed from home	Parents (MAGA) and caretaker relatives (MAGN) with child(ren) removed from home, and some child(ren) remain in home	Other Child Welfare Caretakers of children who have been removed from the home
Out of Home Care **or** **Kinship Care (voluntary or court-ordered)**	If cooperating with a reunification permanency plan, they continue to be considered a parent or caretaker relative of the temporarily absent child(ren) under the BadgerCare Plus parent category.	Because there are other children in the home, eligibility is under the BadgerCare Plus parent category.	May only qualify for BadgerCare Plus as a childless adult (MAGS) while the child is temporarily absent.
Long-term kinship care **or** **Subsidized Guardianship**	May only qualify for BadgerCare Plus as a childless adult (MAGS).	Because there are other children in the home, eligibility is under the BadgerCare Plus parent category.	May only qualify for BadgerCare Plus as a childless adult (MAGS).

These factors and tax filing statuses impact the BadgerCare Plus group size.

Example 1	Stacy's child, Jared, was placed in out-of-home care with Laura, by the child welfare agency. Stacy files taxes but is not claiming Jared as her tax dependent. Because Laura has had Jared in her care most of the year, she is claiming Jared as her tax dependent. Stacy is cooperating with the reunification goal of Jared's permanency plan. There are no other children, tax filers, or tax dependents in either Stacy's or Laura's households. If Stacy applies for BadgerCare Plus and meets all non-financial and financial requirements, she may be eligible for BadgerCare Plus as a parent with a group size of one.
Example 2	Ben's daughter, Megan, was placed in court-ordered Kinship Care with her grandfather, James (age 60). Ben does not file taxes, but James does. Because Megan was in James's home most of the year, he claims Megan as his dependent. There are no other children, tax filers, or tax dependents in either Ben's or James's households. Ben is cooperating with the reunification goal of Megan's permanency plan. If Ben applies for BadgerCare Plus and meets all non-financial and financial requirements, he may be eligible for BadgerCare Plus as a parent with a group size of two.
Example 3	Jenny's son, Simon, was placed with Jerry (age 66) in out-of-home care by the child welfare agency. Jenny is cooperating with the reunification goal of Simon's permanency plan. Jenny files taxes and claims Simon as a dependent. If Jenny applies for health care, she may be eligible for BadgerCare Plus as a parent with a group size of two.

10.2 Eligibility for Child Welfare Caretakers

Child welfare caretakers may qualify for BadgerCare Plus under a caretaker category (MAGN). However, the child may not always be included in the MAGI group (see SECTION 2.2 COVERAGE GROUP DEFINITIONS).

The following chart explains the impact of placement type, cooperating with a reunification permanency plan goal, and the BadgerCare Plus eligibility of the parent or caretaker from which the child was removed:

Type of Placement/Agreement or Service	Child Welfare Caretaker Relatives (see SECTION 2.2.2 CARETAKER RELATIVE)	Other Child Welfare Caretakers
Out of Home Care **Kinship Care (voluntary or court-ordered)**	If the parent or caretaker relative whose home the child was removed from is enrolled in BadgerCare Plus as the parent or caretaker of the child and is cooperating with a reunification permanency plan goal, and there are no other dependent children in the current caretaker's home, the caretaker is considered a childless adult for purposes of BadgerCare Plus eligibility. If the parent or caretaker relative whose home the child was removed from is not enrolled in BadgerCare Plus as the parent or caretaker of the child or **is not** cooperating with a reunification permanency plan goal, the current caretaker relative is considered the caretaker for BadgerCare Plus eligibility.	May only qualify for BadgerCare Plus as a childless adult.
Long-Term kinship care **or** **Subsidized Guardianship**	May qualify for BadgerCare Plus as a caretaker relative.	May only qualify for BadgerCare Plus as a childless adult.

These factors and tax filing statuses impact the BadgerCare Plus group size.

See Process Help, Section 12.26 Child Welfare Parents, for information on processing child welfare parent or caretaker relative cases.

Example 1	Stacy's child, Jared, was placed in out-of-home care with Laura by the child welfare agency. Stacy files taxes but is not claiming Jared as her tax dependent. Because Laura has had Jared in her care most of the year, she is claiming Jared as her tax dependent. Stacy is cooperating with the reunification goal of Jared's permanency plan. There are no other children, tax filers, or tax dependents in either Stacy's or Laura's households. If Laura applies for BadgerCare Plus and meets all non-financial and financial requirements, she may be eligible for BadgerCare Plus as a childless adult with a group size of two.
Example 2	Ben's daughter, Megan, was placed in court-ordered Kinship Care with her grandfather, James (age 60). Ben does not file taxes, but James does. Because Megan was in James's home most of the year, he claims Megan as his dependent. There are no other children, tax filers, or tax dependents in either Ben's or James's households. Ben is cooperating with the reunification goal of Megan's permanency

	plan and is enrolled in BadgerCare Plus as Megan's parent. If both Ben and James apply for BadgerCare Plus and meet all non-financial and financial requirements, Ben may be eligible for BadgerCare Plus as a parent with a group size of two and James as a childless adult with a group size of two.
Example 3	Jenny's son, Simon, was placed with Jerry (age 66) in out-of-home care by the child welfare agency. Jenny is cooperating with the reunification goal of Simon's permanency plan. Jenny files taxes and claims Simon as a dependent. If Jerry applies for health care, Jerry may be eligible for EBD Medicaid.
Example 4	Christopher's son, Braden, was placed in Kinship Care with Christopher's sister, Vicki. Christopher is claiming Braden as a tax dependent, but he is not applying for BadgerCare Plus. Vicki also files taxes. If Vicki meets all non-financial and financial requirements, Vicki may be eligible for BadgerCare Plus as a caretaker relative with a group size of one.
Example 5	Heather's son, Caden, was placed in Kinship Care with Heather's sister, Vanessa. Heather is claiming Caden as a tax dependent but is not applying for BadgerCare Plus. Vanessa does not file taxes. If Vanessa meets all non-financial and financial requirements, she may be eligible for BadgerCare Plus as a caretaker relative with a group size of two.

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11.1 Foster Care Medicaid Certification

Children or youth in any of the following placements or agreements are eligible for Foster Care Medicaid without applying:

- Out-of-Home (Foster Care) placement
- Active Subsidized Guardianship Agreement
- Court-ordered Kinship Care placement
- Long-term Kinship Care Agreement
- Active Adoption Assistance Agreement

Child welfare agencies certify eligibility for Foster Care Medicaid when a child has been removed from the home.

Certification of Foster Care Medicaid begins on the date the child or youth entered a placement or agreement, which can be any date of a month.

Children certified for Foster Care Medicaid may not be dually enrolled in BadgerCare Plus or other Medicaid types, with the exceptions of Katie Beckett Medicaid or SSI-Medicaid members.

See SECTION 1.2.8 FOSTER CARE MEDICAID regarding continuous coverage for children.

11.1.1 Foster Care Medicaid Recertification

For children or youth who remain in a placement or agreement at the end of their Foster Care Medicaid certification period, the child welfare agency grants a new 12-month certification period.

11.1.2 Foster Care Medicaid Disenrollment

When a child getting Foster Care Medicaid leaves their placement or their agreement ends, they remain eligible under Foster Care Medicaid for the remainder of their 12-month continuous coverage period or for three months after their placement or agreement ends, whichever is later.

Children who are 19 or older still receive a 3-month grace period but their continuous coverage period concludes at the end of the month they turn 19.

Example 1	Remmy is 18, and turns 19 in July. Remmy has Foster Care Medicaid with a certification period July 1 through August 31. His court-ordered Kinship Care agreement ends on June 20. Remmy will continue to have Foster Care Medicaid until September 30. This is because Remmy receives a minimum of three complete months of Foster Care Medicaid after his agreement end date.
Example 2	Karmi is 18, and turns 19 in January. Karmi has Foster Care Medicaid with a certification period April 1 through March 31. Their placement ends on June 20. Karmi will continue to have Foster Care Medicaid until January 31 because their continuous coverage period ends the month they turn 19.
Example 3	Meg has Foster Care Medicaid with a certification period May 1 through June 30. Her placement ends on February 20. Meg turns 19 on August 15. Meg will continue to have Foster Care Medicaid until June 30, the end of her continuous coverage period, because she remains under age 19.

For details on the transition to other health care types after Foster Care Medicaid ends, see SECTION 26.3.4 REDETERMINATIONS when Foster Care Medicaid Ends.

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11.2 Former Foster Care Youth (FFCY)

Youths who were in certain foster care placements or agreements on their 18th birthday can qualify for BadgerCare Plus as a FFCY. The youth's state residency when they turned 18 years old is not an eligibility factor.

1. To qualify, the youth must be under age 26 and must have been in one of the following placements or agreements (either IV-E or non-IV-E) on the date that they turned 18 years old:

    - Out-of-home care placement
    - Court-ordered Kinship Care
    - Long-Term Kinship Care
    - Subsidized Guardianship

2. The youth must also meet the following eligibility criteria:

    a. SSN or cooperation - Once the SSN is provided, verification is completed through data exchange processes.
    b. U.S. citizen or national or a qualifying immigrant - Any individual who previously received a Title IV-E Foster Care Medicaid type is exempt from verifying U.S. Citizenship.
    c. Cooperates with child support enforcement agencies in obtaining medical support (if a parent).
    d. Cooperates with third party liability (TPL) requirements.
    e. Physically resides in Wisconsin and intends to reside in the state.
    f. Is not already enrolled in another mandatory health care category, such as SSI Medicaid.

There are no financial eligibility criteria for youths while they are eligible as FFCY. They are not required to provide any income information or tax filing information for their BadgerCare Plus eligibility to be determined or redetermined.

Youths may be eligible for BadgerCare Plus as a FFCY until they turn 26 years old.

A 12-month renewal is required to continue eligibility.

Note *If a FFCY is included in another household member's assistance group (AG), their financial information, including tax filing information, may be required to determine eligibility for those other household members.*

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12.1 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 ten months per year in order to accept seasonal employment in the planting, cultivating, raising, harvesting, handling, drying, packing, packaging, processing, freezing, grading, or storing any agricultural or horticultural commodity in its unmanufactured state and is authorized to work in the U.S.

"Migrant worker" does not include 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 (see SECTION 12.4.2 SIMPLIFIED APPLICATION PROCEDURE FOR MIGRANT WORKERS).

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12.2 Nonfinancial Eligibility for Migrant Workers

Migrant workers have the same nonfinancial eligibility requirements as other BadgerCare Plus or Medicaid applicants and members, with one exception: Migrant workers can meet the residency requirement if they are currently living in Wisconsin but do not "intend to reside" in Wisconsin (see SECTION 3.1 RESIDENCE).

Standard BadgerCare Plus and Medicaid rules are used when determining who is included in the migrant worker's assistance group (see CHAPTER 2 BADGERCARE PLUS GROUP and Medicaid Eligibility Handbook Section 15.1.1 Elderly, Blind, or Disabled Fiscal Test Group).

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12.3 Financial Eligibility for Migrant Workers

For migrant worker households that qualify for the simplified application procedure, the IM agency **must not** collect financial information nor apply any financial tests at application (see SECTION 12.4.2 SIMPLIFIED APPLICATION PROCEDURE FOR MIGRANT WORKERS).

For migrant worker households that do **not** qualify for the simplified application procedure, regular financial eligibility rules are used, with one exception: **annualized earned income** must be used at application when determining their financial eligibility for BadgerCare Plus or Medicaid (see SECTION 12.4.3 REGULAR APPLICATION PROCEDURE FOR MIGRANT WORKERS).

Annualized earned income is a prospective monthly estimate of earned income based on the estimated total gross annual earnings divided by 12. Annualized income can be based on the past 12 months of the migrant family's income if it is anticipated that last year's income is the best estimate of the current year's prospective income.

Annualized earned income must also be used at renewal for all BadgerCare Plus and Medicaid members who are migrant workers (see SECTION 12.5 MIGRANT WORKER RENEWALS).

See Process Help Section 11.1.10.1.3 Migrant Eligibility (Financial Processing) for financial processing instructions.

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12.4 Migrant Worker Applications

12.4.1 Application Methods for Migrant Workers

Migrant workers may apply for BadgerCare Plus or Medicaid using any of the application methods described in SECTION 25.2 APPLICATION METHODS.

When an application is received from someone who has indicated that they are a migrant worker, the IM agency must determine whether they qualify for the simplified application processing procedure (see SECTION 12.4.2 SIMPLIFIED APPLICATION FOR MIGRANT WORKERS) or the regular application processing procedure (see SECTION 12.4.3 REGULAR APPLICATION PROCEDURE FOR MIGRANT WORKERS).

12.4.2 Simplified Application Procedure for Migrant Workers

Migrant workers and their families can have their eligibility for Medicaid or BadgerCare Plus determined using a simplified application procedure if **either** of the following conditions are met:

- All household members have current Medicaid eligibility in another state. "Current Medicaid eligibility" means they are eligible for Medicaid in another state for at least the month of their application and the following month. Current Medicaid eligibility can be verified with a copy of the out-of-state Medicaid card or by contacting the other state.
- For at least two consecutive months within the last 12 months, all household members were eligible for Wisconsin Medicaid or BadgerCare Plus, and their eligibility ended only because they no longer reside in Wisconsin.

For migrant worker households that qualify for the simplified application procedure, the IM agency **must not collect financial information nor apply any financial tests** at application. (see SECTION 12.3 FINANCIAL ELIGIBILITY FOR MIGRANT WORKERS). Otherwise, standard BadgerCare Plus and Medicaid application processing procedures apply (see SECTION 12.2 NONFINANCIAL ELIGIBILITY FOR MIGRANT WORKERS).

For information about renewal dates, see section 12.5.2 RENEWAL DATES FOR MIGRANT WORKERS.

Example 1	A migrant worker family consisting of a married couple and their three children comes to Wisconsin. On July 3, 2024, they apply for BadgerCare Plus. The family has current Medicaid eligibility in Texas, with a certification period ending on November 30, 2024. All five members of the household are listed on their Texas Medicaid card. The case must be processed using the simplified application procedure because all members of the household have current Medicaid eligibility in Texas. Their renewal month is November 2024 because that is when their annual renewal would have been due in Texas.
Example 2	The family from Example 1 renews their benefits in November 2024. In December 2024, they go back to Texas and BadgerCare Plus closes because they no longer reside in Wisconsin. In July 2025, the family returns to Wisconsin and again applies for BadgerCare Plus. There are no non-financial changes and no changes in household composition. Regardless of whether they have current Medicaid eligibility in Texas, their application must be processed using the simplified application procedure. Their next renewal will be due on the **later** of the following: If they have current Medicaid eligibility in Texas the month their eligibility in Texas ends. November 2025, which is 12 months after they completed their last renewal in Wisconsin.

12.4.3 Regular Application Procedure for Migrant Workers

For migrant worker households that do **not** qualify for the simplified application procedure, the standard BadgerCare Plus or Medicaid application procedures must be used, with one exception: **annualized earned income** must be used when determining their financial eligibility for BadgerCare Plus or Medicaid (see SECTION 12.3 FINANCIAL ELIGIBILITY FOR MIGRANT WORKERS).

Example 1	A migrant worker applies for BadgerCare Plus on May 1, 2024. Their eligibility in their home state ends on May 31, 2024. Because they do not meet the definition of "current Medicaid eligibility" in another state, they must use the regular application process and provide any required verifications, including financial verification. However, the IM agency must use annualized earned income when determining their financial eligibility for BadgerCare Plus. Their renewal month is April 2025.
Example 2	A migrant worker household applies BadgerCare Plus on May 1, 2024. Their eligibility in their home state ends on July 31, 2024. However, the BadgerCare Plus household now includes the applicant's new spouse who was not eligible for Medicaid in their home state. Because their household now has additional members, they must use the regular application process and provide any required verifications, including financial verification. However, the IM agency must use annualized earned income when determining their financial eligibility for BadgerCare Plus. Their renewal month is April 2025.

12.5 Migrant Worker Renewals

12.5.1 Renewal Methods for Migrant Workers

Migrant workers who are still in Wisconsin during their renewal month may renew their BadgerCare Plus or Medicaid using any of the renewal methods described in SECTION 26.2 CHOICE OF RENEWAL.

12.5.2 Renewal Dates for Migrant Workers

For migrant worker households that had current Medicaid eligibility in another state when they applied through the simplified application procedure (see SECTION 12.4.2 SIMPLIFIED APPLICATION PROCEDURE FOR MIGRANT WORKERS), the **first** renewal must be set for the month when their out-of-state eligibility ends. The next renewal will be due in 12 months after the first renewal.

Example	On July 3, 2024, a migrant family that has current Medicaid eligibility in Texas through December 31, 2024, comes to Wisconsin and is certified for Medicaid through the simplified application process. The renewal date is set for December 2024, because that's when their Texas eligibility ends.

For migrant worker households that were previously open for Wisconsin Medicaid or BadgerCare Plus for at least two consecutive months within the last 12 months, and whose eligibility only ended because they left Wisconsin: if they completed a renewal in Wisconsin prior to closing, and are now reopening through the simplified application procedure, their renewal month must be set for **later** of the following:

- 12 months after their last renewal in Wisconsin.
- The month when their Medicaid eligibility in their home state is ending.

For all migrant worker households that applied using the regular application procedure (see SECTION 12.4.3 REGULAR APPLICATION PROCEDURE FOR MIGRANT WORKERS),the standard 12-month certification period applies, and their renewal is due in 12 months.

12.5.3 Financial Eligibility for Migrant Workers at Renewal

When eligibility for migrant worker households is renewed, the IM agency must collect financial information and apply standard financial eligibility policies, with one exception: Annualized earned income must be used at renewal for all BadgerCare Plus or Medicaid members who are migrant workers. See SECTION 12.3 FINANCIAL ELIGIBILITY FOR MIGRANT WORKERS.

See Process Help, Section 11.1.10.1.3 Migrant Eligibility (Financial Processing) for financial processing instructions.

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16.1 Income

16.1.1 Income Limits

Population	Income Limits for All Members
Pregnant women	306% FPL
Children under 19*	306% FPL
Parents/Caretaker relatives	100% FPL
Childless adults	100% FPL
Family Planning Only Services	306% FPL

*Children and pregnant women with income above the limit can become eligible by meeting a deductible.

See SECTION 50.1 FEDERAL POVERTY LEVEL TABLE for the most recent FPL limits.

The income limits under MAGI rules include the following income disregards.

- Children, pregnant women and individuals eligible under Family Planning Only Services will be allowed an income disregard equal to 5% of the FPL in addition to a conversion factor adjustment equal to 1% of the FPL. While the income limit remains 300% FPL, CWW will actually test against an income limit of 306% FPL once the income disregard and conversion factor are included.
- Parents, caretakers, and childless adults already have the income disregard included in the income limit of 100 percent FPL. CWW will test against an income limit of 100% FPL.

Note *Other effective income limits for children under MAGI rules will also reflect the addition of the 6% disregard with the exception that the income thresholds for children's premiums will only be increased by 1%.*

16.1.2 Income Under Modified Adjusted Gross Income Rules

All taxable income is counted when determining BadgerCare Plus eligibility. Social Security income is also counted. See SECTION 16.2 INCOME TYPES NOT COUNTED for the list of income that is not counted. These rules apply to families that are filing taxes and those who are not.

Within a MAGI group, income will be counted as detailed in CHAPTER 2 BADGERCARE PLUS GROUP. For any member whose income is budgeted for their assistance group, income under the countable income types listed in SECTION 16.4 EARNED INCOME and SECTION 16.5 OTHER INCOME will be counted and deductions under the types listed in SECTION 16.3 INCOME DEDUCTIONS will be allowed. See CHAPTER 2 BADGERCARE PLUS GROUP for determining the assistance group size.

All MAGI group members' income is counted with one exception: If a group member is the child or tax dependent of another group member, their income is only counted if they are "expected to be required" to file a tax return for the current year (see SECTION 2.8 MAGI INCOME COUNTING RULES).

If a member's income is budgeted for their assistance group, their deductions will be counted for that group. In situations where an individual is planning to file a joint tax return with their spouse, the individual's deductions may offset the spouse's income even if the individual has no income.

Note *The availability of income does not affect whether or not the income is counted under MAGI rules*

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16.2 Income Types Not Counted

The following types of income are not included in the countable income when determining eligibility for BadgerCare Plus.

1. Adoption Assistance

2. Agent Orange Settlement Fund

Do not count 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.). This is retroactive to January 1, 1989. Do not count these payments for as long as they are identified separately.

3. Combat Pay

Do not count 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 not be counted when determining the household's income.

Example 1	John's wife Bonnie and their daughter have an open BadgerCare Plus case. John is in the military stationed overseas; his monthly income is $1,000. John sends his wife $1,000 every month. When John is deployed to a combat zone his pay is increased to $1,300 a month, which is deposited into a joint account. Because the $300 is combat zone pay, it is not counted in the determination. The pre-combat pay of $1,000 is budgeted as unearned income for BadgerCare Plus.

4. Other Military Pay

Do not count income received for the following purposes:

- Living allowances
  - Basic Allowance for Housing
  - Basic Allowance for Subsistence
  - Housing and cost-of-living allowances abroad paid by the U.S. government or by a foreign government
  - Overseas Housing Allowance
- Death allowances
- Family allowances
- Moving allowances
- Travel allowances

- Professional education allowances
- ROTC educational and subsistence closure benefit allowances
- Uniform allowances

Note *Military pay can be verified using the Leave and Earnings Statement received by active-duty personnel.*

5. Crime Victim Restitution Program

Payments received from a state-established fund to aid victims of a crime.

6. Disaster and Emergency Assistance

Payments made by federal, state, county, tribal, or local government agencies or disaster assistance organizations.

7. Income of People Younger than 18 Years Old

See SECTION 2.8 MODIFIED ADJUSTED GROSS INCOME COUNTING RULES for information about counting income for people younger than 18 years old.

8. Foster Care

9. Individual Development Account

Payments that are made in the form of matching funds to buy a home, start a business, or to complete post-secondary education.

10. Jury Duty Payments

Count all jury duty payments as earned income for the month in which it is received if the payments are not turned over to the individual's employer. Amounts received separately as reimbursements or allowances for travel to and from the courthouse, meals, and lodging during jury duty are not countable.

11. Kinship Care

12. Life Insurance Policy Dividends

13. Nutrition Benefits

Received from the following:

- Emergency Food and Shelter National Board.
- Federal Emergency Management Assistance.
- FoodShare allotment.
- Home produce for household consumption.
- National School Lunch Act.
- Supplemental food assistance under the Child Nutrition Act of 1966.
- Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965.
- USDA Child Care Food Program.
- USDA-donated food and other emergency food.
- WIC—the supplemental food program for women, infants, and children.

14. Payments to Native Americans

1. Distributions from Alaska Native Corporations and Settlement Trusts, including:
    a. Menominee Indian Bond interest payments.

b. All judgment payments to tribes through the Indian Claims Commission or Court of Claims.
c. Payments under the Alaskan Native Claims Settlement Act.
d. Payments under the Maine Indian Claims Settlement Fund.
e. Payments under PL 93-124 to the Sisseton-Wahpeton Sioux Tribe, except under non-MAGI rules, individual shares over $2,000.
f. 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 under non-MAGI rules, individual shares over $2,000.
g. 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.
h. Payments under PL 96-318 to the Delaware Tribe of Kansas and of Idaho.
i. Payments under PL 96-420 to the Houlton Band of Muliseet Indians, the Passamoquoddy, and Penobscot.
j. 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.
k. Payments under PL 99-346, Saginaw Chippewa Indian Tribe of Michigan.
l. Payments under PL 99-377 to the Mille Lacs, Leech Lake, and White Earth, Minnesota reservations.
m. Payments under PL 101-41, Puyallup Tribe of Indians Settlement Act of 1989.
n. Payments under the Distribution of Judgment Funds Act of 1987 to the Cow Creek Band, Umpqua Tribe.
o. Payments under the Distribution of Indian Judgment to the Crow Creek and Lower Brule Sioux except individual shares over $2,000. Payments under the settlement of the Cobell v. Salazar class-action trust case.
p. Payments under the Michigan Indian Claims Settlement Act (MICSA) to the Sault Ste. Marie Tribe of Chippewa Indians and the Bay Mills Indian Community.

2. Other Exempt Tribal Payments - disregard 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:
        i. Federally-protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources
        ii. Rights of ownership or possession in any lands held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior; or

    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

3. Tribal General Welfare Assistance (GWA) payments received under the Tribal General Welfare Exclusion Act of 2014, even if the source of the payment is gaming revenue.
4. Bureau of Indian Affairs (BIA) General Assistance payments.

15. Payments to Nazi Victims

Made under PL 103-286 to victims of Nazi persecution.

16. Radiation Exposure Compensation Act (PL 101-426)

Payments 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 their surviving spouse, children, parents, or grandparents. This is retroactive to October 15, 1990. Do not count these payments for as long as they are identified separately.

17. Refugee Cash Assistance Program Payments

The Refugee Cash Assistance program is administered by W-2 agencies and is made available for refugees who do not qualify for W-2.

18. Refugee "Reception and Placement" Payments

Refugee "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/family or to a vendor.

19. Reimbursements

Reimbursements for out-of-pocket expenses that an assistance group member has incurred and/or paid. However, reimbursements for normal household living expenses (for example, rent, clothing, or food eaten at home) are counted.

Examples of reimbursements that are not counted:

- Reimbursements 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.
- Reimbursements 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 (for example, transportation, chore services, and child care services).

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

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 and replacement housing and property transfer expenses. Do not count the amounts paid by any

governmental agency or organization listed in Wis. Stat. § 32.02. Do not count 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.

Do not count Experimental Housing Allowance Program payments. Its purpose is to study housing supply. Test areas, which include Brown County, were selected throughout the United States, and contracts were entered into prior to January 1, 1975. A sample of families was selected to receive monthly housing allowance payments.

21. Repayments

Repayments of money the member has received from an economic support program and must give back because of a program error or violation. Since they are not entitled to the money, they must repay it; therefore, it should not be counted as income to the member.

Do not count 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 to equal $300. If the VA overpays Richard by $200, he can only pay back the $50 a month he receives from the VA. If he repays more, for instance, $75 a month, only $50 should be disregarded.

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

22. Special Programs

Income received from any of the following:

- Active Corp. 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 16.4.1 SPECIALLY TREATED WAGES, #5 TITLE V - OLDER AMERICANS ACT OF 1965), except wages or salaries, which are counted as earned income.
- Retired Senior Volunteer Program (RSVP).
- Service Corp. of Retired Executives (SCORE).
- University Year for Action Program.
- 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.
- AmeriCorps Volunteers in Service to America (VISTA).

23. Spina Bifida Child

(PL 104-204) Payments to any child of a Vietnam veteran for any disability resulting from the child's spina bifida.

24. Susan Walker Payments

Susan Walker 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.

25. Student Financial Aids

Work study income and any income from an internship or assistantship should be counted as earned income. Grants, scholarships, fellowships, and any additional financial assistance provided by public or private organizations that exceed the cost of tuition, books, and mandatory fees are counted as unearned income and should be prorated over the period of time they are intended to cover. Student loans are not counted as income regardless of what the loan is used to pay for.

Example 3	Mary was awarded a scholarship for $3,500 in July that is intended to cover her fall semester (September through December). Her tuition and course related expenses are $3,250 for the semester. The $250 that exceeds the amount of tuition and course-related expenses will be prorated over the four-month period from September through December at $62.50 in unearned income each month ($250/4 months = $62.50/month).

The following types of grants, scholarships, and fellowships are counted as income:

- Pell Grants
- Robert Byrd Honors scholarships
- Any grants, scholarships, or fellowships received from the college or university as part of a financial aid package
- Any grants, scholarships, or fellowships provided by public or private organizations

The following educational aid types are not counted as income:

- Loans, including Stafford Loans and Perkins Loans
- AmeriCorps or HealthCorps grant
- Bureau of Indian Affairs grant
- GI Bill/Veterans benefits
- ROTC benefits

Note *These income types will not be considered when determining if grants, scholarships, and fellowships exceed the cost of tuition, books, and mandatory fees.*

The following expense types will be used to offset income from grants, scholarships, fellowships, and other financial aid:

- Tuition
- Required books, supplies, or equipment
- Mandatory fees

The following expense types will not be allowed to offset income from grants, scholarships, or other financial aid:

- Room

- Board (meals or meal plans)
- Personal expenses
- Transportation and parking
- Loan fees
- Health insurance costs

26. Stipends from the University of Wisconsin Upward Bound Program

Paid to high school students to encourage low-income students to further their education.

27. Tax Refunds (Federal income tax refunds, including amounts for the Child Tax Credit and the EITC)

28. Unpredictable Income

Income that is unpredictable, irregular, and has no appreciable effect on ongoing need.

29. Veterans Benefits

Do not count any veterans' benefits paid under any law, regulation, or administrative practice administered by the VA. The following amounts paid to veterans or their families are not countable:

- Education, training, and subsistence allowances (that is, GI Bill benefits).
- Disability compensation and pension payments for disabilities paid either to veterans or their families.
- Grants for homes designed for wheelchair living.
- Grants for motor vehicles for veterans who lost their sight or the use of their limbs.
- Veterans' insurance proceeds and dividends paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death.
- Interest on insurance dividends left on deposit with the VA.
- Benefits under a dependent care assistance program.
- The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001.
- Payments made under the compensated work therapy program.
- Any bonus payment by a state or political subdivision because of service in a combat zone.

Do not count VA allowances for unusual medical expenses that are received by a veteran, their surviving spouse, or dependent. Do not count aid and attendance and housebound allowances received by veterans, spouses of disabled veterans, and surviving spouses. For institutionalized and community waiver cases, do not count these allowances in eligibility and post-eligibility determinations, except for residents of the State Veterans Home at King.

30. Wartime Relocation of Citizens

(PL 100-383) restitution payments made to individual Japanese Americans (or their survivors) and Aleuts who were interned or relocated during World War II.

31. Workforce Innovation and Opportunity Act (WIOA) Unearned Income

Income paid to any adult or minor participating in the Workforce Innovation and Opportunity Act (WIOA), including:

- "Need-related payments" paid to persons as allowances to enable them to participate in a training program.
- "Compensation in lieu of wages" paid to persons in "work experience" and/or “transitional jobs.” This is arranged when private for-profit opportunities are not available.
- "Payments for supportive services" that enable participation in WIOA career and/or training services (for example, transportation, health care, child care, meals).

32. W-2 Payments

Payments for W-2 Transition, Custodial Parent of an Infant, At Risk Pregnancy, Case Management Follow-up Plus (CMF+) and Community Service Jobs. Do not disregard payments for Trial Employment Match Program or Transform Milwaukee Jobs

33. General Relief and Charity

34. SSI

SSI is not counted income for BadgerCare Plus. The following is a brief list of the potential codes for SSI.

- SI - SSI/Supplemental Security Income
- SISE - SSI-E/Supplemental Security Income - Expenditure
- SISS - State Supplemental Security Income

35. Lump Sums Payments

Count lump sum payments (if the payment is otherwise a countable income type) in the month received. Lump sum payments are not counted outside of the month received.

36. Property Settlement

Money received as a property settlement is always an asset, regardless of whether it is paid in one payment or installments. It is never income.

37. Subsidized Guardianship Payments

Subsidized guardianship payments are not counted for BadgerCare Plus.

38. Child Support

Child Support payments are not taxable and are not counted under MAGI rules (see Process Help, Section 11.3.3.6 Entering Child Support Income on an Unearned Income Page). If a household is receiving family support, see SECTION 16.2 #39 FAMILY SUPPORT.

39. Family Support

Family support combines child support and alimony/spousal support. If a household is receiving family support, prorate the payment(s) among the individuals covered by the court order. The amount of the payment allocated to the child(ren) is considered child support and is disregarded (see SECTION 16.2 INCOME TYPES NOT COUNTED, #38 CHILD SUPPORT). The amount of the payment allocated to the adult(s) is considered alimony/spousal support. To determine whether alimony/spousal support is counted as income, see SECTION 16.2 INCOME TYPES NOT COUNTED, #40 ALIMONY/SPOUSAL SUPPORT.

Example 4	Morgan receives $500 a month in family support for herself and her three children, Kyra (age 15), Kevin (age nine), and Katie (age seven). $500/4 people = $125 per person. Disregard the amount allocated to the children ($125 x 3 children = $375).

40. Alimony/Spousal Support

Do not count alimony/spousal support if it meets one of the following criteria:

- The payment was received under a separation or divorce agreement finalized on or before December 31, 2018, that designates the payments as non-taxable.
- The payment was received under a separation or divorce agreement finalized on or after January 1, 2019.
- The payment was received under a separation or divorce agreement finalized on or before December 31, 2018, but modified on or after January 1, 2019, and provides that Section 11051 of Pub. L. 115-97 applies to the modification which makes the alimony/spousal support non-taxable.

Alimony/spousal support must be counted if the date that the separation or divorce agreement was finalized or modified cannot be verified.

41. Gifts

A gift is something a person receives, 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).

Do not count the value of a gift as income. This includes funds received through crowdfunding accounts, such as GoFundMe and Kickstarter. Funds received through a crowdfunding account would be considered a gift. These funds are not taxable and are not counted.

Example 5	Marco's grandmother gave him $1,600 to help pay for his classes at a local technical college. Do not count this $1,600 as income.

42. Money from Another Person

Money 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. Money from another person is not a loan.

Do not count money from another person as income (see SECTION 16.2 INCOME TYPES NOT COUNTED, #43 INHERITANCES, BEQUESTS, AND DEVISES for policies regarding money received from another person through an inheritance, bequest, or devise).

Example 6	Mimi receives $500 each month from her parents. She is not expected to pay back this money. The $500 is not counted as income for BadgerCare Plus eligibility.

Note *If money received from another person is in exchange for goods or services (such as an informal arrangement in which someone rents a room in their house) and if the payment is regular and predictable, it should be counted. See SECTION 16.4.3.1 INCOME SOURCES for information on counting rental income.*

Example 7	Jeremy pays Micah $300 each month to live in a room in Micah's house. Micah and Jeremy do not have a formal lease agreement, but the payment is regular and predictable. Count the $300 per month as income for BadgerCare Plus eligibility.

43. Inheritances, Bequests, and Devises

An inheritance is property received from someone who is deceased without a valid will. A bequest is personal property received from someone who is deceased, as directed by that decedent's will. A devise is real property received from someone who is deceased, as directed by that decedent's will.

Inheritances, bequests, and devises are generally not taxable, and, as a result, the value of the inheritance, bequest, or devise is generally not counted as income.

However, there are a few forms of inheritances or bequests that may be taxable. For example, distributions from an inherited pension are usually taxable to the beneficiary if the distributions would have been taxable if the deceased were still living.

In addition, income generated from an inheritance, bequest, or devise is usually taxable.

For inheritances, bequests, and devises that are taxable, the income should be counted only in the month it was received if it was received as a lump sum. If the payments are regular and predictable, they should be prorated (unless they are received monthly) and counted accordingly.

Example 8	Roger's aunt passed away, and Roger inherited her rental house. It is worth $100,000. The house is occupied by tenants who pay $800 a month in rent. At the time of the deed transfer, the tenants owed $3,200 in back rent. The value of the $100,000 property is not taxable, but if the tenants pay Roger the $3,200 in back rent, that income is taxable and would be counted in the month it was received. If they pay Roger $800 a month on an ongoing basis, this income would also be taxable and would be counted based on rules regarding rental income.

Note	*Income from the sale of inherited property is taxable if the property is sold for more than the fair market value on either the date of the decedent's death or on the alternate valuation date. In Example 9, if Roger were to sell the rental house for $150,000, the $50,000 gain would be taxable. If Roger receives income from the sale in a lump sum, this income would only be counted in the month it was received.*

Example 9	Darcy inherited her husband's $150,000 life insurance policy. In most cases, life insurance policies are not taxable when they are inherited, so the $150,000 should not be counted as income. However, Darcy receives an ongoing interest payment of $1,200 a month from the policy. This amount is taxable and would be counted as unearned income.

Income generated by an inheritance, bequest, or devise includes situations in which someone is the beneficiary of a trust or estate, and the trust or estate holds assets that are generating income. If the trust or estate distributes income to the beneficiary, the beneficiary is responsible for paying taxes on that income.

Example 10	Keisha is the beneficiary of a trust. Land was given to the trust, and it generates interest that is distributed to Keisha as the beneficiary. Count this interest as unearned income.

44. Workers' Compensation

Do not count workers' compensation benefits. This includes workers' compensation benefits received as a settlement.

45. 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. Do not count this income.

46. Loans

If a BadgerCare Plus applicant or member receives a loan and it is available for current living expenses, do not count it as income, even if there is a repayment agreement.

47. Live-In Care Providers

Certain payments received by live-in care providers who provide care to someone enrolled in an HCBW program are not counted for BadgerCare Plus under MAGI budgeting rules. A live-in care provider lives in the same home as the person for whom they are providing care. This means the same house, apartment, duplex unit, or other residential unit. A provider who lives in a separate unit from the person receiving care within a multi-unit building is not a live-in care provider.

Example 11	Ameera provides care to her father, Raheem. Ameera lives in one unit of a duplex. Raheem lives in the other unit of the duplex. Ameera is not a live-in care provider because they do not live together in the same unit.

Live-in care providers are typically paid as employees, but some may be self-employed. They may be related to or not related to the person receiving care. In order to not be counted, payments to live-in care providers must meet all of the following criteria:

- The payments are for HCBW services provided to a member enrolled in one of the following HCBW programs:
    - Children's Long-Term Support (CLTS) waiver programs
    - Community Integration Program I (CIP 1A and CIP 1B)
    - Community Integration Program II (CIP II)
    - Community Options Program Waiver (COP-W)
    - Family Care
    - Family Care Partnership
    - IRIS
    - PACE
- The payments are made to a live-in care provider for services provided to an HCBW member under the member's written HCBW plan of care. Payments made for skilled services that only a nurse or other health professional may perform are not eligible for this exemption.
- The payments are made to a live-in care provider for services provided while the care provider and the HCBW member are living in the same home. The live-in care provider may be related to or not be related to the HCBW member.
- The live-in care provider is not providing care to more than 10 people younger than age 19 at the same time or five people aged 19 or older at the same time.

If the payments received by the live-in care provider meet all of these criteria, they are not counted when determining eligibility for BadgerCare Plus. If the payments received by the live-in care provider do not meet all of these criteria, the payments must be treated like other countable earnings or self-employment income. (See SECTION 16.4.4.2 LIVE-IN CARE PROVIDERS for verification of payments to live-in care providers and the Verifying Tax-Exempt Income for Live-in Care Providers Form (F-02193)).

48. 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:

- 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	*Someone using 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.*

- 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 person reports that a distribution was used for nonqualifying expenses, it should be assumed that the distribution was used for qualified disability expenses.

ABLE account funds remaining after a 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.*

49. Income Allocated to a Community Spouse

When spouses are filing taxes separately and one spouse enrolled in Institutional Medicaid and allocates income to the spouse still living in the community, do not count this income when determining BadgerCare Plus eligibility for the spouse living in the community.

Example 11	Jenny resides in a nursing home and is enrolled in Institutional Medicaid. Her husband, Kevin, lives in the community and is applying for BadgerCare Plus. Jenny and Kevin file taxes separately. Jenny has income from Social Security and a pension. She allocates $1,100 of her monthly income to Kevin as the community spouse. Do not count this allocation when determining Kevin's BadgerCare Plus eligibility.

50. 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 for BadgerCare Plus and some payment types are not counted as income for BadgerCare Plus. 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 is taxable
- Whether the payment can be considered “disaster assistance”

The payment types that do not count as income for BadgerCare Plus 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 (these are payments in addition to regular unemployment benefits)
- Lost Wages Assistance (LWA) payments (these payments are from a Federal Emergency Management Agency (FEMA) program that provides an additional $300 per week to eligible individuals who are unemployed or partially unemployed due to disruptions caused by COVID-19)
- Wisconsin Emergency Rental Assistance (WERA) payments
- 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 16.5 OTHER INCOME, #23 CERTAIN PAYMENT TYPES RELATED TO THE COVID-19 PANDEMIC for countable types of pandemic-related unemployment compensation benefits.

51. Advance payments of the federal EITC and the Child Tax Credit

Advance payments of the federal EITC and the Child Tax Credit are disregarded as income, whether they are received regularly or as a lump sum.

52. Guaranteed Income Payments

A guaranteed income payment is excluded from income if both of the following apply:

- The payment itself is privately funded.
- The payment is administered by a non-profit organization.

Payments that are excluded from income include, but are not limited to, payments from the Madison Forward Fund, the Madison Forward Fund 2.0, and The Bridge Project in Milwaukee.

53. Canceled Debt

Canceled debt is not counted as income.

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16.3 Income Deductions

16.3.1 Child Support Payments

Child support payments are not allowed as an income deduction.

Spousal support, alimony, or maintenance payments may be able to be claimed as a BadgerCare Plus tax deduction (see SECTION 16.3.3 TAX DEDUCTIONS).

16.3.2 Pretax Deductions

Pre-tax deductions are allowed if the payments are taken out of the individual's paycheck on a pre-tax basis. Examples include but are not limited to:

1. Health Insurance premium payments, including pre-tax premium payments for medical, dental or vision plans
2. Health Savings Account (including flexible spending accounts) contributions
3. Retirement contributions
4. Parking & Transit costs
5. Child Care Savings Account contributions
6. Group Life Insurance premium payments

16.3.3 Tax Deductions

Monthly expenses related to tax deductions from page one of the IRS Schedule 1 (Form 1040) are allowed as income deductions for the current year, even if the individual does not plan on filing taxes. If the expense is not incurred on a monthly basis, it will be prorated and counted as a monthly expense.

Most of these deductions are not common, and they do not include itemized tax deductions, like charitable contributions or mortgage interest.

A net loss carryover from previous periods, known as an NOL on IRS tax forms, is allowed as an income deduction. An NOL should be considered as an ongoing tax deduction but should be reviewed each tax year. If claimed, it would be found on of the IRS Schedule 1 (Form 1040).

See SECTION 16.5 OTHER INCOME, #15 CAPITAL AND ORDINARY GAINS AND LOSSES for information on counting capital losses.

In addition, a few deductions have caps, as noted in detail below. If an individual reports and verifies a monthly expense that is more than the monthly cap, the deduction will be the amount of the cap.

1. Student loan interest

Interest on a loan taken to pay for school expenses for the following people at the time the loan was taken out:

- Their spouse;
- Their child under age 19; or
- Their child under age 24 who was a student, lived with the individual for more than half a year, did not provide more than half of their own support for that year, and did not earn more than $3,900 during that year.

Do not count interest on a loan used for anything besides paying for education or if a relative or employer gave the loan.

This deduction is capped at a monthly amount of $208.

2. Self-employment tax deduction

Applies to individuals who are self-employed, who owe self-employment tax, and who are able to deduct a portion of the self-employment tax they pay. Only deduct the portion that the person can deduct on their tax return (as calculated on Schedule SE), not the entire amount of self-employment tax that is paid.

3. Spousal support, alimony, or maintenance

The amount paid for court ordered spousal support, alimony or maintenance or payments under Internal Revenue Code Section 71 for a current or prior spouse as a result of a legal separation or divorce can be deducted if the payments are paid under a separation or divorce agreement finalized on or before December 31, 2018.

Payments cannot be deducted if they meet one of the following criteria:

- The payment was received under a separation or divorce agreement finalized on or after January 1, 2019.
- The payment was received under a separation or divorce agreement finalized on or before December 31, 2018, but modified on or after January 1, 2019, and provides that Section 11051 of Pub. L. 115-97 applies to the modification which makes the alimony/spousal support non-taxable.

Do not deduct more than the court ordered amount. Do not allow any deduction if the separation or divorce agreement designates the payments as being non-taxable or the date that the separation or divorce agreement was finalized or modified cannot be verified.

4. Teachers' tax-deductible expenses

Applies to K-12 teachers who have up to $300 in out-of-pocket work expenses (expenses not paid for by the employer). This is capped at a monthly amount of $25.

5. Self-employed Simplified Employee Pension (SEP) and simple or qualified plan contributions

Examples of these plans include:

- Simplified Employee Pension (SEP) Plan
- Savings Incentive Match Plan For Employees (SIMPLE)
- Qualified Plan Contributions

Note *The person's personal contributions to these plans can be counted for BadgerCare Plus as tax deductions, but they are not counted as business expenses when calculating the self-employment income.*

6. Penalties for early withdrawal of funds

Penalties to a bank or financial institution for withdrawing funds early from a savings account where money must be left in the account for a fixed period of time, such as a time saving account, certificate of deposit (CD) or an annuity.

7. Performing artists tax-deductible expenses

Applies to performing artists who have out-of-pocket business expenses not paid by the employer and meet all of the following criteria:

- Worked for at least two employers who each paid at least $200
- Did not earn more than $16,000 for their work in the current year
- Had out-of-pocket expenses that were more than 10% of their earnings

8. Military reserve members' tax-deductible expenses

Applies to travel expenses for members of the Armed Forces Reserve who travel more than 100 miles away from home to perform work for the Armed Forces Reserve.

9. Out-of-pocket moving expenses for military members

Out-of-pocket moving expenses can be deducted if the person is an active duty member of the military who is ordered to move and that move is a permanent change of station as determined by the military.

10. Loss from sale of business property

Applies to self-employed individuals that had a loss from the sale or exchange of property that they owned for their business.

11. Individual Retirement Account (IRA) contributions

Applies to individuals who had income from a job and made contributions to an IRA. Also applies to self-employed individuals who made contributions to an IRA they set up themselves.

Note *The person's personal IRA contributions can be counted for BadgerCare Plus as tax deductions, but they are not counted as business expenses when calculating the self-employment income.*

12. Fee-based official tax-deductible expenses

Applies to individuals who are fee-based officials and have out-of-pocket business expenses. Examples of fee-based officials include chaplains, county commissioners, judges, justices of the peace, sheriffs, constables, registrars of deeds or building inspectors.

13. Domestic production activities deduction

Applies to self-employed individuals who led the production of things like property, electricity, natural gas, or potable water, as long as these things were produced in the United States. This also applies to individuals who invented or created software, recordings, or films in the United States.

14. Health Savings Account deduction

Applies to contributions made to a health savings account for someone enrolled in a high-deductible health plan, as specified on Form 8889. Contributions made by employers, through roll-overs, or through distributions from Individual Retirement Accounts are not deductible.

15. Self-employed health insurance deduction

Applies to self-employed people who are paying premiums for a medical, dental, or long-term care plan established under their business that covers them, their spouse, and/or their dependents.

16. Allowable write-in expenses

These deductions include:

- Contributions to Archer MSAs
- Deductions attributable to rents and royalties
- Certain deductions of life tenants and income beneficiaries of property
- Jury duty pay given to the employer because the juror was paid a salary during duty
- Reforestation expenses
- Attorney fees and court costs paid to recover a judgment or settlement for a claim of unlawful discrimination, a claim against the U.S. Government, or a claim under section 1862(b)(3)(A) of the Social Security Act
- Attorney fees relating to awards to whistleblowers
- Contributions to section 501(c)(18)(D) pension plans
- Contributions by certain chaplains to section 403(b) plans

17. Live-in care providers

The IRS requires live-in care providers to include the income paid to their self-employment business when it is reported on a 1099 form. When that income meets the required conditions (see SECTION 16.2 INCOME TYPES NOT COUNTED, #45 LIVE-IN CARE PROVIDERS), the providers are allowed to list all of that 1099 income as an expense in Part V of their Schedule C. Likewise, the self-employment income of the care provider has to be counted for EBD Medicaid and other IM programs. To disregard the self-employment income for BadgerCare Plus, the case should receive a tax deduction amount equal to the income.

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16.4 Earned Income

Earned income is income from gainful employment.

Earned income after pre-tax deductions is counted. See SECTION 16.3.2 PRE-TAX DEDUCTIONS for more information on pre-tax deductions.

1. Contractual Income

This provision applies primarily to teachers and other school employees. When an employed BadgerCare Plus group member is paid under a contract, either written or verbal, rather than on an hourly or piecework basis, the income is prorated over the period of the contract. For example, if the contract is

for 18 months, the income is prorated over 18 months no matter the number of installments made in paying the income. The income is prorated even if one of the following is true:

- There are predetermined vacation periods
- They will only be paid during work periods
- They will be paid only at the end of the work period, season, semester, or school year

2. Income In-Kind

Count in-kind benefits as earned income if they are all of the following:

- Regular
- Predictable
- Received in return for a service or product

Do not count the following:

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

In-kind room and board for employees may be considered not countable income in situations where it is provided as a convenience to the employer and when it is provided on the employer's premises. Do not include the value of room or board if the following conditions are met:

- **Board**. All of the following must be met:
    - The meals are furnished on the business premises of the employer.
    - The meals are furnished for the convenience of the employer.
- **Room**. All of the following must be met:
    - The lodging is furnished on the business premises of the employer.
    - The lodging is furnished for the convenience of the employer.
    - The lodging is a condition of your employment. The employee must accept the lodging in order to be able to properly perform the job duties.

Example 1	Alicia is working as a resident assistant at the college she attends. In exchange for working, she receives lodging in a residence hall and a meal plan at the college during the semesters she works. The college requires her to live in the residence hall and use the meal plan as part of her job as a resident assistant. Do not count Alicia's room and board as in-kind income.

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.

3. Wage Advances

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

4. 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 their employer as earned income when they would have received the amount had it not been deferred.

5. Workers' Compensation

Do not count workers' compensation as earned income.

16.4.1 Specially Treated Wages

1. Income Received by Members of a Religious Order.

If a person is a member of a religious order and has taken a vow of poverty, do not count any compensation that a member of a religious order receives if the compensation is turned back over to the order.

2. Housing Allowances for Members of the Clergy.

If an ordained, licensed, or commissioned minister is renting housing, do not count as income an amount officially designated as a housing allowance or rental allowance if the amount is used to pay for rent and pay for utilities and is not more than reasonable pay for services. The amount not counted as income cannot be more than the fair rental value of the home plus the cost of utilities. If the amount of the housing allowance is more than the cost of rent and the cost of utilities, the excess amount is counted as income.

If a church provides a house or parsonage for the minister to live in as part of the minister's earnings, do not count as income the fair rental value of the house or parsonage plus the cost of utilities. The amount not counted as income cannot be more than the reasonable pay for services.

If the minister owns their own home and receives as part of their salary a housing or rental allowance, do not count as income the smallest of:

- The amount actually used to pay for the mortgage and utilities; or
- The amount officially designated as a housing or rental allowance; or
- The fair rental value of the home, including the cost of utilities.

If housing expenses are not verified, the entire housing allowance must be counted as income. Eligibility must not be denied or terminated for failure to provide the requested expense verification.

3. Jury Duty Payments.

Count all jury duty payments as earned income for the month in which it is received if the payments are not turned over to the individual's employer. Amounts received separately as reimbursements or allowances for travel to and from the courthouse, meals, and lodging during jury duty are not countable.

4. AmeriCorps.

Earnings or cash benefits received through AmeriCorps will be counted as earned income. Educational awards received from AmeriCorps are not counted as income.

Note *This does not include earnings or cash benefits received through VISTA (see SECTION 16.2 INCOME TYPES NOT COUNTED, #22 SPECIAL PROGRAMS).*

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5. 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 the following:

- Green Thumb
- Experience Works
- The National Urban League
- National Senior Citizens Education and Research Center (Senior Aides)
- National Indian Council on Aging
- U.S.D.A. Forest Service
- WISE
- Community service employment programs, such as the Older Americans Community Service Program

Identify programs funded under 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 16.2 INCOME TYPES NOT COUNTED, #19 REIMBURSEMENTS).

6. Live-in care providers.

Do not count any wages of a live-in care provider if those wages meet the required conditions listed in SECTION 16.2 INCOME TYPES NOT COUNTED, #47 LIVE-IN CARE PROVIDERS. See SECTION 16.4.4.2 LIVE-IN CARE PROVIDERS for more information about verifying whether the wages should be counted.

7. 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.

16.4.2 Room and Board Income

There are no special deductions if the income is reported as room and board income. If room and board income is reported as self-employment income, see SECTION 16.4.3 SELF-EMPLOYMENT INCOME.

16.4.3 Self-Employment Income

16.4.3.1 Definitions

16.4.3.1.1 Income

Self-employment income is income derived directly from one's own business rather than as an employee with a specified salary or wages from an employer.

16.4.3.1.2 Business

Business means an occupation, work, or trade in which a person is engaged as a means of livelihood.

16.4.3.1.3 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 16.4.3.4.3 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, and there is no one else to carry out the duties of the business, they may claim their business was not in operation for those months.

16.4.3.1.4 Real Property

Real property means land and most things attached to the land, such as buildings and vegetation.

16.4.3.1.5 Non-real Property

Non-real property means all property other than real property. Non-real property is personal or business property that typically is movable rather than attached to land.

16.4.3.2 Identifying Farms and Other Businesses

A farm or other business should be identified according to the following criteria:

16.4.3.2.1 By Organization

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

- A sole proprietorship, which is an unincorporated business owned by one person.
- A partnership, which exists when two 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.
- 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:
    - Is taxed as a separate entity rather than the owners being taxed as individuals, and
    - Provides only limited liability. Each owner’s loss is limited to their investment in the corporation while the owners of unincorporated business are also personally liable.
- 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.

16.4.3.2.2 By IRS Tax Forms

A self-employed person who earns more than $400 net income must file an end-of-year return. 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
    - Schedule K-1 (Form 1065)—Partner's Share of Income, Deductions, Credits, etc.
- Form 1120S—S Corporation
    - Schedule K-1 (Form 1120S)—Shareholder's Share of Income, Deduction, Credits, etc.
- 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
- Other Forms
    - Schedule D (Form 1040)—Capital Gains and Losses

    - Schedule SE (Form 1040)—Social Security Self-Employment
    - Schedule 1 (Form 1040)—Additional Income and Adjustments to Income
    - Form 1040—U.S. Individual Income Tax Return

16.4.3.2.3 By Employee Status

A person is an employee if they are 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 their own business, and:

- Does not have federal income tax and FICA payments withheld from a paycheck.
- Does not complete a W-4 for an employer.
- Is not covered by employer liability insurance or workers' compensation.
- Is responsible for their own work schedule.

Note *A babysitter who works in someone else's home is considered an employee of that household even if the individual employing them does not withhold taxes or FICA.*

Examples of self-employment include:

- Businesses that receive income regularly (for example, daily, weekly, or monthly):
    - Merchants
    - Small businesses
    - Commercial boarding house owners or operators
    - Owners of rental property
- Service businesses that receive income frequently and possibly sporadically:
    - Craft persons
    - Repair persons
    - Franchise holders
    - Subcontractors
    - Sellers of blood and plasma
    - Commission sales persons (such as door-to-door delivery)
- Businesses that receive income seasonally:
    - Summer or tourist-oriented businesses
    - Seasonal farmers (custom machine operators)
    - Migrant farm worker crew leaders
    - Fishers, trappers, or hunters
    - Roofers
- Farming: Farming includes income from cultivating the soil or raising or harvesting any agricultural commodities. It may be earned from full-time, part-time, or hobby farming.

16.4.3.3 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 the IRS as farm or other self-employment income or as rental or royalty income. When income is not reported to the IRS, the worker 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 and ordinary gains or losses are counted as unearned income. See SECTION 16.5 OTHER INCOME for more information.
3. **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.
4. **Rental.** Rental income is rent received from properties owned or controlled. Rental income is either earned or unearned. It is earned only if the owner actively manages the property on an average of 20 or more hours per week. It is unearned when the owner reports it to the IRS as other than self-employment income. Use "net" rental income in the eligibility determination. "Net" rental income means gross rental receipts minus business expenses.

Rental Income Not Reported as Self-Employment Income

When a BadgerCare Plus group member does not report rental income as self-employment income, the net rental income is counted as unearned income. Determine net rental income as follows:

A. When the owner is not an occupant, net rental income is the rent payment(s) received minus the interest portion of the mortgage payment and other verifiable operational costs.

- Operational costs include ordinary and necessary expenses such as insurance, taxes, advertising for tenants, and repairs. Repairs include such expenses as repainting, fixing gutters or floors, plastering, and replacing broken windows.
- Capital expenditures are not deductible from gross rent. A capital expenditure is an expense for an addition or increase in the value of the property. It would include improvements such as finishing a basement; adding a room; putting up a fence; putting in new plumbing, wiring, or cabinets; or paving a driveway.
- If an institutionalized person has excess operational costs above the monthly rental income, carry the excess costs over into later months until they are offset completely by rental income. The carryover should only be done until the end of the year in which the expenses were incurred.
- When a life estate holder moves off the property and the property is rented, count the net rental income the holder is entitled to receive. Net rental income is the gross rental income minus taxes, insurance, and other operational costs. The operational costs are the same as the costs the holder was liable for when living on the property.

B. When the owner is an occupant (of a duplex, triplex, etc.) and lives in one of the units, determine net rental income as follows:

1. 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.
    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 improvements such as finishing a basement; adding a room; putting up a fence; putting in new plumbing, wiring, or cabinets; or paving a driveway.

2. Divide the result in step 1 (the total annual expenses) by the total number of units to get the proportionate annual share of expenses.
3. 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.
4. 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.
5. 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 1	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

16.4.3.4 Calculating BadgerCare Plus Self-Employment Income

BadgerCare Plus income is calculated in one of the following ways:

- Using IRS tax forms (see SECTION 16.4.3.4.1 IRS TAX FORMS AND WORKSHEETS) completed for the previous year
- Anticipating earnings (see SECTION 16.4.3.4.3 ANTICIPATED EARNINGS)

16.4.3.4.1 IRS Tax Forms and Worksheets

IM workers do not fill out 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 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 change in circumstances since the previous year.

If all three conditions are not met or if IRS tax forms were not filed and are not available, use anticipated earnings (see SECTION 16.4.3.4.3 ANTICIPATED EARNINGS).

If you decide to use IRS tax forms, use them together with the chart in Process Help, Section 11.2 Self-Employment Income or the self-employment income worksheets, which identify which income and expenses must 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. There is no worksheet for Sole Proprietor. See Process Help, Section 11.2.2.3.2 Entering Information for a Sole Proprietorship to identify which lines must 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)

CWW will calculate the monthly countable income for each self-employment business, which will be added to the fiscal test group's other earned and unearned income. If monthly income is a loss, the loss will be subtracted from the non-self-employment income.

When a household has more than one self-employment operation, the losses of one may be used to offset the profits of another. Losses from self-employment can be used to offset other income types. In situations where an individual is planning to file a joint tax return with their spouse, losses from self-employment may offset the spouse's income.

Each self-employment operation (Sole Proprietor, Partnership, S Corporation) requires its own Self-Employment page in CWW.

Remember that while a salary or wage paid to a test group member is an allowable business expense, you must count it as earned income to the payee. Similarly, dividends or other types of passive income (as defined by the IRS) must be counted as unearned income.

Even though IRS Schedule D (Form 1040) – Personal Capital Gains and Losses is associated with sole proprietorships, it is not considered self-employment income. If someone reports personal capital gains or losses, it is counted as unearned income (see SECTION 16.5 OTHER INCOME).

16.4.3.4.2 Depreciation, Depletion, and Disallowed Expenses

Countable self-employment income will be the same as the net self-employment taxable income.

Depreciation and depletion expenses are allowable expenses.

The following expenses are disallowed expenses for BadgerCare Plus:

- Charitable donations
- Work-related personal expenses, such as transportation to and from work
- Employer work-related personal expenses, such as pensions, employee benefit and retirement programs, 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.)

Note *The self-employed person's personal contributions to pensions and retirement programs can be counted for BadgerCare Plus as tax deductions, but they are not counted as business expenses when calculating the self-employment income. See SECTION 16.3.3 TAX DEDUCTIONS.*

- Principal payments on loans for the purchase price of income-producing real estate, capital assets and equipment, and durable goods. (An example is the principal portion of mortgage payments. Only the interest portion of business loan payments is an allowable expense.)

Note *Disallowed expenses are added back into an individual's gross income on the BadgerCare Plus Budget page.*

16.4.3.4.3 Anticipated Earnings

If past circumstances do not represent present circumstances, workers should calculate self-employment income based on anticipated earnings. Anticipated earnings should 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 business (for example, one of two retail stores).
    - The owner is ill or injured and will be unable to operate the business for a period of time (nor will anyone else be able 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 their 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 on date.

16.4.3.4.3.1 Reporting Anticipated Earnings

The Self-Employment Income Report form (F-00107) (also called a SEIRF) and the Self-Employment Income Report: Farm Business form (F-00219) simplify reporting income and expenses when earnings must be anticipated. Self-Employment Income Report forms 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 Self-Employment Income Report form 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 will be prepopulated with the individual's and business' information and will identify each individual month for which income and expenses are needed. However, they may complete a separate Self-Employment Income Report form for each month or combine the months on one Self-Employment Income Report form.

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 not more than 12 months) income.

Example 3	James applies for BadgerCare Plus on November 1, 2017. He reports that he was self-employed starting in April 2017. The agency asks James to complete Self-Employment Income Report forms for April, May, June, July, August, September, and October so that his prospective self-employment income can be determined for his BadgerCare Plus certification period (November 2017 through 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 4	Bonnie applies for Child Care and BadgerCare Plus on April 5, 2016. She reports that she was self-employed starting in January 2016. The agency asks Bonnie to complete a Self-Employment Income Report form for January, February, and March so that her prospective self-employment income can be determined for her Child Care and BadgerCare Plus certification period (April 2016 through 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 5	Ricardo applies for FoodShare and BadgerCare Plus on February 5. He was self-employed starting December 15. The agency asks Ricardo to complete a Self-Employment Income Report form for December, January, and February so that his prospective self-employment income can be calculated. The completed Self-Employment Income Report form 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 6	Jenny is a BadgerCare Plus member who has been self-employed as a hairdresser since 2012. Jenny's BadgerCare Plus 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 Self-Employment Income Report form 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, until the person completes an IRS tax form, or until a significant change in circumstances is reported between renewals.

16.4.3.4.4 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:
   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.
   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 7	Maggie applied for BadgerCare Plus 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 BadgerCare Plus for the backdated months of March, April, and May.

Example 8	Glenn applied for BadgerCare Plus 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 BadgerCare Plus for the backdated months of June, July, and August.

Example 9	Hershel applied for BadgerCare Plus 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 BadgerCare Plus 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 BadgerCare Plus for the backdated month of March.

16.4.4 Verification

Self-employment income information is not available through data exchanges and therefore must be verified (see SECTION 9.10 QUESTIONABLE ITEMS).

Completed IRS tax forms (see SECTION 16.4.3.4.1 IRS TAX FORMS AND WORKSHEETS) 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.

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 9.10 QUESTIONABLE ITEMS). If requesting verification, workers must document the reason for the request in case comments.*

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.

16.4.4.1 Self-Employment Hours

Count the time a self-employed person spends on business-related activities involving planning, selling, advertising, and management, along with time spent on the production of goods and services provided as hours of work. Do not request verification of self-reported monthly hours worked unless questionable (see SECTION 9.10 QUESTIONABLE ITEMS).

16.4.4.2 Live-In Care Providers

Because contract agencies may or may not treat payments to a live-in care provider as exempt from federal taxation, workers must not rely on 1099 forms to verify whether the payments are tax exempt. Instead, if an applicant or member claims to be a live-in care provider with tax-exempt income, workers must provide the applicant or member with a Verifying Tax-Exempt Income for Live-in Care Providers form (F-02193) and ask them to complete it to attest to meeting the criteria that makes this income

exempt. If there is a reason to question some or all of the information provided on the form, workers may seek additional verification.

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16.5 Other Income

Other income is any payment that a member receives from sources other than employment that are counted as taxable income. Count the gross payment in the person's income total.

1. Unemployment Compensation

Count unemployment compensation income, including the amount of unemployment compensation that is intercepted to collect child support. See SECTION 16.5 OTHER INCOME, #23 CERTAIN PAYMENT TYPES RELATED TO THE COVID-19 PANDEMIC for countable types of pandemic-related unemployment compensation benefits and SECTION 16.2 INCOME TYPES NOT COUNTED, #50 CERTAIN PAYMENT TYPES RELATED TO THE COVID-19 PANDEMIC for types of pandemic-related benefits that are not counted.

2. Alimony/Spousal Support

Not all alimony/spousal support is countable income. Do not count alimony/spousal support if it meets one of the following criteria:

- The payment was received under a separation or divorce agreement finalized on or before December 31, 2018, that designates the payments as non-taxable.
- The payment was received under a separation or divorce agreement finalized on or after January 1, 2019.
- The payment was received under a separation or divorce agreement finalized on or before December 31, 2018, but modified on or after January 1, 2019, and provides that Section 11051 of Pub. L. 115-97 applies to the modification which makes the alimony/spousal support non-taxable.

3. Family Support

Family support combines child support and alimony/spousal support. If a household is receiving family support, prorate among the individuals covered by the court order. The amount of the payment allocated to the child(ren) is considered child support and is disregarded. The amount of the payment allocated to the adult(s) is considered alimony/spousal support. To determine whether alimony/spousal support is counted as income, see SECTION 16.5 OTHER INCOME, #2 ALIMONY/SPOUSAL SUPPORT.

4. Social Security Benefits

Although a portion of Social Security benefits are usually not taxable, they all must be counted as unearned income. Count Social Security benefits as unearned income in the month received.

The following is a list of some of the codes that should be used in coding Social Security income types:

- SSDC - Social Security Disabled Child
- SSDI - Social Security Disability/Wage Earner
- SSDW - Social Security Disability/Wife
- SSRE - Social Security Retirement

- SSSC - Social Security Surviving Child
- SSSS - Social Security Surviving Spouse
- SSWW - Social Security Disabled Widow(er)

Note *Social Security benefits are not considered when determining if a person is "expected to be required" to file a tax return for the current year (see SECTION 2.8 MODIFIED ADJUSTED GROSS INCOME COUNTING RULES).*

5. Income From a Bequest, Devise, or Inheritance

Count income from a bequest, devise, or inheritance in the month it is received.

6. Income Generated From Property Given to a Trust

Count income generated from property given to a trust if the income is paid, credited, or distributed to the person.

Example 1	Keisha is the beneficiary of a trust. Land was given to the trust, and it generates interest that is distributed to Keisha as the beneficiary. Count the interest as unearned income, but do not count the value of the land or the trust.

7. Land Contract

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

If the income is received monthly, budget it monthly. 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. When Bob applies for BadgerCare Plus in February, prorate the interest portion of 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 multiplied by 10% equals $500 of countable interest income) by the frequency of the payments (six months) to get the budgeted income amount of $83.33 per month. Begin budgeting this amount in March.

8. Loans

If a BadgerCare Plus applicant or member makes a loan (except a land contract), count only the portion of the repayment to that applicant or member that is interest. Count the interest as income in the month received.

9. Profit Sharing

Count profit sharing income as unearned income in the month received. Tax-deferred contributions made to a profit-sharing plan are not taxable and are not counted as income.

10. Retirement Benefits

Retirement benefits include work-related plans for providing income when employment ends (for example, pension disability or retirement plans administered by an employer or union).

Other examples of retirement funds include accounts owned by the individual, such as IRAs and plans for self-employed individuals, sometimes referred to as KEOGH plans.

Count the taxable portion of any retirement distribution as income.

11. Sick Pay

Sick pay refers to any amounts paid to an employee for any period during which the employee is temporarily absent from work because of injury, sickness, or disability. This includes short-term disability payments and long-term disability payments. Sick pay does not include payments for medical and hospitalization expenses. It also does not include retirement benefits for someone who has retired because of a disability.

The pay a person receives from an employer while the person is sick or injured is counted as income.

If a person receives sick pay benefits from an insurance policy and the person paid the premiums on the insurance policy, the benefits the individual receives are not counted as income.

If a person receives sick pay benefits from an insurance policy and both the person and the employer paid the premiums on the insurance policy, only the benefits the person receives that are due to the employer's payments are counted as income.

If a person receives sick pay benefits through a cafeteria plan and the amount of the premiums was not included in the person's income, the benefits the person receives are counted as income. If a person receives sick pay benefits through a cafeteria plan and the amount of the premiums was included in the person's income, the benefits the person receives are not counted as income.

Do not count the following:

- Reimbursement for medical care
- Payments for loss of a member or bodily function or permanent disfigurement
- Amounts computed with reference to the injury but not with respect to the person's absence from work

Example 3	Moises is temporarily not working due to a short-term disability. During this time, he is receiving benefits from an income continuation insurance policy through his employer. Moises paid 25% of the premiums on the insurance policy and his employer paid 75% of the premiums on the insurance policy. Moises' total monthly benefit from this insurance policy is $1,500. The portion of this benefit that Moises receives that is due to the employer's premium payments is $1,125 ($1,500 multiplied by 75%). Therefore, $1,125 is counted as income for BadgerCare Plus.

12. Trusts

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

The term "trust" includes any legal instrument or device 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 holds, manages, or administers the property for the benefit of the grantor or of the beneficiary.

The grantor can be:

- The BadgerCare Plus member.
- The spouse of the BadgerCare Plus 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 regular payments, including dividends and interest, made under the terms of the trust from a trust to the beneficiary are unearned income to the beneficiary. Dividends and interest income are counted even if they are tax exempt.

13. Gambling Winnings

Count gambling winnings that are regular and predictable as income. Gambling losses cannot be used to offset other types of income.

14. Royalties

See SECTION 16.4.3 SELF-EMPLOYMENT INCOME.

15. Capital and Ordinary Gains and Losses

Capital gains are profits from the sale of assets, such as stocks and bonds, real estate, collectibles, or personal items. If personal capital gains are regular and predictable, count as unearned income. Do not count personal capital gains as unearned income if they are not regular or predictable. Personal capital losses can be used to offset the person's other income types. In situations where a person is planning to file a joint tax return with their spouse, personal capital losses may offset the spouse's income.

Note *If a person is in the business of buying and reselling items, it should be reported as self-employment.*

Example 3	Danielle is moving to a different city in Wisconsin. She sold her house and made a profit. This house was her primary residence, and she did not sell it as part of a real estate business. The profit she made from the sale is taxed as capital gains. Since the sale of her house was a one-time event, and the capital gains from the sale are not regular and predictable, these capital gains are not counted as unearned income.

16. Student Financial Aids

Work study income and any income from an internship or assistantship should be counted as earned income.

Grants, scholarships, fellowships, and any additional financial assistance provided by public or private organizations that exceed the cost of tuition, books, and mandatory fees are counted as unearned income and should be prorated over the period of time they are intended to cover.

Types of grants, scholarships, and fellowships counted as income include the following:

- Pell Grants
- Robert Byrd Honors scholarships
- Any grants, scholarships, or fellowships received from the college or university as part of a financial aid package

- Any grants, scholarships, or fellowships provided by public or private organizations

The following expense types can be used to offset income from grants, scholarships, fellowships, and other financial aid:

- Tuition
- Required books, supplies, or equipment
- Mandatory fees

The following expense types are not allowed to offset income from grants, scholarships, or other financial aid:

- Room
- Board (meals or meal plans)
- Personal expenses
- Transportation and parking
- Loan fees
- Health insurance costs

Example 4	Mary was awarded a scholarship for $3,500 in July that is intended to cover her fall semester (September through December). Her tuition and course-related expenses are $3,250 for the semester. The $250 that exceeds the amount of tuition and course-related expenses will be prorated over the four-month period from September through December at $62.50 in unearned income each month ($250/4 months = $62.50/month).

The following educational aid types are not counted as income and cannot be considered when determining if grants, scholarships, and fellowships exceed the cost of tuition, books, and mandatory fees:

- Loans, including Stafford Loans and Perkins Loans (Student loans are not counted as income irrespective of what the loan is used to pay for.)
- AmeriCorps or HealthCorps grant
- Bureau of Indian Affairs grant
- GI Bill/Veterans benefits
- ROTC benefits

Note *When an applicant or member is enrolled in job-related classes or training and the tuition is reimbursed by the applicant's or member's employer, this may be considered reimbursement for job- or training-related expenses (as defined in SECTION 16.2 INCOME TYPES NOT COUNTED). As long as the reimbursement is not more than the cost of the class or training, it does not need to be budgeted as educational aid.*

17. Jury Duty Payments

Count all jury duty payments as earned income for the month in which they are received if the payments are not turned over to the person's employer. Amounts received separately as reimbursements or allowances for travel to and from the courthouse, meals, and lodging during jury duty are not countable.

18. Interest and Dividend Income

Interest and dividend income is counted as unearned income.

19. Lump Sums Payments

Count lump sum payments (if the payment is otherwise a countable income type) in the month received. Lump sum payments are not counted outside the month received.

20. Reimbursements for Normal Household Living Expenses Are Counted as Income

Examples of reimbursements that are counted as income:

- Rent
- Clothing
- Food eaten at home

For examples of reimbursements that are not counted as income, see SECTION 16.2 INCOME TYPES NOT COUNTED, #19 REIMBURSEMENTS.

21. Tribal Per Capita Payments from Gaming Revenue

All of the income from Tribal Per Capita payments from gaming revenue is counted income.

22. REWARD Wisconsin Stipends

REWARD Wisconsin stipends are counted income. These stipends are awarded to child care professionals.

23. 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 for BadgerCare Plus and some payment types are not counted as income for BadgerCare Plus. 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 is taxable
- Whether the payment can be considered “disaster assistance”

The payment types that count as income for BadgerCare Plus include but are not limited to:

- Retroactive Pandemic Unemployment Assistance (PUA), Pandemic Emergency Unemployment Compensation (PEUC), Mixed Earner Unemployment Compensation (MEUC) payments, and Extended Benefits (EB) unemployment compensation (these payments are counted as income in the month they are received)
- Workforce Retention and Recognition Stipend Program payments (these payments are awarded to child care professionals)
- We’re All In Small Business Grants
- Child Care Counts Supplementary Payments (these payments are awarded to child care providers)
- Child Care Counts Stabilization Payments (these payments are awarded to child care providers)
- USDA Coronavirus Food Assistance Program – Direct Payments to Farmers and Ranchers

See SECTION 16.2 INCOME TYPES NOT COUNTED, #50 CERTAIN PAYMENT TYPES RELATED TO THE COVID-19 PANDEMIC for non-countable types of pandemic-related unemployment compensation benefits.

24. 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 in the following situations:

- Received as payment for goods or services
- Received by an independent contractor for performing services
- Received from an employer as remuneration for services (that is, wages)

If virtual currency is sold, income received from the sale is counted as income for BadgerCare Plus only if the income is regular and predictable or if the sale occurs as part of a trade or business.

25. Railroad Retirement Benefits

Although a portion of Railroad Retirement benefits are usually not taxable, they all must be counted as unearned income. Count all Railroad Retirement benefits as unearned income in the month received.

26. Prizes and Awards

Count cash prizes and awards. If the prize of award is in the form of a good or service, count the fair market value of the prize of award.

27. Imputed Income

Count imputed income. Imputed income is noncash taxable compensation that is included in an employee's gross pay.

Example 5	According to Olga's paystub, her employer pays the cost of her long-term disability insurance premium. The value of this compensation is imputed income. Imputed income equal to the amount of the premium is added to Olga's earnings before taxes are taken out. This imputed income is countable income for BadgerCare Plus.

28. Strike Benefits

Count benefits paid by a union, such as a strike or lockout benefits, as income.

Note *Strike benefits are usually taxable compensation, even if taxes are not withheld from the payments upfront. Strike benefits can only be disregarded for BadgerCare Plus if it is clear that the union intended them as gifts.*

29.Restricted Stock Contributions

Count restricted stock contributions as income only after the stock has been substantially vested.

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16.6 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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16.7 Prorating Income

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

Prorate means "to distribute proportionately."

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

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

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

Example 2	Joe receives semi-annual 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.

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16.8 Reserved

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16.9 Gap Filling

Due to differences between the eligibility rules used by the Federally Facilitated Marketplace and the eligibility rules used when counting income for BadgerCare Plus, the Marketplace may find someone to be below 100% of the FPL based on their annual income, while BadgerCare Plus may find someone to be above 100% of the FPL based on their current monthly income. Because of this difference in eligibility rules, the person is eligible for neither BadgerCare Plus nor advanced premium tax credits (APTCs). If people were left in this eligibility "gap," then the only option available to them is to pay for the full cost

of private health insurance through the Marketplace. To prevent this from happening, these people must have eligibility for BadgerCare Plus determined based on their expected annual income. This is also known as "gap filling."

16.9.1 Annual Income Eligibility Determinations

When a parent, caretaker relative, or childless adult has monthly income above 100% FPL, and they meet all other eligibility requirements, their eligibility will be determined using their annual income. The annual income limit is 100% FPL.

Gap filling determinations use the expected annual income for the current year. Since the person may not have yet received the income, documentation of this income may be difficult or impossible to obtain at the time of application or change report. Verification of expected annual income is not required. However, the expected annual income reported by the applicant or member must be validated by the agency using all available information. This may include, but is not limited to:

- Income reported on the application.
- Income discovered or verified through data exchanges.
- Wages earned in previous quarters verified through SWICA.
- Wages verified through the Federal Data Services Hub (FDSH) wage match.
- Wages verified through an Employer Verifications of Earnings (EVFE) form.
- Other verification and data exchanges verifying unemployment and Social Security income.

If the information reported on the application is not clear or the sources of income cannot be validated through available data exchanges, the IM agency must send a request to the applicant or member for more information.

This method should also be used when determining eligibility under gap filling rules for backdated months (see SECTION 25.8.1 BACKDATED ELIGIBILITY).

When budgeting expected annual income for eligibility in the same calendar year, the applicant or member's employment history and pattern of employment will be considered in determining if they are reasonably expected to have a change in income that would impact eligibility.

Example 1	Irene has been enrolled in BadgerCare Plus off and on in previous years. She completes a new health care application on October 2. She reports that she has a seasonal job from September 1 through December 15. During this time, her monthly income is above 100% FPL, but her annual income is under 100% FPL. The worker notices in Irene's case that she has had this seasonal job in previous years. Irene's past years' wages in the second and third quarters are consistent with the income she is reporting on this new application. Based on this past information and the information Irene is reporting on her application, it is reasonable to expect that Irene is continuing this same pattern of employment. The worker uses this past information to validate Irene's reported expected annual income.

If a person is over both the monthly income limit and the annual income limit, they are not eligible for BadgerCare Plus. If this is the only reason they are not eligible for BadgerCare Plus, their application will be sent to the Marketplace.

16.9.2 Gap Filling Certification Period

The certification period for members whose eligibility is determined using annual income is 12 months.

If a BadgerCare Plus member moves from eligibility based on monthly income to eligibility based on annual income, or vice versa, during their certification period, their certification period end date (that is, the renewal date) remains the same.

Example 1	William applies for health care on June 8. He works a seasonal job, and his monthly income is above 100% FPL, but his annual income is below 100% FPL. He is determined eligible for BadgerCare Plus using annual income. His certification period is June 1 through May 31 of the following year. On November 20, he reports to the agency that his monthly income has decreased below 100% FPL and provides verification of his new income. William is now eligible for BadgerCare Plus using monthly income. His BadgerCare Plus certification period end date remains May 31.

Renewals will be conducted the same as other BadgerCare Plus renewals (see CHAPTER 26 RENEWALS for more information).

16.9.3 Change Reporting for People Eligible Under Gap Filling Rules

Members are still subject to change reporting requirements while enrolled in BadgerCare Plus under gap filling rules. A member can lose eligibility during the certification period if:

- They are no longer eligible for any nonfinancial reason such as moving out of the state.
- They experience an increase in income that will make annual income greater than 100% of the FPL.

See CHAPTER 27 CHANGE REPORTING for more information.

16.9.4 New Year Estimated Annual Income

When a 12-month certification period extends over two calendar years, expected annual income will be collected from current members eligible under gap filling rules in January of the new year through a written request for the new year's expected annual income:

- If the member's expected annual income continues to be under the annual income limit, BadgerCare Plus will continue.
- If the member's expected annual income is above the annual income limit, BadgerCare Plus will be terminated following adverse action rules (assuming they are not eligible for BadgerCare Plus under monthly income rules or any other category of BadgerCare Plus or Medicaid).
- If the member does not respond to the request for the new year's expected annual income, BadgerCare Plus will be terminated following adverse action rules due to failure to provide information.

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17.1 Deductibles

Children (younger than 19 years old) with income over 306% of the FPL may become eligible for BadgerCare Plus by meeting a deductible. Children with income over 156% of the FPL who are denied BadgerCare Plus solely due to having current employer-sponsored health insurance coverage may also become eligible for BadgerCare Plus by meeting a deductible. The deductible amount is calculated for a six-month period using the amount of income that exceeds 150% of the FPL.

Pregnant people with incomes above 306% of the FPL can qualify for BadgerCare Plus by meeting a deductible. The deductible amount is calculated for a six-month period using the amount of income that exceeds 300% of the FPL for pregnant people. The deductible is met by incurring medical expenses that equal the deductible amount. Pregnant people who could only qualify for the BadgerCare Plus Prenatal Program may not become eligible for the Prenatal Program by meeting a deductible.

Note	*When determining the deductible amount, only the income of the applicant, the applicant's spouse, and, if the applicant is younger than 19 years old, the applicant's parents, should be considered. If a sibling or other tax dependent has been counted as part of the applicant's regular MAGI assistance group, the sibling's or tax dependent's income should be excluded for purposes of calculating the deductible; however, they should still be included in the assistance group size.*

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17.2 Pregnant Members

17.2.1 Introduction

A pregnant member with assistance group income over 306% of the FPL must meet a deductible to become eligible for BadgerCare Plus.

For a pregnant member, the deductible amount is the amount of countable income above 300% of the FPL for a six-month period. To meet the deductible, the pregnant member or other family members included in the BadgerCare Plus assistance group must incur medical bills equal to the pregnant member's deductible amount.

Note	*If there is more than one pregnant member in the BadgerCare Plus assistance group, all of them become eligible when a deductible is met.*

If an individual applies before the pregnancy ends and meets the deductible while pregnant, they remain eligible for BadgerCare Plus for the rest of the pregnancy and through the end of the month 12 months after the end of the pregnancy. The member remains eligible for this period as a pregnant member regardless of when the deductible period ends.

If an individual applies after the pregnancy ends and becomes eligible by meeting a deductible in backdated months, they are eligible for 12-month postpartum coverage.

For eligibility regarding the BadgerCare Plus Prenatal Program for inmates of a public institution or non-qualifying immigrants, see SECTION 41.2 BADGERCARE PLUS PRENATAL PROGRAM ELIGIBILITY REQUIREMENTS.

Example 1	Janet gives birth on June 30. On July 10, she applies for BadgerCare Plus and requests a BadgerCare Plus deductible period from April through September. Janet paid the full deductible amount, so she is certified from April 1 through June 30 (the end of the month in which her pregnancy ended). She is eligible for 12-month postpartum coverage until June 30 of the following year.

Example 2	Annette applies for BadgerCare Plus as a pregnant woman in May and requests a BadgerCare Plus deductible period from April to September. She gives birth on June 14. Annette paid the full deductible amount, so she is certified from April 1 through June 30 of the following year, including the 12-month postpartum coverage period.

17.2.2 Deductible Period

A pregnant member can choose to begin the BadgerCare Plus deductible period as early as three months prior to the month of application, and as late as the month after the month of application.

A pregnant member can choose a BadgerCare Plus deductible period which includes a month in which they are ineligible for a non-financial reason, with one exception. A deductible period may not begin with a month in which the pregnant member is non-financially ineligible.

Although excess income is still calculated over a six month period, the individual may only be certified for BadgerCare Plus during the dates when they are non-financially eligible.

Example 1	Luanne applied for BadgerCare Plus as a pregnant woman on June 1 and requested a BadgerCare Plus deductible period from April through September. She gave birth on June 2. Luanne paid the full deductible amount, so she is certified from April 1 through June 30 of the following year, including the 12-month postpartum coverage period.

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.

Example 2	Julie is pregnant and due November 15. She applied for BadgerCare Plus April 1. She is eligible for a deductible period from April 1 through September 30. She has not incurred enough expenses to meet the deductible. In July, Julie's income decreased, and she would like to have a new deductible period from July 1 through December 31. Julie must submit a new, signed application for the IM agency to establish a new deductible period.

A pregnant member who is ineligible due to excess income in some backdated months, but has no excess income in others, does not have to choose to have a BadgerCare Plus deductible. They can choose to be certified in the months they are eligible and to accept the ineligibility of the other months when they had excess income.

Example 3	Rachel is pregnant and applied for BadgerCare Plus in July. Her due date is in December. She had no income and did not expect any income in the future. She was eligible in July. She also requested BadgerCare Plus eligibility for April to cover some medical expenses she had in April. In April and May, she had income in excess of 300% of the FPL. In June, she would have been eligible because she had no income. In April and May, her income was over 300% of the FPL by $200 a month. She has two choices: 1. Choose a BadgerCare Plus deductible period of April through September. After meeting the BadgerCare Plus deductible of $400, she would be certified for BadgerCare Plus from April through 12-months past the end of the pregnancy. 2. Not choose a BadgerCare Plus deductible period. She would not have to meet a BadgerCare Plus deductible. She could be certified immediately for June through 12 months past the end of the pregnancy but would have to forgo BadgerCare Plus for April and May because of the excess income in April and May.

17.2.3 Calculating the Deductible Amount

To calculate the dollar amount of the BadgerCare Plus deductible for a pregnant woman:

1. Determine the BadgerCare Plus deductible period.
2. Find the BadgerCare Plus group's total countable income for each month in the deductible period.

3. If the assistance group's total countable income includes the income of someone other than the pregnant woman, her spouse, or, if she is younger than 19 years old, her parents, subtract the income of that person(s), but do not change the size of the assistance group.
4. Compare the total income of each month with 300% of the FPL. If any month's income is less than or equal to 300% of the FPL, ignore it. If any month's income is more than the income limit, find the excess income by subtracting the income limit from the income of that month.
5. Add together the excess income of the months in the deductible period. The result is the pregnant woman's BadgerCare Plus deductible amount.

When calculating a deductible amount for backdated months, use the actual, not prospective, income received in the backdated months.

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17.3 Children Under 19

Children (younger than 19 years old) with income over 306% of the FPL may become eligible for BadgerCare Plus by meeting a deductible. Children with income over 156% of the FPL who are denied BadgerCare Plus solely due to current employer-sponsored health insurance coverage may also become eligible for BadgerCare Plus by meeting a deductible. The deductible amount is calculated for a six-month period using the amount of income that exceeds 150% of the FPL.

To meet the deductible, the child or their parents included in the child's BadgerCare Plus group must incur medical bills equal to the deductible amount. Deductible-based eligibility is not extended to other children or members of the original assistance group. The parents' medical expenses may be used for meeting the deductible of more than one child at a time. Medical expenses of siblings may not be used for a child's deductible.

17.3.1 Deductible Period

The child under 19 can choose to begin the BadgerCare Plus deductible period as early as three months prior to the month of application and as late as the month following the month of application.

Example 1	On November 1, John's mother and stepfather apply for BadgerCare Plus for themselves, John, and John's two stepbrothers. The family's countable income is 225% of the FPL. John's mother has employer-sponsored insurance that covers her and John. John is ineligible for BadgerCare Plus due to having current employer-sponsored health insurance coverage. John's stepbrothers are eligible for BadgerCare Plus with a premium. Because the health insurance does not cover all of John's medical expenses, in December, John's mother requests a deductible for John. The deductible period is December through May. John has medical bills that will meet the deductible as of January 1. John will be covered under BadgerCare Plus with no premium from January through May.

The BadgerCare Plus deductible period for a child can include a month in which they would have been ineligible for a non-financial reason other than having current employer-sponsored health insurance coverage, with one exception. A deductible period may not begin with a month in which the child is non-financially ineligible for a reason other than having current employer-sponsored health insurance coverage. Although excess income is still calculated over a six-month period, the child may only be certified for BadgerCare Plus during the dates when they met all non-financial criteria other than having current employer-sponsored health insurance coverage.

A new deductible period can be established at any time before the current deductible has been met. A new application for the child must be signed and submitted 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.

Example 2	Jose applied for BadgerCare Plus for his 14-year-old child, Ellie, on April 1. Ellie is eligible for a deductible period from April 1 through September 30. She has not incurred enough expenses to meet the deductible. In July, the household's income decreased, and they would like to have a new deductible period for Ellie from July 1 through December 31. Jose must submit a new, signed application for Ellie for the IM agency to establish a new deductible period.

17.3.2 Calculating the Deductible Amount

To calculate the dollar amount of the BadgerCare Plus deductible for a child:

1. Determine the BadgerCare Plus deductible period.
2. Find the child's assistance group's total countable income for each month in the deductible period.
3. If the assistance group's total countable income includes the income of someone other than the child, the child's parents, or, if married, the child's spouse, subtract the income of that person, but do not change the group size of the AG.
4. Compare the total income of each month with 150% of the FPL. If a month's income is less than or equal to 150% of the FPL, ignore it. If a month's income is more than the income limit (150% of the FPL), find the excess income by subtracting the income limit from the income of that month. The child could choose to drop the deductible for months their income decreases so that the child is eligible to enroll in BadgerCare Plus.
5. Add together the excess income of the months in the deductible period. The result is the child's BadgerCare Plus deductible amount.

Example 1	Kyle is 14 years old, and his assistance group's income is over 156% of the FPL. Because of his age and assistance group's income amount, he is subject to the current employer-sponsored health insurance coverage policy. He is ineligible for BadgerCare Plus because he is covered under his mother's employer-sponsored health insurance plan. The household's size is five. Their income is $366.25 over the 150% FPL for a group size of five. Kyle's six-month deductible amount is $2,197.50. (366.25*6=$2,197.50).

Example 2	Mark, who is five years old, is ineligible for BadgerCare Plus because his assistance group's income is over 306% of the FPL. The household is made up of Mark's mother and 17-year-old brother whose income is counted because he is expected to be required to file taxes. Mark's assistance group's income is $3,026 over the 150% FPL for a group size of three. However, because Mark's brother is not his parent or spouse, his income must be excluded from the deductible calculation. This reduces the excess income to $1,526. John's six-month deductible amount is $9,156 ($1,526*6=$9,126).

17.4 Meeting the Deductible

The BadgerCare Plus member or group meets the deductible by incurring medical or remedial 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 pregnant woman or child under 19 can be certified for BadgerCare Plus through the end of the deductible period.

Note *The deductible is built on an individual basis. To meet the deductible, the member and their parents in the BadgerCare Plus group must incur medical bills equal to the deductible amount. The parent's medical expenses may be used for meeting the deductible of more than one child at a time, but deductible-based eligibility is not extended to other children or members of the original assistance group. Medical expenses of siblings may not be used for a child's deductible.*

If an expense was applied to a prior deductible but did not result in BadgerCare Plus certification, it can be applied to a later deductible, as long as it still meets the criteria listed in SECTION 17.4.1 WHEN EXPENSES CAN BE COUNTED TOWARD A DEDUCTIBLE.

17.4.1 When Expenses Can Be Counted Toward a Deductible

To be counted toward the deductible, a medical or remedial expense must meet all of the following conditions:

1. Be incurred by the member, their spouse (if applicable), or, if the member is younger than 19 years old, their parents.

   Expenses may also be counted if incurred for someone the member is legally responsible for if that person's bills could be counted toward the member's deductible. The medical bill may be used even if the person is no longer living or no longer in the current BadgerCare Plus group.

Example 1	Sally's spouse, Michael, died in April. In September, Sally requests that a medical bill incurred for Michael be used toward her deductible. Sally is still legally responsible for the bill. The bill can be used to meet the deductible as long as it did not result in a BadgerCare Plus certification in an earlier period.

Example 2	Jenny's children, Sam and Olivia, each have a $1000 deductible. Jenny has a medical bill for $1000. This bill can be used to meet both Sam's $1000 deductible and Olivia's $1000 deductible at the same time.

2. Meet the Definition of Medical or Remedial expense described in SECTION 17.4.2 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 BadgerCare Plus 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. Because 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	In May, Helen resided in an Institute for Mental Disease (IMD) and incurred a $14,000 bill. In October, Helen becomes pregnant and applies for BadgerCare Plus. Helen turned in the bill for the stay in the IMD which shows the amount as 'deferred charges' which means the member would never be billed for the charges, but if they happen 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's parent applies for BadgerCare Plus in July 2008. A BadgerCare Plus deductible of $700 is calculated for him. In January 2003, he had a blood transfusion. The bill for the transfusion was $800. The bill was never paid. Lestat can use the unpaid bill to meet his BadgerCare Plus deductible but must provide documentation to show that the charges are currently owed. The remaining $100 can be applied to the next deductible period, as long as it is still owed.

b. Paid or written off sometime during the current deductible period. Medical bills written off through bankruptcy proceedings are not allowed as a medical expense to meet a deductible.

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 5	Estelle applies for BadgerCare Plus in March. A deductible period is set up for March through August. In April, she had a two-year-old medical bill of $300 written off. She can apply the $300 toward the March - August deductible because it was written off during the deductible 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, 2007. 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 2006. He may not apply this toward his current deductible.

d. Paid or written off sometime during the three months prior to the start of the first deductible period. This expense can only be used for the first deductible period. Balances cannot be carried forward to future deductible periods.

Example 8	Norah is in her second deductible period which began in September. In June, Norah met her deductible and was certified for BadgerCare Plus. After certification, and before the prior deductible period ended in August , Norah paid for medical services that were not BadgerCare Plus covered services. Norah can apply these paid bills to the deductible period that began in September.

Example 9	Julie applies for BadgerCare Plus in August. Her deductible for the period from August through January is $1,500. On May 10 she paid off a $2,000 outstanding medical bill. She can use that expense to meet her deductible because it was paid in the three months prior to the date of her application. The remaining $500 cannot be applied to future deductible periods.

Example 10	Maria's son Joseph is open for BadgerCare Plus as a child (MAGC). Maria reports an income increase. Starting in October, Joseph must meet a deductible in order to be eligible for BadgerCare Plus. The deductible for the period from October through March is $1,500. Joseph had a medical bill for $2,000 for services not covered by BadgerCare Plus that was written off in September. Maria can apply this written-off bill to Joseph's deductible period that begins in October. The remaining $500 cannot be applied to future deductible periods.

17.4.2 Countable Expenses

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 BadgerCare Plus. Medical expenses for services or prescriptions acquired outside of the U.S. 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, copayments and premiums for BadgerCare Plus, Medicare, private health insurance; and bills for medical services that are not covered by the Wisconsin BadgerCare Plus program. When determining the countable medical expenses under MAGI rules, health insurance premiums that are counted as pre-tax deductions from income cannot also be counted toward a deductible as a medical expense.

Note *MMIS data may be used to calculate BadgerCare Plus copayments from the previous deductible period.*

2. Remedial expenses. Remedial expenses are costs for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. Some examples of remedial expenses are:
   Remedial expenses do not include housing or room and board expenses.

   a. Case management
   b. Day care
   c. Housing modifications for accessibility
   d. Respite care
   e. Supportive home care
      Supportive Home Care is necessary assistance to help people meet their daily living needs, ensure adequate functioning in their home, and safely access their community. Services may include:

i. Assistance with activities of daily living
ii. Attendant care
iii. Supervision
iv. Reporting changes in the member's condition,
v. Assistance with medication and medical procedures which are normally self-administered, or
vi. The extension of therapy services, ambulation and exercise.
vii. 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 member's safety, well-being and care at home.

f. Transportation.
g. Community Based Residential Facility (CBRF), Adult Family/Foster Home (AFH), Residential Care Apartment Complex (RCAC), and all other community substitute care setting program costs not including room and board expenses.

3. Ambulance service and other medical transportation including attendant services
4. Medical insurance premiums paid by a member of the BadgerCare Plus Group. These insurance premiums include disease specific and per diem hospital and nursing home insurance payments. Do not allow accidental insurance policy premiums as a countable cost.

Note *Unlike other expenses listed in this section that may not be applied toward a deductible until they are incurred, count medical insurance premiums from the first day of the deductible period if the premium will be coming due anytime during the current deductible period.*

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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. The cost of 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 #1 through #7 above.
   Examples include:

   a. General Assistance
   b. Community Options Program
   c. AIDS Drug Assistance Program (ADAP)

Example 1	Jenna receives a medical service which will be paid by ADAP. When Jenna becomes pregnant and applies for BadgerCare Plus she has a deductible to meet. This medical bill that has not been paid can be used immediately because it will be paid by the state administered ADAP program.

Example 2	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 BadgerCare Plus for herself and her son, James. Sally has access to health insurance so James must meet a deductible. Since the medical bill was paid by COP within three months of Sally's BadgerCare Plus application it can be used to meet James' BadgerCare Plus deductible.

9. Medical or remedial expenses that have been paid or will be paid by Indian Health Services that meet the conditions detailed in (SECTION 17.4.2 COUNTABLE EXPENSES)

Example 3	On January 1, Michael received a medical service which will be paid by Indian Health Services. When Michael applies for BadgerCare Plus 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 4	Charlie received a medical service in January which was paid by Indian Health Services in the same month. In February, Charlie's mother applies for BadgerCare Plus. Charlie has to meet a deductible. Since the bill was paid by Indian Health Services within three months of Charlie's BadgerCare Plus application, it can be used to meet Charlie's BadgerCare Plus deductible.

17.4.3 Expenses That Cannot Be Counted Toward a Deductible

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 BadgerCare Plus, Medicare or other insurance.

Note *If the third party charges the applicant or member for the medical expenses, then the applicant or member remains the liable party for those medical expenses.*

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 SECTION 17.4.1 WHEN EXPENSES CAN BE COUNTED TOWARD A DEDUCTIBLE.

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17.5 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.

17.5.1 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 sometimes difficult 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 the deductible amount on the date of admission, the first day of admission is the date of service for the

entire bill. The hospital bill is applied 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 12 through July 14. She also submits a physician bill for $2,500 with a date of service of July 12. Apply the $2,000 hospital bill to the deductible first.

17.5.2 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.

The entire "global" pregnancy fee is counted as an expense as of the date an agreement was signed.

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17.6 Prepaying a Deductible

Anyone can prepay a BadgerCare Plus deductible for their self 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.

Instruct the member to make the payment payable to the local Income Maintenance Agency. Report the receipt on the Community Aids Reporting System (CARS) labeled as a Medical Refund.

With the payment, include:

1. Documentation that the payment is voluntary.
2. The member's name and BadgerCare Plus ID number.

17.6.1 Insufficient Funds

If the deductible is paid with a check that is returned for insufficient funds, discontinue the person's eligibility, determine if an overpayment occurred and if so, establish a claim for benefit recovery.

17.6.2 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 1	Laura's deductible period is from March 1 through August 31. The total deductible amount is $1,000. Laura submits payment of $1,000 on August 15. Laura's BadgerCare Plus eligibility begins on March 1.

17.6.3 Combination of Payment and Incurred Expenses

If the deductible is met through a combination of payment and incurred medical expenses, count the incurred medical expenses first. Eligibility, by paying the remaining deductible amount, can begin no earlier than the last date of incurred medical expense within the deductible period.

Example 1	Gloria's deductible period is from March 1 through August 31. The total BadgerCare Plus deductible amount is $1,800. Gloria submits a medical bill with a March 8 date of service for $800. On July 15, she submits payment of $1,000. Gloria's BadgerCare Plus eligibility begins March 8. A BadgerCare Plus

	Remaining Deductible Update (F-10109) must be submitted to identify the provider of service on March 8 and the $800 member share amount.

17.6.4 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 1	Roberta's deductible period is from March 1 through August 31. The total BadgerCare Plus deductible amount is $1,500. She submits an outstanding bill from January 10 for $500. On August 15, she submits payment of $1,000. Roberta's BadgerCare Plus eligibility begins March 1.

Enter the first date of the deductible period on AGTM as the date the payment was received.

17.6.5 Calculation Errors

If any portion of the deductible is paid and you find the amount was wrong due to agency error, refund the paid amount that was incorrect and report the refund on CARS. If the error was caused by an applicant or member error, see SECTION 28.2 RECOVERABLE OVERPAYMENTS for determining the overpayment amount.

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17.7 Remaining Deductible

When the member receives a medical bill that is equal to or greater than the amount they still owe on the deductible, they can be certified for BadgerCare Plus. However, they are still responsible for the part of the bill that equals the deductible. BadgerCare Plus will consider the remainder of the bill for payment (see Process Help, Chapter 12.14 Medicaid Deductibles).

To make sure that BadgerCare Plus does not pay what the member still owes on the deductible, send a BadgerCare Plus Remaining Deductible Update (F-10109) to the fiscal agency indicating the amount of the bill that the member owes. The Fiscal Agent subtracts this amount from the bill and BadgerCare Plus pays the rest.

Fill out the BadgerCare Plus Remaining Deductible Update (F-10109) only if:

1. A BadgerCare Plus certified provider has provided the billed services.
2. The person, having met the deductible, is being certified. If they are not being certified, BadgerCare Plus 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 they have met the deductible, they still owe for all bills prior to that date.

If more than one bill was incurred on the date the deductible was met, send the BadgerCare Plus Remaining Deductible Update (F-10109) for any other bills for which the member would be responsible.

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17.8 Change in Income

Once the deductible has been met, changes in income do not affect the group's eligibility for the remainder of the deductible period.

If there are income changes reported during the BadgerCare Plus deductible period but prior to meeting the deductible, recalculate the BadgerCare Plus 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, or when the group size decreases. 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 income, deductions, or group size. To determine the amount of a decreased deductible:

1. Add together the monthly excess income of the months of the BadgerCare Plus deductible period that have already gone by.
2. Subtract the 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, a pregnant woman with income over 300% FPL, applied for BadgerCare Plus in July. She had excess income of $20 a month. Her BadgerCare Plus deductible was $120. On October 8, she reports a pay decrease of $10 a month. The change is effective for November. The BadgerCare Plus deductible amount is recalculated by: 1. Adding together the excess income of months July through October. The result is $80. 2. Calculating her November excess income. The result is excess income of $10. 3. Prospective excess income for December is $10. 4. Cicely's new BadgerCare Plus deductible amount is: $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 current BadgerCare Plus deductible, or
2. Create a new deductible period.

Example 2	Mary, a pregnant woman, goes from full time to part time employment in the fourth month of her BadgerCare Plus deductible period. She still has excess income, but it is lower than in the previous three months. She can choose either to recalculate her BadgerCare Plus deductible to a lower amount or to start a new deductible period. If she chooses to start a new deductible period, she will forfeit any eligibility she might have acquired in the previous deductible period if she 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.

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17.9 Non-Financial Changes

17.9.1 Non-Financial Changes Introduction

If there is a change in non-financial eligibility during the deductible period, discontinue BadgerCare Plus eligibility for those persons who have become non-financially ineligible.

Every child in a BadgerCare Plus household must have their eligibility for a deductible determined separately. If a child enters the BadgerCare Plus group after a deductible for another child in the group has been set, the new child must have their eligibility for a deductible determined separately.

If an adult caretaker relative who is EBD, or is pregnant, enters the BadgerCare Plus group, their eligibility for a deductible must be determined separately.

If a member loses non-financial eligibility and regains it during the same deductible period, the member may choose:

- To continue with the current deductible period.
  OR
- To reapply and establish a new deductible period if their income still exceeds the appropriate BadgerCare Plus income limit.

17.9.2 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, and the deductible is not met, the deductible must be recalculated. Compare the new group's countable monthly income with the new group's FPL limit. If there is excess monthly income, recalculate the deductible in the same way as for income changes. Beginning July 1, 2020, the deductible amount will no longer be increased when an unmet deductible assistance group has a decrease in the 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 income, deductions, or group size.

17.9.3 Death

If the member dies during the deductible period, and is not already certified, look at all countable expenses prior to death. If those countable expenses meet the deductible, certify the person. The time period for the deductible remains six months. All months that remain of the six-month deductible period from the point the member dies, are considered to have $0 income. The deductible amount should be recalculated. If the deductible was met, eligibility will be the point from which eligibility was determined to have been met through the date of death.

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 pre-payment is refundable.

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17.10 Late Reports of Changes

If the member 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 they reported the changes and the medical costs as they occurred. If the medical bills would have met the deductible for any past date, begin BadgerCare Plus certification on that date.

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18.1 Extensions

18.1.1 Introduction

A BadgerCare Plus extension is a period of eligibility given to a person when the assistance group's (AG) monthly income increases above 100% FPL - either due to an increase in earned income, spousal support, or both - and otherwise meets the BadgerCare Plus eligibility criteria for people with monthly income below 100% FPL.

A parent/caretaker relative or pregnant person can enter an extension due to a monthly income increase above 100% FPL in the AG's earned income, spousal support, or both. The children, stepchildren, and non-legally responsible relative (NLRR) children of the parent/caretaker may also enter the extension at this time, provided they are under age 19, living with the parent/caretaker, and meet the income requirements (see SECTION 18.1.3 CHILDREN). If the child is in their 12-month continuous coverage period, the child will stay in their current BadgerCare Plus assistance group while their parent(s) enter the extension. The child's BadgerCare Plus and the parent's extension renewal dates will align.

BadgerCare Plus members eligible as childless adults are not eligible for an extension. BadgerCare Plus members eligible based on annual income, known as gap filling, are not eligible for an extension.

If a family is moving out of the State of Wisconsin at the time of the income increase, they would not be eligible for the extension.

If all members of the household are eligible for an extension, verification of income is not required. If a member of the household is eligible for BadgerCare Plus but not in an extension, the household may be required to provide verification of income for determining that person's BadgerCare Plus eligibility. If verification is not provided timely, it will not impact the other members' eligibility in a BadgerCare Plus extension.

Example 1	Janine and her son, Zachary, are open for BadgerCare Plus under an extension. Janine's daughter, Amy, is open for non-extension BadgerCare Plus. Janine reports an increase in income. She is required to verify her new income since her income is counted when determining Amy's BadgerCare Plus eligibility.

When income is increasing at renewal, the renewal must be submitted in the month the renewal is due for the family to be eligible for the extension. If the renewal is submitted timely before the end of the renewal due month, but the family submits required verification after the verification due date and within the calendar month after the renewal due month, the family may be eligible for the extension.

Example 2	The Brown family's heath care renewal is due July 31. The renewal is submitted to the agency on July 31. The agency processes the renewal on August 7. The agency determines that the Brown faimly's monthly income is now over 100% of the FPL. No financial verification is required since all members of the family meet BadgerCare Plus extension eligibility criteria. The Brown family is enrolled in an extension starting August 1.
Example 3	The Williams family's health care renewal is due July 31. The renewal is submitted on August 9. They are not eligible for an extension.
Example 4	The Park family's health care renewal is due July 31. The renewal is submitted to the agency on July 5. In the renewal, the Park family reports that their income is below 100% of the FPL. The agency processes the renewal, and the family is required to submit verification of their income by July 31. The family does not submit verification by July 31, but they do submit verification on August 20. The verification they submitted shows their income is actually above 100% of the FPL. The family is enrolled in an extension starting August 1.

Children are not subject to health insurance coverage requirements while on an extension. See SECTION 7.1 HEALTH INSURANCE CONDITIONS OF ELIGIBILITY for more information.

18.1.2 Pregnant Women

A pregnant woman is able to enter an extension if she was eligible for BadgerCare Plus as a pregnant woman or a parent or caretaker relative at any time during the pregnancy with income at or below 100% of the FPL in three of the past six months. In most cases, her continuous eligibility as a pregnant woman will take precedence over the extension, but the extension will be maintained and will result in eligibility if the pregnancy and postpartum period end prior to the end of the extension. The pregnant woman will remain exempt from the premium requirements through the end of the extension certification period.

18.1.3 Children

If the child is in their 12-month continuous coverage period, the child will stay in their current BadgerCare Plus assistance group while their parent(s) enter the extension. The child's BadgerCare Plus and the parent's extension renewal dates may or may not align. If the child remains eligible for their existing coverage, they will get a new 12-month continuous coverage period, and their renewal date will align with the parent's extension renewal date. If the change would move the child to a CHIP category of BadgerCare Plus with a premium, then the child will remain in their current BadgerCare Plus category for the rest of the existing continuous coverage period.

Example 4	Jordan and her 10-year-old son Phoenix are enrolled in BadgerCare Plus with income at 95% of the FPL from January 1, 2025, through December 31, 2025. On July 7, 2025, Jordan reports an increase in earned income which places the household at 125% of the FPL. Jordan moves into an extension from August 1, 2025, to July 31, 2026. Phoenix remains eligible for MAGC in BadgerCare Plus and gets a new 12-month certification period from August 1, 2025, to July 31, 2026.

Example 5	Portia and her 8-year-old daughter Jewel are enrolled in BadgerCare Plus with income at 90% of the FPL from January 1, 2025, through December 31, 2025. On May 9, 2025, Portia reports an increase in earned income which places the household at 175% of the FPL. Portia moves into an extension from June 1, 2025, to May 31, 2026. Jewel cannot move from non-CHIP to CHIP BadgerCare Plus during her continuous coverage period, so Jewel remains enrolled in MAGC BadgerCare Plus in the non-CHIP category for the remainder of her current certification period, through December 31, 2025. At renewal, if the income remained the same and Jewel is determined eligible for BadgerCare Plus at 175% of the

	FPL, she will get a new 12-month continuous coverage period. If Jewel is determined ineligible for any other category of health care, she will move into the remainder of the extension with Portia through May 31, 2026.

Under most circumstances, the end of an extension will apply to all of the members of the BadgerCare Plus Test group. However, when the household income decreases to 100% FPL or less, the extension will end for the parent(s), but any children would remain in the extension. All dependent children, stepchildren, and NLRR children whose parent or caretaker may become eligible for an extension will be eligible for the same extension provided that in the month prior to the start of the extension the child is both eligible for BadgerCare Plus and:

- Has AG income under 306% FPL and is under age one.
- Has AG income under 191% FPL and is age one through age five.
- Has AG income under 156% FPL and is age six through age 18.

Conditions:

1. Children do not have to be eligible for BadgerCare Plus for three of the past six months.
2. The child's AG income does not have to be below 100% FPL at the time the extension starts.
3. CENs are not eligible for extensions.
4. A child who is currently in an extension is not eligible for a new extension.
5. If a parent's income decreases below 100% FPL, the child's extension continues.
6. Once a child is in an extension, the child does not lose the extension for any reason except for death, moving out of Wisconsin, or turning 19 while in an earned income extension.
7. The child is not in a 12-month continuous coverage period.
8. The child is not eligible for other full-benefit coverage.

Note *If a child is in an unexpired extension and a parent qualifies for a new extension, the child's extension will continue to stay in the original extension eligibility category until it expires. The child is not eligible for the new extension.*

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18.2 Increase in Earnings Extensions

18.2.1 Earned Income Extensions

To receive a 12-month BadgerCare Plus extension due to an increase in earnings, a parent, caretaker, or pregnant person must meet all of the following requirements:

1. The monthly income increase which caused the countable income for their BadgerCare Plus assistance group (AG) to exceed 100% FPL must be due solely to one of the following:
    a. Increased earnings (of anyone in the same AG).
    b. Increased earnings along with other income (changed or unchanged).
2. They must be a BadgerCare Plus member with monthly income at or below 100% FPL at the time the income increased to over 100% FPL.
3. They must have been enrolled in BadgerCare Plus with monthly income that was at or below 100% FPL for at least three of the six months immediately preceding the month in which the income went above 100% FPL.

4. They must otherwise meet the BadgerCare Plus eligibility criteria for persons with monthly income below 100% FPL.
5. They must not be eligible as a Former Foster Care Youth.

Note *These requirements do not apply to children (see SECTION 18.1.3 CHILDREN).*

Example 1	Jane lives with her two teenage children and Dave, the non-marital co-parent of the two children. Jane is claiming both children on her taxes and her monthly income for her MAGA AG of three is 90% FPL. Dave's MAGA AG consists only of himself, and he is eligible for BadgerCare Plus with monthly income of 95% FPL. The children-in-common are eligible in a MAGC AG group of four, with both parents as counted adults in their AG and their group's monthly income is 121% FPL. Jane was enrolled in BadgerCare Plus with income below 100% FPL for three of the prior six months. In June, her earned monthly income increased to 120% FPL. She is eligible for a 12-month BadgerCare Plus extension. Dave is not included in the extension because he was not a counted member of Jane's AG. The children are eligible for a 12-month extension because they were eligible in June when Jane's monthly income rose above 100% and their own AG's monthly income was below 156% FPL at the time. The children will remain in their current BadgerCare Plus AG under continuous coverage for children, but their renewal date will align with Jane's extension renewal date.

18.2.2 Supplemental Security Income Exception

A person who was eligible for SSI benefits may be eligible for a 12-month BadgerCare Plus extension if they lose SSI and would have been eligible for BadgerCare Plus with countable monthly income at or below 100% if they had not been an SSI recipient.

Example 2	Mary is receiving SSI. Her two children are enrolled in BadgerCare Plus with countable monthly income at or below 100% FPL. Mary started a job and her earnings put her above the SSI income limit. Her earned income also caused the BadgerCare Plus countable monthly income to exceed 100% FPL. Both Mary and her two children are eligible for a 12-month BadgerCare Plus extension. The children will remain in their current BadgerCare Plus AG under continuous coverage for children, but their renewal date will be extended to the end of the extension period.

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18.3 Increase in Spousal Support or Family Support Income Extensions

18.3.1 Support Extensions

If a parent, caretaker, or pregnant person's countable monthly income increases above 100% FPL and all or part of the excess income consists of spousal support income, grant an extension of either four months or 12 months depending on the case circumstances.

For cases that receive family support, only the spousal support or alimony portion of the family support is considered for support extensions (see SECTION 16.5 OTHER INCOME).

18.3.1.1 Four-Month Extensions

The four-month BadgerCare Plus extension only applies if:

1. The monthly income increase which caused the countable income to exceed 100% FPL must be due solely to one of the following:
    a. Increased spousal support income.
    b. Increased spousal support income along with other unearned income (changed or unchanged).
2. There has been no increase in earned income.
3. They are an eligible BadgerCare Plus member with monthly income at or below 100% FPL at the time the income increased to over 100% FPL.
4. They must have been enrolled in BadgerCare Plus with monthly income that was at or below 100% FPL for at least three of the six months immediately preceding the month in which the monthly income went above 100% FPL.
5. They otherwise meet the BadgerCare Plus eligibility criteria for persons with monthly income below 100% FPL.

18.3.1.2 Twelve-Month Extensions

The 12-month BadgerCare Plus extension applies only if:

1. Earned monthly income increased but spousal support income remained the same or both earned monthly income and spousal support income increased.
2. They are a BadgerCare Plus member with monthly income at or below 100% FPL at the time the monthly income increased to over 100% FPL.
3. They must have been enrolled in BadgerCare Plus with monthly income that was at or below 100% FPL for at least three of the six months immediately preceding the month in which the monthly income went above 100% FPL, and
4. They otherwise meet the BadgerCare Plus eligibility criteria for persons with monthly income below 100% FPL.

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18.4 Income Changes During the Extension

During an extension, a group or person's monthly income may decrease to an amount at or below 100% Federal Poverty Level (FPL) and then increase again to exceed 100% FPL. When the monthly income decreases, the person will be removed from the extension and placed in non-extension BadgerCare Plus. The remaining months of the extension will continue to run in the background. Verification of the monthly income decrease to at or below 100% FPL is required in order to make the person eligible in non-extension BadgerCare Plus. If income verification is not provided, the person will remain in the extension for the remaining months.

If the person's countable monthly income again increases above the 100% FPL, they would be eligible under the previous extension for any remaining months. If the person is eligible for a new extension when the monthly income again increases, because they meet all of the criteria (see SECTION 18.2 INCREASE IN EARNINGS EXTENSIONS and SECTION 18.3 INCREASE IN SPOUSAL SUPPORT OR FAMILY SUPPORT INCOME EXTENSIONS), the person will enter into a new extension.

Example 1	A BadgerCare Plus group with a 12-month extension from January through December has a monthly decrease in income in February that puts them back below 100% FPL. The group provides pay stubs to

	verify the decrease in income. The extension continues to run while the group is on non-extension BadgerCare Plus. In October, the group's countable monthly income again increases to above 100% FPL - this time due to an increase in spousal support income. They are now eligible for a four-month spousal support extension (November through February). Since the four-month extension would be longer than the current extension, the new four-month extension applies.

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18.5 Losing and Regaining Extensions

18.5.1 Losing an Extension

A BadgerCare Plus member loses an extension if one or more of the following happens:

1. Parents and caretaker relatives lose their extension if they fail to cooperate in providing third-party health insurance coverage (TPL). Children younger than 19 years old are exempt from any penalty for not cooperating with this requirement.
2. Parents and caretaker relatives lose their extension if the extension is based on an increase in earned income and all children under the parent's or caretaker relative's care have either left the household, turned 19 years old, or are 18 years old but not a dependent 18-year-old. See SECTION 2.2.1.3 DEPENDENT 18-YEAR-OLD.
3. Parents and caretaker relatives lose their extension if the extension is based on an increase in earned income and the parent or caretaker relative is no longer cooperating with a permanency plan, the goal of which is family reunification, when all the children in their care have been temporarily removed from the home and are in the care of the child welfare system. See SECTION 10.1 ELIGIBILITY FOR PARENT OR CARETAKER RELATIVE OF CHILD REMOVED FROM HOME.
4. Children lose their extension when they turn 19 years old if the extension is based on an increase in earned income.

Children in a support extension do not lose the extension just for turning 19 years old. Parents and caretaker relatives in a support extension do not lose the extension just because all of the children in their care have left the household, turned 19 years old, or are 18 years old but not a dependent 18-year-old.

A member no longer working in the job that increased their earned income does not cause the member to lose the extension. The members in the assistance group do not need to maintain employment to continue the earned income extension. If a member's income decreases, they may be placed in non-extension BadgerCare Plus. See SECTION 18.4 INCOME CHANGES DURING THE EXTENSION.

18.5.2 Regaining Extensions

If a condition necessary for an extension is lost and the extension is closed for a full calendar month, the extension is not regained solely by recovering the lost condition.

If an extension is terminated for failure to verify information, eligibility for the unexpired extension cannot be regained by later providing the verification if it is more than a month after closure.

If an earned income extension ends because all children have turned 19 years old or left the household, but the child(ren) return to the household within the calendar month after the closure, the child and any

people who qualify again as a parent or caretaker of that child(ren) may reopen under an unexpired earned income extension.

Example 1	Bob, his wife, Betty, and their only child, Ben, are open for an earned income extension until May 31. Their eligibility ended on January 31 because Ben left the household. It was reported that Ben returned to the household on February 13. Because it was reported that Ben returned to the home within a calendar month, they (Bob, Betty, and Ben) may regain eligibility for their earned income extension until May 31.

However, people would be able to regain eligibility for an unexpired extension, even after being closed for more than a calendar month, in the following scenarios:

- They move out of the state and return before the extension ends (see SECTION 18.5.2.1 LEAVING WISCONSIN AND REGAINING EXTENSIONS).
- They de-request BadgerCare Plus after their extension has started (that is, the extension has been built and confirmed) and later request to reinstate for the remaining months of an unexpired extension.

  They lose eligibility in another category of BadgerCare Plus or Medicaid solely due to a reason that is not applicable to extension eligibility.

Example 2	Gregory is open for BadgerCare Plus in an extension. His income drops below 100% FPL, and he is moved into non-extension BadgerCare Plus as a parent. He is required to cooperate with the Child Support Agency as a condition of his BadgerCare Plus eligibility, but he stops cooperating. He loses eligibility for BadgerCare Plus as a parent. Since parents and caretaker relatives in BadgerCare Plus extensions are exempt from the cooperation requirement (see SECTION 5.2.2 EXEMPTIONS FROM COOPERATION), he regains eligibility in his unexpired BadgerCare Plus extension for the remaining months of the extension.

18.5.2.1 Leaving Wisconsin and Regaining Extensions

If a BadgerCare Plus member is eligible for an extension and moves out of Wisconsin, they lose the extension. They can regain the extension if they return and become a Wisconsin resident again during any month in the original extension period.

Example 3	Earl, a Wisconsin resident, received a 12-month extension beginning January 1, 2015. He moved out of state, thus losing his extension. On May 1, 2015, he moved back to Wisconsin and became a Wisconsin resident again. He regained the extension at the time he moved back to Wisconsin and became a Wisconsin resident.

If the time period of the extension expires while the person is out of state, they do not regain the extension.

Example 4	Gloria, a Wisconsin resident received a 12-month extension beginning January 1, 2015. She moved out of state, thus losing her extension. In February 2016, she moved back to Wisconsin and became a Wisconsin resident again. She does not regain the extension because the time period has expired.

19.1 BadgerCare Plus Premiums for Children

Effective April 1, 2024, children in families with income over 201% of the FPL are charged a premium for BadgerCare Plus unless the child is exempt. However, payment of a premium is not a condition of

eligibility for BadgerCare Plus. If the premium is not paid, the child will remain eligible for BadgerCare Plus.

New members with an application filing date on or after April 1, 2024, will be charged premiums.

Example 1	Mary applies for BadgerCare Plus for her son, Jack, on April 4, 2024. The household's income is 215% FPL. The application is processed and confirmed on April 5, 2024. Jack is eligible for BadgerCare Plus as of April 1 and a premium will be charged.

Members enrolled prior to April 1, 2024, will not be charged premiums until after their next scheduled renewal for a new certification period beginning May 1, 2024, or later.

Example 2	Aarav's daughter Divya has been open for BadgerCare Plus since August 2023. The household's income is 220% FPL. Because Divya has continuous coverage through July 2024, a premium cannot be charged until her renewal due in July 2024 is completed. Aarav completes the renewal on July 8, 2024, and Divya is determined eligible with household income above 201% of the FPL. A premium will be charged for Divya beginning with the month of August 2024. A premium statement will be sent to Aarav at the end of July for the August premium.

If an individual applies with a filing date before April 1, 2024, the individual will not be charged premiums during the initial certification period, even if the application is processed on or after April 1, 2024. The individual will be charged premiums after they complete their next scheduled renewal.

Example 3	Fatima applies for health care for her daughters, Amina and Aisha, with a filing date of March 25, 2024. The application is processed and confirmed on April 8, 2024, and Amina and Aisha are eligible for BadgerCare Plus with household income at 230% of the FPL. Because they applied before April 1, 2024, premiums will not be charged during the initial certification period. They are eligible for BadgerCare Plus with no premium from March 1, 2024, through February 28, 2025. If their household income remains above 201% of the FPL after they complete their scheduled renewal, a premium will be charged for them at that time.

If a member has a renewal scheduled after April 2024, but completes an early renewal, premiums cannot be charged at that time because the member is still in their 12-month continuous coverage period. Premiums may be charged at the member's next renewal.

Example 4	Maya's son Nathaniel has been open for BadgerCare Plus since November 2023. The household's income is 250% of the FPL. Because Nathaniel has continuous coverage through October 2024, a premium cannot be charged until after his renewal due in October 2024 is completed. Maya calls the agency to renew Nathaniel's BadgerCare Plus in July 2024. This is during Nathaniel's continuous coverage period, so premiums cannot be charged. Premiums may be charged when the household completes their renewal in July 2025.

If a member was disenrolled from BadgerCare Plus before April 2024 because they did not complete their renewal, and they complete a late renewal on or after April 1, 2024, they will be subject to premiums after completing the late renewal.

Example 5	Choua did not complete the renewal for his son Chue's BadgerCare Plus that was due in February 2024, so Chue's BadgerCare Plus ended February 29, 2024. Choua completes a late renewal, the renewal was processed April 2, 2024, and Chue is determined eligible with household income of 228% of the FPL. A premium will be charged for Chue beginning with the month of May 2024. A premium statement will be sent to Choua at the end of April for the May premium.

Payment of a premium is not a condition of eligibility for BadgerCare Plus. If no payment is made, their eligibility for BadgerCare Plus will not be impacted.

Example 6	Mary is charged a premium for her son, Jack, beginning May 2024. A statement is sent to Mary at the end of April, with a due date of May 10. Mary is not able to pay the premium. Jack remains eligible for BadgerCare Plus. Mary will be sent a premium statement for June at the end of May.

The following children are exempt from being charged a premium for BadgerCare Plus:

1. Pregnant minors
2. Former Foster Care Youth (see CHAPTER 11 FOSTER CARE MEDICAID)
3. Children who have met a BadgerCare Plus deductible, during the remainder of the deductible period
4. Children in a BadgerCare Plus extension
5. All children under age one including Continuously Eligible Newborns (see SECTION 8.2 CONTINUOUSLY ELIGIBLE NEWBORNS)
6. American Indian 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
7. Children whose BadgerCare Plus is suspended due to being incarcerated in jail or prison

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Note *Persons who are members of families receiving BadgerCare Plus benefits, but who are individually certified for Elderly, Blind or Disabled (EBD) Medicaid, Wisconsin Well Woman Medicaid, Family Planning Only Services or Emergency Services, are not charged a BadgerCare Plus premium.*

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19.2 Premium Calculations

19.2.1 Premium Calculations

Premiums are initially calculated on an individual basis and then a total for the case is determined. The general rules for calculating the premium amounts are explained below.

1. The minimum monthly premium amount is $10 per child.
2. The maximum monthly premium for a child with income above 301% up to 306% Federal Poverty Level (FPL) is $97.53.
3. Each child's premium amount will be based on their assistance group's (AG) size and income. Under Modified Adjusted Gross Income (MAGI) rules, it is possible for different children within the same household to have different amounts of income counted and to have different AG sizes. For this reason, each child's AG is evaluated separately to determine that AG's income and group size, which is the basis for determining the FPL percentage of that child's income. That FPL percentage, in turn, will determine whether a child potentially owes a premium and the amount of the premium.
4. The premium for the BadgerCare Plus group is the total of the individually-calculated premiums combined, not to exceed 5% cap.
5. The cap will be 5% of the income of the AG with the highest income (in terms of dollar amount) in the case (see SECTION 19.3 PREMIUM LIMITS).

A child cannot be charged a new or increased premium during their 12-month continuous coverage period, but their premium may be reduced, if applicable. If the premium is lowered, that new amount becomes their premium cap for the rest of the 12-month period.

19.3 Premium Limits

Children in an assistance group with income above 201% of the Federal Poverty Level (FPL) will be charged premiums. The total premium for the household is the total of the individual premiums for all children in the household, not to exceed a 5% cap. The cap is 5% of the income of the assistance group (AG) with the highest income (in terms of dollar amount) in the case.

Example 1

Susan and Alan are non-marital co-parents caring for four children: Susan's son, Aaron (15); Alan's daughters Rachel (12) and Hannah (11); and Susan and Alan's son Jacob (9). Alan claims Rachel and Hannah as his two tax dependents, while Susan claims Aaron and Jacob. Susan earns $2,800 per month as a waitress, and Alan earns $4,700 per month as a computer analyst. None of the children have income. All four children are eligible for BadgerCare Plus.

Child	MAGI Group Formation	Assistance Group Income Amount	FPL	Premium Amount
Aaron	Susan, Aaron, and Jacob	$2,800	123%	$0
Rachel	Alan, Rachel, and Hannah	$4,700	206%	$10
Hannah	Alan, Rachel, and Hannah	$4,700	206%	$10
Jacob	Susan, Alan, Aaron, Rachel, Hannah, and Jacob	$7,500	203%	$10

Aaron does not have a premium. Rachel, Hannah, and Jacob each have a $10 premium. Jacob's Modified Adjusted Gross Income (MAGI) group has the greatest income, so this group determines the 5% cap. The maximum premium for this group is 5% of $7,500 per month, or $375 per month. Altogether, the household's monthly premiums are $30. The household will be charged $30 in premiums for their children's coverage.

A child cannot be charged a new or increased premium during their 12-month continuous coverage period, so if an AG's income increases from at or below 201% to above 201% FPL during their 12-month continuous coverage period, they will not be charged a premium.

19.4 Premium Payment Methods

Premium statements will be sent monthly. The statement will provide the amount charged and how to pay the premium.

Members have several options to pay their ongoing monthly premiums, including:

- Check

- Money order
- Electronic Funds Transfer (EFT)
- Wage withholding
- Credit or debit card

Members can make one-time payments using a credit or debit card, or EFT from a checking or savings account, through the ACCESS website.

If they want to make recurring EFT payments, members must submit a complete BadgerCare Plus Premium Member/Employer Electronic Funds Transfer form (F-13026). If they want to have premiums taken out of a paycheck, the BadgerCare Plus Premium Employer Wage Withholding form (F-13025) must be submitted by an employer. Members have the option to submit payments through one of the other methods until they get confirmation that their recurring EFT or wage withholding request has been processed.

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19.5 Initial Payments

Payment of premiums is not a condition of eligibility for BadgerCare Plus. An initial premium will not be charged for a current or past month at application or renewal. Premiums will be charged only for future months after advance notice is provided, following adverse action logic.

If eligibility is determined prior to adverse action, the child will be charged a premium starting the following month.

Example 1	Roberto applies for BadgerCare Plus for himself and his son Jorge on July 2, 2024. The application is processed on July 8, and Jorge is determined eligible effective July 1 with household income at 215% of the FPL. A premium is not charged for July. A premium will be charged for Jorge beginning with the month of August. A statement will be sent to Roberto at the end of July.

Example 2	Melissa's daughter Beth has been open for BadgerCare Plus since August 2023. Beth completes a renewal on July 1, 2024. On July 5, 2024, Beth is determined eligible effective August 1 with household income above 201% of the FPL. A premium will be charged for Beth beginning with the month of August. A premium statement will be sent to Melissa at the end of July.

If eligibility is determined after adverse action, the child will be charged a premium the month after the following month.

Example 3	Lisa and her family apply for BadgerCare Plus on July 25, 2024. The application is processed on July 31, and the family is determined eligible effective July 1 with the household income above 201% of the FPL. A premium is not charged for July or August. A premium will be charged for each child beginning with the month of September. A premium statement will be sent to Lisa at the end of August.

Example 4	Cua applies for BadgerCare Plus for her son Blong on August 31, 2024. The application is processed on September 27, and Blong is determined eligible effective August 1 with a household income at 225% of the FPL. A premium is not charged for August, September, or October. A premium will be charged for

	Blong beginning with the month of November. A premium statement will be sent to Cua at the end of October.

Example 5	Julio's daughter Mia has been open for BadgerCare Plus since September 2023. Julio completes a renewal on August 23, 2024. On August 29, 2024, Mia is determined eligible effective September 1 with household income above 201% of the FPL. A premium is not charged for September. A premium will be charged for Mia beginning with the month of October. A premium statement will be sent to Julio at the end of September.

Example 6	Carly's son Jasper has been open for BadgerCare Plus since October 2023. Carly completes a renewal on September 30, 2024. Due to the need to verify income, Jasper's eligibility is not confirmed until October 22, 2024. Jasper is determined eligible effective October 1 with household income above 201% of the FPL. A premium will not be charged for October or November. A premium will be charged for Jasper beginning with the month of December. A premium statement will be sent to Carly at the end of November.

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19.6 Ongoing Payment

BadgerCare Plus premiums are due on the 10th of the benefit month, regardless of which payment method is chosen. Premium payments may not be paid in advance.

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19.7 Refunds

A refund must be issued if the premium was paid and is for a month in which one of the following situations occurs:

1. The individual or household was ineligible for BadgerCare Plus.
2. A change is reported that results in no premium or a lower premium amount.
    a. If the change is reported within 10 days of when the change occurred, the lower or $0 premium amount is effective during the month in which the change occurred.
    b. If the change is not reported within 10 days of when the change occurred, the lower or $0 premium amount is effective during the month in which it was reported. The fiscal agent will refund any excess premium that was paid. See SECTION 27.2 NONFINANCIAL CHANGE REPORTING and SECTION 27.3 INCOME CHANGE REPORTING REQUIREMENTS for information on change reporting.

Note *When determining if a change was reported within 10 days of when the change occurred, the reported date of change from the member is used. If the worker has information that makes the reported date of change questionable, verification of the date of change may be required.*

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 refunded. See Process Help Section 12.21.3 Premium Refunds.

Example 1	David and Jenny are married and have a child, Megan. Their household income is 285% of the FPL. Megan is enrolled in BadgerCare Plus with a $68 monthly premium. In June, David had a decrease in work hours. At the end of June, David and Jenny found that this reduction in work hours resulted in the household income decreasing to 235% of the FPL in the month of June. David reports this income change to the agency on July 7. Since this change was reported within 10 days of the household monthly income changing, the lower premium is effective the month in which the change occurs (June). Starting in June, Megan's monthly premium is $15. David had already paid $68 each for Megan's June and July premiums, so a refund must be issued.
Example 2	Morgan and Taylor are married and have a child, Kelly. Their household income is 285% of the FPL. Kelly is enrolled in BadgerCare Plus with a $68 monthly premium. In June, Morgan has a decrease in work hours. At the end of June, Morgan and Taylor found that this reduction in work hours resulted in the household income decreasing to 235% of the FPL in the month of June. Morgan reports this income change to the agency on July 18. Since this change was reported more than 10 days after the household monthly income changed, the lower premium amount is effective during the month in which it was reported (July). Starting in July, Kelly's monthly premium is $15. Morgan already paid $68 for Kelly's July premium, so a refund must be issued.
Example 3	Aaron has a child, Emily. Their household income for a group of 2 is 285% of the FPL. Emily is enrolled in BadgerCare Plus with a $68 monthly premium. On September 4, Aaron marries Kathy. Aaron contacts his agency on September 13 to report his marriage to Kathy and add her to his household. Kathy's income must be verified by October 3. Emily's BadgerCare Plus is maintained for the month of October while eligibility is pending for income verification. On October 3, the income verification is processed. Their household income for a group of 3 is 225% of the FPL. Starting in September, Emily's monthly premium is $10. Aaron had already paid $68 each for Emily's September and October premiums, so a refund must be issued.

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19.8 Non-Payment

Payment of a premium is not a condition of eligibility for BadgerCare Plus. Non-payment of BadgerCare Plus plus premiums will not result in a loss of coverage for BadgerCare Plus.

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19.9 Late Payments

If a payment is made after adverse action of the benefit month the payment is applied to the next month's premium.

Example 1	Alan's daughter Victoria is eligible for BadgerCare Plus, and a $15 premium is charged beginning August 2024. A premium statement is sent to Alan at the end of July with a due date of August 10. Alan does

	not make a payment by adverse action of August. Victoria remains eligible for BadgerCare Plus. Alan submits the $15 payment on August 21. The payment is applied to the premium for September that is due on September 10.

If there is no premium for the next benefit month, a payment made after adverse action of the benefit month will be refunded. If the premium for the next benefit month is lower than what is paid, the excess amount will be refunded.

Example 2	Angel's son Felix is receiving BadgerCare Plus and is due for renewal in March 2025. A $15 premium has been charged for Felix during the certification period that ends in March 2025. Angel completes the renewal on March 5, 2025, and Felix is determined eligible for a new certification period starting in April 2025 with a new premium amount of $10. Angel submits a $15 payment on April 1, 2025. This payment exceeds the premium due amount for April by $5, so $10 is applied to the April premium and $5 is refunded to Angel.

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19.10 Premium Changes

19.10.1 Decreased Premium Amount

If a change is reported within 10 days of when the change occurred, the lower or $0 premium amount is effective during the month in which the change occurred.

If a change is not reported within 10 days of when the change occurred, the lower or $0 premium amount is effective during the month in which it was reported.

Premium decreases must be reviewed, and eligibility redetermined, 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. See Process Help Section 12.21.3 Premium Refunds.

The fiscal agent will refund any excess premium that was paid.

19.10.2 Increased Premium Amount

A child cannot be charged a new or increased premium during their 12-month continuous coverage period, but their premium may be reduced, if applicable. If the premium is lowered, that new amount becomes their premium cap for the rest of the 12-month period.

If a new child with a premium is added to a case, a household may have an increase in its total premium amount, but an individual child cannot have an increase in premium during the 12-month period.

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19.11 Reserved

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20.1 Assets

There is no asset limit for BadgerCare Plus.

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25.1 Application

Anyone has the right to apply for BadgerCare Plus. However, people younger than 18 years old must have a parent, caretaker relative, or a legal guardian apply for BadgerCare Plus 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.

Individuals younger than 18 years of age have the right to apply for Family Planning Only Services on their own behalf even if not living independently.

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 25.2 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 form (DWSP-2477) must be provided to all applicants.
- Child Support Cooperation & Good Cause notice (DCF-P-5600) must be provided to all 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.

25.1.1 Health Care Requests for People Open for Other Programs

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 BadgerCare Plus. 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.*

25.2 Application Methods

BadgerCare Plus applicants have the choice of the following application methods:

- ACCESS online application: access.wisconsin.gov
- Mail-in or fax the BadgerCare Plus Application Packet (F-10182)
- Mail-in or fax the Wisconsin Medicaid, BadgerCare Plus, and Family Planning Only Services Registration Application (F-10129)
- Telephone application
- In person application at income maintenance agency
- Application available through the Federally Facilitated Marketplace (FFM)

Note *When a signed F-10129 is submitted, 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.*

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25.3 Where to Apply

25.3.1 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 people in the following state institutions:

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

When an applicant contacts the wrong agency, they must be redirected to the consortium or tribal agency responsible for processing the application immediately. Anytime a paper application is received in the wrong consortium or tribal agency, it must be redirected to the correct agency as soon as it is discovered. The filing date remains the date originally received by the wrong consortium or tribal agency.

25.3.2 Intercounty Placements

When there is a dispute between the placing county and the receiving county 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 renewals.

25.3.3 Applications Outside Wisconsin

Generally, an application should not be taken for a resident of Wisconsin when they are 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 25.1 APPLICATION).

25.3.4 Applications Received from the Federal Marketplace

The FFM sends applications to CARES through an account transfer process for individuals the FFM assesses as potentially eligible for BadgerCare Plus or Medicaid. Such applications are considered full applications for all "insurance affordability programs" including BadgerCare Plus and should be appropriately processed. The 30-day processing requirement begins on the day that the application is received by the local agency or the next business day if received after normal operating hours or on weekends or holidays. If eligible, the individual's benefits will begin on the first day of the month the application was filed at the Marketplace, not the date that the application was received by the agency. If the individual requests backdating, their eligibility will be backdated for up to three months from the first day of the month the application was filed at the FFM.

If a paper application from the Marketplace is mailed to a consortium or tribal agency, the IM agency must consider that application as an application for BadgerCare Plus and/or Medicaid and process it.

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25.4 Valid Application

A valid application for BadgerCare Plus must include all of the following information from the applicant:

- Name
- Address
- Signature (see 25.5.1 VALID SIGNATURE INTRODUCTION)

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25.5 Valid Signature

25.5.1 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):

1. The paper application form Wisconsin Medicaid for the Elderly, Blind, or Disabled Application Packet (F-10101) or BadgerCare Plus Application Packet (F-10182)
2. The Wisconsin Medicaid, BadgerCare Plus and Family Planning Services Registration Application (F-10129)
3. The signature page of the Application Summary (by telephone, electronically, or with a handwritten signature)
4. The ACCESS application with an electronic signature
5. The online or paper Application for Health Coverage & Help Paying Costs from the Federally-Facilitated Marketplace (FFM)

25.5.1.1 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 the applicant's 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 34.1 AUTHORIZED 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 Authorization of Representative form (Person F-10126A or Organization F-10126B). 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 purposes 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 IM agency must do both of the following:

1. 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.
2. Review the document to confirm that the power of attorney for finances authority does not end if the applicant becomes incapacitated (i.e., the power of attorney is durable).

The application is not properly signed unless both 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 by the document used to designate the agent.

The document used to designate the agent with durable power of attorney for finances will specify what authority is granted. The appointment of an agent with durable power of attorney for finances does not prevent an applicant from filing their own application for BadgerCare Plus, 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. The IM agency must retain a copy of this written authorization. The social or human services director may end the delegation when there's reason to believe that the delegated authority is not being carried out properly.

8. Patient's Representative (Wis. Stat. § 50.06)

A patient's representative is an individual under Wis. Stat. § 50.06 who may consent to an incapacitated individual's admission to a nursing home or community-based residential facility from a hospital. A patient's representative can make health care decisions to the same extent as a guardian of the person and enroll an incapacitated individual in Medicaid and authorize expenditures related to health care to the same extent as a guardian of the estate.

The authority of a patient's representative ends if any of the following occurs:

- A court appoints a guardian to make decisions for the incapacitated individual
- The incapacitated individual is discharged to a setting that is not a facility
- A health care power of attorney that was not identified earlier is identified
- The individual is determined to be no longer incapacitated

When an application is signed by someone claiming to be a patient's representative, the IM agency does both of the following:

- Obtains a copy of the patient's representative's Patient's Representative Declaration (F-03436) indicating that they have the authority to act on behalf of the incapacitated individual
- Reviews the document to confirm the authority has not ended due to a change in circumstances

The application is not properly signed unless both conditions are met.

A patient's representative may not authorize expenditures related to health care if the incapacitated individual has an agent under a durable power of attorney for finances who may authorize expenditures related to health care. See #4, above.

25.5.2 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 telephone application.

Note *This does not affect the State of Wisconsin's ability to prosecute for fraud due to an applicant's or member's misstatement or omission of fact.*

25.5.3 Telephone Signature Requirements

Telephonic signatures are valid forms of signatures for BadgerCare Plus.

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 is 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.

25.5.4 Valid Signature on the Federally-Facilitated Marketplace Application

The signature on the FFM application is accepted for all individuals on that application. There may be a need to create companion cases for adult children listed on a FFM application, without obtaining a separate signature or application. 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 health care specific rights and responsibilities information is not provided when a person applies for health care through the FFM, a case summary must be sent to the applicant once the application is processed. No additional signature is required.

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.

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

Example 1	Victoria and Timothy are married and filing taxes jointly. They are claiming Casey, their 24-year-old son, as a tax dependent. Victoria signs and submits an application to the FFM for health care for herself, Timothy, and Casey. The FFM assesses that they are potentially eligible for BadgerCare Plus and transfers the application to the agency. Although Casey is included in the health care request, his BadgerCare Plus eligibility cannot be determined on his parents' CARES case. A separate case is established for Casey. No additional signature or application is required for Casey's health care request.

Example 2	Darrell is filing taxes and claiming Carmen, his 22-year-old niece, as a tax dependent. Darrell signs and submits an application to the FFM for health care for Carmen. The FFM assesses that she is potentially eligible for BadgerCare Plus and transfers the application to the agency. A separate case is established for Carmen. No additional signature or application is required for Carmen's health care request.

Tax dependents living outside the home will not be included in the health care request for their tax filer's household. A separate application is required to determine eligibility for a tax dependent living outside the home.

25.5.5 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.

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25.6 Filing Date

The application filing date helps determine when an applicant can start getting benefits if they meet program rules (see SECTION 25.8 BEGIN DATES).

Paper applications are date stamped on the business day they are received.

25.6.1 In Person/Mail/Fax

The filing date is the day a signed, valid application (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.

25.6.2 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.

25.6.3 By ACCESS

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

25.6.4 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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25.7 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 (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 the requested 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 25.6 FILING DATE). The date received is the date on which the application is delivered to the agency or the next business day if delivered weekdays after business hours, on a weekend, or on a holiday.*

Example 1	A signed application is received on March 15. The agency processes the application on April 7 and requests verification. Verification will be due on April 27 to allow the applicant at least 20 days to provide verification.The applicant does not provide the requested verification by April 27. 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.

Example 2	A signed application was submitted to the FFM on February 28. The Marketplace assessed the person as potentially eligible for BadgerCare Plus and transferred the person's account to the agency on March 5. The first day of the 30-day period for processing requirements was March 6. The end of the 30-day

	period would have been April 4. The application was approved on March 31, and the applicant is determined eligible beginning February 1.

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 3	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.

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

For information on application denials for failure to provide verification, see SECTION 9.2 APPLICATION.

25.7.1 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 25.7 APPLICATION PROCESSING TIME FRAME).

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25.8 Begin Dates

25.8.1 Begin Dates Introduction

BadgerCare Plus eligibility begins the first day of the month in which the valid application is submitted and all eligibility 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. **Newborn -** The date the child was born.
3. **Foster Care Medicare** - The date the person entered into foster care. These dates are established by child welfare agencies.
4. **Inmates** - The restriction on covered services will end the date the member is no longer an inmate of a public institution. See SECTION 45.4 SUSPENSION END DATE.

25.8.2 Backdated Eligibility

Most types of BadgerCare Plus eligibility can be backdated up to three months prior to the month of application.

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.

All pregnant persons, except those eligible under the BadgerCare Plus Prenatal program, may have their eligibility backdated to the first of the month, up to three calendar months prior to the month of application. See SECTION 25.8.2.5 PREGNANT MEMBERS for more information.

All former foster care youth that meet the criteria in SECTION 11.2 FORMER FOSTER CARE YOUTH may have their eligibility backdated to the first of the month, up to three calendar months prior to the month of application.

Children determined eligible for BadgerCare Plus are eligible for the following periods of backdated eligibility:

- Infants less than one-year old may have their eligibility backdated up to the first of the month, three calendar months prior to the month of application for any of the months in which their family income was at or below 306% FPL,
- Children ages one through five may have their eligibility backdated up to the first of the month, three calendar months prior to the month of application for any of the months in which their family income was at or below 191% FPL, and
- Children ages six through 18 may have their eligibility backdated up to the first of the month, three calendar months prior to the month of application for any of the months in which their family income was at or below 156% FPL.

All non-pregnant, non-disabled parents and caretakers may have their eligibility backdated up to the first of the month, three calendar months prior to the month of application for any of the months in which their family income was at or below 100% FPL.

Childless adults with assistance group income under 100% FPL are eligible for backdating.

See SECTION 16.4.3.4.4 BACKDATED MONTHS for information on counting self-employment income for backdated months.

Note *Applicants are not eligible for backdated health care benefits while pending for citizenship and/or identity. Applicants who are otherwise eligible must be certified for health care benefits for the 95-day good-faith period within the normal application processing timeframe. Once verification is provided, the applicant's eligibility must then be determined for backdated health care benefits if they have been requested. See SECTION 4.2 VERIFYING U.S. CITIZENSHIP for more information.*

25.8.2.1 Backdated Eligibility Timeframe

The backdated eligibility cannot 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 they would have been eligible had they applied in that month.

In the case of children, certify the person for any backdate month in which they would have been eligible had they applied in that month and in which their assistance group income was at or below the appropriate FPL level for their age group.

25.8.2.2 Determining Backdated Eligibility

Actual nonfinancial information (for example, household composition) and actual income is used to determine eligibility in the backdated months.

Actual income is used to determine backdated eligibility under gap filling rules for months in a past calendar year. When determining backdated eligibility under gap filling rules for months in the current calendar year, expected annual income is assessed using the same process for non-backdated months.

The reasonable compatibility test is used when determining backdated eligibility (see SECTION 9.12 REASONABLE COMPATIBILITY FOR HEALTH CARE). If the reasonable compatibility test is passed, further verification of income may not be requested or required. If the reasonable compatibility test is not passed, further verification of income is required.

See SECTION 16.4.3.4.4 BACKDATED MONTHS for information on counting self-employment income for backdated months.

25.8.2.3 Medical Bills During Backdated Eligibility Period

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

Example 1	Mary, who is pregnant with an August due date, applied for BadgerCare Plus 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 asks to have her eligibility backdated through February. She meets all nonfinancial and financial eligibility criteria in the months of February and March and is enrolled in BadgerCare Plus for both months.
Example 2	Crystal applied for and was determined eligible for BadgerCare Plus effective February 1. She contacts her IM agency in April to see if she is eligible for coverage back to December 1 of the previous year. Crystal had previously reported no income for the month of January. The worker finds no information contrary to what Crystal reported. She is determined eligible for backdated benefits for the month of January. However, Crystal reported that she received unemployment benefits in the previous year and had a seasonal job from November 1 through December 31. Her last paycheck was received on December 31. Crystal reports she earned $5,000 from the two-month seasonal job. Based on her monthly income ($2,500), she is not eligible for BadgerCare Plus in December. Crystal's annual income is reviewed for the previous year to see if she may be eligible based on annual income gap filling rules. A SWICA match shows that she earned a total of $5,000 during the fourth quarter of the previous year. The unemployment compensation query shows that Crystal received a total of $3,200 in unemployment benefits during the previous year. Her annual income for the previous year is $8,200 ($5,000 from wages earned and $3,200 from unemployment benefits). Her annual income for the previous year is below 100% of the FPL. Crystal is eligible for backdated benefits under gap filling rules for the month of December.

25.8.2.4 Family Planning Only Services

Eligibility for FPOS begins on the first of the month of application if all nonfinancial (see SECTION 40.4 NONFINANCIAL REQUIREMENTS) and financial (see SECTION 40.5 FINANCIAL REQUIREMENTS) eligibility requirements are met. FPOS may be backdated up to three months prior to the month of application.

25.8.2.5 Pregnant Members

Except for those members eligible only under the BadgerCare Plus Prenatal Program, backdate a pregnant member to whichever is more recent:

1. The first of the month in which the pregnancy began.
2. The first of the month, three months prior to the month of application.

The member can only be eligible for backdated eligibility as a pregnant person for the months in which they were pregnant. If the member is not pregnant at the time of application, but was pregnant during the backdate eligibility period, the member could be eligible as a pregnant member during the backdated months.

Before backdating BadgerCare Plus, verify that the member has met all the eligibility requirements during the backdated period.

See SECTION 41.5 BADGERCARE PLUS PRENATAL PROGRAM ELIGIBILITY BEGIN DATE for BadgerCare Plus Prenatal Program eligibility begin date policy.

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25.9 Denials and Terminations

25.9.1 Termination

During the calendar month after a member's enrollment has been terminated for a reason other than not completing a renewal, BadgerCare Plus 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 person must file a new application or make a new request (if another health care AG is open on the case) to reopen their BadgerCare Plus.

Example 1	Leroy is enrolled in BadgerCare Plus 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. BadgerCare Plus coverage for Leroy is maintained while eligibility is pending. Leroy does not submit the required verification by the due date of September 23, so his eligibility for BadgerCare Plus 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 BadgerCare Plus ended, Leroy does not need to submit a new application or new signature. Leroy is re-enrolled in BadgerCare Plus as of November 1.

Example 2	Linda is enrolled in BadgerCare Plus, and her husband, Leo, is enrolled in the Medicaid Purchase Plan (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. The gift 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 a failure to complete the renewal timely or to 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 26.1.2 LATE RENEWALS).

25.9.2 Denial

If the person applied for health care, and the IM agency denied the health care application 30 or fewer days ago, the person 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 submitted an application 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 more than 30 days ago or the only health care eligibility on the case is an unmet deductible, the person must sign and submit 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 a person 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 17.2.2 DEDUCTIBLE PERIOD (PREGNANT MEMBERS) and SECTION 17.3.1 DEDUCTIBLE PERIOD (CHILDREN UNDER 19)).*

26.1 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 26.1.1 TIMELY RENEWALS), existing health care coverage must be maintained until the renewal is completed.

The first required renewal for BadgerCare Plus is 12 months from the most recent certification month, except for the following:

- **CEN**s. The renewal date is 12 months from the date of birth.
- **Pregnant people**. The renewal month is two calendar months after the date the pregnancy ends. Pregnant people in the BadgerCare Plus Prenatal Program lose eligibility on the date the pregnancy ends. However, members who were in the BadgerCare Plus Prenatal Program due to immigration status are automatically eligible for emergency services for two months after eligibility for BadgerCare Plus Prenatal Program ends (see SECTION 41.6 ELIGIBILITY END DATE).
- **Deductibles**. A renewal is not scheduled for a case that did not meet its deductible, unless someone in the case was open for BadgerCare Plus. For members that met the deductible, the renewal month is six months from the start of the deductible period.

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.

Review Dates for Time-Limited Benefits

People whose benefits are time-limited (CENs, pregnant people, people who have met a deductible, or people in an extension) have a renewal at the end of their time-limited benefit unless they are on a case with other members open for BadgerCare Plus. In this situation:

- If the non-time-limited BadgerCare Plus assistance group has a renewal date after the end of the time-limited benefit certification period, the person enrolled in time-limited benefits will have their eligibility redetermined at the end of their certification period, but a full renewal is not required at that time.
- If the non-time-limited BadgerCare Plus assistance group has a renewal date prior to the end of the time-limited benefit certification period, the time-limited benefit will remain open even if there is no renewal completed for the non-time-limited BadgerCare Plus assistance group. If a renewal is completed for the BadgerCare Plus assistance group, the length of the time-limited benefit certification period does not change.

26.1.1 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 BadgerCare Plus. 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 BadgerCare Plus coverage is reinstated for the month of August, and she is sent a notice that she is enrolled in BadgerCare Plus effective August 1 and will remain enrolled while the agency processes her renewal. On August 19, the renewal process was completed, and Marta is no longer eligible for any category of health care. Marta receives a notice that her BadgerCare Plus coverage will end September 30, in accordance with notice requirements.
Example 2	Diana is open for BadgerCare Plus 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 BadgerCare Plus enrollment.

26.1.2 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 a late verification has been submitted.

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 because of 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 for more than three months because of lack of renewal may need to reapply unless there is another individual with open health care benefits on the same case.

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 BadgerCare Plus. Her new certification period starts March 1 with a backdate to February 1. Her next renewal will be due in February of the following year.
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 BadgerCare Plus, she will be enrolled in a new certification period starting on April 1 with a backdate to February 1. Her next renewal will be due in March 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.

26.1.3 Late Verification 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 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 1	Sunny's BadgerCare Plus 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, so Health care coverage is maintained for February. Sunny does not submit the requested verification by January 25, and her BadgerCare Plus 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 BadgerCare Plus and her new certification period begins on April 1 with a backdate to March 1. Her next renewal will be due in March of the following year.

26.1.4 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 BadgerCare Plus members who meet program rules, including children who would not otherwise qualify for backdated coverage because their income is too high (see SECTION 25.8.1 BACKDATED ELIGIBILITY).

If a member requests coverage for past months during a late renewal, they must provide all necessary information and verifications for those months (including verification of income for all months requested). They will not be charged premiums for the past months.

Example 1	Marge's BadgerCare Plus renewal is due in January. No renewal is received by January adverse action. A notice of BadgerCare Plus 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 certification period starts as of April 1 with a backdate to February 1. Her next renewal will be due in March of the following year.

26.1.5 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, 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.

Example 1	Tom is enrolled in Family Planning Only Services (FPOS). His FPOS 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 FPOS coverage is maintained for March. Verification is received on February 19. Tom's income has decreased to below 100% FPL. Tom had a prior health care request on file, so he is now determined eligible for BadgerCare Plus with a new certification period starting April 1. Although FPOS was maintained through March, Tom is also enrolled in BadgerCare Plus 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 2	John and his wife Julieta both applied for health care. Julieta was denied BadgerCare Plus due to being over income for her tax filing group size, but John opened for BadgerCare Plus. 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 BadgerCare Plus coverage is maintained for March. Verification is received on February 19. An income decrease makes both John and Julieta eligible for BadgerCare Plus with a new certification period starting April 1. However, because the income reduction was reported and verified in February, Julieta's eligibility for BadgerCare Plus is determined retroactively for February and March.

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26.2 Administrative Renewals

26.2.1 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 the administrative renewal process.

If information from electronic data exchanges validated information about a 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 and tax filing status have not changed.

26.2.2 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 can be verified through a data exchange (for example, income with a SWICA match or Equifax match through FDSH, Social Security income, and/or 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, alimony/spousal support, interest and dividend income, and other types of countable income for BadgerCare Plus.
- Are age 14 or older and have a missing or unverified SSN.
- Are enrolled in BadgerCare Plus as a Former Foster Care Youth and are turning 26 years old.
- Are enrolled in BadgerCare Plus and turning 19 years old or 65 years old.
- Are pregnant and the due date is on or before the renewal month.
- Are enrolled in BadgerCare Plus after having met a deductible.
- Are enrolled in a BadgerCare Plus extension.
- Have a calendar year tax dependent in their tax filing group.
- Are already in the process of completing a regular renewal.
- Mail was returned for the member's household with no forwarding address, and an up-to-date address has not been received.

26.2.3 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 7.6 Administrative (Admin) Renewals).

26.2.3.1 Successful Administrative Renewals

Members who have a successful administrative renewal will have health care or FPOS eligibility redetermined, will be recertified 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. 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.

26.2.3.2 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.

26.2.3.3 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.

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26.3 Redetermination for Changes

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

Example 1	Martin is enrolled in BadgerCare Plus. Martin is turning 65 in February. On January 16, Martin is asked to verify asset information so eligibility for Medicaid and Medicare Savings Programs can be determined. Martin's BadgerCare Plus benefits are maintained until the eligibility determination for Medicaid and Medicare Savings Programs is completed. On February 4, Martin's verifications are received, but more information is needed about Martin's trust. Another verification request is sent to Martin. On February 24, Martin is determined eligible for Medicaid and Qualified Medicare Beneficiary (QMB). Martin's BadgerCare Plus coverage ends March 31, his Medicaid begins April 1, and QMB begins March 1.
Example 2	Tanika is enrolled in BadgerCare Plus. On April 1, she starts receiving Social Security Disability Insurance (SSDI) and is no longer financially eligible for BadgerCare Plus due to the new income. Before BadgerCare Plus enrollment ends, eligibility must be determined for all relevant health care categories, including the Medicaid Purchase Plan (MAPP) when applicable. This will require the collection of asset

	information from Tanika. BadgerCare Plus benefits will be maintained until eligibility has been determined for all other health care programs. On April 2, Tanika is asked to verify her assets and work activity. On April 23, Tanika is determined eligible for MAPP. Tanika's BadgerCare Plus coverage ends May 31, and MAPP begins June 1.

26.3.1 Changes in Circumstance

Health care eligibility must be promptly redetermined between regular renewals whenever information is received about a change in a member's circumstance(s) that may affect their eligibility. Requests for information or verification must be limited to information related to the change. If enough information is available to determine eligibility following the change, new certification periods may begin. 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 1	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 2	Diego, Sofia, and their 4-year-old daughter Gabriella are enrolled in BadgerCare Plus 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 is closed 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, Sofia, and Gabriella remain eligible for BadgerCare Plus and start a new certification period from September 1 through August 31.
Example 3	Edith is enrolled in BadgerCare Plus 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 BadgerCare Plus. 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 4	Dimitri is enrolled in BadgerCare Plus as a childless adult 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 BadgerCare Plus certification period does not change.

26.3.1.1 Time-Limited Benefits

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

- Pregnant and postpartum people 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 1	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 2	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 person 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.

26.3.1.2 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 continuous coverage period. However, other eligible household members can get new 12-month certification periods. Households may also have different health care renewal dates. See SECTION 1.2.10 CERTIFICATION PERIOD CHANGES FOR CHILDREN IN CONTINUOUS COVERAGE PERIODS for examples.

26.3.1.3 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 for benefits outside of the CARES eligibility system, new 12-month certification periods will not be established for existing members on the case.

26.3.2 Member Transition to Disability

When a member enrolled in BadgerCare Plus or other health care category 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 1	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 the 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.

26.3.3 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 for a current health care program, their eligibility may need to be redetermined for the month(s) 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.

Example 1	Tim applied for health care and Family Planning Only Services (FPOS) on October 2. He was denied for BadgerCare Plus due to being over the income limit, and he opened for FPOS. On February 3, he reports a reduction in income. Verification is requested with a due date of February 23. His FPOS coverage is maintained for March. Verification is received on February 19. His income decrease makes him eligible for BadgerCare Plus with a new certification period starting April 1. However, because the income reduction was reported in February and verified timely, his eligibility for BadgerCare Plus must also be determined 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 2	Jim and his wife Bonnie both applied for health care October 2. Bonnie was denied Badger Care Plus due to being over income for her tax filing group size, but Jim opened for BadgerCare Plus. On February 3 Jim and Bonnie report a reduction in income. Verification is requested with a due date of February 23. Jim's BadgerCare Plus coverage is maintained for March. Verification is received on February 19. The income decrease makes both Jim and Bonnie eligible for BadgerCare Plus on April 1. However, because the income reduction was reported in February and verified timely, eligibility for Bonnie's BadgerCare Plus must also be tested retroactively for February and March.

26.3.4 Redeterminations when Foster Care Medicaid Ends

A Foster Care Medicaid closure notice will be sent approximately 45 days before the member's Foster Care Medicaid coverage ends. In most situations, the IM agency will be notified to redetermine eligibility for the youth or child before the date their Foster Care Medicaid certification ends.

When redetermining eligibility when Foster Care Medicaid is ending, maintain Foster Care Medicaid until one of the following occurs:

- The child or youth is determined eligible for another category of Medicaid or BadgerCare Plus.
- The child or youth is determined ineligible for all categories of Medicaid and BadgerCare Plus.
- Information required to be provided by the child, youth, or family to complete an eligibility determination is not provided.
- The child, youth, or family choose not to pursue other Medicaid benefits.
- The child or youth dies or leaves Wisconsin.

For details about verification, see SECTION 9.9.11 FOSTER CARE MEDICAID AND FFCY BADGERCARE PLUS.

26.3.4.1 Foster Care Medicaid Ends for Child under 19

For children with Foster Care Medicaid ending, it is the responsibility of the IM agency to make the health care eligibility determination before the child's Foster Care Medicaid ends, if the child is not already open for another health care program (e.g. SSI MA or Katie Beckett Medicaid). Because this is considered a redetermination of eligibility, most often there are no requirements for the family to reapply, re-request, or provide a signature.

In limited situations, a family may need to apply for health care when a child's Foster Care Medicaid is ending. If the application filing date is before the Foster Care Medicaid end date, Foster Care Medicaid eligibility is maintained until a determination is completed. If the application filing date is after the Foster Care Medicaid end date, Foster Care Medicaid is not maintained while the agency completes a determination.

Example 1	Tyra was in a Foster Care placement until January. Her Foster Care Medicaid continuous coverage remains in place until April 30. Her family applies for health care for her on April 15. If the agency has not completed the redetermination for other health care programs by April 30, her Foster Care Medicaid eligibility is maintained.
Example 2	Tyson was in a Foster Care placement until February. His Foster Care Medicaid continuous coverage remains in place until April 30. His family applies for health care for him on May 3. Because the application was received after Foster Care Medicaid had already ended, his Foster Care Medicaid is not maintained while the agency determines eligibility for other health care programs.

26.3.4.2 Foster Care Medicaid Ends for Youth Transitioning to FFCY

For most young adults who were in Wisconsin's child welfare system and receiving Foster Care Medicaid, it is the responsibility of the IM agency to make the BadgerCare Plus eligibility

redetermination before the young adult's Foster Care Medicaid ends. If an eligibility determination is not completed by the Foster Care Medicaid end-date, eligibility is maintained until the determination is completed. Neither an application nor signature is required from the member because this is a redetermination of eligibility.

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26.4 Renewal Requirements

26.4.1 Choice of Renewal

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

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

26.4.2 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 25.5 VALID SIGNATURE).

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

26.4.3 Renewal Notices

A BadgerCare Plus 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 Section 7.3 Renewal Notices for renewal notices for manually certified health care programs.

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27.1 Change Reporting Introduction

BadgerCare Plus members are required to report to the agency about changes in circumstance that may impact their eligibility.

Any change that is reported or becomes known to the agency (for example, through data exchange or another source) must be acted upon.

For change reporting policies for Family Planning Only Services, see SECTION 40.8 REPORTING CHANGES.

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27.2 Nonfinancial Change Reporting

BadgerCare Plus members must report the following non-financial changes within 10 days after occurrence:

- Address
- Household composition, including pregnancy and changes to the pregnancy of a BadgerCare Plus member
- Living arrangement (for example, institutionalization, incarceration)
- Change in marital status
- Change in insurance coverage
- Change in expected tax filing status
- Change in tax dependents
- No longer receiving a tax-related deduction

Note *If a member reports their release from prison or jail untimely, suspended BadgerCare Plus must be lifted effective for the first of the month when the person was released from prison or jail (see SECTION 45.4 SUSPENSION END DATE).*

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27.3 Financial Change Reporting

BadgerCare Plus members must report income changes when the total monthly income of the assistance group with the highest monthly income amount exceeds the following FPL percentages for their assistance group size:

- 50% FPL
- 100% FPL
- 133% FPL
- 156% FPL
- 191% FPL
- 200% FPL
- 250% FPL
- 306% FPL
- 350% FPL

- 400% FPL

The income change must be reported by the 10th of the month following the month in which the total income exceeded its previous threshold.

The CARES notice will indicate the dollar amount associated with each FPL level, for the BadgerCare Plus group size.

Example 1	Sally's countable family income has been at 80% of the FPL since she applied in January. In June her income increased to 107%, so she must report the change by July 10.

Example 2	Heidi's countable family income is 128% of the FPL. In September it increased to 164% of the FPL. Heidi must report this change by October 10.

Example 3	Steve's countable family income is 265% of the FPL. In December it increased to 411% of the FPL. Steve must report this change by January 10.

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27.4 Change Reporting Methods

Members can report changes using one of the following methods:

- ACCESS
- Mail or fax the Information Change Report (F-10183)
- Call their agency
- Go to their agency

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27.5 Reserved

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27.6 Reserved

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28.1 Overpayments Introduction

An overpayment occurs when BadgerCare Plus benefits are paid for someone who was not eligible for them or when a member should have paid a higher amount of premiums. Effective April 1, 2023, DHS and IM agencies will no longer establish new BadgerCare Plus overpayment claims for members.

Income maintenance (IM) agencies may refer suspected fraudulent activity to the DHS Office of the 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 CHAPTER 33 ESTATE RECOVERY).*

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28.2 Reserved

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28.3 Reserved

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28.4 Reserved

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28.5 Reserved

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28.6 Reserved

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28.7 Reserved

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28.8 Reserved

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28.9 Reserved

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29.1 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.

29.1.1 Notice Requirements

Applicants and members must receive 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

29.1.2 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 that 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

29.1.3 Notice of Denial

Any notice of denial of BC+ 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

29.1.4 Notice of Adverse Action

An adverse action is a change that will stop or reduce benefits or increase cost sharing. Members have the right to adequate and timely notice of an adverse action.

29.1.4.1 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 and the name of the agency to contact for more information

29.1.4.2 Timely Notice of Adverse Action

Timely 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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29.2 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 BadgerCare Plus and Family Planning Only Services (FPOS).

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.

29.2.1 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 29.2.8 WITHDRAWAL OF FAIR HEARING REQUEST).*

29.2.2 Fair Hearing Request

For BadgerCare Plus and FPOS, the applicant, member, or representative may request a fair hearing in writing by filling out the Request for Fair Hearing form (**Error! Hyperlink reference not valid.**) or writing a letter with the request and sending it to 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 BadgerCare Plus and FPOS 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 federal or state 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.

29.2.3 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, 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:

1. DHA will dismiss the request if the applicant, member, or any representative fails to appear without good cause.
2. The name, address, and phone number of whom to notify if the applicant, member, or representative cannot attend.
3. 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.

29.2.4 Continued Benefits

DHA may order a member’s BadgerCare Plus or FPOS 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.

29.2.5 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.

29.2.6 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 and/or adequate notice requirement applies for the issue that was appealed. BadgerCare Plus or FPOS 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.

29.2.7 Hearing Decision

29.2.7.1 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.

29.2.7.2 Proposed Decisions

The ALJ will sometimes issue a proposed decision, such as if there are questions about BadgerCare Plus 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.

29.2.7.3 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.

29.2.8 Withdrawal of Fair Hearing Request

Only the applicant, member, or their representative may withdraw a fair hearing request for BadgerCare Plus or FPOS. 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.

29.2.9 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 cost 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.

29.2.10 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.*

29.2.11 Judicial Appeals

An applicant or member who 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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30.1 Affirmative Action and Civil Rights

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

Assistance must be provided to all BadgerCare Plus applicants and members to ensure 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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31.1 Interagency Coordination

A case transfer does not impact the certification period(s) of 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 BadgerCare Plus verification policy (see CHAPTER 9 VERIFICATION).

See Process Help Section 20.1 Interagency Case / RFA Transfer Process.

31.1.1 Intercounty Placements

Some Wisconsin residents, due to serious and persistent medical impairments, may need protective services or protective placement by a county agency. These placement options ensure that anyone with such an impairment is placed in a living arrangement that has the least amount of restriction on their rights and that they are protected from abuse, financial exploitation, neglect, and self-neglect.

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

For interstate placements, see Medicaid Eligibility Handbook 6.8 Interstate Placements.

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32.1 Introduction

Presumptive eligibility is a streamlined eligibility determination for temporary enrollment in BadgerCare Plus or Family Planning Only Services. It is based on preliminary household and financial information provided by the applicant. It allows eligible applicants immediate health care coverage for a short period until an application for ongoing coverage is completed and processed.

Note *See the Medicaid Eligibility Handbook, Section 36.2.2.1 Temporary Enrollment/Presumptive Eligibility Available Only To Women Enrolling Through WWWP for information on temporary enrollment under the Wisconsin Well Women Medicaid program for women under age 65 with breast or cervical cancer.*

32.1.1 Definitions

- **Express Enrollment:** The process of making a presumptive eligibility determination to temporarily enroll an individual in BadgerCare Plus or Family Planning Only Services. Qualified entities (see SECTION 32.1.2 QUALIFIED ENTITIES) make these determinations using ACCESS for Partners and Providers (see ACCESS Handbook, Chapter 12 ACCESS for Partners and Providers).
- **Presumptive eligibility:** The determination of whether or not an applicant is eligible to temporarily enroll in BadgerCare Plus or Family Planning Only Services.
- **Temporary enrollment:** Short-term eligibility for BadgerCare Plus or Family Planning Only Services.

32.1.2 Qualified Entities

Qualified entities that can make presumptive eligibility determinations include hospitals, providers, and partners that are approved by ForwardHealth and have received Express Enrollment training. The table below explains which qualified entities can make presumptive eligibility determinations for a population and program:

Qualified Entities:	**Can make presumptive eligibility determinations for:**			
	Children	**Pregnant Women**	**Family Planning Only Services**	**Adults, Parents, and Caretakers**
Qualified Hospitals	X	X	X	X
Providers	X	X	X	

Partners	X			

Examples of qualified partners include:

- Head Start programs.
- Authorized child care providers.
- Women Infant and Children (WIC) agencies.
- Faith-based organizations such as the YMCA.
- Certain community-based organizations, such as the Boys and Girls Club.
- Authorized agencies offering emergency food and shelter.
- Elementary and secondary schools.
- Any other entity the state so deems as approved by the Secretary.

32.1.2.1 Process for a Qualified Entity to Temporary Enroll a Person

A qualified entity follows the process below for a person to get temporary enrollment in BadgerCare Plus or Family Planning Only Services:

1. Complete a presumptive eligibility application through one of the following methods:
    a. Online using ACCESS for Partners and Providers. This is also known as an Express Enrollment application.
    b. Fill out and submit a paper application.
        i. BadgerCare Plus Express Enrollment for Pregnant Women application (F-10081).
        ii. Temporary Enrollment for Family Planning Only Services application (F-10119).
2. If the applicant is found eligible:
    a. Provide a temporary ForwardHealth ID card.
    b. Advise the applicant that a permanent ForwardHealth ID card will be mailed within 3-5 business days, if the member has not already been issued a ForwardHealth card. If the member has been issued a ForwardHealth card in the past, a new one will not be mailed. The member can use their previously issued ForwardHealth card or contact Member Services at 1-800-362-3002 to request a new one.
3. Provide a denial notice if the applicant is found not eligible.
4. Stress the importance of applying through the local agency for ongoing health care coverage. The qualified entity is encouraged to assist the applicant with applying. Advise that the application can be submitted online via ACCESS, by telephone, by mail, or in person.

32.1.3 Coverage Period

32.1.3.1 Begin Date

Temporary enrollment in BadgerCare Plus or Family Planning Only Services begins on the date a person is found presumptively eligible by a qualified entity.

32.1.3.2 End Date

Temporary enrollment in BadgerCare Plus or Family Planning Only Services ends the month following the month in which the person was determined presumptively eligible or the date ongoing health care

or Family Planning Only Services eligibility is determined (see SECTION 32.1.3.3 EARLY TERMINATION and SECTION 32.1.3.4 AUTOMATIC EXTENSION).

32.1.3.3 Early Termination

If a person applies for ongoing health care or Family Planning Only Services coverage and the IM agency makes an eligibility determination prior to the end date of the temporary enrollment period, the temporary enrollment period must end on the date the agency completes processing the application for ongoing coverage, regardless of the result of the eligibility determination. The early termination of temporary enrollment will be applied systematically. Tables 1 and 2 further explain when eligibility for ongoing health care or Family Planning Only Services coverage will end temporary enrollment.

Table 1: Systematic Early Termination of Temporary Enrollment - Applicant Applied for One Program		
Applicant is confirmed in CARES as:	**Applicant is currently receiving temporary enrollment benefits for Badger Care Plus:**	**Applicant is currently receiving temporary enrollment benefits for Family Planning Only Services:**
Eligible for BadgerCare Plus or other ongoing Medicaid coverage	End temporary enrollment	End temporary enrollment
Eligible for Family Planning Only Services	No change to temporary enrollment	End temporary enrollment
Not eligible for BadgerCare Plus or other ongoing Medicaid coverage	End temporary enrollment	No change to temporary enrollment
Not eligible for Family Planning Only Services	No change to temporary enrollment	End temporary enrollment

Table 2: Systematic Early Termination of Temporary Enrollment - Applicant Applied for Multiple Programs		
Applicant is confirmed in CARES as:	**Applicant is currently receiving temporary enrollment benefits for Badger Care Plus:**	**Applicant is currently receiving temporary enrollment benefits for Family Planning Only Services:**
Eligible for BadgerCare Plus or other ongoing Medicaid	End temporary enrollment	End temporary enrollment

coverage but not for Family Planning Only Services		
Eligible for Family Planning Only Services but not for BadgerCare Plus or other ongoing Medicaid coverage	End temporary enrollment	End temporary enrollment
Not eligible for Family Planning Only Services, BadgerCare Plus, or other ongoing Medicaid coverage	End temporary enrollment	End temporary enrollment

Example 1	Joe Green applied for presumptive eligibility for BadgerCare Plus for his son Jim on February 4 at the Center Street Boys Club. Jim was found presumptively eligible for BadgerCare Plus from February 4 through March 31. Joe submits a BadgerCare Plus ACCESS application to the local IM agency on February 10. The agency determines Jim's eligibility for ongoing BadgerCare Plus coverage on March 1. Jim is found ineligible for BadgerCare Plus for February and March and the application is denied. A notice is sent to Joe informing him Jim is not eligible for BadgerCare Plus and his BadgerCare Plus temporary enrollment is terminated effective March 1.

Example 2	Sandra was determined presumptively eligible for BadgerCare Plus for pregnant women on January 10. Her temporary enrollment period lasts from January 10 through February 28. She applied for ongoing BadgerCare Plus through her local income maintenance agency on January 15 and was found eligible on January 28 with an effective date of January 1. Her temporary enrollment will end on January 28.

32.1.3.4 Automatic Extension

If the income maintenance agency is unable to finish processing the application for ongoing coverage by the end of the temporary enrollment period, the system will automatically extend the temporary enrollment period for two additional calendar months. Tables 3 and 4 further explain when temporary enrollment will be extended.

Table 3: Systematic Extension of Temporary Enrollment - Applicant Applied for One Program		
Applicant has applied for one program and eligibility has not been confirmed:	**Applicant is currently receiving temporary enrollment benefits for Badger Care Plus:**	**Applicant is currently receiving temporary enrollment benefits for Family Planning Only Services:**
BadgerCare Plus or other ongoing Medicaid coverage	Extend temporary enrollment for BadgerCare Plus	Do not extend temporary enrollment for Family Planning Only Services

Family Planning Only Services	Do not extend temporary enrollment for BadgerCare Plus	Extend temporary enrollment for Family Planning Only Services

Table 4: Systematic Extension of Temporary Enrollment - Applicant Applied for Multiple Programs		
Applicant has applied for multiple programs, but eligibility has not been confirmed for all programs:	**Applicant is currently receiving temporary enrollment benefits for Badger Care Plus:**	**Applicant is currently receiving temporary enrollment benefits for Family Planning Only Services:**
Eligibility has been confirmed for BadgerCare Plus or other ongoing full-benefit Medicaid coverage but not for Family Planning Only Services	Do not extend temporary enrollment for BadgerCare Plus	Do not extend temporary enrollment for Family Planning Only Services if the applicant is eligible for BadgerCare Plus or other ongoing full-benefit Medicaid coverage Extend temporary enrollment for Family Planning Only Services if the applicant is not eligible for BadgerCare Plus or other ongoing full-benefit Medicaid coverage
Eligibility has been confirmed for Family Planning Only Services but not for BadgerCare Plus or other ongoing full-benefit Medicaid coverage	Extend temporary enrollment for BadgerCare Plus	Do not extend temporary enrollment for Family Planning Only Services

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32.2 Eligibility

32.2.1 Current Enrollment in Ongoing Health Care Benefits

An applicant is not eligible for temporary enrollment if they are already receiving ongoing health care benefits. Table 1 describes the situations where this applies.

Table 1: Current Enrollment in Ongoing Health Care or Family Planning Only Services Coverage

Applicant is currently enrolled in:	Applicant is applying for temporary enrollment in BadgerCare Plus:	Applicant is applying for temporary enrollment in Family Planning Only Services:
BadgerCare Plus or other ongoing Medicaid coverage	Deny temporary enrollment	Deny temporary enrollment
Family Planning Only Services	Allow temporary enrollment*	Deny temporary enrollment

*If all other temporary enrollment criteria are met

32.2.2 Temporary Enrollment Within the Last 12 Months

An applicant may only be temporarily enrolled once in a rolling 12-month period, or once per pregnancy. The 12-month period starts the first day of the presumptive eligibility (PE) period.

Example 1	David is determined presumptively eligible for Family Planning Only Services (FPOS) on January 14. He cannot enroll again in presumptive eligibility for FPOS for 12 months after January 14.

Table 2 describes the situations where this applies.

Table 2: Temporary Enrollment Within the Last 12 Months			
Applicant was temporarily enrolled in:	Applicant is applying for temporary enrollment in BadgerCare Plus (non-pregnant members):	Applicant is applying for temporary enrollment in BadgerCare Plus (pregnant members):	Applicant is applying for temporary enrollment in Family Planning Only Services:
BadgerCare Plus (non-pregnant members)	Deny temporary enrollment	Allow temporary enrollment*	Allow temporary enrollment*
BadgerCare Plus (pregnant members)	Deny temporary enrollment	Allow temporary enrollment* as long as the previous temporary enrollment was not for the same pregnancy	Allow temporary enrollment*
Family Planning Only Services	Allow temporary enrollment*	Allow temporary enrollment*	Deny temporary enrollment
No programs	Allow temporary enrollment*	Allow temporary enrollment*	Allow temporary enrollment*

*If all other temporary enrollment criteria are met

32.2.3 Temporary Enrollment in BadgerCare Plus

32.2.3.1 Children

A child may get temporary enrollment for BadgerCare Plus if they meet all of the following financial and non-financial criteria:

- Be age 18 or younger. Children younger than age 18 must apply with a parent or guardian unless the child is living independently.
- Be a U.S. citizen or lawfully present in the U.S. (there is no requirement for the amount of time the person is lawfully present in the US).
- Be a Wisconsin Resident
- Has household income that is at or below the FPL for the child's age:
    - Younger than age one: 306% of the FPL.
    - Age one through five: 191% of the FPL.
    - Age six through 18: 156% of the FPL.

Note *See SECTION 16.1.2 INCOME UNDER MODIFIED ADJUSTED GROSS INCOME RULES for additional information on MAGI income disregards.*

32.2.3.2 Pregnant Members

An individual may get temporary enrollment for BadgerCare Plus as a pregnant member if they meet all of the following financial and nonfinancial criteria:

- Be pregnant. (Verification of pregnancy is not required.)
- Be a U.S. citizen or lawfully present in the U.S. (There is no requirement for the amount of time the person is lawfully present in the U.S.).
- Be a Wisconsin resident
- Has household income that is at or below 306% of the FPL.
- Has not been temporarily enrolled for BadgerCare Plus for Pregnant Women at any time during the current pregnancy.

Note *Temporary enrollment in BadgerCare Plus for pregnant members only covers ambulatory pregnancy-related care. An application for ongoing health care benefits is required for inpatient services, including the delivery.*

32.2.3.3 Adults

An adult (parent, caretaker, and childless adult) may get temporary enrollment for BadgerCare Plus if they meet the following financial and non-financial criteria:

- Has assistance group income at or below 100% of the FPL.
- Is not currently receiving Medicare Part A or B (applies to childless adults only). This includes adults who are receiving Medicare Parts A or B due to a diagnosis of End Stage Renal Disease (ESRD).
- Meets one of the following:
    - Is a U.S. citizen
    - Has been lawfully residing in the U.S. for at least five years
    - Is lawfully residing in the U.S. and is a refugee or is seeking asylum
    - Is from Cuba or Haiti and is lawfully residing in the U.S.
    - Is lawfully residing in the U.S. under one of the eligible immigration statuses listed in SECTION 4.3.8 IMMIGRATION STATUS CHART.

- Be a Wisconsin resident

32.2.3.4 Former Foster Care Youth

A Former Foster Care Youth may get temporary enrollment for BadgerCare Plus if they meet all of the following nonfinancial criteria:

- Be age 18 through 25.
- Had been receiving Foster Care, subsidized guardianship, or court-ordered Kinship Care on the date that they turned 18. It does not matter what state they were residing in when they turned 18 years old.
- Meet citizenship or immigration criteria for the population above that applies to them.
- Be a Wisconsin resident

There is no income limit for Former Foster Care Youth.

32.2.3.5 Inmates

Qualified hospitals can make presumptive eligibility determinations for patients who are inmates of public correctional institutions (for example, county jails) as long as those patients are expected to remain in the hospital for 24 hours or more. The presumptive eligibility determination process for these patients is the same as for the populations listed above. Inmates of a state correctional facility are not eligible for temporary enrollment in BadgerCare Plus or Family Planning Only Services.

32.2.4 Temporary Enrollment in Family Planning Only Services

Refer to SECTION 40.2 PRESUMPTIVE ELIGIBILITY for information.

32.2.5 Household Size

For presumptive eligibility for BadgerCare Plus, the household size must include all members of the household, even if they are not requesting presumptive eligibility and are not listed on the application. Household members include:

- Children under age 19. If the child is married, their spouse should also be included.
- The biological, adoptive, or stepparents living with the children under age 19.
- Spouses.
- Caretaker relatives.
- For a pregnant individual, the number of babies expected.

For presumptive eligibility for Family Planning Only Services, the household size can only be "1" regardless of whether the individual is under age 18, married and/or has children, so this field will be automatically filled with "1."

32.2.6 Income

32.2.6.1 Monthly Earned Income

For presumptive eligibility for BadgerCare Plus, earned income from all household members listed in ACCESS Handbook, Section 12.4.5.1 Household Size should be reported even if they are not requesting presumptive eligibility and are not listed on the application.

For presumptive eligibility for Family Planning Only Services, only the earned income of the individual on the application should be reported.

Earned income is income resulting from performing a job or providing a service. Earned income includes commissions, tips, salaries, wages, and self-employment. To calculate the amount of the monthly earned income, the user must first determine how the employee is paid:

- Paid Hourly: If the employee is paid hourly, the user must multiply the number of hours worked per week by the amount of pay per hour and then multiply that amount by 4 to get the monthly income. The user should count monthly income before taxes are taken out but after any pre-tax deductions are taken out of the paycheck. Any overtime or weekend pay should also be counted.
- Paid a Salary: If the employee is paid a salary, the user must enter the monthly amount of the salary. If the salary is based on a yearly amount, the user should divide the yearly amount by 12 to determine the monthly amount. The user should count monthly income before taxes are taken out but after any pre-tax deductions are taken out of the paycheck.
- Tips and Commission: If the employee is paid in tips or commission, the user should count the average amount of tips or commission received monthly.

Note	*Former Foster Care Youth are not subject to the income eligibility criteria. If an individual is a Former Foster Care Youth and is the only person in the household, the user should enter income amounts of $0. If an individual is a Former Foster Care Youth and is on the same presumptive eligibility for BadgerCare Plus application as other household members, the user must include the Former Foster Care Youth's income since it must be considered when determining the eligibility of the other household members. The Former Foster Care Youth's income will not be considered when determining the Former Foster Care Youth's eligibility.*

Self-employment Income: Self-employment income (income earned directly from one's own business, rather than earned as an employee with a specified salary or wages from an employer) should be counted as monthly earned income. However, self-employment expenses (the monthly average of expenses) should be deducted from self-employment income to determine the net self-employment amount.

Student income: Income earned from work-study jobs should be counted as monthly earned income.

The following should not be counted as monthly earned income:

- Tax refunds, including Earned Income Tax Credits payments.
- Allowances.

32.2.6.2 Other Monthly Income

For presumptive eligibility for BadgerCare Plus, other monthly income from all household members listed in ACCESS Handbook, Section 12.4.5.1 Household Size, should be reported even if they are not requesting presumptive eligibility and are not listed on the application.

For presumptive eligibility for Family Planning Only Services, only the other monthly income of the individual on the application should be reported.

Other monthly income includes taxable income from a source other than a job or self-employment. For example:

- Social Security (gross amounts should be used).
- Unemployment.
- Pensions (only the taxable amount should be counted).
- Annuity payments (only the taxable amount should be counted).

- Insurance benefits.
- Payments received for the rental of rooms, apartments, dwelling units, buildings, or land (if not reported as self-employment income). Taxes and the expense of property maintenance may be deducted.
- Income from Tribal Per Capita payments from gaming revenue.

The following should not be counted as other monthly income:

- Supplemental Security Income (SSI).
- Student loans.
- Student financial aid including grants, scholarships, and fellowships.
- Child support income.
- Workers' compensation.
- Veteran's benefits.
- Reimbursement for expenses that the applicant has incurred or paid, except for reimbursement for normal household living expenses such as rent, clothing or food eaten at home.
- Foster care or subsidized adoption payments.
- Life insurance policy dividends.
- Payments made by a third party directly to landlords or other vendors.
- Governmental (federal, state, or local) rent and housing subsidies, including payments made directly to the applicant for housing or utility costs (for example, U.S. Department of Housing and Urban Development (HUD) utility allowances).
- Nutrition-related benefits, such as FoodShare Wisconsin.

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32.3 Qualified Hospitals

For the purposes of presumptive eligibility, a hospital is defined as an inpatient hospital facility or an outpatient hospital facility located within the four walls of an inpatient hospital facility, consistent with the definition of hospital for the purpose of billing Medicaid. These facilities are enrolled in Wisconsin Medicaid as Provider Type 01 or Provider Type 58.

Qualified hospitals are certified by ForwardHealth to make presumptive eligibility determinations. Qualified hospitals can make presumptive eligibility determinations for the following populations:

- Children
- Pregnant women
- People applying for Family Planning Only Services (see SECTION 40.2 PRESUMPTIVE ELIGIBILITY)
- Parents and caretakers
- Childless adults
- Women under age 65 with breast or cervical cancer (see the Medicaid Eligibility Handbook, Section 36.2.2.1 Temporary Enrollment/Presumptive Eligibility Available Only To Women Enrolling Through WWWP)
- Inmates of public correctional institutions (see SECTION 32.2.3.5 INMATES)

Hospitals are required to notify ForwardHealth of their interest in becoming a qualified hospital for presumptive eligibility via the ForwardHealth Portal.

Only qualified hospital staff can make presumptive eligibility determinations at qualified hospital locations. Third-party contractors are not allowed to make presumptive eligibility determinations for a qualified hospital, though they can assist an applicant with completing the application for ongoing coverage.

For patients eligible for temporary enrollment in BadgerCare Plus or Family Planning Only Services (FPOS), qualified hospitals are subject to standards on assisting the patient with submitting an application for ongoing BadgerCare Plus or FPOS coverage.

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32.4 Express Enrollment Process in ACCESS

Refer to ACCESS User Guide, Chapter 15 Express Enrollment for information on making presumptive eligibility determinations for BadgerCare Plus or Family Planning Only Services using the Express Enrollment process in ACCESS.

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32.5 Reserved

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32.6 Reserved

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33.1 Estate Recovery Program Definition

The state seeks repayment of certain correctly paid health and long-term care benefits received by BadgerCare Plus members through all the following:

- Liens against property after the death of a member
- Claims against estates
- Affidavits
- Voluntary recoveries

A lien is never filed against the home of a BadgerCare Plus member during their lifetime, even if the member is living in a nursing home or institutionalized in an inpatient hospital.

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33.2 Recoverable Services

Not all services provided by BadgerCare Plus are recoverable. Recoverability depends on what was provided and the member's age when they received the benefit.

The following are the services for which ERP may seek recovery:

1. All BadgerCare Plus services received on or after age 55 while living in a nursing home
2. All BadgerCare Plus services received on or after age 55 while institutionalized in an inpatient hospital.
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 55 or older on or after April 1, 2000.
4. All home and community-based waiver services Community Options Program (COP) Waiver, 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, and:
    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 non-covered hospital services.
5. Family Care services received by members age 55 or older between February 1, 2000, and July 31, 2014, and:
    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.
6. All Family Care Partnership services received by members age 55 and older while residing in a nursing home or while institutionalized in an inpatient hospital on or after March 1, 2009. All Family Care Partnership home and community-based waiver 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 Include, Respect, I, Self-Direct (IRIS) services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older before July 31, 2014.
8. All BadgerCare Plus services received by members age 55 or older participating in a long-term care program on or after August 1, 2014. Long-term care programs include all home and community-based waiver 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 the Program of All-Inclusive Care for the Elderly (PACE)]. The capitation payment made to the Managed Care Organization on or after August 1, 2014, will be recovered for members receiving long-term care program services through managed care.

If a member's services do not meet the criteria listed above, they are not subject to estate recovery.

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33.3 Estate Claims

DHS recovers BadgerCare Plus 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% 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 BadgerCare Plus 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 BadgerCare Plus benefits, for those 55 years of age or older.

Refer any questions about specific estate claims to the ERP staff.

33.3.1 Waiver of Estate Claim

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 their means of livelihood.
3. The waiver applicant is receiving general relief or veteran's benefits based on need under §45.40(1m) Wis. Stats.

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.

33.3.2 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.

33.3.3 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 Division of Hearings and Appeals (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.

33.3.4 Personal Representative's Notice

The personal representative of the estate of a BadgerCare Plus member or the estate of a member's surviving spouse must notify DHS that the estate is being probated [§859.07(2), Wis. Stats.]. The

notification must be by certified mail and include the date by which claims against the estate must be filed.

33.3.5 Real Property as Part of the Estate

When real property is part of the estate, ERP may file a lien equal to the BadgerCare Plus 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 1	Mr. A dies. A claim on his estate is filed and the estate includes real property. His spouse is deceased, and he has no blind or disabled child. He has a child, age 19. This child lives outside Mr. A's home. A lien is placed on the real property but cannot be enforced because the minor child is still alive. The child later turns 21. As there is then no living spouse, child under 21, or disabled or blind child, the lien can be enforced.

DHS will take a lien in full or partial settlement of an estate claim against the portion of an estate that is a home if:

1. A child, of any age of the deceased member:
    a. Resides in the member's home, and
    b. That child resided in that home for at least 24 months before the member entered the nursing home, hospital, or received home and community-based waiver services, and
    c. That child provided care that delayed the member's move to the nursing home, hospital, or their receipt of home and community-based waiver 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 caretaker 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 caretaker 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.

33.3.6 Affidavits in Small Sum Estates and Non-Probate Property

Heirs, guardians, and trustees of revocable trusts created by a deceased BadgerCare Plus member must notify ERP before transferring any of the deceased's property through a Transfer by Affidavit ($50,000 and under) (§867.03, Wis. Stats.). 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 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 their 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 BadgerCare Plus member, whether non-probate or transferred by affidavit, is subject to a lien if the state's claim cannot be satisfied through other assets.

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.

33.3.7 Patient Fund Account

Nursing homes are required to notify ERP when a BadgerCare Plus member dies with money left in their nursing home patient fund account if they have 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 BadgerCare Plus.

33.3.8 Native Americans

Native Americans: Income, Resources and Property Exempt from BadgerCare Plus Estate Recovery

The following income, resources, and property are exempt from BadgerCare Plus 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 BadgerCare Plus 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 through #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 BadgerCare Plus 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 through #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 through #5.

33.3.9 Reparation Payments to Individuals

Government reparation payments to special populations are exempt from BadgerCare Plus estate recovery.

33.3.10 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.

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 5% 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.

33.4 Match System

ERP maintains the Estate Recovery Database. Information you submit on the Estate Recovery Disclosure Form is on the database.

The database is compared to the death record files of the Division of Medicaid Services, Vital Records and State Registrar Section.

When a match shows a BadgerCare Plus member or their 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.

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33.5 Notify Members

A copy of the Wisconsin Estate Recovery Program Handbook (P-13032) must be provided to every BadgerCare Plus member 54 1/2 years old or older at application and review. CARES is programmed to send this automatically.

Have each member or their representative read the notice of liability on the application form ("Recovery of BadgerCare Plus"). They acknowledge understanding of this notice when signing the application.

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33.6 Disclosure Form

The Estate Recovery Program (ERP) must be provided with asset information whenever a BadgerCare Plus member:

1. Enters or resides in a nursing home, or
2. Enters or resides in an inpatient hospital and is required to pay a Medicaid cost of care liability, or
3. Becomes 55 years old.

This information must be provided even if they have zero assets. CARES is programmed to send this information to ERP automatically.

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33.7 Estate Recovery Program (ERP) 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.

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33.8 Incentive Payments

DHS will return to local agencies 5% 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 BadgerCare Plus.

The payments are discretionary. DHS will make them based on compliance with program requirements.

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33.9 Other Programs

ERP also recovers for Medicaid, the Community Options Program (COP), Wisconsin Chronic Disease Program (WCDP), Medicaid and non-Medicaid Family Care.

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34.1 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: Person (F-10126A)
    - Appoint, Change, or Remove an Authorized Representative: Organization (F-10126B)

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 guardian of the person grants them 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**, and the applicant's guardian does not have the authority to enroll the person in BadgerCare Plus, 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.

For other valid signature requirements, refer to SECTION 25.5 VALID SIGNATURE.

There can only be 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 to their IM agency. To remove an authorized representative, the member needs to let the agency know of the removal in writing, for example completing Section 1 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 BadgerCare Plus 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.

34.1.1 Additional Responsibilities

The applicant or member can choose to appoint the person who is acting as their 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 must 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 on Section 1 Part C of the Appoint, Change or Remove Authorized Representative: Person form (F-10126). 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.

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34.2 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 BadgerCare Plus purposes. A guardian of the person is the applicant's or member's guardian for BadgerCare Plus purposes if the court document appointing the legal guardian of the person grants them the authority to enroll the person in BadgerCare Plus, 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 BadgerCare Plus case.

If the court document appointing the guardian of the person does not grant the authority to enroll the applicant or member in BadgerCare Plus, 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.

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 guardian or conservator.

See SECTION 9.9.5 POWER OF ATTORNEY, GUARDIANSHIP, OR CONSERVATOR for information on verification requirements. See SECTION 25.5 VALID SIGNATURE for information on valid application signatures by guardians or conservators.

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34.3 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 BadgerCare Plus 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 BadgerCare Plus 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 9.9.5 POWER OF ATTORNEY, GUARDIANSHIP, OR CONSERVATOR for information on verification requirements. See SECTION 25.5 VALID SIGNATURE for information on valid application signatures by an agent with power of attorney.

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34.4 Patient's Representatives

Certain family members and "next of kin" may consent to an incapacitated individual's admission to a nursing home or community-based residential facility directly from a hospital without requiring a petition for guardianship or protective placement, if all of the following apply:

- The incapacitated individual does not have a valid power of attorney (POA) for health care.
- The incapacitated individual has not been adjudicated incompetent in this state, i.e., a court has not appointed a guardian.
- No person who is listed in the same order of priority, or higher priority, disagrees with the proposed admission.
- No person in any level of priority who lives with the incapacitated individual disagrees with the proposed admission, unless the person consenting also resides with, or is the spouse or domestic partner of, the incapacitated individual.
- The incapacitated individual is not diagnosed as developmentally disabled or as having a mental illness at the time of the proposed admission.
- The incapacitated individual does not verbally object to or otherwise actively protest the admission. (If the individual makes an objection or protest, they may be admitted to the facility, but the facility must notify Adult Protective Services for the appropriate county.)

A patient's representative could be, in order of priority, one of the following individuals:

1. A spouse or domestic partner
2. Adult child
3. Parent
4. Adult sibling
5. Grandparent
6. Adult grandchild
7. Adult close friend

A physician and one advanced practice clinician must complete a Medical Certification of Capacity for Determining a Patient's Representative Authority to Act (F-03435). The patient's representative must

sign a Patient's Representative Declaration (F-03436). The incapacitated individual must be admitted to the facility directly from a hospital inpatient unit. A patient's representative can make health care decisions to the same extent as a guardian of a person and enroll in Medicaid and authorize expenditures related to health care to the same extent as a guardian of the estate. The authority of a patient's representative ends if any of the following occurs:

- A court appoints a guardian to make decisions for the incapacitated individual
- The incapacitated individual is discharged to a setting that in not a facility
- A health care power of attorney that was not identified earlier is identified
- The individual is determined to be no longer incapacitated

See SECTION 9.9.5 POWER OF ATTORNEY, GUARDIANSHIP, CONSERVATOR,OR PATIENT'S REPRESENTATIVE for information on verification requirements. See SECTION 25.5.1.1 SIGNATURES FROM REPRESENTATIVES for information on valid application signatures by a patient's representative.

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35.1 Restoration of Benefits

If it is determined that a member's benefits have been incorrectly denied or terminated, their BadgerCare Plus 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 with a premium obligation, the member can be enrolled without a premium for past months. They will only be charged a premium for future months after advance notice can be provided based on adverse action logic.

If a member already paid for a BadgerCare Plus covered service, the member must contact their provider to bill BadgerCare Plus for services provided during that time. A BadgerCare Plus provider must refund the amount that BadgerCare Plus 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.

If it is determined that a premium amount was incorrectly calculated for BadgerCare Plus and would result in a refund for the member, the correct premium amount for each month in which it was incorrect needs to be determined and reported to the fiscal agent's BadgerCare Plus Unit. The fiscal agent will refund the amount of the premium the member overpaid.

Occasionally, a BadgerCare Plus member is certified for retroactive Katie Beckett Medicaid or Supplemental Security Income (SSI) Medicaid eligibility for a period of time in which they were also certified for BadgerCare Plus. If the BadgerCare Plus member paid a premium during this time frame, they are entitled to a refund of any BadgerCare Plus premiums that they paid during the retroactive Katie Beckett Medicaid or SSI Medicaid certification period.

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36.1 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.

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36.2 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 29.2.3 PRIOR TO THE HEARING).

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36.3 Sensitive Medical Information

The Confidential Information Release Authorization to Agency form (F-82009) 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 designate, 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.

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36.4 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 BadgerCare Plus 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 CHAPTER 34 LEGAL GUARDIANS, CONSERVATORS, POWER OF ATTORNEY, AND OTHER REPRESENTATIVES).*

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37.1 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 that 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:

    1. Federal Title IV-E Foster Care program.
    1. 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 34 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.

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37.2 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.

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37.3 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.

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37.4 Special Circumstances

37.4.1 Legislative Committees

Agencies cannot disclose information for the broad investigatory purposes of legislative committees. Federal legislation prohibits disclosure to any committee or committee's legislative body (federal, state, or local) of any information that identifies by address or name any applicant or recipient.

37.4.2 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 is about eligibility and the amount of benefits in the W-2, CTS, FoodShare, BadgerCare Plus, and Medicaid programs.

37.4.3 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.

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37.5 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.

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37.6 Data Exchanges

37.6.1 Data Exchanges Introduction

CWW Data Exchanges provide query access to databases that store employment information, unemployment income, and Social Security and SSI income (including social security number, citizenship/identification, and Medicare verification).

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.

37.6.2 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.

37.6.3 Query Access

Agencies must take all precautions necessary to ensure that only authorized agency staff have access to the online queries.

37.6.4 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 FoodShare, 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.

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37.7 Documents

37.7.1 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 the agency does not have a date stamp, the agency must write out the date the document was received on the front of the document prior to scanning.

37.7.2 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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38.1 Covered Services

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

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38.2 List of Covered Services and Copayments

38.2.1 Introduction

A BadgerCare Plus member may be required to pay a part of the cost of a service. This payment is called a "copayment" or "copay." The following table shows some of the covered services and copayments under BadgerCare Plus.

Services	**Description**
Chiropractic Services	Full coverage. Copayment $.50 to $3 per service (varies by service provided).
Dental	Full coverage of preventive, restorative and palliative services. Copayment $.50 to $3 per service (varies by service provided).
Disposable Medical Supplies (DMS)	Full coverage. Copayment $0.50 to $3 per service.
Drugs (see also SECTION 38.7 IMPACT ON DUAL ELIGIBLE INDIVIDUALS)	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs. Members are limited to five prescriptions per month for opioid drugs.

	Copayments: $0.50 for OTC Drugs $1 for Generic Drugs $3 for Brand Name Drugs Copayments are limited to $12 per member, per provider, per month. OTCs are excluded from this $12 maximum.
Durable Medical Equipment (DME)	Full coverage. C-payment $0.50 to $3 per item (varies by item provided). Rental items are not subject to a co-payment.
Health Screenings for Children	Full coverage of Health Check screenings and other services for individuals under age 21 years. Copayment $1 per screening for those 18, 19 and 20 years of age.
Hearing Services	Full coverage. Copayment $.50 to $3 per procedure. No copayments for hearing aid batteries.
Home Care Services (home health, private duty nursing and personal care)	Full coverage. No copayment.
Hospice	Full coverage.

	No copayment.
Hospital - Inpatient	Full coverage. Copayment $3 per day with a $75 cap per stay.
Hospital - Outpatient	Full coverage. Copayment $3 per visit.
Hospital - Outpatient Emergency Room	Full coverage. No copayment.
Mental Health and Substance Abuse Treatment	Full coverage (not including room and board). Copayment $.50 to $3 per visit (limited to the first 15 hours or $500 of services, whichever comes first, provided per calendar year). Copayment not required when services are provided in a hospital setting or for residential substance use disorder treatment services.
Nursing Home	Full coverage. No copayment.
Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)	Full coverage. C-payment $.50 to $3 per provider, per date of service.

	Copayment obligation is limited to the first 30 hours or $1,500 whichever occurs first, during one calendar year (copayment limits are calculated separately for each discipline.)
Physician Visits	Full coverage, including laboratory and radiology. Copayment $.50 to $3 copayment per service (varies by service provided). Limited to $30 per provider per calendar year. No copayment for emergency services, anesthesia, or clozapine management.
Podiatric Services	Full coverage. Copayment $.50 to $3 per service.
Prenatal/Maternity Care	Full coverage, including prenatal care coordination and preventive mental health and substance abuse screening and counseling for pregnant women at risk of mental health or substance abuse problems. No copayment.
Reproductive Health Services	Full coverage, excluding infertility treatments, surrogate parenting, and related services, including but not limited to artificial insemination, and subsequent obstetrical care as a non-covered service, and the reversal of voluntary sterilization. No copayment for family planning services.
Routine Vision	Full coverage including coverage of eye glasses.

	Copayment $.50 to $3 per service (varies by service provided).
Smoking Cessation Services	Coverage includes prescription and over-the-counter tobacco cessation products. Copayment (see drugs)
Transportation	Full coverage of emergency and non-emergency transportation to and from a certified provider for a BadgerCare Plus covered service. Copayments are: $2 for non-emergency ambulance trips. $1 per trip for transportation by an SMV. No copayment for transportation by common carrier or emergency ambulance.

If you or the member has additional questions, contact Member Services at 1-800-362-3002.

38.2.2 Copay Exempt Populations

Providers are **prohibited** from collecting copayment from the following members:

- Children under age 19, regardless of income or benefit program.
    - Children in foster care, regardless of age.
    - 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

38.2.3 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

38.2.4 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.
- 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.

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38.3 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, specialized medical vehicle (SMV) or common carrier.

38.3.1 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.

38.3.2 Specialized Medical Vehicle (SMV)

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 DHS 105.39 Wis. Admin Code.

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 them from using a common carrier or private vehicle.

38.3.3 Common Carrier

Common carrier means any mode of transportation other than an ambulance or an SMV.

38.3.4 Transportation Coordination

Non-emergency Medical Transportation (NEMT) is coordinated by Department of Health Services' NEMT manager, Medical Transportation Management, Inc. (MTM Inc.). As the NEMT manager, MTM Inc. arranges and pays for rides to covered Medicaid services for members who have no other way to receive a ride. Rides can include ambulance, SMV or common carrier transportation depending on a member's medical and transportation needs.

The NEMT manager does not coordinate transportation for the following members:

- Members who are residing in a nursing home.
    - Members residing in a nursing home have their NEMT services coordinated by the nursing home.
- Members who are enrolled in Family Care.
    - Members enrolled in Family Care receive NEMT services from the Family Care Managed Care Organization (MCO).

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38.4 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 policies related to enrollment in a BadgerCare Plus HMO and does not cover enrollment in an SSI HMO or Long-Term Care Managed Care Organization (LTC MCO).*

38.4.1 BadgerCare Plus HMO Enrollment

BadgerCare Plus is a mandatory HMO enrollment program, meaning most BadgerCare Plus members are required to enroll in an HMO. All eligible BadgerCare Plus members in the same household must enroll in the same HMO. However, the following persons cannot enroll in a BadgerCare Plus HMO:

- Members enrolled in a long-term care managed care organization (MCO)
- Members who live in a nursing home or medical facility
- Members eligible for both BadgerCare Plus and Medicare, often referred to as a dual eligible (see SECTION 38.7 IMPACT ON DUAL ELIGIBLE INDIVIDUALS)
- Members who are eligible for suspended BadgerCare Plus (see CHAPTER 45 INMATES)

Certain members within a household may enroll in an HMO on a voluntary basis (see SECTION 38.4.1.1 VOLUNTARY HMO ENROLLMENT) or qualify for an exemption from HMO enrollment (see SECTION 38.4.5 ENROLLMENT 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 BadgerCare Plus-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 the 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 BadgerCare Plus HMO enrollment can be found on the **Error! Hyperlink reference not valid.**. This list does not differentiate between voluntary or mandatory HMO enrollment. It is only a compilation of all Medical Status codes under which a member could be enrolled in an HMO.

38.4.1.1 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 BadgerCare Plus 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 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.

If anyone within the household meets the voluntary enrollment criteria listed above, everyone in the household who is enrolled in BadgerCare Plus is considered voluntary.

38.4.2 HMO Selection and Assignment

Members can choose an HMO after they are found eligible for BadgerCare Plus. Applicants who are applying for benefits online through ACCESS can indicate an HMO preference when they submit their application. Indicating a preference does not guarantee they 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 BadgerCare Plus household based on the primary applicant's previous enrollment in a BadgerCare Plus, if applicable, or based on a round-robin HMO assignment.

If the member was previously enrolled in a BadgerCare Plus HMO in the last 12 months, they will be assigned to the previous HMO unless they are joining a household that is already enrolled in a BadgerCare Plus HMO. If the member is joining a household that is already enrolled in a BadgerCare Plus HMO, the member will be enrolled in the same HMO as the other members of the household effective the 1st of the next month.

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, a BadgerCare Plus HMO Program Guide (P-12020) 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.)

38.4.3 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 for BadgerCare Plus.*

Example 1	Lynn applies and is found eligible for BadgerCare Plus on September 15 with a BadgerCare Plus 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 continue to be eligible for BadgerCare Plus) that they can change HMOs.

38.4.4 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.

38.4.4.1 Automatic Disenrollment

Automatic disenrollment occurs when there are changes to the member's eligibility or enrollment status that affect their HMO enrollment and typically occurs automatically once eligibility has been updated. The table below includes a list of automatic disenrollments and the date on which the disenrollment is effective.

Reason for Disenrollment	Disenrollment Date
Loss of BadgerCare Plus eligibility	End of the month in which BadgerCare Plus 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 LTC MCO enrollment start date or up to the last day of the month a member is enrolled in a Waiver program. Note: Waiver Medicaid enrollment can run concurrently with HMO enrollment, but LTC MCO enrollment cannot.

Becoming eligible for Medicare	Depending on when notification of Medicare eligibility was received and the Medicare eligibility start date, if the notification is received: Prior to the Medicare eligibility begin date, the disenrollment date is the end of the month in which notification was received. After the Medicare eligibility begin date, the disenrollment date is the end of the month prior to the month of notification.
Mail was returned for the member's household with no forwarding address, and an up-to-date address has not been received.	End of the month in which it is determined an up-to-date address cannot be received.

38.4.4.2 Voluntary Disenrollment

The member may voluntarily 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 a voluntary disenrollment based on a qualifying reason.

Qualifying reasons for voluntary disenrollments may 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 and not all related services are within the provider network and the member's primary care provider, or another provider determines the risk of receiving services separately would subject the member to unnecessary risk.
Other reasons, including poor quality of care, lack of access to covered 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.

38.4.4.3 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 30 days – The member, the nursing home or the HMO may contact the HMO Enrollment Specialist to disenroll the member from the BadgerCare Plus HMO so that 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.

38.4.5 Enrollment Exemptions

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 the member's legal guardian. They may need to be approved by either the HMO Enrollment Specialist, an HMO Ombuds, or state Nurse Consultant. Exemptions apply to individuals, not households.

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 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 BadgerCare Plus 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 member who wants to see a nurse midwife/practitioner of their choosing who is not part of a BadgerCare Plus HMO's provider network. For a pregnant member, 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 BadgerCare Plus 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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38.5 BadgerCare Plus Cards

38.5.1 BadgerCare Plus Cards Introduction

All BadgerCare Plus members are issued ForwardHealth cards. These cards are plastic and display the words "ForwardHealth."

Members use the same ForwardHealth card each month to receive services on a fee for service basis and/or through a managed care organization, if enrolled. Monthly cards are not issued.

Each person in the family who is eligible receives their own card for the benefit plan for which they are eligible. Members may have multiple ID cards if they have been in one or more of the plans listed above.

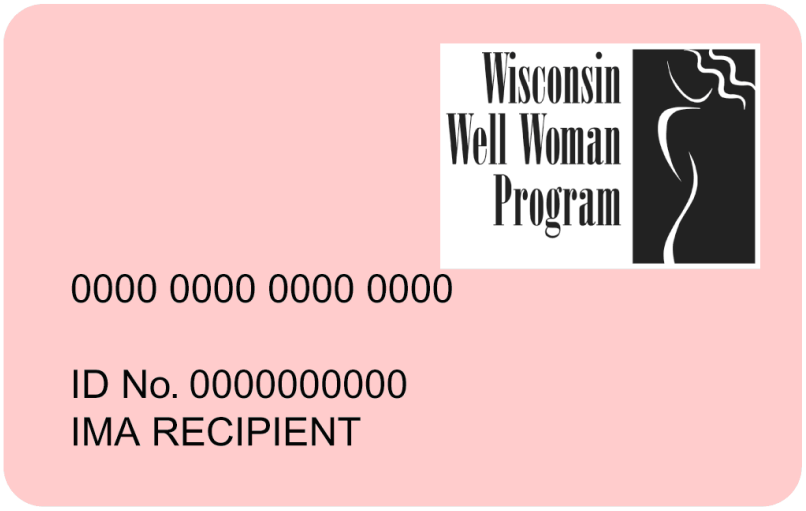
The cards do not display eligibility dates. Health care providers use the ID number on the front of the card to bill for services provided to the member.

Members will know if they are eligible, and for which benefit plan, based on positive and negative notices sent from the IM agency. They will also receive separate notices if enrolled in a Managed Care Organization. Members who receive a notice that they are no longer eligible for BadgerCare Plus should keep their ForwardHealth cards. Cards should not be thrown away. If a member becomes eligible again, they will use the same ForwardHealth card originally issued. If members have questions regarding their eligibility status, they can log into ACCESS> Change My Benefits or call Member Services at 1-800-362-3002.

38.5.1.1 ForwardHealth Card Image

38.5.1.2 SeniorCare Card Image

38.5.1.3 Wisconsin Well Woman Program Card Image



38.5.2 Appeals

Keep a BadgerCare Plus case in appeal status open if the member makes a request prior to the closure date. The member can continue to use their ForwardHealth card until a decision is made regarding their eligibility.

38.5.3 Homeless

Make ID cards available to homeless BadgerCare Plus members who have no fixed address or mailing address. Use your agency address or some other fixed address for delivery.

38.5.4 Pharmacy Services Lock-in Program

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 nonmedical 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 they 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 identification card or excessive use of emergency room services. If a provider suspects that a member is abusing their benefits or misusing their ForwardHealth card, providers are required to notify ForwardHealth by calling Provider Services at 800-947-9627 or by writing to the following:

Division of Medicaid Services Bureau of Benefits Management
P.O. Box 309
Madison, WI 53701-0309

38.5.5 Temporary Cards

With implementation of the ForwardHealth ID card, temporary ID cards are no longer used or available for ordering.

38.5.6 Lost-Stolen Cards

If a member needs a replacement card, they or an authorized representative, can request a replacement card by either:

1. Using ACCESS.
    a. Create an ACCESS Account.
    b. Go to your ACCESS Home Page and select a new ForwardHealth card (see ACCESS User Guide, Section 4.10 Get a New Card).
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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38.6 Reserved

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38.7 Impact on Dual Eligible Individuals

Individuals who are enrolled in Medicare (Part A and/or B) and are eligible for BadgerCare Plus under a Title 19 (Medicaid) funded Med Stat Code are referred to as Dual Eligible individuals. Since January 1, 2006, Medicaid does not provide prescription drug coverage for these individuals. Instead these individuals receive prescription drug coverage through Medicare Part D.

These Dual Eligible individuals are deemed eligible for "Extra Help" from CMS to help pay for their Medicare Part D drug costs.

A Medicare Part D Preferred Drug Plan (PDP) card will be issued to them, and it must be used for prescription drugs instead of their Forward Card.

For more information on Medicare Part D, see the Medicare Drug Coverage (Part D) webpage.

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38.8 Five Percent Cost Share Limit

Members may not pay more than 5% 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 5% 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.

38.8.1 Copay Limits for Members and Programs exempt from copays

Members who are in a copay exempt category (see SECTION 38.2.2 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 (see SECTION 38.2.3 COPAY EXEMPT PROGRAMS) will have a copay limit of $0 as there are no copays for members enrolled in these programs.

38.8.2 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 5% 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.*

38.8.3 Determining the Copay Limit

For members enrolled in BadgerCare Plus or EBD Medicaid subprograms that have 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 CHAPTER 53 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 with two children. The entire family is enrolled in BadgerCare Plus. 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 four. Since both parents are eligible and must 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.

Example 2	Marianne, who is pregnant, and Joe are a married couple enrolled in BadgerCare Plus with income that falls in the >50-100% of FPL income tier for a group size of three. Marianne has a pregnancy due date of March 10. Marianne is exempt from copays beginning with the first month she is certified as a pregnant woman until March 31 of the following year, including 12-month postpartum coverage. While Marianne is certified as a pregnant woman and exempt from copays, Joe's monthly copay limit is $26. After the end of the postpartum period, eligibility and copay limits will be redetermined. Beginning April 1, after Marianne's postpartum period ends, the household's copay limit will be split between Marianne and Joe, and they will each have a $13 copay limit.

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 5% limit.

Example 3	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 their 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.

38.8.3.1 Premiums

For members who are charged a monthly premium, the premium amount will be subtracted automatically when the member's copay limit is calculated in CARES.

38.8.4 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 (after the 10th of the month in which the change was supposed to be reported), the month in which the change was reported, whichever is later.

38.8.5 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 4	Tamika is enrolled in BadgerCare Plus and has a copay limit of $13 for the month of August. On August 12, interChange notifies CARES that Tamika has met her copay limit of $13. CARES issues Tamika an automated notice stating that her $13 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. Starting on September 1, Tamika will be responsible for copays incurred until her monthly limit is met.

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39.1 Emergency Services Introduction

BadgerCare Plus Emergency Services is a limited BadgerCare Plus benefit for documented immigrants who have not been in the U.S. for five years or more and for undocumented immigrants.

An immigrant who is ineligible for BadgerCare Plus because of their immigration status is eligible for BadgerCare Plus Emergency Services coverage if they:

1. Meet the income limits listed in SECTION 39.1.1 EMERGENCY SERVICES INCOME LIMITS.
2. Meet all other BadgerCare Plus eligibility requirements, except having or applying for a Social Security Number (SSN).

3. Qualify for coverage under a BadgerCare Plus category other than that for childless adults (see SECTION 39.1.2 EMERGENCY SERVICES SPECIAL RULES)

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.

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 medical treatment 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

BadgerCare Plus Emergency Services covers:

1. Only those medical services needed for the treatment of an emergency medical condition
2. All labor and delivery services for eligible non-qualifying immigrants

For information on manually processing applications, see Process Help, Section 12.9 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 12.10 Manual Renewal Report.

39.1.1 Emergency Services Income Limits

Group	Income
Pregnant Women	Up to 306% FPL
Newborns to age 1	Up to 306% FPL
Children ages 1 - 5	Up to 191% FPL
Children ages 6 - 18	Up to 156% FPL
Former Foster Care Youth	Any FPL Level
Parents and Caretakers	Up to 100% FPL

Note *These income limits must be applied because not everyone who meets the rules for BadgerCare Plus qualifies for BadgerCare Plus Emergency Services. Emergency Services is funded through the Medicaid Program (T-19), and is only available for people whose coverage is provided under a Medicaid state plan. As a result, children above the income limits for Medicaid (T-19) and childless adults whose coverage is provided under a federal waiver do not qualify for Emergency Services.*

39.1.2 Emergency Services Special Rules

A U.S. citizen is not eligible for BadgerCare Plus Emergency Services even when they cannot produce citizenship verification, identity verification, or both.

Example 1	Jill applies for BadgerCare Plus, 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 BadgerCare Plus 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 BadgerCare Plus Emergency Services eligibility for persons declaring to be U.S. citizens. BadgerCare Plus Emergency Services is reserved for non-qualifying non-citizens.

Verification of identity is not required if the applicant or member is not a U.S. citizen.

Immigrants who only meet the criteria for BadgerCare Plus under the childless adults' coverage group are ineligible for Emergency Services.

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.

Pregnant non-qualifying immigrants may be eligible under the BadgerCare Plus Prenatal Program.

39.1.3 Emergency Services and Public Charge

Emergency Services is not considered in public charge determinations (see SECTION 4.3.4 PUBLIC CHARGE).

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39.2 Determining if an Emergency Exists

It is not the responsibility of the IM agency to determine if the applicant's condition is or was an emergency condition and reimbursable under BadgerCare Plus Emergency Services. The medical provider submits claims for emergency medical services to the fiscal agent. The fiscal agent then determines if a condition is an emergency medical condition covered by BadgerCare Plus Emergency Services.

39.2.1 Determining Eligibility

It is the IM agency's responsibility to manually determine if the non-qualifying immigrant meets all eligibility requirements during the dates of service and to certify if they are eligible for Emergency Services.

Medicaid providers who have treated non-US citizens for emergency services can provide them the Certification of Emergency for Non-U.S. Citizens form (F-01162) to verify that the services provided were to treat an emergency medical condition. Providers are instructed to have the patient present this to the local IM agency when applying for assistance.

Note *The Certification of Emergency for Non-U.S. Citizens form is not required to certify Emergency Services eligibility.*

If a non-qualifying immigrant provides a "Certification of Emergency for Non-U.S. Citizens" at the time of application, their eligibility for BadgerCare Plus Emergency Services is determined for the dates of the emergency indicated on the form. A child under age 19 must remain eligible for 12 months.

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.

Emergency Services coverage begins at the time of the first treatment for the emergency and ends when the condition is no longer an emergency for adults, or at the end of a 12-month period for children under age 19.

Determine eligibility of a pregnant immigrant on the date emergency services were provided. The pregnancy due date is required to determine eligibility for pregnant immigrants (see SECTION 39.3 EMERGENCY FOR PREGNANT MEMBERS).

If a non-qualifying immigrant would only qualify for BadgerCare Plus if they were disabled, follow disability determination procedures (including presumptive disability) before certifying Emergency Services eligibility.

Note *Emergency Services has the same policies on referrals to child support agencies (CSA) and cooperation as BadgerCare Plus. See CHAPTER 5 MEDICAL SUPPORT AND THIRD-PARTY LIABILITY..*

Certification of Emergency Services is not done through CARES and must be done manually. However, all applications should be processed through CARES to determine BadgerCare Plus eligibility. If the immigrant does not have an SSN, CARES will assign a pseudo SSN. That pseudo SSN should be used when submitting the manual certification. When an immigrant is determined eligible for Emergency Services, complete and submit a Medicaid/BadgerCare Plus Eligibility Certification form (F-10110) (see Process Help, Section 24.21.3 Manual F-10110). The fiscal agent needs a beginning and end date to process eligibility. In setting the end date,

- For adults, use the last day of the emergency.
- For children under age 19, use the end of a 12-month period.
- For a child who is turning 19 in the next 12-month period, use the last day of the emergency or the last day of the month the child turns 19, whichever is later.

If the last day of the emergency is not known, use the last day of the month in which the emergency is expected to end. Use the AE medical status code.

Note *The Federally Facilitated Marketplace will send accounts to state consortia and tribal agencies for individuals who have been assessed as potentially eligible for BadgerCare Plus Emergency Services.*

Submit completed Medicaid/BadgerCare Plus Eligibility Certification forms by fax to 608-221-8815 or by mail to:

ForwardHealth

Eligibility Unit

P.O. Box 7636

Madison, WI 53707-7636

An individual eligible for BadgerCare Plus Emergency Services will not receive a ForwardHealth card because BadgerCare Plus Emergency Services eligibility ends when the emergency ends.

However, women determined eligible for the BadgerCare Plus Prenatal Program will be issued a ForwardHealth Card, which can also be used to access emergency services under the Emergency Services coverage group after the BadgerCare Plus Prenatal Program coverage ends.

39.2.2 Providing Manual Positive or Negative Notice

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 BadgerCare Plus Emergency Services. Negative notices must provide the reason(s) for the denial or termination.

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39.3 Emergency for Pregnant Members

A pregnant non-qualifying immigrant may apply for BadgerCare Plus Emergency Services up to one calendar month before the due date. Certify an eligible pregnant non-qualifying immigrant from the date of application, if they apply no more than one calendar month prior to the due date, through the end of the month in which the 60th day occurs following the due date. Adjust the certification period based on the actual pregnancy end date, once it is known.

Note *Pregnancy does not need to be verified (see SECTION 9.9.3 PREGNANCY).*

Example 1	Sara is a pregnant non-qualifying immigrant applying for BadgerCare Plus Emergency Services. Sara has two weeks until her due date, which is March 3. Certify Sara for BadgerCare Plus Emergency Services from the date of application through the end of May.

Example 2	Erica applied for BadgerCare Plus Emergency Services because she was a pregnant non-qualifying immigrant on March 13. Her expected due date is April 5. Erica is certified for BadgerCare Plus Emergency Services from March 13 through the end of June. Erica delivers her son on March 15. Her certification period should be adjusted from March 13 through the end of May.

If a pregnant non-qualifying immigrant applies for BadgerCare Plus Emergency Services prior to the calendar month before the due date, and they have not received a service, deny BadgerCare Plus Emergency Services eligibility because they have not received a service.

If an individual applies for BadgerCare Plus Emergency Services, within three months after the pregnancy has ended, certify BadgerCare Plus Emergency Services from the pregnancy end date through the end of the month in which the 60th day occurs.

Example 3	Vienne miscarries on April 5, which is more than one month from her due date of July 15. Vienne applies on April 6 for BadgerCare Plus Emergency Services. Certify Vienne for BadgerCare Plus Emergency Services from April 5 through the end of June.

Example 4	Guadeloupe was in a car accident and admitted to a Fort Atkinson hospital on February 18. On March 15, Guadeloupe applied for BadgerCare Plus Emergency Services for both the February hospital stay and her pregnancy, with a due date of April 15. Certify Guadalupe for BadgerCare Plus Emergency Services from February 18 through the end of June.

An immigrant who gives birth while enrolled in BadgerCare Plus Emergency Services remains eligible for emergency services for an additional 60 days after the last day of pregnancy through the end of the month in which the 60th day occurs. The emergency does not have to be related to the pregnancy.

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39.4 Newborns

Babies born to mothers covered under BadgerCare Plus Emergency Services are BadgerCare Plus eligible as continuously eligible newborns, if all other eligibility conditions are met (see CHAPTER 8.2 CONTINUOUSLY ELIGIBLE NEWBORNS).

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39.5 Non-Qualifying Immigrants No Longer Eligible for the BadgerCare Plus Prenatal Program

A non-qualifying immigrant is eligible for BadgerCare Plus Emergency Services starting the date BadgerCare Plus Prenatal Program enrollment ends due to the end of the pregnancy or any other reason other than moving out of state. These members are eligible for BadgerCare Plus Emergency Services coverage through the end of the month in which the 60th day occurs, following the member's due date or the pregnancy end date, if that is known.

Example 1	Sofia is a pregnant non-qualifying immigrant who is enrolled in the BadgerCare Plus Prenatal Program. Her expected due date is July 10. On April 5, the agency finds out that she now has access to health insurance through her employer, and the employer will pay over 80% of the premium cost. Her BadgerCare Plus Prenatal Plan enrollment ends on April 30 due to this access to health insurance. Sofia is eligible for BadgerCare Plus Emergency Services starting May 1. She gives birth on July 8. The 60th day after her pregnancy ends falls in September, so her enrollment in BadgerCare Plus Emergency Services lasts through September 30.

See SECTION 39.3 EMERGENCY FOR PREGNANT MEMBERS for information on BadgerCare Plus Emergency Services eligibility for pregnant non-qualifying immigrants who are not eligible for the BadgerCare Plus Prenatal Program.

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39.6 BadgerCare Plus Deductible

Immigrants who apply for Emergency Services and who are under 19 years of age and ineligible due to access to health insurance or who are pregnant and have countable household income over 306% of the

FPL, may become eligible for BadgerCare Plus Emergency Services through a BadgerCare Plus deductible. If, on the date they apply and they meet all other eligibility criteria, apply the same deductible policies to them as any other applicant (see CHAPTER 17 DEDUCTIBLES).

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40.1 Family Planning Only Services

The Family Planning Only Services Program provides limited benefits for family planning services for women and men with income at or below 306% of the FPL and who are:

1. Of child bearing or reproductive age, and
2. Not enrolled in BadgerCare Plus or receiving other full-benefit Medicaid.

For more information about income disregards under MAGI rules, see SECTION 16.1.2 INCOME UNDER MODIFIED ADJUSTED GROSS INCOME RULES.

Individuals who are eligible for the Family Planning Only Services Program may be eligible to receive more than one limited benefit program. These include:

- Tuberculosis-related (see CHAPTER 43 TUBERCULOSIS-RELATED MEDICAID)
- Qualified Medicare Beneficiary (see Medicaid Eligibility Handbook, Section 32.2 QMB)
- Specified Low-Income Medicare Beneficiary (see Medicaid Eligibility Handbook, Section 32.3 SLMB).

In certain circumstances, women enrolled in the Family Planning Only Services Program may be eligible for the Wisconsin Well Woman Medicaid plan (see Medicaid Eligibility Handbook, Chapter 36 WWWMA).

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40.2 Presumptive Eligibility

40.2.1 Introduction

Presumptive eligibility for Family Planning Only Services provides family planning and family planning-related services only (see SECTION 32.1 INTRODUCTION).

40.2.1.1 Qualified Entities

Qualified entities that can be certified by ForwardHealth to make presumptive eligibility determinations for Family Planning Only Services include:

- Medicaid providers
- Qualified hospitals

For more information about qualified entities, see SECTION 32.1.2 QUALIFIED ENTITIES.

40.2.1.2 Coverage Period

For information about when coverage begins and ends, early terminations, and automatic extensions, see SECTION 32.1.3 COVERAGE PERIOD.

40.2.2 Eligibility

A person can get temporary enrollment for Family Planning Only Services if they meet all of the following financial and nonfinancial criteria:

- Be of child bearing or reproductive age.
- Be a Wisconsin resident.
- Have income at or below 306% of the FPL. For information about income disregards under MAGI rules, see SECTION 16.1.2 INCOME UNDER MODIFIED ADJUSTED GROSS INCOME RULES.
- Meet one of the following:
    - For people age 18 and younger:
        - Be a U.S. citizen
        - Be lawfully present in the U.S. (no requirement for the amount of time the person is lawfully present in the U.S.)
    - For people age 19 and older:
        - Be a U.S. citizen
        - Be lawfully residing in the U.S. under one of the eligible immigration statuses or situations listed in SECTION 4.3.8 IMMIGRATION STATUS CHART

  Is not currently receiving Family Planning Only Services, BadgerCare Plus, or other full benefit Medicaid.

40.2.3 Express Enrollment in ACCESS

Refer to ACCESS Handbook, Chapter 12 ACCESS for Partners and Providers for information on making presumptive eligibility determinations for Family Planning Only Services using the Express Enrollment process in ACCESS.

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40.3 Application

Eligibility for FPOS begins on the first of the month of application, if all non-financial (see SECTION 40.4 NONFINANCIAL REQUIREMENTS) and financial (see SECTION 40.5 FINANCIAL REQUIREMENTS) eligibility requirements are met. FPOS may be backdated up to three months from the month of application.

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40.4 Nonfinancial Requirements

The following are FPOS specific nonfinancial requirements:

- The person must be of childbearing or reproductive age.
- The person must be a Wisconsin resident.

- The person must not be enrolled in BadgerCare Plus or receiving other full benefit Medicaid.
- The person must be one of the following:
    - **If under age 19:** Lawfully residing in the United States (no requirement for the amount of time the person is lawfully present in the U.S.).
    - **If age 19 and older:** Either a U.S. citizen or lawfully residing in the United States under one of the eligible immigration statuses/situations listed in SECTION 4.3.8 IMMIGRATION STATUS CHART.
- The person must meet all BadgerCare Plus non-financial criteria (see SECTION 2.1 NONFINANCIAL PROGRAM REQUIREMENTS) with the exceptions listed below:
    - An individual applying for or receiving BadgerCare Plus FPOS is not subject to the health insurance coverage policies.
    - An individual applying for or receiving BadgerCare Plus FPOS is not required to cooperate with Medical Support unless they are also applying for or receiving BadgerCare Plus for any child for whom they are the parent or caretaker relative.
    - An individual applying for or receiving BadgerCare Plus FPOS is not required to cooperate with Third Party Liability (TPL) unless they are also applying for or receiving BadgerCare Plus for any child for whom they are the parent or caretaker relative.
    - Any individual applying for or receiving FPOS who refuses to cooperate with medical support or TPL requirements when they have a child in the home who is receiving BadgerCare Plus or Medicaid is ineligible for FPOS unless they are under 19 or have good cause.

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40.5 Financial Requirements

40.5.1 Financial Eligibility Requirements Specific to FPOS

The following specific financial eligibility requirements apply to FPOS members, regardless of the methodology used to determine their FPOS income:

1. Countable income calculated in the application month is used to determine the member's financial eligibility for the entire 12-month eligibility period. Income changes do not need to be reported until the next review. This policy does not apply to backdated months. Backdated months are determined in addition to the 12-month certification period and are not used as the basis for whether someone's eligibility will be maintained after an increase in income. As with other health care requests, the 12-month certification period will be set based on the filing month, not the first month of backdated eligibility.
2. Any change in income or household size reported after confirmation for FPOS during the 12-month eligibility period is only applied if it results in enrollment in BadgerCare Plus with no premium or eligibility for other full benefit Medicaid.
3. All changes in income or household composition that result in enrollment in BadgerCare Plus with no premium or eligibility for other full benefit Medicaid will result in FPOS closure prior to the 12th month.
4. All changes in income will be applied at the 12-month FPOS eligibility renewal.

40.5.2 Income

Because FPOS eligibility is determined based on a group size of one, the applicant's taxable earned and unearned income is the only income that should be used when calculating their income for purposes of FPOS eligibility (see CHAPTER 16 INCOME). When a child under 19 is applying, their parents' income is not included in their eligibility determination. If a married individual is applying for FPOS coverage, do not include the income of the spouse, even if they are living with their spouse.

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40.6 FPOS Group

For all individuals, including children under 19, the group size of the applicant will always be one, regardless of their marital status and whether or not they have children or tax dependents.

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40.7 Program Choice

An individual applying for both BadgerCare Plus and FPOS may request at any time to discontinue enrollment in BadgerCare Plus in order to receive only FPOS. Change the health care request on the program request page to "No" in order to receive the FPOS.

An individual applying for both BadgerCare Plus and FPOS is not given a choice at the time of confirmation if they meet the eligibility for both benefits. They will be enrolled in BadgerCare Plus.

An individual found to be eligible for a deductible may also be eligible for FPOS benefits during a deductible period. The member may receive FPOS benefits until they have met a deductible. The member can report any out-of-pocket medical bills incurred while they are receiving services through FPOS, in order to meet a deductible. Once a deductible has been met, they are receiving full-benefit BadgerCare Plus/Medicaid, and are no longer eligible for FPOS. However, they will continue to receive the same family planning services through BadgerCare Plus/Medicaid.

Example 1	Theresa is an 18-year-old woman applying for Medicaid, BadgerCare Plus and FPOS for herself and for BadgerCare Plus for her daughter Sara (age three). She is found to be eligible for BadgerCare Plus with a premium or a deductible. If Theresa chooses BadgerCare Plus, she is required to pay a premium but would be able to receive family planning services through BadgerCare Plus as well as having coverage for her whole family. If she chooses the deductible, she can receive family planning-related services through FPOS until her deductible has been met.

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40.8 Reporting Changes

Members receiving FPOS only are not required to report changes in income or household composition during the 12-month certification period. However, FPOS members are still required to report all other

changes that would result in ineligibility such as moving out of state, incarceration, etc. within 10 days of the change.

Changes in income do not affect FPOS eligibility during the 12-month certification period even if the income exceeds the FPOS income limit. Once eligibility has been established, the increase in income will not be considered until the next annual renewal that was originally set for the FPOS eligibility.

Note *Household composition changes will not affect eligibility as all FPOS assistance groups will only include the member in the household composition, regardless of their living arrangement.*

Changes reported in income or household composition may result in eligibility for BadgerCare Plus. If verification is needed for the change, FPOS will be maintained until the eligibility is determined for BadgerCare Plus. If there is a request for BadgerCare Plus on file and the member is otherwise eligible, they will be eligible for BadgerCare Plus as of the month of the change (or the month the change was reported, whichever is later). Eligibility for BadgerCare Plus can overlap with FPOS in this limited situation.

FPOS eligibility ends when a member loses non-financial eligibility. Terminate FPOS eligibility, using adverse action logic, when they:

Move out of state.
Are 19 years or over and no longer cooperating with TPL, Medical Support, or SSN requirements.
Enroll in BadgerCare Plus or become eligible for other full benefit Medicaid.
Become an inmate of a public institution.

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40.9 Ongoing Eligibility

Changes in income do not affect FPOS eligibility during the 12-month certification period, even if the income exceeds the FPOS income limit. Once eligibility has been established, the increase in income will not be considered until the next annual renewal that was originally set for the FPOS eligibility.

This policy does not apply to backdated months. Backdated months are determined in addition to the 12-month certification period and are not used as the basis for whether someone's eligibility will be maintained after an increase in income.

Note *Household composition changes will not affect eligibility as all FPOS assistance groups will only include the member in the household composition, regardless of their living arrangement.*

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40.10 Renewals

A renewal (see CHAPTER 26.1 RENEWALS) is required at the end of the certification period. At the time of the Family Planning Only Services (FPOS) renewal, income and household composition are again tested against the FPOS eligibility criteria. If a member completes a renewal for another program of assistance at any time during the 12-month FPOS certification period, and the information collected from that

renewal indicates that they still meet FPOS eligibility requirements, a new certification period begins for FPOS.

If a member completes a renewal for another program of assistance at any time before FPOS eligibility ends and reports income that is over the income limit for FPOS, the increase in income will not affect current FPOS eligibility. The income is not considered until the next renewal (at the end of the original certification period). If at this renewal, they are found to still have income in excess of the FPOS limit, eligibility for FPOS ends.

If verification is needed at renewal, FPOS will be maintained until the verification is received or the verification due date. If there is a request for BadgerCare Plus on file and the member is otherwise eligible, they can become eligible for BadgerCare Plus back to the month of the change (or the month the change was reported, whichever is later). Eligibility for BadgerCare Plus can overlap with FPOS in this situation.

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40.11 Confidentiality

Members applying for or receiving FPOS benefits will have all of the confidentiality protections as other BadgerCare Plus applicants, as well as the following additional confidentiality protections:

1. If requested, member can have written communication sent to an alternate address instead of the home address.
2. Minors are not referred to child support.
3. Eligibility information regarding minors who apply independently for FPOS is kept confidential from parents or guardians, unless the member gives clear consent for release of the information.

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41.1 BadgerCare Plus Prenatal Program

The BadgerCare Plus Prenatal Program provides coverage for pregnant people who apply for BadgerCare Plus and meet all financial and most nonfinancial eligibility requirements. There are two groups of BadgerCare Plus Prenatal Program members:

- Pregnant people who are non-citizens and do not meet the BadgerCare Plus immigration status requirements. A person who has declared U.S. citizenship is not eligible for BadgerCare Plus Prenatal Program under this group even when they cannot produce citizenship verification, identity verification, or both.
- Pregnant people who are inmates of a public institution (see SECTION 45.8.2 PREGNANT MEMBERS) and would otherwise be placed in suspended status for BadgerCare Plus or who are both an inmate of a public institution and a non-citizen who does not meet the BadgerCare Plus immigration status requirements.

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41.2 Eligibility Requirements

Pregnant members (or when applicable, their assistance group), must meet the following BadgerCare Plus eligibility requirements to qualify for the BadgerCare Plus Prenatal Program:

1. The applicant's net countable income must not exceed 306% of the FPL.
2. The applicant must provide any required verifications. Note: Pregnancy will only be verified if the worker has information that contradicts the applicant's self-declared information (see SECTION 9.9.3 PREGNANCY).
3. The applicant must not have current health insurance coverage through any health insurance plan which qualifies as minimum essential coverage as defined at 26 USC § 5000A(f)(1) (see SECTION 7.4 CURRENT HEALTH INSURANCE COVERAGE).

41.2.1 Unique Aspects of BadgerCare Plus Prenatal Program

1. Providing an SSN is not an eligibility requirement for either inmates or immigrants applying for the BadgerCare Plus Prenatal Program.
2. Cooperation with Child Support Enforcement is not an eligibility requirement for this program.
3. Unlike BadgerCare Plus for pregnant members which locks in eligibility throughout the pregnancy, (see SECTION 8.1 PREGNANT MEMBERS) BadgerCare Plus Prenatal Program eligibility may be terminated with timely notice for failure to meet any of the BadgerCare Plus eligibility requirements (see SECTION 41.1 BADGERCARE PLUS PRENATAL PROGRAM).
4. There is no Presumptive Eligibility for the BadgerCare Plus Prenatal Program. Eligibility for the BadgerCare Plus Prenatal Program may only be determined by the IM agencies.
5. There is no three-month backdating option available for Prenatal Program members.
6. Unlike BadgerCare Plus for Pregnant Members, Prenatal Program members are not eligible for the 12-month postpartum coverage period. They are, however, eligible for Emergency Services until the end of the month 60 days after the end of the pregnancy.

41.2.2 BadgerCare Plus Prenatal Program and Public Charge

BadgerCare Plus Prenatal Program is not considered in public charge determinations (see SECTION 4.3.4 PUBLIC CHARGE).

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41.3 BadgerCare Plus Prenatal Program Policy for Immigrants

1. For non-U.S. citizens with documentation, verify the applicant's immigration status through normal procedures to determine eligibility for BadgerCare Plus. If the pregnant person is not eligible for BadgerCare Plus because of their immigration status only, proceed with determining eligibility for the BadgerCare Plus Prenatal Program.

2. For non-U.S. citizens who are undocumented, do not request SAVE verification and continue with the determination of eligibility for the BadgerCare Plus Prenatal Program.
3. An immigrant whose immigration status changes while they are pregnant and receiving BadgerCare Plus Prenatal benefits must have their eligibility re-determined using their new immigration status. If their new status makes them eligible for BadgerCare Plus, they are no longer eligible for the BadgerCare Plus Prenatal Program.

Note *Verification of identity is not required if the applicant or member is not a U.S. citizen.*

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41.4 BadgerCare Plus Prenatal Program Policy for Inmates

An inmate who is released from jail or prison while receiving BadgerCare Plus Prenatal Program must have their eligibility re-determined based on their new circumstances. Once released from an institution, they are no longer eligible for the BadgerCare Plus Prenatal Program.

When a BadgerCare Plus Prenatal Program member notifies the IM agency of their release from prison or jail, their BadgerCare Plus eligibility must be redetermined based on the new information.

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41.5 Eligibility Begin Date

BadgerCare Plus Prenatal Program eligibility begins no sooner than the first of the month in which a valid application is received.

Immigrants not eligible for the BadgerCare Plus Prenatal Program because they do not meet a non-financial eligibility requirement in SECTION 41.2 ELIGIBILITY REQUIREMENTS should have Emergency Services eligibility determined according to policy in CHAPTER 39 EMERGENCY SERVICES.

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41.6 Eligibility End Date

BadgerCare Plus Prenatal Program eligibility ends when the pregnancy ends. Benefits will continue through the end of the month following timely notice requirements.

Immigrants who lose eligibility for the BadgerCare Plus Prenatal Program when their pregnancy ends, for any reason other than moving out of state, are eligible for Emergency Services after they lose BadgerCare Plus Prenatal Program eligibility (see CHAPTER 39.5 NON-QUALIFYING IMMIGRANTS NO LONGER ELIGIBLE FOR THE BADGERCARE PLUS PRENATAL PROGRAM).

When the pregnancy ends, CARES will automatically send ForwardHealth an emergency services certification through the end of the month in which the 60th day occurs for adults, or 12 months for children under age 19.

BadgerCare Plus Emergency Services is a limited BadgerCare Plus benefit for people who are ineligible for BadgerCare Plus only because of their immigration status.

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41.7 Determining the BadgerCare Plus Prenatal Group

Follow the rules outlined in CHAPTER 2 BADGERCARE PLUS GROUP in order to form group size for the BadgerCare Plus Prenatal Program.

Pregnancy, the number of fetuses, and the due date are not required to be verified unless the worker has information that contradicts the applicant's self-declared information (see SECTION 9.9.3 PREGNANCY). The effective begin date for the BadgerCare Plus Prenatal Program is the first of the month in which they apply and are otherwise eligible.

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41.8 Benefit Information

Women determined eligible for the BadgerCare Plus Prenatal Program receive a ForwardHealth card, which can also be used to access emergency services under BadgerCare Plus Emergency Services only after BadgerCare Plus ends.

BadgerCare Plus Prenatal Program and BadgerCare Plus Emergency Services members will not be enrolled in an HMO. Services will only be provided on a fee-for-service basis.

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42.1 Long-term Care Eligibility Requirements for Childless Adults Eligible for BadgerCare Plus

Institutionalized childless adults who do not meet the eligibility criteria for EBD Medicaid but are eligible for BadgerCare Plus are eligible to have their LTC services covered by BadgerCare Plus if they are functionally eligible. "Institutionalized" means the individual has resided in a medical institution for 30 or more consecutive days or is likely to reside in a medical institution for 30 or more consecutive days. However, an individual is not considered "institutionalized" if they meet this 30-day test but is in a medical institution solely for the purpose of receiving residential substance use disorder treatment.

Note *Once institutionalized and considered out of the home, a parent would be considered a childless adult and may qualify for long-term care as a childless adult.*

42.1.1 Long-Term Care Eligibility Requirements for Childless Adults Eligible for BadgerCare Plus

In order to be eligible to have their LTC services covered by BadgerCare Plus while they are institutionalized, childless adults must meet the following requirements:

- They do not meet the eligibility criteria for EBD Medicaid. This includes any of the following:
  - They do not meet the asset test for EBD Medicaid.
  - They do not meet the income test for EBD Medicaid.
  - They fail to provide or verify asset information or any other information needed to determine EBD Medicaid eligibility.
  - They have not yet been determined disabled.
  - They have not yet been determined presumptively disabled.
- They are eligible for BadgerCare Plus as a childless adult.
- They have not divested in order to qualify for receipt of LTC services (see Medicaid Eligibility Handbook, Chapter 17 Divestment). Institutionalized childless adults who divest are not eligible for LTC services although they remain eligible for Medicaid services.
- They disclose information about any annuities purchased on or after January 1, 2009, in which they or their community spouse have an interest.
- They designate the state of Wisconsin as the remainder beneficiary of any annuities purchased or created on or after January 1, 2009.
- If they own their own home, the equity interest in the home must not exceed the LTC home equity limit (see Medicaid Eligibility Handbook, Section 16.8.1.4 Long-Term Care Home Equity Limit) in order to receive LTC services.
- They assign to the state of Wisconsin their rights to payments from a nursing home, hospital, or LTC insurance policy and send any payments to the state of Wisconsin that they received from a nursing home, hospital, or LTC insurance carrier while receiving BadgerCare Plus.

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42.2 Patient Liability, Estate Recovery, and Other Policies for Childless Adults Eligible for BadgerCare Plus While in Long-term Care

The following conditions apply to any childless adult who is eligible for BadgerCare Plus while institutionalized:

- The person does not have any nursing home patient liability.
- The person is still subject to regular copayments for medical services unless their net countable income is equal to $0.
- The person is exempt from HMO enrollment unless they are enrolled in a Family Care MCO, in which case, the person can continue to be enrolled in the Family Care MCO.
- The person is not subject to an asset limit but is subject to divestment rules (see Medicaid Eligibility Handbook, Chapter 17 Divestment).
- The person is not subject to having a lien put on their home (see Medicaid Eligibility Handbook, Section 22.1.4 Liens).

- The LTC services the person receives are not subject to estate recovery (see Medicaid Eligibility Handbook, Section 22.1.2 Recoverable Services) unless the individual is 55 years old or older.

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42.3 Institutionalized Individuals Determined Eligible for Elderly, Blind, or Disabled Medicaid

The conditions outlined in SECTION 42.2 PATIENT LIABILITY, ESTATE RECOVERY, AND OTHER POLICIES FOR CHILDLESS ADULTS ELIGIBLE FOR BADGERCARE PLUS WHILE IN LONG-TERM CARE only apply to institutionalized individuals while they remain eligible for BadgerCare Plus as a childless adult. When an institutionalized individual has been determined eligible for EBD Medicaid, they are not eligible for BadgerCare Plus as a childless adult. When an individual becomes eligible for LTC under EBD Medicaid rules, they are subject to regular estate recovery rules and will have to pay the monthly nursing home patient liability. If the individual later becomes ineligible for EBD Medicaid, they may again become eligible for BadgerCare Plus.

Example 1	Andrew is institutionalized and is eligible for BadgerCare Plus as a childless adult. BadgerCare Plus covers his LTC services. Andrew starts receiving Medicare Part A on August 1, so he is no longer eligible for BadgerCare Plus as a childless adult as of August 1. To continue receiving coverage for LTC services, Andrew would have to meet all regular EBD Medicaid eligibility criteria. He would then be subject to regular estate recovery rules and patient liability.

Example 2	Jana is an institutionalized childless adult eligible for BadgerCare Plus and is waiting on a disability determination. She will receive coverage for LTC services under BadgerCare Plus until the agency receives and processes the disability determination. Once this happens, if she meets all other criteria for EBD Medicaid (including providing asset information and meeting the asset test), she will begin receiving coverage of LTC services under EBD Medicaid. However, if Jana still does not meet all of the eligibility criteria for EBD Medicaid (for example, because she fails to verify assets), she will continue to receive coverage for LTC services under BadgerCare Plus as long as she continues to meet all of the eligibility criteria for BadgerCare Plus.

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43.1 Nonfinancial Requirements

Individuals who are infected with tuberculosis (TB) and who are not otherwise eligible for full benefit BadgerCare Plus or Medicaid may be eligible for Tuberculosis (TB)-related Medicaid, a special category of Medicaid.

"Infected with TB" means that a physician has examined them and found that one or more of the following diagnoses apply to them:

- They are infected with latent or active TB.
- They have a positive TB skin test.
- They have a negative TB skin test but a positive sputum culture for the TB organism.

- They have a negative test for TB, but a physician certifies that they require TB-related drug therapy, surgical therapy, or both.
- A physician certifies that they require testing to confirm the presence or absence of TB.

An individual's statement that they have one or more of the above conditions should be accepted unless the information provided is questionable (see SECTION 9.10 QUESTIONABLE ITEMS). If questionable, accept any of the following as verification:

- A physician's or registered nurse's written confirmation that the person has one or more of the above conditions.
- Wisconsin Tuberculosis Record (Form P-03429). This card identifies the person and the physician's diagnosis and has the name and telephone number of the treatment provider.

To be eligible for TB-Related Medicaid, a person must also meet the following criteria:

1. Be a Wisconsin resident (see CHAPTER 3 RESIDENCE)
2. Be a U.S. citizen or qualified immigrant (see Chapter 4 Citizenship and Immigration Status)
3. Provide documentation of citizenship and identity or of immigration status (see SECTION 4.1 U.S. CITIZENS AND NATIONALS)
4. Cooperate with establishing medical support and third-party liability (TPL) (see CHAPTER 5 MEDICAL SUPPORT AND THIRD PARTY LIABILITY)
5. Sign over to the state their rights to payments from a third party for medical expenses (see SECTION 5.2 MEDICAL SUPPORT/CHILD SUPPORT AGENCY COOPERATION)
6. Meet BadgerCare Plus SSN requirements (see CHAPTER 6 SOCIAL SECURITY REQUIREMENTS)
7. Cooperate with verification requests when information is mandatory or deemed questionable (see CHAPTER 9 VERIFICATION)

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43.2 Financial Tests

There is no asset test for Tuberculosis (TB)-Related Medicaid.

The income limit for one adult is $2,073. For a married couple, the limit is $3,067. A person's income is determined using Modified Adjusted Gross Income (MAGI) budgeting rules (see SECTION 2.3 MODIFIED ADJUSTED GROSS INCOME TEST GROUP, SECTION 2.8 MODIFIED ADJUSTED GROSS INCOME COUNTING RULES, and SECTION 16 INCOME).

For children infected with TB, income must be budgeted using MAGI rules, the same way it is for children applying for BadgerCare Plus (see SECTION 2.3 MODIFIED ADJUSTED GROSS INCOME TEST GROUP). If a child is determined ineligible for BadgerCare Plus, the countable MAGI income for the child is tested against the TB-Related Medicaid individual monthly income limit of $2,073. If the countable monthly MAGI income for the child is at or less than $2,073 and the child meets all other TB-Related Medicaid eligibility criteria, the child is eligible for TB-Related Medicaid. This income limit applies to each child no matter how many persons are in the assistance group.

Example 1	Mary and her spouse George are both applying for TB-Related Medicaid. Test Mary and George as one MAGI Test Group. Test their MAGI income against the income limit for a married couple.

Example 2	Greg is a 20-year-old with TB and is applying for BadgerCare Plus. Greg lives with his dad, Barry, and is Barry's tax dependent. Under MAGI budgeting rules, Barry and Greg are one MAGI Test Group and we must count Barry's MAGI income (which includes Greg's income if he is required to file taxes). The monthly MAGI income for Barry and Greg is $1,900, which is 105% of the FPL for a group of two. This makes Greg ineligible for BadgerCare Plus as a childless adult. However, that same MAGI income amount is less than the $2,073 TB income limit for an unmarried individual, which makes Greg eligible for TB-Related Medicaid.

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43.3 Tuberculosis-Related Services

People who become eligible for Tuberculosis (TB)-related Medicaid are only eligible for the following Medicaid services:

- Prescribed drugs.
- Physicians' services.
- Laboratory and X-ray services, including services to diagnose and confirm the presence of infection.
- Clinic services and federally qualified health care (FQHC) services.
- Targeted case management services.
- Services, other than room and board, designed to encourage completion of regimens of prescribed drugs by outpatients.
- Services that are necessary as a result of the side effects of prescribed drugs for TB treatment.

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43.4 Immigrants

Tuberculosis (TB)-related services may be covered for individuals who do not meet citizenship requirements under Emergency Services (see SECTION 4.3 IMMIGRANTS and SECTION 39.1 EMERGENCY SERVICES INCOME LIMITS).

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43.5 Processing

See Process Help, Section 12.8 TBMA (Tuberculosis) Manual Application Processing.

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44.1 Reserved

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44.2 Reserved

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44.3 Reserved

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44.4 Reserved

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45.1 Introduction

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

An inmate is someone who is staying 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 purposes of BadgerCare Plus:

- A staff person voluntarily residing in a public institution.
- 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 their 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 Medicaid Eligibility Handbook, 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.

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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45.2 Covered Services

Individuals who are inmates of a public institution may be eligible for suspended BadgerCare Plus. When a member is incarcerated in a public institution, BadgerCare Plus 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.

See SECTION 45.8.5 SERVICES FOR YOUTH for information on coverage for certain pre-release and post-release services for youth.

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45.3 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 45.2 COVERED SERVICES.

45.3.1 Applications

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 BadgerCare Plus on April 20 and is found eligible. 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 BadgerCare Plus on April 20 and is found eligible. She is certified for full-benefit BadgerCare Plus from April 1 until April 30. Jane's suspension starts on May 1. However, the restriction on covered services will be effective April 15 (the date Jane became incarcerated).

45.3.2 Backdated Eligibility

If an applicant is determined eligible for a BadgerCare Plus 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 be enrolled for full-benefit BadgerCare Plus.

45.3.3 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.

Example 1	Olivia is open for full-benefit BadgerCare Plus. On December 23, Olivia reports she is incarcerated as of December 20, Olivia's BadgerCare Plus is suspended starting January 1. However, the restriction on covered services will be effective December 20 (the date Olivia became incarcerated).

45.3.4 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 1	Jordan has a BadgerCare Plus deductible period from April 1 until September 30. He meets his deductible on May 10 and becomes eligible for full-benefit BadgerCare Plus. 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 incarcerated).

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45.4 Suspension End Date

A member's suspension is lifted and full-benefit BadgerCare Plus coverage will start on the first of the month in which the member is released from incarceration if the member continues to meet all other eligibility criteria for BadgerCare Plus. A new application is not needed to lift the suspension and start full-benefit BadgerCare Plus.

The suspension period will have an end date at the end of a benefit month, but the restriction on covered services will end when the person is no longer incarcerated. This means that the restriction on covered services may end on a date after the suspension end date displayed in the system. See SECTION 45.2 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 BadgerCare Plus eligibility prior to the release to lift the suspension and start full-benefit BadgerCare Plus, if eligible, on the first of the month in which the member is released.

Example 1	Dolores is incarcerated and enrolled in suspended BadgerCare Plus. 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 BadgerCare Plus. Her current certification period started January 1. She was released on April 3, but she doesn't inform the IM agency that she has been released. She continues to be enrolled in suspended BadgerCare Plus. On July 5, she reports to the IM agency that she was released from jail on April 3. The suspension is lifted 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 BadgerCare Plus. 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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45.5 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 SECTION 26.1 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 BadgerCare Plus eligibility will be terminated.

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45.6 Change Reporting

Existing change reporting policy applies for members in a suspension (see CHAPTER 27 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 45.4 SUSPENSION END DATE).

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45.7 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 BadgerCare Plus during the suspension. The other household members will also be countable members within the incarcerated member's suspended assistance group. There is no limit to how long inmates can be considered temporarily absent from the BadgerCare Plus 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 1	Quinton and Meg are married, and both are enrolled in BadgerCare Plus. 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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45.8 Special Policy Considerations

45.8.1 Children

45.8.1.1 Children Who Are Inmates

Children who are eligible for suspended BadgerCare Plus are not required to pay premiums.

45.8.1.2 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 BadgerCare Plus will remain eligible for 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 BadgerCare Plus as a household of two as of January 1, 2024. On March 9, 2024, Faye is incarcerated. Faye's suspended BadgerCare Plus starts April 1, 2024. 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.

45.8.2 Pregnant Members

Pregnant people who are incarcerated will have their eligibility determined under the BadgerCare Plus Prenatal Program (see SECTION 41.1 BADGERCARE PLUS PRENATAL PROGRAM). An incarcerated person in a suspension who later reports a pregnancy must have their eligibility redetermined under the BadgerCare Plus Prenatal Program and be enrolled if eligible.

When the pregnancy ends, BadgerCare Plus Prenatal Program members must have their health care eligibility redetermined for the next month. If determined eligible for BadgerCare Plus while still incarcerated, the member will open for suspended BadgerCare Plus.

45.8.3 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 or remain eligible for full-benefit BadgerCare Plus if both the following are true:

1. They intend to return to the home.
2. 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 BadgerCare Plus. Instead, they may be eligible for suspended BadgerCare Plus.

Example 2	Shannon is incarcerated in jail. During her incarceration, her eight-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 three-year-old and five-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 leaves jail during the day to attend school and return to his family's home to care for the children. 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.

45.8.4 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 BadgerCare Plus 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 He is not eligible for BadgerCare Plus in Wisconsin since he is not a Wisconsin resident.

45.8.5 Services for Youth

Youth who are incarcerated and enrolled in suspended BadgerCare Plus 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 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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45.9 State Correctional Institutions

The following is the list of correctional institutions administered by the Wisconsin Department of Corrections.

County	Institution Name
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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48.1 BadgerCare Plus Children's Premium Tables

48.1.1 Premiums for Children

Non-exempt children with an assistance group income above 201% of the Federal Poverty Level (FPL) will be charged premiums. Each child's premium will be based on their own assistance group's (AG) size and income. The 5% cap for the cost of total household premiums for children will continue to apply. The cap will be 5% of the income of the premium assistance group with the highest countable income amount. The total household's premiums will be determined based on the combined amount of all children's premiums or the 5% cap, whichever amount is less. See SECTION 19.2 PREMIUM CALCULATIONS and SECTION 19.3 PREMIUM LIMITS for more information on premium caps.

The below table outlines the premium amounts for children.

FPL Income Range	**Above 201% to 210.99 %**	**211% to 220.99 %**	**221% to 230.99 %**	**231% to 240.99 %**	**241% to 250.99 %**	**251% to 260.99 %**	**261% to 270.99 %**	**271% to 280.99 %**	**281% to 290.99 %**	**291% to 300.99 %**	**301% to 306.00 %**
Premium Amounts	$10	$10	$10	$15	$23	$34	$44	$55	$68	$82	$97.53

Note *Children in extensions are not charged premiums (see SECTION 19.1 BADGERCARE PLUS PREMIUMS).*

A child cannot be charged a new or increased premium during their 12-month continuous coverage period, but their premium may be reduced, if applicable. If the premium is lowered, that new amount becomes their premium cap for the rest of the 12-month period. If the AG's size and income changes during the 12-month period, the child's premium amount may not align with the FPL percentage of the AG's income, as shown in the table above.

48.1.2 Reserved

48.1.3 Five Percent Premium Caps for Children

The table below displays the 5% caps of BadgerCare Plus premiums for children in certain households with incomes above 201% and at or below 306% of the FPL. Families are charged the combined premiums for the children but no more than 5% of the family's countable income.

Example 1	A family with 11 children and an income of 302% of the FPL would ordinarily owe premiums amounting to 11 times $97.53, which equals $1,072.83. However, if the children's assistance group size, including the parent, is 12, the 5% cap found in the table below is $983. That is the maximum premium amount that the family should be charged for that month.

Group Size	201 - 211%	211% - 221%	221 - 231%	231 - 241%	241 - 251%	251 - 261%	261 - 271%	271 - 281%	281 - 291%	291 - 301%	301% - 306%
1	$133.00	$140.00	$146.00	$153.00	$160.00	$166.00	$173.00	$180.00	$186.00	$193.00	$200.00
2	$181.00	$190.00	$199.00	$208.00	$217.00	$226.00	$235.00	$244.00	$253.00	$262.00	$271.00
3	$228.00	$240.00	$251.00	$262.00	$274.00	$285.00	$297.00	$308.00	$319.00	$331.00	$342.00
4	$276.00	$290.00	$303.00	$317.00	$331.00	$345.00	$358.00	$372.00	$386.00	$400.00	$413.00
5	$323.00	$340.00	$356.00	$372.00	$388.00	$404.00	$420.00	$436.00	$452.00	$468.00	$485.00
6	$371.00	$389.00	$408.00	$426.00	$445.00	$463.00	$482.00	$500.00	$519.00	$537.00	$556.00
7	$419.00	$439.00	$460.00	$481.00	$502.00	$523.00	$544.00	$565.00	$585.00	$606.00	$627.00
8	$466.00	$489.00	$513.00	$536.00	$559.00	$582.00	$605.00	$629.00	$652.00	$675.00	$698.00
9	$514.00	$539.00	$565.00	$590.00	$616.00	$642.00	$667.00	$693.00	$718.00	$744.00	$770.00
10	$561.00	$589.00	$617.00	$645.00	$673.00	$701.00	$729.00	$757.00	$785.00	$813.00	$841.00
11	$609.00	$639.00	$669.00	$700.00	$730.00	$760.00	$791.00	$821.00	$851.00	$882.00	$912.00
12	$656.00	$689.00	$722.00	$754.00	$787.00	$820.00	$853.00	$885.00	$918.00	$951.00	$983.00
13	$704.00	$739.00	$774.00	$809.00	$844.00	$879.00	$914.00	$949.00	$984.00	$1019.00	$1,055.00
14	$752.00	$789.00	$826.00	$864.00	$901.00	$939.00	$976.00	$1013.00	$1,051.00	$1,088.00	$1,126.00

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49.1 Health Care Choice

Federal law requires that once a person has been determined eligible for Elderly, Blind, or Disabled (EBD) Medicaid, they must be enrolled in EBD Medicaid, even if they are also eligible for BadgerCare Plus, unless they have a change in circumstances that results in ineligibility for EBD Medicaid. The only exception to this policy is pregnant people who are eligible for both EBD Medicaid and BadgerCare Plus. In these instances, the pregnant person will be enrolled in BadgerCare Plus.

If a person is pending for EBD Medicaid or if a person has an unmet deductible for EBD Medicaid, they are 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 the Disability

Determination Bureau (DDB) or not eligible for Medicare. If a person enrolled in EBD Medicaid becomes ineligible for EBD Medicaid for any reason, including going over the asset limit or failure to pay a Medicaid Purchase Plan (MAPP) premium, they can enroll in BadgerCare Plus if they are still eligible to do so.

People who are eligible for both Wisconsin Well Woman Medicaid and BadgerCare Plus should be enrolled in Wisconsin Well Woman Medicaid.

See the Medicaid Eligibility Handbook, Chapters 24 - 38 for more information about the Medicaid subprograms.

EBD Eligibility	BadgerCare Plus Eligibility	System Choice
MS/NS/MAPP no premium	No premium	EBD
MS/NS/MAPP no premium	Premium	EBD
MS/NS/MAPP no premium	BadgerCare Plus Deductible	EBD
MAPP premium	No premium	BadgerCare Plus
NS Deductible	No premium	BadgerCare Plus
MAPP premium	Premium	The program with the lesser premium
NS Deductible	Premium	Member Choice
MAPP premium	Deductible	Member Choice
NS Deductible	Deductible	Member Choice

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50.1 Federal Poverty Level Table

Group Size	Annual FPL	100% FPL	133% FPL	150% FPL	156% FPL	191% FPL	201% FPL	300% FPL	30
1	$15,960	$1,330.00	$1,768.90	$1,995.00	$2,074.80	$2,540.30	$2,673.30	$3,990.00	$4
2	$21,640	$1,803.33	$2,398.43	$2,705.00	$2,813.19	$3,444.36	$3,624.69	$5,409.99	$5
3	$27,320	$2,276.67	$3,027.97	$3,415.01	$3,551.61	$4,348.44	$4,576.11	$6,830.01	$6

4	$33,000	$2,750.00	$3,657.50	$4,125.00	$4,290.00	$5,252.50	$5,527.50	$8,250.00	$8
5	$38,680	$3,223.33	$4,287.03	$4,835.00	$5,028.39	$6,156.56	$6,478.89	$9,669.99	$9
6	$44,360	$3,696.67	$4,916.57	$5,545.01	$5,766.81	$7,060.64	$7,430.31	$11,090.01	$1
7	$50,040	$4,170.00	$5,546.10	$6,255.00	$6,505.20	$7,964.70	$8,381.70	$12,510.00	$1
8	$55,720	$4,643.33	$6,175.63	$6,965.00	$7,243.59	$8,868.76	$9,333.09	$13,929.99	$1
9	$61,400	$5,116.67	$6,805.17	$7,675.01	$7,982.01	$9,772.84	$10,284.51	$15,350.01	$1
10	$67,080	$5,590.00	$7,434.70	$8,385.00	$8,720.40	$10,676.90	$11,235.90	$16,770.00	$1
11	$72,760	$6,063.33	$8,064.23	$9,095.00	$9,458.79	$11,580.96	$12,187.29	$18,189.99	$1
12	$78,440	$6,536.67	$8,693.77	$9,805.01	$10,197.21	$12,485.04	$13,138.71	$19,610.01	$2
13	$84,120	$7,010.00	$9,323.30	$10,515.00	$10,935.60	$13,389.10	$14,090.10	$21,030.00	$2
14	$89,800	$7,483.33	$9,952.83	$11,225.00	$11,673.99	$14,293.16	$15,041.49	$22,449.99	$2
15	$95,480	$7,956.67	$10,582.37	$11,935.01	$12,412.41	$15,197.24	$15,992.91	$23,870.01	$2
16	$101,160	$8,430.00	$11,211.90	$12,645.00	$13,150.80	$16,101.30	$16,944.30	$25,290.00	$2
17	$106,840	$8,903.33	$11,841.43	$13,355.00	$13,889.19	$17,005.36	$17,895.69	$26,709.99	$2
18	$112,520	$9,376.67	$12,470.97	$14,065.01	$14,627.61	$17,909.44	$18,847.11	$28,130.01	$2
19	$118,200	$9,850.00	$13,100.50	$14,775.00	$15,366.00	$18,813.50	$19,798.50	$29,550.00	$3
20	$123,880	$10,323.33	$13,730.03	$15,485.00	$16,104.39	$19,717.56	$20,749.89	$30,969.99	$3
21	$129,560	$10,796.67	$14,359.57	$16,195.01	$16,842.81	$20,621.64	$21,701.31	$32,390.01	$3
22	$135,240	$11,270.00	$14,989.10	$16,905.00	$17,581.20	$21,525.70	$22,652.70	$33,810.00	$3
23	$140,920	$11,743.33	$15,618.63	$17,615.00	$18,319.59	$22,429.76	$23,604.09	$35,229.99	$3
24	$146,600	$12,216.67	$16,248.17	$18,325.01	$19,058.01	$23,333.84	$24,555.51	$36,650.01	$3

each additional person	$5,680	$473.33	$629.53	$710.00	$738.39	$904.06	$951.39	$1,419.99	$1
		BadgerCare Plus Extensions trigger limit, BadgerCare Plus adults limit		BadgerCare Plus child deductible limit	BadgerCare Plus limit for children 6-18 years old subject to health insurance coverage, backdating, and presumptive eligibility	BadgerCare Plus limit for children 1-5 years old subject to health insurance coverage, backdating, and presumptive eligibility	BadgerCare Plus children premium limit	BadgerCare Plus pregnant member deductible limit	Ba Plu pre me chi an Pla On Se lim

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51.1 BadgerCare Plus Categories

For a list of medical status codes, see Process Help, Chapter 24.21 ForwardHealth iChange.

The following table identifies the copays or premiums for which BadgerCare Plus members may be responsible. The table also provides information on the federal program under which members are eligible, if applicable.

Description	Income (FPL)	Subject to Copays	Premium	Funding
Pregnant woman	0 - 306%	No	No	T19
Pregnant woman **deductible** **(see** **SECTION 17.2.3 CALCULATING THE DEDUCTIBLE AMOUNT** **)**	>306%	No	No	T19
Pregnant minor under age 19	0 - 306%	No	No	T19

Pregnant non-qualifying immigrant	0 - 306%	No	No	T21 Separate CHIP
Pregnant inmate	0 - 306%	No	No	State-Funded
CEN	0 - 156%	No	No	T19
CEN—Mom on T19 on DOB	>156%	No	No	T19
Child under age 19	0 - 100%	No	No	T19
Child under age 6	>100 - 156%	No	No	T19
Child < age 1	>156 - 306%	No	No	T19
Child age 1 through 5	>156 - 191%	No	No	T19
Child age 1 through 5	>191 - 201%	No	No	T21 Separate CHIP
Child age 1 through 5 who is a tribal member	>191% - 201%	No	No	T21 Separate CHIP
Child age 6 through 18	>100 - 133%	No	No	T19
Child age 6 through 18	>133 - 156%	No	No	T19
Child age 6 through 18	>156 - 201%	No	No	T21 Separate CHIP
Child age 6 through 18 who is a tribal member	>156% - 201%	No	No	T21 Separate CHIP
Child age 1 through 18	>201 - 306%	No	Yes	T21 Separate CHIP
Child age 1 through 18 who is a tribal member	>201 - 306%	No	No	T21 Separate CHIP

Child, under age 19 deductible (see SECTION 17.3.2 CALCULATING THE DEDUCTIBLE AMOUNT)	>150%	No	No	T19
Adult Parent/Caretaker	0%	No	No	T19
Adult Parent/Caretaker	>0 - 100%	Yes	No	T19
Youth exiting out-of-home care up to age 21	N/A	No	No	T19
Former Foster Care Youth up to age 26	N/A	No	No	T19
Childless Adult	0%	No	No	T19
Childless Adult	>0 - 100%	Yes (if >50% FPL)	No	T19
Childless Adult	0 - 50%	No	No	T19
Childless Adult	>50 - 100%	Yes	No	T19
Transitional Childless Adult	0 - 50%	No	No	T19
Transitional Childless Adult	>50 - 100%	Yes	No	T19
Transitional Childless Adult	0%	No	No	T19
Transitional Childless Adult	>0 - 100%	Yes (if >50% FPL)	No	T19
12-Month BadgerCare Plus Extension Benefit Adult	>100 - 133%	Yes	No	T19
12-Month BadgerCare Plus Extension Benefit Adult	>133%	Yes	No	T19
12-Month BadgerCare Plus Extension Benefit Disabled Adult	>100%	Yes	No	T19
4-Month BadgerCare Plus Extension Benefit, Adult	>100 - 133%	Yes	No	T19

4-Month BadgerCare Plus Extension Benefit, Adult	>133%	Yes	No	T19
4-Month BadgerCare Plus Extension Benefit, Disabled Adult	>100%	Yes	No	T19
12-Month BadgerCare Plus Extension Benefit, Child Under 19	>100%	No	No	T19
4-Month BadgerCare Plus Extension Benefit, Child Under 19	>100%	No	No	T19
Presumptive eligibility for a child under 1	0 - 306%	No	No	T19
Presumptive eligibility for a child age 1 through 5	0 - 191%	No	No	T19
Presumptive eligibility for a child age 6 through 18	0 - 156%	No	No	T19
Presumptive eligibility for a pregnant woman	0 - 306%	No	No	T19
Presumptive eligibility for parent/caretaker	0 - 100%	No	No	T19
Presumptive eligibility for childless adult	0 - 100%	No	No	T19
Emergency Services for Non-Qualifying Immigrants**	<306%	N/A	No	T19
Family Planning Only Services	<306%	N/A	No	T19

**See SECTION 39.1 EMERGENCY SERVICES INCOME LIMITS.

All of the categories listed in the table have BadgerCare Plus Standard Plan coverage, except the following:

- People enrolled in Emergency Services for Non-Qualifying Immigrants only have emergency services coverage.
- People enrolled in Family Planning Only Services only have family planning services coverage.

52.1 Reserved

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53.1 Copay Tables

53.1.1 Five Percent Copay Limit Tiers

2026 Per-Member Copay Limits											
Status	**Assistance Group Income Tier as Percentage of the Federal Poverty Level**										
	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

53.1.2 Fifty Percent Federal Poverty Level Limits

If the assistance group income is less than the applicable amount listed below, no copays are charged.

Assistance Group Size	Monthly Income
1	$665
2	$901
3	$1,138
4	$1,375
5	$1,611
6	$1,848

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Glossary

ABLE

Achieving a Better Life Experience

adverse action

The last day of the month a change can be made in CARES to affect eligibility for the following month. Adverse Action is usually 13 days prior to the last day of the month to allow for a timely notice to be generated.

AFDC

Aid to Families with Dependent Children

AG

assistance group

applicant

A request for BadgerCare Plus coverage. The request must be on the Department's or Federally-facilitated Marketplace's application, registration form or account transfer (from Federally-facilitated Marketplace) and must contain name, address, and a valid signature. The applicant must submit a signed and completed application form to complete the application process.

application

A request for BadgerCare Plus coverage. The request must be on the Department's application or registration form and must contain name, address, and a valid signature. The applicant must submit a signed and completed application form to complete the application process.

APTC

Advanced Premium Tax Credits

Arrearages

Payments of child support which were due for a prior period.

authorized representative

A person or organization authorized to act on a member's behalf. An authorized representative may be appointed by the member and may exercise all the rights and responsibilities of the member.

Available Income

Income that is actually available or can be made available to the BC+ group for support and maintenance.

BC+ Assistance Group

The primary person and any individuals living in their household whose income and/or needs are considered when determining financial eligibility. Inclusion in the Test Group is determined by qualifying relationships and legal responsibility.

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.

caretaker relative

A caretaker who has a qualifying relationship to but no legal responsibility for the child under 19 under their care.

CEN

Continuously eligible newborn

Centers for Medicare and Medicaid Services (CMS)

Administers the Medicare program and works in partnership with the States to administer Medicaid and other programs. Formerly known as HCFA.

Certification Period

The period of time for which a member is eligible before the next renewal is due.

Child Welfare Parent/Caretaker

A parent or caretaker whose child has been temporarily removed from the home and is in the care of the child welfare system. To be eligible for enrollment in BC+ the Child Welfare Parent must be cooperating with a reunification plan.

CHIP

Children's Health Insurance Program

CLTS

Children's Long-Term Support

COBRA Coverage

A provision of the Consolidated Omnibus Budget Reconciliation Act (COBRA) which requires employers to allow former employees to continue coverage through the employer's group plan for 18 months after the employment has ended (29 months if the employee is disabled). In most cases, the former employee must pay the full cost of COBRA coverage.

COFA

Citizens of the Compact of Free Association

COLA

Cost of Living Adjustment. An increase in income to compensate for inflation

Conservator

A person, official, or institution designated to protect the interests of an incompetent person. A conservator has some, but not all, of the duties and powers of a legal guardian.

Copy of authorized representative

A person or organization authorized to act on a member's behalf. An authorized representative may be appointed by the member and may exercise all the rights and responsibilities of the member.

Cost-Share

An enrollee's financial responsibility for health care program coverage, such as a co-payment or premium.

CSA

Child Support Agency

Custodial Parent

A parent who has physical custody of their minor child.

CWW

CARES Worker Web. The web-based pages used in the CARES operations.

DACA

Deferred Action for Childhood Arrivals

DDB

Disability Determination Bureau

deductible

The amount of health care expenses an insured person is required to incur before benefits are payable under a health insurance plan.

Dependent Child

A child under age 18 residing in the home of a parent or caretaker relative or a child age 18 residing in the home of a parent or caretaker relative, if the child is currently enrolled in high school and expects to graduate prior to turning 19.

Depreciation

A federal income tax deduction for the cost of a business asset that gradually loses value through the wear and tear of use.

DHS

Department of Health Services

DOC

Department of Corrections

EBD

Elderly, Blind, or Disabled

ECF

Electronic Case File

EITC

Earned Income Tax Credit

Eligibility Begin Date

The date a member is eligible for coverage under the Forward Health Care Programs.

EM CAPO

Enrollment Management Central Application Processing Operation

EPP

Error Prone Profile

ERP

Estate Recovery Program

EVHI

Employer Verification of Health Insurance

eWiSACWIS

Wisconsin Statewide Automated Child Welfare Information System

FDSH

Federal Data Services Hub

FEV

front-end verification

FFCY

Former Foster Care Youth, formerly known as Youths Exiting Out of Home Care (YEOHC). Young adults between the ages of 18 and 21 (through 12/31/13) or 18 and 26 (effective 1/1/14) who were placed in Foster Care, court-ordered Kinship Care, or subsidized guardianship in Milwaukee County at the time they turned 18.

FFM

Federally-Facilitated Marketplace (also known as the Marketplace or the Exchange). Applications for BadgerCare Plus or Medicaid may be filed with the Federally-Facilitated Marketplace, run by the U.S. Department of Health and Human Services. The Marketplace will assess their applicants as potentially eligible for the State's Medicaid or CHIP programs, and, if found potentially eligible, will transfer individual accounts to the income maintenance agency for a full determination. Individuals who apply at income maintenance agencies or ACCESS and are found ineligible for Medicaid or CHIP will be sent to the Marketplace.

Filing Date

The filing date for health care is the day a valid application or registration form is submitted to the Income Maintenance agency. The filing date sets the begin date of benefits. For paper applications, the filing date for health care is the date a signed valid application is delivered to the agency or the next business day if it is delivered after the agency's regularly scheduled business hours. For phone applications, the filing date is not set until a valid signature is received by the agency. For online applications, the filing date for health care is the date the application was submitted electronically, regardless of whether or not it was submitted during regular business hours. For applications from the Federally Facilitated Marketplace, the filing date is the application date listed on the application. For ACCESS applications and Marketplace applications, agencies' 30-day processing timelines are set by the date the application is actually received by the agency. Applications received after 4:30 p.m., on a weekend, or on a holiday start the agency's 30-day processing timeline the next business day.

fiscal agent

A private contractor to the State, selected through a competitive procurement process, who operates the State's approved MMIS (Medicaid Management Information System). The Fiscal Agent agreement includes claims processing and other services like data warehousing and manage care enrollment services.

FPL

Federal Poverty Level

FPOS

Family Planning Only Services - This plan provides certain services and supplies to people who are of childbearing or reproductive age to prevent unplanned pregnancies.

good cause

The circumstances beyond a person's control which keep the person from following program requirements or specific eligibility conditions, such as premium payment or cooperation with medical support.

HCBW

Home and Community-Based Waiver

HIPAA

HIPAA is the Health Insurance Portability and Accountability Act. A HIPAA Standard Plan is any group health care plan that provides medical care to covered individuals and/or their dependents directly or through insurance, reimbursement, or by some other means. Medical care means amounts paid for diagnosis, cure, mitigation (moderation), treatment or prevention of disease; or amounts paid for the purpose of affecting any structure or function of the body. A policy that pays for a doctor's services in either an in-patient or outpatient setting qualifies as a HIPAA plan. The amount or type of benefits paid; co-insurance, deductibles, caps, etc., do not matter as long as the plan meets the HIPAA Standard Plan criteria. The health care plan cannot be limited to a single type of covered service or only accessible in a very defined circumstance. Plans limited to accident, disability, vision, long term care or dental are not examples of HIPAA plans.

HIPP

Health Insurance Premium Payment. HIPP pays the employee's portion of the employer subsidized health care coverage when the Fiscal Agent determines it is more cost effective to buy the employer's insurance than enroll them in BC+ or MAPP.

IHS

Indian Health Services

IM

income maintenance

IMD

Institute for Mental Disease

Immigration Status

The legal status conferred on a non-citizen by immigration law

INA

Immigration and Nationality Act

INS

Immigration and Naturalization Service

IPV

Intentional Program Violation

IRA

Individual Retirement Account

IRIS

Include, Respect, I Self-Direct

IRS

Internal Revenue Service

KIDS

Kids Information & Data System

life estate

A life estate is created when a property holder transfers ownership of the property to someone else and retains the right to live on the property and the income from it.

LLC

limited liability company

local agency

The local human services or tribal office responsible for determining eligibility for Forward Health Care Programs.

LTC

long-term care

MAGI

Modified Adjusted Gross Income. MAGI rules are used to determine BadgerCare Plus eligibility for new applicants beginning in 2014 and for existing members as of March 31, 2014, or their next regularly scheduled renewal, whichever is later. MAGI rules are based on tax relationships and family relationships, and they consider taxable income and whether children and tax dependents are required to file.

MAPP

Medicaid Purchase Plan

MCO

managed care organization

NLRR

Non-legally Responsible Relative (NLRR) Caretaker is a caretaker who has no legal responsibility for the child under their care. NLRR caretakers and their spouses can be eligible for BC+ as caretakers.

NOL

net operating loss

non-MAGI

Apply to households whose eligibility is determined using BadgerCare Plus relationship rules (prior to March 31, 2014) to budget income for a household prior to transitioning to MAGI BadgerCare Plus budgeting rules.

non-qualifying immigrants

Non-qualifying immigrants are individuals that are not eligible for BC+ due to immigration status.

PACE

Program of All-Inclusive Care for the Elderly

Page One

The form that includes the applicant’s name, address, and telephone number. This form is used to set the filing date prior to submitting a completed application.

PE

presumptive eligibility

Per Member Per Month Cost of Care

The Capitation Amount paid by the State to the HMO for an individual’s BC+ coverage.

PPRF

Pre-Printed Renewal Form

QDWI

Qualified Disabled and Working Individual

QMB

Qualified Medicare Beneficiary

Qualifying Event

A qualifying event allows an employee to enroll in the employer's health insurance plan outside the designated open enrollment period. Qualifying events include obtaining a new dependent through marriage, birth, adoption or placement for adoption and loss of other insurance coverage the employee was covered under at the time of the last open enrollment period. The employee has 30 days from the qualifying event to enroll in the insurance. This applies to permanent employees who have a normal work week of 30 or more hours.

RRP

Restrictive Re-enrollment Period. The period of time an individual is not eligible to enroll in BadgerCare Plus due to non-payment of a premium.

RRV

Renewal and Redetermination Verification

SAVE

Systematic Alien Verification for Entitlement. A process which allows access to USCIS data to validate the immigration status of immigrants who are applying, or for enrollees who report a change in immigration status, for BC+. Workers access the USCIS data through the Alien Status Verification System (ASVS).

SCHIP

State Children's Health Insurance Program

SLMB

Specified Low-Income Medicare Beneficiary

SLMB+

Specified Low-Income Medicare Beneficiary Plus

SMRF

Six-Month Report form

SOLQ-I

State Online Query Internet

spouse

A person recognized under federal law as another person's legal partner through marriage. This includes a marriage (including common law marriage) that was valid in the state where it was entered into. For marriages entered into outside the United States, this includes a marriage that was valid in the place where it was entered into and could have been entered into in the United States.

SSA

Social Security Administration

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.

SSN

Social Security number

SSP

State Supplementary Payment

SWICA

State Wage Information Collection Agency

Tax Dependent

Any individual who is expected to be claimed as a tax dependent on a tax filer’s federal income tax return.

TPL

Third Party Liability. The obligation of a person or organization other than Medicaid or BadgerCare Plus to pay for a person's medical expenses. Examples of TPL include group or private health insurance, auto insurance, worker's compensation, and personal liability insurance.

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 the Bureau of Citizenship and Immigration Services (BCIS) and Immigration and Naturalization Service (INS).

USDA

U.S. Department of Agriculture

VA

U.S. Department of Veterans Affairs

VISTA

Volunteers in Service to America

VPA

Voluntary Paternity Acknowledgement

W-2

Wisconsin Works

WIC

Special Supplemental Nutrition Program for Women, Infants, and Children

WISE

Wisconsin Senior Employment Program

WWW

Wisconsin Well Woman Program

YEOCH

Youths In or Exiting Out of Home Care. Young adults between the ages of 18 and 21 who were placed in Foster Care, court ordered Kinship Care or Subsidized Guardianship in Milwaukee County at the time they turned 18.